DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year 2027

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) 2027 Congressional Justification. The FY 2027 budget request supports the President's goal of providing safe, efficient, effective, and high-quality health care services. The FY 2027 budget supports Executive Order 14212: Establishing the President's Make America Healthy Again Commission by aggressively combating the critical health challenges facing American Indian and Alaska Native communities. This includes services for mental health, obesity, diabetes, and other chronic diseases.

This FY 2027 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 HHS 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 2027 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 support for 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 Likewise, outdated infrastructure poses challenges in safely providing patient care, recruiting and retaining staff, and meeting accreditation standards.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.

Clayton W. Fulton
Chief of Staff
(Delegated Authority of the IHS Director)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Letter from OPDIV Head
Table of Contents

Page

Executive Summary

Introduction and Mission 1
Overview of Budget Submission 2
Overview of Performance 8
All Purpose Table 10
Detail of Changes FY 2027....11
Staffing / Operating Costs for Newly-Constructed Facilities FY 2027 12

Appropriation Accounts

Budget Exhibits
Summary of Change 13
Appropriations History Table 14

Cross Cutting

Current Services....18
Staffing of Newly Constructed Facilities....20

Services

Clinical Services
- Clinical Services Summary 22
- Hospitals & Health Clinics 25
  - Epidemiology Centers 40
  - Information Technology 44
- Electronic Health Record 52
- Dental Health....57
- Mental Health....64
- Alcohol & Substance Abuse 69
- Purchased/Referred Care 75

Preventive Health
- Preventive Health Summary....80
- Public Health Nursing....82
- Health Education....86

Community Health Representatives 89
Immunization AK 92

Other Services
Urban Health 97
Indian Health Professions 101
Tribal Management Grants 107
Direct Operations 110
Self-Governance 116
Public and Private Collections 120

Facilities

Facilities Summary 124
Maintenance & Improvement 127
Sanitation Facilities Construction 130
Health Care Facilities Construction 134
Facilities & Environmental Health Support
Facilities Support 138
Environmental Health Support 139
Office of Environmental Health & Engineering Support 141
Equipment 145
Quarters 148

Contract Support Costs

Contract Support Costs 150

ISDEAA 105(l) Leases

ISDEAA 105 (*l*) Leases 154

Special Diabetes Program for Indians

Special Diabetes Program for Indians 156

Drug Budget

Drug Control Programs 162

Supplemental Tables

Exhibits
Budget Authority by Object Class 174
Detail of Full-Time Equivalent Employment (FTE) 175
Detail of Positions 176

Operating Division-Specific Requirements

IHS-Specific Requirements
IIJA Spend Plan 177

Self Determination

Self-Determination
Self-Determination Program 183
Self-Determination Tables 184

Legislative Proposals

Legislative Proposals
Legislative Proposals 189

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Executive Summary

	Page
Introduction and Mission	1
Overview of Budget Submission	2
Overview of Performance	8
All Purpose Table	10
Detail of Changes	11
Staffing / Operating Costs for Newly-Constructed Facilities FY 2027	12

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.

INDIAN HEALTH SERVICE
FY 2027 Budget Submission to Congress

Overview of Budget

The Indian Health Service (IHS) carries out the federal government's trust responsibility to provide health care to American Indians and Alaska Natives (AI/AN) and to uphold the Government-to-Government relationship with Tribes. The FY 2027 President's Budget strengthens that commitment by expanding access to direct care, modernizing operations, and making targeted investments that improve quality, accountability, and the patient experience across the Indian health system.

This Budget aligns with the President's Management Agenda's[1] (PMA) by modernizing IHS governance, strengthening enterprise-wide accountability, and deploying a data-driving Electronic Health Record to improve quality, efficiency, and the service delivery across IHS-operated, Tribal, and urban Indian health programs. In FY 2027, the budget builds on this foundation and takes critical steps toward three interconnected priorities:

1. **Advancing the future of the Indian Health Service** by modernizing governance and strengthening accountably across the enterprise.

2. **Meeting the goals of the Make America Healthy Again[2] (MAHA) Initiative** through prevention and focused care delivery and health information technology (IT) modernization that improves outcomes and reduces long-term cost.

3. **Honoring tribal self-governance and aligning with tribal recommendations** by protecting self-determination authorities, sustaining legally required payments, and ensuring continuity of care through advanced appropriations.

FY 2027 Request at a Glance

The FY 2027 Budget includes $9.1 billion in discretionary funding for IHS. This request supports approximately:

- 15,328,239 inpatient and outpatient visits
- 4,526,303 dental services
- 1,028,821 mental health services
- 112,041 alcohol and substance abuse services
- 2,461,278 health education services

The Budget also proposes $5.6 billion in FY 2028 advance appropriations for the same budget lines that have previously received enacted advance appropriations, strengthening continuity of care and protecting services.

Priorities Advanced by President Trump's FY 2027 Budget.

Priority 1: Advancing the Future of the Indian Health Service
For over 50 years, the IHS has organized its operations geographically segmented into 12 Area Offices, each largely operating with autonomy with limited national coordination between Areas. The IHS

[1] President's Management Agenda: https://www.performance.gov/pma/
[2] Make America Health Again: https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/

inherited this organizational structure when its authorities were transferred from the Department of the Interior to HHS in 1955 under the Transfer Act.

The IHS has not examined its overall organizational structure in several decades. During that time the technology, healthcare, practices and the IHS's role has drastically changed. The Agency's responsibilities expanded, but its structure hasn't kept pace. The Agency's authorizing statutes changed significantly with the permanent reauthorization of the Indian Health Care Improvement Act in 2010. As the IHS budget grew and received more complex funding streams, Tribes raised their expectations for accountability, transparency, and partnership. Now 65 percent of the IHS budget is directly operated by Tribes under the Indian Self-Determination and Education Assistance Act. Staffing and resource limitations require a more streamlined approach that promotes efficiency, tribal self-governance, and the patient experience.

To that end, the IHS is conducting tribal consultation on implementing a proposed strategic realignment[3] from a geographic model to a unified Agency-wide approach under three lines of service. This is consistent with the PMA's call to Federal agencies to deliver mission outcomes, provide excellent public services, and leverage technology to deliver faster, more secure services while eliminating duplicative systems and reducing waste. Consulting with change management experts, 1,600 employees, 400 plus tribal leaders and 40 plus tribes/Tribal organizations, and Urban Indian Organizations, the proposed realignment structure reflects those shared priorities by modernizing business functions, improving accountability, and reducing administrative barriers to direct patient care. The proposed new structure represents the core activities of the Agency, including:

- *Health Care Operations:* Encompasses direct health care services at IHS-operated hospitals and health clinics, along with clinical support services.

- *Intergovernmental and External Affairs:* Includes Indian Self-Determination and Assistance Act contracts and compacts, Contract Support Costs, Tribal Lease Payments, and urban Indian health programs.

- *Enterprise Services:* Captures core administrative activities that enable the Agency to meet its mission, including human resources, financial management, acquisitions, information technology, and grants management.

Overall, the goals of the proposed IHS Realignment are to:

- Elevate patient and relative care to the highest level by strengthening accountability, streamlining enterprise-wide business services, and aligning direct health care services across the Agency.

- Promote Indian Self-Determination and the government-to-government relationship by bolstering Indian Self-Determination and Education Assistance Act (ISDEAA) activities.

- Modernize the Agency's organizational structure to accommodate increased ISDEAA Title I contracting and Title V compacting, and to use resources as efficiently as possible.

[3] IHS Realignment Presentation: https://www.ihs.gov/tribalconsultation/ihs-realignment/

The IHS has already taken many steps to advance the future of the Agency. Notable achievements include:

- *IHS Operated Hospital Oversight:* IHS shifted all 20 IHS-operated hospitals under the Agency's Chief Medical Officer, strengthening quality, efficiency, and consistency of patient care system-wide. This structural shift eliminates fragmented oversight and advances the Administration's goal of more streamlined, accountable organizations.

- *Purchased/Referred Care (PRC):* IHS improved access to health care services by reducing unobligated PRC balances by 15 percent from the amount carried over into FY 2025. IHS revised the medical priority system to emphasize preventive care, established targets for PRC carryover funding, and implemented a weekly spend plan for each IHS-operated hospital and health clinic, allowing for enterprise-wide oversight of resources.[4]

- *Patients at the Heart Electronic Health Record (PATH EHR) Pilot Site:* The Lawton Service Unit in Lawton, Oklahoma is the pilot site for the new PATH EHR, a cornerstone of IHS modernization. This initiative will transform patient care across Indian Country by testing functionality, usability, and real-world compatibility before nationwide rollout, ensuring a user-centered design that supports higher quality, data-driven care.

- *Advance Appropriations:* In FY 2026, IHS successfully paid 100% of eligible Title I and Title V funding agreements within the first two weeks of the fiscal year through advance appropriations. This marks a major efficiency improvement, enabling Tribes to access full-year funding faster and more reliably than ever before.

Priority 2: Making America Healthy Again (MAHA) through prevention, modernization and better outcomes

The modernization of IHS operations is just one critical tool for achieving measurable improvements in health outcomes. The FY 2027 budget also seeks to improve health outcomes by advancing the Administration's MAHA initiative through investments that promote efficiency, prevention, and long-term cost reduction. These investments include prevention focused care delivery, Electronic Health Record (EHR) modernization, and strengthened hospital oversight to improve quality of care, increase efficiency, and ensure accountability for performance. These investments will enable earlier identification and management of chronic disease, improved care coordination, and reduced medical errors, resulting in better patient outcomes and reducing long-term costs in Indian Country. These capabilities will allow the IHS to better track outcomes and improve quality and safety.

Making progress towards these goals is especially important across Indian Country. According to the most recent Centers for Disease Control (CDC) life expectancy study that was published in November 2023[5], AI/ANs born today have an average life expectancy that is 9.6 years fewer than the U.S. population. AI/AN life expectancy dropped from an estimated 71.8 years in 2019 to 67.9 years in 2023. AI/AN today, in the 21st century, share the same life expectancy as the general United States population in 1944, meaning advances in life-extending medical science has not yielded improved outcomes in these communities. AI/ANs also experience disproportionate rates of mortality for most major health issues including heart disease, chronic liver disease and cirrhosis, diabetes, unintentional injuries, assault and homicide, and suicide.

A key modernization effort to track these disparities is the modernization of the existing IHS EHR. The first Trump Administration began the PATH EHR modernization project eight years ago to create

[4] https://www.ihs.gov/prc/
[5] Vital Statistics Rapid Release, Number 31 (November 2023)

a generational change in the health status of AI/ANs nationwide. This is also consistent with the PMA's focus on strengthening Federal IT modernization, reducing legacy system risk, and improving the delivery of mission critical services. To support this transformation, the IHS purchased a new commercial-off-the-shelf system, and is currently building the new EHR environment, while also paying to maintain the current, over 40-year-old, electronic health record. By FY 2027, the Lawton Hospital pilot will be complete and the IHS will begin to deploy the new EHR to additional hospitals and health clinics as funding permits.

The EHR is a cornerstone of IHS operations, used to document patient information, manage referrals, track prescriptions and bill for over $3.0 billion in revenue generated annually. It serves as the primary platform for health care delivery across Indian Country, supporting both direct service and tribally-operated facilities. Identified by the Government Accountability Office as one of the ten most critical legacy systems in need of replacement[6], the PATH EHR initiative will equip IHS to deliver higher-quality, data-driven care while reinforcing its mission to improve the physical, mental, social, and spiritual health of AI/AN communities. The EHR also advances PMA objectives by strengthening cybersecurity and system reliability, improving interoperability, and data sharing,

Priority 3: Honoring Tribal Self-Governance and Aligning with Tribal Recommendations
Achieving these goals requires not only modernized systems and targeted health interventions, but also a steadfast commitment to tribal sovereignty, self-determination, and meeting our statutory requirements. The FY 2027 budget reflects the Administration's ongoing partnership with Tribes by incorporating top tribal budget recommendations and investing in systems that enable Tribes to manage their own health programs effectively.

To this end, the Budget proposes advance appropriations for FY 2028. Advance appropriations play a crucial role in allowing the IHS, Tribal, and urban Indian health programs to provide uninterrupted care to AI/AN patients across the country. Requesting advance appropriations for the IHS for FY 2028 demonstrates the Administration's strong commitment to the health and well-being of AI/AN communities by protecting essential clinical health care services. Advance appropriations ensure the continuity of health care operations and allow the IHS to mitigate the risks to the health and well-being of AI/AN communities.

Similarly and in alignment with the Supreme Court's decisions in *Salazar v. Ramah Navajo Chapter (2012), Becerra v. San Carlos Apache Tribe* and *Becerra v. Northern Arapaho Tribe (2024)*, the budget maintains an indefinite discretionary appropriation for Contract Support Costs (CSC) and Section 105(*l*) Tribal Leases, which allows the Agency to meet its statutory requirements for both programs to be fully funded.

Lastly, the IHS meets the annual statutory requirement[5] to consult with and solicit the participation of Tribes and Tribal Organizations in the development of the Agency's budget. Likewise, IHS confers with urban Indian organizations. Input from consultation and confer informs the IHS budget formulation process. The foundation 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 IHS National Tribal Budget Formulation Workgroup[7]. 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

[6] https://www.gao.gov/assets/gao-19-471.pdf
[7] https://www.ihs.gov/ihm/pc/part-6/chapter-6-ihs-tribal-consultation-policy/#6-6.1
National Tribal Budget Formulation Workgroup Consultation: https://www.ihs.gov/budgetformulation/tribalbudgetconsultation/

Human Services (HHS) agencies of Tribal priorities, so that they can consider those priorities as part of their budget requests.

Summary of Budget Submission

The budget includes $9.1 billion in discretionary funding for the IHS. The Budget also proposes $5.6 billion in FY 2028 advance appropriation for the same budget lines that have previously received enacted advance appropriations. The budget will approximately fund over 15 million inpatient and outpatient visits, nearly five million dental services, over one million mental health contacts, over 100,000 alcohol and substance abuse appointments, and two and a half million health education services.

Changes include:

Health Care Operations

- *Staffing of Newly Constructed Facilities*: $84.1 million to support the staffing and operating costs for five new or expanded facilities, which will increase access to direct health care services. This proposal is consistent with the FY 2027 Tribal Budget recommendation to fully fund staffing of newly constructed facilities.

- *PATH EHR Modernization*: +$93.0 million for a total of $287.0 million to support the ongoing modernization of IHS Health IT infrastructure to include licensing, hosting, training, site remediation, implementation, and support costs to implement a modernized EHR system. This is consistent with the FY 2027 Tribal Budget recommendation to increase funding for EHR modernization.

- *IHS-Operated Hospital Oversight:* +$5.0 million for a new initiative to build enterprise-wide oversight of IHS-operated hospitals. The new oversight structure will allow IHS to review biomedical equipment needs, critical systems repairs and upgrades, environmental improvements, and facility enhancements, to institute upgrades and replacements as needed for patient care and safety.

- *Health Care Facilities Construction (HCFC):* +$5.0 million to support the remaining projects on the 1993 IHS Health Care Facilities Construction Priority List. These health care facilities will improve access to direct health care services.

- *Sanitation Facilities Construction (SFC):* -$93.9 million to prioritize maintaining funding for direct health care services. The remaining funding will be allocated to support the implementation of the unobligated balances from the 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.

- *Special Diabetes Program for Indians (SDPI):* $49.4 million in total mandatory funding. The Consolidated Appropriations Act, 2026 (P.L. 119-75) maintains SDPI as mandatory appropriations and provides an extension for the program through December 31, 2026.

Intergovernmental & External Affairs

- *New Tribes:* $11.8 million in total new tribes funding, which continues the request from FY 2026 of $6.0 million for the Lumbee Tribe of North Carolina and an additional +$5.8 million for the United Keetoowah Band of Cherokee Indians (UKB) to meet statutory requirements under the Indian Self-Determination and Education Assistance Act. The budget also requests the reallocation of previously enacted New Tribes funding across budget lines, in alignment with actual services to be provided.

- *CSC:* The budget maintains CSC as an indefinite discretionary appropriation and proposes increasing the score to $2.0 billion[8] in anticipation of increasing costs stemming from the June 2024 *Becerra v. San Carlos Apache Tribe* Supreme Court decision.

- *Section 105(l) Tribal Leases:* The budget maintains Section 105(*l*) Tribal Leases as an indefinite discretionary appropriation and proposes increasing the score to $929 million.

Enterprise Services

- *Current Services*: $264.8 million to meet the rising cost of providing direct health care services, including tribal and federal pay costs, medical and non-medical inflation, and population growth. These resources permit the IHS to maintain services at the FY 2025 levels for IHS, Tribal, and urban Indian health programs. This proposal is consistent with the FY 2027 Tribal Budget Recommendation to fully fund current services.

FY 2028 Advance Appropriations

- *Advance Appropriations:* The FY 2027 budget requests advance appropriations for FY 2028, using the same policy principles as past advance appropriations enacted by Congress. The total request for FY 2028 advance appropriations is $5.6 billion for all programs except Electronic Health Record, Indian Health Care Improvement Fund, Contract Support Costs, Section 105(*l*) Leases, Sanitation Facilities Construction, and Health Care Facilities Construction.

[8] Funding is rounded.

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 2024, IHS and Tribal facilities provided 37,201 inpatient admissions and 15,291,038 outpatient medical care visits (advance data, latest available). 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 65 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 2027 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 accomplishments are reported in the budget narratives and highlighted below the following IHS strategic goals:

Goal 1: Be a leading healthcare organization.

- *Monitoring measures annually* – IHS will continue to monitor clinical measures and report aggregated I/T/U results from the Integrated Data Collection System Data Mart (IDCS DM). IHS will also continue to monitor accreditation status and support accreditation readiness for high quality safe patient care across IHS operated facilities.

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

- *Recruitment and Retention* – During FY 2026, the IHS continues to offer employees leadership development opportunities through the Lead, Engage, and Develop others (LEAD) program and the emerging leader program.

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.
- *Credentialing and Privileging Optimization* - The Credentialing software program continues to be optimized to standardize policy and processes across the agency for oversight of providers enhancing patient safety and quality.

Goal 4: Promote proactive intergovernmental and external relationships.

- *Tribal Consultation and Urban Confer* – During FY 2026, the IHS consults with tribes and confers with Urban Indian Organizations on the new strategic realignment of federally operated hospitals under the Agency's Chief Medical Officer.

The IHS has implemented the following performance reporting and performance management processes to

monitor agency progress.

Performance Reporting

This budget request includes Government Performance and Results Act (GPRA) and GPRA Modernization Act (GPRAMA) measures that support the IHS mission, as reported in each budget narrative Outcomes and Outputs Table. The IHS budget measures support the agency's strategic goals and objectives and are focused on monitoring population health (clinical measures) and strategies to assess program trends and management (non-clinical measures). 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. The FY 2027 budget request includes anticipated targets based on most recent year results and projected funding.

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 cascaded from senior executive performance plans to those of managers and supervisors. From there, they cascaded 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. The IHS utilizes 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 2025 Final /1		FY 2026 Enacted		FY 2027 President's Budget /2, /3		FY 2027 +/- FY 2026		FY 2028 Advance Appropriations
	$	FTE	$	FTE	$	FTE	$	FTE	$
SERVICES									
Clinical Services	**4,498,308**	**6,137**	**4,555,362**	**6,137**	**4,950,679**	**6,395**	**395,317**	**258**	**4,584,999**
Hospitals & Health Clinics	2,585,794	4,975	2,632,772	4,975	2,835,370	5,199	202,598	224	2,835,370
Electronic Health Record System	190,564	63	190,564	63	287,007	63	96,443	0	0
Dental Services	254,117	424	260,360	424	276,225	446	15,865	22	276,225
Mental Health	130,169	159	133,693	159	138,714	167	5,021	8	138,714
Alcohol & Substance Abuse	266,771	234	267,080	234	280,205	238	13,125	4	280,205
Purchased/Referred Care	996,755	232	996,755	232	1,054,485	232	57,730	0	1,054,485
Indian Health Care Improvement Fund	74,138	50	74,138	50	78,673	50	4,535	0	0
Preventive Health	**205,180**	**203**	**206,119**	**203**	**221,139**	**213**	**15,020**	**10**	**221,139**
Public Health Nursing	112,948	181	114,200	181	123,705	191	9,505	10	123,705
Health Education	24,837	11	24,524	11	26,569	11	2,045	0	26,569
Community Health Representatives	65,212	11	65,212	11	68,571	11	3,359	0	68,571
Immunization AK	2,183	0	2,183	0	2,294	0	111	0	2,294
Other Services	**283,952**	**354**	**292,952**	**354**	**292,740**	**354**	**-212**	**0**	**292,740**
Urban Health	90,419	9	95,419	9	95,001	9	-418	0	95,001
Indian Health Professions	80,568	49	84,568	49	81,801	49	-2,767	0	81,801
Tribal Management Grants	2,986	0	2,986	0	3,022	0	36	0	3,022
Direct Operations	103,805	282	103,805	282	106,620	282	2,815	0	106,620
Self-Governance	6,174	14	6,174	14	6,296	14	122	0	6,296
TOTAL, SERVICES	**4,987,440**	**6,694**	**5,054,433**	**6,694**	**5,464,558**	**6,962**	**410,125**	**268**	**5,098,878**
FACILITIES	**800,080**	**1,064**	**809,222**	**1,064**	**742,021**	**1,087**	**-67,201**	**23**	**537,515**
Maintenance & Improvement	170,595	0	170,595	0	173,413	0	2,818	0	173,413
Sanitation Facilities Construction	106,627	116	107,943	116	13,998	116	-93,945	0	0
Health Care Facilities Construction	182,679	0	184,679	0	190,508	0	5,829	0	0
Facilities & Environ Health Support	307,581	946	311,407	946	330,369	969	18,962	23	330,369
Equipment	32,598	2	34,598	2	33,733	2	-865	0	33,733
TOTAL, SERVICES & FACILITIES	**5,787,520**	**7,758**	**5,863,655**	**7,758**	**6,206,579**	**8,049**	**342,924**	**291**	**5,636,393**
CONTRACT SUPPORT COSTS /4, /5									
Total, Contract Support Costs	**1,151,000**	**0**	**1,708,000**	**0**	**1,958,491**	**0**	**250,491**	**0**	**0**
SECTION 105(*l*) LEASES /4, /5									
Total, Section 105(*l*) Leases	**543,000**	**0**	**413,000**	**0**	**929,000**	**0**	**516,000**	**0**	**0**
SPECIAL DIABETES PROGRAM FOR INDIANS /6									
Total, Special Diabetes Program for Indians	159,363	21	200,000	21	49,403	21	-150,597	0	0
TOTAL, Discretionary Budget Authority	**7,481,520**	**7,758**	**7,984,655**	**7,758**	**9,094,070**	**8,049**	**1,109,415**	**291**	**5,636,393**
TOTAL, Program Level /7	**7,640,883**	**7,779**	**8,184,655**	**7,779**	**9,143,473**	**8,070**	**958,818**	**291**	**5,636,393**
FTE Total		**14,406**		**14,406**		**14,697**		**291**	
Other FTE /8, /9		**6,627**		**6,627**		**6,627**		**0**	
Infrastructure Investment and Jobs Act	**700,000**		**700,000**		**0**		**-700,000**		**0**
NEF /10	**128,500**		**TBD**		**TBD**				

1/ The FY 2025 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/ Totals may not add due to rounding.

3/ The FY 2027 discretionary funding includes $5.3 billion in advance appropriations enacted in the Department of the Interior, Environment, and Related Agencies Appropriations Act, 2026 (P.L. 119-74).

4/The FY 2025 levels reflect actuals.

5/ The FY 2026 levels reflect the Administration's scores. The FY 2026 Congressional Budget Office (CBO) score for CSC is $1.8 billion and Leases at $366.0 million. Using the CBO scores, the FY 2026 BA totals to $8.0 billion and P.L. totals to $8.2 billion.

6/ The Consolidated Appropriations Act, 2026 (P.L. 119-75) provides $50.0 million for the mandatory Special Diabetes Program for Indians from October 1, 2026 to December 31, 2026. The FY 2027 amount in the table is reduced by $1.0 million for Budget Control Act sequestration.

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

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

9/ FY 2027 FTE levels reflect estimates for October 1, 2026 and may not represent expected FTE levels across FY 2027. These estimates are subject to change.

10/ FY 2026 and FY 2027 NEF amounts are to be determined.

Indian Health Service
Detail of Changes
FY 2027 President's Budget
(Dollars in Thousands)

Sub IHS Activity	FY 2026 Enacted	FY 2026 President's Budget Changes			FY 2027 President's Budget Changes										FY 2027 President's Budget /3
		Staffing of Newly Constructed Facilities	New Tribes (Lumbee)	Adjustments /1	Staffing of Newly Constructed Facilities	Current Services	Electronic Health Record	IHS Operated Hospital Oversight	New Tribes (UKB)	HCFC	SFC	Contract Support Costs	Section 105(l) Leases	SDPI	Subtotal of Changes /2	
SERVICES																
Hospitals & Health Clinics	2,632,772	34,068	-	(41,559)	64,792	140,297	-	5,000	-	-	-	-	-	-	202,598	2,835,370
Electronic Health Record System	190,564	-	-	-	-	3,443	93,000	-	-	-	-	-	-	-	96,443	287,007
Dental Services	260,360	2,243	-	(5,910)	5,634	13,898	-	-	-	-	-	-	-	-	15,865	276,225
Mental Health	133,693	579	-	(3,493)	1,692	6,243	-	-	-	-	-	-	-	-	5,021	138,714
Alcohol & Substance Abuse	267,080	309	-	(263)	1,012	12,067	-	-	-	-	-	-	-	-	13,125	280,205
Purchased/Referred Care	996,755	-	6,000	-	-	45,958	-	-	5,772	-	-	-	-	-	57,730	1,054,485
Indian Health Care Improvement Fund	74,138	-	-	-	-	4,535	-	-	-	-	-	-	-	-	4,535	78,673
Total, Clinical Services	**4,555,362**	**37,199**	**6,000**	**(51,225)**	**73,130**	**226,441**	**93,000**	**5,000**	**5,772**	**-**	**-**	**-**	**-**	**-**	**395,317**	**4,950,679**
Public Health Nursing	114,200	1,252	-	(1,066)	2,613	6,706	-	-	-	-	-	-	-	-	9,505	123,705
Health Education	24,524	42	-	(36)	31	2,008	-	-	-	-	-	-	-	-	2,045	26,569
Community Health Representatives	65,212	-	-	-	-	3,359	-	-	-	-	-	-	-	-	3,359	68,571
Immunization AK	2,183	-	-	-	-	111	-	-	-	-	-	-	-	-	111	2,294
Total, Preventive Health	**206,119**	**1,294**	**-**	**(1,102)**	**2,644**	**12,184**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**15,020**	**221,139**
Urban Health	95,419	-	-	(5,000)	-	4,582	-	-	-	-	-	-	-	-	(418)	95,001
Indian Health Professions	84,568	-	-	(4,000)	-	1,233	-	-	-	-	-	-	-	-	(2,767)	81,801
Tribal Management	2,986	-	-	-	-	36	-	-	-	-	-	-	-	-	36	3,022
Direct Operations	103,805	-	-	-	-	2,815	-	-	-	-	-	-	-	-	2,815	106,620
Self-Governance	6,174	-	-	-	-	122	-	-	-	-	-	-	-	-	122	6,296
Total, Other Services	**292,952**	**-**	**-**	**(9,000)**	**-**	**8,788**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(212)**	**292,740**
Total, Services	**5,054,433**	**38,493**	**6,000**	**(61,327)**	**75,774**	**247,413**	**93,000**	**5,000**	**5,772**	**-**	**-**	**-**	**-**	**-**	**410,125**	**5,464,558**
FACILITIES																
Maintenance & Improvement	170,595	-	-	-	-	2,818	-	-	-	-	-	-	-	-	2,818	173,413
Sanitation Facilities Construction	107,943	-	-	-	-	506	-	-	-	-	(94,451)	-	-	-	(93,945)	13,998
Health Care Facility Construction (HCFC)	184,679	-	-	(2,000)	-	2,829	-	-	-	5,000	-	-	-	-	5,829	190,508
Facility & Environmental Health Support	311,407	3,826	-	(3,211)	8,296	10,051	-	-	-	-	-	-	-	-	18,962	330,369
Equipment	34,598	-	-	(2,000)	-	1,135	-	-	-	-	-	-	-	-	(865)	33,733
Total, Facilities	**809,222**	**3,826**	**-**	**(7,211)**	**8,296**	**17,339**	**-**	**-**	**-**	**5,000**	**(94,451)**	**-**	**-**	**-**	**(67,201)**	**742,021**
Total, Services & Facilities	**5,863,655**	**42,319**	**6,000**	**(68,538)**	**84,070**	**264,752**	**93,000**	**5,000**	**5,772**	**5,000**	**(94,451)**	**-**	**-**	**-**	**342,924**	**6,206,579**
CONTRACT SUPPORT COSTS																
Total, Contract Support Costs /4	**1,708,000**	**-**	**-**	**-**	-	-	-	-	-	-	-	**250,491**	-	-	250,491	1,958,491
Total, Section 105(l) Leases /4	**413,000**	-	-	**-**	-	-	-	-	-	-	-	-	**516,000**	-	516,000	929,000
SPECIAL DIABETES PROGRAM FOR INDIANS																
Total, Special Diabetes Program for Indians /5	**200,000**	-	-	-	-	-	-	-	-	-	-	-	-	**(150,597)**	(150,597)	49,403
BA TOTAL, IHS	**7,984,655**	**42,319**	**6,000**	**(68,538)**	**84,070**	**264,752**	**93,000**	**5,000**	**5,772**	**5,000**	**(94,451)**	**250,491**	**516,000**	**-**	**1,109,415**	**9,094,070**
PL TOTAL, IHS	**8,184,655**	**42,319**	**6,000**	**(68,538)**	**84,070**	**264,752**	**93,000**	**5,000**	**5,772**	**5,000**	**(94,451)**	**250,491**	**516,000**	**(150,597)**	**958,818**	**9,143,473**

1/ The budget reflects adjustments due to changes in staffing of newly constructed facilities funding in FY 2026.

