DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year 2019

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) 2019 Congressional Justification. The FY 2019 budget request supports the President's goal of providing the most efficient and effective health services. This budget also invests in the Department of Health and Human Services (HHS) Secretary's priority to enhance the health and well-being of Americans, providing a patient-centered system with emphasis on bolstering direct medical services and expanding our efforts to improve medical quality at IHS facilities.

The mission of the IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. This FY 2019 budget submission continues support for our critical work in providing a comprehensive health service delivery system managed by IHS, Tribal and urban Indian health programs in 36 states. Our efforts align with the Administration's priorities and support the HHS' goals to help people live healthy, safe, and productive lives. This budget submission also reflects our continued partnership and consultation with Tribes and conferring with urban Indian organizations to address the health care needs of American Indians and Alaska Natives.

Our FY 2019 budget submission maintains focus on the IHS mission and support for our four priorities:

- People – Recruit, develop, and retain a dedicated, competent, and caring workforce collaborating to achieve the IHS mission;
- Partnerships – Build, strengthen, and sustain collaborative relationships that advance the IHS mission;
- Quality – Excellence in everything we do to assure a high-performing Indian health system; and
- Resources – Secure and effectively manage the assets needed to promote the IHS mission.

Performance management and improvement is critical to our work and we regularly measure our progress. The IHS's priorities provide a shared vision of what needs to be accomplished with our partners and provides a consistent and effective way to measure our achievement as we continue to change and improve the IHS.

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2019 Performance Budget Submission to Congress

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

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NOTE: THE STANDARD ADMINISTRATIVE CODE IS LOCATED IN THE LOWER LEFT HAND CORNER OF EACH BOX.

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 goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people. The strategic goals include building and sustaining healthy communities; providing accessible, quality health care; and fostering collaboration and innovation across the Indian health care systems.

The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to approximately 2.2 million American Indians and Alaska Natives who are primarily members of 573 federally recognized Tribes in 37 states. Comprehensive primary health care and disease prevention services are provided through a network of more than 850 hospitals, clinics, and health stations on or near Indian reservations. These 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 program direction roles that were 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 facilities where Tribes have chosen not to contract or compact health programs.

This Budget represents the President's annual report to Congress on IHS programs and its achievement of the goals of IHCIA as required by 25 USC Sec. 1671.

INDIAN HEALTH SERVICE
FY 2019 President's Budget to Congress

Overview of Budget

The FY 2019 Budget reflects the President's strong support of health care services for American Indians and Alaska Natives. While national priorities dictate austerity in non-essential programs, this budget reflects the importance of providing health care, consistent with statutory authorities, to American Indians and Alaska Natives (AI/AN), prioritizing medical service delivery by bolstering the clinical services portion of the Indian Health Service (IHS) budget by $413 million above the annualized Continuing Resolution (CR) FY 2018 level. This supports the President's agenda to address the Nation's priorities through careful investments of taxpayer resources.

This budget proposes to eliminate the Health Education, Community Health Representatives, and the Tribal Management Grant programs While these programs contribute to community-based care, the Budget prioritizes IHS' mission to provide quality direct health care services.. These reductions along with modest reductions in other services and facilities enable IHS to request a 11 percent increase over the FY 2018 annualized CR level in Clinical Services, with a 8 percent overall budget increase for IHS.

Tribal consultation is important to the IHS budget process. The core of the agency's formulation process consists of the priorities and recommendations developed with Tribes through an independent annual budget formulation process[1]. This process is one to which the IHS is strongly committed, and which helps IHS ensure that this budget is relevant to the health needs and priorities of AI/AN people. The tribal priorities identified in the consultation process are also instrumental to inform senior officials of other U.S. Department of Health and Human Services (HHS) agencies of the health needs of the American Indian and Alaska Native population, so that they have the opportunity to include those priorities in their individual budget requests. The Tribal budget consultation process is a key component of the IHS priority to build, strengthen, and sustain collaborative relationships that advance the IHS mission.

Summary of Budget Submission. The total discretionary budget authority for IHS is $5.4 billion, an increase of $413 million above the FY 2018 annualized CR level. The changes include the following:

- Staffing and Operating Costs for Newly-constructed Facilities: +$159.1 million above the FY 2018 annualized CR level for new staffing of six newly-constructed health care facilities scheduled to complete in FY 2018 and 2019, and one additional facility expansion. These funds will allow new facilities to expand the provision of health care in areas where the existing capacity is overextended, while balancing the need to maintain existing services across the country. These funds include $137.6 million in clinical services and $21.5 million in other lines.

- Clinical Services: +$102.2 million above the FY 2018 annualized CR level, an increase that will sustain funding for direct clinical health services. The proposed funding level supports operating levels consistent with anticipated final FY 2018 funding levels.

[1] The requirements for consultation are contained in statutes and various Presidential Executive orders including the: Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638 as amended; Indian Health Care Improvement Act, P.L. 94-437, as amended; Memorandum to the Heads of Executive Departments and Agencies from President William J. Clinton, April 29, 1994; Presidential Executive Order 13084,Consultation and Coordination with Indian Tribal Governments, May 14, 1998; Presidential Executive Order 13175,Consultation and Coordination with Indian Tribal Governments, November 6, 2000; and Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004.

- Accreditation Emergencies: +$29 million above the FY 2018 annualized CR level of $29 million, for a total of $58 million for IHS to assist health care facilities that are experiencing challenges meeting CMS Conditions of Participation and/or maintaining accreditation, which are important for their ability to bill and collect from third party payers. These funds will supplement services and facilities costs at targeted facilities.

- New Tribes +$1,969,000 – Additional funding is typically requested when a new Tribe is federally-recognized or reinstated so that the increase in healthcare service needs does not impact or diminish the existing Agency base budget, which supports direct service Tribes. Based on currently available information, the request reflects estimated amounts for health care services to the Pamunkey Tribe of Virginia; the United Keetoowah Band of Cherokee Indians (Oklahoma), formerly a part of the Cherokee Nation of Oklahoma, for mental health services; and the Paskenta Band of Nomlaki Indians (California).

- Opioid Prevention, Treatment, and Recovery Support (OPTRS) +$150 million – new funding for grants as part of the $10 billion in new funding for the Department of Health and Human Services to combat the opioid epidemic and address mental health. These funds will expand efforts to prevent opioid abuse, and help AI/ANs seeking treatment to access overdose-reversing drugs, treatment, and recovery support services.

- Program Discontinuations: -$80.9 million below the FY 2018 annualized CR level, for discontinuation of the Health Education, Community Health Representatives, and Tribal Management Grant programs in FY 2019. These programs have supported IHS's mission, but direct clinical services and staffing for newly constructed facilities are prioritized.

- Other Services Reductions: -$7.5 million below the FY 2018 Annualized CR level in other net Services program reductions. This includes the reductions to Urban Indian Health Program (-$0.9 million), Indian Health Professions (-$5.6 million), and Self-Governance (-$1 million). Funding for direct clinical services and staffing for newly constructed facilities are prioritized.

- Facilities Reductions: -$40.5 million below the FY 2018 annualized CR level to facilities program reductions. This includes reductions to Health Care Facilities Construction (-$37.7 million) and for Medical Equipment (-$2.9 million). Funding for direct clinical services and staffing of newly constructed facilities are prioritized.

Overview of Agency Performance

Since 1955, the IHS, in consultation with Tribes, Urban Indian programs, and Indian organizations, has worked diligently to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people.[2]

This FY 2019 performance budget represents the IHS's progress in providing health care services to approximately 2.2 million American Indians and Alaska Natives in 36 states. In pursuing our mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, IHS's strategic goals relate to: people, partnerships, quality, and resources. The IHS operates a health services delivery system providing a range of clinical, public health, community, and environmental services. This system integrates health services delivery through IHS facilities, purchased by IHS through contractual arrangements with providers in the private sector, and delivered through tribally operated programs and urban Indian health programs.

IHS performance improvement is a concerted effort by all members of the Indian health system working together to improve a comprehensive set of existing performance measures. This includes all clinic-based, hospital-based, and community-based programs administered by federal, tribal and urban programs. The IHS budget request reflects Government Performance and Results Act (GPRA) and GPRA Modernization Act (GPRAMA) measures that support our strategic goals and improvement of AI/AN health outcomes. Listed below under each goal are highlights of the Agency's achievements and performance expectations, as appropriate.

People – *Recruit, develop, and retain a dedicated, competent, caring workforce collaborating to achieve the IHS mission.*

- In FY 2016, IHS and Tribes provided 13,882,221 outpatient visits to 1,626,826 AI/ANs. IHS and Tribes provided 39,276 direct care admissions in FY 2016. In FY 2019, it is expected the IHS user population will increase by approximately 56,189 compared to the FY 2017 user population of 1,638,686.
- In FY 2019, IHS expects to maintain current efforts to support the IHS workforce and modify the number of current health professions awards for scholarships and loan repayment.
- In FY 2019, IHS will continue recruitment and training efforts aimed at strengthening the IHS health professions workforce, including implementing a global recruitment plan to recruit for critical vacancies across the Agency. To reach health professions students, IHS has established partnerships with the Health Resources and Services Administration, Bureau of Health Workforce, by participating in nationwide virtual career fairs to promote National Health Service Corps scholarship and loan repayment opportunities. IHS has also partnered with the Department of Veterans Affairs (VA) to establish a workgroup to increase capability and improve quality through training and workforce development as well as sharing of educational and training opportunities for IHS staff.

Partnerships – *Build, strengthen, and sustain collaborative relationships that advance the IHS mission.*

- IHS has numerous partnerships with HHS sister agencies, other federal departments, and countless academic, professional, and other organizations. The bullets below represent a few examples of these important partnerships:

[2] The IHS produces statistical information and publications that measure and document the progress in assuring access to health care services and improving the health status of AI/ANs, publications are available at: https://www.ihs.gov/dps/index.cfm/publications.

- The IHS and VA partnership allows eligible AI/AN veterans more choices of where to access care. The VA provides reimbursement to IHS and tribal facilities for direct care services. In FY 2019, IHS anticipates a collection of $28 million in VA reimbursements.
- To increase access to behavioral health services for native youth, IHS partners with the Bureau of Indian Affairs (BIA) and Bureau of Indian Education (BIE) under a 10-year agreement. The agreement allows each agency to establish local partnerships between IHS federally operated mental health programs, BIE-operated elementary and secondary schools, and BIA OJS-operated juvenile detention centers to provide mental health assessment and counseling services, which includes telebehavioral health services. In FY 2019, IHS will report results for depression screening among AI/AN youth aged 12-17.
- IHS is working with the Pediatric Integrated Care Collaborative (PICC) which is part of the Johns Hopkins Center for Mental Health Services in Pediatric Primary Care. PICC works with national faculty, pediatric primary care providers, mental health professionals and families to increase the quality and accessibility of child trauma service by integrating behavioral and physical health services in Native communities. In FY 2017, 10 IHS and Tribally operated sites participated in a new year long project to integrate trauma - informed care at IHS and tribal facilities.

Quality – *Excellence in everything we do to assure a high-performing Indian Health system.*

- The IHS 2016-2017 Quality Framework explicitly set the goal of establishing the Office of Quality Health Care to lead all quality and safety work for IHS and report to the Deputy Director for Quality Health Care. The related goal for FY 2018 is to enact a budget for the Office enabling initial critical staffing, training resource procurement, and analytic software to support data-driven decision making. The Office of Quality Health Care will continue the work of the Quality Framework Steering Committee in completing implementation of the Framework, in addition to leading future strategic planning that builds on the Framework's success.
- In FY 2018, IHS is implementing several efforts to strengthen the delivery of high quality health care at IHS direct service facilities. The FY 2019 target is to maintain 100 percent accreditation and/or certification at IHS-operated hospitals and outpatient clinics.
- IHS is working with The Joint Commission for accreditation, training, and education services to strengthen quality and patient safety.
- The Centers for Medicare & Medicaid Services (CMS) now includes IHS hospitals in the nationwide Hospital Improvement and Innovation Networks contract for public and private sector hospitals to reduce adverse health events by 20 percent and hospital readmissions by 12 percent.
- An IHS Telehealth contract is providing telehealth services at six hospitals and many health centers and other facilities throughout Iowa, Nebraska, South Dakota, and North Dakota. IHS is leveraging telehealth services as a means of strengthening access to care at its facilities in all 14 Great Plains Area facilities, which serve 130,000 American Indians and Alaska Natives.

Resources – *Secure and effectively manage the assets needed to promote the IHS mission.*

- As of October 1, 2016, IHS and Tribes operated 168 service units, 48 hospitals and 560 ambulatory centers. Urban Indian health programs operated 42 Urban Indian organizations of which there were 21 full ambulatory care programs, 6 limited ambulatory care programs, 6 outreach and referral programs, 7 residential alcohol and addiction treatment programs and 2 hybrid programs.

Performance Management
IHS cascades performance goals and objectives and performance-related metrics Agency-wide. Specific measures cascade from senior executive performance plans to those of subordinate managers and supervisors. From there they cascade into employee performance plans, which ensures that 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 is greater success in meeting the full array of Agency mission requirements.

Performance Reporting
Tribes administer over one-half of IHS resources through Indian Self-Determination and Education Assistance Act (ISDEAA) contracts and compacts and the Agency's performance management activity primarily reflects the IHS programs. However, there are several Tribal programs that choose to participate in GPRA/GPRAMA performance reporting. The IHS budget measures are focused on monitoring population health (clinical measures) and strategies to assess program trends and management (non-clinical measures).

Consistent with the GPRA/GPRAMA, IHS continues to report valid and reliable clinical measures. Additionally, IHS' measures support the following HHS performance products, including the FY 2019 Annual Performance Plan and Report (APP/R). In FY 2019, IHS proposes to report on two GPRAMA measures to be included in the HHS APP/R:

- Intimate Partner (Domestic) Violence (IP DV) Screening
- Increase tele-behavioral health encounters nationally

IHS has reported electronic population level results for GPRA/GPRAMA clinical measures since 2002. Beginning in FY 2018, IHS will use the Integrated Data Collection System Data Mart (IDCS DM) to report clinical measure results. This is a major performance reporting change for the Agency, as measure results can be calculated using any data (RPMS, non-RPMS or Fiscal Intermediary) submitted to the National Data Warehouse (NDW). With this change, IHS will report aggregated federal, tribal and urban (I/T/U) results for the first time. Tribal programs continue to have the option to participate. The IDCS DM, IHS' centralized performance data mart, produces aggregated, clinical performance measure results at an on-demand basis.

Since the IDCS DM will use all data exported to the NDW including non-RPMS tribal and urban data, budget measures previously reported from RPMS cannot be compared to IDCS DM results because of the following reasons:

- *User Population Estimates*: The IDCS DM will standardize the use of the User Population estimates as the denominator for the clinical GPRA/GPRAMA measures;
- *Reporting Year*: The GPRA/GPRAMA year of July 1-June 30 will change to match the User Population Estimates year of October 1-September 30.

National clinical GPRA/GPRAMA results now include urban data.

The FY 2019 Budget Request reflects the reporting transition to the IDCS DM system. The current clinical performance measures reported in individual program narratives are displayed first with their FY 2017 target and result with a note in the FY 2018 target column stating this measure is to "retire and replace". The replacement clinical measures with new HHS Unique Identifier numbers are added in numerical sequence of each Outputs and Outcomes table. The new replacement measures state the FY 2018 and FY 2019 IDCS DM targets.

Discretionary All Purpose Table
Indian Health Service
(Dollars in Thousands)

Program	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
SERVICES				
Clinical Services	**3,359,038**	**3,336,226**	**3,688,883**	**352,657**
Hospitals & Health Clinics	1,935,178	1,922,036	2,189,688	267,652
Dental Services	182,597	181,357	203,783	22,426
Mental Health	94,080	93,441	105,169	11,728
Alcohol & Substance Abuse	218,353	216,870	235,286	18,416
Purchased/Referred Care	928,830	922,522	954,957	32,435
Indian Health Care Improvement Fund	0	0	0	0
Preventive Health	**159,730**	**158,645**	**89,058**	**-69,587**
Public Health Nursing	78,701	78,167	87,023	8,856
Health Education	18,663	18,536	0	-18,536
Community Health Representatives	60,325	59,915	0	-59,915
Immunization AK	2,041	2,027	2,035	8
Other Services	**175,694**	**174,501**	**168,034**	**-6,467**
Urban Health	47,678	47,354	46,422	-932
Indian Health Professions	49,345	49,010	43,394	-5,616
Tribal Management Grants	2,465	2,448	0	-2,448
Direct Operations	70,420	69,942	73,431	3,489
Self-Governance	5,786	5,747	4,787	-960
TOTAL, SERVICES	**3,694,462**	**3,669,372**	**3,945,975**	**276,603**
FACILITIES	**545,424**	**541,721**	**505,821**	**-35,900**
Maintenance & Improvement	75,745	75,231	75,745	514
Sanitation Facilities Construction	101,772	101,081	101,772	691
Health Care Facilities Construction	117,991	117,190	79,500	-37,690
Facilities & Environ Health Support	226,950	225,409	228,852	3,443
Equipment	22,966	22,810	19,952	-2,858
TOTAL, SERVICES & FACILITIES	**4,239,886**	**4,211,093**	**4,451,796**	**240,703**
CONTRACT SUPPORT COSTS[1]				
TOTAL, CONTRACT SUPPORT COSTS	**800,000**	**800,000**	**822,227**	**22,227**
Special Diabetes Program for Indians (SDPI)				
Discretionary Budget Authority	0	0	150,000	150,000
TOTAL, BUDGET AUTHORITY	**5,039,886**	**5,011,093**	**5,424,023**	**412,930**
COLLECTIONS				
Medicare	248,638	248,638	248,638	0
Medicaid	807,605	807,605	807,605	0
Subtotal, M / M	*1,056,243*	*1,056,243*	*1,056,243*	0
Private Insurance	109,272	109,272	109,272	0
VA Reimbursement	28,062	28,062	28,062	0
Total, M / M / PI	*1,193,577*	*1,193,577*	*1,193,577*	0
Quarters	8,500	8,500	8,500	0
TOTAL, COLLECTIONS	**1,202,077**	**1,202,077**	**1,202,077**	0
MANDATORY				
Special Diabetes Program for Indians (SDPI)				
Current Law Mandatory Funding	147,000	75,000	0	-75,000
Proposed Law Mandatory Funding	0	75,000	0	-75,000
Subtotal, Special Diabetes Program for Indians	147,000	150,000	0	-150,000
Total, Mandatory	**147,000**	**150,000**		**-150,000**
TOTAL, PROGRAM LEVEL	**6,388,963**	**6,363,170**	**6,626,100**	**262,930**
Opioid Prevention, Treatment, and Recovery Support (OPTRS)[2]	**0**	**0**	**150,000**	**150,000**
TOTAL, with OPTRS	**6,388,963**	**6,363,170**	**6,776,100**	**412,930**

[1]CSC are maintained as discretionary with a separate, indefinite appropriation in FY 2019.

[2]The Opioid Prevention, Treatment, and Recovery Support is a part of the HHS $10 billion proposal to combat the opioid epidemic and address mental health

INDIAN HEALTH SERVICE
FY 2019 President's Budget
Detail of Changes
(Dollars in Thousands)

10-Feb-18

Sub IHS Activity	FY 2017 Final	FY 2018 Annualized CR /1	FY 2019 Current Services: Pay: Federal Pay	Tribal Pay	Pay Total	Medical Inflation	Current Services Total	Staffing for New Facilities /2	Program Adjustments: Special Diabetes Program for Indians	Clinical Services	Accreditation Emergencies	Contract Support Costs	New Tribes	Facilities	Adjustments /3	Program Reductions	Adjustments Subtotal	FY 2019 President's Budget
SERVICES																		
Hospitals & Health Clinics	1,935,178	1,922,036	12,884	18,875	31,759	13,560	45,319	103,646	0	87,718	29,000	0	1,969	0	0	0	118,687	**2,189,688**
Dental Services	182,597	181,357	1,367	1,867	3,234	2,786	6,020	13,878	0	1,728	0	0	0	0	800	0	2,528	**203,783**
Mental Health	94,080	93,441	515	956	1,471	1,442	2,913	7,736	0	1,079	0	0	0	0	0	0	1,079	**105,169**
Alcohol & Substance Abuse	218,353	216,870	374	2,620	2,994	4,566	7,560	8,684	0	2,172	0	0	0	0	0	0	2,172	**235,286**
Purchased/Referred Care	928,830	922,522	0	0	0	22,465	22,465	3,662	0	6,308	0	0	0	0	0		6,308	**954,957**
Total, Clinical Services	3,359,038	3,336,227	15,140	24,318	39,458	44,819	84,277	137,606	0	99,005	29,000	0	1,969	0	800	0	130,774	**3,688,884**
Public Health Nursing	78,701	78,167	511	870	1,381	1,319	2,700	6,825	0	0	0	0	0	0	0	(669)	(669)	**87,023**
Health Education /2	18,663	18,536	0	0	0	0	0	0	0	0	0	0	0	0	0	(18,536)	(18,536)	**0**
Comm. Health Reps /2	60,325	59,915	0	0	0	0	0	0	0	0	0	0	0	0	0	(59,915)	(59,915)	**0**
Immunization AK	2,041	2,027	0	37	37	48	85	0	0	0	0	0	0	0	0	(77)	(77)	**2,035**
Total, Preventive Health	159,730	158,645	511	907	1,418	1,367	2,785	6,825	0	0	0	0	0	0	0	(79,198)	(79,198)	**89,058**
Urban Health	47,678	47,354	42	684	726	955	1,681	0	0	0	0	0	0	0	0	(2,613)	(2,613)	**46,422**
Indian Health Professions	49,345	49,010	52	0	52	0	52	0	0	0	0	0	0	0	0	(5,668)	(5,668)	**43,394**
Tribal Management /2	2,465	2,448	0	0	0	0	0	0	0	0	0	0	0	0	0	(2,448)	(2,448)	**0**
Direct Operations	70,420	69,942	920	173	1,093	0	1,093	0	0	3,196	0	0	0	0	(800)	0	2,396	**73,431**
Self-Governance	5,786	5,747	52	0	52	0	52	0	0	0	0	0	0	0	0	(1,012)	(1,012)	**4,787**
Total, Other Services	175,694	174,501	1,066	857	1,923	955	2,878	0	0	3,196	0	0	0	0	(800)	(11,741)	(9,345)	**168,034**
Total, Services	3,694,462	3,669,373	16,717	26,082	42,799	47,141	89,940	144,431	0	102,201	29,000	0	1,969	0	0	(90,939)	42,231	**3,945,975**
FACILITIES																		
Maintenance & Improvement	75,745	75,231	0	0	0	0	0	0	0	0	0	0	0	514	0	0	514	**75,745**
Sanitation Facilities Constr.	101,772	101,081	0	0	0	0	0	0	0	0	0	0	0	691	0	0	691	**101,772**
Health Care Fac. Constr.	117,991	117,190	0	0	0	0	0	0	0	0	0	0	0	0	0	(37,690)	(37,690)	**79,500**
Facil. & Envir. Hlth Supp.	226,950	225,409	2,445	1,497	3,942	317	4,259	14,665	0	0	0	0	0	0	0	(15,481)	(15,481)	**228,852**
Equipment	22,966	22,810	0	0	0	441	441	0	0	0	0	0	0	0	0	(3,299)	(3,299)	**19,952**
Total, Facilities	545,424	541,720	2,445	1,497	3,942	758	4,700	14,665	0	0	0	0	0	1,205	0	(56,470)	(55,265)	**505,820**
Total, Services & Facilities	4,239,886	4,211,093	19,162	27,579	46,741	47,899	94,640	159,096	0	102,201	29,000	0	1,969	1,205	0	(147,409)	(13,033)	**4,451,796**
CONTRACT SUPPORT COSTS																		
Total, Contract Support Costs	800,000	800,000	0	0	0	0	0	0	0	0	0	22,227	0	0	0	0	22,227	**822,227**
SPECIAL DIABETES PROGRAM FOR INDIANS /4																		
Total, SDPI	0	0	0	0	0	0	0	0	150,000	0	0	0	0	0	0	0	150,000	**150,000**
TOTAL, BUDGET AUTHORITY	**5,039,886**	**5,011,093**	**19,162**	**27,579**	**46,741**	**47,899**	**94,640**	**159,096**	**150,000**	**102,201**	**29,000**	**22,227**	**1,969**	**1,205**	**0**	**(147,409)**	**159,194**	**5,424,023**

/1 The FY 2018 Annualized Continuing Resolution (CR) does not include an anomaly of $24.234 million for staffing and operating costs for newly-constructed health care facilities (Public Law 115-123).

/2 Discontinuation of three programs: Health Education, -$18 million, Community Health Representatives, -$59 million, and Tribal Management, -$2 million. The Staffing for New Facilities costs for FY 2019 are also reduced by $1 million as a result of the Health Education program discontinuation.

/3 Technical adjustment to return $800,000 to Dental Services, but the Congressional intent for these funds described in the FY 2017 report remains the same--funds will continue to be used to backfill vacant dental health positions in Headquarters.

/4 The Special Diabetes Program for Indians is proposed as a discretionary, no-year account starting in FY 2019. Prior allocations of $150 million per year were included in a mandatory account.

INDIAN HEALTH SERVICE

STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES -- Estimates

FY 2019 Budget Request

(Dollars in Thousands)

	Chandler, AZ		Phoenix, AZ		Winterhaven, CA		Eufaula, OK		Davis, CA		Bethel, AK		Tahlequah, OK				
	Red Tail Hawk Health Center		Phoenix Indian Medical Center		Fort Yuma Health Center (Replacement)		Muskogee (Creek) Nation Health Center (JV)		Northern California Youth Regional Treatment Center		Yukon-Kuskokwim Primary Care Center (JV)		Cherokee Nation Regional Health Center (JV)				
Opening Date	January 2018		January 2018		April 2018		May 2018		March 2019		July 2019		July 2019		**TOTAL**		
Sub Sub Activity	FTE	Amount	FTE	Amount	FTE	Amount	Pos	Amount	FTE	Amount	Pos	Amount	Pos	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	245	$26,702	43	$4,574	48	$5,330	59	$6,444	0	$0	216	$39,065	165	$21,531	336	440	$103,646
Dental Health	57	$5,962	0	$0	6	$658	12	$1,290	0	$0	35	$5,029	7	$939	63	54	$13,878
Mental Health	24	$2,563	0	$0	3	$300	7	$731	0	$0	25	$3,470	5	$672	27	37	$7,736
Alcohol & Substance Abuse	9	$949	0	$0	1	$154	3	$307	65	$6,128	7	$896	2	$250	75	12	$8,684
Purchased/Referred Care	0	$0	0	$0	0	$3,662	0	$0	0	$0	0	$0	0	$0	0	0	$3,662
Total, Clinical Services	335	$36,176	43	$4,574	58	$10,104	81	$8,772	65	$6,128	283	$48,460	179	$23,392	501	543	$137,606
Public Health Nursing	22	$3,015	0	$0	3	$387	5	$679	0	$0	11	$1,975	6	$769	25	22	$6,825
Health Education [1]	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Comm. Health Representatives	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Preventive Health	22	$3,015	0	$0	3	$387	5	$679	0	$0	11	$1,975	6	$769	25	22	$6,825
Total, Services	357	$39,191	43	$4,574	61	$10,491	86	$9,451	65	$6,128	294	$50,435	185	$24,161	526	565	$144,431
Facilities Support	11	$3,181	0	$0	3	$645	6	$1,087	5	$678	22	$5,446	15	$1,971	19	43	$13,008
Environmental Health Support	0	$0	0	$0	4	$594	0	$0	0	$0	5	$1,063	0	$0	4	5	$1,657
Total, FEHS	11	$3,181	0	$0	7	$1,239	6	$1,087	5	$678	27	$6,509	15	$1,971	23	48	$14,665
Total, Facilities	11	$3,181	0	$0	7	$1,239	6	$1,087	5	$678	27	$6,509	15	$1,971	23	48	$14,665
Grand Total [2]	**368**	**$42,372**	**43**	**$4,574**	**68**	**$11,730**	**92**	**$10,538**	**70**	**$6,806**	**321**	**$56,944**	**200**	**$26,132**	**549**	**613**	**$159,096**

[1] Health Education is proposed for discontinuation in the FY 2019 Budget, an adjustment to the Resource Requirements Methodology calculations of -$1.1 million in total

[2] Includes Utilities

Statement of Personnel Resources
INDIAN HEALTH SERVICE

	FY 2017 Final	FY 2018 Annual CR	FY 2019 PB
Direct:			
Hospitals & Health Clinics	6,046	6,046	6,382
Dental Health	572	572	635
Mental Health	181	181	208
Alcohol & Substance Abuse	162	162	237
Purchased/Referred Care	0	0	0
Total, Clinical Services	6,961	6,961	7,462
Public Health Nursing	195	195	220
Health Education	16	16	0
Community Health Reps	2	2	0
Immunization, AK	0	0	0
Total, Preventive Health	213	213	220
Urban Health	6	6	6
Indian Health Professions	22	22	22
Tribal Management	0	0	0
Direct Operations	258	258	258
Self Governance	14	14	14
Contract Support Costs	0	0	0
Total, SERVICES	7,474	7,474	7,982
Maint. & Improvement	0	0	0
Sanitation Facilities	150	150	150
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,036	1,036	1,059
Equipment	0	0	0
Total, FACILITIES	1,186	1,186	1,209
Total, Direct FTE	8,660	8,660	9,191
Reimbursable:			
Buybacks	1,394	1,394	1,394
Medicare	782	782	782
Medicaid	3,853	3,853	3,853
Private Insurance	537	537	537
Quarters	37	37	37
Total, Reimbursable FTE	6,603	6,603	6,603
Trust Funds (Gift)	23	23	23
TOTAL FTE	**15,286**	**15,286**	**15,817**
Total, Civilian FTE	**13,417**	**13,417**	**13,948**
Total, Military FTE	**1,869**	**1,869**	**1,869**

FY 2017 Crosswalk
Budget Authority
Final Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration							Tribal Health Administration							
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	FY 2017 Final
SERVICES															
Hospitals & Health Clinics	884,524	0	0	0	0	0	884,524	1,050,654	0	0	0	0	0	1,050,654	1,935,178
Dental Health	80,562	0	0	0	0	0	80,562	102,035	0	0	0	0	0	102,035	182,597
Mental Health	41,393	0	0	0	0	0	41,393	52,687	0	0	0	0	0	52,687	94,080
Alcohol & Substance Abuse	70,888	0	0	0	0	0	70,888	147,465	0	0	0	0	0	147,465	218,353
Purchased/Referred Care	409,832	0	0	0	0	0	409,832	518,998	0	0	0	0	0	518,998	928,830
Subtotal (CS)	1,487,198	0	0	0	0	0	1,487,198	1,871,840	0	0	0	0	0	1,871,840	3,359,038
Public Health Nursing	0	29,597	0	0	0	0	29,597	0	49,104	0	0	0	0	49,104	78,701
Health Education	0	4,679	0	0	0	0	4,679	0	13,984	0	0	0	0	13,984	18,663
Community Health Repr.	0	4,184	0	0	0	0	4,184	0	56,141	0	0	0	0	56,141	60,325
Immunization AK	0	0	0	0	0	0	0	0	2,041	0	0	0	0	2,041	2,041
Subtotal (PH)	0	38,460	0	0	0	0	38,460	0	121,270	0	0	0	0	121,270	159,730
Urban Health Project	0	0	0	0	0	0	0	0	0	47,678	0	0	0	47,678	47,678
Indian Health Professions	0	0	49,345	0	0	0	49,345	0	0	0	0	0	0	0	49,345
Tribal Management	0	0	2,465	0	0	0	2,465	0	0	0	0	0	0	0	2,465
Direct Operations	0	0	0	61,554	0	0	61,554	0	0	0	8,866	0	0	8,866	70,420
Self-Governance	0	0	0	0	5,786	0	5,786	0	0	0	0	0	0	0	5,786
Subtotal (OS)	0	0	51,810	61,554	5,786	0	119,150	0	0	47,678	8,866	0	0	56,544	175,694
Total, Services	1,487,198	38,460	51,810	61,554	5,786	0	1,644,809	1,871,840	121,270	47,678	8,866	0	0	2,049,653	3,694,462
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	800,000	0	800,000	800,000
FACILITIES															
Maintenance & Improvement	0	0	0	0	0	25,335	25,335	0	0	0	0	0	50,410	50,410	75,745
Sanitation Facilities Constr.	0	0	0	0	0	35,620	35,620	0	0	0	0	0	66,152	66,152	101,772
Health Care Facs. Constr.	0	0	0	0	0	102,191	102,191	0	0	0	0	0	15,800	15,800	117,991
Facs. & Env. Health Sup	0	0	0	0	0	140,592	140,592	0	0	0	0	0	86,358	86,358	226,950
Equipment	0	0	0	0	0	8,099	8,099	0	0	0	0	0	14,867	14,867	22,966
Total, Facilities	0	0	0	0	0	311,838	311,838	0	0	0	0	0	233,586	233,586	545,424
TOTAL, IHS	1,487,198	38,460	51,810	61,554	5,786	311,838	1,956,647	1,871,840	121,270	47,678	8,866	800,000	233,586	3,083,239	5,039,886
% Federal Health Admin.							38.8%								
% Tribal and Urban Health Admin.															61.2%

FY 2018 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration							Tribal Health Administration							
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	FY 2018 CR
SERVICES															
Hospitals & Health Clinics	855,573	0	0	0	0	0	855,573	1,066,463	0	0	0	0	0	1,066,463	1,922,036
Dental Health	77,668	0	0	0	0	0	77,668	103,689	0	0	0	0	0	103,689	181,357
Mental Health	40,113	0	0	0	0	0	40,113	53,328	0	0	0	0	0	53,328	93,441
Alcohol & Substance Abuse	68,853	0	0	0	0	0	68,853	148,017	0	0	0	0	0	148,017	216,870
Purchased/Referred Care	402,577	0	0	0	0	0	402,577	519,945	0	0	0	0	0	519,945	922,522
Subtotal (CS)	1,444,783	0	0	0	0	0	1,444,783	1,891,443	0	0	0	0	0	1,891,443	3,336,226
Public Health Nursing	0	28,097	0	0	0	0	28,097	0	50,070	0	0	0	0	50,070	78,167
Health Education	0	4,468	0	0	0	0	4,468	0	14,068	0	0	0	0	14,068	18,536
Community Health Repr.	0	3,670	0	0	0	0	3,670	0	56,245	0	0	0	0	56,245	59,915
Immunization AK	0	0	0	0	0	0	0	0	2,027	0	0	0	0	2,027	2,027
Subtotal (PH)	0	36,234	0	0	0	0	36,234	0	122,411	0	0	0	0	122,411	158,645
Urban Health Project	0	0	0	0	0	0	0	0	0	47,354	0	0	0	47,354	47,354
Indian Health Professions	0	0	49,010	0	0	0	49,010	0	0	0	0	0	0	0	49,010
Tribal Management	0	0	2,448	0	0	0	2,448	0	0	0	0	0	0	0	2,448
Direct Operations	0	0	0	60,319	0	0	60,319	0	0	0	9,623	0	0	9,623	69,942
Self-Governance	0	0	0	0	5,747	0	5,747	0	0	0	0	0	0	0	5,747
Subtotal (OS)	0	0	51,458	60,319	5,747	0	117,524	0	0	47,354	9,623	0	0	56,977	174,501
Total, Services	1,444,783	36,234	51,458	60,319	5,747	0	1,598,542	1,891,443	122,411	47,354	9,623	0	0	2,070,830	3,669,372
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	800,000	0	800,000	800,000
FACILITIES															
Maintenance & Improvement	0	0	0	0	0	33,572	33,572	0	0	0	0	0	41,659	41,659	75,231
Sanitation Facilities Constr.	0	0	0	0	0	35,378	35,378	0	0	0	0	0	65,703	65,703	101,081
Health Care Facs. Constr.	0	0	0	0	0	117,190	117,190	0	0	0	0	0	0	0	117,190
Facs. & Env. Health Sup	0	0	0	0	0	149,115	149,115	0	0	0	0	0	76,294	76,294	225,409
Equipment	0	0	0	0	0	9,839	9,839	0	0	0	0	0	12,971	12,971	22,810
Total, Facilities	0	0	0	0	0	345,094	345,094	0	0	0	0	0	196,626	196,626	541,721
TOTAL, IHS	1,444,783	36,234	51,458	60,319	5,747	345,094	1,943,636	1,891,443	122,411	47,354	9,623	800,000	196,626	3,067,456	5,011,093
% Federal Health Admin.							38.8%								
% Tribal and Urban Health Admin.															61.2%

FY 2019 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Special Diabetes Program for Indians	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Contract Support	Special Diabetes Program for Indians	Facilities	TOTAL Tribal Health Admini-stration	FY 2019 PB
SERVICES																	
Hospitals & Health Clinics	939,578	0	0	0	0	0	0	939,578	1,250,110	0	0	0	0	0	0	1,250,110	2,189,688
Dental Health	80,981	0	0	0	0	0	0	80,981	122,802	0	0	0	0	0	0	122,802	203,783
Mental Health	41,944	0	0	0	0	0	0	41,944	63,225	0	0	0	0	0	0	63,225	105,169
Alcohol & Substance Abuse	71,314	0	0	0	0	0	0	71,314	163,972	0	0	0	0	0	0	163,972	235,286
Purchased/Referred Care	411,021	0	0	0	0	0	0	411,021	543,936	0	0	0	0	0	0	543,936	954,957
Subtotal (CS)	1,544,839	0	0	0	0	0	0	1,544,839	2,144,044	0	0	0	0	0	0	2,144,044	3,688,883
Public Health Nursing	0	28,776	0	0	0	0	0	28,776	0	58,247	0	0	0	0	0	58,247	87,023
Health Education	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Health Repr.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Immunization AK	0	0	0	0	0	0	0	0	0	2,035	0	0	0	0	0	2,035	2,035
Subtotal (PH)	0	28,776	0	0	0	0	0	28,776	0	60,282	0	0	0	0	0	60,282	89,058
Urban Health Project	0	0	0	0	0	0	0	0	0	0	46,422	0	0	0	0	46,422	46,422
Indian Health Professions	0	0	43,394	0	0	0	0	43,394	0	0	0	0	0	0	0	0	43,394
Tribal Management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Direct Operations	0	0	0	64,246	0	0	0	64,246	0	0	0	9,185	0	0	0	9,185	73,431
Self-Governance	0	0	0	0	4,787	0	0	4,787	0	0	0	0	0	0	0	0	4,787
Subtotal (OS)	0	0	43,394	64,246	4,787	0	0	112,427	0	0	46,422	9,185	0	0	0	55,607	168,034
Total, Services	1,544,839	28,776	43,394	64,246	4,787	0	0	1,686,042	2,144,044	60,282	46,422	9,185	0	0	0	2,259,933	3,945,975
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	822,227	0	0	822,227	822,227
SDPI	0	0	0	0	0	22,690	0	22,690	0	0	0	0	0	127,310	0	127,310	150,000
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	37,726	37,726	0	0	0	0	0	0	38,019	38,019	75,745
Sanitation Facilities Constr.	0	0	0	0	0	0	35,620	35,620	0	0	0	0	0	0	66,152	66,152	101,772
Health Care Facs. Constr.	0	0	0	0	0	0	79,500	79,500	0	0	0	0	0	0	0	0	79,500
Facs. & Env. Health Sup	0	0	0	0	0	0	148,603	148,603	0	0	0	0	0	0	80,249	80,249	228,852
Equipment	0	0	0	0	0	0	5,321	5,321	0	0	0	0	0	0	14,631	14,631	19,952
Total, Facilities	0	0	0	0	0	0	306,770	306,770	0	0	0	0	0	0	199,051	199,051	505,821
TOTAL, IHS	1,544,839	28,776	43,394	64,246	4,787	22,690	306,770	2,015,502	2,144,044	60,282	46,422	9,185	822,227	127,310	199,051	3,408,520	5,424,023
% Federal Health Admin.								37.2%									
% Tribal and Urban Health Admin.																	62.8%

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2019 Performance Budget Submission to Congress

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INDIAN HEALTH SERVICE
INDIAN HEALTH SERVICES

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, [$3,574,365,000]$3,945,975,000, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) and 238b, for services furnished by the Indian Health Service: Provided, That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25U.S.C. 450), shall be deemed to be obligated at the time of the grant or contract award and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: Provided further, That, [$914,139,000] $954,957,000for Purchased/Referred Care, including [$51,500,000] $51,500,000 for the Indian Catastrophic Health Emergency Fund, shall remain available until expended: Provided further, That, of the funds provided, up to [$36,000,000] $36,000,000 shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: Provided further, That, of the funds provided, [$2,000,000]$11,000,000 shall remain available until expended to supplement funds available for operational costs at tribal clinics operated under an Indian Self-Determination and Education Assistance Act compact or contract where health care is delivered in space acquired through a full service lease, which is not eligible for maintenance and improvement and equipment funds from the Indian Health Service, and [$2,000,000] not less than $58,000,000 shall be for accreditation emergencies, including supplementing activities funded under the heading "Indian Health Facilities"1: Provided further, That the amounts collected by the Federal Government as authorized by sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108A(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a): Provided further, That, notwithstanding any other provision of law, the amounts made available within this account for the Substance Abuse and Suicide Prevention Program, for the Domestic Violence Prevention Program, for the Zero Suicide Initiative, for Aftercare Pilot Program at Youth Regional Treatment Centers to improve collections from public and private insurance at Indian Health Service and tribally operated facilities, and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended: Provided further, That funds provided in this Act may be used for annual contracts and grants that fall within 2 fiscal years, provided the total obligation is recorded in the year the funds are appropriated: Provided further, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act, except for those related to the planning, design, or construction of new facilities: Provided further, That funding contained herein for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: Provided further, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended: Provided further, That the Bureau of Indian Affairs may collect from the Indian Health Service, tribes and tribal organizations operating health facilities pursuant to Public Law 93–638, such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act (20 U.S.C. 1400, et seq.): Provided further, That the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account.

Note.—A full-year 2018 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Continuing Appropriations Act, 2018 (Division D of P.L. 115–56, as amended). The amounts included for 2018 reflect the annualized level provided by the continuing resolution.

INDIAN HEALTH CONTRACT SUPPORT COSTS

For payments to tribes and tribal organizations for contract support costs associated with Indian Self-Determination and Education Assistance Act agreements with the Indian Health Service for fiscal year [2018]2019, such sums as may be necessary: Provided, That amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs otherwise due for such agreements for subsequent fiscal years: Provided further, That, notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account.

Note.—A full-year 2018 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Continuing Appropriations Act, 2018 (Division D of P.L. 115–56, as amended). The amounts included for 2018 reflect the annualized level provided by the continuing resolution.

INDIAN HEALTH FACILITIES

For construction, repair, maintenance, improvement, and equipment of health and related auxiliary facilities, including quarters for personnel; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for provision of domestic and community sanitation facilities for Indians, as authorized by section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the Indian Self- Determination Act, and the Indian Health Care Improvement Act, and for expenses necessary to carry out such Acts and titles II and III of the Public Health Service Act with respect to environmental health and facilities support activities of the Indian Health Service, [$446,956,000]]$505,821,000, to remain available until expended: Provided, That, notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation or expansion of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land on which such facilities will be located: Provided further, That not to exceed $500,000 may be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: Provided further, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: Provided further, That not to exceed $2,700,000 from this account and the "Indian Health Services" account may be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: Provided further, That not to exceed $500,000 may be placed in a Demolition Fund, to remain available until expended, and be used by the Indian Health Service for the demolition of Federal buildings.

Note.—A full-year 2018 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Continuing Appropriations Act, 2018 (Division D of P.L. 115–56, as amended). The amounts included for 2018 reflect the annualized level provided by the continuing resolution.

ADMINISTRATIVE PROVISIONS, INDIAN HEALTH SERVICE

Appropriations provided in this Act to the Indian Health Service shall be available for services as authorized by 5 U.S.C. 3109 at rates not to exceed the per diem rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. 5376; hire of passenger motor vehicles and aircraft; purchase of medical equipment; purchase of reprints; purchase, renovation and erection of modular buildings and renovation of existing facilities; payments for telephone service in private residences in the field, when authorized under regulations approved by the Secretary; uniforms or allowances therefor as authorized by 5 U.S.C. 5901–5902; and for expenses of attendance at meetings that relate to the functions or activities of the Indian Health Service: Provided, That in accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651–2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation: Provided further, That notwithstanding any other law or regulation, funds transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86–121, the Indian Sanitation Facilities Act and Public Law 93–638: Provided further, That funds appropriated to the Indian Health Service in this Act, except those used for administrative and program direction purposes, shall not be subject to limitations directed at curtailing Federal travel and transportation: Provided further, That none of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or the House and Senate Committees on Appropriations are notified through the reprogramming process: Provided further, That notwithstanding any other provision of law, funds previously or herein made available to a tribe or tribal organization through a contract, grant, or agreement authorized by title I or title V of the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), may be deobligated and reobligated to a self-determination contract under title I, or a self-governance agreement under title V of such Act and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: Provided further, That none of the funds made available to the Indian Health Service in this Act shall be used to implement the final rule published in the Federal Register on September 16, 1987, by the Department of Health and Human Services, relating to the eligibility for the health care services of the Indian Health Service until the Indian Health Service has submitted a budget request reflecting the increased costs associated with the proposed final rule, and such request has been included in an appropriations Act and enacted into law: Provided further, That with respect to functions transferred by the Indian Health Service to tribes or tribal organizations, the Indian Health Service is authorized to provide goods and services to those entities on a reimbursable basis, including payments in advance with subsequent adjustment, and the reimbursements received therefrom, along with the funds received from those entities pursuant to the Indian Self- Determination Act, may be credited to the same or subsequent appropriation account from which the funds were originally derived, with such amounts to remain available until expended: Provided further, That reimbursements for training, technical assistance, or services provided by the Indian Health Service will contain total costs, including direct, administrative, and overhead associated with the provision of goods, services, or technical assistance: Provided further, That, notwithstanding any other provision of law, for any lease under section 105(l) of the Indian Self-Determination and Education Assistance Act, as amended, no additional compensation is required by the Act above the amount provided to the tribe or tribal organization under section 106(a)(1), except the Secretary, in the discretion of the Secretary, may award compensation for such leases, above the section 106(a)(1) amount, and if the Secretary awards such additional compensation the amount of such compensation may be based on such reasonable expenses, if any, as the Secretary determines to be appropriate, which may include the expenses described in section 105(l)(2), and the exercise of this discretion to award additional compensation and determine its amount is not subject to sections 102(a)-(b), (e) or 507(b)-(d) of the Act.

SPECIAL DIABETES PROGRAMS FOR INDIANS

For making grants under section 330C of the Public Health Service Act, $150,000,000, to remain available until expended.

General Provisions

Contract Support Costs, Fiscal Year 2019 Limitation

Sec. 405. Amounts provided by this Act for fiscal year [2018]2019 under the headings "Department of Health and Human Services, Indian Health Service, Contract Support Costs" and " Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs" are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements for fiscal year [2018]2019 with the Bureau of Indian Affairs or the Indian Health Service: Provided, That such amounts provided by this Act are not available for payment of claims for contract support costs for prior years, or for repayments of payments for settlements or judgments awarding contract support costs for prior years.

