DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year 2025

Indian Health Service

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

March 5, 2024

I present the Indian Health Service (IHS) Fiscal Year (FY) 2025 Congressional Justification. The FY 2025 President's Budget builds on the historic enactment of advance appropriations for the IHS, which is a step towards securing stable and predictable funding to improve the overall health status of American Indians and Alaska Natives, and ensuring that the disproportionate impacts experienced by tribal communities during government shutdowns and continuing resolutions are never repeated.

The FY 2025 budget proposes $8.2 billion in discretionary and mandatory funding for the IHS, an increase of $1.1 billion or 16 percent above the FY 2023 final funding level. This includes $8.0 billion in discretionary funding and $260 million in proposed mandatory funding for the Special Diabetes Program for Indians. The budget also proposes to make all funding for the IHS mandatory beginning in FY 2026. Under the proposed mandatory structure, IHS funding would grow automatically to address inflationary factors, key operational needs, and existing backlogs in both healthcare services and facilities infrastructure.

The bold action in the FY 2025 President's Budget demonstrates the Administration's continued commitment to work to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level and strengthen the Nation-to-Nation relationship. I am excited about what we will achieve together to improve the health and well-being of American Indians and Alaska Natives.

Roselyn Tso -S

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INDIAN HEALTH SERVICE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

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

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

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

United States Government and Indian Nations

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

Indian Health Service and Its Partnership with Tribes

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

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

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

Overview of Budget

The fiscal year (FY) 2025 Indian Health Service (IHS) budget encompasses the overall goals of: 1) ensuring comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian/Alaska Native (AI/AN) people; 2) promoting excellence and quality through innovation of the Indian health system into an optimally performing organization; and 3) strengthening the IHS program management and operations in carrying out the agency mission to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. The budget conveys the President's commitment to provide high-quality health care services for AI/ANs. The budget reflects the importance of providing health care, consistent with statutory authorities, to AI/ANs. In addition, the budget supports the HHS Secretary's priorities to advance health equity and address pressing public health issues such as HIV/Hepatitis C, the opioid epidemic, cancer, and maternal mortality.

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

The IHS meets the annual statutory requirement to consult with and solicit the participation of Tribes and tribal organizations in the development of the budget for IHS. Likewise, IHS confers with urban Indian organizations. The consultation and confer input informs the IHS budget formulation process. The core of the agency's formulation process consists of the priorities and recommendations developed in consultation with Tribes through this independent annual budget process led by the National Tribal Budget Formulation Workgroup[1]. IHS is strongly committed to this process, and it ensures that the IHS budget is relevant to the health needs and priorities of AI/ANs. 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 AI/AN population, so that they have the opportunity to reflect those priorities in the Department's budget requests.

Summary of Budget Submission

The FY 2025 President's Budget aims to address the longstanding underinvestment in IHS through a two-pronged approach. First, in FY 2025, the budget includes $8.2 billion for IHS, an increase of $1.1 billion or 16 percent above FY 2023 enacted. This includes $8.0 billion in discretionary funding and $260 million in proposed mandatory funding for the Special Diabetes Program for Indians.

The FY 2025 President's Budget builds upon the historic enactment of advance appropriations for the IHS by maintaining discretionary funding in FY 2025. This strategic move aims to ensure stable funding for AI/AN health, preventing disruptions during government shutdowns. Advance appropriations play a crucial role in securing stable funding, preventing the disproportionate impact of government shutdowns and continuing resolutions on tribal communities' during government shutdowns. While advance

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

appropriations have made significant progress in addressing budgetary uncertainty for Indian Country, additional funding growth beyond what can be accomplished with discretionary spending is necessary to fulfill federal commitments to Indian Country. Despite a substantial 68 percent growth in IHS funding in the last decade, significant additional funding is needed to address historical underinvestment and persistent health disparities in AI/AN communities.

The Administration remains committed to mandatory funding for IHS as the most suitable long-term solution and will continue, collaborating with tribes and Congress to move towards sustainable, mandatory funding. Until this solution is enacted, it is crucial for Congress to continue to prioritize advance appropriations for IHS through the discretionary appropriations process to avoid disruptions in healthcare services and critical facilities activities.

To this end, the budget shifts all IHS funding to mandatory beginning in FY 2026. Under this proposed structure, IHS funding would automatically grow to address inflation, operational needs, and existing backlogs in healthcare services and facilities infrastructure.

These steps underline the Administration's continued commitment to honoring the United States' treaty responsibility to tribal nations and strengthening the nation-to-nation relationship. Historical trauma and chronic underinvestment contribute significantly to health disparities in Indian Country, reflected in the 10.9 years' lower life expectancy for AI/ANs compared to the U.S. population[2]. Disproportionate rates of mortality from major health issues, worsened by the COVID-19 pandemic, highlight the urgent need for large-scale investments to improve AI/ANs' overall health status.

Mandatory funding is the most appropriate, long-term solution for adequate, stable, and predictable funding for the Indian health system. The challenges of an annual discretionary budget are well documented by the Government Accountability Office in their report "GAO-18-652, Indian Health Service: Considerations Related to Providing Advance Appropriation Authority"[3]. While advance appropriations address some challenges of annual discretionary budgets, does not provide the necessary adequacy and predictability in funding.

Mandatory funding for the IHS provides the opportunity for significant funding increases that could not be achieved under discretionary funding caps. Further, this mandatory funding proposal, along with included legislative proposals, would authorize and appropriate funding through FY 2034, ensuring predictability that would allow IHS, Tribal, and urban Indian health programs the opportunity for long-term and strategic planning.

The budget also exempts IHS from proposed law sequestration, which is the legislatively mandated process of budget control consisting of automatic, across-the-board spending reductions to enforce budget targets to limit federal spending[4]. Exempting the IHS budget from sequestration ensures funding for direct health care services to AI/ANs is not reduced, consistent with the treatment of other critical programs such as veterans' benefits and nutrition assistance programs. The mandatory budget proposal

[2] Centers for Disease Control and Prevention National Center for Health Statistics, Provisional Life Expectancy Estimates for 2021: https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf

[3] Government Accountability Office Report: https://www.gao.gov/products/gao-18-652

[4] Circular Number A-11. Preparation, Submission, and Execution of the Budget. https://www.whitehouse.gov/wp-content/uploads/2018/06/a11.pdf

also includes inflation factors to address the growing cost of providing direct health care services, including pay costs, medical and non-medical inflation, and population growth.

In addition to proposed investments to ensure IHS has adequate operational capacity, the budget also includes several legislative proposals that would provide IHS with critical new or expanded authorities to address operational challenges. Many of these proposals seek to enhance the agency's ability to recruit and retain healthcare providers, and provide parity with other federal agencies to increase IHS' competitiveness when hiring for key positions. The IHS, as a rural health care provider, experiences difficulty recruiting and retaining health care professionals. In particular, recruiting physicians and other primary care clinicians has been especially challenging. Staffing shortages are particularly prevalent in the behavioral and mental health fields, which has only exacerbated the concurrent substance use crisis and suicide crisis that tribes across the country are facing in their communities. Workforce challenges – and the impacts on care that come with them – are one of the top concerns raised to the Department by Tribes.

While this marks a historic step, the IHS recognizes the need for ongoing consultation with Tribes, urban Indian organizations, and partners in Congress to ensure correct budget structuring and implementation over the next 10 years.

FY 2025 President's Budget

In FY 2025, the budget includes $8.2 billion in total funding for the IHS, which includes $8.0 billion in discretionary funding, and $260 million in proposed mandatory funding for the Special Diabetes Program for Indians. This is an increase of $1.1 billion above the FY 2023 Enacted level.

Crosscutting changes from the FY 2023 Enacted level include:

- Current Services: +$345 million to offset the rising cost of providing direct health care services, including tribal and federal pay costs ($124 million), medical and non-medical inflation ($123 million), and population growth ($98 million). These resources will help the IHS to maintain services at the FY 2023 levels by shoring up base operating budgets of IHS, Tribal, and urban Indian health programs in the face of increasing costs.

  Staffing and Operating Costs for Newly-Constructed Health Care Facilities: +$153 million for staffing of newly-constructed health care facilities. These funds support the staffing packages for new or expanded facilities, which will expand the availability of direct health care services in areas where existing health care capacity is overextended. The request includes:

  - $91 million to fully-fund staffing and operating costs for four new or expanded facilities in FY 2025, all of which were constructed through the Joint Venture Construction Program; and

  - $61 million to fully-fund staffing costs of seven new or expanded facilities eligible for funds in FY 2024. This funding is requested due to timing, as the budget was developed before Congress completed action on a full year FY 2024 appropriations. Should Congress fully fund these staffing packages in FY 2024, the funding would become recurring, and the increases would not need to be provided again in FY 2025.

Indian Health Services account changes from the FY 2023 Enacted level include:

- Electronic Health Record: +$213 million to improve the quality of health care in Indian Country and health status of AI/ANs by modernizing the IHS Electronic Health Record (EHR) system.

- Addressing Targeted Public Health Challenges: +$20 million to make targeted investments in IHS as part of Administration initiatives to address our Nation's most pressing public health challenges, which disproportionately impact American Indian and Alaska Native communities. This includes HIV and Hepatitis C (+$10 million) and addressing opioid use (+$10 million).

- Assessments: +$4 million to offset the increasing costs of central assessments charged to the IHS by HHS. To address the growing costs of shared services at HHS, the IHS has delayed hiring and investments in critical systems, working to shield direct health care services to the maximum extent possible. However, the IHS is at a point where it can no longer sacrifice oversight and management of national health programs to absorb these rising costs.

- National Community Health Aide Program (CHAP): +$10 million to support the expansion of CHAP to the lower 48 states. These additional resources would support the further establishment of the evidence-based National CHAP, which will provide a network of health aides trained to support other health professionals while providing direct health care, health promotion, and disease prevention services.

- Direct Operations: +$6 million to support the efficient and effective administration and oversight of national and Area-level functions like financial management, human resources, grants management, acquisitions, performance management, compliance, and other administrative supports and systems.

- New Tribes: +$6 million to support new federally recognized Tribes.

Indian Health Facilities account changes from the FY 2023 Enacted level include:

- Facilities and Environmental Health Support: +$227 thousand for Facilities and Environment Health Support to support administrative costs.

Contract Support Costs and Section 105*(l)* Lease Agreements: The budget includes an indefinite discretionary appropriation for Contract Support Costs and Section 105*(l)* lease agreements with estimated funding levels of $979 million for Contract Support Costs (+$10 million above the FY 2023 Enacted level) and $349 million for Section 105*(l)* Lease Agreements (+$238 million above the FY 2023 Enacted level). The budget also includes appropriations language to allow IHS to use not more than $10 million for management and oversight activities in each of the CSC and Section 105(l) indefinite discretionary appropriations.

Special Diabetes Program for Indians: The budget includes $260 million in mandatory funding for the Special Diabetes Program for Indians (SDPI), and proposes to exempt the program from mandatory sequester. This is a +$113 million increase above FY 2023 Enacted post-sequestration for this evidence-based successful program. The budget includes a legislative proposal to reauthorize the SDPI for three-

years, and increase funding to $250 million in FY 2024, $260 million in FY 2025, and $270 million in FY 2026.

FY 2026 - FY 2034 President's Budget

The budget proposes full mandatory funding for IHS from FY 2026 to FY 2034, and exempts IHS funding from sequestration. Funding would grow automatically to address a number of factors, described below. This mandatory formula culminates in a total funding level of approximately $42.0 billion in FY 2034. When compared with the FY 2023 Enacted level of $7.0 billion, the FY 2034 proposed funding level represents an increase of +$35.0 billion, or approximately 500 percent. When accounting for the discretionary baseline, the net-total for FY 2034 is $32.2 billion

In total, the mandatory budget would provide $288.9 billion for the IHS over ten-years. When accounting for the discretionary baseline, the net-total for the proposal is $208.5 billion over ten-years.
Funding would automatically grow to account for the following factors:

- Inflationary factors including Consumer Price Index for All Consumers medical and non-medical inflation, population growth, and pay cost growth.
- Staffing increases for newly constructed or expanded health care facilities.
- Funding for new federally recognized tribes.
- Increased funding to address the Level of Need Gap documented by the 2018 Indian Health Care Improvement Fund workgroup. The budget would continue growth for direct services once the 2018 gap is addressed.
- Recurring funding for long-COVID treatment, to sustain investments made in the American Rescue Plan Act for behavioral health and public health workforce activities, and to support the Biden Cancer Moonshot.
- Increases in funding from FY 2026 to FY 2030 to address the remaining projects on the 1993 Health Care Facilities Construction Priority List. Funding will continue to increase each year beginning in FY 2031 to begin addressing the full scope of Facilities needs as identified in the most recent IHS Facilities Needs Assessment Report to Congress.[5]
- Increases in funding for Sanitation Facilities Construction starting in FY 2027 to account for the significant resources appropriated for this program in the Infrastructure Investment and Jobs Act (IIJA). FY 2027 is the first year IHS will not receive IIJA resources for this purpose.
- Funding increases in FY 2026 and FY 2027 for Maintenance and Improvement and Medical Equipment to address current backlogs. Once the backlogs are addressed, the budget ensures sufficient funding is maintained for ongoing maintenance and equipment needs.

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

- Increases in funding for Facilities and Environmental Health Support proportional to growth in the other IHS facilities programs to ensure adequate staffing and operational capacity to carry out proposed facilities funding increases.

- A new dedicated funding stream to address public health capacity and infrastructure needs in Indian Country. This funding will support an innovative hub-and-spoke model to address local public health needs in partnership with tribes and urban Indian organizations. Establishing a new program to build public health capacity is a key lesson learned from theCOVID-19 pandemic, and a top recommendation shared by tribal leaders in consultation with HHS.

- Funding for Direct Operations to ensure IHS has adequate administrative capacity to implement and oversee significant proposed funding increases.

Overview of Agency Performance

The IHS provides health care services to American Indians and Alaska Natives (AI/ANs) with the mission to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. Health care services are delivered through a network of hospitals, clinics, and health stations on or near reservations and are managed by IHS, tribal, and urban (I/T/U) Indian health programs. In FY 2023, IHS and Tribal facilities provided 43,036 inpatient admissions and 14,365,764 outpatient medical care visits. The health care system also provides dental services, nutrition services, pharmacy services, community health, sanitation facilities (water supply and waste disposal), injury prevention, and facilities management services. Additionally, for eligible patients, the purchased/referred care (PRC) program may purchase needed services through private health care providers in cases where an IHS or tribal facility does not exist or does not provide the required care.

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

In January 2023, IHS leadership announced implementation of an Agency Work Plan, outlining critical actions the IHS needs to take to address risk priorities. The Agency Work Plan reports on milestones and progress toward the agency's strategic goals of delivering high-quality care, unveiling new facilities, improving systems, and strengthening critical partnerships. The Agency Work Plan First Quarter FY 2024 Performance Report is available on the IHS web page and a few of the FY 2023 accomplishments are highlighted below according to the IHS strategic goals.

The FY 2025 IHS budget measures reflect a range of services and activities across the Indian health care system and, for clinical measures, Tribes have the option to participate in reporting. Recent and planned FY 2025 accomplishments are reported in the budget narratives and highlighted below the following IHS strategic goals:

Goal: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people.

- *Credentialing and Privileging* - Implemented a nationwide electronic provider credentialing system that modernizes provider credentialing and privileging within federally-operated hospitals and clinics.
- *Improving Personnel Background Investigations* - IHS implemented an electronic security manager system to track personnel background investigations. In CY 2023, 5,373 cases pending for more than 90 days have successfully been reduced to zero.
- *Monitoring clinical measures* – In FY 2025, IHS will continue to monitor clinical measures and report aggregated I/T/U results for dental, diabetes, immunizations, prevention, and behavioral health measures from the Integrated Data Collection System Data Mart (IDCS DM).
- *Sanitation Facilities* – In FY 2023, sanitation facilities projects provided service to 39,980 AI/AN homes.

Goal: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.

- *Standardization* - Standardized governing board bylaws across all direct service facilities to provide for oversight and accountability while increasing efficiency and effectiveness of governing board meetings.

- *Compliance* – In FY 2023, IHS established a National Compliance Program that serves as the focal point for coordinating and promoting agency-wide compliance activities.
- *Sharing of Best Practices* – Public health nurses (PHNs) provide critical preventive health services and routinely share culturally appropriate care and best practices across the health care system.

Goal: To strengthen IHS program management and operations.
- *Electronic Health Record (EHR) Modernization* – In FY 2025, the IHS will continue EHR system modernization efforts that will ultimately replace IHS's current medical, health, and billing records systems.
- *PRC Delivery Area Expansion* - Developed a PRC delivery area expansion workflow map and identified opportunities for a goal to reduce cycle time for review of requests from 23 months to nine months.
- *Tribal Consultation and Urban Confer* – Developed an operational plan that is updated annually through tribal consultation and urban confer to ensure that performance measures include appropriate measurable targets in the new IHS and Veterans Affairs Memorandum of Understanding.

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

Performance Reporting

This budget request includes Government Performance and Results Act (GPRA) and GPRA Modernization Act (GPRAMA) measures that support the IHS mission, see the IHS Outcomes and Outputs Table in the budget narratives. The IHS also reports the following four measures in the FY 2025 HHS Annual Performance Plan and Report: the total number of public health activities captured by the PHN data system; influenza vaccination rates among adult AI/AN patients 18 years and older; intimate partner (domestic) violence screening among AI/AN females; and number of Tribal Epidemiology Center-sponsored trainings and technical assistance provided to build tribal public health capacity.

Annually, IHS reports valid and reliable aggregated results for twenty-six clinical measures using a centralized reporting system, the IDCS DM, to meet the GPRA/GPRAMA requirements. The IDCS DM provides Tribes using non-RPMS electronic health records with the option to report data for GPRA/GPRAMA clinical measure purposes. The IDCS DM calculates measure results using any data (RPMS, non-RPMS or Fiscal Intermediary) submitted to the IHS National Data Warehouse and assures reporting of valid and reliable clinical measure results. The IHS clinical GPRA/GPRAMA measure results reported from the IDCS DM reflect aggregated I/T/U results, including participating Tribal programs.

Evaluation

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

centrally managed Evaluation Services Contract. In FY 2024, the IHS will evaluate two critical programs: Trauma Informed Care (TIC) and Evaluation.

Performance Management

IHS cascades performance goals and objectives and performance-related metrics agency-wide and aligns them with the agency's strategic plan. 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.

In 2023, IHS implemented the Office of Personnel Management's USA Performance (USAP) system agency-wide for all civil service employees. USAP is an electronic performance management system. This system will greatly enhance performance management at the IHS, making the process 100% electronic, as well as streamlining the process for rating officials and employees. This system will enable agency-wide tracking of performance plan establishment, mid-year progress reviews, and final ratings.

All Purpose Table
Indian Health Service
(Dollars in Thousands)

Program	FY 2023	FY 2024	FY 2025		
	Final /1	CR /6	President's Budget	+/- FY 2023 Final	FTE
SERVICES					
Clinical Services	**4,433,191**	**4,433,191**	**5,124,813**	**691,622**	**7,188**
Hospitals & Health Clinics	2,503,025	2,503,025	2,929,915	426,890	5,957
Electronic Health Record System	217,564	217,564	435,102	217,538	206
Dental Services	248,098	248,098	276,085	27,987	525
Mental Health	127,171	127,171	138,746	11,575	187
Alcohol & Substance Abuse	266,440	266,440	291,389	24,949	226
Purchased/Referred Care	996,755	996,755	1,053,576	56,821	87
Indian Health Care Improvement Fund /2	74,138	74,138	0	-74,138	0
Preventive Health	**202,527**	**202,527**	**219,035**	**16,508**	**213**
Public Health Nursing	110,782	110,782	120,955	10,173	193
Health Education	24,350	24,350	26,144	1,794	15
Community Health Representatives	65,212	65,212	69,628	4,416	5
Immunization AK	2,183	2,183	2,308	125	0
Other Services	**283,952**	**283,952**	**297,384**	**13,432**	**289**
Urban Health	90,419	90,419	94,992	4,573	9
Indian Health Professions	80,568	80,568	81,252	684	14
Tribal Management Grants	2,986	2,986	2,987	1	0
Direct Operations	103,805	103,805	111,966	8,161	254
Self-Governance	6,174	6,174	6,187	13	12
TOTAL, SERVICES	**4,919,670**	**4,919,670**	**5,641,232**	**721,562**	**7,690**
FACILITIES	**958,553**	**958,553**	**993,825**	**35,272**	**1,106**
Maintenance & Improvement	170,595	170,595	174,355	3,760	0
Sanitation Facilities Construction	196,167	196,167	200,485	4,318	110
Health Care Facilities Construction	260,896	260,896	260,919	23	0
Facilities & Environ Health Support	298,297	298,297	324,192	25,895	996
Equipment	32,598	32,598	33,874	1,276	0
TOTAL, SERVICES & FACILITIES	**5,878,223**	**5,878,223**	**6,635,057**	**756,834**	**8,796**
CONTRACT SUPPORT COSTS /3					
Total, Contract Support Costs	**969,000**	**969,000**	**979,000**	**10,000**	**10**
SECTION 105(*l*) LEASES /3					
Total Section 105(*l*) Leases	**111,000**	**111,000**	**348,876**	**237,876**	**10**
SPECIAL DIABETES PROGRAM FOR INDIANS /7					
Current Law Mandatory Funding	147,000	150,000	0	-147,000	
Proposed Law Mandatory Funding	0	0	260,000	260,000	
Subtotal, Special Diabetes Program for Indians	**147,000**	**150,000**	**260,000**	**113,000**	**22**
TOTAL, Budget Authority	**6,958,223**	**6,958,223**	**7,962,933**	**1,004,710**	**8,816**
TOTAL, Program Level /8	**7,105,223**	**7,108,223**	**8,222,933**	**1,117,710**	**8,838**
FTE Total					**6,621**
Other FTE /4					**6,621**
Infrastructure Investment and Jobs Act	**700,000**	**700,000**	**700,000**	**0**	
NEF /5	**114,788**	**112,373**	**134,388**		

1/ The FY 2023 column reflects final regular appropriation levels, including required and permissive transfers, and rescission of $29 million within Services account total, consistent with P.L. 117-328. Supplemental resources from the Infrastructure Investment and Jobs Act are reflected separately. The IIJA appropriated a total $3.5 billion over 5 years, from FY 2022-FY 2026.

2/ The FY 2024 budget proposes to realign funding for the Indian Health Care Improvement fund into the Hospitals and Health Clinics funding line.

3/ Maintains indefinite discretionary authority for Contract Support Costs and Section 105(l) Lease Agreements.

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

5/ FY 2025 NEF amounts are planned estimates and subject to change.

6/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-35). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

7/ FY 2023 funding reflects mandatory sequester of 2 percent. FY 2024 Current Law funding represents annualized funding level under the current Continuing Resolution (P.L. 118-35). The FY 2025 budget proposes a 3-year reauthorization of the Special Diabetes Program for Indians beginning in FY 2024.

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

Indian Health Service
Detail of Changes
(Dollars in Thousands)

Sub IHS Activity	FY 2023 Final	Proposed Changes															FY 2025 President's Budget Total /4
		FY 2025 Current Services	Staffing of Newly Constructed Facilities FY 2024	Staffing of Newly Constructed Facilities FY 2025	Indian Health Care Improvement Fund /1	Electronic Health Record	Hepatitis C & HIV	CHAP	Opioids Grants	Assessments	Direct Operations	New Tribes /2	FEHS	Contract Support Costs	Section 105(l) Leases	Subtotal of Changes	
SERVICES																	
Hospitals & Health Clinics	2,503,025	208,120	47,489	73,068	74,138	0	10,000	10,000	0	4,075	0	0	0	0	0	426,890	2,929,915
Electronic Health Record System	217,564	4,148	0	0	0	213,390	0	0	0	0	0	0	0	0	0	217,538	435,102
Dental Services	248,098	17,141	4,463	6,383	0	0	0	0	0	0	0	0	0	0	0	27,987	276,085
Mental Health	127,171	7,523	2,594	1,458	0	0	0	0	0	0	0	0	0	0	0	11,575	138,746
Alcohol & Substance Abuse	266,440	14,030	196	723	0	0	0	0	10,000	0	0	0	0	0	0	24,949	291,389
Purchased/Referred Care	996,755	51,049	0	0	0	0	0	0	0	0	0	5,772	0	0	0	56,821	1,053,576
Indian Health Care Improvement Fund /1	74,138	0	0	0	(74,138)	0	0	0	0	0	0	0	0	0	0	(74,138)	0
Total, Clinical Services	4,433,191	302,011	54,742	81,632	0	213,390	10,000	10,000	10,000	4,075	0	5,772	0	0	0	691,622	5,124,813
Public Health Nursing	110,782	7,434	1,252	1,487	0	0	0	0	0	0	0	0	0	0	0	10,173	120,955
Health Education	24,350	1,324	67	403	0	0	0	0	0	0	0	0	0	0	0	1,794	26,144
Community Health Representatives	65,212	4,416	0	0	0	0	0	0	0	0	0	0	0	0	0	4,416	69,628
Immunization AK	2,183	125	0	0	0	0	0	0	0	0	0	0	0	0	0	125	2,308
Total, Preventive Health	202,527	13,299	1,319	1,890	0	0	0	0	0	0	0	0	0	0	0	16,508	219,035
Urban Health	90,419	4,573	0	0	0	0	0	0	0	0	0	0	0	0	0	4,573	94,992
Indian Health Professions	80,568	684	0	0	0	0	0	0	0	0	0	0	0	0	0	684	81,252
Tribal Management	2,986	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2,987
Direct Operations	103,805	2,161	0	0	0	0	0	0	0	0	6,000	0	0	0	0	8,161	111,966
Self-Governance	6,174	13	0	0	0	0	0	0	0	0	0	0	0	0	0	13	6,187
Total, Other Services	283,952	7,432	0	0	0	0	0	0	0	0	6,000	0	0	0	0	13,432	297,384
Total, Services	**4,919,670**	**322,742**	**56,061**	**83,522**	**0**	**213,390**	**10,000**	**10,000**	**10,000**	**4,075**	**6,000**	**5,772**	**0**	**0**	**0**	**721,562**	**5,641,232**
FACILITIES																	
Maintenance & Improvement	170,595	3,760	0	0	0	0	0	0	0	0	0	0	0	0	0	3,760	174,355
Sanitation Facilities Construction	196,167	4,318	0	0	0	0	0	0	0	0	0	0	0	0	0	4,318	200,485
Health Care Facility Construction (HCFC)	260,896	23	0	0	0	0	0	0	0	0	0	0	0	0	0	23	260,919
Facility & Environmental Health Support	298,297	12,448	5,364	7,856	0	0	0	0	0	0	0	0	227	0	0	25,895	324,192
Equipment	32,598	1,276	0	0	0	0	0	0	0	0	0	0	0	0	0	1,276	33,874
Total, Facilities	**958,553**	**21,825**	**5,364**	**7,856**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**227**	**0**	**0**	**35,272**	**993,825**
Total, Services & Facilities	**5,878,223**	**344,567**	**61,425**	**91,378**	**0**	**213,390**	**10,000**	**10,000**	**10,000**	**4,075**	**6,000**	**5,772**	**227**	**0**	**0**	**756,834**	**6,635,057**
CONTRACT SUPPORT COSTS /3																	
Total, Contract Support Costs	**969,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**10,000**	**0**	**10,000**	**979,000**
SECTION 105(l) LEASES /3																	
Total Section 105(l) Leases	**111,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**237,876**	**237,876**	**348,876**
TOTAL, IHS /4	**6,958,223**	**344,567**	**61,425**	**91,378**	**0**	**213,390**	**10,000**	**10,000**	**10,000**	**4,075**	**6,000**	**5,772**	**227**	**10,000**	**237,876**	**1,004,710**	**7,962,933**

1/ The budget proposes to realign funding for the Indian Health Care Improvement fund into the Hospitals and Health Clinics funding line.

2/ Funding for New Tribes is currently reflected in Purchased/Referred Care. However, final funding will need to be realigned in the appropriate Program, Project, or Activity (PPA or budget line) when these numbers are identified.

3/ Maintains indefinite discretionary authority for Contract Support Costs and Section 105(l) Lease Agreements.

4/ Excludes funding for the Special Diabetes Program for Indians.

STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES

FY 2024 Budget -- Estimates

(Dollars in Thousands)

	Dilkon, AZ		Naytahwaush, MN		New Town, ND		El Paso, TX		Rapid City, SD		Scottsdale, AZ		Phoenix, AZ		**TOTAL**		
	Alternative Rural Health Center		Naytahwaush Health Center (JV)		Elbowoods Memorial Health Center (JV)		Ysleta Del Sur Health Center (JV)		Rapid City Health Center		NEACC (Salt River) Health Center		Phoenix Indian Medical Center Central				
Opening Date	July 2023		June 2023		April 2024		August 2022		January 2023		January 2022		January 2022				
Sub Sub Activity	FTE	Amount	Pos	Amount	Pos	Amount	Pos	Amount	FTE	Amount	FTE	Amount	FTE	Amount	**FTE**	**Pos**	**AMOUNT**
Grand Total /2	**223**	**$31,094**	**51**	**$7,087**	**16**	**$2,546**	**34**	**$2,610**	**15**	**$166**	**106**	**$17,246**	**9**	**$676**	**353**	**101**	**$61,425**

1/ Includes Utilities

2/ As a result of JVCPs entering their planning phases and detailed budgets not yet available, preliminary estimates are included for budget planning purposes.

STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES

FY 2025 Budget -- Estimates

(Dollars in Thousands)

	Seward, AK Chugachmiut Regional Health Center (JV)		New Town, ND Elbowoods Memorial Health Center (JV)		Omaha, NE Fred LeRoy Health and Wellness Center (JV)		Sitka, AK Mount Edgecumbe Medical Center (JV)		**TOTAL**		
Opening Date	October 2024		April 2024		November 2024		March 2025				
Sub Sub Activity	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	30	$6,955	7	$1,044	171	$23,668	182	$41,401	0	390	$73,068
Dental Health	6	$926	8	$1,302	25	$3,765	3	$390	0	42	$6,383
Mental Health	1	$142	0	$0	8	$1,004	2	$312	0	11	$1,458
Alcohol & Substance Abuse	0	$0	0	$0	4	$559	1	$164	0	5	$723
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Clinical Services	37	$8,023	15	$2,346	208	$28,996	188	$42,267	0	448	$81,632
Public Health Nursing	2	$354	0	$0	3	$455	4	$678	0	9	$1,487
Health Education	0	$0	0	$0	2	$329	0	$74	0	2	$403
Community Health Representatives	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Preventive Health	2	$354	0	$0	5	$784	4	$752	0	11	$1,890
Total, Services	39	$8,377	15	$2,346	213	$29,780	192	$43,019	0	459	$83,522
Facilities Support /1	0	$441	0	$199	8	$2,485	40	$4,731	0	48	$7,856
Environmental Health Support	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, FEHS	0	$441	0	$199	8	$2,485	40	$4,731	0	48	$7,856
Total, Facilities	0	$441	0	$199	8	$2,485	40	$4,731	0	48	$7,856
Grand Total /2	**39**	**$8,818**	**15**	**$2,545**	**221**	**$32,265**	**232**	**$47,750**	**0**	**507**	**$91,378**

1/ Includes Utilities

2/ As a result of JVCPs entering their planning phases and detailed budgets not yet available, preliminary estimates are included for budget planning purposes.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

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Appropriation Accounts

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, $5,641,232,000, which shall remain available until September 30, 2026, except as otherwise provided herein; together with payments received during the fiscal year pursuant to sections 231(b) and 233 of the Public Health Service Act (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 (25 U.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 $2,500,000 shall be available for grants or contracts with public or private institutions to provide alcohol or drug treatment services to Indians, including alcohol detoxification services: Provided further, That $1,053,576,000 shall remain available until expended for Purchased/Referred Care, including $54,000,000 for the Indian Catastrophic Health Emergency Fund: Provided further, That of the funds provided, up to $51,000,000 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, $58,000,000 shall be for costs related to or resulting from accreditation emergencies, including supplementing activities funded under the heading "Indian Health Facilities", of which up to $4,000,000 may be used to supplement amounts otherwise available for Purchased/Referred Care: 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 in the Fund authorized by section 108A of that Act (25 U.S.C. 1616a–1) and shall remain available until expended and, notwithstanding section 108A(c) of that 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 that Act (25

U.S.C. 1613a and 1616a): Provided further, That the amounts made available within this account for the Substance Abuse and Suicide Prevention Program, for Opioid Prevention, Treatment and Recovery Services, for the Domestic Violence Prevention Program, for the Zero Suicide Initiative, for the housing subsidy authority for civilian employees, for Aftercare Pilot Programs at Youth Regional Treatment Centers, for transformation and modernization costs of the Indian Health Service Electronic Health Record system, for national quality and oversight activities, for improving collections from public and private insurance at Indian Health Service and tribally operated facilities, for an initiative to treat or reduce the transmission of HIV and HCV, for a maternal health initiative, for the Telebehaviorial Health Center of Excellence, for Alzheimer's activities, for Village Built Clinics, for a produce prescription pilot, 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 that are available for two fiscal years may be used in their second year of availability for annual contracts and grants that fall within two fiscal years, provided the total obligation is recorded in such second year of availability: 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 (25 U.S.C. 1613) 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, and from 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 of the funds provided, $74,138,000 is for the Indian Health Care Improvement Fund and may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account.

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 2025, such sums as may be necessary, of which not more than $10,000,000 shall be available for Federal salaries, administration, and oversight activities necessary to carry out such payments:
Provided, That notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account: Provided further, 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 due for such agreements for subsequent fiscal years.

PAYMENTS FOR TRIBAL LEASES

For payments to tribes and tribal organizations for leases pursuant to section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l)) for fiscal year 2025, such sums as may be necessary, which shall be available for obligation through September 30, 2026, and of which not more than $10,000,000 shall be available for Federal salaries, administration, and oversight activities necessary to carry out such payments: 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.

INDIAN HEALTH FACILITIES

For construction, repair, maintenance, demolition, 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, $564,565,000, which shall remain available until expended and shall be in addition to funds previously appropriated under this heading that became available on October 1, 2024: 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.

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 of Health and Human Services; 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 not- withstanding 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 such assessments or charges are identified in the budget justification and provided in this Act, or are notified to the House and Senate Committees on Appropriations 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 et seq.), 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 sub- sequent 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 costs associated with the provision of goods, services, or technical assistance: Provided further, That the Indian Health Service may provide to civilian medical personnel serving in hospitals operated by the Indian Health Service housing allowances equivalent to those that would be provided to members of the Commissioned Corps of the United States Public Health Service serving in similar positions at such hospitals

Language Provision	**Explanation**
INDIAN HEALTH SERVICE PROVISIONS	
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, $5,641,232,000, which shall remain available until September 30, 2026, except as otherwise provided herein, and shall be in addition to funds previously appropriated under this heading that became available on October 1, 2024; together with payments received during the fiscal year pursuant to sections 231(b) and 233 of the Public Health Service Act (42 U.S.C. 238(b) and 238b), for services furnished by the Indian Health Service	Appropriates funding for fiscal year 2025 for the Indian Health Services account.

Provided further, That $1,053,576,000 shall remain available until expended for Purchased/Referred Care, including $54,000,000 for the Indian Catastrophic Health Emergency Fund:	Provides funding for fiscal year 2025 appropriations for Purchased and Referred Care, including the Indian Catastrophic Health Emergency Fund.
Provided further, That of the funds provided, up to $51,000,000 shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act:	Provides funding for fiscal year 2025 for the IHS Loan Repayment program.
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 2025, such sums as may be necessary, of which not more than $10,000,000 shall be available for Federal salaries, administration, and oversight activities necessary to carry out such payments:	Provides fiscal year 2025 appropriations and provides no more than $10 million to allow IHS to pay for management and oversight activities from the CSC indefinite discretionary appropriation.
PAYMENTS FOR TRIBAL LEASES	
For payments to tribes and tribal organizations for leases pursuant to section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l)) for fiscal year 2025, such sums as may be necessary, which shall be available for obligation through September 30, 2026, and of which not more than $10,000,000 shall be available for Federal salaries, administration, and oversight activities necessary to carry out such payments:	Provides fiscal year 2025 appropriations and provides no more than $10 million to allow IHS to pay for management and oversight activities from the Payments for Tribal Leases indefinite discretionary appropriation.
FACILITIES PROVISIONS	
For construction, repair, maintenance, demolition, 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, $993,825,000, which shall remain available until expended:	Appropriates funding for fiscal year 2025 for the Indian Health Facilities account.

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:	Provides funding for fiscal year 2025 appropriations for purchase of TRANSAM equipment.
ADMINISTRATIVE PROVISIONS	
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 such assessments or charges are identified in the budget justification and provided in this Act, or are notified to the House and Senate Committees on Appropriations through the reprogramming process:	Clarifies that funds may be used for assessments or charges by the Department of Health and Human Services if they are identified in the budget justification and provided in this Act or are notified to the House and Senate Committees on Appropriations.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

SERVICES

	FY 2023	FY 2024	FY 2025
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$4,919,670,000	$4,919,670,000	$5,641,232,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$4,919,670,000	$4,919,670,000	$5,641,232,000
Mandatory Appropriation:			
Appropriation[1]	$147,000,000	$250,000,000	$260,000,000
Offsetting Collections:			
Federal sources	($303,000,000)	($303,000,000)	($303,000,000)
Non-federal sources	($2,185,000,000)	($2,185,000,000)	($2,185,000,000)
Subtotal, Offsetting Collections	($2,488,000,000)	($2,488,000,000)	($2,488,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$4,584,000,000	$4,531,000,000	$8,800,000,000
Mandatory, Start of Year	($53,000,000)	$4,269,000,000	$309,000,000
End of Year	$4,531,000,000	$8,800,000,000	$9,109,000,000
Total Obligations, Services	$2,578,670,000	$2,681,670,000	$3,104,232,000

[1]In FY 2023, this reflects the 2% sequester amount for the Special Diabetes Program for Indians. FY 2024 reflects both current and proposed law mandatory funding

INDIAN HEALTH SERVICE
Amounts Available for Obligations

FACILITIES

	FY 2023	FY 2024	FY 2025
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$958,553,000	$958,553,000	$993,825,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$958,553,000	$958,553,000	$993,825,000
Mandatory Appropriation:			
Appropriation	$0	$0	$0
Offsetting Collections:			
Federal sources	($72,000,000)	($72,000,000)	(72,000,000)
Subtotal, Offsetting Collections	($72,000,000)	($72,000,000)	(72,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$2,303,000,000	$2,692,000,000	$3,566,000,000
End of Year	$2,692,000,000	$3,566,000,000	$3,974,000,000
Total Obligations, Facilities	$497,553,000	$12,553,000	$513,825,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

CONTRACT SUPPORT COSTS

	FY 2023	FY 2024	FY 2025
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$969,000,000	$969,000,000	$979,000,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$969,000,000	$969,000,000	$979,000,000
Mandatory Appropriation:			
Appropriation	$0	$0	$0
Total Obligations, CSC	$969,000,000	$969,000,000	$979,000,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

PAYMENTS FOR TRIBAL LEASES

	FY 2023	FY 2024	FY 2025
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$111,000,000	$111,000,000	$ 348,876,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$111,000,000	$111,000,000	$ 348,876,000
Mandatory Appropriation:			
Appropriation	$0	$0	$0
Total Obligations, Payments for Tribal Leases	$111,000,000	$111,000,000	$348,876,000

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

FY 2023 Final	
Total estimated budget authority	$6,958,223.000
(Obligations)	$5,633,999.000
FY 2025 President's Budget	
Total estimated budget authority	$7,962,933.000
(Obligations)	$7,962,933.000
Net Change	$1,004,710.000

	FY 2023 Enacted		FY 2025 President's Budget		FY 2025 +/- FY 2023	
	FTE	BA	FTE	BA	FTE	BA
Increases:						
A. Built-in:						
1. Annualization of 2024 CO pay increase (3 months)	--	--	--	$1,347.911	--	+$1,347.911
2. FY 2025 Pay Raise CO (9 months)	--	--	--	$1,690.294	--	+$1,690.294
3. Annualization of 2024 CS Pay Raise (3 months)	--	--	--	$11,936.036	--	+$11,936.036
4. FY 2025 Pay Raise CS (9 months)	--	--	--	$15,718.732	--	+$15,718.732
5. Prior Year Pay Raise Increase CO and CS, FY2023/FY 2024	--	$34,496.000	--	$41,977.026	--	--
Subtotal, Built-in Increases	**--**	**$34,496.000**	**--**	**$72,670.000**	**--**	**+$30,692.974**
B. Program Adjustments:						
1. Tribal Pay	--	$61,720.000	--	$51,501.000	--	-$10,219.000
2. Cost of Medical Inflation		$18,203.000	--	$117,722.000	--	+$99,519.000
3. Cost of Non-Medical Inflation		$5,987.000	--	$5,375.000	--	-$612.000
4. 105(l) Tribal Leases	--	-$39,000.000	--	$237,876.000	--	+$276,876.000
5. Contract Support Costs	--	$89,000.000	--	$10,000.000	--	-$79,000.000
6. Population Growth	--	--	--	$97,299.000	--	+$97,299.000
Subtotal, Program Increases	**--**	**$135,910.000**	**--**	**$519,773.000**	**--**	**+$383,863.000**
C. Phasing -In of Staff & Operating Cost of New Facilities 1/	572	$63,008.000	353	$152,803.000	-219	+$89,795.000
D. New Tribes	--	--	--	$5,772.000	--	+$5,772.000
E. Assessments	--	--	--	$4,075.000	--	+$4,075.000
F. Program Increases	--	$123,211.000	--	$249,617.000	--	+$126,406.000
Subtotal, Program Increases	**--**	**$123,211.000**	**--**	**$249,617.000**	**--**	**+$126,406.000**
Total Increases	**572**	**$356,625.000**	**353**	**$1,004,710.000**	**-219**	**+$640,603.974**
Decreases:						
A. Built-in:						
1. Decrease in the number of compensable days 2/	--	--	--	$3,517.842	--	+$3,517.842
2. Absorption of FY24 CO Pay Increase (3 months)	--	--	--	--	--	--
3. Absorption of FY24 CS Pay Increase (3 months)	--	--	--	--	--	--
4. Absorption of FY25 CO Pay Increase (9 months)	--	--	--	--	--	--
5. Absorption of FY25 CS Pay Increase (9 months)	--	--	--	--	--	--
6. Absorbed FY 2023 Paycosts	--	--	--	--	--	--
4. Absorption of Unfunded Medical Inflationary Costs	--	--	--	$19,776.880	--	+$19,776.880
5. Absorption of Unfunded Non-Medical Inflationary Costs	--	--	--	$14,940.280	--	+$14,940.280
6. Absorption of Population Growth	--	$86,665.000	--	$4,112.982	--	-$82,552.018
Subtotal, Built-in Decreases	**--**	**$86,665.000**	**--**	**$42,347.984**	**## ###**	**-$44,317.016**
B. Program Decrease						
1. FY 2023 Staffing of New Facilities Rescissions	--	--	--	--	--	--
Subtotal, Program Decreases	**--**	**--**	**--**	**--**	**--**	**--**
Total Decreases	**--**	**$86,665.000**	**--**	**$42,347.984**	**--**	**-$44,317.016**
Net Change	**572**	**$443,290.000**	**353**	**$1,047,057.984**	**-219**	**+$596,286.957**

1/ Includes facilities newly constructed FY 2024 and FY 2025
2/ Increase from 260 to 261 compensable days from FY 2023 to FY 2025

INDIAN HEALTH SERVICE
Budget Authority by Activity

(Dollars in Thousands)

	2023 Final		2024 CR		2025 President's Budget	
	FTE 1/	Amount	FTE 1/	Amount	FTE 1/	Amount
SERVICES						
Hospitals & Health Clinics	5,600	$2,503,025	5,957	$2,503,025	5,957	$2,929,915
Electronic Health Record System	206	$217,564	206	$217,564	206	$435,102
Dental Health	516	248,098	525	248,098	525	276,085
Mental Health	170	127,171	187	127,171	187	138,746
Alcohol & Substance Abuse	226	266,440	226	266,440	226	291,389
Purchased/Referred Care	87	996,755	87	996,755	87	1,053,576
Indian Health Care Improvement Fund	47	74,138	0	74,138	0	0
Total, Clinical Services	6,852	4,433,191	7,188	4,433,191	7,188	5,124,813
Public Health Nursing	192	110,782	193	110,782	193	120,955
Health Education	15	24,350	15	24,350	15	26,144
Comm. Health Reps.	5	65,212	5	65,212	5	69,628
Immunization AK	0	2,183	0	2,183	0	2,308
Total, Preventive Health	212	202,527	213	202,527	213	219,035
Urban Health	9	90,419	9	90,419	9	94,992
Indian Health Professions	14	80,568	14	80,568	14	81,252
Tribal Management	0	2,986	0	2,986	0	2,987
Direct Operations	254	103,805	254	103,805	254	111,966
Self-Governance	12	6,174	12	6,174	12	6,187
Total, Other services	289	283,952	289	283,952	289	297,384
Total, Services	7,353	4,919,670	7,690	4,919,670	7,690	5,641,232
CONTRACT SUPPORT COSTS	0	969,000	0	969,000	0	979,000
PAYMENTS FOR TRIBAL LEASES	0	111,000	0	111,000	0	348,876
FACILITIES						
Maintenance & Improvement	0	170,595	0	170,595	0	174,355
Sanitation Facilities Constr.	110	196,167	110	196,167	110	200,485
Health Care Facs. Constr.	0	260,896	0	260,896	0	260,919
Facil. & Envir. Health Supp.	982	298,297	996	298,297	996	324,192
Equipment	0	32,598	0	32,598	0	33,874
Total, Facilities	1,092	958,553	1,106	958,553	1,106	993,825
SPECIAL DIABETES PROGRAM FOR INDIANS						
SDPI		147,000		147,000		
Total, SDPI	22	147,000	22	147,000	22	0
Total IHS	8,467	$7,105,223	8,818	$7,105,223	8,818	$7,962,933

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

Indian Health Service

Authorizing Legislation

(Dollars in Thousands)

	FY 2023 Amount Authorized	FY 2024 Amount Authorized/2	FY 2025 President's Budget
1. Services Appropriation: Snyder Act, 25 U.S.C. 13. Transfer Act (P.L. 83-568), 42 U.S.C. 2001. Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (most recently amended by the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), § 10221, 124 Stat. 119, 935 (2010)), 25 U.S.C. 1601 *et seq.* Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.* Public Health Service Act, titles II & III, as amended, 25 U.S.C. 201-280m.	4,919,670	4,919,670	5,641,232
2. Contract Support Costs Appropriation /1: Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*	969,000	969,000	979,000
3. Facilities Appropriation: Indian Sanitation Facilities Act (P.L. 86-121), as amended, 42 U.S.C. 2004a. IHCIA, title III, as amended, 25 U.S.C. 1631-1638g. ISDEAA, sec. 102 & 509, as amended, 25 U.S.C. 450f & 458aaa-8. 5 U.S.C. 5911 note (Quarters Rent Funds).	958,553 -	958,553 -	993,825 -
4. Special Diabetes Program for Indians 42 U.S.C. 245c-3.	147,000	150,000	260,000
5. Section 105(*l*) Leases /1: Sec. 900.69	111,000	111,000	348,876
Unfunded authorizations:	-	-	-
Total appropriations:	7,105,223	7,108,223	8,222,933
Total appropriations against Definite authorizations:	7,105,223	7,108,223	8,222,933

1/ Maintains indefinite authority for Contract Support Costs and Section 105(l) Lease Agreements.

2/ FY 2024 Annualized CR amounts.

INDIAN HEALTH SERVICE
Appropriation History Table
Services

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission (PL 108-447, Sec. 501)				($15,638,000)
Rescission (PL 108-447, Sec. 122)				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission (PL 109-54)				($13,006,000)
Rescission (PL 109-148)				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	$2,818,871,000
2008	$2,931,530,000	$3,023,532,000	$2,991,924,000	$3,018,624,000
Rescission (PL 110-161)				($47,091,000)
2009 Omnibus	$2,971,533,000	-	-	$3,190,956,000
2009 ARRA (PL 111-5)	-	-	-	$85,000,000
2010	$3,639,868,000	$3,657,618,000	$3,639,868,000	$3,657,618,000
2011	$3,657,618,000	-	-	$3,672,618,000
Rescission (PL 112-10)				($7,345,000)
2012	$4,166,139,000	$4,034,322,000	-	$3,872,377,000
Rescission (PL 112-74)				($6,195,804)
2013	$3,978,974,000	-	$ 3,914,599,000	$3,914,599,000
Sequestration				($194,492,111)
Rescission				($7,829,198)
2014 Omnibus (PL 113-64)	$3,982,498,000	-	-	$3,982,842,000
2015 Omnibus (PL 113-235)	$4,172,182,000	$4,180,557,000	-	$4,182,147,000
2016 Omnibus (PL 114-39)	$3,745,290,000	$3,603,569,000	$3,539,523,000	$3,566,387,000
2017 Omnibus (PL 115-31)	$3,815,109,000	$3,720,690,000	$3,650,171,000	$3,694,462,000
2018 Omnibus (PL 115-141)	$3,574,365,000	$3,867,260,000	$3,759,258,000	$3,952,290,000
2019 Omnibus (PL 116-6)	$3,945,975,000	$4,202,639,000	$4,072,385,000	$3,965,711,000
2020 Omnibus (PL 116-94)	$4,286,542,000	$4,556,870,000	$4,318,884,000	$4,315,205,000
2021 Omnibus (PL 116-260)	$4,507,113,000	$4,534,670,000	$4,266,085,000	$4,301,391,000
2022 Omnibus (PL 117-103)	$5,678,336,000	$5,799,102,000	$5,414,143,000	$5,600,985,000
2023 Omnibus (PL 117-328) /1	$6,261,680,000	$5,734,044,000	$5,218,127,000	$4,919,670,000
2024 Congressional Justification	$7,012,945,000	$4,901,524,000	$5,011,488,000	
2025 Congressional Justification	$5,641,232,000			

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

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

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

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

INDIAN HEALTH SERVICE
Appropriation History Table
Contract Support Costs

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2016 Omnibus (PL 114-39)	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2017 Omnibus (PL 115-31)	$800,000,000	$800,000,000	$800,000,000	$800,000,000
2018 Omnibus (PL 115-141)	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2019 Omnibus (PL 116-6)	$822,227,000	$822,227,000	$822,227,000	$717,970,000
2020 Omnibus (PL 116-94)	$855,000,000	$820,000,000	$820,000,000	$855,000,000
2021 Omnibus (PL 116-260)	$855,000,000	$916,000,000	$916,000,000	$916,000,000
2022 Omnibus (PL 117-103)	$1,142,000,000	$880,000,000	$880,000,000	$880,000,000
2023 Omnibus (PL 117-328) /1	$1,142,000,000	$969,000,000	$969,000,000	$969,000,000
2024 Congressional Justification /2	$1,168,000,000	$1,051,000,000	$1,051,000,000	
2025 Congressional Justification	$979,000,000			

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

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

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

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2019 Omnibus (PL 116-6)	$0	$0	$0	$0
2020 Omnibus (PL 116-94)	$0	$0	$0	$0
2021 Omnibus (PL 116-260)	$101,000,000	$101,000,000	$101,000,000	$101,000,000
2022 Omnibus (PL 117-103)	$150,000,000	$150,000,000	$150,000,000	$150,000,000
2023 Omnibus (PL 117-328) /1	$150,000,000	$111,000,000	$111,000,000	$111,000,000
2024 Congressional Justification/2	$153,000,000	$149,000,000	$149,000,000	
2025 Congressional Justification	$348,876,000			

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

TABLE OF CONTENTS

Cross-Cutting Activities: Current Services/Staffing of Newly Constructed Facilities

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
CURRENT SERVICES

(Dollars in Thousands)

Program	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Pay Costs	$96,216	$96,216	$124,171	+$27,955
Non-Medical Inflation	$5,987	$5,987	$5,375	-$612
Medical Inflation	$18,203	$18,203	$117,722	+$99,519
Population Growth	$0	$0	$97,299	+$97,299
Current Services, Total	$120,406	$120,406	$344,567	+$224,161

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

BUDGET JUSTIFICATION

The IHS requests an increase of $345 million for Current Services in FY 2025 to offset pay costs, medical and non-medical inflation, and population growth.

