DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year

2022

Indian Health Service

Justification of Estimates for Appropriations Committees

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville, MD 20857

I present the Indian Health Service (IHS) Fiscal Year (FY) 2022 Congressional Justification. The President's FY 2022 Budget makes a historic investment in the IHS, increasing funding by $2.2 billion, or 36 percent. These funds will increase access to high quality health care in Indian Country, and begin to remediate the impacts of chronic underfunding for the IHS.

The budget also proposes advance appropriations for the IHS, which insulates the Agency and health care programs operated by Tribes, Tribal Organizations, and Urban Indian Organizations (UIOs) from the impact of governmental shutdowns and the uncertainty of the annual appropriations process. I also look forward to participating with Tribal Leaders and Urban Indian Organization Leaders in robust Consultation and Confer to evaluate options, including mandatory funding, to provide adequate, stable, and predictable funding for the IHS in the future. This budget also invests in the Department of Health and Human Services (HHS) Secretary's priorities, including efforts to strengthen national and global readiness for the next public health crisis, promote health equity by addressing racial disparities, support improvement of health equity, enhance funding to reduce the maternal mortality rate and end race-based disparities in maternal mortality, and advance the goal of ending the opioid crisis.

In addition to making these significant investments and changes to the way the IHS receives funding from Congress, the FY 2022 budget submission continues support for our critical work in providing a high quality, comprehensive health service delivery system managed by the IHS, Tribes, Tribal Organizations, and UIOs in 37 states. Agency efforts align with the Administration's priorities and support Departmental goals to help people live healthy, safe, and productive lives.

Our FY 2022 budget submission maintains focus on the IHS mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level and support for three main goals that are outlined in our strategic plan:

Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.

Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.

Goal 3: To strengthen IHS program management and operations.

The Indian health system faces challenges related to access, quality, management, and operations. This budget, which is aligned with our strategic plan, aims to address these challenges and builds on the progress that we have already made. I am excited about what we will achieve together to improve the health and well-being of American Indians and Alaska Natives.

Elizabeth A. Fowler
Acting Director

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INDIAN HEALTH SERVICE

Approved:

Date:

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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 2.6 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) 2022 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 AI/AN people; 2) promoting excellence and quality through innovation of the Indian health system into an optimally performing organization; and 3) strengthening IHS program management and operations in carrying out the agency mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) 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. This budget also fully supports the IHS Strategic Plan 2019 – 2023[1]. In addition, the budget supports the HHS Secretary's priorities to advance health equity, address pressing public health issues such as HIV/Hepatitis C and maternal mortality, and ensure adequate oversight and integrity in the administration of Federal programs.

The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to approximately 2.6 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, AI/AN Tribes and tribal organizations in the development of the budget for IHS. Likewise, IHS confers with urban Indian organizations. The consultation and confer input informs the IHS budget formulation process. The core of the agency's formulation process consists of the priorities and recommendations developed in consultation with Tribes through this independent annual budget process led by the National Tribal Budget Formulation Workgroup.[2] 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. The tribal budget consultation process is a key component of the *IHS strategic objectives to build, strengthen, and sustain collaborative relationships (Objective 1.2); improve communication within the organization, with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public (Objective 3.1); and secure and effectively manage the assets and resources (Objective 3.2); objectives that advance the IHS mission*.

Summary of Budget Submission

The Administration is committed to fulfilling America's promise to Tribal Nations by taking bold action to redress systemic inequities in Indian Country. The total FY 2022 discretionary

[1] https://www.ihs.gov/strategicplan

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

budget authority for IHS is $8.5 billion, a historic increase of +$2.2 billion, or 36 percent, above FY 2021 enacted.

Crosscutting Changes from FY 2021 Enacted include:

- Current Services: +$207 million to offset the rising cost of providing direct health care services, including tribal and federal pay costs ($96 million), medical and non-medical inflation ($24 million), and population growth ($87 million). These resources will help the IHS to maintain services at the FY 2021 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: +$125 million for staffing of nine 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.

Indian Health Services Account Changes from FY 2021 Enacted include:

- Hospitals & Health Clinics General Program Increase: +$190 million to expand access to direct health care services. These resources will support efforts to reduce health disparities and improve the overall health status for American Indians and Alaska Natives by increasing the availability of health care services in Indian Country. The IHS estimates that these resources will support 39,000 inpatient admissions, and 12 million outpatient visits.

- Ending HIV and Hepatitis C (Hospitals & Health Clinics): +$22 million, for a total of $27 million, to address the disproportionate impact of HIV, Hepatitis C, and STDs in Indian Country. These additional resources will improve access to testing and treatment for HIV and Hepatitis C, and prevent new HIV infections by increasing the availability of pre-exposure prophylaxis (PrEP).

- National Community Health Aide Program (CHAP) (Hospitals & Health Clinics): +$20 million, for a total of $25 million, to support the expansion of CHAP to the lower 48 states. These additional resources would support the training, certifying, and hiring of health aides, as well as national program management activities.

- Assessments (Hospitals & Health Clinics): +$27 million to offset the increasing costs of central assessments charged to the IHS since FY 2014. 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 now at a point where it can no longer sacrifice oversight and management of national health programs to absorb these rising costs.

- Electronic Health Record Modernization: +$250 million, for a total of $285 million, to improve the quality of health care in Indian Country, and health status of American Indians and Alaska Natives by modernizing the IHS Electronic Health Record (EHR) system. These resources will support efforts to stabilize the aging IHS EHR while modernization is underway, and support the initial build activities for the EHR environment, as well as initial site transition planning.

- Dental Health: +$50 million, to expand access to dental health services in American Indian and Alaska Native communities. The IHS estimates that these funds will support

an additional 1.1 million dental health services across Indian Country.

- Opioids Grants (Alcohol & Substance Abuse): +$5 million, for a total of $15 million, to expand access to opioid use disorder prevention, treatment, recovery, and aftercare services in Indian Country, as part of the HHS-wide initiative to combat opioid use disorder.

- Purchased and Referred Care: +$190 million to support additional contract health care services that are not available in IHS or Tribal health facilities, providing an estimated 8,312 additional inpatient admissions, 195,465 additional outpatient visits, and 10,086 additional patient travel trips.

- Indian Health Care Improvement Fund: +$243 million to provide additional health services and address resource disparities across the Indian health system.

- Urban Health: +$34 million to increase funding for urban Indian health programs to $100 million. These funds will provide additional culturally competent direct health care services for American Indians and Alaska Natives living in urban areas.

- Indian Health Professions: +$25 million to offer additional IHS Scholarship and Loan Repayment awards, bolstering recruitment and retention efforts through these two high demand programs.

- Direct Operations: +$23 million to support the efficient and effective administration and oversight of national and Area-level functions like financial management, human resources, grants management, acquisitions, ISDEAA contracting and compacting administration, contract support costs and tribal lease payments administration, performance management, and other administrative supports and systems.

Indian Health Facilities Account Changes from FY 2021 Enacted include:

- Maintenance and Improvement: +$50 million, for a total of $223 million, for major projects to reduce the Backlog of Essential Maintenance and Repair (BEMAR), as well as routine maintenance and repair to sustain the condition of federal and Tribal healthcare facilities buildings, and environmental compliance projects to meet changing healthcare delivery needs.

- Sanitation Facilities Construction: +$150 million, for a total of $351 million to improve the potable water supply, wastewater disposal, and solid waste infrastructure for nearly 38,184 eligible American Indian and Alaska Native homes.

- Health Care Facilities Construction: +$266 million, for a total of $526 million, to support the remaining projects on the 1993 IHS Health Care Facilities Construction Priority List, and to construct additional Staff Quarters and Small Ambulatory Facilities. These health care facilities will improve access to direct health care services.

- Facility & Environmental Health Support: +$13 million, for a total of $300 million, to 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.

- Equipment: +$71 million, for a total of $101 million, for maintenance and upgrades for existing medical equipment, and procurement of new medical equipment to replace units that are at the end of their useable lifecycle at IHS and Tribal healthcare facilities.

FY 2023 Advance Appropriation

For the first time, the FY 2022 President's Budget proposes advance appropriations for the IHS at $9 billion in discretionary budget authority for FY 2023. Advance Appropriations will protect IHS, Tribal, and urban Indian health programs from the impact of government shutdowns and the uncertainty of the annual appropriations process. Unlike Medicare and Medicaid, which receive substantial mandatory funding, and the Veterans Health Administration, which receives an advance appropriation, IHS is currently funded primarily through annual discretionary appropriations. Advance appropriations will provide stable, predictable funding, allowing IHS, Tribal, and urban Indian health programs to effectively and efficiently manage budgets, coordinate care, and improve health outcomes for American Indians and Alaska Natives.

FY 2023 Contract Support Costs and Section 105(*l*) Lease Agreements

In addition, the Budget proposes reclassification of the appropriations for Contract Support Costs and section 105(l) lease agreements beginning in FY2023. Specifically, the Budget proposes that, beginning in FY 2023, these accounts will continue to be funded through the Appropriations process but will be reclassified as mandatory funding. At present, Congress provides funding for these costs through an indefinite discretionary appropriation. These costs are more appropriately funded from mandatory appropriations, because they arise from the operation of law.

Overview of Agency Performance

The IHS Strategic Plan FY 2019-2023 sets the direction of the agency over the next five years and includes a mission and vision statement, three goals, and eight objectives.[1] IHS's strategic goals are focused on: access to care, quality of care, and strengthening management and operations. The FY 2022 budget supports the three IHS strategic goals and improvement of AI/AN health outcomes in some of the following ways:[2]

Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.

Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce.

- The Indian Health Professions narrative includes several measures related to recruitment and retention. (*HHS Strategic Plan FY 2018-2022 (HHS SP) Objective 1.4, Strengthen and expand the healthcare workforce to meet America's diverse needs.)*

Objective 1.2: Build, strengthen, and sustain collaborative relationships.

- IHS collaborates with tribes and Urban programs in the delivery of healthcare services, see the Self-Governance and Urban Health narratives for an overview. (*HHS SP Objective 1.3, Improve Americans' access to healthcare and expand choices of care and service options.)*

Objective 1.3: Increase access to quality health care services.

- In FY 2022, IHS anticipates the opening of two newly constructed healthcare facilities. (*HHS SP Objective 1.3)*
- The IHS budget provides critical support in meeting targets for clinical measures, including, maintaining or exceeding targets for childhood and adult immunizations; breastfeeding rates; critical health screenings; access to dental services and preventive procedures such as, dental sealants and topical fluorides; and several diabetes care measures. (*HHS SP Objective 2.2, Prevent, treat, and control communicable diseases and chronic conditions.)*
- Funding for Alcohol and Substance Abuse and Mental Health supports five screening measures to promote early intervention. (*HHS SP Objective 2.3, Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support.)*

Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.

Objective 2.1: Create quality improvement capability at all levels of the organization.

- By December 31, 2021, IHS ambulatory care facilities are required to obtain Patient Centered Medical Home (PCMH) certification/recognition. The PCMH models of care promote care standardization across the agency. (*HHS SP Objective 1.3.)*

Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.

- Culturally appropriate care and best practices are routinely provided and shared across the Indian health care system, the budget narratives include several examples. *(HHS SP Objective 2.1: Empower people to make informed choices for healthier living.)*

Goal 3: To strengthen IHS program management and operations.

Objective 3.1: Improve communications within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public.

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[1] See the "IHS Strategic Plan FY 2019-2023 Goals and Objectives" diagram at the end of this section. The IHS Strategic Plan FY 2019-2023 is available at: www.ihs.gov/strategicplan.

[2] The IHS Strategic Plan FY 2019-2023 aligns with the HHS Strategic Plan FY 2018-2022. See IHS Strategic Plan FY 2019-2023, Appendix A: HHS Strategic Plan and IHS Strategic Plan Crosswalk, the plans are aligned according to strategic objectives. The IHS FY 2021 budget supports the IHS and HHS Strategic Plan objectives, as referenced in parentheses and italics.

- IHS, tribes, tribal organizations, and urban Indian organizations provide critical health care services. IHS continues to strengthen tribal consultation and urban confer efforts to ensure stakeholders have the opportunity to provide input and are informed of system or policy changes. (*HHS SP Objective 1.3.)*

Objective 3.2: Secure and effectively manage the assets and resources.

- IHS continues to improve business processes to inform decision making and strengthen partnerships to maximize patient health care options. *(HHS SP Objective 1.3.)*

Objective 3.3: Modernize information technology and information systems to support data driven decisions.

- In FY 2022, IHS will continue Electronic Health Record (EHR) system modernization efforts that will ultimately replace IHS's current medical, health, and billing records systems. The information technology infrastructure is central to management and operations of the health care system. (*HHS SP Objective 5.3, Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals.)*

The FY 2022 budget request provides critical support in assuring the availability and expansion of health care services, assuring the quality of services, and in providing operational support for the Indian health care system. In addition to the above referenced budget measures, IHS has implemented the following performance reporting and management processes to monitor agency progress.

Performance Reporting

The IHS budget measures support the agency's strategic goals and objectives and are focused on monitoring population health (clinical measures) and strategies to assess program trends and management (non-clinical measures). The FY 2022 budget includes several budget related measures as reported in each narrative and in the outcomes and outputs tables, evaluation results may also be reported in the narrative sections. For FY 2020 the IHS is reporting an "interim result" for each clinical GPRA/GPRAMA measure, pending verification of final patient registration data.

IHS reports valid and reliable aggregated clinical measures using a centralized reporting system to meet the Government Performance and Results Act (GPRA) and GPRA Modernization Act (GPRAMA) requirements. IHS annually reports GPRA/GPRAMA clinical measure results. Tribes administer over 62.1 percent of IHS resources through ISDEAA contracts and compacts and may choose to participate in IHS GPRA/GPRAMA performance reporting. Many Tribal programs operate EHR systems that differ from the IHS EHR, Resource and Patient Management System (RPMS).

Since 2002, IHS has reported electronic population level results for GPRA/GPRAMA clinical measures. Over time, as more Tribes assumed responsibility of providing health care for their members and adopted non-RPMS EHR systems, the agency's clinical performance measure results primarily reflected IHS programs. Prior to FY 2018, IHS clinical measure results reflected only RPMS data as non-RPMS data could not be verified or validated for budget-related performance reporting. Beginning in FY 2018, the IHS clinical results were reported from a new system, the Integrated Data Collection System Data Mart (IDCS DM). [3] The IDCS DM provides those Tribes using non-RPMS EHRs the opportunity to report data for GPRA/GPRAMA purposes; reporting is optional for Tribes. The IDCS DM calculates measure results using any data (RPMS, non-RPMS or Fiscal Intermediary) submitted to the IHS National Data Warehouse

[3] The IDCS DM uses all data exported to the NDW, including non-RPMS tribal and urban data. Budget measures previously reported from RPMS cannot be compared to IDCS DM results because: IDCS DM standardizes the use of user population estimates as the denominator for clinical GPRA/GPRAMA measures, and the reporting year changes from July 1-June 30 (GPRA/GPRAMA year) to October 1-September 30 (to match the user population estimate report year).

(NDW) and assures reporting of valid and reliable clinical measure results. The FY 2020 clinical GPRA/GPRAMA measure results are reported from the IDCS DM and reflect aggregated Federal, Tribal, and urban (I/T/U) results. Tribal programs have the option to participate in IDCS DM reporting and aggregated results include participating Tribal programs. The FY 2022 budget request includes anticipated targets based on most recent year results and projected funding.

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.

COVID-19 Impact

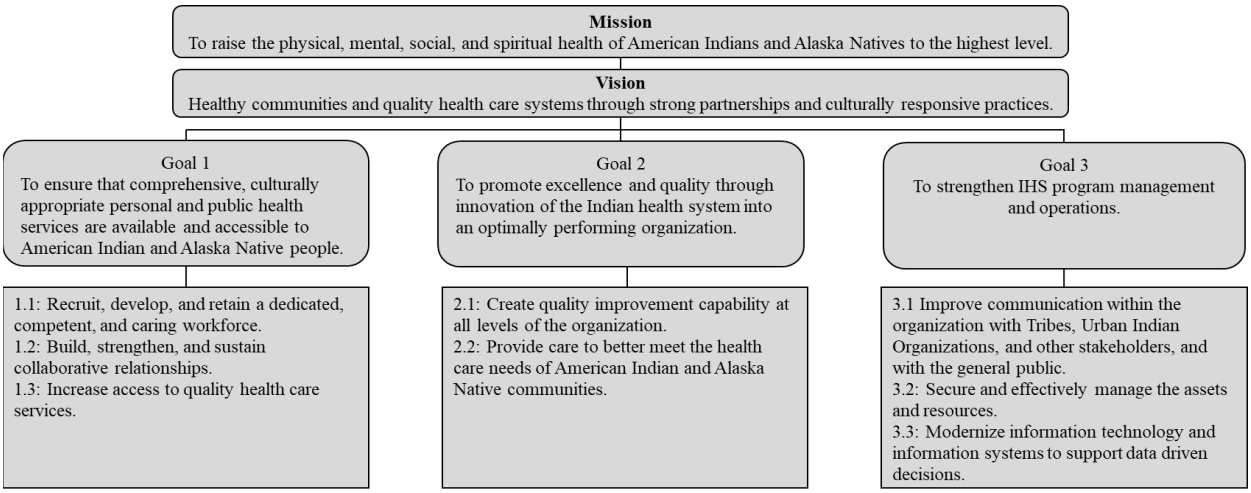
During FY 2020, the Indian health care system has experienced fewer in-person visits as many patients postponed prevention and health maintenance appointments to reduce coronavirus (COVID-19) exposure risk. Several sites also transitioned from in-person primary care to virtual care or reduced services to minimize the risk of COVID-19 transmission, and prioritize COVID-19 testing and response. While patients with acute illnesses or the need for emergency care are still seen at IHS facilities, many patients may be unable or unwilling to have in-person visits during the COVID-19 pandemic due to limited services available or to reduce personal risk. The changes in health care delivery may impact clinical GPRA measures results for FY 2020. The IHS has several examples of how the system modified its delivery system to address COVID-19, including:

- Tribal Consultation and Urban Confer: Consistent with agency policy on tribal consultation and urban confer, the IHS communicated regularly and shared critical information with I/T/Us. Weekly Indian Country COVID-19 Update calls with tribal and Urban Indian Organization leaders call hosted by the White House Office of Intergovernmental Affairs and Federal partners began March 5, 2020. On April 7, 2020, the IHS launched weekly COVID-19 Update calls for UIO Leaders. Call frequency for tribal and Urban Indian Organization leaders has fluctuated from weekly to monthly based on the requirements for COVID-19 situational awareness in Indian country.
- Telehealth Expansion: In March 2020, IHS formed a COVID-19 Telehealth Team that provides outreach to areas and guidance to healthcare providers. IHS expanded its use of telehealth across federal facilities to provide patients with the opportunity to stay home and reduce their risk of infection and keep health care workers safe. IHS released interim guidance to virtual check-in and visit for adults with diabetes. The Increase Tele-behavioral Health Encounters Nationally among American Indians and Alaska Natives is an HHS GPRAMA measure reported in the HHS Annual Performance Plan and Report. Demand for these services has steadily increased. Tele-behavioral visits in the IHS experienced such an increase in services that the IHS revised its FY 2021 target from 26,647 tele-behavioral health encounters to a target of 46,000 encounters.

- Clinical and Administrative Guidance: IHS issued clinical and administrative guidance and recommendation documents to support the delivery of timely, quality, and safe care. IHS focused on sustained care in the Indian health system through developing interim guidance documents. The Division of Oral Health distributed interim guidance for dental clinic operations beyond emergency care as well as for re-opening dental clinic operations. Interim guidance documents were prepared for optometry clinics. Interim guidance was prepared for the role and response of Community Health Representatives/Community Health Workers and later for their virtual home visits during the COVID-19 pandemic.
- Code Updates: The Centers for Medicare & Medicaid Services (CMS) added new reimbursement codes for telehealth and teledentistry visits, those codes were added to measure logic definitions so that facilities using those codes could count those visits. Measures with new telehealth codes were dental access; Screening, Brief Intervention and Referral to Treatment (SBIRT); and, Universal Alcohol Screening.

The FY 2022 narratives may include additional activities related to the COVID-19 response.

IHS Strategic Plan FY 2019-2023 Goals and Objectives



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

Program	FY 2020 Final	FY 2020 COVID-19 Supplemental[5]	FY 2021 Enacted	FY 2021 COVID-19 Supplemental[5]	FY 2022 President's Budget	FY 2022 FY 2022 +/- FY 2021 President's Budget
SERVICES						
Clinical Services	**3,933,462**	**0**	**3,901,877**	**0**	**5,176,642**	**1,274,765**
Hospitals & Health Clinics	2,324,606	0	2,238,087	0	2,703,574	465,487
Electronic Health Record System	8,000	0	34,500	0	284,500	250,000
Dental Services	210,590	0	214,687	0	287,326	72,639
Mental Health	108,933	0	115,107	0	124,622	9,515
Alcohol & Substance Abuse	244,234	0	251,360	0	267,490	16,130
Purchased/Referred Care	964,819	0	975,856	0	1,191,824	215,968
Indian Health Care Improvement Fund	72,280	0	72,280	0	317,306	245,026
Preventive Health	**177,567**	**0**	**178,789**	**0**	**192,588**	**13,799**
Public Health Nursing	91,984	0	92,736	0	102,693	9,957
Health Education	20,568	0	21,034	0	22,164	1,130
Community Health Representatives[1]	62,888	0	62,892	0	65,557	2,665
Immunization AK	2,127	0	2,127	0	2,174	47
Other Services	**204,176**	**0**	**220,725**	**0**	**309,106**	**88,381**
Urban Health	59,053	0	62,684	0	100,000	37,316
Indian Health Professions	65,314	0	67,314	0	92,843	25,529
Tribal Management Grants	2,465	0	2,465	0	2,485	20
Direct Operations	71,538	0	82,456	0	107,788	25,332
Self-Governance	5,806	0	5,806	0	5,990	184
TOTAL, SERVICES	**4,315,205**	**0**	**4,301,391**	**0**	**5,678,336**	**1,376,945**
FACILITIES	**911,889**	**0**	**917,888**	**0**	**1,500,943**	**583,055**
Maintenance & Improvement	168,952	0	168,952	0	222,924	53,972
Sanitation Facilities Construction	193,577	0	196,577	0	351,445	154,868
Health Care Facilities Construction	259,290	0	259,290	0	525,781	266,491
Facilities & Environ Health Support	261,983	0	263,982	0	300,153	36,171
Equipment	28,087	0	29,087	0	100,640	71,553
TOTAL, SERVICES & FACILITIES	**5,227,094**	**0**	**5,219,279**	**0**	**7,179,279**	**1,960,000**
CONTRACT SUPPORT COSTS[1]						
TOTAL, CONTRACT SUPPORT COSTS	**820,000**	**0**	**916,000**	**0**	**1,142,000**	**226,000**
SECTION 105(*l*) LEASES[2]						
Total Section 105(*l*) Leases	**0**	**0**	**101,000**	**0**	**150,000**	**49,000**
Families First Coronavirus Response Act 2020	**0**	**64,000**	**0**	**0**	**0**	**0**
CARES Act - 2020	**0**	**1,032,000**	**0**	**0**	**0**	**0**
Coronavirus Response and Relief Act 2021	**0**	**0**	**0**	**1,000,000**	**0**	**0**
American Rescue Plan Act 2021	**0**	**0**	**0**	**6,094,000**	**0**	**0**
TOTAL, BUDGET AUTHORITY	**6,047,094**	**1,096,000**	**6,236,279**	**7,094,000**	**8,471,279**	**2,235,000**
COLLECTIONS						
Medicare	215,868	0	215,868	0	224,287	8,419
Medicaid	725,122	0	725,122	0	753,402	28,280
Subtotal, M / M	*940,990*	*0*	*940,990*	*0*	*977,689*	*36,699*
Private Insurance	137,029	0	137,029	0	142,373	5,344
VA Reimbursement	6,391	0	6,391	0	6,640	249
Total, M / M / PI	*1,084,410*	*0*	*1,084,410*	*0*	*1,126,702*	*42,292*
Quarters	9,100	0	9,600	0	11,500	1,900
TOTAL, COLLECTIONS	**1,093,510**	**0**	**1,094,010**	**0**	**1,138,202**	**44,192**
MANDATORY						
Special Diabetes Program for Indians (SDPI)[3]						
Subtotal, Special Diabetes Program for Indians	150,000	0	150,000	0	147,000	-3,000
Total, Mandatory	**150,000**	**0**	**150,000**	**0**	**147,000**	**-3,000**
TOTAL, PROGRAM LEVEL	**7,290,604**	**1,096,000**	**7,480,289**	**7,094,000**	**9,756,481**	**2,276,192**
NEF[4]						
IT Projects	38,850	0	0	0	0	0
Facilities Projects	69,525	0	0	0	0	0

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

[2]Maintains a separate, indefinite appropriation for ISDEAA section 105(I) leases.

[3]The Consolidated Appropriations Act (P.L. 116-260) extended the Special Diabetes Program for Indians through FY 2023 at $150 million per year. FY 2022 level reflects mandatory sequester of 2%.

[4]FY 2021 NEF project requests are currently under review and pending OMB approval.

[5] Only includes direct appropriations and directed transfers. Shows supplemental funds post-transfer and post-reallocation.