2/ These changes are compared to FY 2026 Enacted.

3/ The FY 2027 discretionary funding includes $5.3 billion in advance appropriations enacted in the Department of the Interior, Environment, and Related Agencies Appropriations Act, 2026 (P.L. 119-74).

4/ The FY 2026 levels reflect the Administration's scores. The FY 2026 Congressional Budget Office (CBO) score for CSC is $1.8 billion and Leases at $366.0 million. Using the CBO scores, the FY 2026 BA totals to $8.0 billion and P.L. totals to $8.2 billion.

5/ The Consolidated Appropriations Act, 2026 (P.L. 119-75) provides $50.0 million for the mandatory Special Diabetes Program for Indians from October 1, 2026 to December 31, 2026. The FY 2027 amount in the table is reduced by $1.0 million for Budget Control Act sequestration.

STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES

FY 2027 Budget -- Estimates

(Dollars in Thousands)

	Omak, WA		Sitka, AK		Bodaway Gap, AZ		Omaha, NE		Phoenix, AZ		TOTAL		
	Omak Clinic (JV)		Mount Edgecumbe Medical Center (JV)		Bodaway-Gap AKA Echo Cliffs Health Center		Fred LeRoy Health and Wellness Center (JV)		Phoenix Indian Medical Center				
Opening Date	December 2025		February 2026		October 2026		June 2027		January 2022				
Sub Sub Activity	Pos	Amount	Pos	Amount	FTE	Amount	Pos	Amount	FTE	Amount	**FTE /2**	**Pos /2**	**AMOUNT**
Hospitals & Health Clinics	12	$1,704	78	$17,743	162	$25,653	63	$9,693	51	$9,999	213	153	$64,792
Dental Health	1	$192	2	$167	22	$3,928	8	$1,347	0	$0	22	11	$5,634
Mental Health	1	$86	1	$133	8	$1,074	3	$399	0	$0	8	5	$1,692
Alcohol & Substance Abuse	0	$54	0	$70	4	$666	1	$222	0	$0	4	1	$1,012
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Clinical Services	14	$2,036	81	$18,113	196	$31,321	75	$11,661	51	$9,999	247	170	$73,130
Public Health Nursing	1	$179	2	$291	10	$1,840	2	$303	0	$0	10	5	$2,613
Health Education	0	$0	0	$31	0	$0	0	$0	0	$0	0	0	$31
Community Health Representatives	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Preventive Health	1	$179	2	$322	10	$1,840	2	$303	0	$0	10	5	$2,644
Total, Services	15	$2,215	83	$18,435	206	$33,161	77	$11,964	51	$9,999	257	175	$75,774
Facilities Support /1	1	$177	17	$2,029	22	$4,444	3	$954	0	$526	22	21	$8,130
Environmental Health Support	0	$24	0	$0	1	$143	0	$0	0	$0	1	0	$167
Total, FEHS	1	$201	17	$2,029	23	$4,587	3	$954	0	$526	23	21	$8,297
Total, Facilities	1	$201	17	$2,029	23	$4,587	3	$954	0	$526	23	21	$8,297
Grand Total	**16**	**$2,416**	**100**	**$20,464**	**229**	**$37,748**	**80**	**$12,918**	**51**	**$10,525**	**280**	**196**	**$84,071**

1/ Includes Utilities

2/ FTEs are full-time equivalents, used to designate staffing personnel in federally owned and operated facilities. Pos are positions for Joint Venture (JV) facilities, typically identifying the number and type of staff required to support operations in the Joint Venture Construction Program (JVCP). Pos are considered Tribal therefore are not included in the overall IHS employee count.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Appropriation Accounts

Page

Budget Exhibits
Summary of Changes....13
Appropriations History Table....14

Appropriation Account Title

Summary of Changes

(Dollars in millions)

	Dollars	FTEs
FY 2026 Enacted		
Total budget authority	$7,984,655.000	14,406
FY 2027 President's Budget		
Total estimated budget authority	$9,094,070.000	14,697
Net Change	**+$1,109.415**	**+291**

	FY 2026 Enacted		FY 2027 President's Budget		FY 2027 +/- FY 2026	
	BA	**FTE**	**BA**	**FTE**	**BA**	**FTE**
Increases:						
Built-in:						
Annualization of commissioned corps pay increase	--	--	$23,864.000	--	+$23,864.000	--
Annualization of civilian pay increase	--	--	--	--	--	--
Subtotal, Built-in Increases					*+$23,864.000*	--
B. Program:						
1.Tribal Pay	--	--	$ 36,919.000	--	+$36,919.000	--
2. Cost of Medical Inflation	--	--	$ 127,264.000	--	+$127,264.000	--
3. Cost of Non-Medical Inflation	--	--	$ 6,388.000	--	+$6,388.000	--
4. Population Growth	--	--	$ 70,317.000	--	+$70,317.000	--
4. 105(l) Tribal Leases /1	$ 413,000.000	--	$ 929,000.000	--	+$516,000.000	--
5. Contract Support Costs /1	$ 1,708,000.000	--	$ 1,958,491.000	--	+$250,491.000	--
8. Phasing in of Staff & Operating Costs of New Facilities	$ 42,319.000	--	$ 84,070.000	+280	+$41,751.000	+280
9. Electronic Health Record	$ 190,564.000	--	$ 287,007.000	--	+$96,443.000	--
10. IHS Operated Hospital Oversight	$ -	--	$ 5,000.000	+11	+$5,000.000	+11
11. New Tribes	$ -	--	$ 5,772.000	--	+$5,772.000	--
12. Health Care Facilities Construction	$ 184,679.000	--	$ 190,508.000	--	+$5,829	--
Subtotal, Program Increases					*+$1,162,174.000*	*+291*
Total Increases					**+$1,186,038.000**	**+291**
Decreases:						
A. Built-in:						
1. Adjustments for FY 2026 Staff of New Facilities	--	--	-97,995.0	--	-97,995.000	--
Subtotal, Built-in Decreases					*-$97,995.000*	--
B. Program:						
1. Special Diabetes Program for Indians	$200,000.000	--	$49,403.000	--	-$150,597.000	--
Subtotal, Program Decreases					*-$150,597.000*	--
Total Decreases					**-$248,592.000**	**--**
Net Change					**+$937,446.000**	**+291**

1/ The FY 2026 levels reflect the Administration's scores. The FY 2026 Congressional Budget Office (CBO) score for CSC is $1.8 billion and Leases at $366 million. Using the CBO scores, the FY 2026 BA totals to $8.0 billion and PL totals to $8.2 billion.

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 Enacted (P.L. 119-74)	$5,071,849,000	$5,354,645,000	$5,069,849,000	$5,054,433,000
2027 Congressional Justification	$5,464,558,000			

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 Enacted (P.L. 119-74)	$715,671,000	$865,864,000	$808,806,000	$809,222,000
2027 Congressional Justification	$742,021,000			

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 /4
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 Enacted (P.L. 119-74)	$1,708,000,000	$1,819,000,000	$1,819,000,000	$1,819,000,000
2027 Congressional Justification	$1,958,491,000			

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.
4/ Appropriation column reflects the CBO score for the Enacted bills.

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

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation /4
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 Enacted (P.L. 119-74)	$413,000,000	$366,000,000	$366,000,000	$366,000,000
2027 Congressional Justification	$929,000,000			

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.

4/ Appropriation column reflects the CBO score for the Enacted bills.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Cross Cutting

Page

Current Services....18
Staffing of Newly Constructed Facilities....20

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
CURRENT SERVICES

(Dollars in Thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Pay Costs	--	--	$60,783	+$60,783
Non-Medical Inflation	--	--	$6,388	+$6,388
Medical Inflation	--	--	$127,264	+$127,264
Population Growth	--	--	$70,317	+$70,317
Current Services, Total	--	--	$264,752	+$264,752

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 2027 Authorization ..... Permanent

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

PROGRAM DESCRIPTION

Current Services, also known as annual fixed costs, are funds to meet the rising cost of providing direct health care services, including tribal and federal pay costs, medical and non-medical inflation, and population growth. These funds ensure the IHS can maintain services at prior year levels for IHS, Tribal, and urban Indian health programs. Without these funds, the level of health care services, access to care, and purchasing power are eroded. This can result in decreases in patient service levels from the prior year.

BUDGET JUSTIFICATION

The IHS requests a total of $264.8 million for Current Services in FY 2027 to meet pay costs, medical and non-medical inflation, and population growth, which is +$264.8 million above FY 2026 Enacted.

INDIAN HEALTH SERVICE
FY 2027 -- ESTIMATED CURRENT SERVICES
(Dollars in Thousands)

	FY 2027 Current Services							
	Pay /1			Inflation			Population	
	Federal	Tribal	Pay	non-med	medical	Inflation	Growth	Curr Svcs
Sub Sub Activity	Pay	Pay	Total	1.02%	3.90%	Total	1.21%	Total
SERVICES								
Hospitals & Health Clinics	15,914	25,260	41,174	1,681	65,325	67,006	32,117	140,297
Electronic Health Record	189	0	189	948	0	948	2,306	3,443
Dental Services	1,543	2,638	4,181	77	6,500	6,577	3,140	13,898
Mental Health	431	773	1,204	18	3,432	3,450	1,589	6,243
Alcohol & Substance Abuse	336	612	948	81	7,802	7,883	3,236	12,067
Purchased/Referred Care	474	703	1,177	0	32,648	32,648	12,133	45,958
Indian Health Care Improvement Fund	163	737	900	59	2,390	2,449	1,186	4,535
Total, Clinical Services	19,050	30,723	49,773	2,864	118,097	120,961	55,707	226,441
Public Health Nursing	622	1,488	2,110	15	3,178	3,193	1,403	6,706
Health Education	32	882	914	0	796	796	298	2,008
Comm. Health Reps	4	112	116	0	2,454	2,454	789	3,359
Immunization AK	0	0	0	0	85	85	26	111
Total, Preventive Health	658	2,482	3,140	15	6,513	6,528	2,516	12,184
Urban Health	75	1,190	1,265	347	1,876	2,223	1,094	4,582
Indian Health Professions	241	0	241	3	14	17	975	1,233
Tribal Management	0	0	0	0	0	0	36	36
Direct Operations	780	202	982	535	42	577	1,256	2,815
Self-Governance	42	1	43	0	4	4	75	122
Total, Other Services	1,138	1,393	2,531	885	1,936	2,821	3,436	8,788
Total, Services	20,846	34,598	55,444	3,764	126,546	130,310	61,659	247,413
FACILITIES								
Maintenance & Improvement	0	0	0	752	2	754	2,064	2,818
Sanitation Facilities Constr.	0	0	0	343	0	343	163	506
Health Care Fac. Constr.	0	0	0	619	0	619	2,210	2,829
Facil. & Envir. Hlth Supp.	3,018	2,321	5,339	882	3	885	3,827	10,051
Equipment	0	0	0	28	713	741	394	1,135
Total, Facilities	3,018	2,321	5,339	2,624	718	3,342	8,658	17,339
TOTAL, IHS	**23,864**	**36,919**	**60,783**	**6,388**	**127,264**	**133,652**	**70,317**	**264,752**

1/ Includes 0% pay raise for Civil Service and 3.9% Commissioned Corps.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

STAFFING OF NEWLY CONSTRUCTED FACILITIES

(Dollars in Thousands)

Facility	FY 2027 Staffing		
	Total	POS /1	FTE /1
Omak Clinic (JV) Omak, WA	$2,416	16	--
Mount Edgecumbe Medical Center (JV) Sitka, AK	$20,463	100	--
Bodaway-Gap AKA Echo Cliffs Health Center Bodaway Gap, AZ	$37,748	--	229
Fred LeRoy Health and Wellness Center (JV) Omaha, NE	$12,918	80	--
Phoenix Indian Medical Center Phoenix, AZ	$10,525	--	51
Grand Total	**$84,070**	**196**	**280**

1/ FTEs are full-time equivalents, used to designate staffing personnel in federally owned and operated facilities. Pos are positions for Joint Venture (JV) facilities, typically identifying the number and type of staff required to support operations in the Joint Venture Construction Program (JVCP). Pos are considered Tribal therefore are not included in the overall IHS employee count.

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 2027 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 $84.1 million for Staffing of New Facilities in FY 2027 to provide staffing packages for five new or expanded facilities. This includes:

- $84.1 million to fully-fund staffing and operating costs for five new or expanded facilities in FY 2027, in which three 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Services

Page

Services

Clinical Services
- Clinical Services Summary 22
- Hospitals & Health Clinics 25
  - Epidemiology Centers 40
  - Information Technology 44
- Electronic Health Record 52
- Dental Health 57
- Mental Health 64
- Alcohol & Substance Abuse 69
- Purchased/Referred Care 75

Preventive Health
- Preventive Health Summary 80
- Public Health Nursing 82
- Health Education 86
- Community Health Representatives 89
- Immunization AK 92

Other Services
- Urban Health 97
- Indian Health Professions 101
- Tribal Management Grants 107
- Direct Operations 110
- Self-Governance 116
- Public and Private Collections 120

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

(Dollars in thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$4,498,308	$4,555,362	$4,950,679	+$395,317
FTE /1, 2	6,137	6,137	6,395	+258

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. These estimates are subject to change.

SUMMARY OF THE BUDGET REQUEST

The FY 2027 Indian Health Service (IHS) Budget submission for Clinical Services is $5.0 billion, which is +$395.3 million above the FY 2026 Enacted level. This funding level includes additional resources for:

- Current Services (+$247.4 million);
- Electronic Health Record (+$96.4 million);
- Staffing of Newly Constructed Facilities (+$75.8 million);
- New Tribes – United Keetoowah Band of Indians (+$5.8 million); and
- IHS Operated Hospital Oversight (+$5.0 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 health care 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 health care. 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 War, 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 cavities 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 health care 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. 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.

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 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 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 2025: 22.8% Target: 22.0% (Target Not Met)	22.0%	22.0%	Maintain

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

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$2,585,794	$2,632,772	$2,835,370	+$202,598
FTE /1, 2	4,975	4,975	5,199	+224

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 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 with IHS 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 24 hospitals, 340 health centers, 78 health stations, 147 Alaska village clinics, and 7 school health centers. The remainder of the H&HC budget is managed by direct federal programs that provide health care at the service unit and community

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.

level. The federal system consists of 20 hospitals, 51 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 2027 budget submission for Hospitals and Health Clinics is $2.8 billion, which is +$202.6 million above the FY 2026 Enacted level.

FY 2026 Enacted 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 2027 funding increases include:

- IHS Operated Hospital Oversight: +$5 million to support in-depth analysis of operations at each IHS-operated hospital to identify challenges and fill gaps. It will support the identification and promulgation of best practices, and clinical performance management to ensure patients are receiving the appropriate care. These resources will expand the current team from one to 12 Full-Time Equivalents (FTE).

- Current Services and Staffing of Newly Constructed Facilities: +$140.3 million for Current Services and +$64.8 million for Staffing of Newly Constructed Facilities. Information can be found in the Current Services and Staffing of Newly Constructed Facilities chapters.

IHS will update existing New Tribes funding to reflect the actual services being provided, with amounts agreed on in partnership with each tribe listed below.

- Chickahominy Indian Tribe (Nashville Area)
- Eastern Chickahominy Tribe (Nashville Area)
- Monacan Indian Nation (Nashville Area)
- Nansemond Indian Nation (Nashville Area)
- Rappahannock Indian Tribe (Nashville Area)
- Upper Mattaponi Indian Tribe (Nashville Area)

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$2,503,025,000
2024 Final	$2,550,514,000
2025 Final	$2,585,794,000
2026 Enacted	$2,632,772,000
2027 President's Budget	$2,835,370,000

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 health care system:

Office of Quality

The Office of Quality was established in FY 2019 and reorganized in FY 2024 to realign the Agency's Compliance Program and Enterprise Risk Management Program into the IHS Office of Quality (OQ). The OQ has made significant quality and patient safety improvements across the Agency. The OQ includes four divisions: 1) Division of Quality Assurance and Patient Safety (GAPA), 2) Division of Enterprise Risk Management (GAPB), 3) Division of Innovation and Improvement (GAPC); 4) and Division of Compliance (GAPD) The OQ leads the work on oversight of policy and accreditation standards, implementation of quality improvement strategies, implementation of enterprise risk management strategies, and monitoring accountability and internal controls of federally operated facilities. Under the H&HC funding line, OQ-related activities are funded. Other activities, including patient safety, quality assurance, compliance and risk management are funded and discussed within Direct Operations.

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 9.

To address this public health concern, IHS has been authorized $7.0 million annually, which includes a $4.0 million increase provided in FY 2026 enacted. Initial funding was used to create a pilot program to implement a P4 to increase access to produce and other traditional foods within AI/AN communities. The FY 2026 funding increase will support the expansion of the P4 program to additional tribal 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.

In FY 2023, the IHS provided a Notice of Funding Opportunity (NOFO) welcoming AI/AN communities to apply for a cooperative agreement to establish and implement a P4. From that NOFO, 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, farmer's markets, and grocery store vendors to program participant households. 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 in-person P4 grantee workshops, including trainings on how to effectively evaluate their PPP's and integrate Community Health Representatives into their programs. The P4 grantee programs have implemented strong nutrition education programs, with focus on traditional foods, during the first two years of their programs, as a requirement of the cooperative agreement.

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 four 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 four programs include: Forensic Health care, Public Health Nursing, Advanced Practice Nursing, and the Bureau of Indian Education (BIE) School Health Program. The Emergency Services for Children and Maternal Child Health care programs were transferred to the IHS' Maternal Child Health Program in December 2025.

The DNS HQ team provides technical assistance and program support to I/T/U facilities. The DNS team provides onsite assistance for identified needs in nursing.

The DNS leadership collaborates extensively with the National Nurse Leadership Council (NNLC) to promote communication and transparency to the I/T/U nursing workforce by establishing standardized processes, coordinated communication and collaboration.

The Annual IHS Nurse Conference was re-introduced in 2024 and was held again in 2025 as the IHS Nurse Leadership Summit. The Summit was open to all nurse and health care leaders to attend. One hundred fifty-six (156) attendees participated in the Nurse Summit held September 9 – 11, 2025 in Corpus Christi, Texas. The summit focused on equipping nurses with tools, strategies and insights, to enhance job satisfaction, improve patient outcomes and align with professional and regulatory standards. The summit content included training in self-care, acquisitions, budgeting, planning, human resources, and program management as well as inspirational and practical nursing leadership strategies. In addition, the conference provided nurse professionals the opportunity to network with colleagues on nursing issues of common concern, enhance nursing practice to improve patient care, and receive accredited continuing nursing education. Nurse administrators, directors of public health nursing, clinical nurses, public health nurses, advanced practice nurses and nurses from all specialty areas from across Indian

country attended this event.

The DNS leadership team works in collaboration with the Office of Human Resources (OHR) to identify opportunities for improvement, including defining nursing priorities. This is an ongoing effort aimed at ensuring nursing standards and scopes of practice are prioritized during the OHR transition, ultimately strengthening recruitment and retention of nurses across IHS.

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.

Forensic Health Care

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 2027, 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 health care 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 4,361 continuing nursing and medical education hours have been provided to 799 I/T/U providers.

Additionally, in FY 2023, the IHS established a Forensic Health care Funding Opportunity (FHFO), an award totaling $10.0 million which will be distributed to federally operated IHS sites over a five-year period. The funding opportunity is designed to support building a community's capacity by forensic nursing program development and expansion through training opportunities for health care 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 299 training events, totaling over 6,739 hours of education, for I/T/U health care providers and members within local multidisciplinary teams. Finally, in FY 2023, IHS created a guidebook titled Forensic Health Care and Caring for AI/AN Patients, and in FY 2024, a second guidebook was created titled AI/AN 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 health care providers serving in the I/T/U settings. Each guidebook was edited and updated in FY 2025 to reflect the current Executive Orders and will be available to download for the foreseeable future.

In FY 2025 – FY 2026, the Forensic Nurse Consultant built medical forensic examination workflows to establish standardization for the medical forensic record across IHS using the new IHS EHR. The consultant will continue to build and monitor standardization using best practices in FY 2027.

Domestic Violence Prevention (DVP) Program

The DVP program, established in 2015, provides culturally appropriate domestic violence and sexual assault prevention and intervention resources to AI/AN communities focusing on trauma informed care services. In FY 2022, IHS awarded $7.4 million to thirty-seven (37) Tribal, Tribal organization, and Urban Indian Organization projects for five years, plus $1.0 million annually, for Forensic Health Care (FHC) to support four (4) Tribal, Tribal organization, and Urban Indian Organization facilities for a period of five years. IHS collected data from FY 2023 and 2024 that showed 7,107 client engagements in year one and 19,248 in year two; 2,508 sexual assault screenings in year one and 40,062 in year two; identified victims of domestic violence cases of 1,984 in year one and 2,890 in year two; human trafficking cases of 1,044 in year one and 40 in year two; sexual abuse cases of 1,400 in year one and 1,006 in year two; and, strangulation cases of 1,072 in year one and 76 in year two. The program will continue annual data collection with the 2025 report currently under internal review before public release.

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 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[2], and in FY 2024, a second guidebook was created titled American Indian and Alaska Native Patients and Medical Forensic Examination (MFE) Considerations[3]. 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.

[2]https://www.ihs.gov/sites/forensichealthcare/themes/responsive2017/display_objects/documents/fhcaianguidebook012025.pdf
[3]https://www.ihs.gov/sites/forensichealthcare/themes/responsive2017/display_objects/documents/aianmfeconsiderationsguidebook012025.pdf

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 health care 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 health care agencies continue. 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 health care 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 School Nurse Consultant has led the development of the national school-based health program from its inception. Within the first year, the nurse consultant completed a review of existing school-based health positions and activities across IHS including tribal and urban programs, identifying priority needs, service gaps and program readiness. In addition, partnerships with Area nurse consultants, program directors, and local clinical teams across all Areas have been established, creating a framework to support and guide national implementation. 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 mission to raise the health of AI/AN to the highest level by ensuring health care is provided to all age groups in various settings. 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 health care providers. The goal is to help the student thrive at school and in their home life. 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 a 6.7 percent increase in 2024 from the 2017 baseline.[4] The rate of diagnoses of new HIV infection among AI/AN adults and adolescents decreased by 12.6 percent between 2017 and 2023.[5]

The CDC reported the death rate among AI/AN people living with HIV in 2022 was 46 percent higher than in 2017.[6] 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.[7]

The IHS increased overall cumulative HIV screening to 43.4 percent in FY 2024 – up from 38.9 percent target. To improve AI/AN access to health care 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.

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 Health care 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 Epidemic in Indian Country initiative, bringing the total to eight FTEs.

Hepatitis C Virus (HCV) - As of 2023, AI/AN people had higher rates of acute HCV compared to

[4] Centers for Disease Control and Prevention. NCHHSTP AtlasPlus. https://www.cdc.gov/nchhstp/about/atlasplus.html.
[5] 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.
[6] Centers for Disease Control and Prevention. NCHHSTP AtlasPlus. https://www.cdc.gov/nchhstp/about/atlasplus.html.
[7] Centers for Disease Control and Prevention (CDC) NCHHSTP AtlasPlus. Accessed on January 22, 2025.

non-AI/Ans and over three times the rate of HCV-related mortality compared to non-AI/ANs.[8]

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.

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.[9] 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.[10] 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[11].

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 health care in America's most rural and remote communities where access to care is few and far in between.

Maternal and Child Health

The Maternal Child Health Program aims to increase access to safe, quality maternal and child health services across IHS. When pregnant women 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.

[8] https://gis.cdc.gov/grasp/nchhstpatlas/tables.html
[9] Centers for Disease Control and Prevention (CDC) NCHHSTP AtlasPlus. Accessed on January 22, 2025.
[10] Centers for Disease Control and Prevention. *Sexually Transmitted Infections Surveillance 2023.* Atlanta: U.S. Department of Health and Human Services; 2024
[11] Centers for Disease Control and Prevention (CDC) NCHHSTP AtlasPlus. Accessed on January 22, 2025.

- In response to the closure of rural obstetric units, 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 published the **Obstetric Readiness in the Emergency Department (ObRED)** manual in 2024 and provided a hands on simulation training program to include a manual and training. The draft manual was reviewed by 40 IHS and tribal sites. Seven Areas have participated in ObRED simulation training with 431 staff trained, resulting in increased staff confidence with management of obstetric emergencies. This simulation program follows 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 in partnership with the Northwest Portland Area Indian Health Board (NPAIHB). The 2025 series include nine webinars on topics such as Indigenous birthing practice, maternal cardiovascular health, field testing and treatment for syphilis. Webinars were attended by 656 participants across 33 states and 203 tribes/organizations.
- To improve access to culturally safe care in the community, IHS established the Maternal Child Health Funding Opportunity (MCHFO)/Maternity Care Coordinator (MCC) Program. The program awarded 10 IHS sites across six Areas to reach 12,000+ pregnant patients and families over 5 years. Participating sites include: Billings Area, Chinle Comprehensive Care Facility, Colorado River Service Unit, Crownpoint Service Unit, Gallup Indian Medical Center, Great Plains Area, Lawton Indian Hospital, Northern Navajo Medical Center, Red Lake Hospital, and Whiteriver Service Unit.

Emergency Medical Services for Children

- The IHS/Health Resources and Services Administration **Emergency Medical Services for Children (EMSC)** interagency agreement funding for FY 2025/FY 2026 continues to support a contract with the Children's Hospital of Philadelphia (CHOP) to implement a hybrid simulation program. The IHS-EMSC Hybrid Simulation Program pairs emergency departments (EDs) with academic medical centers (AMC) to implement a curriculum of in-person and tele-simulation training to improve the capacity of the interdisciplinary ED staff to care for children and newborns during pediatric emergencies. Every participating facility has designated a pediatric emergency care coordinator (PECC) to coordinate and implement pediatric specific activities such as pediatric care, education, and training. Nineteen (19) IHS and tribal EDs have a designated PECC, who will add to the sustainability of the training program. The IHS-EMSC Hybrid Simulation Training Program has established partnerships with 13 AMCs. The AMC partners are emergency medicine attending physicians or fellows who assist IHS or Tribal ED staff to conduct simulations, share evidence-based practices, and improve channels of communication for seamless transitions in care.
- Each Emergency Department (ED) completes the **National Pediatric Readiness Project (NPRP)**[12] assessment, which quantifies the level of pediatric readiness for the assessed EDs. The National Pediatric Readiness Project (NPRP) is a longitudinal initiative aimed at improving pediatric care in Emergency Departments across the United States, and the assessment is a key component of this program. Higher NPRP scores are associated with better clinical outcomes and lower mortality rates among children, particularly critically ill patients. EDs that achieve scores in the highest quartile (weighted pediatric readiness scores – wPRS >87/100) show significantly greater pediatric readiness. Over four years

[12] https://emscimprovement.center/domains/pediatric-readiness-project/

of the IHS-EMSC Hybrid Simulation Program, the average pediatric readiness score across all participating sites improved from 35 to 87.

- As the program enters its fourth year, the focus will continue to be on quality improvement. This will be informed by gaps in care identified by local ED staff and the analyses from the NPRP assessment, along with policy development and disaster preparedness initiatives. Notable accomplishments include collaboration with six (6) EMSC state partners to help facilities achieve state recognition for their pediatric readiness efforts, the creation of an IHS webpage dedicated to the IHS-EMSC Hybrid Simulation Program[13], and the recognition of three IHS emergency departments and one individual with the 2023 IHS Director's Award for their improvements in pediatric readiness.

Alzheimer's and Elder Health Program

Program Infrastructure and Collaborations

- **Formal and informal non-Federal collaborations (ongoing):** Continued collaboration with national organizations supporting dementia care, early detection, and workforce development, including the Center to Advance Palliative Care; New York University's Hartford Institute of Gerontology; Ariadne Labs at the Harvard T.H. Chan School of Public Health; the Building Our Largest Dementia (BOLD) Center of Excellence on Early Detection; and the Alzheimer's Association.
- **Federal councils and interagency workgroups (ongoing):** HHS Advisory Council on Alzheimer's Research, Care, and Services (National Alzheimer's Project Act); the Recognize, Assist, Include, Support, & Engage (RAISE) Family Caregiving Advisory Council; the Elder Justice Interagency Workgroup; and the Centers for Medicare & Medicaid Services Tribal Technical Advisory Group.
- **Public-private committees and workgroups (ongoing):** Dementia Friendly America National Council, the Alliance to Improve Dementia Care, and NIH's Data Project, and publication support for the 2025 *Healthy Brain Road Map for AI/AN Communities*.

Local Tribal Capacity Building: Disseminating Funding and Resources

- **Office of Quality Innovation Award partnership (ongoing):** Supported a FY 2025 dementia-focused award to Phoenix Indian Medical Center, resulting in new clinical workflows and EHR updates supporting comprehensive geriatric and case management assessments for 73 percent of patients.
- **Grants (new and ongoing):** FY 2025, ended with IHS support for 16 active Dementia Models of Care grantees, including ten new three-year awards focused on expansion and sustainability. In FY 2026, IHS plans to award a five-year, two-part funding opportunity to support development of a local dementia champion network, with small local funding awards, and caregiving-focused activities informed by findings from the interdisciplinary Caregiving Workgroup report.
- **Tribal Epidemiology Centers (TEC) (new):** Partnered with the Division of Epidemiology and Disease Prevention to offer four TEC award supplements for dementia- and elder-focused clinical research and TA incorporated into the Tribal Epidemiology Center FY 2026 funding opportunity.
- **Technical assistance (TA) (ongoing):** Continued delivery of intensive, structured TA through site visits, quarterly all-grantee virtual meetings, individual monthly meetings, routine technical assistance communications, maintenance of the Alzheimer's grantee listserv, and new IHS Chief Clinical Consultant meetings with grantee medical staff.

