DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year 2026

Indian Health Service

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

I present the Indian Health Service (IHS) Fiscal Year (FY) 2026 Congressional Justification. The FY 2026 budget request supports the President's goal of providing safe, efficient, effective, and high quality health care services. The FY 2026 budget supports Executive Order 14212: Establishing the President's Make America Healthy Again Commission by aggressively combating the critical health challenges facing American Indian/Alaska Native communities. This includes services for mental health, obesity, diabetes, and other chronic diseases.

This FY 2026 budget submission continues support for our critical work in providing a comprehensive health service delivery system managed by the IHS, Tribes, Tribal Organizations, and Urban Indian Organizations in 37 states. Our efforts align with the Administration's priorities and support the Department of Health and Human Services' goals to help people live healthy, safe, and productive lives. This budget submission also reflects our continued partnership and consultation with Tribes and conferral with Urban Indian Organizations to address the health care needs of American Indians and Alaska Natives nationwide.

Our FY 2026 budget submission maintains focus on the IHS mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level and supports four main goals that are outlined in our strategic plan:

Strategic Goal 1: Be a leading health care organization;

Strategic Goal 2: Ensure comprehensive, culturally respectful health care services;

Strategic Goal 3: Optimize operations through effective stewardship; and

Strategic Goal 4: Promote proactive intergovernmental and external relationships.

The Indian health care system faces many challenges related to access, quality, management, and operations. As a rural health care provider, the IHS has difficulty recruiting and retaining health care professionals. Likewise, outdated infrastructure poses challenges in safely providing patient care, recruiting and retaining staff, and meeting accreditation standards. This budget, which is aligned with our strategic plan, aims to address these challenges and maintains the progress that we have already made. This budget also supports our critical work in providing a comprehensive health care service delivery system managed by the IHS, Tribes, Tribal Organizations, and Urban Indian Organizations. I am excited about what we will achieve together to improve the health and well-being of American Indians and Alaska Natives.

Phillip B. Smith -S

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Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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INTRODUCTION AND MISSION
Indian Health Service

The Indian Health Service (IHS), an Agency of the U.S. Department of Health and Human Services, is the principal Federal Agency charged with the mission of raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The IHS provides comprehensive primary health care and disease prevention services to approximately 2.8 million American Indians and Alaska Natives through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations. Facilities are predominantly located in rural primary care settings and are managed by IHS, Tribal, and urban Indian health programs.

United States Government and Indian Nations

The provision of federal health services to American Indians and Alaska Natives is based on a special relationship between Indian Tribes and the United States. The Indian Commerce Clause of the United States Constitution, as well as numerous treaties and court decisions, have affirmed this special relationship and the plenary power of Congress to create statutes that benefit Indian people. Principal among these statutes is the Snyder Act of 1921, which provides the basic authority for health services provided by the Federal Government to American Indians and Alaska Natives.

Indian Health Service and Its Partnership with Tribes

In the 1970s, federal Indian policy was re-evaluated leading to adoption of a policy of Indian self-determination. This policy promotes Tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen any federal obligation but provides an opportunity for Tribes to assume the responsibility of providing health care for their members. IHS partners with Tribes on health care delivery in the context of regular Tribal consultation.

The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, and the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, provided new opportunities for the IHS and Tribes to deliver quality and accessible health care.

The IHCIA includes specific authorizations such as improvements for urban Indian health programs, Indian health professions programs, and the authority to collect from Medicare and Medicaid and other third-party insurers for services rendered at IHS or Tribal facilities. Under the ISDEAA, many Tribes have assumed the administrative and programmatic roles previously carried out by the Federal Government. Tribes currently administer over half of IHS resources through ISDEAA contracts and compacts. The IHS directly administers the remaining resources and manages programs where Tribes have chosen not to contract or compact health programs.

Overview of Budget

The fiscal year (FY) 2026 Indian Health Service (IHS) budget encompasses the overall strategic goals of: 1) Be a leading health care organization; 2) Ensure comprehensive, culturally respectful health care services; and 3) Optimize operations through effective stewardship; and 4) Promote proactive intergovernmental and external relationships. The budget reflects the importance of providing health care, consistent with statutory authorities, to American Indians/Alaska Natives (AI/ANs).

As the 18th largest health care system in the United States, the IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to approximately 2.8 million AI/ANs who are members of 574 federally recognized tribes in 37 states. Comprehensive primary health care and disease prevention services are provided through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations. These facilities are predominately primary care settings and are managed by IHS, tribal, and urban (I/T/U) Indian health programs.

The IHS meets the annual statutory requirement[1] to consult with and solicit the participation of Tribes and tribal organizations in the development of the budget for IHS. Likewise, IHS confers with urban Indian organizations. The consultation and confer input informs the IHS budget formulation process. The core of the agency's formulation process consists of the priorities and recommendations developed in consultation with Tribes through this independent annual budget process led by the National Tribal Budget Formulation Workgroup[2]. This process ensures that the IHS budget reflects the current health needs and priorities of AI/ANs. In addition, the tribal priorities identified in the consultation process inform senior officials of other U.S. Department of Health and Human Services (HHS) agencies of the health needs of the AI/AN population, so that they have the opportunity to reflect those priorities in the Department's budget requests.

Summary of Budget Submission

The Administration prioritizes the IHS in the FY 2026 President's Budget by maintaining funding for direct health care services and providing key increases to uphold the federal government's responsibility consistent with its statutory authorities and Government-to-Government relationship with each Indian tribe. These investments reflect a strategic approach to delivering consistent, accountable health services across IHS's nationwide network, including tribally operated and urban Indian programs. With much of IHS's infrastructure based in rural areas across Indian Country, the budget supports the operational capacity needed to ensure quality health care services are provided.

In alignment with the Administration's Make America Healthy Again[3] (MAHA) initiative, IHS programs advance the broader goals of improving national health outcomes by focusing on efficiency, prevention, and long-term cost reduction. For example, the Special Diabetes Program for Indians (SDPI) has demonstrated measurable success in reducing diabetes-related complications through locally led education and disease management efforts (please refer to the SDPI narrative). Continued investment in

[1] https://www.ihs.gov/ihm/pc/part-6/chapter-6-ihs-tribal-consultation-policy/#6-6.1

[2] National Tribal Budget Formulation Workgroup Consultation: https://www.ihs.gov/budgetformulation/tribalbudgetconsultation/

[3] Make America Health Again: https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/

SDPI strengthens community wellness and supports the administration's emphasis on reducing chronic disease through targeted, results-oriented programming.

In addition to chronic disease prevention, the IHS expands access to care in hard-to-reach areas, bolstering behavioral health services, and promoting healthier lifestyles, all of which support the goals outlined in MAHA. This includes addressing substance use disorders through medication-assisted treatment (MAT), offering physical activity and nutrition programs, and emphasizing personal responsibility in health outcomes.

The IHS is also undertaking an effort to modernize the Electronic Health Record system (EHR), which the Government Accountability Office (GAO) identified as one of the 10 most critical legacy systems in need of modernization[4]. The IHS "Patients at the Heart" – PATH EHR modernization is central to providing high quality health care and demonstrates IHS's dedication to its mission to improve the physical, mental, social, and spiritual health of AI/ANs.

Such practical, community-driven solutions reduce strain on the broader health system and reinforce the Administration's goal of strengthening America's overall public health infrastructure.

The FY 2026 Budget reflects the Administration's commitment and support for tribal self-governance by continuing to invest in systems that enable tribes to manage their own health programs. Specifically, the Budget aligns with the Supreme Court's decision in *Becerra v. San Carlos Apache Tribe* and *Becerra v. Northern Arapaho Tribe* by maintaining an indefinite discretionary appropriation for Contract Support Costs (CSC). This approach promotes government efficiency, reduces federal overhead, and allows solutions to be tailored at the local level consistent with the Administration's principles of accountability, flexibility, and responsiveness. Together, these strategic investments in the IHS demonstrate the success of targeted funding in federal programs to achieve the broader vision of a healthier, stronger America.

FY 2026 President's Budget

In FY 2026, the budget includes $8.1 billion in total funding for the IHS, which includes $7.9 billion in discretionary funding, and $159.0 million in proposed mandatory funding for the Special Diabetes Program for Indians. This is an increase of $921.0 million above the FY 2025 Enacted level.

Crosscutting changes from the FY 2025 Enacted level include:

- Staffing and Operating Costs for Newly Constructed Health Care Facilities: +$87.1 million for staffing of newly constructed healthcare facilities. These funds support the staffing packages for five new or expanded Joint Venture facilities, which will expand the availability of direct health care services in areas where existing health care capacity is overextended.

Indian Health Services account changes from the FY 2025 Enacted level include:

- New Tribes (+$6.0 million): These initial funds will start the support of the delivery of healthcare services for the Lumbee Tribe. Full funding will be determined via the IHS' standard methodology for calculating funding estimates for New Tribes. Funding for the United

[4] https://www.gao.gov/assets/gao-19-471.pdf

Keetoowah Band of Cherokee Indians of Oklahoma for the delivery of healthcare services will be provided through base funding levels.

Indian Health Facilities account changes from the FY 2025 Enacted level include:

- Sanitation Facilities Construction: -$93.1 million for a total of $13.5 million for Sanitation Facilities Construction. Funding will be used to support the construction of sanitation facilities for new and like new AI/AN housing. These funds are necessary to support the implementation of the $3.5 billion provided for sanitation facilities construction from the Infrastructure Investment and Jobs Act through FY 2026.

Contract Support Costs and Section 105*(l)* Lease Agreements: The budget includes an indefinite discretionary appropriation for Contract Support Costs and Section 105*(l)* lease agreements with estimated funding levels of $1.7 billion for Contract Support Costs and $413.0 million for Section 105*(l)* Lease Agreements.

SDPI: The budget includes $159.0 million in mandatory funding for SDPI, which is nearly flat with the FY 2025 Enacted level and reflects a minimal reduction of -$363,000.

Overview of Agency Performance

The IHS provides health care services to American Indians and Alaska Natives (AI/ANs) with the mission to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. Health care services are delivered through a network of hospitals, clinics, and health stations on or near reservations and are managed by IHS, tribal, and urban (I/T/U) Indian health programs.

In FY 2023, IHS and Tribal facilities provided 36,959 inpatient admissions and 13,949,733 outpatient medical care visits (latest available)[1]. The health care system also provides dental services, nutrition services, pharmacy services, community health, sanitation facilities (water supply and waste disposal), injury prevention, and facilities management services. Additionally, for eligible patients, the purchased/referred care (PRC) program may purchase needed services through private health care providers in cases where an IHS or tribal facility does not exist or does not provide the required care.

Tribes that choose to administer their own health programs administer over 62.1 percent of IHS resources through the Indian Self Determination and Education Assistance Act contracts and compacts. The IHS retains the remaining funds and delivers health services directly to Tribes that do not contract or compact services. IHS performance is a concerted effort to strengthen the health status of AI/ANs across all clinic-based, hospital-based, and community-based programs administered by the I/T/U Indian health programs.

The FY 2025 IHS budget measures reflect a range of services and activities across the Indian health care system, and for clinical measures, Tribes have the option to participate in reporting. In December 2024, the IHS released the Strategic Plan for fiscal years (FYs) 2025-2029. Recent and planned FY 2025 accomplishments are reported in the budget narratives and highlighted below the following IHS strategic goals:

Goal 1: Be a leading healthcare organization.

- *Monitoring clinical measures* – In FY 2026, IHS will continue to monitor clinical measures and report aggregated I/T/U results for dental, diabetes, immunizations, prevention, and behavioral health measures from the Integrated Data Collection System Data Mart (IDCS DM).

Goal 2: Ensure comprehensive, culturally respectful health care services.

- *New Tribes Funding* – The FY 2026 IHS budget request includes PRC funding for new tribes to help ensure access to critical health care services.

Goal 3: Optimize operations through effective stewardship.

- *Health Information Technology Modernization* – The new IHS electronic health record, PATH EHR, will be designed to keep "Patients at the Heart." The IHS will continue to build, configure, and test cloud infrastructure in preparation for an initial pilot launch.

Goal 4: Promote proactive intergovernmental and external relationships.

- *Updated Tribal Consultation Policy* – In FY 2025, the IHS issued an updated Tribal Consultation Policy reaffirming the commitment to engage in regular, meaningful, and robust Tribal Consultation and permanently establishing the policy as a chapter in the Indian Health Manual.

In addition to the above-referenced performance measures and activities, IHS has implemented the following performance reporting, evaluation, and performance management processes to monitor agency progress.

[1] https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/IHSProfile.pdf

Performance Reporting

This budget request includes the Government Performance and Results Act (GPRA) and GPRA Modernization Act (GPRAMA) measures that support the IHS mission, see the IHS Outcomes and Outputs Table in the budget narratives. Annually, IHS reports valid and reliable aggregated results for twenty-six clinical measures using a centralized reporting system, the IDCS DM, to meet the GPRA/GPRAMA requirements. The IDCS DM provides Tribes using non-RPMS electronic health records with the option to report data for GPRA/GPRAMA clinical measure purposes. The IDCS DM calculates measure results using any data (RPMS, non-RPMS, or Fiscal Intermediary) submitted to the IHS National Data Warehouse and assures reporting of valid and reliable clinical measure results. The IHS clinical GPRA/GPRAMA measure results reported from the IDCS DM reflect aggregated I/T/U results, including participating Tribal programs.

Evaluation

In anticipation of the Foundations for Evidence-Based Policymaking Act of 2018 (Evidence Act), the IHS established an Evaluation Policy to provide policy and procedures for planning, funding, and using evidence to assess the impact of IHS health care services and the functions related to the delivery of health care services. The policy applies to programs operated by IHS and IHS grantees, as specified in a program's funding announcement. The IHS has implemented the following evaluation activities: evaluations of the Tribal Injury Prevention Cooperative Agreement and Community Opioid Intervention Pilot; reviews of all program Notice of Funding Opportunity announcements for evaluative components; supporting an Agency-wide Evaluation Working Group; and increased use of program funds to support a centrally managed Evaluation Services Contract. In FY 2025, the IHS will evaluate three critical programs: Evaluation policy roll-out, Telehealth, and Alzheimer's.

Performance Management

The IHS cascades performance goals and objectives and performance-related metrics agency-wide and aligns them with the agency's strategic plan. In FY 2025, specific measures cascade from senior executive performance plans to those of subordinate managers and supervisors. From there, they cascade into employee performance plans, ensuring that the performance of all employees relates to key agency performance objectives. Agency leadership periodically reviews progress in meeting these agency performance objectives, holding regular discussions with senior executives to identify challenges to success and determine feasible solutions. Agency leadership then implements those solutions, making specific adjustments or taking corrective actions that eliminate or minimize obstacles preventing the achievement of desired results. The connection between performance objectives, performance measures, and employee accountability enables agency leadership to direct the efforts of the workforce more accurately and to make more informed and effective decisions. The impact demonstrates greater success in meeting the full array of agency mission requirements. In 2023, IHS implemented the Office of Personnel Management's USA Performance (USAP) system agency-wide for all civil service employees. The USAP is an electronic system that streamlines the process for rating officials and employees, enabling agency-wide tracking of performance plans, mid-year progress reviews, and final ratings.

All Purpose Table
Indian Health Service
(Dollars in Thousands)

Program	FY 2024 Enacted /1		FY 2025 Enacted /6		FY 2026 President's Budget		FY 2026 +/- FY 2025	
	$	FTE	$	FTE	$	FTE	$	FTE
SERVICES								
Clinical Services	**4,460,933**	**7,053**	**4,498,663**	**6,550**	**4,579,959**	**6,550**	**81,296**	**0**
Hospitals & Health Clinics	2,550,514	5,818	2,586,204	5,320	2,654,289	5,320	68,085	0
Electronic Health Record System	190,564	40	190,564	50	190,564	50	0	0
Dental Services	252,561	507	254,117	455	259,501	455	5,384	0
Mental Health	129,765	172	130,114	171	131,308	171	1,194	0
Alcohol & Substance Abuse	266,636	246	266,771	251	267,404	251	633	0
Purchased/Referred Care	996,755	232	996,755	249	1,002,755	249	6,000	0
Indian Health Care Improvement Fund	74,138	38	74,138	54	74,138	54	0	0
Preventive Health	**203,846**	**236**	**204,825**	**218**	**207,938**	**218**	**3,113**	**0**
Public Health Nursing	112,034	209	112,948	194	115,926	194	2,978	0
Health Education	24,417	13	24,482	12	24,617	12	135	0
Community Health Representatives	65,212	14	65,212	12	65,212	12	0	0
Immunization AK	2,183	0	2,183	0	2,183	0	0	0
Other Services	**283,952**	**387**	**283,952**	**381**	**283,952**	**381**	**0**	**0**
Urban Health	90,419	13	90,419	9	90,419	9	0	0
Indian Health Professions	80,568	58	80,568	51	80,568	51	0	0
Tribal Management Grants	2,986	0	2,986	0	2,986	0	0	0
Direct Operations	103,805	299	103,805	306	103,805	306	0	0
Self-Governance	6,174	17	6,174	15	6,174	15	0	0
TOTAL, SERVICES	**4,948,731**	**7,676**	**4,987,440**	**7,149**	**5,071,849**	**7,149**	**84,409**	**0**
FACILITIES	**813,183**	**1,247**	**800,080**	**1,144**	**715,671**	**1,144**	**-84,409**	**0**
Maintenance & Improvement	170,595	1	170,595	0	170,595	0	0	0
Sanitation Facilities Construction	123,650	138	106,627	125	13,492	125	-93,135	0
Health Care Facilities Construction	182,679	0	182,679	0	182,679	0	0	0
Facilities & Environ Health Support	303,661	1,108	307,581	1,017	316,307	1,017	8,726	0
Equipment	32,598	0	32,598	2	32,598	2	0	0
TOTAL, SERVICES & FACILITIES	**5,761,914**	**8,923**	**5,787,520**	**8,293**	**5,787,520**	**8,293**	**0**	**0**
CONTRACT SUPPORT COSTS /2								
Total, Contract Support Costs	**1,051,000**	**0**	**1,051,000**	**0**	**1,708,000**	**0**	**657,000**	**0**
SECTION 105(*l*) LEASES /2								
Total, Section 105(*l*) Leases	**149,000**	**0**	**149,000**	**0**	**413,000**	**0**	**264,000**	**0**
SPECIAL DIABETES PROGRAM FOR INDIANS /7								
Total, Special Diabetes Program for Indians	155,484	21	159,363	21	159,000	21	-363	0
TOTAL, Budget Authority /8	**6,961,914**	**8,923**	**6,987,520**	**8,293**	**7,908,520**	**8,293**	**921,000**	**0**
TOTAL, Program Level /9	**7,117,398**	**8,944**	**7,146,883**	**8,314**	**8,067,520**	**8,314**	**920,637**	**0**
FTE Total		**16,140**		**15,232**		**15,232**		**0**
Other FTE /3, 4		**7,196**		**6,918**		**6,918**		**0**
Infrastructure Investment and Jobs Act	**700,000**		**700,000**		**700,000**		**0**	
NEF /5	**112,373**		**TBD**		**TBD**			

1/ The FY 2024 column reflects final regular appropriation levels, including required and permissive transfers. Supplemental resources from the Infrastructure Investment and Jobs Act are reflected separately. The IIJA appropriated a total $3.5 billion over 5 years, from FY 2022-FY 2026.

2/ Maintains indefinite discretionary authority for Contract Support Costs and Section 105(l) Lease and reflects the FY 2025 Enacted scores. The FY 2025 IHS operating plan reflect updated estimated scores of $1,708 billion for Contract Support Costs and $413 million for Section 105(l) Leases.

3/ Other FTE includes reimbursable FTE and FTE from trust funds (gift).

4/ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change

5/ FY 2025 and FY 2026 NEF amounts are to be determined.

6/ The FY 2025 column reflects final full year continuing resolution levels, including required and permissive transfers consistent with P.L. 119-4 and includes $5.1 billion in FY 2025 advance appropriations across the Services and Facilities Accounts.

7/ FY 2025 Current Law funding represents funding level under the Full Year Continuing Resolution (P.L. 119-4). The FY 2026 budget proposes a 1-year reauthorization of the Special Diabetes Program for Indians beginning in FY 2026.

8/ The FY 2024 Enacted total does not include the -$90 million rescission for Accreditation Emergencies

9/ Excludes estimated third-party collections. The budget does not propose any changes to the treatment of third-party collections.

Indian Health Service
Detail of Changes
(Dollars in Thousands)

Sub IHS Activity	FY 2025 Enacted /1	Changes						FY 2026 President's Budget
		Staffing of Newly Constructed Facilities	New Tribes	CSC	105(l)	Adjustments	Subtotal of Changes	
SERVICES								
Hospitals & Health Clinics	2,586,204	68,085	0	0	0	0	68,085	2,654,289
Electronic Health Record System	190,564	0	0	0	0	0	0	190,564
Dental Services	254,117	5,384	0	0	0	0	5,384	259,501
Mental Health	130,114	1,194	0	0	0	0	1,194	131,308
Alcohol & Substance Abuse	266,771	633	0	0	0	0	633	267,404
Purchased/Referred Care	996,755	0	6,000	0	0	0	6,000	1,002,755
Indian Health Care Improvement Fund	74,138	0	0	0	0	0	0	74,138
Total, Clinical Services	4,498,663	75,296	6,000	0	0	0	81,296	4,579,959
Public Health Nursing	112,948	2,978	0	0	0	0	2,978	115,926
Health Education	24,482	135	0	0	0	0	135	24,617
Community Health Representatives	65,212	0	0	0	0	0	0	65,212
Immunization AK	2,183	0	0	0	0	0	0	2,183
Total, Preventive Health	204,825	3,113	0	0	0	0	3,113	207,938
Urban Health	90,419	0	0	0	0	0	0	90,419
Indian Health Professions	80,568	0	0	0	0	0	0	80,568
Tribal Management	2,986	0	0	0	0	0	0	2,986
Direct Operations	103,805	0	0	0	0	0	0	103,805
Self-Governance	6,174	0	0	0	0	0	0	6,174
Total, Other Services	283,952	0	0	0	0	0	0	283,952
Total, Services	**4,987,440**	**78,409**	**6,000**	**0**	**0**	**0**	**84,409**	**5,071,849**
FACILITIES								
Maintenance & Improvement	170,595	0	0	0	0	0	0	170,595
Sanitation Facilities Construction	106,627	0	0	0	0	-93,135	-93,135	13,492
Health Care Facility Construction (HCFC)	182,679	0	0	0	0	0	0	182,679
Facility & Environmental Health Support	307,581	8,726	0	0	0	0	8,726	316,307
Equipment	32,598	0	0	0	0	0	0	32,598
Total, Facilities	**800,080**	**8,726**	**0**	**0**	**0**	**-93,135**	**-84,409**	**715,671**
Total, Services & Facilities	**5,787,520**	**87,135**	**6,000**	**0**	**0**	**-93,135**	**0**	**5,787,520**
CONTRACT SUPPORT COSTS /2								
Total, Contract Support Costs	**1,051,000**	**0**	**0**	**657,000**	**0**	**0**	**657,000**	**1,708,000**
SECTION 105(l) LEASES /2								
Total, Section 105(l) Leases	**149,000**	**0**	**0**	**0**	**264,000**	**0**	**264,000**	**413,000**
SPECIAL DIABETES PROGRAM FOR INDIANS /3								
Total, Special Diabetes Program for Indians	**159,363**	**0**	**0**	**0**	**0**	**-363**	**-363**	**159,000**
BUDGET AUTHORITY TOTAL, IHS	**6,987,520**	**87,135**	**6,000**	**657,000**	**264,000**	**-93,135**	**921,000**	**7,908,520**
PROGRAM LEVEL TOTAL, IHS	**7,146,883**	**87,135**	**6,000**	**657,000**	**264,000**	**-93,498**	**920,637**	**8,067,520**

1/ The FY 2025 column reflects final full year continuing resolution levels, including required and permissive transfers consistent with P.L. 119-4.

2/ Maintains indefinite discretionary authority for Contract Support Costs and Section 105(l) Lease and reflects the FY 2025 Enacted scores. The FY 2025 IHS operating plan reflect updated estimated scores of $1,708 billion for Contract Support Costs and $413 million for Section 105(l) Leases.

3/ FY 2025 Current Law funding represents funding level under the Full Year Continuing Resolution (P.L. 119-4). The FY 2026 budget proposes a 1-year reauthorization of the Special Diabetes Program for Indians beginning in FY 2026.

STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES

FY 2026 Budget -- Estimates

(Dollars in Thousands)

	New Town, ND		Seward, AK		Sitka, AK		Omak, WA		Bodaway Gap, AZ		**TOTAL**	
	Elbowoods Memorial Health Center (JV)		Chugachmiut Regional Health Center (JV)		Mount Edgecumbe Medical Center (JV)		Omak Clinic (JV)		Bodaway-Gap AKA Echo Cliffs Health Center (JV)			
Opening Date	February 2025		March 2025		May 2025		August 2025		March 2026			
Sub Sub Activity	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	**Pos**	**AMOUNT**
Hospitals & Health Clinics	5	$696	12	$2,898	182	$41,401	53	$8,562	95	$14,528	347	$68,085
Dental Health	5	$867	2	$386	4	$390	7	$1,516	13	$2,225	31	$5,384
Mental Health	0	$0	0	$59	2	$311	1	$216	5	$608	8	$1,194
Alcohol & Substance Abuse	0	$0	0	$0	1	$164	1	$92	2	$377	4	$633
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
Total, Clinical Services	10	$1,563	14	$3,343	189	$42,266	62	$10,386	115	$17,738	390	$75,296
Public Health Nursing	0	$0	1	$147	4	$678	5	$1,111	6	$1,042	16	$2,978
Health Education	0	$0	0	$0	1	$73	1	$62	0	$0	2	$135
Community Health Representatives	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
Total, Preventive Health	0	$0	1	$147	5	$751	6	$1,173	6	$1,042	18	$3,113
Total, Services	10	$1,563	15	$3,490	194	$43,017	68	$11,559	121	$18,780	408	$78,409
Facilities Support /1	0	$132	0	$184	40	$4,731	2	$1,081	13	$2,517	55	$8,645
Environmental Health Support	0	$0	0	$0	0	$0	0	$0	1	$81	1	$81
Total, FEHS	0	$132	0	$184	40	$4,731	2	$1,081	14	$2,598	56	$8,726
Total, Facilities	0	$132	0	$184	40	$4,731	2	$1,081	14	$2,598	56	$8,726
Grand Total	**10**	**$1,695**	**15**	**$3,674**	**234**	**$47,748**	**70**	**$12,640**	**135**	**$21,378**	**464**	**$87,135**

1/ Includes Utilities

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2026 Performance Budget Submission to Congress

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Appropriation Accounts

Indian Health Service - Combined
Summary of Changes
(Dollars in millions)

	Dollars	FTEs /1
FY 2025 Estimates		
Total estimated budget authority	$6,987,520.000	15,232
FY 2026 President's Budget		
Total estimated budget authority	$7,908,520.000	15,232
Net Change	$921,000.000	0

	FY 2025 Estimate		FY 2026 President's Budget		FY 2026 +/- FY 2025	
	FTE	BA	FTE	BA	FTE	BA
Increases:						
A. Built-in:						
1. Annualization of 2025 CO pay increase (3 months)	--	--	--	--	--	--
2. FY 2026 Pay Raise CO (9 months)						
3. Annualization of 2024 CS Pay Raise (3 months)	--	--	--	--	--	--
4. FY 2023 Pay Raise CS (9 months)	--	--	--	--	--	--
Subtotal, Built-in Increases	**--**	**--**	**--**	**--**	**--**	**--**
B. Program Adjustments:						
1. 105(l) Tribal Leases /2	--	$149,000.000	--	$413,000.000	--	+$264,000.000
2. Contract Support Costs /2	--	$1,051,000.000	--	$1,708,000.000	--	+$657,000.000
Subtotal, Program Increases	**--**	**$1,200,000.000**	**--**	**$2,121,000.000**	**--**	**+$921,000.000**
C. Phasing -In of Staff & Operating Cost of New Facilities (non-add) /3	--	$42,629.000	--	$87,135.000	--	+$44,506.000
D. New Tribes (non-add)	--	--	--	$6,000.000	--	+$6,000.000
Subtotal, Program Increases (non-add)	**--**	**$42,629.000**	**--**	**$93,135.000**	**--**	**$50,506.000**
Total Increases	**--**	**--**	**--**	**--**	**--**	**$921,000.000**
Decreases:						
A. Built-in:						
1. Decrease in the number of compensable days	--	--	--	--	--	--
2. Absorption of FY25 CO Pay Increase (3 months)	--	--	--	-$2,827.805	--	-$2,827.805
3. Absorption of FY25 CS Pay Increase (3 months)	--	--	--	-$771.906	--	-$771.906
4. Absorption of FY26 CO Pay Increase (9 months)	--	--	--	-$12,788.747	--	-$12,788.747
5. Absorption of FY26 CS Pay Increase (9 months)	--	--	--	-$1,561.183	--	-$1,561.183
4. Absorption of Unfunded Medical Inflationary Costs	--	--	--	-$127.670	--	-$127.670
5. Absorption of Unfunded Non-Medical Inflationary Costs	--	--	--	-$13.404	--	-$13.404
6. Absorption of Unfunded Population Growth	--	--	--	-$92.192	--	-$92.192
Subtotal, Built-in Decreases	**--**	**$0.000**	**--**	**-$18,182.907**	**--**	**-$18,182.907**
B. Program Decrease						
1. FY 2025 Congressionally Directed Spending Decrease	--	-$17,023.000	--	--	--	-$17,023.000
1. FY 2026 Sanitation Facilities Construction Decrease	--	--	--	-$93,135.000	--	-$93,135.000
Subtotal, Program Decreases	**--**	**-$17,023.000**	**--**	**-$93,135.000**	**--**	**-$110,158.000**
Total Decreases	**--**	**-$17,023.000**	**--**	**-$111,317.907**	**--**	**-$128,340.907**
Net Change	**--**	**-$17,023.000**	**--**	**-$111,317.907**	**--**	**+$792,659.093**

1/ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.
2/ Maintains indefinite discretionary authority for Contract Support Costs and Section 105(l) Lease Agreements. The FY 2025 IHS operating plan reflects updated estimated scores of $1.708 billion for Contract Support Costs and $413 million for Section 105(l) Leases.
3/ Includes facilities newly constructed FY 2025 and FY 2026

INDIAN HEALTH SERVICE
Appropriation History Table
Services

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission (PL 108-447, Sec. 501)				($15,638,000)
Rescission (PL 108-447, Sec. 122)				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission (PL 109-54)				($13,006,000)
Rescission (PL 109-148)				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	$2,818,871,000
2008	$2,931,530,000	$3,023,532,000	$2,991,924,000	$3,018,624,000
Rescission (PL 110-161)				($47,091,000)
2009 Omnibus	$2,971,533,000	-	-	$3,190,956,000
2009 ARRA (PL 111-5)	-	-	-	$85,000,000
2010	$3,639,868,000	$3,657,618,000	$3,639,868,000	$3,657,618,000
2011	$3,657,618,000	-	-	$3,672,618,000
Rescission (PL 112-10)				($7,345,000)
2012	$4,166,139,000	$4,034,322,000	-	$3,872,377,000
Rescission (PL 112-74)				($6,195,804)
2013	$3,978,974,000	-	$ 3,914,599,000	$3,914,599,000
Sequestration				($194,492,111)
Rescission				($7,829,198)
2014 Omnibus (PL 113-64)	$3,982,498,000	-	-	$3,982,842,000
2015 Omnibus (PL 113-235)	$4,172,182,000	$4,180,557,000	-	$4,182,147,000
2016 Omnibus (PL 114-39)	$3,745,290,000	$3,603,569,000	$3,539,523,000	$3,566,387,000
2017 Omnibus (PL 115-31)	$3,815,109,000	$3,720,690,000	$3,650,171,000	$3,694,462,000
2018 Omnibus (PL 115-141)	$3,574,365,000	$3,867,260,000	$3,759,258,000	$3,952,290,000
2019 Omnibus (PL 116-6)	$3,945,975,000	$4,202,639,000	$4,072,385,000	$3,965,711,000
2020 Omnibus (PL 116-94)	$4,286,541,000	$4,556,870,000	$4,318,884,000	$4,315,205,000
2021 Omnibus (PL 116-260)	$4,507,113,000	$4,534,670,000	$4,266,085,000	$4,301,391,000
2022 Omnibus (PL 117-103)	$5,678,336,000	$5,799,102,000	$5,414,143,000	$5,600,985,000
2023 Omnibus (PL 117-328) /1	$6,261,681,000	$5,734,044,000	$5,218,127,000	$4,919,670,000
2024 Enacted (P.L. 118-112)	$7,012,945,000	$4,901,594,000	$5,011,488,000	$4,948,731,000
2025 Full Year CR (P.L. 119-4)	$5,641,232,000	$5,274,783,000	$5,211,808,000	$4,987,440,000
2026 Congressional Justification	$5,071,849,000			

1/ Funding for this account was requested as mandatory in the FY 2023 budget.

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2009 Omnibus	$353,329,000	-	-	$390,168,000
2009 ARRA (PL 111-5)	-	-	-	$415,000,000
2010	$394,757,000	$394,757,000	$394,757,000	$394,757,000
2011	$394,757,000	-	-	$404,757,000
Rescission (PL 112-10)				($810,000)
2012	$457,669,000	$427,259,000	-	$441,052,000
Rescission (PL 112-74)				($705,683)
2013	$443,502,000	-	$ 441,605,000	$441,605,000
Sequestration				($22,152,062)
Rescission				($883,210)
2014 Omnibus (PL 113-64)	$448,139,000	-	-	$451,673,000
2015 Omnibus (PL 113-235)	$461,995,000	$461,995,000	-	$460,234,000
2016 Omnibus (PL 114-39)	$639,725,000	$466,329,000	$521,818,000	$523,232,000
2017 Omnibus (PL 115-31)	$569,906,000	$557,946,000	$543,607,000	$545,424,000
2018 Omnibus (PL 115-141)	$346,956,000	$551,643,000	$563,658,000	$867,504,000
2019 Omnibus (PL 116-6)	$505,821,000	$882,748,000	$877,504,000	$868,704,000
2020 Omnibus (PL 116-94)	$803,026,000	$964,121,000	$902,878,000	$911,889,000
2021 Omnibus (PL 116-260)	$769,455,000	$934,863,000	$927,113,000	$917,888,000
2022 Omnibus (PL 117-103)	$1,500,943,000	$1,285,064,000	$1,172,107,000	$940,328,000
2023 Omnibus (PL 117-328) /1	$1,567,343,000	$1,306,979,000	$1,081,936,000	$958,553,000
2024 Enacted (P.L. 118-112)	$1,066,055,000	$976,699,000	$965,389,000	$813,183,000
2025 Full Year CR (P.L. 119-4)	$993,825,000	$850,864,000	$891,594,000	$800,080,000
2026 Congressional Justification	$715,671,000			

1/ Funding for this account was requested as mandatory in the FY 2023 budget.

INDIAN HEALTH SERVICE
Appropriation History Table
Contract Support Costs

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2016 Omnibus (PL 114-39) /1	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2017 Omnibus (PL 115-31)	$800,000,000	$800,000,000	$800,000,000	$800,000,000
2018 Omnibus (PL 115-141)	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2019 Omnibus (PL 116-6)	$822,227,000	$822,227,000	$822,227,000	$717,970,000
2020 Omnibus (PL 116-94)	$855,000,000	$820,000,000	$820,000,000	$855,000,000
2021 Omnibus (PL 116-260)	$855,000,000	$916,000,000	$916,000,000	$916,000,000
2022 Omnibus (PL 117-103)	$1,142,000,000	$880,000,000	$880,000,000	$880,000,000
2023 Omnibus (PL 117-328) /2	$1,142,000,000	$969,000,000	$969,000,000	$969,000,000
2024 Enacted (P.L. 118-112) /3	$1,168,000,000	$1,051,000,000	$1,051,000,000	$1,051,000,000
2025 Full Year CR (P.L. 119-4)	$979,000,000	$2,036,000,000	$2,036,000,000	$1,051,000,000
2026 Congressional Justification	$1,708,000,000			

1/ Contract Support Costs became a separate, indefinite discretionary account.

2/ Funding for this account was requested as mandatory in the FY 2023 budget.

3/ Funding for this account was requested as mandatory in the FY 2024 budget.

INDIAN HEALTH SERVICE
Appropriation History Table
ISDEAA 105*(l)* Leases

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2019 Omnibus (PL 116-6)	$0	$0	$0	$0
2020 Omnibus (PL 116-94)	$0	$0	$0	$0
2021 Omnibus (PL 116-260) /1	$101,000,000	$101,000,000	$101,000,000	$101,000,000
2022 Omnibus (PL 117-103)	$150,000,000	$150,000,000	$150,000,000	$150,000,000
2023 Omnibus (PL 117-328) /2	$150,000,000	$111,000,000	$111,000,000	$111,000,000
2024 Enacted (P.L. 118-112) /3	$153,000,000	$149,000,000	$149,000,000	$149,000,000
2025 Full Year CR (P.L. 119-4)	$348,876,000	$400,000,000	$400,000,000	$149,000,000
2026 Congressional Justification	$413,000,000			

1/ ISDEAA 105*(l)* Leases became a separate, indefinite discretionary account.

2/ Funding for this account was requested as mandatory in the FY 2023 budget.

3/ Funding for this account was requested as mandatory in the FY 2024 budget.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2026 Performance Budget Submission to Congress

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Cross Cutting

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Staffing of Newly Constructed Facilities

(Dollars in Thousands)

Facility	FY 2026 Staffing	
	Total	**POS**
Elbowoods Memorial Health Center (JV) New Town, ND	$1,695	10
Chugachmiut Regional Health Center (JV) Seward, AK	$3,674	15
Mount Edgecumbe Medical Center (JV) Sitka, AK	$47,748	234
Omak Clinic (JV) Omak, WA	$12,640	70
Bodaway-Gap AKA Echo Cliffs Health Center (JV)	$21,378	135
Grand Total	**$87,135**	**464**

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal; PL 93-638 Tribal Contracts/Compacts, Tribal shares

PROGRAM DESCRIPTION

The IHS is authorized by the Snyder Act of 1921, the Transfer Act and the Indian Health Care Improvement Act to use government funds to plan, construct, and staff facilities for the provision of health care services. Each year the budget includes a staffing request for newly constructed facilities that provides funding for the personnel sufficient to operate a new facility in the first year of operation. This funding becomes part of the recurring funds that the facility receives each year. The staffing tables in the budget request result from collaboration between the Headquarters Office of Finance and Accounting (Budget Formulation), Public Health Support (Division of Planning, Evaluation and Research), Clinical and Preventive Services, Environmental Health and Engineering (Division of Facilities Planning Construction) and the Area Office for the new facility. Each office provides important input as part of the planning process for designing, constructing, and opening new facilities that use standard agency planning tools and federal financial accounting practices. Most projects require a two-step process: the first is to develop the overall facility plan for services and space, and the second is to request funds to staff the new facility based on the opening year. For the Joint Venture projects, the IHS and a Tribe enters into a joint venture agreement whereby the Tribe finances and builds their own health facility and IHS requests funds for the staffing and operating costs for issuance upon completion and opening of the project.

Allocation Methodology

The Indian Health Service determines the allocation of staffing for its newly constructed facilities utilizing the Resource Requirements Methodology (RRM). The RRM methodology criteria are used in concert with empirical data and other driving variables, such as Inpatient and Outpatient workload, service population, facility information and budget formulation data to determine the estimates for staffing requirements and operating costs in full-time equivalents. Once the facility opening date is determined, a revised staffing plan is developed by the Area Planning Officer as part of the planning phase for the IHS budget. The Budget RRM is reviewed and approved by headquarters offices. IHS provides the approved staffing proposal in a combination of new and existing funds, which includes salaries and overhead, facility operating costs and other support. The new staffing request is for funds needed in addition to the existing staff already funded to reach the desired staffing for the new facility.

BUDGET JUSTIFICATION

The IHS requests an increase of $87.1 million for Staffing of New Facilities in FY 2026 to provide staffing packages for five newly constructed Joint Venture facilities. This includes:

- $87.1 million to fully-fund staffing and operating costs for five new or expanded facilities in FY 2026, all of which were constructed through the Joint Venture Construction Program.

These funds support the staffing packages for new or expanded facilities, which will expand the availability of direct health care services in areas where existing health care capacity is overextended.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2026 Performance Budget Submission to Congress

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Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service Services: 75-0390-0-1-551
CLINICAL SERVICES

(Dollars in thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$4,460,933	$4,498,663	$4,579,959	+$81,296
FTE /1, 2	7,053	6,550	6,550	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

SUMMARY OF THE BUDGET REQUEST

The FY 2026 Indian Health Service (IHS) Budget submission for Clinical Services is $4.6 billion, which is +$81.3 million above the FY 2025 Enacted level. This funding level includes additional resources for:

- Staffing of Newly Constructed Facilities (+$75.3 million) and
- New Tribes – Lumbee Tribe of North Carolina (+$6.0 million)

The budget narratives that follow this summary include detailed explanations of the request.

- **Hospitals and Health Clinics**, supports essential personal health services and community-based disease prevention and health promotion services. Health services include: inpatient care, routine and emergency ambulatory care; and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, and other services. Specialized programs are conducted to address: diabetes; maternal and child health; youth services; communicable diseases including human immunodeficiency virus (HIV)/acquired immune deficiency syndrome, tuberculosis, and hepatitis; women's and men's health; elder health including Alzheimer's disease; disease surveillance; and healthcare quality improvement.

- **Electronic Health Record (EHR)**, holds an extremely high degree of mission criticality given the ability to provide much-anticipated clinical and administrative capabilities used in modern systems for the delivery of timely and impactful healthcare. Expected benefits from adopting and implementing a modernized or new system include but are not limited to improved patient safety, improved patient outcomes, better disease management, enhanced population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, agency performance reporting, etc. By identifying and properly selecting the best match for proposed system capabilities, the system will support the IHS mission. Additionally, the IHS will obtain interoperability with the Department of Veterans Affairs, Department of Defense, Tribal and urban Indian health programs, academic affiliates, and community partners, many of whom are on different Health Information Technology platforms. The IHS must consider an integrated EHR system solution that will allow for a meaningful integration to create a system that serves IHS/Tribal/Urban beneficiaries in the best possible way.

- **Dental Health**, supports preventive care, basic care, and emergency care, with approximately 90 percent of services covering basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crowns and bridges, dentures, and surgical extractions. The demand for dental treatment remains high due to a high dental caries rate in American Indian and Alaska Native (AI/AN) children; however, a continuing emphasis on community oral health promotion and disease prevention is essential to impact long-term improvement of the oral health of AI/AN people.

- **Mental Health**, supports a community-oriented clinical and preventive mental health service program that provides outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services. This funding is critical as suicide was the second leading cause of death for AI/ANs between the ages of 10 and 34.[1]

- **Alcohol and Substance Abuse**, supports an integrated behavioral health approach to collaboratively reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

- **Purchased/Referred Care (PRC)**, supports the purchase of essential health care services not available in IHS and Tribal healthcare facilities including inpatient and outpatient care, routine and emergency ambulatory care, transportation, specialty care services (mammograms, colonoscopies, etc.), medical support services (e.g., laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc.), and surgical procedures. The demand for PRC remains high as the cost of medical care increases. The PRC program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources available to them (such as Medicare, Medicaid and private insurance), negotiating discounted rates with medical providers, and implementing improvements recommended by Tribes and oversight authorities. Funding for the United Keetoowah Band of Cherokee Indians of Oklahoma for the delivery of healthcare services will be provided through Purchased/Referred Care bridge funding as was accomplished in FY 2025.

The majority of clinical services funds are provided to 12 Area (regional) Offices that distribute resources, monitor and evaluate activities, and provide administrative and technical support to approximately 2.8 million AI/ANs through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations in service areas that are rural, isolated, and underserved.

Performance Summary Table

The following long-term performance measures are considered overarching because they are accomplished through a variety of programs and activities in the IHS Services budget.

[1] U.S. Department of Health and Human Services Office of Minority Health. Mental and Behavioral Health- American Indians/Alaska Natives. https://minorityhealth.hhs.gov/mental-and-behavioral-health-american-indiansalaska-natives#1

OUTPUTS/OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
71 Childhood Weight Control: Proportion of children, ages 2-5 years with a BMI at or above the 95th percentile. IHS-All (Outcome)	FY 2024: 21.9% Target: 23% (Target Exceeded)	22%	22%	Maintain

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

HOSPITALS AND HEALTH CLINICS

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$2,550,514	$2,586,204	$2,654,289	+$68,085
FTE /1, 2	5,818	5,320	5,320	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2026 Authorization.....Permanent

Allocation Method… .....Direct Federal, P.L. 93-638 contracts and compacts, Tribal shares, interagency agreements, commercial contracts, and grants

PROGRAM DESCRIPTION

Hospitals and Health Clinics (H&HC) funds essential, personal health services for approximately 2.8 million American Indians and Alaska Natives (AI/AN). The Indian Health Service (IHS) provides medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. The IHS and tribes primarily serve small, rural populations with primary medical care and community health services, relying on the private sector for much of the secondary and most of the tertiary medical care needs. Some IHS and tribal hospitals provide secondary medical services such as ophthalmology, orthopedics, infectious disease, emergency medicine, radiology, general and gynecological surgery, and anesthesia.

The IHS system of care is unique in that personal health care services are integrated with community health services. The program includes public/community health programs targeting health conditions disproportionately affecting AI/AN populations such as diabetes, maternal and child health, and communicable diseases including influenza, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), syphilis, and viral hepatitis. The health status of AI/AN people has improved significantly in the past 60 years since IHS's inception. However, AI/AN people born today have a life expectancy that is 10.8 years less than non-AI/AN people in the Nation, 65.6 years to 76.4 years, respectively.[1]

More than 60 percent of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to tribal governments or tribal organizations that design and manage the delivery of individual and community health services through 22 hospitals, 330 health centers, 78 health stations, 147 Alaska village clinics, and 7 school health centers. The remainder of the H&HC budget is

1 Arias E, Xu JQ, Kochanek KD. United States life tables, 2021. National Vital Statistics Reports; vol 72 no 12. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: https://dx.doi.org/10.15620/cdc:132418.

managed by direct federal programs that provide health care at the service unit and community level. The federal system consists of 22 hospitals, 50 health centers, 24 health stations, and 12 school health centers.

The H&HC funds provide critical support for direct health care services provided at Federal/Tribal/Urban (I/T/U) sites, ensure comprehensive, culturally appropriate services in line with the mission of the IHS, provides available and accessible personnel, promote excellence and quality through implemented quality improvement strategies, and strengthen the IHS program management and operations to raise the health status of AI/AN populations to the highest level.

Included in H&HC funding are Tribal Epidemiology Centers and Health Information Technology program (which is separate from the Electronic Health Record). Collecting, analyzing, and interpreting health information is done through a network of tribally operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology supports personal health services (including telemedicine) and public health initiatives (such as *Baby Friendly Hospitals* and *Improving Patient Care*) which are primarily funded through the H&HC budget.

BUDGET REQUEST

The FY 2026 budget submission for Hospitals and Health Clinics is $2.7 billion, which is +$68.1 million above the FY 2025 Enacted level.

FY 2025 Final level Funding of $2.6 billion - supports the largest portion of clinical care at IHS and Tribal health facilities, including salaries and benefits for hospital/clinic administration; salaries and benefits for physicians, nurses, and ancillary staff; pharmaceuticals; and medical supplies. These funds make up the lump sum recurring base distribution to the Areas each fiscal year. Funding to support IHS facilities to promote efficient, effective, high-quality care to the AI/AN population is also included in the base.

FY 2026 Funding Increase of $68.1 million includes:

- Staffing of Newly Constructed Facilities: +$68.1 million. Information can be found in the Newly Constructed Facilities chapter.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$2,399,169,000
2023 Final	$2,503,025,000
2024 Final	$2,550,514,000
2025 Enacted	$2,586,204,000
2026 President's Budget	$2,654,289,000

TRIBAL SHARES

H&HC funds are subject to tribal shares and are transferred to Tribes when they assume responsibility for operating associated programs, functions, services, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall H&HC budget line is reserved for inherently federal functions and is therefore retained by IHS to perform the basic operational services of the Agency.