INDIAN HEALTH SERVICE
FY 2022 Budget
Detail of Changes
(Dollars in Thousands)

Sub IHS Activity	FY 2021 Enacted (P.L. 116-260)	FY 2022 Changes: Current Services	FY 2022 Staffing for New Facilities	EHR	Hospitals and Health Clinics General Increase	Hepatitis C & HIV	National Community Health Aide Program	Assessments	Dental Health	Opioids Grants	Purchased and Referred Care	Indian Health Care Improvement Fund	Urban Indian Health	Indian Health Professions	Direct Operations	Sanitation Facilities Construction	Health Care Facilities Construction	Maintenance and Improvement	Equipment	Facilities and Environ. Health Support	Program Increases/ Adjustments	Subtotal of Changes	FY 2022 Budget
SERVICES																							
Hospitals & Health Clinics	2,238,087	115,059	91,696	0	189,732	22,000	20,000	27,000	0	0	0	0	0	0	0	0	0	0	0	0	0	465,487	**2,703,574**
Electronic Health Record System	34,500	0	0	250,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	250,000	**284,500**
Dental Services	214,687	11,076	11,563	0	0	0	0	0	50,000	0	0	0	0	0	0	0	0	0	0	0	0	72,639	**287,326**
Mental Health	115,107	4,941	4,574	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9,515	**124,622**
Alcohol & Substance Abuse	251,360	9,286	1,844	0	0	0	0	0	0	5,000	0	0	0	0	0	0	0	0	0	0	0	16,130	**267,490**
Purchased/Referred Care	975,856	26,235	0	0	0	0	0	0	0	0	189,733	0	0	0	0	0	0	0	0	0	0	215,968	**1,191,824**
Indian Health Care Improvement Fund	72,280	2,526	0	0	0	0	0	0	0	0	0	242,500	0	0	0	0	0	0	0	0	0	245,026	**317,306**
Total, Clinical Services	3,901,877	169,123	109,677	250,000	189,732	22,000	20,000	27,000	50,000	5,000	189,733	242,500	0	0	0	0	0	0	0	0	0	1,274,765	**5,176,642**
Public Health Nursing	92,736	4,649	5,308	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9,957	**102,693**
Health Education	21,034	1,022	108	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,130	**22,164**
Community Health Representatives	62,892	2,665	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,665	**65,557**
Community Health 7/	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Immunization AK	2,127	47	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47	**2,174**
Total, Preventive Health	178,789	8,383	5,416	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,799	**192,588**
Urban Health	62,684	3,002	0	0	0	0	0	0	0	0	0	0	34,314	0	0	0	0	0	0	0	0	37,316	**100,000**
Indian Health Professions	67,314	529	0	0	0	0	0	0	0	0	0	0	0	25,000	0	0	0	0	0	0	0	25,529	**92,843**
Tribal Management	2,465	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20	**2,485**
Direct Operations	82,456	2,759	0	0	0	0	0	0	0	0	0	0	0	0	22,573	0	0	0	0	0	0	25,332	**107,788**
Self-Governance	5,806	184	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	184	**5,990**
Total, Other Services	220,725	6,494	0	0	0		0			0	0	0	34,314	25,000	22,573	0	0	0	0		0	88,381	**309,106**
Total, Services	**4,301,391**	**184,000**	**115,093**	**250,000**	**189,732**	**22,000**	**20,000**	**27,000**	**50,000**	**5,000**	**189,733**	**242,500**	**34,314**	**25,000**	**22,573**	**0**	**0**	**0**	**0**		**0**	**1,376,945**	**5,678,336**
FACILITIES																							
Maintenance & Improvement	168,952	3,972	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	50,000	0	0	0	53,972	**222,924**
Sanitation Facilities Construction	196,577	4,868	0	0	0	0	0	0	0	0	0	0	0	0	0	150,000	0	0	0	0	0	154,868	**351,445**
Health Care Facility Construction	259,290	603	0	0	0	0	0	0	0	0	0	0	0	0	0	0	265,888	0	0	0	0	266,491	**525,781**
Facility & Environmental Health Support	263,982	12,988	9,984	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,199	0	36,171	**300,153**
Equipment	29,087	640	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70,913	0	0	71,553	**100,640**
Total, Facilities	917,888	23,071	9,984	0	0	0	0	0	0	0	0	0	0	0	0	150,000	265,888	50,000	70,913	13,199	0	583,055	**1,500,943**
Total, Services & Facilities	**5,219,279**	**207,071**	**125,077**	**250,000**	**189,732**	**22,000**	**20,000**	**27,000**	**50,000**	**5,000**	**189,733**	**242,500**	**34,314**	**25,000**	**22,573**	**150,000**	**265,888**	**50,000**	**70,913**		**0**	**1,960,000**	**7,179,279**
CONTRACT SUPPORT COSTS																							
Total, Contract Support Costs	**916,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**226,000**	**226,000**	**1,142,000**
SECTION 105(l) LEASES																							
Total Section 105(l) Leases	**101,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**49,000**	**49,000**	**150,000**
TOTAL, IHS BUDGET AUTHORITY /1	**6,236,279**	**207,071**	**125,077**	**250,000**	**189,732**	**22,000**	**20,000**	**27,000**	**50,000**	**5,000**	**189,733**	**242,500**	**34,314**	**25,000**	**22,573**	**150,000**	**265,888**	**50,000**	**70,913**	**0**	**275,000**	**2,235,000**	**8,471,279**

INDIAN HEALTH SERVICE
FY 2023 Advance Appropriation
Detail of Changes
(Dollars in Thousands)

Sub IHS Activity	FY 2021 Enacted (P.L. 116-260)	FY 2022 President's Budget	FY 2023 Advance Appropriation				FY 2023 Advance Appropriations
			Current Services 1/	FY 2023 Staffing for New Facilities	Program Increases/ Adjustments	Subtotal of Changes	
SERVICES							
Hospitals & Health Clinics	2,238,087	2,703,574	115,059	29,920	0	144,979	**2,848,553**
Electronic Health Record System	34,500	284,500	0	0	0	0	**284,500**
Dental Services	214,687	287,326	11,076	3,361	0	14,437	**301,763**
Mental Health	115,107	124,622	4,941	1,181	0	6,122	**130,744**
Alcohol & Substance Abuse	251,360	267,490	9,286	560	0	9,846	**277,336**
Purchased/Referred Care	975,856	1,191,824	26,235	0	0	26,235	**1,218,059**
Indian Health Care Improvement Fund	72,280	317,306	2,526	0	0	2,526	**319,832**
Total, Clinical Services	3,901,877	5,176,642	169,123	35,022	0	204,145	**5,380,787**
Public Health Nursing	92,736	102,693	4,649	1,760	0	6,409	**109,102**
Health Education	21,034	22,164	1,022	0	0	1,022	**23,186**
Community Health Representatives	62,892	65,557	2,665	0	0	2,665	**68,222**
Immunization AK	2,127	2,174	47	0	0	47	**2,221**
Total, Preventive Health	178,789	192,588	8,383	1,760	0	10,143	**202,731**
Urban Health	62,684	100,000	3,002	0	0	3,002	**103,002**
Indian Health Professions	67,314	92,843	529	0	0	529	**93,372**
Tribal Management	2,465	2,485	20	0	0	20	**2,505**
Direct Operations	82,456	107,788	2,759	0	0	2,759	**110,547**
Self-Governance	5,806	5,990	184	0	0	184	**6,174**
Total, Other Services	220,725	309,106	6,494	1,760	0	6,494	**315,600**
General Program Increases	0	0	0	0	253,562	253,562	**253,562**
Total, Services	**4,301,391**	**5,678,336**	**177,506**	**36,782**	**253,562**	**474,344**	**6,152,680**
FACILITIES							
Maintenance & Improvement	168,952	222,924	3,972	0	0	3,972	**226,896**
Sanitation Facilities Construction	196,577	351,445	4,868	0	0	4,868	**356,313**
Health Care Facility Construction	259,290	525,781	603	0	0	603	**526,384**
Facility & Environmental Health Support	263,982	300,153	12,988	2,585	0	15,573	**315,726**
Equipment	29,087	100,640	640	0	0	640	**101,280**
Total, Facilities	917,888	1,500,943	23,071	2,585	0	25,656	**1,526,599**
Total, Services & Facilities	**5,219,279**	**7,179,279**	**200,577**	**39,367**	**253,562**	**500,000**	**7,679,279**
CONTRACT SUPPORT COSTS 2/							
Total, Contract Support Costs	**916,000**	**1,142,000**			**0**	**0**	**1,142,000**
SECTION 105(l) LEASES 2/							
Total Section 105(l) Leases	**101,000**	**150,000**			**0**	**0**	**150,000**
TOTAL, IHS BUDGET AUTHORITY	**6,236,279**	**8,471,279**	**200,577**	**39,367**	**253,562**	**500,000**	**8,971,279**

1/ Uses same current services estimate as FY 2022 President's Budget, given that FY 2023 economic assumptions and final FY 2021/FY 2022 data are not yet available.

2/ The FY 2022 President's Budget proposes to reclassify CSC and 105(l) lease costs as mandatory funding in FY 2023. The FY 2023 President's Budget will include an updated score for these costs.

INDIAN HEALTH SERVICE
STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES
FY 2022 Budget -- Estimates

(Dollars in Thousands)

	Bethel, AK		Naytahwaush, MN		Scottsdale, AZ		Phoenix, AZ		El Paso, TX		Dilkon, AZ		Omak, WA		New Town, ND		Seward, AK				
	Yukon-Kuskokwim Primary Care Center (JV)		Naytahwaush Health Center (JV)		NEACC (Salt River) Health Center		Phoenix Indian Medical Center Central		Ysleta Del Sur Health Center (JV)		Alternative Rural Health Center		Omak Clinic (JV)		Elbowoods Memorial Health Center (JV) [2]		North Star Health Clinic (JV)[2]				
Opening Date	April 2021		September 2022		December 2021		December 2021		December 2021		December 2021		December 2021		July 2022		April 2022		**TOTAL**		
Sub Sub Activity	Pos	Amount	Pos	Amount	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount	Pos	Amount	Pos	Amount	Pos	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	71	$13,021	6	$827	265	$33,234	30	$2,254	38	$4,455	183	$24,363	67	$9,167	8	$875	20	$3,500	516	172	$91,696
Dental Health	12	$1,676	1	$128	44	$6,618	0	$0	4	$475	19	$2,666	0	$0	0	$0	0	$0	67	13	$11,563
Mental Health	8	$1,156	0	$46	18	$2,120	0	$0	3	$288	8	$964	0	$0	0	$0	0	$0	29	8	$4,574
Alcohol & Substance Abuse	2	$299	0	$23	8	$1,050	0	$0	1	$113	3	$359	0	$0	0	$0	0	$0	12	2	$1,844
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Clinical Services	93	$16,152	7	$1,024	335	$43,022	30	$2,254	46	$5,331	213	$28,352	67	$9,167	8	$875	20	$3,500	624	195	$109,677
Public Health Nursing	3	$658	1	$77	21	$3,288	0	$0	3	$503	5	$782	0	$0	0	$0	0	$0	29	4	$5,308
Health Education	1	$108	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	1	$108
Community Health Representatives	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Preventive Health	4	$766	1	$77	21	$3,288	0	$0	3	$503	5	$782	0	$0	0	$0	0	$0	29	5	$5,416
Total, Services	97	$16,918	8	$1,101	356	$46,310	30	$2,254	49	$5,834	218	$29,134	67	$9,167	8	$875	20	$3,500	653	200	$115,093
Facilities Support	7	$1,815	1	$84	12	$3,649	0	$0	3	$563	10	$2,619	0	$0	0	$0	0	$0	25	8	$8,730
Environmental Health Support	2	$354	0	$11	2	$187	0	$0	1	$126	4	$576	0	$0	0	$0	0	$0	7	2	$1,254
Total, FEHS	9	$2,169	1	$95	14	$3,836	0	$0	4	$689	14	$3,195	0	$0	0	$0	0	$0	32	10	$9,984
Total, Facilities	9	$2,169	1	$95	14	$3,836	0	$0	4	$689	14	$3,195	0	$0	0	$0	0	$0	32	10	$9,984
Grand Total[1]	**106**	**$19,087**	**9**	**$1,196**	**370**	**$50,146**	**30**	**$2,254**	**53**	**$6,523**	**232**	**$32,329**	**67**	**$9,167**	**8**	**$875**	**20**	**$3,500**	**685**	**210**	**$125,077**

[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.

NEACC = Northeast Ambulatory Care Center

INDIAN HEALTH SERVICE
STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES
FY 2023 Budget -- Estimates

(Dollars in Thousands)

	Naytahwaush, MN Naytahwaush Health Center (JV)		Scottsdale, AZ NEACC (Salt River) Health Center		Phoenix, AZ Phoenix Indian Medical Center Central		El Paso, TX Ysleta Del Sur Health Center (JV)		Dilkon, AZ Alternative Rural Health Center		Omak, WA Omak Clinic (JV)		New Town, ND Elbowoods Memorial Health Center (JV) [2]		Seward, AK North Star Health Clinic (JV) [2]				
Opening Date	September 2022		December 2021		December 2021		December 2021		December 2021		December 2021		July 2022		April 2022		**TOTAL**		
Sub Sub Activity	Pos	Amount	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount	Pos	Amount	Pos	Amount	Pos	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	70	$9,101	53	$6,647	6	$451	8	$891	37	$4,872	13	$1,833	22	$2,625	20	$3,500	104	125	$29,920
Dental Health	10	$1,409	9	$1,324	0	$0	1	$95	4	$533	0	$0	0	$0	0	$0	14	10	$3,361
Mental Health	5	$507	4	$424	0	$0	0	$57	2	$193	0	$0	0	$0	0	$0	6	5	$1,181
Alcohol & Substance Abuse	2	$256	1	$210	0	$0	0	$22	0	$72	0	$0	0	$0	0	$0	1	2	$560
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Clinical Services	87	$11,273	67	$8,605	6	$451	9	$1,065	43	$5,670	13	$1,833	22	$2,625	20	$3,500	125	142	$35,022
Public Health Nursing	5	$845	4	$658	0	$0	1	$101	1	$156	0	$0	0	$0	0	$0	6	5	$1,760
Health Education	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Community Health Representatives	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Preventive Health	5	$845	4	$658	0	$0	1	$101	1	$156	0	$0	0	$0	0	$0	6	5	$1,760
Total, Services	92	$12,118	71	$9,263	6	$451	10	$1,166	44	$5,826	13	$1,833	22	$2,625	20	$3,500	131	147	$36,782
Facilities Support	2	$926	2	$730	0	$0	0	$113	2	$524	0	$0	0	$0	0	$0	4	2	$2,293
Environmental Health Support	1	$115	0	$37	0	$0	0	$25	1	$115	0	$0	0	$0	0	$0	1	1	$292
Total, FEHS	3	$1,041	2	$767	0	$0	0	$138	3	$639	0	$0	0	$0	0	$0	5	3	$2,585
Total, Facilities	3	$1,041	2	$767	0	$0	0	$138	3	$639	0	$0	0	$0	0	$0	5	3	$2,585
Grand Total[1]	**95**	**$13,159**	**73**	**$10,030**	**6**	**$451**	**10**	**$1,304**	**47**	**$6,465**	**13**	**$1,833**	**22**	**$2,625**	**20**	**$3,500**	**136**	**150**	**$39,367**

[1] Includes Utilities

[2] These JVCPs are entering their planning phases and detailed budgets are not yet available. Preliminary estimates are included for budget planning purposes.

NEACC = Northeast Ambulatory Care Center

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2022 Performance Budget Submission to Congress

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Appropriation Accounts

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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, **[**$4,301,391,000**]** *$5,678,336,000* to remain available until September 30, **[**2022**]** *2023*, except as otherwise provided herein**[**,**]***; and, in addition, $6,152,680,000, which shall become available on October 1, 2022 and remain available through September 30, 2024, except as otherwise provided herein;* together with payments received during **[**the**]** *each* 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 avail- able to the tribe or tribal organization without fiscal year limitation: *Provided further*, That $2,500,000 shall be available *for each of fiscal years 2022 and 2023* 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 **[**$975,856,000**]** *of the total amount of funds provided, $2,409,883,000 shall remain available until expended* for Purchased/Referred Care, **[**including $53,000,000**]** *of which $1,218,059,000 shall be from funds that become available on October 1, 2022: Provided further, That of the total amount specified in the preceding proviso for Purchased/Referred Care, $106,000,000 shall be* for the Indian Catastrophic Health Emergency Fund, **[**shall remain available until expended**]** *of which $53,000,000 shall be from funds that become available on October 1, 2022*: Provided further, That **[**of the funds provided**]** *for each of fiscal years 2022 and 2023*, up to **[**$41,000,000**]** *$66,000,000* shall remain available until ex- pended for implementation of the loan repayment

program under section 108 of the Indian Health Care Improvement Act: *Provided further*, That of the *total amount of* funds provided, **[**$58,000,000**]** *$116,000,000, including $58,000,000 from funds that become available on October 1, 2022,* 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 *for each of fiscal years 2022 and 2023* may be used to supplement amounts other- wise 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, **[**to improve**]** *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 **[**grants**]** *activities*, for Village Built Clinics*,* and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until ex- pended: *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 2 fiscal years, provided the total obligation is recorded in **[**the year the

funds are appropriated**]** *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 *total amount of* funds provided, **[**$72,280,000**]** *$637,138,000, including $319,832,000 from the amounts that become available on October 1, 2022,* 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**[**:*Provided further*, That none of the funds appropriated by this Act, or any other Act, to the Indian Health Service for the Electronic Health Record system shall be available for obligation or expenditure for the selection or implementation of a new Information Technology infrastructure system, unless the Committees on Appropriations of the House of Representatives and the Senate are consulted 90 days in advance of such obligation: *Provided further*, That none of the amounts made available under this heading to the Indian Health Service for the Electronic Health Record system shall be available for obligation or expenditure for the se- lection or implementation of a new Information

Technology Infrastructure system until the report and directive is received by the Committees on Appropriations of the House of Representatives and the Senate in accordance with the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act)**]**. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2021.)*

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 **[**2021**]** *2022*, such sums as may be necessary*; and, in addition, for fiscal year 2023, such sums as may be necessary, which shall become available on October 1, 2022 and shall remain available through September 30, 2023*: *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. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2021.)*

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 **[**2021**]** *2022*, such sums as may be necessary**[**, which shall be available for obligation through September 30, 2022**]***; and, in addition, for fiscal year 2023, such sums as may be necessary, which shall become available on October 1, 2022 and shall remain available through September 30, 2023*: *Provided*, That notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2021.)*

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, **[**$917,888,000**]** *$1,500,943,000* to remain available until expended*; and, in addition, $1,526,599,000, which shall become available on October 1, 2022 and remain available until expended*: *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation, or expansion of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land on which such facilities will be located: *Provided further*, That not to exceed $500,000 may be used *for each of fiscal years 2022 and 2023* 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. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2021.)*

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 **[**approved by**]** *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: *Provided further*, That the appropriation structure for the Indian Health Service may not be altered without advance notification to the House and Senate Committees on Appropriations. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2021.)*

General Provisions

Contract Support Costs, Prior Year Limitation

SEC. 405. Sections 405 and 406 of division F of the Consolidated and Further Continuing Appropriations Act, 2015 (Public Law 113–235) shall continue in effect in fiscal [year 2021] *years 2022 and 2023*.

Contract Support Costs, Fiscal Year [2021] *2022 AND 2023* Limitation

SEC. 406. Amounts provided by this Act for fiscal [year 2021] *years 2022 and 2023* under the headings "Department of Health and Human Services, Indian Health Service, Contract Support Costs" and "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs" are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements for *each such* fiscal year [2021] with the Bureau of Indian Affairs or the Indian Health Service: Provided, That such amounts provided by this Act are not available for payment of claims for contract support costs for prior years, or for repayments of payments for settlements or judgments awarding contract support costs for prior years*: Provided further, That notwithstanding any other provision of law, funds appropriated under the heading "Department of Health and Human Services, Indian Health Service, Contract Support Costs" in this or prior Acts shall remain available for disbursement until any claims relating to such amounts and submitted under chapter 71 of title 41, United States Code, are resolved*.

Tribal Leases

SEC. [431.] *428.* (a) Notwithstanding any other provision of law, in the case of any lease under section 105(l) of the Indian Self- Determination and Education Assistance Act (25 U.S.C. 5324(l)), the initial lease term commence no earlier than the date of receipt of the lease proposal.

[b) The Secretaries of the Interior and Health and Human Services shall, jointly or separately, during fiscal year 2021 consult with tribes and tribal organizations through public solicitation and other means regarding the requirements for leases under section 105(l) of the Indian Self-

Determination and Education Assistance Act (25 U.S.C. 5324(l)) on how to implement a consistent and transparent process for the payment of such leases.]

Facilities Renovation for Urban Indian Organizations to the extent Authorized for Other Government Contractors

SEC. 433. The Secretary of Health and Human Services may authorize an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) that is awarded a grant or contract under title V of that Act (25 U.S.C. 1651 et seq.) to use funds provided in such grant or contract for minor renovations to facilities or construction or expansion of facilities, including leased facilities, to assist the urban Indian organization in meeting or maintaining standards issued by Federal or State governments or by accreditation organizations.

Language Provision	Explanation
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, **[**$4,301,391,000**]** *$5,678,336,000* to remain available until September 30, **[**2022**]** *2023*, except as otherwise provided herein**[**,**]***; and, in addition, $6,152,680,000, which shall become available on October 1, 2022 and remain available through September 30, 2024, except as otherwise provided herein;*	Provides fiscal year 2022 appropriations and advance fiscal year 2023 appropriations for the Indian Health Services account.
Provided further, That **[**$975,856,000**]** *of the total amount of funds provided, $2,409,883,000 shall remain available until expended* for Purchased/Referred Care, **[**including $53,000,000**]** *of which $1,218,059,000 shall be from funds that become available on October 1, 2022: Provided further, That of the total amount specified in the preceding proviso for Purchased/Referred Care, $106,000,000 shall be* for the Indian Catastrophic Health Emergency Fund, **[**shall remain available until expended**]** *of which*	Provides fiscal year 2022 appropriations and advance fiscal year 2023 appropriations for Purchased and Referred Care, including the Indian Catastrophic Health Emergency Fund.

$53,000,000 shall be from funds that become available on October 1, 2022:	
Provided further, That **[**of the funds provided**]** *for each of fiscal years 2022 and 2023*, up to **[**$41,000,000**]** *$66,000,000* shall remain available until ex- pended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act:	Provides up to $66 million in both fiscal years 2022 and 2023 for the IHS Loan Repayment program.
Provided further, That of the *total amount of* funds provided, **[**$58,000,000**]** *$116,000,000, including $58,000,000 from funds that become available on October 1, 2022,* 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 *for each of fiscal years 2022 and 2023* may be used to supplement amounts other- wise available for Purchased/Referred Care:	Provides fiscal year 2022 appropriations and advance fiscal year 2023 appropriations for Accreditation Emergencies.
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 2 fiscal years, provided the total obligation is recorded in **[**the year the funds are appropriated**]** *such second year of availability*:	Provides that funds that are available for two fiscal years may be used in their second year of availability for annual contracts that extend beyond two fiscal years, so long as the total obligation for such a contract is recorded in the second year of availability of the funds.
*Provided further, That of the total amount of funds provided, **[**$72,280,000**]** $637,138,000, including $319,832,000 from the amounts that become available on October 1, 2022,* 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	Provides fiscal year 2022 appropriations and advance fiscal year 2023 appropriations for the Indian Health Care Improvement Fund.
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 **[**2021**]** *2022*, such sums as may be necessary*; and, in addition, for fiscal year 2023, such sums as may be necessary, which shall become available on October 1, 2022 and shall remain available through September 30, 2023*:	Provides fiscal year 2022 appropriations and advance fiscal year 2023 appropriations for the Contract Support Costs account.
PAYMENT 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 **[**2021**]** *2022*, such sums as may be necessary**[**, which shall be available for obligation through September 30, 2022**]***; and, in addition, for fiscal year 2023, such sums as may be necessary, which shall become available on October 1, 2022 and shall remain available through September 30, 2023*:	Provides fiscal year 2022 appropriations and advance fiscal year 2023 appropriations for the Payment for Tribal Leases 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, **[**$917,888,000**]** *$1,500,943,000* to remain available until expended*; and, in addition, $1,526,599,000, which shall become available on October 1, 2022 and remain available until expended*:	Provides fiscal year 2022 appropriations and advance fiscal year 2023 appropriations for the Indian Health Facilities account.
GENERAL PROVISIONS	
Contract Support Costs, Fiscal Year [2021] *2022 AND 2023* Limitation SEC. 406. Amounts provided by this Act for fiscal [year 2021] *years 2022 and 2023* under the headings "Department of Health and Human Services, Indian Health Service, Contract Support Costs" and "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs" are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding	Provides that prior year contract support costs appropriations remain available for disbursement and do not cancel until any claims under the Contract Disputes Act stemming from prior years are resolved

agreements for *each such* fiscal year [2021] with the Bureau of Indian Affairs or the Indian Health Service: Provided, That such amounts provided by this Act are not available for payment of claims for contract support costs for prior years, or for repayments of payments for settlements or judgments awarding contract support costs for prior years*: Provided further, That notwithstanding any other provision of law, funds appropriated under the heading "Department of Health and Human Services, Indian Health Service, Contract Support Costs" in this or prior Acts shall remain available for disbursement until any claims relating to such amounts and submitted under chapter 71 of title 41, United States Code, are resolved*.	
Tribal Leases SEC. [431.] *428.* (a) Notwithstanding any other provision of law, in the case of any lease under section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l)), the initial lease term commence no earlier than the date of receipt of the lease proposal. [b) The Secretaries of the Interior and Health and Human Services shall, jointly or separately, during fiscal year 2021 consult with tribes and tribal organizations through public solicitation and other means regarding the requirements for leases under section 105(l) of the Indian Self- Determination and Education Assistance Act (25 U.S.C. 5324(l)) on how to implement a consistent and transparent process for the payment of such leases.]	Proposes deletion of one-time directive for the Departments of Interior and Health and Human Services to consult with tribes and tribal organizations regarding the requirements for Section 105(*l*) leases and how to implement a consistent and transparent process for payment of such leases. IHS is currently undertaking this consultation requirement in coordination with the Bureau of Indian Affairs.
Facilities Renovation for Urban Indian Organizations to the extent Authorized for Other Government Contractors *SEC. 433. The Secretary of Health and Human Services may authorize an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) that is awarded a grant or contract under title V of that Act (25 U.S.C. 1651 et seq.) to use funds provided in such grant or contract for minor renovations to facilities or construction or expansion of*	Provides authority for IHS to make funds available to IHS-funded Urban Indian Organizations for minor renovations to facilities or construction or expansion of facilities, including leased facilities, to the extent authorized for other government contractors. This would allow UIOs the full authority that exists for other Federal Acquisition Regulation (FAR) contractors. Providing UIOs with broader authority, similar to other FAR contractors, to improve their health care facilities will assist in

facilities, including leased facilities, to assist the urban Indian organization in meeting or maintaining standards issued by Federal or State governments or by accreditation organizations.	providing the high quality, safe, and culturally relevant health care for the Urban Indian population.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

SERVICES

	FY 2020	FY 2021	FY 2022
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$4,315,205,000	$4,301,391	$5,678,336,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$4,315,205,000	$4,301,391	$5,678,336,000
Mandatory Appropriation:			
Appropriation 1/	$150,000,000	$150,000,000	$147,000,000
Offsetting Collections:			
Federal sources	($325,000)	($436,000)	($436,000)
Non-federal sources	($1,630,000,000)	($1,432,000,000)	($1,432,000,000)
Subtotal, Offsetting Collections	($1,630,325,000)	($1,432,436,000)	($1,432,436,000)
Unobligated Balances:			
Discretionary, Start of Year	$1,510,000,000	$2,109,000,000	$11,652,000,000
Mandatory, Start of Year	$599,000,000	$9,543,000,000	$244,000,000
End of Year	$2,109,000,000	$11,652,000,000	$11,896,000,000
Total Obligations, Services	$2,834,880,000	($1,278,134,609)	$4,148,900,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

FACILITIES

	FY 2020	FY 2021	FY 2022
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$911,889,000	$917,888,000	$1,500,943,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$911,889,000	$917,888,000	$1,500,943,000
Offsetting Collections:			
Federal sources	(46,000,000)	($60,000,000)	(59,000,000)
Subtotal, Offsetting Collections	(46,000,000)	($60,000,000)	(59,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$630,000,000	$944,000,000	$1,753,000,000
End of Year	$944,000,000	$1,753,000,000	$1,812,000,000
Total Obligations, Facilities	$551,889,000	$48,888,000	$1,382,943,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

CONTRACT SUPPORT COSTS

	FY 2020	FY 2021	FY 2022
General Fund Discretionary Appropriation:			
Appropriation (Interior) 1/	$820,000,000	$916,000,000	$1,142,000,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$820,000,000	$916,000,000	$1,142,000,000
Total Obligations, CSC	$820,000,000	$916,000,000	$1,142,000,000

1/ The Congressional Budget Office score for FY 2020 for Contract Support costs is $820,000,000.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

PAYMENTS FOR TRIBAL LEASES

	FY 2020	FY 2021	FY 2022
General Fund Discretionary Appropriation:			
Appropriation (Interior) 1/	$0	$101,000,000	$150,000,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$0	$101,000,000	$150,000,000
Total Obligations, Payments for Tribal Leases	$0	$101,000,000	$150,000,000

1/ The FY 2021 President's Budget proposes a new indefinite discretionary appropriation for payments of tribal leases, owing to Section 105(l), ISDEAA (P.L. 93-638). Amounts for FY 2019 and FY 2020 are located in the Hospitals and Health Clinics line of the Services Appropriation.