[13] https://www.ihs.gov/dccs/ems/emsresources/

Workforce Development, Training, and Technical Assistance

- **Early dementia detection initiative (ongoing):** Continued implementation of an early dementia detection initiative evaluating the feasibility of Community Health Representatives conducting Mini-Cog® screenings in twenty new Tribal and Urban Indian health programs, with expanded in-person training. Pending funding availability, additional cohorts are planned.
- **Training and Resources for the Indian Health Services on Alzheimer's and Dementia (TRIAD) (ongoing):** Continued implementation of TRIAD contract to create and competency-based dementia training, workforce development program support, and a new Dementia Clinical Support Line for clinical and community-based staff across the Indian health system. Seventeen new training modules were piloted in FY 2025.
- **Clinical and Community Workforce Summit (new)**: The first-time FY 2025 division-wide Summit drew more than 350 participants to nine breakout and plenary sessions, a grantee reverse site visit, a Virtual Dementia Tour, poster sessions, and a grant-funded documentary viewing. Continued work includes a de-scoped contract to host a national summit focused on dementia and elder health.
- **Dementia Clinical Pathway (new):** A new three-part primary care pathway was published and promoted via a national webinar, social media, and embedded in new workforce training modules in FY 2025 and 2026.
- **Workforce supports (ongoing):** Continued workforce development activities, including national dementia and elder health convenings, caregiver support initiatives informed by interdisciplinary input, support for two clinical and caregiver ECHOs with the Northwest Portland Area Indian Health Board, and support for Indian Health GeriScholars and the Geriatric Nurse Fellowship.

Outreach, Awareness, and Recognition

- **Communications and outreach (ongoing):** Continued implementation of an Alzheimer's communications contract to support routine outreach, digital content development, media assets, videos, and website maintenance, including materials supporting early detection and advanced care planning. FY 2025 targeted awareness-building activities included 25 IHS Week in Review or Tribal and Urban Leader updates, IHS blog posts, 21 newsletters, a press release, 32 social media messages across the IHS platforms, and more than 1,000 views of the Mini-Cog training YouTube videos.
- **Education and engagement (ongoing):** Continued delivery of provider education, presentations, webinars, and 11 Area-level elder-focused brain health and dementia risk reduction activities through the Health Promotion and Disease Prevention program.

Data to Inform Decision-Making and Transform Care

- **Elder Health Clinical Data dashboard (new):** Commenced work in FY 2025 on agency dashboard using the Geriatric 5Ms framework to support monitoring of clinical dementia- and elder-focused activities, with phased testing and implementation in FY 2026.
- **Grant program evaluation (new and ongoing):** Initiated a FY 2025 contract with a tribal-owned small business to evaluate the Dementia Models of Care grant program and create future performance measures that were recognized in the HHS FY 2025 Evaluation Plan. Incorporated new artificial intelligence tools (AI) to analyze workplan, evaluation plan, and regular report data from grant program participants.

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 are 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.

OUTPUTS/OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 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 2025: 100% Target: 100 % (Target Met)	100%	100%	Maintain
55 Nephropathy Assessed (Outcome)	FY 2025: 41.3% Target: 44.8% (Target Not Met)	44.8%	42.2%	-2.6 percentage points
56 Retinopathy Exam (Outcome)	FY 2025: 45.0% Target: 47.6% (Target Not Met)	47.6%	45.9%	-1.7 percentage points
66 AI/AN 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	FY 2025: 35.0% Target: 37.8% (Target Not Met)	37.8%	35.7%	-2.1 percentage points

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
conjugate. (Outcome)				
67 Influenza Vaccination Rates among children 6 months to 17 years (Outcome)	FY 2025: 15.3% Target: 18.3% (Target Not Met)	18.3%	15.6%	-2.7 percentage points
68 Influenza vaccination rates among adults 18 years and older (Outcome)	FY 2025: 17.9% Target: 21.0% (Target Not Met)	21.0%	18.3%	-2.7 percentage points
70 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among AI/ANs (Outcome)	FY 2025: 35.6% Target: 36.9% (Target Not Met but improved)	36.9%	36.3%	-0.6 percentage points
72 Tobacco Cessation Intervention (Outcome)	FY 2025: 24.8% Target: 27.5% (Target Not Met)	27.5%	25.3%	-2.2 percentage points
73 HIV Screening Ever (Outcome)	FY 2025: 45.8% Target: 42.5% (Target Exceeded)	43.4%	46.8%	+3.4 percentage points
74 Breastfeeding Rates (Outcome)	FY 2025: 43.2% Target: 44.1% (Target Not Met but Improved)	44.1%	44.1%	Maintain
75 Controlling High Blood Pressure - MH (Outcome)	FY 2025: 46.7% Target: 48.2% (Target Not Met)	48.2%	47.7%	-0.5 percentage points
81 Increase Intimate Partner (Domestic) Violence screening among AI/AN (AI/AN) Females (Outcome)	FY 2025: 30.6% Target: 30.5% (Target Exceeded)	31.9%	31.2%	-0.7 percentage points
87 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Output)	FY 2025: 40.3% Target: 40.5% (Target Not Met but Improved)	40.5%	41.1%	+0.6 percentage points

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
88 Colorectal Cancer Screening Rate (Outcome)	FY 2025: 24.1% Target: 24.6 % (Target Not Met but Improved)	24.6%	24.6%	Maintain
89 Cervical Cancer Screening (Outcome)	FY 2025: 35.4% Target: 35.6% (Target Not Met but Improved)	35.6%	36.1%	+0.5 percentage points
91 Adult Composite Immunization (Output)	FY 2025: 40.0% Target: 39.0% (Target Exceeded)	39.0%	40.8%	+1.8 percentage points

GRANT AWARDS - H&HC funds support the Healthy Lifestyles in Youth Project,[14] 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 41 DVP (37) and FHC (4) program grants.

(whole dollars)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	42	42	42
Average Award	$200,000	$200,000	$200,000
Range of Awards	$200,000-$1,250,000	$200,000-$1,250,000	$200,000-$1,250,000

[14] 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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$2,585,794	$2,632,772	$2,835,370	+$202,598
Epi Centers (non-add)	*$34,433*	*$39,433*	*$39,433*	--

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 2027 Authorization.....Permanent

Allocation Method .....Cooperative Agreements

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Tribal Epidemiology Center (TEC) Program was first authorized by Congress in 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 a role in IHS' overall public health infrastructure. Operating within Tribal organizations and governments, TECs are uniquely positioned to provide epidemiologic and public health support to local AI/AN communities. All TECs monitor the health status of their constituent Tribes, perform disease surveillance, produce a variety of reports that describe activities and progress towards public health goals, and provide epidemiological support to Tribes.

The TEC program funds eleven TECs that provide comprehensive geographic coverage for all IHS administrative areas and one additional TEC serving 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 programs, and by promoting public health career pathways for Tribal members. Since the conclusion of the Covid-19 public health emergency, a significant portion of TEC activities have been devoted to improving Tribal public health infrastructure and 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.

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 informing intervention for high-impact health priorities such as diabetes, cancer, and infectious disease.

BUDGET REQUEST

The FY 2027 budget submission for the TECs under Hospitals and Health Clinics (H&HC) is $39.4 million and is flat with the FY 2026 Enacted level.

The funding per TEC supports the salaries of a director, staff epidemiologists, and related administrative support activities. The funding also expands local capacity for evaluation, Public Health response and collaboration, comprehensive local Public Health planning, data collection and disease surveillance, special projects specific to disease priorities or local outbreaks, and the execution of additional time-sensitive projects or other tribal priorities.

IHS will fund a new TEC cycle starting in FY 2026 which expands the opportunities for awardees to design their program activities based on tribal priorities and local assessments. This expansion includes an enhanced reporting and monitoring rubric focusing on outcomes and cross-site coordination designed to improve dissemination of successful projects across sites.

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*
2023 Final	$34,433,361
2024 Final	$34,433,361
2025 Final	$34,433,361
2026 Enacted	$39,433,361
2027 President’s Budget	$39,433,361

*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

Training and technical assistance offered by the TECs are designed to be responsive to the needs and interests of the Tribes and 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. The TECs offered training and technical assistance on topics including, but not limited to, first aid certification, data collection and analysis, data visualization, survey writing, and infectious disease prevention.

Nationally Managed Data Projects that Engage Local Resources

Data that is collected and analyzed by TECs enable Tribes to evaluate community-specific health status for planning the key health needs of local AI/AN communities. Immediate feedback is provided to the local data systems and leads to improvements in AI/AN health data quality. The Indian Health Care Improvement Act (Section 130) includes language that designates the TECs as public health authorities regarding 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. Each TEC executes and administers data sharing and data use agreements with various Tribal, regional, state, and national organizations. Additionally, the development and dissemination of regional community health assessments have provided valuable guidance for regional planning to improve the health of local AI/AN communities. Some TECs have developed and launched regional data dashboards on topics selected by community input, such as mortality, morbidity, and maternal and child health.

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 and reduce incidence of SUD in AI/AN communities. Multi-disciplinary collaborations provide data-driven analysis of major public health issues, including SUD, to support evidence-based strategic planning and prevention initiatives for tribal programs, leaders and other stakeholders.

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, nutrition, behavioral health, workforce development, epidemiology, data analysis, strategic planning, and public health accreditation.

OUTPUTS AND OUTCOMES

DISCUSSION

The TECs provide critical support to the communities they serve. In FY 2025, TECs responded to 1,834 requests for technical support (EPI-4) and completed 542 TEC-sponsored trainings for tribal public health capacity building (EPI-5). Technical support and trainings reflect core public health services that specifically target community needs and emphasize long-term project collaborations and strengthening of 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.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 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 2025: 1,834 Target: 1,897 (Target Not Met but Improved)	1,200	1,200	Maintain
EPI-5 Number of TEC-sponsored trainings and technical assistance provided to build tribal public health capacity. (Output)	FY 2025: 542 Target: 200 (Target Exceeded)	200	200	Maintain

* Administrative and technical support of the TECs is provided by the Division of Epidemiology and Disease Prevention and is included in the average award amount.

GRANTS AWARDS

(whole dollars)	FY 2025 Final	FY 2026 Enacted	FY 2027 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

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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$2,585,794	$2,632,772	$2,835,370	+$202,598
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 2027 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 health care 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 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 health care operations of the I/T/U with comprehensive health information solutions, including an Electronic Health Record (EHR) system[1] 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, 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,

[1] For further information on EHR, please refer to the Electronic Health Record chapter.

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 health care 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 Business Intelligence and Business Analytic (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 health care 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 IT portfolio investments.

BUDGET REQUEST

The FY 2027 budget submission of $182.1 million for Health Information Technology is flat with the FY 2026 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 Veterans Affairs (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.

FUNDING HISTORY

Fiscal Year	Amount*
2023 Final	$182,149,000
2024 Final	$182,149,000
2025 Final	$182,149,000
2026 Enacted	$182,149,000
2027 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 2025 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 HITSS Investment, software updates and changes were developed, tested, and released to support updated requirements as set by associations, agencies, authorities, and/or accrediting bodies. The Practice Management team continues to support area offices, federal, tribal, and urban facilities for revenue generation as well as the Purchased Referred Care (PRC) program in Resource Patient Management System (RPMS) application enhancement requests, patch updates, or support ticket submissions. This includes 84 national application releases in fiscal year 2025, and closing out 756 incident tickets submitted to IHS teams. The Practice Management team streamlined processes for increased efficiency. A new dashboard was established in collaboration with the National Patient Information Reporting System (NPIRS) to facilitate revenue generation/PRC file transmissions for the Unified Financial Management System (UFMS) from sites, thereby reducing tickets and facilitating easier resubmission practices for IHS federal sites.

The Informatics and Interoperability domains—enabled by sustained Division of Technology (DIT) investment—successfully certified the HHS Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) HTI-2 Update for the 2025 reporting period, including full compliance with the United States Core Data for Interoperability Version 3 (USCDIv3). This work demonstrates how DIT-funded infrastructure and staffing directly support federal certification, regulatory alignment, and modernization requirements. DIT resources also enabled the Interoperability team to expand the Personal Health Record (PHR) Medication Refill capability, increasing flexibility for facilities with Pharmacies and improving patient application usability. These enhancements strengthen the digital patient experience and reduce operational burden—outcomes made possible through continued support for the DIT budget. With DIT's foundational technology investments, IHS became the first Federal agency to onboard to the Trusted Exchange Framework and Common Agreement (TEFCA), advancing nationwide Health Information Exchange (HIE) participation. The team also met all certification requirements for the 2015 Edition Cures Update, ensuring continued eligibility for incentive payments totaling $1.4 million for Federal sites and $3.1 million for Tribal sites in 2023. DIT-supported development work advanced a modernized patient consent approach to enhance eHealth Exchange data functionality. The team updated key policies and procedures—including the Multi-Purpose Agreement and Part 8 Chapter 23—to ensure 4DH and patient consent readiness across the enterprise. Finally, DIT funding enabled critical collaboration and configuration work with the Four Direction Warehouse (4DW) and PATH EHR teams, supporting integration activities essential to future interoperability, modernization, and enterprise alignment.

For the domain of System and Hardware Infrastructure, the Computer Systems Management Team (CSMT) has maintained a robust security posture by performing continuous monitoring and regular patching of DIT systems, resulting in no reportable security incidents for the HITSS Investment in the past five years. The team added redundancy and failover capabilities to support over 600 users in the RDS. Additionally, the team has supported the testing, deployment, and updates of the Windows 11 desktop environment and the Microsoft Office 365 suite to certify them for use with the RPMS. The team has successfully supported the testing of the InterSystems HealthShare platforms on IRIS 2022 and 2025, as well as the deployment of IRIS 2025 to sites. Additionally, they have facilitated the upgrade of Windows Server Operating System (OS) 2016 and 2019 to Windows Server 2022 for all I/T/U sites.

Other program accomplishments include updates from the HITSS Project Management Program (PMP), and Software Quality Assurance (SQA) team. The HITSS PMP 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 FY 2025, the HITSS PMO managed over $50 million in Annual Funding Requests (AFR's), and $75,000 in Memorandum of Understandings (MOU's), representing the work from 102 completed projects. Finally, the HITSS PMP 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 147 RPMS patches in FY 2025, including version updates, and coordinated RPMS training events, exceeding 200+ Health IT eLearning training courses delivered to 6,772 I/T/U users during FY 2025. The RPMS User Support teams received 2,710 incidents, averaging 219 incidents per month, and resolved a total of 2,782 incidents. Other achievements include providing technical oversight for SQA and User Support operations, test system environment maintenance, workflow development, and improvements to build processing; refinements to SQA standard operating procedures (SOPs), templates, and build processes to ensure compliance with IHS standards, while overseeing the integration of Azure DevOps test plans, test suites, and test cases to modernize the quality assurance (QA) testing process. Supporting high-volume SQA build, documentation, and release operations, ensuring that national documentation remained 508-compliant and responding promptly to redaction requests in accordance with Executive Orders. Improvements to ServiceNow Knowledge Management and Problem Management processes to provide better communication and services to customers.

The NPIRS investment continues to maintain and oversee the Enterprise Business Intelligence and Business Analytics (BI/BA) environment that provides 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 Division of Data Management and Analysis (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 continued in FY 2025, 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.

DDMA delivered 24 ad-hoc reports, to include but not limited to, Reach Out and Read Report,

Pylori Report, Office of Public Health Support (OPHS) Contract Support Costs (CSC) report, ED Emergency Department report, Regional Differences, HIV/STI Monthly Syphilis report (also integrated into the HIV/STI dashboard), and Heroin Opioids and Pain Efforts (HOPE) Opioid Surveillance Dashboard (OSD) report for Walmart in response to an Office of General Counsel (OGC) inquiry. DDMA collaborated with a clinical workgroup to deliver 4 reports for a Cascades of Care (Opioid Use Disorder and Treatment) and continues an ongoing project to finalize measures that will be utilized in congressional reporting for IHS on opioid use disorder (OUD) diagnoses and treatments. Satisfied numerous health systems planning measures that will assist Division of Facilities Planning and Construction (DFPC) with planning future construction and renovation projects for agency facilities nationwide. Developed a report to support a collaborative research study for the Fred Hutchison Cancer Center and Navajo Area Epidemiology office providing information on Helicobacter Pylori infections and treatments within the Navajo Area tribal communities. Generated reports to satisfy a requirement to provide information on Social Determinants of Health/COVID 19 Vaccine/Emergency Room Acuity/Syphilis.

DDMA completed the re-engineering or migration of the Phoenix area analytic solutions from the legacy analytic technology to the Enterprise QlikSense business intelligence platform. DDMA also migrated the SAP Business Objects Government Performance and Results Act (GPRA) to the enterprise BI platform, completing and delivering eighteen dashboard migrations to PHX and OPHS customers for validation to support the reduction of technical debt and align the agency with the Enterprise Architecture.

The second iteration of a National Vaccine Coverage (NVC) dashboard was developed to support the replacement of the legacy web application that supports critical public health prevention initiatives to increase vaccine coverage of the AI/AN community and protect against vaccine-preventable illnesses. The NVC dashboard was updated to include eleven vaccine/age metrics were delivered for adult reports, 9 vaccine/age metrics delivered for 2 year old patients and 30 vaccine/age metrics for 3-27 month old pediatric patients. The measures were extended to adopt Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) measure definitions and guidelines.

DDMA released an enhancement to the Patient Centered Medical Care (PCMH) dashboard, incorporating the ability to annotate statistical charts to communicate crucial context, highlight key insights and guide dashboard consumers on how to interpret data, especially for less savvy dashboard users. Capability provides the ability for the agency to easily see outliers, sudden changes, explain trends or patterns and break down complex data into digestible information.

DDMA released five new analytic solutions across the agency. A dashboard for the Office of Environmental Health and Engineering (OEHE) Director and offices, a Diagnosis and Dementia dashboard for the Office of Clinical and Preventive Services/Division of Behavioral Health, a Telehealth/Telemed dashboard for the Office of Information Technology and a conversion of a legacy web application to a Notifiable Disease and External Cause of Injury (NDECI) dashboard. DDMA also enhanced several dashboards, introducing new measures and/or capability in the Opioid Surveillance dashboard to increase visibility and oversight of controlled substances, promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and improve access to culturally appropriate treatment.

DDMA developed a new Buy Indian Act web application for the Office of Management Services/Division of Acquisition Policy to collect information on deviation from non-Indian vendors and the workflow that supports review and approvals. Enhancements to the National

Accountability Dashboard for Quality were updated to include facility form updates and inclusion of a new form to collect training quality measures. Enhancements to the Division of Urban Indian Affairs (DUIA) Budget Formulation and National Uniform Data System, the urban Indian organization (UIO) onsite review application and the OPHS/OIT Reference Management Tool. Annual updates to the ORAP Third Party Internal Control and federal medical assistance percentage (FMAP) systems were completed to support end of fiscal year data collection and reporting.

DDMA also upgraded all deprecated server environments, to include operating system upgrades and software upgrades. The enterprise business intelligence and analytics environment was upgraded from the February 2024 release to the May 2025 Patch 10 version. DB2 environments were upgraded from v9 to v11.

The IT Operations program implements new enterprise technologies while sustaining and providing customer support for hundreds of IT services. In FY 2025, 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.

IT Operations completed over 100 significant IT initiatives/projects and acquired over 100 products and services. Notable projects and accomplishments are as follows:

- Acquired Microsoft Dynamics 365 licensing as part of the Microsoft Enterprise Agreement via the HHS Vendor Management Office (VMO) to provide a modern platform for Customer Relationship Management development.
- Acquired Microsoft Copilot 365 licenses for AI adoptions by Agency employees.
- Completed Man-Technology-Organization (MTO) sync with HHS OPDIVS.
- Implemented circuit upgrades at 22 sites, adding approximately 5Gb of additional bandwidth.
- Exercised labor contract option years for three contracts.
- Deployed Palo Alto Global Protect VPN client to IHS endpoints for remote access modernization.

The FY 2026 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 health care 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 (comprehensive cloud security) 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 (cybersecurity platform designed to enhance the efficient and effectiveness of security operations), 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 IT Portfolio Management Tool (EPMT) that provides an enterprise IT portfolio and project management capability enabling IHS to improve project performance oversight and monitoring corrective actions through to completion. We continue working to improve our line-of-sight linkage between IHS strategic goals and 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 90 federal and 65 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 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome)	FY 2025: 3.3 Target: 4.0[2](Target Not Met but Improved)	4.0	4.0	Maintain

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

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

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$190,564	$190,564	$287,007	+$96,443
FTE /1, 2	63	63	63	--

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 2027 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Electronic Health Record (EHR) System Modernization - The health information technology (IT) 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. The IHS relies on RPMS for all aspects of patient care, including the patient record, prescriptions, care referrals, and billing public and private insurance for over $2 billion in reimbursable health care services annually. The RPMS, however, is more than 40 years old, and the Government Accounting Office has identified it as one of the 10 most critical federal legacy systems in need of modernization[1]. Modernization of this mission-critical system will bring the IHS improved and expanded clinical and administrative capabilities on par with other modern health care organizations, supporting the delivery of timely and impactful care for AI/AN people.

IHS Health IT Modernization is well underway, having leveraged funding received in prior fiscal years to add federal workforce and contractor support, and to acquire industry-leading health IT products and technologies for deployment across Indian country. The new Patients at the Heart (PATH) EHR will be implemented at the first (pilot) facilities in late FY 2026, to be followed by a multi-year rollout in cohorts of IHS, Tribal, and Urban Indian Organization sites beginning in FY 2027. The IHS enterprise approach to health IT modernization will position the agency in the best possible way to accomplish its mission in the coming years.

BUDGET REQUEST

The FY 2027 budget submission for Electronic Health Record Modernization is $287.0 million, which is +$96.4 million above the FY 2026 Enacted level.

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

FY 2027 funding increases include:

With $93.0 million, the IHS will continue to build upon the groundwork laid in prior years to enable a successful EHR transition. This will include the continuation of Program Management and Organizational Change Management operations, and the award of additional Task Orders on the 10-year Indefinite Delivery / Indefinite Quantity (IDIQ) contract for the EHR integrator and product solution, to carry the work forward. The IHS will continue its cadence of Tribal Consultation and Urban Confer, infrastructure assessments and mitigation, site implementation planning, and 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, as well as that of our Federal partners.

- Health Information Technology Modernization – The IHS Health Information Technology Modernization effort has already started to issue Task Orders under the awarded IDIQ contract and will use the FY 2027 resources to continue to execute several core activities in FY 2027 many of which are efforts from FY 2026 and prior. Specifically, the IHS expects to address the following:

    - Legacy Stabilization: Funds will support legacy RPMS stabilization and standardization efforts. The current RPMS system must remain fully functional until all PATH EHR implementations are complete
    - Interoperability: Funds will provide for the continued implementation of systems used to extract, transform, load, archive, seed, and serve data for interoperability and analytics applications from both legacy and modernized electronic health record systems.
    - Electronic Health Record (EHR) Integrator and Product - Task Orders: Funds will continue the optimization and configuration of the Enterprise baseline, operations, and site implementation of the PATH EHR, including all system cloud hosting, software configuration management, training, interfacing, integration testing, legacy data migration, and implementations at prepared sites.
    - Network Modernization & Business Software: Funds will support hardware and infrastructure needs to prepare facilities for the new PATH EHR implementation and deployment, to include a modeling software tool to construct business and clinical process models consistently, collaboratively, and efficiently, facilitating the standardization of IHS's business processes and IT systems.
    - Modernization Program Administration: Funds will support administration for the complex operations of the Modernization Program Management Office and related activities, including project management, engineering, product management, deployment, testing and verification, as well as system-wide organizational change management, communications, and support for effective governance.
    - Cybersecurity: Funds will support operational expenditures necessary to implement and manage a robust cybersecurity infrastructure to keep IHS systems secure and protect critical Personally Identifiable Information (PII) and Protected Health Information (PHI) from vulnerabilities across the IHS network, while maintaining the existing cybersecurity infrastructure.
    - Telehealth: Clinical Video Telehealth technology supports improved access to care through virtual provider visits, especially important in the extremely rural environments of Indian country where transportation to a distant clinic is not readily available.
    - Federal Staffing and Expenses: Funds will be used to support federal staff assigned to

the Modernization project.

The IHS will complete the configuration of the baseline enterprise solution set and will begin field implementation at health care sites in late 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 health care. 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 War, Tribal and Urban Indian health programs, academic affiliates, and community partners, many of whom use different HIT platforms.

  The Indian Health Service and its Tribal and Urban Indian Organization partners comprise a statutorily mandated national health care system. The Electronic Health Record is the technology infrastructure that enables the Agency to effectively carry out this mandate. The legacy EHR discussed earlier in this document is critically outdated and unsustainable. Sufficient recurring funding for the EHR is required to ensure a timely and successful modernization of these technologies in support of the IHS mission.

- Current Services: +$3.4 million for Current Services. Information can be found in the Current Services chapter.

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[2]
2023 Final	$217,564,000
2024 Final	$190,564,000
2025 Final	$190,564,000
2026 Enacted	$190,564,000
2027 President's Budget	$287,007,000

PROGRAM ACCOMPLISHMENTS

In FY 2025, the IHS Modernization of Health IT Systems & Support (mHITSS) investment made significant progress. The IHS is committed to collaborating with IHS partners and leveraging their feedback to build the new enterprise electronic health record EHR solution, PATH EHR, to meet the specific needs of its users across Indian Country. PATH stands for

[2]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.

"Patients at the Heart," and demonstrates the IHS' 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 four tribal consultation and urban confer sessions to provide tribal and urban Indian organization partners updates about the status of Program activities and to seek input on these activities.
- 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.
- Began to identify and define configurations for the Federal Oracle Cloud, the cloud-based host for PATH EHR.
- Completed 98 percent of data collection needs as of November 2025
- Completed 88 percent of the Enterprise Build as of November 2025
- Validated 85 percent of the Enterprise Build as of November 2025
- Engaged clinical and administrative subject matter experts from around the nation in the Enterprise Collaboration Group, in which end-users of the new system contribute directly to its build and configuration through numerous in-person and virtual design events.
- 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.
- Conducted Pilot Implementation Kickoff.
- Began purchasing hardware to remediate technology gaps required for EHR integration at the site.
- Conducted several Change Leadership Alignment sessions with Lawton Service Unit staff to facilitate adjustment to the business process changes that will be introduced with PATH EHR implementation.
- Started Pilot Design Workshop Sessions with subsequent sessions to continue and complete by March 2026, which will be followed by staff training.
- Began design and build of the Four Directions Warehouse (4DW) for production. The 4DW will be the permanent repository and archive for decades of legacy data previously held in numerous disparate RPMS databases in accordance with record retention requirements and will also be a resource of historical patient information for users of PATH EHR.
- Continued to bring on federal staffing for the Division of Health IT Modernization and Operations (DHITMO) and the Chief Medical Information Officer (CMIO) informatics team: these staff will be critical to the management and sustainment of the PATH EHR.

- Held the Health IT Modernization Program Implementation and Deployment planning meeting to align the resources and activities to plan scope, timelines, and methodology for implementing PATH EHR.
- Established network connections between Oracle Cloud 2 (OC2) and IHS Network 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.

OUTPUTS/OUTCOMES

As the 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 accreditation of health care facilities.

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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$254,117	$260,360	$276,225	+$15,865
FTE /1, 2	424	424	446	+22

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 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 96 percent of the dental services provided. In FY 2025 the DHP provided a total of 3,683,977 basic dental services, a 3.46 percent decrease from FY 2024, in which the DHP provided 3,816,127 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 230,781 dental services in FY 2025, a 10 percent decrease from FY 2024 where 256,496 higher level services were performed. The DHP provided these services through 1,144,229 dental visits in FY 2025, a 9.54 percent decrease from FY 2024 (1,264,859 dental visits).

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 are 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 are 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.

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. At the end of FY 2025, the IHS has 1,046 dentists (including part-time) in the IHS I/T/U dental clinic system, according to the IHS Dental Directory, a decrease of 16 from FY 2024.

BUDGET REQUEST

The FY 2027 budget submission for Dental is $276.2 million which is +$15.9 million above the FY 2026 Enacted level.

FY 2026 Enacted level Funding of $260.4 million supports oral health care services provided by IHS and tribal programs, maintains 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 2027 funding increases include:

- Current Services and Staffing of Newly Constructed Facilities: +$13.9 million for Current Services and +$5.6 for Staffing of Newly Constructed Facilities. Information can be found in the Current Services and Staffing of Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$248,098,000
2024 Final	$252,561,000
2025 Final	$254,117,000
2026 Enacted	$260,360,000
2027 President's Budget	$276,225,000

TRIBAL SHARES

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 decreased from 27.8 percent in FY 2024 to 24.8 percent in FY 2025, an 11 percent decrease. The proportion of 2-15 year-old AI/AN children receiving dental sealants – a second GPRA indicator – decreased from 11.8 percent in FY 2024 to 11.4 percent in FY 2025, and the proportion of 1-15 year-old AI/AN children received topical fluorides – another GPRA indicator – decreased from 28.4 percent in FY 2024 to 25.3 percent in FY 2025.

IHS Electronic Dental Record (EDR). The IHS EDR IT system supports dental services delivered to over 2.8 million AI/AN across 37 states. The IHS EDR program is a mission-critical IT system supporting 350+ I/T/U dental clinics by enabling standardized clinical documentation, secure patient information management, billing and claims processing, reporting, and interoperability with enterprise health systems. Since 2008, the IHS EDR has delivered a Commercial Off-The-Shelf solution customized to meet clinical, operational, revenue cycle, and data sovereignty requirements of federally operated, tribally operated, and urban (I/T/U) dental clinics. With the addition of Congressional financial support for implementation of the IHS electronic dental record (EDR) over the past few years, over 90 percent of IHS I/T/U dental clinics have transitioned to an EDR system to support the delivery of effective, quality dental services. However, there are still approximately 40 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. The IHS EDR Program also provided continuous hardware and software maintenance and 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 ensures 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.