FY 2025 Current Services Estimates

INDIAN HEALTH SERVICE
FY 2025 -- ESTIMATED CURRENT SERVICES

(Dollars in Thousands)

Sub Activity	FY 2023 Enacted	FY 2025 Current Services							
		Pay			Inflation			Population	
		Federal Pay	Tribal Pay	**Pay Total**	non-med 1.02%	medical 4.00%	**Inflation Total**	**Growth 1.80%**	**Curr Svcs Total**
SERVICES									
Hospitals & Health Clinics	2,503,025	62,439	37,454	99,893	1,331	60,508	61,839	45,054	206,786
Electronic Health Record	217,564	48	0	48	184	0	184	3,916	4,148
Dental Services	248,098	2,595	4,050	6,645	67	5,963	6,030	4,466	17,141
Mental Health	127,171	788	1,276	2,064	7	3,163	3,170	2,289	7,523
Alcohol & Substance Abuse	266,440	782	1,497	2,279	119	6,836	6,955	4,796	14,030
Purchased/Referred Care	996,755	442	659	1,101	1	32,005	32,006	17,942	51,049
Indian Health Care Improvement Fund /1	74,138	0	0	0	0	0	0	1,334	1,334
Total, Clinical Services	4,433,191	67,094	44,936	112,030	1,709	108,475	110,184	79,797	302,011
Public Health Nursing	110,782	854	1,713	2,567	12	2,861	2,873	1,994	7,434
Health Education	24,350	80	353	433	0	782	782	109	1,324
Comm. Health Reps	65,212	28	766	794	9	2,439	2,448	1,174	4,416
Immunization AK	2,183	0	0	0	0	86	86	39	125
Total, Preventive Health	202,527	962	2,832	3,794	21	6,168	6,189	3,316	13,299
Urban Health	90,419	86	1,068	1,154	285	1,506	1,791	1,628	4,573
Indian Health Professions	80,568	124	0	124	560	0	560	0	684
Tribal Management	2,986	0	0	0	1	0	1	0	1
Direct Operations	103,805	1,507	418	1,925	236	0	236	0	2,161
Self-Governance	6,174	10	0	10	3	0	3	0	13
Total, Other Services	283,952	1,727	1,486	3,213	1,085	1,506	2,591	1,628	7,432
Total, Services	4,919,670	69,783	49,254	119,037	2,815	116,149	118,964	84,741	322,742
FACILITIES									
Maintenance & Improvement	170,595	0	0	0	689	0	689	3,071	3,760
Sanitation Facilities Constr.	196,167	0	0	0	787	0	787	3,531	4,318
Health Care Fac. Constr.	260,896	0	0	0	23	0	23	0	23
Facil. & Envir. Hlth Supp.	298,297	2,887	2,247	5,134	1,059	886	1,945	5,369	12,448
Equipment	32,598	0	0	0	2	687	689	587	1,276
Total, Facilities	958,553	2,887	2,247	5,134	2,560	1,573	4,133	12,558	21,825
TOTAL, IHS - Services and Facilities	**5,878,223**	**72,670**	**51,501**	**124,171**	**5,375**	**117,722**	**123,097**	**97,299**	**344,567**

1/ IHCIF is included in H&HC. It is being moved back into H&HC rather than as its own budget line.

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

(Dollars in Thousands)

Facility	FY 2024 Staffing		FY 2025 Staffing		FY 2025 President's Budget Total	
	Total	FTE/POS	Total	FTE/POS	Total	FTE/POS
Alternative Rural Health Center Dilkon, AZ	$31,094	223	N/A	N/A	$31,094	223
Naytahwaush Health Center (JV) Naytahwaush, MN	$7,087	51	N/A	N/A	$7,087	51
Ysleta Del Sur Health Center (JV) El Paso, TX	$2,610	34	N/A	N/A	$2,610	34
Rapid City Health Center Rapid City, SD	$166	15	N/A	N/A	$166	15
NEACC (Salt River) Health Center Scottsdale, AZ	$17,246	106	N/A	N/A	$17,246	106
Phoenix Indian Medical Center Central Phoenix, AZ	$676	9	N/A	N/A	$676	9
Elbowoods Memorial Health Center (JV) New Town, ND	$2,546	16	$2,545	15	$5,155	49
Chugachmiut Regional Health Center (JV) Seward, AK	N/A	N/A	$8,818	39	$8,818	39
Fred LeRoy Health and Wellness Center (JV) Omaha, NE	N/A	N/A	$32,265	221	$32,265	221
Mount Edgecumbe Medical Center (JV) Sitka, AK	N/A	N/A	$47,750	232	$47,750	232
Grand Total	**$61,425**	**N/A**	**$91,378**	**N/A**	**$152,803**	**N/A**
FTE/ POS	**N/A**	**353 101**	**N/A**	**0 507**	**N/A**	**353 608**

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The IHS is authorized by the Snyder Act of 1921, the Transfer Act and the Indian Health Care Improvement Act to use government funds to plan, construct, and staff facilities for the provision

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

Allocation Methodology

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

BUDGET JUSTIFICATION

The IHS requests an increase of $153 million for Staffing of New Facilities in FY 2024 and FY 2025 to provide staffing packages for seven newly constructed facilities. This includes:

- $91 million to fully-fund staffing and operating costs for four new or expanded facilities in FY 2025, all of which were constructed through the Joint Venture Construction Program; and

- $61 million to fully-fund staffing costs of 7 new or expanded facilities eligible for funds in FY 2024. This funding is included because the budget was developed before Congress completed action on a full year FY 2024 appropriations. Should Congress fully-fund these costs in FY 2024, this funding would become recurring and the increases would not need to be provided again in FY 2025.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

TABLE OF CONTENTS

Services

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

(Dollars in thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR/1	President's Budget	FY 2025 +/- FY 2023
PL	$4,433,191	$4,433,191	$5,124,813	+$691,622
FTE*	6,852	7,188	7,188	+336

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

SUMMARY OF THE BUDGET REQUEST

The FY 2025 Indian Health Service (IHS) Budget submission for Clinical Services is $5.1 billion, which is +$692 million above the FY 2023 Final level. This funding level includes additional resources for:

- Current Services (+$302 million),
- Staffing of Newly Constructed Facilities (+$136 million),
- Electronic Health Record (+$213 million),
- Hepatitis C/HIV (+$10 million),
- Opioids Grants (+$10 million),
- Assessments (+$4 million),
- National Community Health Aide Program (+$10 million), and
- New Tribes (+$6 million)

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

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

- **Electronic Health Record (EHR)**, holds an extremely high degree of mission criticality given the ability to provide much-anticipated clinical and administrative capabilities used in modern systems for the delivery of timely and impactful healthcare. Expected benefits from adopting and implementing a modernized or new system include but are not limited to improved patient safety, improved patient outcomes, better disease management, enhanced

population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, agency performance reporting, etc. By identifying and properly selecting the best match for proposed system capabilities, the system will support the IHS mission. Additionally, the IHS will obtain interoperability with the Department of Veterans Affairs, Department of Defense, tribal and urban Indian health programs, academic affiliates, and community partners, many of whom are on different Health Information Technology platforms. The IHS must consider an integrated EHR system solution that will allow for a meaningful integration to create a system that serves IHS/Tribal/Urban beneficiaries in the best possible way.

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

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

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

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

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

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

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.

OUTPUTS/OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
28 Unintentional Injury Rates: Age-Adjusted Unintentional injuries mortality rate in AI/AN population (Outcome)	FY 2012: 90.9 Target: Not Defined (Target Not In Place)	N/A	Retired	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 2023: 22.0% Target: 22.6% (Target Exceeded)	23%	23%	Maintain

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$2,503,025	$2,503,025	$2,929,915	+$426,890
FTE*	5,690	5,957	5,957	+357

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

The IHS system of care is unique in that personal health care services are integrated with community health services. The program includes public/community health programs targeting health conditions disproportionately affecting AI/AN populations such as diabetes, maternal and child health, and communicable diseases including influenza, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), syphilis, and viral hepatitis. The health status of AI/AN people has improved significantly in the past 60 years since IHS's inception. However, AI/AN people born today have a life expectancy that is 10.9 years less than the U.S. all races population, 65.2 years to 76.1 years, respectively.[1]

More than 60 percent of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to tribal governments or tribal organizations that design and manage the delivery of individual and community health services through 22 hospitals, 330 health centers, 559 ambulatory clinics,

[1] https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf

76 health stations, 146 Alaska village clinics, and 7 school health centers. The remainder of the H&HC budget is managed by direct federal programs that provide health care at the service unit and community level. The federal system consists of 21 hospitals, 53 health centers, 25 health stations, and 12 school health centers.

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.

The H&HC funds provide critical support for direct health care services, ensures comprehensive, culturally appropriate services, provides available and accessible personnel, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to raise the health status of AI/AN populations to the highest level.

BUDGET REQUEST

The FY 2025 budget submission for Hospitals and Health Clinics is $2.9 billion, which is $427 million above the FY 2023 Final level.

FY 2023 Final level Funding of $2.5 billion - supports the largest portion of clinical care at IHS and Tribal health facilities, including salaries and benefits for hospital/clinic administration; salaries and benefits for physicians, nurses, and ancillary staff; pharmaceuticals; and medical supplies. These funds make up the lump sum recurring base distribution to the Areas each fiscal year. Funding to support IHS facilities to promote efficient, effective, high quality care to the AI/AN population is also included in the base.

FY 2025 Funding Increase of $427 million includes:

- Indian Health Care Improvement Fund (IHCIF): +$74 million to realign the IHCIF from a separate budget line back into the H&HC budget line.

- Elimination of HIV, Hepatitis C (HCV), and Syphilis +$10 million to expand efforts to diagnose all HIV, HCV, and syphilis-positive, including congenital syphilis, IHS patients as early as possible after infection, treat those living with HIV, HCV, and syphilis rapidly to achieve and sustain viral suppression or cure, and protect individuals at high risk of HIV, HCV, and syphilis using medications like pre-and-post exposure prophylaxis (PrEP/PEP). These resources will also help the IHS to reduce new infections, and respond rapidly to growing clusters.

  The additional $10 million requested would:
  - Expand patient screening and treatment for those living with HIV, HCV, and syphilis;
  - Provide targeted pre-and-post-exposure therapies and expedited partner therapy to those at greater risk for acquiring HIV, HCV, and syphilis;
  - Effectively screen and treat those patients living with HIV, HCV, and syphilis;

- Sufficiently staff and resource oversight activities to ensure success;
- Bolster public health surveillance and data infrastructure;
- Evaluate these efforts; and
- Support outreach, education, and training.

The proposed funding level directly supports IHS's efforts to provide high-quality health care across the Indian health system. IHS will concentrate efforts on building up its HIV, HCV, and syphilis infrastructure in the 12 Area Offices and Service Units.

- National Community Health Aide Program (CHAP): +$10 million to further establish the evidence-based National CHAP, which will provide a network of health aides trained to support other health professionals while providing direct health care, health promotion, and disease prevention services. The program will increase access to direct health services, including inpatient and outpatient visits and will include additional staff.

    - The additional $10 million will support:
        - Training Center Network Development;
        - Dedicated CHAP Certification Boards; and
        - Tribal CHAP Expansion.

- Assessments: +$4 million to offset the cost of central assessments charged to the IHS. These charges are significant and affect the amount of care that can be provided to American Indians and Alaska Natives. Current agency resources are unable to fully absorb these costs, which must then be distributed across the agency, resulting in decrease resources for health services. Central assessments are costs for central services paid by assessment to HHS department operations.

- Current Services and Staffing of Newly Constructed Facilities: +$329 million. Information can be found in the Current Services and Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2021	$2,237,687,000
2022	$2,399,169,000
2023 Final	$2,503,025,000
2024 CR	$2,503,025,000
2025 President's Budget	$2,929,915,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

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

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

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

The OQ manages the Innovations Projects, which began its 7th year on October 1, 2023. Since its inception, the OQ has funded nineteen projects at federal sites and four at Urban Indian Organizations. IHS-operated Direct Service health care facilities develop and implement a quality improvement project with OQ coaching in quality improvement. These projects are selected to meet the demonstrated need of the population served, represent a significant innovation in improving the quality of care and outcomes for AI/AN patients, and, in FY 2024, must also address social drivers of health (SDOH). Further, the OQ can identify and develop proven innovative approaches for adaptation and replication in the IHS to widen impact. For example, lessons learned through the Yakama Service Unit project on Telehealth are informing the development and rollout of AA Ring MD, the IHS telehealth platform. The completed FY 2023 Innovations Projects are Yakama Service Unit: Telehealth for Chronic Conditions; Gallup Indian Medical Center: Improving Quality of Heart Failure Care for Patients; and Chinle Service Unit: Improving Patient Experience of Care by Expanding Interpreter Services, and Cultural Safety.

Starting in October 2022, the OQ led the Learning Lab to test and develop health-related social needs (HRSN) screening programs as a component of the IHS SDOH Strategic Plan. Four teams from different service units graciously aided the evaluation of HRSN screening tools, workflow, EHR integration, and data collection and analysis. The Learning Lab 2023 culminated in a published Toolkit leveraging lessons learned to facilitate HRSN screening programs in all IHS facilities. EHR enhancements to decrease the burden of documentation and reporting also resulted from this engagement and are expected in early 2024. These outcomes will support clinical care, accreditation, payer requirements compliance, and moving upstream to impact social drivers of health (SDOH) in the communities the IHS serves. Finally, the Learning Lab is anticipated to continue in 2024 to spread HRSN screening implementation and evaluate how to bridge the gap between clinical and community in working together to address SDOH.

Highlights in continued leadership development include engagements with senior leadership regarding the Baldrige framework in healthcare, relationship- and strengths-based team development (using the Strengths Deployment Index (SDI)), and facilitation of a governance approach in regular senior leadership meetings. Technical assistance requests, such as process mapping, were also supported to help teams achieve their desired outcomes for Agency-priority projects under the IHS Director's Work Plan for 2023. Additional leadership requests from Areas and HQ Offices for relationship- and strengths-based team development were supported.

The OQ continues to work towards a framework to capture those systemic structural and process measures that drive and inform our most important outcomes in serving AI/AN patients. In collaboration with the newly established Office of Clinical Performance and Health Impact (OCPHI), the OQ is adapting the Primary Health Care (PHC) framework from the World Health Organization, aligning with current efforts by HHS and States such as Massachusetts. To better capture patient experience data in the IHS, the OQ initiated a project to capture patient experience surveys by hosting it on the IHS' website and centralizing the data collection; this project is accepted into the development queue for 2024. This initiative will allow IHS Areas and HQ to track, trend, and compare patient experience data across the Agency, which will be required in the PHC framework.

The Division of Nursing Services – 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. Nurses are actively engaged in the transformation of the health care system by placing more emphasis on prevention, wellness, and coordination of care.

Emergency Medical Services for Children/Geriatric Emergency Department Accreditation
The IHS/Health Resources and Services Administration Emergency Medical Services for Children (EMSC) interagency agreement funding for FY 2023/FY 2024 continues to support a contract with Children's Hospital of Philadelphia (CHOP) to build and implement a hybrid simulation training program. The simulation training program pairs emergency departments with academic medical centers (AMC) to implement a curriculum of in-person or tele-simulations to prepare the interdisciplinary emergency room staff to become competent in the care of children and newborns during pediatric emergencies. Every participating site have designated a pediatric emergency care coordinator (PECC) to coordinate and implement pediatric specific activities such as pediatric care, education, and training. Thirteen (13) IHS and tribal EDs have a designated PECC, who will add to the sustainability of the training program. The IHS EMSC Hybrid Simulation Training Program has established partnerships with 13 AMCs. The AMC partners are emergency medicine attending physicians or fellows who volunteer their time to work with ED staff to run the hybrid simulations and to share evidence-based practices. In the third year of this program, the goal is to focus on quality improvement based on gaps in care found in the first two years.

The National IHS Geriatric ED Accreditation (GEDA) Initiative workgroup partnered with American College of Emergency Physicians Geriatric ED Accreditation Program to recruit 11 IHS and tribal EDs to pursue Bronze – Level 3 Geriatric ED Accreditation. Nine out of 11 participating EDs received Bronze – Level 3 accreditation. A second cohort of 5 facilities have begun their accreditation journey in FY 2023/FY 2024. The IHS and tribal Geriatric ED teams implemented geriatric-focused policies or protocols for Fall Prevention, Depression and Suicide Screening, Medication Management/Reconciliation, Geriatric Trauma Considerations, and Decreasing Prolonged ED Stays. The goal is to utilize the Geriatric Emergency Department

Accreditation program criteria to establish a defined standard of excellence for emergency care for geriatric patients in the IHS system.

Women's Health
The Women's Health Consultant continues to work in collaboration internally, and with our federal partners and other external agencies in order to improve health outcomes for American Indian and Alaska Native women and children, including participating in various internal and external workgroups and initiative meetings aimed at improving Women's Health, including: City Match; Health Resources and Services Administration/Centers for Medicare and Medicaid Services-Birthing Friendly Collaboration; Obstetrical Readiness/Maternal Safety; American Hospital Association, FY 2025 United States Department of Health and Human Services Maternal Health Workgroup, Alliance for Innovation on Maternal Health, and the Alliance for Innovation on Maternal Health Community Care Initiative, American College of Obstetricians and Gynecologists, Pre-Eclampsia Foundation, Association of Women, Health, Obstetric and Neonatal Nurses; United States Department of Health and Human Services Maternal Health Blueprint, Reproductive Health Task Force Data and Research subgroup; participated in planning of 4 interagency Reproductive Roundtables; Federal Partners Maternal Health Working Group; Maternal Health Convening; Alzheimer's Program Partnership, including Geriatric Emergency Department Accreditation Expansion Collaboration and Geriatric Fellowship development; Advanced Practice Registered Nursing Workgroup; Block Grant Evaluation Process- Montana and North Dakota, and collaboration with Office of Quality regarding maternal health tracers.

HIV Program –The overall HIV diagnosis trend shows a 17 percent decrease from the 2017 baseline. The rate of diagnoses of new HIV infection among AI/AN adults and adolescents increased by 10 percent between 2017 and 2021. From 2017-2021, the HIV diagnosis increased by 31 percent among AI/AN men with male-to-male (MSM) sexual contact as the mode of transmission. Among AI/AN women, the main transmission route was heterosexual contact, accounting for 63 percent of new diagnoses[2].

The CDC reported the death rate among AI/AN people living with HIV in 2021 was 63 percent higher than in 2017.[3] The rate of HIV-related deaths rose by 44 percent between 2017 and 2021. The increase in death rates from HIV confirms the need to continue providing the vital funding and resources needed to support IHS's HIV treatment programs like those at the Phoenix and Gallup Indian Medical. These sites use intensive and specialized case management to initiate care, adherence, and support for co-morbidities and social barriers that are unique to their patients' social and cultural contexts. The rate of viral suppression among AI/AN who received an HIV diagnosis in 2019 was 63 percent, lower than the 69.2 percent nationally.

The IHS increased overall prenatal HIV screening to 87 percent in FY 2016 – a 15 percent increase over FY 2006 data. To improve AI/AN access to healthcare in remote areas, the IHS HIV Program provides technical support to IHS, tribal, and urban Indian health sites on screening and treatment, and the use of telehealth.

In Summer 2023, the IHS National HIV/HCV Program received $11 million from the competitive HHS Minority HIV/AIDS Fund to expand partnerships between the IHS and Native communities

[2] Centers for Disease Control and Prevention. HIV Surveillance Report, 2021; vol. 34. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2023. Accessed January 12, 2024.
[3] Centers for Disease Control and Prevention. NCHHSTP AtlasPlus. https://www.cdc.gov/nchhstp/atlas/index.htm. Accessed January 12, 2024.

to End the HIV Epidemic in the U.S. National-level projects include Empowering Healthier Tribal Communities (National Native HIV Network, The Southern Plains Tribal Health Board "HIV Self-Testing" and "Tele-PrEP" pilot project, National Council of Urban Indian Health, and the Indigenous HIV/AIDS Strategy.

The IHS uses EHE funds to address diagnoses, prevention, and treatment activities associated with HIV, HCV and syphilis. Funds also support clinical training, including funding for an ECHO (Extensions for Community Health Outcomes) model for ongoing case-based training and technical assistance, and support national infrastructure and a national media campaign for HIV, HCV, and STI diagnosis, prevention, and treatment.

The National HIV/HCV Program continues to collaborate with OIDP to ensure IHS pharmacies and patients have the best possible access to PrEP drugs under the Ready Set PrEP (RSP) program.

In FY 2024, IHS added eight new FTEs to support the Ending the HIV Syndemic in Indian Country initiative from IHS headquarters and at least four IHS Area Offices.

Hepatitis C Virus (HCV) - As of 2021, AI/AN had three times the rate of acute HCV compared to Whites (2.7 vs. 0.9 per 100,000) and over three times the rate of HCV-related mortality compared to Whites (9.99 vs. 2.98 per 100,000)[4]. IHS data also identifies fewer than 1,000 HCV patients currently undergoing treatment. HCV death rates among AI/ANs are more than twice the national average compared to other ethnic groups.[5]

The IHS has sustained a steady increase in HCV screening[6]. The national recommendations since 2012 are to screen persons born 1945-1965, or 'baby boomers.' More recently, the IHS screening recommendations were expanded to all persons 18 years and older – called 'universal screening' – in large part because of data emphasizing the importance and effectiveness of early diagnosis, treatment, and cure. For boomers, IHS screening coverage increased from 11 percent in 2012 to 66 percent in 2019. These improvements in screening go hand-in-hand with changes at I/T/U facilities.

IHS aligned program initiatives with the *Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination 2021-2025* (Viral Hepatitis Plan or Plan), 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 65.6 percent in 2019. IHS anticipates higher costs associated with HCV care in FY 2024 and FY 2025 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.

Syphilis - Arguably, one of the next public health emergencies will be responding to the increase in syphilis. Gonorrhea and syphilis often present as co-morbid conditions with HIV diagnosis,

[4] Source: CDC Hepatitis Surveillance Report, 2021 https://www.cdc.gov/hepatitis/statistics/2021surveillance/hepatitis-c.htm

[5] https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm

[6] https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm

particularly among men who have sex with men (MSM). Data show that the incidence rates of chlamydia and gonorrhea among AI/AN people are approximately four times that of whites, and AI/AN have the second highest overall rates for both conditions when compared to all other races and ethnicities. Syphilis rates among AI/AN are five times that of whites[7]. Recent and sustained outbreaks of syphilis have also been observed among AI/AN communities, some related to injection drug and methamphetamine use, and both are recognized risk factors for HIV transmission.

For AI/AN women, the incidence of primary and secondary syphilis in 2019 was three-fold higher than that for non-Hispanic White women (15.4 vs. 2.3 per 100 000)[8]. Congenital syphilis cases among AI/AN were higher than for any other race or ethnicity in the US, increasing from 10.7 cases per 100 000 in 2015 to 154.9 per 100 000 in 2019, a 1348 percent increase[9].

Strategies and activities developed by IHS include:

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

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

- Office of Information Technology/Office of Resource Access and Partnerships (OIT/ORAP) Conference Participation: The CHAP Team's involvement in the OIT/ORAP Partnership Conference in Atlanta, Georgia, marked a significant step in enhancing inter-organizational collaboration and visibility. Collaborating with the Massachusetts Institute of Technology Research and Education, contracted business process modeling experts, the team presented in-depth insights about CHAP's critical role within OIT and Business Office systems, highlighting CHAP's heritage and its active involvement in Tribal and Federal collaborations, and positioning the CHAP for national expansion**.**
- National Standards and Procedures Workgroups Launch: The initiation of the National Standards and Procedures Workgroups, with a virtual orientation, was a significant move to foster high standards and collaborative efforts.

[7] Centers for Disease Control, STI Surveillance Report, 2021 https://www.cdc.gov/std/statistics/2021/tables.htm

[8] CDC Atlas which you can cite as "Centers for Disease Control and Prevention. NCHHSTP AtlasPlus. https://www.cdc.gov/nchhstp/atlas/index.htm. Accessed 03/01/2024

[9] Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2019. Atlanta: U.S. Department of Health and Human Services; 2021. (Note: The data can be found at https://www.cdc.gov/std/statistics/2019/std-surveillance-2019.pdf notes on slide 51.)

- EHR Modernization Protocol Development: The CHAP Team's efforts in outlining EHR Modernization protocols, in collaboration with IT and Business Office, underscore the importance of technology in healthcare management. This initiative focuses on enhancing EHR accessibility, streamlining community documentation processes, and ensuring effective EHR communications.
- Information Collections and the System of Records Notice (SORN) Submission[10] to Congress and OMB: The publication of the SORN in the Federal Register represents a crucial step in regulatory compliance, signifying progress in aligning CHAP with current legislative and regulatory frameworks, contributing to Strategic Plan Goal 2, Objective 2.1. The SORN is a single piece of the larger Information Collection which will require extensive work to review and map out processes integral to the CHAP certification processes, including additional publication in the Federal Register. Additionally, the development of a contract with a FedRamp certified contractor to store all CHAP records electronically will be required as of June, 2024. File storage sufficient to house this nation-wide program will require funding not currently available under current budgetary constraints.
- Establishment of Qualitative Metrics and Data Collection Systems: The CHAP Team's efforts to establish robust qualitative metrics and advanced data collection systems for CHAP services aim to showcase the program's transformative impact. This initiative seeks to enhance support and expand outreach, facilitating objective reporting and highlighting the uniqueness and innovation of CHAP programs, especially in serving Native American communities.
- Grant Activities to Increase Tribal Healthcare Capacity: The pandemic significantly raised tribal interest in CHAP. In 2023, four Tribal Assessment and Planning and five Tribal Planning and Implementation grants were awarded, indicating strong commitment to expansion of healthcare service delivery. Grantees are located in the Billings, Oklahoma City, California, Great Plains and Portland Areas. The ten grants awarded previously resulted in extraordinary growth in CHAP Certification Board readiness, monumental progress in the development of area-specific standards and procedures, readiness surveys, community and staff education and program staff development, along with a myriad of other program actions. The program also saw high participation in technical assistance webinars. Tribes have stated the available funding is insufficient to meet the CHAP implementation demands and/or that the grant application process is too time-consuming for the limited funds available. Grant applications and activities would likely increase if additional funds were made available.
- Expanding Understanding of the Role of Dental Health Aides and Dental Health Aide Therapists: The CHAP Dental subject matter expert presented an overview of the comprehensive training of Dental Health Aides and Dental Health Aide Therapists at the National Oral Health Council meeting, which is the preeminent meeting of dental educators, globally. Improving education is essential to program growth. At this time, such outreach is limited due to financial constraints.
- Strategic Collaboration with the Office of Minority Health (OMH)**:** The strategic collaboration between the OMH and CHAP to develop the Community Health Aide Program Readiness Assessment Project (CHAPRAP) Toolkit (Toolkit) provides an invaluable resource for Tribal Communities to assess and prepare for CHAP implementation. The partnership has worked diligently to fine-tune the Toolkit, ensuring a resource progressing from initial assessment through program sustainability that is culturally sensitive and relevant to the variable levels of program readiness.

[10] https://www.federalregister.gov/documents/2023/10/31/2023-23964/privacy-act-of-1974-system-of-record

- Partnership with the Substance Abuse and Mental Health Support Association (SAMHSA): SAMHSA has supported the CHAP to develop a Behavioral Health Aide curriculum.
- Area Office Transfers: Although a large portion of the CHAP is designed to be tribally led, other portions are inherently Federal. Area Offices are instrumental in the development of the Federal Area Certification Boards (ACBs), central to the CHAP certification process. Annual transfers of $160,000 have been made to two IHS Areas demonstrating significant advancement in ACB and other Area-level CHAP infrastructure development. These funds are woefully inadequate to meet the expenses associated with this monumental task. Additional Areas will be requesting funds as their Area-level infrastructure continues to progress. Area Directors have requested additional funds to improve funding of staff dedicated to CHAP which will improve the momentum of CHAP development.

Domestic Violence Prevention (DVP) Program –
The DVP program was established in 2015, as a nationally coordinated program that provides culturally appropriate domestic violence and sexual assault prevention and intervention resources to AI/AN communities with a focus on providing trauma informed services. In FY 2022, IHS awarded $7,400,000 in funding to thirty-seven (37) Tribal, Tribal organization, and Urban Indian Organization projects. The IHS also awarded a total of $1,000,000 annually, for a five year funding cycle to Forensic Health Care (FHC) service grantees that will support four Tribal, Tribal organization, and Urban Indian Organization facilities. IHS anticipates releasing data from all grant-based partners for Year One in FY 2024. This report will include tribal grant-based partners completed for any types of violence and screenings specific to sexual assaults for FY 2023 including health and legal services for victims of violence. In FY 2024 and FY 2025, the DVP program will continue the collection of annual data on services provided.

The Indian Health Service (IHS) Forensic Health Care (FHC) Program was established to address sexual assault, intimate partner violence, child sexual abuse, and elder maltreatment within American Indian and Alaskan Native (AI/AN) communities. In FY 2025, The FHC team will continue to provide subject matter expertise, policy development, training, education, and technical assistance to strengthen comprehensive medical forensic services across Indian country. In 2023, IHS awarded Texas A&M University Center of Excellence in Forensic Nursing to provide specialized training and technical assistance for tribal programs and healthcare providers to ensure I/T/U healthcare providers have the necessary training and education to care for patients, families, and communities affected by violence, and ensure patients have access to appropriate resources, such as patient-centered, trauma-informed medical forensic examinations, including additional pathways to connect with advocates and the criminal justice system. Additionally, in FY 2023, the IHS established a Forensic Healthcare Funding Opportunity[11] – Building Capacity to Develop and/or Expand Forensic Services awarding $10,000,000 over a five-year period which includes funding to federal IHS sites (e.g., IHS Service Units, IHS Clinics, or IHS hospital). The funding opportunity is designed to support building a community's capacity by forensic nursing program development and/or expansion through training opportunities for healthcare providers. Finally, in FY 2023, IHS created a guidebook titled Forensic Health Care and Caring for American Indian and Alaska Native Patients. The purpose of the guidebook is to enhance care delivery, provide resources, and support for forensic healthcare providers serving in the I/T/U settings.

[11] Federal Register :: Domestic Violence Prevention: Forensic Healthcare Services

Maternal Health - Obstetrics

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

- IHS and Tribal sites have engaged in implementation of the Alliance for Innovation on Maternal Health (AIM) bundles, with an early emphasis on implementation of the Obstetric Hemorrhage and Hypertension bundles and other bundles as prioritized by the individual sites.
- In response to the closure of rural obstetric units and decline in national birth volume, IHS has prioritized simulation drills for obstetric emergency preparedness. Many IHS clinicians have completed the Advanced Life Support in Obstetrics (ALSO) course, which are offered regularly across the I/T/U system. IHS has expanded the Obstetric Readiness in the Emergency Department (ObRED) program to include a manual and training. The draft manual has been reviewed by 20 IHS and tribal sites. Five sites have participated in ObRED simulation training with 225+ staff trained, resulting in increased staff confidence with management of obstetric emergencies. IHS will standardize this manual and training and scale up to provide technical assistance and training to other Areas. This simulation program is following the Emergency Medicine principles of quality improvement, emphasizing attention to tools, training, and tracking.
- To increase education, consultation, and resources for the clinical workforce, IHS has developed a monthly Indian Country ECHO Care and Access for Pregnant People in partnership with the Northwest Portland Area Indian Health Board (NPAIHB). The first three webinars on congenital syphilis, substance use in pregnancy, and Indigenous birthing practices were attended by 835 participants across IHS and 764 have registered for the 2024 series.
- IHS has supported self-efficacy in prenatal care and provided glucometers, continuous glucose monitors (CGMs), and blood pressure cuffs when indicated. A new Maternal Child Health (MCH) initiative will work to study acquisition, distribution, accuracy and clinical utility of Self Measured Blood Pressure (SMBP) cuffs.
- IHS has had a consultative relationship with the American College of Obstetricians and Gynecologists (ACOG) Committee on American Indian and Alaska Native Women's Health for over 50 years. ACOG provides quality-benchmarking site visits, guidance on maternity care and women's health best practices, and ongoing training for IHS, Tribal, and Urban staff and a biennial "Meeting on Indigenous Women's Health" which provides an important forum to address common themes and share solutions.

Breastfeeding

All federal hospitals providing planned birth services have earned the "Baby Friendly" designation by Baby-Friendly USA. Comprehensive breastfeeding education and continued lactation support are mainstays of this designation. The Baby Friendly Hospital designation ensures education is provided during prenatal care and lactation support is routinely offered throughout the hospital stay and postpartum. IHS further promotes breastfeeding opportunities through the Baby Friendly Hospital Initiative, building organizational capacity and practice-based resources, developing partnerships to advance breastfeeding, and incorporating breastfeeding into its robust public health programs.

Baby-Friendly hospital designation naturally leads to education and support of breastfeeding to become engrained in daily operations of the hospitals. Education on early warning signs, how to recognize these warning signs, when to return to care, whether that should be for routine or

emergent care, and information on a large network of resources available for new mothers are important pieces of this breastfeeding support post-discharge. In addition to efforts specifically related to maintaining the BF Hospital designation, IHS continues to monitor Government Performance and Results Act (GPRA) rates and several sites have initiated intensive QI projects around breastfeeding. IHS has built partnerships between Tribes and the AIM Community Care Initiative (AIM CCI) and has enjoyed a long-standing partnership with the American Academy of Pediatrics-Committee on Native American Child Health (CONACH) and works closely with these entities in implementation of any recommendations to improve infant feeding outcomes and resultant child health indicators.

Alzheimer's and Elder Care

In 2022, the IHS established the Alzheimer's Grant Program. Work is focused on four main IHS priorities identified through tribal consultation and urban confer. These priorities are pillars of the new IHS Elder Health team's vision of optimized quality of life and longevity for older AI/AN people, their caregivers, and their families. Pursuant to the FY 2021 Consolidated Appropriations Act (P.L. 116-260), the IHS Alzheimer's Grant Program targets resources directly to Tribes, Tribal organizations, Urban Indian organizations, and IHS direct service hospitals and clinics to build local capacity (priority area one). The program is also developing initiatives supporting workforce development, education, and training aimed at improving the diagnosis and management of dementia and the provision of caregiver support services (priority two). Priority three focuses on increasing outreach, awareness, and recognition. Data and systems to drive decision-making and transform care (priority four) underpins all priorities.

For a complete set of 2023 program accomplishments or more details, please refer to the Office of Clinical and Preventive Services (OCPS) annual accomplishments and the National Plan to Address Alzheimer's Disease: 2023 Update.

Program Infrastructure

- Onboarded a new management analyst in July 2023.
- Participated in multiple federal Councils and interagency workgroup meetings, including the DHHS Advisory Council on Alzheimer's Research, Care, and Services (NAPA); National Alzheimer's Project Act (NAPA); RAISE Family Caregiving Advisory Council; CDC's leadership committee for the Healthy Brain Initiative Road Map for Indian Country, and Elder Justice Interagency Workgroup, and others.
- Participated in multiple public-private committees and workgroups, including the Dementia Friendly America National Council, Alliance to Improve Dementia Care, Public Health Center of Excellence on Early Detection of Dementia Advisory Group, and joined The Data Project, an NIA-funded dementia research consortium.
- Convened multiple meetings with formal and informal external organizations to foster ongoing collaboration and explore new formal engagement opportunities.

Local Tribal Capacity Building: Disseminating Funding and Resources

- Announced eight new tribal and urban Indian health clinic and systems grant awards in September 2023[12], bringing the total to 12. Developed a new NOFO for additional three-year models of care expansion grants to be awarded in FY 2024.
- Initiated an enhanced intensive grantee technical assistance approach incorporating one-on-one monthly calls, quarterly collaborative meetings, and engagement in early site visit planning and implementation to accelerate and enhance performance and monitoring.

[12] IHS Awards $1.5 Million to Address Alzheimer's Disease on World Alzheimer's Day | 2023 Press Releases

- Collaborated with the Division of Oral Health to offer clinical support for a pilot project at five sites to increase recognition of cognitive impairment in dental settings.
- Initiated planning and recruitment for a six 6-month Community Health Representative (CHR) multi-site pilot to test the use of the Mini-Cog dementia screening tool.
- Partnered with the IHS Division of Nursing to recruit a second cohort for the American College of Emergency Physician's Geriatric Emergency Department Accreditation.
- Initiated work with the Alzheimer's Association adapting clinical pathway resources for rural and frontier IHS and Tribal clinics.
- Exploration of a CHR-led risk reduction pilot program based on existing global dementia risk reduction research findings planned for 2024.
- Collaborated to bring together grantees funded through the IHS Alzheimer's Grant program, ACL, and CDC at the ACL National Title VI Training.
- Initiated planning for the 2024 national division-wide conference to feature Alzheimer's and elder health content, and grantee, scholar, and fellowship affinity meetings for best practice sharing and training.

Workforce Development, Training, and Technical Assistance

- Implemented year one of the Indian Health Geriatric Scholar (IH GeriScholars) pilot[13], modeled after the VA program, for 15 physicians, nurse practitioners, physician assistants, and pharmacists at 10 sites. Recruited a second cohort of GeriScholars from 14 sites.
- Planned and implemented recruitment for a new Geriatric Nurse Fellowship[14] that attracted 19 APRNs, RNs, and LPNs; offering protected time for training and skill building.
- Conducted an environmental scan of available federal and non-federal dementia training and certification programs to inform future planning, including recruitment of more than 30 APRNs and RNs to evaluate the content of a Dementia Care Specialist Course.
- Finalized an acquisitions package for a base + 4 dementia workforce training and education contract with an RFQ issued in December 2023.
- Hosted a Models of Dementia Care Webinar Series[15] (five sessions) in the spring of 2023 to increase awareness and stimulate interest in adapting models of care and services for over 200 individuals representing all 12 IHS areas.
- Initiated two new Dementia teleECHO (ECHO) series in partnership with the Indian Country ECHO program of the Northwest Portland Area Indian Health Board, reaching 526 participants with clinical training, case-based education, and mentorship.
- Partnered with the IHS CHR program in a collaboration with the University of Oklahoma (OU) Health Sciences' GWEP program to disseminate the OU CHW/CHR dementia training, developed in conjunction with local Tribal community health staff.
- Completed an environmental scan of existing dementia caregiver interventions and reviewed experiences of IHS and Tribal programs in REACH into Indian Country pilot.

Outreach, Awareness, and Recognition

- Awarded a base + 4-year Alzheimer's Communications Contract for work on biweekly e-newsletter, videos, social media, and website redesign.

[13] Indian Health Geriatric Scholars Pilot Program | Alzheimer's Training and Education (ihs.gov)

[14] Indian Health Geriatric Nurse Fellowship Program | Alzheimer's Training and Education (ihs.gov)

[15] Webinars | Alzheimer's Training and Education (ihs.gov)

- Health promotion and awareness for nine observances, including World Elder Abuse Awareness Day, Alzheimer's Day, Falls Prevention, and more.
- Initiated a targeted awareness-building campaign including social media, IHS Week in Review, two IHS blog posts, IHS area office newsletter stories, development of a YouTube channel. Social media messages reached 167,691 people through July 2023.
- Conducted 12 presentations about dementia and the IHS Alzheimer's Program efforts.
- Modified IHS Listserv technology to enhance dissemination opportunities and create communities of practice.

Data to Inform Decision-Making and Transform Care

- Developing the Alzheimer's and Elder Care Data Dashboard.
- Collection and analysis of data from Grant Program participants and other new and emerging Alzheimer's Program initiatives and activities to support evaluation, possible pilot expansions, increase evidence-based knowledge, and drive program enhancements.

Emergency Medical Services for Children

The Indian Health Service (IHS) Emergency Medical Services for Children (EMSC) Program is working to expand and improve pediatric emergency care for American Indian and Alaska Native (AI/AN) children and youth. AI/AN children and youth are at greater risk for unintentional injuries which are the leading cause of mortality and morbidity in tribal communities. IHS EMSC Program and the HRSA Maternal Child Health Bureau work collaboratively through an Inter-Agency Agreement (IAA) to bring resources, expertise and supported efforts to improve EMSC in IHS and Tribal Healthcare programs. This collaboration through the IAA ensures that quality pediatric emergency care and resources continue to be improved for and are accessible to AI/AN children and youth. A joint policy statement and technical report from the American Academy of Pediatrics (AAP) and several other EMS agencies recommended the development of EMS infrastructure and oversight that includes evidence-based, pediatric-specific equipment, training, skills standards to support the care of pediatric patients[16].

The IHS EMSC Program funds) a contract with Children's Hospital of Philadelphia to develop a hybrid simulation training program. The training program partners emergency departments (ED) pediatric emergency care coordinator (PECC) with academic medical centers (AMCs) to implement a curriculum of in-person and tele-simulations to prepare interdisciplinary ED staff and pre-hospital EMS personnel to become competent in the care of children and newborns during pediatric emergencies. The goal is to replicate the hybrid simulation training program and develop the Pediatric Emergency Care Coordinator (PECC) role for all IHS emergency departments and pre-hospital EMS partners to ensure safe, high-quality emergency care and EMS transport.

FUNDING HISTORY: IHS – HRSA INTERAGENCY AGREEMENT

Fiscal Year	Amount
2020	$150,000
2021	$150,000
2022	$150,000
2023	$150,000

[16] https://publications.aap.org/pediatrics/article/145/1/e20193308/36984/Pediatric-Readiness-in-Emergency-Medical-Services

2024	$150,000

For fiscal years 2021 – 2024, the IHS EMSC Hybrid Simulation Program had 13 participating IHS and tribal emergency departments (EDs).

The hybrid simulation program pilot outcomes[17] for 2023 were: 1) 100 percent compliance with curriculum by AMC-PECC dyads at 13 sites, 2) 100 percent PECC and AMC retention for FY 2022 – 2023, 3) A Net Promoter Score of 69/100 – participants would recommend the program to colleagues, 4) Demonstrated change in provider knowledge, attitudes, and teamwork during simulations, and 5) Obtained Pediatric Readiness Score for each site. The IHS EMSC Hybrid Simulation Program has had positive and direct impact to pediatric emergency care and met essential training needs, especially during the COVID-19 pandemic.

Pediatric investments in 2025 include expanding the IHS EMSC Hybrid Simulation Program to six more IHS/tribal emergency departments. Additional pediatric investments will also include pediatric-specific education and training for ED staff to acquire and maintain advanced certifications such as the Neonatal Resuscitation Program, Certified Pediatric Emergency Nurse, and Pediatric Advanced Life Support. Other important use of funds will be used for equipment and supplies to help provide specialized pediatric equipment for ambulance transports of pediatric and special needs infants and children. IHS will continue to engage and promote concerted outreach to IHS and Tribal sites to support their participation in National Quality Improvement Projects hosted by the EMSC Innovation and Improvement Center and the Regional Pediatric Pandemic Network – collaboratives include: the EMSC Mental Health QI Collaborative project, the EMSC Pediatric Readiness Quality Collaborative, the PECC Workforce Development Collaborative, the Disaster Networking QI Collaborative, and the ED STOP Suicide Collaborative.

OUTPUTS/OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
20 100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited or certified (excluding tribal and urban facilities). (Outcome)	FY 2023: 96% Target: 100 % (Target Not Met)	100 %	100 %	Maintain
55 Nephropathy Assessed (Outcome)	FY 2023: 42.5% Target: 45.1% (Target Not Met)	45.1%	44.8%	-0.3 percentage point(s)

[17] EMSC Innovation and Improvement Center working with IHS: https://emscimprovement.center/

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
56 Retinopathy Exam (Outcome)	FY 2023: 45.2% Target: 44.7% (Target Exceeded)	44.7%	47.6%	+2.9 percentage point(s)
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 2023: 35.9% Target: 40.9% (Target Not Met)	40.9%	37.8%	-3.1 percentage point(s)
67 Influenza Vaccination Rates among children 6 months to 17 years (Outcome)	FY 2023: 17.4% Target: 19.8% (Target Not Met)	19.8%	18.3%	-1.4 percentage point(s)
68 Influenza vaccination rates among adults 18 years and older (Outcome)	FY 2023: 19.9% Target: 19.7% (Target Exceeded)	19.7%	21.0%	+1.3 percentage point(s)
70 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2023: 35.0% Target: 37.8% (Target Not Met)	37.8%	36.9%	-0.9 percentage point(s)
72 Tobacco Cessation Intervention (Outcome)	FY 2023: 26.1% Target: 24.4% (Target Exceeded)	24.4%	27.5%	+3.1 percentage point(s)
73 HIV Screening Ever (Outcome)	FY 2023: 40.3% Target:	38.9%	42.5%	+3.6 percentage point(s)

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
	38.9% (Target Exceeded)			
74 Breastfeeding Rates (Outcome)	FY 2023: 41.8% Target: 42.6% (Target Not Met but Improved)	42.6%	44.1%	+1.4 percentage point(s)
75 Controlling High Blood Pressure - MH (Outcome)	FY 2023: 45.7% Target: 45.8% (Target Not Met)	45.8%	48.2%	+2.3 percentage point(s)
81 Increase Intimate Partner (Domestic) Violence screening among American Indian and Alaska Native (AI/AN) Females (Outcome)	FY 2023: 28.9% Target: 29.6% (Target Not Met but Improved)	29.6%	30.5%	+0.9 percentage point(s)
87 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Output)	FY 2023: 38.4% Target: 28.7% (Target Exceeded)	28.7%	40.5%	+11.7 percentage point(s)
88 Colorectal Cancer Screening Rate (Outcome)	FY 2023: 23.3% Target: 23.7 % (Target Not Met)	23.7%	24.6%	+0.9 percentage point(s)
89 Cervical Cancer Screening (Outcome)	FY 2023: 33.8% Target: 33.2% (Target Exceeded)	33.2%	35.6%	+2.4 percentage point(s)
91 Adult Composite Immunization (Output)	FY 2023: 37.0% Target: 37.0% (Baseline)	37.0%	39.0%	+2.0 percentage point(s)

GRANT AWARDS - H&HC funds support the Healthy Lifestyles in Youth Project,[18] a $1.3 million 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 DVP Program grants.

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

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Number of Awards	84	84	84
Average Award	$148,207	$148,207	$148,207
Range of Awards	$49,750-$1,250,000	$49,750-$1,250,000	$49,750-$1,250,000

AREA ALLOCATION

Hospital and Health Clinics

(dollars in thousands)

DISCRETIONARY	FY 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY '23
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$5,212	431,880	$437,092	$5,214	$431,877	$437,091	$6,104	$505,533	$511,637	$74,545
Albuquerque	48,876	40,876	$89,752	48,897	40,876	$89,773	57,237	47,847	$105,084	$15,332
Bemidji	30,236	84,099	$114,335	30,249	84,098	$114,347	35,408	98,441	$133,849	$19,514
Billings	51,675	19,962	$71,637	51,697	19,962	$71,659	60,514	23,366	$83,881	$12,244
California	3,994	77,785	$81,779	3,996	77,784	$81,780	4,677	91,051	$95,728	$13,949
Great Plains	115,211	102,028	$217,239	115,261	102,027	$217,288	134,919	119,428	$254,347	$37,108
Nashville	23,372	73,544	$96,916	23,382	73,543	$96,926	27,370	86,086	$113,456	$16,540
Navajo	193,082	84,489	$277,571	193,165	84,488	$277,654	226,110	98,898	$325,008	$47,437
Oklahoma	107,655	388,985	$496,640	107,702	388,982	$496,684	126,070	455,323	$581,393	$84,753
Phoenix	127,263	150,291	$277,554	127,318	150,290	$277,608	149,032	175,922	$324,954	$47,400
Portland	26,563	57,654	$84,217	26,574	57,654	$84,228	31,107	67,486	$98,593	$14,376
Tucson	2,024	20,119	$22,143	2,025	20,119	$22,144	2,370	23,550	$25,920	$3,777
Headquarters	235,591	150	$235,741	235,693	150	$235,843	275,890	176	$276,066	$40,325
Total, H&HC	**$970,754**	**$1,531,862**	**$2,502,616**	**$971,174**	**$1,531,851**	**$2,503,025**	**$1,136,807**	**$1,793,108**	**$2,929,915**	**+$427,300**

1/ Note: 2023, 2024, and 2025 are estimates.

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 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$2,503,025	$2,503,025	$2,929,915	+$426,890
Epi Centers	*$34,433*	*$34,433*	*$34,443*	-

1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization ..... Permanent

Allocation Method ..... Cooperative Agreements

PROGRAM DESCRIPTION

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

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

The TEC program funds eleven TECs that provide comprehensive geographic coverage for all IHS administrative areas and one additional TEC serving American Indian and Alaska Native (AI/AN) populations residing in major urban centers. The TEC Program supports Tribal communities by providing technical training and assistance in applied public health practice and prevention-oriented research, and by promoting public health career pathways for Tribal members. Beginning in FY 2021, a significant portion of TEC activities have been devoted to supporting Tribes in confronting the COVID-19 public health emergency.

Annually, approximately 95 percent or more of the TEC Program budget is distributed to TECs through cooperative agreements based on a 5-year competitive award cycle. In the current 5-year award cycle beginning in FY 2021 the average annual award was $699,073 increasing to $2,547,000 in FY 2023.

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

The work of the TECs to collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the IHS, Indian Tribes, Tribal organizations, and urban Indian organizations in each IHS service area is an essential part of reducing health disparities in the AI/AN population by highlighting disparities. This includes identifying the significant and disproportionate impacts of many health conditions, including the COVID-19 pandemic, the Opioid crisis in Indian Country, and the epidemic of HIV/AIDS, HCV, and sexually transmitted infections.

BUDGET REQUEST

The FY 2025 budget submission for the TECs under Hospitals and Health Clinics (H&HC) is $34 million and is the same as the FY 2023 Final level.

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

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

FUNDING HISTORY

Fiscal Year	Amount*
2021	*$10,433,361*
2022	*$24,433,361*
2023 Final	*$34,433,361*
2024 CR	*$34,433,361*
2025 President's Budget	*$34,433,361*

*Funded under the Hospitals & Health Clinics budget.

PROGRAM ACCOMPLISHMENTS

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

Technical Assistance and Tribal Support

Technical assistance and trainings offered by the TECs are designed to be responsive to the needs and interests of the communities they serve. This focus on Tribal and community requests is balanced by comprehensive epidemiological work to educate communities on the conditions and disparities that affect their citizens.

Nationally-Managed Data Projects that Engage Local Resources

Data generated locally and analyzed by TECs enable Tribes to evaluate 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 that designates the TECs as public health authorities in regards to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This designation permits TECs to access IHS-generated data sets used to support various public health activities.

Continued COVID-19 Response Activities

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

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

In 2021, six TEC programs successfully competed for supplemental funding to support the establishment and/or expansion of Tribal Public Health Departments (TPHDs). In FY 2023, they reported progress on providing trainings to TPHDs on a variety of topics, including grant writing, COVID-19 response, cancer prevention and control, motor vehicle safety, injury prevention, and, behavioral health.

DISCUSSION

The TECs provide critical support to the communities they serve. In FY 2022, TECs responded to 3,369 requests for technical support (EPI-4) and completed 1,197 TEC-sponsored trainings for tribal public health capacity building (EPI-5). Recent increases in technical support and trainings from prior years likely reflect expanded Tribal Public Health activities and needs during the COVID-19 response. Technical support delivery showed a decrease from 2021 activity levels.

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

OUTPUTS AND OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 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 2022: 3369 Target: 1897 (Target Exceeded)	1897	1897	Maintain
EPI-5 Number of TEC-sponsored trainings and technical assistance provided to build tribal public health capacity. (Output)	FY 2022: 1197 Target: 89 (Target Exceeded)	200	200	Maintain

GRANTS AWARDS

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Number of Awards	12	12	12
Average Award	$2,547,000	$2,547,000	$2,547,000
Range of Awards	$2,532,500 - $2,557,100	$2,532,500 - $2,557,100	$2,532,500 - $2,557,100

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

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$2,503,025	$2,503,025	$2,929,915	+$426,890
HIT	*$182,149*	*$182,149*	*$182,149*	-

1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

1) **Health Information Technology Systems and Support (HITSS)** investment provides an enterprise health information system supporting the underlying IT layer of the clinical,

practice management, and revenue cycle business processes at I/T/U facilities nationwide. The HITSS investment encompasses the Resource and Patient Management System (RPMS) EHR that is certified according to criteria published by the ONC and is in use at approximately 430 healthcare facilities across the country. The RPMS Network is evolving to support health information sharing within the I/T/U enterprise, external connections through the eHealth Exchange, and better patient engagement to support quality initiatives and the Medicare Access & Children's Health Insurance Program Reauthorization Act (MACRA) of 2015.

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

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

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

5) **IT Management** investment is an enterprise-wide IT Governance program that provides IT Management, Capital Planning Investment Control, Strategic Planning, Enterprise Architecture, IT Finance, and IT Vendor Management activities for all IHS IT investments. These essential activities promote compliance with federal laws and regulations to improve the efficiency and effectiveness of all IHS HIT portfolio investments.

BUDGET REQUEST

The FY 2025 budget submission of $182 million for Health Information Technology is the same as the FY 2023 Final level.

This funding will continue progress made in past years by minimizing infrastructure costs and maintaining a high level of productivity and commitment by both federal and contractor staff supporting the IHS-developed health information solutions. IHS uses open-source tools where possible to minimize acquisition costs. Following the VA announcement to sunset their VistA EHR application the IHS and HHS Chief Technology Officers began an analysis of alternatives to assess the sustainability of the entire RPMS HIT platform. The HHS-IHS HIT Modernization Research Project to examine alternatives to replace or modify RPMS as the IHS HIT platform was completed in FY 2020. The HIT Modernization Project identified the need to change the current EHR platform to a modern commercial-off-the-shelf (COTS) EHR to improve the impact and quality of direct patient care, increase cost recovery and promote continuous health improvements, expanded telehealth care services, as well as predictive population health analytics. The current RPMS infrastructure must be maintained during the implementation period of the new Oracle Healthcare EHR system.

FUNDING HISTORY

Fiscal Year	Amount*
2021	$182,149,000
2022	$182,149,000
2023 Final	$182,149,000
2024 CR	$182,149,000
2025 President's Budget	$182,149,000

*Funded under the Hospitals & Health Clinics budget.

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

The Office of Information Technology (OIT) successfully provided a secure and effective suite of technology solutions to support the agency and its mission throughout the country. Collaboration with tribal health programs and other federal agencies is key to the success of the HIT Portfolio. IHS works closely with the ONC, CMS, Agency for Healthcare Research and Quality, VA, and other federal entities on IT initiatives to ensure the direction of its HIT systems is consistent with other federal agencies. In addition, IHS has routinely shared HIT artifacts (e.g.,

design and requirement documents, clinical quality logic, etc.) with both public and private organizations.