Language Provision	*Explanation*
INDIAN HEALTH SERVICE PROVISIONS	
Provided further, That, of the funds provided, [$2,000,000]$11,000,000 shall remain available until expended to supplement funds available for operational costs at tribal clinics operated under an Indian Self-Determination and Education Assistance Act compact or contract where health care is delivered in space acquired through a full service lease, which is not eligible for maintenance and improvement and equipment funds from the Indian Health Service, and [$2,000,000] not less than $58,000,000 shall be for accreditation emergencies, including supplementing activities funded under the heading "Indian Health Facilities".	*Language is changed to add clarity regarding the minimum funding for accreditation emergencies and to allow accreditation emergencies funding to be used to pay for related facilities activities.*
Provided further, That, notwithstanding any other provision of law, the amounts made available within this account for the Substance Abuse and Suicide Prevention Program, for the Domestic Violence Prevention Program, for the Zero Suicide Initiative, for Aftercare Pilot Program at Youth Regional Treatment Centers to improve collections from public and private insurance at Indian Health Service and tribally operated facilities, and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended:	*Methamphetamine language is changed to better reflect broader use of the funds and new language is included for Zero Suicide and Aftercare.*

SEC.405. Amounts provided by this Act for fiscal year [2018] 2019 under the headings "Department of Health and Human Services" Indian Health Service, Contract Support Costs" and "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs" are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements for fiscal year [2018]2019 with the Bureau of Indian Affairs or the Indian Health Service: Provided, That such amounts provided by this Act are not available for payment of claims for contract support costs for prior years, or for repayments or payments for settlements or judgments awarding contract support costs for prior years.	*Added to ensure that the FY 2019 appropriation for Contract Support Costs will not be used to pay prior year contract support costs claims or to repay the Judgment Fund for payments on prior year claims.*
SPECIAL DIABETES PROGRAMS FOR INDIANS PROVISION	
For making grants under 330C of the Public Health Service Act, $150,000,000, to remain available until expended.	*Language and account added to appropriate discretionary funds for the Special Diabetes Programs for Indians.*

INDIAN HEALTH SERVICE
Amounts Available for Obligations

SERVICES

	FY 2017	FY 2018	FY 2019
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,694,462,000	$3,669,372,000	$3,945,975,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$3,694,462,000	$3,669,372,000	$3,945,975,000
Mandatory Appropriation:			
Appropriation	$147,000,000	$75,000,000	$150,000,000
Offsetting Collections:			
Federal sources	($476,000,000)	($276,000,000)	($276,000,000)
Non-federal sources	($1,075,000,000)	($1,172,000,000)	($1,174,000,000)
Subtotal, Offsetting Collections	($1,551,000,000)	($1,448,000,000)	($1,450,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$829,000,000	$1,007,000,000	$1,199,000,000
Mandatory, Start of Year	$178,000,000	$192,000,000	--
End of Year	$1,007,000,000	$1,199,000,000	$1,306,000,000
Total Obligations, Services	$2,290,462,000	$2,296,372,000	$2,538,975,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

FACILITIES

	FY 2017	FY 2018	FY 2019
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$545,424,000	$541,721,000	$505,821,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$545,424,000	$541,721,000	$505,821,000
Offsetting Collections:			
Federal sources	(32,000,000)	($57,000,000)	(57,000,000)
Subtotal, Offsetting Collections	(32,000,000)	($57,000,000)	(57,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$285,000,000	$309,000,000	$366,000,000
End of Year	$309,000,000	$366,000,000	$423,000,000
Total Obligations, Facilities	$489,424,000	$427,721,000	$391,821,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

CONTRACT SUPPORT COSTS

	FY 2017	FY 2018	FY 2019
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$800,000,000	$800,000,000	$822,227,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$800,000,000	$800,000,000	$822,227,000
Total Obligations, CSC	$800,000,000	$800,000,000	$822,227,000

INDIAN HEALTH SERVICE

SERVICES

Summary of Changes

FY 2018 Annualized CR	3,669,372,000
Total estimated budget authority	3,669,372,000
Less Obligations	(3,669,372,000)
FY 2019 Estimate	3,945,975,000
Less Obligations	(3,945,975,000)
Net Change	276,603,000
Less Obligations	(276,603,000)

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE/Pos	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	501,000
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	1,716,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	3,078,000
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	11,422,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	26,082,000
7 Increased Cost of Travel	--	40,568,000	--	1,703,000
8 Increased Cost of Transportation & Things	--	6,959,000	--	245,000
9 Increased Cost of Printing	--	180,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	28,432,000	--	770,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	553,224,000	--	21,856,000
12 Increased Cost of Supplies	--	87,117,000	--	3,619,000
13 Increased Cost of Medical or other Equipment	--	11,094,000	--	469,000
14 Increased Cost of Land & Structure	--	2,000	--	3,000
15 Increased Cost of Grants	--	2,206,083,000	--	53,919,000
16 Increased Cost of Insurance / Indemnities	--	1,231,000	--	9,000
17 Increased Cost of Interest / Dividends	--	45,000	--	1,000
18 Population Growth	--	n/a	--	67,535,000
Subtotal, Built-In	--	2,934,935,000	--	192,928,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	1,091	144,431,000
C. Program Restoration	--	0	--	97,277,000
D. Program Increases	--	0	--	36,693,000
TOTAL INCREASES	--	2,934,935,000	1,091	471,329,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(102,988,000)
B. Program Reductions	--	0	--	(91,738,000)
TOTAL DECREASES	--	0	--	(194,726,000)
NET CHANGE	**--**	**2,934,935,000**	**1,091**	**276,603,000**

INDIAN HEALTH SERVICE
CLINICAL Services
Summary of Changes

FY 2018 Annualized CR	3,336,226,000
Total estimated budget authority	3,336,226,000
Less Obligations	(3,336,226,000)
FY 2019 Estimate	3,688,883,000
Less Obligations	(3,688,883,000)
Net Change	352,657,000
Less Obligations	(352,657,000)

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	457,000
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	1,560,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	2,788,000
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	10,335,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	24,318,000
7 Increased Cost of Travel	--	35,319,000	--	1,531,000
8 Increased Cost of Transportation & Things	--	5,793,000	--	203,000
9 Increased Cost of Printing	--	60,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	26,149,000	--	726,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	518,203,000	--	20,574,000
12 Increased Cost of Supplies	--	81,511,000	--	3,400,000
13 Increased Cost of Medical or other Equipment	--	9,794,000	--	248,000
14 Increased Cost of Land & Structure	--	2,000	--	3,000
15 Increased Cost of Grants	--	1,998,370,000	--	49,045,000
16 Increased Cost of Insurance / Indemnities	--	689,000	--	8,000
17 Increased Cost of Interest / Dividends	--	45,000	--	1,000
18 Population Growth	--	n/a	--	65,051,000
Subtotal, Built-In	--	2,675,935,000	--	180,248,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	1,044	137,606,000
C. Program Restoration	--	0	--	97,277,000
D. Program Increases	--	0	--	33,497,000
TOTAL INCREASES	--	2,675,935,000	1,044	448,628,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(95,971,000)
TOTAL DECREASES	--	0	--	(95,971,000)
NET CHANGE	--	**2,675,935,000**	**1,044**	**352,657,000**

INDIAN HEALTH SERVICE

Hospitals & Health Clinics

Summary of Changes

FY 2018 Annualized CR	1,922,036,000
Total estimated budget authority	1,922,036,000
Less Obligations	(1,922,036,000)
FY 2019 Estimate	2,189,688,000
Less Obligations	(2,189,688,000)
Net Change	267,652,000
Less Obligations	(267,652,000)

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE/Pos	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	377,000
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	1,284,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	2,387,000
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	8,836,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	18,875,000
7 Increased Cost of Travel	--	4,963,000	--	189,000
8 Increased Cost of Transportation & Things	--	5,275,000	--	184,000
9 Increased Cost of Printing	--	56,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	25,465,000	--	716,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	132,727,000	--	5,636,000
12 Increased Cost of Supplies	--	53,741,000	--	2,457,000
13 Increased Cost of Medical or other Equipment	--	8,635,000	--	145,000
14 Increased Cost of Land & Structure	--	2,000	--	0
15 Increased Cost of Grants	--	1,131,768,000	--	16,424,000
16 Increased Cost of Insurance / Indemnities	--	540,000	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	37,408,000
Subtotal, Built-In	--	1,363,172,000	--	94,918,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	776	103,646,000
C. H&HC Restoration	--	0	--	87,718,000
D. Program Increases	--	0	--	30,969,000
TOTAL INCREASES	--	1,363,172,000	776	317,251,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(49,599,000)
B. Adjustments	--	0	--	0
TOTAL DECREASES	--	0	--	(49,599,000)
NET CHANGE	--	**1,363,172,000**	**776**	**267,652,000**

INDIAN HEALTH SERVICE

Dental Health

Summary of Changes

FY 2018 Annualized CR	181,357,000
Total estimated budget authority	181,357,000
Less Obligations	(181,357,000)
FY 2019 Estimate	203,783,000
Less Obligations	(203,783,000)
Net Change	22,426,000
Less Obligations	(22,426,000)

		FY 2018 Annualized CR Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	62,000
2	FY 2019 Pay Raise CO (9months)	--	n/a	--	212,000
3	Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	231,000
4	FY 2019 Pay Raise CS (9months)	--	n/a	--	862,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,867,000
7	Increased Cost of Travel	--	507,000	--	17,000
8	Increased Cost of Transportation & Things	--	227,000	--	11,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	205,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	5,602,000	--	310,000
12	Increased Cost of Supplies	--	7,861,000	--	257,000
13	Increased Cost of Medical or other Equipment	--	831,000	--	67,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	106,235,000	--	3,980,000
16	Increased Cost of Insurance / Indemnities	--	2,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	3,595,000
	Subtotal, Built-In	--	121,470,000	--	11,473,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	117	13,878,000
C. Dental Adjustment		--	0	--	800,000
D. Program Increase		--	0	--	1,728,000
TOTAL INCREASES		--	121,470,000	117	27,879,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(5,453,000)
TOTAL DECREASES		--	0	--	(5,453,000)
NET CHANGE		--	**121,470,000**	**117**	**22,426,000**

INDIAN HEALTH SERVICE

Mental Health

Summary of Changes

FY 2018 Annualized CR	93,441,000
Total estimated budget authority	93,441,000
Less Obligations	(93,441,000)
FY 2019 Estimate	105,169,000
Less Obligations	(105,169,000)
Net Change	11,728,000
Less Obligations	(11,728,000)

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	Pos	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	9,000
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	32,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	100,000
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	374,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	956,000
7 Increased Cost of Travel	--	262,000	--	13,000
8 Increased Cost of Transportation & Things	--	184,000	--	6,000
9 Increased Cost of Printing	--	1,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	122,000	--	2,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	4,481,000	--	144,000
12 Increased Cost of Supplies	--	3,085,000	--	60,000
13 Increased Cost of Medical or other Equipment	--	63,000	--	3,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	63,624,000	--	2,094,000
16 Increased Cost of Insurance / Indemnities	--	26,000	--	1,000
17 Increased Cost of Interest / Dividends	--		--	0
18 Population Growth	--	n/a	--	1,653,000
Subtotal, Built-In	--	71,848,000	--	5,447,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	64	7,736,000
C. Mental Health Restoration	--	0	--	1,079,000
TOTAL INCREASES	--	71,848,000	64	14,262,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(2,534,000)
TOTAL DECREASES	--	0	--	(2,534,000)
NET CHANGE	--	**71,848,000**	**64**	**11,728,000**

INDIAN HEALTH SERVICE

Alcohol and Substance Abuse

Summary of Changes

FY 2018 Annualized CR	216,870,000
Total estimated budget authority	216,870,000
Less Obligations	(216,870,000)
FY 2019 Estimate	235,286,000
Less Obligations	(235,286,000)
Net Change	18,416,000
Less Obligations	(18,416,000)

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE/Pos	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	9,000
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	32,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	70,000
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	263,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	2,620,000
7 Increased Cost of Travel	--	560,000	--	16,000
8 Increased Cost of Transportation & Things	--	107,000	--	2,000
9 Increased Cost of Printing	--	3,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	209,000	--	6,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	10,796,000	--	527,000
12 Increased Cost of Supplies	--	970,000	--	55,000
13 Increased Cost of Medical or other Equipment	--	249,000	--	33,000
14 Increased Cost of Land & Structure	--	0	--	3,000
15 Increased Cost of Grants	--	184,029,000	--	6,728,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	4,112,000
Subtotal, Built-In	--	196,923,000	--	14,476,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	87	8,684,000
C. ASA Restoration	--	0	--	2,172,000
TOTAL INCREASES	--	196,923,000	87	25,332,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(6,916,000)
TOTAL DECREASES	--	0	--	(6,916,000)
NET CHANGE	--	**196,923,000**	**87**	**18,416,000**

INDIAN HEALTH SERVICE
Purchased/Referred Care
Summary of Changes

FY 2018 Annualized CR	922,522,000
Total estimated budget authority	922,522,000
Less Obligations	(922,522,000)
FY 2019 Estimate	954,957,000
Less Obligations	(954,957,000)
Net Change	32,435,000
Less Obligations	(32,435,000)

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	29,027,000	--	1,296,000
8 Increased Cost of Transportation & Things	--	0	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	148,000	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	364,597,000	--	13,957,000
12 Increased Cost of Supplies	--	15,854,000	--	571,000
13 Increased Cost of Medical or other Equipment	--	16,000	--	0
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	512,714,000	--	19,819,000
16 Increased Cost of Insurance / Indemnities	--	121,000	--	7,000
17 Increased Cost of Interest / Dividends	--	45,000	--	1,000
18 Population Growth	--	n/a	--	18,283,000
Subtotal, Built-In	--	922,522,000	--	53,934,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	--	3,662,000
C. PRC Restoration	--	0	--	6,308,000
TOTAL INCREASES	--	922,522,000	--	63,904,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(31,469,000)
TOTAL DECREASES	--	0	--	(31,469,000)
NET CHANGE	--	**922,522,000**	**--**	**32,435,000**

INDIAN HEALTH SERVICE
PREVENTIVE Health
Summary of Changes

FY 2018 Annualized CR	158,645,000
Total estimated budget authority	158,645,000
Less Obligations	(158,645,000)
FY 2019 Estimate	89,058,000
Less Obligations	(89,058,000)
Net Change	(69,587,000)
Less Obligations	69,587,000

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	24,000
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	86,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	83,000
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	318,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	907,000
7 Increased Cost of Travel	--	278,000	--	7,000
8 Increased Cost of Transportation & Things	--	690,000	--	23,000
9 Increased Cost of Printing	--	8,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	188,000	--	3,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	2,480,000	--	77,000
12 Increased Cost of Supplies	--	3,524,000	--	80,000
13 Increased Cost of Medical or other Equipment	--	218,000	--	7,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	127,612,000	--	2,013,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	1,589,000
Subtotal, Built-In	--	134,998,000	--	5,217,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	47	6,825,000
C. Program Restoration	--	0	--	0
TOTAL INCREASES	--	134,998,000	47	12,042,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(2,432,000)
B. Program Reductions	--	0	--	(79,197,000)
TOTAL DECREASES	--	0	--	(81,629,000)
NET CHANGE	**--**	**134,998,000**	**47**	**(69,587,000)**

INDIAN HEALTH SERVICE

Public Health Nursing

Summary of Changes

FY 2018 Annualized CR	78,167,000
Total estimated budget authority	78,167,000
Less Obligations	(78,167,000)
FY 2019 Estimate	87,023,000
Less Obligations	(87,023,000)
Net Change	8,856,000
Less Obligations	(8,856,000)

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	Pos	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	24,000
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	86,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	83,000
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	318,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	870,000
7 Increased Cost of Travel	--	203,000	--	7,000
8 Increased Cost of Transportation & Things	--	657,000	--	23,000
9 Increased Cost of Printing	--	4,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	106,000	--	3,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	1,552,000	--	77,000
12 Increased Cost of Supplies	--	3,074,000	--	80,000
13 Increased Cost of Medical or other Equipment	--	72,000	--	7,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	52,073,000	--	1,937,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	1,550,000
Subtotal, Built-In	--	57,741,000	--	5,065,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	47	6,825,000
TOTAL INCREASES	--	57,741,000	47	11,890,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(2,365,000)
B. Program Reductions	--	0	--	(669,000)
TOTAL DECREASES	--	0	--	(3,034,000)
NET CHANGE	--	**57,741,000**	**47**	**8,856,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2018 Annualized CR	18,536,000
Total estimated budget authority	18,536,000
Less Obligations	(18,536,000)
FY 2019 Estimate	0
Less Obligations	0
Net Change	(18,536,000)
Less Obligations	18,536,000

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	Pos	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	65,000	--	0
8 Increased Cost of Transportation & Things	--	30,000	--	0
9 Increased Cost of Printing	--	4,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	38,000	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	172,000	--	0
12 Increased Cost of Supplies	--	430,000	--	0
13 Increased Cost of Medical or other Equipment	--	43,000	--	0
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	15,138,000	--	0
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	15,920,000	--	0
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	--	0
C. Health Education Restoration	--	0	--	0
TOTAL INCREASES	--	15,920,000	--	0
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
B. Program Reductions	--	0	--	(18,536,000)
TOTAL DECREASES	--	0	--	(18,536,000)
NET CHANGE	--	**15,920,000**	**--**	**(18,536,000)**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2018 Annualized CR	59,915,000
Total estimated budget authority	59,915,000
Less Obligations	(59,915,000)
FY 2019 Estimate	0
Less Obligations	0
Net Change	(59,915,000)
Less Obligations	59,915,000

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	10,000	--	0
8 Increased Cost of Transportation & Things	--	3,000	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	44,000	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	756,000	--	0
12 Increased Cost of Supplies	--	20,000	--	0
13 Increased Cost of Medical or other Equipment	--	103,000	--	0
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	58,374,000	--	0
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	59,310,000	--	0
B. CHR Restoration	--	0	--	0
TOTAL INCREASES	--	59,310,000	--	0
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
B. Program Reductions	--	0	--	(59,915,000)
TOTAL DECREASES	--	0	--	(59,915,000)
NET CHANGE	--	**59,310,000**	**--**	**(59,915,000)**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2018 Annualized CR	2,027,000
Total estimated budget authority	2,027,000
Less Obligations	(2,027,000)
FY 2019 Estimate	2,035,000
Less Obligations	(2,035,000)
Net Change	8,000
Less Obligations	(8,000)

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	37,000
7 Increased Cost of Travel	--	0	--	0
8 Increased Cost of Transportation & Things	--	0	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12 Increased Cost of Supplies	--	0	--	0
13 Increased Cost of Medical or other Equipment	--	0	--	0
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	2,027,000	--	76,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	39,000
Subtotal, Built-In	--	2,027,000	--	152,000
B. Immunization AK Restoration	--	0	--	0
TOTAL INCREASES	--	2,027,000	--	152,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(67,000)
B. Program Reductions	--	0	--	(77,000)
TOTAL DECREASES	--	0	--	(144,000)
NET CHANGE	--	**2,027,000**	**--**	**8,000**

INDIAN HEALTH SERVICE

OTHER Services

Summary of Changes

FY 2018 Annualized CR	174,501,000
Total estimated budget authority	174,501,000
Less Obligations	(174,501,000)
FY 2019 Estimate	168,034,000
Less Obligations	(168,034,000)
Net Change	(6,466,000)
Less Obligations	6,466,000

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	20,000
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	70,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	207,000
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	769,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	857,000
7 Increased Cost of Travel	--	4,971,000	--	165,000
8 Increased Cost of Transportation & Things	--	476,000	--	19,000
9 Increased Cost of Printing	--	112,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	2,095,000	--	41,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	32,541,000	--	1,205,000
12 Increased Cost of Supplies	--	2,082,000	--	139,000
13 Increased Cost of Medical or other Equipment	--	1,082,000	--	214,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	80,101,000	--	2,861,000
16 Increased Cost of Insurance / Indemnities	--	542,000	--	1,000
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	895,000
Subtotal, Built-In	--	124,002,000	--	7,463,000
B. Program Increase	--	0	--	3,196,000
TOTAL INCREASES	--	124,002,000	--	10,659,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(4,585,000)
B. Program Reductions	--	0	--	(12,541,000)
TOTAL DECREASES	--	0	--	(17,126,000)
NET CHANGE	--	**124,002,000**	**--**	**(6,467,000)**

INDIAN HEALTH SERVICE

Urban Indian Health

Summary of Changes

FY 2018 Annualized CR	47,354,000
Total estimated budget authority	47,354,000
Less Obligations	(47,354,000)
FY 2019 Estimate	46,422,000
Less Obligations	(46,422,000)
Net Change	(932,000)
Less Obligations	932,000

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	3,000
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	10,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	6,000
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	23,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	684,000
7 Increased Cost of Travel	--	219,000	--	5,000
8 Increased Cost of Transportation & Things	--	10,000	--	1,000
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	174,000	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	13,198,000	--	537,000
12 Increased Cost of Supplies	--	191,000	--	7,000
13 Increased Cost of Medical or other Equipment	--	35,000	--	5,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	30,789,000	--	1,120,000
16 Increased Cost of Insurance / Indemnities	--	134,000	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	895,000
Subtotal, Built-In	--	44,750,000	--	3,296,000
B. Urban Restoration	--	0	--	0
TOTAL INCREASES	--	44,750,000	--	3,296,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(1,615,000)
B. Program Reductions	--	0	--	(2,613,000)
TOTAL DECREASES	--	0	--	(4,228,000)
NET CHANGE	--	**44,750,000**	**--**	**(932,000)**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2018 Annualized CR	49,010,000
Total estimated budget authority	49,010,000
Less Obligations	(49,010,000)
FY 2019 Estimate	43,394,000
Less Obligations	(43,394,000)
Net Change	(5,616,000)
Less Obligations	5,616,000

		FY 2018 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2019 Pay Raise CO (9months)	--	n/a	--	4,000
3	Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	10,000
4	FY 2019 Pay Raise CS (9months)	--	n/a	--	37,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	64,000	--	2,000
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	45,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	2,822,000	--	1,000
12	Increased Cost of Supplies	--	4,000	--	0
13	Increased Cost of Medical or other Equipment	--	1,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	43,599,000	--	1,639,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	46,535,000	--	1,694,000
B. IHP Restoration		--	0	--	0
	TOTAL INCREASES	--	46,535,000	--	1,694,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,642,000)
B. Program Reductions		--	0	--	(5,668,000)
	TOTAL DECREASES	--	0	--	(7,310,000)
NET CHANGE		--	**46,535,000**	**--**	**(5,616,000)**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2018 Annualized CR	2,448,000
Total estimated budget authority	2,448,000
Less Obligations	(2,448,000)
FY 2019 Estimate	0
Less Obligations	0
Net Change	(2,448,000)
Less Obligations	2,448,000

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	0	--	0
8 Increased Cost of Transportation & Things	--	0	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12 Increased Cost of Supplies	--	0	--	0
13 Increased Cost of Medical or other Equipment	--	0	--	0
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	2,448,000	--	0
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	2,448,000	--	0
B. TMG Restoration	--	0	--	0
TOTAL INCREASES	--	2,448,000	--	0
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
B. Program Reductions	--	0	--	(2,448,000)
TOTAL DECREASES	--	0	--	(2,448,000)
NET CHANGE	--	**2,448,000**	**--**	**(2,448,000)**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2018 Annualized CR	69,942,000
Total estimated budget authority	69,942,000
Less Obligations	(69,942,000)
FY 2019 Estimate	73,431,000
Less Obligations	(73,431,000)
Net Change	3,489,000
Less Obligations	(3,489,000)

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	16,000
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	56,000
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	180,000
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	668,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	173,000
7 Increased Cost of Travel	--	4,579,000	--	151,000
8 Increased Cost of Transportation & Things	--	465,000	--	18,000
9 Increased Cost of Printing	--	64,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	1,904,000	--	41,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	16,513,000	--	647,000
12 Increased Cost of Supplies	--	1,877,000	--	131,000
13 Increased Cost of Medical or other Equipment	--	1,046,000	--	207,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	894,000	--	37,000
16 Increased Cost of Insurance / Indemnities	--	408,000	--	1,000
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	27,750,000	--	2,326,000
B. Direct Ops Restoration	--	0	--	3,196,000
TOTAL INCREASES	--	27,750,000	--	5,522,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(1,233,000)
B. Program Reductions	--	0	--	(800,000)
TOTAL DECREASES	--	0	--	(2,033,000)
NET CHANGE	--	**27,750,000**	**--**	**3,489,000**

INDIAN HEALTH SERVICE

Self-Governance

Summary of Changes

FY 2018 Annualized CR	5,747,000
Total estimated budget authority	5,747,000
Less Obligations	(5,747,000)
FY 2019 Estimate	4,787,000
Less Obligations	(4,787,000)
Net Change	(960,000)
Less Obligations	960,000

		FY 2018 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	11,000
4	FY 2019 Pay Raise CS (9months)	--	n/a	--	41,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	109,000	--	7,000
8	Increased Cost of Transportation & Things	--	1,000	--	0
9	Increased Cost of Printing	--	3,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	17,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	8,000	--	20,000
12	Increased Cost of Supplies	--	10,000	--	1,000
13	Increased Cost of Medical or other Equipment	--	0	--	2,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,371,000	--	65,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	2,519,000	--	147,000
B. Self-Governance Restoration		--	0	--	0
	TOTAL INCREASES	--	2,519,000	--	147,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(95,000)
B. Program Reductions		--	0	--	(1,012,000)
	TOTAL DECREASES	--	0	--	(1,107,000)
NET CHANGE		--	**2,519,000**	**--**	**(960,000)**

INDIAN HEALTH SERVICE

Contract Support Costs

Summary of Changes

FY 2018 Annualized CR	800,000,000
Total estimated budget authority	800,000,000
Less Obligations	(800,000,000)
FY 2019 Estimate	822,227,000
Less Obligations	(822,227,000)
Net Change	22,227,000
Less Obligations	(22,227,000)

		FY 2018 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2019 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	800,000,000	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	800,000,000	--	0
B. CSC Increase		--	0	--	22,227,000
	TOTAL INCREASES	--	800,000,000	--	22,227,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**800,000,000**	**--**	**22,227,000**

INDIAN HEALTH SERVICE

FACILITIES

Summary of Changes

FY 2018 Annualized CR	541,721,000
Total budget authority	541,721,000
Less Obligations	(541,721,000)
FY 2019 Estimate	505,821,000
Less Obligations	(505,821,000)
Net Change	(35,900,000)
Less Obligations	35,900,000

		FY 2018 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	159,000
2	FY 2019 Pay Raise CO (9months)	--	n/a	--	542,000
3	Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	368,000
4	FY 2019 Pay Raise CS (9months)	--	n/a	--	1,376,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,497,000
7	Increased Cost of Travel	--	2,707,000	--	102,000
8	Increased Cost of Transportation & Things	--	3,437,000	--	130,000
9	Increased Cost of Printing	--	74,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	15,397,000	--	609,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	133,349,000	--	4,046,000
12	Increased Cost of Supplies	--	7,426,000	--	264,000
13	Increased Cost of Medical or other Equipment	--	12,798,000	--	525,000
14	Increased Cost of Land & Structure	--	79,164,000	--	4,079,000
15	Increased Cost of Grants	--	182,631,000	--	3,775,000
16	Increased Cost of Insurance / Indemnities	--	103,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	6,938,000
	Subtotal, Built-In	--	437,086,000	--	24,410,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	71	14,665,000
	TOTAL INCREASES	--	437,086,000		40,280,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(19,710,000)
B. Adjustments		--	0	--	(56,470,000)
	TOTAL DECREASES	--	0	--	(76,180,000)
NET CHANGE		**--**	**437,086,000**	**71**	**(35,900,000)**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2018 Annualized CR	75,231,000
Total budget authority	75,231,000
Less Obligations	(75,231,000)
FY 2019 Estimate	75,745,000
Less Obligations	(75,745,000)
Net Change	514,000
Less Obligations	(514,000)

		FY 2018 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2019 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	51,000	--	2,000
8	Increased Cost of Transportation & Things	--	35,000	--	1,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	167,000	--	14,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	16,374,000	--	748,000
12	Increased Cost of Supplies	--	4,784,000	--	161,000
13	Increased Cost of Medical or other Equipment	--	436,000	--	14,000
14	Increased Cost of Land & Structure	--	2,515,000	--	244,000
15	Increased Cost of Grants	--	50,869,000	--	1,215,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	1,200,000
	Subtotal, Built-In	--	75,231,000	--	3,599,000
B. M&I Restoration		--	0	--	514,000
	TOTAL INCREASES	--	75,231,000	--	4,113,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,599,000)
	TOTAL DECREASES	--	0	--	(3,599,000)
NET CHANGE		**--**	**75,231,000**	**--**	**514,000**

INDIAN HEALTH SERVICE

Sanitation Facilities Construction

Summary of Changes

FY 2018 Annualized CR	101,081,000
Total budget authority	101,081,000
Less Obligations	(101,081,000)
FY 2019 Estimate	101,772,000
Less Obligations	(101,772,000)
Net Change	691,000
Less Obligations	(691,000)

		FY 2018 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2019 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	79,000	--	4,000
8	Increased Cost of Transportation & Things	--	675,000	--	28,000
9	Increased Cost of Printing	--	2,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	4,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	61,528,000	--	2,670,000
12	Increased Cost of Supplies	--	182,000	--	6,000
13	Increased Cost of Medical or other Equipment	--	309,000	--	0
14	Increased Cost of Land & Structure	--	1,724,000	--	60,000
15	Increased Cost of Grants	--	28,870,000	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	1,508,000
	Subtotal, Built-In	--	93,373,000	--	4,276,000
B. SFC Restoration		--	0	--	691,000
	TOTAL INCREASES	--	93,373,000	--	4,967,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(4,276,000)
	TOTAL DECREASES	--	0	--	(4,276,000)
NET CHANGE		**--**	**93,373,000**	**--**	**691,000**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2018 Annualized CR	117,190,000
Total budget authority	117,190,000
Less Obligations	(117,190,000)
FY 2019 Estimate	79,500,000
Less Obligations	(79,500,000)
Net Change	(37,690,000)
Less Obligations	37,690,000

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2019 Pay Raise CS (9months)	--	n/a		0
5 One Days Pay	--	n/a		0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	0	--	0
8 Increased Cost of Transportation & Things	--	10,000	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	8,000	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	38,709,000	--	1,000
12 Increased Cost of Supplies	--	105,000	--	2,000
13 Increased Cost of Medical or other Equipment	--	3,528,000	--	223,000
14 Increased Cost of Land & Structure	--	74,817,000	--	3,773,000
15 Increased Cost of Grants	--	13,000	--	0
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Increased Cost of Service & Supply Fund	--	0	--	0
19 Population Growth	--	0	--	0
Subtotal, Built-In	--	117,190,000	--	3,999,000
B. HCFC Restoration	--	0	--	0
TOTAL INCREASES	--	117,190,000	--	3,999,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(3,999,000)
B. Adjustments	--	0	--	(37,690,000)
TOTAL DECREASES	--	0	--	(41,689,000)
NET CHANGE	**--**	**117,190,000**	**--**	**(37,690,000)**

INDIAN HEALTH SERVICE

Facilities & Environmental Health Support

Summary of Changes

FY 2018 Annualized CR	225,409,000
Total budget authority	225,409,000
Less Obligations	(225,409,000)
FY 2019 Estimate	228,852,000
Less Obligations	(228,852,000)
Net Change	3,443,000
Less Obligations	(3,443,000)

	FY 2018 Annualized CR Base		Change from Base		
	FTE	BA	FTE/Pos	BA	
INCREASES					
A. Built-In:					
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	159,000	
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	542,000	
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	368,000	
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	1,376,000	
5 One Days Pay	--	n/a	--	0	
6 Tribal Pay Cost	--	n/a	--	1,497,000	
7 Increased Cost of Travel	--	2,575,000	--	96,000	
8 Increased Cost of Transportation & Things	--	2,522,000	--	91,000	
9 Increased Cost of Printing	--	72,000	--	0	
10 Increased Cost of Rents, Communications, & Utilities	--	14,876,000	--	590,000	
11 Increased Cost of Health Care Provided under Contracts & Grants	--	15,790,000	--	587,000	
12 Increased Cost of Supplies	--	2,192,000	--	92,000	
13 Increased Cost of Medical or other Equipment	--	3,449,000	--	80,000	
14 Increased Cost of Land & Structure	--	108,000	--	2,000	
15 Increased Cost of Grants	--	86,795,000	--	2,068,000	
16 Increased Cost of Insurance / Indemnities	--	103,000	--	0	
17 Increased Cost of Interest / Dividends	--	0	--	0	
18 Increased Cost of Service & Supply Fund	--	0	--	0	
19 Population Growth	--	n/a	--	3,840,000	
Subtotal, Built-In	--	128,482,000	--	11,388,000	
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	71	14,665,000	
TOTAL INCREASES	--	128,482,000	--	26,053,000	
DECREASES					
A. Built-In					
Absorption of Built-In Increases	--	0	--	(7,129,000)	7,129,000
B. Program Reduction	--	0	--	(15,481,000)	
TOTAL DECREASES	--	0	--	(22,610,000)	
NET CHANGE	**--**	**128,482,000**	**71**	**3,443,000**	

INDIAN HEALTH SERVICE

Equipment

Summary of Changes

FY 2018 Annualized CR	22,810,000
Total budget authority	22,810,000
Less Obligations	(22,810,000)
FY 2019 Estimate	19,952,000
Less Obligations	(19,952,000)
Net Change	(2,858,000)
Less Obligations	2,858,000

	FY 2018 Annualized CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2018 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2019 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2018 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2019 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	2,000	--	0
8 Increased Cost of Transportation & Things	--	195,000	--	10,000
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	342,000	--	5,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	948,000	--	40,000
12 Increased Cost of Supplies	--	163,000	--	3,000
13 Increased Cost of Medical or other Equipment	--	5,076,000	--	208,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	16,084,000	--	492,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Increased Cost of Service & Supply Fund	--	0	--	0
19 Population Growth	--	0	--	390,000
Subtotal, Built-In	--	22,810,000	--	1,148,000
TOTAL INCREASES	--	22,810,000	--	1,148,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(707,000)
B. Adjustments	--	0	--	(3,299,000)
TOTAL DECREASES	--	0	--	(4,006,000)
NET CHANGE	**--**	**22,810,000**	**--**	**(2,858,000)**

INDIAN HEALTH SERVICE

Budget Authority by Activity

(Dollars in Thousands)

	2017 Final		2018 Annualized CR		2019 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES						
Hospitals & Health Clinics	6,046	$1,935,178	6,046	$1,922,036	6,382	$2,189,688
Dental Services	572	182,597	572	181,357	635	203,783
Mental Health	181	94,080	181	93,441	208	105,169
Alcohol & Substance Abuse	162	218,353	162	216,870	237	235,286
Contract Health Services	0	928,830	0	922,522	0	954,957
Total, Clinical Services	6,961	3,359,038	6,961	3,336,226	7,462	3,688,883
Public Health Nursing	195	78,701	195	78,167	220	87,023
Health Education	16	18,663	16	18,536	0	0
Comm. Health Reps.	2	60,325	2	59,915	0	0
Immunization AK	0	2,041	0	2,027	0	2,035
Total, Preventive Health	213	159,730	213	158,645	220	89,058
Urban Health	`	47,678	6	47,354	6	46,422
Indian Health Professions	22	49,345	22	49,010	22	43,394
Tribal Management	0	2,465	0	2,448	0	0
Direct Operations	258	70,420	258	69,942	258	73,431
Self-Governance	14	5,786	14	5,747	14	4,787
Total, Other services	294	175,694	300	174,501	300	168,034
Total, Services	7,468	3,694,462	7,474	3,669,372	7,982	3,945,975
CONTRACT SUPPORT COSTS	0	800,000	0	800,000	0	822,227
SPECIAL DIABETES PROGRAM FOR INDIANS						
SDPI (Proposed Discretionary Funding)	0	0	0	0	0	150,000
Total, SDPI	0	0	0	0	0	150,000
FACILITIES						
Maintenance & Improvement	0	75,745	0	75,231	0	75,745
Sanitation Facilities Constr.	150	101,772	150	101,081	150	101,772
Health Care Facs. Constr.	0	117,991	0	117,190	0	79,500
Facil. & Envir. Health Supp.	1,036	226,950	1,036	225,409	1,059	228,852
Equipment	0	22,966	0	22,810	0	19,952
Total, Facilities	1,186	545,424	1,186	541,721	1,209	505,821
Total IHS	8,654	$5,039,886	8,660	$5,011,093	9,191	$5,424,023

FTE estimates exclude FTEs funded by reimbursements such as Medicaid and Medicare collections.

INDIAN HEALTH SERVICE
Budget Authority by Activity

(Dollars in Thousands)

	2017 Final		2018 Annualized CR		2019 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES						
Hospitals & Health Clinics	6,046	$1,935,178	6,046	$1,922,036	6,382	$2,189,688
Dental Services	572	182,597	572	181,357	635	203,783
Mental Health	181	94,080	181	93,441	208	105,169
Alcohol & Substance Abuse	162	218,353	162	216,870	237	235,286
Contract Health Services	0	928,830	0	922,522	0	954,957
Total, Clinical Services	6,961	3,359,038	6,961	3,336,226	7,462	3,688,883
Public Health Nursing	195	78,701	195	78,167	220	87,023
Health Education	16	18,663	16	18,536	0	0
Comm. Health Reps.	2	60,325	2	59,915	0	0
Immunization AK	0	2,041	0	2,027	0	2,035
Total, Preventive Health	213	159,730	213	158,645	220	89,058
Urban Health	`	47,678	6	47,354	6	46,422
Indian Health Professions	22	49,345	22	49,010	22	43,394
Tribal Management	0	2,465	0	2,448	0	0
Direct Operations	258	70,420	258	69,942	258	73,431
Self-Governance	14	5,786	14	5,747	14	4,787
Total, Other services	294	175,694	300	174,501	300	168,034
Total, Services	7,468	3,694,462	7,474	3,669,372	7,982	3,945,975
CONTRACT SUPPORT COSTS	0	800,000	0	800,000	0	822,227
SPECIAL DIABETES PROGRAM FOR INDIANS						
SDPI (Current Law Mandatory Funding)	0	147,000	0	75,000	0	0
SDPI (Proposed Law Mandatory Funding)	0	0	0	75,000	0	150,000
Total, SDPI	0	147,000	0	150,000	0	150,000
FACILITIES						
Maintenance & Improvement	0	75,745	0	75,231	0	75,745
Sanitation Facilities Constr.	150	101,772	150	101,081	150	101,772
Health Care Facs. Constr.	0	117,991	0	117,190	0	79,500
Facil. & Envir. Health Supp.	1,036	226,950	1,036	225,409	1,059	228,852
Equipment	0	22,966	0	22,810	0	19,952
Total, Facilities	1,186	545,424	1,186	541,721	1,209	505,821
Total IHS	8,654	$5,186,886	8,660	$5,161,093	9,191	$5,424,023

FTE estimates exclude FTEs funded by reimbursements such as Medicaid and Medicare collections.

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Hospitals & Health Clinics	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	25 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-148	$2,189,688,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Dental	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	25 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-149	$203,783,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Mental Health	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	26 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-150	$105,169,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Alcohol & Substance Abuse	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	25 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-151	$235,286,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Purchased/ Referred Care	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	26 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-152	$954,957,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Public Health Nursing	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	27 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-153	$87,023,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Health Education	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	28 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-153	$0	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Comm. Health Reps	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	29 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-154	$0	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Immunization AK	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	30 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-154	$2,035,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Urban Health	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	31 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-154	$46,422,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Indian Health Professions	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	32 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-154	$43,394,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Tribal Management	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	33 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-154	$0	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Direct Operations	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	34 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-154	$73,431,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Services	Self-Governance	Snyder Act, Transfer Act (P.L. 83-568), Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) sec. 10221, 124 Stat. 119,935 (2010)), Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, Public Health Services Act titles II & III, as amended.	34 U.S.C. 13 42 U.S.C. 2001 25 U.S.C. 1601 *et seq.* 25 U.S.C. 450 *et seq.* 25 U.S.C. 201-280m	P.L. 111-154	$4,787,000	Permanent	Program Authority AND Appropriation in Auth Leg
Indian Health Service	Facilities	Maintenance & Improvement	Snyder Act; Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010	(25 U.S.C. 13),(42 U.S.C. 2001 et seq.),(25 USC § 1601 et seq.)	P.L. 67-85, 42 Stat. 208, P.L. 83-568, 68 Stat. 674,P.L. 94-437, 90 Stat. 1400	$75,745,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Facilities	Sanitation Facilities Constr.	Snyder Act; Transfer Act; Indian Sanitation Facilities Act; Indian Health Care Improvement Act (IHCIA), as amended 2010	25 U.S.C. 13, (42 U.S.C. § 2004a)	P.L. 86-121, 73 Stat. 267	$101,772,000	Permanent	Program Authority AND Appropriation in Auth Leg
Indian Health Service	Facilities	Health Care Fac. Constr.	Snyder Act; Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010	(25 U.S.C. 13),(42 U.S.C. 2001 et seq.),(25 USC § 1601 et seq.)	P.L. 67-85, 42 Stat. 208, P.L. 83-568, 68 Stat. 674,P.L. 94-437, 90 Stat. 1400	$79,500,000	Permanent	Program Authority AND Appropriation in Auth Leg
Indian Health Service	Facilities	Facil. & Envir. Hlth Supp.	Snyder Act; Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010	(25 U.S.C. 13),(42 U.S.C. 2001 et seq.),(25 USC § 1601 et seq.)	P.L. 67-85, 42 Stat. 208, P.L. 83-568, 68 Stat. 674,P.L. 94-437, 90 Stat. 1400	$228,852,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Facilities	Equipment	Snyder Act; Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010	(25 U.S.C. 13),(42 U.S.C. 2001 et seq.),(25 USC § 1601 et seq.)	P.L. 67-85, 42 Stat. 208, P.L. 83-568, 68 Stat. 674,P.L. 94-437, 90 Stat. 1400	$19,952,000	Permanent	Program Authority AND Appropriation in Auth Leg
Indian Health Service	Facilities	Personnel Quarters/Quarters Return Funds	Snyder Act; Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010, Sec. 320 as amended	(25 U.S.C. 13),(42 U.S.C. 2001 et seq.),(25 USC § 1601 et seq.)	P.L. 98-473,42 Stat. 208, P.L. 83-568, 68 Stat. 674,P.L. 94-437, 90 Stat. 1400	$8,500,000	Permanent	Program Authority AND Appropriation in Auth Leg
Indian Health Service	Contract Support Costs	Total Contract Support Costs	Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended	25 U.S.C. 450 *et seq.*	P.L. 93-638	$822,227,000	Permanent	Program Authority AND Appropriation in Auth Leg

Indian Health Service Authorizing Legislation

OPDIV/ StaffDiv	Account Name	Program Name	Location of Program Authorization	Legal Citation (US Code)	Most Recent (Re)Authorizing Legislation	FY 2019 Funding Level in the Authorization	FY Auth. Expires or Expired	Nature of Expiration
Indian Health Service	Special Diabetes Program for Indians (SDPI)	SDPI	H.R. 2 - Medicare Access and CHIP Reauthorization Act of 2015	45 U.S.C. 245c-3	P.L. 115-63, and P.L. 115-96	$150,000,000	Expires 9/31/2017	Program Authority AND Appropriation in Auth Leg
Indian Health Service	Public and Private Collect	Public and Private Collections	IHCIA sec. 206, Social Security Act, sec. 1880 & 1911	25 U.S.C. 1621e 42 U.S.C. 1395qq & 1396j	P.L. 111-148	$1,193,577,000	Permanent	Program Authority

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
Recission (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 Congressional Justification	$3,574,365,000	$3,867,260,000	$3,759,258,000	-
2019 Congressional Justification	$3,945,975,000	-	-	-

INDIAN HEALTH SERVICE
Appropriation History Table
Contract Support Costs

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2016 Omnibus (PL 114-39)	$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 Congressional Justification	$717,970,000	$717,970,000	$717,970,000	-
2019 Congressional Justification	$822,227,000	-	-	-

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 Congressional Justification	$346,956,000	$551,643,000	$563,658,000	-
2019 Congressional Justification	$505,821,000	-	-	-

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2019 Performance Budget Submission to Congress

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$3,359,038	$3,336,226	$3,688,883	+$352,657
FTE*	6,961	6,961	7,462	+501

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

SUMMARY OF THE BUDGET REQUEST

The FY 2019 Budget submission for Clinical Services of $3.7 billion is $352.7 million above the FY 2018 Annualized CR level. Included in the budget is additional funding of $84.3 million for Current Services, $138 million for Staffing of New and Replacement Facilities, $2 million to address funding needs for 3 New Tribes, $29 million for accreditation emergencies, and $99 million for Clinical Services program increases.

The detailed explanation of the request is described in each of the budget narratives that follow this summary.

- **Hospitals and Health Clinics**, which 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 HIV/AIDS, tuberculosis, and hepatitis; women's and men's health; geriatric health; disease surveillance; and healthcare quality improvement. The Budget proposes an increase of $267.7 million for a total of $2.2 billion for Hospitals and Health Clinics.

- **Dental Health**, which 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 the high dental caries rate in American Indian and Alaska Native (AI/AN) children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to impact long-term improvement of the oral health of AI/AN people. The Budget proposes an increase of $22.4 million for a total of $203.8 million for Dental Health.

- **Mental Health**, which 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. The Budget proposes an increase of $11.7 million for a total of $105.2 million for Mental Health.

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

communities. The Budget proposes an increase of $18.4 million for a total of $235.3 million for Alcohol and Substance Abuse.

- **Purchased/Referred Care (PRC)**, supports the purchase of essential health care services not available in IHS and Tribal healthcare facilities including inpatient and outpatient care, routine emergency ambulatory care, transportation, specialty care services (mammograms, colonscopies, etc.), and medical support services (e.g., laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc.). The demand for PRC remains high as the cost of medical care increases. The PRC program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources available to them (such as Medicare, Medicaid and private insurance), negotiating discounted rates with medical providers, and implementing improvements recommended by Tribes and oversight authorities. The Budget proposes an increase of $32.4 million for a total of $955 million for Purchased/Referred Care.

The majority of clinical services funds are provided to 12 Area (regional) Offices which distribute resources, monitor and evaluate activities, and provide administrative and technical support to 168 Federal and Tribal Service Units (local level) for 608 healthcare facilities providing care to approximately 2.2 million AI/ANs primarily in service areas that are rural, isolated, and underserved.

Performance Summary Table

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

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
28 Unintentional Injury Rates: Age-Adjusted Unintentional injuries mortality rate in AI/AN population (Outcome)	FY 2008: 94.5 (Target Not In Place)	94.5	TBD	N/A
71 Childhood Weight Control: Proportion of children, ages 2-5 years with a BMI at or above the 95th percentile. IHS-All (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 22.6 % (Pending)	22.6 %	N/A	N/A

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$1,935,178	$1,922,036	$2,189,688	+$267,652
FTE*	6,046	6,046	6,382	+336

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 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 2.2 million American Indians and Alaska Natives (AI/AN). The Indian Health Service (IHS) provides medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. The IHS and Tribes primarily serve small, rural populations with primary medical care and community-health services, relying on the private sector for much of the secondary and most of the tertiary medical care needs. Some IHS and Tribal hospitals provide secondary medical services such as ophthalmology, orthopedics, infectious disease, emergency medicine, radiology, general and gynecological surgery, and anesthesia.

The IHS system of care is unique in that personal health care services are integrated with community health services. The program includes public/community health programs targeting health conditions disproportionately affecting AI/ANs such as diabetes, maternal and child health, and communicable diseases including influenza, HIV/AIDS, and hepatitis. Although the health status of AI/ANs has improved significantly in the past 60 years since the inception of the IHS, the average life expectancy at birth is 73.7 years (data years 2007-2009) compared to the U.S. all races life expectancy of 78.1 years.[1]

More than 60 percent of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to Tribal governments or Tribal organizations that design and manage the delivery of individual and community health services through 22 hospitals, 289 health centers, 73 health stations, 150 Alaska village clinics, and 15 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 level. The federal system consists of 26 hospitals, 53 health centers, 30 health stations, and 4 school health centers.

[1] *Life Expectancy, American Indians and Alaska Natives, Data Years 2007-2009 Report*. Indian Health Service Division of Program Statistics, Indian Health Service, United States Department of Health and Human Services, December 2014.

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 the Electronic Health Record and telemedicine) and public health initiatives (such as Baby Friendly Hospitals and Improving Patient Care) that are primarily funded through the H&HC budget.

PROGRAM ACCOMPLISHMENTS

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

Quality Framework **-** In 2016, IHS published the IHS 2016-2017 Quality Framework to establish a plan for substantial improvement activities necessary to ensure the quality and safety of care provided to AI/AN patients. The Quality Framework established the vision of providing patient-centered, timely, effective, safe, and reliable health care of the highest quality and to accomplish that, two Quality Goals:

1) Improve health outcomes for patients receiving care;
2) Provide a care delivery service all patients trust.

To achieve these Goals, five Quality Priorities were identified:

1) Strengthen Organizational Capacity to Improve Quality of Care and Systems;
2) Meet and Maintain Accreditation for IHS Direct Service Facilities;
3) Align Service Delivery Processes to Improve Patient Experience;
4) Ensure Patient Safety;
5) Improve Transparency and Communication Regarding Patient Safety and Quality to IHS Stakeholders.

Implementation of the plan began prior to its publication and has continued through FY 2017 under the oversight of the Quality Framework Steering Committee with significant progress. The Quality Framework explicitly set the goal of establishing the Office for Quality Health Care to lead all quality and safety work for IHS and report to the Deputy Director for Quality Health Care. The related goal for FY 2018 is to identify a budget for the Office enabling initial critical staffing, training resource procurement, and analytic software to support data-driven decision making. The Office of Quality Health Care will continue the work of the Quality Framework Steering Committee in completing implementation of the Framework, in addition to leading future strategic planning that builds on the Framework's success. An Acting Deputy Director for Quality Health Care currently directs the Quality Framework Steering Committee's implementation activities.

In May 2017, acquisition of credentialing and privileging software was announced and implementation activities began immediately. A two-phased implementation strategy was developed by a dedicated IHS Information Technology project team working with the vendor. Phase I was completed on November 9, 2017, by half of the IHS Direct Service Areas. Lessons learned from Phase I were incorporated into Phase II implementation to accelerate progress. Implementation across all IHS Direct Service Areas will be complete by January 31, 2018. Credentialing software will standardize processes for credentialing tasks, streamline applications, automate reminders and notifications, facilitate electronic verifications of credentials through

approved sources, provide portability of credentials throughout IHS Direct Service facilities, and enhance the review of credentials by recommending authorities and governing boards.

In early January 2017, hospital Governing Board (GB) Bylaws for inpatient acute care hospitals were standardized across IHS. Bylaws must now include the following, at a minimum:

- Frequency of formal governing board meetings: At least twice per year, but may meet more often if desired/necessary to meet the needs of the service unit.
- Membership of the GB: The minimum number of GB members is determined by the Chair (Area Director) and ensures adequate representation of disciplines to carry out the required activities. All GB members have a vote and the majority of voting members must represent the Area Office and may also include similar representation from Service Units.
  - Due to the inherent federal functions of governing federal facilities, members of the Governing Board must be IHS federal employees/officers.
  - Tribal consultation is encouraged through CEO communications with Tribal Leadership, and Tribal representatives may be invited to open forums or town hall meetings in order to provide input.
- Meeting Agendas: At a minimum, Governing Board meeting agendas must include the following elements:
  - Quality of Care – including quality improvement and quality assurance/compliance
  - Patient Safety
  - Hospital/Facility Operations

These three primary components ensure a baseline of standards IHS-wide while maintaining maximum flexibility for the Areas and Service Units to amend their respective bylaws based upon needs specific to their locations and service populations.

A Quality Accountability Dashboard Working Group was established by the Steering Committee to develop metrics that will allow oversight and management of compliance with policy or regulatory requirements to ensure quality and safety of care. The measure definitions, data collection tool, and dashboard have been piloted for the 4th Quarter of FY 2017. The dashboard will be publicized in January 2018 and updated quarterly. Changes in healthcare may occasionally necessitate modifications to the dashboard and IHS will remain vigilant for such needs. The success of developing this dashboard has also led to development efforts related to the other three agency priorities: People, Partnerships, and Resources.

All IHS hospitals are being aligned under a single source of accreditation to ensure a standardized approach and consistent standards across the system. To support this activity and ensure sustainment, IHS developed an acquisition plan to contract with a single accreditation organization for surveys and accreditation technical assistance at all IHS Direct Service hospitals. This will achieve economy of scale and a uniform knowledge base of accreditation standards, best practices for quality and safety, and cross-agency support for accreditation readiness activities. The contract was awarded to The Joint Commission on September 29, 2017 for accreditation of all IHS direct service hospitals. Similarly, a contract was also awarded to the Accreditation Association for Ambulatory Health Care (AAAHC) to provide accreditation services to IHS direct service ambulatory health centers.

A Patient Experience of Care Survey Working Group was established by the Steering Committee to develop a standardized patient experience of care survey instrument for use at all IHS

healthcare facilities. The anonymous surveys are completed and the results analyzed by each IHS healthcare facility, separately. The analysis will determine what actions, if any, are required. The instrument was finalized in March 2017 and the first phase of pilot testing of survey administration using electronic tablets (to facilitate data collection and reporting) has been completed. Continued piloting and expansion of the number of facilities implementing this tool will continue into FY 2018.