IHS EDR Program accomplishments include:

- Oral Health Status (OHS) Measure automation:
    - Improved efficiency for use of the IHS OHS measure (oral health assessment).
    - This function allows dental clinics to identify patients at risk of oral health disease so patient care can be tailored to individual patient-specific preventive, restorative and surgical care to establish and maintain oral health care. Health care can be tailored to individual patient-specific preventive, restorative and surgical care to establish and maintain oral health
    - This function can also allow data aggregation at the clinic level to track the oral health status of the entire clinic population in real time, eliminating the reliance on the once-every-five years periodic patient surveys.
    - If fully funded, this data aggregation could be conducted at higher levels of the IHS medical IT system allowing real-time reporting capability of the oral health of all patients that receive dental care in IHS dental facilities.
- Electronic Patient Health Assessment (Health History) module updates:
    - Facilitates integration of medical and dental health record information
    - Compliant with NARA guidance for health IT modernization of previously paper-based document creation and archiving processes to all electronic document formats and archival storage.
- Standardized EDR Clinical Note data entry to facilitate integration of medical and dental health record information:
    - Establishes standardized data fields to expedite development of medical information interoperability with IHS PATH EHR and numerous other EMR/EHR systems used by Tribal clinics.
- Created GPRA data-related reporting capability direct from IHS EDR IT system to NPIRS/NDW:
    - Eliminated additional data interface development in PATH EHR to transition this data to NPIRS/NDW.
- Electronic claims (837i) filing development:
    - Allows IHS clinics in multiple states to meet the CMS / State Medicaid program's

unique state electronic claims filing requirements
    - Greatly increases capability for Service Units to be financially self-sustaining
- Continued development of the EDR Dental Clinic Manager's Handbook to maximize IHS EDR capabilities to support safe, effective and efficient oral health care:
    - Created specific new chapter to guide IHS Service Units in creating and submitting claims to bill 3rd party payors and ensure appropriate remittance processing in both UFMS and the IHS EDR IT system

With the current $3.5 million Congressional allocation, the IHS DHP will continue to build upon the groundwork laid in previous years to enable a successful EDR transition to a modernized EDR-Single Instance (EDR-SI) cloud-based platform. This will include the continuation of Program management and organizational change management operations, comprehensive training, and the award of additional Task Orders on the existing 5-year (base- year plus four option years) IHS EDR Implementation and Support contract to continue to carry the work forward to deliver a fully integrated electronic health record (EHR) for the IHS. Additionally, this funding will continue to support optimal interoperability with the existing IHS Resource and Patient Management System (RPMS) as well as Tribal and Urban service unit's existing non-RPMS EHR systems. The IHS DHP will continue its cadence of Tribal communication, infrastructure assessments and mitigation, site implementation planning, and existing Dentrix Enterprise EDR 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, as well as that of our Federal partners.

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. A third project is the American Dental Association sponsored Give Kids a Smile®, with 133 events held in I/T/U sites in 2025. Over the course of the five years of this program, the DHP has held 658 events with 1,319 I/T/U dentists and 3,599 I/T/U dental hygienists & dental assistants participating, resulting in 76,368 children receiving preventive and restorative services with an estimated benefit of $6.2 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. The sixth and final project was the implementation of cognitive screenings on geriatric patients by dental providers, with five programs conducting screenings. 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 2025, a total of 273 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 2024 due to a complete review of all available courses and removal of outdated courses.) A total of 1,824 dentists participated in CDE courses, while 2,912 dental hygienists and dental assistants participated in

CDE events CY 2025. A total of 26,853 CDE participant hours were awarded CY 2025. 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 ten years, one oral maxillofacial surgeon, one endodontist, and twelve pediatric dentists have returned from LTT to serve AI/AN patients.

Dental Clinical and Preventive Support Centers (DSC). The DHP provides a total of $4 million annually in program-award funding and grant funding for nine DSCs. The program has been in place since FY 2000. In FY 2026, a new five-year cycle will begin. This funding will continue to allow 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 2025 Organization for Safety, Asepsis and Prevention (OSAP) boot camp federal breakout sessions. Over 50 I/T/U members attended the boot camp. The DHP (IPCS) provided 24 bi-weekly infection control tips in 2025. At least 1058 dental providers reviewed the IC tips which provided over 919 Continuing Dental Education (CDE) hours to participants. The DHP (IPCS) continued to work with the IHS Office of Quality in 2025 to review and update the dental specific infection control tracers that were developed in 2023. In total, seven specific tracers were reviewed and updated. These tracers have been distributed throughout IHS and are being tracked using the Joint Commission Tracers with AMP software. Additionally, Chapter 6B of the IHS Oral Health Program Guide was reviewed and updates were completed in December 2025[1].

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 approximately 60 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

[1] https://www.ihs.gov/doh/clinicmanagement/ohpgpdf/Chapter 6/12IHS-OPHS790-DEN_HNB_Chapter6_SectionB.pdf

services delivered by dental programs up to 5.1 percent, and increase the total services per patient visit by up to 14 percent.

In 2025, the DHP graduated the third class of Community Dental Health Coordinators (CDHCs), bringing the total to 19 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 FY 2026, the DHP initiated a fourth cohort of CDHCs with 5 dental assistants and dental hygienists.

Overall Improvements.
As a result of these various initiatives, the DHP has demonstrated a decrease in dental disease in specifically targeted patient populations. Through the DHP periodic oral health surveillance program, the DHP has shown that oral health among some AI/AN preschool children is improving. However, despite these gains, AI/AN children continue to experience a disproportionately high burden of oral disease. Closing this gap will require sustained efforts from IHS and Tribal programs to engage individuals, families, communities, Tribal leaders, and health and social service providers. The initiatives outlined in this report are needed to further assist the IHS DHP to properly assess overall oral health care needs in real time to facilitate appropriately timed preventive as well as interceptive restorative and rehabilitative care for all age groups. The IHS DHP has also developed a database to aggregate and report dental clinic personnel vacancies in real time. These management tools have greatly enhanced the ability of the IHS DHP to advocate for, and support, the overall IHS I/T/U oral health program.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
61 Topical Fluorides (Outcome)	FY 2025: 25.3% Target: 27.4% (Target Not Met)	28.4%	25.9%	-2.5 percentage points
62 Access to Dental Services (Outcome)	FY 2025: 24.8% Target: 27.0% (Target Not Met)	27.8%	25.3%	-2.5 percentage points
63 Dental Sealants (Outcome)	FY 2025: 11.4 % Target: 11.8% (Target Not Met)	11.8%	11.7%	-0.1 percentage points

GRANTS AWARDS

The DHP provides $430,000 in annual grant funding to each of the six Dental Clinical and Preventive Support Centers (DSCs). Additional funding in FY 2026 will support expansion of services to AI/AN communities and will cover program administrative costs.

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 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	6	6	6
Average Award	$444,444	$430,000	$763,000
Range of Awards	$444,444	$430,000	$7630,00

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

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$130,169	$133,693	$138,714	+$5,021
FTE /1, 2	159	159	167	+8

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 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 2027 budget submission for Mental Health is $138.7 million, which is +$5.0 million above the FY 2026 Enacted level.

FY 2026 Enacted level Funding of $133.7 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 2027 funding increases include:

- Current Services and Staffing of Newly Constructed Facilities: +$6.2 million for Current Services and +$1.7 million for Staffing of Newly Constructed Facilities. Information can be found in the Current Services and Staffing of Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$127,226,000
2024 Final	$129,765,000
2025 Final	$130,169,000
2026 Enacted	$133,693,000
2027 President's Budget	$138,714,000

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 AI/ANs 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 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]

Per a 2025 Morbidity and Mortality Weekly Report, during 2018–2023, U.S. suicide rates

[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)

remained stable overall but differed among demographic groups, Rates were highest among non-Hispanic AI/AN persons but declined between 2021 and 2023. During 2021–2023, rates declined significantly among AI/AN persons aged 25–44 years (14.5%), overall rates among AI/AN persons declined significantly (15.3%).[7]

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.

As of FY 2025 the IHS has provided online training to 25,381 Indian health staff including 311 staff receiving in-person Question, Persuade, and Refer (QPR) training and 264 staff receiving train the trainer across the 12 area offices through a contract with Sister Sky Inc. Through this collaboration, they have been able to develop and foster best practices, a monthly newsletter, training support, technical assistance, and culturally adapted QPR training specific to AI/AN populations.

The DBH initiated crisis response team planning via contract with Koniag Government Services in 10 IHS Areas and allocated resources to assist in hiring or contracting crisis response staff over the next three years. The intent is for the Areas to develop crisis response teams to address mental and behavioral health crisis in their communities.

A five-year Suicide Prevention Strategic plan for AI/AN people with a workgroup was launched in January 2025, including Tribal SMEs and IHS staff to provide input in the strategic plan based on the National Strategy for Suicide Prevention.

Lethal means counseling and education for AI/AN was included in the Federal Action Plan as part of the National Strategy for Suicide Prevention released by the White House in April 2024. A curriculum focusing on suffocation and hanging and firearms within Tribal communities is under development in partnership with Tribal programs and organizations.

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 health care system. In FY 2025, sites made improvements according to information from their care and treatment of patients at risk for suicide focusing on the seven elements of the Zero Suicide Model. In FY 2023, the Division of Behavioral Health established ZSI Coordinating Centers to provide 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.

[7] https://www.cdc.gov/mmwr/volumes/74/wr/mm7435a2.htm

Trauma-Informed Care: As of FY 2025, a total of 94 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 has assisted 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 2025, 37.6 percent of AI/AN adults over the age of 18 were screened for depression using a standardized screening assessment for depression. In FY 2025, this same measure was reported for youth ages 12-17 and data indicated 33.4 percent of eligible youth were screened for depression. The FY 2025 depression screening targets were not met for the AI/AN population and anticipate an increase in patients screened for both age cohorts in FY 2026.

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 26 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 2025, the TBHCE provided 8,675 hours of telehealth service across the I/T/U health system, with over $1.7 million in billable hours.

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 health care providers. In FY 2025, TBHCE provided 49 webinars that included 3,273 attendees with an average of 67 attendees per webinar. In FY 2026, tele-education will continue providing virtual, live, and on demand behavioral health trainings for I/T/U providers.

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

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
65 Proportion of AI/AN adults 18 and over who are screened for depression. (Outcome)	FY 2025: 37.6% Target: 39.6% (Target Not Met but Improved)	39.6%	38.3%	-1.3 percentage points
85 Depression Screening ages 12-17. (Outcome)	FY 2025: 33.4% Target: 36.1% (Target Not Met but Improved)	36.1 %	34.0%	-2.1 percentage points
MH-1 Increase Tele-behavioral health encounters nationally among AI/AN (Output)	FY 2025: 58,837 Target: 71,000 (Target Not Met)	52,000	52,000	Maintain

GRANTS AWARDS

The proposed FY 2027 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 2026 non-competitive grants are included below:

(whole dollars)	FY 2025 Final	FY 2026 Enacted	FY 2027 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

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

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$266,771	$267,080	$280,205	+$13,125
FTE /1, 2	234	234	238	+4

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 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 2027 budget submission for Alcohol and Substance Abuse is $280.2 million, which is +$13.1 million above the FY 2026 Enacted level.

FY 2026 Enacted level Funding of $267.1 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 2027 funding increases include:

- Current Services and Staffing of Newly Constructed Facilities: +$12.1 million for Current Services and +$1.0 million for Staffing of Newly Constructed Facilities. Information can be found in the Current Services and Staffing of Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$266,440,000
2024 Final	$266,636,000
2025 Final	$266,771,000
2026 Enacted	$267,080,000
2027 President's Budget	$280,205,000

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. The IHS has developed focused educational outreach and practice transformation materials to improve screening for substance use disorders and deployed clinical screening measurement tools (TAPS and CAGE-AID) into the IHS Electronic Health Record to track implementation and opportunities for improvement.

In FY 2025, the SBIRT was utilized in 23.5 percent of the patient visits for those ages 9 through 75, exceeding the national target rate of 15.8 percent. For FY 2026, the national target rates for SBIRT are set at 17.9 percent. In FY 2025, IHS actively worked 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 Treatment for Persons with Substance Use Disorder (SUD): IHS is working to expand access to Medications for Opioid Use Disorder (MOUD) across the continuum of care. In FY 2025, the IHS Pain and Addiction Care in the Emergency Department (PACED) pilot

project expanded to include an additional site and continued its emphasis on improving services and patient outcomes. The objective of the PACED 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 2025, an evaluation of this pilot program was designed to include both quantitative and qualitative metrics to determine the cost of potential scope and scale of integrated SUD approaches across the continuum of care.

The IHS Educational Outreach Program (EOP) created three new campaigns in FY 2025: MOUD, syphilis and STI (to address 'syndemic' related concerns), and opioid stewardship. These campaigns leverage academic detailing principles and support peer-to-peer interventions and scientific training to promote quality of care. Each campaign included an evidence-based guideline, IHS specific key messages, and patient health-promotion information. In FY 2026, the EOP is expected to expand to include additional chronic disease states such as Alcohol Use Disorder and lifestyle medicine to enhance prevention strategies.

IHS has also created a robust workforce development strategy to include didactic training. The IHS continued mandatory IHS-ALL 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. Additionally, in FY 2025, the IHS continued the 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. The IHS supports access to the Clinician Consultation Center to provide I/T/U clinicians with no-cost tele-consultation for SUD treatment. These services enhance clinical decision-making, support provider education, and assist health systems in developing local SUD protocols.

In FY 2025, IHS launched a pilot program offering case-based learning and peer facilitation for clinical pharmacists expanding their role in MOUD management. Eighteen pharmacists from 14 organizations participated. IHS also continued the Advancing Pharmacist Roles in SUD Treatment and Recovery Teams ECHO program, providing monthly sessions to strengthen pharmacists' clinical and leadership capacity within multidisciplinary SUD treatment teams.

In FY 2024, the IHS announced the Naloxone Safety Net Program[3,4] which 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 2025, 3,736 doses have been disbursed.

Finally, as part of the workforce development strategy, the IHS continued the *Essential Training on Pain and Addiction* and the *Refresher Training* 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) (881 prescribers completed training in FY 2025; with a cumulative 2589 prescribers completing training since the course was launched 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

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

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

30. The Pain Management visualization for the iCARE population health tool was released in July 2025 in addition to two new patient pain functional status assessment tools. In FY 2026, the IHS anticipates it will complete Prescription Drug Monitoring Program integration with the IHS EHR and it 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 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): The YRTCs provide residential substance use disorder and mental health treatment services to AI/AN youth. 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 2025, 83 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 2025, ICP provided fifteen webinars on neurodevelopmental disorders with a total of 631 attendees, including 439 who attended for CE Credit. The ICP also provides additional clinician support 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 Healthy 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): In FY 2024 the IHS concluded the third and final year of the pilot project. Approximately $500,000 annually was provided to each of the 35 Tribal, Tribal organizations, and Urban Indian Organizations to increase public awareness and education about the impact of opioids on individuals, families and communities. The 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.

1. The 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. IHS collected data from all grant-based partners for Year One (FY 2023), Year Two (FY 2024), and Year Three (FY2025). Tribal grant-based partners reported the following data pertaining to the first three years of the SAPTA program: Client engagements of 7,361 (year one), 12,919 (year two), and 28,582 (year three); screenings for general substance use of 1,683 (year one), 10,059 (year two), and 2,769 (year three); screenings for alcohol use disorder of 33,581 (year one), 53,954 (year two), and 38,416 (year three); screenings for drug use disorder of 5,355 (year one), 27,155 (year two), and 20,774 (year three); cases of alcohol use disorder as 1,121 (year one), 9,243 (year two), and 1,031 (year three); cases of methamphetamine use disorder as 342 (year one), 411 (year two), and 571 (year three); cases of opioid use disorder as 300 (year one), 4,272 (year two), and 490 (year three); and cases of other use disorder as 829 (year one), 413 (year two), and 889 (year three). The SAPTA program will continue the collection of annual data on services provided.

2. The 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 collected data from all grant-based partners for Year One (FY 2023), Year Two (FY 2024), and Year Three (FY 2025). Tribal grant-based partners reported the following data pertaining to the first three years of the SPIP program: Client engagements of 25,867 (year one), 23,522 (year two), and 26,643 (year three); screenings for suicidal risk of 13,531 (year one), 6,035 (year two), and 6,449 (year three); cases of general psychological risk as 866 (year one), 2,007 (year two), and 4,488 (year three); and cases of suicide risk as 321 (year one), 1,374 (year two), and 851 (year three). The SPIP program will continue the collection of annual data on services provided.

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 2025, 34.0 percent of patients were screened and the FY 2026 national target rate for UAS is set at 36 percent.

Preventing Alcohol-Related Deaths (PARD): In FY 2023, IHS awarded $2.0 million 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 year two (May 2024 – May 2025) report a total of 823 SBIRT (Screening, Brief Intervention, and Referral to Treatment) screenings were conducted using the Health Lifestyle Questionnaire. At the time of the screening, 274 (33percent) individuals were classified as needing Brief Intervention (BI), 376 (46 percent) as needing Brief Treatment (BT), and 164 (20 percent) as requiring Referral to Treatment (RT). Almost all individuals screened were provided with a brief intervention (784 – 95 percent) based on Motivational Interviewing principles. For the same period, service volume included 19,637 total admissions – an increase of over 4,000 from year one's total admissions (15,477), indicating higher usage of the facility and its programs among community members.

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 96 AI/AN youth, of which, 53 AI/AN youth participating in the most recent reporting year where the aftercare program successfully delivered services to them through 318 aftercare contacts.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). (Outcome)	FY 2025: 83% Target: 100 % (Target Not Met)	100%	100%	Maintain
80 Universal Alcohol Screening (Outcome)	FY 2025: 34.0% Target: 36.0% (Target Not Met)	36.0%	34.6%	-1.4 percentage points
90 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome)	FY 2025: 23.5% Target: 15.8 % (Target Exceeded)	17.9%	23.9%	+6.0 percentage points

GRANTS AWARDS

(whole dollars)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	93	93	93
Average Award	$350,000	$350,000	$350,000
Range of Awards	$300,000 - $500,000	$300,000 - $500,000	$300,000 - $500,000

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

(Dollars in thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$996,755	$996,755	$1,054,485	+$57,730
FTE /1, 2	232	232	232	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 AI/ANs.[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 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 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,

[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.

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, were 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 providing 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

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

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 FY 2025 threshold is $19,095. The CHEF is centrally 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.

BUDGET REQUEST

The FY 2027 budget request for Purchased/Referred Care is $1.1 billion, which is +$57.7 million above the FY 2026 Enacted level.

FY 2026 Enacted level: $996.8 million supported almost 33,000 inpatient admissions, over 1.2 million outpatient visits, and nearly 42,000 patient transports.

FY 2027 President's Budget: $1.1 billion will support over 34,600 inpatient admissions, over 1.27 million outpatient visits, and 44,000 patient transports.

FY 2027 funding increases include:

- New Tribes (+$5.8 million): +$5.8 million to support the delivery of health care services for the United Keetoowah Band of Cherokee Indians (UKB) and continues the request of $6.0 million for the Lumbee Tribe for a total of $11.8 million in New Tribes funding to meet statutory requirements under the Indian Self-Determination and Education Assistance Act.

- Current Services: +$46.0 million for Current Services. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	PRC	CHEF	Total
2023	$942,755,000	$54,000,000	$996,755,000
2024	$942,755,000	$54,000,000	$996,755,000
2025 Final	$942,755,000	$54,000,000	$996,755,000
2026 Enacted	$942,755,000	$54,000,000	$996,755,000
2027 President's Budget	$1,000,485,000	$54,000,000	$1,054,485,000

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 (Core Essential), including some intermediate and elective services, thus increasing access to patient care services. In FY 2025, 88 percent of IHS-operated PRC programs were able to purchase services beyond Medical Priority II – Intermediate Necessary Services.

The IHS PRC Workgroup helped IHS develop a more accurate form for annually reporting denied and deferred PRC services. In FY 2025, PRC programs denied and deferred an estimated $288,407,400 for an estimated 64,595 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 2024, 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.

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. This increased 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 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
PRC-2 Track IHS PRC referrals (Outcome)	FY 2025: 60.0 days Target: 60.0 days (Target Met)	60.0 days	60.0 days	Maintain
PRC-3 Track PRC self-referrals (Outcome)	FY 2025: 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.

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

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$205,180	$206,119	$221,139	+$15,020
FTE /1, 2	203	203	213	+10

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. These estimates are subject to change.

SUMMARY OF THE BUDGET REQUEST

The FY 2027 Indian Health Service (IHS) Budget request for Preventive Health Services includes a total of $221.1 million, which is +$15.0 million above the FY 2026 Enacted level.

This funding increase includes:

- Current Services (+$12.2 million)
- Staffing of Newly Constructed Facilities (+$2.6 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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$112,948	$114,200	$123,705	+$9,505
FTE /1, 2	181	181	191	+10

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 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 health care needs of the AI/AN population by removing barriers to access. In FY 2025, the PHN program provided 253,583 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 2027 budget request for Public Health Nursing is $123.7 million, which is +$9.5 million above the FY 2026 Enacted level.

FY 2026 Enacted level Funding of $114.2 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 2027 funding increases include:

- Current Services and Staffing of Newly Constructed Facilities: +$6.7 million for Current Services and +$2.6 million for Staffing of Newly Constructed Facilities. Information can be found in the Current Services and Staffing of Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$110,782,000
2024 Final	$112,034,000
2025 Final	$112,948,000
2026 Enacted	$114,200,000
2027 President's Budget	$123,705,000

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 2025, $1.5 million was awarded for six 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. In FY 2025, one of the seven cooperative agreement awards was terminated due to noncompliance, and the remaining six awardees received the annual funding evenly distributed as supplemental awards to support their continuous application awards. In July 2025 a two- and half-day PHN program technical assistance meeting was held in Rockville, MD with presentations to provide direction, information and guidance for success. This included sharing established STI informatics response for PHN Field Treatment for Syphilis and other STIs and PHN protocols and procedures for

syphilis screening in the community. To disseminate promising PHN services to address STI treatment services these programs presented at the National Alaska Native American Indian Nurses Association Conference 2025 in Anchorage, Alaska and at the national 2025 IHS Nurse Summit on September 11, 2025, to support an essential step to meet the needs of nurses, students, patients and communities. PHN interventions are monitored with the PHN data mart tool for performance measurement and outcome reporting. PHNs provided 19,863 patient encounters in FY 2025 that encompassed 35,213 patient education services documented for STI visits which included communicable disease, medications, contact with exposure, immunizations, alcohol and other drugs, and tobacco use.

Performance Reporting: The PHN program reports the following measure as part of the HHS Annual Performance Plan and Report: the total number of public health activities captured by the PHN data system. The PHN program supports GPRA screening criteria, strategies for partnerships, and collaborations that result in improved health outcomes over the long term. In FY 2025, PHN documented patient screening of 2,932 Tobacco Screening, 10,756 Domestic Violence Screening, 10,249 Depression Screening, 10,931 Alcohol Screening, and the administration of 25,748 Adult Influenza Vaccines. In FY 2025, the PHN continued efforts to decrease childhood obesity and prevent diabetes by supporting hospital Baby Friendly re-designation with a total of 5,827 PHN patient encounters to foster breastfeeding as the exclusive feeding choice for infants. These encounters included 12,197 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.

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. To ensure comprehensive, culturally respectful health care services are provided, in FY 2025 to support PHN workforce development, the program is implementing a contract for curriculum development, training, and technical assistance. This training provides 96 hours of instruction to help ensure PHNs provide high-quality care by keeping nursing skills current. The curriculum includes community planning for community organizations such as schools to enhance AI/AN student health, safety, and education. In FY 2026, the program will continue to strengthen workforce capacity and improve program performance through structured education and training that updates clinical skills, incorporates evidence-based practices, enhances decision-making, and fosters leadership and teamwork. This activity includes a formal assessment to identify ongoing and future training needs. During FYs 2025 and 2026, the program provides PHN recommendations for the operational aspects and future deployment of the IHS Patients at the Heart (PATH) electronic health record (EHR), which will help ensure PHN activities are captured and reported in the new system. To support program maintenance and capacity building, a PHN presentation was provided at the national 2025 IHS Nurse Summit, “Leading, Guiding, and Empowering Nurses” entitled the PHN Role in Health Care Services for AI/AN Communities Utilizing Community Health Needs Assessments on September 11, 2025.

Expand access to health care services. The PHN program helps to remove barriers to health care access by meeting AI/AN people in the clinics, in their homes, and in the community. In

FY 2025, the PHN program provided 253,583 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). 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 Ongoing analysis of FY 2026 and FY 2027 data will be used to predict future performance target(s), especially since results prior to FY 2025 fell below the productivity target. The FY 2027 PHN performance target is 255,000 individual patient activities based on the FY 2025 results.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
23 Public Health Nursing (PHN): Total number of IHS public health activities captured by the PHN data system. (Outcome)	FY 2025: 253,583 Target: 300,000 [1] (Target Not Met)	285,000[2]	255,000	-30,000

[1] The FY 2025 Target is revised from 350,000 to 300,000 based on prior year results and projected funding.
[2] The FY 2026 Target is revised from 300,000 to 285,000 based on prior year results.

GRANTS AWARDS

(whole dollars)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	7	6	6
Average Award	$150,000	$175,000	$175,000
Range of Awards	$150,000	$175,000	$175,000

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

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$24,837	$24,524	$26,569	+$2,045
FTE /1, 2	11	11	11	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 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 2027 budget submission for Health Education of $26.6 million is +$2.0 million above the FY 2026 Enacted level.

FY 2027 funding increases include:

- Current Services and Staffing of Newly Constructed Facilities: +$2.0 million for Current Services and +$31,000 for Staffing of Newly Constructed Facilities. Information can be found in the Current Services and Staffing of Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$24,350,000
2024 Final	$24,417,000
2025 Final	$24,837,000
2026 Enacted	$24,524,000
2027 President's Budget	$26,569,000

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 2025, the Health Education (HE) program collaborated with the Health Promotion and Disease Prevention (HPDP) program to maximize resources and deliver best and promising practices through education, training, and technical assistance.
- The Health Education program's health literacy contractor in implementing post-training virtual sessions twice per month as part of the continued learning process to enhance health literacy skills.
- The Health Education Consultant assisted with the review of cancer materials, including the Cancer Patient Navigation Training materials and the Comprehensive Cancer Toolkit to Increase Colorectal Screening.
- The Health Education and HPDP programs facilitated discussion and planning to implement special projects focused on promoting men's health initiatives and the development of educational materials. Funds were provided to the Oklahoma City Area to support a men's health special project in partnership with the Wewoka Service Unit and Oklahoma City Indian Clinic, reaching 47 participants.
- The Health Education program led the planning and coordination of the Health Education track at the National Clinical and Community Services Summit held in May 2025.
- The Health Education program purchased an inflatable colorectal cancer display for the Lower Brule and Catawba Service Units to increase awareness of the importance of preventive screenings in the communities.
- The program purchased tobacco prevention displays for 5 Area Health Education programs to increase awareness of the adverse health effects of commercial tobacco use in the Indian Health Service/Tribal/Urban Indian Organizations (I/T/U) facilities.
- The HE Program funded two colorectal cancer screening pilot projects in Fort Yuma and Zuni Service Units.
- In collaboration with the Public Health team and the HPDP Consultant, a contract was initiated with Good Health TV/KAT & Company, potentially reaching 19 million target audience, focusing on a wide array of public health topics. This includes up to 30 new no-cost subscriptions for I/T/U sites.
- The HE Consultant assists the Phoenix Area Office with contract management and technical assistance for four Area Urban Indian Health Programs.

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 2025, there was a total of 2,305,385 health/patient education visits, which did not meet the 2,823,012 target. The FY 2025 result reflects a decrease of 155,893 health/patient education visits from the 2,461,278 health/patient education visits reported for FY 2024.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2026 Target**	**FY 2027 Target**	**FY 2027 Target +/-FY 2026 Target**
HE-1 Number of visits with Health/Patient Education (Output)	FY 2025: 2,305,385 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.

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

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$65,212	$65,212	$68,571	+$3,359
FTE /1, 2	11	11	11	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 health care services for 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 health care and social services. As such, CHRs improve health outcomes by addressing a broader range of health needs impacting community health and primary and preventive health.

BUDGET REQUEST

The FY 2027 budget request for Community Health Representatives of $68.6 million which is +$3.4 million above the FY 2026 Enacted level. The proposed funding level directly supports IHS's efforts to provide high-quality health care across the Indian health system.

FY 2027 funding increases include:

- Current Services: +$3.4 million for Current Services. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$65,212,000
2024 Final	$65,212,000
2025 Final	$65,212,000
2026 Enacted	$65,212,000
2027 President's Budget	$68,571,000

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

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. CHR accomplishments in FY 2025 were:

- Implemented a second CHR Mini-Cog cognitive screening pilot with the Elder Health team, expanding to 20 CHR program sites across eight IHS regions for a total of 957 individuals screened.
- Trained 940 CHRs under the Northwest Portland Area Indian Health Board Indian Country ECHO platform.
- Presented on addressing Alzheimer's and other dementias in tribal communities for the Alzheimer's Association webinar.
- Awarded national CHR training contract establishing updated core competencies and new navigation/coaching and CHR supervisor training tracks.
- Implemented a new process for CHR training enrollment, verification, and ongoing tracking for CHR workforce competency trainings.

CHR Performance Measures

In FY 2025, 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. Only one of the three reporting categories exceeded targets in FY 2025.

Tribes who provided data reported during FY 2025, for CHR-1 performance measure were 372,701 CHR patient contacts. This is a decrease of 82,716 patient contacts below the target measure of 455,417, representing a 19 percent decrease. Key health problem areas supported by CHRs included nutrition, diabetes, hypertension, injury control, cardiovascular disease, and other health-related areas.

Tribes who provided data during FY 2025 for the CHR-2 performance measure reported 158,338 CHR patient-reported contacts for visits to patients with chronic diseases. This equates to a decrease of 7,091 patient contacts below the target measure of 165,429, a 4 percent decrease.