The Health Information Technology Systems and Support (HITSS) program completed development for the 2015 Edition Cures Update for the Certified Electronic Health Record criteria required for 2022. IHS will continue development work to meet the remaining ONC requirements for 2024. Deployment of the certified software is complete for 2023. The HITSS program supported rapid development and deployment of software updates in response to the COVID-19 pandemic to support new diagnoses code sets, laboratory testing and results, and vaccine administration and reporting to the Centers for Disease Control (CDC). The program's work to support COVID includes major development to provide mechanisms for centralized reporting through the AIMS portal for COVID lab testing, as well as the development of a centralized COVID vaccine reporting system, which also feeds a national dashboard available to IHS stakeholders. As part of the Agency's effort for stabilization and modernization, the HITSS program completed the 4 Directions Hub pilot project focused on health information exchange within the government as well as the eHealth Exchange. Pilot sites were onboarded and completed testing with the Veteran's Administration (VA). The HITSS program certified our software to the FY 2022 eCQM certification requirements, and also completed the bi-annual re-certification of Electronic Prescribing of Controlled Substances (EPCS) capabilities. The HITSS program completed a major software infrastructure database upgrade, which facilitates the ability for sites to participate in planned health information exchange and interoperability requirements that were delivered with the 21 Century Cures Act initiative. HITSS also successfully implemented a replacement for the Immunization Forecasting software used across our facilities.

For 2024, the HITSS program will continue to develop software to comply with new requirements for the ONC Certification. The development will continue with the United States Core Data for Interoperability application for the ONC Standards Version Advancement Process requirement, the Electronic Health Information Export, and the Antimicrobial Resistance capability reporting. Other initiatives include development and testing software for the new Windows 11 desktop platform, mandated IPv6 transitions, implementing the Zero Trust Architecture, O&M for server database vendor updates, and implementing Project US@ - Unified Specification for Address in health care.

In addition to the high-velocity response to COVID, our HITSS program staff delivered 9 full version updates, and 42 required maintenance updates in FY 2023.

In response to the social distancing guidance, IHS adjusted the delivery of training to focus on virtual offerings. The program provided 317 HIT training courses to 11,919 I/T/U users in FY 2022. As of January 2023, the program provided 108 HIT training courses to 4,917 I/T/U users. Over 528,287 messages were exchanged between patients, providers, administrators, message agents, and external HISPs through approximately 55,236 unique direct e-mail addresses since Sept 2015. The IHS Personal Health Record (PHR) has approximately 51,827 total users, and 49 percent of these registered PHR users were verified/linked to their IHS Medical Record. The remaining 51 percent are registered but not yet verified/linked.

The National Patient Information Reporting System (NPIRS) investment continues to enhance the IHS Disease Surveillance solutions in response to the COVID-19 pandemic. The initial NPIRS COVID surveillance data was captured from manual entry in the COVID-19 data collection portal. The agency's COVID-19 data collection and reporting solutions enable data collection for over 300 federal, tribal, and urban sites and provides immediate insight into testing results at the site, area, and national levels. During FY 2022 and FY 2023, NPIRS has transitioned seven

Areas that utilize the RPMS software from the manual data collection portal to the automated BDW Covid data feed. NPIRS anticipates completing the transition of the remaining Areas by the end of FY 2023. NPIRS also created customized BI reports that are auto-generated and distributed to tribal and urban partners unable to access the national dashboard. As part of the COVID-19 vaccination initiative, NPIRS worked closely with the HITSS Investment and the Centers for Disease Control (CDC) to define the strategy for immunization collection and reporting. Since the initial release of the COVID-19 Immunization dashboard, NPIRS has implemented various enhancements to the business intelligence/business analytic solution to support extended vaccine administration (patient and employee), vaccine manufacturer, dosage, demographic and population information. In FY 2022 NPIRS integrated the IHS AI/AN user population into the dashboard to provide statistics on vaccinations across Indian country. The Vaccine Task Force (VTF) has FY 2023 requirements to enhance the dashboard to promote better patient and population management of immunizations. NPIRS is working on the phase II requirements of the Opioid Surveillance dashboard for the National Committee on Heroin Opioids and Pain Efforts (HOPE) to promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and improve access to culturally appropriate treatment. Eight new measures are planned for release in FY 2023 and an additional 4 measures are planned for FY 2024. NPIRS continues to maintain and support the Enterprise BI/Analytic solutions within the Qlik Enterprise Environment to include user access support, data refresh activities and enhancements for the agency. FY 2023 plans include environment upgrades and extending the security framework to support onboard of new tribal users. FY 2024 plans are to transition several legacy solutions to the Enterprise BI tool, in addition to working with sites to convert Qlikview solutions to Qliksense. Enterprise BI solution support is provided to headquarters program offices, trial, urban, area, service unit, and facility stakeholders. This support enables reporting, data discovery, data mining, predictive analysis and trending of key performance indicators supporting patient care and patient care management by providing strategic actionable information to key stakeholders. NPIRS continues to facilitate and improve reporting capabilities for programs, such as the Office of Urban Indian Health Program (OUIHP) Uniform Data Set (UDS) reporting requirements, the Office of Clinical and Preventive Services (OCPS) GPRA/GPRAMA national reporting, Maternal Child Health, Partnership to Advance Tribal Health, Behavioral Health, Pharmacy reporting, and Quality initiatives. Quality initiatives include, but are not limited to the Inpatient/Outpatient Quality Reports, National Accountability for Quality, Wait Time and Improved Patient Care. In addition, extensive support has been provided to the Office of Finance and Accounting (OFA) national reporting efforts for budget execution and monitoring solutions. These efforts are ongoing and support national adhoc and recurring reporting requirements.

The IT Operations program implements new enterprise technologies while sustaining and providing customer support for hundreds of IT services. In FY 2023, IT Operations completed over 100 significant IT initiatives/projects and acquired over 100 products and services. Notable projects and accomplishments are as follows:

- Replaced the legacy IT Access Control (ITAC) system with SailPoint and improved access control and auditing across the IHS.
- Implemented Okta Authentication-as-a-Service to provide a secure means to authenticate users to any IT system we purchase or develop in the Agency.
- Implemented the AA RingMD Clinical Video Telehealth service.
- Established a Zero Trust initiative and hired a new federal employee to oversee Cybersecurity tool management in IT Operations.
- Upgraded network circuits at 31 facilities and one Data Center, adding an additional 16Gb of bandwidth to support access to administrative and Health IT applications.

- Enabled 4G/LTE service as a supported connection option for IHS mobile health vans to access health IT applications when providing patient care.
- Upgraded the Wide Area Network architecture to incorporate Software-Defined Network (SD-WAN) features.

In FY 2023, IT Operations improved data sharing and collaboration within the IHS and between the IHS and HHS, Tribal entities, Business partners, and other government agencies. The most significant investment for IT Operations in FY 2023 is an upgrade to our Microsoft Enterprise Agreement and expansion of Microsoft 365 tools such as Microsoft Teams and SharePoint. A key factor to share data is developing the skills and tools necessary to protect the data from unauthorized disclosure or corruption. IT Operations is making significant investments in cybersecurity this year to better protect sensitive data as we expand access to information within our IT platforms.

The forecasted activities for IT Operations in FY 2024 are focused on IT Modernization and improving cybersecurity by adopting a Zero Trust cybersecurity framework and enhanced capabilities. Specifically, IT Operations will make measurable progress toward enhancing visibility into IHS IT assets and associated vulnerabilities as required by the Cybersecurity and Infrastructure Security Agency (CISA) Binding Operational Directive 23-01 (BOD 23-01).

IT Cybersecurity Program has three new cybersecurity policies pending approval: Security Assessment and Authorization; Audit and Accountability; and Configuration Management. Implementation of these new policies will help ensure cybersecurity activities are defined and executed consistently across the IHS enterprise to protect both information and information systems. In response to increased demand for telehealth services, the IHS Cybersecurity Program, in conjunction with Operations and the Chief Health Informatics Officer, sponsored a cloud service provider, RingMD, through the Federal Risk and Authorization Management Program (FedRAMP) to authorize its use not only at IHS, but at federal agency. In addition, the IHS Cybersecurity Program is enhancing the threat analysis capability by adding tools to improve the security posture of domain joined endpoints. This tool is able to detect patch status as well as other metrics and quarantine the device from the network in the event of noncompliance. By quarantining the device, we have reduced the attack surface of the network. Additionally, we are in compliance with new directives from the Department of Homeland Security regarding patch compliance. This tool has allowed us to implement USB drive controls preventing the use of unencrypted USB media, preventing data leakage as well as compliance with existing security policies. We are also leveraging a new cloud based centralized data integrator for log management, capturing and analyzing threats and creating automated alerts to make informed and timely decisions. We continue to remediate open audit findings and weaknesses within OIT. In FY 2022, a total of 100 Plan of Action and Milestones were closed. IHS has responded timely to all Emergency Directives and Cybersecurity Executive Orders to ensure compliance levels are met as mandated. The IHS Cybersecurity Program responded to over 8,300 incidents and requests for assistance in the past year.

IT Management continues improving IT governance through enhanced configuration and utilization of the Planview Portfolio Resource Management (PRM) System that provides an enterprise IT portfolio and project management capability enabling IHS to improve project performance oversight and monitoring corrective actions through to completion. The Planview PRM system also provides a comprehensive Enterprise Architecture capability enabling line-of-sight linkage between IHS strategic goals & objectives, business capabilities, and the IT requirements needed to support those capabilities. These continued enhancements provide management tools to help ensure IHS prioritizes IT spending on investments that directly support

strategic goals. OIT staff provided virtual presentations on HIT initiatives at various tribal or tribal health board conferences and meetings such as TribalNet, National Tribal Health Conference, Tribal Technical Advisory Group, National Indian Health Board (NIHB), NIHB Medicare, Medicaid, and Health Reform Policy Committee, IHS Tribal Self Governance Advisory Committee, and the Direct Service Tribes Advisory Committee quarterly meetings, etc. OIT staff regularly participated in Tribal Delegation Meetings and the Alaska Area Pre-negotiation/Negotiation meetings to address IT/HIT issues. The OIT Healthcare Connect Fund Program provided support to 109 federal and 75 tribal locations to collect $3.18 million.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome)	FY 2023: 3.0 Target: 4.0[1] (Target Not Met)	3.0	4.0	+1.0

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

FY 2025 Cyber Activities - Government-wide Tracking of Resources (Dollars in Millions)				
Indian Health Services NIST Framework/Capability	FY 2023 Actual	FY 2024 CR	FY 2025 Pres Bud	FY 2025 +/- FY 2023
Detect - Data Loss Prevention	0.009	0.009	0.009	0
Detect - Data Loss Prevention	0.165	0.16	0.16	-0.005
Detect - Intrusion Prevention	1.5	1.106	1.106	-0.394
Detect - Other Detect Capabilities	0	1.7	1.7	1.7
Detect - Other Detect Capabilities	1.903	3.958	3.958	2.055
Identify - Non-CDM Information Security Continuous Monitoring (ISCM)	0.415	0.435	0.435	0.02
Identify - Non-CDM Information Security Continuous Monitoring (ISCM)	3	3.568	3.568	0.568
Identify - Non-CDM Information Security Continuous Monitoring (ISCM)	0.4	0.4	0.4	0
Protect - Credentialing and Access Management	0	0.06	0.06	0.06
Protect - Credentialing and Access Management	0	0.02	0.02	0.02
Protect - Credentialing and Access Management	0	1.805	1.805	1.805
Protect - Credentialing and Access Management	0.004	0.004	0.004	0
Protect - Credentialing and Access Management	0.14	0.14	0.14	0
Protect - Credentialing and Access Management	0.055	0.055	0.055	0
Protect - Credentialing and Access Management	0.06	0.06	0.06	0
Protect - Credentialing and Access Management	0.14	0.14	0.14	0
Protect - Credentialing and Access Management	0.3	0.3	0.3	0
Protect - Credentialing and Access Management	0.373	0	0	-0.373
Protect - Security Log Management	2.497	3.036	3.036	0.539
Protect - Security Log Management	1.8	1.69	1.69	-0.11
Protect - Security Log Management	0	0.391	0.391	0.391
Protect - Security Training	0.048	0.066	0.066	0.018
Protect - Security Training	0.071	0.088	0.088	0.017
Protect - Security Training	0.002	0.002	0.002	0
Protect - Trusted Internet Connections	1.095	1.1	1.1	0.005
Respond - Incident Management and Response	0.09	0.095	0.095	0.005
Respond - Incident Management and Response	1.708	3.554	3.554	1.846
Respond - Incident Management and Response	3.138	2.2	2.2	-0.938
Respond - Incident Management and Response	0.01	0	0	-0.01
Respond - Other Respond Capabilities	3.92	4.078	4.078	0.158
Respond - Other Respond Capabilities	0.69	0.69	0.69	0
Respond - Other Respond Capabilities	0.184	0.184	0.184	0
Total Cyber Request	23.717	31.094	31.094	7.377

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$217,564	$217,564	$435,102	+$217,538
FTE*	206	206	206	-

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Electronic Health Record System Modernization - The health information technology (HIT) system currently in use at the Indian Health Service (IHS) is the Resource and Patient Management System (RPMS), a comprehensive health information suite that supports a broad range of clinical, population health, and business processes from patient registration through the billing cycle. In recent years, advances in health-related standards and technologies, an increasingly complex regulatory environment around HIT, and the decision of the Department of Veterans Affairs (VA) to move to a commercial off-the-shelf HIT solution have combined to make the current approach to IHS HIT development and support non-sustainable going forward.

In 2018-19, IHS, in collaboration with HHS, engaged in comprehensive research and analysis of the current state of its HIT infrastructure and options for modernization. Informed by the outcomes of that project, IHS has published its intent to move forward with modernization by transitioning from its legacy RPMS to state-of-the-art, commercial off-the-shelf systems. The approach to modernization is not limited to an Electronic Health Record (EHR), but must support a true enterprise approach to HIT, enabling the highest quality inpatient, ambulatory, behavioral health, dental, pharmacy, laboratory, imaging, referral, and revenue cycle services, with standards-based interoperability and analytics capabilities, positioning IHS in the best possible way to accomplish its mission in the coming years.

BUDGET REQUEST

The FY 2025 budget submission for Electronic Health Record Modernization is $435 million. This is an increase of $218 million above the FY 2023 Final level.

FY 2025 Funding Increase of $218 million includes:

EHR Increase: +$213 million will support the ongoing modernization of the Health IT infrastructure. OIT will use the funds for licensing, hosting, training, site remediation, implementation, and support costs to implement a modernized system.

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

This funding will lay the groundwork to improve the quality of care, reduce the cost of care, promote interoperability, simplify IT service management, increase the security of patient data, enhance cybersecurity, and update infrastructure across rural locations to enable a successful EHR transition. This will include the continuation of project management operations, acquisition planning, EHR selection, additional tribal consultation, initial infrastructure build, site implementation planning, and continued RPMS stabilization and support. The project will follow industry standards for modernization or replacement of EHR systems to leverage expertise and experience in the private sector.

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

    - RPMS Stabilization: IHS will complete updates to the legacy systems to achieve compliance with the 21st Century Cures updates for 2015 Edition Office of the National Coordinator for Health Information Technology Organization (ONC) certification. Significant development, testing, patching, rollout and training efforts will be required, using expanded contract resources.
    - Interoperability: The IHS completed its interoperability pilot in FY 2023, and will begin a national rollout to enable exchange both within the IHS enterprise and with external referral network partners.
    - Immunization Information Systems: The IHS is planning additional initiatives to move certain capabilities from the local to the enterprise level, including centralized systems to accomplish exchange with state immunization information systems and reporting to public health agencies.
    - Initial Build of EHR Environment: With the selection of General Dynamics Information Technology (GDIT) as the prime contractor, partnered with Oracle Health, for the new EHR system in early FY 2024, work will begin on the design and build steps, to prepare the commercial system for operation in the IHS environment. The Program is preparing to issue Task Order 3 and 4 mid FY 2024 focused heavily on setting up the cloud hosted environment, implementing security controls, and the robust planning and configuration of the Enterprise Solution and setting the stage for all aspects of the solution build, testing, and deployment of the solution.

- Local Needs: With the selection of an EHR product, the Agency will define the technology architecture required for optimal performance of and support for the system. The IHS can then target identified gaps at local facilities and in the wide area network and hosting systems.
- Initial Site(s) Transition Planning: Resources will support the development of a core planning template and master deployment schedule. This will also accommodate individual site planning using the template to address technology infrastructure remediation, site configuration, end-user training, change management, communication, and stakeholder engagement at the local level near the deployment target for each site.

The IHS anticipates building the enterprise solution and preparing and planning site deployments in FY 2024 and FY 2025.

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

  The IHS must acquire a state-of-the-art EHR system that supports a true enterprise approach to HIT, enabling the highest quality inpatient, ambulatory, behavioral health and other ancillary healthcare and business office services, with standards-based interoperability and analytics capabilities, positioning IHS in the best possible way to accomplish its mission in the coming years.

  During the implementation, IHS expects to temporarily increase the HIT workforce to acquire and implement this system.

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

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

The Dentrix software will be upgraded nationwide to coordinate care in a national enterprise HIT environment. Additionally, funding will allow for improved recruitment and retention of providers and reduce industry risk by adopting standards and systems used by a broader base of healthcare systems.

Funding will allow for improved revenue from third-party payers, improved training through standardized user interfaces and integration across health facilities, reduced workload to

support the infrastructure, and improved quality and operational oversight through improved national reporting and data analytics.

- Current Services: +$4 million. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount[1]
2021	$34,500,000
2022	$145,019,000
2023 Final	$217,564,000
2024 CR	$217,564,000
2025 President's Budget	$435,102,000

PROGRAM ACCOMPLISHMENTS

The Health IT Modernization Program achieved significant milestones in 2023. The program awarded three critical modernization acquisition packages: Program Management Office (PMO), Organizational Change Management (OCM) Services/Support, and a new Mitre Task Order. The Program also continued the acquisition process to award the EHR Product and Integrator Services contract that was awarded in early FY 2024. With the award of the PMO and OCM contracts, the Program successfully transitioned all activities previously supported by the Mitre contract resources to the new PMO and OCM resources and has continued to establish the planning and governance framework to support the new EHR solution.

IHS conducted four Tribal Consultation and Urban Confer sessions with more than 900 participants over the calendar year to discuss the Preparing for Change, Modernization Resources, Leaders Engaging in Governance, and The Path Forward with Tribal and Urban Partners.

IT Infrastructure and Operations Modernization - Significant improvements are required in order for the information technology (IT) infrastructure at IHS to fully support the deployment of a new, modern HIT solution. IHS must enhance cybersecurity, improve IT service management, expand storage and computing capacity, and increase network bandwidth at dozens of rural locations to enable a successful EHR transformation. IT operations throughout IHS will need to be managed and coordinated more effectively to successfully execute a complex modernization project.

Current active projects in support of the modernization goal include rolling out a national hub for connection to the eHealth Exchange in order to support health information exchange (HIE) with the VA, Department of Defense, and other external partners, as well as leveraging the experience of COVID-19 to improve the agency's capabilities for enterprise reporting of immunizations, laboratory results, and public health notifications to state and federal entities.

The IHS Modernization of Health IT System & Support (mHITSS) investment is the primary mechanism IHS will utilize to modernize.

[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.

OUTPUTS/OUTCOMES

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

GRANT AWARDS

Not applicable to this funding.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$248,098	$248,098	$276,085	+$27,987
FTE*	516	525	525	+9

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Services Provided. The purpose of the Indian Health Service (IHS) Dental Health Program (DHP) is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The DHP is a service-oriented program providing basic dental services (e.g., diagnostic, emergency, preventive, and basic restorative care), which represents approximately 90 percent of the dental services provided. In FY 2023 the DHP provided a total of 3,492,927 basic dental services, a 19 percent increase from FY 2022, in which the DHP provided 2,937,955 services. This marked a continued slow recovery from the diminished services during the pandemic major periods of FY 2020 and FY 2021. More complex rehabilitative care (e.g., root canals, crowns and bridges, dentures, and surgical extractions) is provided where resources allow and accounted for the additional 227,973 dental services in FY 2023, an 11 percent increase from FY 2022 where 205,980 higher level services were performed. The DHP provided these services through 1,193,398 dental visits in FY 2023, a 19 percent increase from FY 2022 (1,003,471 dental visits), another sign of a slow emergence from the pandemic accompanied by increased patient confidence in the safety of dental services.

Oral Health Disparities. 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 three times that of U.S. white children. In the 6-9 year-old age group, 8 out of 10 AI/AN children have a history of dental caries compared with only 45 percent of the general U.S. population, and almost half of AI/AN children have untreated tooth decay compared to just 17 percent of the general U.S. population in this age group. In the 13-15 year-old age group, three out of four AI/AN dental clinic patients have a history of tooth decay, compared to half of 13-15 year-olds in the general U.S. population, and almost three times as many 13-15 year-old AI/AN youth have untreated decay compared to the

general U.S. population. In adults, the disparity in dental disease is equally as pronounced. 56 percent of AI/AN adults 35-49 years have untreated decay compared to just 26 percent of the general U.S. population, and across all other age groups studied (50-64 years, 65-74 years, and 75 and older), AI/AN adults have more than double the prevalence of untreated tooth decay as the general U.S. population. In addition, the rate of severe periodontal disease in AI/AN adults is double that of the general U.S. population. Data for all of these disparities can be found in the data briefs published by the DHP at www.ihs.gov/doh.

Pandemic Effect. The lack of regular dental care during the COVID-19 Pandemic may have led to an increase in oral health issues among American Indian and Alaska Native (AI/AN) children. Compared to 2017, fewer AI/AN dental patients have protective dental sealants on permanent molars, and more are experiencing oral pain or infection. For example, in AI/AN children 6-9 years of age, between 2017 and 2023, the proportion who had dental sealants decreased from 51 percent to 45 percent, and the proportion reporting oral pain or infection increased from 8 percent to 15 percent.

Workforce Disparities. The dentist to population ratio in the IHS system continues to be very low when compared to the ratio in the U.S. private sector. This low dentist to population ratio and an increase in population growth in the AI/AN population will continue to present a challenge in achieving the access rate goal. In FY 2023, the IHS has 1,018 dentists (including part-time) in the system, according to the IHS Dental Directory, a decrease of 28 from FY 2022. In 2023, there were 3,083,103 AI/AN registrants in the U.S., according to the most recent user population estimate. That means that the IHS system has approximately one dentist per 3,028 patients served. According to the American Dental Association, there were an estimated 201,927 dentists in the U.S. in 2021 serving a population of 333,287,557, meaning that there is approximately one dentist per 1,650 people served. This disparity shows the understaffing of dentists in the DHP.

BUDGET REQUEST

The FY 2025 budget submission for Dental is $276 million which is $28 million above the FY 2023 Final level.

FY 2023 Final level Funding of $248 million supports oral health care services provided by IHS and tribal programs, maintain the program's progress in raising the quality of and access to oral care through continuing recruitment of oral health care professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2025 Funding Increase of $28 million includes:

- Current Services and Staffing of Newly Constructed Facilities: +$28 million. Information can be found in the Current Services and Staffing of New Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2021	$214,687,000
2022	$235,788,000
2023 Final	$248,098,000
2024 CR	$248,098,000
2025 President's Budget	$276,085,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

Government Performance and Results Act (GPRA). Overall access to care increased from 22.33 percent in FY 2022 to 25.28 percent in FY 2023, one of the largest percentage increases ever experienced by the DHP in access to dental services. The proportion of 2-15 year-old AI/AN children receiving dental sealants – a second GPRA indicator – improved from 8.95 percent in FY 2022 to 11.02 percent in FY 2023, and the proportion of 1-15 year-old AI/AN children received topical fluorides – another GPRA indicator – increased from 20.94 percent in FY 2022 to 25.63 percent in FY 2023. In fact, FY 2023 marked the first time since 2018 that IHS met all three of the dental GPRA targets.

IHS Electronic Dental Record (EDR). Through support of implementation of an electronic dental record (EDR), over 87 percent of IHS Federal, Tribal, and Urban (I/T/U) dental clinics have transitioned to an EDR system to support the delivery of effective quality dental services. The IHS Dentrix Enterprise (DXE) EDR program has been successfully implemented at 311 of these I/T/U dental clinics. There remains approximately 42 IHS clinics that have not transitioned to an EDR system. Funding increases in the past have supported continued development of the EDR and implementation across the system. Continuous EDR upgrade support for the more than 300 I/T/U dental clinics using the IHS DXR EDR is essential to maintain data integrity, cybersecurity, and ensure the IHS provides state-of- the-art electronic records support for both direct patient care quality and safety as well as provider/clinic effectiveness and efficiency.

Oral Health Promotion/Disease Prevention (HPDP) Initiatives. The DHP continues to provide seed funding to IHS, tribal, and urban programs to carry out national initiatives aimed at prevention and early intervention of dental disease. Successful projects in the past few years include an early childhood caries initiative that increased access to dental care by 30 percent in AI/AN children and reduced untreated tooth decay in young children by 14 percent, the largest such decrease ever measured. Another project was a depression screening by dental provider project that resulted in a 382 percent increase in referrals from dental providers to behavioral health providers. A third project is the American Dental Association sponsored Give Kids a Smile®, with over 113 events held in I/T/U sites in 2023. Over the course of the four years of this program, the DHP has held 427 events with 942 I/T/U dentists and 2,811 other dental staff participating, resulting in 47,241 children receiving preventive and restorative services with an estimated benefit of $3.8 million. A fourth project called “Triaging and Treating Dental Conditions in the Emergency Department” resulted in training over three dozen emergency department staff in five hospitals on how to better triage and treat patients presenting with dental problems. A fifth project aimed at early intervention was teaching medical providers how to apply silver diamine fluoride to stop tooth decay in AI/AN children, with four medical providers participating. A sixth and final project was the implementation of cognitive screenings on geriatric patients by dental providers, with five programs conducting screenings that resulted in an 85 percent compliance for follow-up referrals to primary care providers. A summary of initiatives can be viewed at the IHS Dental Portal at www.ihs.gov/doh under the “initiatives” tab.

Continuing Dental Education (CDE). The DHP continues to improve the delivery of services and retention of staff through a sustained continuing dental education (CDE) program, one of the largest, if not the largest, in the federal sector. In FY 2023, a total of 434 CDE courses were offered to oral health professionals, a 16 percent increase from FY 2022. A total of 2,121 dentists participated in CDE courses, while 2,086 dental hygienists and dental assistants participated in CDE events. A total of 29,054 CDE participant hours were awarded, a 28 percent increase from FY 2022, and over the past three years, 78,283.5 CDE hours have been awarded. Through the IHS CDE Program, most dentists, dental hygienists, and dental assistants have been able to meet their respective state licensure maintenance requirements.

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

Dental Clinical and Preventive Support Centers (DSC). The purpose of Indian Health Service Division of Oral Health grant funded and program-award funded ($444,444 to nine centers providing services to all 12 IHS Areas) Dental Clinical and Preventive Support Center program is to combine the existing resources and infrastructure of American Indian and Alaska Native communities with Indian Health Service Headquarters and Area resources, in order to address the broad challenges and opportunities associated with the IHS oral health promotion, and oral health disease prevention, programs.

Dental Infection Control Program. The DHP continues to provide guidance to dental programs on infection control issues, including those arising from the recent COVID-19 pandemic. The pandemic increased dental programs' interest in infection control and prevention procedures, and the DHP infection control committee developed a series of six virtual continuing education courses spanning from late 2022 through 2023. The DHP participated in the 2022 and 2023 Organization for Safety, Asepsis and Prevention (OSAP) boot camp federal breakout sessions. The DHP infection control committee provided 52 bi-weekly infection control tips in 2022-23. The DHP committee teamed up with the IHS Office of Quality to develop dental specific infection control tracers. In total seven specific tracers were developed with nearly 400 elements to review. These tracers have been distributed throughout IHS and are being tracked using the Joint Commission Tracers with AMP software.

Workforce Innovations. The DHP continues to support workforce innovations to improve access to care including Dental Health Aides (DHAs), Expanded Function Dental Assistants (EFDAs), and Community Dental Health Coordinators (CDHCs). The DHP now has over two dozen DHA Therapists serving in Alaska, Washington, Oregon, and Idaho in tribal programs, and the DHP continues to support the IHS strategic goal to expand the DHA Program, as part of the Community Health Aide Program expansion, to federal programs in the future. The DHP is the largest trainer of EFDAs in the Nation. Since 2016, the IHS CDE Program has held 168 different in-person EFDA courses that have resulted in 423 being training in periodontal expanded functions and 503 being trained in restorative expanded functions. EFDAs have been shown to increase access to dental care in the DHP by up to 3.0 percent, increase total services delivered by dental programs up to 5.1 percent, and increase the total services per patient visit by up to 14 percent. In 2023, the DHP graduated the first class of Community Dental Health Coordinators (CDHCs), elevating six dental assistants to mid-level providers responsible for leading

community-based initiatives and coordinating continuity of care for special patient populations, and initiated a second cohort of CDHCs with 10 dental assistants and dental hygienists in 2024.

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

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2024 Target +/-FY 2023 Target
61 Topical Fluorides (Outcome)	FY 2023: 25.6% Target: 21.1% (Target Exceeded)	21.1%	27.4%	+6.3 percentage point(s)
62 Access to Dental Services (Outcome)	FY 2023: 25.3% Target: 24.4% (Target Exceeded)	24.4%	27.0%	+2.7 percentage point(s)
63 Dental Sealants (Outcome)	FY 2023: 11.0 % Target: 9.9% (Target Exceeded)	9.9%	11.8%	+1.8 percentage point(s)

GRANTS AWARDS

The DHP solicited, through a Federal Register Notice of Funding Opportunity in June 2020, applications for the Dental Clinical and Preventive Support Centers (DSC) Program. For a five-year cycle starting December 1, 2020, six grant awards were made, at an annual funding level of $350,000 each, with the purpose being to establish DSC Programs. $1,000,000 of new FY 2021 funding for DSCs was the first program increase since FY 2000 and was utilized to increase the number of DSCs and the grant funding to each DSC, resulting in an expansion of services to AI/AN communities. In FY 2022, the DSC Program received an additional $1,000,000 to allow the DSCs the ability to expand the services provided to the AI/AN communities. The additional funding now allows the DHP to utilize funds to cover administrative costs and for each of the DSC's to be supported annually at the $440,000 funding level. The DSCs combine IHS and tribal resources and infrastructure in order to address challenges faced by I/T/U dental programs. DSCs provide support through conduction of oral health surveillance, assisting dental programs with health fairs and special prevention initiatives such as the Give Kids A Smile Campaign (one-day events designed to provide preventive procedures on AI/AN children), supporting continuing dental education to standardize care across IHS Areas and to help recruit and retain quality oral health

care professionals, and in developing educational resources for AI/AN communities to help improve oral health literacy and promote access to culturally-competent dental care in I/T/U dental programs.

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Number of Awards	6	6	6
Average Award	$444,444	$444,444	$440,000
Range of Awards	$444,444	$444,444	$440,000

AREA ALLOCATION

Dental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY 23
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$	$44,482	$44,482	$	$44,458	$44,458	$	49,474	$49,474	$4,992
Albuquerque	5,659	4,087	9,746	5,664	4,085	9,749	6,303	4,546	$10,849	$1,103
Bemidji	2,674	2,554	5,228	2,676	2,553	5,229	2,978	2,841	$5,819	$591
Billings	6,424	2,087	8,511	6,430	2,086	8,516	7,155	2,321	$9,476	$965
California	$273	2,140	2,413	273	2,139	2,412	304	2,380	$2,684	$271
Great Plains	10,087	13,469	23,556	10,096	13,462	23,558	11,235	14,980	$26,215	$2,659
Nashville	724	6,285	7,009	725	6,282	7,006	806	6,990	$7,797	$788
Navajo	28,276	9,445	37,721	28,301	9,440	37,741	31,494	10,505	$41,999	$4,278
Oklahoma	10,826	41,129	51,955	10,836	41,107	51,943	12,058	45,744	$57,802	$5,847
Phoenix	10,511	23,942	34,453	10,520	23,929	34,450	11,707	26,629	$38,336	$3,883
Portland	4,876	3,680	8,556	4,880	3,678	8,558	5,431	4,093	$9,524	$968
Tucson	0	2,092	2,092	0	2,091	2,091	0	2,327	$2,327	$235
Headquarters	$12,376	0	12,376	12,387	0	12,387	13,784	0	$13,784	$1,408
Total, Dental	**$92,706**	**$155,392**	**$248,098**	**$92,789**	**$155,309**	**$248,098**	**$103,257**	**$172,829**	**$276,085**	**+$27,987**

1/ Note: 2023, 2024, and 2025 are estimates.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$127,171	$127,171	$138,746	+$11,575
FTE*	170	187	187	+17

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

BUDGET REQUEST

The FY 2025 budget submission for Mental Health is $139 million, which is $12 million above the FY 2023 Final level.

FY 2023 Final level Funding of $127 million – This funding will maintain the program's progress in addressing mental health needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2025 Funding Increase of $12 million includes:

- Current Services and Staffing of Newly Constructed Facilities: +$12 million. Information can be found in their corresponding chapters.

FUNDING HISTORY

Fiscal Year	Amount
2021	$115,107,000
2022	$121,109,000
2023 Final	$127,226,000
2024 CR	$127,171,000
2025 President's Budget	$138,801,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

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

In 2019, AI/AN adolescents (12 to 17 years old) had the highest prevalence (11.5 percent) of major depressive episode with severe impairment compared to other ethnicities.[4] In 2019, AI/AN adults had the highest prevalence (9.4 percent) of major depressive episode with or without

[1] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Deaths: Leading Causes for 2019.

[2] US Department of Health and Human Services, Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, Notes from the Field: Recent changes in suicide rates by race, ethnicity, and age group, United States 2021. https://www.cdc.gov/mmwr/volumes/72/wr/mm7206a4.htm?s_cid=mm7206a4_w

[3] Ibid.

[4] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health. Available from https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases.

severe impairment compared to other ethnicities.[5] Furthermore in 2019, AI/AN adults had the second highest prevalence (18.7 percent) of serious mental illness among U.S. adults compare to other ethnicities.[6]

In FY 2022, IHS collaborated with the US Department of Health and Human Services, Centers for Disease Control and Prevention on a Morbidity and Mortality Weekly Report[7] highlighting disparities in circumstances that contribute to suicide among AI/AN persons. The report's key findings showed that nearly 75 percent of AI/AN suicides were among people ages 44 years and younger, compared to 46.5 percent among non-AI/AN suicides. The greatest proportion of suicides among AI/AN (46.9 percent) were among people ages 25-44 years; the greatest proportion of suicides among non-AI/AN (35 percent) were among people ages 45-64 years.

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

The IHS initiated a suicide surveillance data protocol focusing on suicide related behaviors to identify suicide within the IHS Electronic Health Records (EHR) in a standardized and systematic fashion. The suicide surveillance protocol will capture data related to suicide ideation; suicide attempts; and other suicide related behaviors.

Ten percent of those who die by suicide had visited the emergency department within 2 months of death. In FY 2025, the IHS and the National Institute of Health (NIH) will continue to work together to implement the Ask Suicide Screening Questions (ASQ) and its accompanying toolkit for universal screening within IHS Emergency Departments (ED). The ASQ is a suicide screening resource developed by NIMH for medical settings to help nurses or physicians successfully identify individuals at risk for suicide. In FY 2025, IHS will fully integrate the validated suicide risk screening instrument into the IHS electronic health records system for field implementation, data collection and reporting.

In FY 2025, IHS will implement mandatory training for all staff in recognizing and responding to suicide through the implementation of a culturally customized suicide prevention gatekeeper program, Question Persuade and Refer (QPR). As of 2024, 9,554 staff have completed training with 123 IHS staff certified as QPR trainers.

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

[5] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health. Available from https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases.
[6] Ibid.
[7] Communication Plan: Suicides Among American Indian/Alaska Native Persons — National Violent Death Reporting System, 2015–2020 https://www.cdc.gov/mmwr/volumes/71/wr/mm7137a1.htm

according to information from their data collections. In FY 2023, the Division of Behavioral Health established ZSI Coordinating Center provided technical assistance to address the unique needs of Tribes and Tribal organizations implementing the ZSI model.

Tribes and tribal organizations utilize evidence-based treatments in suicide care, initiating safety plans with patients at risk for suicide, implementing intensive follow-up upon missed or cancelled appointments, universal suicide screening of all at-risk patients.

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

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

In FY 2022, IHS awarded 14 new BH2I grantees, totaling $5.5 million, on a five-year funding cycle through FY 2026. Additionally, IHS awarded a technical assistance contract which will assist grantees in the implementation of integrated care efforts.

In FY 2025, IHS will continue support for seven federal facilities that currently participate in the Improving Pain and Addiction Care in IHS Emergency Departments (PACED) pilot project to develop model clinical care pathways following patient overdose resuscitation within emergency departments.

Reflective of the Agency's priority to raise the mental health of the AI/AN population IHS Division of Behavioral Health initiatives have focused on increased implementation of depression screening in primary care clinics. In FY 2023, 37.4 percent of AI/AN adults over the age of 18 screened for depression using a standardized screening assessment for depression. In FY 2023, this same measure was reported for youth ages 12-17 and data indicated 34.1 percent of eligible youth were screened for depression. The FY 2023 depression screening targets were met for the AI/AN population and anticipate an average 2.9 percent increase for both age cohorts in FY 2025.

According to CDC, racial and ethnic minority groups have experienced disparities in mental health and substance misuse related to access to care, psychological stress, and social determinants of health[8]. In FY 2023, IHS continued its partnership with the Northwest Portland Indian Health Board to provide a 24/7 Crisis Text Line for AI/ANs, which includes texting the keywords "Native" and "Indigenous" to 741-741. The Crisis Text Line connects individuals to a live, trained Crisis Counselor.

TeleBehavioral Health and Workforce Development: The IHS TeleBehavioral Health Center of Excellence (TBHCE) provides behavioral health services to many IHS and Tribal facilities, I/T/U patients that face issues surrounding access to care, particularly specialty care. Providers working in these remote areas often face barriers to maintaining the required continuing education (CE) credits required for licensure and remaining up to date on current clinical guidelines. The TBHCE assists IHS, Tribal, and urban Indian organizations providers and facilities in overcoming

[8] https://www.cdc.gov/mmwr/volumes/70/wr/mm7005a3.htm

these challenges by providing a range of telebehavioral health services and virtual training. There are 23 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 2023, the TBHCE provided 66,235 encounters.

Additionally, the TBCHE hosted webinars designed to meet the specific training needs of IHS, Tribal, and Urban Indian (I/T/U) health care providers[9]. More specifically, IHS utilizes tele-education (otherwise known as distance learning) to deliver national continuing education (CE) programming to I/T/U healthcare providers. In FY 2023, TBHCE provided 43 webinars that included 4,511 attendees. In FY 2023, TBHCE provided 40 on demand (self-paced) trainings that included 2,247 attendees. On demand trainings focused on various topics including compassion fatigue, trauma informed care and the IHS Essential Training on Pain and Addiction. In FY 2025, TBHCE will continue to provide virtual live and on demand behavioral health trainings for I/T/U providers.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
65 Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression. (Outcome)	FY 2023: 37.4% Target: 36.4% (Target Exceeded)	36.4 %	39.6%	+3.2 percentage point(s)
85 Depression Screening ages 12-17. (Outcome)	FY 2023: 34.1% Target: 29.5% (Target Exceeded)	29.5 %	36.1%	+6.6 percentage point(s)
MH-1 Increase Tele-behavioral health encounters nationally among American Indians and Alaska Natives (Output)	FY 2023: 66,235 Target: 48,000 (Target Exceeded)	71,000	71,000	Maintain

GRANTS AWARDS

The proposed FY 2025 budget will be used for IHS facilities, Tribes, Tribal organizations, and urban Indian organizations to develop innovative programs to address behavioral health services and deliver those services within and outside of the traditional health care system. The actual number of FY 2023 non-competitive grants are included below:

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

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Number of Awards	20	20	20
Average Award	$450,000	$450,000	$450,000
Range of Awards	$400,000 - $500,000	$400,000 - $500,000	$400,000 - $500,000

AREA ALLOCATION

Mental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY '23
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$	$19,118	$19,118	$	$19,103	$19,103	$	$20,842	$20,842	$1,724
Albuquerque	1,568	3,473	5,041	1,568	3,470	5,039	1,711	3,786	5,497	$456
Bemidji	356	2,468	2,824	356	2,466	2,822	388	2,691	3,079	$255
Billings	2,208	2,016	4,224	2,208	2,014	4,223	2,409	2,198	4,607	$383
California	54	2,458	2,512	54	2,456	2,510	59	2,680	2,739	$227
Great Plains	6,516	6,290	12,806	6,517	6,285	12,802	7,110	6,857	13,967	$1,161
Nashville	327	2,509	2,836	327	2,507	2,834	357	2,735	3,092	$256
Navajo	9,799	7,458	17,257	9,800	7,452	17,253	10,692	8,131	18,823	$1,566
Oklahoma	3,244	18,320	21,564	3,244	18,306	21,551	3,540	19,972	23,512	$1,948
Phoenix	4,003	11,505	15,508	4,004	11,496	15,500	4,368	12,543	16,911	$1,403
Portland	461	4,098	4,559	461	4,095	4,556	503	4,468	4,971	$412
Tucson	0	1,611	1,611	0	1,610	1,610	0	1,756	1,756	$145
Headquarters	17,366	0	17,366	17,369	0	17,369	18,949	0	18,949	$1,583
Total, Mental	**$45,902**	**$81,324**	**$127,226**	**$45,909**	**$81,262**	**$127,171**	**$50,087**	**$88,659**	**$138,746**	**$11,520**

1/ Note: 2023, 2024, and 2025 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 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$266,440	$266,440	$291,389	+$24,949
FTE*	226	226	226	-

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

1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

In July 2022, the CDC's National Center for Health Statistics reported that from 2019 to 2020, overall drug overdose death rates (per 100,000 people) increased 39 percent for non-Hispanic (NH) AI/AN persons compared to White persons (22 percent).[1] During that time, deaths rose more than 500 percent among AI/ANs. Due to misclassification of race and ethnicity on death certificates, the actual number of deaths for AI/ANs may be underestimated by up to 35 percent.[2]

BUDGET REQUEST

The FY 2025 budget submission for Alcohol and Substance Abuse is $291 million, which is $25 million above the FY 2023 Final level.

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

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

FY 2023 Final level Funding of $266 million – This funding maintains the program's progress in addressing alcohol and substance abuse needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2025 Funding Increase of $25 million includes:

- Opioids Grants: +$10 million to expand the IHS Opioid Grant program to a total of $21 million. These additional resources will support opioid use disorder prevention, treatment, recovery, and aftercare services. Increased funds will prioritize projects targeted at recovery and aftercare practices and efforts by supporting community-based peer recovery training programs. Funds will support access to peer-recovery specialists, including access to training platforms with virtual learning and collaborative support, shared resources, and information. Funds will also provide evaluation and technical assistance for ongoing activities responding to the opioid crisis. Increased funding will support an estimated 38 additional grant awards.

- Current Services and Staffing of Newly Constructed Facilities: +$15 million. Information can be found in the Current Services and Staffing of Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2021	$251,360,000
2022	$258,024,000
2023 Final	$266,440,000
2024 CR	$266,440,000
2025 President's Budget	$291,389,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

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

Intervention, and Referral to Treatment (SBIRT)[3] is an early intervention and treatment service for people with Substance Use and Substance Use Disorders (SUD) and those at risk of developing these disorders. IHS has broadly promoted SBIRT as an integral part of a sustainable, primary care-based activity that aims to support and integrate behavioral health into overall care. In
FY 2023, the SBIRT was utilized in 15 percent of the patient visits for those ages 9 through 75, establishing a baseline for FY 2024 and FY 2025 screenings, respectively. In FY 2025, IHS is actively working to expand local SBIRT use including a focus on substance use in women of childbearing age, to assist in early identification and referral for treatment and reduce illicit perinatal substance exposure for infants.

Increasing access to Medication Assisted Treatment (MAT): IHS is working to expand access to MAT in acute care settings. In FY 2025, the IHS Pain and Addiction Care in the Emergency Department (PACED) will funded IHS emergency departments. The objective of this intervention is to improve access to Medications for Opioid Use Disorder (MOUD) or improve pain management outcomes in acute care settings. Secondary objectives are to leverage the opioid surveillance dashboard to inform stewardship activities, to create a learning collaborative to share promising practices, and to assist sites with obtaining relevant accreditation. In FY 2023, the IHS emergency departments (EDs) received training from the American College of Emergency Physicians (ACEP) to identify and develop new systems of care and best practices to improve addiction and pain treatment outcomes in the ED by improving patient screening and increasing access to MOUD.

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

IHS has also created a robust workforce development strategy to include didactic training. In FY 2023, the IHS continued its *Pain Management and Opioid Use Disorder Continuing Medical Education* webinar series[4]. The IHS has hosted learning sessions with approximately 600 attendees with majority of attendees receiving continuing education credits. The IHS has expanded access to harm reduction interventions that include increased access to the opioid overdose reversal medication, naloxone. In 2023, the IHS updated agency policy to expand to first-responder definitions to include community members and employees who are designated to immediately respond in an emergency in a variety of work settings such as schools, businesses, or other places where people gather. In addition, Naloxone tool kits were developed and released for community members and schools.

Finally, In December 2023, the IHS announced the Naloxone Safety Net Program[5,6] which supports expanded harm reduction activities and works to promote low-barrier access to naloxone. The two year pilot program ($500,000 annually) will support I/T/Us struggling to meet

[3] Screening, Brief Intervention, and Referral to Treatment | Information and Tools for Providers (ihs.gov)

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

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

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

naloxone needs due to increased utilization and are meant to augment existing program naloxone forecasting.

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

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

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

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

Youth Regional Treatment Centers (YRTCs): YRTCs are facilities which provide medically managed care and other essential treatment and recovery services to AI/AN youth experiencing SUDs. Congress authorized the establishment of YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. The YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values and cultural identification. In FY 2023, 83 percent of the federal YRTCs in operation 18 months or longer have achieved accreditation status.

Indian Children's Program (formerly, Fetal Alcohol Spectrum Disorders (FASD): Training and technical assistance on FASD is provided through the IHS TeleBehavioral Health Center of Excellence (TBHCE) Indian Children Program (ICP). The focus of the ICP is training clinicians on developmental and neurobiological issues that can affect AI/AN children. In FY 2023, ICP provided seven webinars on neurodevelopmental disorders with a total of 360 attendees. The ICP

also provides additional clinician supports through virtual consultation designed to help clinicians successfully diagnose, manage, and treat AI/AN youth with FASD, ASD, and other neurodevelopmental issues.

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

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

IHS Community Opioid Intervention Pilot Program (COIPP): In FY 2023[7], continued third year funding at approximately $500,000 annually to 35 Tribal, Tribal organizations, and Urban Indian Organizations to increase public awareness and education about the impact of opioids on individuals, families and communities. These tribal grantees prioritized efforts to reduce unmet needs and opioid overdose deaths through education, partnerships, and increased access to treatment for persons with OUD.

Substance Abuse and Suicide Prevention Program (SASP): The SASP is a nationally-coordinated $31.97 million program providing funds for culturally appropriate substance abuse and suicide prevention programming in AI/AN communities. In FY 2023 the IHS continued funding two separate grant programs under SASP. The first, Substance Abuse Prevention, Treatment, and Aftercare (SAPTA), awarded $13.698 million to 36 Tribal, Tribal organizations, and Urban Indian Organizations and $2 million to eight federal IHS facilities. The second, Suicide Prevention, Intervention, and Postvention (SPIP), awarded $13.772 million to 36 Tribal, Tribal organizations, and Urban Indian Organizations and $2 million to eight federal IHS facilities. The program will fund 88 projects for a period of five years ending in FY 2027.

IHS established the Universal Alcohol Screening (UAS) as a national measure to increase screening and improve detection and intervention strategies among patients 9 through 75 years of age. In FY 2023, 34.2 percent of patients were screened and IHS screening efforts exceeded the national target rate of 32.2 percent. For FYs 2024 and 2025, the national target rates for UAS are set at 32.2 percent and 34.6 percent, respectively.

Preventing Alcohol-Related Deaths (PARD): In FY 2023 IHS awarded $2,000,000 to an alcohol detoxification center located in the city of Gallup, New Mexico to address the high rates of alcohol related deaths within McKinley County, New Mexico, and surrounding counties, which yield 48 percent of all alcohol-related death for AI/AN in the nation. The project period for this cooperative agreement is from FY 2023 – FY 2028.

YRTC Aftercare Project*: :* In FY 2023, the IHS awarded $600,000 to the Cherokee Nation's Jack Brown Center, a Tribal-operated YRTC, to operate and refine an aftercare program. This five-year program will end in 2027. Additionally, the IHS will support federal-operated YRTC sites in FY 2023, to implement the new objectives of the YRTC Aftercare Project.

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

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). (Outcome)	FY 2023: 83 % Target: 100 % (Target Not Met)	100%	100%	Maintain
80 Universal Alcohol Screening (Outcome)	FY 2023: 34.2% Target: 32.2% (Target Exceeded)	32.2%	36.0%	+3.8 percentage point(s)
90 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome)	FY 2023: 15.0% Target: 15.0% (Baseline)	15.0%	15.8%	+0.8 percentage point(s)

GRANTS AWARDS

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Number of Awards	109	101	140
Average Award	$350,000	$350,000	$350,000
Range of Awards	$300,000 - $400,000	$300,000 - $400,000	$300,000 - $400,000

AREA ALLOCATION

Alcohol and Substance Abuse

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY '23
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$447	$36,856	$37,303	$447	$36,838	$37,285	$489	$40,287	$40,777	$3,474
Albuquerque	2,940	10,636	13,576	2,943	10,631	13,574	3,219	11,626	14,845	$1,269
Bemidji	1,593	9,573	11,166	1,595	9,568	11,163	1,744	10,464	12,208	$1,042
Billings	197	11,956	12,153	197	11,950	12,147	216	13,069	13,285	$1,132
California	14,981	9,985	24,966	14,997	9,980	24,977	16,401	10,915	27,316	$2,350
Great Plains	3,349	12,729	16,078	3,353	12,723	16,075	3,666	13,914	17,580	$1,502
Nashville	3,023	7,036	10,059	3,026	7,033	10,059	3,310	7,691	11,001	$942
Navajo	1,654	21,100	22,754	1,656	21,090	22,745	1,811	23,064	24,875	$2,121
Oklahoma	4,142	16,184	20,326	4,146	16,176	20,322	4,535	17,691	22,225	$1,899
Phoenix	7,233	14,176	21,409	7,241	14,169	21,410	7,919	15,496	23,414	$2,005
Portland	393	17,515	17,908	393	17,506	17,900	430	19,146	19,576	$1,668
Tucson	0	3,440	3,440	0	3,438	3,438	0	3,760	3,760	$320
Headquarters	46,018	9,283	55,301	46,066	9,278	55,345	50,380	10,147	60,527	$5,226
Total, ASA	**$85,970**	**$180,469**	**$266,440**	**$86,060**	**$180,380**	**$266,440**	**$94,119**	**$197,270**	**$291,389**	**$24,950**

1/ Note: 2023, 2024, and 2025 are estimates.

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

(Dollars in thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$996,755	$996,755	$1,053,576	+$56,821
FTE*	87	87	87	-

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

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

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

[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.

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, and laboratory, dental, radiological, pharmaceutical, or transportation services. When funds are not sufficient to purchase the volume of PRC services needed by the eligible population residing in the PRC delivery area of the local facility, IHS PRC regulations require IHS or Tribal PRC programs to use a medical priority system to fund the most urgent referrals first.

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

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

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

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

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

The PRC Program also administers the Catastrophic Health Emergency Fund (CHEF). Created in 1988, the CHEF was established for the sole purpose of meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses.[6] The CHEF is used to reimburse PRC programs for high cost cases (e.g., burn victims, motor vehicle crashes, high risk obstetrics, cardiology, etc.) after a threshold payment amount is met, the current threshold is $25,000. The CHEF is centrally managed at IHS Headquarters. In 2023, IHS published an NPRM that proposed reducing the CHEF

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

threshold from $25,000 to $19,000.

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

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

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

BUDGET REQUEST

The FY 2025 budget request for Purchased/Referred Care is $1.1 billion, which is $57 million above the FY 2023 Final level.

FY 2023 Final level Funding: $997 million will support over 36,000 inpatient admissions, over 1.1 million outpatient visits, and over 42,000 patient transports.

FY 2025 funding increase of $57 million includes:

- New Tribes (+$6 million): These funds will support the delivery of health care services for the United Keetoowah Band of Cherokee Indians of Oklahoma.

- Current Services (+$51 million): Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	PRC	CHEF	Total
2021	$922,856,000	$53,000,000	$975,856,000
2022	$931,887,000	$53,000,000	$984,887,000
2023 Final	$942,755,000	$54,000,000	$996,755,000
2024 CR	$942,755,000	$54,000,000	$996,755,000
2025 President's Budget	$999,576,000	$54,000,000	$1,053,576,000

TRIBAL SHARES

Purchased and Referred Care funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. The CHEF management is federally inherent and no part of CHEF or its administration can be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act. CHEF fund cannot be allocated, apportioned, or delegated on an Area Office, Service Unit or other similar basis (25 U.S.C. 1621(a)(c)).

PROGRAM ACCOMPLISHMENTS

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

Medical Priorities – Recent PRC program increase in purchasing power through the PRC rates described above continues to allow most of the IHS and Tribally-managed PRC programs to approve referrals in priority categories other than Medical Priority I (life or limb), including some preventive care services, thus increasing access to patient care services. In FY 2022, 90 percent of IHS-operated PRC programs were able to purchase services beyond Medical Priority II – Preventive Care Services. Prior funding increases and Medicaid expansion have enabled programs to purchase preventive care beyond emergency care services, such as mammograms or colonoscopies.

The IHS PRC Workgroup helped IHS develop a more accurate form for annually reporting denied and deferred PRC services. In FY 2022, PRC programs denied and deferred an estimated $551,858,726 for an estimated 119,938 services for eligible AI/ANs. Because Tribally-managed programs are not required to report denials data, it is difficult to provide a verifiable and complete measure of the total unmet need for the entire I/T/U system. Therefore, the denied services estimate is based on actual data from federal programs and estimated Tribal data.