A Patient Wait Times Working Group was established by the Steering Committee to develop standards for primary care patient wait times for appointments. The Working Group completed standard development in June 2017, establishing the following standards: 28 days or less for primary care non-follow-up appointments, and 48 hours or less for primary care urgent visit appointments. This standard has been incorporated into a measure for the Quality Accountability Dashboard so that it can be monitored routinely and improved.

The IHS Patient Safety Event Reporting System, WebCident, is under evaluation for replacement to improve the user interface. Aligned with efforts to improve adverse event reporting, IHS has begun implementing the Just Culture model to ensure appropriate supervisory responses to adverse events and to support earlier identification and reporting of risk before manifesting as an adverse event. This model is also expected to improve staff satisfaction with work and retention of staff. Nine Area Office personnel received certification training in Just Culture in November 2017 to increase training capacity to support implementation across IHS in 2018.

IHS has continued its productive partnerships with the Premier Inc. Hospital Improvement and Innovation Network (HIIN) and HealthInsight New Mexico Quality Improvement Organization (QIO) with its Partnership to Advance Tribal Health (PATH). The Premier HIIN provides technical assistance and learning platforms to reduce Hospital Acquired Conditions and Readmissions. They coach hospital care teams and staff on best practices, lessons learned, and quality improvement activities aligned with these goals. The HealthInsight NM QIO and PATH provide leadership development learning opportunities, care team effectiveness enhancement, patient safety resources, patient/family engagement technical assistance, and system level assessments.

Leaders across IHS are intimately familiar with the 2016-2017 Quality Framework and not only embrace and support current implementation activities, but also look for innovative methods to implement local initiatives aligned with principles of the Framework. Volunteerism to participate in Quality Framework pilots and Working Groups has become common, indicating very strong interest and support for continued efforts.

Improving Patient Care (IPC) Program 2.0 **-** The purpose of the IPC Program is to promote the development and application of the quality improvement processes and to promote the implementation of the Patient-Centered Medical Home (PCMH) model of care to improve the health and wellness of AI/ANs. The IPC program provides a regional model of collaborative learning to develop proficiency in quality improvement. Data management and analysis are used drive improvements. Success will be measured in FY 2018 and beyond by achievement of clinical and process industry-benchmarks, as well as ultimate recognition or certification of participating sites as PCMHs. Participating teams report on clinical outcome measures aligned with the Government Performance and Results Act (GPRA) measures and some additional clinical process measures

In 2017, the IPC program completed on-site training for care teams in 9 of the 12 IHS Areas for over 400 clinicians and staff. The IPC program provided 1000 subscriptions to the Institute for

Healthcare Improvement (IHI) Open School to support I/T/U facility staff in their quality improvement efforts with enrolled of over 400 staff. In 2017, the IPC program began the development of reporting systems for the 21 PCMH measures. In 2017, began the development of a web based collaborative learning environment to support quality improvement and PCMH information dissemination and knowledge exchange. As of the end of FY 2017, 32 percent of the IHS health care facilities providing ambulatory care services have obtained PCMH designation from either the Joint Commission or the Accreditation Association for Ambulatory Health Care.

Nursing – Nursing represents the largest category of health care providers in the Indian health system and has a major impact on patient safety and health care outcomes. According to the 2017 IHS Nurse Position Report (NPR), there are 2044 Registered Nurses (RNs) and 392 Licensed Practical Nurses (LPNs) employed in IHS. The 2017 IHS NPR identified a RN/Advanced Practice Nurse (APN) vacancy rate of 19 percent and a LPN vacancy rate of 11 percent. Nurses are actively engaged in the transformation of the health care system by placing more emphasis on prevention, wellness, and coordination of care.

The IHS adopted the Baby-Friendly® Hospital Initiative (BFHI) as the official standard of care for AI/AN mothers and babies in FY 2011. IHS received 100 percent Baby-Friendly® designation of all its obstetric care hospitals in FY 2014. Baby-Friendly® designated hospitals are re-surveyed every 5 years. IHS has sustained 100 percent (n=10) Baby-Friendly® designation. This IHS initiative promotes breastfeeding to reduce the risk that AI/AN children will develop obesity, diabetes, and other obesity-related conditions in the future.[2]

IHS nurses are instrumental in promoting and sustaining Baby-Friendly® practices and promoting breastfeeding as the exclusive feeding choice for AI/AN infants in their first six months of life. IHS nurses support the BFHI through enhanced team-based care, self-management support, and the integration of Baby-Friendly® practices with primary care services.

In FY 2017, the percentage of babies at the age of 2 months who were exclusively or mostly breastfed was over 30 percent, which is an increase of 5.6 percent since the beginning of the BFHI. IHS is committed to maintaining Baby Friendly® practices and designation into FY 2018 and beyond.

Trauma Care – Trauma is the leading cause of death and disability among the AI/AN population under age 45, and AI/AN trauma death rates are three times higher than U.S. all races rates.[3] Local IHS hospitals are frequently the nearest emergency medical facility that can receive patients with traumatic injuries from emergency medical services providers (Paramedics, EMTs). Of the 26 IHS emergency departments (EDs), 24 are located at inpatient facilities and 2 are in health centers; 74 percent are more than 50 miles from the nearest designated trauma center at any level and 52 percent are more than 100 miles. According to the FY 2016 IHS emergency department memo, there were 396,766 direct outpatient ED visits and 15,100 direct inpatient ED visits for the 26 IHS facilities. Recruitment and retention of competent and proficient staff for EDs at certain facilities has posed a significant challenge to continuity of emergency services in FY 2017. A coordinated effort to address this challenge across all levels aims to improve recruitment and retention activities.

[2] Ip, S. Chung M., Raman G., et al. *Breastfeeding and Maternal Infant Health Outcomes in Developed Countries*. Evid Rep Technol Assess. 2007 (153): 1-186.
[3] U.S. Department of Health and Human Services, Indian Health Service, Trends in Indian Health 2014 Edition (Released March 2015), ISSN 1095-2896

Trauma Center designation is determined by state and local municipalities based on unique criteria such as: trauma readiness, resources available, policies, patient care, and performance improvement. Currently, out of 24 IHS hospitals with an ED, only one is designated a Level III (provides prompt assessment, resuscitation, surgery, intensive care, and stabilization of injured patients and emergency operations) and one other is designated a Level IV (provides evaluation, stabilization, and diagnostics for injured patients prior to the transfer of the patient to a higher Level Trauma Center).

Adequate staffing levels and capabilities, as well as state of the art equipment, are essential for quality care. Emergency medicine physicians, RNs, Advanced Practice Nurses (APNs), and other highly trained staff are essential for crisis and disaster management to improve patient outcomes. For RNs from rural IHS emergency departments and critical care areas, the IHS Capstone program develops critical thinking skills, competence and confidence in trauma nurses in the emergency department setting. This program includes population specific services, pediatric emergency services, and geriatric trauma. In FY 2017, 6 RNs completed the IHS Capstone program.

HIV/AIDS Program – AI/AN people face significant health disparities in rates of sexually transmitted infections (STIs) including Human Immunodeficiency Virus (HIV). From 2005 to 2014, the Centers of Disease Control and Prevention (CDC) reported a 63 percent increase in HIV rates among gay and bisexual AI/AN men alone, while the overall HIV rate for all AI/AN increased by 19 percent. Racial and ethnic differences in HIV/AIDS survival from 2006-2011 showed that AI/ANs had the lowest survival rate after an AIDS diagnosis of any race.[4] Nearly all communities served by IHS have been affected by HIV; as of FY 2016, more than 95 percent reported at least one patient with an HIV diagnosis.

The HIV/AIDS Program goal is to prevent new HIV infections and ensure access to quality health services for AI/ANs living with HIV/AIDS. IHS increased overall prenatal HIV screening to 87 percent in FY 2016 – a 15 percent increase over FY 2006 data. In FY 2016, IHS included HIV screening of 13-64 year-olds in its nationally reportable quality of care metrics. This resulted in 80,000 unique AI/AN patients receiving HIV screening for the first time. The overall HIV screening rate has increased by 22 percent. Some of the highest performing IHS facilities have achieved HIV screening levels of more than 70 percent for the eligible population. To improve access to care in remote areas IHS HIV/AIDS Program provides technical support to IHS, tribal, and urban Indian health sites on screening and treatment, and the use of tele-health. The HIV/AIDS Program goal is to ensure access to quality health services for AI/ANs living with HIV/AIDS and those at risk of contracting HIV and commonly co-occurring infections.

Hepatitis C Virus (HCV) infections can result in illness varying in severity from mild-lasting a few weeks, to serious-a lifelong illness ending in death by liver failure. The likelihood of liver damage is related to the duration and severity of untreated infection. HCV death rates among AI/ANs are more than twice the national average compared to other ethnic groups. The CDC estimate 3.5 million persons have HCV in the US, and approximately 120,000 of those are in Indian Country. AI/ANs have the largest increase of liver and intrahepatic bile duct cancer compared to any other race/ethnic groups. The IHS National Patient Information Reporting System (NPIRS) data identifies 34,000 IHS patients with HCV and estimates nearly 200 new

[4] https://www.cdc.gov/hiv/group/racialethnic/aian/index.html

cases each year. This data does not include up to 50 percent of patients who remain undiagnosed. IHS data also identifies fewer than 1,000 HCV patients currently undergoing treatment.

The CDC and the U.S. Preventive Services Task Force (USPSTF) recommends that all persons born from 1945-1965 should be screened for HCV. IHS aligned program initiatives with The National Viral Hepatitis Action Plan (NVHAP) 2017-2020, to eliminate new viral hepatitis infections, increase knowledge of hepatitis diagnoses, improve access to high quality health care and curative treatments, and eliminate stigma and discrimination. IHS clinical data shows that screening for HCV among AI/ANs born from 1945-1965, increased from 8 percent in 2012 to 54 percent in 2017. This achievement is due in part to the development of technical support tools like electronic health records (EHR) clinical reminders, publication of IHS policy guidelines for HIV and HCV, and creation of clinical linkages to care. IHS anticipates higher costs associated with HCV care in FY 2018 and 2019 associated with the increased rate of diagnosis (based on increased screening of Baby-Boomers and women of reproductive age) and the substantially high cost of curative medications.

Domestic Violence Prevention Program (DVPP) (formerly known as the Domestic Violence Prevention Initiative) – Domestic and intimate partner violence has a disproportionately large impact on AI/AN communities. According to the CDC, 45.9 percent of AI/AN woman have experienced intimate partner violence – the highest rate of any race or ethnicity in the U.S.[5] In addition, it is estimated that one out of every three AI/AN women is sexually assaulted in her lifetime,[6] and AI/AN victims of intimate and family violence are more likely than victims of all other races to be injured and need hospital care.[7]

DVPP is a nationally-coordinated program that provides culturally appropriate domestic violence and sexual assault prevention and intervention resources to AI/AN communities with a focus on providing trauma informed services. The DVPP focuses on domestic and sexual violence prevention, advocacy, and coordinated community responses, as well as providing forensic healthcare services to victims of domestic and sexual violence.

In FY 2015, IHS established a new five-year funding cycle for the DVPP that will operate from 2015-2020. IHS received an additional $4 million in FY 2017 and issued 26 new awards to participate in the DVPP.

A total of 83 grantees and federal awardees work to meet the following goals:

- Build Tribal, Urban Indian Health Programs and Federal capacity to provide coordinated community responses to AI/AN victims of domestic and sexual violence,
- Increase access to domestic and sexual violence prevention, advocacy, crisis intervention, and behavioral health services for AI/AN victims and their families,
- Promote trauma-informed services for AI/AN victims of domestic and sexual violence and their families,
- Offer health care provider and community education on domestic violence and sexual violence,

[5] *National Intimate Partner and Sexual Violence Survey. 2010.* Centers for Disease Control and Prevention. Available at, http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf
[6] *Restoration of Native Sovereignty, 5.* Restoration of Safety for Native Women .Sacred Circle and the National Congress of American Indians Task Force on Violence Against Women in Indian Country. (2006, September).
[7] *American Indians and Crime, 1992-96 Report*. Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.

- Respond to the health care needs of AI/AN victims of domestic and sexual violence, and
- Incorporate culturally appropriate practices and/or faith-based services for AI/AN victims of domestic and sexual violence.

The second year concluded on September 29, 2017 with 100 percent of projects submitting their progress reports. Evaluation of the data for year two will be available in March 2018.

TRIBAL SHARES

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 portion of the overall H&HC budget line is reserved for federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

FUNDING HISTORY

Fiscal Year	Amount	DVPP
2015	$1,836,789,000	($8,967,278)
2016	$1,857,225,000	($8,967,278)
2017	$1,935,178,000	($12,967,278)
2018 Annualized CR	$1,922,036,000	($8,967,278)
2019 President's Budget	$2,189,688,000	($8,967,278)

BUDGET REQUEST

The FY 2019 budget submission for Hospitals and Health Clinics of $2,189,688,000 is $267,652,000 above the FY 2018 Annualized CR level.

FY 2018 Base Funding of $1,922,036,000 - 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. In addition, an amount of H&HC funding that initially is allocated to Headquarters each year is reallocated on a non-recurring basis to Areas during the fiscal year and supports national activities. Also included in the base is funding to provide technical assistance to IHS facilities to promote efficient, effective, high quality care to the AI/AN population. The IHS will strengthen its quality system to ensure alignment with and attainment of national standards for quality and patient safety for inpatient and outpatient facilities. This will include accreditation preparation, readiness, and survey activities; bringing health care quality expertise to IHS; and development and/or dissemination of education tools and experiential opportunities to ensure staff competencies in quality assurance and quality improvement.

FY 2019 Funding Increase of $267,652,000 includes:

- Current Services: +$45,319,000 for current services including:
    - Pay Costs +$31,759,000 – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$13,560,000 – to fund inflationary costs of providing health care services.

- Staffing for New Facilities +$103,646,000 - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Red Tail Hawk Health Center, Chandler, AZ	$26,702,000	245
Phoenix Indian Medical Center, Phoenix, AZ	$4,574,000	43
Fort Yuma Health Center (Replacement), Winterhaven, CA	$5,330,000	48
Muskogee (Creek) Nation Health Center (JV), Eufaula, OK	$6,444,000	59
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$39,065,000	216
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$21,531,000	165
Grand Total:	**$103,646,000**	**776**

- New Tribes +$1,969,000 – Additional funding is typically requested when a new Tribe is federally-recognized or reinstated so that the increase in healthcare service needs does not impact or diminish the existing Agency base budget, which supports direct service Tribes. The Pamunkey Tribe of Virginia was recognized in January 2016 and funding of approximately $1,135,000 is requested to establish healthcare services for their estimated 337 members. The United Keetoowah Band of Cherokee Indians (Oklahoma), formerly a part of the Cherokee Nation of Oklahoma, has an estimated need of $99,000 for mental health services for their estimated 1,299 members. The Paskenta Band of Nomlaki Indians (California) requests an estimated $519,000 for 192 members.

- Accreditation Emergencies +$29,000,000 – Additional funding to assist IHS-operated hospitals that are at risk or out of compliance with the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation. Funds will be used to resolve CMS findings and may be used to sustain operations of an affected service unit.

- Clinical Services +$87,718,000 – The program increase will increase access to direct health services, including inpatient and outpatient visits. The proposed funding level also supports IHS' efforts to provide high quality health care across the Indian health system.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
5 Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy. IHS-All (Outcome)	FY 2017: 64.5 % Target: 63.3 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
5 Tribally Operated Health Programs (Outcome)	FY 2017: 57.8 % Target: 59.2 % (Target Not Met but Improved)	Retire	Retire	Maintain
6 Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receive an annual retinal examination. (Outcome)	FY 2017: 61.4 % Target: 63.1 % (Target Not Met but Improved)	Retire and Replace	Retire and Replace	Maintain
6 Tribally Operated Health Programs (Outcome)	FY 2017: 58.7 % Target: 61.7 % (Target Not Met but Improved)	Retire	Retire	Maintain
7 Pap Screening Rates: Proportion of eligible women who have had cervical cancer screening appropriate for their age (Outcome)	FY 2017: 54.8 % Target: 56.1 % (Target Not Met)	Retire and Replace	Retire and Replace	Maintain
7 Tribally Operated Health Programs (Outcome)	FY 2017: 53.8 % Target: 55.5 % (Target Not Met)	Retire	Retire	Maintain
8 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Outcome)	FY 2017: 55.4 % Target: 56.7 % (Target Not Met but Improved)	Retire and Replace	Retire and Replace	Maintain
8 Tribally Operated Health Programs (Outcome)	FY 2017: 55.7 % Target: 57.3 % (Target Not Met but Improved)	Retire	Retire	Maintain
9 Colorectal Cancer Screening Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening. (Outcome)	FY 2017: 41.4 % Target: 40.2 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
9 Tribally Operated Health Programs (Outcome)	FY 2017: 42.6 % Target: 41.7 % (Target Exceeded)	Retire	Retire	Maintain
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 2017: 99 %* Target: 100 % (Target Not Met)	100 %	100 %	Maintain
24 American Indian and Alaska Native patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR (measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Outcome)	FY 2017: 70.9 % Target: 74.8 % (Target Not Met)	Retire and Replace	Retire and Replace	Maintain
24 Tribally Operated Health Programs (Outcome)	FY 2017: 64.8 % Target: 68.5 % (Target Not Met)	Retire	Retire	Maintain
26 Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All (Outcome)	FY 2017: 86.8 % Target: 86.7 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain
26 Tribally Operated Health Programs (Outcome)	FY 2017: 82.8 % Target: 82.2 % (Target Exceeded)	Retire	Retire	Maintain
32 Tobacco Cessation Intervention: Proportion of	FY 2017: 52.2 % Target: 53.2 %	Retire and Replace	Retire and Replace	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
tobacco-using patients that receive tobacco cessation intervention. IHS-All (Outcome)	(Target Not Met but Improved)			
32 Tribally Operated Health Programs (Outcome)	FY 2017: 45.3 % Target: 45.8 % (Target Not Met but Improved)	Retire	Retire	Maintain
43 Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed (Outcome)	FY 2017: 40.1 % Target: 36.4 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain
43 Tribally Operated Health Programs (Outcome)	FY 2017: 40.6 % Target: 37 % (Target Exceeded)	Retire	Retire	Maintain
44 Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native population (Outcome)	FY 2009: 86.3 years (Target Not In Place)	89.3 years	86.3 years	-3 years
45 Hospital admissions per 100,000 service population for long-term complications of diabetes (Efficiency)	FY 2016: 58.1 Target: 56.0 (Target Not Met)	74.6	TBD	N/A
46 Controlling High Blood Pressure (Outcome)	FY 2017: 59 % Target: 59.7 % (Target Not Met)	Retire and Replace	Retire and Replace	Maintain
46 Tribally Operated Health Programs (Outcome)	FY 2017: 59 % Target: 58.5 % (Target Exceeded)	Retire	Retire	Maintain
47 HIV Screening Ever: Percentage of 13-64 year olds screened for HIV (Outcome)	FY 2017: 45.1 % Target: 41.9 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain
47 TOHP HIV Screening Ever (Outcome)	FY 2017: 34.7 % Target: 31.3 % (Target Exceeded)	Retire	Retire	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
48 Influenza Vaccination Rates Among Children 6 months to 17 years (Outcome)	FY 2017: 37.2 % Target: 37.1 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain
48 TOHP Influenza 6 months to 17 years (Outcome)	FY 2017: 31.4 % Target: 29.4 % (Target Exceeded)	Retire	Retire	Maintain
49 Influenza Vaccination Rates Among Adults 18 years and older (Outcome)	FY 2017: 39.2 % Target: 38.7 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain
49 TOHP Influenza 18 years and older (Outcome)	FY 2017: 35.1 % Target: 33.6 % (Target Exceeded)	Retire	Retire	Maintain
51 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2017: 48.1 % Target: 48.1 % (Baseline)	Retire and Replace	Retire and Replace	Maintain
51 TOHP Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2017: 49.8 % Target: 49.8 % (Baseline)	Retire	Retire	Maintain
55 Nephropathy Assessed (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 34 % (Pending)	34 %	34 %	Maintain
56 Retinopathy Exam (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 49.7 % (Pending)	49.7 %	49.7 %	Maintain
57 Pap Smear Rates (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 35.9 % (Pending)	35.9 %	35.9 %	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
58 Mammogram Rates (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 42 % (Pending)	42 %	Retire and Replace	N/A
59 Colorectal Cancer Screening Rates (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 32.6 % (Pending)	32.6 %	32.6 %	Maintain
64 TOHP IPV/DV Screening (Output)	FY 2017: 65.9 % Target: 64.3 % (Target Exceeded)	Retire	Retire	Maintain
64 IPV/DV Screening (Output)	FY 2017: 66.6 % Target: 65.3 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain
66 American Indian and Alaska Native patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR (measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 45.6 % (Pending)	45.6 %	45.6 %	Maintain
67 Influenza Vaccination Rates among children 6 months to 17 years (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 20.6 % (Pending)	20.6 %	20.6 %	Maintain
68 Influenza vaccination rates among adults 18 years and older (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 18.8 % (Pending)	18.8 %	18.8 %	Maintain
69 Adult Composite Immunization (Output)	FY 2018: Result Expected Jan 31, 2019 Target:	Baseline	TBD	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
	Set Baseline (Pending)			
70 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 26.6 % (Pending)	26.6 %	26.6 %	Maintain
72 Tobacco Cessation Intervention (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 27.5 % (Pending)	27.5 %	27.5 %	Maintain
73 HIV Screening Ever (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 17.3 % (Pending)	17.3 %	17.3 %	Maintain
74 Breastfeeding Rates (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 39 % (Pending)	39 %	39 %	Maintain
75 Controlling High Blood Pressure - MH (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 42.3 % (Pending)	42.3 %	42.3 %	Maintain
81 IPV/DV Screening (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 41.6 % (Pending)	41.6 %	41.6 %	Maintain
87 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Output)	FY 2019: Result Expected Jan 31, 2020 Target: Set Baseline (Pending)	N/A	Baseline	Maintain
H&HC-4 Inpatient Admissions - IHS Direct (Output) (Output)	FY 2015: 17,254 admissions Target: 19,500 admissions (Target Exceeded)	Retire after 2016	Retire after 2016	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
TOHP-2 Number of designated annual clinical performance goals met. (Outcome)	FY 2016: 10[8] Target: 13[9] (Target Not Met but Improved)	Retire after 2017	Retire after 2017	Maintain

*Measure 20: Accreditation FY 2016 result is 99%, target: 100% (Target Not Met).

GRANTS AWARDS - H&HC funds support the Healthy Lifestyles in Youth Project,[10] a $1,250,000 cooperative agreement with the National Congress of American Indians. This grant program promotes healthy lifestyles among AI/AN youth using the curriculum "Together Raising Awareness for Indian Life" at selected Boys and Girls Club sites across the country and represents responsiveness to Tribal input for more prevention activities.

H&HC also funds 83 DVPP grants.

(whole dollars)	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	83	83	83
Average Award	$148,207	$148,207	$148,207
Range of Awards	$49,750-$1,000,000	$49,750-$1,000,000	$49,750-$1,000,000

AREA ALLOCATION

Hospital and Health Clinics

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$6,913	$317,613	$324,526	$7,004	$322,392	$329,396	$7,691	$377,909	$385,600	$56,204
Albuquerque	48,788	29,098	77,886	49,426	29,536	78,962	54,279	34,622	88,901	9,939
Bemidji	21,928	77,672	99,600	22,214	78,841	101,056	24,396	92,418	116,813	15,758
Billings	50,045	14,103	64,149	50,700	14,316	65,016	55,678	16,781	72,459	7,443
California	5,357	66,851	72,208	5,427	67,857	73,284	5,960	79,542	85,502	12,218
Great Plains	132,339	37,559	169,898	134,070	38,124	172,194	147,234	44,689	191,923	19,729
Nashville	12,823	60,520	73,343	12,991	61,430	74,422	14,267	72,009	86,276	11,854
Navajo	176,471	66,728	243,200	178,780	67,732	246,512	196,333	79,396	275,729	29,217
Oklahoma	108,662	241,175	349,836	110,083	244,803	354,886	120,891	286,959	407,850	52,964
Phoenix	107,978	70,524	178,503	109,391	71,585	180,976	120,131	83,912	204,044	23,068
Portland	24,590	50,811	75,401	24,912	51,576	76,487	27,358	60,457	87,815	11,327
Tucson	2,185	18,000	20,184	2,213	18,270	20,484	2,431	21,417	23,847	3,364
Headquarters	186,444	0	186,444	148,363	0	148,363	162,930	0	162,930	14,567
Total, H&HC	**$884,524**	**$1,050,654**	**$1,935,178**	**$855,573**	**$1,066,463**	**$1,922,036**	**$939,578**	**$1,250,110**	**$2,189,688**	**+$267,652**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

[8] FY 2016 result is 10 of 21 clinical performance goals met.
[9] FY 2016 target is for 13 of 18 annual clinical performance goals to be met.
[10] The current Healthy Lifestyles in Youth cooperative agreement expires August 31, 2022.

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 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$1,935,178	$1,922,036	$2,189,688	+$267,652
*Epi Centers**	*$4,433*	*$4,433*	*$4,433*	*0*

**Amount updated based on FY 2016 actuals.*

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 2019 Authorization..Permanent

Allocation Method ....Cooperative Agreements

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Tribal Epidemiology Center (TEC) Program was first authorized and funded by Congress in FY 1996. The intent has been 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 critical role in IHS' overall public health infrastructure. Operating within Tribal organizations, TECs are uniquely positioned to provide support to local Tribal disease surveillance and control programs, and assess the effectiveness of public health programs. All TECs monitor the health status of their constituent Tribes, produce a variety of reports annually or bi-annually that describe activities and progress towards public health goals, and provide support to Tribes who self-govern their health programs.

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 nationally. The IHS Division of Epidemiology and Disease Prevention (DEDP) functions as the national coordinating center and provides technical support and guidance to TECs. The DEDP and TECs collect, analyze, interpret, and disseminate health information in addition to identifying diseases to target for intervention, suggesting strategies, and testing the effectiveness of implemented health interventions. The TEC Program supports Tribal communities by providing technical training in public health practice and prevention-oriented research, and promoting public health career pathways for Tribal members.

Over 90 percent of the TEC Program budget is distributed through cooperative agreements based on a 5-year competitive award cycle. In the current award cycle, all 12 TECs were awarded an annual average of $341,000 (beginning FY 2016). The next 5-year competitive award cycle will encompass FYs 2021-2026 and projected at similar funding levels for each TEC.

The TECs are fundamental to the IHS' partnership with Tribes by supporting epidemiology and public health functions critical to the delivery of healthcare services. Independent TEC goals are set as directed by their constituent Tribes and health boards. The DEDP tracks these goals and objectives as written in their cooperative agreements (i.e., surveillance of disease and control programs and collecting epidemiological data for use in determining health status of Tribal communities).

PROGRAM ACCOMPLISHMENTS

Data Projects that Engage Local Resources
Data generated locally and analyzed by TECs enable Tribes to evaluate Tribal and community-specific health status for planning the needs of their Tribal membership. Immediate feedback is provided to the local data systems and leads to improvements in Indian health data overall. The Indian Health Care Improvement Act (Section 130) includes language to designate the TECs as public health authorities. To ensure the security of the agency data access, data sharing agreements are required, before TECs access IHS-generated data sets.

TECs assist Tribes with projects such as conducting behavioral risk factor surveys to establish a base of measurement for successfully evaluating intervention and prevention activities related to behavioral health needs. Because national surveys (e.g., Behavioral Risk Factor Surveillance System Survey, Youth Risk Behavior Survey) do not consistently capture representative data for AI/AN populations, TECs have had an essential role in piloting adapted versions of these national surveys to include AI/AN populations. These surveys provide baseline and trend data used by Tribes and Urban Indian Health organizations (UIHOs) to identify health-related needs and to prioritize interventions and prevention services. For example, one TEC combines these surveys and other data to generate reports on the health disparities of urban Indians and distributes nationally to all UIHOs to identify health priorities, seek opportunities for new data collection, and support competitive, evidence-driven applications for funding opportunities to address these priorities.

Disease Surveillance and Evaluation
In the expanding environment of Tribally-operated health programs, TECs provide additional public health services, such as disease control and prevention programs, in areas such as sexually transmitted disease control, HIV, and cancer prevention.

TEC efforts build capacity in the Indian health system by evaluating and monitoring the effectiveness of health and public health programs. This allows TECs to assess access, use, and/or quality of care and develop recommendations for the targeting of services needed by the populations served.

Collaboration
The DEDP collaborates with the National Institutes of Health, the Centers for Disease Control and Prevention (CDC), and other federal agencies to supplement TEC activities, create stronger interagency partnerships, and prevent costly duplication of effort.

TECs support national public health goals by working to improve data for the Government Performance and Results Act, agency performance reports, and monitoring of the Healthy People 2020 objectives at the Tribal level. Health status reports across all TECs will lead to a more comprehensive picture of Indian health. In the long term, these activities create opportunities for IHS to improve the delivery of services by calling attention to health disparities or concerns experienced by the population the Agency serves.

FUNDING HISTORY

Fiscal Year	Amount*
2015	*$4,433,361*
2016	*$4,433,361*
2017	*$4,433,361*
2018 Annualized CR	*$4,433,361*
2019 President's Budget	*$4,433,361*

*Funded under the H&HC budget.

BUDGET REQUEST

The FY 2019 budget submission for the TECs under Hospitals and Health Clinics is $4,433,361, which is the same as the FY 2018 Annualized CR level. Current funding, an average of $341,000 per TEC, covers the salaries of a Director, one full-time Epidemiologist, administrative assistance/support, and the execution of one or two pressing disparity projects or tribal priorities. The table below identifies the twelve TECs and their respective locations.

Tribal Epidemiology Centers and Locations		
1	Alaska Native Tribal Health Consortium	Anchorage, AK
2	Albuquerque American Indian Health Board	Albuquerque, NM
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI
4	Inter-Tribal Council of Arizona	Phoenix, AZ
5	Montana/Wyoming Tribal Leaders Council	Billings, MT
6	Navajo Nation Division of Health	Window Rock, AZ
7	Northern Plains – Great Plains Area	Rapid City, SD
8	Northwest Portland Area Indian Health Board	Portland, OR
9	Oklahoma City Area Inter-Tribal Health Board	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

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 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 2016: 850 Target: 850[1] (Baseline)	850	850	Maintain
EPI-5 Number of TEC-sponsored	FY 2016: 89 Target:	89	89	Maintain

[1]Measure implementation initiated along with any applicable database or performance structure.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
trainings and technical assistance provided to build tribal public health capacity. (Output)	89 (Baseline)			

New measures adopted by Tribal Epidemiology Centers Consortium during mid-FY 2016

GRANTS AWARDS

(whole dollars)	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	12	12	12
Average Award	$341,000	$341,000	$341,000
Range of Awards	$265,250 -$412,000	$265,250 -$412,000	$265,250 -$412,000

* Administrative and technical support of the TEC's is provided by the Division of Epidemiology and Disease Prevention (DEDP) and is included in the average award amount.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$1,857,225	$1,922,036	$2,189,688	+$267,652,110
HIT	*$182,149*	*$182,149*	*$182,149*	*0*

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 2019 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) Program 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 the IHS, Tribal, and Urban (I/T/U) programs that care for 2.2 million American Indian and Alaska Native (AI/AN) people across the Indian health system. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS HIT also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record (EHR) and more than eighty applications. IHS' EHR received 2014 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 program directly supports better ways to 1) care for patients , 2) pay providers, and 3) refer care when needed 4) recover costs, and 5) distribute information, resulting in better care, wiser spending of our health dollars, and healthier communities, economy, and country.

The HIT Program is dedicated to providing the most innovative, effective, cost-efficient, and secure HIT system in the federal government. The HIT program is comprised of two Mission Delivery IT investments: 1) Health Information Technology Systems and Support (HITSS); 2) National Patient Information Reporting System (NPIRS); and three Part 3 IT investments; 1) Infrastructure, Office, Automation, and Telecommunications (IOAT); 2) IT Security and Compliance; 3) IT Management. These investments support federal and tribal priorities for improving the delivery of healthcare and are fully integrated with the Agency's programs and are critical to carrying out the IHS mission and priorities.

1) **HITSS** is and enterprise wide enterprise health information system that underlies the clinical, practice management and revenue cycle business processes at I/T/U facilities across the

country. The IHS investment encompasses the RPMS EHR that is certified according to criteria published by the ONC and is in use at approximately 430 health care facilities across the country. In pursuit of expanding capabilities, the HITSS Program Management Office (PMO) continued the deployment of new health information sharing and patient engagement features, collectively called the RPMS Network, throughout FY 2017 and began its planning efforts for the IHS implementation of the IT requirements for the Medicare Access & Children's Health Insurance Program (Reauthorization Act (MACRA) of 2015) and other quality improvement initiatives.

2) **NPIRS** is an enterprise-wide data warehouse and business intelligence environment that produces 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. This investment, is evolving to add rigor to 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) **IOAT** program provides the technical infrastructure for federal and some tribal healthcare facilities and is the foundation upon which all health IT services are delivered. The IOAT investment includes a highly available and secure wide-area network which 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 IT infrastructure incorporates government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and pioneering opportunities.

4) **IT Security and Compliance** is an enterprise-wide IT Security Program which creates information security policy, secures centralized resources, and provides cybersecurity training for employees and contractors.

5) **IT Management** investment is an enterprise-wide program that supports IT Management, Capital Planning, Strategic Planning, Enterprise Architecture, IT Finance, and IT Vendor Management activities in support of the two Mission Delivery IT investments. This program serves to promote compliance with federal law and mandates and to improve efficiency and effectiveness of all IHS HIT investments.

PROGRAM ACCOMPLISHMENTS

The Office of Information Technology (OIT) achieved numerous accomplishments during FY 2017, some examples follow:

FY 2017 Accomplishments and Progress to Date

People

- Office of Information Technology (OIT) staff presented current 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 at IHS Headquarters and attended the Alaska Area Pre-negotiation/Negotiation meetings to address IT/HIT issues. IHS Senior Leadership also visited Cherokee Nation and Muscogee Creek Nation to view Tribal Electronic Health Record (EHR) modernization efforts.

- A representative from the Health and Human Services (HHS) Office of the Chief Technology Officer attended the IHS Information Systems Advisory Committee (ISAC) September 2017 bi-annual meeting to provide HHS technical support and share information with IHS, and participated in the IHS visit to the Muscogee Creek Nation to view commercial EHR systems in use at this Tribal site.

- Continued deployment of the new health information sharing and patient engagement capabilities in support of improving how we deliver services. Resource and Patient Management System (RPMS) Network accomplishments include:

    - RPMS Direct Messaging: Over 20,000 messages were exchanged between *patients, providers, administrators, and message agents through a*pproximately 13,771 Unique Direct e-mail Addresses.

    - Personal Health Record (PHR): PHR implementation is underway with approximately 11,000 PHR Users. *Fifty-six percent of these registered PHR users were verified/linked to their IHS Medical Record. The remaining 44 percent are registered but not yet verified/linked.*

- In response to issues identified by field and program staff, OIT significantly reduced 4,750 active RPMS/RPMS EHR service desk tickets by 80 percent and closed over 4,400 tickets with approximately 350 remaining open.

- Provided a total of 337 HIT training courses to 6,707 IHS/Tribal/Urban (I/T/U) users. This included 78 classroom/satellite sessions with 706 participants and 259 eLearning/eLearning hands-on sessions with 6,001 participants. Added 166 training recordings with 4,598 views in Fiscal Year (FY) 2017 for a total of 243 recordings since the FY 2015 recording repository inception culminating in 12,515 views.

- In support of Purchased/Referred Care (PRC) Program Reform, the OIT consistently provided RPMS practice management training to I/T/U users and worked closely with Office of Resource Access and Partnership to keep PRC software maintained and up-to-date.

Partnerships

- The ISAC held two semi-annual meetings (June in Chicago/September in Oklahoma City). Both meetings were well attended with an aggregated total of over 85 I/T/U participants, both in person and by teleconference. The agenda included reports and updates on the latest projects and initiatives within the HIT realm. The discussions which came out of the meeting included the current and future state of the IHS HIT platform including the EHR and the current IHS cyber-security efforts for the protection of the network, as well as infrastructure updates.

- The OIT conducted four highly attended Tribal listening sessions to share IHS efforts and solicit Tribal input on how best to modernize and improve our HIT Systems and Support

(HITSS) investments, including the RPMS EHR (approximately 1,000 participants). The current IHS EHR platform is related to the Department of Veterans Affairs (VA) EHR platform (VistA); however, the VA is adopting a commercial system to replace VistA. Options discussed at the listening sessions will be issued in a report in Fiscal Year 2018.

- The OIT conducted 15 Tribal Consultation and Urban Confer sessions on the draft IT Service Catalog, generating considerable Tribal participation with over approximately 125 participants. The final report will be issued in Fiscal Year 2018, and IT Service Catalog implementation will follow.
- The IHS Chief Information Officer (CIO) began reporting on the IHS's monthly "All Tribal and Urban Indian Organization Leaders" conference calls to share IHS IT/HITSS information. Reports have been well received.
- Collaboration with Tribal health programs and other federal agencies is key to the success of the HIT Program. IHS worked closely with the Office of the National Coordinator for HIT, Centers for Medicare and Medicaid Services, Agency for Healthcare Research and Quality, VA, and other federal entities on IT initiatives to ensure that the direction of its HIT systems are consistent with other federal agencies.
- Collaborating with the Open Source Electronic Health Record Alliance to facilitate making IHS HIT innovations and advances available to the broader public.

Quality

Health Information Technology

- Modernizing the way provider credentialing and privileging is carried out across the Agency to facilitate the hiring of qualified providers and ensuring patient safety. IHS acquired and is now utilizing a centralized electronic credentialing database across all federally operated facilities.
- Planning for system changes required to support implementation of Medicare Access and CHIP Reauthorization Act (MACRA). Participated in the IHS MACRA Working Group in providing Headquarters/field staff with information, webinars, and a quality initiative boot camp on the Quality Payment Program and MACRA requirements.
- Implemented and successfully completed the first year of a predictable, quarterly release schedule for the IHS electronic health records system software applications, to improve the efficiency of the development and release processes and to continuously demonstrate value for end-users.
- Realigned HIT software development contracts to improve on their efficiency and effectiveness, to move to a responsive, agile development process, and to leverage the benefits of performance-based contracting. Specifically, consolidated four legacy contracts under one prime contractor with an additional sub-contractor. This streamlines the acquisition of resources and administrative overhead and provides greater consistency for the implementation of organizational process improvements related to the software development life-cycle.
- Continued implementation of a VA-developed Bar Code Medication Administration (BCMA) solution, which is designed to prevent medication errors in healthcare settings and improve the quality and safety of medication administration, across the Indian health system. The

overall goals of BCMA are to improve accuracy, prevent errors, and generate online records of medication administration.

National Patient Information Reporting System

- Completed initial deployment of the new Integrated Data Collection System (IDCS), which will improve the quality, effectiveness, and utility of GPRA reporting. Supported quality improvement initiatives for the Great Plains Area.

- Implemented a new system to facilitate the improved Uniform Data System (UDS) reporting capabilities for the Urban Indian Health Program. UDS reporting is required performance reporting for HRSA-funded health centers.

Infrastructure, Office Automation, and Telecommunications

- In support of bandwidth modernization, implemented network circuit upgrades to provide additional bandwidth at over 50 IHS hospital and clinics to improve access to the HIT and administrative applications essential to support daily operations. Upgrades ensure IHS is positioned to meet future bandwidth needs, simplifies the process to add bandwidth as growth is needed, and reduces costs.

- In support of the OMB Data Center Optimization Initiative (DCOI), implemented a high-density blade server environment and upgraded Storage Area Network to improve IHS Headquarters data center hosting capabilities of HIT, infrastructure and administrative applications.

Cybersecurity

- The IHS Cybersecurity Program was selected as one of 50 organizations (and people within them) to win a CSO Magazine's CS050 award for developing and implementing security initiatives that drive business value. The IHS was selected due to the quality of our cybersecurity program and security initiatives that demonstrate outstanding business value and thought leadership. IHS was recognized at the CSO50 Security Conference + Awards in May 2017, focusing on "Aligning Proactive Security with Modern Threats," in Scottsdale, Arizona.

Resources

Health Information Technology

- Continued planning for the deployment of systems changes needed in support of the proposed Meaningful Use (MU) 3 initiative. Challenges to this initiative include diminution of the MU incentive funding, together with inflationary costs that will constrain the ability of the HIT investments to maintain current services or to enhance systems.

- Participated in the "New Medicare Card" project team to address impacted RPMS applications and provided information/outreach to IHS facilities to assist in preparing for the new Medicare Beneficiary Identifier.

Infrastructure, Office Automation, and Telecommunications

- Implemented a new Microsoft Active Directory domain to support secured centralized authentication of IHS HIT applications.

- Implemented the Information Technology Service Management (ITSM) project to consolidate and standardize ITSM governance, processes and tools. Engaged a contractor who has begun IT process data collection.

- Initiated work on the IHS Enterprise Infrastructure Solutions (EIS) contract (GSA Networx replacement) to ensure all items on the Networx contract are transitioned smoothly to the EIS contract. The IHS is required to take on a much larger role with the EIS contract which requires cross-organization involvement and to enhance service options available on contract and lower overall costs.

- Continue to work through HHS Trusted Internet Connection (TIC) changes to provide segmentation between non-Federal networks and IHS through a TIC, control access to IHS network resources on an as-needed basis only, and have only IHS controlled networks on the IHS wide area network to create a defined network security boundary.

- Initiated an IT Access Control (ITAC) replacement project aimed at utilizing a commercial product to eliminate the overhead of maintaining an in-house application, provide system integration for automation, add efficiency and enforce security standards, and ensure IHS meets requirements for IT security.

Cybersecurity

- Continuous Diagnostics and Mitigation efforts are underway to fortify the cybersecurity of computer networks and systems and provide a standard toolset across IHS and Government giving insight to network security and the IHS and Federal level. This aids IHS in identifying vulnerabilities rapidly, provides a common operational picture of network health/ integrity, allows comparison of cross-agency performance using common objective data, and reduces total costs for purchasing cybersecurity tools/ services through commodity of scale.

- Enterprise Patch Management efforts are ever present through deployment of critical Windows security patches to systems that remain unpatched the 1st Tuesday of the following month that the patch is released. This will secure IHS IT systems to the highest possible levels.

- Performed nine system security assessments resulting in "Authorizations to Operate." To comply with HHS policy, all weaknesses from security assessments are captured and reported to HHS on a monthly basis.

- Implemented a comprehensive "Plan of Action and Milestones" process. All weaknesses from previous assessments and audits are now formally tracked and updated. Quarterly reviews are now occurring which requires staff to provide remediation updates to their reported weaknesses.

Capital Planning and Investment Control

- Effective implementation of the Federal IT Acquisition Reform Act (FITARA) is critical for IHS to demonstrate good stewardship of the funding we have been entrusted with, and to enable IHS to effectively negotiate for increased funding necessary to continue to improve our capabilities and service delivery to all IHS customers. The HHS CIO delegated authority related to FITARA to the IHS CIO, who subsequently implemented the following IT resource acquisition process changes Agency-wide:

- Implemented IT acquisition control reforms in the Unified Financial Accounting System to route all IT Category approvals through OIT to comply with FITARA governance requirements.
- Established an enterprise-wide IT Approved Equipment List with examples and correct Object Class Codes.
- Created IHS Enterprise contracts to combine buying power to lower IHS operating costs, including mobile services, laptop/desktop, Apple iPad, and various software.

Policies and Procedures

- Completed the following approved and published Indian Health Manual (IHM) issuances:
  - Part 8 Chapter 1, "Chief Information Officer"
  - Part 8, Chapter 17, "Agency-Issued Mobile Devices Including Cellular Telephones, Smartphones, and Tablets"
  - Part 8, Chapter 23, "Resource and Patient Management System Network"
  - Administrative Delegation #52, "Security of Information Technology Systems"
  - Administrative Delegation #54, "Operating Division Chief Information Officer (CIO) Delegation of Authority, FY 2017"
- Work is underway to develop the new Part 10, "Cybersecurity," a major policy change that will improve the security posture of the Agency.

Collaboration with Tribal health programs and other federal agencies is key to the success of the HIT Program. IHS works closely with the ONC, CMS, Agency for Healthcare Research and Quality, VA, and other federal entities on IT initiatives to ensure that the direction of its HIT systems are 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. IHS considers the RPMS suite, built on the shared technology with the Department of Veteran's Affairs' VistA system, to be a public utility and collaboration with the Open Source Electronic Health Record Alliance (OSEHRA) will facilitate making the innovations and advances that IHS has made in HIT available to the broader public.

Through continued maintenance and enhancement of the IHS HIT suite, the agency Quality Framework initiatives has foundational data to generate baselines and adapt performance metrics. Some of this data has supported the recognition that the agency and patients are experiencing progressive health improvements in patient diabetic populations.

Immediate Priorities and Challenges

The IHS HIT Program continues to face increased demand for systems improvements and enhancements, rising costs, and increased IT security requirements driven in part by medical advances, and ever-growing and more complex requirements for health information technology capabilities. These requirements come from government and industry initiatives, program needs of health programs, and operational requests of I/T/U health care facilities. Virtually any new program initiative has information technology requirements for functionality, modality, data collection, and reporting which then must be added to a clinician's work flow and managed within the HIT portfolio.

The largest priority and challenge involves the IHS RPMS system and its dependency on the Veteran's Administration for software development. RPMS is impacted by the VA's recent announcement to adopt the Military Health System "Genesis" solution to replace their current legacy Health IT platform, VistA. This move will impact the IHS as the RPMS system is dependent on the VA's VistA system through shared software development. The IHS adopts software developed by the VA and adapts it for use in RPMS. Thus, the VA's decision means that a significant supplier of software source code that modernizes and supports RPMS will eventually decline over time. The IHS previously adopted the VA software with minimal funding expenditure in support of a similar but different agency mission. The loss of the VA as a source of software code will raise the cost of continuing to use the RPMS system, and/or require IHS to procure commercial-off-the-shelf (COTS) replacements for RPMS

In addition, CyberSecurity challenge include minimizing unsecured systems and data to reduce the possibility of identity theft, risk to patient health data, system breaches and loss of business continuity in the event of a disaster. System breach or intrusion into an unsecure network puts patient data at risk and impacts the IHS mission by delaying or halting patient care and harms IHS patients which may lead to a lack of trust in patient services.

Human resource shortages and slow staff backfill contributes to challenges in keeping up with evolving technology and new Federal, Department and Agency projects/initiatives including FITARA Implementation.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount[1]
2015	$182,149,000
2016	$182,149,000
2017	$182,149,000
2018 Annualized CR	$182,149,000
2019 President's Budget	$182,149,000

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 portion of the overall H&HC budget line is reserved for federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2019 budget submission for Health Information Technology is $182,149,000, which is the same as the FY 2018 Annualized CR level.

This funding will continue progress made in the past several years by keeping infrastructure costs as low as possible 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

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

source tools where possible to minimize acquisition costs and is reducing use of more costly assisted acquisition providers such as the General Services Administration. However, following the announcement by the VA, the IHS is considering the sustainability of the entire RPMS HIT platform. Efforts are underway to examine alternatives to replacing RPMS as the IHS HIT platform. The IHS must work through thorough analysis activities that result in informed decision making of any replacement option. Any change in the EHR platforms will impact the quality of direct patient care, increase cost recovery and promote continuous health improvements such as, expanded telehealth care services and predictive population health analytics. These potential returns highlight the value of health IT and its impact on the agency mission.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome)	FY 2017: 4.0 Target: 4.0[2] (Target Met)	4.0	4.0	N/A
HIT-2 HHS CIO Workplan - The IHS will score 90% or greater on the annual scoring of the HHS CIO Workplan (Outcome)	FY 2017: Result Expected Jan 31, 2019 (Pending)	Achieved more than expected	Achieved more than expected	Maintain
RPMS-2 Derive all clinical measures from RPMS and integrate with EHR. (Output)	FY 2017: 66 Measures / 12 IHS Areas Target: 75 Measures / 12 IHS Areas (Target Not Met)	Retired	Retired	Maintain

GRANTS AWARDS - IHS does not fund grants for health information technology.

[2] >= out of 5 for all investments

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$182,597	$181,357	$203,783	+$22,426
FTE*	572	572	635	+63

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 Authorization...Permanent

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

PROGRAM DESCRIPTION

The purpose of the Indian Health Service (IHS) Dental Health Program (DHP) is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The DHP is a service-oriented program providing basic dental services (e.g., diagnostic, emergency, preventive, and basic restorative care), which represents approximately 90 percent of the dental services provided. In FY 2017, the dental program provided a total of 3,828,214 basic dental services. More complex rehabilitative care (e.g., root canals, crowns and bridges, dentures, and surgical extractions) is provided where resources allow and account for the additional 257,112 dental services provided in FY 2017. The DHP provided these services through 1,371,172 dental visits in FY 2017 in 404 dental programs in 35 states.

The demand for dental treatment remains high due to the high incidence of dental caries in AI/AN children. Over 80 percent of AI/AN children ages 6-9 and 13-15 years suffer from dental caries, while less than 50 percent of the U.S. population in the same age cohort have experienced cavities.[1,2] In addition to this disparity in prevalence, there is a significant disparity in severity of dental disease. AI/AN children ages 2-5 years exhibit an average of four decayed teeth, while the same age group in the U.S. population averages one decayed tooth.[3] A continuing emphasis on community oral health promotion/disease prevention is essential in order to address the current high prevalence, reduce the severity of oral disease and improve the oral health of AI/AN people. Prevention activities improve health and reduce the amount and cost of subsequent dental care. The DHP measures performance in part through the delivery of preventive services. The DHP maintains data and tracks three key program objectives:

[1] Phipps KR, Ricks TL, Blahut P. The oral health of 6-9 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2014[1]).
[2] Phipps KR, Ricks TL, Blahut P, The oral health of 13-15 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief, Rockville, MD: Indian Health Service, 2014.
[3] Indian Health Service. The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children. Rockville, M.D.: U.S. Department of Health and Human Services, Indian Health Service, 2014

1) Increase the proportion of 2-15 year-olds with dental sealants;
2) Increase the proportion of 1-15 year-olds receiving at least one application of topical fluorides; and
3) Increase access to care across all age groups.