INDIAN HEALTH SERVICE

SERVICES

Summary of Changes

FY 2021 Enacted	4,301,391,000
Total estimated budget authority	4,301,391,000
Less Obligations	(4,301,391,000)
FY 2022 Estimate	5,678,336,000
Less Obligations	(5,678,336,000)
Net Change	1,376,945,000
Less Obligations	(1,376,945,000)
	0

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	933,670
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	2,605,581
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	2,989,910
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	24,433,840
5	Tribal Pay Cost	--	n/a	--	58,120,000
6	Increased Cost of Travel	--	29,271,448	--	160,601
7	Increased Cost of Transportation & Things	--	7,294,734	--	139,255
8	Increased Cost of Printing	--	35,525,676	--	814,633
9	Increased Cost of Rents, Communications, & Utilities	--	955,470	--	28,004
10	Increased Cost of Other Services	--	506,044,547	--	13,850,205
11	Increased Cost of Health Care Provided under Contracts & Grants	--	2,310,078,075	--	69,897,570
12	Increased Cost of Supplies	--	107,550,466	--	1,878,665
13	Increased Cost of Medical or other Equipment	--	28,245,367	--	747,031
14	Increased Cost of Land & Structure	--	3,205,079	--	49,760
15	Increased Cost of Grants	--	1,045,895,478	--	2,221,970
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	576,763	--	19,504
17	Population Growth	--	n/a	--	74,918,000
	Subtotal, Built-In	--	4,074,643,103	--	253,808,197
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	115,093,000
C. New Tribes		--	0	--	0
D. Program Adjustments		--	0	--	0
E. Program Increases		--	0	42	1,077,852,000
TOTAL INCREASES		--	4,074,643,103	42	1,446,753,197
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(69,808,197)
	Subtotal Build-In Decreases	--	0	--	(69,808,197)
B. Transfer					
	Transfer of NIAAA Programs from Alcohol to Urban	--	0	--	0
C. Program Adjustments		--	0	--	0
TOTAL DECREASES		--	0	--	(69,808,197)
NET CHANGE		--	**4,074,643,103**	**42**	**1,376,945,000**

INDIAN HEALTH SERVICE
CLINICAL Services
Summary of Changes

FY 2021 Enacted	3,901,877,000
Total estimated budget authority	3,901,877,000
Less Obligations	(3,901,877,000)
FY 2022 Estimate	5,176,642,000
Less Obligations	(5,176,642,000)
Net Change	1,274,765,000
Less Obligations	(1,274,765,000)

	FY 2021 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	851,448
2 FY 2022 Pay Raise CO (9 months)	--	n/a	--	2,376,923
3 Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	2,699,187
4 FY 2022 Pay Raise CS (9 months)	--	n/a	--	22,055,442
5 Tribal Pay Cost	--	n/a	--	52,195,000
6 Increased Cost of Travel	--	29,138,384	--	124,943
7 Increased Cost of Transportation & Things	--	5,220,156	--	120,064
8 Increased Cost of Printing	--	35,347,161	--	813,114
9 Increased Cost of Rents, Communications, & Utilities	--	812,468	--	17,718
10 Increased Cost of Other Services	--	455,333,778	--	12,199,059
11 Increased Cost of Health Care Provided under Contracts & Grants	--	2,144,244,056	--	63,586,316
12 Increased Cost of Supplies	--	60,101,034	--	1,833,133
13 Increased Cost of Medical or other Equipment	--	27,820,706	--	709,417
14 Increased Cost of Land & Structure	--	2,163,463	--	49,760
15 Increased Cost of Grants	--	978,119,677	--	2,155,981
16 Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	576,763	--	13,266
17 Population Growth	--	n/a	--	70,684,000
Subtotal, Built-In	--	3,738,877,646	--	232,484,768
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	0	109,677,000
D. Program Increases	--	0	25	995,965,000
TOTAL INCREASES	--	3,738,877,646	25	1,338,126,768
DECREASES				
A. Built-In				
1 Decrease in the number of compensable days	--	0	--	0
2 Absorption of Built-In Increases	--	0	--	(63,361,768)
Subtotal Build-In Decreases	--	0	--	(63,361,768)
TOTAL DECREASES	--	0	--	(63,361,768)
NET CHANGE	--	**3,738,877,646**	**25**	**1,274,765,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2021 Enacted	2,238,087,000
Total estimated budget authority	2,238,087,000
Less Obligations	(2,238,087,000)
FY 2022 Estimate	2,703,574,000
Less Obligations	(2,703,574,000)
Net Change	465,487,000
Less Obligations	(465,487,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	699,382
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	1,944,982
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	2,264,420
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	18,525,217
5	Tribal Pay Cost	--	n/a	--	42,175,000
6	Increased Cost of Travel	--	2,507,178	--	57,665
7	Increased Cost of Transportation & Things	--	4,671,849	--	107,453
8	Increased Cost of Printing	--	35,336,714	--	812,744
9	Increased Cost of Rents, Communications, & Utilities	--	42,605	--	980
10	Increased Cost of Other Services	--	152,986,558	--	3,518,691
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,430,260,312	--	44,338,070
12	Increased Cost of Supplies	--	42,362,498	--	974,337
13	Increased Cost of Medical or other Equipment	--	12,331,553	--	283,626
14	Increased Cost of Land & Structure	--	2,125,912	--	48,896
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	568,512.00	--	13,076
17	Population Growth	--	n/a	--	41,843,000
	Subtotal, Built-In	--	1,683,193,691	--	157,607,537
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	91,696,000
C. Program Adjustments		--	0	--	0
D. Built-In					
1	Hospitals and Health Clinics General Increase			544	189,732,000
2	Hepatitis C & HIV			2	22,000,000
3	National Community Health Aide Program			5	20,000,000
4	Assessments			0	27,000,000
	Subtotal Program Changes	--	0	551	258,732,000
	TOTAL INCREASES	--	1,683,193,691	551	508,035,537
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	0	0	--	0
2	Absorption of Built-In Increases	--	0	--	(42,548,537)
	Subtotal Build-In Decreases	--	0	--	(42,548,537)
B. Program Adjustments					
1	None				0
	Subtotal Program Changes	--	0	--	0
	TOTAL DECREASES	--	0	--	(42,548,537)
NET CHANGE		--	**1,683,193,691**	**551**	**465,487,000**

INDIAN HEALTH SERVICE
Electronic Health Record
Summary of Changes

FY 2021 Enacted	34,500,000
Total estimated budget authority	34,500,000
Less Obligations	(34,500,000)
FY 2022 Estimate	284,500,000
Less Obligations	(284,500,000)
Net Change	250,000,000
Less Obligations	(250,000,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 20210 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	1,180,031	--	27,141
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	7,254	--	167
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	20,172,776	--	463,974
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	11,486	--	264
13	Increased Cost of Medical or other Equipment	--	13,128,453	--	301,954
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	34,500,000	--	793,500
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Program Adjustment		--	0	--	0
D. Program Increase		--	0	38	250,000,000
	TOTAL INCREASES	--	34,500,000	38	250,793,500
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(793,500)
	Subtotal Build-In Decreases	--	0	--	(793,500)
	TOTAL DECREASES	--	0	--	(793,500)
NET CHANGE		--	**34,500,000**	**38**	**250,000,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2021 Enacted	214,687,000
Total estimated budget authority	214,687,000
Less Obligations	(214,687,000)
FY 2022 Estimate	287,326,000
Less Obligations	(287,326,000)
Net Change	72,639,000
Less Obligations	(72,639,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	91,653
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	254,886
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	233,467
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	1,909,994
5	Tribal Pay Cost	--	n/a	--	4,169,000
6	Increased Cost of Travel	--	246,301	--	5,665
7	Increased Cost of Transportation & Things	--	267,182	--	6,145
8	Increased Cost of Printing	--	413	--	9
9	Increased Cost of Rents, Communications, & Utilities	--	213,661	--	4,914
10	Increased Cost of Other Services	--	5,822,854	--	965,357
11	Increased Cost of Health Care Provided under Contracts & Grants	--	141,308,954	--	4,380,578
12	Increased Cost of Supplies	--	3,305,541	--	548,018
13	Increased Cost of Medical or other Equipment	--	632,082	--	104,791
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	3,791,000
	Subtotal, Built-In	--	151,796,988	--	16,465,478
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	11,563,000
C. Program Adjustment		--	0	--	0
D. Program Increase		--	0	27	50,000,000
	TOTAL INCREASES	--	151,796,988	27	78,028,478
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(5,389,478)
	Subtotal Build-In Decreases	--	0	--	(5,389,478)
	TOTAL DECREASES	--	0	--	(5,389,478)
NET CHANGE		--	**151,796,988**	**27**	**72,639,000**
					359,965,000
					219,380,000
					140,585,000

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2021 Enacted	115,107,000
Total estimated budget authority	115,107,000
Less Obligations	(115,107,000)
FY 2022 Estimate	124,622,000
Less Obligations	(124,622,000)
Net Change	9,515,000
Less Obligations	(9,515,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	21,318
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	59,286
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	89,794
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	734,602
5	Tribal Pay Cost	--	n/a	--	1,726,000
6	Increased Cost of Travel	--	154,981	--	3,565
7	Increased Cost of Transportation & Things	--	193,978	--	4,461
8	Increased Cost of Printing	--	670	--	15
9	Increased Cost of Rents, Communications, & Utilities	--	51,147	--	1,176
10	Increased Cost of Other Services	--	4,964,372	--	114,181
11	Increased Cost of Health Care Provided under Contracts & Grants	--	87,689,068	--	2,718,361
12	Increased Cost of Supplies	--	1,574,319	--	36,209
13	Increased Cost of Medical or other Equipment	--	38,907	--	895
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--		--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	1,961,000
	Subtotal, Built-In	--	94,667,442	--	7,470,864
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	4,574,000
C. Program Adjustments		--	0	29	0
	TOTAL INCREASES	--	94,667,442	29	12,044,864
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(2,529,864)
	Subtotal Build-In Decreases	--	0	--	(2,529,864)
	TOTAL DECREASES	--	0	--	(2,529,864)
NET CHANGE		--	**94,667,442**	**29**	**9,515,000**

INDIAN HEALTH SERVICE
Alcohol and Substance Abuse
Summary of Changes

FY 2021 Enacted	251,360,000
Total estimated budget authority	251,360,000
Less Obligations	(251,360,000)
FY 2022 Estimate	267,490,000
Less Obligations	(267,490,000)
Net Change	16,130,000
Less Obligations	(16,130,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	26,388
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	73,386
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	85,636
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	700,589
5	Tribal Pay Cost	--	n/a	--	3,189,000
6	Increased Cost of Travel	--	158,256	--	3,640
7	Increased Cost of Transportation & Things	--	69,362	--	1,595
8	Increased Cost of Printing	--	482	--	11
9	Increased Cost of Rents, Communications, & Utilities	--	484,304	--	10,170
10	Increased Cost of Other Services	--	15,916,215	--	165,138
11	Increased Cost of Health Care Provided under Contracts & Grants	--	175,307,216	--	3,681,452
12	Increased Cost of Supplies	--	442,837	--	4,595
13	Increased Cost of Medical or other Equipment	--	1,280,549	--	13,286
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	207,795,636	--	2,155,981
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	4,421,000
	Subtotal, Built-In	--	401,454,857	--	14,531,868
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	0	1,844,000
C. Program Adjustment		--	0	12	0
D. Opioid Grant Increase		--	0	--	5,000,000
	TOTAL INCREASES	--	401,454,857	12	21,375,868
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(5,245,868)
	Subtotal Build-In Decreases	--	0	--	(5,245,868)
	TOTAL DECREASES	--	0	--	(5,245,868)
NET CHANGE		--	**401,454,857**	**12**	**16,130,000**

INDIAN HEALTH SERVICE
Purchased/Referred Care
Summary of Changes

FY 2021 Enacted	975,856,000
Total estimated budget authority	975,856,000
Less Obligations	(975,856,000)
FY 2022 Estimate	1,191,824,000
Less Obligations	(1,191,824,000)
Net Change	215,968,000
Less Obligations	(215,968,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	9,912
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	81,088
5	Tribal Pay Cost	--	n/a	--	200,000
6	Increased Cost of Travel	--	24,886,117	--	27,141
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	1,628	--	167
9	Increased Cost of Rents, Communications, & Utilities	--	4,598	--	106
10	Increased Cost of Other Services	--	250,649,846	--	5,764,946
11	Increased Cost of Health Care Provided under Contracts & Grants	--	682,634,973	--	7,770,145
12	Increased Cost of Supplies	--	11,009,843	--	253,226
13	Increased Cost of Medical or other Equipment	--	2,500	--	58
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	8,251	--	190
17	Population Growth	--	n/a	--	17,367,000
	Subtotal, Built-In	--	969,197,756	--	31,473,979
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Purchased/Referred Care General Increase		--	0	2	189,733,000
D. Program Adjustment		--	0	--	0
	TOTAL INCREASES	--	969,197,756	2	221,206,979
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(5,238,979)
	Subtotal Build-In Decreases	--	0	--	(5,238,979)
B. Program Adjustment		--	0	--	0
	TOTAL DECREASES	--	0	--	(5,238,979)
NET CHANGE		--	**969,197,756**	**2**	**215,968,000**

INDIAN HEALTH SERVICE
Indian Health Care Improvement Fund
Summary of Changes

FY 2021 Enacted	72,280,000
Total estimated budget authority	72,280,000
Less Obligations	(72,280,000)
FY 2022 Estimate	317,306,000
Less Obligations	(317,306,000)
Net Change	245,026,000
Less Obligations	(245,026,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	12,706
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	44,383
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	15,959
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	103,952
5	Tribal Pay Cost	--	n/a	--	736,000
6	Increased Cost of Travel	--	5,520	--	127
7	Increased Cost of Transportation & Things	--	17,785	--	409
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	16,153	--	372
10	Increased Cost of Other Services	--	4,821,157	--	1,206,772
11	Increased Cost of Health Care Provided under Contracts & Grants	--	59,028,660	--	697,710
12	Increased Cost of Supplies	--	1,394,510	--	16,483
13	Increased Cost of Medical or other Equipment	--	406,662	--	4,807
14	Increased Cost of Land & Structure	--	37,551	--	864
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	1,301,000
	Subtotal, Built-In	--	65,727,998	--	4,141,543
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Program Adjustment		--	0	--	0
D. Program Increase		--	0	--	242,500,000
	TOTAL INCREASES	--	65,727,998	--	246,641,543
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(1,615,543)
	Subtotal Build-In Decreases	--	0	--	(1,615,543)
B. Program Adjustment		--	0	--	0
	TOTAL DECREASES	--	0	--	(1,615,543)
NET CHANGE		--	**65,727,998**	--	**245,026,000**

INDIAN HEALTH SERVICE
PREVENTIVE Health
Summary of Changes

FY 2021 Enacted	178,789,000
Total estimated budget authority	178,789,000
Less Obligations	(178,789,000)
FY 2022 Estimate	192,588,000
Less Obligations	(192,588,000)
Net Change	13,799,000
Less Obligations	(13,799,000)
	0

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	33,904
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	94,288
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	85,046
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	695,761
5	Tribal Pay Cost	--	n/a	--	3,664,000
6	Increased Cost of Travel	--	133,064	--	3,060
7	Increased Cost of Transportation & Things	--	702,902	--	16,167
8	Increased Cost of Printing	--	46,242	--	1,064
9	Increased Cost of Rents, Communications, & Utilities	--	2,402	--	55
10	Increased Cost of Other Services	--	2,163,300	--	49,756
11	Increased Cost of Health Care Provided under Contracts & Grants	--	148,497,300	--	4,603,416
12	Increased Cost of Supplies	--	1,733,231	--	39,864
13	Increased Cost of Medical or other Equipment	--	121,360	--	2,791
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,058,000	--	47,334
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	3,196,000
	Subtotal, Built-In	--	155,457,801	--	12,532,508
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	5,416,000
C. Program Adjustment		--	0	--	0
C. Program Change		--	0	6	0
	TOTAL INCREASES	--	155,457,801	6	17,948,508
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(4,149,508)
	Subtotal Build-In Decreases	--	0	--	(4,149,508)
B. Program Adjustments		--	0	--	0
	TOTAL DECREASES	--	0	--	(4,149,508)
NET CHANGE		**--**	**155,457,801**	**6**	**13,799,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2021 Enacted	92,736,000
Total estimated budget authority	92,736,000
Less Obligations	(92,736,000)
FY 2022 Estimate	102,693,000
Less Obligations	(102,693,000)
Net Change	9,957,000
Less Obligations	(9,957,000)
	0

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	31,619
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	87,931
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	74,986
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	613,464
5	Tribal Pay Cost	--	n/a	--	1,895,000
6	Increased Cost of Travel	--	92,669	--	2,131
7	Increased Cost of Transportation & Things	--	676,926	--	15,569
8	Increased Cost of Printing	--	37,605	--	865
9	Increased Cost of Rents, Communications, & Utilities	--	2,402	--	55
10	Increased Cost of Other Services	--	1,645,861	--	37,855
11	Increased Cost of Health Care Provided under Contracts & Grants	--	67,734,453	--	2,099,768
12	Increased Cost of Supplies	--	1,422,006	--	32,706
13	Increased Cost of Medical or other Equipment	--	49,415	--	1,137
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	1,656,000
	Subtotal, Built-In	--	71,661,337	--	6,549,086
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	0	5,308,000
C. Program Adjustment		--	0	29	0
	TOTAL INCREASES	--	71,661,337	29	11,857,086
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(1,900,086)
	Subtotal Build-In Decreases	--	0	--	(1,900,086)
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	(1,900,086)
NET CHANGE		--	**71,661,337**	**29**	**9,957,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2021 Enacted	21,034,000
Total estimated budget authority	21,034,000
Less Obligations	(21,034,000)
FY 2022 Estimate	22,164,000
Less Obligations	(22,164,000)
Net Change	1,130,000
Less Obligations	(1,130,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	2,286
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	6,357
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	8,861
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	72,496
5	Tribal Pay Cost	--	n/a	--	499,000
6	Increased Cost of Travel	--	8,884	--	204
7	Increased Cost of Transportation & Things	--	17,325	--	398
8	Increased Cost of Printing	--	4,351	--	100
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	179,370	--	4,126
11	Increased Cost of Health Care Provided under Contracts & Grants	--	18,782,879	--	582,269
12	Increased Cost of Supplies	--	137,948	--	3,173
13	Increased Cost of Medical or other Equipment	--	70,520	--	1,622
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	370,000
	Subtotal, Built-In	--	19,201,277	--	1,550,892
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	108,000
	TOTAL INCREASES	--	19,201,277	--	1,658,892
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(528,892)
	Subtotal Build-In Decreases	--	0	--	(528,892)
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	(528,892)
NET CHANGE		--	**19,201,277**	**--**	**1,130,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2021 Enacted	62,892,000
Total estimated budget authority	62,892,000
Less Obligations	(62,892,000)
FY 2022 Estimate	65,557,000
Less Obligations	(65,557,000)
Net Change	2,665,000
Less Obligations	(2,665,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	1,198
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	9,802
5	Tribal Pay Cost	--	n/a	--	1,270,000
6	Increased Cost of Travel	--	31,511	--	725
7	Increased Cost of Transportation & Things	--	8,651	--	199
8	Increased Cost of Printing	--	4,286	--	99
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	338,069	--	7,776
11	Increased Cost of Health Care Provided under Contracts & Grants	--	61,979,968	--	1,921,379
12	Increased Cost of Supplies	--	173,277	--	3,985
13	Increased Cost of Medical or other Equipment	--	1,425	--	33
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	1,132,000
	Subtotal, Built-In	--	62,537,187	--	4,347,195
	TOTAL INCREASES	--	62,537,187	--	4,347,195
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(1,682,195)
	Subtotal Build-In Decreases	--	0	--	(1,682,195)
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	(1,682,195)
NET CHANGE		--	**62,537,187**	--	**2,665,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2021 Enacted	2,127,000
Total estimated budget authority	2,127,000
Less Obligations	(2,127,000)
FY 2022 Estimate	2,174,000
Less Obligations	(2,174,000)
Net Change	47,000
Less Obligations	(47,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,058,000	--	47,334
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	38,000
	Subtotal, Built-In	--	2,058,000	--	85,334
B. Program Adjustment		--	0	--	0
	TOTAL INCREASES	--	2,058,000	--	85,334
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(38,334)
	Subtotal Build-In Decreases	--	0	--	(38,334)
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	(38,334)
NET CHANGE		--	**2,058,000**	--	**47,000**

INDIAN HEALTH SERVICE
OTHER Services
Summary of Changes

FY 2021 Enacted	220,725,000
Total estimated budget authority	220,725,000
Less Obligations	(220,725,000)
FY 2022 Estimate	309,106,000
Less Obligations	(309,106,000)
Net Change	88,382,000
Less Obligations	(88,382,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	48,317
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	134,370
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	205,676
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	1,682,637
5	Tribal Pay Cost	--	n/a	--	2,261,000
6	Increased Cost of Travel	--	0	--	32,598
7	Increased Cost of Transportation & Things	--	1,371,676	--	3,024
8	Increased Cost of Printing	--	132,273	--	455
9	Increased Cost of Rents, Communications, & Utilities	--	140,600	--	10,230
10	Increased Cost of Other Services	--	48,547,469	--	1,601,390
11	Increased Cost of Health Care Provided under Contracts & Grants	--	17,336,719	--	1,707,839
12	Increased Cost of Supplies	--	45,716,201	--	5,668
13	Increased Cost of Medical or other Equipment	--	303,301	--	34,823
14	Increased Cost of Land & Structure	--	1,041,616	--	0
15	Increased Cost of Grants	--	65,717,801	--	18,655
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	6,239
17	Population Growth	--	n/a	--	1,038,000
	Subtotal, Built-In	--	180,307,656	--	8,790,921
B. Program Increase		--	0	12	81,887,000
	TOTAL INCREASES	--	180,307,656	12	90,677,921
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(2,296,921)
	Subtotal Build-In Decreases	--	0	--	(2,296,921)
B. Program Adjustments		--	0	--	0
	TOTAL DECREASES	--	0	--	(2,296,921)
NET CHANGE		--	**180,307,656**	**12**	**88,382,000**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2021 Enacted	62,684,000
Total estimated budget authority	62,684,000
Less Obligations	(62,684,000)
FY 2022 Estimate	100,000,000
Less Obligations	(100,000,000)
Net Change	37,316,000
Less Obligations	(37,316,000)
	0