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

IHS expects to publish the Final Rule for CHEF Regulations in FY 2024 which will reduce the CHEF threshold to $19,000 which will lead to more cases qualifying for CHEF reimbursement. The CHEF regulations also include an appeal process and state that tribal self-insurance is not considered as an alternate resource.

COVID-19 Medicaid Unwinding

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19, including long haul COVID-19. Since the beginning of the Public Health Emergency through January 2, 2024, the PRC Fiscal Intermediary has processed 52,992 COVID related claims in the amount of $72 million. National data from the Centers for Medicare & Medicaid Services and results from an IHS data call show a 4 percent decrease in coverage compared to one year ago. Maintaining coverage is important for all age

groups. Routine medical services and medications are paused due to Medicaid disenrollment for AI/ANs who do not utilize ITU facilities. When AI/AN utilize emergency services, they can risk ending up with a large bill. Losing Medicaid coverage can cause impacts to the PRC program and can cause delays when being referred out for care. PRC funds could be depleted faster if less patients have coverage when they are referred out for care.

PRC Delivery Area Expansions – IHS expanded three PRCDAs for the Hoh Tribe, Spokane Tribe and Mid-Atlantic Tribes increasing PRC eligible beneficiaries by 1,527.

Veterans Administration Reimbursement Agreement and PRC Reimbursements – A new VA-IHS reimbursement agreement was executed in December 2023 that includes PRC reimbursements.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
PRC-2 Track IHS PRC referrals (Outcome)	FY 2023: 59.0 days Target: 60.0 days (Target Exceeded)	60.0 days	60.0 days	Maintain
PRC-3 Track PRC self-referrals (Outcome)	FY 2023: 52.0 days Target: 45.0 days (Target Not Met but Improved)	45.0 days	45.0 days	Maintain

GRANT AWARDS. This program does not fund grant awards.

AREA ALLOCATION

Purchased/Referred Care

(dollars in thousands)

DISCRETIONARY	FY 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY '23
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$96,989	$96,989	$0	$96,960	$96,960	$0	$102,487	$102,487	$5,498
Albuquerque	26,660	21,353	48,013	26,672	21,347	48,019	28,192	22,564	50,756	$2,743
Bemidji	14,962	52,840	67,802	14,969	52,824	67,792	15,822	55,835	71,657	$3,855
Billings	52,051	22,832	74,884	52,074	22,825	74,900	55,043	24,127	79,170	$4,286
California	0	54,384	54,384	0	54,367	54,367	0	57,467	57,467	$3,083
Great Plains	65,978	33,883	99,861	66,007	33,873	99,880	69,770	35,804	105,574	$5,713
Nashville	5,714	34,641	40,355	5,717	34,631	40,347	6,043	36,605	42,648	$2,292
Navajo	64,509	45,409	109,918	64,538	45,395	109,933	68,217	47,983	116,199	$6,282
Oklahoma	44,502	79,796	124,298	44,522	79,772	124,294	47,060	84,319	131,380	$7,081
Phoenix	47,520	36,252	83,772	47,541	36,241	83,782	50,252	38,307	88,559	$4,786
Portland	13,031	92,643	105,674	13,037	92,614	105,651	13,780	97,894	111,674	$6,000
Tucson	2	22,228	22,230	2	22,221	22,223	2	23,487	23,490	$1,260
Headquarters	68,575	0	68,575	68,606	0	68,606	72,517	0	72,517	$3,942
Total, PRC	**$403,505**	**$593,250**	**$996,755**	**$403,686**	**$593,069**	**$996,755**	**$426,698**	**$626,878**	**$1,053,576**	**$56,821**

1/ Note: 2023, 2024, and 2025 are estimates.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR/1	President's Budget	FY 2025 +/- FY 2023
PL	$202,527	$202,527	$219,035	+$16,508
FTE*	212	213	213	+1

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

SUMMARY OF THE BUDGET REQUEST

The FY 2025 Indian Health Service (IHS) Budget request for Preventive Health Services includes a total of $219 million, which is +$17 million above the FY 2023 Final level.

This funding increase includes:

- Current Services (+$13 million), and
- Staffing of Newly Constructed Facilities (+$3 million).

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

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

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

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

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

These **Preventive Health** services contribute widely to the performance measures that fall under the auspices of Hospitals & Health Clinics. PHN clinical services directly contribute to community health and wellness through immunizations, case management, and patient education. CHRs are also community-based and contribute to follow up care and lay health education. Health Education activities permeate the Indian health system and are integral to the fulfillment

of the performance screening measures. The Immunization Alaska Program plays a key role by tracking immunization rates through specific immunization registries throughout the State of Alaska, and such efforts contribute to the national immunization rates.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR/1	President's Budget	FY 2025 +/- FY 2023
PL	$110,782	$110,782	$120,955	+$10,173
FTE*	192	193	193	+1

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Services Provided. The Indian Health Service (IHS) Public Health Nursing (PHN) Program is a community health nursing program which strives to raise the health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level by providing quality, culturally sensitive health promotion and disease prevention nursing care services through primary, secondary and tertiary prevention services to individuals, families, and community groups. The PHN program meets the diverse healthcare needs of the AI/AN population by removing barriers to access to advance health equity and reduce disparities. In FY 2023, the PHN provided 292,427 individual patient encounters which were recorded in the electronic health record (the vast amount of PHN group services are not included in this individual patient documentation data metric).

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

BUDGET REQUEST

The FY 2025 budget request for Public Health Nursing is $121 million, which is $10 million above the FY 2023 Enacted level.

FY 2023 Final level Funding of $111 million – 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 2025 Funding Increase of $10 million includes:

- Current Services and Staffing of Newly Constructed Facilities: +$10 million. Information can be found in the Current Services and Staffing of Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2021	$92,736,000
2022	$101,641,000
2023 Final	$110,782,000
2024 CR	$110,782,000
2025 President's Budget	$120,955,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

Communicable disease prevention. To support a community population nurse visiting program to serve the patient and family in the home and community, in FY 2023, $1.5 million was awarded for seven cooperative agreements and three program awards to federal, Tribal, and Urban PHN programs with the purpose to mitigate the prevalence of sexually transmitted infections (STIs) within Indian Country through a PHN case management model. Ongoing consultation efforts include participation in the End-the-Syndemic STI Informatics Response webinar series by hosting the PHN Field Treatment for Syphilis. The Gallup Indian Medical Center PHN Program field tested Syphilis screening, resulting in a September 6-7, 2023 site visit to share lessons learned to 30 PHN participants from Phoenix, Billings, Great Plains, Albuquerque, Navajo and Oklahoma. PHN interventions are monitored with the PHN data mart tool for performance measurement and outcome reporting. PHNs provided 18,778 patient encounters in FY 2023 that encompassed 19,737 patient education codes documented for STI visits which included communicable disease, medications, contact with exposure, immunizations, alcohol and other drugs, and tobacco use. PHNs strive to meet targeted agency goals for childhood immunizations by participating in the IHS National E3 Vaccine Strategy – to ensure every patient at every encounter will be offered every recommended vaccine, when

appropriate. PHN sponsored webinars in October 2023 on "Fall Immunization Prevention Season" included COVID-19, Respiratory Syncytial Virus, and influenza vaccines which prevent patients from getting sick or hospitalized from these diseases and shared best practices of PHN community immunization clinics and collaboration with local entities to promote immunizations with a total audience of over 200 attendees.

Health Promotion/disease prevention. The PHN program supports GPRA screening criteria, strategies for partnerships, and collaborations that result in improved health outcomes over the long term. In FY2023, PHN documented patient screening of 5,016 Tobacco Screening, 9,687 Domestic Violence Screening, 9,766 Depression Screening, 10,633 Alcohol Screening, and the administration of 29,915 Adult Influenza Vaccines. In FY 2023, the PHN continued efforts to decrease childhood obesity and prevent diabetes by supporting hospital Baby Friendly re-designation with a total of 5,098 PHN patient encounters to foster breastfeeding as the exclusive feeding choice for infants. These encounters included 14,010 documented patient education topics provided by the PHN during prenatal, postpartum and newborn encounters, including topics on breastfeeding, child health for the newborn, immunizations, family planning, tobacco use/prevention, gestational diabetes, formula feeding, and child health. Several PHN programs in Navajo and Phoenix area enrolled in a Certification Breastfeeding Specialist online training for PHN staff.

PHN workforce. The PHN to population ratio in the IHS system continues to be very low when compared to the recommended ratio in the IHS Staffing Standards Reference Model on staffing criteria used in the Resource Requirements Methodology (RRM). The RRM PHN staffing module estimates the requirement of 1.58 PHN for every 1,250 User or Census Population. The PHN program funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities; however, tribes are not required to report ongoing PHN staffing activity. The result is a low PHN to population ratio and with an increase in AI/AN population growth presents a challenge in achieving PHN program goals. To strengthen infrastructure by supporting PHN workforce development the 2023 PHN virtual conference, Caring for the Community, was held on August 7-9, 2023 to improve quality of care by sharing best practices with a focus on STI prevention and treatment, resulting in over 190 participants with nurse continuing education awarded and an on-demand option for viewing of the PHN conference modules online until September 30, 2023. In FY2024, a PHN leadership development, training, and mentorship program will be established to improve placement rates for recently graduated BSN-prepared nurses, PHNs, and newly hired PHNs. The focus will be on PHNs to provide rapid, creative, and effective solutions to public health problems in AI/AN communities to include the establishment of infrastructure and teams at the local areas in partnership with federal, tribal and state entities. Additional plans for FY 2024 is to secure strategic partnerships with BIE schools and the health care facilities that are associated with each of the schools in pursuit of upstream changes that enhance AI/AN student health, safety, and education.

Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services. The PHN program meets the diverse healthcare needs of the AI/AN population by removing barriers to access to advance health equity and reduce disparities. In FY 2023 the PHN measure target was 415,438 individual patient encounters and the final result of 292,426 did not meet the target (the vast amount of PHN *group services* are not included in this individual patient documentation data metric). The decrease in FY 2023 PHN individual patient encounters is attributed to a shift in services away from pandemic activity, e.g., hosting mass COVID-19 testing, vaccination and immunization clinics, contact tracing and investigation efforts. During the IHS COVID-19 pandemic response, PHNs reported patient encounters for

communicable disease, surveillance, contact tracing, testing, patient monitoring, and vaccination activities, resulting in a significant increase in the number of PHN encounters reported in FY 2020 and 2021. The current PHN staff shortage challenges efforts to administer, support, and provide services. Additionally, the PHN program is impacted by Tribal programs migrating away from using the IHS Resource and Patient Management System which results in PHN data not being collected in the PHN data mart. The FY 2024 and FY 2025 targets are lowered compared to FY 2023 as the performance spike in FY 2020 and FY 2021 was the result of the increased PHN activity related to the COVID-19 pandemic. Ongoing analysis of FY 2022, FY 2023 and FY 2024 data results will be used to predict future performance target(s), especially since results prior to FY 2020 and FY 2021 fell below the results during the pandemic.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2024 Target**	**FY 2025 Target**	**FY 2025 Target +/-FY 2024 Target**
23 Public Health Nursing (PHN): Total number of IHS public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups. (Outcome)	FY 2022: 385,356 Target: 411,325 (Target Not Met)	400,000[1]	350,000	-50,000

GRANTS AWARDS

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Number of Awards	7	7	7
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

[1] IHS proposes a revised FY 2024 target.

AREA ALLOCATION

Public Health Nursing

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY '23
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$	$15,465	$15,465	$	$15,474	$15,474	$	$16,895	$16,895	$1,431
Albuquerque	1,917	2,305	4,222	1,914	2,307	4,221	2,090	2,519	4,609	$387
Bemidji	5	2,719	2,724	5	2,721	2,725	5	2,971	2,975	$252
Billings	2,889	1,759	4,648	2,886	1,760	4,645	3,151	1,921	5,072	$424
California	0	1,209	1,209	0	1,210	1,210	0	1,321	1,321	$112
Great Plains	5,089	7,505	12,594	5,083	7,510	12,592	5,549	8,199	13,749	$1,154
Nashville	425	1,760	2,185	424	1,762	2,186	463	1,923	2,387	$201
Navajo	9,888	8,273	18,161	9,875	8,278	18,153	10,782	9,038	19,820	$1,659
Oklahoma	3,724	17,458	21,182	3,719	17,469	21,188	4,060	19,073	23,134	$1,952
Phoenix	4,968	12,636	17,604	4,961	12,644	17,605	5,417	13,805	19,222	$1,618
Portland	815	2,614	3,429	814	2,615	3,429	889	2,856	3,744	$315
Tucson	0	1,139	1,139	0	1,139	1,139	0	1,244	1,244	$105
Headquarters	6,221	0	6,221	6,213	0	6,213	6,783	0	6,783	$562
Total, PHN	**$35,940**	**$74,842**	**$110,782**	**$35,893**	**$74,889**	**$110,782**	**$39,189**	**$81,765**	**$120,955**	**$10,173**

1/ Note: 2023, 2024, and 2025 are estimates.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR/1	President's Budget	FY 2025 +/- FY 2023
PL	$24,350	$24,350	$26,144	+$1,794
FTE*	15	15	15	-

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

BUDGET REQUEST

The FY 2025 budget submission for Health Education of $26 million is $2 million above the FY 2023 Final level.

FY 2025 Funding Increase of $2 million includes:

- Current Services and Staffing of Newly Constructed Facilities: +$2 million. Information can be found in the Current Services and Facilities Construction chapters.

FUNDING HISTORY

Fiscal Year	Amount
2021	$21,034,000
2022	$23,250,000
2023 Final	$24,350,000
2024 CR	$24,350,000
2025 President's Budget	$26,144,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

In FY 2023, the Health Education Program collaborated with the Health Promotion/Disease Prevention (HP/DP) program to share best/promising practices webinar with more than 300 attendees; provided adult Mental Health First Aid training; and hosted a youth Mental Health First Aid Instructor Certification training with 15 participants. The program collaborated with the HP/DP program to implement colorectal screening pilot projects in three sites; hosted a virtual physical activity event with more than 200 participants, hosted a 4-week employee challenge with over 400 participants, and hosted an in-person elderly event with 87 participants.

- In FY 2023, updated the Health Education Chapter of the Indian Health Manual, promoted and awarded the annual Health Literacy Award to recognize teams and individuals who are advancing health literacy, and collaborated with Tribes, health boards, schools, and local state health programs to increase outreach prevention activities focusing on immunization, diabetes, sexually transmitted diseases, cancer, suicide, alcohol, tobacco, and other drugs.
- In FY 2024, continue collaborating with various programs and partners to address obesity, sexually transmitted diseases, physical activity, alcohol, tobacco and other drugs, cancer, and diabetes.
- In FY 2024, continue to collaborate with various programs to promote health literacy activities that include training, webinars, and sharing of best/promising practices (.
- If the funding level allows, in FY 2024, plan to hire a full-time Health Education Consultant. This position has been vacant for several years due to funding limitations.

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

In FY 2023, there was a decrease of 8 percent or 243,695 patient visits from the previous year. In FY 2023, there were 2,504,243 patient education visits. In FY 2023, patient education visits did not meet the target results, with 71,028 fewer patient visits.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
HE-1 Number of visits with Health/Patient Education (Output)	FY 2022: 2,747,938 visits Target: 2,575,271 visits (Target Exceeded)	2,823,012 visits	2,823,012 visits	Maintain

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

AREA ALLOCATION

Health Education

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY '23
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$	$3,791	$3,791	$	$3,734	$3,734	$	$4,010	$4,010	$219
Albuquerque	$295	1,134	1,428	291	1,117	1,408	312	1,199	1,512	$83
Bemidji	$118	730	848	117	719	835	125	772	897	$49
Billings	$497	908	1,405	491	894	1,385	527	960	1,487	$82
California	$38	422	461	38	416	454	41	447	487	$27
Great Plains	$328	1,987	2,314	323	1,957	2,280	347	2,101	2,448	$134
Nashville	$197	750	948	195	739	934	209	794	1,003	$55
Navajo	$40	3,532	3,572	40	3,479	3,519	43	3,736	3,778	$206
Oklahoma	$904	3,566	4,470	893	3,513	4,406	959	3,772	4,731	$260
Phoenix	$1,244	1,762	3,006	1,228	1,735	2,964	1,319	1,863	3,182	$176
Portland	$118	1,036	1,154	116	1,021	1,137	125	1,096	1,221	$67
Tucson	0	281	281	0	277	277	0	297	297	$16
Headquarters	$1,029	0	1,029	1,016	0	1,016	1,091	0	1,091	$62
Total, Hlth Ed	**$4,809**	**$19,897**	**$24,705**	**$4,748**	**$19,602**	**$24,350**	**$5,098**	**$21,046**	**$26,144**	**$1,439**

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR/1	President's Budget	FY 2025 +/- FY 2023
PL	$65,212	$65,212	$69,628	+$4,416
FTE*	5	5	5	-

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

In 1968, the Indian Health Service (IHS) funded the Community Health Representative (CHR) Program as a component of healthcare services for American Indian Alaska Native (AI/AN) people. CHRs are considered members of the evidence-based Community Health Worker (CHW) workforce and share core roles and competencies. Today, 97 percent of the 299 CHR programs are tribally governed. The primary purpose of the CHR program includes: (1) Relationship and trust-building – to identify specific needs of clients; (2) Communication – especially the continuity and clarity between provider and patient; and traditional knowledge and language, and (3) A focus on the Social Determinants of Health – conditions in which people are born, grow, work, live, and age, including social connectedness, traditional knowledge, spirituality, relationship to the environment, and a shared history.

CHRs are the frontline workforce for Tribal underserved populations to decrease health inequities. CHR activities impact SDOH with access to care and coverage, social/cultural cohesion, transportation, food access, environmental quality, social justice, housing, and educational training opportunities.

The CHR Program has made significant contributions to Indian health in its efforts to provide community-oriented primary health care services serving as a way to bolster primary and preventive health. CHRs are trusted community members and serve as a link between the Indian health system, including associated health programs, and AI/AN patients and communities. This community-based care delivery is coordinated with tribal health departments and programs. The CHR Program has made significant contributions to Indian health in its efforts to provide community-oriented primary health care services serving as a way to bolster primary and preventive health

BUDGET REQUEST

The FY 2025 budget request for Community Health Representatives of $70 million is $4 million above the FY 2023 Final level. The proposed funding level directly supports IHS's efforts to provide high-quality health care across the Indian health system.

FY 2025 Funding Increase of $4 million includes:

- Current Services and Staffing of Newly Constructed Facilities: +$4 million. Information can be found in Current Services and Staffing of Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2021	$62,892,000
2022	$63,679,000
2023 Final	$65,212,000
2024 CR	$65,212,000
2025 President's Budget	$69,628,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

CHR Performance Measures

In FY 2023, CHR performance measures comprise three categories tracked per fiscal year: a) CHR-1, Number of patient contacts; b) CHR-2, CHR patient contacts for chronic disease services; and c) CHR-3, Number of CHRs trained.

Two reporting categories exceeded targets, and one did not meet the target.

Tribes who provided data reported during FY 2023 for CHR-1 performance measure were 439,739 CHR patient contacts. This is a decrease of 15,678 patient contacts below the target measure of 455,417, which is a 3 percent decrease. The CHRs provide essential services in terms of case management, patient care, patient education, screening, health promotion/disease prevention, and transportation for members of their communities. Likely, the CHR services across the IHS Areas have not declined to the extent indicated but reflect a structural IT barrier limiting access to the IHS Electronic Health Record (EHR) and Resource Patient Management System (RPMS) for CHR health care integration and services. There is no proper accounting of services since many of the Tribal Health Care Programs have moved to non-RPMS, non-IHS EHR systems. Additionally, IHS does not currently have a method for capturing CHR activity (services and contacts) from non-RPMS users, those without access to a CHR Reporting Package. Such system challenges are barriers to capturing CHR data from non-RPMS users and influence attempts to understand the actual impact of CHR work. CHRs often work hand-in-hand with

healthcare professionals to extend services into the community setting, providing invaluable services that bridge coverage gaps by connecting patients with much-needed healthcare and socio-economic services in communities where aging population, high chronic disease burden, and limited resources (funding and staff shortages) may lead to ultimately unacceptably poor health and quality of life outcomes for AI/AN populations.

Tribes who provided data reported during FY 2023 for CHR-2 performance measure was 171,935 CHR patient reported contacts for visits to patients with chronic diseases. This equates to an increase of 14,384 patient contacts above the target measure of 157,551 for a 9 percent increase.

Tribes participating in IHS CHR E-learning reported that during FY 2023, the CHR-3 performance measure was 821 trained CHRs through an online training platform on Basic/Advanced CHR series courses. This equates to an increase of 445 CHRs prepared above the target measure of 376 for an 84 percent increase.

Program Goal Accomplishments

In FY 2023, the CHR Program had an 87.5 percent completion rate (meeting or exceeding 14/16 objectives) of the DCCS CHR 2023 Program Goals. This translated into demonstrating exceptional initiative in achieving results critical to Agency success with CHR program goals of awareness, training, workforce development, reimbursement, and career ladder.

In FY 2023, accomplishments include formalizing a 5-year National CHR Program Strategic Plan to include national requirements for the CHR program (community health education, prevention, intervention, and treatment implementation). In addition, a partnership was established with the IHS Alzheimer's Dementia Initiative to implement quality improvement intervention training using the CHR workforce using the mini-cog assessment and document the referral process. The CHR Dementia Mini-Cog Screening Pilot is now positioned as a six-month applied pilot that includes CHW competency training provided by Oklahoma University Dementia Care Network as pre-requisite training for the CHR Dementia Mini-Cog Screening Pilot Sites.

In FY 2023, the CHR Program aligned with Healthy People 2030 objectives of reducing health disparities by addressing the social determinants of health to include the development of public-facing facts sheets and infographics communicating messaging and providing education, information, outreach, and support to Tribal CHR programs housed on the IHS CHR webpage.

The CHRs have proven to be a critical asset in AI/AN communities' response to COVID-19 by providing much-needed long-term contact tracing, case management follow-ups, home visits, patient and community education on vaccine and public health measures, and transportation for tribal community members. The CHRs are a vital link between the patient and the medical home by providing culturally appropriate care and supporting community health.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
CHR-1 Number of patient contacts (Output)	FY 2023: 439,739 patient contacts Target: 455,417	478,188 patient contacts	478,188 patient contacts	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
	patient contacts (Target Not Met)			
CHR-2 CHR patient contacts for Chronic Disease Services (Output)	FY 2023: 171,935 patient contacts Target: 157,551 patient contacts (Target Exceeded)	165,429 patient contacts	165,429 patient contacts	Maintain
CHR-3 Number of CHRs Trained (Output)	FY 2023: 821 CHRs Target: 376 CHRs (Target Exceeded)	414 CHRs	414 CHRs	Maintain

AREA ALLOCATION

Community Health Representatives

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY '23
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$5,017	$5,017	$0	$5,020	$5,020	$0	$5,359	$5,359	$342
Albuquerque	0	3,780	3,780	0	3,782	3,782	0	4,038	4,038	$258
Bemidji	0	5,250	5,250	0	5,253	5,253	0	5,608	5,608	$358
Billings	661	4,121	4,782	653	4,123	4,776	698	4,402	5,099	$317
California	1	2,249	2,250	1	2,250	2,251	1	2,403	2,404	$153
Great Plains	475	7,287	7,763	470	7,291	7,760	501	7,784	8,286	$523
Nashville	425	3,450	3,875	420	3,452	3,872	449	3,685	4,134	$259
Navajo	0	7,748	7,748	0	7,752	7,752	0	8,277	8,277	$528
Oklahoma	0	10,054	10,054	0	10,058	10,058	0	10,739	10,739	$686
Phoenix	3	6,730	6,732	2	6,733	6,735	3	7,189	7,191	$459
Portland	1	5,088	5,089	1	5,090	5,091	1	5,435	5,436	$347
Tucson	0	2,126	2,126	0	2,127	2,127	0	2,272	2,272	$145
Headquarters	744	0	744	735	0	735	785	0	785	$41
Total, CHR	**$2,310**	**$62,901**	**$65,212**	**$2,282**	**$62,930**	**$65,212**	**$2,437**	**$67,191**	**$69,628**	**$4,416**

1/ Note: 2023, 2024, and 2025 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 2023	FY 2024	FY 2025	
	Final	CR/1	President's Budget	FY 2025 +/- FY 2023
PL	$2,183	$2,183	$2,308	+$125
FTE*	0	0	0	--

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

1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

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

BUDGET REQUEST

The FY 2025 budget request for Alaska Immunization is $2 million, which is $125,000 above the FY 2023 Final level.

FY 2025 Funding Increase of $125,000 includes:

- Current Services: +$125,000. Information can be found in the Current Services chapter.

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

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

FUNDING HISTORY

Fiscal Year	Amount
2021	$2,127,000
2022	$2,148,000
2023 Final	$2,183,000

2024 CR	$2,183,000
2025 President's Budget	$2,308,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

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

Hepatitis B Program

The Hepatitis B program continues to prevent and monitor hepatitis B infection among a large population of Alaska Natives with or susceptible to the disease. The program evaluates hepatitis A and hepatitis B vaccination coverage of Alaska Natives, and the total number of Alaska Native patients targeted for screening and the total number of patients screened for hepatitis B and hepatitis C as well as other causes of liver disease that disproportionately affect the Alaska Native population. The Program is actively engaged in a statewide HCV elimination project. This involves recruiting patients for treatment through our local outpatient clinic, field clinics and video clinics as well as performing provider in-person and webinar education seminars on treating hepatitis C. The Program website provides online treatment documents and a treatment algorithm for Alaska Tribal healthcare providers. Since 2014, over 1,350 American Indian/Alaska Native persons have been treated for HCV through the ATHS.

In FY 2023:

- Hepatitis A vaccination coverage did not achieve the target, and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 86 percent (90 percent target) and hepatitis B vaccination coverage was 94 percent (90 percent target).
- Overall, at least 75 percent of AI/ANs with either chronic hepatitis B (67 percent screened) or hepatitis C (79 percent screened) infection were screened for liver cancer and for liver aminotransferase (enzyme) levels.

Haemophilus Immunization (Hib) Program

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

Routine immunizations were disrupted by the COVID-19 pandemic. Childhood immunization coverage[1] with 4:3:1:3*:3:1:4 series for Alaska Native children age 19-35 months dropped to 58

[1] https://www.ihs.gov/epi/immunization-and-vaccine-preventable-diseases/statistics-and-reports/

percent in July 2022, and only increased one percent over the following three quarters. Routine immunization coverage rates increased from 59 percent to 62 percent as reported in October 2023. Aligned with the Healthy People 2030 measures, the Program continues to monitor the additional immunization performance measures for Alaska Native children age 19-35 months, 4 doses DTaP and 1 MMR.

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

During FY 2023:

- Immunization Coverage for Alaska Natives age 19-35 months was 62 percent, for the 4:3:1:3*:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Var, 4 PCV).
  - 4 DTaP in this age group was 66 percent, the Healthy People 2030 vaccination objective IID-06 to increase the coverage level of 4 doses of DTaP vaccine by age two years.
  - 1 MMR in this age group was 87 percent, the Healthy People 2030 vaccination objective IID-03 to maintain the coverage level of 1 dose of MMR in children by age 2 years.
- Achieved 86 percent coverage with full series Haemophilus influenza type b (Hib) vaccine in children age 19-35 months.
- Provided technical assistance to Tribal health facilities with the following:
  - Maintaining interface connection with the statewide immunization information system, VacTrAK
  - Implementation and maintenance of clinical support system tools (i.e., vaccine forecaster)
  - Utilization of VacTrAK patient reminder/recall system

A summary of immunization[2] results is included below:

Immunization Measure	Age Group	Alaska Native coverage as of 9/30/2023	Alaska Native coverage as of 6/30/22
4:3:1:3*:3:1:4	19-35 months	62%	59%
4:3:1:3:3:1	19-35 months	63%	60%
3 Hib vaccines doses		86%	83%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	84%	85%
4 DTaP	19-35 months	66%	64%
1 MMR	19-35 months	87%	83%
1+ HPV	13-17 years female	77%	77%

The Hib program continues to collaborate 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 organizations that may result in temporary loss or delay of Area-wide reporting of vaccine coverage. Regular reporting of immunization coverage is critical in assuring sufficient monitoring and follow-up with facilities experiencing vaccination administration issues.

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

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)[1]	FY 2024 Target	FY 2025 Target[3]	FY 2025 Target +/-FY 2024 Target
AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output)	FY 2023: 600 Screened Target: 600 Screened (Target Met)	550 Screened	550 Screened	Maintain
AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output)[4]	FY 2023: 1395 Screened Target: 1300 Screened (Target Exceeded)	1300 Screened	1300 Screened	Maintain
AK-3 Other Liver Disease Patients Screened (Output) [5]	FY 2023: 429 Screened Target: 300 Screened (Target Exceeded)	300 Screened	300 Screened	Maintain
AK-4 Hepatitis A vaccination (Output) [6]	FY 2023: 86 % Target: 90 % (Target Not Met)	90 %	90 %	Maintain
AK-5 Hepatitis B vaccinations (Output) [7]	FY 2023: 94 % 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 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY '23
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$2,183	$2,183	$0	$2,183	$2,183	$0	$2,308	$2,308	$125
Total, Imm AK	**$0**	**$2,183**	**$2,183**	**$0**	**$2,183**	**$2,183**	**$0**	**$2,308**	**$2,308**	**$125**

1/ Note: 2023, 2024, and 2025 are estimates.

[3] Hepatitis Program (Known Cases Screened) Sum of known hepatitis B cases FY 2023: 893. Decline is hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.

[4] Hepatitis Program (Known Cases Screened) Sum of known hepatitis C cases FY 2023: 1,759. New cases still at an annual rate nearing pre-pandemic levels. Treated cases with advanced fibrosis/cirrhosis being followed indefinitely.

[4] Hepatitis Program (Known Cases Screened) Sum of known other liver disease cases FY 2023: 495. Other liver disease includes AIH and PBC (344 cases), plus the addition of NAFLD with NASH (151 cases).

[5] Hepatitis A/B Immunization rates for Alaska Native children who achieve Hepatitis A 1-dose completion and Hepatitis B 3-dose completion aged 19-35 months are compiled and reported throughout the Alaska Native Tribal Health System on a quarterly basis.

[6] The rates reported herein represent the most recent reporting period. Established target immunization rate for each vaccine is 90%.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /2	President's Budget	FY 2025 +/- FY 2023
PL	$90,419	$90,419	$94,992	+$4,573
FTE*	9	9	9	-

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

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

BUDGET REQUEST

The FY 2025 budget submission for Urban Indian Health is $95 million, which is $5 million above the FY 2023 Final level.

FY 2023 Final level Funding of $90 million – The base funding provides for the following activities:

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

FY 2025 Funding Increase of $5 million includes:

- Current Services: +$5 million. Information can be in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2021	$62,684,000
2022	$73,424,000
2023 Final	$90,419,000
2024 CR	$90,419,000
2025 President's Budget	$94,992,000

PROGRAM ACCOMPLISHMENTS

In Calendar Year 2021, UIOs provided 696,229 health care visits for 70,388 Urban Indian people who do not have access to the resources offered through IHS or Tribally operated health care facilities because they do not live on or near a reservation. The UIOs are described as follows:

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

The major Urban Indian Health focus areas and activities are:

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

- Urban Indian Education and Research Organization Cooperative Agreement: In FY 2023, the OUIHP awarded the National Council of Urban Indian Health $1,350,000 to provide national-level education and research services for UIOs and the OUIHP through a cooperative agreement. The grantee was awarded a five-year funding cycle from June 1, 2022

– May 31, 2027. The cooperative agreement includes five project areas: (1) public policy; (2) research and data; (3) training and technical assistance; (4) education, public relations, and marketing; and (5) payment system reform/monitoring regulations. This cooperative agreement also addresses the unmet needs of 4-in-1 grantees under the training and technical assistance focus area.

- Urban Indian Health Institute: In FY 2023, the OUIHP awarded $100,000 to a cooperative agreement with the Urban Indian Health Institute to provide training and technical assistance on planning, conducting, and implementing community health needs assessment, develop new and updating existing community health profiles; and provide ongoing training and tutorials on how to interpret data.

- Albuquerque Indian Dental Clinic: Provides dental services through the Albuquerque Area IHS Dental Program.

The UIOs are evaluated in accordance with the IHCIA requirements. The OUIHP integrates Enterprise Risk Management by annually reviewing UIO progress with set goals and objectives. The IHS UIO On-Site Review Manual is used by the IHS Areas to conduct annual onsite reviews of IHS-funded UIOs to monitor compliance with Federal Acquisition Regulation contractual requirements established through legislation. The results are submitted to OUIHP for review and follow-up to ensure corrective action plans are successfully completed prior to continuation of funding. Requirements in the manual are based on best-practice standards for delivering safe and high quality health care and are similar to standards used by accrediting organizations. Many UIOs are seeking or maintaining accreditation from several accreditation organizations such as the Joint Commission, Accreditation Association for Ambulatory Healthcare (AAAHC), and Commission on Accreditation of Rehabilitation Facilities. In FY 2023, through an IHS contract with AAAHC, accreditation services were provided to 20 out of the 41 UIOs.

The UIOs fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report and the Diabetes Non-Clinical Audit report. From October 1, 2020, to September 30, 2021, the UIO FY 2021 GPRA cycle accomplishments included:

- 88 percent of the UIOs reported on 26 of the 26 performance measures (although not all have facility-specific data available due to inclusion in an IHS Service Unit);
- 68 percent of the UIOs (23 UIOs) have GPRA data available by facility via any reporting method (Integrated Data Collection System or Manual);
- 79 percent of the UIOs reported through the Integrated Data Collection System Data Mart (IDCS DM) (although not all have facility-level data available in IDCS);
- 38 percent (13 UIOs) have GPRA data specific to their health program available in IDCS DM;
- 6 UIOs reported through the Clinical Reporting System (2 of these programs reported both through IDCS DM and through CRS); and
- 12 UIOs reported manually using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records).

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

In FY 2023, the OUIHP approved Urban Emergency Funds (UEF) totaling $200,000. The OUIHP approved one UEF request for the Billings Urban Indian Health and Wellness Center operated by the Native American Development Corporation totaling $200,000 for an emergency remodeling project.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome)	FY 2021: 70,388 Target: 70,000 (Target Exceeded) FY 2020: 66,830 Target: 81,350 (Target Not Met)	77,412	76,491	-921

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

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Number of Awards	35	35	35
Average Award	$344,510	$315,939	$315,939
Range of Awards	$194,009 - $1,350,000	$181,239 - $1,350,000	$181,239 - $1,350,000

AREA ALLOCATION

Urban Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2023 Estimate/1			FY 2023 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY '23
	Federal	Urban	Total	Federal	Urban	Total	Federal	Urban	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$
Albuquerque	740	5,161	5,900	739	5,161	5,900	776	5,422	6,198	$298
Bemidji	286	11,062	11,347	285	11,063	11,348	300	11,622	11,922	$574
Billings	265	7,874	8,139	265	7,874	8,139	278	8,273	8,551	$412
California	457	17,567	18,024	457	17,568	18,025	480	18,456	18,936	$912
Great Plains	122	3,901	4,023	122	3,902	4,023	128	4,099	4,227	$204
Nashville	95	2,895	2,989	95	2,895	2,990	99	3,041	3,141	$151
Navajo	6	1,983	1,989	6	1,983	1,989	6	2,083	2,090	$101
Oklahoma	216	5,723	5,939	216	5,723	5,939	227	6,013	6,239	$300
Phoenix	44	7,663	7,707	44	7,664	7,707	46	8,051	8,097	$390
Portland	78	9,497	9,575	78	9,498	9,576	82	9,978	10,060	$485
Tucson	25	1,600	1,625	25	1,600	1,625	26	1,681	1,707	$82
Headquarters	2,103	11,058	13,161	2,100	11,059	13,159	2,207	11,618	13,824	$664
Total, Urban	**$4,436**	**$85,983**	**$90,419**	**4,430**	**$85,989**	**$90,419**	**4,654**	**$90,338**	**$94,992**	**$4,573**

1/ Note: 2023, 2024, and 2025 are estimates.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR/1	President's Budget	FY 2025 +/- FY 2023
PL	$80,568	$80,568	$81,252	+$684
FTE*	14	14	14	--

*FTE numbers reflect only Federal staff and do not include increases for tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

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

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

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

BUDGET REQUEST

The FY 2025 budget submission for Indian Health Professions of $81 million is $684,000 above the FY 2023 Final level.

FY 2023 Final level Funding of $81 million – The base funding enables AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs; serve as a catalyst in developing AI/AN communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care; and assist Indian health programs to recruit and retain qualified health professionals.

FY 2025 Funding Increase of $684,000 includes:

- Current Services: +$684,000. Information can be found in the Current Services chapter.

The budget also includes numerous legislative proposals that would provide IHS with critical new or expanded authorities to address recruitment and retention challenges. Many of these proposals are cost neutral and include (additional information on the legislative proposals can be found in the Legislative Proposals chapter):

- Provide the IHS discretionary use of additional Title 38 personnel authorities through expansion of the Office of Personnel Management's delegation authority;
- Meet Loan Repayment/Scholarship Service Obligations on a Half-Time Basis;
- Provide Tax Exemption for IHS Health Professions Scholarship and Loan Repayment Programs;
- Provide IHS with permanent authority to hire and pay experts/consultants;
- Provide the IHS with an on-call pay authority through a revision to premium pay provisions under Title 5 of the United States Code (U.S.C.); and
- U.S. Public Health Service Commissioned Officers to be Detailed to Urban Indian Organizations to Cooperate in or Conduct Work Related to the Functions of the Department of Health and Human Services.

FUNDING HISTORY

Fiscal Year	Amount
2021	$67,314,000
2022	$73,039,000
2023 Final	$80,568,000
2024 CR	$80,568,000
2025 President's Budget	$81,252,000

PROGRAM ACCOMPLISHMENTS

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

- Recruiting well-qualified health care professionals through various sources: IHS Scholarship Recipients, US Public Health Service Commissioned Corps, and Uniformed Services University of the Health Sciences (USUHS), various social media networking sites, virtual career fair events and in person physician specialty conferences.
- Conducting IHS Scholarship Program and LRP webinar-based general information session webinars for potential applicants; updating SP and LRP websites with up-to-date programmatic information.
- Increasing the LRP award amount to $25,000 per year.
- Collaborating with the National Health Service Corps Loan Repayment Program that received an additional funding for loan repayment awards to clinicians working at IHS facilities, Tribally-operated 638 health programs, and Urban Indian programs to combat the nation's opioid crisis.
- Consulting annually with IHS Area Directors, Tribal health directors, and Urban Indian health directors regarding their health professions priorities eligible for Scholarship and Loan Repayment Program funding.
- Enhancing IHS recruitment and retention strategies through the development and management of the IHS Exit Survey Program Agency-wide and the IHS Housing Subsidy Program (piloting in 1 Area).

While the IHP programs have seen successes, IHP continues to strive to improve performance and identify areas of risk. Placement of new scholars within 90 days of completing their training continues to be a challenge. The use of outreach activities such as recruitment and placement webinars, direct emails to scholarship recipients, and the referral of graduates to area and site recruiters have all been used to facilitate the 90-day scholar placement. In FY 2023, 52 percent of scholars were placed within 90 days (target was 50 percent). Attaining higher success rates are often impacted by scholars of certain disciplines being unable to register for their licensing board examinations until after successful completion of their education and finding positions within the 90-day period. The Scholarship program continues to seek new ways to assist IHS scholars to meet this requirement.

Loan Repayment Program (Section 108): In FY 2023, a total of 1,821 health professionals were receiving IHS loan repayment. This included 739 new two-year contracts, 541 one-year extension contracts, and 541 health professionals starting the second year of their FY 2022 two-year contract. There were no "matched unfunded" applicants and 455 "unmatched unfunded" health professionals (including 85 behavioral health providers, 29 dentists, 52 mid-level providers and 166 nurses among others). The inability to fund these 455 health professional applicants is a significant challenge for the recruitment efforts of the agency. A more detailed breakout of loan repayment awards in FY 2023 by discipline is included in a table at the end of the narrative.

Scholarship Program (Sections 103 and 104): In FY 2023, there were 539 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 180 of these new scholarship applications accepted the scholarship. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education. A total of 196 extension awards were funded for

FY 2023. A detailed breakout of scholarships awarded by discipline for FY 2023 is included in a table at the end of the narrative.

Extern Program (Section 105): In summer 2023, the Extern Program funded a total of 4 student externs. A table of extern awards by Area Offices is included in a table at the end of the narrative.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome)	FY 2023: 52 % Target: 40% (Target Exceeded)	40%	40%	Maintain
IHP-1 Number of scholarship awards under section 103 (Output)	FY 2023: 116 Awards Target: 40 Awards (Target Exceeded)	103 Awards	103 Awards	Maintain
IHP-2 Number of scholarship awards under section 104 (Output)	FY 2023: 260 Awards Target: 250 Awards (Target Exceeded)	253 Awards	253 Awards	Maintain
IHP-3 Number of externs under section 105 (Output)	FY 2023: 4 Externs Target: 35 Externs (Target Not Met but Improved)	35 Externs	35 Externs	Maintain
IHP-4 Number of new 2-year contract awarded loan repayments under section 108 (Output)	FY 2023: 739 contracts Target: 570 contracts (Target Exceeded)	610 contracts	580 contracts	-30 Contracts
IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output)	FY 2023: 541 Awards Target: 680 Awards (Target Not Met)	655 Awards	600 Awards	-55 Awards
IHP-6 Total number of new awards funded in previous fiscal year under section 108 (Outcome)	FY 2023: 541 awards Target: 570 awards (Target Not Met)	610 awards	610 awards	Maintain

* FY 2022 "Targets" include estimates based on complete FY 2021 funding cycle data.
** The "Number of Loan Repayments – Total" includes New Awards, Contract Extensions and Continuation Awards.
*** In FY 2023 a total of 321 awardees to date declined their award. The main reason for declinations is that the applicants also applied to the National Health Service Corps LRP and were accepted.

GRANTS AWARDS

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

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
American Indians Into Nursing Program (Section 112) – CFDA No. 93.970			
Number of Awards	5	5	5
Average Award	$337,341	$337,341	$337,341
Range of Awards	$337,341	$337,341	$337,341
Indians Into Medicine Program (Section 114) – CFDA No. 93.970			
Number of Awards	4	4	4
Average Award	$321,250	$321,250	$321,250
Range of Awards	$195,000 - $700,000	$195,000 - $700,000	$195,000 - $700,000
American Indians Into Psychology Program (Section 217) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$240,791	$240,791	$240,791
Range of Awards	$240,791	$240,791	$240,791

Scholarship Program Awards –For FY 2023, the IHS Scholarship Program made awards to the following disciplines:

Section 103 Pre-professional 38 students				
Pre-Nursing	38			
Section 103 Pre-graduate –78 students				
Pre-Dentistry	17			
Pre-Medicine	61			
Section 104 Health Professions - 260 students				
Chiropractor	0		Optometry	20
Clinical Lab Science	3		Pharmacy	29
Clinical Psychology	5		Physical Therapy	19
Dentistry	21		Physician Assistant	21
Engineering (Civil/Environmental)	0		Physician, Allopathic	32
Environmental Health	0		Physician, Osteopathic	31
Nurse Practitioner	18		Podiatry	3
Nurse, Baccalaureate Degree	36		Social Work	13
Nurse Midwife	4			
Nurse Anesthetist	5			

Loan Repayment Program Awards – In FY 2023, the IHS LRP made awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Behavioral Health	64	40	24	0
Dental*	108	61	47	0
Nurse	273	219	54	0
Optometrists	49	36	13	0
Pharmacists	211	100	111	0
Physician Assistants/ Advanced Practice Nurses	202	106	96	0
Physicians	159	56	103	0
Podiatrists	17	3	14	0
Rehabilitative Services	103	49	54	0
Other Professions	94	69	25	0
TOTAL	**1280**	**739**	**541**	**0**

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

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Acupuncturist	6	0	Tribal Employee	833
Chiropractors	10	0	Civil Service	340
Dietetics/Nutrition	25	0	Commissioned Corps	63
Engineering	12	0	Urban Health Employees	44
Medical Laboratory Scientist	4	0		
Medical Technology	10	0		
Radiology Technicians	18	0		
Sanitarian	4	0		
Respiratory Therapists	5	0		
TOTAL	**94**	**0**	**Total**	**1280**

Extern Program Awards – In summer 2023, the IHS Extern Program had a total of 4 student externs.

AREA OFFICES	NUMBER OF STUDENT EXTERNS
Albuquerque	1
Bemidji	2
Portland	1

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

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR/1	President's Budget	FY 2025 +/- FY 2023
PL	$2,986	$2,986	$2,987	+$1
FTE*	--	--	--	--

*Tribal Management Grant funds are not used to support FTEs.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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

FY 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

The IHS established four funding priorities for the TMG program:

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

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

(1) Planning - fund up to $50,000 with project periods not to exceed 12 months. A Planning Project allows establishment of goals and performance measures for current health programs or to design their health programs and management systems.

(2) Evaluation - fund up to $50,000 with project periods not to exceed 12 months. An Evaluation Study Project determines the effectiveness and efficiency of a program or if new components are needed to assist the T/TO to improve its health care delivery system.
(3) Feasibility - fund up to $70,000 with project periods not to exceed 12 months. A Feasibility study analyzes programs to determine if T/TO management is practicable.
(4) Health Management Structure (HMS) grants are funded up to $300,000 with project periods not to exceed 36 months. HMS projects include the design and implementation of systems to manage PFSA, such as Electronic Health Records (EHR) systems or billing and accounting systems, management systems, health accreditation, as well as correction of audit material weaknesses.

BUDGET REQUEST

The FY 2025 budget submission for Tribal Management Grants of $2 million is $1,000 above the FY 2023 Final level.

FY 2025 Funding Increase of $1,000 includes:

- Current Services: +$1,000. Information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2021	$2,465,000
2022	$2,466,000
2023 Final	$2,986,000
2024 CR	$2,986,000
2025 President's Budget	$2,987,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

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

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

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
TMG-1 Planning Grants (Output)	FY 2023: 1 planning grants Target:2 planning grants (Target Not Met) FY 2022: 0 planning grants Target: 2 planning grants (Target Not Met)	2 planning grants	4 planning grants	+2 planning grants
TMG-2 Health Management Structure (HMS) grants (Output)	FY 2023: 11HMS grants Target:10 planning grants (Target Met) FY 2022: 6 HMS grants Target: 9 planning grants (Target Not Met)	10 HMS grants	12 HMS grants	+2 HMS grants

GRANTS AWARDS

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Number of Awards	20 Total Awards: 11 Noncompeting Continuations and 9 New	20 Total Awards: 10 Noncompeting Continuations and 10 New [1]	20 Total Awards: 10 Noncompeting Continuations and 10 New [2]
Average Award	$105,135	$105,135	$105,135
Range of Awards	$50,000 - $150,000	$50,000 - $150,000	$50,000 - $150,000

[1] FY 2022 is an estimate will update when awarded.
[2] FY 2023 is an estimate will update when awarded.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2024
PL	$103,805	$103,805	$111,966	+$8,161
FTE*	254	254	254	-

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The IHS Direct Operations budget supports the provision of Agency-wide leadership, oversight, and executive direction for the comprehensive public and personal health care provided to American Indians and Alaska Natives. Each year, additional tribal shares are taken from the Direct Operations budget by tribes who choose to contract or compact their health care programs. As a result, over the past 5 years the amount of Direct Operations funding retained by IHS for carrying out inherently federal functions and supporting direct service tribes has decreased on average by approximately 2 percent per year. In an individual year, this amount has been as high as 6 percent. This unique aspect of the IHS Budget puts additional pressure on resource needs for core management functions.

BUDGET REQUEST

The FY 2025 budget submission for Direct Operations of $112 million is $8 million above the FY 2023 Final level.

FY 203 Final level Funding of $104 million – Funding provides for the direct operations of IHS's system-wide administrative, management, and oversight priorities at the discretion of the IHS Director that include, but are not limited to:

- Continuing vital investments to enhance the IHS's capacity for providing comprehensive oversight and accountability in key administrative areas such as: human resources, property, acquisition, financial management, information technology, and program and personnel performance management.
- Improving responsiveness to external authorities such as Congress, the Government Accountability Office (GAO), and the Office of Inspector General (OIG); and addressing Congressional oversight and reports issued by the GAO and the OIG to make

improvements in management of IHS programs, such as the PRC program, quality oversight, and workforce.
- Addressing requirements for national initiatives associated with privacy requirements, facilities, and personnel security.
- Continuing analysis and settlement of tribal contracting and compacting Contract Support Costs (CSC) claims and maintaining policies and procedures to accurately determine CSC needs in the future.

- FY 2025 Funding Increase of $8 million includes:

  - Direct Operations: +$6 million to improve oversight and management of inherently federal functions at the Indian Health Service. The IHS continues to prioritize improvement of oversight, accountability, and transparency; and the IHS needs additional staff and modernized systems to meet the expectations of Congress, GAO, OIG, and Tribal Leaders. These additional resources are necessary to support work aimed at removing the IHS from the GAO High Risk List.

    - These funds will be used to support the efficient and effective administration and oversight of national and Area-level functions like financial management, human resources, grants management, acquisitions, Indian Self-Determination and Education Assistance Act contracting and compacting administration, performance management, compliance, and other administrative supports and systems.

  - Current Services: +$2 million. Information can be found in the Current Services Chapter.

The budget also includes numerous legislative proposals (see the Legislative Proposals chapter for additional information) that would address critical IHS challenges, including GAO recommendations. Proposals include:
- Exempt the IHS from sequester;
- Provide Tax Exemption for IHS Health Professions Scholarship and Loan Repayment Programs;
- Provide IHS with permanent authority to hire and pay experts/consultants;
- Provide the IHS with an on-call pay authority through a revision to premium pay provisions under Title 5 of the United States Code (U.S.C.); and
- U.S. Public Health Service Commissioned Officers to be Detailed to Urban Indian Organizations to Cooperate in or Conduct Work Related to the Functions of the Department of Health and Human Services.

FUNDING HISTORY

Fiscal Year	Amount
2021	$82,456,000
2022	$95,046,000
2023 Final	$103,805,000
2024 CR	$103,805,000
2025 President's Budget	$111,966,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

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

The IHS is committed to making improvements and ultimately being removed from the GAO High-Risk list. In response to the GAO's High-Risk reports, the IHS developed an action plan in 2021 to meet GAO's criteria for removal from the High-Risk List. This action plan built internal capacity and led to sustainable improvements in the management and oversight of IHS programs and services. The development of this action plan provided a foundation upon which the Agency implemented the IHS 2023 Agency Work Plan, which outlined critical actions the IHS took throughout 2023 to address risk priorities. The IHS continues to make significant progress and has now transitioned to the 2024 Agency Work Plan, which will be used to demonstrate our efforts in meeting GAO's criteria for removal from the High-Risk List.

In FY 2023, the IHS focused on improving human resource systems and processes to bolster agency recruitment and retention activities. One example of system and process improvements includes the agency-wide implementation of the USA Performance management system, which is an electronic performance management system developed by the Office of Personnel Management. This system was piloted at the IHS Headquarters level in FY 2022 and now provides agency-wide capacity to manage and track all performance plans in one system that replaces paper performance plans. The use of an electronic system provides a streamlined and standardized performance management process.

The IHS has made significant quality and patient safety improvements across the Agency, providing the structure to promote accountability and oversight with a focus on quality assurance to promote and sustain compliance with Centers for Medicare and Medicaid Services and accreditation organizations; quality improvement through innovation and implementation of quality improvement science; and improve patient safety and reduce all-cause harm. During FY 2023, the IHS Office of Quality (OQ), which provides national coordination for agency quality and safety of healthcare services, supported patient safety through the implementation of a national IHS Patient Safety Policy and a national Infection Prevention and Control Policy, as well as continued standardization of credentialing practices. In addition, the OQ improved regulatory compliance through the implementation of standardized facility Governing Body Bylaws across IHS direct health care programs. The Compliance Division provides national leadership and consultation on compliance functions to ensure internal policies and procedures are properly authorized by and adequately implement applicable laws, regulations, and HHS policies and directives. In FY 2023, IHS implemented a qualitative approach to evaluating risks in nine business process areas to identify control areas for testing that were of the highest risk. As a result of the testing in FY 2023, the IHS provides reasonable assurance that internal control over reporting, operations, and compliance is operating effectively.

Quality Assurance and Patient Safety - The Division of Quality Assurance and Patient Safety focused intently on ensuring the quality of care in IHS facilities through external accreditation and certification support. The OQ provides oversight to survey readiness by making available tools, resources, and consultations for all IHS Area Offices and facilities. The OQ supported IHS facilities in all 12 IHS Areas to achieve and maintain The Joint Commission (TJC) and Accreditation Association for Ambulatory Health Care (AAAHC) accreditation standards and CMS regulations. This includes IHS Hospitals, Health Centers, Behavioral Health facilities, Critical Assess Hospitals (CAH), and Youth Regional Treatment Centers (YRTC). As of January 11, 2024, 100 percent of all IHS hospitals and CAHs have achieved and maintained CMS conditions of participation, 20 of 21 hospitals and CAHs have TJC accreditation. All 32 eligible IHS ambulatory health centers are accredited by TJC or the AAAHC.

The OQ monitors and provides oversight on certification and accreditation activities with the development and sharing of quarterly IHS accreditation reports to the IHS executive leadership team. The information from the reports is shared with leadership to increase transparency and strengthen the planning and collaboration of continuous improvement efforts. Certification and accreditation activities promote the evidence of quality standardization of health care programs.