PROGRAM ACCOMPLISHMENTS

The following are examples of specific activities funded through H&HC that improve the quality of services throughout the IHS healthcare system:

Office of Quality – Established in FY 2019, the IHS Office of Quality (OQ) has made significant quality and patient safety improvements across the Agency. At establishment, the OQ included four divisions: 1) Quality Assurance, 2) Patient Safety and Clinical Risk Management, 3) Innovation and Improvement; and Division of Enterprise Risk Management and Internal Controls (DERMIC) (GAPD) that led the work on oversight of policy and accreditation standards, implementation of quality improvement strategies, implementation of enterprise risk management strategies, and monitoring accountability of federally operated facilities. To further support the work of the Agency to ensure effective quality programs and more closely align with HHS initiatives to incorporate Enterprise Risk Management (ERM) within all operating divisions in early FY 2025, the IHS initiated a realignment of the Office of Quality. This realignment incorporated the Agency's Compliance program into the OQ as the Division of Compliance, providing additional staff support for the program and fostering alignment with the IHS ERM program. The IHS OQ divisions include: 1) Division of Patient Safety and Quality Assurance (GAPA), 2) Division of Enterprise Risk Management (GAPB), 3) Division of Innovation and Improvement (GAPC), and 4) Division of Compliance (GAPD). Under the H&HC funding line, the Division of Innovation and Improvement and OQ-related activities are funded. Other activities, including patient safety, quality assurance, compliance and risk management are funded and discussed within Direct Operations.

The OQ Division of Innovation and Improvement (DII) develops and implements programs to increase quality improvement (QI) capacity in the IHS; leads change management to embrace new care delivery models and enhance efficiency; and develops and implements training, leadership development, and skill-building programs.

The DII manages the Innovations Projects, which began its 8th year on October 1, 2024. Since its inception, the DII has funded twenty-nine (29) projects: twenty-five (25) at federal sites and four at Urban Indian Organizations. Direct Service IHS-operated facilities develop and implement a QI project with DII coaching in quality improvement. These projects are selected to meet the demonstrated needs of the population served and represent a significant innovation in improving the quality of care and outcomes for AI/AN patients. Further, the DII can identify and develop proven innovative approaches for adaptation and replication in the IHS to widen impact. For example, the Whiteriver Service Unit's Project *Increasing Engagement with Substance Abuse Services through the use of Substance Use Navigators (SUNs)* increased patient engagement with substance abuse services. The SUNs increased hospital-wide screening compliance by 50 percent through the Brief Intervention and Referral for Treatment (SBIRT) intervention. It improved communication with patients after their medical visits, provided appointment reminders, patient encouragement, and follow-up after appointments or missed appointments. The intervention broadened from the Whiteriver Service Unit's Emergency Department to all departments, and streamlined access to resources is now more efficient and organized through this intervention.

The DII Improvement Advisors conducted a 10-week Advancing Health-Related Social Needs (HRSN) Screening Sprint from September to November 2024 with eight (8) participating IHS Service Units reaching over 30 participants. The DII conducted one-hour weekly virtual sessions with training utilizing the Model for Improvement Framework. Each of the eight (8) IHS Service Unit's team accomplishments included the selection of a nationally validated tool for use as the

baseline instrument for screening in clinics, the development of a resource list specific to the programs available to the patients and community, and test and adjust a workflow based on tests of change using the Model for Improvement.

The collaborative pilot for FY 2025, Reshaping the Drivers of Health in Communities (ReD), sponsored by the IHS, focuses on approaches to address the Social Drivers of Health (SDOH) in Tribal communities. Twenty-five (25) participants from 5 IHS Service Units were recruited to participate in this effort. Five teams comprised healthcare facility personnel, Tribal representatives, and community members. The teams traveled to Albuquerque, New Mexico, from October 22-24, 2024, to launch the collaboration. The two-and-a-half-day in-person meeting centered on strengthening empathy, collaboration, and the integration of Indigenous Knowledge in SDOH work. The two DII Improvement Advisors plan to coach one team throughout the project on practical tools and strategies designed to test and implement improvements in SDOH response and engagement.

The DII continues to work on the Measurement framework for assessing clinical performance across all service delivery lines with the IHS Office of Clinical Performance and Health Impact Clinical Performance Monitoring Program and a dedicated measurement framework for assessing primary health care using three primary work streams. The IHS Executive Leadership Team endorsed 27 indicators from the Primary Health Care to best reflect the needs of the Agency in FY 2024. The process involves gathering responses from Agency points of contact to identify and collect data sources. IHS Service Units will be surveyed to determine percentage compliance with the criteria for the indicators. A tracking mechanism and mock dashboard have been developed to organize and illustrate the information received.

The Division of Nursing Services – Nursing represents the largest category of health care providers in the Indian health system, with approximately 3,200 nurses across IHS (2,700 registered nurses and 500 advanced practice nurses), and has a major impact on patient safety and health care outcomes. Nurses are actively engaged in the transformation of the health care system by placing more emphasis on prevention, wellness, and coordination of care. Division of Nursing Services has six programs with specific focuses on improving overall health outcomes in Indian Country by providing support and guidance to I/T/U facilities and nurse leaders. The six programs include: Emergency Services for Children, Forensic Healthcare, Public Health Nursing, Advanced Practice Nursing, Maternal Child Healthcare, and the Bureau of Indian Education (BIE) School Health Program.

Geriatric Emergency Department Accreditation

The National IHS Geriatric ED Accreditation (GEDA) Initiative workgroup partnered with the American College of Emergency Physicians Geriatric ED Accreditation Program to encourage both the Indian Health Service (IHS) and tribal emergency departments (EDs) to pursue Bronze – Level 3 Geriatric ED Accreditation. Nine out of eleven participating EDs received Bronze – Level 3 accreditation. The IHS and Tribal Geriatric ED teams implemented geriatric-focused policies or protocols for Fall Prevention, Depression and Suicide Screening, Medication Management/Reconciliation, Geriatric Trauma Considerations, and Reducing Prolonged ED Stays. The primary goal is to utilize the Geriatric Emergency Department Accreditation program criteria to establish a defined standard of excellence for emergency care for geriatric patients in the IHS system.

A second cohort of four facilities began their accreditation journey in fiscal years 2023 and 2024. The Division of Nursing Services collaborated with the IHS Alzheimer's team to support the

second cohort of emergency departments in obtaining geriatric ED accreditation. The American College of Emergency Physicians Geriatric ED Accreditation Program aligns with the Age-Friendly Health System model, focusing on the 4Ms: What Matters, Medication, Mentation, and Mobility in the care of older adults. These goals are similar to those of the IHS Alzheimer's Program.

The IHS Alzheimer's program allocated funding to reimburse the facilities for their accreditation application fees. Initially, the second cohort, consisting of three IHS EDs and one tribal ED, aimed to meet the requirements for both Bronze-level 3 and Silver-level 2 GEDA designations. However, three IHS facilities decided to prioritize other emergency department objectives and did not complete GEDA applications requirements, while one tribal ED successfully completed the requirements for Silver-level accreditation, and will receive designation upon completion of board review.

Women's Health

The IHS Forensic Health Care (FHC) Program was established to address sexual assault, domestic and intimate partner violence, child sexual abuse, and elder maltreatment within AI/AN communities. In FY 2026, the FHC team will continue to provide subject matter expertise, policy development, training, education, and technical assistance to strengthen comprehensive medical forensic services across Indian country. In 2023, IHS awarded the Forensic Nursing Consultation Program contract to Texas A&M University Center of Excellence in Forensic Nursing (awarding roughly $5.5 million dollars over a 5 year period). The contract aims to provide specialized training and technical assistance to ensure I/T/U healthcare providers have the necessary training and education to care for patients, families, and communities affected by violence, and ensure patients have access to quality care and be offered appropriate resources, such as patient-centered, trauma-informed medical forensic examinations, including additional pathways to connect with advocates and the criminal justice system. Since the inception of the FNCP contract, over 4,195 continuing nursing and medical education hours have been provided to 538 I/T/U providers. Additionally, in FY 2023, the IHS established a Forensic Healthcare Funding Opportunity (FHFO), awarding $10.0 million over a five-year period which includes funding to federal IHS sites. The funding opportunity is designed to support building a community's capacity by forensic nursing program development and expansion through training opportunities for healthcare providers. Awards have been made annually since 2023, and training and education continues through these funding opportunities. To date, the FHFO programs have hosted over 270 training events, totaling over 5,763 hours of educations, for I/T/U healthcare providers and members within local multidisciplinary teams. Finally, in FY 2023, IHS created a guidebook titled Forensic Health Care and Caring for American Indian and Alaska Native Patients, and in FY 2024, a second guidebook was created titled American Indian and Alaska Native Patients and Medical Forensic Examination (MFE) Considerations. The purpose of these guidebooks is to enhance care delivery, provide resources, education and support for forensic healthcare providers serving in the I/T/U settings.

Advanced Practice Registered Nursing: The Advanced Practice Nurse Consultant (APNC) continues to focus on efforts to improve Advanced Practice Registered Nurse (APRN) recruitment and retention for this vital provider group who often serves as the sole provider, holds their own patient panel and sees a large percentage of the patient volume while working in hard to fill and remote locations. Recruitment and retention have a broad range of activities from compensation, workforce development, career path development and modernizing and aligning policies that impact APRN role utilization to make Indian Health Service a destination employer for APRNs and improve access to high quality care for AI/ANs. The APN Consultant developed

a national APRN Workgroup in line with external healthcare agencies where APRNs from across the agency are working on various initiatives and priorities and provides a shared governance model for input into national initiatives and strategies. Ongoing collaboration with the Office of Human Resources, attending national recruitment events and on compensation standards including GS level standardization. The Certified Nurse Midwife pay tables were updated in 2025 with ongoing monitoring during implementation of the updated pay tables. The collaboration with OHR will continue to refine the process for implementation of the CNM pay tables across IHS. Efforts with the APRN career path development utilizing APRNs in hard to fill leadership positions in line with outside healthcare agencies continues. The APTN program is working on position descriptions and recommendations to support APRN retention and delivery of high-quality care through seamless leadership coverage. Collaboration with IHS Office of Quality on credentialing and privileging policies nationally and evaluation of implementation at a local level to ensure standardization and full role utilization is not hindered by outdated policies. Participation on national committees and intra-agency workgroups on substance use disorder, pain management, cancer care and maternal child health representing APRNs in the agency and encouraging other APRNs to participate as an important retention/engagement effort. Several workforce development initiatives will continue, including the APRNs in the Geriatric Nurse Fellowship, online learning contract for continuing education offerings and an initial cohort funding APRNs completing training that would yield expanded service offerings, improve access to care and revenue generation for services that would otherwise require referral to an outside agency and result in higher costs and potentially longer time to diagnose and treat, completed with successful outcomes. Given the national APRN vacancy rate of 38 percent and minimal new graduate hiring due to the complexity of rural healthcare and remote locations, development of an APRN postgraduate training program toolbox/road map which will be used to seek support funding in the future for implementation is a recruitment and retention initiative under development.

The IHS - Bureau of Indian Education (BIE) School-based health services initiative was established in FY 2024, to ensure students' health needs are addressed and to improve age-appropriate health screenings, immunization rates, and case management for chronically ill patients. The IHS-funded initiative focuses on assisting BIE schools to implement and maintain school-based health services to improve health care needs while achieving optimal learning for school aged children. In FY 2025, the BIE school-based health initiative was funded at $37.0 million for the staffing of 76 registered nurses and health technicians, in addition to supplies and equipment. The staff will work under the Public Nursing Programs to serve the students, families, and communities. A standardized position description for a community-health school nurse and school health technician were developed to assist field operations. The school-based services will promote the IHS's E3 (Every Patient. Every Encounter. Every Recommended Vaccine Offered, when appropriate) strategy to include administer vaccines to ensure all students are following the pediatric immunization schedule to prevent communicable diseases. The staff will also be involved in planning and implementing community and school health related fairs to provide health education and promotion, community vaccine events, and physical examinations fairs for annual sports physicals. Health assessments, immunizations, screenings, medication administration, first aid, emergency care and coordinate emergency response protocols will be additional services available at the school. This may also include behavioral health services for counseling. Case management is crucial for a registered nurse to be involved to increase access to care and care coordination for chronically-ill students and their families. The school-based initiative will improve coordination of care with parents, teachers, and healthcare providers. The goal is to help the student thrive at school and in their homelife. The initiative will continue to focus on the well-being of each student physically, mentally, socially, and spiritually.

HIV Program –The overall HIV diagnosis trend shows an 8.6 percent increase in 2023 from the 2017 baseline. The rate of diagnoses of new HIV infection among AI/AN adults and adolescents decreased by 12.6 percent between 2017 and 2023.[2]

The CDC reported the death rate among AI/AN people living with HIV in 2022 was 63 percent higher than in 2017.[3] IHS-funded sites, Phoenix and Gallup Indian Medical, use intensive and specialized case management to initiate care, adherence, and support for co-morbidities. The rate of viral suppression among AI/AN who received an HIV diagnosis in 2023 was 65.2 percent, below the 70.7 percent nationally.[4]

The IHS increased overall cumulative HIV screening to 59.6 percent in FY 2024 – up from 30.6 percent in FY 2012 data. To improve AI/AN access to healthcare in remote areas, the IHS HIV Program provides technical support to IHS, tribal, and urban Indian health sites on screening and treatment, and the use of telehealth.

In Summer 2023, the IHS National HIV/HCV/STI Program received $11.0 million from the competitive HHS Minority HIV/AIDS Fund to expand partnerships between the IHS and Native communities to End the HIV Epidemic in the U.S. National-level projects include Empowering Healthier Tribal Communities (National Native HIV Network, The Southern Plains Tribal Health Board "HIV Self-Testing" and "Tele-PrEP" pilot project, National Council of Urban Indian Health, and the Indigenous HIV/AIDS Strategy).

The IHS has used Ending the HIV Epidemic Initiative funds to address diagnoses, prevention, and treatment activities associated with HIV, HCV and syphilis. Funds have also supported clinical training, including funding for an ECHO (Extensions for Community Healthcare Outcomes) model for ongoing case-based training and technical assistance; and supported national infrastructure and a national media campaign for HIV, HCV, and STI diagnosis, prevention, and treatment.

In FY 2024, the IHS added additional staff to support the Ending the HIV Syndemic in Indian Country initiative, bringing the total to eight FTEs.

Hepatitis C Virus (HCV) - As of 2022, AI/AN people had higher rates of acute HCV compared to non-AI/Ans and over three times the rate of HCV-related mortality compared to non-AI/ANs.

The IHS has sustained a steady increase in HCV screening since the 2012 CDC recommendation to screen persons born 1945-1965, or 'baby boomers'. HCV screening coverage of the birth cohort in IHS facilities nationwide has increased from 11 percent in 2013 to 69 percent in 2023. In 2019, the IHS screening recommendations were expanded to all persons 18 years and older – called 'universal screening' – in large part because of data emphasizing the importance and effectiveness of early diagnosis, treatment, and cure. As of 2023, universal HCV screening coverage in IHS facilities reached 53 percent.

[2] Data for 2017 is from Centers for Disease Control and Prevention. NCHHSTP AtlasPlus. https://www.cdc.gov/nchhstp/about/atlasplus.html. Accessed on May 22, 2025. Data for 2023 is from 2023: HIV Diagnoses, Deaths, and Prevalence. Centers for Disease Control and Prevention. Published April 29, 2025. https://www.cdc.gov/hiv-data/nhss/hiv-diagnoses-deaths-prevalence.html.

[3] Source: CDC 2022 Viral Hepatitis Surveillance Report Figure 3.6 – Acute – Case Rates by Race/Ethnicity | 2022 Hepatitis Surveillance | CDC and Table 3.8 – Death Rates by Demographics | 2022 Hepatitis Surveillance | CDC

[4] Centers for Disease Control and Prevention (CDC) NCHHSTP AtlasPlus. Accessed on January 22, 2025.

Syphilis - Gonorrhea and syphilis often present as co-morbid conditions with HIV diagnosis. Data for 2023 show that the incidence rates of chlamydia and gonorrhea among AI/AN people are higher than non-AI/AN people in the Nation.[5] Recent and sustained outbreaks of syphilis have also been observed among AI/AN communities, some related to injection drug and methamphetamine use, and both are recognized risk factors for HIV transmission.

For AI/AN women, the rate of primary and secondary syphilis in 2023 was higher than non-AI/AN women in the Nation.[6] The rate of congenital syphilis cases among AI/AN people was higher than for any non-AI/AN people in the US, increasing from 187.1 cases per 100,000 in 2019 to 680.7 per 100,000 in 2023, a 263.9 percent increase[7].

Strategies and activities developed by IHS include:

- Improving syphilis surveillance and outbreak response with stronger state collaboration;
- Creating disease intervention services capacity within local clinics and communities;
- Increasing access to presumptive treatment for symptomatic persons and sexual contacts;
- Improving clinical practices by optimizing electronic health records with automated screening reminders and treatment flags;
- Expanding access to testing beyond routine clinic appointments;
- Tailoring interventions to the different outbreaks (by priority populations); and
- Expanding partnerships.

National Community Health Aide Program (CHAP): provides a network of health aides trained to support licensed health professionals while providing direct health care, health promotion, and disease prevention services. These providers work within a referral relationship under the supervision of licensed clinical providers that includes clinics, service units, and hospitals. The program increases access to direct health services, including inpatient and outpatient visits through a focus on primary, emergency, behavioral, and dental health to equip Tribal communities with a network that expands the system of care and aids in the mobilization of healthcare in America's most rural and remote communities where access to care is few and far in between.

- In March 2024, the CHAP Headquarters (HQ) Team successfully executed the CHAP Reset, aligning the program with Tribal leadership directives and reinforcing its foundation as a Tribally led initiative. This effort streamlined operational processes, empowered Tribal communities, and promoted greater ownership of healthcare delivery. The CHAP Reset marked a pivotal step in strengthening the program's capacity to provide culturally responsive and effective healthcare services by fostering tailored solutions to meet specific community needs.
- The CHAP Headquarters HQ Team and Office of Clinical and Preventive Services Leadership, in collaboration with the CHAP Tribal Advisory Group, successfully published the Indian Health Manual, CHAP Circular 24-16[8] on November 7, 2024. The revised Circular provides clarity to the organization, administration, responsibilities, and policies of the National CHAP in accordance with the statutory requirements of the Indian Health Care Improvement Act, 25 U.S.C. § 1616*l*, or by Indian Self-

[5] Centers for Disease Control and Prevention (CDC) NCHHSTP AtlasPlus. Accessed on January 22, 2025.

[6] Centers for Disease Control and Prevention. *Sexually Transmitted Infections Surveillance 2023.* Atlanta: U.S. Department of Health and Human Services; 2024

[7] Centers for Disease Control and Prevention (CDC) NCHHSTP AtlasPlus. Accessed on January 22, 2025.

[8] Indian Health Service (IHS). Indian Health Manual Circular 24-16.

Determination and Education Assistance Act contractors in the lower 48 states outside of Alaska. This Circular supersedes IHS Circular 20-06, Community Health Aide Program, dated June 10, 2020.

- The CHAP HQ Team made significant progress in advancing health aide certification in the Portland Area. On November 26, 2024, the former IHS Director signed the Portland Area CHAP Certification Board (PACCB) Establishment letter. This authorization enables the PACCB to certify Primary Dental Health Aide (PDHA), Dental Health Aide Therapists (DHATs) and Behavioral Health Aids (BHAs; BHA I-III). Previously, Portland Area health aides — four DHAs and three BHAs — were facilitated through the Alaska CHAP Board. The establishment recognizes PAACB as the first Area Certification Board (ACB) in the lower 48 states.
- The IHS received and vetted 10 nominations, representing 10 IHS Areas, for the National CHAP Board. The inaugural National CHAP Board meeting was hosted on February 26, 2025.
- The CHAP HQ Team provided comprehensive technical assistance (TA) to grantees focused on strengthening operational capabilities and improving program outcomes through regular calls with CHAP grantees and site visits. The National CHAP Team conducted a visit to the Portland Area (Northwest Portland Area Indian Health Board [NPAIHB], Swinomish Dental Clinic, Skagit Valley College, Northwest Indian College, and Marimn Health) and California Area (California Rural Indian Health Board) to understand and support CHAP developments in the lower 48 states. This activity supported grantees in addressing community needs through targeted training, resource development, and strategic guidance, empowering them to deliver high-quality, culturally competent care and enhance healthcare services across Tribal communities.
- The CHAP HQ Team awarded substantial funding for the FY 2023–2025 grant period, allocating $375,000 each to Tribal Assessment and Planning grantee (Fort Peck Assiniboine, Cherokee Nation, Indian Health Council, and California Rural Indian Health Board) and a minimum of $540,000 each to Tribal Planning and Implementation grantees (Southern Plains Tribal Health Board, Osage Nation, Wichita and Affiliated Tribes, and Northern Arapaho). A significant nonrecurring allotment of $3,650,000 from FY 2023 was sent to the Alaska Area Office to support infrastructure and expand CHAP initiatives across the lower 48 states.

Domestic Violence Prevention (DVP) Program –

The DVP program was established in 2015, as a nationally coordinated program that provides culturally appropriate domestic violence and sexual assault prevention and intervention resources to AI/AN communities with a focus on providing trauma informed services. In FY 2022, IHS awarded $7.4 million in funding to thirty-seven (37) Tribal, Tribal organization, and Urban Indian Organization projects for a five-year period. The IHS also awarded a total of $1.0 million annually, for a five-year funding cycle to Forensic Health Care (FHC) service grantees to support four (4) Tribal, Tribal organization, and Urban Indian Organization facilities. IHS collected data from all grant-based partners for Year One (FY 2023) and Year Two (FY 2024). Tribal grant-based partners reported the following data pertaining to the first two years of the DVP program: Client engagements of 7,107 (year one) and 19,248 (year two); screenings for sexual assaults of 2,508 (year one) and 40,062 (year two); identified victims of domestic violence cases of 1,984 (year one) and 2,890 (year two); human trafficking cases of 1,044 (year one) and 40 (year two); sexual abuse cases of 1,400 (year one) and 1,006 (year two); and, strangulation cases of 1,072

(year one) and 76 (year two). The DVP program will continue the collection of annual data on services provided.[9]

The IHS Forensic Health Care (FHC) Program was established to address sexual assault, domestic and intimate partner violence, child sexual abuse, and elder maltreatment within AI/AN communities. In FY 2026, the FHC team will continue to provide subject matter expertise, policy development, training, education, and technical assistance to strengthen comprehensive medical forensic services across Indian country. In 2023, IHS awarded the Forensic Nursing Consultation Program contract to Texas A&M University Center of Excellence in Forensic Nursing (awarding roughly $5.5 million dollars over a 5 year period). The contract aims to provide specialized training and technical assistance to ensure I/T/U healthcare providers have the necessary training and education to care for patients, families, and communities affected by violence. The contract will also ensure patients have access to quality care and be offered appropriate resources, such as patient-centered, trauma-informed medical forensic examinations, including additional pathways to connect with advocates and the criminal justice system. Since the inception of the FNCP contract, over 4.195 continuing nursing and medical educations hours have been provided to 583 I/T/U providers.

Additionally, in FY 2023, the IHS established a Forensic Healthcare Funding Opportunity (FHFO), awarding $10.0 million over a five-year period which includes funding to federal IHS sites. The funding opportunity was designed to support building a community's capacity by forensic nursing program development and expansion through training opportunities for healthcare providers. To date, the FHFO programs have hosted over 270 training events, totaling over ~~4,200~~5,763 hours of education for IHS, Tribal, and Urban Indian (I/T/U) healthcare providers and members within the local ~~of~~ multidisciplinary teams. Finally, in FY 2023, IHS created a guidebook titled Forensic Health Care and Caring for American Indian and Alaska Native Patients, and in FY 2024, a second guidebook was created titled American Indian and Alaska Native Patients and Medical Forensic Examination (MFE) Considerations. The purpose of these guidebooks is to enhance care delivery, provide resources, education and continued support for forensic healthcare providers serving in the I/T/U settings.

Maternal Health - Obstetrics

The Maternal Child Health Program aims to increase access to safe, quality maternal and child health services across IHS. When pregnant people are healthy and well cared for, newborns, children, and communities thrive.

- IHS and Tribal sites have engaged in implementation of the Alliance for Innovation on Maternal Health (AIM) bundles, with an early emphasis on implementation of the Obstetric Hemorrhage and Hypertension bundles and other bundles as prioritized by the individual sites.
- In response to the closure of rural obstetric units and decline in national birth volume, IHS has prioritized simulation drills for obstetric emergency preparedness. Many IHS clinicians have completed the Advanced Life Support in Obstetrics (ALSO) course, which are offered regularly across the I/T/U system. IHS has expanded the Obstetric Readiness in the Emergency Department (ObRED) program to include a manual and training. The draft manual has been reviewed by 40 IHS and tribal sites. Four Areas have participated in ObRED simulation training with 250+ staff trained, resulting in increased staff confidence with management of obstetric emergencies. In 2024, IHS leased this manual and has provided technical assistance and training to other Areas. This simulation

[9] Year One data reported at https://www.ihs.gov/dbh/reports/. Year Two data will be reported at the same site when released.

program is following the Emergency Medicine principles of quality improvement, emphasizing attention to tools, training, and tracking.

To increase education, consultation, and resources for the clinical workforce, IHS has developed a monthly Indian Country ECHO Pregnancy Care and Access for Pregnant People in partnership with the Northwest Portland Area Indian Health Board (NPAIHB). The 2024 series include nine webinars on topics such as Indigenous birthing practice, maternal mental health, field testing and treatment for syphilis, and pregnancy loss. Webinars were attended by 1,205 participants across 37 states and 275 tribes/organizations.

Alzheimer's and Elder Health Program

Program Infrastructure and Collaborations

- Formal and informal non-Federal collaborations (new): Explored new formal engagement opportunities, including Center to Advanced Palliative Care, New York University, Hartford Institute of Gerontology, and Montreal Cognitive Assessment (MoCA) Cognition for workforce training opportunities.
- Federal Council and interagency workgroups (ongoing): HHS Advisory Council on Alzheimer's Research, Care, and Services National Alzheimer's Project Act (NAPA) Council; Recognize, Assist, Include, Support, & Engage (RAISE) Family Caregiving Advisory Council; Centers for Disease Control and Prevention's leadership committee for the Healthy Brain Initiative Road Map for Indian Country, Elder Justice Interagency Workgroup, Veteran Affairs (VA)'s Mental Health and Aging federal working group, Centers for Medicare and Medicaid Services Tribal Technical Advisory Group (TTAG). As part of these efforts, the Elder Health team was responsible for drafting updates for three federal agency "Reports to Congress" and drafting a separate IHS Report to Congress.
- Public-private committee and workgroups (new and ongoing): Participation in the Dementia Friendly America National Council, Alliance to Improve Dementia Care, Public Health Center of Excellence on Early Detection of Dementia Advisory Group, and joined The Data Project, a National Institute on Aging-funded dementia research consortium.

Local Tribal Capacity Building: Disseminating Funding and Resources

- Partnership on Office of Quality Innovation Awards (new): Program and funding support provided for dementia-focused award to an IHS service unit in Phoenix, Arizona via the Division of Innovation and Improvement.
- Grants (new and ongoing): 2025 began with 14 active Dementia Models of Care grantees and a new 2025 Notice of Funding Opportunity (NOFO) near-finalized for publication, offering current two-year grantees and other Tribes and Urban Indian facilities a competitive three-year funding opportunity for model expansion and sustainability. FY 2026 plans include a new five-year Models of Care NOFO and a five-year multi-service national clinical champions cooperative agreement.
- Intensive grantee technical assistance (TA) (new and ongoing): Conducted eight site visits, four all-grantee virtual collaborative learning meetings, 144 individual one-on-one grantee and team meetings, 612 individualized weekly resource and reminder emails, support for the Alzheimer's grantee listserv, and medical staff presentations on dementia diagnosis to five clinics/health systems.

Workforce Development, Training, and Technical Assistance

- Training and Resources for the Indian Health Services on Alzheimer's and Dementia (TRIAD)(new): Branded initiative that aims to consolidate and market new competency-based dementia training, existing workforce development programs, and a new Dementia Clinical Support hotline[10] as part of a contract award to the University of Washington to support service and training development and implementation.
- Early Dementia Detection Initiative pilot (ongoing): Implemented year one of a six-month pilot to evaluate the feasibility of Community Health Representatives performing Mini-Cog® screenings with six tribal locations that conducted 193 screenings, resulting in 34 positive screenings (17.6 percent). In-person training and pilot kick-off began in FY 2025. FY 2026 will include expanded training and dissemination.
- Other (new and ongoing): Implement dementia caregiver interventions, services, and supports based on feedback and recommendations from a six-month interdisciplinary workgroup, including IHS, Tribal, UIO staff, and other tribal and federal partners, provided in a 2025 report. Continue a base plus four contract for a bi-annual workforce training Summit. Continue two clinical ECHO programs in partnership with the Northwest Portland Area Indian Health Board (NPAIHB) Indian Country ECHO Program (annually reaches more than 400 participants from 20 states).

Outreach, Awareness, and Recognition

- Communications infrastructure (ongoing): Implement a base + four-year Alzheimer's Communications Contract to a tribally owned small business for biweekly newsletter, social media, media assets, and website maintenance. FY 2025 included photoshoots of local facilities and community members producing media assets for training materials and media in Arizona and Alaska, and video production supporting early detection.
- Targeted awareness-building campaign (new and ongoing): Published 22 IHS Week in Review posts, three IHS blog posts, 15 newsletters, one press release, ongoing posts to YouTube channel, four-part Mini-Cog training videos in 2024 and development of a three-part Early Detection series for patients in 2025, 35 themed social media messages across the IHS Facebook, LinkedIn, and X accounts, including World Elder Abuse Awareness Day, Alzheimer's Month, Falls Prevention, and more following social media field testing.
- Other (ongoing): Presentations, webinars, and training include 11 presentations about dementia, five provider clinical trainings on dementia diagnosis, and to tribal capacity-building webinar series that attracted 250 people from 64 Tribes representing 11 IHS areas. Funding for up to 12 IHS area offices to pilot elder-focused brain and dementia risk reduction events through the Health Promotions/ Disease Prevention program.

Data to Inform Decision-Making and Transform Care

- Elder Health Clinical Data Dashboard (new): Memorandum of Understanding (MOU) with the Office of Information Technology finalized. Work commences in late 2025.
- Grant program evaluation (new and ongoing): Collect and analyze data from Grant Program participants and emerging Alzheimer's Program activities, including contracting for external support for program evaluation, future performance measure development, increasing evidence-based knowledge, and driving program enhancements.

[10] "https://www.ihs.gov/newsroom/announcements/2024-announcements/ihs-announces-alzheimers-program-training-and-education-contract-award/"

Indian Children's Program

The IHS Indian Children's Program (ICP) is part of the IHS Telebehavioral Health Center of Excellence (TBHCE). The funds available through the ICP have helped TBHCE address behavioral health issues among AI/AN children and youth. Specifically, TBHCE provides ongoing trainings on topics such as Autism Spectrum Disorder, including recognition, screening, diagnosis, and treatment. Additional topics have included Fetal Alcohol Spectrum Disorders, pervasive developmental disorders, traumatic brain injury, and substance use in teens. Office hours and provider-to-provider consultation is also freely available to providers working with AI/AN children and youth. In 2024, funds from the ICP allowed TBHCE to hire a Pediatric Psychiatrist. This psychiatrist provides pediatric prescribing services to IHS and Tribal programs across multiple states.

Produce Prescription Pilot Program (P4)

AI/AN people are disproportionately impacted by food insecurity when compared to non-AI/AN people. They are also more likely to live in areas with low or no access to fresh foods than any other racial or ethnic group. About one in four AI/AN people experience food insecurity, compared to one in nine Americans overall[11].

To address this public health concern, IHS has been authorized $3.0 million annually to create a pilot program to implement a P4 to increase access to produce and other traditional foods within AI/AN communities. The purpose of P4 is to help establish produce prescription programs (PPP) through collaborations with stakeholders from various healthcare and food industries in Tribal and Urban communities. The goal of P4 is to demonstrate and evaluate the impact of PPP on AI/AN people and their families, specifically by reducing food insecurity; improving overall dietary health by increasing fruits, vegetables, and traditional food consumption; and improving healthcare outcomes.

The IHS provided a NOFO welcoming AI/AN communities to apply for a cooperative agreement to establish and implement a P4. Of that funding, five tribes and tribal organizations were awarded grant funding in 2023, to implement a produce prescription program in their communities.

P4 grantees are in full program implementation. Grantees are providing either vouchers or food boxes/bags through partnerships with local organizations and grocery store vendors to program participants. The grantees have been receiving ongoing technical assistance by the IHS support team through bi-monthly one- on- one meetings and monthly cohort meetings. Additional support has included site visits and P4 grantee workshop, including training on how to effectively evaluate their PPP's. The P4 grantee programs have implemented strong nutrition education programs during the first year of their programs, as a requirement of the cooperative agreement.

OUTPUTS/OUTCOMES

[11] https://moveforhunger.org/native-americans-food-insecure#:~:text=About%20one%20in%20four%20Native,access%20to%20sufficient%2C%20affordable%20food

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
20 100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited or certified (excluding tribal and urban facilities). (Outcome)	FY 2024: 100% Target: 100 % (Target Met)	100%	100%	Maintain
55 Nephropathy Assessed (Outcome)	FY 2024: 41.8% Target: 45.1% (Target Not Met)	44.8%	44.8%	Maintain
56 Retinopathy Exam (Outcome)	FY 2024: 45.4% Target: 44.7% (Target Exceeded)	47.6%	47.6%	Maintain
66 American Indian and Alaska Native patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR (measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Outcome)	FY 2024: 36.1% Target: 40.9% (Target Not Met but Improved)	37.8%	37.8%	Maintain
67 Influenza Vaccination Rates among children 6 months to 17 years (Outcome)	FY 2024: 15.7% Target: 19.8% (Target Not Met)	18.3%	18.3%	Maintain
68 Influenza vaccination rates among adults 18 years and older (Outcome)	FY 2024: 18.4% Target: 19.7% (Target Not Met)	21.0%	21.0%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
70 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2024: 35.4% Target: 37.8% (Target Not Met but Improved)	36.9%	36.9%	Maintain
72 Tobacco Cessation Intervention (Outcome)	FY 2024: 26.2% Target: 24.4% (Target Exceeded)	27.5%	27.5%	Maintain
73 HIV Screening Ever (Outcome)	FY 2024: 43.4% Target: 38.9% (Target Exceeded)	42.5%	43.4%	+0.9 percentage point(s)
74 Breastfeeding Rates (Outcome)	FY 2024: 43.0% Target: 42.6% (Target Exceeded)	44.1%	44.1%	Maintain
75 Controlling High Blood Pressure - MH (Outcome)	FY 2024: 46.9% Target: 45.8% (Target Exceeded)	48.2%	48.2%	Maintain
81 Increase Intimate Partner (Domestic) Violence screening among American Indian and Alaska Native (AI/AN) Females (Outcome)	FY 2024: 31.9% Target: 29.6% (Target Exceeded)	30.5%	31.9%	+1.4 percentage point(s)
87 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Output)	FY 2024: 38.9% Target: 28.7% (Target Exceeded)	40.5%	40.5%	Maintain
88 Colorectal Cancer Screening Rate (Outcome)	FY 2024: 23.6% Target: 23.7 % (Target Not Met but Improved)	24.6%	24.6%	Maintain
89 Cervical Cancer Screening (Outcome)	FY 2024: 34.4% Target: 33.2% (Target Exceeded)	35.6%	35.6%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
91 Adult Composite Immunization (Output)	FY 2024: 38.6% Target: 37.0% (Target Exceeded)	39.0%	39.0%	Maintain

GRANT AWARDS - H&HC funds support the Healthy Lifestyles in Youth Project,[12] a $1.3 million cooperative agreement with the Boys and Girls Club of America. This grant program promotes healthy lifestyles among AI/AN youth using the curriculum "Together Raising Awareness for Indian Life" at selected Boys and Girls Club sites across the country and represents responsiveness to Tribal input for more prevention activities.

H&HC also funds 83 DVP Program grants.

(whole dollars)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	84	84	84
Average Award	$148,207	$148,207	$148,207
Range of Awards	$49,750-$1,250,000	$49,750-$1,250,000	$49,750-$1,250,000

AREA ALLOCATION

Hospital and Health Clinics

(dollars in thousands)

	FY 2024			FY 2025			FY 2026			FY '26
DISCRETIONARY	Estimate/1			Estimate/1			Estimate/1			+/- FY '25
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$5,181	$431,840	$437,021	$5,254	$437,976	$443,230	$5,392	$449,506	$454,898	$11,669
Albuquerque	48,823	42,229	$91,052	49,510	42,829	$92,339	50,814	43,957	$94,770	$2,431
Bemidji	43,309	83,853	$127,162	43,919	85,044	$128,963	45,075	87,283	$132,358	$3,395
Billings	50,219	21,448	$71,667	50,926	21,753	$72,679	52,266	22,325	$74,592	$1,913
California	4,042	76,879	$80,921	4,099	77,971	$82,070	4,207	80,024	$84,231	$2,161
Great Plains	150,149	112,261	$262,410	152,262	113,856	$266,118	156,271	116,853	$273,124	$7,006
Nashville	23,305	72,736	$96,041	23,633	73,769	$97,402	24,255	75,712	$99,967	$2,564
Navajo	192,878	103,125	$296,003	195,593	104,590	$300,183	200,742	107,344	$308,085	$7,903
Oklahoma	109,425	388,990	$498,416	110,965	394,517	$505,482	113,886	404,903	$518,789	$13,307
Phoenix	131,920	150,413	$282,334	133,777	152,550	$286,327	137,299	156,566	$293,865	$7,538
Portland	36,015	57,795	$93,809	36,522	58,616	$95,138	37,483	60,159	$97,643	$2,505
Tucson	2,023	20,140	$22,162	2,051	20,426	$22,478	2,105	20,964	$23,069	$592
Headquarters	188,406	2,700	$191,106	191,058	2,738	$193,796	196,087	2,810	$198,898	$5,102
Total, H&HC	**$985,695**	**$1,564,409**	**$2,550,104**	**$999,568**	**$1,586,636**	**$2,586,204**	**$1,025,883**	**$1,628,406**	**$2,654,289**	**+$68,085**

1/ Note: 2024, 2025, and 2026 are estimates.

[12] Healthy Lifestyles in Youth Project | About Us (ihs.gov)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HOSPITALS AND HEALTH CLINICS
Tribal Epidemiology Centers

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$2,550,514	$2,586,204	$2,654,289	+$68,085
Epi Centers (non-add)	*$34,433*	*$34,433*	*$34,433*	--

Authorizing Legislation ..... 25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2026 Authorization ..... Permanent

Allocation Method ..... Cooperative Agreements

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Tribal Epidemiology Center (TEC) Program was first authorized by Congress in fiscal year (FY) 1992. The IHS program supporting TECs was first funded in FY 1996. The program was founded to develop public health infrastructure by augmenting existing Tribal organizations with expertise in epidemiology and public health via Epidemiology Centers. Funding is distributed to the TECs through cooperative agreements to Tribes and Tribal organizations such as Indian Health Boards.

The TECs play an essential role in IHS' overall public health infrastructure. Operating within Tribal organizations and governments, TECs are uniquely positioned to provide support to local Tribal disease surveillance and control programs and assess the effectiveness of public health programs. All TECs monitor the health status of their constituent Tribes, produce a variety of reports that describe activities and progress towards public health goals, and provide support to Tribes.

The TEC program funds eleven TECs that provide comprehensive geographic coverage for all IHS administrative areas and one additional TEC serving American Indian and Alaska Native (AI/AN) populations residing in major urban centers. The TEC Program supports Tribal communities by providing technical training and assistance in applied public health practice and prevention-oriented research, and by promoting public health career pathways for Tribal members. Beginning in FY 2021, a significant portion of TEC activities have been devoted to supporting Tribes in Public Health response activities.

Annually, approximately 95 percent or more of the TEC Program budget is distributed to TECs through cooperative agreements based on a 5-year competitive award cycle. In the current 5-year award cycle beginning in FY 2021 the average annual award was $699,073 increasing to $2,611,397 in FY 2024.

The TEC funds provide critical support in strengthening the collaborative partnerships among the 12 TEC constituent AI/AN communities.

TECs collect data and monitor the progress towards health status objectives of the IHS, Indian Tribes, Tribal organizations, and urban Indian organizations in each IHS service area. TECs are an essential part of promoting health in the AI/AN population by identifying and addressing disparities. This includes identifying the significant and disproportionate impacts of high-impact health priorities, including but not limited to Substance Use Disorder, Maternal and Child Health, and Sexually Transmitted Infections.

BUDGET REQUEST

The FY 2026 budget submission for the TECs under Hospitals and Health Clinics (H&HC) is $34.4 million and is flat with the FY 2025 Enacted level.

The funding per TEC covers the salaries of a director, staff epidemiologists, administrative assistance/support, evaluation capacity, Public Health response and collaboration capacity, comprehensive local Public Health planning efforts, data collection and disease surveillance, special projects specific to disease states or local outbreaks, and the execution of additional pressing disparity projects or tribal priorities.

Tribal Epidemiology Centers and Locations		
1	Alaska Native Tribal Health Consortium	Anchorage, AK
2	Albuquerque Area Indian Health Board	Albuquerque, NM
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI
4	Inter-Tribal Council of Arizona	Phoenix, AZ
5	Rocky Mountain Tribal Leaders Council	Billings, MT
6	Navajo Nation Division of Health	Window Rock, AZ
7	Great Plains Tribal Chairmen's Health Board Northern Plains – Great Plains Area	Rapid City, SD
8	Northwest Portland Area Indian Health Board	Portland, OR
9	Southern Plains Tribal Health Board Foundation	Oklahoma City, OK
10	Seattle Indian Health Board	Seattle, WA
11	United South and Eastern Tribes, Inc.	Nashville, TN
12	California Rural Indian Health Board	Sacramento, CA

FUNDING HISTORY

Fiscal Year	Amount*
2022 Final	$24,433,361
2023 Final	$34,433,361
2024 Final	$34,433,361
2025 Enacted	$34,433,361
2026 President’s Budget	$34,433,361

*Funded under the Hospitals & Health Clinics budget.

PROGRAM ACCOMPLISHMENTS

The TEC funds provide critical support in strengthening the collaborative partnerships among the 12 TECs, AI/AN communities, and the IHS. Below are key TEC activities.

Training, Technical Assistance and Tribal Support

Technical assistance and trainings offered by the TECs are designed to be responsive to the needs and interests of the communities they serve. Training and technical assistance are further informed by comprehensive epidemiological work to educate communities on the conditions and disparities that affect their citizens.

Nationally Managed Data Projects that Engage Local Resources

Data generated locally and analyzed by TECs enable Tribes to evaluate community-specific health status for planning the needs of their Tribal membership. Immediate feedback is provided to the local data systems and leads to improvements in AI/AN health data overall. The Indian Health Care Improvement Act (Section 130) includes language that designates the TECs as public health authorities in regard to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This designation permits TECs to access IHS-generated data sets used to support various public health activities. Additionally, the development and dissemination of regional community health assessments have provided valuable guidance for regional planning.

Continued COVID-19 Response Activities

As the COVID-19 response evolved, TECs continued to collaborate with each other, IHS, other agencies, and the communities they serve. Notable activities and successes of TECs have included the development and dissemination of culturally appropriate COVID-19 informational products, case and testing information, analysis and dissemination of morbidity and mortality statistics, and the production and distribution of public communication informed by community-specific concerns. All of the TECs have continually contributed to the resources posted on their common COVID-19 website at https://tribalepicenters.org/tec-covid-19-resources/.

Substance Use Disorder

Addressing Substance Use Disorder (SUD) was also identified as a top priority among TECs. Key initiatives include surveillance and data analysis to regionally monitor SUD trends and identify risk factors. This data-driven approach will ultimately be used to inform tribal communities in developing and disseminating interventions and resources to raise awareness of SUD in native communities.

TEC roles in the establishment and/or expansion of Tribal Public Health Departments

Since 2021, TEC programs have supported the establishment and/or expansion of Tribal Public Health Departments (TPHDs). In FY 2024, they reported progress on providing trainings to TPHDs on a variety of topics, including maternal and child health, COVID-19, behavioral health, workforce development, and epidemiology.

DISCUSSION

The TECs provide critical support to the communities they serve. In FY 2024, TECs responded to 1,572 requests for technical support (EPI-4) and completed 580 TEC-sponsored trainings for tribal public health capacity building (EPI-5). Recent decreases in technical support and trainings from prior years likely reflect a transition away from the intense cadence of the COVID-19 pandemic and a shift back on core public health services that are specifically targeting community needs and emphasize collaboration and partnerships.

Completed trainings and technical support to Tribes and Tribal organizations show the sustained efforts of the TECs to engage, train, and collaborate with the Tribes in their service area. These efforts are responsive to Tribal priorities as they are driven by Tribal requests and invitations and not directed by the IHS.

OUTPUTS AND OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2025 Target**	**FY 2026 Target**	**FY 2026 Target +/-FY 2025 Target**
EPI-4 Number of requests for technical assistance including data requests for T/U organization, communities, or AI/AN individuals responded to. (Output)	FY 2024: 1,572 Target: 1,897 (Target Not Met) FY 2023: 1,586 Target: 1,897 (Target Not Met)	1,897	1,200	-697
EPI-5 Number of TEC-sponsored trainings and technical assistance provided to build tribal public health capacity. (Output)	FY 2024: 580 Target: 200 (Target Exceeded) FY 2023: 302 Target: 89 (Target Exceeded)	200	200	Maintain

GRANTS AWARDS

(whole dollars)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	12	12	12
Average Award	$2,547,000	$ 2,861,397	$2,547,000
Range of Awards	$2,532,500 - $2,557,100	$2,532,500 - $ $2,761,397.00	$2,532,500 - $2,557,100

* Administrative and technical support of the TECs is provided by the DEDP and is included in the average award amount.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HOSPITALS AND HEALTH CLINICS
Health Information Technology

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$2,550,514	$2,586,204	$2,654,289	+$68,085
HIT (non-add)	*$182,149*	*$182,149*	*$182,149*	--

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal; PL 93-638 Tribal Contracts/Compacts, Tribal shares

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Information Technology (HIT) Portfolio uses secure and reliable information technology (IT) in innovative ways to improve healthcare delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. IHS HIT provides support for Federal/Tribal/Urban (I/T/U) programs that care for 2.8 million American Indian and Alaska Native (AI/AN) people across the Indian health system. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS HIT supports the mission-critical healthcare operations of the I/T/U with comprehensive health information solutions, including an Electronic Health Record (EHR) system with more than eighty applications. IHS' EHR received 2015 certification for meeting requirements set by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), which established standards and other criteria for structured data that EHRs must use. The IHS HIT portfolio directly supports better ways to: 1) care for patients, 2) pay providers, 3) refer care when needed, 4) recover costs, and 5) distribute information, resulting in better care, more efficient spending, and healthier communities, economy, and country.

The HIT Portfolio is dedicated to providing the most innovative, effective, cost-efficient, and secure HIT system in the federal government. The HIT portfolio is comprised of two Mission Delivery IT investments: 1) Health Information Technology Systems and Support (HITSS); 2) National Patient Information Reporting System (NPIRS); and eight Standard investments: 1) IT Management; 2) IT Security and Compliance; 3) Data Center and Cloud Standard Investment; 4) Network Standard Investment; 5) Platform Standard Investment; 6) Delivery Standard Investment; 7) End User Standard Investment; and 8) Application Standard Investment.