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	8,907
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	24,770
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	4,719
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	38,604
5	Tribal Pay Cost	--	n/a	--	1,484,000
6	Increased Cost of Travel	--	45,684	--	1,051
7	Increased Cost of Transportation & Things	--	56	--	1
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	121,414	--	2,793
10	Increased Cost of Other Services	--	47,778,013	--	1,481,118
11	Increased Cost of Health Care Provided under Contracts & Grants	--	12,708,141	--	292,287
12	Increased Cost of Supplies	--	50,913	--	1,171
13	Increased Cost of Medical or other Equipment	--	108,599	--	2,498
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	1,038,000
	Subtotal, Built-In	--	60,812,820	--	4,379,919
B. Program Adjustment		--	0	--	0
C. Increase					
	Urban General Increase	--	0	1	34,314,000
	TOTAL INCREASES	--	60,812,820	1	38,693,919
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(1,377,919)
	Subtotal Build-In Decreases	--	0	--	(1,377,919)
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	(1,377,919)
NET CHANGE		--	**60,812,820**	**1**	**37,316,000**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2021 Enacted	67,314,000
Total estimated budget authority	67,314,000
Less Obligations	(67,314,000)
FY 2022 Estimate	92,843,000
Less Obligations	(92,843,000)
Net Change	25,529,000
Less Obligations	(25,529,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	188
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	524
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	576
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	4,712
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	830	--	19
9	Increased Cost of Rents, Communications, & Utilities	--	231	--	5
10	Increased Cost of Other Services	--	443,631	--	13,753
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	2,341	--	54
13	Increased Cost of Medical or other Equipment	--	1,523	--	35
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	64,906,713	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	65,355,269	--	19,866
B. Recruitment and Retention Program Change		--	0	--	25,000,000
	TOTAL INCREASES	--	65,355,269	--	25,019,866
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	509,134
	Subtotal Build-In Decreases	--	0	--	509,134
B. Program Adjustments		--	0	--	0
	TOTAL DECREASES	--	0	--	509,134
NET CHANGE		--	**65,355,269**	--	**25,529,000**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2021 Enacted	2,465,000
Total estimated budget authority	2,465,000
Less Obligations	(2,465,000)
FY 2022 Estimate	2,485,000
Less Obligations	(2,485,000)
Net Change	20,000
Less Obligations	(20,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	n/a	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	2,682	--	62
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	811,088	--	18,655
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	813,770	--	18,717
B. Program Change		--	0	--	0
	TOTAL INCREASES	--	813,770	--	18,717
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	1,283
	Subtotal Build-In Decreases	--	0	--	1,283
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	1,283
NET CHANGE		--	**813,770**	--	**20,000**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2021 Enacted	82,456,000
Total estimated budget authority	82,456,000
Less Obligations	(82,456,000)
FY 2022 Estimate	107,788,000
Less Obligations	(107,788,000)
Net Change	25,332,000
Less Obligations	(25,332,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	39,222
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	109,076
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	191,232
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	1,564,470
5	Tribal Pay Cost	--	n/a	--	699,000
6	Increased Cost of Travel	--	1,285,181	--	29,559
7	Increased Cost of Transportation & Things	--	129,907	--	2,988
8	Increased Cost of Printing	--	18,955	--	436
9	Increased Cost of Rents, Communications, & Utilities	--	283,305	--	6,516
10	Increased Cost of Other Services	--	4,569,491	--	105,098
11	Increased Cost of Health Care Provided under Contracts & Grants	--	42,131,412	--	1,306,074
12	Increased Cost of Supplies	--	188,947	--	4,346
13	Increased Cost of Medical or other Equipment	--	1,041,616	--	32,290
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	271,241	--	6,239
17	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	49,920,055	--	4,096,545
B. Program Adjustments					
1	Program Increase	--	0	27	22,573,000
Subtotal Program Adjustments		--	0	--	22,573,000
	TOTAL INCREASES	--	49,920,055	27	26,669,545
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(1,337,545)
	Subtotal Build-In Decreases	--	0	--	(1,337,545)
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	(1,337,545)
NET CHANGE		--	**49,920,055**	**27**	**25,332,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2021 Enacted	5,806,000
Total estimated budget authority	5,806,000
Less Obligations	(5,806,000)
FY 2022 Estimate	5,990,000
Less Obligations	(5,990,000)
Net Change	184,000
Less Obligations	(184,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	9,149
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	74,851
5	Tribal Pay Cost	--	n/a	--	78,000
6	Increased Cost of Travel	--	86,439	--	1,988
7	Increased Cost of Transportation & Things	--	1,536	--	35
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	39,838	--	916
10	Increased Cost of Other Services	--	59,087	--	1,359
11	Increased Cost of Health Care Provided under Contracts & Grants	--	3,531,535	--	109,478
12	Increased Cost of Supplies	--	4,232	--	97
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	3,722,667	--	275,874
	TOTAL INCREASES	--	3,722,667	--	275,874
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(91,874)
	Subtotal Build-In Decreases	--	0	--	(91,874)
B. Program Reductions		--	0	--	0
	TOTAL DECREASES	--	0	--	(91,874)
NET CHANGE		--	**3,722,667**	--	**184,000**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2021 Enacted	916,000,000
Total estimated budget authority	822,227,000
Less Obligations	(822,227,000)
FY 2022 Estimate	1,142,000,000
Less Obligations	(855,000,000)
Net Change	226,000,000
Less Obligations	(226,000,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
11	Increased Cost of Supplies	--	0	--	0
12	Increased Cost of Medical or other Equipment	--	0	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	916,000,000	--	0
15	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
16	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	916,000,000	--	0
B. CSC Increase		--	0	10	226,000,000
	TOTAL INCREASES	--	916,000,000	10	226,000,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**916,000,000**	**10**	**226,000,000**

INDIAN HEALTH SERVICE
Payments for Tribal Leases
Summary of Changes

FY 2021 Enacted	101,000,000
Total estimated budget authority	101,000,000
Less Obligations	(101,000,000)
FY 2022 Estimate	150,000,000
Less Obligations	(150,000,000)
Net Change	49,000,000
Less Obligations	(49,000,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
11	Increased Cost of Supplies	--	0	--	0
12	Increased Cost of Medical or other Equipment	--	0	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	0	--	0
15	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
16	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	0	--	0
B. Increased funding to support larger number of submitted leases		--	0	5	49,000,000
	TOTAL INCREASES	--	0	5	49,000,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**0**	**5**	**49,000,000**

INDIAN HEALTH SERVICE

FACILITIES

Summary of Changes

FY 2021 Enacted	917,888,000
Total estimated budget authority	917,888,000
Less Obligations	(917,888,000)
FY 2022 Estimate	1,500,943,000
Less Obligations	(1,500,943,000)
Net Change	583,055,000
Less Obligations	(583,055,000)
	0

	FY 2020 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2021 CO Pay Raise (3 months)				240,033
2 FY 2022 Pay Raise CO (9 months)	--	n/a	--	667,532
3 Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	285,964
4 FY 2022 Pay Raise CS (9 months)	--	n/a	--	2,339,471
5 Tribal Pay Cost	--	n/a	--	3,600,000
6 Increased Cost of Travel	--	544,453	--	12,522
7 Increased Cost of Transportation & Things	--	1,086,192	--	24,982
8 Increased Cost of Printing	--	1,358	--	31
9 Increased Cost of Rents, Communications, & Utilities	--	7,436,421	--	171,037
10 Increased Cost of Other Services	--	245,647,573	--	5,649,894
11 Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12 Increased Cost of Supplies	--	3,802,889	--	87,466
13 Increased Cost of Medical or other Equipment	--	2,706,233	--	62,243
14 Increased Cost of Land & Structure	--	11,913,420	--	272,966
15 Increased Cost of Grants	--	312,026,625	--	7,176,612
16 Increased Cost of Insurance / Indemnities	--	7,102	--	163
17 Population Growth	--	n/a	--	11,747,000
Subtotal, Built-In	--	585,172,266	--	32,337,919
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	52	9,984,000
C. Program Adjustment	--	0	--	0
C. Program Increase	--	0	--	550,000,000
TOTAL INCREASES	--	585,172,266		592,321,919
DECREASES				
A. Built-In				
1 Decrease in the number of compensable days	--	0	--	0
2 Absorption of Built-In Increases	--	0	--	(9,266,919)
Subtotal Build-In Decreases	--	0	--	(9,266,919)
B. Adjustments	--	0	--	0
TOTAL DECREASES	--	0	--	(9,266,919)
NET CHANGE	**--**	**585,172,266**	**52**	**583,055,000**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2021 Enacted	168,952,000
Total estimated budget authority	168,952,000
Less Obligations	(168,952,000)
FY 2022 Estimate	222,924,000
Less Obligations	(222,924,000)
Net Change	53,972,000
Less Obligations	(53,972,000)

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	18,282	--	420
7	Increased Cost of Transportation & Things	--	13,156	--	303
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	117,367	--	2,699
10	Increased Cost of Other Services	--	51,787,315	--	1,191,108
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	2,487,290	--	57,208
13	Increased Cost of Medical or other Equipment	--	181,981	--	4,186
14	Increased Cost of Land & Structure	--	521,273	--	10,947
15	Increased Cost of Grants	--	113,825,292	--	2,617,982
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	0	--	3,041,000
	Subtotal, Built-In	--	168,951,956	--	6,925,852
B. Program Increase		--	0	--	50,000,000
	TOTAL INCREASES	--	168,951,956	--	56,925,852
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B Program Adjustment		--	0	--	(2,953,852)
	TOTAL DECREASES	--	0	--	(2,953,852)
NET CHANGE		**--**	**168,951,956**	**--**	**53,972,000**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2021 Enacted	196,577,000
Total estimated budget authority	196,577,000
Less Obligations	(196,577,000)
FY 2022 Estimate	351,445,000
Less Obligations	(351,445,000)
Net Change	154,868,000
Less Obligations	(154,868,000)
	0

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	218
4	FY 2022 Pay Raise CS (9 months)	--	n/a		1,782
5	Tribal Pay Cost	--	n/a		0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	9,355	--	215
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	162	--	3
10	Increased Cost of Other Services	--	184,209,065	--	4,236,808
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	288	--	6
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	12,293,480	--	282,750
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	0	--	3,484,000
	Subtotal, Built-In	--	196,512,350	--	8,005,783
B. Program Increase		--	0	--	150,000,000
	TOTAL INCREASES	--	196,512,350	--	158,005,783
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Program Adjustment		--	0	--	(3,137,783)
	TOTAL DECREASES	--	0	--	(3,137,783)
NET CHANGE		**--**	**196,512,350**	**--**	**154,868,000**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2021 Enacted	259,290,000
Total estimated budget authority	259,290,000
Less Obligations	(259,290,000)
FY 2022 Estimate	525,781,000
Less Obligations	(525,781,000)
Net Change	266,491,000
Less Obligations	(266,491,000)
	0

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2022 Pay Raise CS (9 months)	--	n/a		0
5	Tribal Pay Cost	--	n/a		0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	6,000,000	--	138,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	11,391,039	--	261,994
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
####	Population Growth	--	0	--	0
	Subtotal, Built-In	--	17,391,039	--	399,994
B. Program Adjustment		--	0	--	0
C. Health Care Facility Construction Increases					
1	Health Care Facility Funding Increase	--	0	--	265,888,000
	Subtotal Increases	--	0	--	265,888,000
	TOTAL INCREASES	--	17,391,039	--	266,287,994
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	203,006
	Subtotal Build-In Decreases	--	0	--	203,006
B. Program Adjustment		--	0	--	0
	TOTAL DECREASES	--	0	--	203,006
NET CHANGE		**--**	**17,391,039**	**--**	**266,491,000**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2021 Enacted	263,982,000
Total estimated budget authority	263,982,000
Less Obligations	(263,982,000)
FY 2022 Estimate	300,153,000
Less Obligations	(300,153,000)
Net Change	36,171,000
Less Obligations	(36,171,000)
	0

		FY 2020 Enacted Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	240,033
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	667,532
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	285,746
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	2,337,688
5	Tribal Pay Cost	--	n/a	--	3,600,000
6	Increased Cost of Travel	--	526,171	--	12,102
7	Increased Cost of Transportation & Things	--	1,062,318	--	24,433
8	Increased Cost of Printing	--	530	--	12
9	Increased Cost of Rents, Communications, & Utilities	--	7,318,892	--	168,335
10	Increased Cost of Other Services	--	2,961,565	--	68,116
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	1,273,119	--	29,282
13	Increased Cost of Medical or other Equipment	--	450,458	--	10,361
14	Increased Cost of Land & Structure	--	1,108	--	25
15	Increased Cost of Grants	--	159,628,700	--	3,671,460
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	7,102	--	163
17	Population Growth	--	n/a	--	4,716,000
	Subtotal, Built-In	--	173,229,963	--	15,831,289
B. Program Increase		--	0	52	23,183,000
1	General Progam Increase				13,199,000
2	Staffing New Facilities	--	0		9,984,000
	TOTAL INCREASES	--	173,229,963	52	39,014,289
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	(2,843,289)
	Subtotal Build-In Decreases	--	0	--	(2,843,289)
B. Program Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(2,843,289)
NET CHANGE		**--**	**173,229,963**	**52**	**36,171,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2021 Enacted	29,087,000
Total estimated budget authority	29,087,000
Less Obligations	(29,087,000)
FY 2022 Estimate	100,640,000
Less Obligations	(100,640,000)
Net Change	71,553,000
Less Obligations	(71,553,000)

		FY 2021 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2021 CO Pay Raise (3 months)	--	n/a	--	0
2	FY 2022 Pay Raise CO (9 months)	--	n/a	--	0
3	Annualization of FY 2021 CS Pay Raise (3 months)	--	n/a	--	0
4	FY 2022 Pay Raise CS (9 months)	--	n/a	--	0
5	Tribal Pay Cost	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	1,363	--	31
8	Increased Cost of Printing	--	828	--	19
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Other Services	--	689628	--	15,861
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	42192	--	970
13	Increased Cost of Medical or other Equipment	--	2073794	--	47,697
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	26279153	--	604,421
16	Increased Cost of Other (includes Insurance, Indemnities, Interest)	--	0	--	0
17	Population Growth	--	0	--	506,000
	Subtotal, Built-In	--	29,086,958	--	1,175,000
B. Program Increase		--	0	--	70,913,000
	TOTAL INCREASES	--	29,086,958	--	72,088,000
DECREASES					
A. Built-In					
1	Decrease in the number of compensable days	--	0	--	0
2	Absorption of Built-In Increases	--	0	--	0
	Subtotal Build-In Decreases	--	0	--	0
B. Adjustments		--	0	--	(535,000)
	TOTAL DECREASES	--	0	--	(535,000)
NET CHANGE		**--**	**29,086,958**	**--**	**71,553,000**

INDIAN HEALTH SERVICE
Budget Authority by Activity

(Dollars in Thousands)

	2020 Final /3		2021 Enacted		2022 President's Budget	
	FTE 1/	Amount	FTE 1/	Amount	FTE 1/	Amount
SERVICES						
Hospitals & Health Clinics	5,627	$2,323,898	5,912	$2,238,087	6,463	$2,703,574
Electronic Health Record System (NEW)	0	$8,000	6	$34,500	44	$284,500
Dental Health	530	210,602	530	214,687	597	287,326
Mental Health	167	109,036	175	115,107	204	124,622
Alcohol & Substance Abuse	222	245,618	232	251,360	244	267,490
Purchased/Referred Care	85	965,015	89	975,856	91	1,191,824
Indian Health Care Improvement Fund	48	72,280	48	72,280	48	317,306
Total, Clinical Services	6,679	3,934,449	6,992	3,901,877	7,691	5,176,642
Public Health Nursing	188	91,984	197	92,736	226	102,693
Health Education	15	20,925	15	21,034	15	22,164
Comm. Health Reps.	5	62,892	5	62,892	5	65,557
Immunization AK	0	2,127	0	2,127	0	2,174
Total, Preventive Health	208	177,928	217	178,789	246	192,588
Urban Health	8	57,684	8	62,684	9	100,000
Indian Health Professions	14	65,314	14	67,314	14	92,843
Tribal Management	0	2,465	0	2,465	0	2,485
Direct Operations	253	71,558	264	82,456	291	107,788
Self-Governance	12	5,806	12	5,806	12	5,990
Total, Other services	287	202,827	298	220,725	326	309,106
Total, Services	7,174	4,315,204	7,507	4,301,391	8,263	5,678,336
CONTRACT SUPPORT COSTS	0	820,000	0	916,000	10	1,142,000
PAYMENTS FOR TRIBAL LEASES 4/	0	0	0	101,000	5	150,000
FACILITIES						
Maintenance & Improvement	0	168,952	0	168,952	0	222,924
Sanitation Facilities Constr.	113	193,577	119	196,577	119	351,445
Health Care Facs. Constr.	0	259,290	0	259,290	0	525,781
Facil. & Envir. Health Supp.	989	261,983	1,044	263,982	1,096	300,153
Equipment	0	28,087	0	29,087	0	100,640
Total, Facilities	1,102	911,889	1,163	917,888	1,215	1,500,943
SPECIAL DIABETES PROGRAM FOR INDIANS						
SDPI 2/	111	150,000	111	150,000	111	147,000
Total, SDPI	111	150,000	111	150,000	111	147,000
Total IHS	15,151	$6,197,093	15,545	$6,386,279	16,368	$8,618,279

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

2/ The Budget requests an extension of the Special Diabetes Program for Indians through FY 2023.

3/ Reflects Services account adjustments related to formal reprogramming notifications submitted to Congress in FY 2020. Amounts by "Sub IHS Activity" will continue to be adjusted during the period of availability, which concludes on Sept. 30, 2021, for impacted funds.

4/ A new separate, indefinite discretionary appropriation is created for Section 105(l), ISDEAA (P.L. 93-638) leases.

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 Congressional Justification	$3,574,365,000	$3,867,260,000	$3,759,258,000	$3,952,290,000
2019 Congressional Justification	$3,945,975,000	$4,202,639,000	$4,072,385,000	$3,965,711,000
2020 Congressional Justification	$4,286,542,000	$4,556,870,000	$4,318,884,000	$4,315,205,000
2021 Congressional Justification	$4,507,113,000	$4,534,670,000	$4,266,085,000	$4,301,391,000
2022 Congressional Justification	$5,678,336,000	-	-	-

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2009 Omnibus	$353,329,000	-	-	$390,168,000
2009 ARRA (PL 111-5)	-	-	-	$415,000,000
2010	$394,757,000	$394,757,000	$394,757,000	$394,757,000
2011	$394,757,000	-	-	$404,757,000
Rescission (PL 112-10)				($810,000)
2012	$457,669,000	$427,259,000	-	$441,052,000
Rescission (PL 112-74)				($705,683)
2013	$443,502,000	-	$ 441,605,000	$441,605,000
Sequestration				($22,152,062)
Rescission				($883,210)
2014 Omnibus (PL 113-64)	$448,139,000	-	-	$451,673,000
2015 Omnibus (PL 113-235)	$461,995,000	$461,995,000	-	$460,234,000
2016 Omnibus (PL 114-39)	$639,725,000	$466,329,000	$521,818,000	$523,232,000
2017 Omnibus (PL 115-31)	$569,906,000	$557,946,000	$543,607,000	$545,424,000
2018 Congressional Justification	$346,956,000	$551,643,000	$563,658,000	$867,504,000
2019 Congressional Justification	$505,821,000	$882,748,000	$877,504,000	$868,704,000
2020 Congressional Justification	$803,026,000	$964,121,000	$902,878,000	$911,889,000
2021 Congressional Justification	$769,455,000	$934,863,000	$927,113,000	$917,888,000
2022 Congressional Justification	$1,500,943,000	-	-	-

INDIAN HEALTH SERVICE
Appropriation History Table
Contract Support Costs

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2016 Omnibus (PL 114-39)	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2017 Omnibus (PL 115-31)	$800,000,000	$800,000,000	$800,000,000	$800,000,000
2018 Congressional Justification	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2019 Congressional Justification	$822,227,000	$822,227,000	$822,227,000	$717,970,000
2020 Congressional Justification	$855,000,000	$820,000,000	$820,000,000	$855,000,000
2021 Congressional Justification	$855,000,000	$916,000,000	$916,000,000	$916,000,000
2022 Congressional Justification	$1,142,000,000	-	-	-

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

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2019 Congressional Justification	$0	$0	$0	$0
2020 Congressional Justification	$0	$0	$0	$0
2021 Congressional Justification	$101,000,000	$101,000,000	$101,000,000	$101,000,000
2022 Congressional Justification	$150,000,000	-	-	-

Indian Health Service

Authorizing Legislation

(Dollars in Thousands)

	FY 2021		FY 2022	
	Amount Authorized	Amount Appropriated	Amount Authorized	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.	4,301,391	4,301,391	5,678,336	5,678,336
2. Contract Support Costs Appropriation: Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*	916,000	916,000	1,142,000	1,142,000
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).	917,888 11,500	917,888 11,500	1,500,943 11,500	1,500,943 11,500
4. Public and Private Collections: IHCIA sec. 206, 25 U.S.C. 1621e. Social Security Act, sec. 1880 & 1911, 42 U.S.C. 1395qq & 1396j.	1,203,805	1,203,805	1,126,702	1,126,702
5. Special Diabetes Program for Indians: 42 U.S.C. 245c-3.	150,000	150,000	150,000	150,000
6. Section 105(*l*) Leases Sec. 900.69	101,000	101,000	150,000	150,000
Unfunded authorizations:	0	0	0	0
Total appropriations:	7,601,584	7,601,584	9,759,481	9,759,481
Total appropriations against Definite authorizations:	7,601,584	7,601,584	9,759,481	9,759,481

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2022 Performance Budget Submission to Congress

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Services

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

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$3,934,449	$3,901,877	$5,176,642	+$1,274,765
FTE*	6,679	6,992	7,691	+699

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

SUMMARY OF THE BUDGET REQUEST

The FY 2022 Indian Health Service (IHS) Budget submission for Clinical Services is $5.2 billion, which is $1.3 billion above the FY 2021 Enacted level. This funding level includes additional resources for:

- Current Services (+$169 million),
- Staffing of New Facilities (+$110 million),
- Electronic Health Record (+$250 million),
- Hospitals and Health Clinics (+$190 million),
- The HIV/Hepatitis C Initiative (+$22 million),
- National Community Health Aide Program Expansion (+$20 million),
- Assessments (+$27 million),
- Dental Health (+$50 million),
- Opioid Grants (+$5 million),
- Purchased/Referred Care (+$190 million), and the
- Indian Health Care Improvement Fund (+$243 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/acquired immune deficiency syndrome (HIV), 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 aims to 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 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.

- **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 emergency ambulatory care, transportation, specialty care services (mammograms, colonoscopies, etc.), and medical support services (e.g., laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc.). The demand for PRC remains high as the cost of medical care increases. The PRC program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources available to them (such as Medicare, Medicaid and private insurance), negotiating discounted rates with medical providers, and implementing improvements recommended by Tribes and oversight authorities.

The 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 2.6 million AI/ANs through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations[1] in service areas that are rural, isolated, and underserved.

Performance Summary Table

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

[1] The over 600 number represents actual health care facilities that can be found in the OPDIV-Specific section of the Fiscal Year 2021 Congressional Justification publication titled: "Number of Service Units and Facilities Operated by IHS and Tribes, October 1, 2018."

OUTPUTS/OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
28 Unintentional Injury Rates: Age-Adjusted Unintentional injuries mortality rate in AI/AN population (Outcome)	FY 2010: 93.7 Target: Not Defined (Target Not In Place)	Not Defined	Not Defined	Maintain
71 Childhood Weight Control: Proportion of children, ages 2-5 years with a BMI at or above the 95th percentile. IHS-All (Outcome)	FY 2020: 22.6 %[2] Target: Not Defined (Historical Actual)	Not Defined	22.6%	N/A

[2] Interim result.

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

HOSPITALS AND HEALTH CLINICS

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$2,323,898	$2,238,087	$2,703,574	+$465,487
FTE*	5,627	5,912	6,463	+551

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

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

FY 2022 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 2.6 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 direct health care services supports the IHS Strategic Plan FY 2019-2023 and integrates the Department's Strategic Goal to protect the health of Americans where they live, learn, work, and play *(HHS Strategic Plan FY 2018-2022, Goal 2, Objective 2.1 Empower people to make informed choices for healthier living, 2.2 Prevent, treat, and control communicable diseases and chronic conditions, 2.3 Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery, & 2.4 Prepare for and respond to public health emergencies)*. 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), 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 5.5 years less than the U.S. all races population, 73.0 years to 78.5 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, 280 health centers, 79 health stations, 59 Alaska village clinics, and six 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 24 hospitals (23 hospitals have emergency departments), 50 health centers, 24 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 *(HHS Strategic Plan FY 2018-2022, Goal 4, Objective 4.1 Foster sound, sustained advances in the sciences).*

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 (*IHS Strategic Plan FY 2019–2023, Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; Goal 3: To strengthen IHS program management and operations; HHS Strategic Plan FY 2018-2022 Goal 1: Reform, strengthen, and modernize the Nation's healthcare system; Goal 2: Protect the health of Americans where they live, learn, work, and play; Goal 3: Strengthen the economic and social well-being of Americans across the lifespan; Goal 4: Foster sound, sustained advances in the sciences; Goal 5: Promote effective and efficient management and stewardship.*

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. The OQ has three divisions: 1) Quality Assurance; 2) Patient Safety and Clinical Risk Management; and, 3) Innovation and Improvement that lead the work on oversight of policy and accreditation standards, implementation of quality improvement strategies, and monitoring accountability of federally-operated facilities. The establishment of the OQ met the *IHS Strategic Plan Goal 2, To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; IHS Strategic Plan Goal 3 To Strengthen IHS program management and operations; and, the HHS Strategic Plan Goal 1, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

[1] Data comparing the AI/AN population to the U.S. general population are documented and updated annually by the IHS.