The IHS has also directed that all ambulatory care facilities attain Patient-Centered Medical Home (PCMH) designation. As of January 11, 2024, 32 of 32 Ambulatory facilities, 15 of 15 Hospitals, and 7 of 7 CAHs have achieved PCMH designation.

During FY 2023, the OQ deployed the software system Tracers with AMP® to support ongoing accreditation readiness activities for TJC-accredited hospitals, critical access hospitals, behavioral health, and ambulatory facilities. In-person and virtual training opportunities were provided agency-wide as well as regular meetings to provide ongoing technical assistance and collaboration opportunities. By the end of the 1st Quarter of FY 2024, over 11,000 compliance observations have been recorded utilizing the standardized Tracers with AMP® tool.

Between October 1, 2023, to January 11, 2024, there were 48 successful accreditation surveys by TJC (including TJC Lab surveys), AAAHC, and CMS completed at IHS facilities.

The IHS monitors the credentialing and privileging system and continuously optimizes its functions. In Calendar Year (CY) 2023, the OQ prioritized the IHS credentialing and privileging process through the optimization and standardization of Applied Statistics & Management (ASM) credentialing and privileging software products across all federal facilities. All 11 eligible Areas utilize the software to facilitate the hiring, verification, and ongoing monitoring of qualified practitioners. In CY 2023, 44 fields in the software and 23 forms/processes were standardized agency-wide. For CY 2023, there have been 67,747 user logins processing 3,819 initial appointment and reappointment applications with 120,782 initial and ongoing verifications, along with 21,589 reports generated. The IHS manages the Medical Staff Services LISTSERV with 99 IHS users who distribute credentialing software updates and training opportunities and provide expert technical assistance across the health system. Medical Service Professional (MSP) office hours reoccur monthly, providing credentialing and privileging case studies to review and discuss and provide time for MSPs to collaborate on sharing knowledge and best practices. MSP town halls reoccur monthly reviewing and educating attendees on core elements of medical staffing, privileging, and software use. In FY 2023, de-duplication of 4,261 files for 1,921 providers was completed. In CY 2023, all medical staff applications and forms were updated, and two new applications were created, along with the new process to capture factual real-time summaries of clinical performance and professional conduct at the time a clinician leaves in an Exit Clinical

Provider Summary. The IHS provided a collection of continuously updated tools, best practices, and compliance tips for credentialing, privileging, and peer review topics developed by industry experts to their Areas through an off-the-shelf subscription service. With 3,733 inquiry views and over 526 hours of use for one sample month, the data demonstrates that IHS is utilizing this resource to build knowledge and stay current on the rapidly evolving areas of medical staff services and accreditation standards.

Patient Safety and Clinical Risk Management – The IHS Safety Tracking & Response (I-STAR), a system for reporting adverse events and good catches, is fully implemented across the Agency. A good catch event is an event or a potential safety hazard that is caught before it reaches a patient, worker, visitor, or facility. The OQ monitors the system and is continuously optimizing its functions. Since I-STAR was rolled out in August 2020, events have been reported from each of the 12 IHS Areas, 197 facilities, and 50 Tribal facilities. In FY 2023, 22,405 events were entered with 8,078 medication good catch events entered. The OQ is responsible for the oversight and administration of the I-STAR application and for providing educational opportunities for I-STAR users. In FY 2023, the OQ held 18 office hours and provided 43 Q&A sessions; modified I-STAR to allow for enhanced efficiency and investigation of good catch medication category A/B events; developed a Patient Safety Dashboard that includes 22 standard reports commonly used for identifying facility level patient safety trends and for reporting to Area Governing Boards; added 2 new facilities as I-STAR users; developed and posted 16 new job aides to assist users; and added 28 new drugs to the I-STAR formulary. The patient safety team collaborated with National Combined Councils (NCC), Area Directors (ADs), and the Chief Medical Officer (CMO) to develop an agency patient and workforce safety strategy, the Total System Safety Strategy. This strategy is in line with the Department of Health and Human Services (HHS) initiative, the Action Alliance to Advance Patient Safety. In November of 2023, the IHS published the Indian Health Manual (IHM) 3-42, Patient Safety which is the first system-level patient safety policy for the agency.

The OQ patient safety program worked with area offices to conduct patient safety program assessments at all federal facilities to assess the maturity of the different components of facility patient safety programs and to collect baseline patient safety program data that will be used to identify agency-level patient safety priorities. The Total System Safety Data Report was completed and disseminated to IHS leaders and key stakeholders in September 2023. The OQ Patient Safety team has increased its focus on communication. In December of 2023, the patient safety program created a patient safety intranet page and listserv. The patient safety page consolidates key patient safety tools, resources, and training in one central place for all IHS staff to access. The patient safety listserv provides timely patient safety program updates, tools, and resources as well as a forum for quality and safety staff to ask questions and share best practices. The safety alert Listserv, Safety Advisory Facilitating Excellence (SAFE), which can be used to communicate important patient safety alerts to leadership, safety, and quality staff agency-wide, 109 staff subscribed agency-wide. A total of five alerts were issued for FY 20203. The Patient Safety Program has a forum to communicate routine patient safety information via a dedicated Patient Safety Corner in the Division of Nursing Newsletter. In January of 2024, the nurse consultant for patient safety provided updates and education regarding “IHM 3-42, Patient Safety” implementation to IHS senior leaders, Chief Medical Officers (CMOs), Area Directors (ADs), the IHS Nurse leaders, facility Chief Executive Officers (CEOs), Area Quality Managers, IHS Safety Officers, and all IHS staff during an IHS all employee call.

Clinical Risk Management provides the inherent Federal Residual Function as mandated by statute. Major functions include:

- Coordinating the federally mandated processing of Medical Malpractice Federal Tort Claims Act (FTCA) filed against IHS, Tribal and Urban Providers
- Representing the Agency when paid claims are presented for mandatory review to the Department of Human and Health Services (DHHS) Medical Claims Review Panel
- Representing the Agency as Administrator for the National Practitioner Data Bank and responsible for submitting mandatory payment reports and review of subject matter statements
- Representing the Agency when filing mandatory reports to State Licensing Boards for the provider for whose benefit settlement was made.

The OQ Infection Control and Prevention (ICP) program created an integrated audit tool to assist facilities in reviewing compliance of their Infection Control Programs for key elements provided through the IHS Indian Health Manual Infection Control and Prevention Policy (Chapter 33), which was published in August of 2023. This audit tool has been presented to and educated on throughout the agency to all levels of IHS. The audit tool is available agency-wide through Tracer © AMP software mentioned above, giving IHS the ability to analyze and track compliance agency-wide. The purpose of the chapter is to establish infection control and prevention program policies, procedures, and responsibilities required for ensuring a comprehensive ICP program exists in all IHS healthcare facilities and Service Units. An ICP program is required to meet and maintain readiness with applicable healthcare accreditation standards.

The OQ manages the ICP Listserv with 375 I/T/U users, regularly distributes infection control and prevention resources and updates, and provides expert technical assistance across the health system. Resources and education from ICP Office Hours are also shared on the ICP Listserv. ICP Office Hours reoccur monthly, reviewing for attendees' core elements of Infection Control and Prevention and also allowing attendees to ask questions as needed.

In collaboration with subject matter experts from the Centers for Disease Control and Prevention (CDC), the IHS Office of Quality offers a virtual Infection Control Assessment and Response (ICAR) to allow facilities the opportunity to review critical elements of infection control including; training, audits and feedback, hand hygiene, transmission-based precautions, environmental services, high-level disinfection and sterilization, injection safety, point of care testing, wound care, healthcare laundry, antibiotic stewardship, and water exposure. In FY 2021, IHS concluded an ICAR project that provided 76 total COVID-19 ICARs at IHS and Tribal Facilities. Now with the shift of looking at ICP Programs as a whole, 5 ICARs have been completed for CY 2023. Following the ICAR assessments, the IHS-CDC ICAR team provides a written report that identifies strengths and recommendations/resources for improvement opportunities. Facilities are advised to track improvements and implementation of best practices through local Governing Board Quality Management Programs. The ICP program has also integrated ICAR assessment results into Tracers © AMP. This tool will be utilized to identify gaps in infection control practices, drive educational needs, and provide resources to the I/T/U Infection Preventionists. ICARs have been designated as "best practice" by multiple accreditation surveyors and are of noted value in mitigating risk related to Occupational Health and Safety Administration (OSHA) investigations.

In collaboration with the CDC and Partnerships to Advance Tribal Health (PATH), 21 Acute Care and Critical Access IHS Hospitals are reporting Hospital Associated Infection (HAI) data, healthcare personnel COVID vaccination, and healthcare personnel influenza vaccination data to the National Healthcare Safety Network (NHSN) meeting the Centers for Medicaid and Medicare (CMS) requirements. NHSN enables participating healthcare facilities to submit and analyze data

on patient and healthcare personnel safety. It also provides analysis tools that enable users to generate a variety of reports, many of which use data for benchmarking purposes. The ICP program is currently collaborating with the CDC to optimize the use of data entered to identify prevention and quality improvement opportunities.

The ICP program is also continuing to collaborate with other divisions within IHS such as the Environmental Health Division and the Division of Oral Health to provide training and educational opportunities for front-line staff.

Compliance Program - The IHS Compliance Division provides IHS-wide and national-in-scope leadership, guidance, and support of compliance initiatives, including strategic planning, evaluation, and research related to quality-focused compliance. The Compliance Division provides national leadership and consultation on compliance functions to ensure internal policies and procedures are properly authorized by and adequately implement applicable laws, regulations, and HHS policies and directives. The Compliance Division leads key components of the agency's Enterprise Risk Management (ERM) efforts, and the related implementation of the Federal Managers Financial Integrity Act (FMFIA) including identifying, assessing, analyzing, mitigating, and monitoring mission-critical risk areas and forecasting the impact on the IHS.

Enterprise Risk Management and Internal Audit under OMB Circular A123 - In FY 2023, IHS implemented a qualitative approach to evaluating risks in nine business process areas to identify control areas for testing that were of the highest risk. As a result of the testing in FY 2023, the IHS provides reasonable assurance that internal control over reporting, operations, and compliance is operating effectively.

In 2023, the IHS made significant investments in its ERM program. The Division of Enterprise Risk Management built upon the foundational work accomplished previously within the agency and updated the risk profile in 2023. Teams were assembled to develop response plans to the top risks in the profile. Program accomplishments include drafting a governance structure, developing an agency-wide dissemination plan that conforms to the HHS ERM framework, actively participating in the HHS ERM activities, performing risk assessments to support deliberations and decision making among IHS senior leaders. Planned activities for 2024 include updating the risk profile as required by OMB A-123, developing a risk appetite statement for the Agency as required by OMB A-123, facilitating the development of risk response plans designed to minimize uncertainty, finalizing and implementing the dissemination plan, finalizing and implementing the governance structure and standard operating procedure, developing a curriculum targeting staff at different levels of the Agency, deploying a risk survey tool for the Agency.

Quality Assurance/Risk Management - The IHS Quality Assurance Risk Management Committee (QARMC) provides senior-level oversight and management of complex, adverse patient safety events and administrative matters involving fraud, waste, abuse, and employee misconduct within IHS-operated hospitals and clinics; and perform Agency-wide clinical and administrative risk management to identify systematic changes needed to improve the quality of health care services and IHS-operated hospitals and clinics. The QARMC is a component of the overall ERM governance structure and is intended to ensure enterprise-wide accountability and effectiveness of those internal and external reporting systems, necessary management responses, and swift and effective corrective action. In FY 2023, the IHS QARMC drafted standard operating procedures for uniform reporting by all IHS Areas and HQ Offices.

AREA ALLOCATION

Direct Operations

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY 25 +/- FY 23
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$150	$7,322	$7,472	$148	$7,686	$7,834	$162	$7,908	$8,070	$598
Albuquerque	1,353	890	2,243	1,336	934	2,270	1,459	961	2,420	$177
Bemidji	1,801	773	2,574	1,778	812	2,589	1,942	835	2,777	$203
Billings	2,115	836	2,952	2,088	878	2,966	2,281	903	3,184	$232
California	1,813	820	2,633	1,790	861	2,651	1,955	886	2,841	$208
Great Plains	2,308	1,174	3,482	2,278	1,232	3,510	2,489	1,268	3,756	$275
Nashville	1,280	1,308	2,588	1,264	1,373	2,637	1,381	1,413	2,793	$205
Navajo	3,619	1,267	4,886	3,572	1,330	4,902	3,902	1,369	5,271	$385
Oklahoma	2,626	4,384	7,010	2,592	4,602	7,194	2,832	4,735	7,567	$556
Phoenix	3,357	1,073	4,431	3,314	1,127	4,440	3,620	1,159	4,779	$349
Portland	2,460	1,390	3,850	2,428	1,459	3,887	2,653	1,501	4,154	$304
Tucson	919	221	1,140	907	232	1,140	991	239	1,230	$90
Headquarters	58,543	0	58,543	57,785	0	57,785	63,124	0	63,124	$4,581
Total, Direct Ops	**$82,345**	**$21,460**	**$103,805**	**$81,279**	**$22,526**	**$103,805**	**$88,789**	**$23,177**	**$111,966**	**$8,161**

1/ Note: 2023, 2024, and 2025 are estimates.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$6,174	$6,174	$6,187	+$13
FTE*	12	12	12	--

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

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

and Area Senior officials.

BUDGET REQUEST

The FY 2025 budget submission for Self-Governance of $6 million is $13,000 above the FY 2023 Final level.

FY 2023 Final level Funding of $6 million: The base funding supports further implementation of the IHS Tribal Self-Governance program, continues funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, and continues to fund performance projects and Tribal share needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program**.**

FY 2025 Funding Increase of +$13,000 includes Current Services (see Current Services chapter).

FUNDING HISTORY

Fiscal Year	Amount
2021	$5,806,000
2022	$5,850,000
2023 Final	$6,174,000
2024 CR	$6,174,000
2025 President's Budget	$6,187,000

TRIBAL SHARES

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

PROGRAM ACCOMPLISHMENTS

The IHS TSGP has grown dramatically since the execution of the initial 14 compacts and funding agreements in 1994. In FY 2023, IHS transferred approximately $2.8 billion of the total IHS budget appropriation to Tribes and Tribal organizations to support 112 ISDEAA self-governance compacts and 139 funding agreements.[1]

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

- Providing technical assistance, disseminating communication, and supporting the disbursement of funds to Self-Governance Tribes to build, strengthen, and sustain collaborative relationships. In FY 2023, the Office of Tribal Self-Governance (OTSG)

[1] For FY 2024, 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.

worked collaboratively to update the OTSG Funds Management System (OTSGFM) by interfacing the Unified Financial Management System (UFMS) obligation process and the financial information entered into the OTSGFM. Through this interface the high number of reporting variances between UFMS and OTSGFM will decrease and the monthly reconciliation between the two systems will be more efficient. In February of FY 2023, the interface between the two systems was implemented and obligations were initiated through the OTSGFM. In FY 2024, the two systems will be interfaced for a full year and the goal is to significantly decrease the reporting variances and easily reconcile the two systems on a monthly basis.

- Providing support for projects that assist Tribally operated health programs that build, strengthen, and sustain collaborative relationships. For example, the IHS collaborated with Tribes and Tribal Organizations to coordinate the FY 2023 Annual Self-Governance Tribal Conference which brings together Self-Governance Tribes, the Department of Interior, and other federal agencies to discuss key topics with Self-Governance Tribes to share and learn best practices, and to promote the participation of all American Indian and Alaska Native Tribes in IHS Tribal Self-Governance activities
- Collaborating on crosscutting issues and processes including, but not limited to: program management issues; self-determination issues; Tribal shares methodologies; and working towards effectively managing assets and resources. In FY 2023, the IHS coordinated with Tribes and Tribal Organizations three Tribal Self-Governance Advisory Committee and Joint Tribal-Federal Technical Workgroup meetings. This Committee advocates for Self-Governance Tribes and Tribal Organizations, suggests policy guidance on the implementation of the TSGP, and advises the IHS Director on issues of concern to all Self-Governance Tribes. Additionally, in FY 2023, the IHS implemented Tribal Consultation, and in FY 2024, the IHS continues to work with the Tribal Consultation Policy Workgroup of Tribal and Federal leaders, to update the IHS Tribal Consultation Policy and establish it as permanent policy in the Indian Health Manual. Activities in FY 2025 will focus on the continued education of the new Tribal Consultation policy.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
TOHP-SP Implement recommendations from Tribes annually to improve the Tribal consultation process and IHS operations. (Output)	FY 2023: 5 recommendations Target: 5 recommendations (Target achieved)	5 recommendations	5 recommendations	Maintain

GRANT AWARDS

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Planning Cooperative Agreements			
Number of Awards	0	8	3
Award Amount	$0	$180,000	$180,000
Negotiation Cooperative Agreements			
Number of Awards	0	8	3
Award Amount	$0	$84,000	$84,000

AREA ALLOCATION

Self-Governance

(dollars in thousands)

DISCRETIONARY	FY 2023 Estimate/1			FY 2024 Estimate/1			FY 2025 Estimated/1			FY 25 +/- FY 23
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$
Albuquerque	0	0	0	0	0	0	0	0	0	$
Bemidji	0	0	0	0	0	0	0	0	0	$
Billings	0	0	0	0	0	0	0	0	0	$
California	0	241	241	0	0	0	0	0	0	$
Great Plains	0	0	0	0	0	0	0	0	0	$
Nashville	0	19	19	0	0	0	0	0	0	$
Navajo	0	0	0	0	0	0	0	0	0	$
Oklahoma	0	383	383	0	0	0	0	0	0	$
Phoenix	0	0	0	0	0	0	0	0	0	$
Portland	0	2	2	0	0	0	0	0	0	$
Tucson	0	0	0	0	0	0	0	0	0	$
Headquarters	5,529	0	5,529	6,174	0	6,174	6,187	0	6,187	$13
Total, Self-Gov	**$5,529**	**$645**	**$6,174**	**$6,174**	**$**	**$6,174**	**$6,187**	**$**	**$6,187**	**$13**

1/ Note: 2023, 2024, and 2025 are estimates.

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

PUBLIC AND PRIVATE COLLECTIONS

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR*	President's Budget	FY 2025 +/- FY 2024
Medicare	$253,619	$252,185	$262,525	+$10,340
Medicaid	$1,206,302	$1,288,152	$1,340,967	+$52,815
M/M Total	**$1,459,921**	**$1,540,337**	**$1,603,492**	**+$63,155**
Private Insurance	$210,497	$213,209	$221,950	+$8,741
VA Reimbursements	$7,202	$7,548	$7,858	+$310
Total	**$1,677,620**	**$1,761,094**	**$1,833,300**	**+$72,206**
FTE	6,619	6,621	6,621	--

***** The FY 2024 estimates above are based on the FY 2023 estimated collections.

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

PROGRAM DESCRIPTION

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

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

Regulation Review and Compliance - IHS continues to ensure compliance with rules and regulations that impact third party collections directly and indirectly, especially regarding the Medicare and Medicaid programs IHS reviews new policies and draft regulations prior to publication and provides feedback to CMS. After they are published for public review, IHS is able to discuss the impacts with Tribal government representatives and urban programs.

Partnerships – In addition to working with the Centers for Medicaid and Medicare Services (CMS), IHS partners with the Department of the Treasury with Treasury Fiscal Services to further protect, control, and monitor all third-party collections, as well as the Department of Veterans Affairs (VA) to facilitate payment from the VA to IHS for services to AI/AN veterans.

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

PROGRAM ACCOMPLISHMENTS

Meetings and Workgroups - In FY 2023, the IHS convened a Third Party Billing Technical Advisory Group Workgroup meeting to update and enhance the Third Party Billing Package in the IHS electronic health solution. In FY 2023 the IHS held a National Business Office Committee Meeting to strengthen Business Office capabilities and functions; ensure appropriate communication occurs with all relevant parties to enhance third party revenue; and coordinate and expand third party revenue activities. In FY 2023, the IHS convened a National IHS Business Office Coordinators and Health Information Management (HIM) Consultants meeting to ensure coordination and cooperation between the business office function and the HIM function in regards to the revenue cycle. In FY 2023, the IHS held an Accounts Receivable File, Account, and Cash Reconciliation Workshop to train on and facilitate reconciliation of IHS treasury deposits and A/R Balances which makes the funds available to support health care delivery. In FY 2023, the IHS convened an Accounts Receivable Technical Advisory Group Working meeting to update and enhance the Accounts Receivable Package in the IHS electronic health solution. In FY 2023, the IHS held a Patient Registration Technical Advisory Group and Revenue Operation Manual (ROM) Edits Working meeting to update and enhance the Patient Registration system in the IHS electronic health solution and to update the ROM to provide further guidance to business office staff on the revenue cycle process.

Outreach, Education, and Enrollment – In FY 2023 and FY 2024, through the IHS National Indian Health Outreach and Education (NIHOE) cooperative agreement, the IHS furthered its mission and goals related to providing quality health care to the AI/AN community through health care policy analysis, outreach and education efforts with a focus on improving Indian health care, promoting awareness, visibility, advocacy, training, and technical assistance. Through the NIHOE, IHS partners have provided training sessions and webinars for Tribes and tribal members, helped coordinate numerous enrollment events, created toolkits for youth and elders and offered technical assistance to AI/AN and non-AI/AN enrollment assisters. Recently, NIHOE partners have included activities related to COVID-19 response messaging and the Medicaid Unwinding.

2023 Annual IHS Partnership Conference - In FY 2023, the IHS Office of Resource Access and Partnerships (ORAP) hosted a joint Partnership Conference with over 2,400 attendees from the Business Office, OIT, Health Information Management, Purchased/Referred Care, Finance, and other components of the Revenue Cycle. The conference convened a series of training sessions showcasing advances and improvements of these mission-critical functions. Training sessions covered: Patient Registration, Patient Benefit Coordination, Billings, Account Receivables, Account Reconciliation, Denial Management and the impacts in the revenue cycle from HIT-OIT, HIM-Coding, Finance, Purchased/Referred Care, and Clinical components.

Reimbursement for Services to Veterans - In FY 2024, the IHS announced that the Department of Veterans

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

Revenue Cycle Initiative – In FY 2023 and FY 2024, IHS made further progress on improving oversight of the revenue cycle operations at IHS operated facilities. The primary objective is to equip revenue cycle stakeholders with web-based tools to proactively identify potential threats to revenue cycle operations and to timely respond. IHS plans to develop a prototype of a Revenue Cycle Dashboard, powered by the IHS electronic health record solution and Unified Financial Management System by December 31, 2024. The dashboard will be accessible to all revenue cycle stakeholders.

Telehealth Documentation - In FY 2023 and FY 2024, IHS continued to analyze documentation of telemedicine services to ensure appropriate and consistent documentation for workload reporting for annual all-inclusive rate negotiations, budgeting purposes, and compliance with billing standards.

Medicaid Unwinding – In FY 2023 and FY 2024, IHS continued to engaged in significant planning and outreach, and data analysis related to Medicaid Unwinding. Activities have focused on providing resources that prepare staff to assist patients with maintaining coverage or seeking alternate coverage if they are no longer eligible for Medicaid such as through the Health Insurance Marketplace.

Training and Workforce Development - In FY 2023 and FY 2024, the IHS continued its Training and Workforce Development Workgroup to develop a business office workforce planning assessment so that staffing needs can be measured, training and development goals can be established, and workforce options can be used to create an optimally staffed and trained workforce.

Regulation Review – In FY 2023 and FY 2024, IHS participated in over 300 rounds of clearance of HHS regulations and policy proposals. In FY 2024, IHS continues to review new proposals for impacts on the Indian health system as they are introduced and provide feedback to the proposing agencies.

FY 2024 - 2025 Collections Estimates

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

***Medicare and Medicaid (M&M)* -- The FY 2025 Budget estimate assumes collections of $1.6 billion, $63 million above FY 2024 collections:**

- ***Medicaid* – The FY 2025 budget estimate assumes collections of $1.34 billion, $52 million above FY 2024 collections.** IHS continues to educate its users on the benefits of Medicaid enrollment. IHS continues to monitor its user population and insurance coverage and is making all possible efforts to maximize Medicaid enrollment in all States and to maintain current collection levels.

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

- *Medicare* – **The FY 2025 budget estimate assumes collections of $262 million, $10 million above FY 2024 collections.** IHS hospitals and clinics have taken strong steps to increase enrollment of its population in Medicare. In addition, IHS has expanded efforts to improve the quality of care and maintain current collections.

- *Private Insurance* – **The FY 2025 budget estimate assumes collections of $222 million, $8.7 million above FY 2024 collections.** IHS will continue to monitor its user population and increase direct assistance to stabilize and expand insurance coverage whenever possible to maintain and maximize private insurance collections.

- *VA/IHS National Reimbursement Agreement* **– The FY 2025 budget estimate assumes collections of $7.8 million, $310,000 above FY 2024 collections.** The FY 2025 estimate is based on the FY 2024 projected collections. The estimate includes estimated collections received by IHS for Federal health programs. IHS and VA have agreed to continue to monitor actual reimbursements and work together to improve the quality of care for all veterans and maximize payments whenever possible. IHS continues to work with the VA in identifying the actual number of AI/ANs with VA benefits eligibility and, of those, how many receive direct care from IHS. IHS and the VA continue to work in partnership to identify and resolve billing and reimbursement issues and provide sites with on-going support and training. All IHS sites have signed implementation plans and have the ability to bill the VA for Veterans Services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

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Facilities

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
BA	$958,553	$958,553	$993,825	+$35,272
FTE*	1,092	1,106	1,106	+14

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

1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 budget submission for Facilities is $994 million and is $35 million above the FY 2023 Final Level.

Maintenance & Improvement –The FY 2025 budget submission for Maintenance and Improvement is $174 million, which is $4 million above the FY 2023 Final Level. These funds are the primary source for providing maintenance, repair, and improvement of health care facilities. Specific objectives and program priorities to address the condition of facilities include:

- Providing routine maintenance and repairs to upkeep facilities at their current conditions;
- Achieving compliance with buildings and grounds accreditation standards of the Joint Commission or other applicable accreditation bodies;
- Providing improvements to facilities for enhanced patient access and care through larger M&I projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR), which is estimated at $1 billion for all IHS and reporting Tribal facilities;
- Ensuring that health care facilities meet building codes and standards;
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security; and
- Demolishing facilities when excess to the needs of the Service and/or a liability to health and safety.

Sanitation Facilities Construction –The FY 2025 budget submission for Sanitation Facilities Construction is $200 million, which is $4 million above the FY 2023 Final Level.

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

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

Health Care Facilities Construction – The FY 2025 budget submission for Health Care Facilities Construction is $261 million, which is $23,000 above the FY 2023 Final Level.

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

- Whiteriver Hospital, Whiteriver, AZ
- Alamo Health Center, Alamo, NM
- Bodaway Gap Health Center, The Gap, AZ
- Small Ambulatory
- New and Replacement Staff Quarters
- Green Infrastructure

Facilities and Environmental Health Support (FEHS) – The FY 2025 budget submission for Facilities and Environmental Health Support is $324 million, which is $26 million above the FY 2023 Final Level.

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

FEHS funds provide for:

- Personnel who provide facilities and environmental health services and for operating costs associated with provision of those services and activities.

Equipment –The FY 2025 budget submission for Equipment is $34 million, which is $1 million above the FY 2023 Final Level.

These funds provide for:

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

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$170,595	$170,595	$174,355	+$3,760
FTE*	--	--	--	--

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 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. On average, IHS hospitals are 39 years old, over 3 times the age of the average hospital in the United States. Many IHS and Tribal health care facilities are operating at or beyond capacity, and their designs are not efficient in the context of modern health care delivery. In addition, as existing health care facilities continue to age, the operational and maintenance costs increase. (The 'average age of hospital plant' measures the average age of the facility including capital improvements, replacement of built-in equipment and modernization.)

IHS hospital administrators have reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. The physical condition of IHS-owned and many tribally

owned healthcare facilities is evaluated through routine observations by facilities personnel and by in-depth condition surveys. These observations and surveys identify facility, fire-life-safety, and program deficiencies, and are used to develop IHS' estimate of the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The BEMAR is a measure of the condition of health care facilities in the Indian health system and establishes priorities for larger M&I projects. The FY 2023 BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2023, is $1,477 million. When IHS replaces an older, obsolete hospital or clinic with a new facility, all deficiencies associated with the old facility are removed from the backlog.

M&I Funds Allocation Method

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

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

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

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

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

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

BUDGET REQUEST

The FY 2025 budget submission for Maintenance & Improvement of $174 million is an increase of $4 million above the FY 2023 Final level.

FY 2023 Final level Funding of $171 million supports maintenance, repair, and improvements for existing IHS and Tribal facilities.

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

2025 Funding Increase of $4 million includes:

- Current Services: +$4 million, information can be found in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2021	$168,952,000
2022	$169,664,000
2023 Final	$170,595,000
2024 CR	$170,595,000
2025 President's Budget	$174,355,000

TRIBAL SHARES

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

OUTPUTS / OUTCOMES

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

GRANT AWARDS – This program has no grant awards.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$196,167	$196,167	$200,485	+$4,318
FTE*	110	110	110	--

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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

FY 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

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

criteria, project planning, and funding priorities remain the same, regardless of the delivery methods chosen by a Tribe.

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

BUDGET REQUEST

The FY 2025 budget submission for Sanitation Facilities Construction of $200 million is $4 million above the FY 2023 Final level.

FY 2023 Final level Funding of $196 million supports construction of sanitation facilities to serve new and existing American Indian and Alaska Native homes.

FY 2025 Funding Increase of $4 million includes:

- Current Services: +$4 million, information can be found in the Current Services Chapter

FY 2025 funding level of $200 million will include:

- Up to $85 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.[1] 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 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). HUD and IHS plan to conduct a joint Tribal consultation on how their funding streams interact and potential opportunities to better serve tribal communities.

- Up to $19 million[2] will be used to cover cost increases due to inflation on projects funded during the pandemic with pre-pandemic cost estimates serving AI/AN homes and communities.

- Up to $90 million may be distributed to the Areas for prioritized projects identified in the IHS data system as Tier 1 Ready to Fund serving 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

[1] 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.

[2] Assumed 8% inflation associated with $675.5M in project funding from FY2023 IIJA.

favors Areas with larger numbers of AI/AN homes without water supply or sewer facilities, or without both. If there are insufficient Tier 1 projects then these funds will be used to support project planning, design, and construction administration to address existing sanitation deficiencies impacting AI/AN homes are fully designed and construction ready in FY 2025. These funds will be used in conjunction with the Infrastructure Investment and Jobs Act.

- Up to $4 million will be reserved at IHS Headquarters for special projects to include up to $3 million to improve reporting and data quality of homes with sanitation deficiencies, continue the transition of data into the SFC Program Geographic Information System (GIS) portal, and to maintain, and enhance the SFC Program data system to report on construction projects. The remaining special project funds will be used to pay for Area requested research studies, training, or other needs related to sanitation facilities construction, but which are not eligible for construction funds.

- Up to $2 million will be reserved at IHS Headquarters 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 investment in sanitation facilities. Any emergency funds unused by the end of the fiscal year may be distributed to address the SDS projects in the Areas.

FUNDING HISTORY

Fiscal Year	Amount
2021	$196,577,000
2022	$197,783,000
2023 Final	$196,167,000
2024 CR	$196,167,000
2025 President's Budget	$200,485,000

PROGRAM ACCOMPLISHMENTS

The SFC Program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated to provide water and waste disposal facilities for eligible AI/AN homes and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have declined. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus.[3] Researchers associated the increasing illnesses with the restricted access to clean water for hand washing and hygiene. The SFC Program works collaboratively with Tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply and waste disposal facilities as soon as possible.

In FY 2023, IHS funded projects to provide service to 39,980 AI/AN homes. IHS also completed construction on 237 projects with an average project duration of 3.8 years. However, at the end of FY 2023, about 1.2 percent of all AI/AN homes tracked by IHS lacked water supply or wastewater disposal facilities; and, about 121,620 or approximately 32 percent of AI/AN homes tracked by IHS

[3] 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.

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.[4] 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 has increased approximately $0.2 billion from $4.4 billion to $4.6 billion from FY 2022 to FY 2023. In FY 2023, the IHS was appropriated $871.7 million (FY 2023 appropriations of $196.2 million and $675.5 million in IIJA funding) to address sanitation deficiencies and support provision of sanitation facilities to eligible AI/AN homes and communities. The magnitude of the sanitation facility needs increase is due to the underlying challenges of construction cost inflation, construction material availability, material supply chain challenges, and failing infrastructure. The failing infrastructure challenge is due to a combination of the infrastructure's age and inadequate operation and maintenance. Under the IHCIA, the IHS is authorized to provide operation and maintenance assistance for, and emergency repairs to, Tribal sanitation facilities, when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities, however resources have not been appropriated specifically for this purpose.

During the period from FY2020 to FY 2022, 316 construction projects to address water supply and wastewater disposal needs were funded with a construction cost of $1.24 billion using IHS and contributed funds. Once constructed, these sanitation facilities will benefit an estimated 539,700 AI/AN people and help avoid over 969,200 inpatient and outpatient visits related to respiratory, skin and soft tissue, and gastro enteric disease over 30 years. The health care cost savings for these visits alone is estimated to be over $473 million. Every $1 spent on water and sewer infrastructure will save $0.92 in avoided direct healthcare cost. This figure is down from the FY 2021 figure of $1.23 due to funding of higher capital cost projects to bring piped water and sewer services to especially hard to serve populations living in rural and extreme climate locations.

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

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
35 Number of new or like-new and existing AI/AN homes provided with sanitation facilities. (Outcome) [1]	FY 2023: 39,980 Target: 54,000 (Target Not Met)	54,400	49,000[1]	-5,400
SFC-E Track average project duration from the Project	FY 2023: 3.8 yrs Target:	4.5 yrs	4.5 yrs	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
Memorandum of Agreement (MOA) execution to construction completion. (Outcome)	4 yrs (Target Exceeded)			

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

GRANT AWARDS – This Program has no grant awards.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$260,896	$260,896	$260,919	+$23
FTE*	--	--	--	--

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

1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

The HCFC program is funded based on an IHS-wide list of priorities for construction projects. During FY 1990, at the direction of Congress, the IHS established the Health Facilities Construction Priority System (HFCPS) methodology. The remaining health care facilities projects on the HFCPS list, including those partially funded, total approximately $6.3 billion as of April 2023. The total need for the HCFC Program is approximately $23 billion for expanded and active authority facility types according to *The 2021 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*[1].

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

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

The Small Ambulatory Program (SAP) provides funding for small Tribal health care facilities. The SAP is authorized by the Indian Health Care Improvement Act. The SAP program is available for AI/AN Tribes or Tribal organizations to competitively obtain funding for the construction, expansion or modernization of tribally owned small ambulatory health care facilities. The selected projects will not be a part of the IHS HFCPS.

A new facility is designed to meet the demand for health services from a growing population by providing more healthcare providers, improved imaging systems, and other expanded services. Administration staff is increased to strengthen management, collections and bring health care quality expertise to the replacement facility. Each facility also incorporates additional space for Tribal health programs which complements IHS programs and how the HCFC programs are implementing.

BUDGET REQUEST

The FY 2025 budget submission for Health Care Facilities Construction of $261 million is $23,000 above the FY 2023 Final level. Current Services increase of $23,000 is described in the Current Services chapter.

The total $261 million requested for FY 2025 would support:

Whiteriver Hospital, Whiteriver, AZ $115.315 million
These funds will be used for construction of the replacement hospital. It will serve a projected user population of 36,113 providing 67,000 primary care provider visits and 101,200 outpatient visits annually. This project also includes an estimated 144 staff quarters for health care professionals serving at the facility.

Alamo Health Center, Alamo, NM $28.604 million
These funds will be used for 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.

Bodaway Gap Health Center, The Gap, AZ $76.0 million
These funds will be used to complete construction of the health center and 82 staff quarters located in The Gap, AZ. The Health Center will serve a projected user population of 4,646 generating 18,458 primary care provider visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.

Small Ambulatory $25 million
These resources would support 7 to 10 small ambulatory facilities in American Indian and Alaska Native communities. Consistent with prior years, the IHS will request applications from interested Tribes. Funds will support for construction, expansion or modernization of non-IHS owned, small Tribal ambulatory health care facilities located apart from a hospital.

New and Replacement Staff Quarters $11 million
These funds will fund new or replacement staff quarters. Many of the 2,700 quarters across the IHS health delivery system are more than 40 years old and in need of major renovation or total replacement. Additionally, in a number of locations the amount of housing units is insufficient.

The identified unmet need, of housing units in isolated, remote locations is a significant barrier to the recruitment and retention of quality healthcare professionals across Indian Country. The amount distributed to each Area will be based on each Area's internal priority list.

Green Infrastructure: $5 million

The IHS will use these funds to incorporate green infrastructure and the current energy efficiency codes and standards available in its planning, design, and operations of buildings to the maximum extent practicable. This approach will reduce costs, minimize environmental impacts, and use renewable energy.

FUNDING HISTORY

Fiscal Year	Amount
2021	$259,290,000
2022	$259,293,000
2023 Final	$260,896,000
2024 CR	$260,896,000
2025 President's Budget	$260,919,000

PROGRAM ACCOMPLISHMENTS

Each healthcare facility project that is completed increases access to much needed health care services. Each completed replacement facility is typically larger to meet the increased demand for health services from a growing population.

The FY 2023 appropriation will contribute to the Phoenix Indian Medical Center, Phoenix, AZ, Whiteriver Hospital, Whiteriver, AZ; Gallup Indian Medical Center, Gallup, NM; Bodaway Gap Health Center, The Gap, AZ; Albuquerque West Health Center, Albuquerque, NM; and Sells Alternative Rural Hospital, Sells, AZ projects.

The FY 2023 appropriation also contributed $25 million to the IHS SAP, $11 million to the Staff Quarters Program and $5 million to the Green Infrastructure Program. The selection and agreements to award the funds beagn in late FY 2023.

The JVCP has saved the Federal Government over $1 billion dollars in capital expenses[2] since its inception. The outcome of the JVCP provides the same accomplishments as described above.

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

[2] The DFPC Project Reporting System JVCP report shows a construction cost of $1,342,486,046 for completed projects and a cost of $ 3,325,505,263 projects in planning or construction. The date of this report was March 2024.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/- FY 2024 Target[2]
36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome)	FY 2023: 1 project(s) Target: 1 project(s) (Target Met)	0 project(s)	1 project(s)	+1 project(s)
HCFC-E Energy consumption in Leadership in Energy and Environmental Design (LEED) certified IHS health care facilities compared to the industry energy consumption standard for comparable facilities. (Outcome)	FY 2023: 1 project(s) Target: 1 project(s) (Target Met)	0 project(s)	1 project(s)	+1 project(s)

1. Projects completed in FY 2022 is River People Health Center (PIMC NE) and the Rapid City Health Center. In FY 2023 the Dilkon Health Center was completed.
2. In FY 2024, the IHS HCFC program has six (6) projects in planning and three (3) in design. The FY 2024 target is listed as zero (0), as no projects will be completed during the FY.

GRANT AWARDS – Program has no grant awards.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$298,297	$298,297	$324,192	+$25,895
FTE*	982	996	996	+14

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

SUMMARY OF PROGRAMS

Facilities and Environmental Health Support Account (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs directly and indirectly support all of the IHS facilities performance measures and improved access to quality health services. The programs and staff at the IHS Headquarters, Area Office, and Service Unit levels work collaboratively with Tribes and other agencies to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities. These activities are aligned in sub-activities: Facilities Support, Environmental Health Support, and Office of Environmental Health and Engineering Support. In addition to personnel salary and benefits costs and administrative costs such as contracts for facilities-related Information Technology data systems, funding under this activity is used for utilities, certain non-medical supplies personal property, and biomedical equipment repair. Administrative costs have been increasing rapidly in recent years.

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. Facilities operations, maintenance, repair, and improvements address deficiencies/BEMAR and medical equipment, which are complex and involve many variables such as accreditation standards, healthcare patient satisfaction, changing

healthcare delivery standards, building codes, old building equipment/system, and medical devices/equipment plus telemedicine used by healthcare professionals.

The IHS owns approximately 11,000,000 square feet of facilities (totaling 2,141 buildings) and 1,760 acres of federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 170 years, with an average age greater than 40 years. A professional and fully-functional workforce is essential to ensure effective and efficient operations. An estimated 600 Federal positions (fulltime equivalents) are funded under this sub-activity. Typical staff functions funded may include:

- Facilities engineers and maintenance staff responsible for ensuring that building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe;
- Specialized clinical engineers and technicians who maintain and service medical equipment;
- Realty staff that manages the real property requirements and quarters; and
- Facilities planning, project management, and construction-monitoring that assist in the planning and construction of projects.

In addition, FS provides partial funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance.

ENVIRONMENTAL HEALTH SUPPORT

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, engineering aides, injury prevention specialists, and institutional environmental health officers. In accordance with congressional direction, these funds are distributed to the Areas based upon the workload and need associated with the two programs noted below.

Sanitation Facilities Construction Program (SFC) – This program works collaboratively with Tribes to provide safe water supply and waste disposal facilities for AI/AN people and communities. The program manages annual project funding that includes contributions from Tribes, states, and other federal agencies. The SFC Program is the environmental engineering component of the IHS health delivery system.

As a result of this program, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus.[1] Researchers associate the increasing illnesses with the restricted access to clean water for hand washing and hygiene.

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

Consistent with the 1994 Congressional set aside for "…tribal training on the operation and maintenance of sanitation facilities," $1 million of these support funds are used for technical assistance, training, and guidance to Indian families and communities regarding the operation and maintenance of water supply and sewage disposal facilities. Starting in FY 2021, Congress allocated an additional $3 million for tribal training for operation and maintenance of sanitation facilities.

In accordance with the Indian Health Care Improvement Act, the staff annually updates its inventory of sanitation facilities deficiencies for existing Indian occupied homes.[2] This is accomplished through extensive consultation with Tribes. The SFC staff also develops and updates an inventory of all open dump sites on Indian lands as required under the Indian Lands Open Dump Cleanup Act.[3] Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation facilities construction projects.

The IIJA appropriates $700 million in each year from FY 2022 – FY 2026, for a total of $3.5 billion for the IHS Sanitation Facilities Construction (SFC) program. These resources are available until expended, for the provision of domestic and community sanitation facilities for Indians, as authorized. Funding from the IIJA appropriation is being used to fund sanitation facilities construction projects listed in the IHS Sanitation Deficiency System.

Environmental Health Services (EHS) – EHS is comprised of three components, General Environmental Health, and two specialty programs, which include Injury Prevention, and Institutional Environmental Health. EHS National priority areas include: food safety, children's environments, healthy homes, vector-borne and communicable disease, and safe drinking water.

The General EH component identifies environmental hazards and risk factors in Tribal communities and proposes control measures to prevent adverse health effects; monitors and investigates disease and injury; and provides inspections to identify environmental hazards in homes, healthcare facilities, food service establishments, Head Start centers, and many other types of Tribal establishments. Additionally, EHS provides training, technical assistance, and cooperative agreements to enhance the capacity of Tribal communities to address environmental health issues.

Examples of services EHS provides to AI/ANs: referrals for home investigations to reduce environmental triggers for asthma; home investigations to reduce exposure to lead-based paint or other hazards (including drinking water sources); animal bite investigations in Tribal communities and potential patient exposure to rabies virus; and referrals for investigation of communicable disease outbreaks.

The IHS Injury Prevention Program (IPP) leads IHS efforts to address injury disparities between AI/AN communities and U.S. all races. AI/AN experience injury mortality rates that are 2.5 to 8.7 times higher than the U. S. all races' rates[4]. The IPP works with AI/AN, other agencies, and IHS programs to prevent unintentional injuries (e.g., motor vehicle-related, falls, burns,

[2] Title III, Section 302(g) 1 and 2 of P.L. 94-437.
[3] P.L. 103-399.
[4] Trends in Indian Health 2017 Edition, IHS, Division of Program Statistics

drowning, poisoning) and intentional injuries (e.g., suicide and violence-related) through technical assistance, training, and the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP). Technical assistance is provided in the areas of data collection for project evaluation, building partnerships, implementing evidence-based strategies or innovative interventions, and developing tribal injury prevention programs.

The IHS Institutional Environmental Health (IEH) Program identifies hazards and risk factors in the built environment and proposes control measures to prevent adverse health effects to patients, staff, and visitors in health care and other community facilities. The IEH program supports development and management of safe, functional health care facilities which contributes to the quality of care and workforce retention. The IEH program collaborates with entities such as the National Institutes of Health, Administration for Children and Families, and Uniformed Services University to improve IEH practices in IHS facilities and in our tribal communities.

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.

Activities include national policy development and implementation, budget formulation, project review and approval, preparing reports for Congress, program oversight, program coordination and developing partnerships, project management functions for major construction, and real property asset management.

In accordance with appropriation committee direction, OEHE staff develop, maintain, and utilize data systems to distribute Facilities Appropriation resources to Area offices for facilities and environmental health activities and construction administration and management, based upon workload and need. Also, technical guidance, information, and training are provided throughout the IHS system in support of the Facilities Appropriation.

BUDGET REQUEST

The FY 2025 budget submission for Facilities and Environmental Health Support of $324 million is $26 million above the FY 2023 Final level.

FY 2023 Final level Funding of $298 million – Supports Facilities and Environmental Health Support for existing IHS and Tribal facilities.

FY 2024 Funding Increase of $26 million includes:

- General Increase: +$227,000 for Facilities and Environmental Health Support for administrative costs.

- Current Services and Staffing of New Facilities: +$26 million, described in the Current Services and Staffing of Newly Constructed Facilities chapters.

FUNDING HISTORY

Fiscal Year	Amount
2021	$263,982,000
2022	$283,124,000
2023 Final	$298,297,000
2024 CR	$298,297,000
2025 President's Budget	$324,192,000

PROGRAM ACCOMPLISHMENTS – FACILITIES SUPPORT

The Facilities Support Account and associated staffing level directly supports to the medical equipment, maintenance and repair of, and adjustments/modifications to IHS and Tribal healthcare sites to prevent, prepare for, and respond to medical services.

In FY 2023, total utility costs were $16.0 million and total utility costs per Gross Square Feet (GSF) were $3.05/GSF. In FY 2024, the total utility cost is expected to be $16.0 million reflecting no annual increase. The cost per GSF is expected to remain unchanged at approximately $3.05/GSF. IHS makes conscious efforts to help stem the growth in utility costs to ensure appropriations are sufficient to fund these needs. For example, the IHS constructs new space that is at least 30 percent more energy efficient than building code requires and expects LEED Silver certification at those facilities. Additionally, the IHS seeks opportunities to fund renewable energy systems at IHS and tribally owned installations.

PROGRAM ACCOMPLISHMENTS - ENVIRONMENTAL HEALTH SUPPORT

The Environmental Health Support Account directly supports field level activities for the Sanitation Facilities Construction and the Environmental Health Services programs described above.

In 2023, DEHS explored opportunities to expand its role in addressing Asthma Control in Tribal Communities (ACT). In addition to conducting healthy homes assessments, community-based IAQ surveys, and related outreach & consultations, DEHS is currently engaged with clinical program leadership to identify ways to improve patient outcomes through referral enhancements and improvements in how we communicate findings with clinical providers. In addition, the IEH program is actively determining best practices for addressing occupationally acquired asthma in healthcare facilities and tribal communities.

DEHS Climate Change Workgroup began work in CY 2023 to provide recommendations related to roles DEHS should have regarding climate change. The Area DEHS Directors are expected to finalize a Division work plan through consensus at our annual meeting in spring 2024. EHS staff have remained active participants on the IHS Sustainability Advisory Board and the newly formed IHS Environmental Public Health workgroup.

From 1997-2024, the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP) funded 111 Tribal injury prevention programs and provided $44 million in funding. Through these efforts, the IHS Injury Prevention Program (IPP) has contributed to the 58 percent decrease

in injury mortality rates since 1973[5]. EHS continues to invest in preventing injuries instead of treating the impacts of injury and violence through our healthcare delivery system.

The IEH program promotes and supports a safety culture through extensive management, technical assistance, and workforce competency development for safety management, facilities management, leadership, and many multi-disciplinary staff in healthcare facilities. These efforts have reduced the IHS total occupational injury & illness case rate, which has continued to decrease from 4.35 injuries/100 employees in 2004 to 2.32 injuries & illnesses/100 employees in 2023. In addition, the IEH program supports healthcare management by providing on-site consultation and industrial hygiene services, local accreditation leadership, and support with risk assessments, program reviews, and environment-of-care mock surveys.

PROGRAM ACCOMPLISHMENTS - OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

OEHE is responsible for the design, construction, and maintenance of health care facilities as well as sanitation infrastructure serving American Indians and Alaska Natives. OEHE completed the construction of the Oyate (Rapid City) Health Center in January 2023 and the grand opening was in February 2023. Construction of the Dilkon Medical Center was completed in July 2023 and the grand opening was in August 2023. Both of these facilities were on the Healthcare Facilities Construction Priority List. HQ OEHE staff also oversaw the provision of water, sanitation, and solid waste services to over 50,000 AI/AN homes and completed construction on over 300 sanitation projects passing final inspection in FY 23. OEHE also completed an annual Sanitation Deficiency System (SDS) inventory of deficiencies across Indian country in coordination with Indian Tribes.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
EHS-5 Number of persons who received injury prevention training (Output)	FY 2023: 599 trained Target: 473 trained (Target Exceeded)	473 trained	473 trained	Maintain

[5] https://www.ihs.gov/sites/dps/themes/responsive2017/display_objects/documents/Indian_Health_Focus_Injuries_2017_Edition_508.pdf

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
EHS-6 Percent of food establishments with Certified Food Protection Manager (CFPM) (Output)	FY 2023: 80.6% Target: 87.5% (Target Not Met)	87.5%	87.5%	Maintain

GRANT AWARDS

In FY 2023, the TIPCAP 2021-2025 five-year funding cycle entered its third year in which 27 tribes or tribal programs from eleven IHS Areas were awarded a cumulative total of $2.4 million per year. This cycle of funding addresses motor vehicle related injuries, falls, and other emerging issues based on tribal needs. This funding was used to address motor vehicle-related injuries, older adult falls, poisoning/opioids, suicide, and traumatic brain injury and establish new databases.

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

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$32,598	$32,598	$33,874	+$1,276
FTE*	--	--	--	--

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health diagnosis. The IHS and Tribal health programs manage approximately 110,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $850 million. With today's medical devices/systems having an average life expectancy of approximately six to eight years and rapid technological advancements, medical equipment replacement is a continual process making it necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment. To replace the equipment at the end of its six to eight-year life would require approximately $150 million per year.

Equipment Funds Allocation Method

In consultation with Tribes and the Federal healthcare sites, the IHS is allocating funding to the IHS Area Offices to replace and modernize medical equipment necessary to support health care delivery in the health care facilities and to modernize the health care facilities to support health care delivery and expand access to quality health care services.

In FY 2023, the IHS Equipment funds were allocated in four categories: Tribally-constructed health care facilities, TRANSAM program, Tribal emergency generator, and new and replacement equipment:

1. Tribally-Constructed Health Care Facilities - The IHS provides medical equipment funds to support the initial purchase of equipment for tribally-constructed health care facilities. FY 2023 funds supported $5 million for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS

funding sources. Tribes and Tribal organizations will use these funds to serve approximately 500,000 patients with newly purchased medical equipment.

2. TRANSAM Program - Equipment funds may be used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans) Program and to procure ambulances for IHS and Tribal emergency medical services programs.[1] FY 2023 appropriations included $500,000 for the TRANSAM Program from the Equipment budget. Under the TRANSAM Program, excess equipment and supplies, at an annual estimated value of $5 million, are acquired for distribution to federal and Tribal sites.

3. Tribal Emergency Generator - The IHS provides medical equipment funds to support the purchase of emergency generators at Tribally-operated health care facilities. FY 2023 funds support $3 million for Tribal Health Programs located in areas impacted by de-energization events. Funding is allocated to the Tribal Health Program using the IHS ISDEAA compact/contract.

4. New and Replacement Equipment - Approximately $24.1 million allocated to IHS and Tribal health care facilities to maintain existing and purchase new medical equipment, including the replacement of existing equipment used in diagnosing illnesses. The funding allocation is formula based.

BUDGET REQUEST

The FY 2025 budget submission for Equipment of $34 million is $1 million above the FY 2023 Final level.

FY 2023 Final level Funding of $33 million – Supports maintenance and purchase of equipment for existing IHS and Tribal facilities.

FY 2025 Funding Increase of $1 million.

- Current Services: +$1 million, described in the Current Services chapter.

FUNDING HISTORY

Fiscal Year	Amount
2021	$29,087,000
2022	$30,464,000
2023 Final	$32,598,000
2024 CR	$32,598,000
2025 President's Budget	$33,874,000

TRIBAL SHARES

Equipment funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities at a Federal or Tribe healthcare site.

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

OUTPUTS / OUTCOMES

This program measures outcomes through its inventory of medical equipment. Maintaining and fielding modern medical equipment improve the ease and access to care, enhance the diagnostic capabilities leading to better health outcomes, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment with which to deliver services.

IHS targets Equipment funding and supplements these funds with collections where available, toward equipment purchases to reduce the backlog of over-age equipment and field new, state-of-the-art equipment and systems. A few examples of these purchases include: digital x-ray systems (dental, 3D panoramic x-ray, full radiology rooms, 3D mammography, computed tomography), optometry equipment (visual field analyzers, simultaneous fundus and optical coherence tomography), lab analyzers for in-house testing, sterilization equipment, specialized microscopes, patient lifting equipment, picture archiving & communications systems (PACS), central patient monitoring systems, and ultrasound systems. This equipment will improve diagnostic capabilities, provide faster analysis, and facilitate provision of services to American Indian and Alaska Native communities.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
PERSONNEL QUARTERS / QUARTERS RETURN FUNDS

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR /1	President's Budget	FY 2025 +/- FY 2023
PL	$10,094	$11,500	$11,500	+$1,406
FTE*	--	--	--	--

Quarters funds are not BA but are rents collected for quarters which are returned to the service unit for maintenance and operation costs. They fall under the Program Level Authority.