1) **Health Information Technology Systems and Support (HITSS)** investment provides an enterprise health information system supporting the underlying IT layer of the clinical, practice management, and revenue cycle business processes at I/T/U facilities nationwide. The HITSS investment encompasses the Resource and Patient Management System (RPMS)

EHR that is certified according to criteria published by the Office of the National Coordinator for Health Information Technology (ONC) and is in use at approximately 430 healthcare facilities across the country. The RPMS Network is evolving to support health information sharing within the I/T/U enterprise, external connections through the eHealth Exchange, and better patient engagement to support quality initiatives and the Medicare Access & Children's Health Insurance Program Reauthorization Act (MACRA) of 2015.

2) **National Patient Information Reporting System (NPIRS)** investment is an enterprise-wide data warehouse and business intelligence environment that produces standardized reports required by statute and regulation and provides a broad range of clinical and administrative information, and associated analytical tools, to managers at all levels of the Indian Health system. The NPIRS investment hosts an enterprise business intelligence and business analytics platform that promotes a data-centric approach to data mining, discovery, reporting and analytics. The NPIRS BI/BA platform enables actionable insights into primary care, disease management and promotes outcome improvements that are aligned with the agencies strategic and tactical business objectives. Reporting and analytics are available at the site, area and national levels. The NPIRS enterprise information strategy leverages Business Intelligence (BI) technology to collect, manage, govern. This enterprise information strategy promotes collaboration between IHS, tribes and urban stakeholders for posturing data for enterprise reporting, data sharing and assures data confidence to support I/T/U. NPIRS is evolving to mature the analytic platform, adding additional data domains, defining a data governance framework, adopting industry standards and best practices to exploit Business Intelligence capabilities, and is enabling IHS to produce and make more informed, quality decisions against agency-level measurement, performance and enterprise data.

3) **IT Operations** investments provide the technical infrastructure for federal and limited tribal healthcare facilities that are the foundation upon which all health IT services are delivered. The IT Operations program comprises six IT investments: Data Center and Cloud Standard Investment, Network Standard Investment, Platform Standard Investment, Delivery Standard Investment, End User Standard Investment, and Application Standard Investment. These investments enhance and maintain critical IT infrastructure required for HIT modernization. The IT Operations program includes a highly available and secure wide area network that includes locations with unique telecommunication challenges, a national e-mail and collaboration capability that is designed specifically to support health care communication and data sharing, enterprise application services and supporting hardware including servers and end-user devices. The program incorporates government and industry standards for the collection, processing, storage, and transmission of information and uses the IT Infrastructure Library (ITIL) IT Service Management (ITSM) framework to optimize the delivery of IT services.

4) **IT Security and Compliance** investment supports the IHS Cybersecurity Program by implementing security controls and continuously assessing the efficacy of those controls while managing information security risk. The IHS Cybersecurity Program protects the information and information systems that support IHS operations by implementing cybersecurity policy, securing centralized resources, and providing cybersecurity training for all employees and contractors.

5) **IT Management** investment is an enterprise-wide IT Governance program that provides IT Management, Capital Planning Investment Control, Strategic Planning, Enterprise Architecture, IT Finance, and IT Vendor Management activities for all IHS IT investments.

These essential activities promote compliance with federal laws and regulations to improve the efficiency and effectiveness of all IHS HIT portfolio investments.

BUDGET REQUEST

The FY 2026 budget submission of $182.1 million for Health Information Technology is flat with the FY 2025 Enacted level.

This funding will continue progress made in past years by minimizing infrastructure costs and maintaining a high level of productivity and commitment by both federal and contractor staff supporting the IHS-developed health information solutions. IHS uses open-source tools where possible to minimize acquisition costs. Following the VA announcement to sunset their VistA EHR application, the IHS and HHS Chief Technology Officers began an analysis of alternatives to assess the sustainability of the entire RPMS HIT platform. The HHS-IHS HIT Modernization Research Project was completed in FY 2020. The Project identified the need to replace the legacy EHR platform with a modern commercially available EHR suite to improve the impact and quality of direct patient care, increase cost recovery and promote continuous health improvements, expanded telehealth care services, and predictive population health analytics. The IHS Health Information Technology Modernization Program was initiated in FY 2021 and is further described in detail in a subsequent section of this document. As of mid-FY 2025, the Modernization Program is engaged in in the enterprise system build for the new EHR suite, with pilot site implementation targeted for June 2026. A multi-year rollout implementing the new EHR across the remainder of IHS and participating Tribes and Urban Indian Programs will follow, throughout which the current RPMS infrastructure must be maintained The current RPMS infrastructure must be maintained.

FUNDING HISTORY

Fiscal Year	Amount*
2022 Final	$182,149,000
2023 Final	$182,149,000
2024 Final	$182,149,000
2025 Enacted	$182,149,000
2026 President's Budget	$182,149,000

*Funded under the Hospitals & Health Clinics budget.

TRIBAL SHARES

H&HC (IT is funded out of H&HC) funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A small portion of the overall H&HC budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

PROGRAM ACCOMPLISHMENTS

The Office of Information Technology (OIT) successfully provided a secure and effective suite of technology solutions to support the agency and its mission throughout the country. Collaboration with tribal health programs and other federal agencies is key to the success of the HIT Portfolio. In FY 2024-2025, IHS worked closely with the ONC, CMS, Agency for Healthcare Research and Quality, VA, and other federal entities on IT initiatives to ensure the

direction of its HIT systems is consistent with other federal agencies. In addition, IHS has routinely shared HIT artifacts (e.g., design and requirement documents, clinical quality logic, etc.) with both public and private organizations.

The Health Information Technology Systems and Support (HITSS) Investment accomplishments for FY 2024 included major achievements for the respective domains and programs supported by the HITSS Investment and Division of Information Technology (DIT) staff.

Within the Practice Management domain of the HITSS Investment, major software updates were coded, tested, and released, to support changes in IHS facilities billing to Change Healthcare (Change CH). These updates were made to mitigate the service impacts that resulted from the Change HC national data breach. The breach caused a cessation in revenue reimbursement to healthcare providers and facilities nationwide. Thanks to the efforts of the Practice Management team within the DIT, billing services were able to be restored in a short period of time, ahead of many other software vendors.

The Informatics and Interoperability domains worked to certify the HHS ASPT/ONC 2015 Edition Cures Update for the 2024 reporting period, to include meeting the United States Core Data for Interoperability (USCDI) requirement. The Interoperability team also made updates to expand the use and flexibility of the Personal Health Record (PHR) Medication Refill option. This update allowed for better patient application use and configuration options for facilities with Pharmacies. The IHS was the first Federal agency on-boarding to the Trusted Exchange Framework and Common Agreement (TEFCA) for health information exchange (HIE) data sharing. In addition, the certification requirements for the 2015 Edition Cures Update were met. Federal and Tribal incentive payments for 2022 totaled $1.4 million for Federal, and $3.1 million for Tribal.

For the domain of System and Hardware Infrastructure, the Computer Systems Management Team (CSMT) has been able to maintain a robust security posture, by performing continuous monitoring and regular patching of DIT systems, resulting in no reportable security incidents for the HITSS Investment. Additionally, the team has been able to support the testing, deployment, and updates of Windows Server 2022 to certify it for use with the Resource and Patient Management System (RPMS). Along with Windows Server 2022, the team has been able to support the testing and deployment of the InterSystems HealthShare platforms to IRIS, for all I/T/U sites.

Other program accomplishments include updates from the HITSS Project Management Office, Software Quality Assurance (SQA) team, and with DIT policies. The HITSS PMO has made significant improvements to the HITSS Investment SharePoint site, migrating all data from a legacy site, while modernizing the current site to facilitate improved accessibility to the HITSS program and project information. For FY2024, the HITSS PMO managed over $33 million in Annual Funding Requests (AFR's), representing the work from 102 completed projects. Finally, the HITSS PMO has made improvements to the Azure DevOps (ADO) tool, addressing functionality to support the agency A-123 submissions. The SQA team coordinated a total of 29 RPMS patches, 2 version updates, and completed 71 RPMS related events for the 2024 calendar year. Additionally, a total of 256 Health IT eLearning training courses were delivered to 10,659 I/T/U users during 2024.

The DIT policy development and update efforts drafted 6 standard operating procedures at 95 percent, with 3 DIT policies drafted and shared with IHS partners and business owners for their comment. Those policy updates included Indian Health Manual (IHM) Part 2 Chapter 6 – Patient

Registration System, Direct Messaging Policies; Part 2 Chapter 7 – HIPAA and Privacy; Updates to Health Information Management Part 3 Chapter 3.

The National Patient Information Reporting System (NPIRS) investment continues to maintain and oversee the Enterprise Business Intelligence and Business Analytic (BI/BA) environment that deep insights into data, empowering Indian Health Services to make actionable and informed decisions on patient population and patient care management statistics, trends, patterns, and predictions. The BI/BA framework enables the ability to collect, consolidate, store, process and analyze large volumes of data across various data domains. The DDMA/NPIRS investment supports eleven of the agencies program offices and delivers reusable solutions that leverage a robust security model that delivers data at the headquarters, area, service unit and federal, tribal and/or urban facility levels.

DDMA/NPIRS partnered with the Phoenix area to technical debt by migrating two of the 14 dashboards from QlikView to the enterprise QlikSense BI tool. The Human Resource dashboard was one of the converted dashboards that was not only migrated but extended to integrate all twelve areas data to result in an enterprise solution that supported the IHS Director's initiative to recruit, retain and promote a high performing civil service staff to further the agencies mission. An Emergency Department dashboard was also part of the migration effort. FY 2024 activities also included the transition of static, tabular reports for Opioid Surveillance and HIV Syndemic and Sexually Transmitted Infections (HIV/STI) to an interactive nimble analytic solution that provides insights into the epidemics of HIV, HCV, STI and Opioid usage, diagnosis, linkage to care affecting AI/AN patients, enabling data-driven decisions that support planning, implementation and evaluations to address the HIV, STI and Opioid issues. Eight new measures were released in FY2024 to promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse and improve access to culturally appropriate treatment. All dashboards present relevant data at the IHS national, area, service unit and local facility levels.

The first iteration of a National Vaccine Coverage (NCV) dashboard was developed to replace and scale a legacy web application that will support a critical public health prevention initiative to increase vaccine coverage of the AI/AN community and protect against vaccine-preventable illnesses. The NCV dashboard will assist in amplifying the efforts of the agency to ensure comprehensive vaccine access and coverage for all age groups both for emerging infectious disease and routine vaccine preventable diseases.

NPIRS also released enhancements to the Patient Centered Medical Care (PCMH) dashboard, incorporating advancements into the Shewhart/control charts that utilize statistical calculations that help to bring insights into variation and special causes when analyzing critical patient data. Also introduced 'phasing' into the dashboard to enable easy detection of data anomalies, deviations or outliers to proactively identify opportunities for process improvement.

A self-service, digital, analytic portal was developed and released for the Office of the Director to provide the agency with a central hub for all agency historical and FY 2024 analytic solutions developed by DDMA/NPIRS. The digital portal is also postured to scale and include additional analytic solutions developed outside of NPIRS as they become available. NPIRS continued in FY 2024, to generate annual and recurring mission critical enterprise reports that support statutory, regulatory, and administrative enterprise reporting requirements to include, but not limited to, user population, workload, accreditation, and various performance measurement reports.

The IT Operations program implements new enterprise technologies while sustaining and providing customer support for hundreds of IT services. In FY 2024, IT Operations completed over 105 significant IT initiatives/projects and acquired over 100 products and services. Notable projects and accomplishments are as follows:

- Acquired ShareGate migration tool and initiated the modernization from legacy SharePoint 2013 to SharePoint Online.
- Introduced Just-in-Time (JIT) access for Microsoft 365 security roles to minimize the risk of granting continuous administrative access.
- Continued to improve the capabilities of the IHS network through circuit upgrades implemented at approximately 40 sites, plus the deployment of Starlink at approximately 10 sites, to verify and prove the viability of the service as a connection option to the IHS network.
- Configured the deployment of CrowdStrike mobile app, the first Endpoint Detection and Response (EDR) implemented on IHS MDM enrolled devices; fulfilled FISMA requirement.
- Planned and implemented the transition of 2,000 + mobile devices from IBM MaaS360 to Microsoft Intune, resulting in a cost savings of 607,000 + over a 5-year period.
- Continued to improve the capabilities of the IHS network through circuit upgrades implemented at approximately 40 sites, plus the deployment of Starlink at approximately 10 sites, to verify and prove the viability of the service as a connection option to the IHS network.
- Replaced the VPN Phone-factor solution being deprecated by Microsoft with the Okta Verify MFA solution and successfully migrated over 1,500 users to the new solution with minimal post-migration user support issues.

In FY 2024, IT Operations continued to improve data sharing and collaboration within the IHS and between the IHS and HHS, Tribal entities, Business partners, and other government agencies. IT Operations also continued to support cybersecurity operations to better protect sensitive data as we expanded access to information within our IT platforms.

The FY 2025 forecasted activities for IT Operations are focused on IT Modernization and improving cybersecurity by adopting a Zero-Trust cybersecurity framework and enhanced capabilities.

In FY 2024, the IT Cybersecurity Program made significant strides in supporting the Health IT Modernization initiative by enhancing the adoptability of Zero Trust Architecture (ZTA) and achieving compliance with the Zero Trust Maturity Model (ZTMM). These efforts have fortified the security and reliability of healthcare operations, with a strong emphasis on preventing data leaks and safeguarding privacy. During this fiscal year, foundational solutions were successfully implemented at the headquarters level, setting the stage for broader deployment across the organization. These technologies include PRISMA to optimize network performance and security and ensuring reliable connectivity for the new electronic health record system PATH EHR, automated security orchestration and incident response using XSOAR, and centralized management of security policies within Panaroma. As these technologies expand to the Area level, they will ensure that all IHS sites benefit from this new cybersecurity standard.

IT Management continues improving IT governance through enhanced configuration and utilization of the Planview Enterprise Portfolio Resource Management (PRM) System that provides an enterprise IT portfolio and project management capability enabling IHS to improve project performance oversight and monitoring corrective actions through to completion. The

Planview PRM system also provides a comprehensive Enterprise Architecture capability enabling line-of-sight linkage between IHS strategic goals & objectives, business capabilities, and the IT requirements needed to support those capabilities. These continued enhancements provide management tools to help ensure IHS prioritizes IT spending on investments that directly support strategic goals. OIT staff provided virtual presentations on HIT initiatives at various tribal or tribal health board conferences and meetings such as TribalNet, National Tribal Health Conference, Tribal Technical Advisory Group, National Indian Health Board (NIHB), NIHB Medicare, Medicaid, and Health Reform Policy Committee, IHS Tribal Self Governance Advisory Committee, and the Direct Service Tribes Advisory Committee quarterly meetings, etc. OIT staff regularly participated in Tribal Delegation Meetings and the Alaska Area Pre-negotiation/Negotiation meetings to address IT/HIT issues. The OIT Healthcare Connect Fund Program provided support to 68 federal and 59 tribal locations to collect $2.0 million in refunds for data circuit costs.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome)	FY 2024: 3.125 Target: 3.0[1](Target Exceeded)	4.0	4.0	Maintain

[1]>= out of 5 for all investments.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
ELECTRONIC HEALTH RECORD SYSTEM

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$190,564	$190,564	$190,564	--
FTE /1, 2	40	50	50	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal; PL 93-638 Tribal Contracts/Compacts, Tribal shares

PROGRAM DESCRIPTION

Electronic Health Record System Modernization - The health information technology (HIT) system currently in use at the Indian Health Service (IHS) is the Resource and Patient Management System (RPMS), a comprehensive health information suite that supports a broad range of clinical, population health, and business processes from patient registration through the billing cycle.

In 2018-19, IHS, in collaboration with HHS, engaged in comprehensive research and analysis of the current state of its HIT infrastructure and options for modernization. Informed by the outcomes of that project, IHS published its intent to move forward with modernization by transitioning from its legacy RPMS to state-of-the-art, commercial systems. The approach to modernization is not limited to an Electronic Health Record (EHR), but must support a true enterprise approach to HIT, positioning IHS in the best possible way to accomplish its mission in the coming years.

BUDGET REQUEST

The FY 2026 budget submission for Electronic Health Record Modernization is $191.0 million, which is flat with the FY 2025 Enacted level.

The current IHS electronic health record system is more than 40 years old, and the Government Accounting Office identifies it as one of the 10 most critical federal legacy systems in need of modernization. The IHS expects to begin the site implementation phase in FY 2023, which will require significant additional resources to analyze the needs of hundreds of sites, implement the new system, replace outdated equipment, and other related steps.

This funding will lay the groundwork to improve the quality of care, reduce the cost of care, promote interoperability, simplify IT service management, increase the security of patient data, enhance cybersecurity, and update infrastructure across rural locations to enable a successful

EHR transition. This will include the continuation of project management operations, acquisition planning, EHR selection, additional tribal consultation, initial infrastructure build, site implementation planning, and continued RPMS stabilization and support. The project will follow industry standards for modernization or replacement of EHR systems to leverage expertise and experience in the private sector.

- Health Information Technology Modernization – The IHS Health Information Technology Modernization effort has already started to issue Task Orders under the awarded Indefinite Delivery, Indefinite Quantity (IDIQ) contract and will use the FY 2025 resources to continue to execute several core activities in FY 2025 many of which are efforts from FY 2024 and prior. Specifically, the IHS expects to address the following:

    - RPMS Stabilization: IHS will continue to update the legacy systems to maintain EHR Certification compliance. Significant development, testing, patching, rollout and training efforts will be required, using expanded contract resources.
    - Interoperability: The IHS will continue a national rollout to enable exchange both within the IHS enterprise and with external referral network partners.
    - Complete Build of EHR Environment: With the selection of General Dynamics Information Technology (GDIT) as the prime contractor, partnered with Oracle Health, for the new EHR system in early FY 2024, work will continue on the design and build steps, to prepare the commercial system for operation in the IHS environment. The Program is initiating work under Task Orders 5, 6, and 7 focused on Enterprise and Pilot Design Configuration and Implementation.
    - Local Needs: With the selection of an EHR product, the Agency will define the technology architecture required for optimal performance of and support for the system. The IHS can then target identified gaps at local facilities and in the wide area network and hosting systems.
    - Initial Site(s) Transition Planning: Resources will support the development of a core planning template and master deployment schedule. This will also accommodate individual site planning using the template to address technology infrastructure remediation, site configuration, end-user training, change management, communication, and stakeholder engagement at the local level near the deployment target for each site.

    The IHS anticipates completion of the enterprise solution and preparing and planning site deployments in beginning in FY 2026.

    - This project holds an extremely high degree of mission criticality given the ability to provide much-anticipated clinical and administrative capabilities used in modern systems for the delivery of timely and impactful healthcare. Expected benefits from adopting and implementing a modernized system include, but are not limited to: improved patient safety, improved patient outcomes, better disease management, enhanced population health, improved clinical quality measures, opioid tracking, patient data exchange, third - party revenue generation, agency performance reporting, and more. Additionally, the IHS intends to achieve the best possible interoperability with the Department of Veterans Affairs, Department of Defense, Tribal and Urban Indian health programs, academic affiliates, and community partners, many of whom use different HIT platforms.

- IHS Legacy EHR System Maintenance - The current IHS EHR, Resource and Patient Management System (RPMS), has been identified by the GAO as one of HHS's top three systems in most need of modernization due to lack of development and enhancement work over the past decade. IHS must maintain the existing EHR system until implementation of the new system is complete.

- IT Infrastructure and Operations Modernization - These IT Infrastructure Modernization initiatives are required to provide the platform for which the EHR operates and support redundancy capacity.

Funding will allow for improved revenue from third-party payers, improved training through standardized user interfaces and integration across health facilities, reduced workload to support the infrastructure, and improved quality and operational oversight through improved national reporting and data analytics.

FUNDING HISTORY

Fiscal Year	Amount[1]
2022 Final	$145,019,000
2023 Final	$217,564,000
2024 Final	$190,564,000
2025 Enacted	$190,564,000
2026 President's Budget	$190,564,000

PROGRAM ACCOMPLISHMENTS

In 2025, the IHS Modernization of Health IT System & Support (mHITSS) investment made significant progress across the Indian Health Service. The IHS is committed to collaborating with our partners and leveraging their feedback to build our new enterprise electronic health record (EHR) solution, PATH EHR, to meet the specific needs of its users across Indian Country. PATH stands for "Patients at the Heart," and demonstrates our dedication to assisting individuals on their journey to healing, promoting empowerment, and advancing health and wellness. Program accomplishments include:

- Began the design and build phase of the PATH EHR software to align the standardized workflows, long-term goals, objectives, and program milestones.
- Facilitated a tribal consultation and urban confer sessions to provide tribal and urban Indian organization partners updates about the status of Program activities; Deployment Site Readiness and Training, the Four Directions Warehouse, including an overview of the key data elements for ensuring organizational readiness and the comprehensive training approach that will be used to seed information in PATH.
- Held focus groups for interested IHS, tribal, and urban (I/T/U) organization members, regardless of their selected EHR solution, to inform and support the design and configuration of PATH EHR.
- Continued the Modernization Leader Alignment Interview initiative to better understand the level of alignment among leadership around program goals, success factors, and identified challenges.

[1]This represents the total cost of HIT within IHS federal programs. The majority is from Hospitals & Health Clinics budget line with a small amount from Direct Operations for federal personnel and travel.

- Began to identify and define configurations for the Federal Oracle Cloud, the cloud-based host for PATH EHR.
    - Completed 56 percent of data collection needs
    - Completed 42 percent of the Enterprise Build as of May 2025
    - Validated 32 percent of the Enterprise Build as of May 2025
- Continued work with our Enterprise Collaboration group to inform the configuration of the Enterprise PATH EHR
- Launched Videos 2 and 3 of the Modernization Video Series, titled "Modernization Program Leadership Testimonials" to generate awareness of the Modernization efforts.
- Conducted a preliminary technical assessment at Lawton Service Unit that covered:
    - End-point integration assessment of devices, data drops, power, and power outlets.
    - Infrastructure assessment for voice, cabling, cooling, access control, video, and paging systems.
    - Biomedical device assessment for middleware gateways and compatibility.
    - Network assurance assessment for wired current state, remediations, and mitigations; as well as wireless network current state, remediations, and mitigations.
- Began design and build of Four Directions Warehouse (4DW) for production.
- Continued staffing the DHITMO Branch.
- Held the Health IT Modernization Program Implementation and Deployment planning meeting to align the resources and activities to plans scope, timelines, and methodology for implementing PATH EHR.
- The initial network connection between OC2 and IHS Network is connected via IPSec Tunnel (aka VPN) to support workshops.
- Began and submitted multiple Authority to Operate drafts for review to support PATH EHR testing and hosting.
- The Health Data Intelligence platform (HDI), formerly HealtheIntent, passed the Tech Ready test on 11/21/2024. This means the two key platforms, Millennium and HDI, were cleared for the Workshops to begin in the second quarter of FY 2025.

OUTPUTS/OUTCOMES

As IHS continues to review options, costs, and potential benefits, output and outcome measures will be developed. The new EHR environment will support existing measures for the Government Performance and Results Act (GPRA)/GPRA Modernization Act and electronic quality measures to support healthcare accreditation.

GRANT AWARDS

Not applicable to this funding.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
DENTAL HEALTH

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$252,561	$254,117	$259,501	+$5,384
FTE /1, 2	507	455	455	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal, P.L. 93-638 Self-Determination Contracts, Tribal shares, Grants, and Self-Governance Compacts

PROGRAM DESCRIPTION

Services Provided. The purpose of the Indian Health Service (IHS) Dental Health Program (DHP) is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The DHP is a service-oriented program providing basic dental services (e.g., diagnostic, emergency, preventive, and basic restorative care), which represents approximately 93 percent of the dental services provided. In FY 2024 the DHP provided a total of 3,816,127 basic dental services, a 7.67 percent increase from FY 2023, in which the DHP provided 3,492,927 services. More complex rehabilitative care (e.g., root canals, crowns and bridges, dentures, and surgical extractions) is provided where resources allow and accounted for the additional 256,496 dental services in FY 2024, a 10 percent increase from FY 2023 where 227,973 higher level services were performed. The DHP provided these services through 1,264,859 dental visits in FY 2024, a 6 percent increase from FY2023 (1,193,398 dental visits). Most DHP clinics have not yet returned to pre-pandemic staffing levels, and this continues to be the major contributing factor as to why both the number of dental visits and number of dental services continue to remain below pre-pandemic levels by 14 percent and 8 percent respectively.

Oral Health Disparities. Across all age groups, AI/ANs suffer disproportionately from dental disease. When compared to non-AI/AN children, AI/AN children 2-5 years old have more than double the number of decayed teeth and overall dental caries experience. In the 6-9 year-old age group, 8 out of 10 AI/AN children have a history of dental caries compared with only 45 percent of the general U.S. population, and almost half of AI/AN children have untreated tooth decay compared to just 17 percent of the general U.S. population in this age group. In the 13-15 year-old age group, three out of four AI/AN dental clinic patients have a history of tooth decay, compared to half of 13-15 year-olds in the general U.S. population, and almost three times as many 13-15 year-old AI/AN youth have untreated decay compared to the general U.S. population. In adults, the differences in dental disease is equally as pronounced. 56 percent of AI/AN adults 35-49 years have untreated decay compared to just 26 percent of the general U.S.

population, and across all other age groups studied (50-64 years, 65-74 years, and 75 and older), AI/AN adults have more than double the prevalence of untreated tooth decay as the general U.S. population. In addition, the rate of severe periodontal disease in AI/AN adults is double that of the general U.S. population. Data for all of these differences can be found in the data briefs published by the DHP at www.ihs.gov/doh.

Pandemic Effect. The lack of regular dental care during the COVID-19 Pandemic may have led to an increase in oral health issues among American Indian and Alaska Native (AI/AN) children. Future oral health surveillance surveys will be needed to further quantify this impact.

Workforce Challenges. The dentist to population ratio in the IHS system continues to be very low when compared to the ratio in the U.S. private sector. This low dentist to population ratio and an increase in population growth in the AI/AN population will continue to present a challenge in achieving the access rate goal. In FY 2024, the IHS has 1,046 dentists (including part-time) in the system, according to the IHS Dental Directory, an increase of 28 from FY 2022. According to the FY 2023 annual IHS Chief Medical Officer (CMO) User Population Report, there were 3,083,103 AI/AN registrants in the U.S. That means that the IHS Federal/Tribal/Urban (I/T/U) dental care system has approximately one dentist per 3,028 patients served. According to the American Dental Association[1], there were an estimated 202,304 dentists in the U.S. in 2023 serving a population of 334.9 million people (US Census Bureau), meaning that there is approximately one dentist per 1,655 people served in the general US population. This disparity shows the understaffing of dentists in the DHP I/T/U workforce. (Note: Final FY 2024 IHS AI/AN population data is currently not available.)

BUDGET REQUEST

The FY 2026 budget submission for Dental is $259.5 million which is $5.4 million above the FY 2025 Enacted level.

FY 2025 Final level Funding of $254.1 million supports oral health care services provided by IHS and tribal programs, maintain the program's progress in raising the quality of and access to oral care through continuing recruitment of oral health care professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2026 Funding Increase of $5.4 million includes:

- Staffing of Newly Constructed Facilities: +$5.4 million. Information can be found in the Staffing of New Facilities chapter.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$235,788,000
2023 Final	$248,098,000
2024 Final	$252,561,000
2025 Enacted	$254,117,000
2026 President's Budget	$259,501,000

TRIBAL SHARES

[1] https://www.ada.org/resources/research/health-policy-institute/dentist-workforce#:~:text=Dentist%20workforce%20FAQs,Ratios%20vary%20by%20state.

Dental funds are subject to tribal shares and are transferred to tribes when they assume the responsibility for operating the associated programs, functions, services, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall Dental budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

PROGRAM ACCOMPLISHMENTS

Government Performance and Results Act (GPRA). Overall access to care increased from 25.28 percent in FY 2023 to 27.82 percent in FY 2024, a 10 percent increase. The proportion of 2-15 year-old AI/AN children receiving dental sealants – a second GPRA indicator – improved from 11.02 percent in FY 2023 to 11.77 percent in FY 2024, and the proportion of 1-15 year-old AI/AN children received topical fluorides – another GPRA indicator – increased from 25.63 percent in FY 2023 to 28.35 percent in FY 2024. FY 2024 marked the second time since 2018 that IHS met all three of the dental GPRA targets.

IHS Electronic Dental Record (EDR). With the addition of Congressional and IHS OIT financial support for implementation of the IHS electronic dental record (EDR), over 87 percent of IHS I/T/U dental clinics have transitioned to an EDR system to support the delivery of effective, quality dental services. The IHS Dentrix Enterprise (DXE) EDR program has been successfully implemented at 332 of these I/T/U dental clinics. However, there are still approximately 42 IHS I/T/U clinics that have not transitioned to an EDR system and new dental clinics are being built every year. The DHP expects to continue to need to provide 9-15 new implementations each year to continue this EDR transition objective. More recent Congressional funding increases have also supported continued development of the IHS EDR system to make it more effective for the unique scenario of the AI/AN population and IHS I/T/U clinic needs. The EDR Program also provided continuous upgrade support for the I/T/U dental clinics using the IHS DXE EDR to ensure this essential IT system meets data integrity, cybersecurity requirements and ensure the IHS provides state-of-the-art electronic record support for both direct patient care quality and safety as well as enhance provider/clinic effectiveness and efficiency.

Oral Health Promotion/Disease Prevention (HPDP) Initiatives. The DHP continues to provide seed funding to IHS, tribal, and urban programs to carry out national initiatives aimed at prevention and early intervention of dental disease. Successful projects in the past few years include an early childhood caries initiative that increased access to dental care by 30 percent in AI/AN children and reduced untreated tooth decay in young children by 14 percent, the largest such decrease ever measured. Another project was a depression screening by dental provider project that demonstrated the feasibility of conducting behavioral health screenings in the dental clinic setting. This project will be further followed up with an interoperability analysis for electronic data exchange of these types of screenings between the IHS EDR and IHS EHR (electronic health record). A third project is the American Dental Association sponsored Give Kids a Smile®, with 98 events held in I/T/U sites in 2024. Over the course of the four years of this program, the DHP has held 525 events with 1,112 I/T/U dentists and 2,755 I/T/U dental hygienists & dental assistants participating, resulting in 57,483 children receiving preventive and restorative services with an estimated benefit of $4.8 million. A fourth project called “Triaging and Treating Dental Conditions in the Emergency Department” resulted in training over three dozen emergency department staff in five hospitals on how to better triage and treat patients presenting with dental problems. A fifth project aimed at early intervention was teaching medical providers how to apply silver diamine fluoride to stop tooth decay in AI/AN children, with four

medical providers participating. A sixth and final project was the implementation of cognitive screenings on geriatric patients by dental providers, with five programs conducting screenings. Similar to the depression screening project, additional interoperability research will be conducted to allow these screenings to transition electronically into the IHS medical record and be readily available for follow-up by appropriate medical staff. A summary of initiatives can be viewed at the IHS Dental Portal at www.ihs.gov/doh under the "initiatives" tab.

Continuing Dental Education (CDE). The DHP continues to improve the delivery of services and retention of staff through a sustained continuing dental education (CDE) program, one of the largest, if not the largest, in the federal sector. In CY 2024, a total of 333 individual live and recorded CDE courses were available to IHS I/T/U oral health professionals. (Note: this is a slight decrease in the total number of live and recorded sessions from FY 2023 due to a complete review of all available courses and removal of outdated courses.) A total of 1,558 dentists participated in CDE courses, while 2,190 dental hygienists and dental assistants participated in CDE events CY 2024. A total of 26,050 CDE participant hours were awarded CY 2024. Through the IHS CDE Program, most dentists, dental hygienists, and dental assistants have been able to meet their respective state licensure maintenance requirements without travel to attend in-person CDE courses. This greatly increases the net amount of time an IHS dental provider can remain in direct patient care as well as saves the DHP and individual I/T/U Service Units significant funds.

Long-Term Training (LTT). DHP has improved the delivery of care through ongoing support of long-term training (LTT) of general dentists to build the cadre of dental specialists in IHS and tribal dental programs. Dentists completing DHP-sponsored LTT become specialists – such as pediatric dentists, periodontists, and endodontists – and have a service payback obligation to serve AI/AN patients. In the past eight years, one oral maxillofacial surgeon and ten pediatric dentists have returned from LTT to serve AI/AN patients.

Dental Clinical and Preventive Support Centers (DSC). The DHP provides a total $4 million annually in program-award funding and grant funding for nine DSCs. This funding allows the nine DSCs to provide assistance to the federal, Tribal and Urban Service Units and/or individual clinics within all twelve IHS Areas. The purpose of the DSCs is to support patient-directed activities within the clinics as well as provide literature and other educational materials designed to improve oral health of the AI/AN population via prevention rather than treatment.
The grants and program awards are not for direct patient care. Many DSC programs train dental staff (DHA trainings in AK; expanded function training for dental assistants (i.e. Restorative/Perio/CDHA)); and coordinating the IHS Oral Health Surveillance Screening training as well as help support the screening efforts. They all develop programs for Continuing Dental Education of staff and create many patient education materials.

Dental Infection Control Program. The DHP continues to provide guidance to dental programs on infection prevention control and safety issues with the assistance of the DHP infection prevention control and safety committee (IPCS). The DHP (IPCS) developed a series of three virtual continuing education courses focused on Building Core IPC Practices, Improving Sharp and Nitrous Safety. The DHP participated in the 2024 Organization for Safety, Asepsis and Prevention (OSAP) boot camp federal breakout sessions. Over 90 I/T/U members attended the boot camp. The DHP (IPCS) provided 26 bi-weekly infection control tips in 2024. At least 857 reviewed the IC tips which provided over 680 CDE hours to participants. The DHP (IPCS) teamed up with the IHS Office of Quality to develop dental specific infection control tracers in 2023. In total, seven specific tracers were developed with nearly 400 elements to review. These tracers have been distributed throughout IHS and are being tracked using the Joint Commission Tracers with AMP software.

Workforce Innovations. The DHP continues to support workforce innovations to improve access to care including Dental Health Aides (DHAs), Expanded Function Dental Assistants (EFDAs), and Community Dental Health Coordinators (CDHCs). The DHP now has over 50 DHA Therapists serving in tribal programs in Alaska, Washington, Oregon, and Idaho. The DHP is the largest trainer of EFDAs in the nation. Since 2016, the IHS CDE Program has held 168 different in-person EFDA courses that have resulted in 423 dental assistants being trained in periodontal expanded functions and 503 being trained in restorative expanded functions. EFDAs have been shown to increase access to dental care in the DHP by up to 3 percent, increase total services delivered by dental programs up to 5.1 percent, and increase the total services per patient visit by up to 14 percent.

In 2024, the DHP graduated the second class of Community Dental Health Coordinators (CDHCs), bringing the total to 13 I/T/U dental assistants and dental hygienists who have completed the program. CDHCs are trained to lead community-based initiatives and coordinate continuity of care for special patient populations. In 2025, the DHP initiated a third cohort of CDHCs with 6 dental assistants and dental hygienists.

Overall Improvements. As a result of these various initiatives, the DHP has experienced an unprecedented decrease in dental disease across the lifespan. Through our annual oral health surveillance program, the DHP has shown: (1) a decrease of 5 percent in the prevalence of early childhood tooth decay and a 14 percent reduction in untreated tooth decay in AI/AN children 1 to 5 years of age; (2) a decrease of 36 percent in prevalence of tooth decay and 36 percent reduction in untreated tooth decay in AI/AN children 6 to 9 years of age; (3) a decrease of 10 percent in prevalence of tooth decay and a 30 percent reduction in untreated tooth decay in AI/AN youth 13 to 15 years of age; (4) a reduction of 16 percent in untreated decay and 39 percent in periodontal (gum) disease in AI/AN adults 35 to 44 years of age; and (5) a reduction of 26 percent in untreated decay in AI/AN adults 55 years of age and older. All of these improvements can be viewed in the published data briefs available at www.ihs.gov/doh.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
61 Topical Fluorides (Outcome)	FY 2024: 28.4% Target: 21.1% (Target Exceeded)	27.4%	28.4%	+1.0 percentage point(s)
62 Access to Dental Services (Outcome)	FY 2024: 27.8% Target: 24.4% (Target Exceeded)	27.0%	27.8%	+0.8 percentage point(s)
63 Dental Sealants (Outcome)	FY 2024: 11.8 % Target: 9.9% (Target Exceeded)	11.8%	11.8%	Maintain

GRANTS AWARDS

The DHP currently provides $444,444 (each) in grant funding for six of the nine Dental Clinical and Preventive Support Centers (DSCs). For a five-year cycle starting December 1, 2020, six DSC grant awards were made, at an annual funding level of $350,000 each. $1,000,000 of additional FY 2021 funding for DSCs was the first program increase since FY 2000 and was utilized to increase the number of DSCs and the grant funding to each DSC, resulting in an expansion of services to AI/AN communities. In FY 2022, the DSC Program received an additional $1,000,000 to allow the DSCs the ability to expand the services provided to the AI/AN communities. The additional funding allows the DHP to utilize funds to cover administrative costs and for each of the DSC's to be supported annually at the $440,000 funding level.

The DSC personnel have multiple recurring duties and responsibilities as well as providing periodic support for numerous ad hoc activities. Recurring duties include: coordinate clinic activities by management of the DHP oral health surveillance program (requiring oral screenings for thousands of patients for specific age groups in five-year increments); creating oral health literature appropriate for their IHS Areas and tribes; and coordinating meetings for local, Area and national DHP meetings. The DSC personnel also assist dental clinics with health fairs and special prevention initiatives (such as the national Give Kids A Smile campaign); support continuing dental education for all dental staff; create, share and disseminate standardized oral health promotion information across IHS Areas and promote clinic staff and provider workplace satisfaction activities to help recruit and retain quality oral health care professionals.

(whole dollars)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	6	6	6
Average Award	$444,444	$444,444	$440,000
Range of Awards	$444,444	$444,444	$440,000

AREA ALLOCATION

Dental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY '26 +/- FY 24
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$	$44,481	$44,481	$	44,759	$44,759	$	45,707	$45,707	$948
Albuquerque	5,645	4,230	9,875	5,679	4,256	$9,935	5,799	4,347	$10,146	$211
Bemidji	3,718	2,568	6,286	3,740	2,584	$6,324	3,820	2,639	$6,458	$134
Billings	5,545	2,933	8,478	5,578	2,951	$8,530	5,697	3,014	$8,710	$181
California	255	2,141	2,396	257	2,154	$2,411	262	2,200	$2,462	$51
Great Plains	10,077	14,685	24,762	10,138	14,777	$24,914	10,352	15,090	$25,442	$528
Nashville	724	6,236	6,960	728	6,275	$7,003	744	6,408	$7,152	$148
Navajo	28,005	11,221	39,226	28,174	11,291	$39,465	28,771	11,530	$40,301	$836
Oklahoma	10,932	41,124	52,056	10,998	41,381	$52,379	11,231	42,257	$53,488	$1,110
Phoenix	10,451	23,939	34,389	10,514	24,088	$34,602	10,737	24,599	$35,335	$733
Portland	4,871	3,680	8,551	4,900	3,703	$8,603	5,004	3,781	$8,786	$182
Tucson	0	2,091	2,091	0	2,104	$2,104		2,149	$2,149	$45
Headquarters	13,010	0	13,010	13,088	0	$13,088	13,365		$13,365	$277
Total, Dental	**$93,233**	**$159,328**	**$252,561**	**$93,795**	**$160,322**	**$254,117**	**$95,781**	**$163,720**	**$259,501**	**+$5,384**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
MENTAL HEALTH

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$127,171	$130,114	$131,308	+$1,194
FTE /1, 2	172	171	171	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal; P.L. 93-638 Self-Determination compacts and contracts; Tribal shares

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Mental Health/Social Services (MH/SS) program is a community-based clinical and preventive service program that provides vital outpatient mental health counseling and access to dual diagnosis services, mental health crisis response and triage, case management services, community-based prevention programming, and outreach and health education activities. The most common MH/SS program model is an outpatient service staffed by one or more mental health professionals providing individual, family, and group psychotherapeutic services and case management. After hours emergency services are generally provided through local emergency departments and contracts with non-IHS hospitals and crisis centers. Inpatient services are generally purchased from non-IHS hospitals or provided by state or county hospitals providing mental health services. Intermediate level services such as group homes, transitional living support, intensive case management, and related activities are typically offered through state and local resources. Additionally, slightly more than one-half of the Tribes administer and deliver their own mental health programs.

IHS continues to support Tribal communities in their ability to address the mental health disparities experienced among the American Indian and Alaska Native (AI/AN) population. In partnership with Tribal community entities, a collaborative community of learning will support IHS efforts to promote excellence and quality through the development of innovative, community-based projects to expand mental health services and treatment in integrated clinical settings.

BUDGET REQUEST

The FY 2026 budget submission for Mental Health is $131.3 million, which is $1.2 million above the FY 2025 Enacted level.

FY 2025 Final level Funding of $130.1 million – This funding will maintain the program's progress in addressing mental health needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2026 Funding Increase of $1 million includes:

- Staffing of Newly Constructed Facilities: +$1.2 million. Information can be found in the Staffing of Newly Constructed Facilities chapter.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$121,109,000
2023 Final	$127,226,000
2024 Final	$129,765,000
2025 Enacted	$130,114,000
2026 President's Budget	$131,308,000

TRIBAL SHARES

Mental Health funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, services, functions, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall Mental Health budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

PROGRAM ACCOMPLISHMENTS

Suicide Prevention: Suicide rates among American Indian and Alaska Natives (AI/AN) are historically higher than non-AI/AN people within the U.S. population and is the eighth leading cause of death among all AI/AN across all ages[1]. Suicide rates have increased in 2021 with AI/AN people having the highest suicide rates overall, and the biggest increase (26 percent) between 2018 to 2021[2]. As reported in 2020, suicide rates for AI/AN adolescents are 1.9 times higher than the national average for others in the same age group, and 2.1 times higher than the national average for other young adults[3].

In 2022, suicide was the second leading cause of death for non-Hispanic AI/AN ages 10–34.[4] The overall death rate from suicide for AI/AN was 50 percent higher than for non-Hispanic whites in 2020.[5] The death rate in 2021, in suicide among adolescent AI/AN females, ages 15–19, was more than five times higher than non-AI/AN white females in the same age group.[6]

[1] https://beta.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7137a1-H.pdf
[2] https://www.cdc.gov/mmwr/volumes/72/wr/mm7206a4.htm
[3] https://www.cdc.gov/mmwr/volumes/67/wr/mm6708a1.htm
[4] CDC. National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). [Accessed 06/11/2024]. (back)
[5] CDC, 2024. Deaths: Final Data for 2021. National Vital Statistics Report, Vol. 73, No. 8. Table 10. (back)
[6] CDC. National Center for Injury Prevention and Control. Web Based Injury Statistics Query and Reporting System (WISQARS). National Violent Death Reporting System. Violent Deaths Report. (back)

The IHS utilizes and promotes collaborations and partnerships with patients and their families, including Tribes and Tribal organizations, Urban Indian organizations, federal, state, and local agencies, as well as public and private organizations.

In 2024, the IHS initiated a universal suicide risk screening across the healthcare system focusing on identification of suicide across the healthcare system using the IHS Electronic Health Records (EHR) in a standardized and systematic fashion. The universal suicide risk screening will enable the IHS to maintain high quality patient care related to the care and treatment of patients at risk for suicide.

The IHS has trained 4,352 Indian Health Staff in Question, Persuade and Refer (QPR) and trained 168 trainers across 12 IHS Areas in 2024. In addition to this training, a monthly newsletter is disseminated along with monthly technical assistance calls for training support and a heritage adapted QPR training specific to AI/AN. The IHS initiated crisis response team planning in 10 IHS Areas, including hiring or contracting crisis response staff over the next three years. To date, six Areas have initiated crisis response planning with eight initiating a crisis response team for outreach to Tribes. Currently, six Areas have initiated crisis response planning with eight initiating a crisis response team for outreach to tribes. The IHS partnered with the Northwest Portland Indian Health Board and Kauffman and Associates on the development of a tool kit for boarding school survivors[7] in the United States. The IHS has initiated a health and wellness campaign for providers focusing on compassionate care messaging, resiliency, and debriefing. In September 2024, the first mini-campaign was launched in partnership with the Crisis Text Line. The focus was on educating IHS providers on crisis services and self-care. A webinar was hosted in September 2024 with 168 participants.

The IHS developed four Agency Actions for inclusion in the 2024 National Strategy for Suicide Prevention Revision to be completed within or by three years. A specific focus of the Agency Actions focuses on standardized universal suicide risk screening. In FY 2024, the Ask Suicide-Screening Questions (ASQ) was launched via updates to the Indian Health Manual, Part 3, Chapter 34, Suicide Prevention and Care policy. The screening tool is expected to be implemented by the end of FY 2025, with Area implementation and training expected to start in early 2025. Additionally, a Five-year Strategic plan for AI/AN will launch in early 2025 which will include input by Tribal subject matter experts and IHS staff, based on the National Strategy for Suicide Prevention.

In FY 2025, IHS will implement mandatory training for all staff in recognizing and responding to suicide through the implementation of a culturally customized suicide prevention gatekeeper program, Question Persuade and Refer (QPR).

Zero Suicide Initiative: The Zero Suicide philosophy is a key concept of the National Strategy for Suicide Prevention (NSSP) to develop a system-wide approach to improving care for individuals at risk of suicide who are currently utilizing health and behavioral health systems. Health care systems are uniquely poised to identify those struggling with thoughts of suicide considering 50 percent of those who die by suicide had contact with a primary care provider within 1 month of suicide. In FY 2022, IHS received $3.6 million to fund a new five-year cohort for a total of 15 IHS, Tribal and urban health organization sites to reduce the prevalence of suicide among the AI/AN population within IHS hospitals through improved care coordination. Funded sites have implemented the Zero Suicide Initiative (ZSI) model within their healthcare system. In FY 2024,

[7] https://www.npaihb.org/tribal-boarding-school-toolkit-for-healing/.

sites made improvements according to information from their care and treatment of patients at risk for suicide. In FY 2023, the Division of Behavioral Health established ZSI Coordinating Center provided technical assistance to address the unique needs of Tribes and Tribal organizations implementing the ZSI model. Tribes and Tribal organizations utilize scientific treatments in suicide care, initiating safety plans with patients at risk for suicide, implementing intensive follow-up upon missed or cancelled appointments, universal suicide screening of all at-risk patients.

Trauma-Informed Care: As of FY 2024, a total of 96 percent of IHS staff completed the "Overview of Trauma Informed Care and Historical Trauma Guidance" in the HHS Learning Management System.

Behavioral Health Integration Initiative (BH2I): The statistics facing AI/AN peoples for suicide, alcohol-related deaths, domestic and sexual violence, and homicide require the Indian Health system to develop a system of comprehensive screening and effective intervention to reduce morbidity and early mortality. IHS supports changing the paradigm of mental health and substance abuse disorder services from being episodic, fragmented, specialty, or disease focused to incorporating it into the patient-centered medical home.

In FY 2022, IHS awarded 14 new five-year BH2I grants, totaling $5.5 million. Additionally, IHS awarded a training, technical assistance, and evaluation contract which will assist grantees in the implementation of specialized integrated care across IHS, Tribal, and Urban Indian Organizations. In FY 2025, the IHS continues support for federal facilities that currently participate in the Improving Pain and Addiction Care in IHS Emergency Departments (PACED) pilot project. The project supports the development of model clinical care pathways following patient overdose resuscitation within emergency departments.

Reflective of the Agency's priority to raise the mental health of the AI/AN population IHS Division of Behavioral Health initiatives have focused on increased implementation of depression screening in primary care clinics. In FY 2024, 37.1 percent of AI/AN adults over the age of 18 were screened for depression using a standardized screening assessment for depression. In FY 2024, this same measure was reported for youth ages 12-17 and data indicated 32.7 percent of eligible youth were screened for depression. The FY 2024 depression screening targets were met for the AI/AN population and anticipate an average 2.9 percent increase for both age cohorts in FY 2025.

AI/ANs have experienced challenges in mental health and substance misuse related to access to care, psychological stress, and social determinants of health. In FY 2023, IHS continued its partnership with the Northwest Portland Indian Health Board to provide a 24/7 Crisis Text Line for AI/ANs, which includes texting the keywords "Native" and "Indigenous" to 741-741. The Crisis Text Line connects individuals to a live, trained crisis counselor.