Tribes who reported training data reported during FY 2025 for the CHR-3 performance measure were 1,244 CHRs trained. This comprised the following tracked benchmarks: IHS CHR E-learning platform reported a total of 304 CHRs trained in Basic/Advanced/Specialty training modules, and a total of 940 CHRs receiving training under the NPAIHB ECHO series reporting data to the IHS CHR program. This equates to a 200 percent increase above the target measure of 414.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2026 Target**	**FY 2027 Target**	**FY 2027 Target +/-FY 2026 Target**
CHR-1 Number of patient contacts (Output)	FY 2025: 372,701 patient contacts Target: 455,417 patient contacts (Target Not Met)	521,936 patient contacts	521,936 patient contacts	Maintain
CHR-2 CHR patient contacts for Chronic Disease Services (Output)	FY 2025: 158,333 patient contacts Target: 165,429 patient contacts (Target Not Met)	173,700 patient contacts	173,700 patient contacts	Maintain
CHR-3 Number of CHRs Trained (Output)	FY 2025: 1,244 CHRs Target: 414 CHRs (Target Exceeded)	600 CHRs	600 CHRs	Maintain

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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$2,183	$2,183	$2,294	+$111
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 2027 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 health care 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 2027 budget request for Alaska Immunization is $2.3 million, which is +$111,000 above the FY 2026 Enacted level.

FY 2027 funding increases include:

- Current Services: +$111,000 for Current Services. Information can be found in the Current Services chapter.

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
2023 Final	$2,183,000
2024 Final	$2,183,000
2025 Final	$2,183,000
2026 Enacted	$2,183,000
2027 President's Budget	$2,294,000

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 health care providers. Since 2014, over 1,500 American Indian/Alaska Native persons have been treated for HCV through the ATHS.

In FY 2025:

- Hepatitis A vaccination coverage did not achieve the target, and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 82.9 percent (90 percent target), and hepatitis B vaccination coverage was 92.7 percent (90 percent target).
- Overall, at least 83 percent of AI/ANs with either chronic hepatitis B (69 percent screened) or hepatitis C (92 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 to Tribal organizations for their electronic health record systems to enhance vaccine coverage. Vaccine coverage rates for Alaska Native patients were reported to the IHS National Immunization Program, including infants, adolescents, and health care 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 2025 immunization coverage rates, there were no significant coverage rate changes from FY 2024.

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 2025:

- Immunization Coverage for Alaska Natives age 19-35 months was 62.7 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 73.8 percent, the Healthy People 2030 vaccination objective IID-06 to increase the coverage level of 4-fold doses of DTaP vaccine by age two years.
  - One MMR in this age group was 86.3 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 83.3 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
  - Training on VacTrAK vaccine coverage reports

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

Immunization Measure	Age Group	Alaska Native coverage as of 9/30/2025	Alaska Native coverage as of 9/30/24
4:3:1:3*: 3:1:4	19-35 months	62.7%	63%
4:3:1: 3:3:1	19-35 months	70.5%	64%
3 Hib vaccines doses	19 – 35 months	83.3%	85%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	81.4%	84%
4 DTaP	19-35 months	73.8%	67%
1 MMR	19-35 months	86.3%	88%
1+ HPV	13-17 years female	72.5%	79%

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 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output) [1]	FY 2025: 584 Screened Target: 550 Screened (Target Exceeded)	Discontinued	Discontinued	N/A
AK-1b Chronic Hepatitis B Patients Screened/Targeted (Output)	N/A	75.0% Screened	75.0% Screened	Maintain
AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output) [2]	FY 2025: 1236 Screened Target: 1300 Screened (Target Not Met)	Discontinued	Discontinued	N/A
AK-2b Chronic Hepatitis C Patients Screened/Targeted (Output)	N/A	75.0% Screened	75.0% Screened	Maintain
AK-3 Other Liver Disease Patients Screened (Output) [3]	FY 2025: 392 Screened Target: 300 Screened (Target Exceeded)	Discontinued	Discontinued	N/A
AK-3b Other Liver Disease Patients Screened (Output)	N/A	75.0% Screened	75.0% Screened	Maintain
AK-4 Hepatitis A vaccination (Output) [4]	FY 2025: 82.9 % Target: 90.0 % (Target Not Met)	90.0 %	90.0 %	Maintain
AK-5 Hepatitis B vaccinations (Output) [5]	FY 2025: 92.7 % Target: 90.0 % (Target Exceeded)	90.0 %	90.0 %	Maintain

1 Hepatitis Program (Known Cases Screened) Sum of known hepatitis B cases FY 2025: 852. Decline in hepatitis B cases is due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations. Changed measure to percent screened to account for the decrease in population.

2 Hepatitis Program (Known Cases Screened) Sum of known hepatitis C cases FY 2025: 1,345. Known hepatitis C cases decreased by over 300 due to a successful treatment program and a change in guidelines under simplified treatment where post treatment sustained viral response to 4 weeks post-treatment instead of 12. Also, new case detection decreased by 30% per year over the past two years from its peak in 2019. Changed measure to percent screened to account for population fluctuations. Treated cases with cirrhosis are being followed indefinitely.

3 Hepatitis Program (Known Cases Screened) Sum of known other liver disease cases FY 2025: 523. Other liver disease includes AIH and PBC (361 cases), plus the addition of MASLD with MASH (162 cases). Changed measure to percent screened to account for population fluctuations.

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. The 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. The established target immunization rate for each vaccine is 90%.

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

GRANTS AWARDS -- The program does not award grants.

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

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$90,419	$95,419	$95,001	-$418
FTE /1, 2	9	9	9	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

The IHS administers limited, competitive contracts and grants with 41 501(c)(3) non-profit Urban Indian Organizations (UIOs) across 22 states and 11 IHS Areas. The UIOs define their scope of services based on the priorities of the community, health status, and unmet needs, and governed by a Board of Directors composed of at least 51 percent of Urban Indian people.

The UIOs are a part of the Indian health care system, supporting both Tribal and Urban Indian communities. Urban Indian people often face unique barriers to accessing health care, including poverty and culturally relevant health care services. The UIOs help bridge these gaps, providing essential support, care, and serving as cultural and community anchors for the Urban Indian population.

The UIOs are identified as one of five types of health care levels**:**

- 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 do not offer direct medical care.

- Residential and Outpatient Substance Abuse Treatment: Programs providing residential and outpatient substance abuse treatment, recovery, and prevention services.

BUDGET REQUEST

The FY 2027 budget submission for Urban Indian Health is $95.0 million, which is -$418,000 below FY 2026 Enacted level.

FY 2026 Enacted level Funding of $95.4 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.
- Implementing and utilizing advanced health information technology.
- Implementing IHCIA authorities specific to UIOs.

FY 2027 funding includes:

- Current Services: +$4.6 million for Current Services. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$90,419,000
2024 Final	$90,419,000
2025 Final	$90,419,000
2026 Enacted	$95,419,000
2027 President's Budget	$95,001,000

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 major Urban Indian Health focus areas and activities are:

- 4-in-1 Grant Program: 4-in-1 Grant Program: The DUIA grantees were awarded a five-year funding cycle from April 1, 2022 - March 31, 2027. In the FY 2025 budget cycle, 31 recipients received their base awards and 30 of them also received a non-recurring administrative supplement, for a combined total of $9.7 million. 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 Program Cooperative Agreement: The National Council of Urban Indian Health (NCUIH) was awarded a five-year funding cycle from June 1, 2022 – May 31, 2027. The DUIA awarded NCUIH in the FY 2025 budget cycle, a

Cooperative Agreement (non-competing continuous process) to for $1,350,000. 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 grant recipients and supports a national conference through its' training and technical assistance, education, public relations, and marketing project areas.

- Urban Indian Health Institute: In FY 2026, the DUIA awarded $155,000 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 DUIA 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 DUIA 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. Some UIOs are seeking or maintaining accreditation from several accreditation organizations such as the Joint Commission, Accreditation Association for Ambulatory Health care (AAAHC), and Commission on Accreditation of Rehabilitation Facilities. In FY 2025, through an IHS contract with AAAHC, the DUIA expanded slightly over $100,000, a modest increase from the previous year, and served 20 of 41 UIOs. Funding primarily supported accreditation surveys and application fees (63 percent), while also contributing to seminars, toolkits, and distribution of the amended v43.1 Handbook. Two UIOs, Native Americans for Community Action (Flagstaff, AZ) and Helena Indian Alliance (Helena, MT) achieved initial accreditation. Several others, including Texas Native Health, Sacramento Native American Health Center, and South Dakota Urban Indian Health, were reaccredited for three more years.

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, 2023, to September 30, 2024, the UIO FY 2024 GPRA cycle accomplishments included:

- 86 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);
- 64 percent of the UIOs (23 UIOs) have GPRA data available by facility via any reporting method (Integrated Data Collection System or Manual);
- 72 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;
- 2 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 DUIA published a new 2023-2027 DUIA Strategic Plan in June 2023[1]. Three Urban Confers and Tribal Consultations were held to receive recommendations. The new priorities in the 2023-2027 DUIA 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 2025, the DUIA allocated $250,000 towards the Urban Emergency Funds (UEF). The DUIA approved two UEF request for the Indian Health Center of Santa Clara Valley for $51,397 to address critical water and electrical damages at four of their sites, and the South Dakota Urban Indian Health in relation to an unanticipated HVAC failure at their Pierre, SD clinic.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome)	FY 2022: 67,801 Target: 70,000 (Target Not Met)	78,785	80,361	+1,576

GRANTS AWARDS - FY 2026 grant awards include the 4-in-1 Program and the Urban Indian Education and Research Program.

(whole dollars)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	32	35	35
Average Award	$345,558	$315,939	$315,939
Range of Awards	$214,492 - $1,350,000	$181,239 - $1,350,000	$181,239 - $1,350,000

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

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

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$80,568	$84,568	$81,801	-$2,767
FTE /1, 2	49	49	49	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 health care 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 2027 budget submission for Indian Health Professions of $81.8 million which is -$2.8 million below the FY 2026 Enacted level.

FY 2026 Enacted level of $84.6 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.

FY 2027 funding includes:

- Current Services: +$1.2 million for Current Services. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$80,568,000
2024 Final	$80,568,000
2025 Final	$80,568,000
2026 Enacted	$84,568,000
2027 President's Budget	$81,801,000

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 and current recipients; 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 continued development and management of 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 2025, 49 percent of scholars were placed within 90 days (target was 40 percent). Attaining higher success rates is 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 2025, a total of 1,970 health professionals were receiving IHS loan repayment. This included 698 new two-year contracts, 640 one-year extension contracts, and 632 health professionals starting the second year of their FY 2024 two-year contract. There were 28 "matched unfunded" applicants (including 2 physicians, 4 dentists, 1 pharmacist, 6 rehab, 5 behavioral health, 2 optometrists, 3 nurses, 2 dietitians, 1 ultrasonographer, and 2 chiropractors) and 483 "unmatched unfunded" health professionals (including 8 physicians, 79 behavioral health providers, 23 dentists, 6 optometrists, 68 pharmacists, 84 mid-level providers and 157 nurses and 58 others). The inability to fund these 511 health professional applicants is a significant challenge for the recruitment efforts of the agency. A more detailed breakout of loan repayment awards in FY 2025 by discipline is included in a table at the end of the narrative.

Scholarship Program (Sections 103 and 104): In FY 2025, there were 757 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 214 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 253 extension awards were funded for FY 2025. A detailed breakout of scholarships awarded by discipline for FY 2025 is included in a table at the end of the narrative.

Extern Program (Section 105): In summer 2025, the Extern Program funded a total of 11 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 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome)	FY 2025: 49.0 % Target: 40.0% (Target Exceeded)	40.0%	40.0%	Maintain
IHP-1 Number of scholarship awards under section 103 (Output)	FY 2025: 146 Awards Target: 103 Awards (Target Exceeded)	105 Awards	110 Awards	+5 Awards
IHP-2 Number of scholarship awards under section 104 (Output)	FY 2025: 321 Awards Target: 253 Awards (Target Exceeded)	255 Awards	260 Awards	+5 Awards
IHP-3 Number of externs under section 105 (Output)	FY 2025: 11 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 2025: 698 contracts Target: 580 contracts (Target Exceeded)	580 contracts	610 contracts	+30 contracts
IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output)	FY 2025: 640 Awards Target: 600 Awards (Target Exceeded))	600 Awards	620 Awards	+20 Awards
IHP-6 Total number of new awards funded in previous fiscal year under section 108 (Outcome)	FY 2025: 632 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 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
American Indians Into Nursing Program (Section 112) – CFDA No. 93.970			
Number of Awards	5	5	5
Average Award	$350,493	$350,493	$350,493
Range of Awards	$320,000 - $396,925	$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	$365,276	$365,276	$365,276
Range of Awards	$206,304 - $700,000	$206,304 - $700,000	$206,304 - $700,000
American Indians Into Psychology Program (Section 217) – CFDA No. 93.970			
Number of Awards	4	4	4
Average Award	$201,483	$201,483	$201,483
Range of Awards	$201,483	$201,483	$201,483

Scholarship Program Awards –For FY 2025, 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 –120 students				
Pre-Dentistry	22			
Pre-Medicine	71			
Pre-Pharmacy	6			
Pre-Physical Therapy	14			
Pre-Physician's Assistant	7			
Section 104 Health Professions – 321 students				
Associate Degree in Nursing	11		Nurse, Bachelor's	59
Clinical Lab Science	3		Occupational Therapy	1
Clinical Psychology	7		Optometry	16
Dental Hygiene	0		Pharmacy	27
Dentistry	36		Physical Therapy	17
Diagnostic Radiology, Associate's	2		Physician Assistant	29
Diagnostic Radiology, Bachelor's	0		Physician, Allopathic	24
Engineering (Civil/Environmental)	4		Physician, Osteopathic	28
Environmental Health	2		Podiatry	1

Mental Health	9		Social Work	19
Nurse Anesthetist	4			
Nurse Midwife	0			
Nurse Practitioner	22			

Loan Repayment Program Awards – In FY 2025, the IHS LRP made awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Behavioral Health	61	44	17	5
Dental*	110	53	57	4
Nurse	321	258	63	0
Optometrists	49	8	41	2
Pharmacists	237	95	142	1
Physician Assistants/ Advanced Practice Nurses	176	81	95	3
Physicians	121	41	80	2
Podiatrists	22	3	19	0
Rehabilitative Services	148	65	83	6
Other Professions	93	50	43	5
TOTAL	**1338**	**698**	**640**	**28**

* Includes Dentists and Dental Hygienists.
**Awards are through July award cycle.

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Acupuncturist	5	0	Tribal Employee	943
Chiropractors	16	2	Civil Service	304
Dietetics/Nutrition	34	2	Commissioned Corps	44
Engineering	5	0	Urban Health Employees	47
Medical Laboratory Scientist	7	0		
Medical Technology	2	0		
Radiology Technicians	15	1		
Sanitarian	4	0		
Respiratory Therapists	5	0		
TOTAL	**93**	**5**	**Total**	**1338**

Extern Program Awards – In summer 2025, the IHS Extern Program had a total of 11 student externs.

AREA OFFICES	NUMBER OF STUDENT EXTERNS
Billings	3
Great Plains	3
Navajo	4
Oklahoma City	1

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

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$2,986	$2,986	$3,022	+$36
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 2027 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 2027 budget submission for Tribal Management Grants of $3.0 million which is $36,000 above the FY 2026 Enacted level.

FY 2027 funding increases include:

- Current Services: +$36,000 for Current Services. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$2,986,000
2024 Final	$2,986,000
2025 Final	$2,986,000
2026 Enacted	$2,986,000
2027 President's Budget	$3,022,000

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.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
TMG-1 Planning Grants (Output)	FY 2025: 2 planning grants Target: 4 planning grants (Target Not Met)	4 planning grants	4 planning grants	Maintain
TMG-2 Health Management Structure (HMS) grants (Output)	FY 2025: 14 HMS grants Target: 12 HMS grants (Target Exceeded)	12 HMS grants	12 HMS grants	Maintain

GRANTS AWARDS

(whole dollars)	FY 2025 Final /1	FY 2026 Enacted /2	FY 2027 President's Budget /3
Number of Awards	28 Total Awards: 10 Noncompeting Continuations and 18 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 2025 is an estimate will update when awarded.
[2] FY 2026 is an estimate will update when awarded.
[3] FY 2027 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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$103,805	$103,805	$106,620	+$2,815
FTE /1, 2	282	282	282	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 AI/ANs. 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 4 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 health care 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 2027 budget submission for Direct Operations of $106.6 million is +$2.8 million above the FY 2026 Enacted level.

FY 2026 Enacted level 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 Purchased/Referred Care 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.

FY 2027 funding increases include:

- Current Services: +$2.8 million for Current Services. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$103,805,000
2024 Final	$103,805,000
2025 Final	$103,805,000
2026 Enacted	$103,805,000
2027 President's Budget	$106,620,000

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. The agency's goal is to create a more accountable and responsive agency that maximizes resources, enhances coordination, and delivers the highest possible level of care—while continuing to honor and strengthen our government-to-government relationships with Tribal Nations and Urban Indian Organizations.

Office of Human Resources

In FY 2025, the IHS focused on improving human resource services through the implementation of human resource (HR) specific development opportunities and initiatives. One example of this organizational improvement includes the development and execution of a HR trainee program. This program successfully recruited specialized adult educators as training staff to carry-out a comprehensive junior HR training program for newly hired junior HR specialists. Nearly 600 applications were received for this opportunity which ultimately resulted in hiring over 30 Native American junior HR specialists. This trainee program curriculum was administered over a year providing the junior HR specialists with a dedicated opportunity to learn the full spectrum of HR functions and services. The specialized HR trainer/educators also launched an enterprise-wide new employee orientation as well as supervisory training to augment local learning opportunities. Both of these HR initiatives resulted in positive feedback and continue to be offered year-round.

Office of Quality

In FY 2025, the IHS made organizational changes within the Office of Quality (OQ) to meet the needs of the Agency and ensure high-quality, safe patient care. The aim of the reorganization was to support a consistent reporting structure and clarify functional responsibilities within each of the four new divisions, enabling the Agency to meet its quality needs by utilizing a high-reliability framework that strengthened the oversight of internal controls and enhanced the quality and safety within IHS. The Office of Quality (OQ*) i*mplemented the IHS Credentialing and Privileging Policy and maintained updates to the IHS Credentialing Standard Operating Procedure Manual to strengthen and improve credentialing practices, developed the IHS Safety Tracking and Response (I-STAR) Policy and Standard Operating Procedure Manual to support Agency-wide event reporting and conducted and completed all design, testing, and reporting requirements for the A-123 Audit.

The Office of Quality Division of Compliance leads key components of the Agency's Enterprise Risk Management (ERM) efforts and implementation of the Federal Managers Financial Integrity Act (FMFIA) and identifies, assesses, analyzes, mitigates, and monitors mission-critical risk areas and forecasts their impact on IHS. The Division of Compliance developed and implemented new procedures for completing A-123 audits without contractor support, implemented a new action plan template to improve Agency responses to GAO and OIG findings, increased program office accountability and responsibility for identifying and addressing root causes and closed 62 percent of open GAO and OIG recommendations.

The Office of Quality Division of Enterprise Risk Management is home to the IHS Quality Assurance Risk Management Committee (QARMC). QARMC serves as a key component of the

IHS Enterprise Risk Management (ERM) governance structure and provides senior-level oversight and management of complex adverse patient safety events and administrative matters, including fraud, waste, abuse, and employee misconduct, within IHS-operated hospitals and clinics. It also conducts Agency-wide clinical and administrative risk management to identify systemic improvements needed to enhance the quality of health care services and ensure enterprise-wide accountability and effectiveness of internal and external reporting systems, management responses, and timely corrective actions. A key IHS QARMC accomplishment for FY 2025 includes updating the QARMC charter, procedures document, and closure form to support uniform reporting across all IHS Area Offices and Headquarters Offices.

The Office of Quality Division of Quality Assurance and Patient Safety aims to ensure the quality of care in IHS facilities through external accreditation and certification support by managing the coordination of ongoing accreditation compliance efforts. The Division of Quality Assurance and Patient Safety ensured that all IHS hospitals and Critical Access Hospitals (CAH) met Centers for Medicare and Medicaid Services (CMS) Conditions of Participation. In addition, 21 out of 22 maintained Joint Commission (JC) accreditation, and all eligible ambulatory health centers were accredited by JC or Accreditation Association for Ambulatory Health Care (AAAHC). During FY 2025 IHS facilities successfully completed 40 accreditation surveys conducted by JC, AAAHC, and CMS. Additionally, all 31 ambulatory facilities and 22 hospitals/CAHs maintained their ongoing Patient Care Medical Home (PCMH) designation and over 1500 staff participated in IHS wide Tracers Office Hours, in person and virtual trainings for ongoing accreditation readiness. Since FY 2024, utilization of the Tracers with AMP® tool has doubled to over 16,000 actions per month at the end of FY 2025.

The HQ Credentialing Program (CP) strengthened oversight through comprehensive monitoring of credentialing policy and standard operating procedures (SOP) compliance, achieving an average turnaround time of 24 days—well below the national average and resulted in closing two of the three credentialing recommendations for the GAO. Weekly monitoring and reporting eliminated expired appointments and privileges and significantly reduced expired credentials over one year. The program also implemented a standardized audit process, reducing audit issues from 53 to 1, and enhanced records management through new processes, training, and an innovative batch-update method that saved staff time and ensured compliance, including the disposal or preparation for disposal of 12,743 provider profiles. CP also enhanced systemwide capability by developing an IHS-specific credentialing and privileging training program and delivered three in-person credentialing & privileging training sessions to four IHS Areas, along with a provider-focused training in Albuquerque.

The I-STAR policy was finalized and the program was fully implemented Agency-wide to report adverse events and good catches and is continuously monitored and optimized. Since its launch in 2020, all IHS Areas and numerous federal and Tribal facilities have reported events. In FY 2025, 164 federal and tribal facilities entered 26,552 events, including 12,011 medication good catches. The program also oversees system administration, user training, and education; developed job aids covering 26 safety measures; expanded the formulary; and provided regular reporting to IHS leadership.

The Patient Safety Program advanced the Total System Safety (TSS) strategy, strengthening patient and workforce safety across IHS. By year-end, 45 percent of TSS action items were complete and 35 percent in progress. The program improved the I-STAR adverse event system, reducing overdue high-risk events by 98 percent, 94 percent reduction in aging overdue events and decreased cycle time from 204 to 38 days. Safety training expanded through partnerships with the VHA (306 staff trained) and RCA2 training for 187 staff. Initiatives like the Inpatient

Fall Prevention Change Package reduced falls by 21 percent. TSS was embedded in the IHS 2025–2029 Strategic Plan to ensure sustained focus on safety.

The Environment of Care and Life Safety (EC/LS) program closed 5 of 12 priority recommendations from the 2023 leadership governance request and the Infection Control and Prevention (ICP) Program strengthened system-wide infection prevention across IHS by delivering more than 18 targeted training sessions, site visits, and strategic guidance to Areas and Service Units, in close collaboration with federal partners like the Centers for Disease Control (CDC). The ICP Subcommittee launched working groups on Sterile Processing and High-Level Disinfection to create toolkits and resources enhancing safety, standardization, and quality of care. CDC partnerships supported on-site training, ICAR assessments at four facilities, and guidance on water quality and high-risk areas.

Office of Management Services

In FY 2025, the IHS Office of Management Services (OMS) advanced agency-wide strategic goals and Presidential priorities. The Division of Administrative and Emergency Services (DAES) achieved full OMB M-25-25 compliance in three days, completed a three-phase return-to-office transition, modernized emergency preparedness functions, and secured CPIC approval for onboarding modernization. DAES also reduced federal office space in Frederick, MD by nearly 80 percent and strengthened cross-agency partnerships, directly contributing to the President's Management Agenda.

The OMS Division of Acquisition Policy (DAP) led critical reforms that improved acquisition governance and workforce readiness. DAP issued standardized policies that reduced acquisition cycle times and risk exposure, conducted two contracting summits, reviewed over 5,000 contracts for cost savings and improvement performance oversight, and delivered 720 under-budget training slots that enhanced competencies for over 200 professionals. The OMS Division of Grants Management (DGM) issued nine policy guidance documents, conducted 25 trainings, recovered $29 million from closed grants, and processed $272 million in awards. The OMS Division of Regulatory and Policy Coordination (DRPC) finalized 39 directives, doubled output from the prior year, and delivered weekly regulatory reports aligned with Executive Order 14192, "Unleashing Prosperity Through Deregulation." The OMS Division of Asset Management (DAM) enhanced executive accountability by enforcing property and fleet compliance across Area Offices.

Contract Dispute Acts (CDA) Claims

In FY 2025, the Office of Finance and Accounting's Contract Support Costs (CSC) Contract Dispute Acts (CDA) Claims team began settling CSC claims related to the Supreme Court decision on *Becerra v. San Carlos Apache Tribe* for program income expenditures. This milestone was made possible following the completion of a mandatory Tribal Consultation and agreement with tribes and tribal organizations, and the issuance of a Dear Tribal Leader Letter on December 20, 2024[1], which provided guidance on CSC calculations for third-party reimbursements. During FY 2025, the team developed and tested standardized analysis templates and procedures to ensure consistency in reviewing the 721 claims submitted. By the end of FY 2025, 53 CSC CDA claims received from 2011-2025 totaling $231.4 million had been closed or settled.

[1] Final Decision on Becerra and CSC (https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2024_Letters/DTLL_12202024.pdf)

Purchased/Referred Care
FTEs for PRC are funded through Direct Operations.

The IHS implemented strategic spending plans to reduce Purchased/Referred Care (PRC) unobligated balances, resulting in a 31percent reduction from $378 million in FY 2023 to $259 million in FY 2024. Continued monitoring and execution of these plans in FY 2025 are expected to further lower carryover to $150–$200 million, or approximately 18 percent of appropriations.

In calendar year 2024, IHS fully implemented new PRC medical priorities and conducted agency-wide and Tribal trainings to support implementation. Currently, 98 percent of Federal facilities fund priority level 1 and 2 referrals and cover some or all priority level 3 referrals, expanding access to preventive care, additional medical, dental, and vision services, and durable medical equipment previously unavailable through PRC.

The IHS collaborated with its Fiscal Intermediary to strengthen authorization and payment processes, leading to a 50 percent reduction in pending claims between December 2023 and January 2025. As a result, 98 percent of "clean" claims are now paid within 30 days, and the FI processed 405,796 claims in FY 2024.

The IHS updated referral language to incorporate the Indian Health Care Improvement Act's No Patient Liability provisions and applied the same language to FI and vendor communications. These actions build on ongoing efforts to improve payment processes, support patients facing improper billing or collection practices, and collaborate with HHS Office of the General Counsel to issue cease-and-desist letters to debt collectors.

The Office of Public Health Services (OPHS) Performance
During CY 2025, the IHS supported agency-wide leadership, performance, and data initiatives. This included coordinating the Presidential Transition response through weekly reporting on implementation of Executive Orders and Memoranda, finalizing FY 2024 National and Area Government Performance and Results Act (GPRA) results, and integrating those outcomes with FY 2026 targets into the FY 2026 Congressional Justification materials. The Agency also supported national performance planning, HHS and OMB reporting cycles for FY 2026–FY 2027, and the development of Agency Priority Goals, while updating the FY 2025–2029 IHS Strategic Plan to align with revised Executive Order language.

In addition, the IHS advanced data governance, budget, and reporting efforts by developing administrative memoranda to support budget formulation and funding formulas, responding to numerous FOIA requests, and coordinating Contract Support Costs analyses to validate beneficiary categories and Area-level results. Key data initiatives included drafting a data use agreement (DUA) with the Veterans Health Administration to identify AI/AN veterans served by IHS with anticipated finalization in March 2026, delivering the complete five-year New Mexico Tumor Registry dataset to strengthen cancer surveillance, and producing a Life Expectancy Report covering 2018–2020.

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

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$6,174	$6,174	$6,296	+$122
FTE /1, 2	14	14	14	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 AI/AN Tribes in the IHS TSGP and expand access to health care 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.
- Assists with the coordination of self-governance Tribal Delegation Meetings for IHS Headquarters and Area Senior officials.

BUDGET REQUEST

The FY 2027 budget submission for Self-Governance is $6.3 million, which is +$122,000 above the FY 2026 Enacted level.

FY 2026 Enacted level Funding of $6.2 million: The base funding supports further implementation of the IHS TSGP, continues funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS TSGP, and continues to fund outreach and education projects and Tribal share needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS TSGP**.**

FY 2027 funding increases include:

- Current Services: +$122,000 for Current Services. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$6,174,000
2024 Final	$6,174,000
2025 Final	$6,174,000
2026 Enacted	$6,174,000
2027 President's Budget	$6,296,000

TRIBAL SHARES

Program funds are not subject to Tribal shares. However, a 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 2025, IHS transferred approximately $3.2 billion of the total IHS budget appropriation to Tribes and Tribal Organizations to support 120 ISDEAA self-governance compacts and 147 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 2025, the Office of Tribal Self-Governance Funds Management (OTSGFM) System successfully interfaced with the Unified Financial Management System (UFMS). The interfacing of these two systems continues to

[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.

significantly decrease reporting variances and has made it easier to reconcile the two systems on a monthly basis. In FY 2026, the goal is to improve the OTSGFM process coordination across the IHS Areas and Program Offices 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 2025 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 AI/AN 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 2025, 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 2025, the IHS implemented a recurring training to support staff development and knowledge sharing of ISDEAA topics. These trainings improved staff engagement and learning opportunities. Activities in FY 2026 will focus on continued education and promote collaboration.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
TOHP-SP Implement recommendations from Tribes annually to improve the Tribal consultation process and IHS operations. (Output)	FY 2025: 5 recommendations Target: 5 recommendations (Target Met)	5 recommendations	5 recommendations	Maintain

GRANT AWARDS

(whole dollars)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Planning Cooperative Agreements			
Number of Awards	3	3	3
Award Amount	$180,000	$180,000	$180,000
Negotiation Cooperative Agreements			
Number of Awards	2	3	3
Award Amount	$84,000	$84,000	$84,000

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

(Dollars in Thousands)

	FY 2025	FY 2026 /3	FY 2027 /3	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
Medicare	$288,564	$299,754	$311,445	+$22,881
Medicaid	$1,255,550	$1,325,131	$1,376,811	+$121,261
M/M Total	**$1,544,114**	**$1,624,885**	**$1,688,256**	**+$144,142**
Private Insurance	$247,662	$250,518	$260,288	+$12,626
VA Reimbursements	$8,166	$9,670	$10,048	+$1,882
Total	**$1,799,942**	**$1,885,073**	**$1,958,592**	**+$158,650**
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 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. These estimates are subject to change.
3/ FY 2026 Projections are actual collections data for October 2026 to November 2026; 10 months are an average based on final FY 2025 collections and multiplied by Medical Inflation Rate of 3.9%. FY 2027 Projections are identical to FY 2026 projections and multiplied by Medical Inflation Rate 3.9%.