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

1/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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 2025 Authorization.....Permanent

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

PROGRAM DESCRIPTION

When available housing is limited in the area of Indian Health Service (IHS) health care facilities, staff quarters are provided to assist with recruitment and retention of health care providers. The operation, maintenance, and improvement costs of the staff quarters are funded with this funding designated as Quarters Return (QR) funds, i.e., the rent collected from tenants residing in the quarters. The use of the funds includes maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.). In certain situations, Maintenance and Improvement Program funds may be used, in conjunction with QR funds, to ensure adequate quarters' maintenance. For example, this may be necessary in locations with few quarters where QR funds are insufficient to pay for all required maintenance costs.

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

BUDGET REQUEST

The FY 2025 budget estimate for Staff Quarters of $11.5 million.

The IHS has increased the total number of quarters by about 6 percent since 2017, which is approximately 2 percent annually. In addition, OMB Circular A-45, "Rental and Construction of Government Housing" requires agencies with employee housing to adjust rent and related charges for inflation based on the Consumer Price Index (CPI). For 2022, the CPI adjustment is +2.6% in regions that were not resurveyed for market values/rental rates. Regions with new market values/rental rates surveys, the new rent and utilities rates will be implemented.

As a result of the growth in the total number of quarters, and increasing rental rates, the IHS collections were approximately $10 million in FY 2023, and anticipates collections of approximately $11.5 million in FY 2024.

As a result, the FY 2025 request includes anticipated collections of $11.5 million which is $1 million above the FY 2023 Final level.

These funds support the following activities:

The operation, management, and general maintenance of quarters, including maintenance personnel services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.).

FUNDING HISTORY

Fiscal Year	Amount
2021	$9,100,000
2022	$10,659,2230
2023 Final	$10,093,959
2024 CR	$11,500,000
2025 President's Budget	$11,500,000

OUTPUTS / OUTCOMES - This program measures outcomes through the inventory of staff quarters. Well-maintained and modern housing units are an essential element in recruiting and retaining healthcare professionals at IHS and Tribal healthcare sites. Rent collections, augmented with Maintenance & Improvement funding and collections where available, are used to maintain, repair, and modernize existing quarters. Typically work may include painting, carpeting, new appliances, roof replacement, etc.

GRANT AWARDS – This program has no grant awards.
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Contract Support Costs

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

CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final /1	CR /2	President's Budget	FY 2025 +/- FY 2023
PL	$969,000	$969,000	$979,000	+$10,000
FTE*	--	--	10	+10

*Contract Support Costs are not currently used to support FTEs.
1/ Displays the amount estimated as part of the FY 2023 Consolidated Appropriations Act (P.L. 117-328). Consistent with the nature of an indefinite appropriation account, the amount adjusts to align with the necessary funding level.
2/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40). The FY 2023 Consolidated Appropriations Act (P.L. 117-328) included $5.1 billion in FY 2024 advance appropriations across the Services and Facilities Accounts.

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

FY 2025 Authorization.....Permanent

Allocation Method ..... P.L. 93-638 Self-Determination Contracts and Compacts

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, provides Tribes or Tribal Organizations (T/TO) the authority to contract with the Department of Health and Human Services, through the Indian Health Service (IHS), to operate Federal programs serving eligible persons and to receive not less than the amount of funding that the Secretary would have otherwise provided for the direct operation of the program for the period covered by the contract (otherwise known as the "Secretarial amount"). The 1988 amendments to the Act authorized Contract Support Costs (CSC) be paid in addition to the Secretarial amount.

CSC are defined as necessary and reasonable costs for activities that T/TO must carry out to ensure compliance with the contract and prudent management but that the Secretary either did not normally carry out in his or her direct operation of the program or provided from resources other than those transferred under contract. The IHS CSC policy was established in 1992 and most recently revised on August 6, 2019, which updates from the October 2016 policy revisions,[1] an update to reflect necessary changes. These changes include the method by which Congress has funded CSC, and moves from limited to uncapped awards, and the provision of CSC to an indefinite appropriation.

CSC is administered for IHS by the Office of Direct Services and Contracting Tribes (ODSCT), an office with responsibility for three primary functions that directly impact the relationship with

[1] *Indian Health Manual*, Part 6 – Services to Tribal Governments and Organizations, Chapter 3 – Contract Support Costs, *available at* http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p6c3.

each Indian T/TO. The ODSCT serves as the primary conduit between the IHS and the Direct Service Tribes, management of P.L. 93-638 Title I, ISDEAA contracts, and CSC in support of both Title I contracts and Title V compacts.

BUDGET REQUEST

The FY 2025 budget submission for Contract Support Costs of $979 million is $10 million above the FY 2023 Final level. The budget request maintains an indefinite discretionary appropriation for Contract Support Costs that would continue to fully-fund Contract Support Costs payments to Tribes.

The overall funding level varies with need that is adjusted to meet the actual need for each fiscal year, which means that the appropriated amount will continue to fluctuate until the CSC need is fully reconciled for each year. The requested funding level reflects IHS's best current estimate of the need.

The FY 2025 funding increase of $10 million supports:

- Contract Support Costs Administrative Costs: +$10 million to allow IHS to pay for management and oversight activities from the CSC indefinite discretionary appropriation. This would be accomplished through a proposed appropriations language change. This change is necessary to hire additional FTEs and to update or establish systems for management and oversight of these rapidly growing activities.

PROGRAM ACCOMPLISHMENTS

- Following is a summary CSC funds for FY 2018 – FY 2023, as of January 16, 2024:

	FY 2018	FY 2019	FY 2020
Appropriations*	$ 762,642,272	$ 822,277,000	$ 855,000,000
Paid to Tribes	$ (787,530,043)	$ (799,257,969)	$ (914,713,024)
Balance*	$ (24,887,771)	$ 23,019,031	$ (59,713,024)
	FY 2021	FY 2022	FY 2023
Appropriations*	$ 916,000,000	$ 880,000,000	$ 969,000,000
Paid to Tribes	$(1,138,674,782)	$ (846,041,315)	$ (867,527,328)
Balance*	$ (222,674,782)	$ 33,958,685	$ 101,472,672

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

- IHS developed a SharePoint to track CSC requirements for COVID-19 funds. Separate data set are maintained for the period of funds availability for each Supplemental Appropriation.

- IHS Headquarters reconciles CSC fund requests on a quarterly basis and allocates funds to each Area office to pay tribes.

- IHS uses the CSC automated data system to track and monitor all CSC activity. The CSC data set is used to track all CSC funds, including any new and expanded assumption, renegotiation of CSC amounts, and distribution and payment of funds. IHS also uses the system to project CSC need based on the most current data.

- IHS continues to use the internal electronic database to monitor each Title I and V ISDEAA negotiation, including CSC negotiations. The database monitors each phase of a negotiation to ensure that IHS uses a consistent agency business approach, meet statutory deadlines, and accurately calculate required funding amounts. In addition, the database tracks new and expanded assumptions and is used to determine the status of funds, workload, planning of resources, and subsequent years' funding needs.

- IHS continues to make progress in resolving Contract Disputes Act claims from T/TO for additional CSC funding for prior years. As of January 20, 2023, the IHS has extended settlement offers on 1,716 of the 1,861 claims, with total settlement payments of approximately $977 million that has been tentative or confirmed for payment from the Judgment Fund.

FUNDING HISTORY

Fiscal Year	Amount
2021	$916,000,000
2022	$880,000,000
2023 Final	$969,000,000
2024 CR	$969,000,000
2025 President's Budget	$979,000,000

AREA ALLOCATION

CONTRACT SUPPORT COSTS

(dollars in thousands)

DISCRETIONARY	FY 2023* Estimate/1			FY 2024 Estimate/1			FY 2025 Estimate/1			FY '25 +/- FY '23
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$253,682	$253,682	$0	$273,034	$273,034	$0	$275,851	$275,851	$2,818
Albuquerque	0	31,379	$31,379	0	33,773	33,773	0	34,122	34,122	$349
Bemidji	0	44,501	$44,501	0	47,896	47,896	0	48,390	48,390	$494
Billings	0	15,282	$15,282	0	16,448	16,448	0	16,618	16,618	$170
California	0	65,523	$65,523	0	70,522	70,522	0	71,249	71,249	$728
Great Plains	0	52,016	$52,016	0	55,984	55,984	0	56,562	56,562	$578
Nashville	0	37,515	$37,515	0	40,376	40,376	0	40,793	40,793	$417
Navajo	0	80,681	$80,681	0	86,835	86,835	0	87,731	87,731	$896
Oklahoma	0	174,646	$174,646	0	187,969	187,969	0	189,908	189,908	$1,940
Phoenix	0	70,013	$70,013	0	75,354	75,354	0	76,131	76,131	$778
Portland	0	64,440	$64,440	0	69,356	69,356	0	70,071	70,071	$716
Tucson	0	10,642	$10,642	0	11,454	11,454	0	11,572	11,572	$118
Headquarters	0	0	$	0	0	$	0	0	$	$
Total, CSC	**$**	**$900,322**	**$900,322**	**$0**	**$969,000**	**$969,000**	**$0**	**$979,000**	**$979,000**	**$10,000**

1/ Note: 2023, 2024, and 2025 are estimates.

*FY 2023 total enacted was $969,000,000, the total amount shown in the table is total obligations for FY 2023.

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ISDEAA 105 *(l)* Leases

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Payments for Tribal Leases: 75-0200-1-551
ISDEAA SECTION 105(*l*) LEASES

(Dollars in Thousands)

	FY 2023	FY 2024	FY 2025	
	Final /1	CR /2	President's Budget	FY 2025 +/- FY 2024
PL	$111,000	$111,000	$348,876	+$237,876
FTE*	--	--	10	+10

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Displays the amount estimated as part of the FY 2023 Consolidated Appropriations Act (P.L. 117-328). Consistent with the nature of an indefinite appropriation account, the amount adjusts to align with the necessary funding level.
2/ Displays annualized FY 2024 funding level under the current Continuing Resolution (P.L. 118-40).

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

FY 2025 Authorization.....Permanent

Allocation Method .....P.L. 93-638 Self-Determination Contract and Compacts, Lease Cost Agreements

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA), at 25 U.S.C. § 5324(*l*), also referred to as Section 105(*l*), requires the Indian Health Service (IHS) to enter a "lease" upon the request of a tribe or tribal organization furnishing a tribally owned or leased facility used in support of its tribally operated ISDEAA contract or compact. The IHS does not directly use or occupy the tribal facility under the lease. Through regulations contained in 25 C.F.R. Part 900, Subpart H, IHS identified elements of compensation included in a Section 105(*l*) lease.

A 2016 Federal Court's decision (Maniilaq Association v. Burwell) prohibits IHS from capping funding under Section 105(*l*) at the level that IHS would have otherwise spent to operate a facility if it were carrying out the Federal health programs. There is no statutory or regulatory limitation on when proposals may be submitted to the IHS, so IHS is unable to reliably predict or project annual costs. Lease costs have grown exponentially since the Maniilaq decision; for example, costs quadrupled between FY 2018 and FY 2019.

Beginning in FY 2021, Congress provided a separate, indefinite discretionary appropriation for Section 105(*l*) leases. The indefinite appropriation provides the IHS with access to funding authority that adjusts to fully meet funding needs. Prior to FY 2021, Section 105(*l*) lease costs were paid from the IHS lump sum appropriation for the Indian Health Services account, which resulted in reallocation of funding from other budget lines within the account to address Section 105(*l*) lease costs. The Indian Health Services account is now protected from reallocation since Section 105(*l*) lease costs may only be paid through the separate, indefinite appropriation.

BUDGET REQUEST

The FY 2025 budget submission for ISDEAA Section 105(*l*) leases of $349 million is $238 million above the FY 2023 Final level. The budget request maintains an indefinite discretionary appropriation for ISDEAA Section 105(*l*) leases to fully fund tribal lease payments.

Consistent with the nature of an indefinite appropriation, the overall funding level will adjust to meet the actual need for the fiscal year. The requested funding level reflects a point in time estimate of the need.

The FY 2025 funding increase of $238 million supports:

- Section 105(*l*) Lease Costs: +$228 million for additional Section 105(*l*) estimated costs.

- Section 105(*l*) Administrative Costs: +$10 million to allow IHS to pay for management and oversight activities from the Section 105(*l*) leases indefinite discretionary appropriation. This would be accomplished through a proposed appropriations language change. This change is necessary to hire additional FTE and support enhancement of systems for management and oversight of these rapidly growing activities.

PROGRAM ACCOMPLISHMENTS

As of February 2024, the IHS has received 767 lease cost agreements or proposals totaling an estimated $374 million. This amount will continue to adjust as lease cost agreements are finalized and new proposals are received before the end of the fiscal year.

The current FY 2024 estimate reflects a 27 percent increase over FY 2023. In FY 2023, the IHS received 673 proposals for an estimated total of $294 million. The IHS anticipates funding needs will continue to grow each fiscal year.

In FY 2023, the IHS continued efforts to enhance program operations and oversight. The IHS reviewed the internal organizational alignment of Section 105(*l*) lease activities to identify opportunities for bolstering program capacity. In addition, the IHS worked on a draft policy for Section 105(*l*) leases to assist with clarifying program operations. This work involved coordination with counterparts at the Department of the Interior and engagement with the IHS's tribal advisory groups. Continued engagement with tribes and tribal organizations is anticipated in FY 2024 as the IHS works toward finalization of the policy.

In alignment with Congress's direction in the FY 2023 annual appropriation, the IHS continues to partner with the Department of the Interior on the requirements and process for Section 105(*l*) leases. These collaborative efforts include engagement with tribes and tribal organizations to maximize consistent and transparent processes where feasible and appropriate for the different types of programs administered by each agency.

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

(Dollars in thousands)

	FY 2023	FY 2024	FY 2025	
	Final	CR	President's Budget /1	FY 2025 +/- FY 2023
PL	$147,000	$147,000	$260,000	+$113,000
Current Law Mandatory Funding	*$147,000*	*$150,000*	--	*-$147,000*
Proposed Law Mandatory Funding	--	*$100,000*	*$260,000*	*+$260,000*
FTE*	111	111	111	--

** FTE numbers reflect only Federal staff and do not include increases in tribal staff.*
/1 FY 2023 funding reflects mandatory sequester of 2 percent. FY 2024 Current Law funding represents annualized funding level under the current Continuing Resolution (P.L. 118-35). The FY 2025 budget proposes a 3-year reauthorization of the Special Diabetes Program for Indians beginning in FY 2024.

Authorizing Legislation ..... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians (SDPI) to extend funding through FY 2011, the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013, the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014, the Protecting Access to Medicare Act of 2014 (P.L. 113-93; H.R. 4302) to extend funding through FY 2015. P.L. 114-10 – The Medicare Access and CHIP Reauthorization Act of 2015 authorized SDPI for FY 2016 and FY 2017, P.L. 115-63 — Disaster Tax Relief and Airport and Airway Extension Act authorized SDPI for the first quarter of FY 2018, and P.L. 115-96— Department of Homeland Security Blue Campaign Authorization Act of 2017 authorized SDPI for the second quarter of FY 2018, P.L. 115-123 – Bipartisan Budget Act of 2018 authorized SDPI for the rest of FY 2018 and all of FY 2019, the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59) authorized SDPI through November 21, 2019, the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69) authorized SDPI through December 20, 2019. SDPI was authorized through May 22, 2020 through the Further Consolidated Appropriations Act, 2020 (P.L. 116-94). The Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-36) authorized SDPI through November 30, 2020. The Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159) authorized SDPI through December 11, 2020. The Further Continuing Appropriations Act, 2021, and Other Extensions Act (P.L. 116-215) authorized SDPI through December 18, 2020. The Consolidated Appropriations Act, 2021 (P.L. 116-260) authorized SDPI until September 30, 2023. The Continuing Appropriations Act, 2024 and Other Extensions Act (P.L. 118-15) authorized $19,726,027 for the period beginning on October 1, 2023 and ending on November 17, 2023. The Further Continuing Appropriations and Other Extensions Act (P.L. 118-22), 2024 authorized $25,890,411 for the period beginning on November 18, 2023, and ending on January 19, 2024. The Further Additional Continuing Appropriations and Other Extensions Act (P.L. 118-35), 2024 authorized $20,136,986 for the period beginning January 20, 2024, and ending March 8, 2024.

FY 2025 Authorization..... Expires March 8, 2024

Allocation Method ..... Grants and Contracts

PROGRAM DESCRIPTION

The Special Diabetes Program for Indians (SDPI) is made up of two separate grant programs (SDPI and SDPI-2). The SDPI-2 is a new grant program that started in 2024. Both SDPI and SDPI-2 are funded by the same authorizing legislation and both provide funding for diabetes treatment and prevention to Indian Health Service (IHS), Tribal, and Urban (I/T/U) Indian health grant programs. There are 302 grant recipients in SDPI and 8 grant recipients in SDPI-2, for a total of 310 grant programs. Funds for SDPI were first authorized in FY 1998; as such, FY 2025 would be the 28th year of the SDPI. SDPI is currently authorized through March 8, 2024[1]. 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 310 SDPI grants at I/T/U sites across the country.

Target Population: American Indians and Alaska Natives

Diabetes and its complications are major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (13.6 percent) among all racial and ethnic groups in the United States, more than twice the rate of the non-Hispanic white population (6.9 percent).[2] 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.[3]

Allocation Method

In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes among AI/AN people. The entities eligible to receive these grants were I/T/Us. The IHS distributes this funding to 310 I/T/U sites annually through a process that includes Tribal Consultation/Urban Confer, development of a formula for distribution of funds, and a formal grant application and administrative process.

Strategy

The SDPI brings Tribes together to work toward a common purpose and share information and lessons learned. The Tribal Leaders Diabetes Committee, established in 1998, reviews

[1] FY 2024 Current Law funding represents annualized funding level under the current Continuing Resolution (P.L. 118-35).

[2] Centers for Disease Control and Prevention. National Diabetes Statistics Report website. https://www.cdc.gov/diabetes/data/statistics-report/index.html#anchor_00215. Last Reviewed: November 29, 2023.

[3] 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.

information on the SDPI progress and provides recommendations on diabetes-related issues to the IHS Director. Through partnerships with federal agencies, private organizations, and an extensive I/T/U network, DDTP undertook one of the most strategic diabetes treatment and prevention efforts ever attempted in AI/AN communities and demonstrated the ability to design, manage, and measure a complex, long-term project to address this chronic condition. Because of the significant costs associated with treating diabetes, I/T/Us have used best and promising practices for their local SDPI funding to address the primary, secondary, and tertiary prevention of diabetes and its complications.

This collaborative approach supports the strategic planning process necessary to identify the goals and objectives needed to achieve the intended SDPI outcomes.

BUDGET REQUEST

The FY 2025 budget submission for the Special Diabetes Program for Indians is $260 million which is $113 million above the FY 2023 Final level. The budget includes a legislative proposal to reauthorize mandatory funding for the SDPI for three-years at the following funding levels: $250 million in FY 2024, $260 million in FY 2025, and $270 million in FY 2026. The proposal would also exempt the program from sequestration. Increased funding will allow the program to serve additional grantees, and will enable current grantees to more effectively conduct long-term program planning.

The SDPI is currently authorized through March 8, 2024[4]. The annualized funding level under the Further Additional Continuing Appropriations and Other Extensions Act, 2024 is $66 million. The FY 2023 funding level of $147 million reflects mandatory sequester of two percent.

PROGRAM ACCOMPLISHMENTS

Impact of the SDPI Grant Programs

SDPI funding has enabled staff and programs at the local and national levels to increase access to diabetes treatment and prevention services throughout the Indian health system. The following table demonstrates substantial increases in access to many activities and services:

Diabetes treatment and prevention services available to AI/AN individuals	Access in 1997	Access in 2019	Absolute Percentage increase
Diabetes clinical teams	30%	95%	+65%
Diabetes patient registries	34%	96%	+62%
Nutrition services for adults	39%	94%	+55%
Access to registered dietitians	37%	85%	+48%
Culturally tailored diabetes education materials	36%	96%	+60%
Access to physical activity specialists	8%	84%	+76%
Adult weight management services	19%	76%	+57%

Clinical Diabetes Outcomes during SDPI

[4] FY 2024 Current Law funding represents annualized funding level under the current Continuing Resolution (P.L. 118-35).

At the same time that access to these diabetes services increased, key outcome measures for AI/ANs with diabetes showed improvement or maintenance at or near national targets. These results have been sustained throughout the inception of SDPI. Examples include:

- The average blood sugar level (as measured by the A1C test) among AI/ANs with diabetes served by the IHS has decreased from 9.0 percent in 1996 to 7.9 percent in 2023.
- The average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 87 mg/dL in 2023, surpassing the goal of less than 100 mg/dL.
- The rate of new cases of kidney failure due to diabetes leading to dialysis declined by more than half (54 percent) in AI/AN people from 1996 to 2013. This is a much larger decline than in any other racial group in the US.[5]

1. Diabetes Data and Program Delivery Infrastructure

Facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit. The Diabetes Audit is the cornerstone of the IHS DDTP diabetes care surveillance system, tracking annual performance on diabetes care and health outcome measures. Data collection for the Diabetes Audit follows a standardized protocol to ensure statistical integrity and comparability of measures over time. The 2023 Diabetes Audit included a review of 137,843 patient charts at 321 I/T/U health facilities. The Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national levels, as well as enhance quality improvement capabilities across AI/AN communities. DDTP provides Diabetes Audit training through online and webinar formats. DDTP receives evaluations on all trainings provided to guide improvements for future sessions.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
53 Controlled BP <140/90 (Outcome)	FY 2023: 54.6 % Target: 52.4 % (Target Exceeded)	52.4%	57.5%	+5.2 percentage point(s)
54 Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes (Intermediate Outcome)	FY 2023: 49.9 % Target: 54.5 % (Target Not Met)	54.5%	52.6%	-1.9 percentage point(s)
86 Reduce the proportion of American	FY 2023: 13.2 % Target:	14.4%	12.5%	-2.0 percentage point(s)

[5] Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. MMWR Morb Mortal Wkly Rep 2017;66:26-32. DOI: http://dx.doi.org/10.15585/mmwr.mm6601e1.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2024 Target	FY 2025 Target	FY 2025 Target +/-FY 2024 Target
Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)[1]	14.4 % (Target Exceeded)			

1. The decrease shows improvement in percentage of AI/AN diagnosed with poor glycemic control.

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to I/T/U health programs in 35 states. The SDPI grant programs provide local diabetes treatment and prevention services based on community needs.

(whole dollars)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Number of Awards	302	302	302
Average Award	$452,011	$459,367	$459,367
Range of Awards	$25,000 - $7,553,570	$22,500 - $7,553,570	$25,000 - $7,553,570

FY 2025 State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2023 Annual Financial Assistance Awards[6]					
State	State Name	FY 24 Total # Grant Programs	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
AK	Alaska	20	10,196,244	$10,196,244	$10,196,244
AL	Alabama	1	279,211	279,211	279,211
AZ	Arizona	28	35,522,502	35,522,502	35,522,502
CA	California	36	9,670,825	9,670,825	9,670,825
CO	Colorado	3	903,625	903,625	903,625
CT	Connecticut	2	232,777	232,777	232,777
FL	Florida	2	486,980	486,980	486,980
IA	Iowa	1	304,592	304,592	304,592
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

[6] Please note that the numbers provided for FY 2024 are likely to change due to the start of the new SDPI grant cycle.

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2023 Annual Financial Assistance Awards[6]					
State	State Name	FY 24 Total # Grant Programs	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
ME	Maine	5	543,580	543,580	543,580
MI	Michigan	12	2,363,824	2,363,824	2,363,824
MN	Minnesota	9	3,378,922	3,378,922	3,378,922
MS	Mississippi	1	1,256,112	1,256,112	1,256,112
MT	Montana	13	6,869,529	6,869,529	6,869,529
NE	Nebraska	5	1,931,172	1,931,172	1,931,172
NV	Nevada	12	4,649,823	4,649,823	4,649,823
NM	New Mexico	24	7,693,403	7,693,403	7,693,403
NY	New York	6	1,481,491	1,481,491	1,481,491
NC	North Carolina	1	1,351,228	1,351,228	1,351,228
ND	North Dakota	5	3,168,173	3,168,173	3,168,173
OK	Oklahoma	26	23,396,634	23,396,634	23,396,634
OR	Oregon	9	1,832,727	1,832,727	1,832,727
RI	Rhode Island	1	113,475	113,475	113,475
SC	South Carolina	1	163,399	163,399	163,399
SD	South Dakota	10	6,294326	6,294,326	6,294,326
TX	Texas	4	784,901	784,901	784,901
UT	Utah	5	2,031,434	2,031,434	2,031,434
VA	Virginia	4	417,983	417,983	417,983
WA	Washington	26	4,272,980	4,272,980	4,272,980
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	**302**	$138,733,719	$138,733,719	$138,733,719
	Indian Tribes	**256**	$115,542,394	$115,542,394	$115,542,394

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs (SDPI-2) by State and FY 2024 Annual Financial Assistance Awards				
State	State Name	FY 24 Total # Grant Programs	FY 2024	FY 2025 President's Budget
AK	Alaska	2	298,334	298,334
KS	Kansas	1	55,360	55,360

NV	Nevada	2	575,721	575,721
OK	Oklahoma	1	150,000	150,000
UT	Utah	1	192,407	192,407
WA	Washington	1	519,357	519,35
	Total States	**8**	$1,791,179	$1,791,179
	Indian Tribes	**8**	$1,791,179	$1,791,179

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
MANDATORY FORMULA

SUMMARY OF THE BUDGET REQUEST

Beginning in FY 2026, the budget proposes full mandatory funding for all of IHS, and exempts IHS funding from sequestration. The enactment of a mandatory funding formula will take critical steps towards:

1. Securing adequate, stable and predictable funding to improve the overall health status of AI/ANs;

2. Improving access to high quality health care through strategic investments; and

3. Addressing shortfalls that have resulted from chronic underfunding.

This mandatory formula culminates in a total funding level of approximately $42 billion in FY 2034. In total, the mandatory formula would provide approximately $289 billion for the IHS over ten-years. When accounting for the discretionary baseline, the net-total for the proposal is approximately $208 billion over ten-years.

Formula components include:

- **Inflationary growth:** The budget accounts for inflationary and population growth across IHS funding accounts. Population growth is estimated at 1.8% percent in FY 2026. This includes current services funding, which consists of pay costs, medical and non-medical inflation, and population growth. Under the mandatory proposal, current services will be fully funded each fiscal year.

  For the Services account, the proposal applies the current CPI-U medical inflation factor each year (currently estimated at 3.9 percent from FY 2026-2034) to the entire Services account base from the prior year, and then adds any other programmatic and policy increases on top of the inflated base.

  For the Facilities account, the proposal applies the current CPI-U inflation factor each year (currently estimated at 2.3 percent from FY 2026-FY 2034) to the entire Facilities account base from the prior year, and then adds any other programmatic and policy increases on top of the inflated base.

- **Staffing of Newly Constructed Facilities:** The FY 2025 President's Budget fully funds staffing and operating costs for newly opening facilities every year for 10 years. These estimates are based on the existing methodology for calculating staffing and operating costs associated with such facilities, and will be updated annually through the budget formulation process. Under the mandatory proposal, staffing of newly constructed facilities will be fully funded each fiscal year.

- **Level of Need Funded Gap:** Over five years, from FY 2026 to FY 2030, the budget addresses the funding gap for direct healthcare services documented in the FY 2018 level of need funded analysis. The level of need gap analysis calculated $11.2 billion as the

point in time estimated funding shortfall identified for a baseline of health services in FY 2018. At that time, the overall funds needed were determined to be $16.203 billion. In FY 2018, the IHS received $4.9 billion in resources for direct health care services, which leaves a funding deficiency of $11.2 billion. The Budget grows the funding deficiency of $11.2 billion by CPI-U medical for a revised funding deficiency total of $11.6 billion, which is addressed over five years from FY 2026-FY 2030. From FY 2031-FY 2034, the budget provides additional funding to address any additional needs. This funding would be distributed using the Indian Health Care Improvement Fund (IHCIF) formula. The formula is used to target IHCIF appropriations to the sites with the greatest need, as compared to the benchmark of National Health Expenditure Data, which is maintained by CMS. The formula is the product of longstanding consultation with Tribes. The IHS uses the Level of Need Funded percentage to allocate IHCIF appropriations increases to IHS and Tribal facilities. The methodology allocates funds to sites with the lowest Level of Need Funded percentages.

- **Electronic Health Record:** The budget fully-funds the IHS Electronic Health Record modernization effort from FY 2025-FY 2029. In FY 2025, the budget provides $435 million in discretionary funding for EHR modernization. The budget then builds funding for EHR by +$1.3 billion each year from FY 2026-FY 2030. Once the EHR modernization effort is complete, the budget ensures sufficient recurring funding is maintained for ongoing maintenance of the new system.

- **Public Health Capacity Building:** The budget authorizes and appropriates funding for a new public health infrastructure and capacity building funding stream under the formula. This includes $150 million in FY 2026, and would grow for inflation in the outyears under the formula, for a total of $500 million over nine-years. Funding would enable IHS to implement a public health infrastructure system for IHS, Tribal, and urban Indian health programs, which is a key lesson learned from the pandemic and a top priority of tribal leaders. Additional resources are necessary to develop appropriate public health and emergency preparedness capacity in AI/AN communities to prevent these disproportionate impacts in the future. Tribes do not receive dedicated public health funding from CDC, and the IHS does not currently have substantial funding to support ongoing public health and emergency preparedness infrastructure. Specifically, most tribes do not currently have well established public health systems – as of 2021, only four tribal public health agencies are accredited through the Public Health Accreditation Board. Comparatively, 40 State and 305 local public health agencies were accredited as of 2021.[1] The proposal complements the budget's proposed investments in public health readiness and pandemic preparedness by ensuring IHS and Tribal communities have comparable resources to prepare for the next pandemic.

- **One Time Base Increase:** The budget increases funding for the Services account for select priority items. These activities will receive one-time dedicated funding increases in FY 2026, and then grow by the inflationary factors mentioned above in the outyears:

    - ***COVID-19 Recovery:*** +$130 million to support IHS patients in recovery from the long-lasting effects of the COVID-19 pandemic, including treatment for long haul COVID-19. Based on data from 14 states, age-adjusted COVID-19 associated mortality among AI/AN was 1.8 times that of non-Hispanic Whites. In

[1] https://health.gov/healthypeople/objectives-and-data/browse-objectives/public-health-infrastructure/increase-number-tribal-public-health-agencies-are-accredited-phi-03/data

23 states with adequate race and ethnicity data, the cumulative incidence of laboratory-confirmed COVID-19 among AI/AN was 3.5 times that of non-Hispanic Whites. In the state of Montana, COVID-19 incidence and mortality rates among AI/AN were 2.2 and 3.8 times those among White persons, respectively.

- ***Cancer Moonshot:*** +$108 million to develop a nation-wide coordinated public health and clinical cancer prevention initiative to implement best practices and prevention strategies to address incidence of cancer and mortality among the American Indian and Alaska Native (AI/AN) population, in support of the President's Cancer Moonshot initiative. These funds would support:

  - *Cancer Prevention and Treatment:* +$68 million for cancer prevention and treatment services across the Indian health system to: 1) improve the provision of clinical prevention and treatment services, 2) facilitate planning among partners to promote evidence-based strategies in communities for prevention and treatment and 3) improve cancer surveillance. IHS, Tribal, and urban Indian health programs have limited access to cancer treatment services and rely heavily on Purchased/Referred Care, which often requires significant travel to cancer treatment centers. This additional funding ensures that cancer prevention and treatment services become available in rural areas where cancer prevention and treatment is often non-existent.

  - *IHS Cancer Center of Excellence staff:* +$8 million to develop and implement multilevel and multidisciplinary approaches to increase preventive screenings for early detection and treatment, to increase educational outreach, and to improve access to cessation services. Staff would be multidisciplinary and include staff at the regional and area levels to establish and manage the Center of Excellence. The cancer prevention team will develop a cancer prevention plan with input from key stakeholders to coordinate, implement, and monitor activities, provide technical assistance to demonstration sites and cooperative agreement grantees, and IHS, Tribal, and urban Indian health programs.

  - *Establish Clinical/Community Demonstration Projects:* +$30 million for the IHS Improved Patient Care (IPC) and community health programs (public health nursing, health education, Community Health Representatives) to implement evidence-based interventions to increase preventive screenings, enhance referrals for follow-up and/or treatment. These funds would support three activities and national infrastructure:
    - Award demonstration projects to coordinate patient care, enhance and expand preventive screenings, referrals, and follow up, as well to establish Patient Navigator positions;
    - Develop a Patient Navigation training program to train professionals and laypeople to coordinate patient care, connect patients with resources, and guide patients through the health care system; and
    - Support 8 FTEs to support the demonstration projects, Patient Navigation

- training program, and Patient Navigator positions within the IHS Areas.

- *Develop National Campaigns:* +$2 million to increase awareness of behavioral risk factors that are associated with cancer risk. Campaigns using positive messaging related to healthy weight, not using commercial tobacco, limiting alcohol use, and increasing daily physical activity. Developing stories of individuals affected by cancer, prevention information, and social media to increase awareness of cancer and importance of preventive screenings.

- **Health Care Facilities Construction:** The budget provides an additional $10.3 billion over nine years to address Health Care Facilities Construction needs. From FY 2026-2030, the budget fully-funds the remaining projects on the 1993 Health Care Facilities Construction Priority List. After the 1993 Priority List is eliminated in 2030, funding increases will continue to address other remaining needs, starting in 2031. On average, IHS hospitals are 39 years old, over 3 times the age of the average hospital in the United States. 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. Infrastructure deficiencies directly contribute to poorer health outcomes for AI/AN. This investment proposes a holistic approach to addressing infrastructure needs by going beyond the 1993 Priority List.

- **Sanitation Facilities Construction:** Beginning in FY 2027, the Budget provides an additional $250 million to address operation and maintenance costs related to the completion of the Sanitation Deficiencies System backlog with Infrastructure Investment and Jobs Act (IIJA) resources. FY 2027 is the first year IHS will not receive Infrastructure Investment and Jobs Act (IIJA) resources.

- **Maintenance and Improvement:** The budget provides an additional +$1 billion in each of FYs 2026 and 2027 to fully fund the 2023estimated Backlog of Essential Maintenance, Alteration, and Repair for IHS and Tribal facilities cost, and to account for anticipated growth in the BEMAR between now and FY 2026. Beginning in FY 2028, the budget maintains sufficient outyear recurring funding to address future maintenance backlogs.

- **Equipment:** The budget provides an additional +$227 million in each of FYs 2026 and 2027 to fully fund the medical equipment backlog. Beginning in FY 2027, the budget maintains sufficient outyear recurring funding to address future equipment needs.

- **Facilities and Environmental Health Support:** The budget increases the Facilities and Environmental Health Support funding line at 13 percent of the rate of growth in Sanitation Facilities Construction and 5 percent of the rate of growth in Health Care Facilities Construction, consistent with historical funding needs and IHS' current estimation methodology. This funding supports staff to oversee and implement facilities projects, as well as a comprehensive environmental health program within IHS. Within this increase, the IHS will utilize $10 million in to support a nation-wide analysis to understand the cost implications of implementing 25 U.S.C. 1632 of the Indian Health Care Improvement Act, which authorizes funding for operations and maintenance costs for tribes who choose to directly complete their own SFC projects. The results of this analysis will be utilized and implemented as part of the updated mandatory formula

structure. These funds would be used by tribes to ensure that existing SFC projects are reaching their maximum life-cycle and operations of these projects are sustainable for as long as possible.

- **Direct Operations:** The budget grows Direct Operations by 25% each year to ensure there are sufficient resources to implement these large-scale activities. This funding level ensures adequate administrative and oversight capacity by enhancing core management functions, patient safety and quality initiatives, and implementation of GAO and OIG recommendations. This approach also ensures IHS' administrative funding would continue to grow commensurate with overall budget growth. Funds are eligible to be administered through tribal shares.

- **New Tribes:** The budget fully-funds the cost of providing health care to newly federally-recognized tribes (estimated $1 million per year). Costs would be evaluated and adjusted annually consistent with IHS' standard methodology for determining funding estimates for new tribes.

- **Contract Support Costs and Section 105*(l)* Leases:** The budget fully funds Contract Support Costs and Section 105*(l)* Leases by maintaining an indefinite mandatory appropriation for both of these programs. The formula projects growth in each account based on the inflation factors described above, but ultimately the funding levels would continue to adjust to fully fund actual costs each year

Mandatory Budget Ten-Year
Table

(dollars in millions)

	2025/ 1	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025-2034 Total
Services and Facilities Accounts	6,635	14,244	21,198	25,222	31,075	37,148	33,274	35,609	38,034	40,519	276,323
Contract Support Costs	979	989	999	1,009	1,020	1,030	1,041	1,051	1,062	1,073	9,274
Section 105(l) Leases	349	352	356	360	363	367	371	375	378	382	3,305
Mandatory Request, Total /2	7,963	15,585	22,553	26,591	32,458	38,545	34,685	37,035	39,475	41,974	288,902
Estimated Discretionary Baseline /3	-7,963	-8,146	-8,333	-8,525	-8,721	-8,922	-9,127	-9,337	-9,552	-9,771	-80,434
Net Cost, Mandatory Proposal	**0**	**7,439**	**14,219**	**18,066**	**23,737**	**29,623**	**25,558**	**27,698**	**29,923**	**32,202**	**208,467**

1/ The Budget requests discretionary resources in FY 2025. All accounts will be mandatory starting in 2026.

2/ This table excludes funding for the Special Diabetes Program for Indians.

3/ Reflects estimated baseline discretionary spending if IHS were to remain discretionary. This figure is used to calculate the net-cost of the mandatory funding proposal, and does not represent a reduction in funding for the IHS budget.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

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Drug Budget

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2025

Budget Authority (in Millions)			
	FY 2023 Final	FY 2024 Annualized CR	FY 2025 President's Budget
Drug Resources by Function[1]			
Treatment - ASA	103.476	103.476	112.542
Treatment - Urban	3.871	3.445	3.445
Prevention	37.316	37.316	38.797
Total Drug Resources by Function	144.663	144.237	154.784
Drug Resources by Program			
Alcohol and Substance Abuse[1]	140.792	140.792	151.339
Urban Indian Health Program	3.871	3.445	3.445
Total Drug Resources by Program	144.663	144.237	154.784
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as Percent of Budget			
Agency Budget	6,958.223	6,958.223	7,962.933
Drug Resources Percentage	2.08%	2.07%	1.94%

[1] Adult Treatment funds are excluded from the ONDCP Drug Control Budget and Moyer Anti-Drug Abuse methodologies because this program reflects the original authorized program for IHS with the sole focus of alcoholism treatment services for adults. This determination was made in consultation with ONDCP when the drug control budget was initially developed in the early - 1990s.

MISSION

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

METHODOLOGY

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

BUDGET SUMMARY

In FY 2025, IHS requests $154.8 million, which is an increase of $10.5 million over the FY 2024 Continuing Resolution level.

Alcohol and Substance Abuse
FY 2025 Request: $151.3 million

In FY 2025, the IHS budget request for its drug control activities supports the Office of National Drug Control and Policy (ONDCP) funding priorities as well as the ONDCP *Strategy*. The *Strategy* emphasizes the partnership between Federal agencies and their state, local, Tribal, and international counterparts and reduce drug-induced mortality. IHS is also working with Federal partners to implement ONDCP's efforts to address the current crisis.

The Administration's ONDCP *Strategy* guides and expands Federal government efforts to: 1) expand access to evidence-based treatment ; 2) advancing racial equity issues in our approach to drug policy; 3) enhancing evidence-based harm reduction efforts; 4) supporting evidence-based prevention efforts to reduce youth substance use; 5) reducing the supply of illicit substances; 6) advancing recovery-ready workplaces and expanding the addiction workforce; and, 7) expanding access to recovery support services. The *Strategy* offers a valuable opportunity for IHS to advance its mission by strengthening existing programs to control and reduce substance use and eliminate its deleterious effects on the health and safety of AI/AN patients and communities.

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

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

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

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

Increasing Access to Medications for Opioid Use Disorder: Since 2019, IHS has required federal IHS facilities to create an action plan to identify or create local medication-assisted treatment resources and coordinate patient access to these services when indicated.[1] Key components of these approaches include enhanced screening and early identification of opioid use disorders; improved care coordination and patient referral for treatment; and workforce development strategies to increase education and resources surrounding using medications in the support of

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

recovery. In addition, the IHS created workforce development strategies[2] that include SUD training for healthcare workers and technical assistance materials to support sites with creating integrated SUD approaches to care. IHS has partnered with the Northwest Portland Area Indian Health Board and the Clinician Consultation Center to facilitate I/T/U clinician access to free Substance Use Disorder tele-consultation services. These services are intended to assist clinicians with patient treatment planning, facilitate didactic learning, and provide support for health systems that desire to create local protocols.

The IHS also supports enhanced team-based care approaches. In 2021, the IHS will continue the "Advancing Pharmacist Roles in Substance Use Disorder Treatment and Recovery Teams ECHO[3]." Participants increase knowledge surrounding patient screening, assessments, evidence-based practices for the management of Opioid Use Disorders, and trauma-informed care principles. Additionally, the IHS will expand an Academic Detailing Service pilot project to create tailored peer-to-peer interventions to support opioid stewardship activities, increase access to treatment services, and promote quality of care.

The IHS does face challenges in providing MAT in certain sectors within Indian Country. The rural and frontier nature of where AI/ANs live creates barriers to accessing health facilities. This is especially evident in Alaska where patients often have only access to a community health aide serving within a village-based clinic, and live hours away by plane from a larger health center. Additionally, IHS has felt the impact of a declining supply of specific health professionals who could support the IHS workforce and address behavioral health needs. The IHS recognizes that telemedicine is one tool for increasing access to specialized medical services, such as MAT. The IHS has published a policy in the Indian Health Manual (Chapter 38) entitled *Internet Eligible Controlled Substance Prescriber Designation* to assure access to MAT using telemedicine models for remotely located Tribal members.[4] In December 2019, the IHS processed the first tribal clinician application to receive this designation. Since 2020, the IHS has made a tele-MOUD toolkit available to assist sites with creating and supporting tele-MOUD services.

In FY 2025, the IHS Pain and Addiction Care in the Emergency Department (PACED) will funded IHS emergency departments. The objective of this intervention is to improve access to Medications for Opioid Use Disorder (MOUD) or improve pain management outcomes in acute care settings. Secondary objectives are to leverage the opioid surveillance dashboard to inform stewardship activities, to create a learning collaborative to share promising practices, and to assist sites with obtaining relevant accreditation. In FY 2023, the IHS emergency departments (EDs) received training from the American College of Emergency Physicians (ACEP) to identify and develop new systems of care and best practices to improve addiction and pain treatment outcomes in the ED by improving patient screening and increasing access to MOUD. The IHS has also collaborated to produce a cultural adaptation of best practices for Plans of Safe Care/Family Wellness Plans for pregnant persons who use substances. This cooperative project shares best practices for providers and sample patient resources to improve outcomes for pregnant persons and families.

IHS Opioid Grant Program: In FY 2021, IHS awarded a total of $16 million in grants to combat the opioid crisis[5]. IHS awarded thirty-five grants under the Community Opioid Intervention Pilot

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

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

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

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

Project (COIPP) for AI/ANs. In FY 2024, IHS will award a new cohort of grantees to develop innovative, locally-designed, culturally-appropriate prevention, treatment, recovery, and aftercare services for opioid use disorders. The projects will focus on increasing public awareness and education about the impact of MOUD on individuals, families and communities; and create comprehensive support teams to strengthen and empower families addressing the opioid crisis. Finally, all projects will prioritize efforts to reduce unmet needs and opioid overdose deaths through increased access to MAT.

IHS Substance Abuse and Suicide Prevention (SASP): The SASP is a nationally-coordinated $31.97 million program providing funds for culturally appropriate substance abuse and suicide prevention programming in AI/AN communities. In FY 2023 the IHS continued awards through two separate opportunities under SASP[6]. The first, Substance Abuse Prevention, Treatment, and Aftercare (SAPTA), awarded $15.698 million to 36 Tribal, Tribal organizations, and Urban Indian Organizations and eight federal IHS facilities. The second, Suicide Prevention, Intervention, and Postvention (SPIP), awarded $13.772 million to 36 Tribal, Tribal organizations, and Urban Indian Organizations. The program will fund 174 projects for a period of five years ending in FY 2027.

IHS established the Universal Alcohol Screening (UAS) as a national measure to increase screening and improve detection and intervention strategies among patients 9 through 75 years of age. In FY 2023, 34.2 percent of patients were screened and IHS screening efforts exceeded the national target rate of 32.2 percent. For FYs 2024 and 2025, the national target rates for UAS are set at 32.2 percent and 34.6 percent, respectively.

The Substance Abuse and Suicide Prevention (SASP) Program funding is organized by two grant programs, Substance Abuse Prevention, Treatment, and Aftercare (SAPTA) and Suicide Prevention, Intervention, and Postvention (SPIP). The first year of the FY 2022 SAPTA and SPIP programs demonstrated notable engagement with AI/AN persons in Indian Country. Among the 72 grant-funded partners, they completed 47,465 substance use screenings, including 8,372 specific to opioid use disorder. IHS encourages all grant-funded partners to report their substance use screening. Among the 113 total grant-funded partners across all programs, including violence prevention, they completed 71,108 substance use screenings, including 10,904 screenings for opioid use disorder. Among all partners, a total of 8,782 positive substance use screenings were referred for treatment, including 1,733 for opioid use disorder. A total of 905 cases were referred for medically-assisted treatment.

Preventing Alcohol-Related Deaths (PARD):
In the 2017 Senate Appropriations Committee Report 114-281, the Committee directed IHS to "allocate $2,000,000 of the increase provided for the alcohol and substance abuse program to fund essential detoxification and related services." Specifically, the report detailed the number of alcohol related deaths in the community of Gallup, New Mexico stating, "these deaths underscore the urgent need for substance abuse treatment, residential services and detoxification services" in this community. As a result, in FY 2023, funds were made available through a cooperative agreement to the City of Gallup, New Mexico[7] to an alcohol detoxification center to address the high rates of alcohol related deaths within McKinley County, New Mexico, and surrounding counties, which yield 48 percent of all alcohol-related death for AI/AN in the nation. The project period for this cooperative agreement is from FY 2023 – FY 2028.

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

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

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

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

Youth Regional Treatment Centers (YRTC): The YRTCs provide residential substance use disorder and mental health treatment services to AI/AN youth. The IHS received funding for 12 YRTCs located throughout the country with six federally-operated centers and six tribally-operated centers. The YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values, and cultural identification. The IHS opened a new YRTC, Sacred Oaks Healing Center, in the October 2022.

YRTC Aftercare Project: YRTCs have an important role in maintaining the health of patients after discharge. In FY 2017-2022, IHS supported a YRTC Aftercare Pilot Project to develop culture-based treatment that prevents alcohol and substance abuse relapse among youth discharged. In FY 2023, IHS released an evaluation that examined the capacities and challenges in improving coordination of aftercare and case management, increasing training of community supports for the adolescents, improving identification of transitional living, increasing awareness of the use of treatment engagement through social media, and improving follow-up with data collection after discharge. In FY 2023, the IHS awarded[8] the Cherokee Nation's Jack Brown Center, a Tribal-operated YRTC, to operate and refine an aftercare program, based on an amount of $600,000 per year for five years which started November 14, 2022.

The U.S. Department of the Interior through the Bureau of Indian Affairs (BIA) and the Bureau of Indian Education (BIE), and with the IHS, have a Memorandum of Agreement (MOA)[9] 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 and BIE), DOJ (Office of Justice Programs and 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 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.

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

[9] Federal Register :: Memorandum of Agreement Between the Indian Health Service and the Department of Interior; Bureau of Indian Affairs and Bureau of Indian Education

Enhancing Evidence-Based Harm Reduction Efforts:

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

Additionally, the IHS has expanded the number of regional harm reduction mentors to assist sites with harm reduction implementation and expansion. Since 2015, the IHS has maintained an ongoing collaboration with the Bureau of Indian Affairs (BIA) to train and provide naloxone to BIA Law Enforcement Officers (LEO) for responding to opioid overdoses. These initial efforts have evolved into a robust harm reduction strategy that includes a combination of policy and workforce development efforts. In March 2018, the IHS implemented a policy in the Indian Health Manual (Chapter 35) entitled *Prescribing and Dispensing of Naloxone to First Responders*[11] to require IHS federal pharmacies to provide naloxone to Tribal law enforcement agencies and other trained first responders. In 2023, the IHS updated agency policy to expand to first-responder definitions to include community members and employees who are designated to immediately respond in an emergency in a variety of work settings such as schools, businesses, or other places where people gather. In addition, Naloxone tool kits were developed and released for community members and schools.

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

In December 2023, the IHS announced the Naloxone Safety Net Program which supports expanded harm reduction activities and works to promote low-barrier access to naloxone. The two-year pilot program ($500,000 annually) will support I/T/Us struggling to meet naloxone needs due to increased utilization and are meant to augment existing program naloxone forecasting.

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

IHS continues to support the integration of substance use disorder treatment into primary care and emergency services through its activities to implement the ONDCP *Strategy*. Integrating treatment services into outpatient primary care offers opportunities for healthcare providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, and refer patients with more severe substance use-related problems to treatment.[12] One integration activity is the Screening, Brief Intervention, and

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

[11] https://www.ihs.gov/ihm/pc/part-3/chapter-35-dispensing-of-naloxone-to-first-responders/

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

Referral to Treatment (SBIRT) method, which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders.

IHS has increased efforts to implement the SBIRT across IHS facilities as an evidence-based practice to identify patients with alcohol related problems. The SBIRT is a Government Performance and Results Act (GPRA) measure that IHS reports annually. In FY 2023, the SBIRT was administered at 15.0 percent of patient visits for those ages 9-75, establishing the Agency target for FY 2024. IHS promotes the use of this clinical process by training providers in clinical and community settings and as an additional resource released an SBIRT training https://www.ihs.gov/asap/providers/sbirt/. In FY 2025, IHS is actively working to expand SBIRT resources and will include a focus on substance use in women of childbearing age, to assist in early identification and referral for treatment and reduce illicit perinatal substance exposure for infants.

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

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

In FY 2022, IHS awarded 14 new BH2I grantees[13], totaling $5.5 million, which will be on a five-year funding cycle through FY 2026. Additionally, IHS awarded a technical assistance contract which will assist grantees in the implementation of integrated care efforts.

In FY 2025, IHS will continue support for seven federal facilities that currently participate in the Improving Pain and Addiction Care in IHS Emergency Departments (PACED) pilot project to develop model clinical care pathways following patient overdose resuscitation within EDs. Reflective of the Agency's priority to raise the mental health of the AI/AN population IHS Division of Behavioral Health initiatives have focused on increased implementation of depression screening in primary care clinics. In FY 2023, IHS reported 37.4 percent of AI/AN adults over the age of 18 screened for depression using a standardized screening assessment for depression. In FY 2023, this same measure was reported for youth ages 12-17 and data indicated 34.1 percent of eligible youth were screened for depression. The FY 2023 depression screening targets were met for the AI/AN population and anticipate an average 2.9 percent increase for both age cohorts in FY 2025.

While screenings remain critical to ensure that appropriate health services are available to AI/AN population, IHS acknowledges the importance of understanding a patient's life experiences in

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

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

Proper Pain Management, Opioid Stewardship and Training: In FY 2023, the IHS created and released a comprehensive Opioid Stewardship Campaign[14] to support sites with creating best practices surrounding safe opioid prescribing and increasing access to integrative pain treatments. The campaign includes evidence-based documents, an automated workbook that emphasizes utilizing opioid surveillance strategies to evaluate population health outcomes, target opioid interventions, enhance clinical decision support, and create professional practice evaluation strategies. The IHS opioid stewardship program evaluation considers metrics related to opioid prescribing, harm reduction, and treatment access, metrics now made available for review at the local, regional and national level in the IHS Opioid Prescribing dashboard. The implementation of the dashboard will support Opioid Stewardship efforts through development of dashboard super-users within each IHS region that will apply population health/opioid stewardship principles and clinical decision support tools, and facilitate end-user training.

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

In FY 2023, 301 clinicians completed the Essential Training on Pain and Addiction and the Refresher Training on Pain and Addiction course[15]. An updated IHS Essential Training on Pain and Addiction was released in September 2023. This training is an on-demand, three-hour training with continuing education to align with evidence-based guidelines for pain management and OUD. IHS also reports approximately 600 attendees for the FY 2023 IHS Pain and Opioid Use Disorder Webinar Series.

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

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

[15] Ibid

Increase Mandatory Prescriber Education and Continuing Training on Best Practices and Current Clinical Guidelines: The IHS implemented the "Chronic Non-Cancer Pain Management Policy[16]" to promote appropriate pain management as a primary prevention tool. In February 2018, IHS released a revised policy[17] to include clinical practice guidelines contained in the 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain*. This revised policy adopts CDC guidance and specifically requires IHS sites to establish and implement local chronic non-cancer pain protocols and procedures; requires prescribers to complete training on appropriate and effective use of controlled substance medications; and establishes the requirement to initiate opioid treatment as a shared decision between the prescriber and the patient to respect and support the patient's right to optimal pain assessment and management.