TeleBehavioral Health and Workforce Development: The IHS TeleBehavioral Health Center of Excellence (TBHCE) provides behavioral health services to many IHS and Tribal facilities, I/T/U patients that face issues surrounding access to care, particularly specialty care. Providers working in these remote areas often face barriers to maintaining the required continuing education (CE) credits required for licensure and remaining up to date on current clinical guidelines. The TBHCE assists IHS, Tribal, and urban Indian organizations providers and facilities in overcoming these challenges by providing a range of telebehavioral health services and virtual training. There are 25 sites receiving direct care services through the TBHCE. These services include, adult counseling, child counseling, family counseling, trauma/Post Traumatic Stress Disorder (PTSD)

counseling, child psychiatry, adult psychiatry, addiction psychiatry, and medication management. In FY 2024, the TBHCE provided 59,216 encounters.

Additionally, the TBCHE hosted webinars designed to meet the specific training needs of IHS, Tribal, and Urban Indian (I/T/U) health care providers[8]. More specifically, IHS utilizes tele-education (otherwise known as distance learning) to deliver national continuing education (CE) programming to I/T/U healthcare providers. In FY 2024, TBHCE provided 48 webinars that included 2,848 attendees. In FY 2024, TBHCE provided 19 on demand (self-paced) trainings that included 1,047 attendees completing CE certificates. On demand trainings focused on various topics including compassion fatigue, trauma informed care and the IHS Essential Training on Pain and Addiction. In FY 2025, TBHCE will continue to provide virtual live and on demand behavioral health trainings for I/T/U providers.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
65 Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression. (Outcome)	FY 2024: 37.1% Target: 36.4% (Target Exceeded)	39.6%	39.6%	Maintain
85 Depression Screening ages 12-17. (Outcome)	FY 2024: 32.7% Target: 29.5% (Target Exceeded)	36.1 %	36.1%	Maintain
MH-1 Increase Tele-behavioral health encounters nationally among American Indians and Alaska Natives (Output)	FY 2024: 59,216 Target: 71,000 (Target Not Met)	71,000	52,000	-19,000

[8] https://www.ihs.gov/teleeducation/webinar-archives/

GRANTS AWARDS

The proposed FY 2026 budget will be used for IHS facilities, Tribes, Tribal organizations, and urban Indian organizations to develop innovative programs to address behavioral health services and deliver those services within and outside of the traditional health care system. The actual number of FY 2023 non-competitive grants are included below:

(whole dollars)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	24	24	24
Average Award	$450,000	$450,000	$450,000
Range of Awards	$400,000 - $500,000	$400,000 - $500,000	$400,000 - $500,000

AREA ALLOCATION

Mental Health

(dollars in thousands)

DISCRETIONARY	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY '26 +/- FY '24
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$	$19,118	$19,118	$	$19,161	$19,161	$	$19,337	$19,337	$176
Albuquerque	1,549	3,579	5,128	1,553	3,587	5,140	1,567	3,620	5,187	$47
Bemidji	356	2,860	3,216	357	2,866	3,223	360	2,893	3,253	$30
Billings	2,165	2,062	4,227	2,170	2,067	4,237	2,190	2,086	4,275	$39
California	106	2,407	2,513	106	2,412	2,519	107	2,435	2,542	$23
Great Plains	6,505	7,023	13,528	6,520	7,039	13,559	6,580	7,103	13,683	$124
Nashville	327	2,509	2,836	328	2,515	2,842	331	2,538	2,868	$26
Navajo	9,799	8,326	18,125	9,821	8,345	18,166	9,911	8,421	18,333	$167
Oklahoma	3,244	18,319	21,563	3,251	18,360	21,612	3,281	18,529	21,810	$198
Phoenix	4,005	11,503	15,508	4,014	11,529	15,543	4,051	11,635	15,686	$143
Portland	491	4,068	4,559	492	4,077	4,569	497	4,115	4,611	$42
Tucson	0	1,611	1,611	0	1,615	1,615		1,629	1,629	$15
Headquarters	17,888	0	17,888	17,929	0	17,929	18,093		18,093	$165
Total, Mental	**$46,436**	**$83,384**	**$129,820**	**$46,542**	**$83,572**	**$130,114**	**$46,968**	**$84,340**	**$131,308**	**$1,194**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

ALCOHOL AND SUBSTANCE ABUSE

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$266,636	$266,771	$267,404	+$633
FTE /1, 2	246	251	251	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal; P.L. 93-638 Self-Determination contracts and compacts, Tribal Shares

PROGRAM DESCRIPTION

Substance abuse and substance abuse disorders are among the most severe public health and safety problems facing American Indian and Alaska Native (AI/AN) individuals, families, and communities. The purpose of the Indian Health Service (IHS) Alcohol and Substance Abuse Program (ASAP) is to raise the health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven. These collaborative activities strive to integrate substance abuse treatment into primary care. For instance, the Substance Abuse and Suicide Prevention Program (SASP) provides prevention and intervention resources developed and delivered by local community partners to address the dual crises of substance abuse and suicide in AI/AN communities.

In July 2022, the CDC's National Center for Health Statistics reported that from 2019 to 2020, overall drug overdose death rates (per 100,000 people) increased 39 percent AI/AN persons.[1] During that time, deaths rose more than 500 percent among AI/ANs. The actual number of deaths for AI/ANs may be underestimated by up to 35 percent.[2]

BUDGET REQUEST

The FY 2026 budget submission for Alcohol and Substance Abuse is $267.4 million, which is $633,000 above the FY 2025 Enacted level.

FY 2025 Final level Funding of $266.8 million – This funding maintains the program's progress in addressing alcohol and substance abuse needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

[1] https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7129e2-h.pdf

[2] https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf

FY 2026 Funding Increase of $633,000 includes:

- Staffing of Newly Constructed Facilities: +$633,000. Information can be found in the Staffing of Newly Constructed Facilities chapter.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$258,024,000
2023 Final	$266,440,000
2024 Final	$266,636,000
2025 Enacted	$266,771,000
2026 President's Budget	$267,404,000

TRIBAL SHARES

Alcohol and Substance Abuse funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, services, functions, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall Alcohol and Substance Abuse budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

PROGRAM ACCOMPLISHMENTS

As alcohol and substance abuse prevention and treatment have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS' role has shifted to providing support to enable communities to plan, develop, and implement traditionally informed programs. Organized to develop programs and program leadership, the major IHS ASAP activities and focus areas are:

Integrated Substance Abuse Treatment in Primary Care: IHS continues to support the integration of substance abuse treatment into primary care and acute care services. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an early intervention and treatment service for people with Substance Use and Substance Use Disorders (SUD) and those at risk of developing these disorders. IHS has broadly promoted SBIRT as an integral part of a sustainable, primary care-based activity that aims to support and integrate behavioral health into overall care. In FY24, the IHS created focused educational outreach and practice transformation materials to improve screening for substance use disorders. New clinical screening measurement tools (TAPS and CAGE-AID) were programmed into the IHS Electronic Health Record, training webinars were developed, and a short clinician video created. In FY 2024, the IHS met its screening goal.

In FY 2024, the SBIRT was utilized in 17.9 percent of the patient visits for those ages 9 through 75, exceeding the national target rate of 15 percent. For FYs 2025 and 2026, the national target rates for SBIRT are set at 15.8 percent and 16.4 percent, respectively. In FY 2025, IHS is actively working to expand local SBIRT use including a focus on substance use in women of childbearing age, to assist in early identification and referral for treatment and reduce illicit perinatal substance exposure for infants.

Increasing access to Medication for Opioid Use Disorder (MOUD): IHS is working to expand access to Medically Assisted Treatment (MAT) in acute care settings. In FY 2025, the IHS Pain and Addiction Care in the Emergency Department (PACED) will continue to fund and expand

IHS emergency departments seeking accreditation. The objective of this intervention is to improve access to Medications for Opioid Use Disorder (MOUD) or improve pain management outcomes in acute care settings. Secondary objectives are to leverage the opioid related dashboards to inform stewardship activities, to create a learning collaborative to share promising practices, and to assist sites with obtaining relevant accreditation. In FY 2024, the IHS created workforce development strategies that include SUD training for healthcare workers and technical assistance materials to support sites with creating integrated SUD approaches to care across the continuum of care.

IHS has partnered with the Northwest Portland Area Indian Health Board and the Clinician Consultation Center to facilitate IHS/Tribal/Urban (I/T/U) clinician access to free Substance Use Disorder tele-consultation services. These services are intended to assist clinicians with patient treatment planning, facilitate didactic learning, and provide support for health systems that desire to create local protocols.

IHS has also created a robust workforce development strategy to include didactic training. In FY 2024, the IHS developed and released mandatory employee training on *Reversing Opioid Overdose with* Naloxone. This training provides an overview of the IHS Opioid Stewardship program, risk factors for opioid overdose, and opioid overdose reversal with naloxone. Since launch, over 11,000 employees have completed the training (82 percent of the Agency). In FY 2024, the IHS continued its Pain Management and Opioid Use Disorder Continuing Medical Education webinar series with quarterly webinars. The IHS has hosted learning sessions with approximately 600 attendees with majority of attendees receiving continuing education credits.

Finally, In December 2023, the IHS announced the Naloxone Safety Net Program[3,4] which supports expanded harm reduction activities and works to promote low-barrier access to naloxone. The two-year pilot program ($500,000 annually) will support I/T/Us struggling to meet naloxone needs due to increased utilization and are meant to augment existing program naloxone forecasting. As of December 2024, 2,952 doses have been disbursed.

The IHS Educational Outreach Pilot Program championed the development of a pain management and opioid stewardship campaign that will support peer-to-peer interventions and scientific training to promote quality of care.

In FY 2024, 271 clinicians completed the *Essential Training on Pain and Addiction* and the *Refresher Training on Pain and Addiction* course. This is an on-demand, three-hour training with continuing education to align with scientific guidelines for pain management and Opioid Use Disorder (OUD) (a total of 1800 prescribers have completed since launch in September 2023).

Information Systems Supporting Behavioral Health Care: IHS released enhanced clinical decision support tools for the Resource and Patient Management System (RPMS) to assist providers in meeting documentation standards outlined in the Indian Health Manual (IHM), Part 3 - Chapter 30. The Electronic Health Record (EHR) Reminders and dialog note templates facilitate accurate and timely documentation to support best practices and implementation of pain management policy requirements. In FY 2025, IHS will continue efforts to standardize instruments and clinical decision support tools within the IHS EHR to support routine and effective screening for alcohol and substance use disorder and other behavioral health disparities. Data will be maintained to

[3] https://www.ihs.gov/opioids/news/

[4] https://www.facebook.com/share/p/tEay2QPHpv6Q3B8E/?mibextid=WC7FNe

support local, national and other program reporting requirements as well as quality performance measurements for numerous screening and prevention initiatives.

Youth Regional Treatment Centers (YRTCs): YRTCs are facilities which provide medically managed care and other essential treatment and recovery services to AI/AN youth experiencing SUDs. Congress authorized the establishment of YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. The YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values and heritage identification. In FY 2024, 90 percent of the federal YRTCs in operation 18 months or longer have achieved accreditation status.

Indian Children's Program (formerly, Fetal Alcohol Spectrum Disorders (FASD): Training and technical assistance on FASD is provided through the IHS TeleBehavioral Health Center of Excellence (TBHCE) Indian Children Program (ICP). The focus of the ICP is training clinicians on developmental and neurobiological issues that can affect AI/AN children. In FY 2023, ICP provided seven webinars on neurodevelopmental disorders with a total of 360 attendees. The ICP also provides additional clinician supports through virtual consultation designed to help clinicians successfully diagnose, manage, and treat AI/AN youth with FASD, Autism Spectrum Disorder (ASD), and other neurodevelopmental issues.

Partnerships and Grant and Federal Award Programs: IHS is collaborating with other agencies working in the field of SUDs such as the Department of Interior (DOI) Bureau of Indian Affairs (BIA) and Bureau of Indian Education (BIE), and the Administration for a Health America (AHA).

The IHS Division of Behavioral Health administers community-based grants and cooperative agreements that promote the use and development of scientific and practice-based models that represent heritage-appropriate prevention and treatment approaches to substance abuse from a community-driven context.

IHS Community Opioid Intervention Pilot Program (COIPP): FY 2024, concluded the third, and final year of the pilot project, funding at approximately $500,000 annually to 35 Tribal, Tribal organizations, and Urban Indian Organizations to increase public awareness and education about the impact of opioids on individuals, families and communities. These Tribal grantees prioritized efforts to reduce unmet needs and opioid overdose deaths through education, partnerships, and increased access to treatment for persons with Opioid Use Disorder (OUD). In FY 2025, IHS awarded the Community Opioid Intervention Prevention Program, to develop innovative, locally-designed, heritage-appropriate prevention, treatment, recovery, and aftercare services for OUDs.

Substance Abuse and Suicide Prevention Program (SASP): The SASP is a nationally-coordinated $31.97 million program providing funds for heritage appropriate substance abuse and suicide prevention programming in AI/AN communities. In FY 2024 the IHS continued funding two separate grant programs under SASP. The first, Substance Abuse Prevention, Treatment, and Aftercare (SAPTA), awarded $13.7 million to 36 Tribal, Tribal organizations, and Urban Indian Organizations and $2.0 million to eight federal IHS facilities. The second, Suicide Prevention, Intervention, and Postvention (SPIP), awarded $13.8 million to 36 Tribal, Tribal organizations, and Urban Indian Organizations and $2.0 million to eight federal IHS facilities. The program will fund 88 projects for a period of five years ending in FY 2027.

IHS established the Universal Alcohol Screening (UAS) as a national measure to increase screening and improve detection and intervention strategies among patients 9 through 75 years of age. In FY 2024, 34.4 percent of patients were screened and IHS screening efforts exceeded the national target rate of 32.2 percent. For FYs 2025 and 2026, the national target rates for UAS are set at 36 percent.

Preventing Alcohol-Related Deaths (PARD): In FY 2023, IHS awarded $2,000,000 to an alcohol detoxification center located in the city of Gallup, New Mexico to address the high rates of alcohol related deaths within McKinley County, New Mexico, and surrounding counties, which yield 48 percent of all alcohol-related death for AI/AN in the nation. The project period for this cooperative agreement is from FY 2023 – FY 2028. The data for the first year of the second round indicates the center service volume averages 1,600 admissions a month, which is 37 percent below the pre-COVID monthly trends. For the same period, seventeen clients have entered medically-assisted treatment for recovery from substance use disorders.

Youth Regional Treatment Center (YRTC) Aftercare Project*:* In FY 2023, the IHS awarded $600,000 to the Cherokee Nation's Jack Brown Center, a Tribal-operated YRTC, to operate and refine an aftercare program. This five-year program will end in 2027. The focus of the YRTC Aftercare Program is to develop treatment capacity for aftercare management, overcome performance barriers that affect the YRTCs, and for IHS to develop effective and responsive solutions to client engagement and assessment within the scope of youth's behavioral health treatment requirements and their interactions among treatment, court, and other service sectors. The aftercare program has successfully built a robust continuum of service capacity for AI/AN youth that includes strengthening the effectiveness of service protocols, associated staff training, and adoption of reinforcing service tools. To date, the aftercare program has served 78 AI/AN youth, of which, 36 AI/AN youth participate in the most recent reporting year. With reference to the 36 youth, the aftercare program successfully delivered services to them through 274 aftercare contacts, an average of 7.6 contacts per youth. In FY 2024 The aftercare program received a supplemental budget of $150,000 to concentrate on technical support in digital prototyping and protocol testing to define, verify, and record operational changes that can potentially enable patient-centered care tools and data sharing processes among youth.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). (Outcome)	FY 2024: 90 % Target: 100 % (Target Not Met but Improved)	100%	100%	Maintain
80 Universal Alcohol Screening (Outcome)	FY 2024: 34.4% Target: 32.2% (Target Exceeded)	36.0%	36.0%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
90 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome)	FY 2024: 17.9% Target: 15.0 % (Target Exceeded)	15.8%	17.9%	+2.1 percentage point(s)

GRANTS AWARDS

(whole dollars)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	110	75	94
Average Award	$350,000	$350,000	$350,000
Range of Awards	$300,000 - $400,000	$300,000 - $400,000	$300,000 - $500,000

AREA ALLOCATION

Alcohol and Substance Abuse

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY '26 +/- FY '24
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$447	$36,856	$37,303	$447	$36,876	$37,323	$448	$36,963	$37,412	$89
Albuquerque	2,935	10,672	13,607	2,936	10,678	13,614	2,943	10,703	13,646	$32
Bemidji	1,489	9,881	11,370	1,490	9,886	11,376	1,493	9,910	11,403	$27
Billings	248	11,904	12,152	248	11,910	12,159	249	11,939	12,187	$29
California	14,851	10,115	24,966	14,858	10,120	24,978	14,893	10,144	25,037	$59
Great Plains	3,358	12,840	16,198	3,360	12,847	16,206	3,367	12,877	16,245	$38
Nashville	3,023	7,036	10,059	3,024	7,040	10,064	3,032	7,057	10,088	$24
Navajo	1,643	21,541	23,184	1,644	21,553	23,196	1,648	21,604	23,251	$55
Oklahoma	4,142	16,185	20,327	4,144	16,194	20,338	4,154	16,232	20,386	$48
Phoenix	7,232	14,176	21,408	7,235	14,184	21,419	7,252	14,217	21,470	$51
Portland	394	17,515	17,909	394	17,524	17,919	395	17,566	17,961	$43
Tucson	0	3,440	3,440	0	3,442	3,442		3,450	3,450	$8
Headquarters	54,712		54,712	54,737		54,737	54,867		54,867	$130
Total, ASA	**$94,474**	**$172,161**	**$266,635**	**$94,517**	**$172,254**	**$266,771**	**$94,741**	**$172,663**	**$267,404**	**$633**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service Services:
75-0390-0-1-551
PURCHASED / REFERRED CARE

(Dollars in thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$996,755	$996,755	$1,002,755	+$6,000
FTE /1, 2	232	249	249	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method ..... Direct Federal, PL 93-638 Tribal Contracts and Compacts, Commercial contracts, and Tribal shares

PROGRAM DESCRIPTION

The Snyder Act provides the formal legislative authority for the expenditure of funds for the "relief of distress and conservation of health of Indians."[1] In 1934, Congress provided the specific authority to enter into medical services contracts for American Indians and Alaska Natives.[2] These, among other authorities[3] established the basis for the Indian Health Service (IHS) and the Purchased/Referred Care (PRC) Program.[4]

The PRC Program is integral to ensure comprehensive health care services are available and accessible to eligible American Indians and Alaska Natives (AI/AN). The general purpose of the PRC Program is for IHS or Tribal facilities to purchase services from private health care providers in situations where:

1) No IHS or Tribal direct care facility exists,
2) The direct care element is not capable of providing required emergency and/or specialty care,
3) The direct care element has an overflow of medical care workload, and
4) Full expenditure of alternate resources (e.g., Medicare, private insurance) has been met and supplemental funds are necessary to provide comprehensive care to eligible Indian people.

In addition to meeting the eligibility requirements for direct services at an IHS or Tribal facility, PRC eligibility is determined based on residency within the service unit or Tribal PRC delivery Area; authorization of payment for each recommended medical service by a PRC authorizing official; medical

[1] The Snyder Act, Public Law 67-85, November 2, 1921, 25 U.S.C § 13.

[2] The Johnson O'Malley Act of April 16, 1934, as amended, 25 U.S.C. § 452.

[3] Transfer Act, 42 U.S.C. § 2001; Indian Health Care Improvement Act, as amended, 25 U.S.C § 1601, et seq.

[4] The Consolidated Appropriation Act of 2014, Public Law 113-76, January 18, 2014, adopted a new name for the IHS Contract Health Services (CHS) program to Purchased/Referred Care (PRC). The IHS will administer PRC in accordance with all law applicable to CHS.

necessity of the service and inclusion within the established Area IHS/Tribal medical/dental priorities; and full expenditure of all alternate resources (i.e., Medicare, Medicaid, private insurance, state or other health programs, etc.). Alternate resources must pay for services first because the IHS PRC Program is the payer of last resort.[5] Services purchased may include hospital, specialty physician, outpatient, laboratory, dental, radiological, pharmaceutical, or transportation services. When funds are not sufficient to purchase the volume of PRC services needed by the eligible population residing in the PRC delivery area of the local facility, IHS PRC regulations require IHS or Tribal PRC programs to use a medical priority system to fund the most urgent referrals first.

Medical priority (MP) levels of care prior to January 1, 2024, are defined as follows:

MP Level I: Emergent or Acutely Urgent Care Services are defined as threats to life, limb and senses.
MP Level II: Preventive Care Services are defined as primary health care that is aimed at the prevention of disease or disability.
MP Level III: Specialty Services are considered ambulatory care which include inpatient and outpatient care services.
MP Level IV: Chronic Tertiary and Extended Care Services are defined as requiring rehabilitation services, skilled nursing facility care.
MP Level V: Excluded Services are services and procedures that are considered purely cosmetic in nature, i.e., plastic surgery.

Beginning January 1, 2024, IHS implemented revised IHS Medical Priority Levels. PRC services are now divided into four general categories, each considered equal, and within each category are three priority levels: Priority 1, Core – Essential Services; Priority 2, Intermediate – Necessary Services; and Priority 3, Elective – Justifiable Services. The revised medical priority categories are:

A. Preventive and Rehabilitative Services;
B. Medical, Dental, Vision, and Surgical Services;
C. Reproductive & Maternal/Child Health Services; and
D. Behavioral Health Services.

A PRC rate, a capitated rate based on Medicare payment methodology, is used to purchase care, and Medicare participating hospitals are required to accept this rate as payment in full for all hospital-based health care services (Public Law 108-173). This allows IHS to purchase care at a lower cost than if each service were negotiated individually increasing access to quality health care services and provide care to better meet the health care needs of AI/ANs. Physician and non-hospital providers of supplies and services are purchased at the PRC rate. However, if a physician or non-hospital provider does not accept the PRC capitated rate, agreements or contracts can be negotiated with individual providers of supplies or services using the provider's most favored customer rate as a ceiling for negotiation (42 CFR 136 Subpart I). Program funds are administered and managed at IHS Headquarters, at each of the 12 IHS Areas, and at IHS and Tribal facilities across the nation. The regulation has demonstrated that IHS is able to stretch the same amount of money to cover additional necessary health care services and improve access to care.

The PRC Program also administers the Catastrophic Health Emergency Fund (CHEF). Created in 1988, the CHEF was established for the sole purpose of meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses.[6] The CHEF is used to reimburse PRC programs for high cost cases (e.g., burn victims, motor vehicle crashes, high risk obstetrics, cardiology, etc.) after a threshold payment amount is met, the current threshold is $19,000. The CHEF is centrally

[5] 25 U.S.C. § 1621e, 1623; 42 CFR 136.61 (2010)
[6] 25 U.S.C. § 1621a

managed at IHS Headquarters.

The PRC Program contracts with a fiscal intermediary (FI), currently Blue Cross/Blue Shield of New Mexico, to ensure payments are made in accordance with IHS' payment policy, and coordinate benefits with other payers to maximize PRC resources. All IHS-managed PRC programs and some tribally-managed PRC programs use the FI to ensure the use of PRC rates for inpatient services and PRC or negotiated rates for physician and non-hospital providers of supplies and services.

PRC funding provides critical access to essential health care services and remains a top request by Tribes in the budget formulation recommendations.

Note: On February 28, 2019, IHS updated the *Indian Health Manual,* Part 2, Services to Indians and Others, Chapter 3, Purchased/Referred Care. In this IHM update IHS adopted the policy that PRC funds may be used for staff administrating the PRC program at administrative levels. This adopts the GAO recommendation for the use of PRC funds for PRC staff where appropriate. This policy change requires Areas to ensure they are funding requests through Priority Level II before these PRC administrative expenses can be charged.

BUDGET REQUEST

The FY 2026 budget request for Purchased/Referred Care is $1.0 billion, which is $6.0 million above the FY 2025 Enacted.

FY 2025 Enacted: $996.8 million supported over 32,500 inpatient admissions, over 1.2 million outpatient visits, and nearly 41,000 patient transports.

FY 2026 President' Budget: $996.8 million will support over 31,000 inpatient admissions, over 1.2 million outpatient visits, and nearly 39000 patient transports.

FY 2026 funding increase of +$6.0 million includes:

- New Tribes (+$6.0 million): These initial funds will start the support of the delivery of health care services for the Lumbee Tribe of North Carolina. Funding for the United Keetoowah Band of Cherokee Indians of Oklahoma for the delivery of healthcare services will be provided through Purchased/Referred Care as was accomplished in FY 2025.

FUNDING HISTORY

Fiscal Year	PRC	CHEF	Total
2022 Final	$931,887,000	$53,000,000	$984,887,000
2023 Final	$942,755,000	$54,000,000	$996,755,000
2024 Final	$942,755,000	$54,000,000	$996,755,000
2025 Enacted	$942,755,000	$54,000,000	$996,755,000
2026 President's Budget	$948,755,000	$54,000,000	$1,002,755,000

TRIBAL SHARES

Purchased and Referred Care funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. The CHEF management is federally inherent and no part of CHEF or its administration can be subject to

contract or grant under any law, including the Indian Self-Determination and Education Assistance Act. CHEF fund cannot be allocated, apportioned, or delegated on an Area Office, Service Unit or other similar basis (25 U.S.C. 1621(a)(c)).

PROGRAM ACCOMPLISHMENTS

Purchased/Referred Care (PRC) Rates – The PRC rates for all hospital-based services implemented in 2007 and the PRC rates for physicians and non-hospital providers of supplies and services implemented in 2016 have continued to increase access to care by allowing IHS/Tribal/Urbans (I/T/Us) to purchase additional services with these Medicare methodology capitated rates, referred to as PRC rates. The PRC rates rule (42 CFR 136 Subpart I) for physicians and non-hospital providers of supplies and services applies to tribally-operated PRC programs only to the extent the programs agree to "opt-in" via its Indian Self Determination and Education Assistance Act contract or compact. The rule has flexibility that allows PRC programs to negotiate rates that are higher than the PRC rate based on Medicare methodology, but equal to or less than the rates accepted by the provider or supplier's most favored customer rate; in the absence of Medicare payment methodology for a service, the IHS payment amount is calculated at 65 percent of billed charges from the provider or supplier.

Medical Priorities – Recent PRC program increase in purchasing power through the PRC rates described above continues to allow most of the IHS and Tribally-managed PRC programs to approve referrals in priority categories other than Medical Priority I (life or limb), including some preventive care services, thus increasing access to patient care services. In FY 2023, 97 percent of IHS-operated PRC programs were able to purchase services beyond Medical Priority II – Preventive Care Services. Prior funding increases and Medicaid expansion have enabled programs to purchase preventive care beyond emergency care services, such as mammograms or colonoscopies.

The IHS PRC Workgroup helped IHS develop a more accurate form for annually reporting denied and deferred PRC services. In FY 2023, PRC programs denied and deferred an estimated $509,195,219 for an estimated 121,918 services for eligible AI/ANs. Because Tribally-managed programs are not required to report denials data, it is difficult to provide a verifiable and complete measure of the total unmet need for the entire I/T/U system. Therefore, the denied services estimate is based on actual data from federal programs and estimated Tribal data.

Catastrophic Health Emergency Fund (CHEF) – In FY 2023, all high-cost cases submitted for reimbursement from the CHEF have been reimbursed. It is estimated that more cases may qualify for CHEF reimbursement but were not reported by local IHS and Tribally-managed PRC programs. Catastrophic case requests are reimbursed from the CHEF until funds are depleted. The implementation of PRC rates for inpatient and non-hospital providers of supplies and services as well as the increase of I/T/U beneficiaries enrolled in Medicaid, Medicare and Private Insurance has enabled CHEF to reimburse PRC programs for high-cost catastrophic events and illnesses that occur through the end of the fiscal year.

IHS published the Final Rule for CHEF Regulations, 88 FR 45867, in August 2024 which reduced the CHEF threshold to $19,000 for FY 2024 which will lead to more cases qualifying for CHEF reimbursement. The CHEF regulations also included an appeal process and stated that tribal self-insurance is not considered as an alternate resource.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. During FY 2020 and early FY 2021, the Indian health care system has

modified health care delivery and adapted programming to address COVID-19, including long haul COVID-19. Since the beginning of the Public Health Emergency through January 7, 2025, the PRC Fiscal Intermediary has processed 62,463 COVID related claims in the amount of $76.0 million.

PRC Delivery Area Expansions – IHS expanded four PRCDAs for the Confederated Tribes of the Grand Ronde Community of Oregon, Mashantucket Pequot Tribal Nation in Connecticut, Mississippi Band of Choctaw Indians, and Pokagon Band of Potawatomi Indians of Michigan and Indiana. Increasing PRC eligible beneficiaries by 967.

Veterans Administration Reimbursement Agreement and PRC Reimbursements – A new VA-IHS reimbursement agreement was executed in December 2023. IHS continues to work with the VA on PRC reimbursements posting parameters.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
PRC-2 Track IHS PRC referrals (Outcome)	FY 2024: 60.0 days Target: 60.0 days (Target Met)	60.0 days	60.0 days	Maintain
PRC-3 Track PRC self-referrals (Outcome)	FY 2024: 54.0 days Target: 45.0 days (Target Not Met)	45.0 days	45.0 days	Maintain

GRANT AWARDS. This program does not fund grant awards.

AREA ALLOCATION

Purchased/Referred Care

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY '26 +/- FY '25
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$96,411	$96,411	$0	$96,410	$96,410	$0	$96,991	$96,991	$580
Albuquerque	26,502	21,512	48,014	26,502	21,512	48,014	26,662	21,641	48,303	$289
Bemidji	14,860	52,763	67,623	14,860	52,763	67,623	14,950	53,080	68,030	$407
Billings	49,866	25,007	74,873	49,867	25,007	74,873	50,167	25,157	75,324	$451
California	0	54,310	54,310	0	54,310	54,310		54,637	54,637	$327
Great Plains	63,257	34,414	97,671	63,258	34,414	97,671	63,638	34,621	98,259	$588
Nashville	5,669	34,617	40,286	5,669	34,617	40,286	5,703	34,825	40,528	$242
Navajo	63,680	44,937	108,617	63,681	44,937	108,617	64,064	45,207	109,271	$654
Oklahoma	44,522	79,753	124,275	44,522	79,752	124,275	44,790	80,233	125,023	$748
Phoenix	46,887	36,783	83,670	46,887	36,783	83,670	47,170	37,004	84,174	$504
Portland	12,882	92,333	105,215	12,882	92,332	105,214	12,960	92,888	105,848	$633
Tucson	2	22,227	22,229	2	22,227	22,229	2	22,361	22,363	$134
Headquarters	73,561	0	73,561	73,562	0	73,562	74,005		74,005	$444
Total, PRC	**$401,688**	**$595,067**	**$996,755**	**$401,692**	**$595,063**	**$996,755**	**$404,110**	**$598,645**	**$1,002,755**	**$6,000**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
PREVENTIVE HEALTH

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$203,846	$204,825	$207,938	+$3,113
FTE /1, 2	236	218	218	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

SUMMARY OF THE BUDGET REQUEST

The FY 2026 Indian Health Service (IHS) Budget request for Preventive Health Services includes a total of $207.9 million, which is +$3.1 million above the FY 2025 Enacted level.

This funding increase includes:

- Staffing of Newly Constructed Facilities (+$3.1 million).

The detailed explanation of the request is described in each of the budget narratives that follow:

- **Public Health Nursing** (PHN) to support prevention-focused nursing care interventions for individuals, families, and community groups as well as improving health status by early detection through screening and disease case management. The PHN Program home visiting service provides primary, secondary, and tertiary prevention focused health interventions.

- **Health Education** to support the provision of community health, school health, worksite health promotion, and patient education.

- **Community Health Representatives** (CHRs) to help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members.

- **Hepatitis B and Haemophilus Immunization Programs (Alaska)** will support the provision of vaccines for preventable diseases, immunization consultation/ education, research, and liver disease treatment and management through direct patient care, surveillance, and education for Tribal facilities throughout Alaska. The Immunization Alaska Program budget supports these priorities through direct patient care, surveillance, and educating Alaska Native patients.

These **Preventive Health** services contribute widely to the performance measures that fall under the auspices of Hospitals & Health Clinics. PHN clinical services directly contribute to community health and wellness through immunizations, case management, and patient education. CHRs are also community-based and contribute to follow up care and lay health education. Health Education activities permeate the Indian health system and are integral to the fulfillment of the performance screening measures. The Immunization Alaska Program plays a key role by tracking immunization rates through specific immunization registries throughout the State of Alaska, and such efforts contribute to the national immunization rates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
PUBLIC HEALTH NURSING

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$112,034	$112,948	$115,926	+$2,978
FTE /1, 2	209	194	194	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal, P.L. 93-638 Tribal Contracts and & Compacts, Tribal Shares, Grants

PROGRAM DESCRIPTION

Services Provided. The Indian Health Service (IHS) Public Health Nursing (PHN) Program is a community health nursing program which strives to raise the health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level by providing quality, culturally sensitive health promotion and disease prevention nursing care services through primary, secondary and tertiary prevention services to individuals, families, and community groups. The PHN program meets the multiple healthcare needs of the AI/AN population by removing barriers to access. In FY 2024, the PHN program provided 263,303 individual patient encounters which were recorded in the electronic health record (the vast amount of PHN group services is not included in this individual patient documentation data metric).

Sharing of Best Practices. PHNs provide critical preventive health services and routinely share culturally appropriate care and best practices across the health care system. The PHN Program strengthens and sustains the PHN workforce infrastructure with training and access to financial resources such as cooperative agreements which are available to reduce health disparities. The PHN program provides direct patient care services and manages community health initiatives for the AI/AN population, from developing population-based nursing interventions to preparing for and responding to public health disasters. The PHN Program provides direct health care services in the community which improves access to health care and expands service options. PHNs are licensed, professional nursing staff available to improve transitions of care by providing patients with support to promote knowledge and self-management of their condition as they transition from the hospital to home. PHN expertise in communicable disease assessment, outreach, investigation, and surveillance helps to manage and prevent the spread of communicable diseases. PHNs conduct nurse home visiting services via referral. PHNs perform a community assessment to identify high-risk populations and implement scientific interventions to address identified areas of need. This activity targets fragmentation in patient care services and improves care continuums, including patient safety. Interventions are monitored with data collection and evaluated for outcome.

BUDGET REQUEST

The FY 2026 budget request for Public Health Nursing is $115.9 million, which is +$3.0 million above the FY 2025 Enacted level.

FY 2025 Final level Funding of $112.9 million – This funding supports the public health nursing services provided by IHS and Tribal programs, maintain the programs progress in raising the quality of and access to public health nursing care through continuing recruitment of nursing professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2026 Funding Increase of $3.0 million includes:

- Staffing of Newly Constructed Facilities: +$3.0 million. Information can be found in the Staffing of Newly Constructed Facilities chapter.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$101,641,000
2023 Final	$110,782,000
2024 Final	$112,034,000
2025 Enacted	$112,948,000
2026 President's Budget	$115,926,000

TRIBAL SHARES

Public Health Nursing funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Public Health Nursing budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

PROGRAM ACCOMPLISHMENTS

Communicable disease prevention. To support a community population nurse visiting program to serve the patient and family in the home and community, in FY 2024, $1.5 million was awarded for seven cooperative agreements and three program awards to federal, Tribal, and Urban PHN programs with the purpose to mitigate the prevalence of sexually transmitted infections (STIs) within Indian Country through a PHN case management model. Ongoing consultation efforts include participation in the End-the-Syndemic STI Informatics Response by distributing established guidance for the PHN Field Treatment for Syphilis and other STIs. The Gallup Indian Medical Center PHN Program award continues Syphilis screening in the community and the sharing of PHN protocols and procedures for such activities. PHN interventions are monitored with the PHN data mart tool for performance measurement and outcome reporting. PHNs provided 19,806 patient encounters in FY 2024 that encompassed 35,344 patient education services documented for STI visits which included communicable disease, medications, contact with exposure, immunizations, alcohol and other drugs, and tobacco use. PHNs strive to meet targeted agency goals for childhood immunizations by participating in the IHS National E3 (Every Patient. Every Encounter. Every Recommended Vaccine Offered,

when appropriate) Vaccine Strategy – to ensure every patient at every encounter will be offered every recommended vaccine, when appropriate.

Performance Reporting: The PHN program reports the following measures as part of the FY 2025 HHS Annual Performance Plan and Report: the total number of public health activities captured by the PHN data system and supports the influenza vaccination rates among adult AI/AN patients 18 years and older. The PHN program supports GPRA screening criteria, strategies for partnerships, and collaborations that result in improved health outcomes over the long term. In FY 2024, PHN documented patient screening of 2,557 Tobacco Screening, 9,500 Domestic Violence Screening, 9,478 Depression Screening, 9,660 Alcohol Screening, and the administration of 31,169 Adult Influenza Vaccines. In FY 2024, the PHN continued efforts to decrease childhood obesity and prevent diabetes by supporting hospital Baby Friendly re-designation with a total of 5,873 PHN patient encounters to foster breastfeeding as the exclusive feeding choice for infants. These encounters included 14,377 documented patient education topics provided by the PHN during prenatal, postpartum and newborn encounters, including topics on breastfeeding, child health for the newborn, immunizations, family planning, tobacco use/prevention, gestational diabetes, formula feeding, and child health. Several PHN programs in Navajo and Phoenix area enrolled in a Certification Breastfeeding Specialist online training for PHN staff.

PHN workforce. The PHN to population ratio in the IHS system continues to be very low when compared to the recommended ratio in the IHS Staffing Standards Reference Model on staffing criteria used in the Resource Requirements Methodology (RRM). The RRM PHN staffing module estimates the requirement of 1.58 PHN for every 1,250 User or Census Population. The PHN program funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities; however, tribes are not required to report ongoing PHN staffing activity. The result is a low PHN to population ratio and with an increase in AI/AN population growth presents a challenge in achieving PHN program goals. To promote excellence and quality through innovation of the Indian health system into an optimally performing organization, the PHN program is strengthening infrastructure by supporting the PHN workforce with a PHN leadership development, training, and mentorship program to improve placement rates for recently graduated BSN-prepared nurses, PHNs, and newly hired PHNs. The focus is on PHNs to provide rapid, creative, and effective solutions to public health problems in AI/AN communities to include the establishment of infrastructure and teams at the local areas in partnership with federal, tribal and state entities. The August 2024 Supervisor PHN program meeting was held in Rockville, MD to develop an overall PHN continuity plan for improvement in FY 2025. This event included objectives related to the overall strategic goals of the agency presented by such Agency leads as the IHS Acting Deputy Chief Medical Officer, 40 PHN program supervisors attended, and program funds transferred to support the attendance of participants. Additional plans for FY 2025 are to continue strategic partnerships with Bureau of Indian Education (BIE) schools and the health care facilities that are associated with each of the schools in pursuit of upstream changes that enhance AI/AN student health, safety, and education.

Expand access to healthcare services. The PHN program meets the multiple healthcare needs of the AI/AN population by removing barriers to access to reducing disparities. In FY 2024 the PHN measure target was 400,000 individual patient encounters and the result of 263,303 did not meet the target (the vast amount of PHN group services is not included in this individual patient documentation data metric). The current PHN staff shortage challenges efforts to administer, support, and provide services. Additionally, the PHN program is impacted by Tribal programs migrating away from using the IHS Resource and Patient Management System which results in

PHN data not being collected in the PHN data mart. The FY 2024 and FY 2025 targets were lowered compared to FY 2023 as the performance spike in FY 2020 and FY 2021 was the result of the increased PHN activity related to the COVID-19 pandemic. Ongoing analysis of FY 2023, FY 2024, and FY 2025 data results will be used to predict future performance target(s), especially since results prior to FY 2020 and FY 2021 fell below the results during the pandemic. The PHN performance results prior to FY 2020 fell below the targeted results in comparison to the PHN activity during the pandemic. Analysis of FY 2020 to FY2023 PHN performance results were used to predict future performance targets. The FY 2024 PHN performance target was revised from 415,438 to 400,000; and, the FY 2025 target was revised from 350,000 to 300,000 based on prior year results and projected funding.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
23 Public Health Nursing (PHN): Total number of IHS public health activities captured by the PHN data system. (Outcome)	FY 2024: 263,303 Target: 400,000 [1] (Target Not Met) FY 2023: 292,426 Target: 415,438 (Target Not Met)	300,000[2]	300,000	Maintain

[1] The FY 2024 Target is revised from 415,438 to 400,000.
[2] The FY 2025 Target is revised from 350,000 to 300,000 based on prior year results and projected funding.

GRANTS AWARDS

(whole dollars)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	7	7	7
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION

Public Health Nursing

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY '26 +/- FY '24
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$	$15,464	$15,464	$	$15,590	$15,590	$	$16,001	$16,001	$411
Albuquerque	1,927	2,456	4,384	1,943	2,476	4,419	1,994	2,541	4,535	$117
Bemidji	5	3,265	3,270	5	3,292	3,296	5	3,378	3,383	$87
Billings	1,193	3,452	4,646	1,203	3,480	4,683	1,234	3,572	4,806	$123
California	0	1,210	1,210	0	1,220	1,220		1,252	1,252	$32
Great Plains	5,084	8,104	13,188	5,125	8,170	13,296	5,261	8,386	13,646	$351
Nashville	425	1,760	2,185	428	1,774	2,203	440	1,821	2,261	$58
Navajo	9,790	9,461	19,251	9,870	9,538	19,408	10,130	9,790	19,920	$512
Oklahoma	3,721	17,458	21,179	3,751	17,600	21,352	3,850	18,064	21,915	$563
Phoenix	5,111	12,636	17,747	5,153	12,739	17,892	5,289	13,075	18,364	$472
Portland	813	2,614	3,427	820	2,635	3,455	841	2,705	3,546	$91
Tucson	0	1,139	1,139	0	1,148	1,148		1,179	1,179	$30
Headquarters	4,946	0	4,946	4,986	0	4,986	5,118		5,118	$131
Total, PHN	**$33,015**	**$79,019**	**$112,034**	**$33,284**	**$79,664**	**$112,948**	**$34,161**	**$81,764**	**$115,926**	**$2,978**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HEALTH EDUCATION

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$24,417	$24,482	$24,617	+$135
FTE /1, 2	13	12	12	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation 25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts, and Tribal Shares

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Education Program has been in existence since 1955 to educate American Indian/Alaska Native (AI/AN) patients, school-age children, and communities about their health. The program focuses on the importance of educating patients in a manner that empowers them to make positive choices in their lifestyles and how they utilize health services. Accreditation requirements at IHS and tribal facilities specifically require the provision and documentation of patient education as evidence of the delivery of quality care.

The Health Education funds provide critical support for direct health care services focused on strengthening the collaborative partnerships among direct care providers, patients, communities, and internal and external stakeholders. Funds are utilized to ensure IHS, Tribal, and Urban Indian health care programs have comprehensive, culturally appropriate services, available and accessible personnel, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to address health disparities and raise the health status of AI/AN populations to the highest level possible.

BUDGET REQUEST

The FY 2026 budget submission for Health Education of $24.6 million is +$135,000 above the FY 2025 Enacted level.

FY 2026 Funding Increase of $135,000 includes:

- Staffing of Newly Constructed Facilities: +$135,000. Information can be found in the Facilities Construction chapter.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$23,250,000
2023 Final	$24,350,000
2024 Final	$24,417,000
2025 Enacted	$24,482,000
2026 President's Budget	$24,617,000

TRIBAL SHARES

Health Education funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating out the associated programs, functions, services, and activities. A portion of the overall Health Education budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

PROGRAM ACCOMPLISHMENTS

- In FY 2024, the health education program collaborated with the Health Promotion/Disease Prevention Program to implement colorectal screening pilot projects in three sites; hosted a virtual physical activity event with more than 100 participants; hosted a four-week employee challenge with over 800 participants; and hosted an in-person elderly event with more than 2,000 participants. In FY 2024, the health education program continues to collaborate with various programs and partners to address obesity, sexually transmitted diseases, physical activity, alcohol, tobacco and other drugs, cancer, and diabetes.
- In FY 2024, the health education program collaborated with the Partnership to Advance Tribal Health organization to develop health literacy posters, videos, and resources available on the website for public access.
- The health education consultant presented on Strategies to Advance Health Literacy at the Partnership to Advance Tribal Health webinar, which was held on January 31, 2024, and had more than 60 participants.
- Health Education presented at the California Area Best Practices conference focusing on *health literacy* on May 20, with more than 100 participants, and *Strategies to Address Commercial Tobacco Use* on May 21, 2024, with over 20 participants.
- Hired a contractor to develop *a video titled "Talking to Your Doctor About Medication*" to encourage patients to discuss concerns and side effects with their healthcare provider.
- The IHS Health Literacy White Paper, which includes call-to-action strategies to advance health literacy, was approved in November 2024.
- The health education program announced the recipients of the 2024 IHS Annual Health Literacy Champions for individual and team categories in October 2024. Recipients and intervention descriptions are available on the health literacy website.
- Health education purchased an inflatable colorectal cancer display for the Navajo and California Areas to increase awareness of the importance of preventive screenings in the communities.
- Health education purchased tobacco prevention displays for 10 Area HP/DP programs to increase awareness of the adverse health effects of commercial tobacco use in the I/T/Us.
- Health education coordinated the Catch My Breath Instructor certification training with 14 participants in September 2024.

- In August 2024, the acting health education consultant and Phoenix Area HP/DP Coordinator visited the Hopi Service Unit to discuss health education program accomplishments, challenges, and collaborative partners that meet local health priorities.
- The health education program hosted *a webinar titled "Why Grade Leveling Leads to Less Equitable Health Materials—and What to Do Instead"* in August 2024, with over 50 participants, and an *Introduction to Health Literacy* in September, with 60 participants.
- The health education program recruited and hired a health education consultant in September 2024.
- In FY 2024, the health education program continues collaborating with various programs to promote health literacy activities, including training, webinars, and sharing of best/promising practices.

The Health Education Program maintains data tracking of key program objectives. Tracked data includes educational encounters, the number of patients who received patient education services, provider credentials of who delivered the patient education, site location where patient education was provided, health information provided, amount of time spent providing patient health education, patient understanding, and behavior goals.

In FY 2024, there was a total of 2,461,278 patient visits, which did not meet the 2,823,012 target. The FY 2024 result reflects a decrease of 48,755 patient visits from the 2,510,033 patient education visits reported for FY 2023.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2025 Target**	**FY 2026 Target**	**FY 2026 Target +/-FY 2025 Target**
HE-1 Number of visits with Health/Patient Education (Output)	FY 2024: 2,461,278 visits Target: 2,823,012 visits (Target Not Met)	2,823,012 visits	2,823,012 visits	Maintain

GRANT AWARDS – The Health Education budget does not fund grants.

AREA ALLOCATION

Health Education

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY '26 +/- FY '24
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$	$3,791	$3,791	$	$3,747	$3,747	$	$3,767	$3,767	$21
Albuquerque	305	1,134	1,439	301	1,121	1,422	303	1,127	1,430	$8
Bemidji	225	730	955	222	721	944	224	725	949	$5
Billings	453	951	1,404	448	940	1,388	450	945	1,395	$8
California	38	422	460	38	417	455	38	419	458	$3
Great Plains	328	1,987	2,315	324	1,964	2,288	326	1,975	2,301	$13
Nashville	197	750	947	195	741	936	196	745	941	$5
Navajo		3,532	3,532		3,491	3,491		3,510	3,510	$19
Oklahoma	913	3,566	4,479	902	3,524	4,427	907	3,544	4,451	$24
Phoenix	1,253	1,762	3,015	1,238	1,741	2,980	1,245	1,751	2,996	$16
Portland	116	1,034	1,150	115	1,022	1,137	115	1,028	1,143	$6
Tucson	0	281	281	0	278	278		279	279	$2
Headquarters	1,005	0	1,003	993	0	993	999	0	999	$5
Total, Hlth Ed	**$4,833**	**$19,940**	**$24,772**	**$4,777**	**$19,707**	**$24,482**	**$4,803**	**$19,815**	**$24,617**	**$135**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
COMMUNITY HEALTH REPRESENTATIVES

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$65,212	$65,212	$65,212	--
FTE /1, 2	14	12	12	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts, Tribal Shares

PROGRAM DESCRIPTION

In 1968, the Indian Health Service (IHS) funded the Community Health Representative (CHR) Program as a component of healthcare services for American Indian/Alaska Native (AI/AN) people. Today, 97 percent of the 299 CHR programs are tribally governed and coordinated with tribal health departments and programs. CHRs are frontline public health workers who serve as a link between the Indian health system, including associated health programs, and AI/AN patients and communities. They are trained as public health professionals under the occupation of community health workers who provide outreach, education, informal counseling, social support, patient-centered care, and advocacy services that improve the health and wellbeing of Tribal populations. The CHR Program focuses primarily on health promotion and health education, chronic disease prevention and management, community outreach and support, health-related social needs, and facilitating access to healthcare and social services. As such, CHRs improve health outcomes by addressing a broader range of health needs impacting community health and primary and preventative health.