Across all age groups, AI/ANs suffer disproportionately from dental disease. When compared to other racial or ethnic groups, AI/AN children 2-5 years old have more than double the number of decayed teeth and overall dental caries experience as the next highest ethnic group, U.S. Hispanics, and more than four times that of U.S. white children.[4] 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.[5] In the 13-15 year-old age group, eight out of 10 AI/AN dental clinic patients have a history of tooth decay, compared to just 44 percent in the general U.S. population, and almost five times as many 13-15 year-old AI/AN youth have untreated decay compared to the general U.S. population.[6] In adults, the disparity in disease is equally as pronounced. 64 percent of AI/AN adults 35-49 years have untreated decay compared to just 27 percent of the general U.S. population, and across all other age groups studied (50-64 years, 65-74 years, and 75 and older), AI/AN adults have more than double the prevalence of untreated tooth decay as the general U.S. population. In addition, the rate of severe periodontal disease in AI/AN adults is almost double that of the general U.S. population.[7]

PROGRAM ACCOMPLISHMENTS

The IHS Early Childhood Caries (ECC) Collaborative was a nationwide initiative that was conducted from 2009 to 2017 and focused on preventing tooth decay in AI/AN children under the age of 71 months. Dental caries are the most common health problem in children, almost eight times more common than childhood asthma, and have significant consequences such as delayed speech development, more missed school days when children begin school, poor self-esteem, and a greater chance of tooth decay in permanent teeth.[8] AI/AN children suffer disproportionately from this disease, with more than double the number of decayed teeth as the next highest minority population, U.S. Hispanics, and more than 3 times the number of decayed teeth as U.S. White children.[9] The ECC Collaborative began with the goal of reducing dental caries in the AI/AN population through a coordinated, nationwide collaborative utilizing not only dental programs but also medical and community partners such as medical providers, public health nurses, community health representatives, pharmacists, and Head Start teachers. By the end of this initiative, the IHS had increased access to dental care for AI/AN children under 71 months by 7.9 percent and

[4] Indian Health Service. The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service, 2014.
[5] Phipps KR, Ricks TL, Blahut P. The Oral Health of 6-9 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief. Rockville, MD: Indian Health Service 2014.
[6] Phipps KR, Ricks TL, Blahut P. The Oral Health of 13-15 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief. Rockville, MD: Indian Health Service 2014.
[7] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native adult dental patients; results of the 2015 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service 2016.
[8] 1. US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, US Public Health Service. Oral Health in America: Report of the US Surgeon General. NIH publication no. 00-213. Washington, DC: DHHS, NIDCR, USPHS; 2000
[9] Indian Health Service. The 2010 Indian Health Service. The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children. Rockville, MD: U.S. Department of Health and Human Services, Indian Health Service, 2013. Available at http://www.ihs.gov/doh .

significantly increased prevention and early intervention efforts (sealants increased by 65.0 percent, the number of children receiving fluoride varnish increased by 68.2 percent, and the number of therapeutic fillings increased by 161 percent), resulting in a net decrease of dental caries prevalence from 54.9 percent in 2010 to 52.6 percent in 2014, and an even more dramatic decrease in dental caries experience from 33.4 percent to 27.1 percent in 1-2 year-olds, one of the largest decreases in caries experience evident in dental literature over such a short time span.[10] To support this initiative, the IHS conducted a nationwide surveillance of 1-5 year-old AI/AN children through two coordinated efforts of 8,451 children in 2010[3] and 11,873 in 2014 – the largest oral health surveillance sample size ever of this age group in the AI/AN population.[11] While the national initiative has since ended, the IHS DHP continues to promote evidence-based best practices in ECC primary and secondary prevention including early access to dental services, dental sealants in primary and permanent teeth, fluoride varnish applications, and secondary prevention tactics such as interim therapeutic restorations and silver ion antimicrobials aimed at reducing the spread of dental caries once it has begun.

In recent years, the DHP has utilized field dental programs in conjunction with its Dental Clinical and Preventive Support Centers (DSC) to achieve national performance objectives and IHS Area initiatives. The DSCs were designed and implemented in FY 1999 and FY 2000 to augment the dental public health infrastructure necessary to best meet the oral health needs of AI/AN communities. A new five-year cycle began September 15, 2015 with eight DSCs, three are funded by program awards and five are funded through grants. The primary purpose of a DSC is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to AI/AN communities. As a direct result of the advocacy efforts of the DSCs, the number of key preventive procedures has increased significantly in recent years. For example, the number of dental sealants placed per year has tripled in the last decade, and the number of patients receiving topical fluoride treatments has more than doubled in the last five years. In FY 2013, the DHP began tracking the coverage or prevalence of children and adolescents receiving sealants and topical fluoride, rather than simply counting procedures. These assessments allow improved comparisons with data from the U.S. population compiled by the Healthy People 2020 initiative.

Congressional appropriations created initial funding for the DSCs in FYs 1999 and 2000. In the ensuing years, these DSCs had an immediate positive impact on the direct delivery of dental care in a number of ways:

- All centers advocated for an appropriate focus on the dental Government Performance and Results Act (GPRA) performance objectives to increase specific clinical services.
- All centers provided continuing education opportunities to enhance the quality of care delivered.
- Several centers provided on-site clinical and community based program reviews to enhance the quality of care, assuring that field programs maintained a high level of expertise with respect to challenges such as infection control, preparing for accreditation and certification reviews, and patient scheduling practices aimed at maximizing access to care.

[10] Ricks TL, Phipps KR, Bruerd BB. The Indian Health Service Early Childhood Caries Collaborative: A Five-year Summary. Ped Dent 2015, 37;3: 275-80.

[11] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native Children aged 1-5 years; results of the 2014 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2015. Available at http://www.ihs.gov/doh .

- Several centers provided an array of health education materials or designed materials customized to the specific needs of the IHS Areas they serve. These materials have increased the quality of IHS oral health education efforts throughout Indian Country.
- Several centers provided or arranged for direct clinical services that otherwise would not have been provided.
- The aggregate accomplishments of the DSCs have resulted in an increase in clinical preventive care, an increase in overall clinical services, and an enhancement of the quality of clinical and community based care delivered by the dental field programs.

Access to dental services is a prerequisite to the control of oral disease in susceptible or high-risk populations. The access to care GPRA objective is currently aligned with Healthy People 2020 methodology as a percentage of patients who have visited the dentist within the previous 12 months. The access to care goal in FY 2017 was 29.7 percent and the performance was 29.5 percent. While this measure was not met, it was a significant improvement from FY 2016 and represented the highest access rate in the IHS since dental access first began being measured in the 1990's. 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. The IHS has 1,023 dentists (including part-time) in our system, according to the IHS Dental Directory.[12] In 2017, there were 2,895,571 American Indian/Alaska Natives in the U.S., according to the most recent user population estimate.[13] That means that in the IHS system we have approximately 1 dentist per 2,830 patients served. According to the U.S. Bureau of Labor Statistics, there were an estimated 153,500 dentists in the U.S. in 2016[14] serving a population of 325,719,178,[15] meaning that there is approximately 1 dentist per 2,122 people served.

Topical fluorides and dental sealants have been extensively researched and documented in the dental literature as safe and effective preventive interventions to reduce tooth decay. In FY 2013, the tracking of dental sealants and the tracking of patients receiving topical fluoride measures changed from simple counts of procedures or patients to the percentage of children receiving either sealants or topical fluorides. New annual targets were set for these two objectives as of July 1, 2013. In FY 2017, 31.9 percent of 1-15 year-old children received topical fluoride, an increase of 0.8 percent from FY 2016 and surpassing the annual goal of 29.9 percent. In FY 2017, 18.5 percent of 2-15 year-old children received dental sealants, an increase of 0.4 percent from FY 2016 and surpassing the annual goal of 16.6 percent.

The DHP continues to assess the care provided by its programs. Through an annual continuous surveillance program, the DHP monitors disease burden and progress across all age groups, a process that began in its current form in 2010 with a combination of community-based, school-based, and clinic-based surveillance methodologies. In 2017, the DHP surveyed AI/AN children 6-9 years of age, following up on surveillance conducted in 2011-2012. While this age group continues to suffer disproportionately from dental disease – 86 percent of 6-9 year-old AI/AN children have tooth decay compared to 56 percent of the U.S. population and 6-9 year-old AI/AN

[12] Indian Health Service, Department of Health and Human Services. IHS Dental Directory Report. www.ihs.gov/doh, accessed 13 January 2018.
[13] Indian Health Service, Department of Health and Human Services. User Population Estimates – FY 2017 Final, Revised 12/27/17.
[14] Bureau of Labor Statistics, U.S. Department of Labor. Occupational Outlook Handbook: Dentists. https://www.bls.gov/ooh/healthcare/dentists.htm, accessed 13 January 2018.
[15] U.S. Census Bureau. Population Estimates, July 1, 2017. https://www.census.gov/quickfacts/fact/table/US/PST045217, accessed 13 January 2018.

children had three times the rate of untreated decay as the U.S. white children – this survey showed, for the first time, a significant decrease in dental disease in this age group. Specifically, compared to a similar oral health survey conducted in 1999, AI/AN children 6-9 years of age had a decrease of 5 percent in tooth decay overall and a 17 percent decrease in tooth decay in permanent teeth, while untreated decay dropped from 73 percent in 1999 to just 47 percent in 2017. These changes mark the most significant decline in dental disease ever measured on a national scale in the DHP.[16]

The DHP has also made significant improvements in the way dental services are delivered. Through the implementation of an electronic dental record, over 90 percent of IHS and Tribal dental programs have been transformed to and electronic system that will improve the quality and delivery of dental services. A second improvement was the release of 20 new dental clinic efficiency and effectiveness standards by which IHS and Tribal dental programs can measure clinical productivity, staffing ratios, and specific clinical efficiency indicators against national averages. A third way the DHP has improved the delivery of care is through the development of new national protocols for the early screening and treatment of periodontal disease in adults. A fourth way the DHP has improved the delivery of care is through ongoing support of long-term training (LTT) of general dentist to build the cadre of dental specialists in the IHS and Tribal dental programs. Dentists completing DHP- sponsored LTT to become specialist such as pediatric dentists, periodontists, and endodontists have a service payback obligation to serve AI/AN patients. In the past 2 years, an Oral Maxillofacial Surgeon, an endodontist, and periodontist have returned from LTT to serve AI/AN patients. A fifth way the DHP is improving the delivery of services is through the adoption of an integrated care model, specifically in promoting depression screenings by dental health providers through a collaboration with the IHS Behavioral Health Program. A final way the DHP continues to improve the delivery of services is through a sustained (20+ years) continuing dental education (CDE) program. The IHS CDE program provides American Dental Association Commission for Continuing Education Provider Recognition approved quality education with over 200 clinical and public health courses to IHS and Tribal dentists, dental hygienists, dental assistants, and dental public health leadership.

FUNDING HISTORY

Fiscal Year	Amount
2015	$173,982,000
2016	$178,286,000
2017	$182,597,000
2018 Annualized CR	$181,357,000
2019 President’s Budget	$203,783,000

TRIBAL SHARES

Dental 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 portion of the overall Dental budget line is reserved for federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

[16] Phipps KR and Ricks TL. The oral health of American Indian and Alaska Native children aged 6-9 years: results of the 2016-2017 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2017.

BUDGET REQUEST

The FY 2019 budget submission for Dental Health of $203,783,000 is $22,426,000 above the FY 2018 Annualized CR level.

FY 2018 Base Funding of $181,357,000 will support oral health care services provided by IHS and Tribal programs, maintain the program's progress in raising the quality of and access to oral care through continuing recruitment of oral health care professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2019 Funding Increase of $22,426,000, a net increase, includes:

- Current Services: +$13,878,000 for current services including:
    - Pay Costs +$3,234,000 – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$2,786,000 – to fund inflationary costs of providing health care services.
- Staffing for New Facilities +$13,878,000 – These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Red Tail Hawk Health Center, Chandler, AZ	$5,962,000	57
Fort Yuma Health Center (Replacement), Winterhaven, CA	$658,000	6
Muskogee (Creek) Nation Health Center (JV), Eufaula, OK	$1,290,000	12
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$5,029,000	35
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$939,000	7
Grand Total:	**$13,878,000**	**117**

- Clinical Services +$1,728,000 – The funding level will increase funding for direct dental health services, including basic dental services, such as diagnostic, emergency, preventive, and basic restorative care, and more complex rehabilitative care, such as root canals, crowns and bridges, dentures, and surgical extractions. The proposed funding level supports operating levels consistent with anticipated final FY 2018 funding levels.

- Transfer +$800,000 from Direct Operations. This is a technical adjustment to move funds appropriated in FY 2017 to Dental Services, reflecting Congressional intent for these funds to be used to backfill vacant dental health positions in Headquarters, as described in the FY 2017 Joint Explanatory Statement.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
12 Topical Fluorides: Percentage of patients, ages 1 to 15, who received one or more topical fluoride application during the report period (Outcome)	FY 2017: 31.9 % Target: 29.9 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain
13 Dental Access: Percent of patients who receive dental services. (Outcome)	FY 2017: 29.5 % Target: 29.7 % (Target Not Met but Improved)	Retire and Replace	Retire and Replace	Maintain
14 Dental Sealants: Percentage of patients, ages 2 to 15, with at least one or more intact dental sealant (Outcome)	FY 2017: 18.5 % Target: 16.6 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain
61 Topical Fluorides (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 30 % (Pending)	30 %	30 %	Maintain
62 Access to Dental Services (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 27.2 % (Pending)	27.2 %	27.2 %	Maintain
63 Dental Sealants (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 16 % (Pending)	16 %	16 %	Maintain

GRANTS AWARDS

The purpose of the 5 grant awards is to support the Dental Preventive and Clinical Support Centers program (aka Dental Support Centers or DSCs). The 5 DSCs combine IHS and Tribal resources and infrastructure in order to address broad challenges and opportunities associated with preventive and clinical dental programs. Centers also rigorously measure and evaluate their work with the goal of demonstrably improving dental health outcomes through the technical assistance and services they provide. Centers may work simultaneously to improve many different dental programs in a region, providing support, guidance, training, and enhancement to these programs, which then provide services to patients.

(whole dollars)	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	5	5	5
Average Award	$250,000	$250,000	$250,000
Range of Awards	$250,000	$250,000	$250,000

AREA ALLOCATION

Dental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$347	$30,418	$30,765	$335	$30,911	$31,245	$349	$36,609	$36,957	$5,712
Albuquerque	4,848	3,473	8,321	4,674	3,530	8,204	4,873	4,180	9,054	850
Bemidji	2,068	2,193	4,261	1,994	2,229	4,223	2,079	2,639	4,719	496
Billings	5,874	1,581	7,456	5,663	1,607	7,270	5,905	1,903	7,808	538
California	385	1,661	2,046	371	1,688	2,059	387	2,000	2,386	327
Great Plains	10,387	6,753	17,139	10,014	6,862	16,876	10,441	8,127	18,568	1,692
Nashville	735	5,532	6,267	708	5,622	6,330	739	6,658	7,397	1,066
Navajo	25,398	7,660	33,057	24,485	7,784	32,269	25,530	9,219	34,748	2,479
Oklahoma	9,653	29,901	39,554	9,306	30,386	39,692	9,703	35,987	45,690	5,998
Phoenix	8,768	7,832	16,600	8,453	7,959	16,412	8,813	9,426	18,240	1,828
Portland	4,410	3,196	7,606	4,252	3,247	7,499	4,433	3,846	8,279	780
Tucson	39	1,835	1,873	37	1,864	1,902	39	2,208	2,247	345
Headquarters	7,651	0	7,651	7,376	0	7,376	7,691	0	7,691	315
Total, Dental	**$80,562**	**$102,035**	**$182,597**	**$77,668**	**$103,689**	**$181,357**	**$80,981**	**$122,802**	**$203,783**	**+$22,426**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$94,080	$93,441	$105,169	+$11,728
FTE*	181	181	208	+27

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 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) is a community-based clinical and preventive service program that provides ongoing 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.

PROGRAM ACCOMPLISHMENTS

Specific focus areas that meet the Agency's priority relating to People, Partnerships and Quality for the IHS MH/SS program are:

Suicide Prevention: In 2015, the suicide rate for AI/AN adolescents and young adult ages 15 to 34 (19.5 per 100,000) was 1.5 times than the national average for that age group (12.9 per 100,000). [1] Suicide is the eighth leading cause of death among all AI/AN across all ages. [1] Strategies to address behavioral health, alcohol, substance use disorder, and suicide prevention require comprehensive clinical strategies, and approaches. The IHS utilizes and promotes collaborations and partnerships with patients and their families, including Tribes and Tribal organizations, Urban Indian health programs, federal, state, and local agencies, as well as public and private organizations. The 2017 – 2022 National AI/AN Suicide Prevention Strategic Plan

advances the 2012 National Suicide Strategic Plan with culturally relevant approaches and strategies specific for AI/AN communities.[1]

The IHS utilizes a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to a specific incident of suicide, including date and location of act, method, contributing factors, and other useful epidemiological information to better understand the issue, identified risk factors and target resources appropriately.

Zero Suicide Initiative: In FY 2015, IHS launched the Zero Suicide Initiative in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), an approach developed by the Education Developmental Center's (EDC) Suicide Prevention Resource Center (SPRC). Zero Suicide is a priority to transform health systems to significantly reduce suicides for those individuals under our care. The initiative includes educating healthcare providers on screening for suicide, conducting suicide risk assessments, and ensuring the infrastructure exists to support evidence-based suicide care. IHS contracted with EDC's SPRC which held two AI/AN Zero Suicide Academies with 20 IHS, Tribal, and Urban Indian organizations in attendance.

In FY 2017, IHS received $3.6 million to fund pilot sites to implement the Zero Suicide model. IHS funded 8 IHS and Tribal sites to participate in its first cohort of the Zero Suicide Initiative. These projects will operate from November 15 to November 14 for a three year funding cycle, dependent on appropriations.

Trauma-Informed Care: Developing and implementing a trauma informed care approach to address childhood trauma, including historical trauma, is necessary to comprehensively address the root causes of violence, suicide, depression, anxiety, self-harm, and chronic physical diseases. IHS has worked to implement the principles of trauma informed care to ensure its system understands the prevalence and impact of trauma, facilitates healing, avoids re-traumatization, and focuses on strength and resilience.

In September 2016, the MH/SS and Improving Patient Care and the Johns Hopkins University partnered to develop a tribal specific Pediatric Integrated Care Collaborative (PICC), a pilot project to increase the quality and accessibility of child trauma services by integrating behavior and physical health services in patient centered medical homes. Ten PICC pilot sites attended in-person and virtual quality improvement learning collaborative sessions to receive tailored technical assistance to integrate trauma informed care into pediatric primary care. The goal of the pilot site project is to harvest lessons learned to apply for screening of trauma in the pediatric population, engaging families, and developing policy recommendations for the Indian health system. In FY 2018, IHS will onboard seven new sites who will work alongside the previous ten sites in a quality improvement model. Lessons learned from the PICC will be used by IHS to incorporate into a standalone trauma informed care policy in the Indian Health Manual.

In 2016, IHS contracted with the University of New Mexico (UNM) to develop an online training curriculum related to trauma and trauma-informed care tailored for IHS staff, clinical staff, and supervisors. UNM adapted the Creating Cultures of Trauma Informed Care (CCTIC) model to be culturally appropriate and for use in AI/AN communities. UNM provided 19 separate online

[1] Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013, 2011) National Center for Injury Prevention and Control, CDC (producer). Available from http://www.cdc.gov/injury/wisqars/index.html

trainings in 2017 with the goal of facilitating organizational change built around five core values: safety, trustworthiness, choice, collaboration, and empowerment. Staff training focused on recognizing trauma and its impact, becoming trauma informed, treating trauma, and ensuring supervisors at all managerial levels understand the impact of trauma and historical trauma in employee performance, coworker relationships, and well-being.

Behavioral Health Integration Initiative (BH2I): IHS supports changing the paradigm of mental health and substance abuse disorder services from being episodic, fragmented, specialty, and/or disease focused to incorporating it into the patient-centered medical home. 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 launched an Improving Patient Care learning intensive focused on behavioral health integration with primary care. The intensive focused on the key areas of the Behavioral Health Integration Initiative (BH2I): formalizing integration across the system, developing care teams, strengthening infrastructure, and enhancing clinical processes. The goal was increased depression screening in primary care clinics through utilization of the Public Health Questionnaire (PHQ) (PHQ-2 and PHQ-9). Despite setting the goal of improving screening rates, the learning intensive did not result in significant improvements. The seven participating teams reported progress in advancing their organizational strategy for behavioral health integration. IHS will plan to include additional measures that reflect organizational change for behavioral health integration outside of focusing solely on screening rates.

In FY 2017, IHS received $6 million to launch its BH2I. In September 2017, IHS funded 12 IHS, Tribal, and Urban Indian organizations to integrate behavioral health with primary care services in their local health facilities. Additionally, IHS contracted with a technical assistance provider to guide pilot project through the implementation of their integrated care work with expertise from psychiatrists, primary care physicians, and social workers. The contractor will also complete an evaluation of the BH2I to assist IHS in determining the impact of BH2I.

TeleBehavioral Health and Workforce Development: The IHS TeleBehavioral Health Center of Excellence (TBHCE) was established in 2009, utilizing funds from the Methamphetamine and Suicide Prevention Initiative, to assess the feasibility of providing behavioral health services via televideo. Due to the rural nature of many IHS and Tribal facilities, our patients face many issues surrounding access to care, particularly specialty care. Providers working in these remote areas often face barriers in maintaining the required continuing education (CE) credits required for licensure and up to date on current clinical guidelines. The TBHCE assists IHS, Tribal, and Urban Indian healthcare providers and facilities in overcoming these challenges by providing a range of telebehavioral health services and training. There are 25 sites receiving direct care services through the TBHCE. These services include, adult counseling, child counseling, family counseling, trauma/Post Traumatic Stress Disorder (PTSD) counseling, child psychiatry, adult psychiatry, and addiction psychiatry. In FY 2017, the TBHCE provided more than 4051 hours of behavioral health services to over 8101 patients. Additionally, the TBHCE hosts a robust weekly schedule designed to meet the specific training needs of IHS, Tribal, and Urban Indian health care providers. In FY 2017, the TBHCE awarded 4336 hours of CE credits and over 8,900 hours of training during 118 online seminars.

FUNDING HISTORY

Fiscal Year	Amount
2015	$81,145,000
2016	$82,100,000
2017	$94,080,000
2018 Annualized CR	$93,441,000
2019 President's Budget	$105,169,000

TRIBAL SHARES

Mental Health 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 portion of the overall Mental Health budget line is reserved for federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2019 budget submission for Mental Health of $105,169,000 is $11,728,000 above the FY 2018 Annualized CR level.

FY 2018 Base Funding of $93,441,000 – 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 2019 Funding Increase of $11,728,000 includes:

- Current Services: +$7,736,000 for current services including:
    - Pay Costs +$1,471,000 – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$1,442,000 – to fund inflationary costs of providing health care services.
- Staffing for New Facilities +$7,736,000 - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	**Amount**	**FTE/Tribal Positions**
Red Tail Hawk Health Center, Chandler, AZ	$2,563,000	24
Fort Yuma Health Center (Replacement), Winterhaven, CA	$300,000	3
Muskogee (Creek) Nation Health Center (JV), Eufaula, OK	$731,000	7
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$3,470,000	25
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$672,000	5
Grand Total:	**$7,736,000**	**64**

- Clinical Services +$1,079,000 – The funding level will increase funding for direct clinical health services, including 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.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
18 Proportion of American Indian and Alaska Native adults 18 & over who are screened for depression (Outcome)	FY 2017: 69.4 % Target: 70 % (Target Not Met but Improved)	Retire and Replace	Retire and Replace	Maintain
18 Tribally Operated Health Programs (Outcome)	FY 2017: 67.3 % Target: 65 % (Target Exceeded)	Retire	Retire	Maintain
29 Suicide Surveillance: Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals (Outcome)	FY 2016: 2,109 completed reporting forms FY 2016 Target: 1,798 completed reporting forms (Target Exceeded)	2,561 completed reporting forms	TBD	N/A
65 Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression. (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 42.2 % (Pending)	42.2 %	42.2 %	Maintain
77 Anti-Depressant Medication Management: Acute Treatment (Intermediate Outcome)	FY 2017: 41.9 % Target: 41.9 % (Baseline)	Retire	Retire	Maintain
77 TOHP Anti-Depressant Medication Management: Acute Treatment (Intermediate Outcome)	FY 2017: 38.2 % Target: 38.2 % (Baseline)	Retire	Retire	Maintain
78 Anti-Depressant Medication	FY 2017: 21.9 % Target:	Retire	Retire	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
Management: Continuous Treatment (Intermediate Outcome)	21.9 % (Baseline)			
78 TOHP Anti-Depressant Medication Management: Continuous Treatment (Intermediate Outcome)	FY 2017: 18.6 % Target: 18.6 % (Baseline)	Retire	Retire	Maintain
79 Depression Screening of American Indians and Alaska Natives ages 12-17. (Output)	FY 2017: 50.1 % Target: 50.1 % (Baseline)	Retire and Replace	Retire and Replace	Maintain
79 TOHP Depression Screening of American Indian and Alaska Native patients ages 12-17. (Output)	FY 2017: 45.7 % Target: 45.7 % (Baseline)	Retire	Retire	Maintain
85 Depression Screening ages 12-17. (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 27.6 % (Pending)	27.6 %	27.6 %	Maintain
MH-1 Increase Tele-behavioral health encounters nationally (Output)	FY 2017: 12,212 Target: 10,359 (Target Exceeded)	11,600	13,600	+2,000

GRANTS AWARDS

The proposed FY 2019 budget increases will be used, in part, for grants 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. Grants will be publicly competed. The actual number of grants to be awarded is to be determined.

AREA ALLOCATION

Mental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$73	$11,316	$11,390	$71	$11,454	$11,525	$74	$13,579	$13,654	$2,129
Albuquerque	1,751	2,532	4,283	1,696	2,563	4,259	1,774	3,039	4,812	553
Bemidji	323	1,918	2,241	313	1,941	2,255	328	2,302	2,629	375
Billings	2,580	1,226	3,806	2,500	1,241	3,741	2,615	1,471	4,086	344
California	112	2,027	2,138	108	2,051	2,160	113	2,432	2,545	386
Great Plains	7,067	2,444	9,511	6,848	2,474	9,322	7,161	2,933	10,094	772
Nashville	322	2,218	2,540	312	2,245	2,557	326	2,662	2,988	431
Navajo	8,953	6,378	15,330	8,676	6,455	15,131	9,072	7,653	16,725	1,594
Oklahoma	3,103	12,186	15,289	3,007	12,334	15,342	3,145	14,623	17,768	2,426
Phoenix	3,326	5,463	8,789	3,223	5,529	8,752	3,370	6,555	9,925	1,173
Portland	494	3,554	4,048	478	3,598	4,076	500	4,265	4,766	690
Tucson	11	1,426	1,437	11	1,443	1,454	12	1,711	1,722	268
Headquarters	13,278	0	13,278	12,867	0	12,867	13,455	0	13,455	587
Total, Mental	**$41,393**	**$52,687**	**$94,080**	**$40,113**	**$53,328**	**$93,441**	**$41,944**	**$63,225**	**$105,169**	**+$11,728**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$218,353	$216,870	$235,286	+$18,416
FTE*	162	162	237	+75

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 Authorization...Permanent

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

PROGRAM DESCRIPTION

Alcoholism, addiction, and alcohol and substance abuse are among the most severe public health and safety problems facing American Indian and Alaska Native (AI/AN) individuals, families, and communities. The purpose of the Indian Health Service (IHS) Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral 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 and culturally competent. The ASAP addresses the Agency's priorities of People, Partnerships, and Quality through these collaborative activities, and works to integrate substance abuse treatment into primary care. For instance, the Substance Abuse and Suicide Prevention Program (SASP) (formerly known as the Methamphetamine and Suicide Prevention Initiative - MSPI) provides community developed and delivered prevention and intervention resources to address the dual crises of methamphetamine and suicide in AI/AN communities.

In general, AI/AN populations suffer disproportionately from substance abuse disorders compared with other racial groups in the United States. The age-adjusted AI/AN drug-related death rate is 4.1 deaths per 100,000 population for the three-year period 1979-1981, as compared to the AI/AN death rate of 22.7 in 2007-2009. This is an increase of 454 percent since drug-related death rates were first introduced for AI/AN populations in 1979. The 2007-2009 AI/AN rate is 1.8 times greater than the U.S. all races rate of 12.6 for 2008.[1]

PROGRAM ACCOMPLISHMENTS

As alcohol and substance abuse treatment and prevention have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS' role has transitioned to providing support to enable communities to plan, develop, and implement

[1] U.S. Department of Health and Human Services, Indian Health Service. Trends in Indian Health 2014 Edition. Released March 2015. ISSN 1095-286

culturally 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 emergency services. Integrating treatment into health care offers immediate and same-day opportunities for health care providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, obtain substance abuse consultations, and refer patients with more severe substance use-related problems to treatment.[2] One integration activity is Screening, Brief Intervention, Referral to Treatment (SBIRT), which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders. IHS is broadly promoting SBIRT as an integral part of a sustainable, primary care-based, behavioral health program through reimbursement from the Centers for Medicare and Medicaid Services (CMS). IHS has incorporated screening and SBIRT as national measures to be tracked and reported. IHS provides annual national training on SBIRT. Guidelines for clinical documentation in the electronic health record have also been instituted.

Medication Assisted Treatment (MAT): MAT is an approach that uses Food and Drug Administration approved pharmacological treatments, often in combination with psychosocial treatments, for patients with opioid use disorders.[3] In FY 2017, IHS provided two sessions for providers to be eligible for MAT waivers with a total of 18 physicians trained.

Proper Opioid Prescriber Training: IHS provided four sessions of its mandatory five-hour training course for providers on proper opioid prescribing. In FY 2017, IHS trained 96 percent of its workforce on proper opioid prescribing. IHS offers on demand training to capture new employees who require training, as well as refresher courses every three years.

Pain and Opioid Use Disorder Case Consultation Services: To provide clinical support for providers, IHS launched weekly Pain and Addiction consultations, in partnership with the University of New Mexico. Healthcare providers receive a no-cost consultation from an expert panel. In FY 2017, IHS offered 42 case consultation session on pain and addiction.

Youth Regional Treatment Centers (YRTCs): YRTCs provide residential substance abuse and mental health treatment services to AI/AN youth. Congress authorized the establishment of these YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. The Southern California facility, Desert Sage, opened in FY 2017. The Alaska and Portland Areas divided their funds to provide residential treatment services for two programs. The second treatment facility for the Portland Area opened in October 2017.

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, and providing expert consultation to help clinicians successfully diagnose, manage, and/or treat these conditions. A training series on FASD was offered in FY 2017 with nine webinars and eight expert case consultations. In FY 2018, IHS will offer a four hour course for community health workers on FASD and Autism Spectrum Disorder.

[2] U.S. Office of National Drug Control Policy. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.
[3] U.S. Office of National Drug Control Policy. Medication Assisted Treatment for Opioid Addiction. *Available at* http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.

Information Systems Supporting Behavioral Health Care: The Resource and Patient Management System (RPMS) includes functionality designed to meet the unique business processes of behavioral health (BH) providers and support BH-related initiatives. Standardized instruments and clinical decision support tools are available to support routine and effective screening for alcohol and substance use, depression, domestic violence and smoking status. Additionally, surveillance tools are available to capture suicide data at the point of care. Aggregate national RPMS behavioral health data is maintained to support local, national and other program reporting requirements as well as quality performance measurements for numerous screening and prevention initiatives including screening for alcohol and substance use, depression, domestic violence, smoking, and suicide data collection.

Partnerships: IHS is collaborating with other agencies working in the field of substance disorders such as the Substance Abuse and Mentla Health Administration (SAMHSA), Veterans Health Administration, Health Resources and Services Administration, Office of National Drug Control Policy, and CMS to ensure that the best available information, trainings, protocols, evaluations, performance measures, data needs, and management skills are incorporated and shared with all agencies and organizations working on substance use disorders.

The Department of the Interior (DOI) through the Bureau of Indian Affairs (BIA), the Bureau of Indian Education (BIE), and the IHS have a Memorandum of Agreement (MOA) on Indian Alcohol and Substance Abuse Prevention, which was amended in 2011 as a result of the permanent reauthorization of the Indian Health Care Improvement Act. Through this MOA, BIA, BIE, and IHS coordinate and implement plans in cooperation with Tribes to assist Tribal governments in their efforts to address behavioral health issues. The MOA includes coordination of data collection, resources, and programs of IHS, BIA, and BIE.

The Tribal Law and Order Act (TLOA) requires interagency coordination and collaboration among HHS (IHS and SAMHSA), DOI (BIA/BIE), Department of Justice (Office of Justice Programs/Office of Tribal Justice), and the Office of the Attorney General. The coordination of Federal efforts and resources will assist in determining both the scope of alcohol and substance abuse problems as well as effective prevention and treatment programs. The MOA required by Section 241 of the TLOA was signed on July 29, 2011 by the Secretaries of the Departments of Health and Human Services and the Interior and the Attorney General to: (1) determine the scope of the alcohol and substance abuse problems faced by Tribes; (2) identify and delineate the resources each entity can bring to bear on the problem; (3) set standards for applying those resources to the problems; and (4) coordinate existing agency programs.

In FY 2017, the IHS and BIA continued their formal partnership to reduce deaths from prescription drug and heroin overdoses by providing naloxone, a medication that reverses the effects of heroin or prescription opioid overdose and saves lives.

ASA Grant and Federal Award Programs

Substance Abuse and Suicide Prevention Program (SASP): The SASP, formerly known as the Methamphetamine and Suicide Prevention Initiative, is a nationally-coordinated $31.975 million program providing funds for culturally appropriate substance use and suicide prevention programming in AI/AN communities. The program funds 175 projects.

The goals of SASP are to: 1) increase IHS, Tribal, and Urban (I/T/U) capacity to operate successful methamphetamine prevention, treatment, and aftercare and/or suicide prevention,

intervention, and postvention services through implementing community and organizational needs assessment and strategic plans; 2) develop and foster data sharing systems among I/T/U behavioral health service providers to demonstrate efficacy and impact; 3) identify and address suicide ideations, attempts, and contagions among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postvention strategies; 4) identify and address methamphetamine use among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, treatment, and aftercare strategies; 5) increase provider and community education on suicide and methamphetamine use by offering appropriate trainings; and 6) promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance use.

SASP projects were awarded for funding in at least one of four purpose areas and work to address the corresponding SASP goal listed above. SASP Purpose Areas are: 1) Community Needs Assessment and Strategic Planning; 2) Suicide Prevention, Intervention, and Postvention, 3) Substance Use Prevention, Treatment, and Aftercare, and 4) Generation Indigenous (Gen-I) Support.

In year 2, 99 percent of projects submitted progress reports as a requirement of funding. Year 2 evaluation information will be available in March 2018.

Preventing Alcohol-Related Deaths (PARD): In September 2017, IHS funded one Tribe and a city government for a total of $2 million to participate in the PARD to implement alcohol detoxification services, including shelter services, for individuals with alcohol use disorders at risk for death.

YRTC Aftercare Pilot Project: In December 2017, IHS utilized $1.8 million to implement a pilot project for aftercare services for Native youth discharged from residential substance use treatment. Two YRTCs are funded to develop approaches to aftercare, recovery, and other support services for Native youth that can be used across other IHS and tribal YRTCs.

FUNDING HISTORY

Fiscal Year	Amount	SASP	Gen I
2015	$190,981,000	($15,475,000)	N/A
2016	$205,305,000	($15,475,000)	($10,000,000)
2017	$218,353,000	($15,475,000)	($16,500,000)
2018 Annualized CR	$216,870,000	($15,475,000)	($10,000,000)
2019 President's Budget	$235,286,000	($15,475,000)	($16,500,000)

TRIBAL SHARES

Alcohol and Substance Abuse 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 portion of the overall Alcohol and Substance Abuse budget line is reserved for federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2019 budget submission for Alcohol & Substance Abuse of $235,286,000 is $18,416,000 above the FY 2018 Annualized CR level.

FY 2018 Base Funding of $216,870,000 – This funding will maintain 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.

FY 2019 Funding Increase of $11,643,000 includes:

- Current Services +7,560,000 for current services including:
    - Pay Costs +$2,994,000 – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$4,566,000 – to fund inflationary costs of providing health care services.
- Staffing for New Facilities +$8,684,000 - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	Tribal Positions
Red Tail Hawk Health Center, Chandler, AZ	$949,000	9
Fort Yuma Health Center (Replacement), Winterhaven, CA	$154,000	1
Muskogee (Creek) Nation Health Center (JV), Eufaula, OK	$307,000	3
Northern California Youth Regional Treatment Center, Davis, CA	$6,128,000	65
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$896,000	7
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$250,000	2
Grand Total:	**$8,684,000**	**87**

- Clinical Services +$2,172,000 – The funding level will increase access for Tribal behavioral health programs focused on substance abuse, crisis response, and to expand the number of behavioral health professionals throughout Indian Country.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers	FY 2017: 100 % Target: 100 % (Target Met)	100 %	100 %	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
(in operation 18 months or more). (Outcome)				
60 Universal Alcohol Screening (Outcome)	FY 2017: 68 % Target: 68 % (Baseline)	Retire and Replace	Retire and Replace	Maintain
60 Tribally Operated Health Programs (Outcome)	FY 2017: 66.3 % Target: 66.3 % (Baseline)	Retire	Retire	Maintain
76 Screening, Brief, Intervention, and Referral Treatment (SBIRT) (Outcome)	FY 2017: 3.0 % Target: 3.0 % (Baseline)	Retire and Replace	Retire and Replace	Maintain
76 TOHP Screening, Brief, Intervention and Referral to Treatment (SBIRT) (Outcome)	FY 2017: 4.8 % Target: 4.8 % (Baseline)	Retire	Retire	Maintain
80 Universal Alcohol Screening (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 37.0 % (Pending)	37.0 %	37.0 %	Maintain
82 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 8.9 % (Pending)	8.9 %	8.9 %	Maintain

GRANTS AWARDS

(whole dollars)	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	143	178	178
Average Award	$150,000	$150,000	$168,800
Range of Awards	n/a	n/a	n/a

AREA ALLOCATION

Alcohol and Substance Abuse

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$595	$31,402	$31,998	$578	$31,520	$32,098	$599	$34,917	$35,516	$3,418
Albuquerque	2,807	9,339	12,146	2,726	9,374	12,101	2,824	10,384	13,208	1,108
Bemidji	1,787	8,218	10,005	1,735	8,249	9,984	1,797	9,138	10,936	951
Billings	477	10,576	11,052	463	10,615	11,078	480	11,760	12,239	1,161
California	3,161	13,653	16,814	3,070	13,705	16,774	3,180	15,182	18,361	1,587
Great Plains	3,582	10,397	13,979	3,479	10,436	13,915	3,603	11,561	15,164	1,249
Nashville	2,915	6,158	9,073	2,831	6,181	9,012	2,933	6,847	9,780	767
Navajo	1,622	17,893	19,516	1,576	17,960	19,536	1,632	19,896	21,529	1,992
Oklahoma	4,150	12,102	16,252	4,031	12,147	16,178	4,175	13,457	17,631	1,453
Phoenix	6,878	10,447	17,324	6,680	10,486	17,166	6,919	11,616	18,535	1,369
Portland	1,935	14,220	16,155	1,880	14,273	16,153	1,947	15,812	17,759	1,606
Tucson	50	3,059	3,109	49	3,070	3,119	50	3,401	3,452	333
Headquarters	40,930	0	40,930	39,755	0	39,755	41,176	0	41,176	1,421
Total, ASA	**$70,888**	**$147,465**	**$218,353**	**$68,853**	**$148,017**	**$216,870**	**$71,314**	**$163,972**	**$235,286**	**+$18,416**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

(Dollars in thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$928,830	$922,522	$954,957	+$32,435
FTE*	--	--		--

* PRC Funds are not used for Federal or Tribal Staff

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 2018 Authorization...Permanent

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

PROGRAM DESCRIPTION

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

The PRC Program is integral to providing comprehensive health care services to eligible American Indians and Alaska Natives (AI/AN). The Indian health system delivers care through direct care services provided in an IHS, Tribal or Urban Indian Health Program (I/T/U) facility (e.g., hospitals, clinics) and through PRC services delivered by non-IHS providers. The general purpose of the PRC Program is for I/T/U 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.

[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.

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 service delivery Area; authorization of payment for the 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, 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 service delivery area of the local facility, IHS PRC regulations require I/T/U PRC programs to use a medical priority system to fund the most urgent referrals first. Medical priority (MP) levels of care are defined as follows:

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

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 (Pub. L. 108-173). This allows IHS to purchase care at a lower cost than if each service were negotiated individually. Physician and non-hospital providers of supplies and services are purchased at the PRC rate. However, 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. 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 PRC Program also administers the Catastrophic Health Emergency Fund (CHEF). Created in 1988, the CHEF was established for the sole purpose of meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses.[6] The CHEF is used to reimburse PRC programs for high cost cases (e.g., burn victims, motor vehicle accidents, high risk obstetrics, cardiology, etc.) after a threshold payment amount of $25,000 is met. The CHEF is centrally managed at IHS Headquarters and is available to IHS and Tribally-managed PRC programs annually on a first come basis.

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

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

for inpatient services and PRC or negotiated rates for physician and non-hospital providers of supplies and services.

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

PROGRAM ACCOMPLISHMENTS

Purchased/Referred Care (PRC) Rates – On March 21, 2016, the IHS published in the Federal Register the Final Rule with comment period for Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital Based Care. The Final Rule became effective on May 20, 2016, with an implementation date of March 21, 2017. The regulation is consistent with the recommendations from the Government Accountability Office (GAO)[7] and the HHS Office of Inspector General[8] and could potentially achieve substantial PRC savings that may be used to expand IHS beneficiary access to care. The rates were originally referred to as Medicare-like rates (MLR) for hospital based services but are now identified as PRC rates based Medicare payment methodology for all hospital based services, physician and non-hospital providers of supplies and services. The Final Rule established payment rates that are consistent with all federal health care programs; aligns IHS provider payments with inpatient service rates; and enables the I/T/U health programs to expand beneficiary access to medical care. Changes to the rule include: an applicability provision to specify that the rule applies to I/T/Us but only to the extent the tribally- operated programs agree to “opt-in” via their ISDEAA contract or compact; a definition section including Notification of a Claim, Provider, Supplier, Referral and Repricing Agent; 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; in the absence of Medicare payment methodology for a service, the IHS payment amount will be calculated at 65 percent of billed charges from the provider or supplier.

Medical Priorities – Recent program funding increases have allowed some of the IHS and Tribally-managed PRC programs to approve referrals in priority categories other than Medical Priority I (life or limb), including some preventive care services, thus increasing access to patient care services. In FY 2016, 70 percent of IHS-operated PRC programs were able to purchase services beyond Medical Priority I – Emergent or Acutely Urgent Care Services. Prior funding increases as well as increased third-party collections and Medicaid expansion ensure programs can purchase preventive care beyond emergency care services, such as mammograms or colonoscopies.

The IHS PRC Workgroup helped IHS develop a more accurate form for reporting denied and deferred PRC services each year. In FY 2016, PRC denied and deferred an estimated $423,634,760 for an estimated 92,354 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 system. Therefore, the denied services estimate is based on actual data from federal programs and estimated Tribal data.

[7] Government Accountability Office, *Indian Health Service: Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services* (April 2013)

[8] Department of Health and Human Services, Office of Inspector General, *IHS Contract Health Services Program: Overpayments and Potential Savings* (Sept. 2009).

Catastrophic Health Emergency Fund (CHEF) – In FY 2017, all high cost cases submitted for reimbursement from the CHEF through mid-November were funded. It is estimated that more cases may qualify for CHEF reimbursement but were not reported by the 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 ensures the CHEF is able to reimburse PRC programs for high cost catastrophic events and illnesses that occur through the end of the fiscal year.

FUNDING HISTORY

Funding History	PRC	CHEF	Total
FY 2015	$862,639,000	$51,500,000	$914,139,000
FY 2016	$862,639,000	$51,500,000	$914,139,000
FY 2017	$875,830,000	$53,000,000	$928,830,000
FY 2018 Annualized CR	$871,372,000	$51,150,000	$922,522,000
FY 2019 President's Budget	$903,457,000	$51,500,000	$954,957,000

TRIBAL SHARES

Purchased and Referred Care 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.

BUDGET REQUEST

The FY 2019 budget submission for Purchased/Referred Care of $954,957,000 is $32,435,000 above the FY 2018 Annualized CR.

The FY 2018 base funding will provide for the following approximate services:

- 32,200 inpatient admissions
- 742,100 outpatient visits
- 41,400 patient travel trips

The FY 2019 funding increase of $32,435,000 would provide the following additional estimated services:

- 1,076 Inpatient admissions
- 24,824 Outpatient visits
- 1,386 Patient travel trips

FY 2019 Funding Increase of $32,435,000 includes:

- Current Services +$22,464,000 for current services includes:
    - Inflation +$22,464,000 to fund inflationary costs of providing health care services.
- Staffing for New Facilities +$3,662,000 – to fund one healthcare facility that is planned to open in FY 2018. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. Additional PRC is included in the request to address the additional PRC need resulting from replacing an inpatient facility with an outpatient facility. The following table displays this request.

New Facilities	Amount	FTE
Fort Yuma Health Center (Replacement), Winterhaven, CA	$3,662,000	0

- Clinical Services +$6,308,000 for Purchased and Referred Care costs.

Performance Impact

Since 2011, the GAO has published four reports on the PRC program.[9] The IHS PRC Workgroup has reviewed the recommendations and the Agency is implementing a majority of the GAO recommendations, including the capitated rate rule described above and many programmatic and policy improvements. In addition, the program has identified several risk categories and is working to ensure proper policies and procedures are in place to maintain programmatic consistency across all Areas. These ongoing activities continue to be monitored by PRC staff at the IHS Area office and Headquarters level.

In its 14-57 GAO report, the GAO recommended the PRC program to change the IHS GPRA measure into two measures by modifying the IHS's claims data system to track:

(1) by an established timeframe for payment specific to authorized IHS referrals[10]
(2) by an established timeframe for payment specific to authorized self referrals[11]

In the FY 2018 Budget, IHS adopted the GAO recommendation in recognition of the differences in payment processes for these two types of authorized referrals using CY 2017 data for a baseline. **:** The number of days to medical claims payment is **b**ased on medical industry standards for a Preferred Provider Organization, such as Kaiser Permanente, the average days to medical claims payment is as follows:

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
PRC-2 Track IHS PRC referrals (Outcome)	FY 2017: 69.0 days Target: 60.0 days (Target Not Met)	60.0 days	60.0 days	Maintain
PRC-3 Track PRC self-referrals (Outcome)	FY 2017: 61.0 days Target: 45.0 days (Target Not Met)	45.0 days	45.0 days	Maintain

GRANT AWARDS. This program does not fund grant awards.

[9] GAO-11-767, "IHS Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need;" GAO-12-466, "Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Services Program;" GAO-13-272, "Capping Payment Rates for Nonhospital Services Could Save Millions For Contract Health Services;" GAO-14-57, "Opportunities May Exist To Improve The Contract Health Services Program."
[10] As defined by the GAO, IHS referrals are "cases in which an IHS-funded provider refers a patient for care to an external provider."
[11] As defined by the GAO, self-referrals are "typically emergency situations where the patient receives services from external providers without first obtaining a referral from an IHS-funded provider."

AREA ALLOCATION

Purchased/Referred Care

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$90,183	$90,183	$0	$90,347	$90,347	$0	$94,516	$94,516	$4,169
Albuquerque	28,176	16,808	44,984	27,678	16,838	44,516	28,258	17,615	45,873	1,357
Bemidji	14,524	48,834	63,358	14,266	48,924	63,190	14,566	51,181	65,747	2,557
Billings	45,784	19,079	64,863	44,973	19,114	64,087	45,917	19,996	65,912	1,825
California	761	49,807	50,568	748	49,898	50,645	763	52,200	52,963	2,318
Great Plains	70,536	21,117	91,653	69,287	21,155	90,443	70,741	22,132	92,872	2,429
Nashville	6,447	31,291	37,738	6,333	31,348	37,681	6,466	32,794	39,261	1,579
Navajo	60,510	41,081	101,590	59,438	41,156	100,594	60,685	43,055	103,740	3,146
Oklahoma	48,082	67,656	115,738	47,231	67,779	115,010	48,221	70,907	119,128	4,118
Phoenix	46,473	29,525	75,997	45,650	29,579	75,229	46,607	30,944	77,551	2,322
Portland	13,830	84,463	98,293	13,585	84,617	98,202	13,870	88,522	102,391	4,189
Tucson	293	19,155	19,448	288	19,190	19,478	294	20,076	20,369	891
Headquarters	74,418	0	74,418	73,100	0	73,100	74,633	0	74,633	1,533
Total, PRC	**$409,832**	**$518,998**	**$928,830**	**$402,577**	**$519,945**	**$922,522**	**$411,021**	**$543,936**	**$954,957**	**+$32,435**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$159,730	$158,645	$89,058	-$69,587
FTE*	213	213	220	+7

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

SUMMARY OF THE BUDGET REQUEST

The FY 2019 budget submission for Preventive Health programs of $89.1 million is $69.6 million below the FY 2018 Annualized CR level. Included in the budget is $7 million for Staffing for New Facilities. These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

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. The budget proposes $87 million for Public Health Nursing.

- **Health Education** to support the provision of community health, school health, worksite health promotion, and patient education. In order to prioritize health care services and staffing of newly constructed facilities, the Budget discontinues the Health Education program.

- **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. In order to prioritize health care services and staffing of newly constructed facilities, the Budget discontinues the Community Health Representative program.

- **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. The Budget proposes $2 million for the Hepatitis B and Haemophilus Immunization Programs (Alaska).