Substance Use Disorder and Chronic Pain Case Resources and Consultation Services: To provide ongoing clinical support for providers, IHS, in partnership with the University of New Mexico Pain Center, provided a Substance Use Disorder and Chronic Pain ECHO[18]. ECHO is a case-based learning model in which consultation is offered through virtual clinics to healthcare providers by an expert team to share knowledge and elevate the level of specialty care available to patients.

The IHS released its "*Recommendations for Management of Acute Dental Pain*[19]" for prescribing opioids for acute pain secondary to common general dentistry conditions and procedures. These guidelines limit opioid prescribing for patients who cannot safely use alternative pain medication. The guidelines also include a decision tree for pre- and post-operative pain management, as well as recommended dosage limits for analgesics based on the degree of anticipated operative pain. The IHS collaborated to create content for a five-part CEU webinar series to influence dental prescribing practices and enhance screening for substance use disorders in general dentistry.

In March 2019, the IHS released the *Recommendations to the Indian Health Service on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder*[20] developed in collaboration with the American College of Obstetricians and Gynecologists' (ACOG) Committee on American Indian and Alaska Native Women's Health.[21] This resource will help providers improve maternal participation in early prenatal care, improve screening for substance use disorder, and increase access to MAT for pregnant women and women of child-bearing age. The goal of these clinical recommendations is to foster relationships and improve awareness surrounding trauma-informed approaches to maternal opioid use that may lead to recovery, hope, and healing. Additionally, the IHS and the American Academy of Pediatrics Committee on Native American Child Health (CONACH) recently released the *Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome*[22] that includes clinical recommendations on the prevention and management of neonatal opioid withdrawal syndrome.[23] These recommendations provide standards of care for screening, diagnosing, support, and treatment of pregnant mothers and infants affected by prenatal opioid exposure.

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

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

[18] 2022 Hope Newsletters | HOPE Committee (ihs.gov)

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

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

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

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

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

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Enhanced communication during the opioid crisis response is vital to program development, policy implementation, and ongoing evaluation. The IHS created an Opioid Information Sheet[26] that serves as a public-facing logic model to share opioid-related measure, agency goals, and available resources for both clinicians and tribal stakeholders. The IHS opioid strategy and a host of available resources is housed on two IHS webpages that support a unified user experience in addition to publication of a quarterly opioid newsletter.

Increase Prescription Drug Monitoring Program (PDMP) Interoperability and Usage: The IHS has also implemented IHM Chapter 32 "State Prescription Drug Monitoring Programs[27]" that establishes policy requirement for Federal facilities to participate with state-based Prescription

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

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

[26] Opioids | Indian Health Service (IHS)

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

Drug Monitoring Programs (PDMP). Controlled substance prescribers working in IHS federal-government-operated facilities must query state PDMP databases prior to prescribing opioids for pain treatment longer than seven days and periodically throughout chronic pain treatment. In FY 2019, IHS developed and released software programming to automate controlled substance dispensing reports to state-based PDMPs to near real-time reporting to improve the fidelity of IHS dispensing data in state PDMP databases. The IHS is in active software development and design for PDMP interoperability and integration into the IHS Electronic Health Record.

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

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

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
FY 2025 Request: $3.4 million

The 41 UIOs are an integral part of the Indian health care system and serve as resources to both tribal and urban communities. Urban Indians are often invisible in the urban setting and face unique challenges when accessing healthcare. A large proportion of Urban Indians live in or near poverty and face multiple barriers such as the lack of quality and culturally relevant health care services in cities. The UIOs are an important support to Urban Indians seeking to maintain their tribal values and cultures and serve as a safety net for our urban patients. The UIOs that offer inpatient and outpatient substance use disorder treatment have become reliable referral sites for Tribes and Urban Indians. In FY 2025, the IHS is proposing $3.4 million for the urban ONDCP budget.

Urban Indian people who live in urban centers present a unique morbidity and mortality profile. Urban Indian populations suffer disproportionately higher mortality from certain causes in sharp contrast to mainstream society. These unique challenges require a targeted response. Existing UIOs see their efforts in health education, health promotion, and disease prevention as essential to impacting the behavioral contributors to poor health[28]:

- Alcohol-induced death rates are 2.8 times greater for Urban Indian people than urban all races.
- Chronic liver disease death rates are 2.1 times greater for Urban Indian people than urban all races.

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

- Accidents and external causes of death rates are 1.4 times greater for Urban Indian people than urban all races.

Alcohol and drug-related deaths continue to plague Urban Indian people. Alcohol-induced mortality rates for Urban Indian people are markedly higher than for urban all races. All regions, with the exception of eastern seaboard cities in the Nashville Area, show dramatically higher rates for Urban Indian people than for all races 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.[29]

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

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

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

[29] Ibid.

According to the most recent Urban Indian data[30], 70,388 Urban Indian patients access services through UIO programs. Also, UIOs performed 696,229 visits for Urban Indian patients including medical, dental, behavioral health, other professional and enabling services directly or by paid referral. Data also indicates that members from 529 of the 574 (92 percent) Federally recognized Tribes accessed services from at least one of the 41 UIOs.

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

EQUITY

Alcohol and Substance Abuse

IHS actively engages in promoting equity by providing healthcare services to the underserved, vulnerable, and marginalized American Indian and Alaska Native (AI/AN) population. The IHS Alcohol and Substance Abuse Branch expands and supports efforts to increase availability, access, and implementation of evidence-based, culturally-informed treatment and recovery services for substance use disorders (SUDs), particularly in rural, urban, and underserved tribal communities. In May of 2020, IHS released a trauma-informed care (TIC) policy and by December of 2023, 96 percent of IHS staff completed the "Overview of Trauma Informed Care and Historical Trauma Guidance" training. In addition, the TIC policy requires all facilities to examine the health care environment and current policies and protocols to create and sustain a culture of physical, psychological, and emotional safety for all individuals and staff that have experienced trauma. In FY 2025 IHS will conduct an agency-wide readiness assessment in the implementation of TIC practices. In addition, many of the IHS Division of Behavioral Health SUD programs and initiatives include "Increasing Access to Care and Treatment" and "Increasing Access to Medication-assisted Treatment/Medications for Opioid Use Disorder." Between FY 2022-2023, five Indian Health Service facilities achieved accreditation through the American College of Emergency Physicians in the Pain and Addiction Care in the Emergency Department (PACED) pilot project to improve access to Medications for Opioid Use Disorder (MOUD) or improve pain management outcomes in acute care settings. In FY2023, the IHS awarded the Preventing Alcohol Related Death through Social Detoxification to the City of Gallup to provide detoxification and shelter services in the McKinley County, New Mexico, that continues to report high alcohol-related mortality among the AI/AN population. Understanding the urgent need to the prioritize specific populations such as children and youth and their families as appropriate in SUD prevention, treatment, and recovery efforts, IHS requires each of the Substance Abuse and Suicide Prevention (SASP) grantees to develop culturally-appropriate approaches to engage youth in prevention and treatment activities. To increase access to care for our rural and remote populations, IHS also recognizes that telemedicine is one tool for increasing access to specialized medical services, such as telebehavioral health. To that end, IHS anticipates similar demand in telebehavioral health encounters nationally among AI/AN between FY 2023 and FY 2025.

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

Finally, as a resource to AI/AN healthcare providers, IHS hosted Clinician Extension for Community Healthcare Outcomes (ECHO) sessions to provide timely, up-to-date information related to emerging SUD treatment and services among rural and remote AI/AN communities.

Urban Indian Health Program

The IHS provides funding to UIOs, which contributes to advancing health equity by providing access to high-quality, culturally appropriate health care and addressing key social determinants of health. The UIOs identify gaps between the unmet health needs of Urban Indians and the resources available to meet those needs at the local level. This investment in the health of Urban Indians is as important as ever due to the fact that the majority of AI/AN people reside in urban areas. Despite this concentrated investment, there remains a significant level of unmet needs. The UIOs provide access to a variety of basic health and social services for Urban Indian populations and are an important and necessary part of the system of health care for AI/AN people in the United States. At the community level, each health center adapts to meet its community's shifting needs, with a special focus on physical, mental, and spiritual wellness. The UIOs engage in outreach efforts to build awareness, increase knowledge, and encourage active engagement in UIO services. The integration of cultural practices into service delivery is a priority for all UIOs, which improves health care, primary care, and social-support services. Although there are still unmet needs for this population, UIOs are able to respond with innovation and agility to meet their local community's needs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

TABLE OF CONTENTS

Supplemental Tables

Object Classification

Indian Health Service

(Dollars in Thousands)

	FY 23 Actual	FY 24 CR	FY 25 CJ	FY 2025 +/- FY 2023
[Object Class]				
Personnel compensation:				
Full-time permanent (11.1)	$419,575	$557,107	$644,914	$225,339
Other than full-time permanent (11.3)	$16,700	$26,392	$28,341	$11,641
Other personnel compensation (11.5)	$66,126	$76,858	$84,906	$18,780
Military personnel (11.7)	$69,353	$91,232	$98,086	$28,733
Special personnel services payments (11.8)	$248	$286	$286	$38
Subtotal personnel compensation	**$572,002**	**$751,874**	**$856,533**	**$284,531**
Civilian benefits (12.1)	$198,562	$257,800	$289,755	$91,193
Military benefits (12.2)	$9,804	$12,454	$14,600	$4,796
Benefits to former personnel (13.0)	$14	$16	$16	$2
Subtotal Pay Costs,	**$780,382**	**$1,022,144**	**$1,160,903**	**$380,521**
Travel and transportation of persons (21.0)	$26,759	$36,438	$40,556	$13,797
Transportation of things (22.0)	$6,271	$7,205	$7,316	$1,045
Rental payments to GSA (23.1)	$9,697	$10,895	$13,654	$3,957
Rental payments to others (23.2)	$31,201	$12,959	$39,948	$8,747
Communication, utilities, and misc. charges (23.3)	$8,347	$10,097	$12,258	$3,911
Printing and reproduction (24.0)	$169	$197	$198	$29
Other Contractual Services:				
Advisory and assistance services (25.1)	$1,901	$98,402	$103,810	$101,909
Other services (25.2)	$136,712	$344,179	$516,253	$379,541
Purchase of goods and services from government accounts (25.3)	$79,407	$197,590	$204,588	$125,181
Operation and maintenance of facilities (25.4)	$2,650	$4,074	$4,465	$1,815
Research and Development Contracts (25.5)	$0	$0	$0	$0
Medical care (25.6)	$218,435	$257,318	$341,485	$123,050
Operation and maintenance of equipment (25.7)	-$12,256	-$13,262	$29,203	$41,459
Subsistence and support of persons (25.8)	$53,722	$159,385	$160,398	$106,676
AP Branch Services (25.9)	$31,506	$0	$2,755	-$28,751
Subtotal Other Contractual Services	**$594,521**	**$1,125,477**	**$1,476,889**	**$882,368**
Supplies and materials (26.0)	$41,032	$48,548	$70,356	$29,324
Equipment (31.0)	$13,712	$16,359	$49,094	$35,382
Land and Structures (32.0)	$3,974	$43,191	$43,214	$39,240
Investments and Loans (33.0	$0	$0	$0	$0
Grants, subsidies, and contributions (41.0)	$4,198,821	$4,701,116	$5,161,082	$962,261
Insurance payments (42.0)	$678	$757	$759	$81
Interest and dividends (43.0)	$393	$62	$63	-$330
Refunds (44.0)	-$23	$0	$0	$23
Unvouchered (91.0)	$509	$568	$573	$64
Subtotal Non-Pay Costs	**$4,853,617**	**$5,936,079**	**$6,802,030**	**$1,948,413**
Total Direct Obligations	**$5,633,999**	**$6,958,223**	**$7,962,933**	**$2,328,934**

Salary and Expenses INDIAN HEALTH SERVICE (Budget Authority in Thousands)			
Object Class	FY 2023 Final Level	FY 2024 CR Level	FY 2025 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$419,575	$557,107	$644,914
Other than full-time permanent (11.3)	$16,700	$26,392	$28,341
Other personnel compensation (11.5)	$66,126	$76,858	$84,906
Military personnel (11.7)	$69,353	$91,232	$98,086
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Benefits to former personnel (13.0)	$14	$16	$16
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Travel (21.0)	$26,759	$36,438	$40,556
Transportation of things (22.0)	$6,271	$7,205	$7,316
Communication, utilities, and misc. charges (23.3)	$8,347	$10,097	$12,258
Printing and reproduction (24.0)	$169	$197	$198
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Advisory and assistance services (25.1)	$1,901	$98,402	$103,810
Other services (25.2)	$136,712	$344,179	$516,253
Purchase of goods and services from government accounts (25.3)	$79,407	$197,590	$204,588
Operation and maintenance of facilities (25.4)	$2,650	$4,074	$4,465
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Medical care (25.6)	$218,435	$257,318	$341,485
Operation and maintenance of equipment (25.7)	-$12,256	-$13,262	$29,203
Subsistence and support of persons (25.8)	$53,722	$159,385	$160,398
Subtotal Other Contractual Services	$480,571	$1,047,687	$1,360,203
Supplies and materials (26.0)	$41,032	$48,548	$70,356
Subtotal Non-Pay Costs	$563,149	$1,150,172	$1,490,888
Total Salary and Expenses			
Rental Payments to GSA(23.1)	$9,697	$10,895	$13,654
Rental Payments to Others(23.2)	$31,201	$12,959	$39,948
Grant Total, Salaries & Expenses and Rent	$1,384,429	$2,196,169	$2,705,393
Direct FTE 1/	8,467	8,818	8,818

1/ Reflects staff paid for only within Indian Health Services and Indian Health Facilities Accounts.

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

	FY 2023 Final	FY 2024 Estimate	FY 2025 Estimate
Headquarters			
Sub-Total, Headquarters	864	864	864
Area Offices			
Alaska Area Office	215	215	215
Albuquerque Area Office	878	878	878
Bemidji Area Office	611	611	611
Billings Area Office	983	983	983
California Area Office	179	179	179
Great Plains Area Office	1,866	1,881	1,881
Nashville Area Office	196	196	196
Navajo Area Office	4,194	4,417	4,417
Oklahoma City Area Office	1,877	1,877	1,877
Phoenix Area Office	2,563	2,678	2,678
Portland Area Office	502	502	502
Tucson Area Office	158	158	158
Sub-Total, Area Offices	14,222	14,575	14,575
TOTAL FTES[1]	15,086	15,439	15,439

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

INDIAN HEALTH SERVICE

DETAIL OF POSITIONS[1]

(Dollars in Thousands)

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Total - ES	27	27	27
Total - ES Salaries	$5,478	$5,752	$6,039
GS/GM-15	462	468	468
GS/GM-14	418	423	423
GS/GM-13	650	681	681
GS-12	1,402	1418	1418
GS-11	1,453	1483	1483
GS-10	569	577	577
GS-9	990	992	992
GS-8	486	489	489
GS-7	1,286	1306	1306
GS-6	1,601	1604	1604
GS-5	1,601	1562	1562
GS-4	724	695	695
GS-3	107	110	110
GS-2	22	21	21
GS-1	0	0	0
Subtotal	11,771	11,829	11,829
Total - GS Salaries	$625,937	$821,164	$937,689
CO-08	4	4	4
CO-07	3	3	3
CO-06	223	207	207
CO-05	412	394	394
CO-04	467	464	464
CO-03	207	203	203
CO-02	19	20	20
CO-01	17	15	15
Subtotal	1,352	1,310	1,310
Total - CO Salaries	$79,157	$103,686	$112,686
Wage Grade	1,234	1,222	1,222
Other	702	595	650
Subtotal	1,936	1,817	1,872
Total - Ungraded Salaries	$69,549	$91,240	$104,188
Average ES level	ES	ES	ES
Average ES salary	$203	$213	$224
Average GS grade	12	12	12
Average GS salary	$122	$124	$127

[1] FTE totals might not match MAX.

In December 2021, President Biden signed Executive Order 14058 on Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government. This EO directed a whole-of-government approach to managing customer experience. In the two years since the Executive Order was signed, agencies worked towards making meaningful progress on improving government efficiency by ensuring the public is able to do basic tasks with the government in a manner that is simple, seamless, and secure. In FY 2024, as part of an HHS-wide Agency Priority Goal IHS will join all other HHS operating divisions in pursuing substantial projects to improve customer experience and begin work as a designated High Impact Service Provider.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

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Operating Division-Specific Requirements

January 25, 2024

FY 2025 Annual Facilities Planning (Five-Year Plan) a/

(Dollars in Thousands)

FACILITY	Prior to FY 24*	FY 24 PB	FY 25 Est.	FY 26 Est.	FY 27 Est.	FY 28 Est.	Out years Est.	Total Cost **
Planning Studies	-	1,000		500			500	
Inpatient Facilities b/ c/ d								
PIMC, AZ, Health Care System								
Central - Hospital & ACC 1/ 8/	84,728			150,000	300,000	500,000	2,171,000	3,205,728
Whiteriver, AZ, Hospital 2/	135,000	200,000	115,315	200,000	300,000	154,000	0	1,104,315
Gallup, NM Hospital 3/ 8/	66,000				300,000	300,000	500,000	1,166,000
Outpatient Facilities b/ c/ d/								
Alamo, NM	132,396		28,604					161,000
Pueblo Pintado, NM	207,400	24,000						231,400
Bodaway Gap, AZ 4/	181,200		76,000					257,200
Albuquerque Health Care System								
Albuquerque West, NM 5/	164,143			88,000				252,143
Albuquerque Central, NM 6/	20,734				151,000	190,000		361,734
Sells, AZ 7/	150,008			193,000	193,000	137,000		673,008
Total Legacy Projects		225,000	219,919	631,500	1,244,000	1,281,000	2,671,500	7,412,528
Small Ambulatory Program (Section 306)								
Small Health Clinics		25,000	25,000	25,000	25,000	25,000		
Staff Quarters Program 25 U.S.C. 13, Snyder Act e/								
Staff Quarters		5,899	11,000	20,000	20,000	20,000		
Green Infrastructure (CWA)								
Sustainability Projects		5,000	5,000	5,000	5,000	5,000		
Joint Venture Construction Program (Section 818e)								
Equipment funding								
FY TOTALs		260,899	260,919	681,500	1,294,000	1,331,000	2,671,500	
Priority Project Total cost								7,412,528
UNFUNDED (FY 2024-Outyears) Priority Projects only								6,046,919

NOTES:

All funds appropriated prior to FY 2023 are consolidated including NEF for Albuquerque West & Sells projects.

Cost based on mid-point of construction. FY 23 and earlier are know values, FY 24 is the President's Budget, FY 25 and later are estimated values.

This project list includes projects from the IHS Construction Priority List of 1992.

Subject to the availability of funds and does not include M&I, or staffing.

An initiative to fund new and replacement energy efficient staff quarters in isolated and remote locations.

The total cost includes inpatient, outpatient, and a hostel. The budget will be updated when planning is complete.

Total cost estimate includes 200 new staff quarters.

The need for staff quarters is being evaluated. This estimate includes 100 staffing quarters units. The cost includes the cost of land.

Total estimate includes 92 staff quarters.

The Albuquerque West Project was supplemented with $13.9 million of NEF. The budget will be updated when planning is complete.

The budget will be updated when planning is complete.

The Sells Project was supplemented with $30 million of NEF. The Cost includes 108 staff quarters. The budget will be updated when planning is complete.

Land purchase is required for this Project

Indian Health Service
Sanitation Facilities Construction
FY 2023 Spend Plan

Activity	FY 2023 BIL	FY 2023 Enacted	Total
Tier 1 Projects Construction Costs /1	583.7	45.8	629.5
Tier 1 Design & Construction Documents	28.9	2.0	30.9
Tier 2 Planning, Design, & Construction Documents	--	16.3	16.3
Project Shortfalls, Add'l Planning, Design, & Construction Documents	65.5	6.9	72.4
New and Like-New Housing	--	85.0	85.0
Congressionally Directed Spending	--	15.2	15.2
Special and Emergency Projects	--	4.0	4.0
subtotal, Regular Projects	*678.1*	*175.2*	*853.3*
Salaries, Expenses, and Administration (3%) /2, 3	21.0	21.0	42.0
HHS Office of the Inspector General (0.5%) /4	3.5	--	3.5
Total	**702.6**	**196.2**	**898.8**

1/ Includes $2,599,832 FY 2022 BIL Undispersed Funds.
2/$21 million in BIL funding is limited to federal activities only.
3/ $21 million in FY 2023 Enacted (P.L. 117-383) funding is pending 30-day Congressional reprogramming notification period. Funding will be reprogrammed from the Sanitation Facilities Construction PPA to the Facilities & Environmental Health Support PPA to support federally- and tribally-operated programs.
4/ BIL directed transfer.

Overview

The Infrastructure Investment and Jobs Act or Bipartisan Infrastructure Legislation (BIL) appropriates $700 million in each year from FY 2022 – FY 2026, for a total of $3.5 billion for the IHS Sanitation Facilities Construction (SFC) program. These resources are available until expended.

The statute provides up to three percent ($21 million) of these funds for "salaries, expenses, and administration" each year. It also requires that one-half of one percent of these funds be transferred to the Department of Health and Human Services (HHS) Office of Inspector General "for oversight of funding provided in the BIL" ($3.5 million). The statute also directs the IHS to use up to $2.2 billion for "projects that exceed the economical unit cost," also referred to as "economically infeasible" projects.

Economically infeasible projects are those that exceed a per unit cost set for each IHS Area, and three different regions within the Alaska Area IHS. While there was not a statutory barrier to funding economically infeasible projects before the BIL was enacted, the IHS had not been able to fund these projects due to limited annual appropriations.

On December 29, 2022, the Consolidated Appropriations Act, 2023 (FY 2023 Enacted), appropriated $196.2 million for the Sanitation Facilities Construction (SFC) program. The FY 2023 Enacted includes $15.2 million in Congressionally Directed Spending for four projects, which are located in Alaska, New Mexico, and Washington. The FY 2023 Enacted appropriation also includes $1.4 million for medical inflation. These funds are available until expended.

The IHS tracks projects to address sanitation needs through the Sanitation Deficiency System (SDS). As of December 31, 2022, there are 1,369 projects, totaling $4.4 billion in eligible costs, and $1.1 billion in ineligible costs. Of the 1,369 total projects, 751 are considered economically feasible, and 618 are considered economically infeasible. The IHS completed its last annual update of the SDS on December 31, 2022, which is the most up to date complete data set on projects and costs. A breakout of projects and costs by Area can be found in Appendix A.

The total 1,369 projects in the SDS as of December 31, 2022, includes 901 projects that were in the SDS at the end of 2021, and 468 projects that were added in 2022. The 486 projects that were added in 2022 total approximately $886 million in eligible costs.

Ineligible costs are the costs associated with serving commercial, industrial, or agricultural establishments, including nursing homes, health clinics, schools, hospitals, hospital quarters, and non-American Indian/Alaska Native (AI/AN) homes. The Sanitation Facilities Act and the Indian Health Care Improvement Act (IHCIA) prevent the IHS from using its appropriations for these costs. However, the IHS regularly partners with Tribes and other Federal agencies to identify alternative resources to successfully support these ineligible costs.

Tribal Consultation

The IHS conducted virtual Tribal Consultations on the BIL on April 12, 2023, and accepted written comments through April 28, 2023. The common themes from Tribal Consultation noted that the IHS should:

- Retain some funding at IHS Headquarters to cover project costs above budgeted amounts for design, construction documents, and construction;

- Prioritize funding projects with BIL using the SDS list (Legacy) reported at the time the BIL passed Congress (e.g., end-of-year December 2021);

- Utilize FY 2023 Enacted funding to address projects added to SDS after December 2021;

- Prioritize funding of Tier 1 (ready to fund) projects while also providing funds to complete needed design and construction document preparation to accelerate the construction completion times; and

- Provide funds to support planning, design, and construction document preparation for Tier 2 (engineering assessed) and Tier 3 (preliminary assessed) to transition the projects to Tier 1 (ready-to-fund).

The FY 2023 BIL spend plan is based on these recommendations from Tribal Leaders.

SDS Project Funding

The IHS will allocate FY 2023 resources from the BIL and the FY 2023 Enacted appropriation for SDS projects as follows.

Design, Construction Contract Document Creation, and Construction Costs for Tier 1 Projects

The FY 2023 SFC spend plan fully funds construction costs for 197 Tier 1 projects tracked in the SDS. These Tier 1 projects total $660.3 million, and the IHS will use $612.5 million in FY 2023 BIL funding and $47.8 million in FY 2023 Enacted appropriations for these costs. In addition, $15.2 million in Congressionally Directed Spending funded three Tier 1 projects, and one Tier 3 project.

A table displaying the allocation of Tier 1 projects and funding amounts by Area can be found in Appendix B.

A Tier 1 project is considered ready to fund because planning is complete. However, design and construction contract document creation activities are not yet complete for current Tier 1 projects. These steps must be finalized before a construction contract can be initiated through Federal or Tribal procurement methods. The IHS also allocates $30.9 million to support contracts with Architecture

& Engineering Firms to complete these activities for Tier 1 projects. Of this amount, $28.9 million is FY 2023 BIL funding and $2.0 million is from FY 2023 Enacted.

These Tier 1 projects span Deficiency Levels 2 – 5. Deficiency Levels are assigned in accordance with the IHCIA for each sanitation facilities project that has been identified as a need to support Indian Tribes and communities. The Deficiency Levels are explained in the table below.

Sanitation Deficiency Level		**Sanitation Deficiency Levels [25 U.S.C. § 1632(g)(4)]**
		Description
V	5	An Indian tribe or community that lacks a safe water supply and a sewage disposal system.
IV	4	An Indian tribe or community with a sanitation system which lacks either a safe water supply system or a sewage disposal system.
III	3	An Indian tribe or community with a sanitation system which has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or has no solid waste disposal facility.
II	2	An Indian tribe or community with a sanitation system which complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to capital improvements that are necessary to improve the facilities in order to meet the needs of such tribe or community for domestic sanitation facilities.
I	1	An Indian tribe or community with a sanitation system which complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to routine replacement, repair, or maintenance needs.
0	0	No deficiencies to correct.

There are $105.1 million in ineligible costs associated with these projects. The IHS works closely with other Federal agencies, Tribes, and other project participants to identify funding for the portions of projects that serve non-AI/AN homes, businesses and public

institutions. For example, the IHS partners with the Environmental Protection Agency (EPA), USDA Rural Development, the US Department of Housing and Urban Development, the Department of Interior's Bureau of Reclamation, the National Tribal Water Center, the Rural Water Association, the Rural Community Assistance Partnership, the Denali Commission, the State of Alaska, and Tribal Consortia to secure resources for ineligible costs. The IHS also participates in the EPA-led Infrastructure Task Force, along with other Federal partners, which serves as a forum to discuss funding for ineligible costs associated with SFC projects. The IHS will continue to work with its Tribal and Federal partners to identify resources to fund these ineligible costs.

Within the $612.5 million allocated for Tier 1 projects, $496.6 million will support economically infeasible projects.

Planning, Design, and Construction Contract Document Creation for Tier 2 Projects

The FY 2023 SFC spend plan allocates approximately $16.3 million in FY 2023 Enacted appropriations for the planning, design, and construction contract document creation for 33 Tier 2 Projects.

Tier 2 projects are projects that have a level of engineering assessment completed, such that the deficiency is understood and a recommended solution has been analyzed and scoped. These projects have a cost estimate and design parameters that are accurate within plus or minus 25 percent.

A breakout of FY 2023 Tier 2 project counts by Area and associated costs to be funded with FY 2023 Enacted appropriations can be found in Appendix C.

Project Shortfalls, Additional Planning, Design, and Construction Contract Document Creation

The FY 2023 SFC spend plan allocates $72.4 million in FY 2023 BIL and Enacted appropriations to address potential project shortfalls, and to support additional planning, design, and construction document creation activities. Project shortfall funding is needed to support previously funded SFC projects that exceed the original project budget due to increasing construction costs driven by inflation and supply chain constraints.

New and Like-New Housing

The FY 2023 SFC spend plan allocates $85 million in FY 2023 Enacted appropriations for sanitation projects for new- and like-new housing, such as Indian homes being constructed or rehabilitated by the Bureau of Indian Affairs Home Improvement Program,

Tribes, individual homeowners, or other nonprofit organizations. This funding level is consistent with the FY 2023 President's Budget and the current estimate for these projects.

Special and Emergency Projects

The FY 2023 spend plan allocates $4 million in FY 2023 enacted appropriations for special and emergency projects. Special project funds are used to pay for research studies, training, or other needs related to SFC, but which are not prioritized for construction funds. Emergency project funds are provided to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize or eliminate real and potential threats to public health.

Salaries, Expenses, and Administration

The FY 2023 SFC spend plan allocates $42 million for program support activities like salaries, expenses and administration. This amount includes $21 million in FY 2023 BIL funding, and $21 million from FY 2023 Enacted appropriation, pending a 30-day Congressional reprogramming notification period.

FY 2023 BIL funds that are available for SFC project support activities can support the same activities that are typically funded through the Facilities and Environmental Health Support annual appropriation. However, these funds are limited to Federal activities only, due to the following subsequent provision in the BIL:

> *Provided further*, that no funds available to the Indian Health Service for salaries, expenses, administration, and oversight shall be available for contracts, grants, compacts, or cooperative agreements under the provisions of the Indian Self- Determination and Education Assistance Act as amended:

The FY 2023 SFC spend plan allocates $21 million in FY 2023 Enacted appropriation to bolster program support activities overall, and to ensure that resources are available for the program support needs of Tribes that choose to manage their SFC projects directly pending completion of a 30-day reprogramming notification to Congress.

The IHS expects to use approximately 90 percent of the $21 million in FY 2023 BIL funding on additional FTE to support the implementation of SFC projects, and approximately 10 percent on systems improvements, stakeholder engagement, recruitment activities, and other related needs.

The IHS will use these funds to hire the additional engineers, field technicians, inspectors, Geographic Information System analysts, and other critical roles that are necessary to support the planning, design, and construction of SFC projects.

The IHS will also use these funds to hire additional contract specialists, human resources specialists, and other necessary support roles to successfully recruit for the above-mentioned positions, and to manage the significant influx of construction contracting needs resulting from the BIL.

The IHS will continue to use multiple strategies and available authorities to support BIL recruitment and hiring. This includes the use of global job announcements to streamline the hiring of multiple candidates for jobs across the IHS system, establishing efficiencies with a Headquarters Agency team to facilitate hiring on behalf of the IHS Areas as appropriate, developing a dedicated website, marketing materials, and increased outreach by targeting engineering job fairs. This will include leveraging partnerships with the American Indian Science and Engineering Society (AISES) to increase awareness of engineering employment opportunities within the IHS. The IHS will strategically utilize the authority granted by the Office of Personnel Management (OPM) to waive the regulatory payment limitation to provide recruitment, relocation, or retention incentive options up to 50% above pay table amounts with a service agreement. This authority will aid in the ability to recruit and retain Civil Service employees based on superior qualifications and locations that are hard to fill in the general engineer (0801), civil engineer (0810), and environmental engineer (0819) occupational series. The IHS will continue to explore the development and/or the leveraging of other agencies Special Salary Rates for engineers. This is necessary to increase IHS' competitiveness with both private and public sector organizations.

Appendix A: All Projects and Associated Costs as of December 31, 2022

Area	Eligible Cost	Ineligible Cost	Total Cost	Project Count
Albuquerque (AL)	$235,908,259	$19,563,041	$255,471,300	98
Alaska (AN)	$2,250,725,035	$155,896,250	$2,406,621,285	270
Bemidji (BE)	$98,534,504	$37,399,488	$135,933,992	100
Billings (BI)	$61,498,247	$6,047,582	$67,545,829	55
California (CA)	$177,512,150	$99,384,279	$276,896,429	73
Great Plains (GP)	$383,298,762	$355,542,659	$738,841,421	169
Navajo (NA)	$682,156,806	$37,583,985	$719,740,791	264
Nashville (NS)	$43,139,493	$4,123,121	$47,262,614	13
Oklahoma (OK)	$117,733,527	$279,471,442	$397,204,969	183
Phoenix (PH)	$165,852,850	$48,259,020	$214,111,870	71
Portland (PO)	$136,592,417	$58,874,637	$195,467,054	61
Tucson (TU)	$12,923,919	$604,311	$13,528,230	12
Total	**$4,365,875,969**	**$1,102,749,815**	**$5,468,625,784**	**1,369**

Appendix B: FY 2023 Tier 1 Projects Counts and Associated Cost to be Funded with the FY 2023 BIL Funding and FY 2023 Enacted Appropriation

Area	Construction Eligible Cost	Construction Ineligible Cost	Design and Construction Document Cost	Project Count*
Albuquerque (AL)	$41,033,968	$2,421,832	$2,607,400	17
Alaska (AN)	$401,750,071	$20,292,888	$17,586,854	37
Bemidji (BE)	$9,141,560	$2,471,440	$1,419,000	10
Billings (BI)	$4,413,600	$351,463	$420,000	6
California (CA)	$2,342,570	$128,105	$467,295	4
Great Plains (GP)	$34,120,764	$8,919,236	$0	19
Navajo (NA)	$58,353,255	$45,755	$5,963,290	37
Nashville (NS)	$2,524,905	$130,095	$0	1
Oklahoma (OK)	$27,865,605	$51,877,903	$533,300	45
Phoenix (PH)	$37,523,125	$15,347,875	$662,175	9
Portland (PO)	$8,307,138	$3,125,341	$1,197,630	9
Tucson (TU)	$2,105,000	$0	$0	3
Total	**$629,481,561**	**$105,111,933**	**$30,856,944**	**197**

(*Tier 1 DL 2 – DL 5 Projects)

Appendix C: FY 2023 Tier 2 Project Counts and Associated Cost to be Funded with the FY 2023 Enacted Appropriation

Area	Planning, Design and Construction Document Cost	Project Count*
Albuquerque (AL)	$782,400	5
Alaska (AN)	$7,800,621	3
Bemidji (BE)	$1,081,000	4
Billings (BI)	$0	0
California (CA)	$1,392,144	3
Great Plains (GP)	$72,000	1
Navajo (NA)	$2,759,600	12
Nashville (NS)	$0	0
Oklahoma (OK)	$1,387,650	1
Phoenix (PH)	$1,040,188	4
Portland (PO)	$0	0
Tucson (TU)	$0	0
Total	**$16,315,603**	**33**

(*Tier 2 DL 2 – DL 5 Projects)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

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Self Determination

Indian Health Service

Indian Self Determination

Indian Health Service Philosophy – The Indian Health Service (IHS) implements the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law (Pub. L. No.) 93-638, as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Accordingly, the IHS supports Tribal sovereignty: (1) by assisting Tribes in exercising their right to administer the IHS health programs, or portions thereof, and (2) by continuing to directly provide services to Tribes that choose the IHS as their health care provider. A Tribal decision to enter or not enter into ISDEAA agreements are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts – Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1975, the IHS has entered agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, over $6.2 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 206 Tribes and Tribal Organizations operating 246 contracts and annual funding agreements. Under Title V, IHS is party to 112 compacts and 139 funding agreements; through which approximately $2.8 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-seven percent of federally recognized Tribes participate in Title V.

Indian Health Service
Self-Governance Funded Compacts FY 2023
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALABAMA	**4,677**	**407**	**170**	**673**	**5,926**
Poarch Band of Creek Indians	4,677	407	170	673	5,926
ALASKA	**635,214**	**62,749**	**58,811**	**198,343**	**955,118**
Alaska Native Tribal Health Consortium	107,992	22,046	12,988	23,044	166,070
Aleutian Pribilof Islands Association, Inc.	1,734	38	194	1,401	3,367
Arctic Slope Native Association, Ltd	24,782	2,642	3,668	7,351	38,443
Bristol Bay Area Health Corporation	21,942	1,264	2,466	10,099	35,772
Chickaloon Native Village	61	1	17	15	94
Chugachmiut	3,876	74	250	1,988	6,187
Copper River Native Association	6,398	477	549	2,061	9,486
Council of Athabascan Tribal Governments	1,816	182	104	1,356	3,458
Eastern Aleutian Tribes, Inc.	3,376	36	198	1,921	5,531
Kenaitze Indian Tribe, I.R.A.	13,190	1,253	442	3,699	18,585
Ketchikan Indian Community	5,944	260	613	4,253	11,070
Knik Tribal Council	77	1	11	10	99
Kodiak Area Native Association	7,748	269	508	3,587	12,112
Maniilaq Association	29,317	1,310	3,148	16,942	50,717
Metlakatla Indian Community	6,693	1,124	530	1,159	9,505
Mount Sanford Tribal Consortium	416	3	45	146	610
Native Village of Eklutna	189	4	7	56	256
Native Village of Eyak	848	58	98	761	1,765
Norton Sound Health Corporation	46,584	4,624	4,841	12,933	68,983
Seldovia Village Tribe	1,957	16	97	987	3,057
Southcentral Foundation	96,872	4,650	11,194	33,702	146,417
SouthEast Alaska Regional Health Consortium	40,700	2,255	3,981	19,430	66,366
Tanana Chiefs Conference	66,476	4,682	6,333	16,313	93,803
Tanana Tribal Council	1,041	72	63	420	1,596
Yakutat Tlingit Tribe	4,881	409	35	2,089	7,413
Yukon-Kuskokwim Health Corporation	140,307	14,998	6,428	32,621	194,354
ARIZONA	**274,442**	**22,172**	**10,471**	**50,993**	**358,077**
Ak-Chin Indian Community	512	16	7	7	542
Gila River Indian Community	81,632	6,824	1,907	27,831	118,194
Pascua Yaqui Tribe	16,060	193	205	3,435	19,893
Salt River Pima-Maricopa Indian Community	63,984	4,792	2,279	2,914	73,969
Tohono O'Odham Nation	37,169	4,020	2,707	4,295	48,192
Tuba City Regional Health Care Corporation	44,119	4,205	2,439	4,466	55,229
Winslow Indian Health Care Center, Inc.	30,965	2,121	926	8,046	42,058
CALIFORNIA	**92,628**	**6,313**	**4,407**	**38,237**	**141,584**
Chapa-De Indian Health Program, Inc.	7,140	863	198	3,826	12,027
Consolidated Tribal Health Project, Inc.	4,347	50	112	1,554	6,062
Feather River Tribal Health, Inc.	5,968	156	178	2,185	8,486
Hoopa Valley Tribe	6,377	265	293	1,647	8,582
Indian Health Council, Inc.	9,175	59	301	4,264	13,799
Karuk Tribe of California	3,254	448	103	958	4,764
Lake County Tribal Health Consortium, Inc.	6,966	1,159	185	4,262	12,573
Northern Valley Indian Health, Inc.	4,493	1,067	122	1,410	7,092
Pinoleville Pomo Nation	95	0	3	6	104
Pit River Health Service, Inc.	2,108	508	69	697	3,382
Redding Rancheria Tribe	7,178	658	640	2,878	11,354
Riverside-San Bernardino County Indian Health, Inc.	23,067	225	968	9,383	33,643
Rolling Hills Clinic	562	175	1	265	1,003
Round Valley Indian Health Center, Inc.	2,256	602	103	528	3,489
Santa Ynez Band of Chumash Mission Indians	2,036	15	38	802	2,891
Southern Indian Health Council, Inc.	5,799	50	920	2,682	9,451
Susanville Indian Racheria	1,807	14	172	889	2,882
CONNECTICUT	**4,198**	**97**	**63**	**1,003**	**5,361**
Mashantucket Pequot Tribal Nation	1,552	17	63	486	2,117
Mohegan Tribe of Indians of Connecticut	2,645	80	0	518	3,244
FLORIDA	**8,145**	**709**	**1,084**	**2,287**	**12,225**
Seminole Tribe of Florida	8,145	709	1,084	2,287	12,225
IDAHO	**17,078**	**1,190**	**2,096**	**4,682**	**25,046**
Coeur D'Alene Tribe	6,722	562	1,534	3,551	12,369
Kootenai Tribe of Idaho	692	36	85	134	947
Nez Perce Tribe	9,664	592	477	996	11,730

Indian Health Service
Self-Governance Funded Compacts FY 2023
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
KANSAS	**7,271**	**195**	**280**	**3,156**	**10,902**
Iowa Tribe of Kansas and Nebraska	2,299	35	181	1,517	4,034
Prairie Band Potawatomi Nation	4,972	159	99	1,638	6,868
LOUISANA	**1,292**	**111**	**139**	**388**	**1,930**
Chitimacha Tribe of Louisiana	1,292	111	139	388	1,930
MAINE	**3,610**	**133**	**190**	**711**	**4,644**
Penobscot Indian Nation	3,610	133	190	711	4,644
MASSACHUSETTS	**758**	**45**	**244**	**0**	**1,048**
Wampanoag Tribe of Gay Head Aquinnah	758	45	244	0	1,048
MICHIGAN	**30,411**	**1,360**	**3,002**	**3,796**	**38,569**
Grand Traverse Band of Ottawa and Chippewa Indians	3,022	105	346	581	4,054
Keweenaw Bay Indian Community	3,548	318	908	689	5,463
Little River Band of Ottawa Indians	2,174	10	280	264	2,727
Match-E-Be-Nash-She-Wish Band of Pottawatomi	1,229	13	247	233	1,721
Nottawaseppi Huron Band Of The Potawatomi	1,853	44	351	209	2,456
Sault Ste. Marie Tribe of Chippewa Indians	18,586	871	870	1,820	22,147
MINNESOTA	**21,939**	**309**	**3,170**	**1,993**	**27,411**
Bois Forte Band of Chippewa Indians	2,800	50	449	679	3,979
Fond du Lac Band of Lake Superior Chippewa	12,822	183	1,365	825	15,195
Mille Lacs Band of Ojibwe	4,446	59	1,336	489	6,330
Shakopee Mdewakanton Sioux Community	1,872	16	19	0	1,907
MISSISSIPPI	**40,638**	**4,211**	**1,393**	**5,755**	**51,998**
Mississippi Band of Choctaw Indians	40,638	4,211	1,393	5,755	51,998
MONTANA	**35,076**	**1,380**	**3,338**	**3,711**	**43,505**
Chippewa Cree Tribe of the Rocky Boy's Reservation	11,155	325	2,447	2,310	16,237
Confederated Salish and Kootenai Tribes of the Flathead Nat	23,921	1,055	891	1,401	27,268
NEBRASKA	**18,747**	**3,280**	**1,904**	**3,844**	**27,776**
Winnebago Tribe of Nebraska	18,747	3,280	1,904	3,844	27,776
NEVADA	**30,392**	**1,394**	**2,416**	**4,166**	**38,368**
Duck Valley Shoshone-Paiute Tribes	7,328	526	844	0	8,697
Duckwater Shoshone Tribe	1,147	7	225	1,030	2,408
Ely Shoshone Tribe	1,396	32	71	494	1,993
Fort McDermitt Paiute and Shoshone Tribe	1,706	104	8	85	1,904
Las Vegas Paiute Tribe	3,653	83	134	293	4,164
Reno-Sparks Indian Colony	7,471	435	757	1,203	9,867
Washoe Tribe of Nevada and California	5,548	79	264	693	6,584
Yerington Paiute Tribe of Nevada	2,143	126	114	367	2,751
NEW MEXICO	**13,316**	**364**	**1,462**	**2,181**	**17,322**
Pueblo of Jemez	10,389	292	1,057	1,677	13,415
Pueblo of Sandia	1,920	64	169	230	2,382
Taos Pueblo	1,008	8	236	274	1,525
NEW YORK	**8,527**	**483**	**359**	**2,339**	**11,708**
St. Regis Mohawk Tribe	8,527	483	359	2,339	11,708
NORTH CAROLINA	**21,254**	**1,623**	**1,117**	**9,050**	**33,044**
Eastern Band of Cherokee Indians	21,254	1,623	1,117	9,050	33,044
NORTH DAKOTA	**11,677**	**595**	**1,717**	**2,557**	**16,546**
Spirit Lake Tribe	11,677	595	1,717	2,557	16,546
OKLAHOMA	**602,762**	**51,408**	**46,117**	**122,686**	**822,973**
Absentee Shawnee Tribe of Oklahoma	19,467	1,708	2,169	4,700	28,044
Cherokee Nation	255,131	17,849	15,414	36,282	324,677
Chickasaw Nation	91,497	14,661	11,361	23,053	140,572
Choctaw Nation of Oklahoma	93,627	11,151	7,141	34,889	146,807
Citizen Potawatomi Nation	23,337	704	1,841	9,004	34,886
Kaw Nation of Oklahoma	2,991	120	237	727	4,075
Kickapoo Tribe of Oklahoma	10,550	215	325	1,816	12,907
Modoc Nation	63	18	7	20	108
Muscogee Nation	62,676	3,934	6,358	4,882	77,849
Northeastern Tribal Health System	7,970	159	172	1,380	9,681
Osage Nation	13,466	47	415	2,369	16,298
Pawnee Nation of Oklahoma	723	14	20	195	951
Ponca Tribe of Oklahoma	6,606	105	292	969	7,971
Quapaw Tribe of Oklahoma	237	0	38	113	388
Sac and Fox Nation of Oklahoma	10,411	87	186	1,290	11,974
Seminole Nation of Oklahoma	526	514	55	168	1,263
Wichita & Affiliated Tribes	340	25	44	89	498
Wyandotte Nation	3,142	98	43	742	4,025
OREGON	**31,198**	**1,188**	**3,135**	**10,890**	**46,411**
Confederated Tribes of Siletz Indians of Oregon	8,528	14	854	2,295	11,691
Confederated Tribes of the Coos, Lower Umpqua & Siuslaw	1,943	82	335	303	2,663
Confederated Tribes of the Umatilla Reservation	7,320	363	839	1,976	10,498
Confederated Tribes of Grand Ronde	7,160	417	621	2,842	11,040
Coquille Indian Tribe	2,212	68	265	2,626	5,171
Cow Creek Band of Umpqua Tribe of Indians	4,036	244	222	847	5,349

Indian Health Service
Self-Governance Funded Compacts FY 2023
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
TEXAS	**10,254**	**866**	**1,203**	**1,560**	**13,883**
Ysleta del Sur Pueblo	10,254	866	1,203	1,560	13,883
UTAH	**10,709**	**98**	**2,340**	**3,971**	**17,118**
Paiute Indian Tribe of Utah	2,459	33	273	546	3,311
Utah Navajo Health System, Inc.	8,250	65	2,067	3,425	13,807
WASHINGTON	**64,030**	**3,472**	**3,316**	**19,030**	**89,848**
Cowlitz Indian Tribe	7,204	47	26	1,978	9,254
Jamestown S'Klallam Indian Tribe	1,053	71	105	101	1,330
Kalispel Tribe of Indians	1,180	48	25	228	1,480
Lower Elwha Klallam Tribe	2,021	107	124	327	2,579
Lummi Indian Nation	8,683	622	308	1,839	11,452
Makah Indian Tribe	4,197	283	348	1,189	6,017
Muckleshoot Tribe	7,884	388	239	2,699	11,211
Nisqually Indian Tribe	2,492	64	132	512	3,200
Port Gamble S'Klallam Tribe	2,810	181	163	1,437	4,591
Quinault Indian Nation	6,032	534	262	3,211	10,039
Samish Indian Nation	1,201	7	111	472	1,791
Shoalwater Bay Indian Tribe	1,937	55	335	735	3,063
Skokomish Indian Tribe	2,223	99	134	544	3,000
Squaxin Island Indian Tribe	2,957	369	236	1,229	4,791
Suquamish Tribe	1,827	5	177	613	2,621
Swinomish Indian Tribal Community	2,423	118	212	594	3,347
Tulalip Tribes of Washington	7,905	475	380	1,324	10,084
WISCONSIN	**37,351**	**1,976**	**5,696**	**4,901**	**49,924**
Forest County Potawatomi Community	2,129	354	846	401	3,730
Ho-Chunk Nation	8,758	645	1,021	1,340	11,763
Oneida Tribe of Indians of Wisconsin	22,929	313	3,282	2,808	29,332
Stockbridge-Munsee Community	3,535	664	548	352	5,099
WYOMING	**5,620**	**488**	**121**	**1,169**	**7,399**
Northern Arapaho Tribe of Indians	5,620	488	121	1,169	7,399
GRAND TOTAL	**2,043,215**	**168,616**	**159,760**	**504,071**	**2,875,661**

Indian Health Service
FY 2023 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	675,024	13,523	9,416	58,811	198,343	**955,118**
ALBUQUERQUE	23,142	1,241	417	2,664	3,741	**31,205**
BEMIDJI	89,678	1,840	1,828	11,867	10,690	**115,903**
BILLINGS	38,961	2,540	1,063	3,459	4,881	**50,904**
CALIFORNIA	92,595	3,726	2,620	4,407	38,237	**141,584**
GREAT PLAINS	32,660	1,281	358	3,622	6,401	**44,321**
NASHVILLE	93,872	5,638	1,408	4,758	22,206	**127,883**
NAVAJO	85,074	2,569	2,083	5,431	15,937	**111,094**
OKLAHOMA	636,482	12,083	13,071	46,397	125,842	**833,875**
PHOENIX	188,224	2,198	1,616	6,883	35,463	**234,384**
PORTLAND	111,177	4,007	2,973	8,547	34,601	**161,305**
TUCSON	53,991	2,662	790	2,912	7,730	**68,085**
Total, IHS	**2,120,880**	**53,309**	**37,642**	**159,760**	**504,071**	**2,875,661**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

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Legislative Proposals

Authorization for the Special Diabetes Program for Indians

Proposal: Reauthorize for three years and increase funding for the Special Diabetes Program for Indians (SDPI) from
FY 2024-FY 2026.

Current Law: The Balanced Budget Act of 1997 (P.L. 105-33, Section 4922) established the SDPI to address the need for diabetes prevention and treatment for American Indian and Alaska Native (AI/AN) populations. The SDPI, established under section 330C of the Public Health Service Act (42 U.S.C. § 254c-3), has been reauthorized through September 30, 2023.

Rationale: Absent additional Congressional action, SDPI will face a funding cliff in FY 2024. Reauthorization of the SDPI will be required to continue progress in prevention and treatment of diabetes in AI/AN communities. The proposal increases funding for the program from $150 million to $250 million in FY 2024, $260 million in FY 2025, and $270 million in FY 2026. The additional funding will provide more American Indian and Alaska Native communities with access to this critical resource and allow the program to accommodate the increasing costs of providing health care. The Budget also proposes to exempt this program and other IHS funding from sequestration.

The SDPI currently provides grant funding to 301 Indian Health Service (IHS), tribal, and urban Indian (I/T/U) programs in 35 states.

The SDPI has provided funding that has enabled AI/AN programs to implement and sustain quality diabetes treatment and prevention services. As the six SDPI Reports to Congress in FYs 2000, 2004, 2007, 2011, 2014, and 2020 have demonstrated, substantial improvements in clinical measures and outcomes have been associated with the diabetes prevention and treatment activities implemented with SDPI funding.

IHS data indicate that, after years of rising, the prevalence of diabetes in AI/AN people nationally decreased from 15.4 percent in 2013 to 14.6 percent in 2017, the first known decrease in this population[1]. Another positive trend is that rates of obesity in AI/AN children and youth aged 2-19 years remained nearly constant from 2006-2015[2].

Key clinical outcome measures have continued to improve overall at I/T/U facilities since the inception of the SDPI:

- Improved Blood Sugar Control: Blood sugar control among AI/ANs with diabetes served by the I/T/U system has improved over time. The average blood sugar level (as measured by the A1C test) decreased from 9.0 percent in 1996 to 8.1 percent in 2019[3], nearing the A1C goal for most patients of less than 8 percent.
- Improved Blood Lipid Levels: Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 90 mg/dL in 2019, surpassing the goal of less than 100mg/dL[4].
- Reduced Kidney Failure: The rate of new cases of kidney failure due to diabetes 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 US racial group and represents a significant decrease in the need for dialysis

[1] Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006–2017, *BMJ Open*
[2] *Am. J. Public Health* 2017; 107:1502-1507.
[3] IHS Diabetes Care and Outcomes Audit.
[4] *Id.*

and kidney transplantation[5]. The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) released an Issue Brief on May 10, 2019 titled "The Special Diabetes Program for Indians: Estimates of Medicare Savings.[6]" ASPE estimated that the decrease in the incidence of diabetes-related kidney failure resulted in 2,200 to 2,600 fewer cases and $436 million to $520 million of savings to Medicare over a ten-year period. ASPE also discussed how the SDPI was a critical factor in these improvements.

The IHS proposes to continue support for data infrastructure improvements, focusing on the Diabetes Care and Outcomes Audit, estimates of diabetes prevalence, the National Data Warehouse, and updates to the Diabetes Management System and iCare programs. Given the complexity and number of the SDPI grant programs, the IHS will continue to provide administrative support to ensure appropriate implementation and evaluation.

The SDPI grantees have implemented diabetes prevention and treatment activities that are culturally appropriate, community-driven, and centered on evidence-based best practices. These programs will continue to implement specific prevention and treatment strategies and best practices for AI/AN adults, children, and youth.

Reauthorization is highly supported by AI/AN Tribes. In 2019, Tribes submitted testimony to the House Appropriations Subcommittee on Interior, Environment and Related Agencies on March 6, 2019, and to the Senate Committee on Indian Affairs on May 8, 2019, indicating SDPI progress and the need for continued support. Furthermore, this proposal is consistent with the recommendations of the IHS National Tribal Budget Formulation Workgroup.

Budget Impact: The reauthorization of this program will cost a total of $780 million over three years.

Effective Date: October 01, 2023

Equity Impact Assessment: Reauthorizing SDPI for three years at $250 million in 2024 and increasing funding by +$10 million in FY 2026 and FY 2027 would give the funding continuity needed by programs to plan the needed long-term interventions and activities, resulting in continued overall positive clinical outcomes. It would also significantly enhance their ability to recruit and retain qualified staff in rural and remote locations, which funding unpredictability has made even more difficult. This will ultimately improve access to health care for AI/AN communities, who often experience unique challenges and barriers to care. Improving access to care by strengthening IHS workforce capacity can contribute to better outcomes for AI/AN people and reduce health disparities.