BUDGET REQUEST

The FY 2026 budget request for Community Health Representatives of $65.2 million is flat with the FY 2025 Enacted level. The proposed funding level directly supports IHS's efforts to provide high-quality health care across the Indian health system.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$63,679,000
2023 Final	$65,212,000
2024 Final	$65,212,000

2025 Enacted	$65,212,000
2026 President's Budget	$65,212,000

TRIBAL SHARES

Community Health Representatives funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Community Health Representative's budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

PROGRAM ACCOMPLISHMENTS

As CHR programs have transitioned from IHS direct services to local community control via tribal contracting and compacting, IHS' role has shifted to providing training support and technical assistance to plan, develop, and implement community-specific programs and health services. Incorporating IHS Agency and National CHR priority areas, the following CHR activities and focus areas in FY 2024 were:

Priority Area Goal 1: Increase Awareness and Advocacy for the National CHR Program and CHR workforce.

- The CHR program implemented a CHR communications contract (base year) producing resource materials for communication and information sharing of the CHR workforce. 2024 deliverables included four quarterly newsletters; sixteen social media posts; two new CHR style guides; two blog posts; IHS Maestro templates for CHR e-blasts and announcements; photo and video production shoots across select IHS areas (California, Nashville, Oklahoma City, and Phoenix), resulting in 350 photos depicting CHRs working across community, clinic, and social systems and four CHR workforce videos. The videos will communicate how CHRs meet the unique needs of AI communities, the impact of CHRs from the patient perspective, the role of CHRs in health and health care, and the lesser-known duties of CHRs.
- The CHR program presented at the following venues increasing awareness and outreach in 2024: Panel presenter at RAND/ASPE/IHS SDOH session on May 9, 2024; CHR With uS! Conference on May 15; CHWSD Annual Conference Meeting on May 22; Hopi CHR Wellness Day on July 17; Oklahoma Area Association for CHR Conference on September 19 and 20; Arizona Tribal CHR Directors Meeting on September 24; and the Alzheimer's Association Addressing Alzheimer's & Dementia in Trial Communities webinar on November 20th.

Priority Area Goal 2: Strengthen partnerships that support the National CHR Program and CHR workforce in improving systems of care for AI/AN communities.

- The CHR program with regional CHR Association collaboration, the IHS National CHR program successfully ensured four CHR regional conferences for competency training and education. Conference topics included dementia and Alzheimer's training, Medicaid billing and reimbursement for CHW/CHRs, MCH, chronic disease prevention, elder wellness, HIV/STI point of care testing, CHR integration, public health and emergency preparedness training, and vaccine deployment.

- The National CHR Program Consultant served on four workgroups: the CDC CHW Sustainable Financing Project headed by the National Association of Community Health Workers (NACHW), the HHS CHW Sustainability workgroup, the Administration for Community Living (ACL) Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregiving Advisory Council and the Advisory Council to Support Grandparents Raising Grandchildren (SGRG) workgroup. All work groups interface with IHS Initiatives – Alzheimer's Program/Elder Health and CHW/CHR workforce.
- With the HHS CHW workgroup collaborated to provide consultation and understanding for a wider description of various job titles and descriptions identified as a "community-based workforce" in public health and health care delivery. This resulted in a published journal article, The Community-Based Health Workforce in Public Health and Health Care Delivery, in the Journal of Public Health Management and Practice, September/October 2024, Volume 30, Number 5.
- The CHR program with Arizona Advisory Council of Indian Health Care (AACIHC) and Northern Arizona University (NAU), the IHS National CHR Program contributed to the *CHR WITH uS initiative*, a Center for Disease Control and Infection (CDC), Community Health Workers (CHW) for COVID Response and Resilient Communities (CCR) grant focused on improving and expanding existing CHW efforts. CHW-CCR grant goals and objectives target 19 CHR programs across the Phoenix Area in Medicaid reimbursement, Community Health Worker Voluntary Certification, workforce development, and training opportunities.

Priority Area Goal 3: Strengthen and sustain the CHR workforce to promote continuity of care for AI/AN people.

- The CHR program created a new collaboration, CHR Program Medicaid Billing and Reimbursement, with the Community Health Worker Collaborative of South Dakota (CHWSD). The IHS National CHR program funded the Fee-For-Service Medicaid Billing Environmental Scan and Recommendations summary and accompanying one-pager as a briefing tool for increasing CHR Medicaid reimbursement in the 14 states with a Medicaid CHW state plan amendment. Included are recommendations for policy changes to allow for equitable CHR reimbursement in all 14 states. In FY 2025, this is a priority area for the National CHR program, providing training and technical assistance for changes with CHR Medicaid billing and reimbursement.

Priority Area Goal 4: Develop the capacity of the CHR workforce.

- The CHR Program partnered with Northwest Portland Area Indian Health Board (NPAIHB) to deliver an Indian Country CHR ECHO (Tele-ECHO) designed and implemented to support CHRs and other IHS employees working to improve health behaviors and conditions at the community level. This program held nine 60-minute sessions through 2024, and hosted regional and national subject matter experts. The total number of participants attending was 1,099, and continuing education hours were provided for CHR/CHW recertification. The topics presented included CHR roles and competencies, program and workforce development, dementia screening tools, public health emergency preparedness and response, vaccine deployment, sustainability, and elder abuse.
- The CHR Program administered regionally and nationally online CHR E-learning training to 1,133 CHRs during 2024. This is a three-part CHR series on basic, advanced,

and specialty training that aligns with capacity building and knowledge of CHR/CHW core competencies as part of the CHR scope of work with health education and outreach services, health system navigation and resource coordination, health promotion, and coaching. A new specialty training module was developed on CHR Home Visiting. Currently, four states (Arizona, Michigan, New Mexico, and South Dakota) explicitly state that the IHS CHR training program is an approved training program for Medicaid reimbursement within that state.

- The CHR program with the IHS Elder Health team began a collaboration implementing a 2024 CHR dementia screening pilot using the Mini-Cog tool, resulting in six CHR program applicants. IHS program staff facilitated six monthly technical assistance calls and training on the Mini-Cog dementia screening tool. CHW dementia training was provided by the Oklahoma University Dementia Care Network, a Health Resources and Services Administration (HRSA) Geriatrics Workforce Enhancement Program (GWEP) recipient.
- The CHR program with IHS CHR Area Office Consultants and program partners worked extensively in 2024 to update the Indian Health Manual (IHM) Part 3 – Chapter 16, Community Health Representative Program. This will include a new scope of work, continuing education requirements, and updated standards and practices. Final completion is set for July 2025.

Priority Area Goal 5: Optimize CHR data systems

- The CHR program increased IHS CHR listserv subscriber count to 644 and enhanced CHR listserv messaging, posting an average of ten e-blasts/month on CHR and CHW-related topics, training, and monthly observances. The CHR Program provided four regional-specific CHR RPMS PCC training and office-hour technical assistance support across the following IHS Areas: Albuquerque, Oklahoma City, and Phoenix.
- The CHR program supported efforts for CHR data mart enhancements and improvements with support from HQ NIPRS staff for maintenance and updates for CHR reporting, such as CHR provider productivity and the number of CHR health services provided, to support decision-making and promote data reporting.
- The CHR program participated in EHR Modernization for CHR workflow and design improvements with support from HQ IT staff for Enterprise Community Groups (ECG) - Public and Community Health utilization to align with CHR business processes, workflow, patient flow, and documentation flow.
- The CHR Program Consultant coordinated a National Health Coach Pilot Project, resulting in 94 graduated health coaches over two cohorts of 108 training slots. Given that the health coach training was over six months, this is considered a very successful retention rate of 88 percent. This has the potential as a new service for IHS with health coach training, documenting, and coding for interdisciplinary staff.

CHR Performance Measures

In FY 2024, CHR performance measures comprise three categories tracked per fiscal year: a) CHR-1, Number of patient contacts; b) CHR-2, CHR patient contacts for chronic disease services; and c) CHR-3, Number of CHRs trained. All three reporting categories exceeded targets in FY 2024.

Tribes who provided data reported during FY 2024, for CHR-1 performance measure were 497,082 CHR patient contacts. This is an increase of 18,894 patient contacts above the target measure of 478,188 which is a 3.9 percent increase. Key health problem areas CHRs impacted were nutrition, health promotion, diabetes, hypertension, and other health-related areas.

Tribes who provided data reported during FY 2024, for CHR-2 performance measure was 207,251 CHR patient reported contacts for visits to patients with chronic diseases. This equates to an increase of 41,822 patient contacts above the target measure of 165,429 for a 25 percent increase.

Tribes participating in IHS CHR E-learning reported that during FY 2024, the CHR-3 performance measure was 1,133 trained CHRs through an online training platform on Basic/Advanced CHR series courses. This equates to an increase of 173 percent above the target measure of 414.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
CHR-1 Number of patient contacts (Output)	FY 2024: 497,082 patient contacts Target: 478,188 patient contacts (Target Exceeded)	455,417 patient contacts[1]	521,936 patient contacts	+66,519 patient encounters
CHR-2 CHR patient contacts for Chronic Disease Services (Output)	FY 2024: 207,251 patient contacts Target: 165,429 patient contacts (Target Exceeded)	165,429 patient contacts	173,700 patient contacts	+8,271 patient contacts
CHR-3 Number of CHRs Trained (Output)	FY 2024: 1,133 CHRs Target: 414 CHRs (Target Exceeded)	414 CHRs	600 CHRs	+186 CHRs

1 The FY 2025 Target is revised from 478,188 to 455,417 due to operational changes.

AREA ALLOCATION

Community Health Representatives

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY '26 +/- FY '25
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$5,017	$5,017	$0	$5,017	$5,017	$0	$5,017	$5,017	$
Albuquerque	0	3,780	3,780	0	3,780	3,780	0	3,780	3,780	$
Bemidji	0	5,250	5,250	0	5,250	5,250	0	5,250	5,250	$
Billings	662	4,120	4,782	662	4,120	4,782	662	4,120	4,782	$
California	1	2,249	2,250	1	2,249	2,250	1	2,249	2,250	$
Great Plains	460	7,287	7,747	460	7,287	7,747	460	7,287	7,747	$
Nashville	425	3,450	3,875	425	3,450	3,875	425	3,450	3,875	$
Navajo	0	7,748	7,748	0	7,748	7,748	0	7,748	7,748	$
Oklahoma	0	10,054	10,054	0	10,054	10,054	0	10,054	10,054	$
Phoenix	3	6,730	6,733	3	6,730	6,733	3	6,730	6,733	$
Portland	2	5,086	5,088	2	5,086	5,088	2	5,086	5,088	$
Tucson	0	2,126	2,126	0	2,126	2,126	0	2,126	2,126	$
Headquarters	758	0	758	758	0	758	758	0	758	$
Total, CHR	**$2,311**	**$62,901**	**$65,212**	**$2,311**	**$62,901**	**$65,212**	**$2,311**	**$62,901**	**$65,212**	**$**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$2,183	$2,183	$2,183	--
FTE /1, 2	--	--	--	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method ..... Self-Governance Compact, Tribal Shares

PROGRAM DESCRIPTION

Hepatitis B Program – The Hepatitis B Program was initiated in 1983 to prevent and monitor hepatitis B infections among a large population of Alaska Natives with or susceptible to the disease. Evaluation of vaccine effectiveness and the medical management of persons with hepatitis and liver disease is also included.

Haemophilus Immunization (Hib) Program – The Hib Program started in 1989 with a targeted Haemophilus Influenzae type b prevention project in the Yukon Kuskokwim Delta and now focuses on maintaining high vaccine coverage in a continued effort to prevent communicable disease by providing resources, training, and coordination to Tribal facilities throughout Alaska. Alaska's geography necessitates innovation in program delivery and use of technology as many Tribal facilities are located in remote areas off any continuous road system. The Program maintains immunization practice procedures in partnership with Alaska's statewide Community Health Aide Program to ensure Health Aides working in both urban and remote Tribal facilities have the resources needed to provide high quality vaccination services where Alaska Native families live and play. Through strong collaboration with local Tribal health partners and regional immunization coordinators, the State of Alaska Immunization Program and the IHS Area Immunization Program, the Hib Program offers clinical expertise in advancing vaccine reporting and data management capacity in an environment of evolving and expanding electronic health record systems. In collaboration with statewide partners, the Hib Program promotes continued access to affordable vaccine through public vaccine funding programs. The Hib Program continues to focus on optimizing available information technology to advance capacity in maintaining high vaccine coverage rates, through refining electronic health record processes and expanding capacity for training, social marketing and consultation throughout Alaska.

The Hepatitis B Program and the Hib Program of the Alaska Native Tribal Health Consortium, in collaboration with Alaska Tribal Health Care System (ATHS) partners, provides clinical expertise

and consultation, trainings, research, evaluation and surveillance with the goal to reduce the occurrence of infectious disease and improve access to healthcare in the Alaska Native population. The programs support immunization, patient screening, development of electronic health record reminders and systems, providing an infrastructure to maintain high vaccine coverage, and high clinical management coverage of hepatitis B and C in Alaska Natives. The program also manages patients with autoimmune hepatitis (AIH), primary biliary cirrhosis (PBC), and nonalcoholic fatty liver disease (NAFLD). The Program promotes semi-annual screening of chronic hepatitis patients for both liver cancer and liver function (enzyme testing).

BUDGET REQUEST

The FY 2026 budget request for Alaska Immunization is $2.2 million, which is flat with the FY 2025 Enacted level.

Hepatitis B Program – Outpatient clinics will be conducted five days a week at the Alaska Native Medical Center, travel to regional health centers to conduct outpatient clinics, and the web-based application for video-conferencing, accessible to the statewide ATHS audience, will provide relevant clinical information to assist in the care and management of hepatitis and liver disease patients. Annual field clinics will be conducted across Alaska to provide direct patient care, clinical updates to ATHS staff, and to recruit and conduct follow-up on participants enrolled in the program's research studies. Hepatitis A and Hepatitis B vaccine coverage for Alaska Natives will be measured. In addition, the total number of Alaska Native patients targeted and screened will be measured for hepatitis B, hepatitis C, and other liver disease.

Haemophilus Immunization (Hib) Program – The budget will allow staff to provide continued expertise and support to regional Tribal programs on-site and for many partner locations, including rural and isolated locations. Funding allows support of Alaska Tribal immunization activities, and Area reporting to IHS Headquarters. Funding provides the maintenance of statewide Alaska Native vaccine coverage rate reporting to IHS Headquarters, establishing capacity for vaccine coverage reporting where necessary. It also provides technical support for electronic clinical decision support systems (i.e., vaccine forecaster), coverage reporting and patient reminder systems. Additionally, funding addresses the efficiency of consultations and trainings offered to Tribal facilities will improve through technology optimization such as utilization of widely available videoconferencing systems and local Distance Learning Network. Community outreach and patient education activities will continue to include limited print of media materials while also expanding to digital and electronic formats.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$2,148,000
2023 Final	$2,183,000
2024 Final	$2,183,000
2025 CR	$2,183,000
2026 President's Budget	$2,183,000

TRIBAL SHARES

Alaska Immunization funds are paid out as tribal shares in their entirety.

PROGRAM ACCOMPLISHMENTS

The Immunization Alaska Program comprised of both the Hepatitis B and Hib Programs has several performance measures to monitor progress in achieving the goal of high vaccine coverage for Alaska Native people as described below.

Hepatitis B Program

The Hepatitis B program continues to prevent and monitor hepatitis B infection among a large population of Alaska Natives with or susceptible to the disease. The program evaluates hepatitis A and hepatitis B vaccination coverage of Alaska Natives, and the total number of Alaska Native patients targeted for screening and the total number of patients screened for hepatitis B and hepatitis C as well as other causes of liver disease that disproportionately affect the Alaska Native population. The Program is actively engaged in a statewide HCV elimination project. This involves recruiting patients for treatment through our local outpatient clinic, field clinics and video clinics as well as performing provider in-person and webinar education seminars on treating hepatitis C. The Program website provides online treatment documents and a treatment algorithm for Alaska Tribal healthcare providers. Since 2014, over 1,450 American Indian/Alaska Native persons have been treated for HCV through the ATHS.

In FY 2024:

- Hepatitis A vaccination coverage did not achieve the target, and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 87.5 percent (90 percent target), and hepatitis B vaccination coverage was 95 percent (90 percent target).
- Overall, at least 74 percent of AI/ANs with either chronic hepatitis B (65 percent screened) or hepatitis C (79 percent screened) infection were screened for liver cancer and for liver aminotransferase (enzyme) levels.

Haemophilus Immunization (Hib) Program

The Hib program continues to provide resources, training and coordination to Tribes in Alaska to increase and maintain high vaccine coverage among Alaska Native people. Vaccine coverage data was collected and measured in collaboration with Tribal health coordinators. Technical support was provided for electronic health record systems in Tribal organizations to enhance vaccine coverage. Vaccine coverage rates for Alaska Native patients were reported to the IHS National Immunization Program, including infants, adolescents, and healthcare personnel. Efforts involved participation in national EHR advisory groups, advocating for Tribal health record advancements, and implementing clinical decision support systems.

Aligned with the Healthy People 2030 measures, the Program continues to monitor the immunization performance measures for the Alaska Native community. For FY 2024 immunization coverage rates, there were no significant coverage rate changes from FY 2023.

The Program continued to encourage the use of evidence-based strategies to improve vaccine coverage rates across the lifespan, in collaboration with statewide partners and Tribal public relations. Activities included technical assistance in optimizing available information technology capacity for efficient accessible childhood, adolescent and adult vaccine coverage reporting within the ATHS.

During FY 2024:

- Immunization Coverage for Alaska Natives age 19-35 months was 63 percent, for the 4:3:1:3*:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Var, 4 PCV).
  - 4 DTaP in this age group was 70 percent, the Healthy People 2030 vaccination objective IID-06 to increase the coverage level of four doses of DTaP vaccine by age two years.
  - 1 MMR in this age group was 89 percent, the Healthy People 2030 vaccination objective IID-03 to maintain the coverage level of one dose of MMR in children by age two years.
- Achieved 87 percent coverage with full series Haemophilus influenza type b (Hib) vaccine in children age 19-35 months.
- Provided technical assistance to Tribal health facilities with the following:
  - Maintaining interface connection with the statewide immunization information system, VacTrAK
  - Implementation and maintenance of clinical support system tools (i.e., vaccine forecaster)
  - Utilization of VacTrAK patient reminder/recall system

A summary of immunization[1] results is included below:

Immunization Measure	Age Group	Alaska Native coverage as of 9/30/2024	Alaska Native coverage as of 6/30/23
4:3:1:3*: 3:1:4	19-35 months	63%	62.5%
4:3:1: 3:3:1	19-35 months	66%	63%
3 Hib vaccines doses	19 – 35 months	87%	85%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	88%	84%
4 DTaP	19-35 months	70%	66%
1 MMR	19-35 months	89%	86%
1+ HPV	13-17 years female	77%	76%

The Hib program continues to collaborate with federal partners in networking with IHS, State, and Tribal agencies to provide technical assistance regarding EHRs. Challenges include the assortment of EHRs employed by Tribal organizations that may result in temporary loss or delay of Area-wide reporting of vaccine coverage. Regular reporting of immunization coverage is critical in assuring sufficient monitoring and follow-up with facilities experiencing vaccination administration issues.

[1] IHS vaccination rates compare favorably with overall National vaccination rates. The CDC conducts National Immunizations Surveys which allows self-reporting of vaccines. https://www.cdc.gov/vaccines/vaxview/index.html

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output) [1]	FY 2024: 566 Screened Target: 550 Screened (Target Exceeded)	550 Screened	550 Screened	Maintain
AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output) [2]	FY 2024: 1344 Screened Target: 1300 Screened (Target Exceeded)	1300 Screened	1300 Screened	Maintain
AK-3 Other Liver Disease Patients Screened (Output) [3]	FY 2024: 388 Screened Target: 300 Screened (Target Exceeded)	300 Screened	350 Screened	+50 Screened
AK-4 Hepatitis A vaccination (Output) [4]	FY 2024: 87.5 % Target: 90 % (Target Not Met but Improved)	90 %	90 %	Maintain
AK-5 Hepatitis B vaccinations (Output) [5]	FY 2024: 95 % Target: 90 % (Target Exceeded)	90 %	90 %	Maintain

1 Hepatitis Program (Known Cases Screened) Sum of known hepatitis B cases FY 2024: 872. Decline in hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.
2 Hepatitis Program (Known Cases Screened) Sum of known hepatitis C cases FY 2024: 1,687. New cases still at an annual rate nearing pre-pandemic levels. Treated cases with cirrhosis are being followed indefinitely.
3 Hepatitis Program (Known Cases Screened) Sum of known other liver disease cases FY 2024: 515. Other liver disease includes AIH and PBC (356 cases), plus the addition of NAFLD with NASH (159 cases).
4 Hepatitis A/B Immunization rates for Alaska Native children who achieve Hepatitis A 1-dose completion and Hepatitis B 3-dose completion aged 19-35 months are compiled and reported throughout the Alaska Native Tribal Health System on a quarterly basis. The rates reported herein represent the most recent reporting period. Established target immunization rate for each vaccine is 90%.
5 Hepatitis A/B Immunization rates for Alaska Native children who achieve Hepatitis A 1-dose completion and Hepatitis B 3-dose completion aged 19-35 months are compiled and reported throughout the Alaska Native Tribal Health System on a quarterly basis. The rates reported herein represent the most recent reporting period. Established target immunization rate for each vaccine is 90%.

All data reported is from the Alaska Native Tribal Health Consortium.

GRANTS AWARDS -- The program does not award grants.

AREA ALLOCATION

Immunization Alaska

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY '26 +/- FY '25
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$2,183	$2,183	$0	$2,183	$2,183	$0	$2,183	$2,183	$
Total, Imm AK	**$0**	**$2,183**	**$2,183**	**$0**	**$2,183**	**$2,183**	**$0**	**$2,183**	**$2,183**	**$**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
URBAN INDIAN HEALTH

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$90,419	$90,419	$90,419	--
FTE /1, 2	13	9	9	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026Authorization.....Permanent

Allocation Method .....Formula Contracts and Competitive Formula Grants awarded to Urban Indian Organizations

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Office of Urban Indian Health Programs (OUIHP) was established in 1976 to make health care services more accessible to Urban Indian people. The IHS OUIHP provides oversight to improve access to high-quality, culturally appropriate health care services and programs authorized by the Indian Health Care Improvement Act (IHCIA).

The IHS enters into limited, competitive contracts and grants with 41 501(c)(3) non-profit Urban Indian Organizations (UIOs) to provide unique access to quality health care and referral services for Urban Indian people in 22 states and 11 IHS Areas. The UIOs define their scope of work and services based upon the service population, health status, and unmet needs of the community they serve. Each UIO is governed by a Board of Directors that must include at least 51 percent of Urban Indian people.

The UIOs are an integral part of the Indian health care system and serve as resources to both Tribal and Urban Indian communities. Urban Indian people are often invisible in the urban setting and face unique challenges when accessing health care. A large proportion of Urban Indian people live in or near poverty and face multiple barriers such as the lack of quality and culturally relevant health care services in cities. The UIOs are an important support to Urban Indian people seeking to maintain their Tribal values and cultures and serve as a safety net for Urban Indian patients.

BUDGET REQUEST

The FY 2026 budget submission for Urban Indian Health is $90.4 million, which is flat with the FY 2025 Enacted level.

FY 2025 Final level Funding of $90.4 million – The base funding provides for the following activities:

- Improving Urban Indian access to health care to improve health outcomes in urban centers.
- Strengthening programs that serve Urban Indian people throughout the United States.
- Enhancing UIO third party revenue, implementing payment reforms such as the transition to a new prospective payment system, and increasing quality improvement efforts.
- Increasing the number of accredited UIO programs and patient centered medical homes.
- Implementing and utilizing advanced health information technology.
- Expanding access to quality, health care for Urban Indian people through collaboration with other Federal agencies.
- Implementing IHCIA authorities specific to UIOs.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$73,424,000
2023 Final	$90,419,000
2024 Final	$90,419,000
2025 Enacted	$90,419,000
2026 President's Budget	$90,419,000

PROGRAM ACCOMPLISHMENTS

In Calendar Year 2022, UIOs provided 698,535 health care visits for 67,801 Urban Indian people who do not have access to the resources offered through IHS or Tribally operated health care facilities because they do not live on or near a reservation. The UIOs are described as follows:

- Full Ambulatory Care: Programs providing direct medical care to the population served for 40 or more hours per week.
- Limited Ambulatory Care: Programs providing direct medical care to the population served for less than 40 hours per week.
- Outreach and Referral: Programs providing case management of behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling but not direct medical care services.
- Residential and Outpatient Substance Abuse Treatment: Programs providing residential and outpatient substance abuse treatment, recovery, and prevention services.

The major Urban Indian Health focus areas and activities are:

- 4-in-1 Grant Program: In FY 2023, the OUIHP awarded two additional 4-in-1 grants bringing the grantee total to 34 UIOs. The grantees were awarded a five-year funding cycle from April 1, 2022 - March 31, 2027. These grants provide funding to support four health program areas: health promotion and disease prevention services; immunization services; alcohol and substance abuse related services; and mental health services.

- Urban Indian Education and Research Organization Cooperative Agreement: In FY 2023, the OUIHP awarded the National Council of Urban Indian Health $1,350,000 to provide national-level education and research services for UIOs and the OUIHP through a cooperative agreement. The grantee was awarded a five-year funding cycle from June 1, 2022 – May 31, 2027. The cooperative agreement includes five project areas: (1) public policy; (2) research and data; (3) training and technical assistance; (4) education, public relations, and marketing; and (5) payment system reform/monitoring regulations. This cooperative

agreement also addresses the unmet needs of 4-in-1 grantees under the training and technical assistance focus area.

- Urban Indian Health Institute: In FY 2024, the OUIHP awarded $100,000 to a cooperative agreement with the Urban Indian Health Institute to provide training and technical assistance on planning, conducting, and implementing community health needs assessment, develop new and updating existing community health profiles; and provide ongoing training and tutorials on how to interpret data.

The UIOs are evaluated in accordance with the IHCIA requirements. The OUIHP integrates Enterprise Risk Management by annually reviewing UIO progress with set goals and objectives. The IHS UIO On-Site Review Manual is used by the IHS Areas to conduct annual onsite reviews of IHS-funded UIOs to monitor compliance with Federal Acquisition Regulation contractual requirements established through legislation. The results are submitted to OUIHP for review and follow-up to ensure corrective action plans are successfully completed prior to continuation of funding. Requirements in the manual are based on best-practice standards for delivering safe and high quality health care and are similar to standards used by accrediting organizations. Many UIOs are seeking or maintaining accreditation from several accreditation organizations such as the Joint Commission, Accreditation Association for Ambulatory Healthcare (AAAHC), and Commission on Accreditation of Rehabilitation Facilities. In FY 2024, through an IHS contract with AAAHC, accreditation services were provided to 27 out of the 41 UIOs.

The UIOs fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report and the Diabetes Non-Clinical Audit report. From October 1, 2022, to September 30, 2023, the UIO FY 2023 GPRA cycle accomplishments included:

- 94 percent of the UIOs reported on 26 of the 26 performance measures (although not all have facility-specific data available due to being included in an IHS Service Unit);
- 68 percent of the UIOs (21 UIOs) have GPRA data available by facility via any reporting method (Integrated Data Collection System or Manual);
- 86 percent of the UIOs reported through the Integrated Data Collection System Data Mart (IDCS DM) (although not all have facility-level data available in IDCS);
- 37 percent (13 UIOs) have GPRA data specific to their health program available in IDCS DM;
- 3 UIOs reported through the Clinical Reporting System (2 of these programs reported both through IDCS DM and through CRS); and
- 10 UIOs reported manually using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records).

The OUIHP published a new 2023-2027 OUIHP Strategic Plan in June 2023[1]. Three Urban Confers and Tribal Consultations were held to receive recommendations. The new priorities in the 2023-2027 OUIHP Strategic Plan are to support UIOs in identifying infrastructure and capacity needs, the modernization of information technology, and expanding UIO capacity and reach to meet service population needs for existing and new UIOs.

In FY 2024, the OUIHP approved Urban Emergency Funds (UEF) totaling $200,000. The OUIHP approved three UEF request for Santa Clara Valley for $90,892 for expenses for critical

[1] https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2023_Letters/DTLL_DUIOLLL_060523_Enclosure.pdf

roof and interior wall due to an earthquake; Bakersfield American Indian Health Project for $73,501 for a sewer line repair; and a request from South Dakota Urban Indian Health $35,607 for roof repair due to inclement weather

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome)	FY 2022: 67,801 Target: 70,000 (Target Not Met)	76,491	78,785	+2,294

GRANTS AWARDS - Funding for UIOs for FY 2025 includes both grants and contracts awarded to the programs.

(whole dollars)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	35	35	35
Average Award	$344,510	$315,939	$315,939
Range of Awards	$194,009 - $1,350,000	$181,239 - $1,350,000	$181,239 - $1,350,000

AREA ALLOCATION

Urban Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY '26 +/- FY '25
	Federal	Urban	Total	Federal	Urban	Total	Federal	Urban	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$
Albuquerque	736	5,120	5,856	736	5,120	5,856	736	5,120	5,856	$
Bemidji	276	10,939	11,214	276	10,939	11,215	276	10,939	11,215	$
Billings	265	7,558	7,823	265	7,558	7,823	265	7,558	7,823	$
California	455	17,495	17,951	455	17,495	17,950	455	17,495	17,950	$
Great Plains	122	3,888	4,010	122	3,888	4,010	122	3,888	4,010	$
Nashville	95	2,845	2,939	95	2,845	2,940	95	2,845	2,940	$
Navajo	6	1,959	1,965	6	1,959	1,965	6	1,959	1,965	$
Oklahoma	210	5,656	5,866	210	5,656	5,866	210	5,656	5,866	$
Phoenix	44	7,556	7,600	44	7,556	7,600	44	7,556	7,600	$
Portland	78	9,434	9,512	78	9,434	9,512	78	9,434	9,512	$
Tucson	25	1,576	1,600	25	1,576	1,601	25	1,576	1,601	$
Headquarters	3,024	11,058	14,082	3,024	11,058	14,082	3,024	11,058	14,082	$
Total, Urban	**5,334**	**$85,085**	**$90,419**	**5,334**	**$85,085**	**$90,419**	**5,334**	**$85,085**	**$90,419**	**$**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$80,568	$80,568	$80,568	--
FTE /1, 2	58	51	51	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method ..... Direct Federal, Grants and Contracts

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) Public. Law 94-437, as amended, authorizes the Indian Health Service (IHS) Scholarship program, Loan Repayment program (LRP), health professions training related grants, and recruitment and retention activities. The IHS made its first scholarship program awards in 1978 when Congress appropriated funds for the Indian Health Professions (IHP) program.

Loan Repayment Program (Section 108): The LRP offers healthcare professionals the opportunity to reduce their student loan debts through service to Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to $25,000 per year in loan repayment funding and up to an additional $6,000 per year to offset tax liability. Loan repayment recipients can extend their initial two-year contract on an annual basis until their original approved educational loan debt is paid.

Applicants who apply for but do not receive funding, are identified as either "matched unfunded" or "unmatched unfunded". The "matched unfunded" applicants are health professionals employed in an Indian health program. The "unmatched unfunded" applicants are health professionals that either decline a job offer because they did not receive loan repayment funding or those unable to find a suitable assignment meeting their personal or professional needs.

Scholarship Program (Sections 103 and 104) – Section 103 scholarships include the Preparatory and Pre-Graduate Scholarship programs that prepare students for health professions training programs. Section 104 includes the Health Professions Scholarship program, which provides financial support consisting of tuition, fees and a monthly stipend for AI/AN students from federally recognized Tribes enrolled in health profession or allied health profession programs. Students accepting a Health Professions Scholarship incur a service obligation and payback requirement.

Extern Program (Section 105) – The Extern Program is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. This program is open to IHS scholars and non-scholars. Students are employed up to 120 days annually, typically during the summer months.

BUDGET REQUEST

The FY 2026 budget submission for Indian Health Professions of $80.6 million is flat with FY 2025 Enacted.

FY 2025 Enacted of $80.6 million – The base funding enables AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs; serve as a catalyst in developing AI/AN communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care; and assist Indian health programs to recruit and retain qualified health professionals.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$73,039,000
2023 Final	$80,568,000
2024 Final	$80,568,000
2025 Enacted	$80,568,000
2026 President's Budget	$80,568,000

PROGRAM ACCOMPLISHMENTS

The IHP program has seen much success throughout the years including, but not limited to, the following:

- Recruiting well-qualified health care professionals through various sources: IHS Scholarship Recipients, US Public Health Service Commissioned Corps, and Uniformed Services University of the Health Sciences (USUHS), various social media networking sites, virtual career fair events and in person health professions specialty conferences.
- Conducting IHS Scholarship Program and LRP webinar-based general information session webinars for potential applicants; updating SP and LRP websites with up-to-date programmatic information.
- Collaborating with the National Health Service Corps Loan Repayment Program that received an additional funding for loan repayment awards to clinicians working at IHS facilities, Tribally-operated 638 health programs, and Urban Indian programs to combat the nation's opioid crisis.
- Consulting annually with IHS Area Directors, Tribal health directors, and Urban Indian Organization health directors regarding their health professions priorities eligible for Scholarship and Loan Repayment Program funding.
- Enhancing IHS recruitment and retention strategies through the development and management of the IHS Exit Survey Program Agency-wide and the IHS Housing Subsidy Pilot Program.

While the IHP programs have seen successes, IHP continues to strive to improve performance and identify areas of risk. Placement of new scholars within 90 days of completing their training

continues to be a challenge. The use of outreach activities such as recruitment and placement webinars, direct emails to scholarship recipients, and the referral of graduates to area and site recruiters have all been used to facilitate the 90-day scholar placement. In FY 2024, 48 percent of scholars were placed within 90 days (target was 40 percent). Attaining higher success rates are often impacted by scholars of certain disciplines being unable to register for their licensing board examinations until after successful completion of their education and finding positions within the 90-day period. The Scholarship program continues to seek new ways to assist IHS scholars to meet this requirement.

Loan Repayment Program (Section 108): In FY 2024, a total of 1,927 health professionals were receiving IHS loan repayment. This included 632 new two-year contracts, 556 one-year extension contracts, and 739 health professionals starting the second year of their FY 2023 two-year contract. There were no "matched unfunded" applicants and 581 "unmatched unfunded" health professionals (including 94 behavioral health providers, 20 dentists, 68 mid-level providers and 261 nurses among others). The inability to fund these 632 health professional applicants is a significant challenge for the recruitment efforts of the agency. A more detailed breakout of loan repayment awards in FY 2024 by discipline is included in a table at the end of the narrative.

Scholarship Program (Sections 103 and 104): In FY 2024, there were 630 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 227 of these new scholarship applications accepted the scholarship. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education. A total of 214 extension awards were funded for FY 2024. A detailed breakout of scholarships awarded by discipline for FY 2024 is included in a table at the end of the narrative.

Extern Program (Section 105): In summer 2024, the Extern Program funded a total of 7 student externs. A table of extern awards by Area Offices is included in a table at the end of the narrative.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome)	FY 2024: 48 % Target: 40% (Target Exceeded)	40%	40%	Maintain
IHP-1 Number of scholarship awards under section 103 (Output)	FY 2024: 130 Awards Target: 103 Awards (Target Exceeded)	103 Awards	105 Awards	+2 Awards
IHP-2 Number of scholarship awards under section 104 (Output)	FY 2024: 311 Awards Target: 253 Awards (Target Exceeded)	253 Awards	255 Awards	+2 Awards
IHP-3 Number of externs under section 105 (Output)	FY 2024: 7 Externs Target: 35 Externs (Target Not Met but Improved)	35 Externs	35 Externs	Maintain
IHP-4 Number of new 2-year contract awarded loan repayments under section 108 (Output)	FY 2024: 632 contracts Target: 610 contracts (Target Exceeded)	580 contracts	580 contracts	Maintain
IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output)	FY 2024: 556 Awards Target: 655 Awards (Target Not Met but Improved)	600 Awards	600 Awards	Maintain
IHP-6 Total number of new awards funded in previous fiscal year under section 108 (Outcome)	FY 2024: 739 awards Target: 610 awards (Target Exceeded)	610 awards	610 awards	Maintain

GRANTS AWARDS

The IHP administers three grant programs which fund colleges and universities to train students for health professions: (1) American Indians into Nursing Program (Section 112), (2) Indians into Medicine Program (Section 114), and (3) American Indians into Psychology Program (Section 217). These programs provide support to students during their health career professional pathway and encourage students to practice in the Indian health system.

(whole dollars)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
American Indians Into Nursing Program (Section 112) – CFDA No. 93.970			
Number of Awards	5	5	5
Average Award	$337,341	$350,493	$350,493
Range of Awards	$337,341	$320,000 - $396,925	$320,000 - $396,925
Indians Into Medicine Program (Section 114) – CFDA No. 93.970			
Number of Awards	4	4	4
Average Award	$321,250	$365,276	$365,276
Range of Awards	$195,000 - $700,000	$206,304 - $700,000	$206,304 - $700,000
American Indians Into Psychology Program (Section 217) – CFDA No. 93.970			
Number of Awards	3	4	4
Average Award	$240,791	$201,483	$201,483
Range of Awards	$240,791	$201,483	$201,483

Scholarship Program Awards –For FY 2024, the IHS Scholarship Program made awards to the following disciplines:

Section 103 Preparatory – 26 students				
Pre-Nursing	26			
Post-Baccalaureate Medical/Dental	0			
Section 103 Pre-Graduate –104 students				
Pre-Dentistry	21			
Pre-Medicine	83			
Section 104 Health Professions – 311 students				
Clinical Lab Science	3		Nurse, Bachelor's	73
Clinical Psychology	7		Occupational Therapy	1
Dental Hygiene	1		Optometry	19
Dentistry	28		Pharmacy	30
Diagnostic Radiology, Associate's	3		Physical Therapy	16
Diagnostic Radiology, Bachelor's	0		Physician Assistant	26
Engineering (Civil/Environmental)	1		Physician, Allopathic	28
Environmental Health	0		Physician, Osteopathic	31
Nurse Anesthetist	4		Podiatry	0
Nurse Midwife	1		Social Work	17
Nurse Practitioner	22			

Loan Repayment Program Awards – In FY 2024, the IHS LRP made awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Behavioral Health	62	51	12	0
Dental*	93	47	46	0
Nurse	299	236	63	0
Optometrists	49	9	40	0
Pharmacists	200	74	126	0
Physician Assistants/ Advanced Practice Nurses	158	79	79	0
Physicians	123	41	82	0
Podiatrists	20	4	16	0
Rehabilitative Services	98	39	59	0
Other Professions	86	53	33	0
TOTAL	**1188**	**632**	**556**	**0**

* Includes Dentists and Dental Hygienists.

**Awards are through July award cycle.

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Acupuncturist	4	0	Tribal Employee	814
Chiropractors	31	0	Civil Service	299
Dietetics/Nutrition	27	0	Commissioned Corps	38
Engineering	7	0	Urban Health Employees	37
Medical Laboratory Scientist	7	0		
Medical Technology	3	0		
Radiology Technicians	3	0		
Sanitarian	2	0		
Respiratory Therapists	4	0		
TOTAL	**86**	**0**	**Total**	**1188**

Extern Program Awards – In summer 2024, the IHS Extern Program had a total of 7 student externs.

AREA OFFICES	NUMBER OF STUDENT EXTERNS
Oklahoma City	7

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$2,986	$2,986	$2,986	--
FTE*	--	--	--	--

*Tribal Management Grant funds are not used to support FTEs.

Authorizing Legislation ..... 25 U.S.C. 450, Indian Self-Determination and Education Assistance Act, as amended 2010

FY 2026 Authorization ..... Permanent

Allocation Method ..... Discretionary competitive grants to Tribes and Tribal organizations

PROGRAM DESCRIPTION

The Tribal Management Grant (TMG) program was authorized in 1975 under Sections 103(b)(2) and 103(e) of Public Law (P.L.) 93-638, Indian Self-Determination and Education Assistance Act (ISDEAA), as amended. Under the authority of the ISDEAA, the program was established to assist all federally recognized Indian Tribes and tribally-sanctioned tribal organizations (T/TO) to plan, prepare, or decide to assume all or part of existing Indian Health Service (IHS) programs, functions, services, and activities (PFSA) and to further develop and enhance their health program management capability and capacity.

The IHS established four funding priorities for the TMG program:

- Tribes that receive federal recognition or restoration within the last five years with implementing or developing management and infrastructure systems for their organization
- T/TO that need to improve financial management systems to address audit material weaknesses
- Eligible Direct Service and Title I Federally recognized Indian Tribes or Tribal organizations submitting a competing continuation application or new application
- Eligible Title V Self Governance Federally recognized Indian Tribes or Tribal organizations submitting a competing continuation or new application.

The TMG program offered four project types with three different award amounts and project periods:

(1) Planning - fund up to $50,000 with project periods not to exceed 12 months. A Planning Project allows establishment of goals and performance measures for current health programs or to design their health programs and management systems.
(2) Evaluation - fund up to $50,000 with project periods not to exceed 12 months. An Evaluation Study Project determines the effectiveness and efficiency of a program or if new components are needed to assist the T/TO to improve its health care delivery system.

(3) Feasibility - fund up to $70,000 with project periods not to exceed 12 months. A Feasibility study analyzes programs to determine if T/TO management is practicable.
(4) Health Management Structure (HMS) grants are funded up to $300,000 with project periods not to exceed 36 months. HMS projects include the design and implementation of systems to manage PFSA, such as Electronic Health Records (EHR) systems or billing and accounting systems, management systems, health accreditation, as well as correction of audit material weaknesses.

BUDGET REQUEST

The FY 2026 budget submission for Tribal Management Grants of $3.0 million is flat with FY 2025 Enacted.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$2,466,000
2023 Final	$2,986,000
2024 Final	$2,986,000
2025 Enacted	$2,986,000
2026 President's Budget	$2,986,000

TRIBAL SHARES

Program funds are not subject to tribal shares since they are transferred through a federally-administered grant program.

PROGRAM ACCOMPLISHMENTS

- Provided technical assistance to potential applicants and provided post award technical assistance to recipients.

- Developed and posted a second notice of funding opportunity in Fiscal Year (FY) 2025 to promote the TMG program and provide ample time for T/TO to apply.

- Provided internal Agency training to enhance knowledge and awareness of the TMG program and the benefits to T/TO.

- Approximately one percent of TMG funding has been used for overall administration of the program; these funds provide TMG program requirements, training, and general technical assistance.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
TMG-1 Planning Grants (Output)	FY 2024: 3 planning grants Target: 2 planning grants (Target Exceeded)	4 planning grants	4 planning grants	Maintain
TMG-2 Health Management Structure (HMS) grants (Output)	FY 2024: 5 HMS grants Target: 10 HMS grants (Target Not Met)	12 HMS grants	12 HMS grants	Maintain

GRANTS AWARDS

(whole dollars)	FY 2024 Final /1	FY 2025 Enacted /2	FY 2026 Presidents Budget /3
Number of Awards	20 Total Awards: 10 Noncompeting Continuations and 10 New [1]	20 Total Awards: 11 Noncompeting Continuations and 10 New [2]	20 Total Awards: 10 Noncompeting Continuations and 10 New [3]
Average Award	$105,135	$105,135	$105,135
Range of Awards	$50,000 - $150,000	$50,000 - $150,000	$50,000 - $150,000

[1] FY 2024 is an estimate will update when awarded.
[2] FY 2025 is an estimate will update when awarded.
[3] FY 2026 is an estimate will update when awarded.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
DIRECT OPERATIONS

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$103,805	$103,805	$103,805	--
FTE /1, 2	299	306	306	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts, and Tribal Shares

PROGRAM DESCRIPTION

The IHS Direct Operations budget supports the provision of Agency-wide leadership, oversight, and executive direction for the comprehensive public and personal health care provided to American Indians and Alaska Natives. Each year, additional tribal shares are taken from the Direct Operations budget by tribes who choose to contract or compact their health care programs. As a result, over the past five years, the amount of Direct Operations funding retained by IHS for carrying out inherently federal functions and supporting direct service tribes has decreased on average by approximately 2 percent per year. In an individual year, this amount has been as high as 6 percent. This unique aspect of the IHS Budget puts additional pressure on resource needs for core management functions.

The IHS Headquarters provides overall program direction, authorities, and oversight for the 12 IHS Areas and 170 Service Units; formulates policy and distributes resources; provides technical expertise to all components of the Indian health care system, which includes IHS direct, Tribally operated programs, and urban Indian organizations (I/T/U); maintains national statistics and public health surveillance; identifies trends; and projects future needs. The IHS Headquarters works in partnership with the Department of Health and Human Services (HHS) and sister agencies to formulate and implement national health care priorities, goals, and objectives for AI/ANs within the framework of its mission. The IHS Headquarters also works with HHS to formulate the annual budget and necessary legislative proposals, respond to congressional inquiries, and collaborate with other governmental entities to enhance and support health care services for AI/ANs.

By delegation from the IHS Director, the 12 Area Offices distribute resources, carry out policies and internal controls, monitor and evaluate the full range of comprehensive healthcare and community-oriented public health programs, and provide technical support to local Service Units and I/T/U staff. They ensure the delivery of quality health care through the 170 Service Units and participate in the development and demonstration of alternative means and improvement

techniques of health services management and delivery to promote the optimal provision of health services to Indian people throughout the Indian health system.

BUDGET REQUEST

The FY 2026 budget submission for Direct Operations of $103.8 million is flat with the FY 2025 Enacted.

FY 2025 Enacted level Funding of $103.8 million – Funding provides for the direct operations of IHS's system-wide administrative, management, and oversight priorities at the discretion of the IHS Director that include, but are not limited to:

- Continuing vital investments to enhance the IHS's capacity for providing comprehensive oversight and accountability in key administrative areas such as: human resources, property, acquisition, financial management, information technology, and program and personnel performance management.
- Improving responsiveness to external authorities such as Congress, the Government Accountability Office (GAO), and the Office of Inspector General (OIG); and addressing Congressional oversight and reports issued by the GAO and the OIG to make improvements in management of IHS programs, such as the PRC program, quality oversight, and workforce.
- Addressing requirements for national initiatives associated with privacy requirements, facilities, and personnel security.
- Continuing analysis and settlement of tribal contracting and compacting Contract Support Costs (CSC) claims and maintaining policies and procedures to accurately determine CSC needs in the future.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$95,046,000
2023 Final	$103,805,000
2024 Final	$103,805,000
2025 Enacted	$103,805,000
2026 President's Budget	$103,805,000

TRIBAL SHARES

Direct Operations funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Direct Operations budget line is reserved for inherently federal functions and is therefore retained by the IHS.

PROGRAM ACCOMPLISHMENTS

The Direct Operations budget is critical for continued progress in assuring an accountable, quality, and high-performing Indian health system. Examples of Agency activities made possible by Direct Operations funds are provided below.