The novel coronavirus disease (COVID-19) pandemic has disproportionately impacted the AI/AN population IHS serves and has caused the Agency to rethink and redesign the traditional approaches to providing health care to adapt to circumstances changed by the pandemic. The IHS rapidly redesigned service delivery methods and is leveraging local, tribal, state and federal resources and guidance to safely and efficiently meet new challenges and health care needs of AI/AN people while maintaining its commitment to the mission of the IHS. The OQ has led this redesign by staffing the planning section for the IHS Incident Command Structure (ICS); developing and disseminating three Concept of Operations (CONOPS) for COVID-19 response, contact tracing, and recovery; collected situation and resource status information, analyzed it, and processed for use in developing the Agency's action plan. The planning section supports daily ICS operations, disseminating of information through daily response documents like the Incident Action Plan, Common Operating Picture, and situation reports; as well as informal briefings and map and status board displays.

The OQ also leveraged its clinical experts in drafting and approving clinical and administrative guidance documents. In FY 2020, the Agency distributed over 150 guidance documents on items such as managing Personal Protective Equipment (PPE), use of medical equipment, and triaging patients. The OQ provided The Joint Commission (TJC), Accreditation Association for Ambulatory Health Care (AAAHC), and Centers for Medicare and Medicaid Services (CMS) accreditation updates on a monthly basis to provide awareness of changing standards and assist facilities to maintain compliance with updated and new standards and accreditation requirements during the pandemic. In addition, the OQ completed 35 Infection Control Assessment and Response (ICAR) hospital assessments at IHS and tribal locations in partnership with the Centers for Disease Control and Prevention (CDC). These assessments assess and identify any infection control gaps and provide remedial resources. The continued work of the OQ to address COVID-19 meets the *IHS Strategic Plan Goal 2, To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; IHS Strategic Plan Goal 3 To Strengthen IHS program management and operations; and, the HHS Strategic Plan Goal 1, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

Other OQ FY 2020 activities and accomplishments include the following:

Quality Assurance - The Division of Quality Assurance focused intently on ensuring quality of care in IHS facilities through external accreditation and certification. The OQ supports all IHS facilities through collaboration, assistance, and participation in the facility Mock Survey process. Mock surveys use the accreditation standards to evaluate facility preparedness to ensure a state of continual readiness to achieve accreditation standards to provide high quality safe patient care. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal 1, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

The OQ supported and provided assistance to IHS facilities in all 12 IHS Areas to achieve and maintain The Joint Commission (TJC) and Accreditation Association for Ambulatory Health Centers (AAAHC) accreditation standards and Centers for Medicare and Medicaid (CMS) regulations for IHS Hospitals, Health Centers, Behavioral Health facilities, and Critical Assess Hospitals (CAH). The IHS has also directed that all ambulatory care facilities attain Patient Centered Medical Home (PCMH) designation by the end of calendar year 2021. In FY 2020, 18 surveys occurred in IHS facilities, including: 3 TJC hospital surveys, one CAH survey, 12 CMS

certification or CMS Infection Control surveys in ten hospitals, and 1 AAAHC Health Center survey. As of September 2020, 100 percent of all IHS hospitals and CAHs have achieved and maintained CMS conditions of participation, 21 of 24 hospitals and CAHs have TJC accreditation, and 12 of 24 hospitals and CAHs have PCMH designation, and 90 percent of the IHS Health Centers and 50 percent of IHS hospital with ambulatory care services have attained PCMH designation. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities; the HHS Strategic Plan Goal 1, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition; and, the HHS Strategic Plan Goal 1, Strategic Objective 1.3, Improve Americans' access to healthcare and expand choices of care and service options.*

In addition, the IHS has modernized its credentialing and privileging process through the implementation of ASM Products credentialing and privileging software, which is being used in all Areas to facilitate the hiring and ongoing monitoring of qualified practitioners. The credentialing process evaluates the qualifications and practice history of a provider such as education, training, residency, and licensing. Privileging authorizes a healthcare practitioner to practice within a specified scope of patient care services. The OQ managed the rollout and training of the new software system, and continuously monitored processes and system changes for improvements. In FY 2020, the system completed a monthly check on an average of 3,000 active medical staff provider credentials, flagging any negatively changed items. The system also processed nearly 800 initial appointment applications and roughly 1,500 reappointment applications. This improved process provides real time situational awareness to governing boards on providers. The automation of the software also funnels information to Area and IHS Leadership allowing oversight capability. This is a critical effort in facilitating the timely hiring of appropriately qualified providers and ensuring patient safety. The improved credentialing and privileging process meets the *IHS Strategic Plan Goal 3, Objective 3.3 Modernize information technology and information systems to support data driven decisions and the HHS Strategic Plan Goal 5, Strategic Objective 5.3, Optimize information technology investments to improve efficiency and enable innovation to advance program mission goals.*

Patient Safety and Clinical Risk Management – In FY 2020, the IHS transitioned to the IHS Safety Tracking & Response (I-STAR), a system for reporting adverse events. The I-STAR replaced the legacy WebCident platform, a system originally developed in 2002 that was intended for tracking worker injury reporting. After a phased rollout of I-STAR, including a pilot session, the system has now successfully launched across the Agency offering improved reporting of patient safety data and increased analytic capability. The OQ managed the rollout and continues to monitor the implementation of I-STAR. This activity meets the *IHS Strategic Plan Goal 2: Objective 2.2, Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal 1: Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

The OQ also focused on increasing infection control capacity. The Infection Prevention and Control program developed resources for CEO oversight of infection control programs and presented on common infection control accreditation findings and worked with the I-STAR team to incorporate infection control breaches and adverse incidents within the new reporting system. The Infection Prevention and Control coordinator facilitated American Hospital Association Certified Healthcare Environmental Services (EVS) Training (CHEST) (Train the Trainer) workshop for 50 multidisciplinary IHS staff throughout the IHS (February 4-6). Training promoted standardization of evidence based infection control best management practices throughout the IHS. This is the first EVS certification training deployed nationally within the

IHS. The OQ also provided guidelines to all IHS Area facilities to improve patient safety and compliance with new and upcoming US Pharmacopeia (USP) requirements for compounding sterile preparations. In addition, the OQ has collaborated with the CDC to provide infection control training to IHS areas to help meet industry standards for infection control, including sterilization and decontamination of surgical instruments used in patient care within hospitals, ambulatory care and dental facilities. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal 1, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

Innovation and Improvement - The Division of Innovation and Improvement has increased quality improvement capacity within the Agency. A survey was developed to assess the experience and satisfaction with the care provided. This Patient Experience of Care Survey was established to develop a standardized survey instrument for use at all IHS health care facilities. These anonymous surveys are administered and the results analyzed individually by each IHS healthcare facility to determine what improvements, if any, are required to improve the patient experience. Expansion of the number of facilities implementing this tool will continue throughout FY 2021. By directly gathering the opinions and experiences of our patients, the survey directly supports improved quality of care provided by the IHS. This activity meets the *IHS Strategic Plan Goal 2: Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal 1: Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.* The OQ continued implementation of the accelerated model for improvement (Ami™) improvement science framework, and supported the training Healthcare Improvement Professionals (HIP) to support quality improvement initiatives throughout the IHS areas. There are 45 HIPs implementing various improvement projects and Ami™ and as of September 2020, over 120 quality improvement projects have been started or completed across the Agency. The projects focus on improving both administrative and clinical processes, all project information is housed on a server that allows for sharing across the Agency resulting in increased transparency of new best practices. This activity meets the *IHS Strategic Plan Goal 2, Objective 2., Create quality improvement capability at all levels of the organization; IHS Strategic Plan Goal Two, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities; and, the HHS Strategic Plan Goal 1, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

The OQ manages the Innovations Project, which was implemented for the 4th year on October 1, 2020. The purpose of the project is to develop and implement quality improvement innovation initiatives to address the social determinants of health in AI/AN communities. These projects strengthen the link between clinics and communities and explore the application of quality improvement science to address one or more social determinants of health in education, transportation, housing or employment to improve community health. 2020 Innovations Project Awardees: Ft. Hall Service Unit, Improving the Lives of Patients with Uncontrolled Diabetes through Collaborative Practice with Continuous Glucose Monitoring and Patient Focus Groups; Wellpinit Service Unit: WSU Telehealth Collaboration with BIA Corrections/Jail on Spokane Indian Reservation; Oklahoma City Indian Clinic: Expanding Women's Health Services by Creating a Comprehensive Women's Health Center. Funded project teams will use the Ami™ model to guide and implement their projects. Ami™ is a proven quality improvement method supported by the Office of Quality that uses an Actionable Improvement Plan and Charter to accelerate results due at the end of the project year. This activity meets the *IHS Strategic Plan Goal 2, Objective 2, Create quality improvement capability at all levels of the organization and*

IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities.

Improving Patient Care (IPC) Program - The purpose of the IPC Program is to promote the development and application of the quality improvement processes and to promote the implementation of the PCMH model of care to improve the health and wellness of AI/AN people. The IPC program provides a model of collaborative learning to develop proficiency in quality improvement. Data management and analysis are used to drive improvements. Success will be measured by achievement of clinical and process industry-benchmarks, as well as ultimate recognition or certification of participating sites as PCMHs. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal 1, Strategic Objective 1.3, Improve Americans' access to healthcare and expand choices of care and service options.*

In 2020, the IPC program has provided 1,000 subscriptions to the Institute for Healthcare Improvement (IHI) Open School to support I/T/U facility staff in their quality improvement efforts with enrollment of over 900 staff. The IPC program has awarded over 3,400 Continuing Education Units (CEU) and over 310 Certificates in Quality and Patient Safety for I/T/U staff to date. In 2019, the IHS implemented a web based collaborative learning environment, the Quality Portal, to support quality improvement and PCMH information dissemination and knowledge exchange. The portal includes subscription and notification settings, integration of a calendar invitation, the ability for the IHS staff to create "affinity groups" to manage quality improvement work, and the ability to upload resources when replying to a request in the Community Exchange. In FY 2020, there was an increase of 42 percent of its membership from FY 2019 and portal members have viewed over 845 times resources in the Quality Portal, averaging over 80 views a month of those resources, and members have uploaded over 200 resources to the portal. The IPC Program completed a gap analysis and identified multiple process improvement and functionality enhancements for development in FY 2020 and has developed a process to further improve the costumer experience of the active members of the portal utilizing the Community Exchange. This activity meets the *IHS Strategic Plan Goal : Objective 2.1, Create quality improvement capability at all levels of the organization; Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities; and, the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

The IPC program supports I/T/U facilities in providing them with the tools and resources needed to determine when a change is an improvement and to monitor the spread and scale-up of change using PCMH measures. The IPC program continues to develop an ambulatory care measure set integrated in the health information system in collaboration with the IHS Office of Information Technology (OIT). There are currently 21 approved measures and in FY 2020, the majority of these measures were available in our population health management tool (iCare) for facilities to view, monitor, and use to guide quality improvement measures. The IPC program in FY 2020 worked with IHS OIT to enable IHS and Tribal practices participating in the Comprehensive Primary Care Plus (CPC+) model offered through the CMS Innovation Center and in the CMS MIPS program to report on required electronic clinical quality measures at a practice level. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.1 Create quality improvement capability at all levels of the organization; Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities; and, the HHS Strategic Plan Goal 1: Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

Enterprise Risk Management (ERM) – In January 2020, IHS established a National Compliance Program in the immediate Office of the Director overseen by the IHS Chief Compliance Officer in the new Compliance Program. ERM drives the A123 annual internal control assessment, and also the completion of HQ Oversight Reviews of each IHS Area, each year.

In FY 2020, IHS identified two programs that received CARES Act funding and performed risk assessments, Purchase Referred Care (PRC) and Telehealth assessing both programs as low risk for improper payments. The ERM program at IHS also addressed the impact of the COVID-19 public health emergency on the Agency. As part of the OMB A-123 Appendix A Self-Assessments, program offices assessed additional questions specifically geared to risk associated with addressing the COVID-19 public health emergency. Selected program offices assessed whether the public health emergency had led to the implementation of new controls to mitigate risk of the COVID-19 health emergency or if the operating effectiveness of existing controls had been impacted. The COVID-19 public health emergency was assessed to have a low impact on the ERM Program at IHS. To address the pandemic, IHS contracted for a special ERM project to prepare a Recovery Concept of Operations (CONOPS) and a Contact Tracing CONOPS for the AI/AN community. These documents provide a compilation of information from the CDC, National Institute of Health (NIH), and other sources that provide safety recommendations and best practices for people and communities to follow in order to combat COVID-19 and keep the AI/AN population safe by minimizing risk of infection from COVID-19. IHS also continues to focus on data for improved reporting, collection, and decision making during this health crisis and future crises.

In FY 2020, IHS selected three risks to begin risk response planning; Hospital Accreditation, Retention, and Quality of Care. IHS engaged senior leaders to conduct qualitative and quantitative research to uncover root causes for these risks, validate and prioritize these root causes and develop response action plans to address them. Response tactics were then aligned to those root causes, emphasizing that one tactic could help address multiple root causes. Overall, there were over 80 recommended actions across three risk response plans, enabling IHS to take action and address its top risks.

Also in FY 2020, IHS established the Quality Assurance Risk Management Committee (QARMC) to provide 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. This activity meets the *IHS Strategic Plan Goal 3, Objective 3.2, Secure and effectively manage the assets and resources and, the HHS Strategic Plan Goal 5, Strategic Objective 5.1, Ensure responsible financial management.*

Patient Wait Times- the IHS continued monitoring wait time standards for both the Emergency Department (ED) and Primary Care Visits. The ED wait time consists of two standards: 1) Median Time from ED Arrival Time to ED Departure Time for discharged ED patients of 120 minutes or less; and 2) “Left Without Being Seen” rate of two (2)% or less (both measures align with industry standards). Access to the e-dashboards and reports for Wait Times Primary Care Visit went live on June 10, 2019 and monthly reports continue to be generated to monitor progress. The ED wait time standards automation process (access to the e-dashboard for select

IHS stakeholders) went live on June 24, 2019. Subsequently, ED Communication Memorandum and process flow were sent to Area Directors and Chief Medical Officers and monthly reports are also being generated and disseminated for ED wait times. Finally on July 2, 2020, IHS provided access to the Primary Care Visit e-dashboard for all stakeholders that were able to access a PDF report. Since the ED wait time went live, there has been improvement and both wait time standards continue to be monitored. Improving patient wait times ensures that timely primary care is available and accessible to IHS patients; this is a direct response to the GAO recommendation to improve oversight of patient wait times which has since been closed as of March 2020. In addition, in 2020 there was increased collaboration with the Assistance Secretary for Planning and Evaluation (ASPE) to review the wait time's data from January 2017- January 2020. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high quality healthcare options, and encourage innovation and competition.*

Nursing – Nursing represents the largest category of health care providers in the Indian health system and has a major impact on patient safety and health care outcomes. Nurses are actively engaged in the transformation of the health care system by placing more emphasis on prevention, wellness, and coordination of care.

As part of the *Let's Move! In Indian Country* (LMIC), the Indian Health Service (IHS) launched the Baby Friendly Hospital Initiative (BFHI) in 2011. This IHS initiative promotes breastfeeding to reduce the risk that children will develop obesity, diabetes, and other obesity-related conditions in the future.[1] The BFHI is a quality improvement initiative to increase breastfeeding (BF) initiation and duration, thereby creating a healthy start in life and preventing childhood obesity. Exclusive BF protects against obesity and type II diabetes, conditions to which American Indian/Alaska Natives (AI/ANs) are particularly prone. The BFHI initiative requires the following: establish a written BF policy; train all staff in the skills necessary to implement the policy; inform pregnant women of the benefits and management of BF; assist mothers initiate BF within 1 hour of birth; show mothers how to breastfeed and how to maintain lactation; give infants no food or drink other than breast-milk, unless medically indicated; allow mothers and infants to remain together 24 hours a day (rooming in); encourage breastfeeding on demand; give no pacifiers or artificial nipples to breastfeeding infants; and, foster the establishment of BF support groups and refer mothers to them upon discharge.

Ten IHS federally operated obstetrical (OB) hospitals are designated as Baby-Friendly. Baby Friendly designated facilities are required to be surveyed and re-designated every five years. The following obstetric hospitals have successfully completed Baby Friendly Re-designation assessment: Claremore Indian Hospital, Phoenix Indian Medical Center, Quentin N. Burdick Memorial Health Care Facility, Zuni Comprehensive Health Center, and Pine Ridge Service Unit; and, five IHS obstetrical hospitals are engaging in the re-designation process in 2019. One hospital, Blackfeet Community Hospital located in Browning, MT, has Re-Designation Pending. This activity meets *IHS Objective 1.3 Access: Ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people and the HHS Goal 2.2 Prevent, treat and control chronic conditions*

Collaborations have been established with Tribal health care systems with the goal of providing safe and quality care for Native communities. A collaborative agreement was formed between IHS and the Chickasaw Nation Medical Center, Ada, Oklahoma, to enhance clinical competencies for IHS Emergency Department, Perioperative Room, and Labor and Delivery

Registered Nurses (RNs). The agreement is designed to enhance IHS specialty nurses' clinical competency through preceptored clinical rotations offered at the Tribally-managed Chickasaw Medical Center, which maintains higher patient volume. Factors that impact IHS's capacity to assist RNs to maintain their level of clinical competency, beyond initial licensure, credentialing, and continuing education, are attributable to geographically isolated IHS hospitals that are further challenged with fluctuating patient volume. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goals 1, Strategic Objective 1.2, Expand safe, high quality Healthcare options, and encourage innovation and competition.*

The Division of Nursing Services (DNS) implemented the Rural Obstetrical Nurse Residency Program (RONR). The purpose of RONR is to facilitate a structured professional nursing experience for new and inexperienced obstetrical nurses in an effort to alleviate critical shortages of practicing nurses within the Indian Health System. To sustain the RONR, DNS led a workgroup to develop and draft a RONR charter. The workgroup consisted of Area Nurse Consultants through the agency. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goals 1, Strategic Objective 1.2, Expand safe, high quality Healthcare options, and encourage innovation and competition.*

DNS made available 400 subscriptions to the Emergency Severity Index (ESI) web-based course. The web course was offered to Registered Nurses and Advanced Practice Nurses who care for patients in the emergency department, urgent care or other critical care settings, as well as nurses who provide additional coverage for these units. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goals 1, Strategic Objective 1.2, Expand safe, high quality Healthcare options, and encourage innovation and competition.*

HIV Program In 2018, 37,968 people received an HIV diagnosis in the United States and dependent areas. Of those, approximately 3,600 were American Indian or Alaska Native. According to the CDC's HIV Surveillance Report using data reported through December 2019, the undiagnosed rate for AI/AN living with HIV is about 18 percent compared to the national average at 13 percent. An estimated one out of five AI/AN with HIV had been diagnosed. Although there is a slight variation from year-to-year, the new HIV diagnosis trend for AI/AN demonstrates stability from 2014-2018. The HIV diagnosis rate is approximately 8 per 100,000 for AI/AN compared to 5 per 100,000 for Whites. A high majority, 84 percent, of the reported HIV diagnoses in AI/AN people were among men. Most of the documented HIV transmission among these men was male-to-male sexual contact, accounting for 75 percent of new diagnoses. The second most common transmission route was from injection drugs combined with male-to-male sexual contact, accounting for 15 percent of new diagnoses. Among AI/AN women, the main transmission route was heterosexual contact, accounting for 57 percent of new diagnoses, followed by injection drug use at 43 percent of new diagnoses. Among AI/AN women, the main transmission route was heterosexual contact, accounting for 57 percent of new diagnoses, followed by injection drug use at 43 percent of new diagnoses.

In this same CDC report, the death rate among AI/AN people living with HIV in 2018 was 30 percent lower than in 2014.[2] While IHS cannot infer direct causation on a national scale, the

[2] CDC. Diagnoses of HIV infection in the United States and dependent areas, 2018 (updated). *HIV Surveillance Report* 2020;31.. Published May 2020. Accessed February 19, 2021.

largest HIV treatment programs like those at the Phoenix and Gallup Indian Medical Centers show outstanding HIV testing, linkage to care, and viral suppression outcomes among their HIV patients. 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. In IHS, HIV screening increases are plateauing at 50 percent to 60 percent of those who have used IHS clinics in the past three years, especially in large IHS hospitals. Some of IHS' primary care facilities reach screening rates over 90 percent, but not all IHS patients access primary care and therefore go unscreened for HIV. It is important to remember that while HIV screening programs in emergency departments, urgent care, and other non-primary care settings is crucial, these programs are difficult to start and sustain. (IHS Clinical Reporting System).

IHS data shows that from 2005-2014, there were 2,273 HIV diagnoses in IHS facilities.[3] CDC data ranks AI/AN people fourth in the nation for the estimated rate of new HIV diagnoses when compared with all other races and ethnicities. Diagnosing HIV quickly and linking people to treatment immediately are crucial to achieving further reduction in new HIV infections.

Primary care providers are the front line for detecting and preventing the spread of HIV. People with HIV who are aware of their status should be prescribed antiretroviral therapy (ART) and, by achieving and maintaining an undetectable (<200 copies/mL) viral load, can remain healthy for many years.[4] ART is now recommended for all people with HIV, regardless of CD4 count.[5] Studies show that the sooner people start treatment after diagnosis, the more they benefit from ART. Early diagnosis followed by prompt ART initiation[6]:

- Reduces HIV-associated morbidity and mortality;
- Greatly decreases HIV transmission to others; and
- May reduce risk of serious non-AIDS–related diseases.

A new analysis from CDC shows the vast majority – or about 80 percent – of new HIV infections in the U.S. in 2016 were transmitted from the nearly 40 percent of people with HIV who either did not know they had HIV, or who had been diagnosed but were not receiving HIV care. There is no reason to believe this statistic is different among American Indian and Alaska Native people. These data underscore the impact of undiagnosed and untreated HIV in the nation and also the critical need to expand HIV testing and treatment throughout Indian Country.

While IHS has done excellent screening in primary care, annual increases in screening are experiencing diminishing returns, and we are looking at ways to better screen patients who do not

[3] Reilley B, Haberling DL, Person M, Leston J, Iralu J, Haverkate R, Siddiqi AE. Assessing New Diagnoses of HIV Among American Indian/Alaska Natives Served by the Indian Health Service, 2005-2014. Public Health Reports. 2018 Mar;133(2):163-8. https://journals.sagepub.com/doi/full/10.1177/0033354917753118

[4] Bavinton B, Grinsztejn B, Phanuphak N, et al, for the Opposites Attract Study Group. HIV treatment prevents HIV transmission in male serodiscordant couples in Australia, Thailand and Brazilexternal icon. Presented at the 9th IAS Conference on HIV Science; July 25, 2017; Paris, France

[5] USDHHS. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. https://aidsinfo.nih.gov/guidelines/html/1/adultand-adolescent-treatment-guidelines/0/external icon. Accessed June 28, 2018

[6] . Rodger AJ, Cambiano V, Bruun T, et al, for the PARTNER Study Group. Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy. *JAMA* 2016;316:171-181. PubMed abstractexternal icon.

have — or use — a primary care provider, such as those individuals using only emergency departments and urgent care clinics.

According to the CDC, from 2010 to 2017, the annual number of HIV diagnoses increased 39 percent among AI/AN overall, but trends varied by age and gender. While HIV diagnoses for AI/AN women remained stable, CDC's most recent data shows a 54 percent increase for men. When looking at age grouping among AI/AN, CDC data shows a 67 percent increase in HIV diagnoses for those in the 25-34-year-old group. Most new diagnoses were among gay and bisexual men – a group that accounted for 77 percent of all AI/AN diagnoses. In the same report, the CDC also stated that when compared to other people overall with HIV, AI/AN people have lower viral suppression rates. For every 100 AI/AN with HIV, 60 received some HIV care, 46 were retained in care, and 49 were virally suppressed.[7]

AI/AN living in the U.S. Southwest have more than 50 percent of all HIV diagnoses in the IHS system. Over 500 IHS patients are currently in HIV treatment in the Southwest, with over 85 percent viral suppression. IHS programs supported by the Minority HIV/AIDS Fund in the Southwest include PIMC, GIMC, Chinle, and Northern Navajo Medical Center (Shiprock). Data from the Southwest show that viral suppression rates are above 85 percent and moving the needle positively on statewide AI/AN HIV statistics in those states.