These **Preventive Health** services contribute widely to the performance measures that fall under the auspices of Hospitals & Health Clinics.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$78,701	$78,167	$87,023	+$8,856
FTE*	195	195	220	+25

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 Authorization..Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Public Health Nursing (PHN) Program is a community health nursing program that focuses on the goals of promoting health and quality of life, and preventing disease and disability. The PHN Program provides quality, culturally sensitive health promotion and disease prevention nursing care services through primary, secondary and tertiary prevention services to individuals, families, and community groups:

- *Primary prevention interventions* aim to prevent disease and include such services as health education/behavioral counseling for health promotion, risk reduction, and immunizations.
- *Secondary prevention interventions* detect and treat problems in their early stages. Examples include health screening of high-risk populations, screening for diabetes and hypertension, fall risk assessments, and school health assessments.
- *Tertiary prevention interventions* prevent or limit complications and disability in persons with an existing disease. The goal of tertiary prevention is to prevent the progression and complications associated with chronic and acute illness by providing optimal care for the patient. Examples include chronic disease case management, self-management education, medication management, and care coordination.

PHNs support population-focused services to promote healthier communities through community based direct nursing services, community development, and health promotion and disease prevention activities. PHNs are licensed, professional nursing staff available to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they transition from the hospital to home. The PHN expertise in communicable disease assessment, outreach, investigation, and, surveillance helps to manage and prevent the spread of communicable diseases. PHNs contribute to several agency's primary prevention efforts such as providing community immunization clinics, administering immunizations to homebound American Indian/Alaska Natives (AI/AN), and through public health education, inspiring AI/AN people to engage in healthy lifestyles and ultimately live longer lives.

PHNs conduct home visiting services for:

- Maternal and pediatric populations, including childhood obesity prevention through breastfeeding promotion, screening for early identification of developmental problems, and parenting education;
- Elder care services including safety and health maintenance care;
- Chronic disease care management; and
- Communicable disease investigation and treatment.

PHNs perform a community assessment to identify high-risk populations and implement evidenced based interventions to address identified areas. This activity targets fragmentation in services and improves care continuums, including patient safety, and patient services. Interventions are monitored with data collection and evaluated for outcome with an emphasis on producing a good return on investments in terms of service provided.

PROGRAM ACCOMPLISHMENTS

The PHN Program aligns with the Agency's priorities and contributes to patient care coordination activities and access to quality, culturally competent care that aims to promote health and quality of life through a community populations focused nurse visiting program which serves the patient and family in the home and in the community. The PHN Program assesses the care provided in meeting the agency's priority Government Performance and Results Act (GPRA) measures and integrates the Department's Strategic Goal to strengthen the economic and social well-being of Americans across the lifespan. GPRA reporting begins on July 1 and ends on June 30. PHN Data Mart reports for GPRA year 2017 reflect a total number of individual PHN patient related encounters was 362,358; and, some of the PHNs accomplishments in GPRA screening activities include the following encounter numbers:

- Tobacco Screening (7,812)
- Domestic Violence Screening (9,625)
- Depression Screening (10,280)
- Alcohol Screening (11,262)
- Adult Influenza Vaccines (19,081)

In 2017, the PHN Program sustained efforts to support the IHS' goal to decrease childhood obesity and prevent diabetes by supporting Baby Friendly designation by accomplishing the following activities: providing patient education, assessment and referral services for prenatal, postpartum and newborn clients during home visits, and utilizing a standardized PHN electronic health record template to document intervention. To assess how the PHN program delivers services, PHN data mart provides a mechanism to evaluate this evidence-based prevention service of promoting breastfeeding during the nurse home visit. For GPRA year 2017, there were a total of 12,895 PHN patients encounters related to this initiative with documented 38,032 patient education on breastfeeding provided during prenatal, postpartum and newborn encounters by the PHN. The PHN documented education provided as follows:

- prenatal (42,097)
- postpartum (13,554)
- newborn (23,824)
- immunizations (265,982)

In FY 2015, the IHS established a Memorandum of Understanding with the Department of Veterans Affairs (VA) and the University of Tennessee to begin the implementation of the Resource to Enhance All Caregivers Health (REACH) program, an evidenced-based program that provides a structured intervention to support caregivers of individuals suffering from dementia.

Caregivers supported by the REACH-VA program show improvement in depression, the effect of depression on daily life, and caregiver burden and frustration. In 2015-2016, PHN training, certification and support from the VA and University of Tennessee was provided in the Navajo, Phoenix, Albuquerque, Billings, California, Bemidji, Nashville, and Oklahoma Areas. For GRPA year 2017, there have been 5,464 PHN encounters to patients with dementia. Services provided at these PHN encounters include the following:

- Immunizations (950)
- Medications (955)
- Life adaptation (312)
- Safety and fall prevention (635)

The overall goal to implement this service in 50 tribal communities by 2018 was met in December 2017, as this service is currently available in 52 communities. Efforts to adapt this intervention to deliver and sustain the program in AI/AN communities is ongoing.

Addressing behavioral health issues, in 2016, the Pine Ridge PHN Mental Health Case Management Program was established to focus on suicide prevention in the local community. This intervention will improve health outcomes of high risk patients through a community case management model that utilizes the PHN as a case manager. In FY 2017-2018, the program will continue billing for this service as a means of leveraging revenue to expand the services in the community, include data collection reports on the PHN Data Mart to report outcome, and in FY 2018 collaborate and replicate this service at the Standing Rock Service PHN Program. In FY 2018, this service will be shared as a best practice as a resource for the PHN grant program for tribal and urban grant recipients.

PHNs provide support services for improving quality care and safety of patients during transitions across care settings by follow up on hospital discharges in an effort to decrease hospital readmissions; in 2017 GPRA year, PHNs had: 65,554 patient encounters with patients who were discharged from the hospital and provided a total of 12,330 follow-up visits; some of these patients had multiple post discharge follow-up visits. Top patient education topics provided during these encounters include immunizations, lifestyle adaptation and medication. In support of the Million Hearts campaign to prevent heart attacks and strokes, PHNs provided 34,838 patient encounters that encompassed patient education on tobacco cessation at 4,230, hypertension at 27,218 and sodium reduction at 3,390. Additional education provided during these PHN encounters include tobacco use, immunizations, diabetes, and medications.

In FY 2016, the PHN program began a review of the delivery service for safe and quality service standards of various accrediting bodies to develop recommendations for the public health nursing program. This activity included coordinating with the Joint Commission agency to define the PHN services as an integrated IHS service for review and hosted the first webinar for PHN to share practices on safe and quality care with a focus on the Accreditation Association for Ambulatory Health Care survey. This activity will continue into FY 2018, helping to ensure that quality PHN services are provided in a safe manner. In 2018-2019, as the primary care system is foundational to achieving high-quality, accessible, efficient health care for AI/AN clients, expanded PHN engagement will be made to support the patient centered medical home efforts as a promising model for transforming the delivery of primary care. In 2018, the PHN program will align prevention services to target sexually transmitted infections to improve quality by implementing evidence-based practices and PHN data mart decision-support tools as performance measurement and improvement as a means of practicing population health management. Data and improvement activities will be shared publicly as PHN Program's commitment to quality.

In FY 2017, the PHN grant program awarded 9 grants; these awards have a narrow and defined area of focus, seeking to improve specific behavioral health outcomes and to support the efforts of AI/AN communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention services for individuals and their families. The purpose of this IHS PHN grant is to improve specific behavioral health outcomes through a case management model with the PHN as a case manager. Case management involves the client, family, and other members of the health care team. In addition to reducing the cost of health care, case management has worth in terms of improving rehabilitation, improving quality of life, increasing client satisfaction and compliance by promoting client self-determination. The community based case management model addresses the PHN scope of practice of working with individuals and families in a population-based practice to provide nursing care services in the community setting. Pine Ridge PHN Program initiated a similar PHN Case Management Program in 2016 and serves as a best practice for replication. The program has data to reflect increased home visits for behavioral health follow up and increased coordination and collaboration with the local Behavioral Health Department.

The FY 2017 target for the PHN Program measure was 381,314 encounters. The final result of 362,358 encounters did not meet the target by 18,956 encounters, a 4.9 percentage decrease. Data exporting processes have impacted the overall PHN performance outcome as several tribal programs have migrated away from the IHS Patient Management System (RPMS) resulting in less visits being exported to the agency's National Data Warehouse database. The end result has been a decrease in the number of PHN activities being reported. In FY 2018, additional PHN data briefs will be created and posted on the PHN data mart to reflect the PHN activity in meeting several Agency goals (such as decreasing STI rates, childhood immunizations) and to supplement the PHN program's accomplishments report. These reports provide an avenue to monitor the PHN program's support of the health care delivery services in the community. In FY 2018 the PHN Documentation Manual will be updated to include PHN electronic health record templates and include information on the PHN data mart reports to improve reporting of outcome.

FUNDING HISTORY

Fiscal Year	Amount
2015	$75,640,000
2016	$76,623,000
2017	$78,701,000
2018 Annualized CR	$78,167,000
2019 President's Budget	$87,023,000

TRIBAL SHARES

Public Health Nursing 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 portion of the overall Public Health Nursing budget line is reserved for federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2019 budget submission for Public Health Nursing of $87,023,000 is $8,856,000 above the FY 2018 Annualized CR level.

FY 2018 Base Funding of $77,498,000 – This funding will support 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 2019 Funding Increase of $8,856,000 includes:

- Current Services: +$2,700,000 for current services includes:
    - Pay Costs +$1,381,000 – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$1,319,000 – to fund inflationary costs of providing health care services.
- Staffing for New Facilities +$6,825,000 - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Red Tail Hawk Health Center, Chandler, AZ	$3,015,000	22
Fort Yuma Health Center (Replacement), Winterhaven, CA	$387,000	3
Muskogee (Creek) Nation Health Center (JV), Eufaula, OK	$679,000	5
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$1,975,000	11
Cherokee Nation Regional Health Center (JV), Tahlequah, OK	$769,000	6
Grand Total:	**$6,825,000**	**47**

FY 2019 funding reduction of -$669,000 from base funding to fully fund staffing for new facilities.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
23 Public Health Nursing: Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families	FY 2017: 362,358 Target: 381,314 (Target Not Met)	381,314	381,314	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
and community groups. (Outcome)				

GRANTS AWARDS

(whole dollars)	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	9	9	9
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION

Public Health Nursing

(dollars in thousands)

DISCRETIONARY	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$134	$10,004	$10,138	$127	$10,201	$10,328	130	$11,867	$11,997	$1,669
Albuquerque	1,865	1,513	3,378	1,771	1,543	3,314	1,813	1,795	3,609	295
Bemidji	33	2,124	2,157	31	2,166	2,197	32	2,519	2,551	354
Billings	1,735	2,434	4,169	1,647	2,482	4,129	1,687	2,888	4,574	445
California	14	1,014	1,027	12,861	1,034	1,047	13,172	1,202	1,216	169
Great Plains	4,884	4,431	9,315	4,637	4,518	9,154	4,749	5,256	10,004	850
Nashville	425	1,542	1,967	404	1,572	1,976	413	1,829	2,242	267
Navajo	8,798	6,856	15,654	8,352	6,991	15,343	8,554	8,132	16,687	1,344
Oklahoma	3,616	11,263	14,879	3,433	11,484	14,917	3,516	13,360	16,876	1,958
Phoenix	4,123	4,640	8,763	3,914	4,731	8,645	4,009	5,504	9,513	867
Portland	633	2,287	2,919	601	2,332	2,932	615	2,712	3,327	395
Tucson	17	997	1,014	16,084	1,016,673	1,033	16	1,182,707	1,199	166
Headquarters	3,321	0	3,321	3,153	0	3,153	3,229	0	3,229	76
Total, PHN	**$29,597**	**$49,104**	**$78,701**	**$28,097**	**$50,070**	**$78,167**	**$28,776**	**$58,247**	**$87,023**	**+$8,856**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$18,663	$18,536	$0	-$18,536
FTE*	16	16	0	-16

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 Authorization...Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Education Program has been in existence since 1955 to educate American Indian/Alaska Native (AI/AN) patients, school age children and communities about their health. The program focuses on the importance of educating patients in a manner that empowers them to make better 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.

At a national level, the Health Education Program assists in developing policy, planning health education programs, setting priorities that impact meeting and monitoring "Healthy People 2020," and complying with the National Health Education Standards.

The Health Education Program has supported the IHS' performance goals through the measures: number of visits with Health/Patient Education, and proportion of tobacco-using patients that receive tobacco cessation intervention. The Health Education Program documented 3,831,812 patient visits with patient education provided in FY 2016. In FY 2017, there was a decline of 6.85 percent or 262,642 patient visits from the previous year; staffing shortages significantly impacted provision of patient services, which was demonstrated in the decrease in documented patient education encounters for FY 2017.

PROGRAM ACCOMPLISHMENTS

In FY 2017, the National Patient Education Committee (NPEC) identified commonly used ICD-10 codes for health education. The Indian Health Service NPEC will ultimately phase out the current system and focus on protocols/guides for a well-defined and specific subset within the Resource Patient Management System. NPEC will also formalize an education data mart to provide reports for commonly used health education codes using the Systematized Nomenclature of Medicine -- Clinical Terms (SNOMED-CT). 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 on providing patient health education, patient understanding, and behavior goals.

The Health Education program funded the following activities in FY 2017:

- Assessing care through collaborate efforts with clinical staff at health fairs and in the clinic-conducted patient needs assessments and patient satisfaction surveys, reviewed data stored in the National Patient Information Reporting System (NPIRS)/National Data Warehouse (NDW) to target top diagnosis areas.
- Analyzing patient satisfaction surveys/needs assessments and collaborating with Improving Patient Care teams to target areas of patient concern.
- Addressing behavioral health issues by assisting Tribes, health boards, and States in Behavioral Risk Factor Surveillance Surveys (BRFSS), providing health education in schools by addressing "bullying" and using the "Courage 2 Care" curriculum as well as, providing physical education classes and opportunities, implementing the Basic Tobacco Intervention Skills for Native Communities curriculum to increase smoking cessation efforts to Tribal, Indian Health Service and Urban Indian clinics and communities.
- Strengthening management by providing training to staff to increase patient education and documentation of education provided through the Basic Tobacco Intervention Skills for Native Communities to increase commercial tobacco cessation documentation.
- Educating patients on the "medical home model" and preventable chronic diseases such as heart disease and diabetes, and training staff on tobacco cessation, sexually transmitted diseases/infections, and methamphetamine/prescription drug abuse.
- Collaborating with Tribes, health boards, universities, county, state and national organizations to increase patient education in the community. Partnerships include the American Lung Association, American Cancer Society, University of Arizona's HealthCare Partnership, and Bureau of Indian Education. Efforts include increasing immunizations, and providing and improving Human Papilloma Virus education and immunization.

FUNDING HISTORY

Fiscal Year	Amount
2015	$18,026,000
2016	$18,255,000
2017	$18,663,000
2018 Annualized CR	$18,536,000
2019 President's Budget	$0

TRIBAL SHARES

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

BUDGET REQUEST

The FY 2019 budget submission for Health Education of $0 is $18,536,000 below the FY 2018 Annualized CR level. The request discontinues the program at federal sites and discontinues funding for this program to tribal entities; however, Tribes may choose to use their own resources to support similar functions. The budget prioritizes funding for direct health care services and staffing of newly constructed facilities.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
HE-1 Number of visits with Health/Patient Education (Output)	FY 2017: 3,569,170 visits Target: 3,987,514 visits (Target Not Met but Improved)	TBD	0 visits	N/A

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

AREA ALLOCATION

Health Education

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$41	$2,493	$2,534	$39	$2,508	$2,547	$0	$0	$0	-$2,547
Albuquerque	349	843	1,191	333	848	1,181	0	0	0	-1,181
Bemidji	72	546	618	68	549	618	0	0	0	-618
Billings	282	921	1,203	269	926	1,196	0	0	0	-1,196
California	37	292	329	36	294	329	0	0	0	-329
Great Plains	405	1,537	1,943	387	1,546	1,933	0	0	0	-1,933
Nashville	200	588	788	191	592	783	0	0	0	-783
Navajo	45	2,738	2,783	43	2,755	2,797	0	0	0	-2,797
Oklahoma	914	2,010	2,923	872	2,022	2,894	0	0	0	-2,894
Phoenix	1,074	998	2,071	1,025	1,004	2,029	0	0	0	-2,029
Portland	123	804	927	117	809	926	0	0	0	-926
Tucson	5	214	219	5	215	220	0	0	0	-220
Headquarters	1,134	0	1,134	1,083	0	1,083	0	0	0	-1,083
Total, Hlth Ed	**$4,679**	**$13,984**	**$18,663**	**$4,468**	**$14,068**	**$18,536**	**$0**	**$0**	**$0**	**-$18,536**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$60,325	$59,915	$0	-$59,915
FTE*	2	2	0	-2

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 Authorization...Permanent

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

PROGRAM DESCRIPTION

The Community Health Representatives (CHRs) program began in 1968 and was established to meet the following four goals: (1) greater involvement of AI/AN people in their own health and in the identification and treatment of their health problems; (2) greater understanding between AI/AN people and IHS staff; (3) improving cross-cultural communication between the Indian community and health service providers; and, (4) increasing basic health care and instruction in AI/AN homes and communities.

Today, CHRs play a role in the health care delivery system to link the patient to the Indian health care system and are intended to prevent avoidable hospital readmissions and emergency department visits through home visits to patients with chronic health conditions such as asthma, diabetes, and hypertension. The aim of the CHR Program is to help AI/AN patients and communities achieve an optimal state of well-being by providing health promotion and disease prevention, wellness and injury prevention education, translation and interpretation, transportation to medical appointments, and delivery of medical supplies and equipment within their tribal community.

PROGRAM ACCOMPLISHMENTS

As CHR programs have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS's role has transitioned to providing support for training CHRs and providing technical assistance to expand and enhance culturally-informed programs.

Final FY 2017 results for CHR patient contacts and CHR patient contacts for chronic diseases will be available in March 2018.

The FY 2017 training target for CHRs was exceeded. IHS trained 724 CHRs to equip them with skills to provide early intervention home visits for pregnant mothers and new parents through a program called Family Spirit, an evidence-based, culturally tailored, home-visiting

program shown to promote optimal health and wellbeing of parents and their children. The program is the first to demonstrate efficacy of paraprofessionals and is uniquely tailored to address the behavioral health disparities, including increasing parental knowledge and involvement; decreased maternal depression; increased home safety; decreased emotional and behavioral problems of mothers; and decreased emotional and behavioral problems of children.

With serious mental illness as one of the top three clinical priorities for the Department of Health and Human Services, IHS offered six Mental Health First Aid (MHFA) courses across the Nation. IHS trained more than 100 CHRs in MHFA with the goal that paraprofessionals are able to help individuals during a mental health crisis and learn skills to assist with access to care with anxiety, depression, psychosis, and addictions with competencies in knowing how to help individuals access care before they begin to experience negative outcomes.

FUNDING HISTORY

Fiscal Year	Amount
2015	$58,469,000
2016	$58,906,000
2017	$60,325,000
2018 Annualized CR	$59,915,000
2019 President’s Budget	$0

TRIBAL SHARES

Community Health Representatives funds were subject to tribal shares and were transferred to Tribes when they assumed the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall Community Health Representative’s budget line was reserved for federally inherent functions and was therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2019 budget submission for Community Health Representatives of $0 is $59,915,000 below the FY 2018 Annualized CR level. The budget prioritizes funding for direct health care services and staffing of newly constructed facilities.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
CHR-1 Number of patient contacts (Output)	FY 2016: 1,102,164 patient contacts Target: 992,464 patient contacts (Target Exceeded)	1,265,000 patient contacts	0 patient contacts	-1,265,000 patient contacts
CHR-2 CHR patient contacts for Chronic Disease Services (Output)	FY 2016: 453,252 patient contacts Target:	505,900 patient contacts	0 patient contacts	-505,900 patient contacts

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
	429,814 patient contacts (Target Exceeded)			
CHR-3 Number of CHRs Trained (Output)	FY 2017: 724 CHRs Target: 600 CHRs (Target Exceeded)	600 CHRs	0 CHRs	-600 CHRs

GRANTS AWARDS – No grant awards are anticipated for FY 2019.

AREA ALLOCATION

Community Health Representatives

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$85	$4,295	$4,380	$74	$4,303	$4,378	$0	$0	$0	-$4,378
Albuquerque	67	3,377	3,444	59	3,383	3,442	0	0	0	-3,442
Bemidji	92	4,642	4,734	80	4,650	4,731	0	0	0	-4,731
Billings	85	4,296	4,380	74	4,304	4,378	0	0	0	-4,378
California	38	1,932	1,970	34	1,936	1,969	0	0	0	-1,969
Great Plains	435	6,694	7,129	382	6,707	7,088	0	0	0	-7,088
Nashville	462	3,066	3,529	406	3,072	3,477	0	0	0	-3,477
Navajo	131	6,644	6,775	115	6,656	6,771	0	0	0	-6,771
Oklahoma	173	8,754	8,927	152	8,770	8,922	0	0	0	-8,922
Phoenix	119	6,028	6,147	104	6,039	6,144	0	0	0	-6,144
Portland	90	4,516	4,606	79	4,524	4,603	0	0	0	-4,603
Tucson	37	1,897	1,935	33	1,901	1,934	0	0	0	-1,934
Headquarters	2,369	0	2,369	2,078	0	2,078	0	0	0	-2,078
Total, CHR	**$4,184**	**$56,141**	**$60,325**	**$3,670**	**$56,245**	**$59,915**	**$0**	**$0**	**$0**	**-$59,915**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$2,041	$2,027	$2,035	+$8
FTE*	0	0	0	0

* This program is managed by Tribal staff. FTE numbers reflect no Federal staff.

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 2019 Authorization..Permanent

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

PROGRAM DESCRIPTION

Hepatitis B Program – The Hepatitis B Program was initiated in 1983 because of the need to prevent and monitor hepatitis B infections among a large population of Alaska Natives with or susceptible to the disease. It continues to provide this service in addition to evaluation of vaccine effectiveness and the medical management of persons with hepatitis and liver disease.

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 maintains high vaccine coverage by providing resources, training, and coordination to Tribal facilities throughout Alaska. Regular meetings are held with regional Immunization Coordinators, Clinical Directors, Community Health Aide Program, IHS Immunization Coordinators, and the State of Alaska Immunization Program. The Program works with Tribal public relations to address parental immunization hesitancy and highlight the importance of vaccines.

The Hepatitis B Program and the Hib Program of the Alaska Native Tribal Health Consortium, in collaboration with Alaska Tribal Health Care System partners, provides clinical expertise and consultation, trainings, research, evaluation and surveillance with the goal to reduce the occurrence of infectious disease and improve access to healthcare in the Alaska Native population. The programs support immunization, patient screening, development of electronic health record reminders and systems, providing an infrastructure to maintain high immunization coverage, and high clinical management coverage of hepatitis B and C in Alaska Natives. The programs' activities support the IHS priorities on quality and partnerships.

PROGRAM ACCOMPLISHMENTS

The Immunization Alaska program has several performance measures to monitor progress in achieving the goal of high vaccine coverage for Alaska Natives 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 liver disease that disproportionately affect the Alaska Native population.

In FY 2017:

- Hepatitis A vaccination coverage met its target, and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 90 percent (90 percent target) and hepatitis B vaccination coverage was 95 percent (90 percent target).
- At least 71 percent of AI/ANs with chronic hepatitis B (66 percent) or C (74 percent) infection were screened for liver cancer and for liver aminotransferase levels.
- The program maintains its practice of encouraging hepatitis patients to have regular, bi-annual screening.

Haemophilus Immunization (Hib) Program

The Hib program continues to provide resources, training and coordination to Tribes in Alaska to maintain high vaccine coverage among Alaska Natives. Vaccine coverage data is collected for each Tribal region and measured in collaboration with local Tribal immunization coordinators. Consultation for the varying electronic health record systems within each Tribal health organization is provided to improve vaccine coverage for all Tribes. Statewide Alaska Native immunization coverage rates are reported to IHS Headquarters for infants 3-27 months, 19-35 months, adolescents, and older adults and flu vaccine immunization rates are reported for all ages.

During FY 2017:

- Immunization Coverage for Alaska Native 19-35 month olds was 72 percent, which is approaching the Healthy People 2020 goal of 80 percent for child vaccine coverage with 4:3:1:3*:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Var, 4 PCV).
- Achieved 89 percent coverage with full series Haemophilus influenza type b (Hib) vaccine in 19-35 month olds, which is much higher than the US all-races 2016 rate of 81 percent.
- An updated measure, Tdap vaccine coverage in all patients 19 years and older who had received Tdap within the past 10 years, achieved 80 percent in 2017. The previous measure tracked Tdap vaccine coverage in 19-64 year olds, reflected 83 percent coverage in 2015, and 86 percent coverage in 2016.
- Achieved 91 percent pneumococcal vaccine coverage in patients 65 years and older who received pneumococcal vaccine in the past ever.
- Assisted tribal facilities throughout the Alaska Area in implementing new State policy and procedures associated with vaccine inventory management, delivery systems, and documentation.

- Assisted Tribal facilities using the RPMS immunization package or new Electronic Health Records (EHR) in maintaining their interface to share vaccine records with the Alaska State Immunization Information System (SIIS).
  - Provided consultation with numerous facilities who implemented new EHRs on immunization documentation and helped facilitate SIIS interface implementation.

A summary of immunization results is included below:

Immunization Measure	Age Group	Alaska Native coverage as of 9/30/2017
4:3:1:3*:3:1:4	19-35 months	72%
4:3:1:3:3:1	19-35 months	78%
3 Hib vaccines doses		89%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	92%
1+ HPV	13-17 years female	88%
Pneumococcal vaccine	65+ years	91%
Tdap	19 years and older	80%

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

The program continues to maintain collaborations with Centers for Disease Control and Prevention in networking with IHS, State, and Tribal agencies to provide technical assistance regarding EHRs. Challenges include the diversity of EHRs employed by Tribal agencies that may result in a temporary loss or delay of Area-wide reporting of immunization coverage. Regular reporting of immunizations is critical in assuring follow-up with facilities experiencing vaccination administration issues. This will continue to be addressed through coordinated efforts by the Hib program, IHS, State, and Tribes. Vaccine and immunization coverage are measured as well as consults provided to Tribal partners.

FUNDING HISTORY

Fiscal Year	Amount
2015	$1,826,000
2016	$1,950,000
2017	$2,041,000
2018 Annualized CR	$2,027,000
2019 President's Budget	$2,035,000

TRIBAL SHARES

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

BUDGET REQUEST

The FY 2019 budget submission for Alaska Immunization of $1,950,000 is $85,000,000 above the FY 2018 Annualized CR level.

FY 2019 Funding Increase of $8,000 includes:

- Current Services: +$85,000 for current services including:

- Pay Costs +$37,000 – to fund pay increases for Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.

- Inflation +$48,000 – to cover inflationary costs of providing immunization services in Alaska.

The FY 2019 funding will provide coordination of vaccine coverage reporting for Tribal facilities, training of Tribal immunization coordinators, and clinic staff in vaccine recommendations and documentation, consultation in the migration to EHRs, and regular notification to hepatitis patients of the need to complete liver function screenings so that program clinicians can identify serious liver disease or liver cancer when it is at an early and treatable stage.

Hepatitis B Program – The program will conduct three days of outpatient clinics at the Alaska Native Medical Center, travel to regional health centers to conduct outpatient clinics, and will continue its web-based application for video-conferencing (Adobe Connect) that is accessible to the statewide Alaska Tribal Health System (ATHS) audience to 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 that affects Alaska Natives.

Haemophilus Immunization (Hib) Program – The budget request will allow staff to provide support to regional Tribal programs on-site and for many partner locations, including rural and isolated locations, as well as limited printing of media materials. Funding of these activities allows maintenance of current program support of Alaska Tribal immunization activities, statewide and national immunization advocacy and technical support, and Area reporting to IHS Headquarters. Statewide Alaska Native immunization coverage rates are reported to IHS Headquarters for infants 3-27 months, 19-35 months, adolescents, older adults, and flu vaccine immunization rates for all ages. In addition, the number of consultations and trainings offered to tribal facilities is also reported.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output)	FY 2017: 674 Screened Target: 600 Screened (Target Exceeded)	600 Screened	600 Screened	Maintain
AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output)	FY 2017: 1215 Screened Target: 990 Screened (Target Exceeded)	990 Screened	990 Screened	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
AK-3 Other Liver Disease Patients Screened (Output)	FY 2017: 229 Screened Target: 200 Screened (Target Exceeded)	200 Screened	200 Screened	Maintain
AK-4 Hepatitis A vaccination (Output)	FY 2017: 90 % Target: 90 % (Target Met)	90 %	90 %	Maintain
AK-5 Hepatitis B vaccinations (Output)	FY 2017: 95 % Target: 90 % (Target Exceeded)	90 %	90 %	Maintain

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

GRANTS AWARDS -- The program does not award grants.

AREA ALLOCATION

Immunization Alaska

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$2,041	$2,041	$0	$2,027	$2,027	$0	$2,035	$2,035	$8
Albuquerque	0	0	0	0	0	0	0	0	0	0
Bemidji	0	0	0	0	0	0	0	0	0	0
Billings	0	0	0	0	0	0	0	0	0	0
California	0	0	0	0	0	0	0	0	0	0
Great Plains	0	0	0	0	0	0	0	0	0	0
Nashville	0	0	0	0	0	0	0	0	0	0
Navajo	0	0	0	0	0	0	0	0	0	0
Oklahoma	0	0	0	0	0	0	0	0	0	0
Phoenix	0	0	0	0	0	0	0	0	0	0
Portland	0	0	0	0	0	0	0	0	0	0
Tucson	0	0	0	0	0	0	0	0	0	0
Headquarters	0	0	0	0	0	0	0	0	0	0
Total, Imm AK	**$0**	**$2,041**	**$2,041**	**$0**	**$2,027**	**$2,027**	**$0**	**$2,035**	**$2,035**	**$8**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$47,678	$47,354	$46,422	-$932
FTE*	6	6	6	0

*FTE numbers reflect only Federal staff and do not include increases for Tribal staff.

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 2019 Authorization..Permanent

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

PROGRAM DESCRIPTION

The Office of Urban Indian Health Programs (OUIHP) was established in 1976 to make health care services more accessible to Urban Indians. The Indian Health Service (IHS) enters into limited, competing contracts and grants with 34 urban Indian 501(c)(3) non-profit organizations to provide health care and referral services for Urban Indians throughout the United States. Urban Indian Organizations (UIOs) define their scope of work and services based upon the service population, health status, and documented unmet needs of the Urban Indian community they serve. Each UIO is governed by a Board of Directors that must be made up of at least 51 percent Urban Indians. UIOs provide unique access to culturally appropriate and quality health care for Urban Indians.

UIOs provide health care services for approximately 54,500 Urban Indians 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. UIO health program sizes and services vary from full and limited ambulatory care, outreach and referral, and residential substance abuse treatment programs, as follows:

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

In addition to the above 34 UIOs funded through contracts and grants, the other major Urban Indian Health focus areas and activities are:

- Former National Institute on Alcohol Abuse and Alcoholism Programs: IHS is beginning the transfer of administrative oversight of the former National Institute on Alcohol Abuse and Alcoholism programs (former-NIAAA programs) that receive an award from IHS and are confirmed to be a UIO as defined by the IHCIA at 25 U.S.C. § 1603(29) from the IHS Alcohol and Substance Abuse Program (ASAP) to the OUIHP. IHS has identified seven (7) former-NIAAA programs for potential transfer. IHS' transition of management of the current award funds and the transfer of funds from the ASAP to the OUIHP will fully implement the transfer authorized by IHCIA at 25 U.S.C. § 1660c – Urban NIAAA transferred programs.
- Urban Indian Education and Research Organization Cooperative Agreement: Provides national education and research services for UIOs and OUIHP through a cooperative agreement.
- Oklahoma City Indian Clinic and Indian Health Care Resource Center of Tulsa: These two urban sites were initially demonstration projects. They are now permanent programs within the IHS' direct care program funded as IHS Service Units; and must continue to qualify as a UIO under the IHCIA definition. 25 U.S.C. § 1660b.
- Albuquerque Indian Dental Clinic: Provides dental services through the Albuquerque Area IHS Dental Program.

UIOs are evaluated in accordance with the IHCIA requirements. The program is administered by OUIHP at IHS Headquarters. OUIHP integrates Enterprise Risk Management by annually reviewing UIO progress with set goals and objectives. The IHS Urban Indian Organization On-Site Review Manual is used by the IHS Area Urban Coordinators to conduct annual onsite reviews of the IHS funded UIOs to monitor compliance with Federal Acquisition Regulation contractual requirements that are established through legislation. The results are submitted to OUIHP for review and follow-up to ensure that corrective action plans are successfully completed prior to continuation of funding.

PROGRAM ACCOMPLISHMENTS

IHS released a plan to guide, support, and improve access to high quality health care services for Urban Indians. The OUIHP 2017-2021 Strategic Plan supports health care solutions that fit the diverse circumstances of Urban Indians and their communities.

UIOs fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report and the Diabetes Non-Clinical Audit report. UIOs currently participate in the IHS Improving Patient Care (IPC) Initiative and are now in the Quality and Innovation Learning Network (QILN) implementing what they have learned across a wider variety of clinical and administrative options.

From July 1, 2016 to June 30, 2017 the UIO 2017 GPRA cycle accomplishments included:

- 97 percent of the UIOs reported on 20 of the 20 performance measures,
- 20 UIOs reported through the Clinical Reporting System (CRS),
- 11 UIOs reported using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records), and
- In FY 2017, UIO improved performance on 7 of the GPRA measures with comparable FY 2017 data.

The IHS will proceed with plans to have UIOs export data to the IHS data center and assist with the National Patient Reporting System (NPIRS) staff to compare data for the budget formulation for Urban programs. OUIHP with the assistance of the Office of Information Technology, will

continue to provide training and technical assistance to urban programs on accurate and uniform data collection, so as to achieve standardization throughout the system.

The IHS has completed development of the Integrated Data Collection System (IDCS). During FY 2018, IHS will evaluate and validate the new performance data mart which contains urban program data submitted to the National Data Warehouse. As the urban program data mart matures, the expectation is to produce all reports from the NPIRS environment to automate and alleviate, where possible, manual data collection and reporting efforts. The goal is to have a consolidated, centralized, and integrated data stored that enables 'on-demand' reporting to support the management and monitoring of key performance measures. The plan is to report performance data from the data mart in FY 2018. With the addition of UIO data, the IHS will report aggregated results in FY 2018 from federal, tribal and urban sites. Currently, aggregated performance results include only federal and tribal sites.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$43,604,000
2016	$44,741,000
2017	$47,678,000
2018 Annualized CR	$47,354,000
2019 President's Budget	$46,422,000

BUDGET REQUEST

The FY 2019 budget submission for the Urban Indian Health program of $46,422,000 is $932,000 below the FY 2018 Annualized CR level.

FY 2018 Budget Funding of $44,741,000 – The base funding provides for the following:

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

FY 2019 Funding Increase of $1,681,000, a net increase, includes:

- Current Services: +$1,681,000 for current services including:
    - Pay Costs +$726,000 – to fund pay increases for federal and Urban employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$955,000 – to fund inflationary costs of providing health care services.

OUTPUTS / OUTCOMES

The Outcomes and Outputs Table(s) list the proposed measure changes for this budget narrative.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
UIHP-2 Percent of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood sugar control. (Outcome)	FY 2017: 46.1 % Target: 48.4 % (Target Not Met)	Retire and Replace	Retire and Replace	Maintain
UIHP-3 Proportion of children ages 2-5 years, with a BMI at or above the 95th percentile. (Outcome)	FY 2017: 24.4 % (Historical Actual)	Retire and Replace	Retire and Replace	Maintain
UIHP-6 Increase the number of diabetic AI/ANs that achieve ideal blood pressure control(<140/90). (Outcome)	FY 2017: 67.8 % Target: 69.4 % (Target Not Met)	Retire and Replace	Retire and Replace	Maintain
UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome)	FY 2016: 54,525 Target: 53,408 (Target Exceeded)	53,408	54,525	+1,117
UIHP-8 Percentage of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood sugar control (Outcome)	FY 2018: 36.2 % Target: 36.2 % (Baseline)	36.2 %	Retire	Maintain
UIHP-9 Proportion of children, ages 2-5 years, with a BMI at or above the 95th percentile (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: Set Baseline (Pending)	Baseline	TBD	Maintain
UIHP-10 Increase the number of diabetic AI/ANs that achieve blood pressure control (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: Set Baseline (Pending)	Baseline	TBD	Maintain
UIHP-11 Reduce the proportion of	FY 2019: Result Expected Jan 31, 2020	N/A	Baseline	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%) (Outcome)	Target: Set Baseline (Pending)			

GRANTS AWARDS - Funding for UIOs for FY 2019 includes both grants and contracts awarded to the programs.

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	30	30	35
Average Award	$279,688	$279,688	$237,143
Range of Awards	$161,293 - $800,000	$161,293 - $800,000	$161,293 - $800,000

AREA ALLOCATION

Urban Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Urban	Total	Federal	Urban	Total	Federal	Urban	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Albuquerque	0	2,841	2,841	0	2,821	2,821	0	2,766	2,766	-56
Bemidji	0	4,295	4,295	0	4,266	4,266	0	4,182	4,182	-84
Billings	0	2,396	2,396	0	2,380	2,380	0	2,333	2,333	-47
California	0	6,564	6,564	0	6,519	6,519	0	6,391	6,391	-128
Great Plains	0	1,605	1,605	0	1,595	1,595	0	1,563	1,563	-31
Nashville	0	957	957	0	950	950	0	932	932	-19
Navajo	0	771	771	0	766	766	0	751	751	-15
Oklahoma	0	2,219	2,219	0	2,204	2,204	0	2,161	2,161	-43
Phoenix	0	2,639	2,639	0	2,621	2,621	0	2,570	2,570	-52
Portland	0	5,817	5,817	0	5,777	5,777	0	5,663	5,663	-114
Tucson	0	544	544	0	541	541	0	530	530	-11
Headquarters	0	17,029	17,029	0	16,914	16,914	0	16,581	16,581	-333
Total, Urban	**$0**	**$47,678**	**$47,678**	**$0**	**$47,354**	**$47,354**	**$0**	**$46,422**	**$46,422**	**-$932**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$49,345	$49,010	$43,394	-$5,616
FTE*	22	22	22	0

*FTE numbers reflect only Federal staff and do not include increases for Tribal staff.

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 2019 Authorization...Permanent

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

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) P.L. 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.

The IHP programs work synergistically to recruit and retain health professionals to provide high-quality primary care and clinical preventive services to American Indians and Alaska Natives (AI/AN). The IHP programs also work with IHS, Tribal facilities and Urban Indian organizations (I/T/U) and the Health Resources and Services Administration (HRSA) to increase the number of sites eligible to participate as National Health Service Corps (NHSC) approved sites for the NHSC Scholarship program and LRP.

PROGRAM ACCOMPLISHMENTS

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

- Enabling AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs.
- Serving as a catalyst in developing AI/AN communities by providing educational opportunities for AI/ANs to become health care professionals and return to their local communities to provide health care.
- Developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/ANs to enter the mental health field.
- Assisting AI/AN health programs to recruit and retain qualified health professionals.

While the IHP programs have seen successes, we continue to strive to improve our 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 online manuals, e-Newsletters, emails, and referral of graduates to recruiters have all been used to facilitate the 90 day scholar placement. In FY 2017, 38 percent of scholars had a hire letter within 90 days (target was 78 percent). Failure to meet this goal was primarily due to nursing scholars not completing their licensing boards and finding positions within the 90 day period. The Scholarship program continues to look for new ways to assist our scholars in meeting this requirement. Assuring scholars and loan repayment recipients meet their service obligation is another critical component of the IHP programs. Annual employment verification through personnel rosters and certification by Tribal employers assist in this process. Scholarship program and LRP databases allow staff to identify when health professionals are expected to complete their service obligation and allow for timely follow-up.

Loan Repayment Program (Section 108): The LRP is an invaluable tool for recruiting and retaining healthcare professionals by offering 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 $20,000 per year in loan repayment funding and up to an additional $5,000 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. In FY 2017, a total of 1,267 health professionals were receiving IHS loan repayment. This included 434 new two-year contracts, 396 one-year extension contracts and 437 health professionals starting the second year of their FY 2016 two-year contract.

Applicants who apply for funding and do not receive it, 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. In FY 2017, there were 412 "matched unfunded" applicants (including 153 nurses, 4 behavioral health providers, 2 dentists, 70 mid-level providers and 144 pharmacists) and 376 "unmatched unfunded" health professionals (including 20 physicians, 58 behavioral health providers, 16 dentists, 46 mid-level providers and 158 nurses). The inability to fund these 788 health professional applicants is a significant challenge for the recruitment efforts of the agency. It is estimated that an additional $39.4 million would be needed to fund the 788 unfunded health professional applicants from FY 2017. A more detailed breakout of loan repayment awards in FY 2016 by discipline is included in a table at the end of the narrative.

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. Graduate students and junior- and senior-level undergraduate students are given priority for funding for programs under Section 103, unless the section specifies otherwise. 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 funding for programs under Section 104 incur a service obligation and payback requirement. In FY 2017, there were 805 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 331 of these new scholarship applications were considered eligible for funding. The IHS Scholarship program was able to fund 108 new awards. An additional $3.3 million in scholarship funding would have been needed to fund all qualified scholarship applicants. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education. A total of 154 continuation awards were funded in FY 2017.

A detailed breakout of scholarships awarded by discipline in FY 2017 is included in a table at the end of the narrative.

In 2013, the IHS Scholarship program provided retention metrics for inclusion in a system design guide for the revision of the Scholarship Management System. System upgrades to date have allowed for easier tracking of scholars throughout the application and award process, while in school and during post graduate training, and while fulfilling their service commitment. Additional enhancements, when completed, will provide annual reports on retention of scholarship recipients employed by IHS beyond the obligated service period.

Extern Program (Section 105) - Section 105 of the IHCIA, 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, with most students working during the summer months. In FY 2017, the Extern Program funded a total of 94 student externs. A breakout of extern awards in FY 2017 by Area Offices is included in a table at the end of the narrative.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$48,342,000
2016	$48,342,000
2017	$49,345,000
2018 Annualized CR	$49,010,000
2019 President's Budget	$43,394,000

BUDGET REQUEST

The FY 2019 budget submission for the Indian Health Professions program of $43,394,000 is $5,616,000 below the FY 2018 Annualized CR level.

FY 2018 Base Funding of $43,342,000 – The base funding is necessary to enable 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 2019 Funding Increase of $52,000, a net increase, includes:

- Current Services: +$52,000 for current services including:
    - Pay Costs +$52,000 – to fund pay increases for federal employees providing health care and related services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target*	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome)	FY 2017: 38 % Target: 78 % (Target Not Met)	78 %	78 %	Maintain
IHP-1 Number of scholarship awards under section 103 (Output)	FY 2016: 69 Awards Target: 89 Awards (Target Not Met)	34 Awards	89 Awards	+55 Awards
IHP-2 Number of scholarship awards under section 104 (Output)	FY 2016: 227 Awards Target: 223 Awards (Target Exceeded)	223 Awards	223 Awards	Maintain
IHP-3 Number of externs under section 105 (Output)	FY 2017: 94 Externs Target: 135 Externs (Target Not Met but Improved)	135 Externs	135 Externs	Maintain
IHP-4 Number of new 2 year contract awarded loan repayments under section 108 (Output)**	FY 2017: 434 contracts Target: 465 contracts (Target Not Met)	367 contracts	465 contracts	+98 contracts
IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output)	FY 2017: 396 Awards Target: 360 Awards (Target Exceeded)	360 Awards	360 Awards	Maintain
IHP-6 Total number of new awards funded in previous fiscal year under section 108 (Outcome)	FY 2017: 437 awards Target: 360 awards (Target Exceeded)	360 awards	360 awards	Maintain

* FY 2018 “Targets” include estimates based on complete FY 2015 funding cycle data and additional Loan Repayment Program funding received in the FY 2016 budget.
** The “Number of Loan Repayments – Total” includes New Awards, Contract Extensions and Continuation Awards.

GRANTS AWARDS

The IHP administers three grant programs which fund colleges and universities to train students for health professions: (1) Quentin N. Burdick 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 critical support to students during their health career professional pathway and encourage students to practice in the Indian health system.

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Quentin N. Burdick American Indians Into Nursing Program (Section 112) – CFDA No. 93.970			
Number of Awards	5	5	5
Average Award	$332,715	$337,225	$337,225
Range of Awards	$332,715	$337,225	$337,225
Indians Into Medicine Program (Section 114) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$365,788	$365,788	$365,788
Range of Awards	$198,682 - $700,000	$198,682 - $700,000	$170,000 - $691,837
American Indians Into Psychology Program (Section 217) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$238,359	$240,780	$240,780
Range of Awards	$200,000-$253,000	$240,780	$240,780

Scholarship Program Awards – In FY 2017, students in the following disciplines received IHS Scholarship Program funding:

Section 103 Pre-professional - 14 students			
Pre-Clinical Psychology	3	Pre-Pharmacy	5
Pre-Nursing	5	Pre-Social Work	1
Section 103 Pre-graduate – 17 students			
Pre-Dentistry	7	Pre-Optometry	3
Pre-Medicine	7		
Section 104 Health Professions - 2 students			
Counseling Psychology	2	Pharmacy	29
Dentistry	31	Physical Therapy	10
Environmental Engineering	1	Physician Assistant	13
Health Records	1	Optometry	10
Medical Technology	1	Physician, Allopathic	37
Nurse Midwife	1	Physician, Osteopathic	16
Nurse Practitioner	16	Podiatry	3
Nurse, Associate Degree	10	Public Health Nutritionist	3
Nurse, Baccalaureate Degree	16	Social Work	13
Nurse, Master's Degree	1	Ultrasonography	1
Nurse, Pediatric	1	X-Ray Technology	1
Nurse, Psychiatric	1	Nurse Anesthetist	3

Loan Repayment Program Awards – In FY 2017, the IHS LRP made awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Behavioral Health	77	61	16	4
Dental*	107	44	63	2
Nurse	167	134	33	153

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Optometrists	52	20	32	4
Pharmacists	160	38	122	144
Physician Assistants/ Advanced Practice Nurses	95	50	45	70
Physicians	87	47	40	5
Podiatrists	14	4	10	1
Rehabilitative Services	51	29	22	17
Other Professions	20	7	13	12
TOTAL	**827**	**434**	**396**	**412**

* Includes Dentists, Dental Hygienists, and Dental Assistants.

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Acupuncturist	1	0	Tribal Employees	452
Certified Professional Coder	0	0	Civil Service	255
Chiropractors	4	0	Commissioned Corps	108
Dietetics/Nutrition	9	11	Urban Health Employees	15
Engineering	2	0		
Health Records	0	0		
Medical Laboratory Scientist	0	0		
Medical Technology	1	0		
Naturopathic Medicine	0	0		
Radiology Technicians	2	0		
Respiratory Therapist	1	0		
Sanitarian	0	0		
TOTAL	**20**	**11**	**Total**	**830**

Extern Program Awards – In FY 2017, the IHS Extern Program funded summer or winter externships for the following Area Offices for a total of 94:

AREA OFFICES	NUMBER OF EXTERNS
ALASKA	4
BEMIDJI	14
BILLINGS	11
CALIFORNIA	2
GREAT PLAINS	8
NASHVILLE	2
NAVAJO	18
OKLAHOMA	20
PHOENIX	13
PORTLAND	0
TUCSON	2

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$2,465	$2,448	$0	-$2,448
FTE*	0	0	0	0

*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 2019 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 TMG program has provided discretionary competitive grants to T/TO, to establish goals and performance measures for current health programs, assess current management capacity to determine if new components are appropriate, analyze programs to determine if T/TO management is practicable, and develop and enhance infrastructure systems to manage or organize PFSA. The nature of the TMG program allowed T/TO the option to enter or not enter into ISDEAA contracts/compact agreements which are equal expressions of self-determination.

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 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.

PROGRAM ACCOMPLISHMENTS

Fiscal Year	New Funded Awards	*Cont: 2/3 Year	Total Award
FY 2015	7	7	$1,164,442
FY 2016	16	3	$1,786,683
FY 2017	16	8	$2,235,271

* Grants which originally had two or three year project periods and were in their secord or third year of funding.

- Since 2015, increased the number of awards for new and continued with available funds.
- Provided training at the 2017 Annual Self-Governance Conference in Spokane, Washington.
- Provided technical assistance to potential applicants
- Approximately one percent of TMG funding has been used for overall administration of the program; these funds provide TMG program requirements, training, and general technical assistance.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$2,442,000
2016	$2,442,000
2017	$2,465,000
2018 Annualized CR	$2,448,000
2019 President's Budget	$0

BUDGET REQUEST

For FY 2019, the Tribal Management Grant program budget request is $2,448,000 below the FY 2018 Annualized CR level of $2,448,000. The budget request does not fund this program to prioritize funding for direct care services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
TMG-1 Planning Grants (Output)	FY 2017: 1 planning grants Target: 2 planning grants (Target Not Met)	0 planning grants	0 planning grants	Maintain
TMG-2 Health Management Structure (HMS) grants (Output)	FY 2017: 15 HMS grants Target: 26 HMS grants (Target Not Met but Improved)	0 HMS grants	0 HMS grants	Maintain

GRANTS AWARDS

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards[1]	$2,465,000 13 Noncompeting Continuations and 3 New	$2,448,000 13 Noncompeting Continuations and 3 New	$0
Average Award	$90,125	$90,125	$0
Range of Awards	$50,000 - $150,000	$50,000 - $150,000	$0

[1] Includes partial awards

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$70,420	$69,942	$73,431	+$3,489
FTE*	258	258	258	0

*FTE numbers reflect only Federal staff and do not include increases for Tribal staff.

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 2019 Authorization..Permanent

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

PROGRAM DESCRIPTION

The Direct Operations budget supports the Indian Health Service (IHS) in providing Agency-wide leadership, oversight, and executive direction for the comprehensive public and personal health care provided to American Indians and Alaska Natives (AI/AN). Funds are used to promote the efficient and effective administration and oversight of national functions such as: human resources (HR), financial management, acquisitions, internal control and risk management, health care and facilities planning, health information technology, Contract Disputes Act claims analysis, and other administrative support and systems accountability. These types of direct operations performed at the Headquarters and Area Office levels provide the foundation necessary to carry out the Agency mission.