The IHS is committed to making improvements and being removed from the GAO High-Risk list. In response to the GAO's High-Risk reports, the IHS developed an action plan in 2021 to meet GAO's criteria for removal from the High-Risk List. This action plan built internal capacity and led to sustainable improvements in managing and overseeing IHS programs and services. The development of this action plan provided a foundation upon which the Agency implemented the IHS 2024 Agency Work Plan, which outlined critical actions the IHS took throughout 2024 to address risk priorities. The IHS continues to make significant progress and has now transitioned to the FY 2025-2029 IHS Strategic Plan, which requires that the IHS be a leading health care organization, ensure comprehensive, culturally respectful health care services, optimize operations through effective stewardship and promote proactive intergovernmental and external relationships.

In FY 2024, the IHS focused on improving human resource systems and processes to bolster Agency recruitment and retention activities. One example of system and process improvements includes the Agency-wide implementation of the USA Performance Management system, which is an electronic performance management system developed by the Office of Personnel Management. This system was piloted at the IHS Headquarters level in FY 2022 and now provides agency-wide capacity to manage and track all performance plans in one system that replaces paper performance plans. The use of an electronic system provides a streamlined and standardized performance management process.

The IHS Office of Quality (OQ) has made significant quality and patient safety improvements across the Agency. It provides the structure to promote accountability and oversight with a focus on establishing and maintaining an effective and efficient internal controls environment through evaluations and audits. OQ maximizes quality improvement efforts to integrate quality collaboratively across the Agency, supporting and improving governance by developing a risk-aware culture that fosters risk-based decision-making. It also supports quality assurance in maintaining accreditation standards and Centers for Medicare and Medicaid Services (CMS) Conditions of Participation within the IHS system and improves patient safety using a patient and family-centered framework to achieve zero incidents of preventable harm and improve outcomes. In FY 2024, the OQ provided national coordination for Agency quality and safety of healthcare services, supported patient safety through the implementation of a national IHS Patient Safety Policy and Credentialing and Privileging Policy as well as updating the IHS Credentialing Standard Operating Procedure Manual to improve credentialing practices. In addition, the OQ developed the IHS Safety Tracking and Response (I-STAR) Policy and Standard Operating Procedure Manual for event reporting Agency-wide. The OQ conducted and completed all design, testing, and reporting for the A-123 Audit. The Office of Management and Budget (OMB) mandates the Agency to continuously monitor and improve the effectiveness of internal control associated with their programs. This includes national leadership and consultation on compliance functions to ensure internal policies and procedures are appropriately authorized and applicable laws, regulations, and the Department of Health and Human Services (HHS) policies and directives are adequately implemented.

Office of Quality - In FY 2024, the IHS made organizational changes within the Office of Quality (OQ) to meet its needs and ensure high-quality, safe patient care. The reorganization aimed to support a consistent reporting structure and clarify functional responsibilities within each division to meet the Agency's quality needs. It also strengthened the oversight of internal controls using a high-reliability framework to enhance quality and safety within IHS. The divisions within the OQ are the Division of Compliance, the Division of Enterprise Risk Management, the Division of

Quality Assurance and Patient Safety, and the Division of Innovation and Improvement. On December 30, 2024, the OQ reorganization was published in the Federal Register.

Division of Compliance - The Compliance Division leads key components of the Agency's Enterprise Risk Management (ERM) efforts and the related implementation of the Federal Managers Financial Integrity Act (FMFIA), including identifying, assessing, analyzing, mitigating, and monitoring mission-critical risk areas and forecasting the impact on the IHS. In FY 2024, in addition to conducting the A-123 Audit without contractor support, new procedures for completing the A-123 audits were developed and implemented with tools to help process owners document internal controls. A new Action Plan template was implemented to address GAO and OIG findings and increase program office accountability and responsibility in identifying and addressing root causes. In HQ Oversight Reviews, 98 percent of recommendations are closed from previous reviews.

Division of Enterprise Risk Management – The IHS Quality Assurance Risk Management Committee (QARMC) provides senior-level oversight and management of complex, adverse patient safety events and administrative matters involving fraud, waste, abuse, and employee misconduct within IHS-operated hospitals and clinics. It performs Agency-wide clinical and administrative risk management to identify systematic changes needed to improve the quality of health care services in IHS-operated hospitals and clinics. The QARMC is a component of the overall Enterprise Risk Management (ERM) governance structure. It is intended to ensure enterprise-wide accountability and effectiveness of those internal and external reporting systems, necessary management responses, and swift and effective corrective action. In FY 2024, the IHS QARMC updated the charter, procedures document, and closure form for uniform reporting by all IHS Area Offices and HQ Offices. An Agency-wide ERM Survey was conducted with an 87 percent response rate from IHS HQ, Area Offices, and Service Units. This led to the development and publishing of an ERM dashboard using data captured from the survey. The ERM Division also developed and published a risk assessment dashboard and a risk assessment for the Agency to support deliberations and decision-making among IHS senior leaders.

Division of Quality Assurance and Patient Safety – The Quality Assurance program focuses on ensuring the quality of care in IHS facilities through external accreditation and certification support. The OQ Quality Assurance program manages and coordinates continuous accreditation compliance programs using multidisciplinary integration of survey readiness activities by making tools, resources, and consultations available for all IHS Area Offices and facilities. The Quality Assurance program supported IHS facilities in all 12 IHS Areas to achieve and maintain The Joint Commission (TJC) and Accreditation Association for Ambulatory Health Care (AAAHC) accreditation standards and CMS regulations. This includes IHS Hospitals, Ambulatory Health Centers, Behavioral Health facilities, Critical Access Hospitals (CAHs), and Youth Regional Treatment Centers. In FY 2024, 100 percent of all IHS hospitals and CAHs have achieved and maintained CMS Conditions of Participation; 21 of 22 hospitals and CAHs have TJC accreditation; and TJC or AAAHC accredits all 31 eligible IHS ambulatory health centers.

The Quality Assurance program tracks healthcare accreditation and certification survey reports and coordinates healthcare accreditation resource management, developing and sharing quarterly IHS accreditation reports with the IHS executive leadership team. The information from the reports is shared with leadership to increase transparency and strengthen the planning and collaboration of continuous improvement efforts. Certification and accreditation activities promote the evidence of quality standardization of health care programs. The IHS directed all ambulatory care facilities to attain Patient-Centered Medical Home (PCMH) designation. In FY

2024, 31 of 31 Ambulatory facilities, 16 of 16 Hospitals, and 7 of 7 CAHs achieved PCMH designation.

In FY 2023, the Quality Assurance deployed the Joint Commission Resources e-Products software system, including Tracers with AMP®, to support ongoing accreditation readiness activities for all IHS federally operated facilities. Biweekly training meetings were offered in addition to in-person and virtual training opportunities to provide ongoing accreditation updates, technical assistance, and multidisciplinary collaboration opportunities for IHS staff. In FY 2024, 100 percent of all IHS facilities completed a compliance audit utilizing the standardized Tracers with AMP® tool. Also, in FY 2024, 48 successful accreditation surveys were completed at IHS facilities by TJC (including TJC Lab surveys), AAAHC, and CMS.

The Credentialing program develops and monitors credentialing and privileging policies, processes, and software systems to support the delivery of safe, quality care services in IHS federally-operated facilities. In Calendar Year (CY) 2024, all ten eligible IHS Areas and their facilities utilized the credentialing and privileging software system to facilitate the hiring, verification, and ongoing monitoring of qualified licensed health practitioners. The final 36 fields and processes of the 80 identified for standardization were standardized Agency-wide to improve the efficiency of credentialing and privileging processes. The Credentialing program collaborated with the Office of Information Technology and the credentialing software vendor to update the version from 9.86 to 11.26 for all IHS sites to enhance automated functions. There have been 67,747 user logins, processing 4,930 initial appointment and reappointment applications, with 217,431 initial and ongoing verifications and 34,656 reports generated.

In CY 2024, the Credentialing program developed credentialing audit forms for initial and reappointments of healthcare practitioners. These audit forms are used by the Credentialing program to conduct quarterly, random audits of provider files. The IHS Areas are encouraged to use them to audit their facilities and develop their credentialing files to ensure all policy and Standard Operating Procedure (SOP) elements are met. The Credentialing program developed weekly automated reports of expiring credentials from the credentialing software to help alert IHS Areas and Service Units of any expiring credentialing elements due for renewal and verification. A yearly credentialing and privileging assessment and attestation was developed to identify any credentialing elements in which an IHS Area may need technical assistance.

In CY 2024, the Credentialing program updated the Indian Health Manual (IHM), Clinical Credentialing and Privileging policy, and the accompanying SOP Manual to provide up-to-date credentialing and privileging standard work for IHS. The Credentialing program developed and implemented a Credentialing Change Control Workgroup to collect, review, and approve/reject change requests for the IHM policy, the SOP Manual, OMB-approved applications, forms, tools, and credentialing software content. The Credentialing program manages the Medical Staff Services LISTSERV with 108 IHS users to communicate and distribute credentialing software updates and training opportunities and provide expert technical assistance across the health system. To build capacity and promote the unification and training of Medical Service Professionals (MSP), the Credentialing program provides three monthly one-hour opportunities: IHS Area MSP Lead Calls, Office Hours, and e-Learning Sessions. The IHS Area MSP Lead Call is a time for the Credentialing program and IHS Area MSP leads to connect, learn, share, and act upon the professional development of credentialing and privileges processes in IHS facilities that help ensure high-quality patient care that complies with SOP and policies, regulatory standards and accreditation standards, and medical staff bylaws. Office Hours allow all IHS MSPs to review and hold discussions on credentialing and privileging case studies. They also provide time for IHS Area MSPs to collaborate on sharing knowledge and best practices in their IHS Areas.

The MSP e-learning sessions are designed to review and educate all IHS MSPs on core elements of medical staffing, privileging, and software use.

In CY 2024, two medical staff applications, two intake tools, and four forms were approved by the OMB for credentialing. The Credentialing program developed an IHS-specific credentialing and privileging training program and provided two in-person credentialing & privileged training opportunities in the IHS Oklahoma City and Navajo Areas. The Credentialing program offers a collection of continuously updated tools, best practices, and compliance tips for credentialing, privileging, and peer review topics developed by industry experts for the IHS Areas through an off-the-shelf subscription resource service. The Credentialing program continues to strengthen and demonstrate progress within the IHS through monitoring, building capacity, and tracking projects on an action plan to completion.

The I-STAR program is a system for reporting adverse events and good catches and is fully implemented across the Agency. A good catch event is a potential safety hazard caught before it reaches a patient, worker, visitor, or facility. The I-STAR program monitors the system and continuously optimizes its functions. Since the I-STAR program was rolled out in August 2020, adverse events have been reported from each of the 12 IHS Areas, 162 federal facilities, and 53 Tribal facilities. In FY 2024, 24,798 events were entered, with 11,376 medication good catch events. The I-STAR program is also responsible for overseeing and administrating the I-STAR application and providing educational opportunities for users. In FY 2024, the I-STAR program held weekly office hours and provided direct Q&A sessions and individualized training to staff; revised and implemented the Medication Safety Dashboard that includes 19 standard reports commonly used for identifying facility-level medication safety trends and for reporting to IHS Area Governing Boards; enhanced I-STAR customer service by adding new job aids and structuring the I-STAR Webpage for ease of use in finding needed resources; and added five new drugs to the I-STAR formulary. The I-STAR program developed a quarterly report that is provided to IHS Headquarters officials for regular review and comparison of trends for adverse events reporting in the I-STAR system. The I-STAR program collaborated with a broad representation from IHS to develop an Agency policy for I-STAR. This policy will be released in FY 2025.

In 2024, the Patient Safety Program created a national workgroup to develop the Total System Safety (TSS) implementation plan, identifying the actions required to achieve the strategy's goals and objectives. The TSS implementation workgroup includes representation from the IHS Areas, National Combined Councils, and patient and workforce safety Subject Matter Experts at the IHS facility, Area, and HQ levels. The TSS implementation plan is a multi-year plan. Each year, the workgroup chooses priority actions that build on the previous years' work. Prioritization includes an environmental scan, informal risk assessment, and knowledge of internal and external patient safety priorities. The Patient Safety program led several TSS 2024 priorities. In 2024, "enhance the total system safety strategy to build on workplace safety" was included as objective 1.2 under the goal of "Be a leading healthcare organization" in the FY 2025-2029 IHS Strategic Plan. Numerous tools and resources were developed to facilitate the implementation of the Agency's newly published Patient Safety Policy, including a nationally classified patient safety program manager position description for hospitals, an IHS Director's Award for Patient Safety, a standard delegation of authority memo for collateral duty patient safety officers, Patient Safety initial and annual training for all staff added to the HHS learning management system, and a policy compliance audit tool in the Tracers with AMP® software. The Patient Safety program provided those tools/resources, training, and consultation Agency-wide, leading to a policy compliance rate of 99.9 percent by the end of 2024. The Patient Safety program led the Agency to standardize the root cause analysis (RCA) process to Root Cause Analysis and Action (RCA2). It coordinated

formal RCA2 training for 124 staff Agency-wide, including one staff member from every federal facility and three from each Area office with federal facilities. Patient safety led a national workgroup to develop the IHS standardized RCA process using RCA2 as the foundational methodology, which is complete and ready for implementation in 2025. The Patient Safety program also developed and maintains a Patient Safety Intranet page that houses patient safety resources, tools, training, and processes developed through TSS. Patient safety continues to facilitate communication through the patient safety listserv, which currently has 112 subscribers and administers the Safety Alert Facilitating Excellence (SAFE) listserv, which is used to communicate important patient safety alerts to leadership, safety, and quality staff Agency-wide; 162 staff subscribed Agency-wide. A total of five alerts were issued in FY 2024.

Clinical Risk Management program provides the inherent Federal Residual Function as mandated by statute. Major functions include coordinating the federally mandated processing of Medical Malpractice Federal Tort Claims Act (FTCA) filed against IHS, Tribal, and Urban (I/T/U) healthcare providers, and representing the Agency when paid claims are presented for mandatory review to the HHS Medical Claims Review Panel; as Administrator for the National Practitioner Data Bank and responsible for submitting mandatory payment reports and review of subject matter statements; and when filing mandatory reports to State Licensing Boards for the provider whose benefit settlement was made.

The Environment of Care and Life Safety (EC/LS) program ensures appropriate risk management activities are completed within accreditation, engineering, utility management, safety, and occupational health. The EC/LS program identifies and remediates any sources of high-risk processes related to compliance with national standards, laws, and regulations within IHS healthcare facilities. The ECLS program utilizes data from accreditation readiness surveys and related activities, facility engineering deficiencies, preventive and regular maintenance activities, and oversight reporting mechanisms to ensure appropriate risk identification techniques and communication are used to maintain compliance with applicable laws and standards. In December 2023, a national EC/LS workgroup was established to find root causes and failure modes within the EC/LS accreditation compliance, recommend to the IHS Executive Leadership Team (ELT) the remediation of the findings, and establish an execution strategy and metrics to show remediation. In FY 2024, the EC/LS program completed an Executive Leadership Request for the identification of pain points and root causes of Agency-wide EC/LS accreditation findings and risks involving a multidisciplinary team of engineers and safety professionals and presented to the IHS ELT on the root causes from the EC/LS workgroup and recommendations for remediation. The EC/LS program completed two in-person courses called ‘Fundamentals of Safety Officer’ with 50 attendees from six IHS Areas in collaboration with the IHS Office of Environmental Health and Engineering. The EC/LS workgroup will start closing EC/LS recommendations by formulating an execution strategy and data metric to track the closure of items. The EC/LS program provided onsite and in-person support at two IHS facilities related to accreditation readiness. Moving forward, the EC/LS program will finish developing 16 execution strategies for the remediation of findings.

The Infection Control and Prevention (ICP) program published the IHS Indian Health Manual Infection Control and Prevention policy (Chapter 33) in August 2023. The chapter established infection control and prevention program policies, procedures, and responsibilities required to ensure a comprehensive ICP program exists in all IHS healthcare facilities and Service Units. An ICP program is required to meet and maintain readiness with applicable healthcare accreditation standards. To assist facilities with reviewing compliance for key elements, an integrated audit tool is available Agency-wide through Tracers with AMP® software, giving IHS the ability to analyze and track compliance.

The ICP program manages the ICP Listserv, which has 408 I/T/U users. It regularly distributes ICP resources and updates and provides expert technical assistance across the health system. Resources and education from ICP Office Hours are also shared on the ICP Listserv. The ICP Office Hours reoccur monthly, with 670 staff in attendance for CY 2024. They review attendees' core elements of ICP and allow attendees to ask questions as needed.

The ICP program has partnered with subject matter experts from the Centers for Disease Control and Prevention (CDC) on ICP-related projects. One of these projects includes conducting Infection Control Assessment and Response (ICAR) assessments, which allows facilities the opportunity to review critical elements of infection control, including training, audits and feedback, hand hygiene, transmission-based precautions, environmental services, high-level disinfection and sterilization, injection safety, point of care testing, wound care, healthcare laundry, antibiotic stewardship, and water exposure. In CY 2023, the focus shifted to the ICP program, and five ICARs were completed. In 2024, IHS and CDC's Health Systems Resilience and Training Branch collaboration focused on staff education. It included a partnership to bring a weekly webinar series on ICP topics to IHS staff in July and August. Facilities are advised to track improvements and implementation of best practices through local Governing Board Quality Management Programs. The ICP program has also integrated ICAR assessment results into Tracers with AMP®. This tool is utilized to identify gaps in infection control practices, drive educational needs, and provide resources to the I/T/U Infection Preventionists. The ICARs have been designated as "best practice" by multiple accreditation surveyors and are valuable in mitigating risks related to Occupational Health and Safety Administration investigations.

In collaboration with a quality improvement organization, 21 Acute Care and Critical Access IHS Hospitals are reporting Hospital Associated Infection (HAI) data and Healthcare Personnel data to the National Healthcare Safety Network (NHSN) per CMS required reporting.

In the winter of 2023 and 2024, the Infection Control and Prevention Subcommittee, an IHS National Quality Council component, was initiated. The subcommittee identifies and prioritizes improvement opportunities, develops strategies, and implements measures to improve patient and workforce safety. This multi-disciplinary team includes OQ staff, Area Quality Managers, and Area and facility Infection Preventionists. As a result of the subcommittee's work, there is an increased focus on improving processes, including staff education and training related to reusable instruments and ensuring policies and procedures promoting patient safety and infection control are in place to reduce adverse events. Facilities assess compliance and identify opportunities for improvement with instrument-related processes utilizing the Tracers with AMP® software. Over 5,000 tracer element observations were conducted in 2024. The ICP program will continue collaborating with other divisions within the IHS, such as the Environmental Health Division and the Division of Oral Health, to provide education and training opportunities for front-line staff.

AREA ALLOCATION

Direct Operations

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY 26 +/- FY 24
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$150	$7,322	$7,472	$150	$7,322	$7,472	$149	$7,321	$7,470	-$2
Albuquerque	1,353	883	2,236	1,353	883	2,236	1,342	883	2,224	-$12
Bemidji	1,784	790	2,574	1,784	790	2,574	1,768	790	2,558	-$16
Billings	2,174	780	2,954	2,174	780	2,954	2,155	780	2,935	-$19
California	2,005	824	2,830	2,005	824	2,830	1,988	824	2,812	-$18
Great Plains	2,316	1,169	3,486	2,316	1,169	3,486	2,296	1,169	3,465	-$20
Nashville	1,311	1,286	2,597	1,311	1,286	2,597	1,299	1,286	2,585	-$12
Navajo	3,594	1,248	4,843	3,594	1,248	4,843	3,563	1,248	4,811	-$31
Oklahoma	2,670	4,384	7,054	2,670	4,384	7,054	2,646	4,384	7,030	-$24
Phoenix	3,357	1,071	4,428	3,357	1,071	4,428	3,328	1,071	4,399	-$29
Portland	2,460	1,362	3,823	2,460	1,362	3,823	2,439	1,362	3,801	-$22
Tucson	919	221	1,140	919	221	1,140	911	221	1,132	-$8
Headquarters	58,369	0	58,369	58,369	0	58,369	57,862	0	57,862	-$507
Total, Direct Ops	**$82,463**	**$21,342**	**$103,805**	**$82,463**	**$21,342**	**$103,805**	**$81,746**	**$21,339**	**$103,085**	**-$720**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
SELF-GOVERNANCE

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026+/- FY 2025
PL	$6,174	$6,174	$6,174	--
FTE /1, 2	17	15	15	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation ..... Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), as amended 25 U.S.C. § 5381 et seq., 42 C.F.R. Part 137

FY 2026 Authorization ..... Permanent

Allocation Method ..... Direct Federal, Cooperative Agreements, and Self-Governance Funding Agreements

PROGRAM DESCRIPTION

The Office of Tribal Self-Governance (OTSG) serves as the primary liaison and advocate for Tribes and Tribal Organizations participating in the Tribal Self-Governance Program (TSGP) as authorized under Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. §5381 et. seq.). Through the TSGP, Tribes have the option to assume IHS program funds and manage them to best fit the needs of their Tribal communities. Tribes participating in the TSGP negotiate with the Indian Health Service (IHS) and take on full funding, control, and accountability for those programs, services, functions, and activities (PSFAs), or portions thereof, that the Tribe chooses to assume.

The Self-Governance budget supports several OTSG activities and functions, which promote the participation by all American Indian/Alaska Native (AI/AN) Tribes in the IHS TSGP and expand access to healthcare services while addressing social determinants of health, such as:

- Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS.
- Participates in nation-to-nation negotiations of ISDEAA Title V Compacts and Funding Agreements and provides oversight of the Agency Lead Negotiators.
- Reviews eligibility requirements for Tribes to participate in the TSGP and receive Self-Governance Planning and Negotiation Cooperative Agreements.
- Provides resources, technical assistance, and TSGP training to Tribes and Tribal Organizations.
- Coordinates national Tribal self-governance meetings, including an annual consultation conference in partnership with the Department of the Interior.
- Coordinates self-governance Tribal Delegation Meetings for IHS Headquarters and Area Senior officials.

BUDGET REQUEST

The FY 2026 budget submission for Self-Governance of $6.2 million is flat with the FY 2025 Enacted level.

FY 2025 Enacted level Funding of $6.2 million: The base funding supports further implementation of the IHS Tribal Self-Governance program, continues funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, and continues to fund performance projects and Tribal share needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program**.**

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$5,850,000
2023 Final	$6,174,000
2024 Final	$6,174,000
2025 Enacted	$6,174,000
2026 President's Budget	$6,174,000

TRIBAL SHARES

Program funds are not subject to Tribal shares. However, certain portion of the program funds support initial program transfers to Tribes when they assume the responsibility for carrying out the associated PSFAs. A portion of the overall program budget line is reserved for federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

PROGRAM ACCOMPLISHMENTS

The IHS TSGP has grown dramatically since the execution of the initial 14 compacts and funding agreements in 1994. In FY 2024, IHS transferred approximately $3.0 billion of the total IHS budget appropriation to Tribes and Tribal Organizations to support 114 ISDEAA self-governance compacts and 141 funding agreements.[1]

The Self-Governance budget brings health care quality expertise to the IHS, and Tribes, by:

- Providing technical assistance, disseminating communication, and supporting the disbursement of funds to Self-Governance Tribes to build, strengthen, and sustain collaborative relationships. In FY 2024, the Office of Tribal Self-Governance Funds Management (OTSGFM) System interfaced for a full year with the Unified Financial Management System (UFMS). The interfacing of these two systems significantly decreased reporting variances and made it easier to reconcile the two systems on a monthly basis. In FY 2025, the goal is to eliminate the variances and improve the

[1] For FY 2025, the IHS estimates an additional six Tribes will be entering into Title V ISDEAA compacts and funding agreements. This estimate corresponds to the number of Self-Governance Negotiation Cooperative Agreements available each fiscal year. Eligibility requirements for these agreements mirror the statutory requirements that Tribes must meet to participate in the IHS Tribal Self-Governance Program (25 U.S.C. §5383; 42 C.F.R. Part 137, Subpart C). For this pool, an average estimate of $5 million per Tribe is used to project estimates for Tribes entering into a Title V ISDEAA compacts and funding agreements, inclusive of both Tribal shares and Contract Support Costs.

OTSGFM process coordination across the IHS Areas to ensure timely and accurate payments.

- Providing support for projects that assist Tribally operated health programs that build, strengthen, and sustain collaborative relationships. For example, the IHS collaborated with Tribes and Tribal Organizations to coordinate the FY 2024 Annual Self-Governance Tribal Consultation Conference which brings together Self-Governance Tribes, the Department of Interior, and other federal agencies to discuss key topics with Self-Governance Tribes to share and learn best practices, and to promote the participation of all American Indian and Alaska Native Tribes in IHS Tribal Self-Governance activities
- Collaborating on crosscutting issues and processes including, but not limited to: program management issues; self-determination issues; Tribal shares methodologies; and working towards effectively managing assets and resources. In FY 2024, the IHS coordinated with Tribes and Tribal Organizations to carry out three Tribal Self-Governance Advisory Committee and Joint Tribal-Federal Technical Workgroup meetings. This Committee advocates for Self-Governance Tribes and Tribal Organizations, suggests policy guidance on the implementation of the TSGP, and advises the IHS Director on issues of concern to all Self-Governance Tribes. Additionally, in FY 2024, the IHS updated the IHS Tribal Consultation Policy with the contributions and recommendations from the IHS Director's Advisory Workgroup on Tribal Consultation and established it as permanent policy in the Indian Health Manual. Activities in FY 2025 will focus on continued education on the new Tribal Consultation Policy and its implementation.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2025 Target**	**FY 2026 Target**	**FY 2026 Target +/-FY 2025 Target**
TOHP-SP Implement recommendations from Tribes annually to improve the Tribal consultation process and IHS operations. (Output)	FY 2024: 5 recommendations Target: 5 recommendations (Target Met)	5 recommendations	5 recommendations	Maintain

GRANT AWARDS

(whole dollars)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Planning Cooperative Agreements			
Number of Awards	5	3	3
Award Amount	$0	$180,000	$180,000
Negotiation Cooperative Agreements			
Number of Awards	2	3	3
Award Amount	$0	$84,000	$84,000

AREA ALLOCATION

Self-Governance

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024 Estimate/1			FY 2025 Estimate/1			FY 2026 Estimated/1			FY 26 +/- FY 24
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Albuquerque	0	0	0	0	0	0	0	0	0	$0
Bemidji	0	0	0	0	0	0	0	0	0	$0
Billings	0	33	33	0	33	33	0	218	218	$185
California	0	0	0	0	0	0	0	0	0	$0
Great Plains	0	0	0	0	0	0	0	0	0	$0
Nashville	0	19	19	0	19	19	0	126	126	$107
Navajo	0	0	0	0	0	0	0	0	0	$0
Oklahoma	0	43	43	0	43	43	0	285	285	$242
Phoenix	0	0	0	0	0	0	0	0	0	$0
Portland	0	2	2	0	2	2	0	13	13	$11
Tucson	0	0	0	0	0	0	0	0	0	$0
Headquarters	6,077	0	6,077	6,077	0	6,077	5,532	0	5,532	-$545
Total, Self-Gov	**$6,077**	**$97**	**$6,174**	**$6,077**	**$97**	**$6,174**	**$5,532**	**$642**	**$6,174**	**$**

1/ Note: 2024, 2025, and 2026 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service Services:
75-0390-0-1-551
PUBLIC AND PRIVATE COLLECTIONS

(Dollars in Thousands)

	FY 2024	FY 2025 /3	FY 2026 /3	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
Medicare	$280,663	$280,061	$290,983	+$10,922
Medicaid	$1,154,927	$1,227,690	$1,275,570	+$47,880
M/M Total	**$1,435,590**	**$1,507,751**	**$1,556,553**	**+$58,802**
Private Insurance	$247,444	$243,072	$252,551	+$9,479
VA Reimbursements	$6,525	$7,045	$7,320	+$275
Total	**$1,689,559**	**$1,757,868**	**$1,826,424**	**+$68,556**
FTE /1, 2	5,720	5,720	5,720	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.
3/ FY 2025 and FY 2026 are collections estimates for the Indian Health Service.

Authorizing Legislation……..…Indian Health Care Improvement Act, Pub. L. 94-437, as amended by Pub. L. 111-148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935); the Social Security Act sec. 1880 & 1911, 42 U.S.C 1395qq &1396j and the Economy Act (31 U.S.C 1535).

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) authorizes the Indian Health Service (IHS) to collect reimbursements for services provided in IHS facilities to: (a) patients with Medicare and Medicaid (M&M) eligibility; (b) patients with Private Insurance (PI); and (c) patients with Department of Veterans Affairs (VA) and Department of Defense eligibility. In general, per the IHCIA, the reimbursements received or recovered must be credited to and remain at the local facility for use. Public and private collections represent a significant portion of the IHS and Tribal health care delivery budgets. Third-party collections are used to improve the delivery of and access to health care for American Indian and Alaska Native (AI/AN) people. Some IHS health care facilities report that 60 percent or more of their yearly budget relies on revenue collected from third-party payers. IHS Headquarters provides daily technical assistance and administrative support to IHS facilities.

Monitoring – IHS management evaluates control deficiencies identified by management's ongoing monitoring of the internal control system as well as any separate evaluations performed by both internal and external sources. In addition to controls established by statute, regulation, and policy, the IHS employs an online system to monitor the third-party reimbursement process for IHS operated facilities. The Third-Party Internal Controls Self-Assessment Tool provides necessary information for local managers and Headquarters staff to monitor compliance with applicable policies and procedures during the third-party revenue collections process so they can take necessary actions and improve overall program activity. The IHS has also implemented Third-Party Revenue Collections and Third-Party Alternate Resource (health insurance coverage) Dashboards to monitor collections and insurance coverage at the National, Area, State and local level.

Regulation Review and Compliance - IHS continues to ensure compliance with rules and regulations that

impact third-party collections directly and indirectly, especially regarding the Medicare and Medicaid programs IHS reviews new policies and draft regulations prior to publication and provides feedback to CMS. After they are published for public review, IHS discusses the potential impacts on healthcare collections with Tribal government representatives and urban Indian healthcare programs.

Partnerships – In addition to regular meetings with the Centers for Medicaid and Medicare Services (CMS), Headquarters staff participate in the CMS Tribal Technical Advisory Group (TTAG) including face to face, monthly calls, and subcommittees. IHS partners with the Department of the Treasury with Treasury Fiscal Services to further protect, control, and monitor all third-party collections, as well as the Department of Veterans Affairs (VA) to facilitate payment from the VA to IHS for services to AI/AN veterans.

Training - IHS provides continuous training to IHS, Tribal, and Urban Indian Organization (I/T/U) health care facility staff in areas related to various functions within the revenue cycle, including patient registration, benefits coordination, coding, third-party billing, management of accounts receivable and other aspects of the revenue cycle. IHS coordinates with CMS to provide I/T/U staff training on Medicare, Medicaid, and Social Security benefit programs. IHS also hosts an annual Partnership Conference to provide the most current information related to the revenue cycle process.

PROGRAM ACCOMPLISHMENTS

Meetings, Workgroups, and Training - In FY 2024, the IHS hosted the following events to support efforts to strengthen revenue cycle operations and support staff development:

- Two in-person National Business Office Committee meetings to strengthen Business Office capabilities and functions; ensure appropriate communication occurs with all relevant parties to enhance third-party revenue; and coordinate and expand third-party revenue activities.
- ORAP presented on Business Office Considerations when Tribes acquire IHS facilities under the ISDEAA. One presentation was given to CEOs, and one presentation was recorded for the ISDEAA bite-size learning series in collaboration with the IHS Office of Self Governance.
- A Patient Registration and Benefits Coordination Training was held in March of 2024. There were over 200 in person attendees and over 200 individuals who participated through Zoom.
- A Third-Party Billing and AR Training was held July 9-11th 2024 that included approximately 200 attendees.
- ORAP in Partnership with the NBOC held a virtual third-party billing training October 1st – 10th. There were over 200 participants through MS Teams.
- IHS continued to plan for training that will continue into FY25. Plans include a virtual lunchtime learning series that presents Revenue Cycle Topics monthly.

Outreach, Education, and Enrollment – In FY 2024, through the IHS National Indian Health Outreach and Education (NIHOE) cooperative agreement, the IHS furthered its mission and goals related to providing quality health care to the AI/AN community through health care policy analysis, outreach and education efforts with a focus on improving Indian health care, promoting awareness, visibility, advocacy, training, and technical assistance. Through the NIHOE, IHS partners have provided training sessions and webinars for Tribes and tribal members, helped coordinate numerous enrollment events, created toolkits, and offered technical assistance to enrollment assisters that assist AI/AN with issues related to enrollment into health care coverage and access to care. NIHOE partners have included activities related to COVID-19 Pandemic response and how to maintain and increase healthcare coverage, especially Medicaid.

2024 Annual IHS Partnership Conference - In FY 2024, the IHS hosted a joint Partnership Conference with over 2,500 attendees from the Business Office, Office of Information Technology (OIT), Health

Information Management (HIM), Purchased/Referred Care (PRC), Finance, and other components of the Revenue Cycle. In FY 2024, the Direct Service Tribes National Meeting was also held in conjunction with the Partnership Conference. The conference convened a series of training sessions showcasing advances and improvements of these mission-critical functions. Training sessions covered: Patient Registration, Patient Benefit Coordination, Billings, Account Receivables, Account Reconciliation, Denial Management and the impacts on the revenue cycle from Health Information Technology -OIT, HIM-Coding, Finance, Purchased/Referred Care, and Clinical components.

Reimbursement for Services to Veterans - In FY 2024, the IHS announced that the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) and the Department of Health and Human Indian Health Service had executed a revised agreement to facilitate reimbursement by VA to IHS for health care and related services provided by the IHS to eligible American Indian and Alaska Native (AI/AN) Veterans[1]. This agreement replaces and expands upon the prior agreement which was originally executed in 2012. Under the new agreement, VA now reimburses the IHS for purchased/referred care and contracted travel for AI/AN Veterans. The VA will also continue to reimburse the IHS for direct care provided to AI/AN Veterans.

Revenue Cycle Initiative – In FY 2024 and FY 2025, IHS made further progress on improving oversight of the revenue cycle operations at IHS operated facilities. The primary objective is to equip revenue cycle stakeholders with web-based tools to proactively identify potential threats to revenue cycle operations and to timely respond. IHS plans to develop a prototype of a Revenue Cycle Dashboard, powered by the IHS electronic health record solution and Unified Financial Management System by December 31, 2024. The dashboard is accessible to all revenue cycle stakeholders.

Centralized Database Project – In FY 2024 and FY 2025 IHS began work on a centralized database project that will provide comprehensive, timely, information that can be analyzed at multiple levels to improve revenue and increase efficiency in the healthcare collections process.

CHC Data Breach - Restoration of Pharmacy Billing and Collection Program – The Change Healthcare Data Breach in February 2024, impacted close to 95 percent of all Pharmacy Collections. Most Pharmacy Billing was transmitted through the CHC, serving as a switch company to transmit all Pharmacy claims to the proper payors. During the period of "correcting" the breach, there was a delay in IHS pharmacy revenue. IHS Headquarters worked with all Pharmacy Benefits Managers and Payors to ensure that the proper transition was restored.

VA PRC Banking Cash Flow establishment – IHS entered into a new VA/IHS agreement that allowed for PRC reimbursements to be received from the Department of Veterans Affairs Veterans Health Administration. New bank accounts and payment methodologies had to be established for the ten IHS Areas that will be receiving these types of payments. These payments are separate from the Direct Care Reimbursements for Accounting purposes.

Telehealth Documentation - In FY 2024 and FY 2025, IHS continued to analyze documentation of telemedicine services to ensure appropriate and consistent documentation for workload reporting for annual all-inclusive rate negotiations, budgeting purposes, and compliance with billing standards.

Enrollment Trends Monitoring – In FY 2024 and FY 2025, IHS continued to engage in significant planning and outreach, and data analysis related to enrollment trends monitoring and the impacts of the Medicaid Unwinding. Activities have focused on providing resources that prepare staff to assist patients

[1] https://www.hhs.gov/about/news/2023/12/07/us-departments-of-health-and-human-services-and-veterans-affairs-renew-reimbursement-agreement.html

with maintaining coverage or seeking alternate coverage if they are no longer eligible for Medicaid such as through the Health Insurance Marketplace.

Training and Workforce Development - In FY 2024 and FY 2025, the IHS continued its Training and Workforce Development Workgroup to develop a business office workforce planning assessment so that staffing needs can be measured, training and development goals can be established, and workforce options can be used to create an optimally staffed and trained workforce.

Regulation Review – In FY 2024 and FY 2025, IHS participated in over 300 rounds of clearance of HHS regulations and policy proposals. IHS continues to review new proposals for impacts on the Indian health system as they are introduced and provide feedback to the proposing agencies.

FY 2025 - 2026 Collections Estimates

The FY 2025 estimate of collections is based on FY 2024/2025 actual collections to date. The FY 2026 amounts are estimated based on the FY 2025 projected collections, multiplied by the medical inflation rate.

***Medicare and Medicaid (M&M)* -- The FY 2026 Budget estimate assumes collections of $1.6 billion, $58.8 million above FY 2025 collections:**

- ***Medicaid* – The FY 2026 budget estimate assumes collections of $1.3 billion, $47.9 million above FY 2025 collections.** IHS continues to educate its users on the benefits of Medicaid enrollment. IHS continues to monitor its user population and insurance coverage and is making all possible efforts to maximize Medicaid enrollment in all States and to maintain current collection levels.

- ***Medicare*** – **The FY 2026 budget estimate assumes collections of $291.0 million, $10.9 million above FY 2025 collections.** IHS hospitals and clinics have taken strong steps to increase enrollment of its population in Medicare. In addition, IHS has expanded efforts to improve the quality of care and maintain current collections.

- ***Private Insurance*** – **The FY 2026 budget estimate assumes collections of $252.6 million, $9.5 million above FY 2025 collections.** IHS will continue to monitor its user population and increase direct assistance to stabilize and expand insurance coverage whenever possible to maintain and maximize private insurance collections.

- ***VA/IHS National Reimbursement Agreement* – The FY 2026 budget estimate assumes collections of $7.3 million, $275,000 above FY 2025 collections.** The FY 2026 estimate is based on the FY 2024/2025 projected collections. The estimate includes estimated collections received by IHS for Federal health programs. IHS and VA have agreed to continue to monitor actual reimbursements and work together to improve the quality of care for all veterans and maximize payments whenever possible. IHS continues to work with the VA in identifying the actual number of AI/ANs with VA benefits eligibility and, of those, how many receive direct care from IHS. IHS and the VA continue to work in partnership to identify and resolve billing and reimbursement issues and provide sites with on-going support and training. All IHS sites have signed implementation plans and have the ability to bill the VA for Veterans Services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2026 Performance Budget Submission to Congress

TABLE OF CONTENTS

Facilities

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
FACILITIES

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
BA	$813,183	$800,080	$715,671	-$84,409
FTE /1, 2	1,247	1,144	1,144	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

SUMMARY OF THE FACILITIES BUDGET

The Indian Health Facilities Appropriation includes facility projects, program support, medical equipment, and personnel quarters activities. Project activities include Maintenance and Improvement (M&I), Sanitation Facilities Construction (SFC), and Health Care Facilities Construction (HCFC). The program support activity is Facilities and Environmental Health Support (FEHS). Equipment and Personnel Quarters collections are also separate activities.

The Facilities Appropriation continues funding for health facility support, public health and preventive services where staff are funded through the Facilities Appropriation to work in healthcare facilities and in the AI/AN communities across Indian country.

BUDGET AUTHORITY

The FY 2026 budget submission for Facilities is $715.7 million and is -$84.4 million below the FY 2025 Enacted level.

Maintenance & Improvement –The FY 2026 budget submission for Maintenance and Improvement is $170.6 million, which is flat with the FY 2025 Enacted level. These funds are the primary source for providing maintenance, repair, and improvement of health care facilities. Specific objectives and program priorities to address the condition of facilities include:

- Providing routine maintenance and repairs to upkeep facilities at their current conditions;
- Achieving compliance with buildings and grounds accreditation standards of the Joint Commission or other applicable accreditation bodies;
- Providing improvements to facilities for enhanced patient access and care through larger M&I projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR), which is estimated at $1.45 billion for all IHS and reporting Tribal facilities;
- Ensuring that health care facilities meet building codes and standards;
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security; and
- Demolishing facilities when excess to the needs of the Service and/or a liability to health and safety.

Sanitation Facilities Construction –The FY 2026 budget submission for Sanitation Facilities Construction is $13.5 million, which is -$93.1 million below the FY 2025 Enacted level.

These funds provide for water supply, sewage disposal, and solid waste disposal facilities, including:

- Projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program, Tribes, individual homeowners, or other nonprofit organizations;
- Projects to serve existing AI/AN housing; and
- Special projects (e.g., studies, training, or other needs related to sanitation facilities construction) and emergency projects.

This total will be allocated to support the implementation of the FY 2026 Infrastructure Investment and Jobs Act (Pub. Law No. 117-58), also referred to as the Bipartisan Infrastructure Law (BIL), Sanitation Facilities Construction Funding. These funds will bolster program support activities overall and will be used to support program activities like salaries, expenses and administration.

Health Care Facilities Construction – The FY 2026 budget submission for Health Care Facilities Construction is $182.7 million, which is flat with the FY 2025 Enacted level.

This funding level for the construction of new and replacement healthcare facilities will allow IHS to continue/complete the following projects:

- Phoenix Indian Medical Center, Phoenix, AZ
- Alamo Health Center, Alamo, NM
- Small Ambulatory
- New and Replacement Staff Quarters
- Area Master Plans
- Infrastructure Projects

Facilities and Environmental Health Support (FEHS) – The FY 2026 budget submission for Facilities and Environmental Health Support is $316.3 million, which is +$8.7 million above the FY 2025 Enacted level.

This total includes funding for leadership and staffing to manage and implement all aspects of the Facilities Appropriation and shared operating costs at existing, new and replacement health care facilities.

FEHS funds provide for:

- Personnel who provide facilities and environmental health services and for operating costs associated with provision of those services and activities.
- Administrative costs, such as Geographic Information System (GIS) technologies and IT cybersecurity contract costs for facilities related data systems.

Equipment –The FY 2026 budget submission for Equipment is $32.6 million, which is flat with the FY 2025 Enacted level.

These funds provide for:

- Routine replacement of medical equipment to over 1,500 federally and tribally-operated health care facilities allocated on workload using a standard formula;
- New medical equipment in tribally-constructed health care facilities; and
- TRANSAM, a program under which IHS acquires and distributes surplus Department of Defense medical equipment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
MAINTENANCE AND IMPROVEMENT

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$170,595	$170,595	$170,595	--
FTE /1, 2	1	--	--	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION

Maintenance and Improvement (M&I) funds are the primary source of funding to maintain, repair, and improve existing Indian Health Service (IHS) and Tribal health care facilities, which are used to deliver and support health care services. M&I funding supports federal, government owned buildings and tribally-owned space where health care services are provided pursuant to contracts or compacts executed under the provisions of the Indian Self-Determination and Education Assistance Act (P.L. 93-638). M&I funds are necessary to achieve and maintain accreditation, to meet building codes and standards, to maintain and repair the physical condition of health care facilities, to modernize existing health care facilities to meet changing health care delivery needs, and to implement mandated requirements (e.g., energy conservation, seismic, environmental, handicapped accessibility, security, etc.). Efficient and effective buildings and infrastructure are vital to delivering health care in direct support of the IHS mission and priorities.

Maintaining reliable and efficient buildings is an increasing challenge as existing health care facilities age and additional space is added into the real property inventory. The average age for IHS-owned health care facilities is approximately 42 years, whereas the average age, including recapitalization of private-sector hospital plants, is 11 to 12 years.[1] Many IHS and Tribal health care facilities are operating at or beyond capacity, and their designs are not efficient in the context of modern health care delivery. In addition, as existing health care facilities continue to age, the operational and maintenance costs increase. (The 'average age of hospital plant' measures the average age of the facility including capital improvements, replacement of built-in equipment and modernization.)

[1] The American Hospital Association Trends Affecting Hospitals and Health Systems Chartbook 2018 edition (page 42): https://www.aha.org/system/files/2018-06/2018-AHA-Chartbook.pdf

IHS hospital administrators have reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. The physical condition of IHS-owned and many tribally owned healthcare facilities is evaluated through routine observations by facilities personnel and by in-depth condition surveys. These observations and surveys identify facility, fire-life-safety, and program deficiencies, and are used to develop IHS' estimate of the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The BEMAR is a measure of the condition of health care facilities in the Indian health system and establishes priorities for larger M&I projects. The FY 2024 BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2024, is $1.45 billion. This includes 1,400 facilities with 11,700 deficiencies listed. When IHS replaces an older, obsolete hospital or clinic with a new facility, all deficiencies associated with the old facility are removed from the backlog.

M&I Funds Allocation Method

In consultation with Tribes and the Federal healthcare sites, IHS is allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements, replace and modernize medical equipment, and provide staff quarters necessary to support health care delivery in the health care facilities and to modernize the health care facilities to support health care delivery and expand access to quality health care services.

The IHS M&I funds are allocated in four categories: routine maintenance, M&I projects, environmental compliance, and demolition:

1. *Routine Maintenance Funds* – These funds support activities that are generally classified as those needed for maintenance and minor repair to keep the health care facility in its current condition. Funding allocation is formula based. The Building Research Board of the National Academy of Sciences has determined that approximately two to four percent of current replacement value of supported buildings is required to maintain (i.e., 'sustain') facilities in their current condition.[2]

2. *M&I Project Funds* – These funds are used for major projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR) and make improvements necessary to support health care delivery. This funding will also provide improvements to facilities for enhanced patient access and care. Funding allocation is formula based.

3. *Environmental Compliance Funds* – These funds are used to address findings and recommendations from environmental audits and correct environmental BEMAR. These funds are available to Federal and Tribal health care facilities on a national basis.

4. *Demolition Funds* – The IHS has a number of Federally owned buildings that are vacant, excess, or obsolete. Demolition funds are used to dispose of these excess assets.

BUDGET REQUEST

The FY 2026 budget submission for Maintenance & Improvement of $170.6 million is flat with the FY 2025 Enacted level.

The FY 2026 budget request supports maintenance, repair, and improvements for existing IHS

[2] *Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings,* The National Academies Press (1990), *available at https://nap.nationalacademies.org/catalog/9807/committing-to-the-cost-of-ownership-maintenance-and-repair-of*

and Tribal facilities.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$169,664,000
2023 Final	$170,595,000
2024 Final	$170,595,000
2025 Enacted	$170,595,000
2026 President's Budget	$170,595,000

TRIBAL SHARES

There are no Tribal Shares allocated from Maintenance & Improvement funds. Rather, Tribal shares associated with the Facilities Program may be transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities at a Federal or Tribal healthcare site. Tribes may also contract or compact to perform individual Maintenance & Improvement projects that are awarded to federally owned sites

OUTPUTS / OUTCOMES

The Outcomes for this program are measured through BEMAR, i.e., progress in addressing maintenance needs and facility deficiencies. Maintaining effective and efficient healthcare buildings improve the ease and access to care, facilitate successful behavioral health services, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment to deliver services.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
SANITATION FACILITIES CONSTRUCTION

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$123,650	$106,627	$13,492	-$93,135
FTE /1, 2	138	125	125	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; 42 U.S .C 2004a, Indian Sanitation Facilities Act; 25 U.S.C. 1632, Indian Health Care Improvement Act, as amended 2010

FY 2026 Authorization .....Permanent

Allocation Method.....Needs-based priority system for construction project fund allocation and implemented through P.L. 86-121 Memorandum of Agreements, P.L. 93-638 Self-Determination Contracts and Self-Governance Construction Project Agreements.

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) requires the Indian Health Service (IHS) to identify the universe of sanitation facilities needs for existing American Indian and Alaska Native (AI/AN) homes by documenting deficiencies and proposing projects to address their needs. These projects prevent communicable diseases by providing new and existing homes with services such as water wells, onsite wastewater disposal systems, or connections to community water supply and wastewater disposal systems. These projects can also include provision of new or upgraded water supply or waste disposal systems.