The HIV Program goal is to prevent new HIV infections and ensure access to quality health services for AI/ANs living with HIV (*IHS Strategic Plan Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; Goal 2, Objective 2.1 Create quality improvement capability at all levels of the organization & 2.2 Provide care to better meet the health care needs of American Indian and Alaska Native communities; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs; Goal 2 Objective 2.1 Empower people to make informed choices for healthier living, 2.2 Prevent, treat, and control communicable diseases and chronic conditions, 2.4 Prepare for and respond to public health emergencies. Integrating the Department's Strategic Goal to protect the health of Americans where they live, learn, work, and play).* IHS increased overall prenatal HIV screening to 87 percent in FY 2016 – a 15 percent increase over FY 2006 data *(HHS Strategic Plan FY 2018-2022 Goal 2, Objective 2.1 Empower people to make informed choices for healthier living*). 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 *(HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs)*

In spring 2020, the IHS National HIV/HCV Program received $8.4 million from the HHS Minority HIV/AIDS Fund to expand partnerships between the IHS and Native communities for End the HIV epidemic in the U.S. National-level projects include the following:

1. National Technical Assistance and Outreach for HIV and HCV ($750,000);

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

2. Project Red Talon ($1,248,483);
3. Enhancing Telehealth ($1,670,822);
4. Clinical Innovations ($1,771,770)
    a. Alaska Area Health Tech Case Management for HIV Care ($157,534);
    b. Chinle Health Tech Case Management for HIV Care ($55,382);
    c. Shiprock Health Tech Case Management for HIV Care ($55,382);
    d. GIMC: Health Tech Case Management for HIV Care, HIV Pharmacist, and HIV Case Manager ($442,848); and
    e. PIMC: HIV Pharmacist, HIV Case Manager, and HCV Pharmacist ($1,060,624)
5. Empowering Healthier Tribal Communities ($2,925,000)
    a. IHS published and funded a $2.4 million limited competition notice of funding opportunity for the TECs to support tribal communities in reducing new HIV infections and relevant co-morbidities, specifically STD and HCV infections, improve HIV-, STI- and HCV-related health outcomes, and to reduce HIV-, STI- and HCV-related health disparities among AI/AN people. *(IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs)*. The TECs will provide resources to help Native communities address the four main pillars of the Ending the HIV Epidemic plan: Diagnose, Treat, Protect, and Respond (*HHS Strategic Plan FY 2018-2022 Goal 4, Objective 4.1 Improve surveillance, epidemiology, and laboratory services*). Only current TEC grantees were eligible to apply for the competing supplemental funding under this announcement and had to demonstrate that they have complied with previous terms and conditions of the TEC program. There were two separate, but related notices in the Federal Register. The first was for those Tribal Epi Centers that do not provide services in the 48 counties or 7 southern states of the EHE Phase One Jurisdictions. These "Group A" applicants could apply for up to $100,000. The second announcement – for "Group B" applicants – was for those TECs whose constituency contains one or more of the 48 counties or seven southern states in the Phase One jurisdictions of the EHE. These "Group B" applicants could apply for up to $275,000.
    b. The National Native HIV Network operated by the Albuquerque Area Indian Health Board for boots-on-the-ground coordinating and program direction to IHS ($100,000);
    c. IHS Office of Public Health Support, Division of Epidemiology and Disease Prevention (OPHS/DEDP) for STD work ($200K); and
    d. The Cherokee Nation "HIV Self-Testing" and "Tele-PrEP" pilot projects ($225,000).

In February 2021, the IHS National HIV/HCV program submitted a proposal to OIDP for $1,500,000 as a congressionally mandated Tribal set-aside within the Minority HIV/ AIDS Prevention and Treatment program. The proposed project will allow AI/AN stakeholders to formulate their own response to HIV in their own communities by incorporating local leadership and knowledge with federal strategic plans and best practices. This proposed strategic planning project will address national-level strategy planning to Ending the HIV Epidemic in the U.S. by

using an environmental scan and community-based assessment framework, working across all Indian Health Service Areas and including Urban Indian Organizations.

In addition, the FY 2021 final appropriation includes "$5,000,000 for the HIV and Hepatitis C initiative." The IHS is conducting tribal consulation and urban confer to understand priorities of Tribal and Urban Indian Organization leaders before making final decisions on funding allocations.

In mid-January 2021, IHS released the HIV Primary Care Treatment Guidelines for Adults and Adolescents. The new guideline offers advice for the care of AI/AN persons with HIV and provides (1) guidance on HIV care specific to the AI/AN population, including tuberculosis prevention and diabetes screening; (2) recommendations for treatment utilizing drugs on the IHS Formulary; (3) specific advice on the care of transgender and gender non-binary persons in Indian Country; and (4) a single site resource that consolidates HIV, TB, STI, and primary care advice in one place for I/T/U care providers.

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. OIDP and IHS have a draft RSP fact sheet for potential AI/AN PrEP users and a draft algorithm for IHS and tribal prescribers to help them navigate the RSP protocols.

All of IHS' HIV projects and activities are supported by the Minority HIV/AIDS Fund, and that includes the $2.4 million in cooperative agreements to Tribal Epidemiology Centers. Following are some of their recent achievements:

- The Albuquerque Area Southwest Tribal Epidemiology Center developed an HIV/AIDS Resource Guide for the 27 tribal communities in New Mexico and southwestern Colorado. The guide contains data on HIV, Hepatitis C Virus, and other sexually transmitted infections in the geographic regions and highlights area resources in the communities that provide HIV testing and PrEP.

- The Alaska Native Epidemiology Center executed the Global Network of People Living with HIV Stigma Index survey in Alaska Native communities.

- The Urban Indian Health Institute's Trial Epi Center created a survey on HIV and PrEP knowledge, attitudes, and beliefs for staff at 41 urban Indian health organizations.

- The Oklahoma Area Tribal Epidemiology Center (OKTEC), in coordination with Northwest Portland Area Indian Health Board, launched a campaign to train providers and increase access to PrEP prescribers. The effort now counts more than 50 providers and represents 34 different tribes and tribal facilities.

- OKTEC and the Cherokee Nation are increasing HIV testing access through a text messaging system already in place and operational. This text messaging system will deliver HIV self-testing kits to doorsteps throughout Indian Country. OKTEC has a goal of a statewide reach by 2021; and a national reaching program by 2022.

- The Northwest Tribal Epi Center is using race-corrected HIV data from the Washington State Department of Health better to understand the HIV disease burden within NW tribal communities. Northwest Portland will use these data, along with virtual and in-person

training on prevention, control, and outbreak investigation, to adopt HIV prevention and control methods on a local level that are de-stigmatizing and culturally appropriate.

- The IHS National HIV/HCV Program continually searches for ways to help the Area Offices and Service Units achieve their HIV and HCV goals. In the summer of 2020, the IHS National HIV/HCV Program created IHS Area-wide and Service Unit-specific report cards for nationally monitored HIV and HCV screening measures.

- In August, IHS, in partnership with the Northwest Portland Area Indian Health Board, released the fourth and final course in the learning module called "PrEP Navigator Training for Community and Public Health Staff." The learning module is available online. Go to www.ihs.gov and search "PrEP Navigator."

- The Northwest Portland Area Indian Health Board's Healthy Native Youth collaborative launched a Talking is Power campaign to help American Indian and Alaska Native parents and caring adults initiate difficult conversations about sexual health topics with their teens and young adults. Caring adults can text the word "EMPOWER" to 97779 to receive weekly text messages that include culturally appropriate tips and resources, covering sexual health, pregnancy, HIV/STDs, condoms, and consent.

- Northwest Portland recently began it's second cohort of a six-month Trans & Gender-Affirming Care ECHO designed for IHS, tribal, and urban Indian health care providers.

- To assess the impact of COVID-19 on our HIV services, in May, August, and December IHS conducted a three-question survey of the clinical leads at our major anti-retroviral therapy programs – specifically those facilities receiving Minority HIV/AIDS Fund support. In total, we interviewed seven sites. The overall impression is that the impact of COVID has been moderate on the overall health of our patients with HIV as well as the impact on ART. However, many providers signaled that the quality of care is suffering and the effects will be manifest in time. A lack of in-person visits means some clinical indicators will go undetected. COVID is causing these HIV medical teams to work in silos more than ever before, and at least one site has reported new HIV patients since COVID-19. Still, one facility noted that resources going towards COVID-19 had actually improved ART adherence, as a proportion of their HIV patient cohort were homeless, but emergency housing was made available as part of the COVID-19 response to stabilize their housing situation.

Hepatitis C Virus (HCV) infections can result in illness varying in severity from mild (lasting a few weeks), to serious (a lifelong illness ending in death by liver failure). The likelihood of liver damage is related to the duration and severity of untreated infection. The CDC estimates that 3.5 million persons in the U.S. have HCV; approximately 120,000 of whom identify as AI/AN.[8] The IHS National Patient Information Reporting System (NPIRS) data identifies 29,803 IHS patients from 2005-2015 with HCV, and estimates nearly 200 new cases each year; 53.4 percent were among persons born 1945–1965. The overall HCV burden was higher among males than females. This data does not include up to 50 percent of patients who remain undiagnosed. AI/AN people have the largest increase in liver and intrahepatic bile duct cancer compared to any other race/ethnic groups. IHS data also identifies fewer than 1,000 HCV patients currently undergoing

[8] https://www.ncbi.nlm.nih.gov/pubmed/?term=Edlin+Toward+amore+accurate+estimate

treatment. HCV death rates among AI/ANs are more than twice the national average compared to other ethnic groups.[9]

The CDC and the U.S. Preventive Services Task Force (USPSTF) recommends that all persons born from 1945-1965 should be screened for HCV. The IHS has sustained a steady increase in HCV screening. 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.

IHS tracks both the baby boomers and universal screening measures nationally. 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. Many have added clinical 'reminders' to ensure that patients who have never been tested are offered an HCV test. Just as important, if a patient tests positive, I/T/U facilities can treat in-house, rather than referring out. Drugs for HCV treatment are free to IHS patients and treatment for most patients is simple enough (a course of 1-3 pills per day, for 8 to 12 weeks) that it can be done in primary care. This course of treatment has more than a 95 percent cure rate.

IHS aligned program initiatives with the National Viral Hepatitis Action Plan (NVHAP) 2017-2020, to eliminate new viral hepatitis infections, increase knowledge of hepatitis diagnoses, improve access to high quality health care and curative treatments, and eliminate stigma and *discrimination (IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs).* IHS clinical data shows that screening for HCV among AI/ANs born from 1945-1965, increased from 8 percent in 2012, to 54 percent in 2017. This achievement is due in part to the *integration of the Department's Strategic Goal One to reform, strengthen, and modernize the Nation's Healthcare System* through the development of technical support tools like electronic health record (EHR) clinical reminders, publication of IHS policy guidelines for HIV and HCV, and creation of clinical linkages to care *(HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options, & 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs*). IHS anticipates higher costs associated with HCV care in FY 2018 and FY 2019 associated with the increased rate of diagnosis (based on increased screening of Baby-Boomers and women of reproductive age) and the substantially high cost of curative medications. In FY 2019, IHS established universal screening for HCV for all patients over the age of 18 years at least once in their lifetime, followed by guideline-based treatment, as appropriate (IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce*, 1.2 *Build, strengthen, and sustain collaborative relationships*, & 1.3 *Increase access to quality health care services*; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 *Expand safe, high-quality healthcare options, and encourage innovation and competition*, 1.3 *Improve Americans' access to healthcare and expand choices of care and*

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

service options, & 1.4 *Strengthen and expand the healthcare workforce to meet America's diverse needs*).

Sexually Transmitted Disease (STD) rates continue to rise in Indian Country, and recurrent STDs can increase the likelihood of HIV transmission. Gonorrhea and syphilis often present as co-morbid conditions with HIV diagnosis, 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.[10] Regional differences in STDs in Indian Country are also observed, and AI/AN youth and AI/AN women, particularly women of reproductive age, have a disparate and increased STD burden.[11] 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.

Domestic Violence Prevention (DVP) – Domestic and intimate partner violence has a disproportionately large impact on AI/AN communities. According to a 2016 report by the National Institute of Justice,[12] more than four in five AI/AN women (84.3 percent) have experienced violence in their lifetime. In fact, Data from the National Institutes for Justice and the Center for Disease Control show that more than 1.5 million American Indian and Alaska Native women have experienced violence, including sexual violence in their lifetimes[13] with 66.4 percent of AI/AN reported having experienced psychological aggression by an intimate partner. Intimate partner violence is preventable and many of the projects supported by the DVPP address this public health problem. Awarded DVP projects have prioritized prevention, providing services, increasing community awareness and identifying resources to address high rates of missing and murdered indigenous women (MMIW) and girls.

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. The DVP program supports IHS *Goal 1 to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people and Goal 1, Objective 1.2 to build, strengthen, and sustain collaborative relationships.* The DVP program funds a total of 83 projects that focus on domestic and sexual violence prevention, advocacy, and education about domestic violence and sexual violence, coordinated community responses, as well as providing forensic healthcare services to victims of domestic and sexual violence. On March 2, 2020, the IHS Director issued a decision on the funding mechanism to continue distribution of the DVP program funds through a new competitive funding cycle. Due to the COVID-19 pandemic, the DVP notice of funding opportunity (NOFO) will be released in the spring of 2021. This new funding opportunity will support Tribes in their continued efforts to offer domestic violence and sexual assault intervention and prevention services as they recover within their community.

[10] https://www.cdc.gov/std/stats17/minorities.htm

[11] https://www.ihs.gov/sites/epi/themes/responsive2017/display_objects/documents/std/Indian_Health_Surveillance_Report_STD_2015.pdf

[12] https://www.ncjrs.gov/pdffiles1/nij/249736.pdf

[13] https://www.whitehouse.gov/presidential-actions/missing-murdered-american-indians-alaska-natives-awareness-day-2019/

Objectives of the DVP program are as follows:

1. Build Tribal, Urban Indian Health Programs, and Federal capacity to provide coordinated community responses to AI/AN victims of domestic and sexual violence,
2. Increase access to domestic and sexual violence prevention, advocacy, crisis intervention, and behavioral health services for AI/AN victims and their families,
3. Promote trauma-informed services for AI/AN victims of domestic and sexual violence and their families,
4. Offer health care provider and community education on domestic violence and sexual violence,
5. Respond to the health care needs of AI/AN victims of domestic and sexual violence, and
6. Incorporate culturally appropriate practices and/or faith-based services for AI/AN victims of domestic and sexual violence.

Data collected through the fifth year of the DVP program indicates an approximate 94,454 direct service encounters from projects focused on coordinated community responses, advocacy, forensic healthcare, integration of traditional healing, faith-based and culturally competent services. Review of most recent data indicate projects have experienced an expansion of services delivered to victims of domestic violence and intimate partner violence. More than 70% of service encounters are those offered to youth ages 17 and under and adults 25-54 years of age. As the DVP emphasizes the important of community-based, culturally tailored projects, recent data shows that 18,640 individuals received cultural and faith-based services. Each year, select DVP grantees participate and present in the monthly DVP webinar series, which is a platform for collaborative learning, however due to the pandemic, many of these webinars were cancelled. In FY 2020, IHS hosted a "Safety Planning Basics" webinar to enable programs across tribal communities to offer safety plans for domestic violence victims facing confinement due to the spread of COVID-19. IHS also released an information sheet "Sexual Assault Awareness Month and the Impact of COVID-19" as a resource document for Tribal communities.

In addition, these funds support the Forensic Health Care (FHC) team within IHS HQ. The Forensic Health Care program established in 2009 has developed multiple policies within the Indian Health Manual to increase recognition of and prevention of sexual assault and child maltreatment (all forms including sexual abuse). The FHC team works with the DVP program to enhance intimate partner violence efforts, and strategy and resources to address human trafficking. The FHC team provides subject matter expertise and high-quality staff training, assistance to local facilities to create or sustain appropriate acute forensic care services, and strengthen on-going comprehensive services that enhance survivor healing. In FY 2020, IHS released a trauma informed care policy and has worked to implement the principles of trauma informed care to ensure its system understands the prevalence and impact of trauma, facilitates healing, avoids re-traumatization, and focuses on strength and resilience. Through the DVP program, more than 2,108 health professionals have received training in Trauma Informed Care. In addition, the FHC program has established a strong partnership with the International Association of Forensic Nurses. The services provided through this agreement include didactic and clinical forensic examination courses, quarterly educational webinars, and technical assistance to sexual assault programs operating within the I/T/U system.

National Community Health Aide Program (CHAP): provides a network of health aides trained to support licensed health professionals while providing direct health care, health promotion, and disease prevention services. These providers work within a referral relationship under the supervision of licensed clinical providers that includes clinics, service units, and hospitals. The program increases access to direct health services, including inpatient and outpatient visits

through a focus on primary, emergency, behavioral, and dental health to equip Tribal communities with a network that expands the system of care and aids in the mobilization of healthcare in America's most rural and remote communities where access to care is few and far in between. In 2016, the IHS begun the efforts to expand the program nationally and in July 2020, the IHS announced the policy that formally established the national CHAP which sees to the use of health aides in the field of primary care, behavioral health, and oral health. There are currently X Tribes in the contiguous 48 ready to begin operating a CHAP. This number is increasing daily as more Tribes advocate at both the state and federal level for the services of CHAP to be a part of their local health care delivery system.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount	DVPP
2018	$2,055,128,000	($12,967,278)
2019	$2,178,088,000	($12,967,278)
2020	$2,323,898,000	($12,967,278)
2021 Enacted	$2,238,087,000	($12,967,278)
2022 President's Budget	$2,703,574,000	($12,967,278)

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.

BUDGET REQUEST

The FY 2022 budget submission for Hospitals and Health Clinics is $2.7 billion, which is $465 million above the FY 2021 Enacted level.

FY 2021 Base Funding of $2.2 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 2022 Funding Increase of $465 million includes:

- Current Services: +$115 million for current services including:
    - Pay Costs +$66 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$8 million – to fund inflationary costs of providing health care services.
    - Population Growth +$42 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.
- Staffing for New Facilities: +$92 million - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated healthcare facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$13,021,000	71
Naytahwaush Health Center (JV), Naytahwaush, MN	$827,000	6
NEACC (Salt River) Health Center, Scottsdale, AZ	$33,234,000	265
Phoenix Indian Medical Center Central, Phoenix, AZ	$2,254,000	30
Ysleta Del Sur Health Center (JV), El Paso, TX	$4,455,000	38
Alternative Rural Health Center, Dilkon, AZ	$24,363,000	183
Omak Clinic (JV), Omak, WA	$9,167,000	67
Elbowoods Memorial Health Center (JV), New Town, ND	$875,000	8
North Star Health Clinic (JV), Seward, AK	$3,500,000	20
Grand Total:	**$91,696,000**	**688**

- Hospitals &Health Clinics General Program Increase: +$190 million – to expand access to direct health care services. These resources will support efforts to reduce health disparities and improve the overall health status for American Indians and Alaska Natives by increasing the availability of health care services in Indian Country. The IHS estimates that these resources will support 39,000 inpatient admissions, and 12 million outpatient visits.
- Elimination of HIV, Hepatitis C, and Sexually Transmitted Diseases +$22 million, for a total of $27 million, to support efforts to diagnose all HIV-positive IHS patients as early as possible after infection, treat those living with HIV rapidly to achieve and sustain viral suppression, and protect individuals at high risk of HIV using pre-exposure prophylaxis (PrEP). These resources will also help the IHS to effectively identify, treat, and prevent related conditions and risks for HIV infection, including hepatitis C virus (HCV) and sexually transmitted disease (STD) infections, and respond rapidly to growing HIV clusters to prevent new HIV infections.

Rates of STDs other than HIV also continue to rise in Indian country and can increase risk for HIV transmission. Additionally, IHS serves a population that is disproportionately affected by HCV—the AI/AN population has more than twice the rate of HCV incidence and nearly three times the rate of HCV-related mortality as the general U.S. population (CDC 2018). Without concerted intervention that includes expanded HIV, STD, and HCV prevention, testing, and treatment, along with increased clinical and public health resourcing and infrastructure, including associated pharmaceuticals and data generation and analysis capacity, rates of AI/AN HIV, STDs, and HCV will likely continue to increase in FY 2022 and beyond. Additional health statistics about these priority diseases are provided in the program accomplishments section of this narrative.

The additional $22 million requested above FY 2021 would:

- Expand patient screening and treatment for those living with HIV, STDs, and HCV,
- Provide targeted PrEP and expedited partner therapy to those at greater risk for acquiring HIV and other STDs,
- Effectively screen and treat those patients living with HIV and HCV,
- 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, as well as IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2018-2022 Goal 1, Objective 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition, 1.3 Improve Americans' access to healthcare and expand choices of care and service options,& 1.4 Strengthen and expand the healthcare workforce to meet America's diverse needs*). IHS will concentrate efforts on building up its HIV and HCV infrastructure in the 12 AreaOffices and Service Units.

- National Community Health Aide Program: +$20 million, for a total of $25 million, to expand the Community Health Aide Program (CHAP) to the lower 48 states, consistent with the Indian Health Care Improvement Act (25 U.S.C. §§ 1616l (d) (l)-(3)), which authorizes the HHS Secretary acting through the IHS to establish a national CHAP outside of Alaska. The funding would support to training, certifying, and hiring health aides, in addition to managing the national program. The proposed spending would:

    - Provide funding to IHS and Tribal Health Programs to establish their own CHAPs, after receiving required training and certification,

    - Expand the training center network supported by Tribal Colleges and Universities and other Tribally-operated training programs.

        - The training center network consists of partnerships with Tribal Colleges and Universities as well as institutions specialized in culturally adapted health care curricula to serve as regional training centers for behavioral, community, and dental health aides, and to provide community education on using CHAP in

Tribal communities.

- Support a new cohort of CHAP Tribal Assessment and Planning Grants and the CHAP Tribal Planning and Implementation Grants. These grants are designed to provide assistance for infrastructure planning to ensure sustainability and healthcare delivery system support of the CHAP workforce model.

- Create sustainable program infrastructure including maintenance, management, and operations of National and Area Certification Boards, setting national standards and procedures, as well as data and evaluation of workforce trends to respond effectively to health care needs in Tribal communities across the nation.

The proposed funding level directly supports IHS's efforts to provide high quality health careacross the Indian health system, as well asthe HHS Strategic Plan Goal 1: Objective 1.4 as this newly expanded program *strengthens and expands the healthcare workforce to meet America's diverse needs.* HHS Strategic Plan Goal 2, Objective 2.2, 2.3., 2.4 as health aides play a critical role in the Indian health system to p*revent, treat, and control communicable diseases and chronic conditions.* The behavioral health aide works to r*educe the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support.* All health aides are required to train in emergency preparedness so they may *prepare for and respond to public health emergencies.* Finally, thesystem of health aides erects a paraprofessional workforce that ultimately supports HHS Strategic Plan Goal 3, Objective 3.1 to *strengthen the economic and social well-being of Americans Across the Lifespan* while eliminating barriers to promote economic opportunity through job creation.

- Assessments: $27 million for a total of $27 million, to offset the increasing costs of central assessments charged to the IHS since FY 2014. 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. The FY 2022 estimate for IHS central assessment costs is $84 million. The IHS is now at a point where it can no longer sacrifice oversight and management of national health programs to absorb these rising costs. By providing additional resources to address these costs, the IHS would be able to redirect its base funding to strengthen its quality system, ensure alignment with national standards for quality and patient safety, support recruitment and retention, and other critical administrative, support, and oversight activities of direct health care programs.

OUTPUTS/OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2021 Target**	**FY 2022 Target**	**FY 2022 Target +/-FY 2021 Target**
20 100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited or certified (excluding	FY 2019: 97 % Target: 100 % (Target Not Met)	100 %	100 %	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
tribal and urban facilities). (Outcome)				
44 Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native population (Outcome)	FY 2009: 86.3 years Target: Not Defined (Target Not In Place)	Not Defined	Not Defined	Maintain
45 Hospital admissions per 100,000 service population for long-term complications of diabetes (Efficiency)	FY 2019: 47.1 Target: Not Defined (Target Not In Place)	Not Defined	Not Defined	Maintain
55 Nephropathy Assessed (Outcome)	FY 2020: 40.1 %[14] Target: 48.1 % (Target Not Met)	45.5%	43.7%	-1.8%
56 Retinopathy Exam (Outcome)	FY 2020: 37.8 %[15] Target: 53.5 % (Target Not Met)	51.4%	41.2%	-10.2%
57 Pap Smear Rates (Outcome)	FY 2020: 35.3 %[16] Target: 39.2 % (Target Not Met)	38.4%	38.4%	Maintain
59 Colorectal Cancer Screening Rates (Outcome)	FY 2020: 28.8 %[17] Target: 34.7 % (Target Not Met)	32.6%	31.4%	-1.2%
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,	FY 2020: 43.9 %[18] Target: 45.9 % (Target Not Met)	42.8%	47.8%	+5%

[14] Interim result.
[15] Interim result.
[16] Interim result.
[17] Interim result.
[18] Interim result.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Outcome)				
67 Influenza Vaccination Rates among children 6 months to 17 years (Outcome)	FY 2020: 27.3 %[19] Target: 26.1 % (Target Exceeded)	26.6%	29.7%	+3.1%
68 Influenza vaccination rates among adults 18 years and older (Outcome)	FY 2020: 25.7 %[20] Target: 25.4 % (Target Exceeded)	24.4%	28%	+3.6%
69 Adult Composite Immunization (Output)	FY 2020: 40.8 %[21] Target: 59.7 % (Target Not Met)	55.1%	44.4%	-10.7%
70 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2020: 37.3 %[22] Target: 35.7 % (Target Exceeded)	33.3%	40.6%	+7.3%
72 Tobacco Cessation Intervention (Outcome)	FY 2020: 27.4 %[23] Target: 31.4 % (Target Not Met)	34.0%	29.8%	-4.2%
73 HIV Screening Ever (Outcome)	FY 2020: 34.9 %[24] Target: 28.4 % (Target Exceeded)	32.0%	38.0%	+6%

[19] Interim result.
[20] Interim result.
[21] Interim result.
[22] Interim result.
[23] Interim result.
[24] Interim result.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
74 Breastfeeding Rates (Outcome)	FY 2020: 38.6 %[25] Target: 43.6 % (Target Not Met)	40.0%	42%	+2%
75 Controlling High Blood Pressure - MH (Outcome)	FY 2020: 37.6%[26] Target: 52.6 % (Target Not Met)	42.9%	40.9%	-2%
81 Increase Intimate Partner (Domestic) Violence screening among American Indian and Alaska Native (AI/AN) Females (Outcome)	FY 2020: 33.3%[27] Target: 41.5 % (Target Not Met)	37.5%	36.3%	-1.2%
87 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Output)	FY 2020: 36.5% Target: 42% (Target Not Met)	43.4%	39.7%	-3.7%

GRANT AWARDS - H&HC funds support the Healthy Lifestyles in Youth Project,[28] 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 DVPP grants.