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

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

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

PROGRAM ACCOMPLISHMENTS

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

Implementation of the Quality Framework continued in FY 2017 to strengthen organizational capacity to improve quality of care, improve our ability to meet and maintain accreditation for IHS direct service facilities, align service delivery processes to improve the patient experience, ensure patient safety, and improve processes and strengthen communications for early identification of risks. The Direct Operations budget helps fund the staff leading and supporting these activities, as well as the oversight needed to measure, track, and report performance outcomes.

To bring quality healthcare expertise and strengthen management, the IHS has focused considerable efforts on Human Resource (HR) management. The IHS historically has difficulties recruiting and retaining healthcare providers. To address these challenges, IHS continues to maximize the use of available recruitment and retention tools such as: pay incentives and the use of Title 38 compensation authorities to offer more competitive salaries to medical providers; implementing global recruitments that focuses on critical health care positions and improves efficiency through a single vacancy announcement for vacant positions at multiple IHS facilities; priority access to expedited commissioning of new Commissioned Corps officers through a partnership with the Office of the Surgeon General; and other available incentives including loan repayment, recruitment/retention/relocation incentive pays, flexible schedules, and Title 38 authorities for competitive salaries.

To ensure consistency and accountability in workforce management, the IHS established an enhanced supervisory training focusing on employee and labor relations and an agency-wide tracking of all employee relations actions. A Leadership Training program was also implemented to build executive leadership capacity within the existing workforce and strengthen succession planning. The Direct Operations budget funds HR leadership and supporting staff, interagency agreements for collaborating with other government agencies to obtain additional expert support, and efforts to streamline and strengthen the overall HR program for maintaining a quality workforce.

The IHS is committed to ensuring quality care for all patients and is actively working on deploying innovative strategies with a focus on achieving and sustaining improvements in quality of care and recruiting and retaining a high performing workforce.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$68,065,000
2016	$72,338,000
2017	$70,420,000
2018 Annualized CR	$69,942,000
2019 President's Budget	$73,431,000

TRIBAL SHARES

Direct Operations 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 portion of the overall Direct Operations budget line is reserved for inherently federal functions and is therefore retained by the IHS.

BUDGET REQUEST

The FY 2019 budget submission for Direct Operations of $73,431,000 is $3,489,000 above the FY 2018 Annualized CR level.

FY 2018 Base Funding of $69,942,000 – Funding is necessary for Direct Operations to continue to fund system-wide administrative, management and oversight priorities at the discretion of the IHS Director that include:

- Continuing vital investments to enhance the IHS' 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 General 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 (PRC) program.
- 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 claims and maintaining policies and procedures to accurately determine CSC needs in the future.

FY 2019 Funding Increase of $3,489,000, a net increase, includes:

- Current Services: +$1,093,000 for current services including:
    - Pay Costs +$1,093,000 – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.

- Clinical Services Support +$3,196,000: The program increase will sustain support of clinical services. The proposed funding supports operating levels consistent with anticipated final FY 2018 funding levels and focus on improved operations nationally. Direct Operations funds continue support for system-wide administrative, management and oversight priorities.

- Transfer to Dental Services -$800,000: This is a technical adjustment to move funds appropriated in FY 2017 to Dental Services, reflecting Congressional intent for these funds to be used to backfill vacant dental health positions in Headquarters, as described in the FY 2017 Joint Explanatory Statement.

Direct Operations Headquarters and Area Offices – Estimated Distribution: The distribution of funds includes Headquarters operations (excluding Urban, Self-Governance, and Office of Environmental Health and Engineering programs), 12 Area Offices operations, and Tribal shares as indicated by the table below:

	FY 2017 Actual	FY 2018 Annualized CR	FY 2019 PB
Headquarters (58.7%)	$41,549,721	$41,267,688	$43,103,997
Title I Contracts (non-add)	*1,841,332*	*1,848,701*	*1,883,382*
Title V Compacts (non-add)	*6,733,776*	*6,760,724*	*6,887,554*
Area Offices (12) (41.3%)	$28,870,279	$28,674,312	$30,327,003
Title I Contracts (non-add)	*411,725*	*413,373*	*421,128*
Title V Compacts (non-add)	*7,869,129*	*7,900,621*	*8,048,834*
BA	**$70,420,000**	**$69,942,000**	**$73,431,000**

AREA ALLOCATION

Direct Operations

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$42	$4,798	$4,839	$41	$5,207	$5,248	$43	$4,970	$5,014	-$234
Albuquerque	1,011	316	1,327	991	343	1,334	1,055	328	1,383	49
Bemidji	1,417	0	1,417	1,388	0	1,388	1,479	0	1,479	90
Billings	2,235	34	2,269	2,190	36	2,227	2,333	35	2,368	141
California	1,504	0	1,504	1,474	0	1,474	1,569	0	1,569	96
Great Plains	2,474	0	2,474	2,424	0	2,424	2,582	0	2,582	158
Nashville	1,041	803	1,844	1,020	871	1,891	1,087	832	1,918	27
Navajo	3,108	0	3,108	3,046	0	3,046	3,244	0	3,244	198
Oklahoma	1,843	1,815	3,657	1,806	1,970	3,775	1,923	1,880	3,803	28
Phoenix	2,697	414	3,111	2,643	450	3,092	2,815	429	3,244	152
Portland	1,941	687	2,628	1,902	745	2,648	2,026	711	2,737	90
Tucson	692	0	692	678	0	678	722	0	722	44
Headquarters	41,550	0	41,550	40,716	0	40,716	43,367	0	43,367	2,651
Total, Direct Ops	**$61,554**	**$8,866**	**$70,420**	**$60,319**	**$9,623**	**$69,942**	**$64,246**	**$9,185**	**$73,431**	**+$3,489**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$5,786	$5,747	$4,787	-$960
FTE*	14	14	14	0

*FTE numbers reflect only Federal staff and do not include increases for Tribal staff.

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 2019 Authorization..Permanent

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

PROGRAM DESCRIPTION

The Office of Tribal Self-Governance (OTSG) is responsible for a wide range of agency functions that are critical to the IHS' relationship with American Indian and Alaska Native (AI/AN) nations, Tribal organizations, and other AI/AN groups. Since 1993, the Indian Health Service (IHS), in cooperation with Tribal representatives, developed formula methodologies for identification of Tribal shares for all Indian Tribes. Tribal shares are those program and administrative funds that Tribes are eligible to assume through self-determination contracts and self-governance compacts.[1] Today, Indian Tribes and Tribal organizations currently administer over one-half of IHS resources through ISDEAA self-determination contracts and self-governance compacts.

PROGRAM ACCOMPLISHMENTS

The IHS Tribal Self-Governance Program has grown dramatically since the initial 14 compacts and funding agreements were signed in 1994. In FY 2017, approximately $2.0 billion of the total IHS budget appropriation was transferred to Tribes and Tribal organizations to support 94 ISDEAA self-governance compacts and 120 funding agreements.[2]

The Self-Governance budget supports activities, including but not limited to: government-to-government negotiations of self-governance compacts and funding agreements; oversight of the IHS Director's Agency Lead Negotiators (ALNs); technical assistance on Tribal Consultation

[1] The ISDEAA provides two mechanisms for Tribes and Tribal organizations to assume responsibility for health care formerly provided by the Federal government. The IHS Tribal Self-Governance Program is authorized under Title V of the Act. Tribes may also contract with the IHS through self-determination contracts and annual funding agreements authorized under Title I of the Act.
[2] For FY 2018, the IHS estimates an additional five 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.

activities; analysis of Indian Health Care Improvement Act (IHCIA) authorities; and supporting the activities of the IHS Director's Tribal Self-Governance Advisory Committee.

The Self-Governance budget engages local Tribal resources through several activities:

- Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS.
- Reviews eligibility requirements for Tribes to participate in the Tribal Self-Governance Program and to receive Self-Governance Planning and Negotiation Cooperative Agreements.
- Provides resources and technical assistance to Tribes and Tribal organizations for the implementation of Tribal self-governance.
- Provides Tribal Self-Governance Program training to Tribes, Tribal organizations, and Tribal groups.
- Coordinates national Tribal self-governance meetings, including an annual consultation conference in partnership with the Department of the Interior, to promote the participation by all AI/AN Tribes in the IHS Tribal Self-Governance program activities and program direction.
- Develops, publishes, and presents information related to the IHS Tribal Self-Governance Program activities to Tribes, Tribal organizations, state and local governmental agencies, and other interested parties.
- Coordinates self-governance Tribal Delegation Meetings for the IHS Headquarters, and Area Senior officials.

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

- Providing support for projects that assist Tribally operated health programs to enhance information technology infrastructure and prepare for meaningful use and other federal reporting standards; and
- Collaborating on crosscutting issues and processes including, but not limited to: budget formulation; program management issues; self-determination issues; Tribal shares methodologies; and emergency preparedness, response and security.

These services are deployed in accordance with strategic planning, are data driven, and support program integrity through adherence to reporting requirements. The Office of Tribal Self-Governance Funds Management Database supports the delivery of services by improved access to data to evaluate performance and identify areas of process improvement.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$5,727,000
2016	$5,735,000
2017	$5,786,000
2018 Annualized CR	$5,747,000
2019 President's Budget	$4,787,000

BUDGET REQUEST

The FY 2019 budget submission for the Tribal Self-Governance Program of $4,787,000 is $960,000 below the FY 2018 Annualized CR level.

FY 2018 Base Funding of $4,735,000 – The base funding is necessary to support further implementation of the IHS Tribal Self-Governance program, to continue funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, to continue to fund performance projects, and to fund Tribal shares needs in IHS Areas and Headquarters for any Indian Tribes that have decided to participate in the IHS Tribal Self-Governance program**.**

FY 2019 Funding Increase of $52,000, a net increase, includes:

- Current Services: +$52,000 for current services including:
  - Pay Costs +$52,000 – to fund pay raises for federal employees which improve the ability of the agency to support Tribes entering into Self-Governance.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2018 Target**	**FY 2019 Target**	**FY 2019 Target +/-FY 2018 Target**
TOHP-1 Percentage of TOHP clinical user population included in GPRA data. (Outcome)	FY 2017: 44.2 % Target: 58.6 % (Target Not Met)	Retire	Retire	Maintain
TOHP-SP Implement recommendations from Tribes annually to improve the Tribal consultation process and IHS operations. (Output)	FY 2016: 7 recommendations Target: 3 recommendations (Target Exceeded)	3 recommendations	3 recommendations	Maintain

GRANT AWARDS

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Planning Cooperative Agreements			
Number of Awards	5	5	5
Award Amount	$120,000	$120,000	$120,000
Negotiation Cooperative Agreements			
Number of Awards	5	5	5
Award Amount	$48,000	$48,000	$48,000

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

(Dollars in Thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Medicare:				
Federal	$184,408	$184,408	$184,408	$0
Tribal[1]	6,986	6,986	6,986	0
Tribal[2]	57,244	57,244	57,244	0
Subtotal:	$248,638	$248,638	$248,638	$0
Medicaid:				
Federal	$659,185	$659,185	$659,185	$0
Tribal[1]	22,517	22,517	22,517	0
Tribal[2]	125,903	125,903	125,903	0
Subtotal:	$807,605	$807,605	$807,605	$0
M/M Total:	**$1,056,243**	**$1,056,243**	**$1,056,243**	**$0**
Private Insurance	$109,272	$109,272	$109,272	$0
VA Reimbursements[3]	$28,062	$28,062	$28,062	$0
TOTAL:	**$1,193,577**	**$1,193,577**	**$1,193,577**	**$0**
FTE[4]	6,603	6,603	6,603	0

[1] Estimated amount based on CMS tribal collection estimates as last provided.
[2] Estimated amount based on tribal collections due to direct billing between FY 2002 – FY 2017.
[3] The FY 2018 and FY 2019 amounts include the payments IHS expects the Veteran's Administration will make for both Federal and Tribal facilities. The VA and IHS will continue to work together to re-evaluate future growth estimates based on FY 2018 actual collections.
[4] FTE numbers reflect only federal staff and do not include increases in tribal staff.

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

In 1976, the Indian Health Care Improvement Act (IHCIA) authorized the Indian Health Service (IHS) to collect Medicare and Medicaid (M&M) reimbursements for services provided in IHS facilities to patients with M&M eligibility. The IHCIA was later amended to allow IHS to collect Private Insurance (PI) reimbursements for services provided in IHS facilities for patients with PI.

In fiscal year (FY) 2017, $1.193 billion was collected from third party insurers, of which $843.593 million was Federal M&M collections and $109.272 million was private insurers. The FY 2019 estimates above are based on the FY 2017 actual collections.

Public and private collections represent a significant portion of the IHS and Tribal health care delivery budgets.

Accreditation - In accordance with IHCIA authorization for collections, the IHS places the highest priority on meeting accreditation and certification standards for its healthcare facilities.
Third party revenue is essential to maintaining facility accreditation, certification and standard of health care through organizations such as The Joint Commission or the Accreditation Association for Ambulatory Health Care. Collection funds are ultimately used to improve the delivery and

access to healthcare for American Indian and Alaska Native (AI/AN) people.

Monitoring – The IHS has developed and implemented a data system to identify deficiencies and monitor the third party collections process for IHS operated facilities. The Third Party Internal Controls Self-Assessment online data tool provides necessary information for local managers and Headquarters staff to monitor compliance with applicable policies and procedures during the collections process so they can take necessary corrective actions and improve overall program activity.

IHS is continuing the development of a third party interface with the Unified Financial Management System and enhancement of systems, reports, and processes to meet legislative requirements for IHS operated facilities. The IHS will also continue improvements to the Electronic Health Record (EHR) and incrementally enhance handling of ICD-10 codes. The IHS will continue to strengthen its revenue generation policies and management practices, including internal controls, patient registration, patient benefits coordination, provider documentation training, certified procedural coding training, third party billing, electronic claims processing, accounts receivable, and debt management. Priority activities include continued enhancement of third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes, compliance with M&M regulations, and industry standards and changes in operational processes. Improvements for IHS operated facilities are coordinated with concurrent enhancements in Purchased Referred Care business practices related to alternate resources.

In addition, IHS is working to incorporate statutory rules and regulations that impact third party collections directly and indirectly. Some rules pertaining to the Medicare and Medicaid programs have a direct impact on revenue generation over the next few years. IHS has formed workgroups to maximize the positive impact for all IHS, Tribal, and Urban Indian health program facilities, such as the National Business Office Committee, which serves as a subcommittee to the National Council of Executive Officers. These efforts support IHS' priority on resources to secure and effectively manage the assets needed to promote the IHS mission.

Partnerships – IHS is working to develop and enhance partnerships with federal and state agencies. IHS continues to work with CMS and the state Medicaid agencies to identify patients who are eligible to enroll in M&M and the state Children's Health Insurance Programs. IHS also continues these partnerships in the implementation of provisions in the IHCIA, and the Children's Health Insurance Program Reauthorization Act. Enrollment and collections depend, in large part, on IHS' successful partnerships/relationships, state participation in Medicaid expansion, and awareness and willingness of IHS users to enroll in Medicaid and other programs.

Areas have developed and shared their Area Business Plan Templates with Tribes in the Areas and continue to monitor implementation progress. IHS anticipates that in-network contracting with health plans may work for many facilities and is working with CMS to identify ways to provide informational resources for implementation. IHS is continuing to implement, train, and participate in the Medicare Payment Reform efforts by CMS. This included increasing awareness, training and implementation of the Quality Payment Program under the Medicare Access and CHIP Reauthorization Act. IHS is now working on implementation of the Merit-Based Incentive Payment System and Advanced Alternative Payment Models with the end goal of improving access to care.

IHS collaborates with CMS and the Tribes on a number of matters, including implementation of and training regarding recent changes in legislation, eligibility policies, covered services policies, reimbursement policies and payment methodologies, claims processing, denials, training and use of information technology resources at IHS and Tribal sites to increase the enrollment of M&M eligible AI/AN patients. IHS continues to coordinate outreach, education, and training efforts in collaboration with other federal, state and Tribal partners. IHS has partnered with CMS to provide a number of training sessions nationwide for Tribal and IHS employees, focusing on outreach and improving access to M&M programs.

In December 2012, IHS and the Department of Veterans Affairs (VA) signed the VA/IHS National Reimbursement Agreement that facilitates reimbursement by the VA to the IHS and Tribal facilities for direct health care services provided to eligible AI/AN veterans. In January 2017 the IHS and VA signed an amendment to the agreement that extends the period of the reimbursement agreement through June 30, 2019. This was a significant step in continuing to ensure implementation of Section 405 of the IHCIA[1]. The agreement represents a positive partnership to support improved coordination of care and non-duplication of resources between IHS federal facilities and the VA and it paved the way for agreements negotiated between VA and tribal health programs. IHS will continue to work directly with the VA to implement billing practices to ensure IHS receives proper payment for care provided at IHS and Tribal facilities to AI/AN veterans. Monitoring, auditing, and compliance with the agreement will continue to be a focus for FY 2017 through FY 2019.

Annually, IHS trains health care facility staff in areas related to various functions within the revenue cycle, including patient registration, benefits coordination, coding, third party billing, accounts receivable and other aspects of the revenue cycle. Area I/T/U staff are highly encouraged to participate in annual CMS trainings. IHS hosts a Partnership Conference to provide the most current information related to finance, information technology, health information management, Purchased/Referred Care, and business office functions; special emphasis is also provided for the specific management needs of Tribes and urban programs.

Claims Processing Improvements - IHS continues to work to enhance each IHS operated facility's capability to identify patients who have private insurance coverage and improve claims processing. The local service units utilize private insurance funds to improve services, purchase medical supplies and equipment, and to improve local service unit business management practices in support of maintaining accreditation. The IHS continues to make use of private contractors to pursue collections on outstanding claims from private payers.

PROGRAM ACCOMPLISHMENTS

- With the agreement between the VA and IHS in place, IHS developed and executed an implementation plan to collect at all IHS federal sites serving eligible Veterans. The VA has approximately 105 agreements with Tribal Health Programs. This partnership with the VA and implementation of VA reimbursement at IHS sites serve to support the IHS priority to build, strengthen, and sustain collaborative relationships that advance the IHS mission and enable IHS to provide further services to local communities funded with these collections.

[1] 25 U.S.C. § 1645(c), "Reimbursement. The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

- The IHS HQ conducted bi-weekly ACA Question and Answer Conference Calls from October 2013 through January 2017. Since May 2017, the IHS HQ has hosted a series of monthly conference calls titled, "Best Practices in Indian Health: Education and Assistance with Health Care Coverage and Other Benefits." The conference calls are designed to provide information regarding programs and benefits available to populations within the AI/AN community as well as to share best practices as to how to reach those populations from across the I/T/U system.
- The IHS HQ has also entered into cooperative agreements since 2010 with organizations such as the National Indian Health Board and the National Congress of American Indians to coordinate and conduct consumer centered outreach and education, training and technical assistance on a national scale for the 566 Federally-recognized Tribes and Tribal organizations on the changes and authorities of the new legislation for the ACA and the IHCIA. The national organization partners have provided well over 100 training sessions and webinars for Tribes and tribal members, helped coordinate numerous enrollment events, created toolkits for youth and elders and offered technical assistance to AI/AN and non-AI/AN enrollment assisters. Through the IHS National Indian Health Outreach and Education (NIHOE) Initiative, the IHS continues to partner with national and regional Tribal/Indian organizations to educate consumers and tribal governments on the health care insurance options available, the process for enrollment, financial assistance, the exemption options for American Indians and Alaska Natives, eligibility determinations, the tribal employer mandate, and maximizing revenue.
- As a result of partnership and discussions with CMS on outreach and enrollment opportunities within the IHS, the IHS HQ conducted a pilot project to increase M&M enrollment at six IHS Service Units in four states during the latter part of CY 2016. The facilities included Phoenix Indian Medical Center in Phoenix, Arizona; Pine Ridge Hospital in Pine Ridge, South Dakota; Rosebud Hospital in Rosebud, South Dakota; Sioux San Hospital in Rapid City, South Dakota; Blackfeet Community Hospital in Browning, Montana; and Quentin Burdick Facility in Belcourt, North Dakota. The pilot project provided an opportunity for the selected Service Units to improve their M&M enrollment numbers, increase their third-party revenue and, in turn, increase their resources. One goal of the pilot project was to help the IHS to identify best practices to increase M&M enrollment which could be shared with all Service Units.
- The IHS hosted a Patient Registration and Patient Benefits Coordination Training in April 2017 which focused on topics related to outreach, education and assistance to patients regarding health benefits coverage. Useful tools, best practices, and informational resources were provided to training participants. More than 300 I/T/U attendees from across the country participated in the 3.5 day training.
- The IHS hosted the Partnership Conference in August 2017 and had over 800 attendees. In June 2018, the IHS expects the Partnership Conference to have at least another 800 I/T/U attendees from the Business Office, Health Information Management, Purchased/Referred Care, Finance, and other components of the Revenue Cycle.

FY 2018 - 2019 Collections Estimates

***Medicare and Medicaid (M&M)* -- The FY 2019 President's Budget submission includes $1.056 billion which continues the FY 2018 collections level.**

***Medicaid* – The FY 2019 budget submission includes $807.605 million, the same level as FY 2018.** IHS continues to educate its users on the benefits of increased Medicaid enrollment. IHS is continuing to monitor its user population and insurance coverage and is making all possible efforts to maximize Medicaid enrollment in all States and maintain current level of collections.

Medicare – **The FY 2019 budget submission includes $248.638 million, the same level as FY 2018 level.** IHS hospitals and clinics are expanding steps to improve quality of care and maintain current levels of collections.

Private Insurance – **The FY 2019 budget submission includes $109.272 million, the same level as FY 2018 level.** IHS will continue to monitor its user population and insurance coverage to maintain and maximize private insurance collections.

VA/IHS National Reimbursement Agreement **– The FY 2019 budget submission includes $28.062 million, the same level as FY 2018.**

The estimates include collections for Federal and Tribal payments made by the VA**.** The FY 2018 estimate and the FY 2019 budget submission based on the FY 2017 actual collections received by IHS for Federal programs and the payments made by the VA to our tribal organizations. IHS and VA have agreed to continue to monitor FY 2018 actual reimbursements and work together to improve the quality of care for all veterans and maximize payments whenever possible. IHS continues to work with the VA in identifying the actual number of AI/ANs with VA benefits eligibility and, of those, how many receive direct care from IHS. IHS and the VA continue to work in partnership to identify and resolve billing and reimbursement issues and provide sites with on-going support and training. All IHS sites have signed implementation plans and have the ability to bill the VA for Veterans Services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2019 Performance Budget Submission to Congress

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

(Dollars in Thousands)

	FY 2017 Enacted	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$545,424	$541,721	$505,821	-$35,900
FTE*	1,223	1,223	1,246	+23

*FTE numbers reflect only federal staff and do not include tribal staff.

SUMMARY OF THE FACILITIES BUDGET

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

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

BUDGET AUTHORITY

The FY 2019 budget submission for Facilities of $505.821 million is $35.900 million below the FY 2018 Annualized Continuing Resolution (CR).

Maintenance & Improvement –The budget submission for M&I of $75.745 million is an increase of $514,000 above the FY 2018 Annualized CR. 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 over $568.8 million for all IHS and reporting Tribal facilities;
- Ensuring that health care facilities meet building codes and standards; and
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security.

Sanitation Facilities Construction –The budget submission for Sanitation Facilities Construction of $101.772 million is an increase of $691,000 above the FY 2018 Annualized CR. 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.

Health Care Facilities Construction –The budget submission for Health Care Facilities Construction of $79.50 million is a decrease of $37.690 million below the FY 2018 Annualized CR. This funding level for the construction of new and replacement healthcare facilities will allow IHS to continue the following projects:

- Dilkon Alternative Rural Health Center, Dilkon, AZ
- Alamo Health Center, Alamo, NM

Facilities and Environmental Health Support (FEHS) – The budget submission for FEHS of $228.852 million is an increase of $3.443 million above the FY 2018 Annualized CR. 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.

Equipment – The budget submission for Equipment of $19.952 million is a decrease of $2.858 million below the FY 2018 Annualized CR. These funds provide for:

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

COLLECTIONS

Personnel Quarters funds are not discretionary budget authority but are rents collected by IHS and returned to the service unit for Quarters maintenance and operation costs. Quarters are displayed under Program Level Authority:

Quarters – The budget submission for Personnel Quarters of $8.500 million is the same as the FY 2018 Annualized CR projection based on FY 2017 collections data. Collected funds are to be used for:

- Operation, management, and general maintenance of quarters, including temporary maintenance personnel services, security guard services, etc.; and
- Repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.).

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$75,745	$75,231	$75,745	$514
FTE	0	0	0	0

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 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 35 years, whereas the average age, including recapitalization of private-sector hospital plants, is 9 to 10 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 physical condition of IHS-owned and many tribally-owned healthcare facilities is evaluated through routine observations by facilities personnel and by in-depth condition surveys. These observations and surveys identify facility, fire-life-safety, and program deficiencies, and are used

[1] The 'average age of hospital plant' measures the average age of the facility including capital improvements, replacement of built-in equipment and modernization.

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 BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2017 is $568.8 million. Approximately 4 percent of the current replacement value, $208.3 million, is needed to fully 'sustain' the facilities and fund a project pool for restoration/modernization/improvement projects to support program requirements. 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

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

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

2. *M&I Project Funds* – These funds are used for major projects to reduce the BEMAR and make improvements necessary to support health care delivery. Funding allocation is formula based.

3. *Environmental Compliance Funds* – These funds are used to address findings and recommendations from environmental audits, to improve energy efficiency and water efficiency, to increase renewable energy usage, to reduce consumption of fossil-fuel generated electricity, and to implement other sustainability initiatives. These funds are available to Federal and Tribal health care facilities on a national basis.

4. *Demolition Funds* – The IHS has a number of Federally-owned buildings that are vacant, excess, or obsolete. Demolition funds are used to dispose of these excess assets. These funds may be augmented with Environmental Compliance Funds as available for demolition and disposal to the extent that the proposed action reduces hazards, environmental concerns, or liability to IHS.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$53,614,000
2016	$73,614,000
2017	$75,745,000
2018 Annualized CR	$75,231,000
2019 President's Budget	$75,745,000

[2] *Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings,* The National Academies Press (1990), *available at* http://www.nap.edu/catalog.

BUDGET REQUEST

The FY 2019 Budget submission for Maintenance and Improvement program of $75,745,000 is $514,000 above the FY 2018 Annualized CR level.

This level of funding provides for the following allocation categories:

- Approximately $69.245 million for routine maintenance to sustain the condition of federal and Tribal healthcare facilities buildings. These funds will support facilities activities that are generally classified as those needed for 'sustainment' of existing facilities and provided to the IHS Area Offices and to Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities. These *Routine Maintenance Funds* may be used for Area and Tribal M&I projects to fund smaller elements of the backlog of work to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR) and program enhancements.

- Approximately $3 million would be available for major Area and Tribal M&I projects to reduce the BEMAR deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. The FY 2019 Budget Request continues funding critical projects to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR), accreditation standards, and program enhancements, all of which is essential to support health delivery.

- Approximately $3 million would be available for environmental compliance projects. The IHS places a high priority on meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. The IHS has currently identified approximately $12.3 million in environmental compliance tasks and included them in the BEMAR database.

- Approximately $500,000 for demolition projects. The IHS has approximately 120 Federally-owned buildings that are vacant, excess, or obsolete which are no longer needed. Many of these buildings are safety and security hazards. Demolition of some of these buildings, in concert with transferring others, reduces hazards and liability. Demolition Funds may be augmented with environmental compliance funds as available for demolition of the Federal buildings to the extent that the proposed action reduces hazards, environmental concerns, or liability to the Indian Health Service.

OUTPUTS / OUTCOMES

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

GRANT AWARDS – This program has no grant awards.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$101,772	$101,081	$101,772	$691
FTE	150	150	150	0

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 (IHCIA), as amended 2010

FY 2019 Authorization ....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) requires the Indian Health Service (IHS) to identify the universe of sanitation facilities needs for existing American Indian and Alaska Native (AI/AN) homes by documenting deficiencies and proposing projects to address their needs. These projects provide new and existing homes with first time services such as water wells, onsite waste water systems or connecting homes to community water, and waste water facilities. The universe of need includes upgrading existing water supply and waste disposal facilities.

The four types of sanitation facilities projects funded through IHS are: (1) projects to serve existing housing; (2) projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the Bureau of Indian Affairs (BIA)-Home Improvement Program, Tribes, individual homeowners, or other nonprofit organizations; (3) special projects (studies, training, or other needs related to sanitation facilities construction); and (4) emergency projects. Projects that serve new or like-new housing are funded based on a priority classification system.

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. The SDS priority position of each unfunded project is reevaluated with the Tribes in each Area annually.

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 who 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.

PROGRAM ACCOMPLISHMENTS

SFC is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for AI/AN eligible homes and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced by about 80 percent since 1973. Research supported by the Centers for Disease Control and Prevention state populations in regions with lower proportion of homes without 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. The SFC Program works collaboratively with tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply systems and sanitary sewage disposal systems as soon as possible.

In FY 2017, IHS provided service to 19,857 AI/AN homes with an average project duration of 3.5 years. However, at the end of FY 2017 about 9,339, or 2.3 percent of all AI/AN homes were without access to adequate sanitation facilities; and, about 171,203 or approximately 42 percent of AI/AN homes were in need of some form of sanitation facilities improvements. The individuals who live in homes without adequate sanitation facilities are at a 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 need reported through SDS from year end 2005 to year end 2017 has increased over 55 percent from $1.86 billion to $2.9 billion. The underlying challenges of construction cost inflation, population growth, an increasing number of regulations, and failing infrastructure still significantly influence sanitation facility needs across Indian country. Failing infrastructure is presumably the largest factor, a result of inadequate operations 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 for this purpose.

The SFC Program will continue in FY 2019 focusing on improving quality of data reported through the SDS on the sanitation facility needs supporting AI/AN homes and communities. These efforts will ensure the sanitation facilities needs included in SDS are:

[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.

[2]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.

- Adequately documented
- Reflect an update of current needs
- Include only sanitation facilities fundable by the SFC program for AI/AN eligible homes and communities and within the intent of the IHCIA consistent with the prescribed Deficiency Levels

Additionally, in FY 2019 the SFC Program will continue to focus on maintaining average construction project duration to less than 4 years. In order to achieve this outcome funds will only be obligated to projects that have been certified by the SFC Program Areas as "ready to fund"; this means they have a well-defined scope, a detailed cost estimate, a completed preliminary design and that known potential risks to project construction, operation and maintenance have been considered and mitigated.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$79,423,000
2016	$99,423,000
2017	$101,772,000
2018 Annualized CR	$101,081,000
2019 President's Budget	$101,772,000

BUDGET REQUEST

The FY 2019 Budget submission for Sanitation Facilities Construction of $101,772,000 is an increase of $691,000 above the FY 2018 Annualized CR level.

The FY 2019 President's Budget of $101,772,000 – provides funding in the following allocation categories:

- Approximately $59.2 million may be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time, or (b) are served by sanitation facilities that are in need of some form of improvement. Another element of the distribution formula is a weight factor that favors Areas with larger numbers of AI/AN homes without water supply or sewer facilities, or without both.

  From this distribution, up to $5.0 million may be used for projects to clean up open dump sites on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994,[3] pending coordination with the EPA on oversight and evaluation of tribal solid waste management programs.

- Up to $3,000,000 will be reserved at IHS Headquarters:

  Of this amount, $1,000,000 will be used for emergency projects as requested by Areas to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situation that require immediate attention to avoid a health hazard or to protect the Federal

[3] Indian Lands Open Dump Cleanup Act of 1994 Pub. L.103-399, Oct. 22, 1994, 108 Stat. 4164 (25 U.S.C. 3091et seq.)

investment in sanitation facilities. Remaining emergency unused funds at the end of the fiscal year may be distributed to address the SDS projects in the Areas.

The remaining $2,000,000 is for funding special projects. Starting in FY 2019 and ending in FY 2021 up to $1,000,000 annually (total anticipated funding $3,000,000) will be utilized for the purpose of updating the inventory of open dumps currently identified in the IHS data system to ensure consistence with the requirments of the Indian Lands Open Dump Cleanup Act (PL103-399). An amount up to $250,000 will be used to incorporate a graphical information system (GIS) functionality into the SFC Program data system. The primary benefit of incorporating a GIS into the SFC Program's data system is to improve the Program's ability to access, store and update sanitation facilities composite as-built drawings. The graphical interface will allow for the collection, uploading and editing of field-collected data on installed sanitation facilities. It will allow users to update sanitation facilities as-built drawings for the purpose of aiding in needs identification, planning, design, construction, and technical assistance. The remaining special project funds will be used to pay for research studies, training, or other needs related to sanitation facilities construction, but which are not eligible for construction funds.

- Approximately $39.572 million will be used to serve new and like-new homes, which are non-Department of Housing and Urban Development (HUD) homes (HUD homes are served under HUD authorities and appropriations). Some of these funds may also be used for sanitation facilities for individual homes of the disabled or sick, with a physician referral, indicating an immediate medical need for adequate sanitation facilities in their home.[4] As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area proposals. Priority will be given to projects under the BIA Housing Improvement Program (HIP) to serve new and like-new homes with the exception of "Category A" BIA HIP homes which are considered existing homes and will be served with the funds described in the first bullet of this section.

The IHS appropriated funds for sanitation facilities construction are prohibited by law from being used to provide sanitation facilities for new homes funded with grants by the housing programs of HUD. These HUD housing grant programs for new homes should continue to incorporate funding for the sanitation facilities necessary for those homes.

[4] Indian Health Service. Chapter 5 Eligibility for IHS SFC Program Services and IHS-Funded Projects. Criteria for the Sanitation Facility Construction Program June 1999 ver. 1.02, 3/13/03.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
35 Number of new or like-new and existing AI/AN homes provided with sanitations facilities. (Outcome)	FY 2017: 19,857 Target: 20,000 (Target Not Met)	17,500	19,478	+1,978
SFC-E Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. (Outcome)	FY 2017: 3.5 yrs Target: 3.5 yrs (Target Met)	3.5 yrs	4 yrs	+0.5 yrs

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 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$117,991	$117,190	$79,500	-$37,690
FTE	0	0	0	0

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 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 optimum availability of functional, modern IHS and tribally operated health care facilities and staff quarters where no suitable housing alternatives are available. The IHS is authorized to construct health care facilities and staff quarters, support Tribal construction of facilities under the Joint Venture Construction Program (JVCP), provide construction funding for Tribal small ambulatory care facilities projects, and provide funding to construct new and replacement dental units.

The construction and modernization of IHS infrastructure through the health care facilities construction program helps ensure the IHS commitment to the Department of Health and Human Services Strategic Objectives 1.2: Increase health care service availability and accessibility; and 1.3: Improve health care quality, safety, cost and value. The health care facilities constructed by the IHS ensure access to quality, culturally competent health care for one of the lowest income populations in the United States, American Indians and Alaska Natives (AI/AN). The focus of the IHS health care service programs provided in these facilities is on prevention and delivery of comprehensive primary care in a community setting.

The HCFC program is funded based on an IHS-wide list of priorities for construction projects. During FY 1990, in consultation with the Tribes, the IHS revised the Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed, age and condition of the existing health care facility, if any, degree of isolation of the population to be served in the proposed health care facility, and availability of alternate health care resources. The remaining health care facilities projects on the HFCPS list, including those partially funded, total approximately $2.3 billion as of June 2017. The reauthorization of the Indian Health Care Improvement Act (IHCIA) includes a provision stating "any project established under the construction priority system in effect on the date of enactment of the Act of 2009 shall not be affected by any change in the construction priority

system taking place after that date…" Total need for the HCFC Program is approximately $14.5 billion for expanded and active authority facility types according to *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*.

The Joint Venture Construction Program (JVCP) authorizes IHS to enter into agreements with Tribes that construct their own health care facilities. The Tribe provides the resources, whether from their own funds, through financing, grants, contributions, or a combination thereof, for the construction of their health care facility. IHS health care facility construction appropriations are not used for construction of facilities in the JVCP but may be used to equip the health care facility. Tribes apply for the JVCP during a competitive process and the approved projects are entered into agreements with IHS. Based on the date of projected completion of construction by the respective Tribe, the IHS 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.

PROGRAM ACCOMPLISHMENTS

Each healthcare facility project that is completed increases access to much needed health care services. Each completed replacement facility is typically larger to meet the increased demand for health services from a growing population. With the increase in facility size comes more healthcare providers and exam rooms, dentists and dental chairs, improved imaging systems, and expanded or new health services such as eye care and audiology. Each new facility includes a component to address behavioral health issues. 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 compliments IHS programs. Tribes typically provide land, at no cost to the Federal Government, for the new or replacement health care facility.

The JVCP has saved the Federal Government over $1.15 billion dollars in capital expenses since its inception. The Congress also provided an incentive for Tribes with a project on HCFC priority list to provide the resources for design and construct the priority list project and benefit from all aspects of the JVCP. The outcome of the JVCP provides the same accomplishments as described above.

The IHS Small Ambulatory Program (SAP) provides funding for tribal health care facilities. The program is available for Federally recognized American Indian and Alaska Native tribes or tribal organizations to competitively obtain funding for the construction, expansion or modernization of tribally owned small ambulatory health care facilities. The selection process utilizing the FY 2017 funds, and any FY2018 appropriated funds, began on December 1, 2017. The selected projects will not be a part of the IHS HCFPS.

The SAP is authorized by Section 306 of the Indian Health Care Improvement Act, Public Law 94-437, and projects are competitively selected for funding as funds are appropriated.

In FY 2017 IHS entered into a Joint Venture with: Yakutat Tlingit Tribe for the Yakutat Community Health Center Yakutat, Alaska.

The federal construction and the Joint Venture programs bring new and increased health care capacity to AI/AN communities where there is a great need. These activities increase the access to quality healthcare in these underserved communities.

In FY 2017 IHS received $5,000,000 for the SAP and is currently in the process of selecting priority projects.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$85,048,000
2016	$105,048,000
2017	$117,991,000
2018 Annualized CR	$117,190,000
2019 President's Budget	$79,500,000

BUDGET REQUEST

The FY 2019 Budget submission for Health Care Facilities Construction of $79,500,000 is $37,690,000 below the FY 2018 Annualized CR level.

FY 2019 Funding of $79,500,000 includes:

Dilkon Alternative Rural Health Center, Dilkon, AZ $42,643,000

These funds will be used to continue construction of the alternative rural health center with 8 short stay beds and 109 staff quarters located in Dilkon, Arizona. The proposed new facility will consist of 150,000 GSF outpatient health center and serve a projected user population of 17,195 generating 61,633 primary care provider visits and 123,080 outpatient visits annually. The new facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services. This request for Dilkon Alternative Rural Health Center is in addition to the prior appropriations and funding from the Nonrecurring Expenses Fund allocated for this facility.

Alamo Health Center, Alamo, NM $ 36,857,000

These funds will be used to complete design-build activities of the health center and 33 staff quarters located on the Alamo Reservation, New Mexico. The proposed new facility will consist of a 55,000 GSF outpatient health center and serve a projected user population of 2,500 generating 9,400 primary care provider visits and 18,080 outpatient visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome)	FY 2016: 1 projects Target: 1 projects[1] (Target Met)	2 projects[2]	1 projects[3]	-1 projects
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 2016: 0 Target: 0 (Target Met)	2	1	-1

GRANT AWARDS – Program has no grant awards.

[1]The health care facility completed in FY 2016 was the Southern California Youth Regional Treatment Center in Hemet, CA.
[2]The health care facilities scheduled to be completed in FY 2018 are the Gila River (Red Rail Hawk) Health Center in Gila River, AZ, and the Fort Yuma Health Center in Winterhaven, CA.
[3]The health care facility to be completed in FY 2019 is the Northern California Youth Regional Treatment Center in Davis, CA.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2017	**FY 2018**	**FY 2019**	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$226,950	$225,409	$228,852	$3,443
FTE	1,077	1,036	1,059	+23

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
Detail Breakout of FEHS Activity	Final	Annualized CR	President's Budget	FY 2019 (+/-) FY 2018
BA	$226,950	$225,409	$228,852	$3,443
Facilities Support	*$136,028*	*$134,780*	*$133,769*	*-$1,011*
Environmental Health Support	*$74,464*	*$74,171*	*$76,883*	*+$2,712*
Office of Environmental Health and Engineering Support	*$16,458*	*$16,458*	*$18,200*	*+$1,742*
FTE	1,077	1,036	1,059	23
Facilities Support	*603*	*586*	*605*	*19*
Environmental Health Support	*405*	*378*	*382*	*4*
Office of Environmental Health and Engineering Support	*69*	*72*	*72*	*0*

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 2019 Authorization...Permanent

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

SUMMARY OF PROGRAMS

Facilities and Environmental Health Support Account (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs directly and indirectly support all of the IHS facilities performance measures and improved access to quality health services. The programs and staff at the IHS Headquarters, Area Office, and Service Unit levels work collaboratively with Tribes and other agencies to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities. These activities are aligned in sub-activities: Facilities Support, Environmental Health Support, and Office of Environmental Health and Engineering Support.

In addition to personnel salary and benefits costs, funding under this activity is used for utilities, certain non-medical supplies and personal property, and biomedical equipment repair.

The IHS may use a limited amount of these FEHS funds for centrally charged assessments that benefit the staff and activities funded through the Indian Health Facilities appropriations. To date, the majority of IHS's assessments have been paid through the Indian Health Services appropriation; however, the amount of assessment costs have significantly exceeded the amount of funds available within Services. In order to continue the emphasis on direct patient care, these FEHS funds that provide other types of administrative support for the Facilities appropriation may share in appropriate assessment charges proportionate to the underlying activities. For example, a centrally managed assessment for payroll services that is charged by the number of employees may be proportionately paid under both the Services and Facilities appropriations according to the number of staff supported by each appropriation.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$219,612,000
2016	$222,610,000
2017	$226,950,000
2018 Annualized CR	$225,409,000
2019 President's Budget	$228,852,000

BUDGET REQUEST

The FY 2019 Budget request for the Facilities & Environmental Health Support Account of $228,852,000 is $3,443,000 above the FY 2018 Annualized CR level. Within the funding level provided, $4,259,000 will fund Current Services and $14,665,000 will support Staffing of New Facilities in the FSA and EHSA accounts.

FY 2019 Funding Increase of $18,924,000, a net increase, includes:

- Current Services +$4,259,000 for current services, including:
    - Pay Costs + $3,942,000 - to fund pay increases for Federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +317,000 – to fund inflationary costs of providing health care services.
- Staffing for New Facilities +$14,665,000 - to fund staffing and operating costs for new and replacement projects. These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following tables display this request.

Staffing and Operating Costs for New/Replacement Facility	Amount	FTE/Pos
Red Tail Hawk Health Center, Chandler, AZ	$3,181,000	11
Fort Yuma Health Center, Winterhaven, CA	$1,239,000	7
Muskogee (Creek) Nation Health Center (JV), Eufaula, OK	$1,087,000	6
Northern California Youth Regional Treatment Ctr, Davis, CA	$678,000	5

Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$6,509,000	27
Cherokee Regional Health Center (JV), Tahlequah, OK	$1,971,000	15
Grand Total:	**$14,665,000**	**71**

This level of funding provides for the following allocation categories:

FACILITIES SUPPORT

PROGRAM DESCRIPTION

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. The sub-activity directly supports the Agency's priorities including: (1) people; (2) partnerships; (3) quality; and (4) resources.

The IHS owns approximately 10,004,000 square feet of facilities (totaling 2,144 buildings) and 1,723 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 165 years, with an average age greater than 37 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 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. Accomplishments include supporting health delivery through the attainment of accreditation and the maintenance of the environment of care of buildings, utility systems, life safety systems, and medical equipment.

Adequate facilities/maintenance staffing both at the Area Offices and service units are paramount to maintain accreditation, for the continuity of health services, and ensuring that major building systems function correctly.

PROGRAM ACCOMPLISHMENTS

In FY 2017, total utility costs were $16.5 million and total utility costs per Gross Square Feet (GSF) were $3.42/GSF. In FY 2019, the total utility cost is expected to be $17.5 million reflecting a 3.25 percent annual increase. The cost per GSF is expected to rise to approximately $3.64/GSF. IHS makes conscious efforts to help stem the growth in utility costs to ensure appropriations are sufficient to fund these needs. For example, IHS reduced the energy related utility consumption for IHS managed facilities from 148,469 British Thermal Units per Square

Foot (BTU/SF) in 2015 to 115,216 BTU/SF in 2017, a 22.4 percent reduction even with a modest increase of energy usage intensity in 2017.

Maintaining effective and efficient healthcare buildings and equipment improve the ease and access to care, facilitate successful behavioral health services, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment to deliver services. This is all integral to quality health care for AI/ANs.

ENVIRONMENTAL HEALTH SUPPORT

PROGRAM DESCRIPTION

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, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers. More than 70 percent of these IHS and Tribal staff live and work in Tribal communities; another 20 percent provide regional services to Tribes or IHS facilities; and less than 10 percent of our staff are administrative managers. AI/ANs face hazards in their environments that affect their health status, including communities in remote and isolated locations, severe climatic conditions, limited availability of safe housing, lack of safe water supply, and lack of public health and safety legislation. 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 is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated for SFC to provide safe water supply and waste disposal facilities for AI/AN people and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced by about 80 percent since 1973. Research supported by the Centers for Disease Control and Prevention state populations in regions with lower proportion of homes and absent of 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. The absence of clean water to sanitation facilities for tribal households exacerbate concern for the Indian Health Service Clinical Health Care program; further decreasing the quality of life for AI/ANs. Efforts by other public health specialists such as nutritionists and public health nurses are much more effective when safe water and adequate wastewater disposal systems are available in the home. In addition, the availability of such facilities is of fundamental importance to social and economic development, which leads to an improved quality of life and an improved sense of well-being.

  The SFC Program staff work collaboratively with tribes to assure all communities and homes are provided with safe water supply and waste disposal systems as soon as possible. Under this program in FY 2017, staff managed and/or provided professional engineering services to construct 429 sanitation projects with a total cost of over $253.0 million. The program manages annual project funding that includes contributions from Tribes, states, and other

[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.

federal agencies. The SFC Program is the environmental engineering component of the IHS health delivery system. Services funded include management of staff, pre-planning, consultation with Tribes, coordination with other federal, state and local governmental entities, identifying supplemental funding outside of IHS, developing local policies and guidelines with Tribal consultation, developing agreements with Tribes and others for each project, providing professional engineering design and/or construction services for water supply and waste disposal facilities, assuring environmental and historical preservation procedures are followed, and assisting Tribes where the Tribes provide construction management.

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.

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.

- Environmental Health Services Program (EHS) –The EHS program identifies environmental hazards and risk factors in Tribal communities and proposes control measures to prevent adverse health effects. These measures include monitoring and investigating disease and injury; inspections to identify environmental hazards in homes, healthcare facilities, food service establishments, Head Start centers, and many other types of Tribal establishments; and providing training, technical assistance, and project funding (including competitive cooperative agreements) to develop the capacity of Tribal communities to address environmental health issues. National priority areas include: food safety, children's environments, healthy homes, vector borne and communicable disease, and safe drinking water.

  EHS provides access to public health services to AI/ANs. Examples include referrals for home investigations to reduce environmental triggers for asthma patients; home investigations to reduce exposure to lead-based paint or other lead hazards (including drinking water sources) for patients with elevated blood-lead levels; animal bite investigations in Tribal communities and potential patient exposure to rabies virus; home investigations to address fall risk for elderly and other patients at risk for falls; and referrals for investigation of community disease outbreaks from multiple patient exposures to contaminated food or water.

  The EHS Institutional Environmental Health Program identifies environmental 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 healthcare accreditation which improves the quality of care. Maintaining accreditation ensures that IHS continues to have access to third-party funding.

[2] Title III, Section 302(g) 1 and 2 of P.L. 94-437.
[3] P.L. 103-399.

PROGRAM ACCOMPLISHMENTS

OEHE staff accomplishments reduce the need for direct healthcare services when environmentally related diseases and injuries are reduced. For example, the IHS Injury Prevention Program has been instrumental in reducing the injury mortality rate of AI/ANs by 58 percent since it moved from an "education only" focus to a public health approach based upon effective strategies and initiatives to reduce the devastating burden of injuries experienced by AI/ANs. Preventing severe, debilitating injuries reduce the cost and need for healthcare service; however, the challenge remains that unintentional injuries are still the leading cause of death for AI/ANs ages 1-44.

Staff collaborate with IHS and Tribal behavioral health programs in supporting suicide and violence prevention initiatives. Examples include initiatives for training students and teachers on suicide prevention and bullying prevention measures and more recent involvement in efforts supporting prevention of prescription drug overdose.

The IEH Program provides technical assistance and program development support for local healthcare worker safety programs. These efforts have led to a reduction in the IHS total occupational injury case rate which has decreased from 4.35 injuries/100 employees in 2004 to 1.97 injuries/100 employees in 2016.

The IEH program supports healthcare management by providing local accreditation support including mock environment of care surveys in which regulatory requirements and conditions for general safety, environmental infection control, environmental compliance, fire safety, chemical safety, and radiation safety are accessed and recommendations for corrective action are provided.

Staff engage Tribal, county, and state public health and public safety officials in Tribal communities. For example, staff engage local Bureau of Indian Affairs law enforcement or Tribal police to enhance motor vehicle related injury prevention efforts through child safety seat interventions and enhanced police enforcement activities such as seat belt usage or driving under the influence checkpoints. Staff work extensively with Tribal, county, and state health departments on a variety of public health issues including response to food-borne (i.e., salmonellosis), vector-borne (i.e., bubonic plague, Rocky Mountain spotted fever, hantavirus), and water-borne (i.e. legionellosis) disease outbreaks. Other examples of collaboration include arbovirus surveillance activities related to emerging diseases and public health emergency preparedness.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2018 Target	FY 2019 Target	FY 2019 Target +/-FY 2018 Target
EHS-3 Injury Intervention: Occupant protection restraint use (Outcome)	FY 2016: 64 <[4] Target: 64 <[5] (Baseline)	63 <	Conduct final data assessment: 62<	N/A
EHS-4 Environmental Surveillance (Outcome)	FY 2017: 5 < Target: 5 <[6] (Baseline)	4.9 <	Conduct final data assessment: 4.8<	N/A

Performance Discussion

Injury Intervention: During the 2016-2020 performance cycle, in FY 2016, Area EHS Programs identified targeted communities from which a national baseline measure of seatbelt use was developed. For the FY 2017 target, 8 of 10 (80 percent) of the Area programs implemented comprehensive interventions using at least three effective strategies to increase seatbelt usage rate in targeted Tribal communities. Examples include: developing or strengthening tribal seat belt laws, increasing partnerships with tribal police, providing classroom curriculum for motor vehicle crash prevention at reservation schools. In FY2018, Area programs will compare restraint use against the baseline and adjust interventions to improve driver seatbelt usage.