Projects that provide sanitation facilities to existing homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS). The SDS is an inventory of the sanitation deficiencies of federally recognized AI/AN eligible homes and communities; the sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. Project selection is driven by objective evaluation criteria including health impact, existing deficiency level, adequacy of previous service, capital cost, local Tribal priority, operations and maintenance capacity of the receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined.

Sanitation Facilities Construction (SFC) projects can be managed by IHS directly or by Tribes that elect to use the Title I or Title V authorization under P.L. 93-638, the Indian Self-Determination and Education Assistance Act. Sanitation facilities projects are carried out cooperatively with the Tribes that will be served, and construction is performed by either the IHS or the Tribes. Projects start with a Tribal project proposal and are funded and implemented through execution of an agreement between a Tribe and IHS. In these agreements, the Tribes also assume ownership responsibilities, including operation and maintenance. The overall SFC goals, reporting requirements, eligibility criteria, project planning, and funding priorities remain the same, regardless of the delivery methods chosen by a Tribe.

The SFC Program leverages its capabilities in partnering with Tribes by also partnering with other Federal agencies in constructing or financing construction of water supply, wastewater and solid waste disposal projects addressing sanitation deficiencies faced by Tribes. One way in which the SFC Program engages in such partnerships is through the Infrastructure Task Force (ITF), a partnership of Federal agencies focused on finding ways to better serve Tribes through cooperative efforts.

BUDGET REQUEST

The FY 2026 budget submission for Sanitation Facilities Construction of $13.5 million is -$93.1 million below the FY 2025 Enacted level. The budget prioritizes maintaining funding for direct health care services and will be allocated to support the implementation of the FY 2026 Infrastructure Investment and Jobs Act (Pub. Law No. 117-58), also referred to as the Bipartisan Infrastructure Law (BIL), Sanitation Facilities Construction Funding. These funds will bolster program support activities overall and will be used to support program activities like salaries, expenses and administration.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$197,783,000
2023 Final	$196,167,000
2024 Final	$123,650,000
2025 Enacted	$106,627,000
2026 President's Budget	$13,492,000

PROGRAM ACCOMPLISHMENTS

The SFC Program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated to provide water and waste disposal facilities for eligible AI/AN homes and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have declined. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus.[1] Researchers associated the increasing illnesses with the restricted access to clean water for hand washing and hygiene. The SFC Program works collaboratively with Tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply and waste disposal facilities as soon as possible.

In FY 2024, IHS funded projects to provide service to 25,060 AI/AN homes. IHS also completed construction on 278 projects with an average project duration of 3.3 years. However, at the end of FY 2024, about 1.2 percent of all AI/AN homes tracked by IHS, lacked water supply or wastewater disposal facilities; and, about 115,862 or approximately 30 percent of AI/AN homes tracked by IHS were in need of some form of sanitation facilities improvements. The individuals who live in homes without adequate sanitation facilities are at higher risk for gastrointestinal disease, respiratory disease

[1] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.

and other chronic diseases.[2] Many of these homes without service are very remote and may have limited access to health care which increases the importance of improving environmental conditions.

The total sanitation facility needs reported through SDS has increased approximately $1.2 billion from $4.7 billion to $5.9 billion from FY 2023 to FY 2024. In FY 2024, the IHS was appropriated $799.2 million (FY 2024 appropriations of $123.7 million and $675.5 million in IIJA funding) to address sanitation deficiencies and support provision of sanitation facilities to eligible AI/AN homes and communities. The magnitude of the sanitation facility needs increase is due to the underlying challenges of construction cost inflation, construction material availability, material supply chain challenges, and failing infrastructure. The failing infrastructure challenge is due to a combination of the infrastructure's age and inadequate operation and maintenance. Under the IHCIA, the IHS is authorized to provide operation and maintenance assistance for, and emergency repairs to, Tribal sanitation facilities, when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities, however resources have not been appropriated specifically for this purpose.

During 2024, 240 construction projects to address water supply and wastewater disposal needs were funded with a construction cost of $573 million using IHS and contributed funds. Once constructed, these sanitation facilities will benefit an estimated 25,060 AI/AN homes and help avoid over 130,500 inpatient and outpatient visits related to respiratory, skin and soft tissue, and gastro enteric disease over 30 years. The health care cost savings for these visits alone is estimated to be over $215 million. Every $1 spent on water and sewer infrastructure will save $0.37 in avoided direct healthcare cost. This figure is down from the FY 2022 figure of $0.92 due to funding of higher capital cost projects to bring piped water and sewer services to especially hard to serve populations living in rural and extreme climate locations.

The SFC Program is working proactively to increase SFC Program staff through streamlining the recruitment and hiring and engaging the Commissioned Corps of the U.S. Public Health Service. The SFC Program has also taken steps to retain current staff by providing pay incentives to current Civil Service staff. The SFC Program is also actively working with other federal partners to resolve these challenges including the Environmental Protection Agency and the US Army Corps of Engineers.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
35 Number of new or like-new and existing AI/AN homes provided with sanitation facilities. (Outcome) [1]	FY 2024: 25,060 Target: 54,400 [1] (Target Not Met)	49,000	5,000	-44,000
SFC-E Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction	FY 2024: 3.3 yrs Target: 4.5 yrs (Target Exceeded)	4.5 yrs	4.0 yrs	-0.5 yrs

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
completion. (Outcome)				

[1]Target based on funding from both FY 2025 President's Budget and $675.5 million from the Infrastructure Investment and Jobs Act (IIJA).

GRANT AWARDS – This Program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
HEALTH CARE FACILITIES CONSTRUCTION

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Full Year Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$182,679	$182,679	$182,679	--
FTE /1, 2	--	--	--	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method ..... Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts Construction Project Agreements

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Care Facilities Construction (HCFC) funds provide access to modern health care facilities and staff quarters. The IHS is authorized to construct health care facilities and staff quarters through several programs.

The health care facilities constructed by the IHS ensure access to quality, culturally competent health care for one of the lowest income populations in the United States, American Indians and Alaska Natives (AI/AN). The focus of the IHS health care service programs provided in these facilities is on prevention and delivery of comprehensive primary care in a community setting.

The HCFC program is funded based on an IHS-wide list of priorities for construction projects. During FY 1990, at the direction of Congress, the IHS established the Health Facilities Construction Priority System (HFCPS) methodology. The remaining six health care facilities projects on the HFCPS list, including those partially funded, total approximately $6.2 billion as of April 2024. The total need for the HCFC Program is approximately $23 billion for expanded and active authority facility types according to *The 2021 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*[1].

The Joint Venture Construction Program (JVCP) authorizes IHS to enter into agreements with Tribes that construct their own health care facilities. Tribes apply for the JVCP during a competitive process and the approved projects are entered into agreements with IHS. The Tribe provides the resources for the construction of its health care facility The IHS then agrees to request a funding increase from Congress for additional staffing and operations consistent with a fully executed beneficial occupancy of the health care facility.

[1] https://www.ihs.gov/newsroom/reportstocongress/

The Small Ambulatory Program (SAP) provides funding for small Tribal health care facilities. The SAP is authorized by the Indian Health Care Improvement Act. The SAP program is available for AI/AN Tribes or Tribal organizations to competitively obtain funding for the construction, expansion or modernization of tribally owned small ambulatory health care facilities. The selected projects will not be a part of the IHS HFCPS.

A new facility is designed to meet the demand for health services from a growing population by providing more healthcare providers, improved imaging systems, and other expanded services. Administration staff is increased to strengthen management, collections and bring health care quality expertise to the replacement facility. Each facility also incorporates additional space for Tribal health programs which complements IHS programs and how the HCFC programs are implementing.

BUDGET REQUEST

The FY 2026 budget submission for Health Care Facilities Construction of $182.7 million is flat with the FY 2025 Enacted level.

The total $182.7 million requested for FY 2026 would support:

Phoenix Indian Medical Center, Phoenix, AZ $110.0 million

These funds will be used to design and construct the first phase of the PIMC facility. The new Phoenix Indian Medical Center Health Care System is planned to decentralize a substantial portion of the primary care services workload to three new satellite facilities. The three satellite facilities are located in the southwest valley, the southeast valley, and in the northeast valley. The satellite facilities are located closer to the user's communities to provide more access to care. A new Central facility will be a major resource to the satellite facilities. The Central facility will be designed and equipped with full telemedicine support and visiting professionals to provide specialty care services and will continue to serve as a referral hospital for specialty consultation and procedures. The final budget amount will be completed when the phasing plan is complete, and a funding is secured.

Alamo Health Center, Alamo, NM $28.604 million

These funds will be used to complete the construction of the 33 staff quarters located in Alamo, New Mexico. The proposed new facility will consist of a 55,000 GSF outpatient health center and serve a projected user population of 2,500 generating 9,400 primary care provider visits and 18,080 outpatient visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.

Small Ambulatory $25.0 million

These resources would support 7 to 10 small ambulatory facilities in American Indian and Alaska Native communities. Consistent with prior years, the IHS will request applications from interested Tribes. Funds will support for construction, expansion or modernization of non-IHS owned, small Tribal ambulatory health care facilities located apart from a hospital.

Replacement Staff Quarters $13.575 million

These funds will fund replacement staff quarters. Many of the 2,700 quarters across the IHS health delivery system are more than 40 years old and in need of major renovation or total replacement. Additionally, in a number of locations the amount of housing units is insufficient. The identified unmet need, of housing units in isolated, remote locations is a significant barrier to

the recruitment and retention of quality healthcare professionals across Indian Country. The amount distributed to each Area will be based on each Area's internal priority list.

Infrastructure Projects: $5.0 million

The IHS will use these funds to incorporate current infrastructure standards and efficiency codes in the planning, design, and operation of facilities to the maximum extent practicable. This approach aims to improve performance, reduce operational costs, and ensure long-term sustainability of infrastructure investments.

Health System Planning Software Program (HSP) $500,000

These funds would be used to update the HSP to include additional new authorities granted in the Indian Health Care Improvement Act (IHCIA), update existing authorities, and integrate HSP with the IHS Geographic Information System (GIS) capabilities. The HSP is a critical tool used in all IHS healthcare facility projects, both Tribal and Federal, to plan services, staffing, equipment, and space. The program has the ability to assess unmet needs in AI/AN communities. Regular updates are necessary to reflect evolving healthcare practices and infrastructure standards.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$259,293,000
2023 Final	$260,896,000
2024 Final	$182,679,000
2025 Enacted	$182,679,000
2026 President's Budget	$182,679,000

PROGRAM ACCOMPLISHMENTS

Each healthcare facility project that is completed increases access to much needed health care services. Each completed replacement facility is typically larger to meet the increased demand for health services from a growing population.

The FY 2024 appropriation contributed to the Whiteriver Hospital, Whiteriver, AZ; Pueblo Pintado Health Center, Pueblo Pintado, NM; and the Echo Cliffs Health Center, Bodaway Gap Chapter of the Navajo Nation, AZ projects.

The FY 2024 appropriation also contributed $25 million to the IHS SAP, $13 million to the Staff Quarters Program and $5 million to Infrastructure Projects. The selection and agreements to award the funds began in late FY 2024.

The JVCP has saved the Federal Government over $1 billion dollars in capital expenses[2] since its inception. The outcome of the JVCP provides the same accomplishments as described above.

The federal construction and the Joint Venture programs bring new and increased health care capacity to AI/AN communities where there is a great need. These activities increase the access to quality healthcare in these underserved communities.

[2] The DFPC Project Reporting System JVCP report shows a construction cost of $1,342,486,046 for completed projects and a cost of $ 3,325,505,263 projects in planning or construction. The date of this report was March 2024.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026Target +/- FY 2025 Target[2]
36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome)	FY 2024: 0 project(s) Target: 0 project(s) (Target Met)	0 project(s)[1]	1 project(s)	+1 project(s)
HCFC-E Energy consumption in Leadership in Energy and Environmental Design (LEED) certified IHS health care facilities compared to the industry energy consumption standard for comparable facilities. (Outcome)	FY 2024: 0 project(s) Target: 0 project(s) [2] (Target Met)	0 project(s)[1]	1 project(s)[3]	+1 project(s)

1. The FY 2025 IHS Congressional Justification reported the FY 2025 Target as "1 project(s)", the FY 2025 target should be reported as "0 project(s)" as no projects are scheduled to be completed during the FY.
2. In FY 2024, the IHS HCFC program had six (6) projects in planning and three (3) in design. The FY 2024 target is listed as zero (0), as no projects were completed during the FY.
3. In FY 2026 IHS HCFC Target is one (1) Echo Cliffs Health Center in Bodaway Gap Chapter, AZ
   The HCFC program has three (3) projects in planning, three (3) in design, three (3) in construction.

GRANT AWARDS – Program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$303,661	$307,581	$316,307	+$8,726
FTE /1, 2	1,108	1,017	1,017	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts and competitive cooperative agreements

SUMMARY OF PROGRAMS

Facilities and Environmental Health Support Account (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs directly and indirectly support all of the IHS facilities performance measures and improved access to quality health services. The programs and staff at the IHS Headquarters, Area Office, and Service Unit levels work collaboratively with Tribes and other agencies to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities. These activities are aligned in sub-activities: Facilities Support, Environmental Health Support, and Office of Environmental Health and Engineering Support. In addition to personnel salary and benefits costs and administrative costs such as contracts for facilities-related Information Technology data systems, funding under this activity is used for utilities, certain non-medical supplies personal property, and biomedical equipment repair. Administrative costs, such as Geographic Information System (GIS) technologies and IT cybersecurity contract costs for facilities related data systems, have been increasing rapidly in recent years.

PROGRAM DESCRIPTION

FACILITIES SUPPORT

Facilities Support Account (FS) provides funding for Area and Service Unit staff for facilities-related management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement health facilities projects. Facilities operations, maintenance, repair, and

improvements address deficiencies/BEMAR and medical equipment, which are complex and involve many variables such as accreditation standards, healthcare patient satisfaction, changing healthcare delivery standards, building codes, old building equipment/system, and medical devices/equipment plus telemedicine used by healthcare professionals.

The IHS owns approximately 11 million square feet of facilities (totaling 2,141 buildings) and 1,760 acres of federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 170 years, with an average age greater than 40 years. A professional and fully-functional workforce is essential to ensure effective and efficient operations. An estimated 600 Federal positions (fulltime equivalents) are funded under this sub-activity. Typical staff functions funded may include:

- Facilities engineers and maintenance staff responsible for ensuring that building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe;
- Specialized clinical engineers and technicians who maintain and service medical equipment;
- Realty staff that manages the real property requirements and quarters; and
- Facilities planning, project management, and construction-monitoring that assist in the planning and construction of projects.

In addition, FS provides partial funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance.

ENVIRONMENTAL HEALTH SUPPORT

The Environmental Health Support Account (EHSA) provides funding for IHS Area, District, and Service Unit management activities and environmental health staff which include engineers, environmental health officers, engineering aides, injury prevention specialists, and institutional environmental health officers. In accordance with congressional direction, these funds are distributed to the Areas based upon the workload and need associated with the two programs noted below.

Sanitation Facilities Construction Program (SFC) – This program works collaboratively with Tribes to provide safe water supply and waste disposal facilities for AI/AN people and communities. The program manages annual project funding that includes contributions from Tribes, states, and other federal agencies. The SFC Program is the environmental engineering component of the IHS health delivery system.

As a result of this program, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus.[1] Researchers associate the increasing illnesses with the restricted access to clean water for hand washing and hygiene.

[1] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.

Consistent with the 1994 Congressional set aside for "…tribal training on the operation and maintenance of sanitation facilities," $1.0 million of these support funds are used for technical assistance, training, and guidance to Indian families and communities regarding the operation and maintenance of water supply and sewage disposal facilities. Starting in FY 2021, Congress allocated an additional $3.0 million for tribal training for operation and maintenance of sanitation facilities.

In accordance with the Indian Health Care Improvement Act, the staff annually updates its inventory of sanitation facilities deficiencies for existing Indian occupied homes.[2] This is accomplished through extensive consultation with Tribes. The SFC staff also develops and updates an inventory of all open dump sites on Indian lands as required under the Indian Lands Open Dump Cleanup Act.[3] Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation facilities construction projects.

The IIJA appropriates $700.0 million in each year from FY 2022 – FY 2026, for a total of $3.5 billion for the IHS Sanitation Facilities Construction (SFC) program. These resources are available until expended, for the provision of domestic and community sanitation facilities for Indians, as authorized. Funding from the IIJA appropriation is being used to fund sanitation facilities construction projects listed in the IHS Sanitation Deficiency System.

Environmental Health Services (EHS) – EHS is comprised of three components, General Environmental Health, and two specialty programs, which include Injury Prevention, and Institutional Environmental Health. EHS National priority areas include: food safety, children's environments, healthy homes, vector-borne and communicable disease, and safe drinking water.

The General EH component identifies environmental hazards and risk factors in Tribal communities and proposes control measures to prevent adverse health effects; monitors and investigates disease and injury; and provides inspections to identify environmental hazards in homes, healthcare facilities, food service establishments, Head Start centers, and many other types of Tribal establishments. Additionally, EHS provides training, technical assistance, and cooperative agreements to enhance the capacity of Tribal communities to address environmental health issues.

Examples of services EHS provides to AI/ANs: referrals for home investigations to reduce environmental triggers for asthma; home investigations to reduce exposure to lead-based paint or other hazards (including drinking water sources); animal bite investigations in Tribal communities and potential patient exposure to rabies virus; and referrals for investigation of communicable disease outbreaks.

The IHS Injury Prevention Program (IPP) leads IHS efforts to address injury disparities between AI/AN communities and U.S. all races. AI/AN experience injury mortality rates that are 2.5 to 8.7 times higher than non-AI/Ans in the Nation[4]. The IPP works with AI/AN, other agencies, and IHS programs to prevent unintentional injuries (e.g., motor vehicle-related, falls, burns, drowning, poisoning) and intentional injuries (e.g., suicide and violence-related) through

[2] Title III, Section 302(g) 1 and 2 of P.L. 94-437.
[3] P.L. 103-399.
[4] Trends in Indian Health 2017 Edition, IHS, Division of Program Statistics

technical assistance, training, and the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP). Technical assistance is provided in the areas of data collection for project evaluation, building partnerships, implementing evidence-based strategies or innovative interventions, and developing tribal injury prevention programs.

The IHS Institutional Environmental Health (IEH) Program identifies hazards and risk factors in the built environment and proposes control measures to prevent adverse health effects to patients, staff, and visitors in health care and other community facilities. The IEH program supports development and management of safe, functional health care facilities which contributes to the quality of care and workforce retention.

OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

The IHS Office of Environmental Health and Engineering Support activity (OEHE) provides funds for executive management activities, personnel, contracts, contractors, and operating costs for the OEHE Headquarters. Personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, perform management functions and have responsibility for all construction contracting in excess of $150,000.

Activities include national policy development and implementation, budget formulation, project review and approval, preparing reports for Congress, program oversight, program coordination and developing partnerships, project management functions for major construction, and real property asset management.

In accordance with appropriation committee direction, OEHE staff develop, maintain, and utilize data systems to distribute Facilities Appropriation resources to Area offices for facilities and environmental health activities and construction administration and management, based upon workload and need. The data from the distribution of Facilities Appropriations to Areas is used to calculate available Tribal shares of HQ OEHE Support for Section 638 of the Indian Self Determination and Education Assistance Act (ISDEAA). Also, technical guidance, information, and training are provided throughout the IHS system in support of the Facilities Appropriation.

BUDGET REQUEST

The FY 2026 budget submission for Facilities and Environmental Health Support of $316.3 million is $8.7 million above the FY 2025 Enacted level.

FY 2025 Enacted level Funding of $307.6 million – Supports Facilities and Environmental Health Support for existing IHS and Tribal facilities.

FY 2026 Funding Increase of $8.7 million includes:

- Staffing of New Facilities: +$8.7 million, described in the Staffing of Newly Constructed Facilities chapter.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$283,124,000
2023 Final	$298,297,000
2024 Final	$303,661,000
2025 Enacted	$307,581,000
2026 President's Budget	$316,307,000

PROGRAM ACCOMPLISHMENTS

FACILITIES SUPPORT

The Facilities Support Account and associated staffing level directly supports the medical equipment, maintenance and repair of, and adjustments/modifications to IHS and Tribal healthcare sites to prevent, prepare for, and respond to medical services.

In FY 2024, total utility costs were $17.0 million and total utility costs per Gross Square Feet (GSF) were $3.14/GSF. In FY 2025, the total utility cost is expected to be $17.4 million reflecting an annual increase of 2.5 percent. The cost per GSF is expected to increase with inflation to approximately $3.21/GSF. IHS makes conscious efforts to help stem the growth in utility costs to ensure appropriations are sufficient to fund these needs. For example, the IHS constructs new space that is at least 30 percent more energy efficient than building code requires and expects LEED Silver certification at those facilities. Additionally, the IHS seeks opportunities to fund renewable energy systems at IHS and tribally owned installations.

PROGRAM ACCOMPLISHMENTS

The Environmental Health Support Account directly supports field level activities for the Sanitation Facilities Construction and the Environmental Health Services programs described above.

In 2024, DEHS continues to explore opportunities to expand its role in addressing Asthma Control in Tribal Communities (ACT). Due to health disparities in AI/AN communities, particularly with children, DEHS is working to increase programmatic capacity to conduct healthy home assessments and complete community-based Indoor Air Quality (IAQ) surveys. It also remains actively engaged in related outreach and consultations. In addition, DEHS is currently engaged with clinical program leadership to identify ways to improve patient outcomes through referral enhancements and improvements in how we communicate findings with clinical providers. In addition, the IEH program is actively determining best practices for addressing occupationally acquired asthma in healthcare facilities and tribal communities.

DEHS is expanding its efforts to address food safety in AI/AN communities through partnerships with other Federal agencies and regulatory organizations. DEHS partnered with the U.S. Food and Drug Administration to increase the standardization of staff concerning retail food operations, allowing for more efficient and comprehensive retail food inspections. DEHS also collaborated with the Association of Food and Drug Officials (AFDO) to address the growing number of food processing/manufacturing facilities in Indian Country. This effort will significantly reduce the confusion of the permitting/licensure process while increasing the safety and oversight of food distributed and sold off the reservation. In order to address the downward trend in the number of Certified Food Protection Managers (CFPM) in recent years, DEHS is

working to increase the number of CFPM trainers within our program, as well as developing options to increase internal capacity within the tribal programs we serve. In addition, we are engaging with credentialing entities to identify ways to offset certification related costs for small, disadvantaged businesses and those with high employee turnover.

From 1997-2024, the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP) funded 111 Tribal injury prevention programs and provided $44.0 million in funding. Through these efforts, the IHS Injury Prevention Program (IPP) has contributed to the 58 percent decrease in injury mortality rates since 1973[5]. EHS continues to invest in preventing injuries instead of treating the impacts of injury and violence through our healthcare delivery system.

The IEH program promotes and supports a safety culture through extensive management, technical assistance, and workforce competency development for safety management, facilities management, leadership, and many multi-disciplinary staff in healthcare facilities. These efforts have reduced the IHS total occupational injury & illness case rate, which has continued to decrease from 4.35 injuries/100 employees in 2004 to 2.32 injuries & illnesses/100 employees in 2023. In addition, the IEH program supports healthcare management by providing on-site consultation and industrial hygiene services, local accreditation leadership, and support with risk assessments, program reviews, and environment-of-care mock surveys.

OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

OEHE is responsible for the design, construction, and maintenance of health care facilities as well as construction of sanitation infrastructure serving American Indians and Alaska Natives. OEHE completed the planning phase of the Portland Area Regional Specialty Referral Center and the Newcastle Joint Venture Demonstration Project. HQ OEHE staff also oversaw the provision of water, sanitation, and solid waste services to over 25,000 AI/AN homes and completed construction on over 270 sanitation projects passing final inspection in FY 2024. OEHE also completed an annual Sanitation Deficiency System (SDS) inventory of deficiencies across Indian country in coordination with Indian Tribes.

[5] https://www.ihs.gov/sites/dps/themes/responsive2017/display_objects/documents/Indian_Health_Focus_Injuries_2017_Edition_508.pdf

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2024 Target
EHS-5 Number of persons who received injury prevention training (Output)	FY 2024: 543 trained Target: 473 trained (Target Exceeded)	473 trained	473 trained	Maintain
EHS-6 Percent of food establishments with Certified Food Protection Manager (CFPM) (Output)	FY 2024: 77.5% Target: 87.5% (Target Not Met)	80.0%[1]	80.0%	Maintain

[1] The FY 2025 Target is revised from 87.5% to 80.0% due to operational changes and in consideration of FY 2024 results.

GRANT AWARDS

In FY 2024 the TIPCAP 2021-2025 five-year funding cycle entered its fourth year in which 27 tribes or tribal programs from eleven IHS Areas were awarded a cumulative total of $2.4 million per year. This cycle of funding addresses motor vehicle related injuries, falls, and other emerging issues based on tribal needs. This funding was used to address motor vehicle-related injuries, older adult falls, poisoning/opioids, suicide, and traumatic brain injury and establish new databases.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
EQUIPMENT

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$32,598	$32,598	$32,598	--
FTE /1, 2	--	2	2	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health diagnosis. The IHS and Tribal health programs manage approximately 110,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $850.0 million. With today's medical devices/systems having an average life expectancy of approximately six to eight years and rapid technological advancements, medical equipment replacement is a continual process making it necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment. To replace the equipment at the end of its six to eight-year life would require approximately $227.0 million per year.

Equipment Funds Allocation Method

In consultation with Tribes and the Federal healthcare sites, the IHS is allocating funding to the IHS Area Offices to replace and modernize medical equipment necessary to support health care delivery in the health care facilities and to modernize the health care facilities to support health care delivery and expand access to quality health care services.

In FY 2024, the IHS Equipment funds were allocated in four categories: Tribally-constructed health care facilities, TRANSAM program, Tribal emergency generator, and new and replacement equipment:

1. Tribally-Constructed Health Care Facilities - The IHS provides medical equipment funds to support the initial purchase of equipment for tribally-constructed health care facilities. FY 2024 funds supported $5 million for competitive awards to Tribes and Tribal

organizations that construct new or expand health care facilities space using non-IHS funding sources. Tribes and Tribal organizations will use these funds to serve approximately 500,000 patients with newly purchased medical equipment.

2. TRANSAM Program - Equipment funds may be used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans) Program and to procure ambulances for IHS and Tribal emergency medical services programs.[1] FY 2024 appropriations included $500,000 for the TRANSAM Program from the Equipment budget. Under the TRANSAM Program, excess equipment and supplies, at an annual estimated value of $5 million, are acquired for distribution to federal and Tribal sites.

3. Tribal Emergency Generator - The IHS provides medical equipment funds to support the purchase of emergency generators at Tribally-operated health care facilities. FY 2024 funds support $3 million for Tribal Health Programs located in areas impacted by de-energization events. Funding is allocated to the Tribal Health Program using the IHS ISDEAA compact/contract.

4. New and Replacement Equipment - Approximately $24.0 million allocated to IHS and Tribal health care facilities to maintain existing and purchase new medical equipment, including the replacement of existing equipment used in diagnosing illnesses. The funding allocation is formula based.

BUDGET REQUEST

The FY 2026 budget submission for Equipment of $32.6 million is flat with the FY 2025 Enacted level.

The FY 2026 budget request will continue to support the maintenance and purchase of equipment for existing IHS and Tribal facilities.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$30,464,000
2023 Final	$32,598,000
2024 Final	$32,598,000
2025 Enacted	$32,598,000
2026 President's Budget	$32,598,000

TRIBAL SHARES

Equipment funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities at a Federal or Tribe healthcare site.

[1] The IHS Facilities appropriation allocates $500,000 of Equipment funding for the TRANSAM Program.

OUTPUTS / OUTCOMES

This program measures outcomes through its inventory of medical equipment. Maintaining and fielding modern medical equipment improve the ease and access to care, enhance the diagnostic capabilities leading to better health outcomes, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment with which to deliver services.

IHS targets Equipment funding and supplements these funds with collections where available, toward equipment purchases to reduce the backlog of over-age equipment and field new, state-of-the-art equipment and systems. A few examples of these purchases include: digital x-ray systems (dental, 3D panoramic x-ray, full radiology rooms, 3D mammography, computed tomography), optometry equipment (visual field analyzers, simultaneous fundus and optical coherence tomography), lab analyzers for in-house testing, sterilization equipment, specialized microscopes, patient lifting equipment, picture archiving & communications systems (PACS), central patient monitoring systems, and ultrasound systems. This equipment will improve diagnostic capabilities, provide faster analysis, and facilitate provision of services to American Indian and Alaska Native communities.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
PERSONNEL QUARTERS / QUARTERS RETURN FUNDS

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$11,500	$11,500	$11,500	--
FTE*	--	--	--	--

Quarters funds are not BA but are rents collected for quarters which are returned to the service unit for maintenance and operation costs. They fall under the Program Level Authority.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010; Public Law 98-473, Sec. 320, as amended

FY 2026 Authorization.....Permanent

Allocation Method .....Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION

When available housing is limited in the area of Indian Health Service (IHS) health care facilities, staff quarters are provided to assist with recruitment and retention of health care providers. The operation, maintenance, and improvement costs of the staff quarters are funded with this funding designated as Quarters Return (QR) funds, i.e., the rent collected from tenants residing in the quarters. The use of the funds includes maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.). In certain situations, Maintenance and Improvement Program funds may be used, in conjunction with QR funds, to ensure adequate quarters' maintenance. For example, this may be necessary in locations with few quarters where QR funds are insufficient to pay for all required maintenance costs.

How the Facilities Program is implementing: In consultation with Tribes and the Federal healthcare sites, the IHS is allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements, replace and modernize medical equipment, and provide staff quarters necessary to support health care delivery in the health care facilities and to modernize the health care facilities to support health care delivery and expand access to quality health care services.

BUDGET REQUEST

The FY 2026 budget estimate for Staff Quarters of $11.5 million is flat with the FY 2025 Enacted level.

OMB Circular A-45, "Rental and Construction of Government Housing" (November 25, 2024) requires agencies with employee housing to adjust rent and related charges for inflation based on the Consumer Price Index (CPI). For 2024, the CPI adjustment is +4.4 percent in regions that

were not resurveyed for market values/rental rates. Regions with new market values/rental rates surveys, the new rent and utilities rates will be implemented.

These funds support the following activities:

The operation, management, and general maintenance of quarters, including maintenance personnel services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.).

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$10,659,223
2023 Final	$10,093,959
2024 Final	$11,500,000
2025 Enacted	$11,500,000
2026 President's Budget	$11,500,000

OUTPUTS / OUTCOMES - This program measures outcomes through the inventory of staff quarters. Well-maintained and modern housing units are an essential element in recruiting and retaining healthcare professionals at IHS and Tribal healthcare sites. Rent collections, augmented with Maintenance & Improvement funding and collections where available, are used to maintain, repair, and modernize existing quarters. Typically work may include painting, carpeting, new appliances, roof replacement, etc.

GRANT AWARDS – This program has no grant awards.
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2026 Performance Budget Submission to Congress

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Contract Support Costs

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Contract Support Costs: 75-0344-0-1-551
CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Final /3	Enacted /4,5	President's Budget	FY 2026 +/- FY 2025
PL	$1,051,000	$1,051,000	$1,708,000	+$657,000
FTE /1, 2	--	--	--	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.
3/ Displays the amount estimated as part of the FY 2024 Consolidated Appropriations Act (P.L. 118-42). Consistent with the nature of an indefinite appropriation account, the amount adjusts to align with the necessary funding level.
4/ Displays the amount estimated as part of the FY 2025 Full-Year Continuing Appropriations and Extensions Act (P.L. 119-4). Consistent with the nature of an indefinite appropriation account, the amount adjusts to align with the necessary funding level.
5/ Maintains indefinite discretionary authority for Contract Support Costs and Section 105(l) Lease and reflects the FY 2025 Enacted scores. The FY 2025 IHS operating plan reflect updated estimated scores of $1,708 billion for Contract Support Costs and $413 million for Section 105(l) Leases.

Authorizing Legislation ..... 25 U.S.C. §§ 450 et seq., Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended

FY 2026 Authorization.....Permanent

Allocation Method ..... P.L. 93-638 Self-Determination Contracts and Compacts

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, provides Tribes or Tribal Organizations (T/TO) the authority to contract with the Department of Health and Human Services, through the Indian Health Service (IHS), to operate Federal programs serving eligible persons and to receive not less than the amount of funding that the Secretary would have otherwise provided for the direct operation of the program for the period covered by the contract (otherwise known as the "Secretarial amount"). The 1988 amendments to the Act authorized Contract Support Costs (CSC) to be paid in addition to the Secretarial amount.

CSC are defined as necessary and reasonable costs for activities that T/TO must carry out to ensure compliance with the contract and prudent management but that the Secretary either did not normally carry out in his or her direct operation of the program or provided from resources other than those transferred under contract. The IHS CSC policy was established in 1992 and most recently revised on August 6, 2019, which updates from the October 2016 policy revisions,[1] an update to reflect necessary changes. These changes include the method by which Congress has funded CSC, and moves from limited to uncapped awards, and the provision of CSC to an indefinite appropriation.

[1] *Indian Health Manual*, Part 6 – Services to Tribal Governments and Organizations, Chapter 3 – Contract Support Costs, *available at* http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p6c3.

CSC is administered for IHS by the Office of Direct Services and Contracting Tribes (ODSCT), an office with responsibility for three primary functions that directly impact the relationship with each Indian T/TO. The ODSCT serves as the primary conduit between the IHS and the Direct Service Tribes, management of P.L. 93-638 Title I, ISDEAA contracts, and CSC in support of both Title I contracts and Title V compacts.

On June 6, 2024, SCOTUS ruled 5-4 in Becerra v. San Carlos Apache Tribe and Becerra v. Northern Arapaho Tribe, that the IHS must also pay eligible CSC incurred by T/TO that expend program income, or third-party reimbursements, under their ISDEAA contracts and compacts.

BUDGET REQUEST

The FY 2026 budget submission for Contract Support Costs of $1.7 billion which is an increase in score of +$657.0 million above the FY 2025 Enacted. The updated score takes into account the Supreme Court decision on the *Becerra v. San Carlos Apache Tribe* case. In addition, the budget request maintains an indefinite discretionary appropriation for Contract Support Costs that would continue to fully-fund Contract Support Costs payments to Tribes.

The overall funding level varies with need that is adjusted to meet the actual need for each fiscal year, which means that the appropriated amount will continue to fluctuate until the CSC need is fully reconciled for each year.

PROGRAM ACCOMPLISHMENTS

- Following is a summary of CSC funds for FY 2020– FY 2025, as of April 28, 2025

	2020	2021	2022
Appropriations*	$855,000,000	$916,000,000	$880,000,000
Paid to Tribes	$920,719,820	$1,170,290,371	$883,687,478
Balance*	($65,719,820)	($254,290,371)	($3,687,478)

	2023	2024	2025
Appropriations*	$1,051,000,000	$969,000,000	$926,000,000
Paid to Tribes	$911,320,734	$956,165,030	$890,407,395
Balance*	$139,679,266	$12,834,970	$35,592,605

- IHS developed a SharePoint to track CSC requirements for COVID-19 funds. Separate data sets are maintained for the period of funds availability for each Supplemental Appropriation. In this report the amounts paid to Tribes include COVID-19 funds.

- IHS Headquarters reconciles CSC fund requests on a quarterly basis and allocates funds to each Area office to pay tribes.

- IHS uses the CSC automated data system to track and monitor all CSC activity. The CSC data set is used to track all CSC funds, including any new and expanded assumption, renegotiation of CSC amounts, and distribution and payment of funds. IHS also uses the system to project CSC needs based on the most current data.

- IHS continues to use the internal electronic database to monitor each Title I and V ISDEAA negotiation, including CSC negotiations. The database monitors each phase of a negotiation to ensure that IHS uses a consistent agency business approach, meets statutory deadlines, and accurately calculates required funding amounts. In addition, the database tracks new and expanded assumptions and is used to determine the status of funds, workload, planning of resources, and subsequent years' funding needs.

- IHS continues to make progress in resolving Contract Disputes Act claims from Tribes and Tribal organizations (T/TO) for Program Income expenditures. On November 20, 2024, IHS settled its first claim on third-party program income expenditures. This settlement came six months after the June 6, 2024, the United States Supreme Court decided Becerra v. San Carlos Apache Tribe and Becerra v. Northern Arapaho Tribe, holding that the Indian Health Service must pay eligible CSC incurred by T/TO that expend program income, or third-party reimbursements, under their Indian Self-Determination and Education Assistance Act contracts and compacts. As of March 5, 2025, the IHS has settled 7 of the 536 claims, with total settlement payments of $8,888,227 which have been confirmed for payment from the Judgement Fund or for those claims on appeal by the Department of Justice. Due to various factors making a claim ineligible, the IHS has closed ten CSC CDA claims with total CDA claim requests of $26,532,212. The IHS has currently 151 claims in various stages of analysis with settlement amounts that cannot be determined at this time.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$880,000,000
2023 Final	$969,000,000
2024 Final	$1,051,000,000
2025 Enacted	$1,051,000,000
2026 President's Budget	$1,708,000,000

AREA ALLOCATION

CONTRACT SUPPORT COSTS

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2024* Estimate/1			FY 2025 Estimate/1			FY 2026 Estimate/1			FY '26 +/- FY '25
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$261,685	$261,685	$0	$285,880	$285,880	$0	$464,590	$464,590	$202,905
Albuquerque	0	33,039	$33,039	0	36,094	36,094	0	58,657	58,657	$25,618
Bemidji	0	46,778	$46,778	0	51,103	51,103	0	83,048	83,048	$36,270
Billings	0	16,506	$16,506	0	18,033	18,033	0	29,305	29,305	$12,799
California	0	68,527	$68,527	0	74,863	74,863	0	121,661	121,661	$53,134
Great Plains	0	52,589	$52,589	0	57,451	57,451	0	93,365	93,365	$40,776
Nashville	0	38,313	$38,313	0	41,856	41,856	0	68,020	68,020	$29,707
Navajo	0	93,216	$93,216	0	101,835	101,835	0	165,494	165,494	$72,278
Oklahoma	0	198,020	$198,020	0	216,329	216,329	0	351,560	351,560	$153,540
Phoenix	0	74,360	$74,360	0	81,236	81,236	0	132,018	132,018	$57,657
Portland	0	68,391	$68,391	0	74,715	74,715	0	121,420	121,420	$53,029
Tucson	0	10,624	$10,624	0	11,606	11,606	0	18,861	18,861	$8,237
Headquarters	0	0	$0	0	0	$0	0	0	$0	$0
Total, CSC	**$0**	**$962,049**	**$962,049**	**$0**	**$1,051,000**	**$1,051,000**	**$0**	**$1,708,000**	**$1,708,000**	**$745,951**

1/ Note: 2024, 2025, and 2026 are estimates.

*FY 2024 total enacted was $1,051,000, the total amount shown in the table is total obligations for FY 2024.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
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ISDEAA 105(*l*) Leases

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Payments for Tribal Leases: 75-0200-1-551
ISDEAA SECTION 105(*l*) LEASES

(Dollars in Thousands)

	FY 2024	FY 2025	FY 2026	
	Enacted /1	Enacted /2	President's Budget	FY 2026 +/- FY 2025
PL	$149,000	$149,000	$413,000	+$264,000
FTE /3, 4	--	--	--	--

1/ Displays the amount estimated as part of the FY 2024 Consolidated Appropriations Act (P.L. 118-42). Consistent with the nature of an indefinite appropriation account, the amount adjusts to align with the necessary funding level.
2/ Displays the amount estimated as part of the FY 2025 Full-Year Continuing Appropriations and Extensions Act (P.L. 119-4). Consistent with the nature of an indefinite appropriation account, the amount adjusts to align with the necessary funding level.
3/ Maintains indefinite discretionary authority for Contract Support Costs and Section 105(l) Lease and reflects the FY 2025 Enacted scores. The FY 2025 IHS operating plan reflect updated estimated scores of $1,708 billion for Contract Support Costs and $413 million for Section 105(l) Leases.
4/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
5/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation ..... 25 U.S.C. § 5324(*l*)
Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended

FY 2026 Authorization.....Permanent

Allocation Method .....P.L. 93-638 Self-Determination Contract and Compacts, Lease Cost Agreements

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA), at 25 U.S.C. § 5324(*l*), also referred to as Section 105(*l*), requires the Indian Health Service (IHS) to enter a "lease" upon the request of a tribe or tribal organization furnishing a tribally owned or leased facility used in support of its tribally operated ISDEAA contract or compact. The IHS does not directly use or occupy the tribal facility under the lease. Through regulations contained in 25 C.F.R. Part 900, Subpart H, IHS identified elements of compensation included in a Section 105(*l*) lease.

A 2016 Federal Court's decision (Maniilaq Association v. Burwell) prohibits IHS from capping funding under Section 105(*l*) at the level that IHS would have otherwise spent to operate a facility if it were carrying out the Federal health programs. There is no statutory or regulatory limitation on when proposals may be submitted to the IHS, so IHS is unable to reliably predict or project annual costs. Lease costs have grown exponentially since the Maniilaq decision; for example, costs quadrupled between FY 2018 and FY 2019.

Beginning in FY 2021, Congress provided a separate, indefinite discretionary appropriation for Section 105(*l*) leases. The indefinite appropriation provides the IHS with access to funding authority that adjusts to fully meet funding needs. Prior to FY 2021, Section 105(*l*) lease costs were paid from the IHS lump sum appropriation for the Indian Health Services account, which resulted in reallocation of funding from other budget lines within the account to address Section 105(*l*) lease costs. The Indian Health Services account is now protected from reallocation since Section 105(*l*) lease costs may only be paid through the separate, indefinite appropriation.

BUDGET REQUEST

The FY 2026 budget submission for ISDEAA Section 105(*l*) leases of $413.0 million is +$264.0 million above the FY 2025 Enacted level. This estimate supports anticipated increased costs for the program. The budget request maintains an indefinite discretionary appropriation for ISDEAA Section 105(*l*) leases to fully fund tribal lease payments.

Consistent with the nature of an indefinite appropriation, the overall funding level will adjust to meet the actual need for the fiscal year. The requested funding level reflects a point in time estimate of the need.

PROGRAM ACCOMPLISHMENTS

In FY 2024, the IHS received 914 proposals for an estimated total of $410.0 million. In FY 2023, the IHS executed 674 lease cost agreements for a total of $288.0 million. The IHS anticipates funding needs will continue to grow each fiscal year.

In FY 2024, the IHS continued efforts to enhance program operations and oversight. The IHS reviewed the internal organizational alignment of Section 105(*l*) lease activities to identify opportunities for bolstering program capacity. The IHS created the Division of 105(*l*) Tribal Leases within the Office of Direct Service and Contracting Tribes. In addition, the IHS continues to work on a draft policy for Section 105(*l*) leases to assist with clarifying program requirements and operations. The IHS continues to work with counterparts at the Department of the Interior on the requirements and process for Section 105(*l*) leases. For FY 2025, these collaborative efforts may include engagement with the IHS's tribal advisory groups, Tribes and Tribal Organizations to maximize consistent and transparent process where feasible and appropriate for the different types of programs administered by each agency.

FUNDING HISTORY

Fiscal Year	Amount
2022 Final	$150,000,000
2023 Final	$111,000,000
2024 Enacted	$149,000,000
2025 Enacted	$149,000,000
2026 President's Budget	$413,000,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2026 Performance Budget Submission to Congress

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Special Diabetes Program for Indians

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in thousands)

	FY 2024	FY 2025	FY 2026	
	Final	Enacted	President's Budget	FY 2026 +/- FY 2025
PL	$155,484	$159,363	$159,000	-$363
FTE /1, 2	21	21	21	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2026 FTE levels reflect estimates for October 1, 2025, and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

Authorizing Legislation ..... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians (SDPI) to extend funding through FY 2011, the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013, the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014, the Protecting Access to Medicare Act of 2014 (P.L. 113-93; H.R. 4302) to extend funding through FY 2015. P.L. 114-10 – The Medicare Access and CHIP Reauthorization Act of 2015 authorized SDPI for FY 2016 and FY 2017, P.L. 115-63 — Disaster Tax Relief and Airport and Airway Extension Act authorized SDPI for the first quarter of FY 2018, and P.L. 115-96— Department of Homeland Security Blue Campaign Authorization Act of 2017 authorized SDPI for the second quarter of FY 2018, P.L. 115-123 – Bipartisan Budget Act of 2018 authorized SDPI for the rest of FY 2018 and all of FY 2019, the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59) authorized SDPI through November 21, 2019, the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69) authorized SDPI through December 20, 2019. SDPI was authorized through May 22, 2020, through the Further Consolidated Appropriations Act, 2020 (P.L. 116-94). The Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-36) authorized SDPI through November 30, 2020. The Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159) authorized SDPI through December 11, 2020. The Further Continuing Appropriations Act, 2021, and Other Extensions Act (P.L. 116-215) authorized SDPI through December 18, 2020. The Consolidated Appropriations Act, 2021 (P.L. 116-260) authorized SDPI until September 30, 2023. The Continuing Appropriations Act, 2024 and Other Extensions Act (P.L. 118-15) authorized $19,726,027 for the period beginning on October 1, 2023, and ending on November 17, 2023. The Further Continuing Appropriations and Other Extensions Act (P.L. 118-22), 2024 authorized $25,890,411 for the period beginning on November 18, 2023, and ending on January 19, 2024. The Further Additional Continuing Appropriations and Other Extensions Act (P.L. 118-35), 2024 authorized $20,136,986 for the period beginning January 20, 2024, and ending March 8, 2024. The Consolidated Appropriations Act, 2024 (P.L. 118-42) authorized $130 million for the period beginning March 9, 2024, and ending on December 31, 2024. The American Relief Act, 2025 (P.L. 118-158) further extends SDPI through March 31, 2025, and provides an additional $39,261,745 of SDPI funding. The Full-Year Continuing Appropriations and Extensions Act, 2025 (P.L. 119-4) further extends SDPI through September 30, 2025, and provides an additional $79,832,215 of SDPI funding.

FY 2026 Authorization..... Expires September 30, 2025

Allocation Method .....Grants and Contracts

PROGRAM DESCRIPTION

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention to 309 Indian Health Service (IHS), Tribal, and Urban (I/T/U) Indian health grant programs. Funds for SDPI were first authorized in FY 1998; as such, FY 2026 will be the 29th year of the SDPI. SDPI is currently authorized through September 30, 2025. The IHS Office of Clinical and Preventive Services (OCPS) Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative, and technical oversight to the SDPI grant program.

The mission of the DDTP is to develop, document, and sustain public health efforts to prevent and control diabetes in American Indians and Alaska Native (AI/AN) people by promoting collaborative strategies through its extensive diabetes network. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, and 309 SDPI grants at I/T/U sites across the country.

Target Population: American Indians and Alaska Natives

Diabetes and its complications are major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (13.6 percent) among all non-AI/AN in the United States.[1] In some AI/AN communities, more than half of adults 45 to 74 years of age have diagnosed diabetes, with prevalence rates reaching as high as 60 percent.[2]

Allocation Method

In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes among AI/AN people. The entities eligible to receive these grants were I/T/Us. The IHS distributes this funding to 309 I/T/U sites annually through a process that includes Tribal Consultation/Urban Confer, development of a formula for distribution of funds, and a formal grant application and administrative process.

[1] Centers for Disease Control and Prevention. National Diabetes Statistics Report website. https://www.cdc.gov/diabetes/data/statistics-report/index.html#anchor_00215. Last Reviewed: November 29, 2023.
[2] Lee ET, Howard BV, Savage PJ, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45-74 years: the Strong Heart Study. *Diabetes Care*. 1995;18:599-610.

Strategy

The SDPI brings Tribes together to work toward a common purpose and share information and lessons learned. The Tribal Leaders Diabetes Committee, established in 1998, reviews information on the SDPI progress and provides recommendations on diabetes-related issues to the IHS Director. Through partnerships with federal agencies, private organizations, and an extensive I/T/U network, DDTP undertook one of the most strategic diabetes treatment and prevention efforts ever attempted in AI/AN communities and demonstrated the ability to design, manage, and measure a complex, long-term project to address this chronic condition. Because of the significant costs associated with treating diabetes, I/T/Us have used best and promising practices for their local SDPI funding to address the primary, secondary, and tertiary prevention of diabetes and its complications.