(whole dollars)	FY 2020 Final	FY 2021 Enacted	FY 2022 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

[25] Interim result.
[26] Interim result.
[27] Interim result.

Hospital and Health Clinics

(dollars in thousands)

DISCRETIONARY	FY 2020 Final			FY 2021 Estimated			FY 2022 Estimated			FY '22 +/- FY '21
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$7,819	$413,781	$421,600	$7,530	398,502	$406,032	$9,096	481,384	$490,480	$84,448
Albuquerque	55,177	37,908	93,085	53,139	36,508	$89,648	64,192	44,101	$108,293	$18,645
Bemidji	24,799	101,190	125,990	23,883	97,454	$121,337	28,851	117,723	$146,574	$25,236
Billings	56,599	18,374	74,973	54,509	17,695	$72,205	65,846	21,376	$87,222	$15,017
California	6,058	87,093	93,151	5,834	83,877	$89,711	7,048	101,322	$108,370	$18,659
Great Plains	149,670	48,931	198,601	144,143	47,124	$191,267	174,122	56,925	$231,048	$39,781
Nashville	14,503	78,844	93,347	13,967	75,933	$89,900	16,872	91,726	$108,598	$18,698
Navajo	199,581	86,933	286,514	192,212	83,723	$275,934	232,189	101,136	$333,324	$57,390
Oklahoma	122,891	314,198	437,090	118,354	302,596	$420,950	142,969	365,532	$508,501	$87,551
Phoenix	122,119	91,878	213,997	117,610	88,485	$206,095	142,071	106,889	$248,959	$42,864
Portland	27,810	66,196	94,006	26,783	63,752	$90,535	32,354	77,011	$109,365	$18,830
Tucson	2,471	23,450	25,920	2,380	22,584	$24,963	2,875	27,281	$30,155	$5,192
Headquarters	165,625	0	165,625	159,509	0	$159,509	192,685		$192,685	$33,175
Total, H&HC	**$955,122**	**$1,368,776**	**$2,323,898**	**$919,854**	**$1,318,233**	**$2,238,087**	**$1,111,169**	**$1,592,405**	**$2,703,574**	**+$465,487**

Note: FY 2021 and FY 2022 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 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$2,323,898	$2,238,087	$2,703,574	+$465,487
Epi Centers	*$5,433*	*$10,433*	*$10,793*	*+$360*

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 2022 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 a critical role in IHS' overall public health infrastructure. Operating within Tribal organizations, TECs are uniquely positioned to provide support to local Tribal disease surveillance and control programs, and assess the effectiveness of public health programs. All TECs monitor the health status of their constituent Tribes, produce a variety of reports annually or bi-annually that describe activities and progress towards public health goals, and provide support to Tribes who self-govern their health programs.

The TEC program funds eleven TECs that provide comprehensive geographic coverage for all IHS administrative areas and one additional TEC serving American Indian and Alaska Native (AI/AN) populations residing in major urban centers nationally. The IHS Division of Epidemiology and Disease Prevention (DEDP) functions as the national coordinating center and provides technical support and guidance to TECs. The DEDP and TECs collect, analyze, interpret, and disseminate health information in addition to identifying diseases to target for intervention, suggesting strategies, and testing the effectiveness of implemented health interventions. The TEC Program supports Tribal communities by providing technical training in public health practice and prevention-oriented research, and promoting public health career pathways for Tribal members. In FY 2020, a significant portion of TEC activities were devoted to supporting Tribes in confronting the COVID-19 public health emergency.

Annually, 90 percent of the TEC Program budget is distributed through cooperative agreements based on a 5-year competitive award cycle. In the current 5-year award cycle beginning

FY 2016, the average annual award across all 12 TECs was $380,341. The next 5-year competitive award cycle begins in FY 2021.

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

The TEC funds provide critical support in strengthening the collaborative partnerships among the 12 TECs' constituent AI/AN communities as a part of the agency's work to address the IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2 (*Build, strengthen, and sustain collaborative relationships)* and the HHS Strategic Plan 2018-2022 Goal 4.1 (*Improve surveillance, epidemiology, and laboratory services*).

The work of the TECs to collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal organizations, and urban Indian organizations in the service area is an essential part of meeting the IHS Goal 1, Objective 1.3, Strategy 7 (*Reduce health disparities in the AI/AN population*) by highlighting disparities in the AI/AN population so they can be reduced through Public Health efforts. This includes the significant health impact of the Opioid crisis in Indian Country and the disproportionate burden of HIV/AIDS, HCV, and sexually transmitted diseases in AI/AN communities. Significant improvements in reducing the burden of disparities in this population would strongly address the HHS Goal 2: *Protect the Health of Americans Where They Live, Learn, Work, and Play*.

PROGRAM ACCOMPLISHMENTS

The TEC funds provide critical support in strengthening the collaborative partnerships among the 12 TECs and AI/AN communities *(IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2)*. Below are key TEC activities.

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.

TECs assist Tribes with projects such as conducting behavioral risk factor surveys to establish a base of measurement for successfully evaluating intervention and prevention activities related to behavioral health needs. Because national surveys (e.g., Behavioral Risk Factor Surveillance System Survey, Youth Risk Behavior Survey) do not consistently capture representative data for AI/AN populations, TECs have had an essential role in piloting adapted versions of these national surveys to include AI/AN populations. These surveys provide baseline and trend data used by Tribes and Urban Indian organizations (UIOs) to identify health-related needs and to prioritize interventions and prevention services. For example, one TEC combines these surveys and other

data to generate reports on the health disparities of urban Indians and distributes nationally to all UIOs to identify health priorities, seek opportunities for new data collection, and support competitive, evidence-driven applications for funding opportunities to address these priorities.

Improving Public Health Reporting for AI/AN Communities

In public health administrative records, AI/AN people are often misidentified as another race, called racial misclassification. Racial misclassification occurs more often in AI/AN records than in records from other racial groups, which makes it hard to accurately measure and describe the health status of AI/AN people. A specific effort by the Urban Indian Health Institute TEC recently drew attention to the omission or misclassification of American Indian and Alaska Native people in current standard data collection practices by many federal, state, and local entities in the report entitled, "Best Practices for American Indian and Alaska Native Data Collection." To further TEC efforts to correct for racial misclassification to improve public health data quality, in 2019, IHS launched a pilot project with one TEC permitting the use of IHS patient data to correct records within numerous existing public health data sets for AI/AN race. This work is currently underway and directly supports the IHS Strategic Plan Goal 3, Objective 3.3, Strategy 8 (*Assure system of data sharing to solidify partnerships with Tribal and urban Epidemiology Centers and other Tribal programs and Urban Indian Organizations*). This increase in information sharing with our TEC partners acknowledges and strengthens the statutory Public Health functions of the TEC program and builds on the expertise developed over the life of the program.

Disease Surveillance and Evaluation

In the expanding environment of Tribally-operated health programs, TECs provide additional public health services, such as disease control and prevention programs, in areas such as sexually transmitted disease control, HIV, and cancer prevention. Since 2019, nine TEC programs have been awarded funding to support the Elimination of HIV, Hepatitis C, and Sexually Transmitted Diseases Initiative.

TEC efforts build capacity in the Indian health system by evaluating and monitoring the effectiveness of health and public health programs. This allows TECs to assess access, use, and/or assess quality of care, and to develop recommendations for the targeting of services needed by the populations served. They manage public health information systems, investigate diseases of concern, manage disease prevention and control programs, communicate vital health information and resources, respond to public health emergencies, and coordinate these activities with other public health authorities.

Collaboration

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

TECs support national public health goals by working to improve data for the Government Performance and Results Act, agency performance reports, and monitoring of the Healthy People 2030 objectives at the Tribal level. Health status reports across all TECs will lead to a more comprehensive picture of Indian health. In the long term, these activities create opportunities for IHS to improve the delivery of services by calling attention to health disparities or concerns experienced by the population the Agency serves.

COVID-19 Response

As part of the Public Health Response to the COVID-19 emergency, TECs coordinated across their centers to hold weekly calls sharing best practices and workshopping concerns, linked their websites for one COVID-19 response page, and shared new tools and materials as they were developed to improve the speed of the collective response.

Using existing dollars, TECs conduct a range of response activities, including:

1) Direct responses to tribal technical assistance requests.
2) Publishing case report and contact tracing tools.
3) Publishing community-specific fact sheets.
4) Identifying gaps in existing fact sheets and communications. These include coding data and how to talk to young children about COVID.
5) Developing fact sheets and communication materials to address Tribal needs for community education.
6) Reporting to local command teams.
7) Coordinating a Tribal public health listserve.
8) Developing and releasing situational awareness reports.
9) Partnering with State and County Public Health Departments.
10) Partnering with local IHS facilities and Area offices.
11) 24 hour hotline staffed for technical assistance requests.
12) Increasing comprehensive community planning.
13) Produced educational materials for their tribes on managing governments while teleworking.
14) Launched Weekly COVID-19 teleecho clinic call for providers.

FUNDING HISTORY

Fiscal Year	Amount*
2018	*$4,433,361*
2019	*$4,433,361*
2020	*$5,433,361*
2021 Enacted	*$10,433,361*
2022 President's Budget	*$10,793,361*

*Funded under the H&HC budget.

BUDGET REQUEST

The FY 2022 budget submission for the TECs under Hospitals and Health Clinics (H&HC) is $11 million and is $360,000 above the FY 2021 Enacted level.

The FY 2022 funding increase includes:

- Current services +$360,000 as follows:

    - Pay Costs +$280,000 – to fund pay increases for federal and Tribal employees, of who approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$80,000 – to fund inflationary costs of providing services.

The funding per TEC covers the salaries of a Director, one full-time Epidemiologist, administrative assistance/support, 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

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 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 2020: 5928 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 2020: 137 Target: 89 (Target Exceeded)	89	89	Maintain

DISCUSSION

The TECs provide critical support to the communities they serve. In FY 2020, TECs responded to 5,928 requests for technical support (EPI-4) and completed 137 TEC-sponsored trainings for tribal public health capacity building (EPI-5). The increase in technical assistance efforts may reflect the additional resources made available during the COVID-19 response. Additionally, while the overall funding amount allocated to the TECs increased by $5 million starting in

FY 2020, the funding allocated for technical assistance and training remains static and, accordingly, the targets remain level.

Funding dedicated to increasing the TECs' direct support to Tribes to translate emerging public health strategies, resources, and information indirectly reduces the burden on the overall health system by supporting prevention.

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, not dictated by the DEDP.

GRANTS AWARDS

(whole dollars)	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	12	12	12
Average Award	$338,675	$422,000	$422,000
Range of Awards	$265,250 -$412,000	$715,000 -$ $1,015,000	$715,000 -$ $1,015,000

* 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 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$2,323,898	$2,238,087	$2,703,574	+$465,487
HIT	*$182,149*	*$182,149*	*$182,149*	--

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

FY 2022 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Information Technology (HIT) Portfolio uses secure and reliable information technology (IT) in innovative ways to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. IHS HIT provides support for the IHS, Tribal, and Urban (I/T/U) programs that care for 2.6 million American Indian and Alaska Native (AI/AN) people across the Indian health system. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS HIT also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record (EHR) and more than eighty applications. IHS' EHR received 2014 certification for meeting requirements set by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), which established standards and other criteria for structured data that EHRs must use. The IHS HIT 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, wiser spending of our health dollars, 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 IHS Strategic Goal 2, *"To promote excellence and quality through innovation of the Indian health systems into an optimally*

performing organization" and Goal 3, *"To strengthen IHS program management and operations."* The HITSS enterprise information system is the underlying Information Technology (IT) layer of the clinical, practice management and revenue cycle business processes at I/T/U facilities across the country and supports Objective 2.1, *"Creates quality improvement capability at all levels of the organization" and* Objective 2.2, *"Provides care to better meet the health care needs of American Indian and Alaska communities."* The HITSS investment encompasses the RPMS EHR that is certified according to criteria published by the ONC and is in use at approximately 430 health care facilities across the country in support of Objective*, "3.1 Improve communication within the organization with Tribes, Urban Indian Organizations and other stakeholders, and with the general public,* Objective, *"3.2 Secures and effectively manages the assets and resources",* and Objective, "*3.3 Modernizes information technology and the information systems to support data driven decisions."* In pursuit of expanding capabilities, the HITSS investment supports IHS Strategic Goal 1, *"To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people."* RPMS Network planning efforts continue in preparation for the implementation and deployment of new features such as health information sharing and patient engagement to support quality initiatives and the Medicare Access & Children's Health Insurance Program Reauthorization Act (MACRA) of 2015 in support of Objective 1.3, *"Increase access to quality health care services."*

2) **National Patient Information Reporting System (NPIRS)** investment supports IHS Strategic Goal 2, "*To promote excellence and quality through innovation of the Indian health system into an optimally performing organization."* and Goal 3, *"To strengthen IHS program management and operations"*. NPIRS 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 and turn data into formation for use across the agency in support of Objective, *2.1 Create quality improvement capability at all levels of the organization.* 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 and supports Objective, *2.2 Provide care to better meet the health care needs of American Indian and Alaska Native communities".* This investment 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. The NPIRS enterprise business intelligence environment leverages technology and industry best practices for enterprise information and data management to promote data accuracy and availability in support of Objective 3.3, *"modernize information technology and information systems to support data driven decisions."* In an effort to support collaboration for the expansion of services the NPIRS investment supports Strategic Goal 1, *"To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American*

Indian and Alaska Native people." The NPIRS investment is expanding services within the BI environment in a continued effort to provide reusable, shared reporting solutions that are made available in a collaborative platform to communicate enterprise reporting solutions globally, across IHS, tribal organizations and Urban Indian programs in support of Objective 1.2, *Build, strengthen, and sustain collaborative relationships.*

3) **IT Operations** investments support IHS Strategic Goal 3, *"To strengthen IHS program management and operations"* by providing the technical infrastructure for federal, and limited tribal, healthcare facilities that is the foundation upon which all health IT services are delivered. The IT Operations program consists of 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 and support Objective 3.3, *"modernize information technology and information systems to support data driven decisions."* 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 in support of Objective 3.1, *"improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public."* This program incorporates government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and pioneering opportunities by adopting the IT Infrastructure Library (ITIL) IT Service Management (ITSM) framework to optimize the delivery of IT services in support of Objective 3.2, *"secure and effectively manage assets and resources."*

4) **IT Security and Compliance** investment supports IHS Strategic Goal 3, *"To strengthen IHS program management and operations."* The IHS Cybersecurity Program implements security controls and assesses the efficacy of those controls annually while managing information security risk on an ongoing basis. 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. The IHS Cybersecurity Program supports Objective 3.2, "*secures and effectively manages the assets and resources"* and Objective 3.3, *"Modernizing information technology and information systems to support data driven decisions."*

5) **IT Management** investment supports IHS Strategic Goal 3, *"To Strengthen IHS program management and operations,* Objective 3.3, *"Modernize information technology and information systems to support data driven decisions."* This 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 efficiency and effectiveness of all IHS HIT portfolio investments.

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

The Health Information Technology Systems and Support (HITSS) program completed development for the 2015 Certified Electronic Health Record criteria. Deployment of the certified software is nearly complete and will be completed by the end of FY2021. 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 resulting, 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 effort for stabilization and modernization, the HITSS program continues work on the 4 Directions Hub pilot project focused on health information exchange within government as well as the eHealth Exchange. Pilot sites have started to onboard and testing is underway with the Veteran's Administration. The HITSS program certified our software to the FY2021 eCQM certification requirements, as well as completed the bi-annual re-certification of EPCS in February that directly supports our provider's ability to electronically prescribe controlled substances. 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 will be delivered with the 21 Century Cures Act initiative. HITSS also successfully implemented a replacement for the Immunization Forecasting software used across our facilities. In addition to the high velocity response to COVID, our HITSS program staff delivered 14 full version updates and 96 required maintenance updates across the health IT portfolio for FY2020 and 4 full version updates and 19 required maintenance updates as of January FY2021. In response to the social distancing guidance, IHS adjusted the delivery of training to focus on virtual offerings. The program provided 309 HIT training courses to 9,331 I/T/U users in FY2020. As of January 2021 for FY2021, the program provided 104 HIT training courses to 9,075 I/T/U users – the number of participants greatly increased as additional COVID focused trainings were provided. Over 458,500 messages were exchanged between patients, providers, administrators, message agents and received from external HISPs through approximately 40,250 unique direct e-mail addresses since Sept 2015. The IHS Personal Health Record (PHR) has approximately 35,650 total users, and 57 percent of these registered PHR users were verified/linked to their IHS Medical Record. The remaining 43 percent are registered but not yet verified/linked.

The National Patient Information Reporting System (NPIRS) investment leveraged its agile rapid application development and deployment lifecycle model to support the development of the IHS Disease Surveillance solutions in response to the COVID-19 pandemic. In Q2 of FY2020, NPIRS assessed various software solutions and made recommendations to senior leadership on the path forward to automate the IHS COVID-19 data collection and reporting effort. NPIRS led the design, development and implementation of the COVID-19 data collection and national surveillance reporting solution which completely automated the initial manual process of managing Abbott inventory, data collection and COVID-19 test administration and reporting across the IHS user population. NPIRS also collaborated with OEHE on the COVID Data Collection Portal design and provided support with the onboarding of I/T/U sites to both testing solutions. The COVID-19 Testing solution supported over 300 federal, tribal and urban users and

provided immediate insight into testing results at the site, area and national levels. NPIRS also created customized BI reports that are auto-generated and distributed to tribal and urban partners unable to access the national dashboard. The COVID-19 testing solution automated the process by 95% and alleviated massive amounts of manual data collection and reporting. NPIRS also collaborated with HHS and developed a custom data feed to support HHS Protect reporting. 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. NPIRS developed several business intelligence/business analytic solutions to support vaccine administration (patient and employee), vaccine manufacturer, dosage, demographic and population information. In addition, a file management and tracking dashboard was developed that provides near real-time information on the submission of standard HL7 v2.5 messages containing patient vaccination information sent to IHS and CDC. All of the NPIRS BI/BA products enable federal, tribal and urban programs to track individual and national views (area, state, headquarters) of COVID data and enables users to validate data and identify gaps data in reporting to CDC. As part of this effort, daily office hour sessions and virtual training in the use of these products was provided to users. NPIRS developed an 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. In support of this effort, a BDW-C Scorecard was created which provides information on data provisioning from the sites to support Opioid Surveillance. Iteration 2 of this effort continues into FY2021. 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. Enterprise BI solution support is provided to headquarters program offices, tribal, 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 continuing in FY 2021.

IT Operations completed over 400 projects and acquired over 100 products and services. Notable projects and accomplishments are as follows:

- Expanded the ServiceNow platform to standardize processes, capabilities, and service alignment across IHS. This project implemented a ServiceNow Knowledge Base and created over 250 articles to allow more efficient self-help options for IHS staff.
- Expanded the Virtual Private Network (VPN) solution to meet the increased telework demands caused by the COVID-19 pandemic.
- Completed the email migrations to the new Microsoft Exchange Online cloud service. The email upgrade project was a multi-year effort.
- Sustained above 99.9% network availability across all WAN and Internet connections used by HQ and Area Offices.
- Upgraded network circuits to increase bandwidth to approximately 25 IHS facilities.

- Enabled Network Access Control (NAC) at Headquarters facilities and data centers to prevent unauthorized network access.
- Deployed an Enterprise Wireless Authentication Service to provide modern authentication controls on wireless networks to prevent unauthorized access.
- Streamlined datacenter operations by re-designed the Rockville Data Center (RDC) to use the same technologies as the Albuquerque Data Center (ADC), provide new critical application redundancy capabilities, and optimize data center leadership by consolidating two data center manager positions into one.

IT Security and Compliance has three new cybersecurity policies pending approval: Security Assessment and Authorization; Audit and Accountability; and Identification and Authentication. 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 cybercriminal efforts to launch coronavirus-related scams, the IHS Cybersecurity Program developed a COVID Vaccine Cybersecurity Awareness Website that provides education about coronavirus scams, phishing attacks, and telework dangers employees might encounter. The website is located at: https://www.ihs.gov/oit/security/covid-vaccine-cybersecurity-awareness. The IHS Cybersecurity Program won the award for Best Security Awareness Website in the 2020 Security Awareness and Training Contest at the annual Federal Information Systems Security Educators' Association (FISSEA) conference hosted by the National Institute of Standards & Technology (NIST). The winning website provided information regarding the hazards of seemingly harmless but sensational web content. The IHS Cybersecurity Program implemented a new GEO-IP blocking solution that reduces the attack landscape for various command and control malware variants, malicious websites, and denial-of-service attacks targeting IHS. The new solution disrupts traffic bound for IHS from non-NATO countries or sent to non-NATO countries from IHS resulting in a significant reduction in denial-of-service attacks. Data from over 380 network devices was successfully imported into Splunk to search, monitor and analyze IHS network traffic. The IHS Cybersecurity Program successfully implemented nine Office of Inspector General recommendations from previous audits and closed out twenty Plan of Action and Milestone weaknesses from system security assessments and waivers; managed creation of more than 100 IHS facility backup/recovery plans for patient-care IT systems; and processed 317 new firewall rule requests and 751 annual firewall renewals.

IT Management has improved IT governance through enhanced utilization of the Planview Portfolio Management System that provides an enterprise IT portfolio and project management capability enabling IHS to improve project performance oversight and monitor corrective actions through to completion. The Planview 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 spend 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 virtually 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 111 federal and 70 tribal locations. The IHS Enterprise Mobile Services Program was established and accomplished the requirements of M-16-20 by establishing enterprise contracts with AT&T FirstNet and Verizon, and has transitioned over 80 percent of all IHS mobile devices to these contracts achieving both cost

savings and cost avoidance by eliminating unnecessary MiFi devices and duplicative acquisition actions.

Immediate Priorities and Challenges

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

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

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

Human resource shortages and slow staff backfill contributes to challenges in keeping up with evolving technology and new Federal, Department and Agency projects/initiatives including FITARA Implementation. OIT has a persistent vacancy rate of 40 percent.

FUNDING HISTORY

Fiscal Year	Amount[1]
2018	$182,149,000
2019	$182,149,000
2020	$182,149,000
2021 Enacted	$182,149,000
2022 President's Budget	$182,149,000

[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.

TRIBAL SHARES

H&HC (IT is funded out of H&HC) funds are subject to tribal shares, currently at approzimately 25 percent, and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall H&HC budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2022 budget submission for Health Information Technology of $182.1 million is the same as the FY 2021 Enacted level.

This funding will continue progress made in past years by minimizing infrastructure costs and maintaining a high level of productivity and commitment by both federal and contractor staff supporting the IHS-developed health information solutions. IHS uses open source tools where possible to minimize acquisition costs and is reducing use of more costly assisted acquisition providers such as the General Services Administration. However, following the announcement by the VA, the IHS is considering the sustainability of the entire RPMS HIT platform. Efforts are underway to examine alternatives to replace or modify RPMS as the IHS HIT platform. The HHS- IHS HIT Modernization Research Project was completed in FY 2020 to examine alternatives to replace or modify RPMS as the IHS HIT platform. The IHS Modernization Project will change the current EHR platform and positively impact the quality of direct patient care, increase cost recovery and promote continuous health improvements such as, expanded telehealth care services and predictive population health analytics. These potential returns highlight the value of health IT and its impact on the agency mission.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome)	FY 2020: 3.0 Target: 4.0[2] (Target Not Met)	4.0	4.0	Maintain
HIT-2 HHS CIO Workplan - The IHS will score 90% or greater on the annual scoring of the HHS CIO Workplan (Outcome)	FY 2019: 97 % Target: 90 % (Target Exceeded)	Retire	Retire	Maintain

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

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

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$8,000	$34,500	$284,500	+$250,000
FTE*	0	6	44	+38

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

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

FY 2022 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Electronic Health Record System Modernization - The IHS has a significant opportunity to dramatically improve health care in Indian Country, and the health care status of American Indians and Alaska Natives, by modernizing the IHS Electronic Health Record, called the Resource and Patient Management System (RPMS). RPMS is over 50 years old, and the GAP identifies it as one of the 10 most critical federal agency legacy systems in need of modernization. The system operates on the Veteran Health Administration's ViSTA system, which is soon to be replaced by the modernized Veterans Affairs/Department of Defense EHR. The system's aging code cannot be supported over the next decade, nor can it be sustained with the current hardware and network.

RPMS is a comprehensive health information technology (HIT) system that supports a broad range of clinical, population health, and business processes from patient registration through the billing cycle. The IHS relies on its EHR for all aspects of patient care, including the patient record, prescriptions, care referrals, and billing public and private insurance for reimbursable health care services (over $1 billion annually).

The IHS developed RPMS internally, leveraging a decades-long collaboration with the Department of Veterans Affairs (VA), and is certified to the 2015 Edition criteria published by the Office of the National Coordinator for Health Information Technology (ONC). In recent years, advances in health- related standards and technologies, an increasingly complex regulatory environment around HIT, and the decision of the 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.

In early FY 2021 the IHS partnered with the Centers for Medicare and Medicaid Services (CMS) Alliance to Modernize Healthcare Federally Funded Research and Development Center (Health FFRDC) to formally launch the IHS health IT modernization initiative. The Health FFRDC, managed by the MITRE Corporation, is responsible for standing up the Program Management Office, supporting the governance structure for the initiative, assisting with acquisition planning, market research, stakeholder engagement, communication, and numerous other aspects of the initiative. IHS expects to issue Requests for Information (RFI) from industry and one or more subsequent Requests for Proposals (RFP) before the end of FY 2021, with an intent to award initial HIT modernization contracts in early FY 2022. In the meantime IHS will add permanent staff to manage the various aspects of HIT modernization that are inherently federal and will need to be sustained for the foreseeable future.

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. Part of the work tasked to the Health FFRDC referenced above is a comprehensive analysis of infrastructure gaps, conducted in collaboration with the IHS technology operations staff. This analysis will facilitate planning and prioritization of infrastructure upgrades in preparation for EHR modernization.