Environmental Surveillance: During the 2016-2020 performance cycle, in FY 2016, Area EHS Programs identified targeted Tribal Head Start and non-residential day care establishments from which a national baseline of foodborne illness risk factors was calculated. For the FY 2017 target, 10 of 10 (100 percent) of the Areas implemented and reported comprehensive interventions using at least three effective strategies to decrease food risk factor deficiencies at targeted Tribal Head Start and non-residential day care establishments. Examples include: developing and implementing active managerial control and corrective action plan processes with local operators, focusing food inspection surveys on targeted risk factors, and providing access to training through the IHS Online Food Handlers Training Course. In FY 2018, Area programs will compare foodborne illness risk factors against the baseline and adjust interventions to decrease food risk factor deficiencies.

The FY 2016 – 2020 EHS performance measures focus on reducing the risk of foodborne illness in children's environments and reducing the risk of motor vehicle-related injuries and deaths through increased use of seatbelts. Barriers that may impact the program's ability to meet these targets include competing local, regional and national priorities, staff turn-over, lapsed vacant positions, and a decentralized approach to program management that can result in non-standardized processes across the country. To help mitigate these barriers, EHS provides ongoing

[4]percent of drivers use seat belts.
[5]percent of drivers use seat belts
[6]percent of foodborne illness risk factors out of compliance

competency development through specialized training programs; strategic planning efforts that support uniform program management; and data management tools to support local staff.

GRANT AWARDS

In FY 2017, the Injury Prevention Program awarded $1,325,000 in cooperative agreements to fund 32Tribal programs. In FY 2018, (year three of the five-year agreements) $1,325,000 in continuation funds were available to the 32 Tribal programs.

OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT PROGRAM DESCRIPTION

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.

Management activities include**:**

- national policy development and implementation
- budget formulation, project review and approval
- congressional report preparation
- quality assurance (e.g., internal control reviews, Federal Managers Financial Integrity Act activities and other oversight)
- technical assistance (e.g., consultation and training)
- construction contracting
- long range planning
- meetings (with HHS, Tribes, and other federal agencies)
- and recruitment and retention efforts.

Typical direct support functions are**:**

- Project officers and contracting officer representatives for health care facilities construction projects: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status.
- Staff support real property asset management requirements. These actions are to ensure management accountability and the efficient and economic use of federal real property.
- Staff serving as contracting officer representatives and project officers in support of data systems, cooperative agreements, inter-agency agreements, and community-based projects.

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. Also, technical guidance, information, and training are provided throughout the IHS system in support of the Facilities Appropriation.

PROGRAM ACCOMPLISHMENTS

The following are activities which focus on the IHS mission and priorities:

- review and approval of Program Justification Documents (PJDs) and Program Of Requirements (PORs)
- announcement and review of Joint Venture and Small Ambulatory projects
- awarding and monitoring contracts for all aspects of the Facilities Appropriation, including all types of construction contracts and 638 construction project agreements.
- OEHE coordinating construction, environmental health, and real property activities through the 12 Area Offices to ensure program consistency, to ensure the most effective use of resources across IHS, and to support field programs through budget preparation and required reporting, thus ensuring the most effective, accountable use of resources to improve access to quality healthcare services.

OEHE strengthens the overall management of IHS by reviewing and approving the planning documents for health care facilities construction projects called PJDs and PORs. Also, announcements and review of joint venture and small ambulatory projects which represent quality health care infrastructure which addresses assessing health care and improving health care delivery including behavioral health services which are included during the planning process. The OEHE facilities programs integrate strategic planning, performance, and program integrity into the office's daily business practices. One example is the Sanitation Facilities Construction Strategic planning efforts and identification of needs. Implementation of this plan has improved project management, reduced project durations and transformed the data system used by IHS and federal partners to manage sanitation programs in Indian country. Another example is the Environmental Health program strategic visioning and the Ten Essential Environmental Health Services as a framework. Implementation of both of these initiatives is ongoing.

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

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$22,966	$22,810	$19,952	-$2,858
FTE	0	0	0	0

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 Authorization..Permanent

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

PROGRAM DESCRIPTION

Equipment funds are used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at Indian Health Service (IHS) and Tribal healthcare facilities. It directly supports the Agency's priorities of Partnerships and Quality.

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 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $500 million. With today's medical devices/systems having an average life expectancy of approximately six years and rapid technological advancements, medical equipment replacement is a continual process making it necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment. To replace the equipment at the end of its six-year life would require approximately $84.0 million per year.

Equipment Funds Allocation Method

The IHS Equipment funds are allocated in three categories: Tribally-constructed health care facilities, TRANSAM program, 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. The Budget Request supports approximately $5 million for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS funding sources. Tribes and Tribal Organizations will use these funds to serve approximately 500,000 patients with newly purchased medical equipment.

2. TRANSAM and Ambulance Programs – Equipment funds may be used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans) Program and to procure ambulances for IHS and Tribal emergency medical services programs.[1] The Budget includes $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. New and Replacement Equipment –Approximately $14.452 million will be 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.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$22,537,000
2016	$22,537,000
2017	$22,966,000
2018 Annualized CR	$22,810,000
2019 President's Budget	$19,952,000

BUDGET REQUEST

The FY 2019 Budget request for Equipment of $19,952,000 is $2,858,000 below the FY 2018 Annualized CR level.

FY 2019 Funding Increase of $441,000, a net increase, includes:

- Current Services: +$441,000 for current services, including:
    - Inflation +441,000 – to fund inflationary costs of providing health care services.

This level of funding provides for the following allocation categories:

- Approximately $14.452 million for new and routine replacement medical equipment to over 1,500 federally and tribally-operated healthcare facilities;
- $5 million for new medical equipment in tribally-constructed health care facilities; and
- $500,000 for the TRANSAM program.

These funds will be used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at IHS and Tribal healthcare facilities.

OUTPUTS / OUTCOMES

This program measures outcomes through its inventory of medical equipment. Maintaining and fielding modern medical equipment improve the ease and access to care, enhance the diagnostic capabilities leading to better health outcomes, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment to deliver services.

[1] The IHS Facilities appropriation limits total expenditures up to $500,000 for equipment purchased through the TRANSAM Program.

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 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$8,500	$8,500	$8,500	$0
FTE	37	37	37	0

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.
*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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 2019 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.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$8,000,000
2016	$8,500,000
2017	$8,500,000
2018 Annualized CR	$8,500,000
2019 President's Budget	$8,500,000

BUDGET REQUEST

The FY 2019 Quarters Return budget submission for Rent Collections of $8,500,000 is the same as the FY 2018 Annualized CR for anticipated rental collections. Rental rates are established in accordance with OMB Circular A-45 and adjusted annually based on the national Consumer Price Index (CPI).

This level of funding for Anticipated Rent Collections provides for the following:

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.).

OUTPUTS / OUTCOMES - This program measures outcomes through the inventory of staff quarters.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2019 Performance Budget Submission to Congress

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
BA	$800,000	$800,000	$822,227	+$22,227
FTE*	0	0	0	0

*Contract Support Costs are not currently used to support FTEs.

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

FY 2019 Authorization...Permanent

Allocation Method .... P.L. 93-638 Self-Determination Contracts and Compacts

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 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) 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 in October 2016,[1] an update to reflect necessary changes. These changes have included the method by which Congress has funded CSC, moving from a system of limited awards to uncapped awards, and the provision of CSC as 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 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.

[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.

PROGRAM ACCOMPLISHMENTS

- Following is a summary CSC funds for FY 2014 – FY 2017, as of December 2017:

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Appropriations[1]	$612,483,901	$662,970,000	$673,256,092	$717,970,000	$800,000,000
Paid to Tribes	$613,330,326	$630,893,894	$671,362,110	$696,348,573	$92,968,956
Balance[2]	($846,425)	$32,076,106	$1,893,982	$21,621,427	$707,031,044

[1] The estimated amount for FY 2017 included $800 million, but using updated projections, only $718 million was apportioned to IHS.
[2] Funds remain in process for payment to tribes and/or pending final reconciliation with tribes to determine the final amounts.

- IHS Headquarters reconciles CSC fund requests on a quarterly basis and allocates funds to each regional office to pay tribes.

- IHS uses the CSC automated data system to track and monitor all CSC activity. The CSC data set is used to track all CSC funds, including any new and expanded assumption, renegotiation of CSC amounts, and distribution of funds. IHS also uses the system to project CSC need based on the most current data.

- IHS updated its CSC Policy in October 2016 and has worked diligently to implement the policy by providing training and guidance to internal and external customers. The updated policy provides detailed guidance and clarifies the data used to determine each T/TO's estimated CSC need and/or final amount. The policy describes IHS's business process and includes a calculation tool which is used to determine each T/TO's CSC amount and subsequent payment is consistent with the ISDEAA. In addition to ongoing internal and external training on the updated CSC Policy to ensure that consistent business practices are used throughout the IHS, in April 2017, IHS rolled out CSC video clips that are available for external customers, with the primary focus of changes in the updated CSC policy.

- On August 16, the IHS CSC Workgroup met to review the implementation process for the recently updated CSC Policy, specifically to engage in tribal input on the updated CSC policy. IHS will use this information to further efforts to improve business processes.

- The updated IHS CSC policy implemented in late 2016 includes a provision that provides a simplified calculation of indirect CSC on recurring service unit shares, referred to as the 97/3. After a year of implementing the revised CSC Policy, the IHS has found that in certain instances, the section of the policy relating to an alternative method for calculating indirect costs (IDC) associated with recurring Service Unit shares – also referred to as the "97/3 method" or "97/3 split" – does not conform with the statutory authority of the Indian Self-Determination and Education Assistance Act (ISDEAA). On December 21, after careful review and consideration, the IHS temporarily recinded this provision until such time that the IHS is able to work with the IHS CSC Workgroup and subsequently Tribal Consultation on any changes.

- IHS continues to use the internal electronic database to monitor each Title I and V ISDEAA negotiation, including CSC negotiations. The database will monitor each phase of a negotiation to ensure that IHS uses a consistent agency business approach, deadlines are met, and funding amounts are correctly calculated. This supports an agency-wide approach to monitor and improve the overall negotiation process. In addition, the information will

track new and expanded activity assumptions and will be used to determine the status of funds, workload, planning of resources, and subsequent years' funding needs.

- For FY 2017, IHS paid $15,181,584 million for one time direct CSC for pre-award and startup funds for 14 tribes that assumed new program, functions, services, and activities (PFSAs) or renegotiated their direct or indirect type CSC amount.
- IHS continues to make progress in resolving Contract Disputes Act claims from T/TO for additional CSC funding for prior years. As of Febrary 23, 2018, the IHS has extended settlement offers on 1,495 of the 1,579 claims, with settlement payments of approximately $860 million that has been tentative or confirmed for payment from the Judgment Fund.

FUNDING HISTORY/REQUEST

Fiscal Year	Amount
2015	$662,970,000
2016	$717,970,000
2017	$800,000,000
2018 Annualized CR	$800,000,000
2019 President's Budget	$822,227,000

BUDGET REQUEST

The FY 2019 budget submission for Contract Support Costs continues the indefinite discretionary appropriation established in FY 2016, with an estimated funding level of $822,227,000, which is $22,227,000 above the FY 2018 Annualized CR level. 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. The requested funding level reflects IHS's best current estimate of the need.

AREA ALLOCATION

CONTRACT SUPPPORT COSTS

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2017 Final			FY 2018 Estimated			FY 2019 Estimated			FY '19 +/- FY '18
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$237,350	$237,350	$0	$237,350	$237,350	$0	$243,944	$243,944	$6,594
Albuquerque	0	19,793	19,793	0	19,793	19,793	0	20,343	20,343	550
Bemidji	0	42,370	42,370	0	42,370	42,370	0	43,547	43,547	1,177
Billings	0	14,874	14,874	0	14,874	14,874	0	15,287	15,287	413
California	0	66,624	66,624	0	66,624	66,624	0	68,475	68,475	1,851
Great Plains	0	7,609	7,609	0	7,609	7,609	0	7,821	7,821	211
Nashville	0	34,487	34,487	0	34,487	34,487	0	35,445	35,445	958
Navajo	0	63,161	63,161	0	63,161	63,161	0	64,916	64,916	1,755
Oklahoma	0	120,850	120,850	0	120,850	120,850	0	124,207	124,207	3,358
Phoenix	0	43,869	43,869	0	43,869	43,869	0	45,088	45,088	1,219
Portland	0	61,287	61,287	0	61,287	61,287	0	62,990	62,990	1,703
Tucson	0	25,405	25,405	0	25,405	25,405	0	26,111	26,111	706
Headquarters	0	62,322	62,322	0	62,322	62,322	0	64,053	64,053	1,732
Total, CSC	**$0**	**$800,000**	**$800,000**	**$0**	**$800,000**	**$800,000**	**$0**	**$822,227**	**$822,227**	**$22,227**

Note: FY 2017 are final. FY 2018 and FY 2019 are estimates.

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

(Dollars in Thousands)

	FY 2017	FY 2018	FY 2019	
	Final	Annualized CR	President's Budget	FY 2019 +/- FY 2018
Proposed Law Discretionary Funding	$0	$0	$150,000	+$150,000
Current Law Mandatory Funding	$147,000	$75,000	$0	-$75,000
Proposed Law Mandatory Funding	$0	$75,000	$0	+$75,000
Total Special Diabetes Program for Indians	$147,000	$150,000	$150,000	$0
FTE*	32	32	32	0

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

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.

FY 2019 Authorization... Expires September 30, 2019

Allocation Method ....Grants and Contracts

PROGRAM DESCRIPTION

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention to approximately 301 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 2019 would be the 22nd year of the SDPI. SDPI operates with a usual budget of $150 million per year and is currently authorized through September 30, 2019. The IHS Office of Clinical and Preventive Services (OCPS) Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative, and technical oversight to the SDPI grant program.

The mission of the DDTP is to develop, document, and sustain public health efforts to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs) by promoting collaborative strategies through its extensive diabetes network. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, and approximately 301 SDPI grants and sub-grants at I/T/U sites across the country.

Target Population: American Indians and Alaska Natives

Diabetes and its complications are major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (15.1 percent) among all racial and ethnic groups in the United States, more than twice the rate of the non-Hispanic white population (7.4 percent).[1] In some AI/AN communities, more than half of adults 45 to 74 years of age have diagnosed diabetes, with prevalence rates reaching as high as 60 percent.[2]

Allocation Method

In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes in AI/ANs. The entities eligible to receive these grants were I/T/Us. The IHS distributes this funding to approximately 301 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 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. This process aligns with the IHS priorities to renew and strengthen partnerships with Tribes and also to improve access to quality health care.

PROGRAM ACCOMPLISHMENTS

SDPI: Two Major Components

[1] Centers for Disease Control and Prevention (CDC). *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2017.* Atlanta, GA: U.S. Department of Health and Human Services; 2017. *Available at*: https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

[2] Lee ET, Howard BV, Savage PJ, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45-74 years: the Strong Heart Study. *Diabetes Care*. 1995;18:599-610.

As directed by Congress and Tribal consultation, the SDPI consists of two major components: (1) SDPI Grant Program; and (2) Diabetes data and program delivery infrastructure.

1. SDPI Grant Program

The SDPI grant program (formerly called the SDPI Community-Directed grant program) provides $138.7 million per year in grants and technical assistance for local diabetes treatment and prevention services at I/T/U health programs in 35 states. Each of the communities served by the SDPI grant program is unique in that its diabetes treatment and prevention needs and priorities are defined locally. Based on these local needs and priorities, the SDPI grant programs implement proven interventions to address the diabetes epidemic.

The Consolidated Appropriations Act of 2001 established statutory authority for SDPI to implement a best practices approach to diabetes treatment and prevention. The SDPI has incorporated these Indian Health Diabetes Best Practices into the SDPI grant application process used throughout AI/AN communities. Grant programs are required to document the use of one SDPI Diabetes Best Practice,[3] corresponding evaluation measures, and progress in achieving program objectives in order to enhance accountability. Grantees receive training on how to collect, evaluate, and improve their data collection and use it to improve their outcome results.

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 2015	Absolute Percentage increase
Diabetes clinics	31%	64%	+33%
Diabetes clinical teams	30%	97%	+67%
Diabetes patient registries	34%	89%	+55%
Nutrition services for adults	39%	83%	+44%
Access to registered dieticians	37%	68%	+31%
Culturally tailored diabetes education programs	36%	95%	+59%
Access to physical activity specialists	8%	73%	+65%
Adult weight management programs	19%	73%	+54%

Clinical Diabetes Outcomes During SDPI
At the same time that access to these diabetes services increased, key outcome measures for AI/ANs with diabetes showed improvement or maintenance at or near national targets. These results have been sustained throughout the inception of SDPI. Examples include:

- *Improving Blood Sugar Control*

[3] *Available at* https://www.ihs.gov/sdpi/sdpi-community-directed/diabetes-best-practices/

Blood sugar control among AI/ANs with diabetes served by the IHS has improved over time. The average blood sugar level (as measured by the A1C test) decreased from 9.0 percent in 1996 to 8.2 percent in 2017, nearing the A1C goal for most patients of less than 8 percent.

- *Improving Blood Lipid Levels*
  Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 91 mg/dL in 2017, surpassing the goal of less than 100 mg/dL.
- *Reducing Kidney Failure*
  The rate of new cases of kidney failure due to diabetes leading to dialysis declined by more than half (54 percent) in AI/AN people from 1996 to 2013. This is a much larger decline than in any other racial group in the US.[44]

2. Diabetes Data and Program Delivery Infrastructure

The IHS has used funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. SDPI supports the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System in all 12 IHS Areas.

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 2017 Diabetes Audit included a review of 124,822 patient charts at 333 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. DDTP provides Diabetes Audit training through online and webinar formats. DDTP receives evaluations on all trainings provided to guide improvements for future sessions.

Key Performance/Accomplishments

Annual SDPI assessments have shown significant improvements in diabetes clinical care and community services provided over time when compared to the baseline SDPI assessment in 1997 (see table above titled "Diabetes treatment and prevention services available to AI/AN individuals").

Ongoing efforts to improve blood glucose, blood pressure, and cholesterol values will continue to reduce the risk for microvascular, as well as macrovascular complications (see "Outputs/Outcomes" table below).

Reporting

In addition to internal monitoring of the SDPI Grant Program, the DDTP has completed five SDPI Reports to Congress to document the progress made since 1997. The SDPI Reports to Congress are as follows:

[4] Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. MMWR Morb Mortal Wkly Rep 2017;66:26-32. DOI: http://dx.doi.org/10.15585/mmwr.mm6601e1.

- January 2000 Interim Report to Congress on SDPI;
- December 2004 Interim Report to Congress on SDPI;
- 2007 SDPI Report to Congress: On the Path To A Healthier Future;
- 2011 SDPI Report to Congress: Making Progress Toward A Healthier Future; and
- 2014 SDPI Report to Congress: Changing the Course of Diabetes: Turning Hope into Reality.

Following Tribal consultation, beginning in FY 2016, SDPI funding has been distributed as follows:

Special Diabetes Program for Indians – Total Yearly Costs

CATEGORY	Percentage of the total	(Dollars in Millions)
SDPI Grant Programs (272 Tribal and IHS grants, sub-grants, and technical assistance in FY 2017).	**86.8%**	**$130.2**
Administration of SDPI grants (includes program support funds to IHS Areas, Tribal Leaders Diabetes Committee, DDTP, Grants Management, evaluation support contracts, etc.)	**4%**	**6.1**
Urban Indian Health Program SDPI Grant Programs ($8.5M allocated to 29 grants and technical assistance in FY 2017)	**5.7%**	**8.5**
Funds to strengthen the Data Infrastructure of IHS	**3.5%**	**5.2**
TOTAL:	**100%**	**$150.0**

BUDGET REQUEST

The SDPI is currently authorized through September 30, 2019, under P.L. 115-123— Bipartisan Budget Act of 2018. The FY 2019 budget request shifts funding for SDPI from mandatory to discretionary spending and maintains funding at $150 million. The distribution of funding is shown in the grant tables that follow.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2018 Target**	**FY 2019 Target**	**FY 2019 Target +/-FY 2018 Target**
2 American Indian and Alaska Native patients with diagnosed diabetes achieve Good Glycemic Control (A1c Less than 8.0%). (Outcome)	FY 2017: 46.1 % Target: 48.4 % (Target Not Met)	Retire and Replace	Retire and Replace	Maintain
2 Tribally Operated Health Programs (Outcome)	FY 2017: 48.4 % Target: 51.4 % (Target Not Met)	Retire	Retire	Maintain
3 Diabetes: Blood Pressure Control: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<140/90). (Outcome)	FY 2017: 67.6 % Target: 63.8 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain

3 Tribally Operated Health Programs (Outcome)	FY 2017: 67.7 % Target: 62.5 % (Target Exceeded)	Retire	Retire	Maintain
50 DM Statin Therapy (Intermediate Outcome)	FY 2017: 64.2 % Target: 61.9 % (Target Exceeded)	Retire and Replace	Retire and Replace	Maintain
50 TOHP DM Statin Therapy (Intermediate Outcome)	FY 2017: 64.2 % Target: 61.7 % (Target Exceeded)	Retire	Retire	Maintain
52 Good Glycemic Control (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 36.2 % (Pending)	36.2 %	Retire	N/A
53 Controlled BP <140/90 (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 52.3 % (Pending)	52.3 %	52.3 %	Maintain
54 Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes (Intermediate Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 37.5 % (Pending)	37.5 %	37.5 %	Maintain
86 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)	FY 2019: Result Expected Jan 31, 2020 Target: Set Baseline (Pending)	N/A	Baseline	Maintain

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to IHS, Tribal and Urban Indian health programs in 35 states. The SDPI grant programs provide local diabetes treatment and prevention services based on community needs.

(whole dollars)	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Number of Awards	301 (includes sub-grants)	301 (includes sub-grants)	301 (includes sub-grants)
Average Award	$450,579	$450,579	$450,579
Range of Awards	$19,394 - $7,553,570	$19,394 - $7,553,570	$19,394 - $7,553,570

FY 2019 State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2019 Annual Financial Assistance Awards

State	State Name	FY 17 Total # Grant Programs	FY 2017 Final	FY 2018 Enacted	FY 2019 President's Budget*
AK	Alaska	19	$8,927,252	$10,191,326	$10,191,326
AL	Alabama	1	279,211	279,211	279,211
AZ	Arizona	28	29,817,025	29,817,025	29,817,025
CA	California	39	9,740,219	9,740,219	9,740,219
CO	Colorado	3	903,625	903,625	903,625
CT	Connecticut	2	232,777	232,777	232,777
FL	Florida	2	487,380	487,380	487,380
IA	Iowa	1	304,592	304,592	304,592
ID	Idaho	4	935,841	935,841	935,841
IL	Illinois	1	281,832	281,832	281,832
KS	Kansas	5	937,919	937,919	937,919
LA	Louisiana	4	364,530	364,530	364,530
MA	Massachusetts	2	168,316	168,316	168,316
ME	Maine	5	543,580	543,580	543,580
MI	Michigan	12	2,363,824	2,363,824	2,363,824
MN	Minnesota	8	3,274,552	3,274,552	3,274,552
MS	Mississippi	1	1,256,112	1,256,112	1,256,112
MT	Montana	10	5,564,865	5,564,865	5,564,865
NE	Nebraska	5	1,931,172	1,931,172	1,931,172
NV	Nevada	14	5,203,730	5,203,730	5,203,730
NM	New Mexico	28	11,712,388	11,712,388	11,712,388
NY	New York	3	1,264,077	1,264,077	1,264,077
NC	North Carolina	1	1,351,228	1,351,228	1,351,228
ND	North Dakota	5	3,168,173	3,168,173	3,168,173
OK	Oklahoma	27	23,460,585	23,460,585	23,460,585
OR	Oregon	9	1,832,727	1,832,727	1,832,727
RI	Rhode Island	1	113,475	113,475	113,475
SC	South Carolina	1	163,399	163,399	163,399
SD	South Dakota	9	6,014,473	6,014,473	6,014,473
TN	Tennessee	1	129,601	129,601	129,601
TX	Texas	4	784,901	784,901	784,901
UT	Utah	5	2,051,292	2,051,292	2,051,292
WA	Washington	27	4,792,337	4,792,337	4,792,337
WI	Wisconsin	12	3,421,213	3,421,213	3,421,213
WY	Wyoming	2	1,032,196	1,032,196	1,032,196
	Total States	**301**	**$136,074,763**	**$136,074,763**	**$136,074,763**

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2019 Annual Financial Assistance Awards					
State	State Name	FY 17 Total # Grant Programs	FY 2017 Final	FY 2018 Enacted	FY 2019 President's Budget*
	Indian Tribes*	**252**	**$114,086,944**	**$114,086,944**	**$114,086,944**

*This is the number tribes that are primary grantees or sub-grantees.

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TRIBAL OPIOID PREVENTION, TREATMENT, AND RECOVERY SUPPORT

(Dollars in Thousands)

	FY 2017	**FY 2018**	**FY 2019**	
	Final	Annualized CR	President's Budget/1	FY 2019 +/- FY 2018
BA	$0	$0	$150,000	+$150,000
FTE*	0	0	10	+10

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/This funding is part of the HHS $10 billion proposal to combat the opioid epidemic and address mental health.

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 2019 Authorization..Through 2024

Allocation Method ....Grants

PROGRAM DESCRIPTION

American Indians and Alaska Natives had the highest drug overdose death rates in 2015, and the largest percentage change increase in drug overdose deaths from 1999-2015 of any population at 519 percent. The IHS Tribal Opioid Prevention, Treatment, and Recovery Support (Tribal Opioid Support) grants program aims to confront the opioid crisis in AI/AN communities by providing targeted funding to increase access to treatment and reduce opioid overdose related deaths through prevention, treatment, and recovery options. Activities will support a comprehensive response to the opioid epidemic with a specific focus to integrate primary care and substance use prevention and treatment activities and establish or enhance community-based support services, such as peer support, behavioral health aides, transitional housing, and other recovery support services.

PROGRAM ACCOMPLISHMENTS

The Tribal Opioid Support grant program will support the following activities:

- Develop a comprehensive Tribal action plan to address gaps in prevention, treatment, and recovery.
- Implement primary and secondary prevention approaches, including culturally appropriate interventions, to reduce the number of individuals with opioid use disorder (OUD) and overdose deaths.
- Implement or expand clinically appropriate treatment for OUDs, such as medication assisted treatment (MAT).
- Hire health care providers, such as physicians, nurse practitioners, physician assistants, counselors, social workers, nurses, care coordinators, and case managers.

- Provide peer and other recovery support services, such as behavioral health aides or other behavioral health providers.
- Cover treatment costs, such as MAT provided by referral providers.
- Establish telehealth services to increase access to MAT services.
- Purchase naloxone for distribution among first responders and families of individuals with OUDs.
- Provide services in criminal justice settings or other rehabilitative settings operated by Tribes and/or the Bureau of Indian Affairs.
- Establish or enhance community-based recovery support networks, such as transitional housing, vocational rehabilitation, sober living communities, and/or vital culturally appropriate supports and services.
- Establish or enhance surveillance systems to increase the capacity of AI/AN communities to monitor the impact of the opioid epidemic on their tribal citizens and/or service population and assess their progress.

Program accomplishments will be determined through the submission of annual reports from funded projects to include the number of people receiving OUD treatment, number of people in recover services, number of providers implementing MAT, number of health care providers hired as a result of the grant funding, number and rates of opioid use, and numbers and rates of opioid overdose-related deaths.

FUNDING HISTORY

Fiscal Year	Amount
2015	$0
2016	$0
2017	$0
2018 Annualized CR	$0
2019 President’s Budget	$150,000,000

BUDGET REQUEST

IHS requests +$150,000,000 to implement its Tribal Opioid Response grant program. This funding is part of the $10 billion in new funding for HHS to address the opioid epidemic and mental health. Funding will be awarded to Tribes using competitive grant amounts based on need with a portion of funding made available to Title V Urban Indian organizations. IHS facilities operating a primary care clinic will be eligible to apply for a federal program award with agreement from the direct service Tribe.

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Indian Health Service
Drug Control Budget
FY 2019

		Budget Authority (in Millions)	
	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Drug Resources by Function			
Prevention	27.057	24.106	25.199
Treatment	87.312	85.856	92.576
Total Drug Resources by Function	**$114.369**	**$109.962**	**$117.775**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	110.765	106.386	114.171
Urban Indian Health Program	3.604	3.575	3.604
Total Drug Resources by Decision Unit	**$114.369**	**$109.961**	**$117.775**
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 6,388.963	$ 6,363.170	$6,626.100
Drug Resources Percentage	1.79%	1.73%	1.78%

Note: The overall total lines under FY 2018 differ by .001 due to round differences in Excel.
1/ This funding is part of the HHS $10 billion proposal to combat the opioid epidemic and address mental health. As part of this effort, the budget requests $150 million for activities in IHS, which is not reflected in this table.

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 Indians and Alaska Natives (AI/AN). IHS supports substance abuse treatment and prevention 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 Program (UIHP) funds from the National Institute on Alcohol Abuse and Alcoholism programs transferred to the IHS under the UIHP budget.

BUDGET SUMMARY

In FY 2019, IHS requests $117.8 million for its drug control activities, an increase of $7.8 over the FY 2018 Annualized CR level.

Alcohol and Substance Abuse
FY 2019 Request: $114.2 million
(Increase of $7.8 million above the FY 2018 Annualized CR)

The FY 2019 budget request is necessary to maintain the program's progress in addressing the 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.

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
FY 2019 Request: $3.6 million
(Increase of $29,000 above the FY 2018 Annualized CR)

The FY 2019 request includes funding for the Urban Indian Health Program which will be used to continue serving urban AI/ANs impacted by alcohol and substance abuse through the Title V grant program, Alcohol and Substance Abuse Prevention and Treatment. Substance abuse prevention, treatment, and education programs address alcohol/drugs, suicide, self-esteem, injury control, domestic violence, and sexual abuse. Several Urban Indian Health Programs have active partnerships with their local Veterans Health Administration programs and several have identified joint alcohol and substance abuse initiatives.

ONDCP FUNDING PRIORITIES

In FY 2019, the IHS budget request for its drug control activities supports the Office of National Drug Control Policy's (ONDCP) funding priorities.

IHS established a multi-disciplinary workgroup to focus on Prescription Drug Abuse in Indian Country in 2012. In March 2017, IHS elevated its workgroup to a National Committee on Heroin, Opioids, and Pain Efforts (HOPE) Committee comprised of multidisciplinary team members with pharmacy, medical, nursing, and behavioral health professional backgrounds. The HOPE Committee will work from a framework based on six tenets: 1) Establishing IHS policies; 2) Training Health Care Providers; 3) Ensuring Effective Pain Management; 4) Increasing Access to Naloxone; 5) Expanding Medication Assisted Treatment (MAT); and 6) Reducing the Inappropriate Use of Methadone.

IHS policy work includes establishing the Indian Health Manual (IHM) Chapter 30 "Chronic Non-Cancer Pain" and Chapter 32 "State Prescription Drug Monitoring Programs." The purpose of Chapter 30 is to assist IHS providers to provide prompt and effective assessment, diagnosis, and treatment of chronic non-cancer pain. In 2016, IHS Implemented IHM Chapter 32, a groundbreaking new policy regarding opioid prescribing which requires all healthcare providers working in IHS federal-government-operated facilities, including doctors, pharmacists, nurse practitioners and other providers who prescribe opioids, to check state Prescription Drug Monitoring Program databases prior to prescribing opioids for pain treatment longer than seven days and periodically throughout chronic pain treatment, one of the first such actions by any federal agency involved in direct medical care.

IHS implemented a mandatory training course, entitled "IHS Essential Training," for all Federal prescribers, contractors, residents and trainees who prescribe controlled substances and spend at least 50 percent of their time in a clinical setting. The purpose of this training is to assure that providers have the knowledge needed to appropriately and effectively prescribe controlled substance medications. In FY 2017, IHS trained 96 percent of its providers who are required to

attend the training. Many Tribal and Urban Indian providers have also taken advantage of the no cost training. IHS will continue to offer the training on a regular basis to capture new employees who require training, as well as offer refresher courses every three years.

To assist providers as they provide effective and optimal pain management, IHS developed two websites "Opioid Use Disorder Management" available at https://www.ihs.gov/odm and "Pain Management," available at https://www.ihs.gov/painmanagement which provide resources, current clinical guidelines, and best practices for providers in the Indian health system. IHS, in partnership with the University New Mexico Pain Center, provides IHS, Tribal, and Urban Indian providers with weekly, real-time consultation with experts in the field of pain management and additional web-based educational services.

To increase access to naloxone, IHS signed a memorandum of agreement with Bureau of Indian Affairs (BIA). The agreement allows IHS to provide BIA officers with training and naloxone rescue kits for responding to incidents of opioid overdose. This partnership has put naloxone in the hands of law enforcement officers, who are often the first responders to incidents of opioid overdose in Tribal communities.

IHS is working to increase access to MAT, the use of medications with counseling and behavioral therapies, to treat opioid use disorders. IHS is currently working to increase the number of primary care providers who have been trained to prescribe MAT. IHS provided waiver training in the Bemidji and Albuquerque IHS Areas in FY 2017.

IHS is actively working to reduce the use of methadone for pain management. Recent guidelines released by the Centers for Disease Control and Prevention pointed to several studies showing that the use of methadone in the treatment of chronic pain was associated with a much higher number of overdose deaths compared to other opioid pain relievers and therefore recommended against using it as a first line medication for the treatment of pain. IHS is currently updating policies to align with this recommendation and providing training to Indian health system providers.

In FY 2019, IHS will continue to serve AI/ANs impacted by substance abuse and dependence through its Youth Regional Treatment Centers (YRTCs) and other IHS, Tribal, and Urban Indian operated substance abuse treatment and prevention programs. In addition to those direct services, the IHS Substance Abuse and Suicide Prevention Program (SASP) (formerly known as the Methamphetamine and Suicide Prevention Initiative, or MSPI) is a nationally-coordinated grant program, focusing on providing targeted substance abuse and suicide prevention and intervention resources to communities in AI/AN communities with the greatest need for these programs. There is mutual development and implementation of the SASP with Tribes, Tribal programs, Urban Indian organizations, and other Federal agencies which now provides support nationally. The strategic goal is to support Tribal programs in their continued substance use prevention, treatment, and recovery services. 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 abuse treatment into primary care and emergency services through its activities to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT). IHS has incorporated SBIRT as a national measure to be tracked and reported.

The IHS provides several training opportunities annually on alcohol and substance abuse issues for its providers. In FY 2017, the TBHCE, in partnership with the University of New Mexico, provided more than 8,920 hours of training on current and pressing behavioral health issues through a series of webinars, including a concentrated focus on substance use disorders with topics including: Introduction to Addiction; Opioid Dependence; Chronic Pain and Depression; Anxiety and Chronic Pain; Fibromyalgia; Chronic Pain and Neurology; Epidemiology of Chronic Pain; Non-Opioid Pain Medication; Screening for Misuse, Diversion, and Addiction; Buprenorphine; Medication Management; Screening for Opiate Addictions; Methadone - An Introduction; FASD; Naloxone and MAT for Opioid Dependence. To provide clinical support for providers, IHS launched weekly Pain and Addiction consultations, in partnership with the University of New Mexico. Healthcare providers may receive a no-cost consultation from an expert panel on the most challenging pain and addiction cases.

The TBHCE evaluates models of care delivery, access to care, and sustainability. A toolkit is available for sites to prepare the infrastructure for tele-behavioral health services. In FY 2017, 12,212 patient encounters were provided nationally via tele-behavioral health. As IHS promotes the use of MAT programming, future development work includes options to expand tele-health for MAT maintenance.

In FY 2019, IHS will begin to track the number of naloxone prescriptions as part of our efforts to increase access to naloxone.

FY 2019 Changes (no change): IHS will continue to serve AI/ANs impacted by substance abuse and dependence through its YRTCs and other IHS, Tribal, and Urban Indian operated substance abuse treatment and prevention programs.

Indian Health Service		
Selected Measures of Performance	**FY 2017 Target**	**FY 2017 Achieved**
» Universal alcohol screening	Baseline	68.0%
» Accreditation rate for Youth Regional Treatment Centers in operation 18 months or more	100%	100%
» Report on number of emergency department patients who receive SUD intervention	41,696	39,658
Report on number of SUD services in primary care clinics	121,343	113,497

Information regarding the performance of the drug control efforts of IHS is based on agency GPRA/GPRAMA documents and other information that measures the agency's contribution to the National Drug Control Strategy from Office of National Drug Control Policy. The table above and accompanying text below represent highlights of IHS's achievements during FY 2017, the latest year for which data are available. The selected performance measures reported in the table provide targets and results from both Tribally-Operated Health Programs and Federally-Administered Health Programs.

To provide more comprehensive routine screening, IHS expanded its Alcohol Screening measure to include all patients 12 through 75 years of age in FY 2017 and retired the Alcohol Screening measure for female patients. Additionally, IHS reported a new SBIRT measure that had 2017 baseline results of 3.0 percent.

The accreditation measure for YRTCs reflects an evaluation of the quality of care associated with accreditation status by either the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), state certification, or regional Tribal health authority certification. For youth with substance use disorders, the YRTCs provide invaluable treatment services. The accreditation measure for YRTCs reflects an evaluation of the quality of care by either the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or State licensure.

The IHS monitors two program measures on the number of substance use disorder (SUD) encounters provided in emergency departments and primary care clinics. In FY 2018, IHS will include overall SUD encounters provided in all clinical settings across the health system to aid in promoting integrated SUD services. Tracking overall clinical SUD encounters will allow IHS to report on the effectiveness of IHS programs that focus on drug abuse. In FY 2017, the result for SUD encounters across all IHS clinics was 688,514 encounters.

Office of Urban Indian Health Programs

Urban Indian Organizations (UIO) are resources to both tribal and urban communities. UIO that offer inpatient and outpatient substance abuse treatment have become reliable referral sites for tribes. In FY 2019 IHS is proposing $3.6 million for the urban ONDCP budget.

AI/AN people who live in urban centers present a unique morbidity and mortality profile. Urban AI/AN populations suffer disproportionately higher mortality from certain causes in sharp contrast to mainstream society. These unique challenges require a targeted response. Existing UIO see their efforts in health education, health promotion, and disease prevention as essential to impacting the behavioral contributors to poor health:[1]

- Alcohol-induced death rates are 2.8 times greater for urban AI/AN people than all races in urban areas.
- Chronic liver disease death rates are 2.1 times greater for urban AI/AN people than all races in urban areas.
- Tuberculosis death rates are 2 times greater for urban AI/AN people than all races in urban areas.
- Accidents and external causes of death rates are 1.4 times greater for urban AI/AN people than all races in urban areas.

Alcohol and drug-related deaths continue to plague urban AI/AN. Alcohol-induced mortality rates for urban AI/AN are markedly higher than all races in urban areas. All regions,[2] with the exception of eastern seaboard cities in the Nashville Area, show dramatically higher rates for urban AI/AN than for all races in urban areas 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.[3]

Urban AI/AN populations are more likely to engage in health risk behaviors. Urban AI/AN are more likely to report heavy or binge drinking compared to all races and urban AI/AN are 1.7 times more likely to smoke cigarettes. Urban AI/AN more often view themselves in poor or only fair health status, with 22.6 percent reporting fair/poor health as compared to 14.7 percent of all races reporting as fair/poor.

[1] Indian Health Service, Office of Urban Indian Health Programs, *Urban Needs Assessment Report*, 2015.
[2] Ibid.
[3] Ibid.

UIO emphasis on integrating behavioral health, health education, health promotion and disease prevention into primary care offered within a culturally appropriate framework, leads to positive outcomes for urban AI/AN. Urban AI/AN in need of substance abuse treatment commonly exhibit co-occurring disorders. UIO programs have recognized the need for more mental health and substance abuse counselors to adequately address the needs presented by AI/AN with co-occurring disorders. AI/AN need gender- and age-appropriate substance abuse treatment. Stakeholders reported the need for more age- and gender-appropriate resources for substance abuse treatment. While male AI/AN can encounter wait times for treatment admission up to 6 months, treatment options for youth, women, and women with children can be greater than 6 months. Some of the best AI/AN treatment programs for youth, women, and women with children are administered by UIO. Affecting lifestyle changes among urban AI/AN families requires a culturally sensitive approach. The existing UIO have operated culturally appropriate initiatives to reduce health risk factors. UIO continued efforts to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population.

Fetal alcohol spectrum disorders (FASD) is used to describe a range of effects that can occur in someone whose mother consumed alcohol during pregnancy. FASD includes disorders such as fetal alcohol syndrome (FAS), alcohol-related neuro developmental disorder (ARND), and alcohol-related birth defects (ARBD). Interventions are needed in urban centers to address prevention efforts for urban AI/AN with a FASD. The IHS Policy on Conferring with Urban Indian Organizations identifies FASD as a provision that requires the IHS to confer with UIO "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 FAS. FAS is the leading and most preventable cause of intellectual disability. The rates of FAS are higher among AI/ANs 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 FAS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2019 Performance Budget Submission to Congress

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FY 2019 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2017 Final	FY 2018 Annualized CR	FY 2019 Pres. Budget	FY 19 +/- FY 2018
DIRECT OBLIGATIONS				
Personnel Compensation:				
Full-Time Permanent(11.0)………………………	449,205	449,205	471,976	22,771
Other than Full-Time Permanent(11.3)…………	20,286	20,286	21,502	1,216
Other Personnel Comp.(11.5)……………………	62,235	62,235	65,172	2,937
Military Personnel Comp (11.7)…………………	84,295	84,295	88,694	4,399
Special Personal Services Payments (11.8)…….	316	316	341	25
Subtotal, Personnel Compensation...……………	616,337	616,337	647,685	31,348
Civilian Personnel Benefits(12.1)…………………	177,424	177,424	186,278	8,854
Military Personnel Benefits (12.2)	35,241	35,241	37,029	1,788
Benefits to Former Personnel(13.0)………………	10,070	10,070	10,250	180
Subtotal, Pay Costs………………….	**839,072**	**839,072**	**881,242**	**42,170**
Travel(21.0)………………………………………	43,640	43,275	45,359	2,084
Transportation of Things(22.0)……………………	10,498	10,396	11,154	758
Rental Payments to GSA(23.1)……………………	16,149	15,989	17,862	1,873
Rental Payments to Others(23.2)………………….	2,066	2,045	2,213	168
Communications, Utilities and Miscellaneous Charges(23.3……………………	26,106	25,795	27,526	1,731
Printing and Reproduction(24.0)…………………	256	254	241	(13)
Other Contractual Services:				
Advisory and Assistance Services(25.1)……….	8,540	8,465	8,848	383
Other Services(25.2)……………………………	208,243	206,563	202,457	(4,106)
Purchases from Govt. Accts.(25.3)………………	74,899	74,141	84,388	10,247
Operation and Maintenance of Facilities(25.4)….	9,905	9,817	9,925	108
Research and Development Contracts(25.5)…….	2	2	3	1
Medical Care(25.6)………………………………	361,619	359,100	373,265	14,165
Operation and Maintenance of Equipment(25.7).	16,872	16,715	18,122	1,407
Subsistence and Support of Persons(25.8)………	11,857	11,770	11,955	185
Subtotal, Other Contractual Current...........……	**691,937**	**686,573**	**708,963**	**22,390**
Supplies and Materials(26.0)………………………	95,410	94,543	105,289	10,746
Equipment (31.0)…………………………………	24,112	23,892	23,701	(191)
Land & Structures (32.0)…………………………	79,709	79,166	56,496	(22,670)
Investments & Loans (33.0)………………………	0	0	0	0
Grants, Subsidies, & Contributions (41.0)……….	2,409,537	2,388,714	2,570,286	181,572
Insurance Claims & Indemnities (42.0)………….	1,349	1,334	1,419	85
Interest & Dividends (43.0)………………………	45	45	45	0
Subtotal Non-Pay Costs.....………	**3,400,814**	**3,372,021**	**3,570,554**	**198,533**
Total, Direct Obligations……………….	**4,239,886**	**4,211,093**	**4,451,796**	**240,703**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
Salaries and Expenses
(Budget Authority - Dollars in Thousands)

Object Class	2017 Final	FY 2018 Annualized CR	FY 2019 Pres. Budget	Increase or Decrease
Personnel Compensation:				
Full-Time Permanent (11.0)	449,205	449,205	471,976	22,771
Other than Full-Time Permanent (11.3)	20,286	20,286	21,502	1,216
Other Personnel Comp. (11.5)	62,235	62,235	65,172	2,937
Military Personnel Comp. (11.7)	84,295	84,295	88,694	4,399
Special Personnel Services Payments (11.8)	316	316	341	25
Subtotal, Personnel Compensation	616,337	616,337	647,685	31,348
Civilian Personnel Benefits (12.1)	177,424	177,424	186,278	8,854
Military Personnel Benefits (12.2)	35,241	35,241	37,029	1,788
Benefits to Former Personnel (13.0)	10,070	10,070	10,250	180
Total, Pay Costs	**839,072**	**839,072**	**881,242**	**42,170**
Travel (21.0)	14,415	14,248	15,253	1,005
Transportation of Things (22.0)	10,498	10,396	11,154	758
Rental Payments to Others (23.2)	2,066	2,045	2,213	168
Communications, Utilities & Misc. Charges (23.3)	26,106	25,795	27,526	1,731
Printing and Reproduction (24.0)	256	254	241	(13)
Other Contractual Services:				
Advisory and Assistance Services (25.1)	8,540	8,465	8,848	383
Other Services (25.2)	208,243	206,563	202,457	(4,106)
Purchases from Govt. Accts. (25.3)	74,899	74,141	84,388	10,247
Operation and Maintenance of Facilities (25.4)	9,905	9,817	9,925	108
Operation and Maintenance of Equipment (25.7)	16,872	16,715	18,122	1,407
Subsistence and Support of Persons (25.8)	11,857	11,770	11,955	185
Subtotal, Other Contractual	330,316	327,471	335,695	8,224
Supplies and Materials (26.0)	95,410	94,543	105,289	10,746
Total, Non-Pay Costs	**479,067**	**474,752**	**497,371**	**22,619**
Total Salaries & Expenses	1,318,139	1,313,824	1,378,613	64,789
Direct FTE	8,660	8,660	9,191	531

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

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 PB
Headquarters			
Sub-Total, Headquarters	442	442	442
Area Offices			
Alaska Area Office	289	289	289
Albuquerque Area Office	1,063	1,063	1,062
Bemidji Area Office	553	553	553
Billings Area Office	992	992	990
California Area Office	110	110	247
Great Plains Area Office	2,258	2,258	2,253
Nashville Area Office	193	193	192
Navajo Area Office	4,175	4,175	4,175
Oklahoma City Area Office	1,712	1,712	1,708
Phoenix Area Office	2,580	2,580	2,987
Portland Area Office	510	510	510
Tucson Area Office	386	386	386
Sub-Total, Area Offices	14,821	14,821	15,352
Trust Funds (Gift)	23	23	23
TOTAL FTES	15,286	15,286	15,817

INDIAN HEALTH SERVICE
DETAIL OF PERMANENT POSITIONS

(Dollars in Thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 Pres. Budget
Total - ES's......................	14	14	14
Total - ES Salaries......................	$3,139	$3,139	$3,139
GS/GM-15..	433	433	452
GS/GM-14..	433	433	452
GS/GM-13..	515	515	537
GS-12..	1,165	1,165	1,216
GS-11..	1,345	1,345	1,404
GS-10..	593	593	619
GS-9..	1,247	1,247	1,302
GS-8..	426	426	444
GS-7...	1,195	1,195	1,247
GS-6...	1,500	1,500	1,566
GS-5..	2,037	2,037	2,127
GS-4...	1,016	1,016	1,061
GS-3..	174	174	181
GS-2...	31	31	32
Subtotal..	12,109	12,109	12,640
Total - GS Salaries................................	$666,249	$666,249	$699,713
Director Grade CO-06...........................	387	387	387
Senior Grade CO-05..............................	561	561	561
Full Grade CO-04...................................	590	590	590
Senior Assistant Grade CO-03............	292	292	292
Assistant Grade CO-02........................	29	29	29
Junior Grade CO-01..............................	9	9	9
Subtotal..	1,869	1,869	1,869
Total - CO Salaries	$119,536	$119,536	$125,723
Ungraded..	1,271	1,271	1,271
Total - Ungraded Salaries	$50,148	$50,148	$52,667
Trust Funds (Gift)	23	23	23
Average ES level................................	ES-02	ES-02	ES-02
Average ES salary..............................	$174	$174	$174
Average GS grade...............................	5.1	5.1	5.1
Average GS salary.............................	$55	$55	$55

FY 2019 Congressional Justification
Programs Proposed for Discontinuation

Three programs within the Indian Health Service budget have been proposed for elimination, Health Education, Community Health Representatives, and the Tribal Management Grants.

Health Education: The FY 2018 Annualized CR amount for Health Education is $18,608,000, with the program discontinued in FY 2019. The rationale for discontinuing this program is to concentrate funding for clinical services and staffing costs of new and replacement health care facilities to provide health care to American Indians and Alaska Natives (AI/AN). This program has played a role in IHS's approach to Native American health care, but direct health care services are a priority.

Community Health Representatives: The FY 2018 Annualized CR amount for Community Health Representatives is $59,915,000, with the program discontinued in FY 2019. The rationale for discontinuing this program is to concentrate funding for clinical services and staffing of new and replacement health care facilities to provide health care to AI/ANs. This program has played a role in IHS's approach to Native American health care.

Tribal Management Grant Program: The FY 2018 Annualized CR amount for the Tribal Management Grant Program is $2,448,000, with the program discontinued in FY 2019. The rationale for discontinuing this program is to concentrate funding for clinical services and staffing of new and replacement health care facilities to provide health care to AI/ANs. This program has played a role in IHS's approach to Native American health care.