This collaborative approach supports the strategic planning process necessary to identify the goals and objectives needed to achieve the intended SDPI outcomes.

BUDGET REQUEST

The FY 2026 budget submission for the Special Diabetes Program for Indians is $159.0 million which is -$363,000 below the FY 2025 Enacted level.

The SDPI is currently authorized through September 30, 2025[3]. The annualized funding level under the Full-Year Continuing Appropriations and Extensions Act, 2025 (P.L. 119-4) brings the total to $159.4 million.

PROGRAM ACCOMPLISHMENTS

Impact of the SDPI Grant Programs

SDPI funding has enabled staff and programs at the local and national levels to increase access to diabetes treatment and prevention services throughout the Indian health system. The following table demonstrates substantial increases in access to many activities and services:

Diabetes treatment and prevention services available to AI/AN individuals	Access in 1997	Access in 2019	Absolute Percentage increase
Diabetes clinical teams	30%	95%	+65%
Diabetes patient registries	34%	96%	+62%
Nutrition services for adults	39%	94%	+55%
Access to registered dietitians	37%	85%	+48%
Culturally tailored diabetes education materials	36%	96%	+60%
Access to physical activity specialists	8%	84%	+76%
Adult weight management services	19%	76%	+57%

[3] The Full-Year Continuing Appropriations and Extensions Act, 2025 (P.L. 119-4).

Clinical Diabetes Outcomes during SDPI

At the same time that access to these diabetes services increased, key outcome measures for AI/ANs with diabetes showed improvement or maintenance at or near national targets. These results have been sustained throughout the inception of SDPI. Examples include:

- The average blood sugar level (as measured by the A1C test) among AI/ANs with diabetes served by the IHS has decreased from 9.0 percent in 1996 to 7.9 percent in 2023.
- The average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 87 mg/dL in 2023, surpassing the goal of less than 100 mg/dL.
- The rate of new cases of kidney failure due to diabetes leading to dialysis declined by more than half (54 percent) in AI/AN people from 1996 to 2013. This is a much larger decline than in any other racial group in the US.[4]

1. Diabetes Data and Program Delivery Infrastructure

Facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit. The Diabetes Audit is the cornerstone of the IHS DDTP diabetes care surveillance system, tracking annual performance on diabetes care and health outcome measures. Data collection for the Diabetes Audit follows a standardized protocol to ensure statistical integrity and comparability of measures over time. The 2023 Diabetes Audit included a review of 137,843 patient charts at 321 I/T/U health facilities. The Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national levels, as well as enhance quality improvement capabilities across AI/AN communities. DDTP provides Diabetes Audit training through online and webinar formats. DDTP receives evaluations on all trainings provided to guide improvements for future sessions.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
53 Increase the proportion of American Indians/Alaska Natives with diagnosed diabetes who have controlled blood pressure <140/90 (Outcome)	FY 2024: 55.8 % Target: 52.4 % (Target Exceeded)	57.5%	57.5%	Maintain
54 Statin Therapy to Reduce Cardiovascular	FY 2024: 49.5 % Target:	52.6%	52.6%	Maintain

[4] Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. MMWR Morb Mortal Wkly Rep 2017;66:26-32. DOI: http://dx.doi.org/10.15585/mmwr.mm6601e1.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
Disease Risk in Patients with Diabetes (Intermediate Outcome)	54.5 % (Target Not Met)			
86 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)[1]	FY 2024: 12.1 % Target: 14.4 % (Target Exceeded)	12.5%	12.1%	-0.4 percentage point(s)

1. The decrease shows improvement in percentage of AI/AN diagnosed with poor glycemic control.

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to 309 I/T/U health programs in 35 states. The SDPI grant programs provide local diabetes treatment and prevention services based on community needs.

(whole dollars)	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
Number of Awards	309	309	309
Average Award	$453,343	$453,343	$453,343
Range of Awards	$25,000 - $7,553,570	$25,000 - $7,553,570	$25,000 - $7,553,570

FY 2026 State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2023 Annual Financial Assistance Awards[5]					
State	State Name	FY 24 Total # Grant Programs	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
AK	Alaska	22	10,494,578	10,494,578	10,494,578
AL	Alabama	1	279,211	279,211	279,211
AZ	Arizona	28	35,522,502	35,522,502	35,522,502
CA	California	34	9,379,046	9,376,046	9,376,046
CO	Colorado	3	903,625	903,625	903,625
CT	Connecticut	2	232,777	232,777	232,777
FL	Florida	2	486,980	486,980	486,980
IA	Iowa	1	304,592	304,592	304,592

[5] Please note that the numbers provided for FY 2024 are likely to change due to the start of the new SDPI grant cycle.

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2023 Annual Financial Assistance Awards[5]					
State	State Name	FY 24 Total # Grant Programs	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
ID	Idaho	4	935,841	935,841	935,841
IL	Illinois	1	281,832	281,832	281,832
KS	Kansas	6	993,279	993,279	993,279
LA	Louisiana	4	364,530	364,530	364,530
MA	Massachusetts	2	168,316	168,316	168,316
ME	Maine	5	543,580	543,580	543,580
MI	Michigan	12	2,363,824	2,363,824	2,363,824
MN	Minnesota	9	3,378,922	3,378,922	3,378,922
MS	Mississippi	1	1,256,112	1,256,112	1,256,112
MT	Montana	13	6,869,529	6,869,529	6,869,529
NE	Nebraska	5	1,931,172	1,931,172	1,931,172
NV	Nevada	14	5,225,544	5,225,544	5,225,544
NM	New Mexico	24	7,693,403	7,693,403	7,693,403
NY	New York	6	1,481,491	1,481,491	1,481,491
NC	North Carolina	1	1,351,228	1,351,228	1,351,228
ND	North Dakota	5	3,168,173	3,168,173	3,168,173
OK	Oklahoma	27	23,578,609	23,578,609	23.578,609
OR	Oregon	9	1,832,727	1,832,727	1,832,727
RI	Rhode Island	1	113,475	113,475	113,475
SC	South Carolina	1	163,399	163,399	163,399
SD	South Dakota	10	6,294326	6,294,326	6,294,326
TN	Tennessee	1	130,001	130,001	130,001
TX	Texas	4	784,901	784,901	784,901
UT	Utah	6	2,223,841	2,223,841	2,223,841
VA	Virginia	4	417,983	417,983	417,983
WA	Washington	27	4,792,337	4,792,337	4,792
WI	Wisconsin	12	3,421,213	3,421,213	3,421,213
WY	Wyoming	2	1,032,196	1,032,196	1,032,196
	Total States	**309**	**$140,392,095**	**$140,392,095**	**$140,392,095**
	Indian Tribes	**264**	**$117,430,560**	**$117,430,560**	**$117,430,560**

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Supplemental Tables

Object Classification
Indian Health Service
(Dollars in Thousands)

	FY 24 Enacted	FY 25 Full Year CR	FY 26 President's Budget	FY 2026 +/- FY 2025
[Object Class]				
Personnel compensation:				
Full-time permanent (11.1)	$455,393	$550,415	$550,415	$0
Other than full-time permanent (11.3)	$18,714	$21,850	$21,850	$0
Other personnel compensation (11.5)	$68,877	$76,029	$76,029	$0
Military personnel (11.7)	$66,989	$86,776	$86,776	$0
Special personnel services payments (11.8)	$290	$318	$318	$0
Subtotal personnel compensation	**$610,263**	**$735,388**	**$735,388**	**$0**
Civilian benefits (12.1)	$209,357	$249,361	$249,361	$0
Military benefits (12.2)	$10,307	$12,255	$12,255	$0
Benefits to former personnel (13.0)	$14	$14	$14	$0
Subtotal Pay Costs,	**$829,941**	**$997,018**	**$997,018**	**$0**
Travel and transportation of persons (21.0)	$29,772	$36,708	$36,708	$0
Transportation of things (22.0)	$7,025	$7,793	$7,793	$0
Rental payments to GSA (23.1)	$14,344	$15,140	$15,140	$0
Rental payments to others (23.2)	$82,346	$86,283	$86,283	$0
Communication, utilities, and misc. charges (23.3)	$11,602	$15,707	$15,707	$0
Printing and reproduction (24.0)	$112	$133	$133	$0
Other Contractual Services:				
Advisory and assistance services (25.1)	$5,028	$6,671	$6,671	$0
Other services (25.2)	$141,389	$172,935	$172,935	$0
Purchase of goods and services from government accounts (25.3)	$193,335	$276,297	$276,297	$0
Operation and maintenance of facilities (25.4)	$8,788	$10,458	$10,458	$0
Research and Development Contracts (25.5)	$0	$0	$0	$0
Medical care (25.6)	$232,152	$260,549	$260,549	$0
Operation and maintenance of equipment (25.7)	-$32,553	$6,932	$6,932	$0
Subsistence and support of persons (25.8)	$50,075	$52,727	$52,727	$0
AP Branch Services (25.9)	$37,843	$67,215	$67,215	$0
Subtotal Other Contractual Services	**$781,258**	**$1,015,548**	**$1,015,548**	**$0**
Supplies and materials (26.0)	$37,946	$44,603	$44,603	$0
Equipment (31.0)	$4,437	$5,760	$5,760	$0
Land and Structures (32.0)	$67,034	$70,204	$70,204	$0
Investments and Loans (33.0	$0	0	$0	$0
Grants, subsidies, and contributions (41.0)	$4,324,455	$4,854,122	$5,775,451	$921,329
Insurance payments (42.0)	$14	$14	$14	$0
Interest and dividends (43.0)	$72	$72	$72	$0
Refunds (44.0)	-$20	$0	$0	$0
Unvouchered (91.0)	$180	$180	$180	$0
Subtotal Non-Pay Costs	**$5,215,376**	**$5,990,502**	**$6,911,831**	**$921,329**
Total Direct Obligations	**$6,045,319**	**$6,987,520**	**$7,908,849**	**$921,329**

INDIAN HEALTH SERVICE
Detail of Full-Time Equivalents (FTE)

	FY 2024 Estimate	FY 2025 Estimate	FY 2026 Estimate /1
Headquarters			
Sub-Total, Headquarters	1,038	1,041	1,041
Area Offices			
Alaska Area Office	204	191	191
Albuquerque Area Office	879	815	815
Bemidji Area Office	685	656	656
Billings Area Office	1,068	996	996
California Area Office	206	193	193
Great Plains Area Office	1,956	1,878	1,878
Nashville Area Office	220	204	204
Navajo Area Office	4,335	4,037	4,037
Oklahoma City Area Office	2,007	1,869	1,869
Phoenix Area Office	2,900	2,759	2,759
Portland Area Office	500	467	467
Tucson Area Office	142	126	126
Sub-Total, Area Offices	15,102	14,191	14,191
TOTAL FTES /2	16,140	15,232	15,232

1/ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

2/ Total does not include Trust Funds FTEs (21)

INDIAN HEALTH SERVICE

DETAIL OF POSITIONS

(Dollars in Thousands)

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget /1
Total - ES	28	27	27
Total - ES Salaries	$6,123	$6,429	$6,751
GS/GM-15	504	478	478
GS/GM-14	434	432	432
GS/GM-13	746	695	695
GS-12	1,649	1448	1448
GS-11	1,748	1514	1514
GS-10	583	589	589
GS-9	1,116	1013	1013
GS-8	510	499	499
GS-7	1,484	1333	1333
GS-6	1,818	1638	1638
GS-5	1,667	1595	1595
GS-4	682	710	710
GS-3	111	112	112
GS-2	18	21	21
GS-1	0	0	0
Subtotal	13,070	12,078	12,078
Total - GS Salaries	$753,687	$768,761	$791,824
CO-08	3	4	4
CO-07	5	3	3
CO-06	193	207	207
CO-05	404	394	394
CO-04	429	464	464
CO-03	176	203	203
CO-02	16	20	20
CO-01	20	15	15
Subtotal	1,246	1,310	1,310
Total - CO Salaries	$77,295	$78,841	$81,206
Wage Grade	1,346	1,222	1,222
Other	451	595	595
Subtotal	1,797	1,817	1,817
Total - Ungraded Salaries	$89,708	$91,173	$104,117
Average ES level	ES	ES	ES
Average ES salary	$219	$238	$250
Average GS grade	12	12	12
Average GS salary	$116	$118	$122

1/ FY 2026 FTE levels reflect estimates for October 1, 2025 and may not represent expected FTE levels across FY 2026. These estimates are subject to change.

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Operating Division-Specific Requirements

Indian Health Service
Sanitation Facilities Construction
FY 2024 Spend Plan

(dollars in millions)

Activity	FY 2024 BIL	FY 2024 Appropriation	Total
Tier 1 Projects Construction Costs	613.8	28.4	642.2
Tier 1 Design & Construction Documents	24.4	0.9	25.3
Tier 2 Planning, Design, and Construction Documents	34.0	--	34.0
Project Shortfalls, Add'l Planning, Design, & Construction Documents	3.3	--	3.3
New and Like-New Housing	--	53.6	53.6
Congressionally Directed Spending	--	17.0	17.0
Projects Construction Costs (non-add)	--	*11.2*	*11.2*
Planning, Design, and Construction Documents (non-add)	--	*5.8*	*5.8*
Special and Emergency Projects	--	2.8	2.8
subtotal, SFC Projects	*675.5*	*102.7*	*778.2*
Salaries, Expenses, and Administration (3%) /1, 2	21.0	21.0	42.0
HHS Office of the Inspector General (0.5%) /3	3.5	--	3.5
Total	**700.0**	**123.7**	**823.7**

1/ $21 million in BIL funding is limited to federal activities only.
2/ $21 million in FY 2024 Appropriation funding is pending 30-day Congressional reprogramming notification period. Funding will be reprogrammed from the Sanitation Facilities Construction Program, Project, or Activity (PPA) to the Facilities & Environmental Health Support PPA to support tribally operated programs and federal operations costs.
3/ BIL directed transfer.

Overview

The Infrastructure Investment and Jobs Act (IIJA) or Bipartisan Infrastructure Legislation (BIL) appropriates $700 million in each year from fiscal year (FY) 2022 – FY 2026, for a total of $3.5 billion for the IHS Sanitation Facilities Construction (SFC) program. These resources are available until expended.

The statute provides up to 3 percent ($21 million) of these funds for "salaries, expenses, and administration" each year. It also requires that one-half of 1 percent of these funds be transferred to the United States (U.S.) Department of Health and Human Services (HHS) Office of Inspector General "for oversight of funding provided in the BIL" ($3.5 million). The statute also directs the IHS to use up to $2.2 billion for "projects that exceed the economical unit cost," also referred to as "economically infeasible" projects.

Economically infeasible projects are those that exceed a per unit cost set for each IHS Area, and three different regions within the Alaska Area IHS. While there was not a statutory barrier to

funding economically infeasible projects before the BIL was enacted, the IHS had not been able to fund these projects due to limited annual appropriations.

On March 9, 2024, the Consolidated Appropriations Act, 2024 (FY 2024 Appropriation), appropriated $123.7 million for the SFC program. The FY 2024 Appropriation includes $17.0 million in Congressionally Directed Spending for eight projects, which are located in Alaska, New Mexico, and Nevada. These funds are available until expended.

The IHS tracks projects to address sanitation needs through the Sanitation Deficiency System (SDS). As of December 1, 2023, there were 1,346 projects, totaling $4.7 billion in eligible costs, and $1.4 billion in ineligible costs. Of the 1,346 total projects, 775 are considered economically feasible, and 571 are considered economically infeasible. The IHS completed its last annual update of the SDS on December 1, 2023, which is currently the most up to date complete data set on projects and costs. A breakout of projects and costs by IHS Area can be found in Appendix A.

The total of 1,346 projects in the SDS as of December 1, 2023, includes 707 projects that were in the SDS at the end of 2021, and 639 projects that were added in 2023. The 639 projects that were added in 2023 total approximately $1.3 billion in eligible costs.

Ineligible costs are the costs associated with serving commercial, industrial, or agricultural establishments, including nursing homes, health clinics, schools, hospitals, hospital quarters, and non-American Indian/Alaska Native (AI/AN) homes. The Sanitation Facilities Act and the Indian Health Care Improvement Act (IHCIA) prevent the IHS from using its appropriations for these costs. However, the IHS regularly partners with Tribes and other Federal agencies to identify alternative resources to successfully support these ineligible costs.

Tribal Consultation

The IHS conducted virtual Tribal Consultations on the BIL on December 18, 2023, and accepted written comments through January 4, 2024. The common themes from Tribal Consultation noted that the IHS should:

- Allocate some funding to cover project costs above budgeted amounts for design, construction documents, and construction;
- Prioritize funding projects with IIJA using the SDS list reported at the time the IIJA was enacted (i.e., end-of-year [EOY] December 2021);
- Prioritize funding of Tier 1 (ready to fund) projects while also providing funds to complete needed design and construction document preparation to accelerate the construction completion times; and
- Provide funds to support planning, design, and construction document preparation for Tier 2 (engineering assessed) and Tier 3 (preliminary assessed) to transition the projects to Tier 1.

The FY 2024 BIL spend plan is based on these recommendations from Tribal Leaders.

SDS Project Funding

The IHS will allocate FY 2024 resources from the BIL and the FY 2024 Appropriation for SDS projects as follows.

Design, Construction Contract Document Creation, and Construction Costs for Tier 1 Projects ($653.4 million total: $613.8 million BIL and $39.6 FY 2024 Appropriation)

The FY 2024 SFC spend plan funds construction costs for 91 Tier 1 and Congressionally Directed Spending projects tracked in the SDS. The construction cost for these projects total $653.4 million and of this, $613.8 million is FY 2024 BIL funding and $39.6 million is FY 2024 Appropriation. This $39.6 million in FY 2024 Appropriation includes $28.4 million for construction of Tier 1 projects and $11.2 million for construction of Congressionally Directed Spending projects.

A table displaying the allocation of projects and funding amounts by Area can be found in Appendix B.

A Tier 1 project is considered ready to fund because planning is complete. However, design and construction contract document creation activities are not yet complete for current Tier 1 projects. These steps must be finalized before a construction contract can be initiated through Federal or Tribal procurement methods. The IHS also allocates $25.3 million to support contracts with Architecture & Engineering Firms to complete these activities for Tier 1 projects. Of this amount, $24.4 million is FY 2024 BIL funding and $0.9 million is from FY 2024 Appropriation.

These Tier 1 projects span Deficiency Levels 2 – 5. Deficiency Levels are assigned in accordance with the IHCIA for each sanitation facilities project that has been identified as a need to support Indian Tribes and communities. The Deficiency Levels are explained in the table below.

Sanitation Deficiency Level		**Sanitation Deficiency Levels [25 U.S.C. § 1632(g)(4)]**
		Description
V	5	An Indian tribe or community that lacks a safe water supply and a sewage disposal system.
IV	4	An Indian tribe or community with a sanitation system which lacks either a safe water supply system or a sewage disposal system.
III	3	An Indian tribe or community with a sanitation system which has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or has no solid waste disposal facility.
II	2	An Indian tribe or community with a sanitation system which complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to capital improvements that are necessary to improve the

		facilities in order to meet the needs of such tribe or community for domestic sanitation facilities.
I	1	An Indian tribe or community with a sanitation system which complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to routine replacement, repair, or maintenance needs.
0	0	No deficiencies to correct.

There are $65.4 million in ineligible costs associated with these 91 Tier 1 projects. The IHS works closely with other Federal agencies, Tribes, and other project participants to identify funding for the portions of projects that serve non-AI/AN homes, businesses and public institutions. The IHS partners with the Environmental Protection Agency (EPA), USDA Rural Development, the US Department of Housing and Urban Development, the Department of Interior's Bureau of Reclamation, the National Tribal Water Center, the Rural Water Association, the Rural Community Assistance Partnership, the Denali Commission, the State of Alaska, and Tribal Consortia to secure resources for ineligible costs. The IHS also participates in the EPA-led Infrastructure Task Force, along with other Federal partners, which serves as a forum to discuss funding for ineligible costs associated with SFC projects. The IHS will continue to work with its Tribal and Federal partners to identify resources to fund these ineligible costs.

Within the $653.4 million allocated for 91 Tier 1 projects, $601.2 million will support eligible costs for 37 economically infeasible Tier 1 projects.

Planning, Design, and Construction Contract Document Creation for Tier 2 Projects ($34.0 million total: $34.0 million BIL)

The FY 2024 SFC spend plan allocates approximately $34.0 million in FY 2024 BIL funding for the planning, design, and construction contract document creation for 47 Tier 2 Projects.

Tier 2 projects are projects that have a level of engineering assessment completed, such that the deficiency is understood and a recommended solution has been analyzed and scoped. These projects have a cost estimate and design parameters that are accurate within plus or minus 25 percent.

A breakout of FY 2024 Tier 2 project counts by Area and associated costs to be funded with the FY 2024 BIL can be found in Appendix C.

Project Shortfalls, Additional Planning, Design, and Construction Contract Document Creation ($3.3 million total: $3.3 million BIL)

The FY 2024 SFC spend plan allocates $3.3 million in FY 2024 BIL funding to address potential project shortfalls, and to support additional planning, design, and construction document creation activities. Project shortfall funding is needed to support previously funded SFC projects that exceed the original project budget due to increasing construction costs driven by inflation and supply chain constraints.

New and Like-New Housing ($56.6 million total: $56.6 million FY 2024 Appropriation)

The FY 2024 SFC spend plan allocates $53.6 million in FY 2024 Appropriation for sanitation projects for new- and like-new housing, such as Indian homes being constructed or rehabilitated by the Bureau of Indian Affairs Home Improvement Program, Tribes, individual homeowners, or other nonprofit organizations. This funding level is approximately 37 percent below FY 2023 Enacted funding levels. This reduction is consistent with the overall reduction in the FY 2024 Appropriation for Sanitation Facilities Construction. The total amount of housing funds requested by the IHS Areas at the end of FY 2023 was $129.8 million, of this amount $108.3 million was identified for the provision of water and/or sewer services for 3,177 new and like-new homes to be completed/constructed during CY 2024 by the tribes. As a result of the decrease in funds 1,874 new and like-new homes will not be supported with sanitation facilities and the tribe's housing development plans will be delayed.

Congressionally Directed Spending ($17.0 million total: $17.0 million FY 2024 Appropriation)

The FY 2024 SFC spend plan also includes $17.0 million for Congressionally Directed Spending included in the FY 2024 Appropriation for eight projects: two projects in Alaska Area IHS; three projects in the Albuquerque Area IHS; and three projects in the Phoenix Area IHS. IHS will use $11.2 million for design and construction costs associated with the Congressionally Directed Spending projects that are designated as Tier 1 (described further above in Tier 1 project section of this plan). The remaining $5.8 million will support planning, design, and construction document creation for the remaining Congressionally Directed Spending projects.

Special and Emergency Projects ($2.8 million total: $2.8 million FY 2024 Appropriation)

The FY 2024 spend plan allocates $2.8 million of the FY 2024 Appropriation for special and emergency projects. Special project funds are used to pay for research studies, training, or other needs related to SFC, but which are not prioritized for construction funds. Emergency project funds are provided to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize or eliminate real and potential threats to public health.

Salaries, Expenses, and Administration ($42.0 million total: $21.0 million BIL and $21.0 million FY 2024 Appropriation)

The FY 2024 SFC spend plan allocates $42 million for program support activities like salaries, expenses and administration. This amount includes $21 million in FY 2024 BIL funding, and $21 million from FY 2024 Appropriation, pending a 30-day Congressional reprogramming notification period.

FY 2024 BIL funds that are available for SFC projects can support the same activities that are typically funded through the Facilities and Environmental Health Support annual appropriation. However, these BIL funds are limited solely to Federal activities, due to the following provision in the BIL:

> *Provided further*, that no funds available to the Indian Health Service for salaries, expenses, administration, and oversight shall be available for contracts, grants, compacts,

or cooperative agreements under the provisions of the Indian Self- Determination and Education Assistance Act as amended[1]:

The FY 2024 SFC spend plan allocates $21 million in the FY 2024 Appropriation to bolster program support activities overall, and to ensure that resources are available for the program support needs of Tribes that choose to manage their SFC projects directly pending completion of a 30-day reprogramming notification to Congress.

The IHS expects to use approximately 90 percent of the $21 million in FY 2024 BIL funding on additional FTE staff to support the implementation of SFC projects. This will include the hiring of 20 term GS-12 engineers to be supported for up to 6 years.

The IHS will use these funds to hire the additional engineers, field technicians, inspectors, Geographic Information System analysts, and other critical roles that are necessary to support the planning, design, and construction of SFC projects.

The IHS will also use these funds to hire additional contract specialists, human resources specialists, and other necessary support roles to recruit for the above-mentioned positions, and to manage the significant influx of construction contracting needs resulting from the BIL. The remaining 10 percent of the funds will be used on systems improvements, stakeholder engagement, recruitment activities, and other related needs.

The IHS will continue to use multiple strategies and available authorities to support BIL-specific recruitment and hiring. Through March 2024, the IHS has hired 59 term positions with funding from the BIL and backfilled 55 permanent positions with funding from the Environmental Health Support Account. This includes through the use of global job announcements to streamline the hiring of multiple candidates for jobs across the IHS system, establishing efficiencies with an IHS Headquarters Agency team to facilitate hiring on behalf of IHS Areas as appropriate, developing a dedicated website, marketing materials, and increased outreach by targeting engineering job fairs. This will also include leveraging partnerships with the American Indian Science and Engineering Society (AISES) to increase awareness of engineering employment opportunities within the IHS.

The IHS will strategically utilize the authority granted by the U.S. Office of Personnel Management (OPM) to waive the regulatory payment limitation to provide recruitment, relocation, or retention incentive options up to 50 percent above pay table amounts with a service agreement. This authority will aid in the ability to recruit and retain Civil Service employees based on superior qualifications and locations that are hard to fill in the general engineer (0801), civil engineer (0810), and environmental engineer (0819) occupational series. The IHS will continue to explore the development and/or the leveraging of other agencies Special Salary Rates for engineers. This is necessary to increase the IHS' competitiveness with both private and public sector organizations.

[1] Public Law 117-58-Nov. 15, 2021, 135 STAT. 1411

Appendix A: SDS Project Counts and Associated Costs as of December 1, 2023

Area	Eligible Cost	Ineligible Cost	Total Cost	Project Count
Albuquerque (AL)	$221,022,664	$22,072,355	$256,182,619	85
Alaska (AN)	$2,239,282,085	$252,962,411	$2,583,573,148	295
Bemidji (BE)	$103,528,220	$28,426,988	$146,935,858	84
Billings (BI)	$75,287,691	$26,498,159	$103,391,950	51
California (CA)	$169,615,993	$97,494,318	$296,887,032	67
Great Plains (GP)	$462,285,484	$351,703,516	$816,127,000	145
Navajo (NA)	$721,655,424	$38,522,509	$890,947,840	239
Nashville (NS)	$81,069,471	$7,578,453	$94,687,079	23
Oklahoma (OK)	$185,665,115	$463,012,796	$650,232,261	194
Phoenix (PH)	$233,547,559	$51,115,484	$313,980,122	79
Portland (PO)	$150,203,001	$61,947,164	$233,895,193	67
Tucson (TU)	$14,956,288	$1,219,712	$16,176,000	17
Total	**$4,658,118,995**	**$1,402,553,865**	**$6,403,016,102**	**1,346**

Appendix B: FY 2024 Tier 1*and Congressional Directed Spending Project Counts and Associated Cost to be Funded with the FY 2024 BIL Funding and FY 2024 Appropriation

Area	Construction Eligible Cost	Construction Ineligible Cost	Design and Construction Document Cost	Project Count*
Albuquerque (AL)	$2,739,865	$7,635	$73,500	4
Alaska (AN)	$490,175,533	$21,066,253	$15,590,760	22
Bemidji (BE)	$7,400,085	$3,103,973	$1,621,900	8
Billings (BI)	$9,683,805	$2,285,595	$50,000	2
California (CA)	$13,863,258	$18,693,342	$0	3
Great Plains (GP)	$26,136,107	$1,056,893	$0	13
Navajo (NA)	$33,219,000	$0	$8,297,600	18
Nashville (NS)	$2,548,834	$354,166	$0	1
Oklahoma (OK)	$20,768,559	$11,932,249	$0	10
Phoenix (PH)	$11,549,490	$355,510	$670,827	6
Portland (PO)	$33,895,776	$6,505,224	$4,734,000	2
Tucson (TU)	$1,493,288	$4,712	$0	2
Total	**$653,473,600**	**$65,365,552**	**$31,038,587**	**91**

(*DL 2 - DL 5 Projects)

Appendix C: FY 2024 Tier 2 Legacy List Project Counts and Associated Cost to be Funded with the FY 2024 BIL

Area	Planning, Design and Construction Document Cost	Project Count*
Albuquerque (AL)	$0	0
Alaska (AN)	$1,621,500	5
Bemidji (BE)	$1,234,500	6
Billings (BI)	$80,000	1
California (CA)	$1,420,204	8
Great Plains (GP)	$1,294,000	2
Navajo (NA)	$26,005,000	22
Nashville (NS)	$0	0
Oklahoma (OK)	$0	0
Phoenix (PH)	$2,187,438	1
Portland (PO)	$142,500	2
Tucson (TU)	$0	0
Total	**$33,985,142**	**47**

(*Tier 2 DL 2 – DL 5 Projects)

FY 2026 Annual Facilities Planning (Five-Year Plan) a/

(Dollars in Thousands)

FACILITY	Prior to FY 24 b/	FY 24 Enacted	FY 25 CR	FY 26 Plan	FY 27 Plan	FY 28 Plan	FY 29 Plan	Out years Est.	Total Cost b/
Planning Studies	-	1,000		500				500	
Inpatient Facilities c/ d/ e/									
PIMC, AZ, Hospital and ACC 1/ 8/									3,014,728
Phase 1 Medical Office Building	15,728			110,000		79,000			
Phase 2 Outpatient Services							180,000	150,000	
Phase 3 to 6								2,480,000	
Whiteriver, AZ, Hospital 2/	501,041	64,000	115,000			150,000	244,500	0	1,074,541
GIMC, Gallup, NM 3/ 8/									1,286,000
Phase 1 Medical Office Building	6,000						180,000		
Phase 2 Outpatient Services								150,000	
Phase 3 to 6								950,000	
Outpatient Facilities c/ d/ e/									
Alamo, NM	141,896			28,604					170,500
Pueblo Pintado, NM	207,400	24,000							231,400
Bodaway Gap, AZ 4/	181,200	51,000	25,000						257,200
Albuquerque Health Care System									
Albuquerque West, NM 5/	22,336				230,000				252,336
Albuquerque Central, NM 6/	1,000							361,000	362,000
Sells, AZ 7/	46,008			0	0			593,000	639,008
Total Legacy Projects	1,122,609	140,000	140,000	139,104	230,000	229,000	604,500	4,684,500	7,287,713
Small Ambulatory Program (Section 306)									
Small Health Clinics		25,000	25,000	25,000	25,000	25,000			
Staff Quarters Program 25 U.S.C. 13, Snyder Act f/									
Staff Quarters		12,679	12,679	13,575	15,000	26,000			
Infrastructure (CWA)									
Infrastructure Projects		5,000	5,000	5,000		5,000			
Demolition									
Demolition related to HCFC projects	5,000								
FY TOTALs		182,679	182,679	182,679	270,000	285,000		4,684,500	
Priority Project Total cost g/									7,287,713
UNFUNDED (FY 2024-Outyears) Priority Projects only									5,886,104

NOTES:

a/ All funds appropriated prior to FY 2024 are consolidated

b/ The Total Cost collumn is based on the Mid point of construction in the estimate. If the schedule changes from this plan the cost will be subject to inflation.

c/ Cost based on mid-point of construction. FY 25 and earlier are know values, FY 26 and later are estimated values.

d/ This project list includes projects from the IHS Construction Priority List of 1992.

e/ Subject to the availability of funds and does not include M&I, or staffing.

f/ An initiative to fund new and replacement staff quarters in isolated and remote locations.

g/ The total cost includes inpatient, outpatient, and a hostel. The budget will be updated when planning is complete.

1/ Total cost estimate includes a hostel.

2/ Total estimate includes 316 staff quarters

3/ The need for staff quarters is being evaluated. This estimate includes 200 staffing quarters units. The cost includes the cost of land.

4/ Total estimate includes 92 staff quarters.

5/ The Albuquerque West Project was supplemented with $13.9 million of NEF. NEF removed in Oct 1, 2024.

6/ The budget will be updated when planning is complete.

7/ The Sells Project was supplemented with $30 million of NEF. The Cost includes 108 staff quarters. The budget will be updated when planning is complete.

8/ Land purchase is required for this Project

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2026 Performance Budget Submission to Congress

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Self Determination

Indian Health Service

Indian Self Determination

Indian Health Service Philosophy – The Indian Health Service (IHS) implements the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law (Pub. L. No.) 93-638, as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Accordingly, the IHS supports Tribal sovereignty: (1) by assisting Tribes in exercising their right to administer the IHS health programs, or portions thereof, and (2) by continuing to directly provide services to Tribes that choose the IHS as their health care provider. A Tribal decision to enter or not enter into ISDEAA agreements are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts – Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1975, the IHS has entered agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Under Title I, there are 232 Tribes and Tribal Organizations operating 247 contracts and annual funding agreements. Under Title V, IHS is party to 114 compacts and 141 funding agreements; through which approximately $3.0 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-eight percent of federally recognized Tribes participate in Title V under IHS.

Indian Health Service
Self-Governance Funded Compacts FY 2024
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALABAMA	**4,675**	**462**	**176**	**629**	**5,943**
Poarch Band of Creek Indians	4,675	462	176	629	5,943
ALASKA	**635,224**	**84,875**	**61,222**	**197,936**	**979,257**
Alaska Native Tribal Health Consortium	107,298	46,861	13,521	16,810	184,489
Aleutian Pribilof Islands Association, Inc.	1,737	39	202	1,328	3,305
Arctic Slope Native Association, Ltd	24,792	2,908	3,819	6,882	38,401
Bristol Bay Area Health Corporation	21,964	1,381	2,568	10,919	36,833
Chickaloon Native Village	62	1	17	15	95
Chugachmiut	3,880	71	260	1,964	6,176
Copper River Native Association	6,398	510	572	1,327	8,807
Council of Athabascan Tribal Governments	1,816	213	108	1,204	3,341
Eastern Aleutian Tribes, Inc.	3,380	33	206	1,918	5,537
Kenaitze Indian Tribe, I.R.A.	13,190	233	460	3,678	17,561
Ketchikan Indian Community	5,950	325	638	4,265	11,177
Knik Tribal Council	77	1	12	10	100
Kodiak Area Native Association	7,844	262	529	3,591	12,225
Maniilaq Association	29,317	1,474	3,277	16,908	50,976
Metlakatla Indian Community	6,696	1,142	552	1,350	9,740
Mount Sanford Tribal Consortium	416	3	47	147	612
Native Village of Eklutna	189	3	7	56	256
Native Village of Eyak	846	56	102	801	1,805
Norton Sound Health Corporation	46,610	2,932	5,039	14,086	68,667
Seldovia Village Tribe	1,958	17	101	984	3,060
Southcentral Foundation	97,274	4,939	11,653	32,718	146,583
SouthEast Alaska Regional Health Consortium	40,729	1,492	4,145	18,893	65,258
Tanana Chiefs Conference	66,513	4,002	6,593	15,629	92,737
Tanana Tribal Council	1,041	78	66	419	1,603
Yakutat Tlingit Tribe	4,882	417	36	1,828	7,163
Yukon-Kuskokwim Health Corporation	140,364	15,484	6,692	40,207	202,747
ARIZONA	**297,372**	**26,281**	**15,087**	**66,688**	**405,427**
Ak-Chin Indian Community	467	4	8	13	492
Gila River Indian Community	81,675	7,028	2,054	28,609	119,366
Pascua Yaqui Tribe	16,061	481	213	3,062	19,817
Salt River Pima-Maricopa Indian Community	64,133	4,785	2,373	2,956	74,247
Tohono O'Odham Nation	37,190	4,165	2,818	4,530	48,704
Tuba City Regional Health Care Corporation	44,180	4,463	2,539	16,652	67,834
Winslow Indian Health Care Center, Inc.	53,666	5,355	5,082	10,865	74,968
CALIFORNIA	**92,864**	**4,804**	**4,985**	**39,883**	**142,536**
Chapa-De Indian Health Program, Inc.	7,148	1,503	206	3,826	12,683
Consolidated Tribal Health Project, Inc.	4,350	55	119	1,627	6,151
Feather River Tribal Health, Inc.	6,392	18	190	2,380	8,980
Hoopa Valley Tribe	5,699	310	293	1,647	7,949
Indian Health Council, Inc.	9,170	63	321	4,786	14,340
Karuk Tribe of California	3,243	493	110	984	4,830
Lake County Tribal Health Consortium, Inc.	7,142	1,317	193	4,458	13,110
Northern Valley Indian Health, Inc.	4,759	69	496	1,710	7,034
Pinoleville Pomo Nation	102	0	3	19	124
Pit River Health Service, Inc.	2,178	174	69	697	3,117
Redding Rancheria Tribe	7,186	62	667	2,998	10,912
Riverside-San Bernardino County Indian Health, Inc.	22,932	234	1,008	9,442	33,616
Rolling Hills Clinic	572	41	1	278	893
Round Valley Indian Health Center, Inc.	2,254	379	107	222	2,962
Santa Ynez Band of Chumash Mission Indians	2,043	16	38	785	2,883
Southern Indian Health Council, Inc.	5,891	53	981	2,781	9,706
Susanville Indian Rancheria	1,802	17	184	1,243	3,246
CONNECTICUT	**4,343**	**99**	**65**	**1,052**	**5,559**
Mashantucket Pequot Tribal Nation	1,700	17	65	501	2,283
Mohegan Tribe of Indians of Connecticut	2,643	82	0	551	3,276
FLORIDA	**8,145**	**437**	**1,128**	**2,637**	**12,348**
Seminole Tribe of Florida	8,145	437	1,128	2,637	12,348
IDAHO	**16,872**	**1,279**	**2,182**	**1,190**	**21,523**
Coeur D'Alene Tribe	6,510	627	1,597	0	8,733
Kootenai Tribe of Idaho	692	45	89	173	999
Nez Perce Tribe	9,671	607	497	1,017	11,791
KANSAS	**7,269**	**169**	**292**	**3,155**	**10,885**
Iowa Tribe of Kansas and Nebraska	2,298	40	189	1,517	4,044
Prairie Band Potawatomi Nation	4,972	129	103	1,638	6,842
LOUISANA	**1,264**	**111**	**145**	**372**	**1,892**
Chitimacha Tribe of Louisiana	1,264	111	145	372	1,892
MAINE	**3,600**	**147**	**197**	**704**	**4,649**
Penobscot Indian Nation	3,600	147	197	704	4,649
MASSACHUSETTS	**761**	**55**	**254**	**0**	**1,070**
Wampanoag Tribe of Gay Head Aquinnah	761	55	254	0	1,070
MICHIGAN	**30,382**	**1,562**	**3,125**	**3,688**	**38,757**
Grand Traverse Band of Ottawa and Chippewa Indians	3,008	123	360	627	4,118
Keweenaw Bay Indian Community	3,550	375	945	688	5,558
Little River Band of Ottawa Indians	2,169	6	291	62	2,527
Nottawaseppi Huron Band Of The Potawatomi	1,854	63	366	208	2,491
Match-E-Be-Nash-She-Wish Band of Pottawatomi	1,229	13	257	227	1,726
Sault Ste. Marie Tribe of Chippewa Indians	18,573	982	906	1,876	22,337
MINNESOTA	**21,920**	**286**	**3,300**	**2,612**	**28,117**
Bois Forte Band of Chippewa Indians	2,791	55	468	668	3,983
Fond du Lac Band of Lake Superior Chippewa	12,827	175	1,421	1,050	15,474
Mille Lacs Band of Ojibwe	4,430	37	1,391	564	6,421
Shakopee Mdewakanton Sioux Community	1,872	18	20	329	2,239
MISSISSIPPI	**40,529**	**4,531**	**1,451**	**5,501**	**52,011**
Mississippi Band of Choctaw Indians	40,529	4,531	1,451	5,501	52,011
MONTANA	**35,026**	**1,160**	**3,418**	**3,836**	**43,439**
Chippewa Cree Tribe of the Rocky Boy's Reservation	11,105	251	2,506	2,310	16,171
Confederated Salish and Kootenai Tribes of the Flathead Nation	23,921	909	912	1,526	27,268
NORTH CAROLINA	**21,176**	**1,132**	**1,163**	**9,557**	**33,028**

Eastern Band of Cherokee Indians	21,176	1,132	1,163	9,557	33,028
NORTH DAKOTA	**11,677**	**669**	**1,717**	**3,059**	**17,123**
Spirit Lake Tribe	11,677	669	1,717	3,059	17,123
NEBRASKA	**18,747**	**2,933**	**7,285**	**2,195**	**31,161**
Winnebago Tribe of Nebraska	18,747	2,933	7,285	2,195	31,161
NEW MEXICO	**13,328**	**409**	**1,544**	**2,234**	**17,514**
Pueblo of Jemez	10,399	328	1,126	1,697	13,550
Pueblo of Sandia	1,921	74	172	236	2,402
Taos Pueblo	1,008	7	246	301	1,562
NEVADA	**30,411**	**1,039**	**2,539**	**5,804**	**39,793**
Duck Valley Shoshone-Paiute Tribes	7,327	586	899	1,254	10,067
Duckwater Shoshone Tribe	1,149	8	234	1,332	2,723
Ely Shoshone Tribe	1,396	32	74	509	2,011
Fort McDermitt Paiute and Shoshone Tribe	1,727	111	8	89	1,935
Las Vegas Paiute Tribe	3,653	99	140	303	4,195
Reno-Sparks Indian Colony	7,468	61	788	1,166	9,482
Washoe Tribe of Nevada and California	5,548	53	275	845	6,722
Yerington Paiute Tribe of Nevada	2,143	89	121	306	2,659
NEW YORK	**8,487**	**447**	**374**	**2,751**	**12,058**
St. Regis Mohawk Tribe	8,487	447	374	2,751	12,058
OKLAHOMA	**602,718**	**62,650**	**48,009**	**143,994**	**857,371**
Absentee Shawnee Tribe of Oklahoma	19,467	1,668	2,258	5,653	29,046
Cherokee Nation	255,112	21,061	16,046	40,958	333,176
Chickasaw Nation	91,487	18,211	11,826	23,053	144,578
Choctaw Nation of Oklahoma	93,609	13,750	7,434	49,576	164,369
Citizen Potawatomi Nation	23,337	1,707	1,916	9,004	35,964
Kaw Nation of Oklahoma	2,991	105	246	553	3,896
Kickapoo Tribe of Oklahoma	10,554	246	339	1,816	12,954
Modoc Nation	63	43	7	12	125
Muscogee Nation	62,680	4,130	6,618	6,335	79,764
Northeastern Tribal Health System	7,967	160	179	1,380	9,686
Osage Nation	13,466	37	432	2,369	16,305
Pawnee Nation of Oklahoma	723	171	21	195	1,109
Ponca Tribe of Oklahoma	6,606	118	304	974	8,002
Quapaw Tribe of Oklahoma	237	0	40	102	379
Sac and Fox Nation of Oklahoma	10,411	101	194	1,290	11,996
Seminole Nation of Oklahoma	526	993	58	156	1,734
Wichita & Affiliated Tribes	340	20	46	111	517
Wyandotte Nation	3,142	129	46	456	3,773
OREGON	**31,069**	**1,455**	**3,264**	**11,719**	**47,507**
Confederated Tribes of Grand Ronde	7,155	215	646	3,072	11,088
Confederated Tribes of Siletz Indians of Oregon	8,530	382	889	2,893	12,693
Confederated Tribes of the Coos, Lower Umpqua & Siuslaw Indians	1,943	70	349	744	3,106
Confederated Tribes of the Umatilla Reservation	7,258	372	873	1,845	10,349
Coquille Indian Tribe	2,178	151	276	2,719	5,325
Cow Creek Band of Umpqua Tribe of Indians	4,004	265	231	446	4,946
SOUTH DAKOTA	**180**	**27**	**0**	**0**	**208**
Great Plains Tribal Leaders Health Board	180	27	0	0	208
TEXAS	**10,254**	**1,173**	**1,252**	**2,907**	**15,587**
Ysleta del Sur Pueblo	10,254	1,173	1,252	2,907	15,587
UTAH	**10,747**	**110**	**2,436**	**3,844**	**17,137**
Paiute Indian Tribe of Utah	2,459	37	284	418	3,199
Utah Navajo Health System, Inc.	8,287	74	2,151	3,425	13,938
WASHINGTON	**63,998**	**3,781**	**3,452**	**20,965**	**92,197**
Cowlitz Indian Tribe	7,215	83	27	3,062	10,388
Jamestown S'Klallam Indian Tribe	1,054	76	109	104	1,342
Kalispel Tribe of Indians	1,179	50	26	190	1,444
Lower Elwha Klallam Tribe	2,020	118	129	535	2,803
Lummi Indian Nation	8,681	746	320	1,921	11,669
Makah Indian Tribe	4,183	300	362	1,065	5,911
Muckleshoot Tribe	7,869	417	249	3,205	11,741
Nisqually Indian Tribe	2,493	108	138	197	2,935
Port Gamble S'Klallam Tribe	2,809	178	169	1,467	4,623
Quinault Indian Nation	6,042	570	273	3,316	10,201
Samish Indian Nation	1,201	8	115	478	1,803
Shoalwater Bay Indian Tribe	1,939	65	349	813	3,166
Skokomish Indian Tribe	2,224	108	139	530	3,001
Squaxin Island Indian Tribe	2,955	242	246	1,091	4,534
Swinomish Indian Tribal Community	2,424	144	220	607	3,395
Suquamish Tribe	1,810	40	184	619	2,653
Tulalip Tribes of Washington	7,902	526	395	1,765	10,589
WISCONSIN	**37,560**	**1,949**	**5,929**	**5,295**	**50,734**
Forest County Potawatomi Community	2,135	416	880	522	3,953
Ho-Chunk Nation	8,916	774	1,063	1,319	12,071
Oneida Tribe of Indians of Wisconsin	22,989	264	3,416	3,118	29,787
Stockbridge-Munsee Community	3,521	495	570	336	4,922
WYOMING	**12,447**	**792**	**455**	**2,618**	**16,311**
Eastern Shoshone Tribe	3,638	468	253	308	4,667
Northern Arapaho Tribe of Indians	8,809	323	202	2,310	11,644
GRAND TOTAL	**2,073,043**	**204,827**	**176,445**	**546,825**	**3,001,140**

Indian Health Service
FY 2024 Self-Governance Funding Agreements
By Area
(Dollars in Thousands)

Area	Program Tribal Shares	Area Office Tribal Shares	Headquarters Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALASKA	696,880	13,517	9,701	61,222	197,936	979,257
ALBUQUERQUE	23,517	1,217	430	2,796	5,141	33,100
BEMIDJI	89,945	1,896	1,818	12,354	11,595	117,607
BILLINGS	45,325	2,968	1,131	3,873	6,453	59,750
CALIFORNIA	91,150	3,704	2,814	4,985	39,883	142,536
GREAT PLAINS (ABERDEEN)	32,591	1,283	361	9,002	5,254	48,492
NASHVILLE	93,573	5,409	1,419	4,954	23,203	128,557
NAVAJO	112,232	1,705	2,088	9,772	30,943	156,740
OKLAHOMA	647,781	11,945	13,081	48,301	147,149	868,256
PHOENIX	188,143	2,196	1,698	7,258	37,801	237,096
PORTLAND	111,427	4,075	2,953	8,898	33,875	161,227
TUCSON	54,446	2,662	790	3,032	7,592	68,521
Total, IHS	**2,187,011**	**52,576**	**38,282**	**176,445**	**546,825**	**3,001,140**