[5] 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), available at: http://dx.doi.org/10.15585/mmwr.mm6601e1.

[6] Office of the Assistant Secretary for Planning and Evaluation (ASPE). The Special Diabetes Program for Indians: estimates of Medicare savings. ASPE Issue Brief. Department of Health and Human Services, May 10, 2019. https://aspe.hhs.gov/pdf-report/special-diabetes-program-indians-estimates-medicare-savings.

Provide the Indian Health Service discretionary use of additional Title 38 personnel authorities through expansion of the Office of Personnel Management's delegation authority

Proposal: The Indian Health Service (IHS) seeks the discretionary use of additional United States Code (USC) Title 38 authorities under Part V, Chapter 74, "Veterans Health Administration – Personnel", that are available to the United States Department of Veterans Affairs (VA) for healthcare 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 are normally governed under Title 5 USC. As shown during the COVID-19 medical crisis, IHS needs increased authority in order to effectively recruit and retain high-performing healthcare staff on par with the VA's ability to do so. The IHS has very high vacancy rates in several key occupations such as physicians (32 percent), advanced practice nurses (37 percent), and behavioral health clinicians (43 percent), and needs additional Title 38 authorities to recruit and retain needed healthcare staff. The IHS is particularly challenged in that many of the IHS work sites are in extremely rural locations that are not attractive to many candidates.

Current Law: The United States (U.S.) Office of Personnel Management (OPM), under the authority of sections 1104 and 5371 of Title 5 USC, has authorized the U.S. Department of Health and Human Services (HHS) and other federal agencies to use the Title 38, Chapter 74 provisions pertaining to pay rates and systems, premium pay, classification, and hours of work. This administrative delegation of authority is described in an agreement between OPM and HHS. If any HHS Operating Division chooses to use a Title 38 provision, the comparable authority under Title 5 is waived. However, 5 U.S.C. § 5371 only allows OPM to delegate Title 38 HR authorities on matters that are covered by Title 5, Chapter 51 – Classification, subchapter V of Chapter 55 – Premium Pay, and Chapter 61 – Hours of Work. Specifically, 5 U.S.C. § 5371 does not let OPM extend the use of the Title 38 authorities on leave, probationary periods, collective bargaining/grievance procedures, and appointment authority to other agencies. This limitation in OPM's administrative delegation authority prevents IHS, and other federal organizations with similar healthcare workforces as the VA, from being as competitive in recruitment and retention as the VA and nonfederal employers. A legislative change expanding OPM's administrative ability to delegate additional Title 38 authorities to IHS and other federal agencies is critically needed since several past legislative proposals requesting that the needed Title 38 authorities be legislatively granted to IHS specifically have not been successful.

The VA operates differently than Title 5 agencies, such as the IHS, in the following important ways:

- Accelerated Granting of Annual Leave Accrual (38 USC § 7421) – The law authorizes the VA Secretary to determine the hours and conditions of employment for certain healthcare staff. As implemented by VA policy, the VA provides eight hours of annual leave per pay period to physicians, dentists, nurses, and several other mission-critical healthcare occupations regardless of length of federal service. All other federal agencies must follow OPM regulations regarding annual leave and all new federal employees only earn four hours of annual leave per pay period.
- Two-year Probationary Periods (38 USC § 7403) – The law establishes two-year probationary periods for many VA healthcare staff. All other federal agencies must follow OPM regulations and may only exercise one-year probationary periods. The VA's ability to extend the initial probationary period for two years for healthcare staff to assess job performance puts the VA in a better position to retain the highest performing staff.
- Exemption from Collective Bargaining and Grievance Procedures (38 USC § 7422) – The law exempts the VA from the requirement of engaging in collective bargaining and grievance procedures on any matters involving an employee's professional competence or conduct, peer review, or compensation.

- Title 38 Appointment Authority (38 USC § 7401) – The law authorizes the VA Secretary to appoint healthcare staff. The IHS would benefit from an appointment authority that allows IHS to directly hire employees without being bound by Title 5 competitive hiring procedures.

Rationale: The IHS would greatly benefit from being able to use more of the Title 38, Chapter 74 authorities than are currently allowed under the constraints on OPM's delegation authority under 5 USC § 5371. As a primarily rural healthcare provider, IHS has difficulty recruiting healthcare professionals in every occupation. The IHS has critical hiring needs for healthcare professionals in IHS, Tribal, and Urban Indian programs including, but not limited to physicians, dentists, nurses, pharmacists, physician assistants, and nurse practitioners. IHS's current ability to use Title 38 for pay purposes is critical, since it allows IHS to offer higher rates of pay than the regular General Schedule through Market Pay to physicians, dentists, and podiatrists as well as Title 38 special salary rates to individuals in other health care occupations. However, IHS's use of these pay authorities is not enough for IHS to compete with other public sector agencies and private sector organizations for healthcare staff.

The private sector and the VA can offer job candidates better paid time off which is a particularly important benefit to providers who serve in remote and rural locations. The VA provides one day, or eight hours, of annual leave per pay period to all (including new) physicians, dentists, podiatrists, optometrists, chiropractors, nurses, physician assistants, and expanded-function dental auxiliaries. Due to the limited scope of 5 U.S.C. § 5371, OPM cannot grant this same leave authority to HHS.

In addition to better scheduling options and paid time off, the IHS is seeking access to other Title 38 authorities mentioned above to increase its competitive stance in the healthcare labor market and to create a more efficient and effective human resources program. This would include two-year probationary periods, exemption from collective bargaining and associated grievance procedures in certain instances, and appointment authority outside of the constraints of Title 5.

HHS staff meet regularly with staff from OPM who manage the Interagency Committee on Health Care Occupations and would consult with OPM staff over the administrative delegation of additional Title 38, Chapter 74 authorities. The HHS Operating Divisions would have the discretion to implement or not implement any additional authorities. HHS Operating Divisions could be audited and monitored regarding the equitable and effective implementation of any new Title 38 authorities. The administrative delegation of the additional Title 38 authorities would create a more level playing field across federal agencies in terms of agencies' ability to recruit and retain healthcare staff. The country's American Indian and Alaska Native (AI/AN) people merit the same level of care from healthcare staff as our country's veterans.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal will enable the IHS to hire and retain mission-critical healthcare staff to provide healthcare to people in AI/AN communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. The requested change will help to raise the level of care provided to AI/AN people to be more on par with care provided to the country's veterans by the VA.

Sequestration Exemption for Indian Health Programs

Proposal: To amend current law to exempt the Indian Health Service from future sequestration cuts.

Current Law: Sequestration is the legislatively mandated process of budget control consisting of automatic, across-the-board spending reductions to enforce budget targets to limit federal spending. It was first established by the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA, Title II of P.L. 99-177, 2 U.S.C. § 900-922) to enforce deficit targets. Section 255 of BBEDCA (2 U.S.C. § 905) identifies programs that are exempt from sequestration, and Section 256 of BBEDCA (2 U.S.C. § 906) establishes special rules.

BBEDCA requires a sequestration of non-exempt mandatory budgetary resources to be ordered with the release of the Budget and take effect the start of the fiscal year. Sequestration of these resources are required in each fiscal year through 2031. The sequestration percentage for all those years are set to be the same as the percentages calculated in FY 2021 which is 5.7 percent for nondefense spending, 8.3 percent for defense programs, and 2 percent for Medicare and certain other health programs. IHS funding is listed in section 256 of BBEDCA and limits their sequestration to 2 percent per fiscal year.

Rationale: The Budget proposes to shift all funding to mandatory starting in FY 2026, which would trigger a 2 percent sequester per fiscal year for the IHS. This sequester would reduce funds for direct health care services.

All programs administered by the Department of Veterans Affairs are exempt from a sequestration reduction ordered under the BBEDCA and the BCA. Through this exemption Congress expressly indicated how critical it is for services provided by the VA not to be disrupted or reduced as a result of sequestration.

Section 255 of BBEDCA (codified at 2 U.S.C. § 905) identifies programs that are exempt from sequestration. These include programs providing critical support to vulnerable groups within the United States, including children (Children's Health Insurance Program (CHIP), Child Nutrition Programs, and foster care) and low income persons/families (Medicaid, TANF, Family Support Programs), health benefits to retirees, veterans and service members (Veterans Affairs, Annuitants, Employees Health Benefits, Postal Service Retiree Health Benefits Fund, Medical Benefits for Commissioned Officers, Public Health Service). Many of the exempted programs reimburse the IHS for services rendered including Medicaid, Medicare (treated under special limiting rules), CHIP, and Veterans Health program reimbursement.

The services provided by the IHS are no less critical. Budget reductions of any kind have implications for the services IHS, Tribes, and Urban Indian organizations provide to American Indian and Alaska Native patients and communities. In FY 2013, these reductions resulted in dramatic oversight and administration reductions to maintain service levels, limitations to patients being able to see outside specialists beyond Priority 1 (emergent or acutely urgent care), and reductions to services paid for through offsetting collections. Future sequesters would not only damage the lives and health of American Indians and Alaska Natives through reduced direct services and care, it would also impair IHS's efforts to improve medical quality, implement improvements/replacement to its Electronic Health Record System, and reduce critical health care staffing vacancies among other impacts.

The impact of a sequestration on the IHS will be highly variable, both based on the overall sequester level, as well as the availability of third-party resources to ameliorate budget reductions to critical care areas.

Budget Impact: While resulting in no change to IHS's funding, it would increase the amount of sequestered funding taken from remaining non-exempt agencies.

Effective Date: Upon enactment.

Equity Impact Assessment: Exempting IHS from sequestration is consistent with the treatment of other Federal programs that serve vulnerable communities, and maximizes the amount of funding available for the provision of direct health care services to American Indians and Alaska Natives.

U.S. Public Health Service Commissioned Officers to be Detailed to Urban Indian Organizations to Cooperate In or Conduct Work Related to the Functions of the Department of Health and Human Services

Proposal: Amend federal law to permit U.S. Public Health Service Commissioned Officers (officers) to be detailed directly to Urban Indian Organizations (UIOs) to cooperate in or conduct work related to the functions of the Department of Health and Human Services (HHS).

Current Law: Current federal law permits HHS to detail officers or employees of the Public Health Service for particular enumerated purposes to specified entities, including State health authorities and certain nonprofit institutions (subsections (b) and (c) of section 214 of the Public Health Service Act (PHSA) (42 U.S.C. § 215(b), (c)). This legislative proposal is limited to seeking authority to detail only officers to UIOs so they can provide health care and related services. Although UIOs are nonprofit organizations, section 214(c) of the PHSA (42 U.S.C. § 215(c)) only authorizes details to nonprofit institutions engaged in health activities for special studies of scientific problems and for the dissemination of information related to public health. Section 215(c) does not provide IHS the authority to detail officers to UIOs for the purpose of providing health care and health care related services. Therefore, in accordance with 25 U.S.C. § 215(b), so that officers may carry-out these activities, IHS has detailed officers to State health authorities that have then designated the UIO as the officer's duty station. UIOs are part of the Indian health care system and provide health care services to eligible American Indians and Alaska Natives residing in urban centers.

Rationale: The Indian Health Service (IHS) enters into limited, competing contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban Indians throughout the United States. UIOs are defined in section 4(29) of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. § 1603(29)) as a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a) of that Act (25 U.S.C. § 1653(a)). UIOs provide unique access to culturally appropriate and quality health care for Urban Indians.

UIOs have requested that officers be detailed to them to fill many roles related to the functions of HHS, as authorized at 42 U.S.C. § 215(b). However, section 214 of the PHSA (42 U.S.C. § 215(c)) does not authorize HHS/IHS to detail officers directly to UIOs for this purpose. 42 U.S.C. § 215(b) has been interpreted as allowing HHS/IHS to detail an officer to a State health authority, which may then designate the UIO as the officer's duty station. The officer is then authorized to perform work at an UIO that is related to the functions of HHS, which has been interpreted to include health care services and supportive functions. The process for such indirect details is completely dependent on the availability of a State or local health authority that is capable and willing to enter into such an arrangement. The process can be burdensome and time consuming for all involved, and State health authorities may be reluctant because of this burden, as well as their potential liability under such an arrangement.

Amending the law would provide HHS/IHS the discretionary authority to detail officers directly to an UIO to perform work related to the functions of HHS, to the same extent it may do so now through the indirect, burdensome process described above. Such authority would be comparable to the existing authority to detail officers to Indian Self Determination and Education Assistance Act (ISDEAA) contractors and compactors for the purpose of carrying out the provisions of their ISDEAA contracts (section 7 of the Act of August 5, 1954 (42 U.S.C. § 2004b)).

This proposal aligns with the IHS vision: "Healthy communities and quality health care systems through strong partnerships and culturally responsive practices."[7] In 2021, the United State Surgeon General published "What Causes the U.S. Health Disadvantage?" It identifies that health is everywhere and most importantly driven by the environment that we are exposed to in our communities.[8] Currently, 1,407 commissioned officers of the USPHS are assigned to the IHS. The officers are America's Health Responders. There are eight officers assigned to states, whose duty stations are at UIOs. See the table below.

Urban Facility Name, City, State	**#Officers**	**Category**
Native American Rehabilitation Association - Portland, Oregon	3	Health Services Officer – Physician Assistant Environmental Health Pharmacy
Oklahoma City Indian Clinic – Oklahoma City, Oklahoma	5	Pharmacy Dietician Therapist Nurse

Strategic Objective 1.3 of the HHS Strategic Plan FY 2022 – 2026 directs HHS to invest in strategies to expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while addressing social determinants of health. American Indian and Alaska Native (AI/AN) people experience unique challenges when attempting to access care, due to factors such as the inadequate supply of health care providers and other workers. The UIOs provide comprehensive, community-based, innovative, and culturally-competent health care services to Urban Indians. Providing the HHS/IHS authority to detail officers directly to UIOs will help address these shortages so that UIOs can provide basic and expanded health care services to eligible Urban Indian people residing in urban centers.

Budget Impact: This is a non-budget related and mandatory proposal.

Personnel Requirements: This proposal does not require additional personnel to implement.

Effective Date: Upon enactment.

Equity Impact Assessment: Permitting officers to be detailed directly to UIOs will address the need to improve access to health care for AI/AN communities, who often experience unique challenges and barriers to care. Improving access to care by strengthening IHS workforce capacity will contribute to better outcomes for AI/AN and reduce health disparities.

[7] https://www.ihs.gov/aboutihs/overview/
[8] https://www.hhs.gov/sites/default/files/chep-sgr-causes-health-disadvantage-fs3.pdf

Meet Loan Repayment/Scholarship Service Obligations on a Half-Time Basis

Proposal: Permit both Indian Health Service (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 that provided in section 331(i) of the Public Health Service Act (42 U.S.C. § 254d(i)) would allow IHS loan repayment and scholarship recipients more options and flexibility to satisfy their service obligations through half-time clinical work (a minimum of 20 hours 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 to accept half the amount of loan repayment award in exchange for a two-year service obligation. This would provide parity with NHSC programs and enable IHS to make better use of these tools to recruit and retain key professionals in a highly competitive environment.

Current Law: Sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. § 1613a, 1616a) 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 section 10501(n) of the Patient Protection and Affordable Care Act (Public Law No. 111-148; 124 Stat. 1002) 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 Public Health Service Act (42 U.S.C. § 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 health care provider, has difficulty recruiting and retaining health care professionals. Recruiting physicians and other primary care clinicians has been especially challenging. Permitting IHS scholarship and loan repayment health professional employees to fulfill their service obligations through half-time clinical practice 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 the 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 Patient Protection and Affordable Care Act (Public Law No. 111-148, 124 Stat. 119) 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 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 health care clinicians to provide primary health care

and specialty services (e.g., Surgery, OG/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 of the IHS to recruit and retain health care clinicians to provide primary health care and specialty services and otherwise support the IHS and HHS priorities.

Budget Impact: This is a budget neutral proposal. The IHS will accommodate funding requirements from within existing resources. Direct hire medical staff costs are lower than the costs to hire temporary, contractor staff.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal would increase IHS's ability to recruit and retain health care clinicians to provide primary health care and specialty services to American Indian/Alaska Native communities which disproportionately suffer from healthcare issues and lack the necessary clinical personnel to provide care to community members. The requested change will also foster equity between the IHS and NHSC loan repayment and scholarship programs which will incentivize clinicians to choose a career with IHS.

Provide Tax Exemption for Indian Health Service Health Professions Scholarship and Loan Repayment Programs

Proposal: The Indian Health Service (IHS) seeks tax treatment similar to that provided to recipients of scholarships and loan repayment from the National Health Service Corps (NHSC). The IHS seeks to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Service Health Professions Scholarships to be excluded from gross income under section 117(c)(2) of the Internal Revenue Code of 1986 (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. With the above exemptions, the IHS programs would also be exempt from any Federal Employment Tax (FICA), making the IHS programs comparable to the current NHSC status.

Current Law: Generally, benefits 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:

- 26 U.S.C. § 117(c)(2), provides that tuition, fee, and other related cost payments by the National Health Service Corps scholarships are not taxable. This tax exemption was made permanent by Congress in December 2012 but did not include IHS scholarships.
- 26 U.S.C. § 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 (42 U.S.C. § 254l-1) or a state loan repayment program described in section 338I of the Public Health Service Act (42 U.S.C. § 254q-1) are permanently not subject to federal income tax.
- 26 U.S.C. § 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 health care provider, has difficulty recruiting and retaining health care professionals. There are over 1,330 vacancies for health care 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 health care professionals needed to fill these vacancies. The IHS Health Professions Scholarship and IHS Loan Repayment Program are very similar to 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 may increase 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. Starting in FY 2023, the IHS Loan Repayment Program award and tax amounts were increased to a maximum of $25,000 per year and 24% to cover the additional Federal taxes the employee would pay. Employer Federal Insurance Contributions Act (FICA) taxes at 7.65% are also paid by the IHS and Employee FICA taxes are withheld from the recipient's award. Because of this, the recipient does not receive the full award.

The ability to exempt scholarship and loan repayment funds from gross income would make this recruitment and retention tool more attractive to potential participants because it would reduce the employee's taxable income and it would allow IHS to make more awards with funds that would otherwise go toward taxes. Based on IHS' calculations, for the last complete award year exempting the IHS Loan Repayment Program would allow IHS to award an additional 218 loan repayment contracts in a given

year. The table below is based on FY 2022 data. Currently, FY 2023 data is not available because the IHS LRP is still accepting applications and making awards. Thus, the IHS would be better able to increase the number of health care providers entering and remaining within the IHS to provide primary health care and specialty services.

Budget Impact:

Federal Tax Revenue Foregone (in 2022 dollars):

Loan	$8,734,131
Scholarship	$332,653.
Total	$9,066,784

Budget impact is the amount of tax revenue withheld by IHS from IHS Health Professions Scholarship and Loan Repayment and forwarded to the Internal Revenue Service. This also includes the tax liability owed by the scholarship recipients.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal would increase IHS's ability to recruit and retain healthcare professionals to provide primary health care and specialty services to American Indian/Alaska Native communities which disproportionately suffer from healthcare issues and lack the needed clinical staff to treat community members. The requested change will also foster equity between the IHS and NHSC loan repayment and scholarship programs which will incentivize clinicians to choose a career with IHS.

Withhold Annuity and Retiree Pay for Retired Civil Service Employees Convicted of Moral Turpitude

Proposal: Amend Federal law to allow for withholding or revoking of annuity and retiree pay for retired civil service employees convicted of moral turpitude, including crimes against children and rape, during the commission of their federal duties

Current Law: Under 5 U.S.C. § 8312, a retired civilian employee's annuity and retiree pay may only be withheld for specific high crimes of treason, aiding the enemy, perjury, and subordination of perjury. The federal government needs additional authorities to address the pay of retirees who commit certain egregious and reprehensible crimes that outrage and offend the American Public's moral sensibility. Expansion of the list of offenses minimally should include crimes against children and rape perpetrated by federal employees during the commission of their federal duties, on federal property, or while otherwise using their federal position.

Rationale: In September 2018, a former U.S. Public Health Service Commissioned Corps officer and civil service employee at the IHS was convicted of sexual assault and exploitation of children for crimes committed while an active-duty Corps officer assigned to the IHS facility in Browning, Montana. In September 2019, the same individual was convicted on additional charges in South Dakota for similar allegations while assigned to the IHS facility in Pine Ridge, South Dakota, and the case was appealed in February 2020. The sexual assailant's conviction exposes the limitations of current statute to fully address and adjudicate crimes of moral turpitude committed by retired federal employees during the commission of their duties while in the federal civil service.

In keeping with the limited scope of current law, e.g., 5 U.S.C. § 8312, the proposed amendment may be limited to the commission of crimes against children and rape, specifically while on duty, on federal property, or while using or misusing the authority of their federal position. This proposed amendment is in line with the Department's mission of protecting vulnerable, underserved populations, and the Presidential Task Force on Protecting Native American Children in the Indian Health Service System.

Budget Impact: In the case of revoking of annuity and retiree pay for retired civil service employees convicted of moral turpitude, there would be a cost savings to the agency.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal will promote equity of treatment against convicted perpetrators of egregious crimes in regards to receipt of federal retirement benefits. The American Indian/Alaska Native population is already a vulnerable and underserved population, and this proposal seeks to deny retirement benefits to those who harm children, who are the most defenseless members of this population. There are restrictions in most states' laws preventing or limiting the receipt of a state pension for convicted felons and this proposal would make federal pensions more consistent with this model.

Provide the Indian Health Service with permanent authority to hire and pay experts/consultants

Proposal: The Indian Health Service (IHS) needs the ability to hire experts/consultants to address challenging tasks in a particular field beyond the usual range of achievement of competent persons (5 C.F.R. § 304.102(d)). An expert/consultant can also provide valuable and pertinent advice generally drawn from a high degree of broad administrative, professional, or technical knowledge or experience including those with health care management or public health expertise. (5 C.F.R. § 304.102(b)).

Unlike most other Department of Health and Human Services (HHS) Operating Divisions and Staff Divisions, the IHS does not have a permanent authority to hire expert/consultants and pay rates not to exceed the daily rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. §5376. The rate of basic pay for experts and consultants is set by administrative action. An agency must determine the appropriate rate of basic pay on an hourly or daily basis. Since experts/consultants are not general schedule employees, they are not covered by locality payments under 5 U.S.C. § 5304 and 5 C.F.R. part 531, subpart 5. The pay may not exceed the GS-15 step 10. IHS had a temporary authority through the FY 2023 annual appropriations bill; however, if not extended, that authority will expire at the end of the 2023 fiscal year.

Current Law: Agencies may appoint experts and consultants temporarily (i.e., not to exceed one year) or on an intermittent basis (i.e., without a regularly scheduled tour of duty). These employees are not covered by the standard provisions related to an appointment in the competitive service (5 C.F.R. part 332), position classification (5 U.S.C. chapter 51), or General Schedule pay-setting (5 U.S.C. chapter 53, subchapter III).

The Department of Interior, Environment, and Related Agencies Appropriations Act, 2023 (Public Law 117-328div. D (Dec. 29, 2022)), authorized IHS to obtain services under 5 U.S.C. §3109 and pay at rates not to exceed the daily rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. §5376.

Rationale: Hiring experts and consultants is another tool IHS can use to strengthen its workforce and better serve the American Indian/Alaska Native population. These highly specialized individuals can bring added skills, knowledge, and expertise to meet mission-critical tasks. To combat future pandemics, emergencies, and unique health-care challenges, it would be beneficial to hire experts/consultants to provide additional high-level resources to the IHS unavailable within the current workforce.

The IHS is at a disadvantage by not hiring experts/consultants that could temporarily provide specialized advice or assistance with projects or planning on a temporary or intermittent basis. IHS could benefit from experts/consultants by:

- Gaining specialized diversity of thought needed to solve complex issues or perform tasks.
- Obtaining advice from experts/consultants in their field of study.
- Hiring experts/consultants from leading universities and colleges to advise on health care.
- Completing short-term mission-critical projects.
- Filling short-term, high-level positions with experts/consultants temporarily, which can be an efficient mechanism as well as a cost savings to the agency.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment of legislative authority.

Equity Impact Assessment: This proposal will enable the Indian Health Service to appoint experts and consultants to support the provision of healthcare to people in AI/AN communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. By authorizing the use of experts and consultants, IHS can strengthen operations and patient care, and as a result, achieve better health care outcomes for American Indians and Alaska Natives.

Provide the Indian Health Service (IHS) with an on-call pay authority through a revision to premium pay provisions under Title 5 of the United States Code (U.S.C.)

Proposal: The Indian Health Service (IHS) needs to be able to provide on-call pay to its health care staff under the premium pay system authorized under Title 5 of the United States Code. This will enable IHS to compensate clinical staff who agree to be on call and to achieve adequate on-site staffing levels when responding to fluctuating patient care demands.

Current Law: IHS uses the premium pay provisions under Title 5 of the U.S.C. to compensate employees for working extended hours (overtime pay) or for working at certain times such as at night, on Sundays or on holidays. Premium pay is paid under Title 5 legal and regulatory provisions and is subject to biweekly and annual aggregate pay limitations, under 5 U.S.C. chapter 55, subchapter V and 5 Code of Federal Regulations (C.F.R.) part 550, subpart A. Current Title 5 premium pay law does not allow for on-call pay.

By comparison, a major pay feature used by the United States Department of Veterans Affairs (VA) and nonfederal health care employers is the ability to provide on-call premium pay to health-care staff. Under the VA's Title 38 premium pay provisions, on-call pay is paid at ten percent of the employee's overtime rate. This type of premium pay is provided when an employee is scheduled to be on call outside of working hours in the event that the employer needs to call the employee back to the work site to provide health-care services. During the on- call period, the employee must remain ready to work and must carry a cell phone or other device in order to be easily contacted in the event the work site needs his or her services. If the employee is called back to the work site, he or she is provided, at a minimum, two hours of overtime pay or more if the employee needs to work on site longer than two hours. The ability to have employees be on call allows the VA to quickly adjust its on-site staffing and is ultimately a cost-savings measure since there is no need to schedule additional staff on-site at their full regular or overtime rate just to prepare for the possibility of increased patient care demands. On- call pay is also a standard pay option in nonfederal health care facilities that are not bound by federal pay regulations.

Rationale: The IHS is the principal federal health care provider and health advocate for American Indians and Alaska Natives (AI/ANs). The IHS provides comprehensive health services for over 500 federally recognized tribes and serves over two million AI/ANs located across 37 states every year.

For various budgetary and administrative reasons, IHS has not adopted the full suite of premium pay provisions available under the delegated Title 38 pay authorities which allow for the payment of on- call premium pay. IHS often competes with the VA and nonfederal employers for needed allied health staff, and IHS's inability to pay on-call pay is a major recruitment and retention challenge.

The success of the IHS clinical mission rests on the ready availability of the appropriate clinical staff who can best address patient needs. To achieve this, IHS needs to be able to compensate employees who are on call, with formally agreed-upon on-call restrictions in place such as continued proximity to the work site, carrying a cell phone, and remaining in a ready and able to work physical condition. A legislative change to the Title 5 premium pay provisions would place IHS on more equal footing with the VA and nonfederal employers of clinical staff that can already provide on-call pay to staff.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal will enable the IHS to hire and retain mission-critical healthcare staff to provide healthcare to people in AI/AN communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. It will enable IHS to better manage its healthcare staff by compensating employees who serve on call. The requested change will make the level of care provided to AI/AN people more on par with care provided to the country's veterans by the VA.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2025 Performance Budget Submission to Congress

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Nonrecurring Expenses Fund

Nonrecurring Expenses Fund

Budget Summary
(Dollars in Thousands)

	FY 2023[2]	FY 2024[3]	FY 2025[4]
Information Technology	$18,000	$31,500	$39,048
Facilities	$96,788	$80,873	$95,340
Notification[1]	$114,788	$112,373	$134,388

[1] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.
[2] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on September 23, 2022.
[3] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on October 19, 2023.
[4] HHS has not yet notified for FY 2025.

Authorizing Legislation:
Authorization.....Section 223 of Division G of the Consolidated Appropriations Act, 2008
Allocation Method.....Direct Federal, Competitive Contract

Overview of NEF and Program Accomplishments

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of the funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions**.**

NEF resources have allowed IHS to address the Health Care Facilities Construction Priority List backlog and to modernize IHS' aging health IT systems. These investments will facilitate improved access to modern facilities and data systems for health care providers, support accurate clinical diagnosis, and effective therapeutic procedures to assure the best possible health outcomes. NEF funds have also allowed IHS to make numerous capital investments through the Health IT Systems and Support project, enabling targeted upgrades toward its quarterly release schedule for the IHS electronic health records system software applications. IHS has been able to replace over-age medical equipment. These funds were distributed to procure prioritized medical equipment across various IHS Area Offices and have allowed replacement of a wide range of equipment including mobile mammography equipment, digital radiology, central patient monitoring systems, nurse call systems, x- rays, ultrasounds, fetal monitoring systems, medical pumps and dental equipment.

IT Projects

Budget Allocation FY 2025

Hardware Lifecycle Replacement Project

NEF funding for this project will replace end-of-life network and data center hardware critical to Health IT services that support medical providers fundamental to raising the physical, mental, social and spiritual health of American Indian/Alaska Native people. IHS has thousands of devices operating beyond the lifecycle, are not covered by warranties or service agreements, and cannot be updated against cybersecurity threats.

This project is part of a multi-year strategy to improve the lifecycle management of all IHS hardware.

Customer Relationship Management Project

This project will implement a new cloud-based Customer Relationship Management platform such as SalesForce and develop applications to meet several critical business needs to improve agency operations. Funding for this initiative is not available within our current budget and requires capital to implement and develop new tools to increase productivity.

Interoperability

The Interoperability project objective is to develop strategies, including the development and/or acquisition of solutions in response to support the HHS requirements of the 21st Century Cures Act, as well as position IHS for further interoperability in preparation for future data interoperability/migration/archiving needs. While the IHS and HHS are implementing a modernized Electronic Health Record, the IHS agency is required to comply with HHS mandates for Certified Health Information Technology and developing or enhancing Immunization reporting systems.

Quality Measures

This project delivers update work needed to prepare the electronic Clinical Quality Measures eCQM for the 2025 CMS Reporting Period (January 1-December 31, 2025) and support local quality performance improvement activities by updating the product to the most current version standards and maintaining ONC Maintenance Certification.

Four Direction Warehouse

This funding request aims to address an identified need for a vendor-neutral data repository that serves as a long-term storage and active longitudinal record for existing electronic health records (EHR) data as well as ingesting data from any future EHR system.

Business Process and Data Modeling

The funding requested would allow Indian Health Service to acquire professional modeling services, and two modeling tools, one focused on business process, architecture, and systems engineering, and a tool focused on data modeling.

Budget Allocation FY 2024

Implement Zero Trust and Critical Cybersecurity Capabilities

OMB Memorandum M-22-09 requires agencies to achieve specific zero trust security goals by the end of Fiscal Year (FY) 2024. NEF investments will develop a Federal zero trust architecture and implement the required capabilities in order to reinforce the Government's defenses against increasingly sophisticated and persistent threat campaigns. Once an agency-wide current state IT assessment is completed utilizing external contracted partners, this initiative will next focus on identifying the tools, applications, IT hardware, and processes necessary to implement the zero trust goals. W here applicable, the IHS will comply with all FISMA and HHS cybersecurity/privacy requirements.

Modernize the Indian Health Service Network

OMB Memorandum M-21-07 requires all federal agencies to have at least 80 percent of IP-enabled IT assets operating in Ipv6-only environment by FY 2025. Ipv6 is the next-generation Internet protocol, designed to replace version 4 (Ipv4) that has been in use since 1983. In order to implement OMB mandate M-21-07, the IHS will need to identify external partners and SMEs via the contracting process to evaluate agency IT infrastructure and applications with the specific goal of transitioning the agency to next-generation internet communication protocols. Once external partners are identified and contracted, the next phase of this initiative will be to identify a path forward to migrate to an Ipv6-only infrastructure. The plan includes performing a current-state assessment, the identification and procurement of tools, applications, and hardware necessary to migrate to an Ipv6 environment.

Modernize Enterprise IT and Cloud Services

The primary objective of this project is to leverage cloud computing capabilities and modernize IHS IT enterprise services, support HIT modernization efforts, and accelerate existing IHS IT initiatives to create a unified, automated, and optimized computing environment by adapting a "Cloud Smart" strategy. Further, the implementation of cloud-computing capabilities will support and accelerate existing IT initiatives including IHS HIT modernization, data center consolidation, shared IT services, and enhance the cybersecurity posture of the IHS network. Utilizing cloud computing capabilities and services is a high priority requirement that is integral to the modernization of the IHS HIT infrastructure. In order to modernize IHS IT enterprise services, the IHS will seek out and identify external partners and SMEs via the contracting process to evaluate agency IT infrastructure and applications with the specific goal to leverage cloud-computing capabilities to modernize and optimize the IHS network.

IT Service Management Enhancements

Information Technology Service Management (ITSM) is the process of designing, delivering, managing, and improving the IT services an organization provides to its end users. The IHS objective is to focus on aligning IT processes and services with business objectives to help the IHS provide improved IT services that directly support direct patient care services. This project builds upon several years of work and will implement important capabilities to improve the ITSM maturity within IHS, reduce costs, enhance managerial oversight, and increase cybersecurity capabilities in IHS. Funding will be used to implement new cloud capabilities in the ITSM tool (ServiceNow cloud platform) to improve IT and HIT services used to directly support direct patient care services. IHS lacks the ability to centrally manage IT service events such as service outages and performance degradation. This project consolidates multiple data sources for configuration items into a single IHS ServiceNow Configuration Management Database dashboard. This project also implements Service Level Management capabilities in the ITSM tool to document and track all service commitments between IT, service providers, and customers. This project centralizes these functions and provides IHS with tools and processes to improve IT services across the Agency.

Advancing Interoperability of Health Information

The Interoperability project objective is to develop strategies, including the development and/or acquisition of solutions in response to support the HHS requirements of the 21st Century Cures Act, as well as position IHS for further interoperability in preparation for future data migration/archiving needs. Primary activities include analyzing and developing requirements to meet the Trusted Exchange Framework, meeting the minimum required terms and conditions for the Trust Exchange, and participating in a Qualified Health Information Network. Components impacted by the Cures Act include, but are not limited to, systems and processes supporting Health Information Exchange, Personal Health Record, Master Patient Index, standardization of application programming interfaces (APIs), analytics supporting quality measure development and reporting, user authentication, patient-initiated health data requests, and data segmentation and privacy policies.

Clinical Quality Measure Development and Training

Activities include new quality measure analysis, existing logic reviews to identify changes needed to meet new measure requirements, updating measures to the current version logic, developing new measures as identified, preparing tests to verify the measures return the intended data, and developing all required workflow reporting processes that must be performed either individually at the site level or through central reporting mechanisms. Additional activities require the identification and creation of new data elements to capture new codes, tests, results, and other applicable information related to the public health emergency and associated workforce training activities to support the response to the pandemic information tracking.

This project delivers update work needed to prepare the electronic Clinical Quality Measures eCQM for the 2024 CMS Reporting Period (January 1-December 31, 2024) and support local quality performance improvement activities by updating the product to the most current version standards and maintaining ONC Maintenance Certification. We anticipate that eCQM will need to recertify with the Authorized Certification Body.

Budget Allocation FY 2023

Modernize Enterprise IT Services
The project supports the acquisition and implementation of cloud capabilities for the IHS enterprise infrastructure that supports the IHS HIT modernization initiative. Leveraging cloud computing capabilities will enable the IHS to leverage five essential characteristics of cloud computing: on-demand IT services, broad network access, resource pooling, rapid elasticity, and measured services.

Ipv6 Cybersecurity Remediation
The project upgrades the IHS Wide Area Network (WAN) to support the migration to an Internet Protocol Ipv6 capable network. This upgrade is critical to support Health IT services and will provide the network hardware, tools and migration support services to enable the IHS WAN to migrate to next-generation networking capabilities and increase the overall security posture of the IHS network.

Quality Measures Development and Reporting
The project develops new data capture capabilities, measure logic, and business intelligence development to respond to mandated requirements from various quality initiative programs and public health emergency management reporting. Activities include updating measures to the current version logic, developing new measures as identified, and developing all required reporting processes that must be performed either individually at the site level or through central reporting mechanisms, such as the Association of Public Health Laboratories Information Messaging Services system.

Budget Allocation FY 2022 and Prior

Improve IT Service Management Maturity
This project will mature the cloud capabilities of IHS HIT systems and improve IT services that support direct patient care.

Lifecycle Replacement of Critical Hardware
This project continues replacing end of life network and data center hardware critical to HIT services that support medical providers. IHS has thousands of devices operating beyond the lifecycle that are not covered by warranties or service agreements and cannot be updated against cybersecurity threats. This project is part of a multi-year strategy to improve lifecycle management of all IHS hardware.

Cybersecurity Operations Center
This project creates a dedicated lab space with specific tools and equipment needed to perform several mission essential functions that aid in HHS and OIG investigations. Some of these functions include malware analysis, eDiscovery and research. This facility will give the incident responders the ability to correlate data from various sources and determine if a critical system has been impacted; provide remediation efforts and support system owners in data/system recovery.

Advancing Interoperability of Health Information
This project will continue work toward expanding capacity and capability of the interoperability framework and meeting the certification requirements of the 21CCA. The upcoming objectives include the performance of Real World Testing of the current released certified criteria in production settings, completion of the coding necessary to transition to the US Core Data for Interoperability (USCDI) v2.0 data requirements, development to meet the certification criteria for Transitions of Care, Clinical Information Reconciliation, Security Tagging, Standardized APIs, and self-declaration criteria supporting auditing requirements. In addition, work continues to complete the necessary documentation to obtain the Authority to Operate for the Four Directions Hub system providing the interoperability framework.

Developing and implementing supporting technology standardization through a planned Enterprise Architecture
Plans for the FY2022 in support of the technology standardization include the efforts to implement the

USCDI v2.0, as well as the implementation of the certified software in scheduled phases for 21CCA. Providing a common data set, software configuration, security orchestration, and standardized API configuration that are the industry standards for interoperability. These efforts will prepare the IHS for the solutions to standardize HIT in use at IHS now and in the future.

Success Stories

Advancing Interoperability of Health Information: The IHS obligated approximately $15M of NEF funding in between FY2021 and FY2022 to acquire and develop solutions to meet the HHS requirements of the 21st Century Cures Act. The IHS is required to comply with HHS mandates for Certified Health Information Technology (CHIT). The NEF funding allowed the IHS to comply with Cures Act standards, I/T/U hospitals, clinics, and health stations where direct patient care is delivered will be subject to reductions in billable services to CMS further impacting resources at the point of care provided through revenue generation. In addition, IHS analyzed and developed requirements to meet the Trusted Exchange Framework, meeting the minimum required terms and conditions for the Trust Exchange, and participating in a Qualified Health Information Network (QHIN). NEF allowed IHS to actively participant in health information exchange activities and most importantly from using interoperability for the benefit of the American Indian and Alaska Native (AI/AN) populations.

ServiceNow: The IHS obligated approximately $4M of NEF funding in between FY2018 and FY2021 to acquire an enterprise Information Technology Service Management (ITSM) platform called ServiceNow to modernize IT incident tracking, knowledge management, and change management capabilities across the enterprise. This effort significantly standardized how IHS manages IT incidents/requests by providing a single ticketing system and multiple channels for customers to request services. Prior to FY2018, ITSM was fragmented in IHS because each of the 12 Areas and Headquarters used different tools for IT Incident management. IHS gained significant improvements to ITSM by implementing a single enterprise tool for managing incidents and service requests across the agency. ServiceNow is a critical capability for the IHS and helps prepares the Agency for the Health IT Modernization efforts underway for the next decade. NEF was essential for the IHS to accomplish this effort because annual appropriations could not support the capital needed to implement this product over several years.

Facilities

Budget Allocation FY 2025

SYRTC – Desert Sage Healing Center Solar Panels, Hemet, CA

This project will consist of the design and installation of installing approximately 13,000 square feet of solar panels consisting of a rooftop and canopy solar system. The solar system will offset approximately 90 percent of the electric utility costs, and the solar carport canopies will provide cover for staff and patients, and cover for vehicles. Using renewable energy sources will reduce the life cycle energy cost for the facility, reduce greenhouse gas emissions by offsetting electrical demand, and further the IHS Sustainability initiative for healthcare facilities. This request will augment the previous $1.11 million, 2020 NEF contributions to complete this project.

NYRTC – Sacred Oaks Healing Center Solar Panels, Davis, CA

This project will consist of the design and installation of installing approximately 5,400 square feet of solar panels consisting of a rooftop and canopy solar system. The solar system will offset approximately 90 percent of the electric utility costs, and the solar carport canopies will provide cover for staff and patients, and cover for vehicles. Using renewable energy sources will reduce the life cycle energy cost for the facility, reduce greenhouse gas emissions by offsetting electrical demand, and further the IHS Sustainability initiative for healthcare facilities. This request is to augment the previous $2.25 million, 2020 NEF contributions to complete this project.

Quentin N. Burdick Memorial Health Care Facility ED Renovation Phase II, Belcourt, ND

The NEF funds will be used to complete Phase II renovations of the Quentin N. Burdick Memorial Health

Care Facility in Belcourt, ND. The project was previously selected to receive $5.765 million to complete the ED renovations. However, the cost has increased, and the project requires additional funding before construction may begin.

Cass Lake Hospital Emergency Department Renovation and Modifications Phase III, Cass Lake, MN

Phases I and II were recently completed with NEF. The scope of the project is an Emergency Department renovation and expansion project to address signification patient safety deficiencies at the existing Emergency Department. It includes the renovation of existing space, relocation of the ambulance garage, and site improvements.

Belcourt Multiplex for Quarters, Belcourt, ND

This project will supply 10 of the required 40 quarter units needed to support healthcare staff at the Belcourt service unit. The project's scope is a single-story multiplex, with 10 units, mechanical and housekeeping space.

Parker Quarters Project 25 Units Phase 2, Parker, AZ

The Parker Indian Health Center Quarters project phase 2 is intended to provide an additional 25 staff quarters units to expand housing availability for the staff at PIHC. This project will provide affordable housing for staff that is located closer to the health center.

Hopi Health Care Center Quarters Project 50 Units, Polacca, AZ

The Phoenix Area Indian Health Service and the Hopi Health Care Center (HHCC) propose to undertake a project to construct 50 quarters units distributed between HHCC and Keams Canyon quarter locations to provide additional housing for staff that work at the healthcare facility. The HHCC is located on the Hopi Reservation in Polacca, Arizona, and serves approximately 7,000 people from the surrounding Hopi and Navajo Tribes. It is an approximately 97,000 sf facility that has been accredited by The Joint Commission for hospital standards.

Wanblee Parking Lot Resurface, Wanblee SD

The project proposes to resurface the existing staff and patient parking lots, remediate the drainage issues with a new system, and add a small new parking lot by the Maintenance building.

Wagner Health Center Parking Lot Replacement, Wagner, SD

The project proposes to replace the north and west parking lots at the Wagner Health Center. The current lot of the health center has drainage issues. The drainage problems have caused potholes, joint deterioration, and created tripping hazards for patients and employees. This project would correct the drainage problems and also correct any ADA deficiencies.

Budget Allocation FY 2024

Design of the Southern Bands Health Center (SBHC), Elko Nevada

This request will complete the design of the new Southern Bands Health Center. The proposed 68,500 BGSF healthcare facility has been planned for the approved User Population of 2,400. New planned services include eye care, social services, visiting specialties (endodontics, cardiology, and podiatry), general radiography, physical therapy, facility management, property and supply, housekeeping, public health nutrition, and a wellness center.

Red Lake Hospital, Red Lake, MN

This project proposes 900 sf of environmental services, 400 sf Audiology, 4,240 sf Pharmacy renovation, loading dock addition, property and supply renovation, a new helipad, and 3,000 sf behavioral health renovation.

NYRTC - Sacred Oaks Healing Center Stormwater, Davis, CA
This project installs stormwater chambers as flood protection structures and complete landscaping improvements above these chambers.

Chinle Comprehensive Health Care Facility Phases 1-4, Chinle, AZ
This project improvements included in Track 2 are the Primary Care, Specialty Care, and Pharmacy Addition. Specifically building an addition for Primary Care expansion, building an addition for Outpatient Pharmacy relocation, and expansion with a drive-thru window. Renovate vacated Outpatient pharmacy for Specialty Care expansion and relocated provider offices, and Nursing Administration Expansion.

Parker Quarters Project, 25 units, Parker, AZ
This project will construct 25 quarters units at the Parker Indian Health Center to provide additional housing for staff that works at the healthcare facility.

Indian Health Service - Medical Equipment
Medical equipment at some IHS and Tribal healthcare sites is old, out of date or obsolete especially at sites with high volumes of patients and limited third-party collections. The NEF resources will be used to mitigate some of the most pressing needs at these sites.

Inscription House Health Care Quarters Renovation, Shonto, AZ
The Inscription House Health Care Facility Quarters Renovation (IHHCQ) is an approximately 19,550 SF health facility located in the northern boundary of Arizona. The IHHCQ was built in 1983. The quarters are to house medical and support staff for the health facility. The renovations of the quarters will help in the recruitment and retention of health care providers and support staff.

Browning Hospital Mechanical Equipment Phase I, Browning, MT
The proposed renovation project of the Browning Hospital Mechanical Equipment in Browning, MT is needed to ensure quality and comprehensive healthcare is accessible to the American Indian and Alaska Native people of the area. The patient centered model is followed to provide care for 108,481 outpatient visits per year to an ever-growing user population that is projected to be 20,736 in 2025. In 2021 a Facilities Condition Assessment was prepared by KF Davis Engineering that identified almost all major mechanical is at or past the end of their useful life in the Browning Hospital.

Budget Allocation FY 2023

Fort Duchesne Health Center Modernization, Ft. Duchesne, UT
The Fort Duchesne PHS Indian Health Center Renovations project modernized the building's mechanical, electrical, plumbing, security, and IT systems and reconfigure the space allocation within the healthcare facility to address current healthcare needs.

Rapid City Health Center Priority Project, Rapid City, SD
The funding was used to equip the healthcare facility to replace the Sioux San Hospital with a new 137,391 sf ambulatory care center. This facility will improve access to medical care as well as improve the collaboration and partnership between the Great Plains Tribes and the IHS. The new healthcare facility provides an expanded outpatient department, community health department, and a full array of ancillary and support services. This facility began construction in September 2019.

Desert Sage Youth Wellness Center Best Road, Hemet, CA
The funds will acquire, from willing sellers, the land in Hemet, California, upon which is located a dirt road known as ``Best Road' 'and construct a reliable and safe all-weather access road between Sage Road (a Riverside County paved road), to the DSC paved entrance. The newly paved all-weather access road is approximately 0.51 of a mile long and 24' wide. It will be constructed along the same alignment as the current Best Road which is currently an unimproved dirt road that traverses across two parcels of private property that will need to be purchased.

Crow 18-Unit Apartment Building, Crow Agency, MT
The NEF funds will be used to construct an 18-Unit apartment building in Crow Agency, Montana. The Program Justification Document for Quarters identifies the shortage of living quarters within the area and that shortage limits IHS' ability to hire and retain staff. The project will expand the availability of living quarters at the remote location, which enables the Service Unit to hire and house the needed staff for delivering adequate health care.

FBSU Hospital Expansion and Renovation, Harlem, MT
This project consists of expanding and renovating the Emergency, Inpatient, Pharmacy and Laboratory Departments at the Fort Belknap Hospital. This will allow the hospital to improve general safety, patient care, COVID response, staff performance and overall hospital efficiency.

Pryor Clinic Expansion and Renovation, Pryor, MT
This project will fund the first phase of capital improvements is anticipated which is to renovate and expand the Pryor Clinic. The renovation and expansion will optimize workflow and expand services to a remote population base at the service unit. The expanded services will include behavior health, physical therapy, radiology, optometry, and create telehealth capabilities. This investment of NEF funds will notably improve patient care and efficiency, increase patient's access to care, and update the facility for treating patients with COVID-19 and other infectious diseases.

Cass Lake Hospital 2023 Expansion and Remodel, Cass Lake, MN
The NEF funds will be used to complete Phases 2.3 and 2.4: remodel of Administrative and Inpatient space, Rooftop Helipad and Medical Office Space Remodel; FFE and Medical Equipment needed for Phases 2.2, 2.3, and 2.4; and facility remodel needed for a pharmacy drive-up window.

Lower Brule Dental Building, Lower Brule, SD
The NEF funds will be used to construct a new dental building on the Lower Brule Service Unit campus. Moving the dental department to the new building will provide space to renovate and expand the existing primary care department.

Rosebud Emergency Department Expansion, Rosebud, SD
This project funding will be used for the expansion and renovation of existing space at the Rosebud Healthcare Center Emergency Department. The current area is under-sized for the high volume of patients and needs to be expanded, with a more functional floorplan, to adequately serve the patient load. The 3,000 sf emergency department space will be expanded to approximately 11,000 sf. The space needs include ligature free exam rooms, two procedure rooms, an isolation room and restroom, birthing room, low acuity exam rooms, a second trauma room, and support space for staff and supplies

Great Plains Area Clinic Pharmacy USP Renovations, Great Plains Area
The funding will be used to redesign, construct, and equip six-Service Unit clinic pharmacies so they will meet the current United States Pharmacopeia (USP) 795, 797, and 800 standards. Site assessments have been completed by a USP consultant

Nationwide Quarters New and Replacement
The NEF funds will be used to design, construct, and equip new and replacement staff quarters. Many locations need to replace existing staff quarters due to deterioration. Staffing health centers in remote locations is difficult when quarters are limited. The shortage of staff limits IHS' ability to provide healthcare.

Budget Allocation FY 2022 and Prior

Generators for California Area Tribal Health Programs
The NEF funds will be used to support the purchase of emergency generators for California Area

Tribal Health programs impacted by public safety power shutoffs in California.

IHS Chemawa Indian Health Center, Salem, OR
The NEF funding will be used to construct a new student wellness building on the Western Oregon Service Unit campus. The construction work aligns with other agency strategic initiatives specific to youth behavioral health needs.

Yakama Dental Building and Modern Primary Care Department
The funds will be used to construct a new dental and optometry building on the Yakama Service Unit campus. An updated site survey for the campus has been completed and is currently being recorded with the Yakama Nation's BIA Realty office and at the US Title Plant. Moving the dental and optometry departments to the new building will provide space to renovate and expand the existing primary care department.

White Earth Health Center Phase II Renovation
This project funding will be used for the renovation of the White Earth Health Center in Ogema, MN, which is needed to meet the demand for health services from the increase in user populations. The 35,800 SF renovation, increases space for Radiology Diagnostics, Behavioral Health, Lab, Optometry, Primary Care, Employee Facilities, Health Information Management and Administration.

Fort Duchesne Health Center Modernization
The Fort Duchesne PHS Indian Health Center Renovations project is intended to modernize the building's mechanical, electrical, plumbing, security and IT systems, and reconfigure the space allocation within the healthcare facility to address current healthcare needs.

Nationwide Quarters New and Replacement
The NEF funds will be used to design, construct, and equip new and replacement staff quarters. Many locations need to replace existing staff quarters due to deterioration. Staffing health centers in remote locations is difficult when quarters are limited. The shortage of staff limits IHS' ability to provide healthcare.

Sells Health Center Replacement Facility
The NEF Funds will augment the FY 2022 HHSJ funding requested for the Sells Health Center Replacement Facility for initial infrastructure and construction.

Success Stories
FY 2019 Replacement of the Havasupai Clinic, in Supai, AZ.
In 2002, the Havasupai Tribal Council passed a resolution supporting the construction of a new clinic and agreed to set aside ½ acre of land for the site. Lack of available funds delayed this project for many years, until in 2014 the Havasupai Council formally setting aside land for a new clinic. In 2016 a contract was awarded to design of the new Clinic. In FY 2019, the IHS was awarded $8,000,000 in NEF funding to the replacement of the Havasupai Clinic. This clinic delivers health care services to 550 members of the Havasupai Tribe. The clinic is in an extremely remote location, in the Grand Canyon, which uniquely impacts the overall planning and delivery of healthcare to this community. Supai is accessed by walking trail from the Canyon rim or by helicopter. Reaching the trailhead is a 3-hour drive from the nearest city. Accessing the nearest higher level of care is an all-day effort.

This project replaced a wooden 2,100 square foot clinic and five staff quarters. The new 8,800 square foot Supai Clinic is a modern, technologically advanced facility expanding the level of health care services specifically designed to meet the health care needs of the Havasupai reservation. The clinic improves access to medical care as well as improve the collaboration and partnership between the Havasupai Tribe and the Indian Health Service. The new facility will provide an expanded outpatient department, community health department, ancillary and support services. The project also provided five of staff quarters. The clinic was completed with beneficial use starting in October 2023. The total project cost was $14.7 million.

FY 2016 Urgent Care Red Lake Hospital, Red Lake, MN
The 2002 master plan indicated that the emergency department for the Red Lake Hospital was undersized by 45 percent. This project was developed to increase space in the emergency and urgent care services areas in the hospital. The urgent care project renovated 7,100 square feet health care space and build 10,521 square feet of new space. This project increased emergency treatment rooms 4 to 10 treatment rooms, increased Emergency Department Drop Off bays from 2 to 3 and added a triage room. The project also provided 8 foot corridors and the required line of sight to all treatment rooms and registration. In addition, staff support, provider, security, and children play area space were increased. This expansion/renovation project improves the quality of patient care serves to 10,300 American Indians and Alaskan Natives and the efficiency and effectiveness of the health care providers.