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 War 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 AI/AN people. Some IHS health care facilities report that 60 percent of their yearly budget relies on revenue collected from third-party payers.

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 the Centers for Medicaid and Medicare Services (CMS) on potential impacts to IHS, Tribal, and Urban Indian Organizations (I/T/U). After they are published for public review, IHS discusses the potential impacts on health care collections with Tribal government representatives and urban Indian health care programs.

Training - IHS provides training to IHS, Tribal, and Urban Indian Organization (I/T/U) health care facility staff in areas related to all functions within the health care 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

Health Information Technology Modernization Efforts – The IHS continued its efforts to modernize the Electronic Health Record. In FY 2025, IHS experts built a "model" program that will work across all impacted Hospitals/Clinics to sustain an IHS revenue cycle that is financially, statistically, legally, and clinically sound. Development, testing and change management continue to be the highest priority to ensure a seamless transition to this new system. In FY 2026, revenue cycle subject matter experts will continue participating in this development with the hope of accomplishing deployment at an IHS pilot site by the end of 2026.

- *Meetings, Workgroups, and Training* - In FY 2025, hour-long training sessions were held virtually including a webinar series that focused on various aspects of the Revenue Cycle to support efforts to strengthen revenue cycle operations and support staff development. IHS continued to plan for training that will continue into FY 2026. Plans include a virtual lunchtime learning series that presents Revenue Cycle Topics monthly.

Monitoring - ORAP in partnership with revenue cycle impacted departments updated the Third-Party Internal Controls Tool for IHS facilities to report on financial operations, ensure compliance with applicable laws, regulations, and Government-wide financial management requirements and standards as they relate to third-party revenue.

Outreach, Education, and Enrollment – In FY 2025, 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. health care

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 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. In FY 2025, the IHS collaborated with the Veterans Health Administration to revise, update, train, and deploy an updated VA Provider Guide.

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 respond timely.

Pharmacy Billing and Collections – In FY 2025, the IHS continued to focus on improving pharmacy reimbursement including collaborating with CMS on updating the Medicare Part D I/T/U Addendum. In FY 2025, IHS conducted a collection analysis that showed that pharmacy reimbursements can represent anywhere from 40 percent to 55 percent or more of total Third-Party Revenue to a Service Unit.

Enrollment Trends Monitoring – In FY 2025, IHS continued to engage in significant planning and outreach, and data analysis related to enrollment trends monitoring and the impacts of changing Medicaid Eligibility. Activities have focused on providing resources that prepare staff to assist patients with maintaining health coverage or seeking alternate coverage if they are no longer eligible for Medicaid such as through the Health Insurance Marketplace.

Regulation Review – In FY 2025, IHS participated in over 100rounds of clearance of HHS regulations and policy proposals. IHS continues to review new proposals for impacts on the Indian health system including reimbursement for health care services, as they are introduced and provide feedback to the proposing agencies.

FY 2026 - 2027 Collections Estimates

The FY 2025 amounts in the table above are actual collections. The projected collections for FY 2026 are estimated on actual collections FY 2026 (October and November 2025), and the average from FY 2025 actual collections multiplied for the remaining 10 months and multiplied by the medical inflation rate of 3.9 percent. The FY 2027 projections use the actual and projected calculations from FY 2026 and are multiplied by 3.9 percent.

***Medicare and Medicaid (M&M)* -- The FY 2026 Budget estimate assumes collections of $1.62 billion, $80.7 million above FY 2025 collections. The FY 2027 Budget estimate assumes collections of $1.68 billion, $63.3 million above FY 2026 collections:**

- ***Medicaid* – The FY 2026 budget estimate assumes collections of $1.32 billion, $69.5 million above FY 2025 collections. The FY 2027 budget estimates collections of $1.37 billion, $51.6 million above FY 2026 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.

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

- *Medicare* – **The FY 2026 budget estimate assumes collections of $299.7 million, $11.1 million above FY 2025 collections. The FY 2027 budget estimate assumes collections of $311.4 million, $11.6 million above FY 2026 collections.** IHS hospitals and clinics continue efforts 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 $250.5 million, $2.8 million above FY 2025 collections. The FY 2027 budget estimate assumes collections of $260.2 million, $9.7 million above FY 2026 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 $8.1 million, $1.5 million above FY 2025 collections. T**he 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 health care services to AI/AN Veterans.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Facilities

Page

Summary of the Request
Facilities Summary 124
Maintenance & Improvement 127
Sanitation Facilities Construction 130
Health Care Facilities Construction 134
Facilities & Environmental Health Support
  Facilities Support 138
  Environmental Health Support 139
  Office of Environmental Health & Engineering Support 141
Equipment 145
Quarters 148

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

FACILITIES

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
BA	$800,080	$809,222	$742,021	-$67,201
FTE /1, 2	1,064	1,064	1,087	+23

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 health care facilities and in the AI/AN communities across Indian country.

BUDGET REQUEST

The FY 2027 budget submission for Facilities is $742.0 million and is -$67.2 million below the FY 2026 Enacted level.

Maintenance & Improvement – The FY 2027 budget submission for Maintenance and Improvement is $173.4 million, which is +$2.8 million above the FY 2026 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 2027 budget submission for Sanitation Facilities Construction is $14.0 million, which is -$93.9 million below the FY 2026 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 unobligated balances from the FY 2026 Infrastructure Investment and Jobs Act (IIJA) (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 2027 budget submission for Health Care Facilities Construction is $190.5 million, which is +$5.8 million above the FY 2026 Enacted level.

This funding level for the construction of new and replacement health care facilities will allow IHS to continue the following projects:

- Albuquerque West Health Center, Albuquerque, NM
- Albuquerque Central Health Center, Albuquerque, NM
- Small Ambulatory
- New and Replacement Staff Quarters
- Area Master Plans
- Infrastructure Projects

Facilities and Environmental Health Support (FEHS) – The FY 2027 budget submission for Facilities and Environmental Health Support is $330.4 million, which is +$19.0 million above the FY 2026 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 2027 budget submission for Equipment is $33.7 million, which is -$865,000 below the FY 2026 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 equipment in tribally-constructed health care facilities; and
- TRANSAM, a program under which IHS acquires and distributes surplus medical equipment from Department of War or other federal agencies.
- Tribal Emergency Generator program to provide backup electrical power for unexpected electrical utility shutdowns during wildfire or other events that cause the local utility provider to deenergize the local system.

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

MAINTENANCE AND IMPROVEMENT

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$170,595	$170,595	$173,413	+$2,818
FTE /1, 2	--	--	--	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 health care 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 2025 BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2025, 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 health care 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 three categories: routine maintenance, M&I projects and environmental compliance:

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.

BUDGET REQUEST

The FY 2027 budget submission for Maintenance & Improvement of $173.4 million, which is +$2.8 million above the FY 2026 Enacted level.

The FY 2027 budget request supports maintenance, repair, and improvements for existing IHS and Tribal facilities.

[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*

FY 2027 funding increase includes:

- Current Services: +$2.8 million for Current Services. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$170,595,000
2024 Final	$170,595,000
2025 Final	$170,595,000
2026 Enacted	$170,595,000
2027 President's Budget	$173,413,000

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 health care 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 health care buildings improves the ease and access to care, facilitates successful behavioral health services, and enables the hiring and retention of health care 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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$106,627	$107,943	$13,998	-$93,945
FTE /1, 2	116	116	116	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 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 2027 budget submission for Sanitation Facilities Construction of $14.0 million is -$93.9 million below the FY 2026 Enacted level. The budget prioritizes maintaining funding for direct health care services. The remaining funding will be allocated to support the implementation of the unobligated balances from the 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
2023 Final	$196,167,000
2024 Final	$123,650,000
2025 Final	$106,627,000
2026 Enacted	$107,943,000
2027 President's Budget	$13,998,000

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 2025, IHS funded projects to provide service to 28,624 AI/AN homes. IHS also completed construction on 367 projects with an average project duration of 4.3 years. However, at the end of FY 2025, about 1.2 percent of all AI/AN homes tracked by IHS, lacked water supply or wastewater disposal facilities; and, about 112,823 or approximately 30 percent of AI/AN homes

[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.

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 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 decreased approximately $0.6 billion from $5.9 billion to $5.3 billion from FY 2024 to FY 2025. In FY 2025, the IHS was appropriated $761.1 million (FY 2025 appropriations of $85.6 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 decrease in FY 2025 was not proportional to the level of funds provided. The reasons for this outcome are 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 2025, 229 construction projects to address water supply and wastewater disposal needs were funded with a construction cost of $500.9 million using IHS and contributed funds. Once constructed, these sanitation facilities will benefit an estimated 26,481 AI/AN homes and help avoid over 138,351 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 $243 million. Every $1 spent on water and sewer infrastructure will save $0.49 in avoided direct health care 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 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
35 Number of new or like-new and existing AI/AN homes provided with sanitation facilities. (Outcome) [1]	FY 2025: 28,624 Target: 49,000 (Target Not Met but Improved)	5,000	1,500	-3,500
SFC-E Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. (Outcome)	FY 2025: 4.3 yrs Target: 4.5 yrs (Target Exceeded)	4.0 yrs	4.0 yrs	Maintain

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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$182,679	$184,679	$190,508	+$5,829
FTE /1, 2	--	--	--	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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, AI/ANs. 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 $6.4 billion as of December 2025. 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.

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

[1] https://www.ihs.gov/newsroom/reportstocongress/

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 health care 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 complement IHS programs and how the HCFC programs are implemented.

BUDGET REQUEST

The FY 2027 budget submission for Health Care Facilities Construction of $190.5 million, which is +$5.8 million above the FY 2026 Enacted level.

FY 2027 funding increases include:

- Health Care Facilities Construction: +$5.0 million to support the remaining projects on the 1993 IHS Health Care Facilities Construction Priority List. These health care facilities will improve access to direct health care services.

- Current Services: +$2.8 million for Current Services. Information can be found in the Current Services chapter.

The total $190.5 million requested for FY 2027 would support:

Albuquerque West Health Center, Albuquerque, NM $125.008 million
These funds will be used for construction of the health center located in central Albuquerque, NM. The Health Center will serve a projected user population of 14,740 generating 61,239 primary care provider visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.

Albuquerque Central Health Center, Albuquerque, NM $25.0 million
These funds will be used for design of the health center located in central Albuquerque, NM. The Health Center will serve a projected user population of 14,126 generating 59,300 primary care provider 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 AI/AN 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 $10.0 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 health care 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 health care 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 health care practices and infrastructure standards.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$260,896,000
2024 Final	$182,679,000
2025 Final	$182,679,000
2026 Enacted	$184,679,000
2027 President's Budget	$190,508,000

PROGRAM ACCOMPLISHMENTS

Each health care 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 2025 appropriation contributed to the Whiteriver Hospital, Whiteriver, AZ; and the Echo Cliffs Health Center, Bodaway Gap Chapter of the Navajo Nation, AZ projects.

The FY 2025 appropriation also contributed $25.0 million to the IHS SAP, $12.7 million to the Staff Quarters Program and $5.0 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 $1.0 billion dollars in capital expenses[2] since its inception. In FY 2025, the IHS has entered into partnerships with seven Tribes to complete the proposed outpatient facilities.

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 health care 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 2026 Target	FY 2027 Target	FY 2027 Target +/- FY 2026 Target[2]
36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome)	FY 2025: 0 project(s) Target: 0 project(s) (Target Met)	1 project(s)[1]	1 project(s)	Maintain
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 2025 0 project(s) Target: 0 project(s) [2] (Target Met)	1 project(s)[1]	1 project(s)[3]	Maintain

1. In FY 2026, the IHS HCFC Target is one (1) Echo Cliffs Health Center in Bodaway Gap Chapter, AZ.
2. In FY 2025, the IHS HCFC program had two (2) projects in planning, five (5) in design, and one (1) in construction. The FY 2025 target is listed as zero (0), as no projects were completed during the FY.
3. In FY 2027, the IHS HCFC Target is one (1) Alamo Health Center, Alamo Navajo, NM.

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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$307,581	$311,407	$330,369	+$18,962
FTE /1, 2	946	946	969	23

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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 Offices, 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, health care patient satisfaction, changing health care delivery standards, building codes, old building equipment/system, and medical devices/equipment plus telemedicine used by health care 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, health care 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 technical assistance, training, and the Tribal Injury Prevention Cooperative Agreement Program

[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

(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 2027 budget submission for Facilities and Environmental Health Support of $330.4 million, which is +$19.0 million above the FY 2026 Enacted level.

FY 2026 Enacted level Funding of $311.4 million – Supports Facilities and Environmental Health Support for existing IHS and Tribal facilities.

FY 2027 funding increase includes:

Current Services and Staffing of Newly Constructed Facilities: +$10.1 million for Current Services and +$8.3 million for Staffing of Newly Constructed Facilities. Information can be found in the Current Services and Staffing of Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$298,297,000
2024 Final	$303,661,000
2025 Final	$307,581,000
2026 Enacted	$311,407,000
2027 President's Budget	$330,369,000

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 health care sites to prevent, prepare for, and respond to medical services.

In FY 2025, total utility costs were $14.7 million and total utility costs per Gross Square Feet (GSF) were $3.58/GSF. In FY 2026, the total utility cost is expected to be $15.0 million reflecting an annual increase of 2.5 percent. The cost per GSF is expected to increase with inflation to approximately $3.65/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.

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 2025, DEHS continued 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 health care 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 the program, as well as developing options to increase internal capacity within the tribal programs served. In addition, the IHS is engaging with credentialing entities to identify ways to offset certification related costs for small, disadvantaged businesses and those with high employee turnover.

From 1997-2025, the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP) funded 111 Tribal injury prevention programs and provided $46.0 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 health care 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 health care 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 2.65 injuries & illnesses/100 employees in 2025. In addition, the IEH program supports health care 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 AI/ANs. 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 26,481 AI/AN homes and completed construction on over 367 sanitation projects passing final inspection in FY 2025. 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 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
EHS-5 Number of persons who received injury prevention training (Output)	FY 2025: 365 trained Target: 473 trained (Target Not Met)	450 trained[2]	450 trained	Maintain
EHS-6 Percent of food establishments with Certified Food Protection Manager (CFPM) (Output)	FY 2025: 77.2% Target: 80.0%[1] (Target Not Met)	75.0%[3]	75.0%	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.
[2] The FY 2026 Target is revised from 473 to 450 trained.
[3] The FY 2026 Target is revised from 80.0% to 75.0%.
The FY 2026 target changes coincide with a new five-year cycle and are based on review of prior cohort results.

GRANT AWARDS

In FY 2025, the TIPCAP 2021-2025 five-year funding cycle entered its fifth 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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$32,598	$34,598	$33,733	-$865
FTE /1, 2	2	2	2	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. 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 2027 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.

Equipment Funds Allocation Method

In consultation with Tribes and the Federal health care 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 2025, 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 2025 funds supported $5.0 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 War (DOW) or other sources through the TRANSAM (i.e., Transfer of DOW Excess Medical and Other Supplies to Native Americans) Program and to procure ambulances for IHS and Tribal emergency medical services programs.[1] FY 2025 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 $5.0 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 2025 funds support $3.0 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 2027 budget submission for Equipment of $33.7 million, which is -$865,000 below the FY 2026 Enacted level.

The FY 2027 budget request will continue to support the maintenance and purchase of equipment for existing IHS and Tribal facilities.

FY 2027 funding includes:

- Current Services: +$1.1 million for Current Services. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$32,598,000
2024 Final	$32,598,000
2025 Final	$32,598,000
2026 Enacted	$34,598,000
2027 President's Budget	$33,733,000

[1] The IHS Facilities appropriation allocates $500,000 of Equipment funding for the TRANSAM Program.

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 health care site.

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 health care 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 AI/AN 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 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$11,276	$13,500	$13,500	--
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 2027 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 health care 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 2027 budget submission for Staff Quarters of $13.5 million, which is flat with the FY 2026 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 2026, the CPI adjustment is +3.4 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
2023 Final	$10,093,959
2024 Final	$9,777,119
2025 Final	$11,276,054
2026 Enacted	$13,500,000
2027 President's Budget	$13,500,000

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 health care professionals at IHS and Tribal health care 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Contract Support Costs

Page

Contract Support Costs 150

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Contract Support Costs: 75-0344-0-1-551
CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2025	FY 2026	FY 2027	
	Final/2	Enacted /3	President's Budget	FY 2027 +/- FY 2026
PL	$1,151,000	$1,708,0000	$1,958,491	+$250,491
FTE /1	--	--	--	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ The FY 2025 levels reflect actuals.
3/ The FY 2026 levels reflect the Administration's scores. The FY 2026 Congressional Budget Office (CBO) score for CSC is $1.8 billion with Leases at $366 million. Using the CBO scores, the FY 2026 BA totals to $8.0 billion and the P.L. totals to $8.2 billion.

Authorizing Legislation ..... 25 U.S.C. §§ 450 et seq., Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended

FY 2027Authorization.....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. This includes updates from the October 2016 policy revisions[1]. 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.

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

[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.

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 2027 budget submission for Contract Support Costs of $1.958 billion is an increase in score of +$139.5 million above the FY 2026 Enacted level. 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.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$969,000,000
2024 Final	$1,051,000,000
2025 Final /1	$1,151,000,000
2026 Enacted /2	$1,708,000,000
2027 President's Budget	$1,958,491,000

1/ The FY 2025 levels reflect actuals.
2/ The FY 2026 levels reflect the Administration's scores. The FY 2026 Congressional Budget Office (CBO) score for CSC is $1.8 billion with Leases at $366 million. Using the CBO scores, the FY 2026 BA totals to $8.0 billion and the P.L. totals to $8.2 billion.

PROGRAM ACCOMPLISHMENTS

Implementation of the *Becerra v. San Carlos Apache Tribe* Supreme Court Decision

- In September and October 2024, the IHS convened five in-person and virtual Tribal Consultation Sessions regarding how to implement the June 2024 *Becerra v. San Carlos Apache Tribe* decision that expanded the purpose of CSC. The Agency received 70 written comments from Tribals and Tribal Organizations.

- From June to November 2024, the IHS convened the Federal-Tribal Contract Support Costs Advisory Group (CSCAG) six times to identify and discuss relevant implementation issues stemming from the *Becerra v. San Carlos Apache Tribe* decision.

- The IHS received the CSCAG's recommendation on November 15, 2024, and issued a final Agency decision on December 20, 2024[2].

[2] https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2024_Letters/DTLL_12202024.pdf

- Agency guidance requires a certification form from the T/TOs to include certain key information necessary for the accurate calculation of CSC need related to the expenditure of program income. In FY 2025 and projected throughout FY 2026 IHS is actively engaged in additional training and outreach with the T/TOs. Approximately 10% of the T/TOs that the IHS expects to request CSC related to program income have submitted a certification form and engaged in the FY 2025 negotiation process.

- CSC appropriations are available for adjustment for five years after the close of the relevant fiscal year— the IHS anticipates that the CSC need for FY 2025 will continue to increase over the next 2-3 years as additional T/TOs participate in the negotiation process.

Resolution of Contract Disputes Act (CDA) Claims Resulting from the Supreme Court Decision

- On November 20, 2024, IHS settled its first claim on third-party program income expenditures in less than six months after the June 6, 2024, the Becerra v. San Carlos Apache Tribe decision. The Agency settled this first CDA Claim in one-third of the time it took the Agency to resolve the first CDA Claim stemming from the 2012 Salazar v. Ramah Navajo Chapter Supreme Court decision.

- As of January 8, 2026, the IHS is working to resolve a total of over 760 claims received under the Contract Disputes Act from approximately 160 tribes and Tribal Organizations totaling $4.6 billion.

- The IHS has also closed 28 ineligible CSC CDA claims totaling $47.6 million.

- An additional 655 CDA claims are in various stages of analysis toward eventual settlement for a total of $3.6 billion.

Oversight & Management

- IHS Headquarters reconciles CSC fund requests on a quarterly basis and allocates funds to each Area office to ensure timely and accurate payments to T/TO.

- IHS uses the CSC automated data system to track and monitor all CSC activity. The system tracks all CSC funds, including any funds associated with new and expanded Tribal Health Programs, renegotiation of CSC amounts, and distribution and payment of funds. IHS also uses the system to project CSC funding need based on the most current data.

IHS continues to use an internal electronic database to monitor each ISDEAA negotiation, including CSC negotiations. The database monitors each phase of a negotiation to ensure that the Agency uses a consistent business approach, meets statutory deadlines, and accurately calculates required funding amounts. In addition, the database tracks new and expanded Tribal Health Programs and is used to determine the status of funds, workload, planning of resources, and subsequent years' funding needs.

Following is a summary of CSC funds for FY 2020– FY 2025, as of September 30, 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*	$969,000,000	$1,051,000,000	$1,051,000,000
Paid to Tribes	$900,322,000	$962,049,000	$1,151,176,000
Balance*	$68,678,000	$88,951,000	($100,176,000)

*Funds remain in process for payment to tribes and/or pending final reconciliation with tribes to determine final amounts.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

ISDEAA 105(*l*) Leases

Page

ISDEAA 105 *(l)* Leases 154

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 2025	FY 2026	FY 2027	
	Final /2, 3	Enacted	President's Budget	FY 2027 +/- FY 2026
PL	$543,000	$413,000	$929,000	+$516,000
FTE /1	--	--	--	--

1/ FTE numbers reflect only Federal staff and do not include increases in tribal staff.
2/ The FY 2025 levels reflect actuals.
3/ The FY 2026 levels reflect the Administration's scores. The FY 2026 Congressional Budget Office (CBO) score for CSC is $1.8 billion with Leases at $366 million. Using the CBO scores, the FY 2026 BA totals to $8.0 billion and the P.L. totals to $8.2 billion.

Authorizing Legislation ..... 25 U.S.C. § 5324(*l*)
Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended

FY 2027 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.

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 2027 budget submission updates the score for Tribal Lease Payments to $929.0 million is an increased score of +$516.0 million above the FY 2026 Enacted level. This estimate supports anticipated increased costs for the program. The budget request maintains an indefinite discretionary appropriation for Section 105(*l*) Tribal Leases, which would continue to fully-fund Section 105(*l*) Tribal Lease 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 Section 105(*l*) Tribal Leases need is fully reconciled for each year.

FUNDING HISTORY

Fiscal Year	Amount
2023 Final	$111,000,000
2024 Final	$149,000,000
2025 Final /1	$543,000,000
2026 Enacted /2	$413,000,000
2027 President's Budget	$929,000,000

1/ The FY 2025 levels reflect actuals.

2/ The FY 2026 levels reflect the Administration's scores. The FY 2026 Congressional Budget Office (CBO) score for CSC is $1.8 billion with Leases at $366 million. Using the CBO scores, the FY 2026 BA totals to $8.0 billion and the P.L. totals to $8.2 billion.

PROGRAM ACCOMPLISHMENTS

In FY 2025, the IHS received 1,201 proposals for an estimated total of $602.0 million. In FY 2024, the IHS executed 914 lease cost agreements for a 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 Tribal Leasing 105(*l*) within the Office of Indian Self-Determination and Self Governance. In addition, the IHS prepared the final draft for review by the Office of the General Counsel who have completed their review and other IHS Headquarters Offices before sending out for Tribal Consultation. 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 continued to include engagement with the IHS's tribal advisory groups, and Tribes and Tribal Organizations to maximize consistent and transparent process where feasible and appropriate for the different types of programs administered by each agency.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Special Diabetes Program for Indians

Page

Special Diabetes Program for Indians 156

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in thousands)

	FY 2025	FY 2026	FY 2027	
	Final	Enacted	President's Budget /2	FY 2027 +/- FY 2026
Discretionary Budget Authority	--	--	--	--
Current Mandatory Law	$159,363	$200,000	$49,403	-$150,597
FTE /1	21	21	21	--

1/ FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
2/ The Consolidated Appropriations Act, 2026 provides $50.4 million for mandatory Special Diabetes Program for Indians from October 1, 2026, to December 31, 2026. The FY 2027 amount in the table is reduced by $1.0 million for Budget Control Act sequestration.

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.

The Consolidated Appropriations Act, 2026 (P.L. 119-75) further extends SDPI through December 31, 2026, and provides an additional $200,000,000 of SDPI funding for FY 2026 and $50,410,959 of SDPI funding for FY 2027.

FY 2027 Authorization……Expires December 31, 2026

Allocation Method ..... Grants and Contracts

SDPI PROGRAM DESCRIPTION

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention to 310 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 2027 will be the 30th year of the SDPI. The IHS 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 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, 310 SDPI grants at I/T/U sites across the country, and the Tribal Leaders Diabetes Committee (TLDC) made up of Tribal leaders from each of the 12 IHS Areas.

Target Population: AI/ANs

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.[1]

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 310 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.

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

[1] 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.

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.

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 2025**	**Absolute Percentage increase**
Diabetes clinical teams	30%	86%	+56%
Diabetes patient registries	34%	81%	+47%
Nutrition services for adults	39%	76%	+37%
Access to registered dietitians	37%	64%	+27%
Culturally tailored diabetes education materials	36%	89%	+53%
Access to physical activity specialists	8%	61%	+53%
Adult weight management services	19%	59%	+40%

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 since the inception of SDPI. Examples include:

- The average blood sugar level (as measured by the A1C test) among AI/AN people with diabetes served by the IHS has decreased from 9.0 percent in 1996 to 7.7 percent in 2024.
- The average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 86 mg/dL in 2024, 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 non AI/AN group in the US.[2]

<u>Diabetes Data and Program Delivery Infrastructure</u>

[2] 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.

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 2024 Diabetes Audit included a review of 140,687 patient charts at 325 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.

BUDGET REQUEST

The FY 2027 budget submission for the Special Diabetes Program for Indians reflects current law mandatory funding for this program of $49.4 million which is -$151.0 million below the FY 2026 Enacted level.

The SDPI is currently authorized through December 31, 2026[3].

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target[2]	FY 2027 Target +/-FY 2026 Target
53 Increase the proportion of AI/AN with diagnosed diabetes who have controlled blood pressure <140/90 (Outcome)	FY 2025: 56.6 % Target: 57.5 % (Target Not Met but Improved)	57.5%	Not defined	N/A
54 Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes (Intermediate Outcome)	FY 2025: 48.5 % Target: 52.6 % (Target Not Met)	52.6%	Not defined	N/A
86 Reduce the proportion of AI/AN with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)[1]	FY 2025: 11.9 % Target: 12.5 % (Target Exceeded)	12.1%	Not defined	N/A

1. A lower result compared to the target represents better performance for this measure.
2. The Consolidated Appropriations Act, 2026 provides $50,411 million for mandatory Special Diabetes Program for Indians from October 1, 2026, to December 31, 2026; therefore, information on targets, grant information, and state amounts are Not Defined. The FY 2027 amount in the table is reduced by $1,008 million for Budget Control Act sequestration.

[3] The Consolidated Appropriations Act, 2026 (P.L. 119-75) and provides $50.4 million for FY 2027 in the period of October 1, 2026-December 31, 2026. The FY 2027 amount is reduced by $1.0 million for Budget Control Act sequestrations.

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to 310 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 2025 Final	FY 2026 Enacted	FY 2027 President's Budget[4]
Number of Awards	309	310	TBD
Average Award	$453,343	$453,722	TBD
Range of Awards	$25,000 - $7,553,570	$25,000 - $7,553,570	TBD

SDPI FY 2027 State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2026 Annual Financial Assistance Awards[5]					
State	State Name	FY 2025 Total # Grant Programs	FY 2025 Enacted	FY 2026 President's Budget	FY 2027 Target Level[6]
AK	Alaska	22	10,494,578	10,494,578	TBD
AL	Alabama	1	279,211	279,211	TBD
AZ	Arizona	28	35,522,502	35,522,502	TBD
CA	California	35	9,379,046	9,637,811	TBD
CO	Colorado	3	903,625	903,625	TBD
CT	Connecticut	2	232,777	232,777	TBD
FL	Florida	2	486,980	486,980	TBD
IA	Iowa	1	304,592	304,592	TBD
ID	Idaho	4	935,841	935,841	TBD
IL	Illinois	1	281,832	281,832	TBD
KS	Kansas	5	993,279	937,919	TBD
LA	Louisiana	4	364,530	364,530	TBD
MA	Massachusetts	2	168,316	168,316	TBD
ME	Maine	5	543,580	543,580	TBD
MI	Michigan	12	2,363,824	2,363,824	TBD
MN	Minnesota	10	3,378,922	3,434,282	TBD
MS	Mississippi	1	1,256,112	1,256,112	TBD
MT	Montana	13	6,869,529	6,869,529	TBD
NE	Nebraska	5	1,931,172	1,931,172	TBD

[4] The Consolidated Appropriations Act, 2026 provides $50.4 million for mandatory Special Diabetes Program for Indians from October 1, 2026, to December 31, 2026; therefore, information on targets, grant information, and state amounts are Not Defined. The FY 2027 amount in the table is reduced by $1.0 million for Budget Control Act sequestration.