Physicians' Comparability Allowance (PCA)

Indian Health Service

Table 1

		PY 2015 (Actual)	**CY 2016** (Estimates)	**BY 2017*** (Estimates)
1) Number of Physicians Receiving PCAs		11	3	3
2) Number of Physicians with One-Year PCA Agreements		0	0	0
3) Number of Physicians with Multi-Year PCA Agreements		11	3	3
4) Average Annual PCA Physician Pay (without PCA payment)		$147,316	$148,562	$148,562
5) Average Annual PCA Payment		$26,455	$24,667	$24,667
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	10	2	2
	Category II Research Position			
	Category III Occupational Health			
	Category IV-A Disability Evaluation			
	Category IV-B Health and Medical Admin.	1	1	1

*FY 2017 data will be approved during the FY 2018 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Not applicable.

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

Maximum annual PCA for Category I (Clinical Position) - $30,000. Factors used were board certification, multi-year agreements, shortage specialty, location (remote), and duties.

Maximum annual PCA for Category IV-B (Health and Medical Administration) - $18,000. Factors used were board certification, multi-year agreement, categorical allowance.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

Overall, Physician vacancy rates continue in the 20% range due to a shortage of physicians, particularly in primary care specialties. IHS has moved to using Title 38 Physician and Dentist Pay instead of PCA as the only option to compete successfully with private sector salaries. Many of our previous PCA recipients have been converted to Title 38.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

IHS is using Title 38 Physician and Dentist Pay authority more than PCA authority at this point in time. In general, PCA does not provide the pay flexibility needed to recruit and retain Physicians.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

Over the next few years IHS PCA levels should decrease. This is based on knowledge of the physicians' contract dates and management intent. If the recipients predicted to change to T38 PDP are converted then only 3 doctors will be left receiving PCA.

INDIAN HEALTH SERVICE
Summary of Reimbursements, Assessments, and Purchases
FY 2019 Estimate

Agreement Type		FY 2017 Estimate /1	FY 2018 Estimate	FY 2019 Estimate
	Reimbursement for Services Purchased within HHS			
SSF-PSC	Service & Supply Fund (SSF) - Program Support Center (PSC)	8,651,647	6,159,425	6,116,297
SSF-NonPSC	Office Business Management Transformation (OBMT)	42,800	42,800	42,800
SSF-NonPSC	Offices of Human Resources (OHR) - e.g. Enterprise Services, Operations	7,020,078	6,111,514	6,111,514
SSF-NonPSC	Office of Enterprise Application Development (OEAD) - OCIO	5,516,571	5,292,588	5,292,588
SSF-NonPSC	Information Technology Infrastructure & Operations (ITIO) - OCIO	2,492,480	3,695,716	3,695,716
SSF-NonPSC	Office of IT Strategy, Policy & Governance (OSPG) - OCIO	1,051,458	600,893	600,893
SSF-NonPSC	Office of Information Security (OIS) - OCIO	2,952,099	2,643,829	2,643,829
SSF-NonPSC	Equal Employment Opportunity Compliance & Operations (EEOCO)	419,307	613,623	613,623
SSF-NonPSC	Office Security & Strategic Information (OSSI)	3,496,002	4,109,435	4,109,435
	Subtotal SSF Non-PSC	22,990,795	23,110,398	23,110,398
SSF-NonASA	Acquisition Integration Modernization (AIM)	239,399	239,000	239,000
SSF-NonASA	Category Management	231,355	231,000	231,000
SSF-NonASA	Commissioned Corps Force Management (CCFM)	7,802,000	8,157,000	8,098,000
SSF-NonASA	Departmental Contract Information System (DCIS)	482,167	429,000	429,000
SSF-NonASA	Departmental Ethics Program - OGC (moved from Joint Funding Agreement)	424,416	431,000	438,000
SSF-NonASA	Web Media (Formerly Web Communications)	3,725,735	5,478,000	5,478,000
SSF-NonASA	Web Crawler	152,546	19,000	19,000
SSF-NonASA	Freedom of Information Act (Request and Appeal)	11,358	16,000	16,000
SSF-NonASA	Grants.gov System	29,990	48,000	37,000
SSF-NonASA	Grants Solutions Center of Excellence-Support & System Services	452,414	434,000	439,000
SSF-NonASA	HHS Broadcast Studio (moved from Joint Funding Agreement)	14,908	35,000	35,000
SSF-NonASA	Consolidated Acquisition System (HCAS) Operations & Maintenance (O&M)	2,711,292	2,610,000	2,610,000
SSF-NonASA	Media Monitoring & Analysis (moved from Joint Funding Agreement)	47,633	84,000	84,000
SSF-NonASA	Office of General Counsel (OGC) Claims	292,488	190,000	193,000
SSF-NonASA	Office of Program Audit Coordination (Formerly Audit Resolution)	530,137	602,000	605,000
SSF-NonASA	Small Business Center (Formerly Small Business Consolidation)	785,640	819,000	819,000
SSF-NonASA	Strategic Planning System	29,000	26,000	26,000
SSF-NonASA	Tracking Accountability Government Grants System (TAGGS)	224,097	305,000	334,000
SSF-NonASA	Unified Financial Management System (UFMS) O&M / Pass-Thru	5,711,586	8,269,000	8,466,000
SSF-NonASA	UFMS (Governance)	1,128,783	1,173,000	1,211,000
SSF-NonASA	UFMS (CFRS, FBIS/OBIEE)	1,398,779	2,135,000	2,191,000
	Subtotal SSF Non-Assistant Secretary Administration (ASA)	26,425,723	31,730,000	31,998,000
	Subtotal - Purchased within HHS through SSF	**58,068,164**	**60,999,823**	**61,224,695**
	Joint Funding Agreement (JFA) Assessments			
JFA	Chief Financial Officer (CFO) Financial Statement Audit	652,613	652,613	652,613
JFA	DATA Act	416,662	416,662	416,662
JFA	Interdepartmental Council on Native American Affairs	80,000	80,000	80,000
JFA	Office of Global Health Affairs	20,000	20,000	20,000
JFA	President's Council on Study of Bioethics	11,400	22,800	22,800
JFA	Regional Health Administrators	308,010	308,010	308,010
	Subtotal - JFA Assessments	**1,488,685**	**1,500,085**	**1,500,085**
	Government-wide Administrative Functions (GAF)			
IAA	Federal Employment Services (USAJOBS)	88,254	88,254	88,254
IAA	Dept. of Homeland & Security (DHS) - HQ, Dallas & Seattle	154,398	154,398	154,398
IAA	General Services Administration (GSA) Fleet (Non-OPS)	6,677	6,677	6,677
IAA	GSA - HQ & Seattle FIT Loan	1,476,990	1,476,990	1,476,990
IAA	GSA - HQ, Dallas & Seattle Rent	4,870,931	4,870,931	4,870,931
IAA	HHS Federal Audit Clearinghouse (FAC)	3,490	3,490	3,490
IAA	National Archives & Records Admin (NARA)	15,000	15,000	15,000
IAA	National Institute of Health - Health Services Research Library	619,171	619,171	619,171
IAA	Office of General Counsel (OGC) - Legal Services	1,519,059	1,519,059	1,550,364
IAA	Office of Personnel Management (OPM) - Credit Monitoring	132,251	132,251	132,251
IAA	Office of Personnel Management (OPM) - Investigations	665,444	665,444	665,444
IAA	Radio Frequency Spectrum	154,102	154,102	154,102
IAA	Unified Communications (UC) Services	321,600	321,600	321,600
	Subtotal - GAF Interagency Agreements (IAA)	**10,027,367**	**10,027,367**	**10,058,672**
	Grand Total	69,584,216	72,527,275	72,783,452

/1 FY 2017 numbers are being confirmed as actual.

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INDIAN HEALTH SERVICE
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INDIAN HEALTH SERVICE
FY 2019 CONGRESSIONAL JUSTIFICATION
House Report 115-238
Significant Items

Indian Health Care Improvement Act - It has been over six years since the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), yet many of the provisions in the law remain unfunded. Tribes have specifically requested that priority areas for funding focus on diabetes treatment and prevention, behavioral health, and health professions. The Committee directs the Service to provide, no later than 90 days after enactment of this Act, a detailed plan with specific dollar amounts identified to fully fund and implement the IHCIA (p. 82).

Action taken or to be taken

IHS appreciates the Committee's interest in the Indian Health Care Improvement Act.
A comprehensive plan, including dollar amounts would require significantly more time than the 90 days allotted in the report, as well as dedicated resources (e.g., necessary funding for a health economist and a team of researchers).

Reimbursable Funding—The Committee directs the Service to report, within 180 days of enactment of this Act, on patient population and service growth over the past ten years and the funding sources used to provide for these medical services. The IHS is to include a breakdown, by dollar amount and percentage, of funding sources which supplement appropriated dollars to cover the provision of medical services at IHS operated and tribally contracted and compacted facilities. The Committee is interested in detailed information on whether medical services have been able to expand over this time period as a result of increases in the ability to charge medical services to supplementary funding sources. As a point of comparison, and to the extent possible, the Service shall compare these impacts across the twelve IHS areas, with the degree to which patient populations services in the respective states has increased (p. 82).

Action taken or to be taken

IHS appreciates the Committee's interest in this topic. IHS will be able to provide information on user population growth over the last 10 years and could provide information on third party collection for federal facilities. In addition, the IHS could provide information on the funding sources and comparisons for IHS operated facilities, however; Tribally contracted and compacted facilities are not required to provide information on funding sources. IHS can encourage tribally contracted and compacted facilities to report this information.

Health Care Facilities Construction - The recommendation includes $117,991,000 for health care facilities construction, $17,991,000 above the budget request and equal to the fiscal year 2017 enacted level. The Committee remains dedicated to providing access to health care for IHS patients across the system. The IHS is expected to aggressively work down the current Health Facilities Construction Priority System list, as well as work with the Department and Tribes to examine alternative financing arrangements and meritorious regional demonstration projects authorized under the Indian Health Care Improvement Act that that would effectively close the service gap. Within 60 days of enactment of this Act, the Service shall submit a spending plan to the Committees on Appropriations that details the project-level distribution of funds provided for healthcare facilities construction. The IHS has no defined benefit package and is not designed to

be comparable to the private sector health care system. IHS does not provide the same health services in each area. Health services provided to a community depend upon the facilities and services available in the local area, the facilities' financial and personnel resources (42 CFR 136.11 (c)), and the needs of the service population. In order to determine whether IHS patients across the system have comparable access to healthcare, the IHS is directed to conduct and publish a gap analysis of the locations and capacities of patient health facilities relative to the IHS user population. The analysis should include: facilities within the IHS system, including facilities on the Health Facilities Construction Priority System list and the Joint Venture Construction Program list; and where possible facilities within private or other Federal health systems for which arrangements with IHS exist, or should exist, to see IHS patients. (p. 83).

Action taken or to be taken

The House Bill for FY 2018 proposes $117,991,000, which is $17,991,000 above the President's Budget request. The additional funds would be used to continue two priority list projects. In addition, within 60 days of the appropriation, the Service shall submit a spending plan to the Committees on Appropriations with the project-level distribution for healthcare facilities construction. This analysis is similar to the "Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress" required every 5 years (last report was 2016). There is a technical workgroup working on the 2021 report. The analysis and report are a multi-year task. There are over 13,000 communities and almost 4,000 IHS, tribal and private facilities within the IHS data base to verify, analyze and compare. There is no due date for submission of the report in the House Report 115-238. The same language appeared in House Report 114-632 (2017 budget documents). The OEHE intends to incorporate as much of the analysis as possible into the 2021 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress.

INDIAN HEALTH SERVICE
FY 2019 CONGRESSIONAL JUSTIFICATION
Senate Report 115-000
Significant Items

Quality of Care—The Committee is extremely concerned about the lack of access to quality healthcare for Tribes around the Nation, including the ongoing healthcare quality problems in the Great Plains. In order to address these issues, the Committee recommendation includes a pilot program and related directives to improve access to quality health services and to improve recruitment and retention of qualified medical personnel as detailed below (p. 91):

Housing Improvements—In addition to funds provided for staffing quarters within the Facilities Appropriation, the administrative provisions section of the bill also contains new language allowing for a program to provide a housing subsidy to medical personnel at facilities operated by the Indian Health Service. The Committee is concerned that the lack of affordable and available housing plays a significant role in the agency's personnel vacancy rates and contributes to lowering the quality of care. The Committee expects the Service to provide a plan within 90 days of enactment of this Act that details how the agency plans to use this authority in fiscal year 2018, including the measures it will use to determine whether the authority is successful and how it should be expanded in future years. The Committee notes that it has restored funds for accreditation emergencies that could be made available for this purpose. The Committee also directs the Service to work with Tribes and with the Department of Housing and Urban Development to develop a long-term strategy to address professional housing shortages in Indian Country and to ensure that the Service and its partner agencies are fully utilizing existing authorities to improve the availability of housing stock (p. 92).

Action taken or to be taken

The IHS will work with the Department of Housing and Urban Development, Tribes and Tribal Housing Authorities to explore and develop strategies that expands the housing stock available to non-local, professional providers where there is currently a shortage. The IHS will provide a plan that details how the Agency plans to use this authority within 90 days of enactment of this Act.

Workforce Development—The Committee believes that expanded workforce development training for all Service personnel—including non-clinical personnel—must be part of efforts to improve healthcare quality. In addition to continuing skills development opportunities, the Committee believes that IHS should expand its efforts to provide education to all staff and Federal employee management training to facility and area leadership that will provide employees a better understanding of their obligations to report failures in quality of care (p. 92).

Action taken or to be taken

IHS has provided quality improvement and patient safety training to clinical and non-clinical staff through the Institute for Healthcare Improvement Open School in FY 2017, continuing into FY 2018. The Open School curriculum is recognized worldwide and has become a required curriculum element in some US medical schools. IHS has made this training available to staff who have not previously completed it via two methods: ambulatory health center staff can access the training through the IHS Improving Patient Care Program and hospital staff can access the training through the Partnership to Advance Tribal Health (PATH – the single Quality Improvement Organization for IHS, funded by CMS).

In FY 2018, IHS is completing implementation of the IHS 2016-2017 Quality Framework which includes development of a patient safety principles curriculum (anticipated to include training on obligations to report failures in quality of care, often termed either Near Misses or Adverse Events). All Quality and Safety efforts undertaken under the Quality Framework are inclusive of non-clinical staff as well as clinical staff. IHS acknowledges the importance of a holistic approach to quality and safety, development of high reliability processes, and a culture of safety that encourages reporting and analysis to manage and mitigate risk.

Title 38 Personnel Authorities—The Committee is aware of significant differences between the personnel authorities used by the Service versus the Department of Veterans Affairs under Title 38 of the United States Code. The Committee believes that an analysis of these differences—which include hiring and benefits authorities—may provide strategies for recruiting and retaining qualified personnel in the same rural and remote locations as the VA. The Committee directs the Service to work with the Department of Health and Human Services to analyze the differences between the two agencies' personnel authorities and to submit a report no later than 90 days after enactment of this Act that details the differences and makes specific legislative recommendations as appropriate to provide parity between the two agencies (p. 92).

Action taken or to be taken

The FY 2019 President's Budget proposes a legislative change to allow IHS full use of Title 38, Chapter 74, authorities so that there is parity between IHS and the VA when recruiting for medical providers. Full authority will help IHS recruit and retain qualified medical staff in the same rural and remote locations as the VA. Under current law, HHS and IHS may only use certain authorities under Title 38, Chapter 74, not all.

Indian Health Facilities – The Committee recommends $563,658,000 for health facilities operations of the Indian Health Service. This amount is $18,234,000 above the enacted level and $116,702,000 above the budget request. All proposed reductions have been restored. Increases above the enacted level include $5,963,000 for the staffing of new facilities; $1,782,000 for facilities maintenance and improvement; and $10,489,000 for healthcare facilities construction for the small ambulatory clinic program. Of the increase for healthcare facilities construction which is provided $5,000,000 is for the small ambulatory clinic program for a total amount of $10,000,000, and $5,489,000 is for quarters which is provided in addition to the $6,000,000 included in fiscal year 2017 to assist with housing shortages across the Service. The Committee expects the Service to continue following its existing interpretation of criteria for the funding of new, improved, or replacement sanitation facilities. The Committee believes that additional funds for quarters is essential to help resolve the widespread housing shortages which have contributed to high vacancy rates for medical personnel throughout the system, particularly in rural areas. These funds have been used in areas with chronic housing shortages like Alaska and the Great Plains in order to ameliorate these problems. The Committee expects a report from the Service within 60 days of enactment of this act on the distribution of funds. The Committee notes its strong support for the small ambulatory clinic program. As the Service testified before the Committee, this program provides another critical tool for addressing facilities maintenance and construction backlogs throughout the nation. The stipulations included in the ''Indian Health Services'' account regarding the allocation of funds for the staffing of new facilities pertain to the funds in this account as well. The Committee is pleased that the Service has followed congressional direction to work with Southeast Alaska Regional Health Consortium to formulate options for facilities upgrades and ultimately a replacement facility at Mt. Edgecombe in Sitka.

The Committee understands that discussions are ongoing and that the parties are hopeful that a path forward is possible for a new facility. Within 90 days of enactment of this act, the Service shall submit a report to the Committee on the status of these negotiations. (p. 93).

Action taken or to be taken

The proposed $5,000,000 for the Small Ambulatory Program (SAP) will be applied to the SAP ranked list of applicants established for the FY 2017 SAP funds. The additional funds for staff quarters will be applied in Areas that have the greatest need. The Sanitation Facilities Construction Program will continue following its existing interpretation of criteria for the funding of new, improved, or replacement sanitation facilities. Within 60 days of the appropriation, the Service shall submit a spending plan to the Committees on Appropriations with the project-level distribution for healthcare facilities construction including quarters projects. The planning report "Upgrades and Replacement Options for Mt. Edgecumbe Hospital Report to the Senate and House Committee on Appropriations" requested in Senate Report 114–281 and will be submitted to Congress within 90 days of the enactment of this act.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2017

Type of Facility	TOTAL	IHS Total	TRIBAL Total	TRIBAL Title I [a]	TRIBAL Title V [b]	TRIBAL Other [c]
Service Units	168	54	114			
Hospitals	48	26	22	2	20	0
Ambulatory	560	78	482	132	343	7
Health Centers	335	55	280	98	181	1
School Health Centers	8	2	6	0	6	0
Health Stations	83	21	62	29	33	0
Alaska Village Clinics	134	0	134	5	123	6

[a] Operated under P.L. 93-638, Self Determination Contracts
[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000
[c] Operated by a local government, not a tribe, for some Alaska Native villages through a standard procurement contract or also to denote certain Navajo Area contractors

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2016 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**15,351**	**23,925**	**39,276**
Alaska	*	11,045	11,045
Albuquerque	392	*	392
Bemidji	185	*	185
Billings	705	*	705
California	*	*	0
Great Plains	2,876	*	2,876
Nashville	*	867	867
Navajo	6,472	4,354	10,826
Oklahoma	1,183	6,917	8,100
Phoenix	3,538	388	3,926
Portland	*	*	0
Tucson	*	354	354

* No direct inpatient facilities in FY 2016

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**5,184,015**	**8,698,206**	**13,882,221**
Alaska	**	1,819,643	1,819,643
Albuquerque	489,129	132,639	621,768
Bemidji	279,227	737,566	1,016,793
Billings	447,521	168,541	616,062
California	**	614,579	614,579
Great Plains	946,400	129,300	1,075,700
Nashville	24,354	561,403	585,757
Navajo	1,120,713	858,836	1,979,549
Oklahoma	647,628	2,257,112	2,904,740
Phoenix	762,212	678,968	1,441,180
Portland	284,668	619,792	904,460
Tucson	182,163	119,827	301,990

** No IHS facilities in FY 2016

INDIAN HEALTH SERVICE
Immunization Expenditures[1]

	FY 2015 Estimate	FY 2016 Estimate	FY 2017 Estimate	FY 2018 Estimate	FY 2019 Estimate	Increase or Decrease
Infants, <2 yrs	$18,793,408	$30,855,296	$18,234,078	$18,370,977	$17,637,372	-$733,605
Adolescents, 13-17 yrs	$11,704,995	$11,551,407	$14,184,614	$14,416,586	$14,539,873	+$123,287
HPV vaccine, Female 19-26 yrs	$7,389,130	$2,654,568	$7,116,136	$3,365,850	$1,888,480	-$1,477,370
HPV Vaccine, Males 19-21 yrs	$6,799,171	$3,136,902	$5,339,282	$3,617,239	$3,007,340	-$609,899
Tdap, 19+ yrs	$6,977,397	$1,399,293	$4,369,742	$4,986,405	$5,642,763	+$656,358
Hepatitis B for diabetics, 19-59 yrs	$4,595,452	$4,870,146	$5,400,839	$3,458,933	$5,001,855	+$1,542,922
Influenza, 19yrs+	$29,225,712	$29,542,047	$25,539,057	$25,865,678	$26,722,962	+$857,284
Zoster vaccine, 60yrs	$36,189	$558,050	$598,728	$634,156	$749,722	+$115,566
Pneumococcal (PPSV23), 65yrs+	$432,156	$179,359	$270,111	$826,614	$1,263,179	+$436,565
Pneumococcal (PCV13), 65yrs+		$4,410,552	$4,790,620	$5,105,479	$6,107,426	+$1,001,947
Monitoring	$118,078	$122,565	$127,100	$132,057	$137,207	+$5,150
TOTAL	$86,071,688	$89,280,185	$85,970,307	$80,780,034	$82,698,180	+1,918,146

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Because the cost of vaccines for infants and adolescents < 19 years of age is covered by the Vaccines for Children (VFC) program, only the costs for vaccine administration, which are not covered by the VFC program, are included for this age group. Vaccine administration fees were based on an average of the CMS Maximum Regional Charges for vaccine administration, multiplied by the number of doses of vaccine routinely recommended for each age group (e.g., 25 doses for children < 2 yrs; 6 doses of vaccine for adolescents).

In order to incorporate the vaccine provisions included in Obamacare, all routinely recommended adult vaccines were added to the IHS Core Formulary in September 2011. Costs for the purchase and administration of these adult vaccines are included in the estimated costs in subsequent years. In prior years, costs were only included for adults 65+ yrs and for influenza vaccine. In August 2014, the Advisory Committee on Immunization Practices (ACIP) for the first time recommended routine use of 13-valent pneumococcal conjugate vaccine (PCV13) among adults aged ≥65 years; the projected costs for incorporating this additional vaccine are included starting with the FY 2016 expenditures. The assumptions for all calculations are included in the table below.

[1] The immunization estimates do not include the Hepatitis B and Haemophilus Immunization (AK) program; estimates for these immunizations are included under the Immunization Alaska budget.

Costs for monitoring of immunization coverage were also included, and represent a 3.9 percent increase over the FY 2018 estimate.

- FY 2015 Estimated Costs = FY 2014 cost plus 3.1 percent
- FY 2016 Estimated Costs = FY 2015 cost plus 3.8 percent
- FY 2017 Estimated Costs = FY 2016 cost plus 3.7 percent
- FY 2018 Estimated Costs = FY 2017 cost plus 3.9 percent
- FY 2019 Estimated Costs = FY 2018 cost plus 3.9 percent

For FY 2019, $82,560,973 is estimated for vaccine costs, and $137,207 for immunization monitoring costs, for a total of $82,698,180 estimated for all immunization expenditures. This represents a $1,918,146 increase over FY 2018 attributable to changes in vaccine costs, redistribution in population age categories, and progress towards vaccination coverage goals aligned with Healthy People 2020 goals (i.e., as progress is made, there are fewer individuals still needing vaccination and thus reduced forecasted costs). Calculations for the costs included as part of the FY 2019 estimated immunization costs were based on the assumptions outlined in the table below:

	Estimated User Pop (FY 2018)	Coverage Goal†	Current Coverage*	No. to be vaccinated	Vaccine costs (per dose)**	Admin fee (per dose)§	No. of doses per patient	Total Immun expenditures per patient	Total
Infants, <2 yrs	40,583	80%	NA	32,466	$0.00	$21.73	25	$543.25	$17,637,372
Adolescents, 13-17 years	139,399	80%	NA	111,519	$0.00	$21.73	6	$130.38	$14,539,873
HPV Females, 19-26 yrs	114,080	60%	56%	4,563	$116.22	$21.73	3	$413.85	$1,888,480
HPV Males, 19-21 yrs	38,246	60%	41%	7,267	$116.22	$21.73	3	$413.85	$3,007,340
Tdap, 19+ yrs	1,112,993	90%	79%	122,429	$24.36	$21.73	1	$46.09	$5,642,763
Hepatitis B for diabetics, 19-59 yrs	124,573	60%	32%	34,880	$26.07	$21.73	3	$143.40	$5,001,855
Influenza, 19+ yrs	1,112,993	70%	NA	779,095	$12.57	$21.73	1	$34.30	$26,722,962
Zoster, 60 yrs[α]	16,031	30%	NA	4,809	$134.16	$21.73	1	$155.89	$749,722
Pneumococcal (PPSV23) 65yrs+	151,395	90%	78%	18,167	$47.80	$21.73	1	$69.53	$1,263,179
Pneumococcal (PCV13) 65yrs+	151,395	30%	NA	45,419	$112.74	$21.73	1	$134.47	$6,107,426
Vaccine Costs									$82,560,973
Monitoring									$137,207
Total Costs									$82,698,180

† Based on Healthy People 2020, where applicable
*Coverage estimates based on most current coverage levels reported by IHS (FY 2017 Quarter 4). HPV estimate is 3 dose coverage. https://www.ihs.gov/epi/vaccine/reports/
**Cost per dose determined from the CDC Adult Vaccine Price List dated December 1, 2017. Lowest published price is generally used where multiple products or formulations are available. https://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/index.html
§Based on an average of the state CMS Maximum Regional Charges for Vaccine administration.
αACIP recently (October 2017) preferentially recommended use of a newly approved Zoster vaccine for adults 50 years and older and requiring two doses versus one dose for the currently available vaccine. IHS will likely implement this new recommendation sometime during FY 2018 – FY 2019, increasing Zoster vaccination costs due to an expanded target population and requirement for a second dose. Estimated costs for use of the new vaccine are not included here, as vaccine availability and pricing are not known at the time of writing.

Overall, the estimated costs for these immunizations are affected by:

1. Individuals outside these target groups are regular recipients of immunizations (e.g., immunization for health care workers and those at specific risk for other vaccine-preventable diseases), however, there is not a methodology to estimate the size of these groups.
2. The CMS Maximum Regional Charges for Vaccine administration was used to estimate indirect costs because there is no specific methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations system-wide, or operation of the overall immunization program.

FISCAL YEAR 2019 DHHS LEGISLATIVE PROPOSAL

Indian Health Service

Meet Loan Repayment/Scholarship Service Obligations on a Half-Time Basis

Proposal: Permit both IHS scholarship and loan repayment recipients to fulfill service obligations through half-time clinical practice, under authority similar to that now available to the National Health Service Corps (NHSC) Loan Repayment Program (LRP) and Scholarship Program. Authority similar to Section 331(i) of the Public Health Service Act would allow IHS loan repayment and scholarship recipients more options and flexibility to satisfy their service obligations through part-time clinical work (20 hours or less per week) for double the amount of service time (e.g., clinician who works 20 hours a week performing clinical duties with a two-year service obligation would increase to a four-year service obligation) or accept half the amount of loan repayment award in exchange for a two-year service obligation. This would provide parity with the National Health Service Corp (NHSC) Programs. This proposal meets the following Secretary's priorities for reforms and reinvestments: Reducing burdens on our partners, providing flexibilities to our partners, and expanding opportunities for individuals and families.

Current Law: Sections 104 and 108 of the Indian Health Care Improvement Act require employees who receive IHS scholarships or loan repayments to provide clinical services on a full-time basis. Section 331(i) of the Public Health Service Act was amended by § 10501(n) of the Affordable Care Act to permit certain NHSC loan repayment and scholarship recipients to satisfy their service obligations through half-time clinical practice for double the amount of time or, for NHSC loan repayment recipients, to accept half the loan repayment award amount in exchange for a two-year service obligation.

Section 331(j) of the PHS Act (42 USC 254d(j)) defines "full-time" clinical practice as a minimum of 40 hours per week, for a minimum of 45 weeks per year. It also defines "half-time" as a minimum of 20 hours per week (not to exceed 39 hours per week), for a minimum of 45 weeks per year.

Rationale: The IHS, as a rural healthcare provider, has difficulty recruiting and retaining healthcare professionals. This has been especially significant with the recruitment of physicians and other primary care clinicians. While IHS has not specifically tracked the number of part-time employment applicants, we believe that having the options and flexibility to permit IHS scholarship and loan repayment health professional employees to fulfill their service obligations through part-time clinical work for double the amount of time and to offer half the loan repayment award amount in exchange for a two-year service obligation could increase the number of providers interested in serving in the Indian health system. Additional half-time direct care employees could also reduce the number and cost of Purchased/Referred Care program referrals, especially at sites that do not need full-time specialty care services. There are also a number of smaller rural IHS sites where clinicians will be able to provide a minimum of half time clinical services with the remainder of their time devoted to much needed administrative/management responsibilities. This proposal will provide flexibility for providers who might not otherwise consider service in IHS by allowing part-time practice in IHS to coincide with a part-time private practice, as well as part-time practice in IHS combined with part-time administrative duties within IHS.

The NHSC was authorized to establish a demonstration project permitting loan repayment recipients to meet their service obligations through less than full-time clinical service in response to requests from clinicians and sites. The Affordable Care Act replaced this demonstration with permanent authority for two specific kinds of

NHSC options (described above under Current Law). The IHS is equally concerned with the requests from clinicians and prospective candidates for loan repayment awards for half-time service by clinicians. Having similar authority as the NHSC would increase the ability for the IHS to recruit and retain healthcare clinicians to provide primary healthcare and specialty services (e.g., Surgery, OB/GYN, Psychiatry, Radiology, and Anesthesiology) and otherwise support the IHS and HHS Priorities.

The ability to provide scholarship and loan repayment awards for half-time clinical service would make these recruitment and retention tools more flexible and cost-effective, providing incentives for an additional pool of clinicians and other medical providers that otherwise may not consider a commitment to the IHS federal, Tribal and Urban Indian sites. Having similar authority as the NHSC would increase the ability for the IHS to recruit and retain healthcare clinicians to provide primary healthcare and specialty services and otherwise support the IHS and HHS priorities.

Budget Impact: Direct hire medical staff costs are lower than the costs to hire temporary, contractor staff.

Personnel Requirements: None.

Effective Date: Upon Enactment.

FISCAL YEAR 2019 LEGISLATIVE PROPOSAL
Indian Health Service

Provide the Indian Health Service Discretionary Use of all Title 38 Personnel Authorities.

Proposal: The Indian Health Service (IHS) is seeking the discretionary use of all United States Code Title 38 authorities under Part V, Chapter 74, "Veterans Health Administration – Personnel", that are primarily available to the Department of Veterans Affairs (VA) in relation to health care positions. The term "health care occupations" refers to positions, other than positions in the Senior Executive Service, that provide direct patient-care services or services incident to direct patient-care which would normally be covered by Title 5 of the United States Code.

Current Law: Title 38 Part V, Chapter 74, governs all aspects of personnel administration for the VA unless expressly overridden by another law or regulation. In many areas of personnel administration, the VA is exempt from Title 5 laws and regulations by virtue of Title 38. The U.S. Office of Personnel Management (OPM), under the authority of sections 1104 and 5371 of Title 5 of the United States Code, has authorized the Department of Health and Human Services (HHS) to use the Title 38 provisions pertaining to pay rates and systems, premium pay, classification, and hours of work. This delegation of authority is described in a delegation of agreement between OPM and HHS – the latest version of which was effective July 1, 2014. If HHS, or a HHS Operating Division under the delegation of authority, chooses to use a Title 38 provision, the comparable authority under Title 5 is waived. However, 5 U.S.C. § 5371 does not provide authority to apply all personnel provisions of Title 38 in lieu of comparable Title 5 provisions.

Rationale: The IHS, as a primarily rural healthcare provider, has difficulty recruiting health care professionals. The IHS has critical hiring needs for health care professionals in IHS, Tribal and Urban Indian programs including, but not limited to, physicians, dentists, nurses, pharmacists, physician assistants, and nurse practitioners. The ability to use Title 38 for pay purposes as discussed above is beneficial because the IHS can offer market pay to physicians and dentists, and special salary rates to individuals in other health care occupations. However, the IHS's use of these compensation authorities is not adequate by itself to compete with other public sector agencies and private sector organizations.

Typically, the private sector and VA can offer candidates better scheduling options and annual leave accrual. The IHS faces specific private and public sector competition in the area of annual leave accrual. Many private organizations offer more lucrative leave for doctors and nurses – even those new to the profession. In addition, the VA provides 8 hours of annual leave accrual per biweekly pay period to all new nurses, doctors, dentists, podiatrists, optometrists, and chiropractors – regardless of their years of experience. Due to the limited scope of 5 U.S.C. § 5371, the IHS does not have this authority as it is covered by 38 U.S.C. § 7421, "Personnel administration: in general". Thus, when a candidate with just a few years of experience is choosing between the IHS and the VA, he or she will invariably choose the organization offering 8 hours of annual leave accrual per pay period, as opposed to 4 or 6 hours of annual leave accrual per pay period. Supervisors report anecdotally that the IHS has lost many candidates due to this difference in accrual rates.

In addition to pursuing 8 hours of annual leave for nurses, doctors, dentists, podiatrists, optometrists, and chiropractors, the IHS is seeking access to other Title 38 authorities to increase its ability to compete with both the public and private sector and to create the best possible human resources program. This would include the potential for hiring non-citizens and instituting two year probationary periods for staff appointed under Title 38.

If the IHS is authorized to offer more competitive leave packages and to hire non-citizens through the discretionary use of all Title 38 authorities under Part V, Chapter 74, recruitment and retention rates will increase while vacancy rates and turnover will decrease. This would bring about a signficant positive impact to the IHS health care system and subsequently to IHS beneficiaries. With additional staff and fewer staffing gaps, the IHS could provide additional services to Native American and Alaska Natives. In addition, current services could be provided more efficiently and effectively; thereby positively impacting both individual and community health.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Personnel Requirements: None

Effective Date: Upon enactment.

FISCAL YEAR 2019 DHHS LEGISLATIVE PROPOSAL
Indian Health Service

Provide Tax Exemption for IHS Health Professions Scholarship and Loan Repayment Programs

Proposal: IHS is seeking tax treatment, similar to the treatment provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships, to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Services Health Professions Scholarships to be excluded from gross income under Section 117(c)(2) of the Internal Revenue Code (IRC) and to allow participants in the IHS Loan Repayment Program to exclude from gross income payments made by the IHS Loan Repayment program under Section 108(f)(4) of the IRC. In addition, IHS is seeking exemption from any Federal Employment Tax (FICA), making the IHS programs comparable to the current NHSC status. *This proposal meets the following Secretary's priorities for reforms and reinvestments: Reducing burdens on our partners, providing flexibilities to our partners, and expanding opportunities for individuals and families.*

Current Law: Generally, benefits awarded in the form of scholarship awards and loan repayments are regarded as federal taxable income by the IRS under Title 25 of the Internal Revenue Code. However, three federal laws currently provide for the non-taxability of federal scholarship awards and loan repayment programs:

- Section 413 of P.L. 107-16, the Economic Growth and Tax Relief Reconciliation Act of 2001 provides that tuition, fee, and other related cost payments by the National Health Service Corps and F. Edward Hebert Armed Forces Health Professions Scholarships and Financial Assistance Program scholarships are not taxable. This tax exemption was made permanent by Congress in December 2012 but did not include IHS scholarships.

- 26 USC 108(f)(4) provides that funds received through the National Health Service Corps Loan Repayment Program authorized under 338B(g) of the Public Health Service Act or a state loan repayment program described in section 338I of the Public Health Service Act are permanently not subject to federal income tax.

- 26 USC 3401(a)(19) excludes NHSC loan repayment from federal employment tax.

As IHS programs are not included in the exceptions, IHS health professions scholarships and loan repayment awards are taxed under the IRC.

Rationale**:** The IHS, as a rural healthcare provider, has difficulty recruiting healthcare professionals. There are over 1,484 vacancies for healthcare professionals including: physicians, dentists, nurses, pharmacists, physician assistants, and nurse practitioners. The IHS Health Professions Scholarship Program and the Loan Repayment Program play a significant role in the recruitment and retention of the healthcare professionals needed to fill these vacancies.

The IHS Health Professions Scholarship and IHS Loan Repayment Program are very similar to other programs that receive preferred tax treatment, and should therefore receive similar tax treatment. Currently, benefits awarded through IHS in the form of loan repayment and scholarships are regarded as federal taxable income to the recipient; however, the same benefits offered under the NHSC are not taxable. This disparate tax treatment of IHS-funded scholarship and loan repayment awards increases the overall tax bracket for the participants and creates a financial disincentive for those otherwise willing

to serve American Indian and Alaska Native patients by working in Indian health facilities.

The ability to exempt scholarship and loan repayment funds from gross income would make this recruitment and retention tool more attractive to potential participants. Thus, the IHS would be better able to increase the number of healthcare providers entering and remaining within the IHS to provide primary healthcare and specialty services.

Budget Impact: To Department of Treasury

Federal Tax Revenue Foregone (in 2016 dollars):

Loan Repayment	$8,118,113
Scholarship	$267,222
Total	$8,385,335

Budget impact is the amount of tax revenue withheld from IHS Health Professions Scholarship and Loan Repayment and forwarded to the Internal Revenue Service. This also includes the tax liability owed by the scholarships recipients.

Personnel Requirements: No new or additional FTEs required

Effective Date: Upon enactment.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2019 Performance Budget Submission to Congress

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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. Today, over $2.7 billion of the Agency's appropriation is transferred to Tribes and Tribal Organizations through Title I contracts and Title V compacts. Under Title I, there are 230 Tribes and Tribal Organizations operating 251 contracts and annual funding agreements which comprise approximately $804.8 million. Under Title V, IHS is party to 94 compacts and 120 funding agreements; through which approximately $1.9 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-three percent of federally recognized Tribes participate in Title V.

Indian Health Service
Self-Governance Funded Compacts FY 2017
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALASKA	**409,322**	**46,676**	**50,940**	**170,350**	**677,288**
Alaska Native Tribal Health Consortium	29,784	22,066	11,261	21,101	84,211
Aleutian Pribilof Islands Association, Inc.	1,582	22	142	1,109	2,855
Arctic Slope Native Association, Ltd	22,852	2,287	3,181	6,747	35,067
Bristol Bay Area Health Corporation	20,818	990	2,138	9,450	33,396
Chickaloon Native Village	58	1	15	14	86
Chugachmiut	3,679	27	217	1,813	5,735
Copper River Native Association	5,504	397	469	2,064	8,434
Council of Athabascan Tribal Governments	1,777	131	96	1,288	3,292
Eastern Aleutian Tribes, Inc.	3,090	25	172	1,819	5,105
Kenaitze Indian Tribe, I.R.A.	11,719	1,088	383	4,307	17,497
Ketchikan Indian Community	5,055	167	531	3,318	9,071
Knik Tribal Council	72	1	10	11	93
Kodiak Area Native Association	6,832	127	440	2,577	9,977
Maniilaq Association	27,850	1,032	2,729	14,503	46,115
Metlakatla Indian Community	6,169	952	460	1,351	8,932
Mount Sanford Tribal Consortium	784	1	79	247	1,111
Native Village of Eklutna	176	1	6	43	226
Native Village of Eyak	779	24	85	238	1,126
Norton Sound Health Corporation	42,392	3,967	4,197	12,601	63,157
Seldovia Village Tribe	1,821	57	84	413	2,375
Southcentral Foundation	74,846	5,126	9,705	31,959	121,636
SouthEast Alaska Regional Health Consortium	35,607	1,790	3,452	16,610	57,460
Tanana Chiefs Conference	59,299	4,109	5,484	15,412	84,303
Yakutat Tlingit Tribe	309	2	30	132	474
Yukon-Kuskokwim Health Corporation	46,469	2,285	5,573	21,224	75,552
ALABAMA	**4,013**	**173**	**147**	**525**	**4,857**
Poarch Band of Creek Indians	4,013	173	147	525	4,857
ARIZONA	**133,850**	**13,044**	**8,494**	**34,746**	**190,135**
Gila River Indian Community	36,347	5,503	1,711	11,858	55,419
Salt River Pima-Maricopa Indian Community	91	0	1,485	49	1,626
Tohono O'Odham Nation	33,747	3,285	2,347	5,846	45,226
Tuba City Regional Health Care Corporation	41,107	3,219	2,149	9,641	56,116
Winslow Indian Health Care Center, Inc.	22,557	1,038	803	7,351	31,748
CALIFORNIA	**75,695**	**2,502**	**3,546**	**31,108**	**112,852**
Chapa-De Indian Health Program, Inc.	6,681	186	173	3,509	10,549
Consolidated Tribal Health Project, Inc.	3,863	95	99	1,428	5,485
Feather River Tribal Health, Inc.	5,899	209	158	1,685	7,950
Hoopa Valley Tribe	5,475	141	254	2,293	8,163
Indian Health Council, Inc.	8,874	286	268	3,530	12,957
Karuk Tribe of California	3,073	95	89	1,516	4,772
Northern Valley Indian Health, Inc.	4,252	215	108	1,179	5,754
Redding Rancheria Tribe	6,788	230	555	3,458	11,031
Riverside-San Bernardino County Indian Health,	21,970	703	839	9,024	32,536
Santa Ynez Band of Chumash Mission Indians	1,683	88	33	470	2,274
Southern Indian Health Council, Inc.	5,440	216	817	2,346	8,819
Susanville Indian Rancheria	1,698	39	153	671	2,562
CONNECTICUT	**2,435**	**88**	**0**	**504**	**3,027**
Mohegan Tribe of Indians of Connecticut	2,435	88	0	504	3,027
FLORIDA	**10,491**	**582**	**940**	**1,574**	**13,587**
Seminole Tribe of Florida	10,491	582	940	1,574	13,587
IDAHO	**15,729**	**745**	**1,797**	**5,245**	**23,516**
Coeur D'Alene Tribe	6,185	289	1,325	3,244	11,043
Kootenai Tribe of Idaho	639	29	72	134	874
Nez Perce Tribe	8,904	427	401	1,867	11,598
KANSAS	**2,593**	**119**	**20**	**1,089**	**3,821**
Prairie Band Potawatomi Nation	2,593	119	20	1,089	3,821
LOUISANA	**1,188**	**112**	**120**	**217**	**1,637**
Chitimacha Tribe of Louisiana	1,188	112	120	217	1,637
MASSACHUSETTS	**701**	**32**	**212**	**321**	**1,265**
Wampanoag Tribe of Gay Head	701	32	212	321	1,265

Indian Health Service
Self-Governance Funded Compacts FY 2017
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
MAINE	**3,363**	**85**	**164**	**845**	**4,458**
Penobscot Indian Nation	3,363	85	164	845	4,458
MICHIGAN	**25,630**	**830**	**2,014**	**2,116**	**30,590**
Grand Traverse Band of Ottawa and Chippewa In	3,009	198	290	492	3,989
Keweenaw Bay Indian Community	3,380	159	760	643	4,942
Little River Band of Ottawa Indians	2,059	65	234	316	2,674
Sault Ste. Marie Tribe of Chippewa Indians	17,181	409	729	666	18,985
MINNESOTA	**20,368**	**1,252**	**2,655**	**2,316**	**26,591**
Bois Forte Band of Chippewa Indians	2,649	90	376	765	3,880
Fond du Lac Band of Lake Superior Chippewa	11,791	678	1,144	766	14,379
Mille Lacs Band of Ojibwe	4,185	473	1,119	468	6,245
Shakopee Mdewakanton Sioux Community	1,743	11	16	318	2,087
MISSISSIPPI	**37,301**	**3,750**	**1,208**	**7,557**	**49,815**
Mississippi Band of Choctaw Indians	37,301	3,750	1,208	7,557	49,815
MONTANA	**30,718**	**1,511**	**1,843**	**5,375**	**39,447**
Chippewa Cree Tribe of the Rocky Boy's Reserva	10,316	576	1,052	2,378	14,322
Confederated Salish and Kootenai Tribes of the F	20,402	935	791	2,997	25,125
NORTH CAROLINA	**19,279**	**1,778**	**968**	**8,967**	**30,993**
Eastern Band of Cherokee Indians	19,279	1,778	968	8,967	30,993
NORTH DAKOTA	**10,738**	**503**	**1,532**	**1,402**	**14,175**
Spirit Lake Tribe	10,738	503	1,532	1,402	14,175
NEW MEXICO	**12,470**	**198**	**1,289**	**2,288**	**16,245**
Pueblo of Jemez	9,623	153	938	1,801	12,515
Pueblo of Sandia	1,942	41	146	231	2,360
Taos Pueblo	904	5	205	256	1,370
NEVADA	**28,293**	**1,137**	**3,278**	**6,286**	**38,994**
Duck Valley Shoshone-Paiute Tribes	6,963	414	749	1,665	9,792
Duckwater Shoshone Tribe	1,110	19	195	540	1,863
Ely Shoshone Tribe	1,316	16	61	343	1,736
Fort McDermitt Paiute and Shoshone Tribe	1,764	65	1,170	433	3,433
Las Vegas Paiute Tribe	3,412	58	116	367	3,953
Reno-Sparks Indian Colony	6,752	301	656	2,284	9,993
Washoe Tribe of Nevada and California	4,995	172	229	380	5,776
Yerington Paiute Tribe of Nevada	1,981	92	101	275	2,449
NEW YORK	**8,090**	**619**	**311**	**1,916**	**10,936**
St. Regis Mohawk Tribe	8,090	619	311	1,916	10,936
OKLAHOMA	**391,949**	**43,678**	**41,638**	**73,514**	**550,780**
Absentee Shawnee Tribe of Oklahoma	17,960	1,624	1,880	4,879	26,344
Cherokee Nation	128,276	11,906	13,364	14,418	167,963
Chickasaw Nation	82,681	15,129	9,849	19,029	126,689
Choctaw Nation of Oklahoma	73,611	10,309	8,079	20,518	112,516
Citizen Potawatomi Nation	13,833	868	1,756	4,629	21,087
Kaw Nation of Oklahoma	1,129	105	205	351	1,790
Kickapoo Tribe of Oklahoma	7,666	112	282	1,612	9,672
Modoc Tribe of Oklahoma	50	107	5	14	175
Muscogee Creek Nation	41,343	2,530	5,512	4,019	53,403
Northeastern Tribal Health System	7,493	56	149	901	8,599
Osage Nation	4,637	107	50	845	5,639
Ponca Tribe of Oklahoma	3,170	64	230	425	3,889
Quapaw Tribe of Oklahoma	155	0	28	83	267
Sac and Fox Nation of Oklahoma	7,539	75	161	1,077	8,852
Seminole Nation of Oklahoma	485	579	48	279	1,391
Wyandotte Nation	1,922	108	38	435	2,503
OREGON	**28,743**	**1,285**	**2,639**	**9,532**	**42,199**
Confederated Tribes of Grand Ronde	6,788	304	536	2,568	10,197
Confederated Tribes of Siletz Indians of Oregon	7,858	226	715	2,345	11,144
Confederated Tribes of the Coos, Lower Umpqua	1,803	59	280	527	2,667
Confederated Tribes of the Umatilla Reservation	6,688	431	703	2,130	9,952
Coquille Indian Tribe	2,037	89	222	1,392	3,740
Cow Creek Band of Umpqua Tribe of Indians	3,570	177	183	570	4,499
UTAH	**7,684**	**79**	**1,821**	**3,416**	**13,000**
Utah Navajo Health System, Inc.	7,684	79	1,821	3,416	13,000

Indian Health Service
Self-Governance Funded Compacts FY 2017
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
WASHINGTON	**55,101**	**2,534**	**2,685**	**17,491**	**77,810**
Cowlitz Indian Tribe	3,144	109	22	994	4,269
Jamestown S'Klallam Indian Tribe	1,281	54	88	476	1,899
Kalispel Tribe of Indians	1,088	49	21	63	1,220
Lower Elwha Klallam Tribe	1,868	92	104	402	2,466
Lummi Indian Nation	8,089	479	258	2,996	11,823
Makah Indian Tribe	3,921	234	291	774	5,221
Muckleshoot Tribe	7,282	240	201	2,922	10,644
Nisqually Indian Tribe	2,299	95	111	475	2,980
Port Gamble S'Klallam Tribe	2,642	143	136	1,339	4,261
Quinault Indian Nation	5,603	371	220	1,592	7,786
Shoalwater Bay Indian Tribe	1,777	40	281	933	3,031
Skokomish Indian Tribe	2,073	70	112	506	2,761
Squaxin Island Indian Tribe	2,749	191	198	1,143	4,281
Suquamish Tribe	1,699	26	148	656	2,528
Swinomish Indian Tribal Community	2,233	88	177	572	3,071
Tulalip Tribes of Washington	7,352	253	318	1,647	9,571
WISCONSIN	**27,359**	**932**	**1,863**	**2,401**	**32,555**
Forest County Potawatomi Community	1,998	71	708	466	3,244
Ho-Chunk Nation	3,499	207	395	389	4,490
Oneida Tribe of Indians of Wisconsin	18,743	479	300	852	20,374
Stockbridge-Munsee Community	3,120	175	459	694	4,447
Grand Total	**1,363,101**	**124,247**	**132,125**	**391,100**	**2,010,573**

Indian Health Service

FY 2017 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	433,548	13,551	8,899	50,940	170,350	677,288
ALBUQUERQUE	11,416	909	343	1,289	2,288	16,245
BEMIDJI	73,182	1,557	1,632	6,532	6,833	89,735
BILLINGS	29,449	1,832	948	1,843	5,375	39,447
CALIFORNIA	74,600	2,912	2,528	3,388	29,424	112,852
GREAT PLAINS	10,509	562	170	1,532	1,402	14,175
NASHVILLE	87,451	5,138	1,490	4,071	22,424	120,575
NAVAJO	71,325	2,672	1,687	4,772	20,409	100,865
OKLAHOMA	414,166	11,111	13,063	41,658	74,602	554,601
PHOENIX	68,103	1,741	1,528	6,474	18,193	96,039
PORTLAND	97,703	3,637	2,797	7,121	32,268	143,526
TUCSON	34,389	2,002	642	2,347	5,846	45,226
Total, IHS	**1,405,841**	**47,624**	**35,727**	**131,967**	**389,414**	**2,010,573**