[5] Please note that the numbers provided for FY 2026 are likely to change due to the start of the new SDPI grant cycle.

[6] The Consolidated Appropriations Act, 2026 provides $50.4 million for mandatory Special Diabetes Program for Indians from October 1, 2026, to December 31, 2026; therefore, information on targets, grant information, and state amounts are Not Defined. The FY 2027 amount in the table is reduced by $1.0 million for Budget Control Act sequestration.

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2026 Annual Financial Assistance Awards[5]					
State	State Name	FY 2025 Total # Grant Programs	FY 2025 Enacted	FY 2026 President's Budget	FY 2027 Target Level[6]
NV	Nevada	14	5,225,544	5,225,544	TBD
NM	New Mexico	24	7,693,403	7,693,403	TBD
NY	New York	6	1,481,491	1,481,491	TBD
NC	North Carolina	1	1,351,228	1,351,228	TBD
ND	North Dakota	5	3,168,173	3,168,173	TBD
OK	Oklahoma	27	23,578,609	23,578,609	TBD
OR	Oregon	9	1,832,727	1,832,727	TBD
RI	Rhode Island	1	113,475	113,475	TBD
SC	South Carolina	1	163,399	163,399	TBD
SD	South Dakota	10	6,294,326	6,294,326	TBD
TN	Tennessee	1	130,001	130,001	TBD
TX	Texas	4	784,901	784,901	TBD
UT	Utah	6	2,223,841	2,223,841	TBD
VA	Virginia	4	417,983	417,983	TBD
WA	Washington	27	4,792,337	4,792,337	TBD
WI	Wisconsin	12	3,421,213	3,421,213	TBD
WY	Wyoming	2	1,032,196	1,032,196	TBD
	Total States	**310**	**$140,392,095**	**$140,653,860**	TBD
	Indian Tribes	**264**	**$117,430,560**	**$117,430,560**	TBD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Drug Budget

Page

Drug Control Programs.....162

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2027

Budget Authority (in Millions)			
	FY 2025 Enacted	FY 2026 Enacted	FY 2027 President's Budget
Drug Resources by Function[1]			
Treatment – ASA	103.597	103.709	108.478
Treatment – Urban	3.292	3.292	3.292
Prevention	37.335	37.353	38.133
Total Drug Resources by Function	144.224	144.354	149.903
Drug Resources by Program			
Alcohol and Substance Abuse[1]	140.932	141.062	146.611
Urban Indian Health Program	3.292	3.292	3.292
Total Drug Resources by Program	144.224	144.354	149.903
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as Percent of Budget			
Agency Budget Authority[2,3]	7,481.520	7,984.655	9,094.069
Drug Resources Percentage	1.93%	1.80%	1.65%

[1] Adult Treatment funds are excluded from the ONDCP Drug Control Budget and Moyer Anti-Drug Abuse methodologies because this program reflects the original authorized program for IHS with the sole focus of alcoholism treatment services for adults. This determination was made in consultation with ONDCP when the drug control budget was initially developed in the early - 1990s. Total Adult Treatment funds for FY 2027 President's Budget $130.3 million + Drug Budget funds $49.9 million total $280.2 million.
[2] The FY 2025 level reflects actuals.
[3] The FY 2026 levels reflect the Administration's scores. The FY 2026 Congressional Budget Office (CBO) score for CSC is $1.8 billion with Leases at $366 million. Using the CBO scores, the FY 2026 BA totals to $8.0 billion and the P.L. totals to $8.2 billion.

MISSION

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing Federal health services to American Indian and Alaska Native (AI/AN) people. IHS supports alcohol and substance abuse disorder prevention and treatment services as part of this mission.

METHODOLOGY

The IHS includes the appropriation for Alcohol and Substance Abuse (excluding the amount designated as Adult Alcohol Treatment) and the portion of Urban Indian Health funds that partially come from the National Institute on Alcohol Abuse and Alcoholism programs transferred to the IHS under the Urban Indian Health budget.

BUDGET SUMMARY

In FY 2027, IHS requests $280.2 million which is +$13.1 million above the FY 2026 Enacted level.

Alcohol and Substance Abuse
FY 2027 Request: $280.2 million

In FY 2027, the IHS budget request for its drug control activities supports the Office of National Drug Control and Policy (ONDCP) funding priorities as well as the ONDCP *Strategy*. The *Strategy* emphasizes the partnership between Federal agencies and their state, local, Tribal, and international counterparts and reduce drug-induced mortality. IHS is also working with Federal partners to implement ONDCP's efforts to address the current crisis.

The Administration's ONDCP *Strategy*[1] guides and expands Federal government efforts to: 1) Reduce the number of overdose fatalities, with a focus on fentanyl; 2) secure the global supply chain against drug trafficking 3)stop the flow of drugs across our borders and into our communities; 4) prevent drug use before it starts 5) provide treatment that leads to long-term recovery; and 6) innovate in research and data to support drug control strategies. The *Strategy* offers a valuable opportunity for IHS to advance its mission by strengthening existing programs to control and reduce substance use and eliminate its deleterious effects on the health and safety of AI/AN patients and communities.

The IHS Alcohol and Substance Abuse program serves AI/ANs impacted by substance use disorders through IHS, Tribal, and Urban Indian operated treatment and prevention programs and Youth Regional Treatment Centers (YRTCs).

The IHS established a multi-disciplinary workgroup to form the IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE). The HOPE Committee is comprised of a multidisciplinary membership to include clinical representation from family medicine, pharmacy, behavioral health, nursing, pediatrics, rehabilitation therapy, epidemiology, and injury prevention. The HOPE Committee work plan supports the HHS Overdose Prevention Strategy with a specific focus on: 1) better pain management; 2) improving access to culturally relevant prevention, treatment, and recovery support services; 3) increasing availability of alcohol and substance abuse services; and, 4) improved public health data reporting and surveillance.

The IHS Division of Behavioral Health administers community-based grants that promote the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to substance misuse from a community-driven context.

<u>Expanding Access to Evidence-Based Treatment:</u>

[1] ONDCP Releases Trump Administration's Statement of Drug Policy Priorities – The White House

Increasing Access to Medications for Opioid Use Disorder: Since 2019, IHS has required federal IHS facilities to create an action plan to identify or create local medication-assisted treatment resources and coordinate patient access to these services when indicated.[2] Key components of these approaches include enhanced screening and early identification of opioid use disorders; improved care coordination and patient referral for treatment; and workforce development strategies to increase education and resources surrounding using medications in the support of recovery. In addition, the IHS created workforce development strategies[3] that include SUD training for healthcare workers and technical assistance materials to support sites with creating integrated SUD approaches to 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.

The IHS also supports enhanced team-based care approaches. In 2026, the IHS will continue the "Advancing Pharmacist Roles in Substance Use Disorder Treatment and Recovery Teams ECHO[4]." Participants increase knowledge surrounding patient screening, assessments, evidence-based practices for the management of Opioid Use Disorders, and trauma-informed care principles. Additionally, the IHS will expand an Academic Detailing Service pilot project to create tailored peer-to-peer interventions to support opioid stewardship activities, increase access to treatment services, and promote quality of care as well as to establish lifestyle medicine services.

The IHS does face challenges in providing Medications for Opioid Use Disorders (MOUD) in certain sectors within Indian Country. The rural and frontier nature of where AI/ANs live creates barriers to accessing health facilities. This is especially evident in Alaska where patients often have only access to a community health aide serving within a village-based clinic, and live hours away by plane from a larger health center. Additionally, IHS has felt the impact of a declining supply of specific health professionals who could support the IHS workforce and address behavioral health needs. The IHS recognizes that telemedicine is one tool for increasing access to specialized medical services, such as MOUD. The IHS has published a policy in the Indian Health Manual (Chapter 38) entitled *Internet Eligible Controlled Substance Prescriber Designation* to assure access to MAT using telemedicine models for remotely located Tribal members.[5]

In FY 2025, the IHS Pain and Addiction Care in the Emergency Department (PACED) funds IHS emergency departments. 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 surveillance dashboard to inform stewardship activities, to create a learning collaborative to share promising practices, and to assist sites with obtaining relevant accreditation. In FY 2023, the IHS emergency departments (EDs) received training from the American College of Emergency Physicians (ACEP) to identify and develop new systems of care and best practices to improve addiction and pain treatment outcomes in the ED by improving patient screening and increasing access to MOUD. The IHS has also collaborated to produce a cultural adaptation of best practices for Plans of Safe Care/Family

[2] https://www.ihs.gov/ihm/sgm/2019/assuring-access-to-medication-assisted-treatment-for-opioid-use-disorder/

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

[4] https://www.ihs.gov/opioids/recovery/providers/

[5] https://www.ihs.gov/ihm/pc/part-3/chapter-38-internet-eligible-controlled-substance-provider-designation/

Wellness Plans for pregnant persons who use substances. This cooperative project shares best practices for providers and sample patient resources to improve outcomes for pregnant persons and families.

IHS Opioid Grant Program: In FY 2021, IHS awarded a total of $16 million in grants to combat the opioid crisis[6]. IHS awarded thirty-five grants under the Community Opioid Intervention Pilot Project (COIPP) for AI/ANs. In FY 2025, IHS awarded a new cohort of grantees to develop innovative, locally-designed, culturally-appropriate prevention, treatment, recovery, and aftercare services for opioid use disorders. The projects will focus on increasing public awareness and education about the impact of MOUD on individuals, families and communities; and create comprehensive support teams to strengthen and empower families addressing the opioid crisis. Finally, all projects will prioritize efforts to reduce unmet needs and opioid overdose deaths through increased access to MOUD.

IHS Substance Abuse and Suicide Prevention (SASP): The SASP is a nationally-coordinated $31.97 million program providing funds for culturally appropriate substance abuse and suicide prevention programming in AI/AN communities. In FY 2023 the IHS continued awards through two separate opportunities under SASP[7]. The first, Substance Abuse Prevention, Treatment, and Aftercare (SAPTA), awarded $15.698 million to 36 Tribal, Tribal organizations, and Urban Indian Organizations and eight federal IHS facilities. The second, Suicide Prevention, Intervention, and Postvention (SPIP), awarded $13.772 million to 36 Tribal, Tribal organizations, and Urban Indian Organizations. The program will fund 174 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, 2026, and 2027, the national target rates for UAS are set at 36.0 percent.

The Substance Abuse and Suicide Prevention (SASP) Program funding is organized by two grant programs, Substance Abuse Prevention, Treatment, and Aftercare (SAPTA) and Suicide Prevention, Intervention, and Postvention (SPIP). The first year of the FY 2022 SAPTA and SPIP programs demonstrated notable engagement with AI/AN persons in Indian Country. Among the 72 grant-funded partners, they completed 207,184 substance use screenings. Among the 113 total grant-funded partners across all programs, including violence prevention, they completed 420,962 substance use screenings. Among all partners, a total of 29,742 positive substance use screenings were referred for treatment, including 6,809 for opioid use disorder. A total of 2,133 cases were referred for medically-assisted treatment.

Preventing Alcohol-Related Deaths (PARD):
In the 2017 Senate Appropriations Committee Report 114-281, the Committee directed IHS to "allocate $2,000,000 of the increase provided for the alcohol and substance abuse program to fund essential detoxification and related services." Specifically, the report detailed the number of alcohol related deaths in the community of Gallup, New Mexico stating, "these deaths underscore the urgent need for substance abuse treatment, residential services and detoxification services" in this community. As a result, in FY 2023, funds were made available through a cooperative

[6] Community Opioid Intervention Prevention Program | Alcohol and Substance Abuse Branch (ASAB) (ihs.gov)

[7] About SASP | Substance Abuse and Suicide Prevention (ihs.gov)

agreement to the City of Gallup, New Mexico[8] to an alcohol detoxification center 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.

Supporting Evidence-Based Prevention Efforts to Reduce Youth Substance Use:

IHS SASP - Generation Indigenous (Gen-I): Of the awarded 72 SASP, SAPTA and SPIP projects funded, IHS requires all interventions focused on substance use prevention, treatment, and aftercare and suicide prevention interventions to prioritize Native youth in the development and implementation of evidence-based practices.

Youth Regional Treatment Centers (YRTC): The YRTCs provide residential substance use disorder and mental health treatment services to AI/AN youth. The IHS received funding for 13 YRTCs located throughout the country with seven federally-operated centers and five tribally-operated centers and one UIO. The YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values, and cultural identification.

YRTC Aftercare Project: YRTCs have an important role in maintaining the health of patients after discharge. In FY 2017-2022, IHS supported a YRTC Aftercare Pilot Project to develop culture-based treatment that prevents alcohol and substance abuse relapse among youth discharged. In FY 2023, IHS released an evaluation that examined the capacities and challenges in improving coordination of aftercare and case management, increasing training of community supports for the adolescents, improving identification of transitional living, increasing awareness of the use of treatment engagement through social media, and improving follow-up with data collection after discharge. In FY 2023, the IHS awarded[9] the Cherokee Nation's Jack Brown Center, a Tribal-operated YRTC, to operate and refine an aftercare program, based on an amount of $600,000 per year for five years which started November 14, 2022.

Enhancing Evidence-Based Alcohol and Substance Abuse Efforts:

The IHS has expanded access to alcohol and substance abuse interventions that include increased access to the opioid overdose reversal medication, naloxone. IHS has also created a robust workforce development strategy to include didactic training. In FY 2023, the IHS continued its Pain Management and Opioid Use Disorder Continuing Medical Education webinar series[10]. The IHS has hosted learning sessions with approximately 600 attendees with majority of attendees receiving continuing education credits. The IHS has expanded access to alcohol and substance abuse interventions that include increased access to the opioid overdose reversal medication, naloxone.

Additionally, the IHS has expanded the number of regional alcohol and substance abuse mentors to assist sites with alcohol and substance abuse implementation and expansion. In 2023, the IHS updated agency policy to expand to first-responder definitions to include community members and employees who are designated to immediately respond in an emergency in a variety of work settings such as schools, businesses, or other places where people gather. In addition, Naloxone tool kits were developed and released for community members and all schools.

[8] IHS Highlights the City of Gallup for their Exemplary and Innovative Project in Support of National Recovery Month | September 2023 Blogs

[9] Supporting American Indian and Alaska Native Youth Aftercare Treatment in Indian Country | November 2022 Blogs (ihs.gov)

[10] https://www.ihs.gov/opioids/trainingopportunities/

The IHS continues to develop and share best practices surrounding expanded alcohol and substance abuse activities including safe syringe services programs and fentanyl test strips. Sample patient education resources, fact sheets, and recommendations have been developed and shared as technical assistance for sites and tribes.

In December 2023, the IHS announced the Naloxone Safety Net Program which supports expanded alcohol and substance abuse 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.

The strategic goal is to support Tribal programs and UIOs in their continued substance abuse prevention, treatment, and infrastructure development. These efforts represent an innovative partnership with IHS to deliver services developed by the communities themselves, with a national support network for ongoing program development and evaluation.

IHS continues to support the integration of substance use disorder treatment into primary care and emergency services through its activities to implement the ONDCP *Strategy*. Integrating treatment services into outpatient primary care offers opportunities for healthcare providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, and refer patients with more severe substance use-related problems to treatment.[11] One integration activity is the Screening, Brief Intervention, and Referral to Treatment (SBIRT) method, which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders.

IHS has increased efforts to implement the SBIRT across IHS facilities as an evidence-based practice to identify patients with alcohol related problems. The SBIRT is a Government Performance and Results Act (GPRA) measure that IHS reports annually. In FY 2024, the SBIRT was administered to 17.9 percent of patient visits for those ages 9-75. IHS promotes the use of this clinical process by training providers in clinical and community settings and as an additional resource released an SBIRT training https://www.ihs.gov/asap/providers/sbirt/. In FY 2025, IHS is actively working to expand SBIRT resources and will include 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.

The IHS requires all prescribers to conduct a full patient medical history and physical examination including a review of the patient's current psychosocial status, any history of mental health or substance abuse concerns, and assessment for relevant signs of misuse or abuse of substances. Examination is done at the time of consideration for chronic opioid therapy and periodically during active pain management treatment. Patient screening surveys and urine drug tests are helpful in determining the risk of opioid misuse and guiding the frequency of ongoing monitoring. Screening surveys are incorporated into the triage/nurse screening process prior to seeing the clinician. IHS developed a Pain Management website: https://www.ihs.gov/painmanagement/substancescreening/.

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

[11] ONDCP. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.

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 BH2I grantees[12], totaling $5.5 million, on a five-year funding cycle through FY 2027. Additionally, IHS awarded a technical assistance contract which will assist grantees in the implementation of integrated care efforts.

In FY 2025, IHS will continue support for seven federal facilities that currently participate in the Improving Pain and Addiction Care in IHS Emergency Departments (PACED) pilot project to develop model clinical care pathways following patient overdose resuscitation within EDs. 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 2023, IHS reported 37.4 percent of AI/AN adults over the age of 18 screened for depression using a standardized screening assessment for depression. In FY 2023, this same measure was reported for youth ages 12-17 and data indicated 34.1 percent of eligible youth were screened for depression. The FY 2023 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.

While screenings remain critical to ensure that appropriate health services are available to AI/AN population, IHS acknowledges the importance of understanding a patient's life experiences in order to deliver effective care and improving treatment adherence. IHS released a trauma informed care policy to provide guidance to IHS facilities to improve patient engagement and health outcomes, as well as supporting provider and staff wellness. IHS continues to implement the principles of trauma informed care to ensure that those in its system understands the prevalence and role of trauma in patient care. As of December 2023, 96 percent of IHS staff have completed the trauma informed care on-demand, online training for clinical and non-clinical staff titled "Overview of Trauma Informed Care and Historical Trauma Guidance" in the HHS LMS. This training will provide guidance to IHS facilities in delivering trauma-informed care services along with promoting self-care to prevent secondary traumatic stress, which can lead to compassion fatigue and burnout. These efforts ensure that comprehensive, culturally appropriate services are provided and support the *Strategy's* priority to *advance racial equity issues in our approach to drug policy.*

Proper Pain Management, Opioid Stewardship and Training: In FY 2023, the IHS created and released a comprehensive Opioid Stewardship Campaign[13] to support sites with creating best practices surrounding safe opioid prescribing and increasing access to integrative pain treatments. The campaign includes evidence-based documents, an automated workbook that emphasizes utilizing opioid surveillance strategies to evaluate population health outcomes, target opioid interventions, enhance clinical decision support, and create professional practice evaluation strategies. The IHS opioid stewardship program evaluation considers metrics related to opioid prescribing, alcohol and substance abuse, and treatment access, metrics now made available for review at the local, regional and national level in the IHS Opioid Prescribing dashboard. The implementation of the dashboard will support Opioid Stewardship efforts through development of dashboard super-users within each IHS region that will apply population health/opioid stewardship principles and clinical decision support tools and facilitate end-user training.

[12] https://www.ihs.gov/mentalhealth/bh2i/

[13] https://www.ihs.gov/opioids/trainingopportunities/

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 evidence-based training to promote quality of care.

In FY 2023, 301 clinicians completed the Essential Training on Pain and Addiction and the Refresher Training on Pain and Addiction course[14]. An updated IHS Essential Training on Pain and Addiction was released in September 2023. This training is an on-demand, three-hour training with continuing education to align with evidence-based guidelines for pain management and OUD. IHS also reports approximately 600 attendees for the FY 2023 IHS Pain and Opioid Use Disorder Webinar Series.

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 IHM, Part 3 - Chapter 30. The 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 support local, national and other program reporting requirements as well as quality performance measurements for numerous screening and prevention initiatives.

Increase Mandatory Prescriber Education and Continuing Training on Best Practices and Current Clinical Guidelines: The IHS implemented the "Chronic Non-Cancer Pain Management Policy[15]" to promote appropriate pain management as a primary prevention tool. In February 2018, IHS released a revised policy[16] to include clinical practice guidelines contained in the 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain*. This revised policy adopts CDC guidance and specifically requires IHS sites to establish and implement local chronic non-cancer pain protocols and procedures; requires prescribers to complete training on appropriate and effective use of controlled substance medications; and establishes the requirement to initiate opioid treatment as a shared decision between the prescriber and the patient to respect and support the patient's right to optimal pain assessment and management.

Substance Use Disorder and Chronic Pain Case Resources and Consultation Services: To provide ongoing clinical support for providers, IHS, in partnership with the University of New Mexico Pain Center, provided a Substance Use Disorder and Chronic Pain ECHO[17]. ECHO is a case-based learning model in which consultation is offered through virtual clinics to healthcare providers by an expert team to share knowledge and elevate the level of specialty care available to patients.

The IHS released its "*Recommendations for Management of Acute Dental Pain*[18]" for prescribing opioids for acute pain secondary to common general dentistry conditions and procedures. These guidelines limit opioid prescribing for patients who cannot safely use alternative pain medication. The guidelines also include a decision tree for pre- and post-operative pain management, as well

[14] Ibid

[15] https://www.ihs.gov/ihm/pc/part-3/p3c30/

[16] https://www.ihs.gov/opioids/painmanagement/chronicpain/

[17] 2022 Hope Newsletters | HOPE Committee (ihs.gov)

[18] Recommendations for Management of Acute Dental Pain (ihs.gov)

as recommended dosage limits for analgesics based on the degree of anticipated operative pain. The IHS collaborated to create content for a five-part CEU webinar series to influence dental prescribing practices and enhance screening for substance use disorders in general dentistry. In FY25, the IHS will update this guideline.

In March 2019, the IHS released the *Recommendations to the Indian Health Service on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder*[19] developed in collaboration with the American College of Obstetricians and Gynecologists' (ACOG) Committee on American Indian and Alaska Native Women's Health.[20] This resource will help providers improve maternal participation in early prenatal care, improve screening for substance use disorder, and increase access to MAT for pregnant women and women of child-bearing age. The goal of these clinical recommendations is to foster relationships and improve awareness surrounding trauma-informed approaches to maternal opioid use that may lead to recovery, hope, and healing. Additionally, the IHS and the American Academy of Pediatrics Committee on Native American Child Health (CONACH) recently released the *Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome*[21] that includes clinical recommendations on the prevention and management of neonatal opioid withdrawal syndrome.[22] These recommendations provide standards of care for screening, diagnosing, support, and treatment of pregnant mothers and infants affected by prenatal opioid exposure.

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[19] IHS and AAP release clinical recommendations to improve care of American Indian, Alaska Native women and infants impacted by prenatal opioid exposure | 2019 Press Releases

[20] https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/acogguidelines2018.pdf

[21] Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome (ihs.gov)

[22] https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/aapnowsrecommendationstoihs.pdf

[23] Additional Training and Resources | Training Opportunities (ihs.gov)

[24] https://www.ihs.gov/opioids/trainingopportunities/additionaltraining/

and OUD. IHS also reports approximately 600 attendees for the FY 2023 IHS Pain and Opioid Use Disorder Webinar Series.
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Enhanced communication during the opioid crisis response is vital to program development, policy implementation, and ongoing evaluation. The IHS created an Opioid Information Sheet[25] that serves as a public-facing logic model to share opioid-related measure, agency goals, and available resources for both clinicians and tribal stakeholders. The IHS opioid strategy and a host of available resources is housed on two IHS webpages that support a unified user experience in addition to publication of a quarterly opioid newsletter.

Increase Prescription Drug Monitoring Program (PDMP) Interoperability and Usage: The IHS has also implemented IHM Chapter 32 "State Prescription Drug Monitoring Programs[26]" that establishes policy requirement for Federal facilities to participate with state-based Prescription Drug Monitoring Programs (PDMP). Controlled substance prescribers working in IHS federal-government-operated facilities must query state PDMP databases prior to prescribing opioids for pain treatment longer than seven days and periodically throughout chronic pain treatment. In FY 2019, IHS developed and released software programming to automate controlled substance dispensing reports to state-based PDMPs to near real-time reporting to improve the fidelity of IHS dispensing data in state PDMP databases. The IHS is in active software development and design for PDMP interoperability and integration into the IHS Electronic Health Record.

Reducing Availability of Illicit and Dangerous Drugs: The IHS supports the safe and effective disposal of unused pharmaceuticals at the enterprise level through the provision of reverse distributor services at Federal pharmacies for unopened expired controlled substances. The agency has participated in interagency efforts to support proper collection and disposal of pain medications. I/T/U pharmacies have continued to enroll as DEA collectors and to participate in prescription drug disposal efforts. A revision to the IHS medication disposal webpage was released in August 2022 and can be found:
https://www.ihs.gov/opioids/harmreduction/medicationdisposal/.

On the IHS pain management website, IHS provides resources for tribal and urban Indian communities on Take-Back Event, Permanent Collection Sites, Mail-Back Programs and Environmentally Safe Options from Home. The website also has two sessions focused on safe storage of medications and medication disposal for providers on proper opioid disposal.
https://www.ihs.gov/painmanagement/disposal/patientdisposal/

[25] Opioids | Indian Health Service (IHS)

[26] Chapter 32 - State Prescription Drug Monitoring Programs | Part 3 (ihs.gov)

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
FY 2027 Request: $3.3 million

The 41 UIOs are an integral part of the Indian health care system and serve as resources to both tribal and urban communities. Urban Indians are often invisible in the urban setting and face unique challenges when accessing healthcare. A large proportion of Urban Indians 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 Indians seeking to maintain their tribal values and cultures and serve as a safety net for our urban patients. The UIOs that offer inpatient and outpatient substance use disorder treatment have become reliable referral sites for Tribes and Urban Indians. In FY 2027, the IHS is proposing $3.3 million for the urban ONDCP budget.

Urban Indian people who live in urban centers present a unique morbidity and mortality profile. Urban Indian populations suffer disproportionately higher mortality from certain causes in sharp contrast to mainstream society. These unique challenges require a targeted response. Existing UIOs see their efforts in health education, health promotion, and disease prevention as essential to impacting the behavioral contributors to poor health[27]:

- Alcohol-induced death rates are 2.8 times greater for Urban Indian people than urban non-AI/ANs.
- Chronic liver disease death rates are 2.1 times greater for Urban Indian people than urban non-AI/ANs.
- Accidents and external causes of death rates are 1.4 times greater for Urban Indian people than urban non-AI/ANs.

Alcohol and drug-related deaths continue to plague Urban Indian people. Alcohol-induced mortality rates for Urban Indian people are markedly higher than for urban non-AI/ANs. All regions, with the exception of eastern seaboard cities in the Nashville Area, show dramatically higher rates for Urban AI/AN people than for non-AI/ANs who live in the same communities: the Billings Area is 4 times greater, the Phoenix Area is 6 times greater, the Tucson Area is 6.7 times greater, and the Great Plains Area has a 13.4 times greater alcohol-induced rate of mortality.[28]

Fetal alcohol spectrum disorders is a term used to describe a range of effects that can occur in someone whose mother consumed alcohol during pregnancy. Fetal alcohol spectrum disorders include disorders such as fetal alcohol syndrome, alcohol-related neuro developmental disorder, and alcohol-related birth defects. Interventions are needed in urban centers to address prevention efforts for urban Indian people with fetal alcohol spectrum disorders. The IHS policy requires the IHS to confer with UIOs "to develop and implement culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders clinics for use in Indian communities and urban centers." Heavy drinking during pregnancy can cause significant birth defects, including fetal alcohol syndrome. Fetal alcohol syndrome is the leading and most preventable cause of intellectual disability. The rates of fetal alcohol syndrome are higher among Indian people than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of fetal alcohol syndrome.

[27] Indian Health Service, Report to Congress: New Needs Assessment of the Urban Indian Health Program and the Communities it Services at 10 (Mar. 31, 2016) (hereinafter New Needs Assessment), available at https://www.ihs.gov/urban/includes/themes/newihstheme/display_objects/documents/ReportToCongressUrbanNeedsAssessment.pdf.
[28] Ibid.

The UIOs emphasize integrating behavioral health, health education, health promotion, and disease prevention into primary care offered within a culturally appropriate framework, which leads to positive outcomes for Urban Indian people. Urban Indian people in need of substance use disorder treatment commonly exhibit co-occurring disorders. The UIOs have recognized the need for more mental health and substance use disorder counselors to adequately address the needs presented by Urban Indian people with co-occurring disorders. While male Urban Indian people can encounter wait times for treatment admission up to six months, treatment options for youth, women, and women with children can be greater than six months. Some of the most successful AI/AN treatment programs for youth, women, and women with children are administered by UIOs. The UIOs have operated culturally appropriate initiatives to reduce health risk factors. Affecting lifestyle changes among Urban Indian families requires a culturally sensitive approach. The continued efforts of UIOs to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban Indian population.

The IHS has contracts and grants with 41 UIOs to provide health care and referral services for Urban Indians in 22 states. The UIOs provide high quality, culturally relevant prevention, early intervention, outpatient and residential substance abuse treatment services, and recovery support to address the unmet needs of the Urban Indian communities they serve. Social determinants of health play a key role in health and wellness and UIOs are addressing a range of factors, which contribute to improved health outcomes.

According to the most recent Urban Indian data[29], 70,388 Urban Indian patients access services through UIO programs. Also, UIOs performed 696,229 visits for Urban Indian patients including medical, dental, behavioral health, other professional and enabling services directly or by paid referral. Data also indicates that members from 529 of the 575 (92 percent) Federally recognized Tribes accessed services from at least one of the 41 UIOs.

To date, the IHS Office of Urban Indian Health Programs awarded 34 4-in-1 grants to UIOs. The grantees are awarded from April 1, 2022, through March 31, 2027. These grants provide funding to UIOs to make health care services more accessible for Urban Indian people residing in urban areas. Funding is used to support four health program areas: health promotion and disease prevention services; immunization services; alcohol and substance abuse related services; and mental health services. Grantees participated in a national evaluation of the 4-in-1 grant program, which included reporting on the cultural interventions integrated into the 4-in-1 program activities, and practice based and evidence-based approaches that are implemented or modified to meet the needs of the Urban Indian service population.

[29] Urban: Urban Indian Organization National Uniform Data System Summary Report – 2021, 6/2/2023, https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2021_UIO_UDS_Summary_Report_Final.pdf

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Supplemental Tables

Page

Exhibits
Budget Authority by Object Class 174
Detail of Full-Time Equivalent Employment (FTE) 175
Detail of Positions 176

Object Classification

Indian Health Service

(Dollars in Millions)

	FY 2025 Actuals	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Personnel compensation:				
Full-time permanent (11.1)	$708	$708	$810	$102
Other than full-time permanent (11.3)	$40	$40	$40	$0
Other personnel compensation (11.5)	$99	$99	$99	$0
Military personnel (11.7)	$90	$90	$90	$0
Special personnel services payments (11.8)	$0	$0	$0	$0
Subtotal personnel compensation	$937	$937	$1,039	$102
Civilian benefits (12.1)	$316	$316	$350	$34
Military benefits (12.2)	$15	$15	$15	$0
Benefits to former personnel (13.0)	$8	$8	$8	$0
Subtotal Pay Costs,	$1,276	$1,276	$1,412	$136
Travel and transportation of persons (21.0)	$14	$13	$13	$0
Transportation of things (22.0)	$36	$33	$35	$2
Rental payments to GSA (23.1)	$9	$8	$8	$0
Rental payments to others (23.2)	$23	$16	$17	$1
Communication, utilities, and misc. charges (23.3)	$11	$11	$11	$0
Printing and reproduction (24.0)	$12	$11	$12	$1
Other Contractual Services:				
Advisory and assistance services (25.1)	$21	$19	$40	$21
Other services (25.2)	$968	$522	$588	$66
Purchase of goods and services from government accounts (25.3)	$351	$327	$332	$5
Operation and maintenance of facilities (25.4)	$22	$15	$16	$1
Research and Development Contracts (25.5)	$0	$0	$0	$0
Medical care (25.6)	$402	$370	$378	$8
Operation and maintenance of equipment (25.7)	$30	$24	$30	$6
Subsistence and support of persons (25.8)	$45	$44	$42	-$2
AP Branch Services (25.9)	$187	$78	$78	$0
Subtotal Other Contractual Services	$2,026	$1,399	$1,504	$105
Supplies and materials (26.0)	$137	$124	$125	$1
Equipment (31.0)	$50	$42	$48	$6
Land and Structures (32.0)	$238	$99	$15	-$84
Investments and Loans (33.0	$0	$0	$0	$0
Grants, subsidies, and contributions (41.0)	$5,248	$5,153	$5,943	$790
Insurance payments (42.0)	$0	$0	$0	$0
Interest and dividends (43.0)	$0	$0	$0	$0
Refunds (44.0)	$0	$0	$0	$0
Unvouchered (91.0)	$0	$0	$0	$0
Subtotal Non-Pay Costs	$7,804	$6,909	$7,731	$822
Total Direct Obligations	$9,080	$8,185	$9,143	$958

INDIAN HEALTH SERVICE
Detail of Full-Time Equivalents (FTE)

	FY 2025 Final	FY 2026 Estimate	FY 2027 Estimate
Headquarters			
Sub-Total, Headquarters	1,000	1,000	1,011
Area Offices			
Alaska Area Office	180	180	180
Albuquerque Area Office	767	767	767
Bemidji Area Office	602	602	602
Billings Area Office	902	902	902
California Area Office	184	184	184
Great Plains Area Office	1,769	1,769	1,769
Nashville Area Office	187	187	187
Navajo Area Office	3,901	3,901	4,130
Oklahoma City Area Office	1,710	1,710	1,710
Phoenix Area Office	2,657	2,657	2,708
Portland Area Office	435	435	435
Tucson Area Office	112	112	112
Sub-Total, Area Offices	13,406	13,406	13,686
TOTAL FTES[1]	14,406	14,406	14,697

[1] Total does not include Trust Funds FTEs (21)

INDIAN HEALTH SERVICE

DETAIL OF POSITIONS[1]

(Dollars in Thousands)

	FY 2025 Final	2026 Estimate	FY 2027 Estimate
Total - ES.....	28	28	28
Total - ES Salaries.....	$5,888	$6,182	$6,492
GS/GM-15.....	460	460	464
GS/GM-14.....	411	411	421
GS/GM-13.....	719	719	733
GS-12.....	1,532	1532	1569
GS-11.....	1,575	1575	1613
GS-10.....	501	501	516
GS-9.....	1,004	1004	1028
GS-8.....	470	470	491
GS-7.....	1,312	1312	1345
GS-6.....	1,532	1532	1571
GS-5.....	1,413	1413	1451
GS-4.....	605	605	620
GS-3.....	106	106	109
GS-2.....	18	18	18
GS-1.....	0	0	0
Subtotal.....	11,657	11,657	11,948
Total - GS Salaries.....	$792,647	$800,573	$800,573
CO-08.....	4	4	4
CO-07.....	5	5	5
CO-06.....	173	173	173
CO-05.....	371	371	371
CO-04.....	414	414	414
CO-03.....	178	178	178
CO-02.....	21	21	21
CO-01.....	22	22	22
Subtotal.....	1,188	1,188	1,188
Total - CO Salaries	$76,360	$79,109	$81,957
Wage Grade.....	1,184	1,184	1,184
Other.....	349	349	349
Subtotal.....	1,533	1,533	1,533
Total - Ungraded Salaries	$94,411	$95,327	$104,142
Average ES level.....	ES	ES	ES
Average ES salary.....	$210	$221	$232
Average GS grade.....	12	12	12
Average GS salary.....	$133	$134	$138

1 Total does not include Trust Funds FTEs (21)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Operating Division-Specific Requirements

Page

IHS-Specific Requirements
IIJA Spend Plan 177

Indian Health Service (IHS)
Sanitation Facilities Construction
FY 2025 Bipartisan Infrastructure Legislation (BIL) Spend Plan

(*dollars in millions*)

Activity	FY 2025
Tier 1 Projects Construction Costs	638.7
Tier 1 Design & Construction Documents	25.2
Project Shortfalls, Add'l Planning, Design, & Construction Documents	11.6
subtotal, SFC Projects	*675.5*
Salaries, Expenses, and Administration (3%) /1	21.0
HHS Office of the Inspector General (0.5%) /2	3.5
Total	**700.0**

1/ $21 million in BIL funding is limited to federal activities only.
2/ BIL directed transfer.

Overview

The Bipartisan Infrastructure Legislation (BIL) appropriates $700 million 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 three percent ($21 million) of these funds for "salaries, expenses, and administration" each year. It also requires that one-half of one percent of these funds ($3.5 million) 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" The remaining $675.5 million in project funding is available for the IHS to allocate to sanitation facilities projects after fulfilling statutory requirements.

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.

The IHS tracks projects to address sanitation needs through the Sanitation Deficiency System (SDS). As of November 19, 2024, there were 1,241 projects, totaling $5.9 billion in eligible costs, and $1.0 billion in ineligible costs. Of the 1,241 total projects, 663 are considered economically feasible, and 578 are considered economically infeasible. The IHS completed its last annual update of the SDS on November 19, 2024, which is the most up-to-date complete data set on projects and costs. A breakout of projects and costs by Area can be found in Appendix A.

The total of 1,241 projects in the SDS as of November 19, 2024, includes 593 of the original 1,513 Legacy (i.e., end-of-year (EOY) 2021 SDS List) projects that remained in the SDS at the

end of 2024, and 648 projects that have been added to the SDS since the end of 2021. The 648 projects that were added to SDS total approximately $1.9 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 did not hold a Tribal Consultation for FY 2025 BIL funding and will continue to use the recommendations gathered through Tribal Consultation for FY 2024 IIJA funding. Tribal Consultation was initiated to seek guidance and recommendations from Tribal Leaders on how the IHS should allocate FY 2024 BIL funding. The Tribal Consultation was held on December 18, 2023, and common themes from the Tribal Consultation recommended that the IHS should:

- Retain some funding at IHS Headquarters to cover project costs above budgeted amounts for design, construction document preparation, and construction;
- Prioritize funding projects with the BIL using the SDS list reported at the time the BIL was enacted (i.e., 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 status.

SDS Project Funding

The IHS will allocate FY 2025 resources from the BIL for SDS projects as follows.

Design, Construction Contract Document Creation, and Construction Costs for Tier 1 Projects ($663.9 million total): Of this amount $638.7 million is for Tier 1 Legacy Projects, $25.2 million for architecture and engineering firms, and $584.6 million are eligible costs and $47 million of these costs are ineligible.

The FY 2025 SFC spend plan funds construction costs for 67 Tier 1 Legacy projects tracked in the SDS. These Tier 1 Legacy projects total $638.7 million, and the IHS will use the FY 2025 IIJA funding for these costs.

A table displaying the allocation of Tier 1 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 $25.2 million to support contracts with Architecture & Engineering Firms to complete these activities for Tier 1 projects. The combined cost of Tier 1 design and construction contract document creation and Tier 1 construction projects for the FY 2025 BIL spend plan spend plan is $663.9 million (not including ineligible construction costs).

These Tier 1 projects span Deficiency Levels 2 through 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 $47 million in ineligible costs associated with these 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. For example, the IHS partners with the U.S. Environmental Protection Agency (EPA), USDA Rural Development, the U.S. 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 $663.9 million allocated for the 67 Tier 1 projects, $584.6 million will support eligible costs for 31 economically infeasible Tier 1 projects.

Project Shortfalls, Additional Planning, Design, and Construction Contract Document Creation ($11.6 million total):

The FY 2025 IIJA spend plan allocates $11.6 million in FY 2025 IIJA 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.

Salaries, Expenses, and Administration ($21 million total)

The FY 2025 IIJA spend plan allocates $21 million for program support activities such as salaries, expenses, and administration.

Fiscal Year 2025 IIJA funds available for SFC project support activities can support the same activities that are typically funded through the Facilities and Environmental Health Support annual appropriation. However, these funds are limited to Federal activities only, due to the following subsequent provision:

> *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:

The IHS will use these funds to hire 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 successfully recruit for the above-mentioned positions, and to manage the significant influx of construction contracting needs resulting from the IIJA.

The IHS will continue to use multiple strategies and available authorities to support IIJA recruitment and hiring. This includes the use of global job announcements to streamline the hiring of multiple candidates for jobs across the IHS system, establishing efficiencies with a Headquarters Agency centralized team to facilitate hiring on behalf of the IHS Areas as appropriate, developing a dedicated website, marketing materials, and increasing outreach by targeting engineering job fairs. This will 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 Office of Personnel Management 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.

Appendix A: SDS Project Counts and Associated Costs as of November 19, 2024

Area	Eligible Cost	Ineligible Cost	Total Cost	Project Count
Albuquerque (AL)	$295,288,894	$32,477,806	$327,766,700	88
Alaska (AN)	$2,374,131,787	$254,714,758	$2,628,846,545	293
Bemidji (BE)	$93,420,684	$31,133,770	$124,554,454	71
Billings (BI)	$50,628,874	$21,803,250	$72,432,124	38
California (CA)	$234,658,619	$107,395,128	$342,053,747	84
Great Plains (GP)	$365,746,324	$43,584,256	$409,330,580	97
Navajo (NA)	$1,780,545,340	$39,581,171	$1,820,126,511	242
Nashville (NS)	$77,112,737	$7,119,333	$84,232,070	19
Oklahoma City (OKC)	$157,912,608	$384,112,228	$542,024,836	165
Phoenix (PH)	$318,580,492	$66,294,024	$384,874,516	78
Portland (PO)	$113,870,323	$49,595,783	$163,466,106	53
Tucson (TU)	$17,842,496	$1,752,504	$19,595,000	13
Total	**$5,879,739,178**	**$1,039,564,011**	**$6,919,303,189**	**1241**

Appendix B: FY 2025 Tier 1 Legacy List - Projects Counts

Area	Construction Eligible Cost	Construction Ineligible Cost	Design and Construction Document Cost	Project Count*
Albuquerque (AL)	$45,707,120	$1,687,380	$3,159,500	9
Alaska (AN)	$383,911,983	$14,418,272	$10,672,050	4
Bemidji (BE)	$4,236,676	$997,924	$45,000	4
Billings (BI)	$1,242,680	$34,320	$0	2
California (CA)	$40,195,711	$1,650,517	$75,200	2
Great Plains (GP)	$57,108,159	$6,081,261	$1,506,000	16
Navajo (NA)	$3,370,700	$0	$181,000	2
Nashville (NS)	$0	$0	$0	0
Oklahoma City (OKC)	$4,069,000	$6,749,173	$29,550	9
Phoenix (PH)	$76,210,220	$3,293,780	$5,971,320	11
Portland (PO)	$21,309,257	$11,983,402	$3,597,000	7
Tucson (TU)	$1,313,760	$66,240	$0	1
Total	**$638,675,266**	**$46,962,269**	**$25,236,620**	**67**

*Tier 1 DL 2 - DL 5 Projects

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Self Determination

Page

Self-Determination
Self-Determination Program 183
Self-Determination Tables 184

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 224 Tribes and Tribal Organizations operating 270 contracts and annual funding agreements. Under Title V, IHS is party to 120 compacts and 147 funding agreements; through which approximately $3.2 billion of the IHS budget is transferred to Tribes and Tribal organizations.

Indian Health Service
Self-Governance Funded Compacts FY 2025
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALABAMA	**4,664**	**411**	**184**	**628**	**5,887**
Poarch Band of Creek Indians	4,664	411	184	628	5,887
ALASKA	**641,653**	**73,955**	**64,608**	**309,260**	**1,089,476**
Alaska Native Tribal Health Consortium	107,422	35,299	14,062	31,708	188,491
Aleutian Pribilof Islands Association, Inc.	1,741	44	210	1,421	3,416
Arctic Slope Native Association, Ltd	24,800	2,843	3,972	7,298	38,912
Bristol Bay Area Health Corporation	22,048	1,361	2,670	11,449	37,527
Chickaloon Native Village	62	1	18	18	98
Chugachmiut	8,767	405	270	5,152	14,595
Copper River Native Association	6,399	495	595	1,594	9,082
Council of Athabascan Tribal Governments	1,816	261	112	1,268	3,457
Eastern Aleutian Tribes, Inc.	3,377	31	215	1,729	5,351
Kenaitze Indian Tribe, I.R.A.	13,122	1,341	479	5,130	20,072
Ketchikan Indian Community	6,019	107	664	9,116	15,906
Knik Tribal Council	77	1	12	20	111
Kodiak Area Native Association	7,873	79	550	3,141	11,643
Maniilaq Association	29,341	317	3,408	16,826	49,891
Metlakatla Indian Community	6,697	936	574	1,662	9,868
Mount Sanford Tribal Consortium	425	3	49	158	635
Native Village of Eklutna	191	5	7	158	362
Native Village of Eyak	851	13	102	848	1,816
Norton Sound Health Corporation	46,497	3,131	5,241	14,642	69,510
Seldovia Village Tribe	1,959	264	105	771	3,099
Southcentral Foundation	97,902	5,120	12,826	100,360	216,208
SouthEast Alaska Regional Health Consortium	40,988	827	4,310	27,408	73,534
Tanana Chiefs Conference	66,881	4,778	6,856	18,784	97,299
Tanana Tribal Council	1,041	76	69	180	1,365
Yakutat Tlingit Tribe	4,882	409	38	3,982	9,311
Yukon-Kuskokwim Health Corporation	140,478	15,808	7,194	44,437	207,917
ARIZONA	**297,333**	**23,516**	**11,313**	**77,270**	**409,432**
Ak-Chin Indian Community	467	0	8	13	488
Gila River Indian Community	81,678	6,634	2,136	30,334	120,783
Pascua Yaqui Tribe	16,062	278	222	3,473	20,034
Salt River Pima-Maricopa Indian Community	64,072	4,863	2,373	11,341	82,648
Tohono O'Odham Nation	37,202	4,070	2,931	4,559	48,762
Tuba City Regional Health Care Corporation	44,192	2,911	2,640	16,686	66,430
Winslow Indian Health Care Center, Inc.	53,660	4,759	1,002	10,865	70,287
CALIFORNIA	**103,555**	**5,918**	**6,831**	**50,767**	**167,070**
Chapa-De Indian Health Program, Inc.	7,145	1,560	206	3,826	12,737
Consolidated Tribal Health Project, Inc.	4,473	54	119	1,493	6,138
Feather River Tribal Health, Inc.	8,908	116	1,189	5,162	15,375
Hoopa Valley Tribe	5,531	350	781	3,308	9,969
Indian Health Council, Inc.	9,160	64	334	6,553	16,112
Karuk Tribe of California	3,216	447	110	917	4,690
Lake County Tribal Health Consortium, Inc.	7,044	1,497	193	4,042	12,776
Northern Valley Indian Health, Inc.	4,473	374	496	1,556	6,898
Pinoleville Pomo Nation	95	0	3	17	116
Pit River Health Service, Inc.	2,126	22	75	846	3,069
Redding Rancheria Tribe	7,183	53	693	1,957	9,887
Riverside-San Bernardino County Indian Health, Inc.	22,937	1,066	1,048	12,148	37,200
Rolling Hills Clinic	570	36	1	253	860
Round Valley Indian Health Center, Inc.	2,260	67	107	334	2,768
Santa Ynez Band of Chumash Mission Indians	2,033	15	40	786	2,874
Sonoma County Indian Health Project, Inc.	7,679	60	241	3,232	11,212
Southern Indian Health Council, Inc.	5,827	39	981	2,772	9,618
Susanville Indian Rancheria	1,795	9	184	1,237	3,225
Tuolumne Me-Wuk Indian Health Center, Inc.	1,099	90	30	328	1,548

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
CONNECTICUT	**4,345**	**88**	**68**	**1,093**	**5,594**
Mashantucket Pequot Tribal Nation	1,700	14	68	542	2,324
Mohegan Tribe of Indians of Connecticut	2,645	74	0	551	3,270
FLORIDA	**8,145**	**383**	**1,173**	**2,650**	**12,352**
Seminole Tribe of Florida	8,145	383	1,173	2,650	12,352
IDAHO	**16,949**	**1,324**	**2,269**	**5,800**	**26,342**
Coeur D'Alene Tribe	6,582	583	1,661	4,112	12,938
Kootenai Tribe of Idaho	692	50	92	147	981
Nez Perce Tribe	9,675	691	517	1,541	12,423
KANSAS	**7,274**	**77**	**303**	**3,128**	**10,782**
Iowa Tribe of Kansas and Nebraska	2,304	18	196	1,748	4,266
Prairie Band Potawatomi Nation	4,970	59	107	1,380	6,515
LOUISANA	**1,264**	**66**	**150**	**355**	**1,835**
Chitimacha Tribe of Louisiana	1,264	66	150	355	1,835
MAINE	**3,615**	**141**	**205**	**704**	**4,666**
Penobscot Indian Nation	3,615	141	205	704	4,666
MASSACHUSETTS	**760**	**28**	**264**	**726**	**1,778**
Wampanoag Tribe of Gay Head Aquinnah	760	28	264	726	1,778
MICHIGAN	**30,346**	**1,449**	**3,509**	**3,194**	**38,499**
Grand Traverse Band of Ottawa and Chippewa Indians	3,004	115	375	614	4,107
Keweenaw Bay Indian Community	3,569	330	983	803	5,685
Little River Band of Ottawa Indians	2,168	5	303	24	2,501
Match-E-Be-Nash-She-Wish Band of Pottawatomi	1,200	13	267	182	1,663
Nottawaseppi Huron Band Of The Potawatomi	1,857	26	380	146	2,409
Sault Ste. Marie Tribe of Chippewa Indians	18,548	960	1,201	1,425	22,134
MINNESOTA	**21,885**	**244**	**3,432**	**2,497**	**28,057**
Bois Forte Band of Chippewa Indians	2,780	29	486	688	3,983
Fond du Lac Band of Lake Superior Chippewa	12,814	152	1,478	904	15,348
Mille Lacs Band of Ojibwe	4,419	47	1,446	575	6,488
Shakopee Mdewakanton Sioux Community	1,871	16	21	329	2,237
MISSISSIPPI	**40,562**	**4,431**	**1,509**	**5,080**	**51,581**
Mississippi Band of Choctaw Indians	40,562	4,431	1,509	5,080	51,581
MONTANA	**38,093**	**1,644**	**3,701**	**3,978**	**47,416**
Chippewa Cree Tribe of the Rocky Boy's Reservation	11,105	359	2,713	2,310	16,486
Confederated Salish and Kootenai Tribes of the Flathead Nation	23,922	1,261	988	1,526	27,698
Little Shell Tribe of Chippewa Indians of Montana	3,065	24	0	142	3,231
NORTH CAROLINA	**21,181**	**1,126**	**1,209**	**9,557**	**33,073**
Eastern Band of Cherokee Indians	21,181	1,126	1,209	9,557	33,073
NORTH DAKOTA	**11,678**	**704**	**1,859**	**3,222**	**17,463**
Spirit Lake Tribe	11,678	704	1,859	3,222	17,463
NEBRASKA	**18,861**	**3,022**	**2,062**	**4,642**	**28,587**
Winnebago Tribe of Nebraska	18,861	3,022	2,062	4,642	28,587
NEW MEXICO	**16,986**	**376**	**2,328**	**2,947**	**22,637**
Pueblo of Jemez	10,397	103	1,171	1,597	13,267
Pueblo of Sandia	1,921	61	178	291	2,453
Pueblo of Zuni	3,660	195	723	756	5,333
Taos Pueblo	1,008	17	256	303	1,584
NEVADA	**30,801**	**1,013**	**2,641**	**6,591**	**41,045**
Duck Valley Shoshone-Paiute Tribes	7,304	579	935	1,875	10,693
Duckwater Shoshone Tribe	1,149	7	243	1,372	2,771
Ely Shoshone Tribe	1,425	32	77	508	2,041
Fort McDermitt Paiute and Shoshone Tribe	1,989	110	8	103	2,210
Las Vegas Paiute Tribe	3,657	83	145	225	4,110
Reno-Sparks Indian Colony	7,641	75	819	1,253	9,788
Washoe Tribe of Nevada and California	5,501	39	286	846	6,672
Yerington Paiute Tribe of Nevada	2,136	88	126	410	2,760
NEW YORK	**8,487**	**465**	**389**	**2,447**	**11,789**
St. Regis Mohawk Tribe	8,487	465	389	2,447	11,789

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
OKLAHOMA	**603,232**	**51,108**	**49,929**	**308,181**	**1,012,451**
Absentee Shawnee Tribe of Oklahoma	19,452	1,719	2,348	7,276	30,796
Cherokee Nation	254,972	17,463	16,688	55,795	344,917
Chickasaw Nation	91,403	14,799	12,299	170,474	288,975
Choctaw Nation of Oklahoma	94,451	11,330	7,731	48,882	162,394
Citizen Potawatomi Nation	23,307	718	1,993	10,309	36,327
Kaw Nation of Oklahoma	2,989	70	256	410	3,724
Kickapoo Tribe of Oklahoma	10,541	235	352	1,816	12,945
Modoc Nation	63	4	7	12	86
Muscogee Nation	62,657	3,857	6,883	6,335	79,732
Northeastern Tribal Health System	7,968	165	186	1,380	9,700
Osage Nation	13,459	58	450	2,204	16,171
Pawnee Nation of Oklahoma	723	16	21	195	955
Ponca Tribe of Oklahoma	6,601	111	316	1,033	8,060
Quapaw Tribe of Oklahoma	237	0	41	116	394
Sac and Fox Nation of Oklahoma	10,402	98	201	1,178	11,879
Seminole Nation of Oklahoma	526	373	60	200	1,159
Wichita & Affiliated Tribes	340	6	48	112	505
Wyandotte Nation	3,140	86	48	457	3,731
OREGON	**31,152**	**1,527**	**3,394**	**11,950**	**48,024**
Confederated Tribes of Grand Ronde	7,152	224	672	3,085	11,133
Confederated Tribes of Siletz Indians of Oregon	8,531	429	925	2,946	12,830
Confederated Tribes of the Coos, Lower Umpqua & Siuslaw Indians	1,944	96	362	674	3,076
Confederated Tribes of the Umatilla Reservation	7,256	372	908	2,032	10,568
Coquille Indian Tribe	2,233	64	287	2,314	4,898
Cow Creek Band of Umpqua Tribe of Indians	4,036	342	240	900	5,518
SOUTH DAKOTA	**72,532**	**5,511**	**3,833**	**12,441**	**94,316**
Great Plains Tribal Leaders Health Board	72,532	5,511	3,833	12,441	94,316
TEXAS	**8,502**	**1,143**	**1,302**	**2,859**	**13,806**
Ysleta del Sur Pueblo	8,502	1,143	1,302	2,859	13,806
UTAH	**10,728**	**252**	**2,533**	**4,553**	**18,066**
Paiute Indian Tribe of Utah	2,460	46	296	424	3,224
Utah Navajo Health System, Inc.	8,269	206	2,238	4,129	14,842
VIRGINIA	**306**	**0**	**107**	**238**	**650**
Pamunkey Indian Tribe	306	0	107	238	650
WASHINGTON	**66,957**	**4,523**	**3,590**	**21,750**	**96,820**
Cowlitz Indian Tribe	7,310	312	29	3,191	10,842
Jamestown S'Klallam Indian Tribe	1,354	61	113	154	1,682
Kalispel Tribe of Indians	1,179	59	27	231	1,496
Lower Elwha Klallam Tribe	2,021	128	134	540	2,822
Lummi Indian Nation	8,797	791	333	2,156	12,077
Makah Indian Tribe	4,176	312	376	1,494	6,359
Muckleshoot Tribe	7,870	469	259	3,023	11,621
Nisqually Indian Tribe	2,494	114	143	208	2,959
Port Gamble S'Klallam Tribe	2,804	50	176	1,484	4,514
Quinault Indian Nation	6,043	620	284	3,381	10,328
Samish Indian Nation	1,201	8	120	467	1,796
Shoalwater Bay Indian Tribe	1,935	71	363	820	3,189
Skokomish Indian Tribe	2,225	117	145	534	3,021
Spokane Tribe of Indians	2,460	287	0	306	3,053
Squaxin Island Indian Tribe	2,952	278	256	649	4,135
Suquamish Tribe	1,809	36	191	620	2,657
Swinomish Indian Tribal Community	2,426	200	229	704	3,560
Tulalip Tribes of Washington	7,904	609	411	1,786	10,709
WISCONSIN	**38,061**	**1,437**	**6,166**	**6,456**	**52,121**
Forest County Potawatomi Community	2,128	364	916	540	3,947
Ho-Chunk Nation	9,135	732	1,105	1,359	12,331
Oneida Tribe of Indians of Wisconsin	23,285	284	3,553	3,878	31,000
Stockbridge-Munsee Community	3,514	58	593	679	4,843
WYOMING	**17,140**	**1,286**	**350**	**2,001**	**20,778**
Eastern Shoshone Tribe	8,330	815	132	59	9,336
Northern Arapaho Tribe of Indians	8,810	472	219	1,942	11,442

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
GRAND TOTAL	**2,177,047**	**187,168**	**181,211**	**866,963**	**3,412,390**

Indian Health Service
FY 2025 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	692,347	13,521	9,740	64,608	309,260	1,089,476
ALBUQUERQUE	24,553	1,660	794	3,630	5,805	36,443
BEMIDJI	89,700	1,851	1,872	13,107	12,147	118,676
BILLINGS	53,585	3,297	1,282	4,051	5,979	68,193
CALIFORNIA	102,223	4,181	3,069	6,831	50,767	167,070
GREAT PLAINS	108,757	2,733	817	7,754	20,305	140,366
NASHVILLE	93,791	5,255	1,423	5,258	23,477	129,204
NAVAJO	110,210	1,705	2,083	5,880	31,681	151,559
OKLAHOMA	635,930	11,932	13,829	50,233	311,309	1,023,233
PHOENIX	188,106	2,245	1,682	7,453	48,702	248,188
PORTLAND	117,544	3,570	1,318	9,254	39,500	171,186
TUCSON	54,195	2,619	799	3,153	8,031	68,796
Total, IHS	**2,270,941**	**54,568**	**38,708**	**181,211**	**866,963**	**3,412,390**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2027 Performance Budget Submission to Congress

TABLE OF CONTENTS

Legislative Proposals

Page

Legislative Proposals 189

FY 2027 CONGRESSIONAL JUSTIFICATION LEGISLATIVE PROPOSAL
Indian Health Service

Reset the CMS Promoting Interoperability Program Hardship Exception Count for Users of the IHS Resource and Patient Management System

This proposal seeks to amend the Social Security Act to reset to zero the five-year lifetime limit on hardship exceptions under the Centers for Medicare and Medicaid Services (CMS) Medicare Promoting Interoperability Program for Indian Health Service (IHS) federal and Tribally-operated eligible hospitals and Critical Access Hospitals (CAHs). Resetting the count would allow facilities that are currently at or have exceeded the five-year limit to maintain full Medicare reimbursement rates and avoid payment reductions tied to noncompliance with the Medicare Promoting Interoperability requirements. Going forward, IHS and Tribally-operated hospitals would again be eligible for up to five years of hardship exceptions before any payment adjustments apply.

Under current law, eligible hospitals and CAHs face statutory limits on hardship exceptions, after which Medicare payment reductions are imposed. These reductions have been in effect since fiscal year (FY) 2015 and have disproportionately affected IHS and Tribal facilities due to longstanding challenges with health information technology systems such as the Resource Patient Management System (RPMS) which were compounded by operational disruptions during the COVID-19 Public Health Emergency. While the reductions do not affect the IHS all-inclusive rate, they significantly lower inpatient prospective payments for acute care hospitals and cost-based reimbursements for CAHs.

The impact of the current policy is growing. By calendar year (CY) 2023, 16 Federal and Tribal facilities were either at or beyond the five-year hardship limit which exposed them to payment penalties. Resetting the hardship exception count would provide immediate financial relief, stabilize Medicare reimbursement for affected facilities, and support continued access to care in Tribal and rural communities, while preserving CMS's ability to apply payment adjustments if the reset limit is reached again in the future.