Current active projects in support of the modernization goal include establishing 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 HIT in support of IHS Strategic Plan Goal 3, Objective 3.3, *"Modernize information technology and information systems to support data driven decisions"*. This investment also supports HHS Goal 5, Objective 5.3, *"Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals"*.

FUNDING HISTORY

Fiscal Year	Amount
2018	$0
2019	$0
2020	$8,000,000
2021 Enacted	$34,500,000
2022 President's Budget	$284,000,000

BUDGET REQUEST

The FY 2022 budget submission for Electronic Health Record Modernization is $285 million. This is an increase of $250 million above the FY 2021 Enacted level.

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 Electronic Health Record 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 Electronic Health Record systems to leverage expertise and experience in the private sector. This effort directly supports IHS's entire Strategic Goals structure.

- Health Information Technology Modernization – The IHS Health Information Technology Modernization effort will use the additional FY 2022 resources to execute several core activities in FY 2022. 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 ONC certification. Significant development, testing, patching, rollout and training efforts will be required, using expanded contract resources.
    - Interoperability: The IHS will complete its interoperability pilot in FY 2021, and then begin a national rollout to enable exchange both within the IHS enterprise and with external referral network partners. This effort will require substantial testing with partners as sites are on-boarded in order to ensure seamless and accurate interoperability.
    - 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 a vendor selection for the new EHR system in early FY 2022, work will begin on the design and build steps, to prepare the commercial system for operation in the IHS environment. This activity typically takes twelve months with significant resources required to convene and gather input from subject matter experts across a range of disciplines and move decisions that could number in the thousands through governance processes to meet the agency's configuration requirements.
    - Local Needs: Once the IHS selects an EHR product, the Agency can define the 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.. This effort will include both capital (equipment) and resource (contract) costs.
    - 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. Many of these activities need to be completed in a short amount of time immediately prior to a site's go-live.

- The IHS anticipates going live at the first site late in FY 2022.
    - 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 estimated 10-year implementation, IHS expects to temporarily increase the HIT workforce to acquire and implement this system.

- IHS Legacy EHR System Modernization - The current IHS EHR, Resource and Patient Management System (RPMS), has been identified by the Government Accountability Office 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.

IHS Strategic Goal 1, Objective 1.2, *"Build, strengthen, and sustain collaborative relationships."* IHS will build a mature governance body to ensure the enterprise HIT investment is properly maintained and configured nationwide.

IHS Strategic Goal 2, Objective 2.1 *"Create quality improvement capability at all levels of the organization"*, and Objective 2.2, *"Provide care to better meet the health care needs of American Indian and Alaska Native communities."*

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 reduced industry risk by adopting standards and systems used by a broader base of healthcare systems

IHS Strategic Goal 3, Objective 3.3, *"Modernize information technology and information systems to support data driven decisions."*

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.

OUTPUTS/OUTCOMES

As IHS reviews options, costs, and potential benefits; output and outcome measures will be developed.

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 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$210,602	$214,687	$287,326	+$72,639
FTE*	530	530	597	+67

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

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

FY 2022 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The purpose of the Indian Health Service (IHS) Dental Health Program (DHP) is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The DHP is a service-oriented program providing basic dental services (e.g., diagnostic, emergency, preventive, and basic restorative care), which represents approximately 90 percent of the dental services provided. In FY 2020, the dental program provided a total of 2,595,059 basic dental services, a 36 percent decrease from FY 2019. This decrease, the largest ever measured in the IHS system, was due entirely to routine dental care shutting down in mid-March 2020 and most dental facilities not resuming routine dental services for the remainder of FY 2020. 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 180,319 dental services in FY 2020, a 34 percent drop from FY 2019. The DHP provided these services through 915,426 dental visits in FY 2020, a substantial drop of 37 percent from FY 2019, the largest such decrease ever recorded and directly attributed to the aforementioned effects of COVID-19 on IHS dental programs throughout the country.

Across all age groups, AI/ANs suffer disproportionately from dental disease. When compared to other racial or ethnic groups, AI/AN children 2-5 years old have more than double the number of decayed teeth and overall dental caries experience as the next highest ethnic group, U.S. Hispanics, and more than four times that of U.S. white children.[1] 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

[1] Phipps KR, Ricks TL, Mork NP, and Lozon TL. The oral health of American Indian and Alaska Native children aged 1-5 years: results of the 2018-19 IHS oral health survey. Indian Health Service data brief. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service, 2019.

to just 17 percent of the general U.S. population in this age group.[2] 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.[3] In adults, the disparity in disease is equally as pronounced. 64 percent of AI/AN adults 35-49 years have untreated decay compared to just 27 percent of the general U.S. population, and across all other age groups studied (50-64 years, 65-74 years, and 75 and older), AI/AN adults have more than double the prevalence of untreated tooth decay as the general U.S. population. In addition, the rate of severe periodontal disease in AI/AN adults is almost double that of the general U.S. population.[4]

Prevention activities improve health and reduce the amount and cost of subsequent dental care. The DHP measures performance in part through the delivery of preventive services. The DHP maintains data and tracks three key program objectives:

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

The DHP funds provide critical support for direct health care services focused upon 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 organizations have comprehensive, culturally appropriate services and personnel available and accessible, 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.

The DHP provides critical services in support of the IHS Strategic Plan FY 2019-2023 (IHS SP) and the HHS Strategic Plan FY 2018-2022 (HHS SP). Dental services are important in ensuring comprehensive, culturally appropriate personal and public health services are available to AI/AN people (IHS SP Goal 1). DHP implements several efforts to improve quality (IHS SP Goal 2) of dental health services and in strengthening management and operations (IHS SP Goal 3). Central to DHP efforts is support of cross-collaboration and partnerships among I/T/U stakeholders (IHS SP Objective 1.2). The DHP provides essential services to increase dental health access and education which supports the HHS SP Goal 1: Reform, strengthen, and modernize the nation's healthcare system, and Goal 5: Promote effective and efficient management and stewardship. The program accomplishments section below provides details about DHP efforts.

PROGRAM ACCOMPLISHMENTS

Early Childhood Caries Collaborative

[2] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native children aged 6-9 years: results of the 2016-2017 IHS oral health survey. Indian Health Service data brief. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service 2017.
[3] Phipps KR, Ricks TL, Mork NP, Lozon TL. The Oral Health of 13-15 year old American Indian and Alaska Native (AI/AN) Dental Clinic Patients – A Follow-Up report to the 2013 Survey. Indian Health Service data brief. Rockville, MD: Indian Health Service 2020.
[4] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native adult dental patients; results of the 2015 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service 2016.

The IHS Early Childhood Caries (ECC) Collaborative was a nationwide initiative that was conducted from 2009 to 2017 and focused on preventing tooth decay in AI/AN children under the age of 71 months. Dental caries are the most common health problem in children, almost eight times more common than childhood asthma, and have significant consequences such as delayed speech development, more missed school days when children begin school, poor self-esteem, and a greater chance of tooth decay in permanent teeth.[5] As previously described, AI/AN children suffer disproportionately from this disease, with more than double the number of decayed teeth as the next highest minority population, U.S. Hispanics, and more than 3 times the number of decayed teeth as U.S. White children.[6] The ECC Collaborative began with the goal of reducing dental caries in the AI/AN population through a coordinated, nationwide collaborative utilizing not only dental programs but also medical and community partners such as medical providers, public health nurses, community health representatives, pharmacists, and Head Start teachers. (*Supports IHS SP 1.2 and HHS SP Objective1.2: Expand safe, high quality healthcare options, and encourage innovation and competition*.) By the end of this collaborative, the IHS had increased access to dental care for AI/AN children under 71 months by 7.9 percent and significantly increased prevention and early intervention efforts (sealants increased by 65.0 percent, the number of children receiving fluoride varnish increased by 68.2 percent, and the number of therapeutic fillings increased by 161 percent). (*Supports IHS SP Objective 1.3: Increase access to quality health care services; and HHS SP Objective 1.3: Improve Americans' access to healthcare and expand choices of care and service options.*) This resulted in a 5 percent reduction in caries (tooth decay) experience from 2010 to 2019, and a 14 percent reduction in untreated decay in 1-5 year-olds (with statistical significance) at a national level; in addition, the Navajo, Oklahoma City, and Phoenix Areas had statistically significant reductions in caries experience from 2010 to 2019. (*Supports the IHS SP Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization, IHS Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities; and HHS SP Objective1.2.)* This represents the first recorded decrease in tooth decay in young children in the IHS and is evidence of success of the Early Childhood Caries Collaborative. Furthermore, this success has impacted older children: the 2016-17 survey of 6-9 year-old children showed that caries experience decreased from 92 percent to 87 percent in this age group from 1999 to 2016-17, while untreated caries decreased from 73 percent to 47 percent over the same time period. These data represent the first recorded decrease in tooth decay in this age group as well and reflects positively on the ECC Collaborative and the ongoing prevention efforts of the DHP focusing on schoolchildren.

Dental Clinical and Preventive Support Centers

In recent years, the DHP has utilized field dental programs in conjunction with its Dental Clinical and Preventive Support Centers (DSC) to achieve national performance objectives, support IHS Area initiatives, and support the IHS Strategic Plan for FY 2019-2023. (*Supports IHS SP Objective 1.2 and HHS SP Objective1.2*.) The DSCs were designed and implemented in FY 2000 to augment the dental public health infrastructure necessary to best meet the oral health needs of AI/AN communities. The current five-year funding cycle began December 1, 2020, with six DSCs funded through grants and two DSCs funded through program awards. In FY 2021, the Division of Oral Health received an additional $1,000,000 to increase the number of DSCs. This increase in funding will allow for the establishment of a ninth DSC and will allow each DSC to have an increased amount of annual funding resulting in an expansion of services to AI/AN communities. Expansion of the DSCs, utilizing best practices learned from programs of the existing DCSs will assist in controlling oral disease and oral health disparities experienced in

susceptible or high-risk populations. The primary purpose of a DSC is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to AI/AN communities. As a direct result of the advocacy efforts of the DSCs, the number of key preventive procedures has increased significantly in recent years. For example, the number of dental sealants placed per year has tripled in the last decade, and the number of patients receiving topical fluoride treatments has more than doubled in the last five years. In FY 2013, the DHP began tracking the coverage or prevalence of children and adolescents receiving sealants and topical fluoride, rather than simply counting procedures. These assessments allow improved comparisons with data from the U.S. population compiled by the Healthy People 2030 initiative.

DSCs were initially funded in FY 2000. In the ensuing years, these DSCs have had an immediate positive impact on the direct delivery of dental care in a number of ways:

- All centers advocated for an appropriate focus on the dental Government Performance and Results Act (GPRA) performance objectives to increase specific clinical services.
- All centers provided continuing education opportunities for clinical staff to enhance the quality of care delivered.
- Several centers provided on-site clinical and community based program reviews to enhance the quality of care, assuring that field programs maintained a high level of expertise with respect to challenges such as infection control, preparing for program accreditation and certification reviews, and patient scheduling practices aimed at maximizing access to care.
- Several centers provided an array of health education materials or designed materials customized to the specific needs of the IHS Areas they serve. These materials have increased the quality and quantity of IHS oral health education efforts throughout Indian Country.
- Several centers provided or arranged for direct clinical services that otherwise would not have been provided.
- The aggregate accomplishments of the DSCs have resulted in an increase in clinical preventive care, an increase in overall clinical services, and an enhancement of the quality and quality of clinical and community based care delivered by the dental field programs.

Dental Health Data

Access to dental services is a prerequisite to the control of oral disease in susceptible or high-risk populations. The access to care GPRA objective is aligned with the Healthy People 2030 methodology as a percentage of patients who have visited the dentist within the previous 12 months. (*GPRA measure data supports the IHS SP Objective 1.3 and HHS SP Objective1.3.*) The access to care goal in FY 2019, was 27.2 percent and the DHP achieved 30 percent, meeting the goal for the first time in two years and increasing from FY 2017 when the final result was 28.24 percent. Unfortunately, the COVID-19 pandemic greatly affected dental care to the AI/AN population. Most IHS facilities ceased routine care, including preventive services, beginning in mid-March 2020, and while a few began to re-open routine care in late May 2020, a substantial number of dental facilities continued to provide emergency or scaled back services well into FY 2021. The dentist to population ratio in the IHS system continues to be very low when compared to the ratio in the U.S. private sector. This low dentist to population ratio and an increase in population growth in the AI/AN population will continue to present a challenge in achieving the access rate goal. The IHS has 1,023 dentists (including part-time) in the system,

according to the IHS Dental Directory.[7] In 2017, there were 2,895,571 AI/AN in the U.S., according to the most recent user population estimate.[8] That means that the IHS system has approximately 1 dentist per 2,830 patients served. According to the U.S. Bureau of Labor Statistics, there were an estimated 153,500 dentists in the U.S. in 2016[9] serving a population of 325,719,178,[10] meaning that there is approximately 1 dentist per 2,122 people served.

Topical fluorides and dental sealants have been extensively researched and documented in the dental literature as safe and effective preventive interventions to reduce tooth decay. In FY 2013, the tracking of dental sealants and the tracking of patients receiving topical fluoride measures changed from simple counts of procedures or patients to the percentage of children receiving either sealants or topical fluorides. New annual targets were set for these two objectives as of July 1, 2013. In FY 2019, 32.10 percent of 1-15 year-old children received topical fluoride, an increase from 16.3 percent when this measure was first tracked in FY 2015, and surpassing the annual goal of 30.0 percent. In FY 2019, 15.9 percent of 2-15 year-old children received sealants, a slight decrease from 16.04 percent in FY 2018, barely missing the national goal of 16 percent.

The DHP continues to assess the care provided by its programs through a robust, continuing oral health surveillance program that started in 2010 and is planned through 2025. (*Supports the IHS SP Goal 3: To Strengthen IHS program management and operations through Objective 3.3: Modernize information technology and information systems to support data driven decision. It also supports the HHS Strategic Plan Goal 4: Foster sound, sustained advances in the sciences through HHS Objective 4.1: Improve surveillance, epidemiology, and laboratory services.)* 0-5 year-old AI/AN children were surveyed in 2010, 2014, and 2018-19; 6-9 year-old children were surveyed in 2011-12 and 2016-17: 13-15 year-old youth were surveyed in 2013 and 2019-20; and AI/AN adults were surveyed in 2015. The surveillance program has been used as a model nationally and helps highlight disparities in disease burden and distribution in the AI/AN population. Results of all surveys can be found in data briefs located on the IHS Dental Portal at www.ihs.gov/doh, and data from this surveillance program is also included in the CDC National Oral Health Surveillance System, allowing public health advocates to compare AI/AN disease prevalence with individual state or national data.

Dental Health Service Delivery Improvements

The DHP has also made significant improvements in the way dental services are delivered. Through the implementation of an electronic dental record (EDR), over 73 percent of IHS and tribal dental programs have been transitioned to an electronic dental record system that will support the delivery of effective quality dental services. The IHS Dentrix Enterprise (DXE) Electronic Dental Record EDR program has been successfully implemented at 259 IHS Federal, Tribal, and Urban dental clinics. The EDR provides accurate data collection and dissemination through the IHS National Data Warehouse. This data supports evaluation of Oral Health Initiatives such as the Early Childhood Caries collaborative and future data development could improve outcome measurements. In FY 2020, the DHP received a $2M appropriation to supplement the DHP-provided funds for the EDR project to complete additional implementations. Despite the pandemic-related travel restrictions, the DHP EDR Implementation and Support contract (EDR Contract) was able to install the IHS version of Dentrix for 5 new locations and expects to add 4 more new EDR implementations by the end of FY 2021. In addition, the

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

increased $2 million funding allowed the DHP to assist 64 I/T/U clinics to upgrade to Windows 10 supported Dentrix versions. This upgrade to Windows 10 supported versions is necessary for all 259 IHS Dentrix-using sites to ensure patient data is safely processed and archived. As the funds are expected to be recurring annually, the plan is to enhance the EDR as follows: in addition to the 10 more new EDR implementations each year, the DHP expects to support approximately 60 clinics to upgrade to the Windows 10 supported and most current versions of the IHS Dentrix Enterprise EDR system. The additional funding will also be used to enhance reporting capability for the recently developed (FY 2018-2020) IHS individual patient-based Oral Health Status (OHS) metric that allows the local clinic to identify patients in need of urgent and/or preventive oral health care. Additional IHS-specific EDR development in FY 2020 included the development of a capability to generate non-standard [dental] claim formats required by multiple states in order for IHS clinics to receive the Medicaid encounter rate reimbursement, the 837i electronic claims form. Further improvements in billing capabilities could increase third party collections. (*Supports IHS SP Goal 3: To Strengthen IHS program management and Operations through Objective 3.3: Modernize information technology and information systems to support data driven decisions. It also supports the HHS Strategic Plan Goal 5: Promote Effective and Efficient Management and Stewardship through Objective 5.3: Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals.)* A second improvement was the release of 20 new dental clinic efficiency and effectiveness standards by which IHS and tribal dental programs can measure clinical productivity, staffing ratios, and specific clinical efficiency indicators against national averages. A third way the DHP has improved the delivery of care is through the development of new national protocols for the early screening and treatment of periodontal disease in adults. (*The implementation of dental clinical and efficiency standards and the national periodontal health screening protocols support the IHS SP Objective 2.1: Create quality improvement capability at all levels of the organization through strategies that focus on providing training, coaching, and mentoring to ensure quality improvement and accountability of staff at all levels of the organization. These 2 accomplishments also support the HHS SP Objective 1.2: Expand safe, high quality healthcare options, and encouraging innovation and competition.)* A fourth way the DHP has improved the delivery of care is through ongoing support of long-term training (LTT) of general dentist to build the cadre of dental specialists in the IHS and tribal dental programs. (*The DHP LTT program supports the IHS SP Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and HHS SP Objective1.4: Strengthen and expand the healthcare workforce to meet America's diverse needs.*) Dentists completing DHP- sponsored LTT to become specialist such as pediatric dentists, periodontists, and endodontists have a service payback obligation to serve AI/AN patients. In the past 6 years, an Oral Maxillofacial Surgeon, an endodontist, six pediatric dentists, and a periodontist have returned from LTT to serve AI/AN patients. A fifth way the DHP is improving the delivery of services is through the adoption of an integrated care model, specifically in promoting depression screenings by dental health providers through a collaboration with the IHS Behavioral Health Program. (*The collaborative efforts between the DHP and the IHS Behavioral Health Program to improve the delivery of services support the IHS SP Objective 2.1. These 2 accomplishments also support the HHS SP Objective 1.2: Expand safe, high quality healthcare options, and encouraging innovation and competition.)*

The DHP continues to improve the delivery of services is through a sustained (20+ years) continuing dental education (CDE) program. The IHS CDE program provides American Dental Association Commission for Continuing Education Provider Recognition approved quality education with almost 300 clinical and public health courses to IHS and tribal dentists, dental hygienists, dental assistants, and dental public health leadership. The total number of CDE courses offered has increased from 149 in FY 2014, to 295 in FY 2020 and, despite numerous cancellations of planned CDE events due to COVID-19, so far 267 were accomplished in

FY 2021. Between 2016 and 2020, a total of over 135,000 hours of CDE were awarded, an estimated value of up to $27 million ($200/hour). During the COVID-19 pandemic, the IHS CDE Program continued to provide vital networking and educational opportunities by shifting from in-person courses to virtual courses, and many of these courses were directly related to this public health emergency, helping provide IHS, tribal, and urban dental programs with the tools and knowledge to reopen their dental programs to provide essential oral health services. In addition, through a concentrated effort to train alternative dental workforce models, since 2016 the CDE Program has trained over 400 dental assistants in expanded functions, thereby increasing productivity and efficiency of IHS and tribal clinics. The models of expanded function dental assistants 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. *(The DHP CDE program supports the IHS SP Objective 2.1 through strategies that focus on providing training, coaching, and mentoring to ensure quality improvement and accountability of staff at all levels of the organization. The DHP continues to evaluate training efforts and staff implementation of improvements, as appropriate. The DHP CDE program also supports the HHS SP Objective 1.2.)*

The DHP continues to be on the forefront of hot issues in public health dentistry. Public health issues such as antibiotic stewardship, opioid overdose reversal in dental settings, managing opioid use disorder through medication-assisted therapy, the growing threat of e-cigarettes in adolescents, community water fluoridation, the new periodontal disease classification standards, improving oral health literacy, issues related to COVID-19 and oral health, silver diamine fluoride, and the U.S. Surgeon General's priorities were all topics addressed by the DHP through continuing education and, in some instances, policy/guideline development. The guidelines are available at the IHS Dental Portal at www.ihs.gov/doh. Another hot issue is the lack of understanding patients have regarding their own oral health, and the DHP has worked to promote oral health literacy through outreach activities and educational materials developed for AI/AN patients through a series of monthly e-mails. (*The IHS Pain Management Guidelines and promotion of health literacy support the IHS SP Objective 1.3 and HHS SP Objective1.3.*)

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2018	$193,283,000
2019	$197,949,000
2020	$210,602,000
2021 Enacted	$214,687,000

Fiscal Year	Amount
2022 President's Budget	$287,326,000

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.

BUDGET REQUEST

The FY 2022 budget submission for Dental is $287 million which is $73 million above the FY 2021 Enacted level.

FY 2021 Base Funding of $215 million will support oral health care services provided by IHS and tribal programs, maintain the program's progress in raising the quality of and access to oral care through continuing recruitment of oral health care professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2022 Funding Increase of $73 million includes:

- Current Services: +$11 million for current services including:
  - Pay Costs +$7 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
  - Inflation +$626,000 – to fund inflationary costs of providing health care services.
  - Population Growth +$11 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.
- Staffing for New Facilities +$12 million – These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$1,676,000	12
Naytahwaush Health Center (JV), Naytahwaush, MN	$384,000	1
NEACC (Salt River) Health Center, Scottsdale, AZ	$6,618,000	44
Ysleta Del Sur Health Center (JV), El Paso, TX	$475,000	4
Alternative Rural Health Center, Dilkon, AZ	$2,666,000	19
Grand Total:	**$11,563,000**	**80**

- General Program Increase: +$50 million, to expand access to dental health services in American Indian and Alaska Native communities. The IHS estimates that these funds will

support an additional 1.1 million dental health services across Indian Country. IHS and Tribal health programs can use these funds to develop new dental health programs, increase the size and scope of existing dental health programs, grow number of dental health professionals serving Indian Country, and other related activities based on the unique needs of the American Indian and Alaska Native communities they serve.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
61 Topical Fluorides (Outcome)	FY 2020: 20.9 %[11] Target: 34.5 % (Target Not Met)	27.6 %	26.8 %	-0.8 %
62 Access to Dental Services (Outcome)	FY 2020: 22.4 %[12] Target: 29.7 % (Target Not Met)	26.6 %	28.8 %	+2.2 %
63 Dental Sealants (Outcome)	FY 2020: 10.7 %[13] Target: 17.2 % (Target Not Met)	13.8 %	13.7 %	-0.1 %

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 $250,000 each, with the purpose being to establish DSC Programs. $1,000,000 of new FY 2021 funding for DSCs will be utilized to increase the number of DSCs, resulting in an expansion of services to AI/AN communities. The DSCs combine IHS and tribal resources and infrastructure in order to address broad challenges and opportunities associated with preventive and clinical dental programs. The DSCs also rigorously measure and evaluate their work with the goal of demonstrably improving dental health outcomes through the technical assistance and services they provide. The DHP has created an online reporting system which will streamline the process by which the DSCs will submit their quarterly progress reports, and will allow the DHP to efficiently collate and analyze DSC achievements. Centers may work simultaneously to improve many different dental programs in a region, providing support, guidance, training, and enhancement to these programs, which then provide services to patients.

[11] Interim result.
[12] Interim result.
[13] Interim result.

(whole dollars)	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	5	6	6
Average Award	$250,000	$250,000	$250,000
Range of Awards	$250,000	$250,000	$250,000

AREA ALLOCATION

Dental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2020 Estimated			FY 2021 Estimated			FY 2022 Estimated			FY'22 +/- FY'21
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$360	$37,858	$38,218	$367	$38,592	$38,959	$491	$51,650	$52,141	$13,182
Albuquerque	5,032	4,323	9,354	5,129	$4,407	9,536	6,865	5,898	12,762	$3,226
Bemidji	2,147	2,730	4,876	2,188	$2,782	4,971	2,929	3,724	6,652	$1,682
Billings	6,097	1,968	8,065	6,215	$2,006	8,221	8,318	2,685	11,003	$2,782
California	399	2,068	2,467	407	$2,108	2,515	545	2,821	3,366	$851
Great Plains	10,780	8,404	19,184	10,989	$8,567	19,556	14,707	11,466	26,173	$6,617
Nashville	763	6,885	7,648	777	$7,019	7,796	1,040	9,394	10,434	$2,638
Navajo	26,358	9,533	35,892	26,870	$9,718	36,588	35,961	13,006	48,967	$12,379
Oklahoma	10,018	37,215	47,233	10,212	$37,937	48,149	13,667	50,773	64,440	$16,291
Phoenix	9,099	9,748	18,847	9,276	$9,937	19,213	12,414	13,299	25,714	$6,501
Portland	4,577	3,977	8,554	4,666	$4,054	8,720	6,244	5,426	11,670	$2,950
Tucson	40	2,283	2,324	41	$2,328	2,369	55	3,115	3,170	$801
Headquarters	7,940	0	7,940	8,094	$	8,094	10,833	0	10,833	$2,739
Total, Dental	**$83,609**	**$126,993**	**$210,602**	**$85,231**	**$129,456**	**$214,687**	**$114,068**	**$173,258**	**$287,326**	**$72,639**

Note: FY 2021 and FY 2022 are estimates.

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$109,036	$115,107	$124,622	+$9,515
FTE*	167	175	204	+29

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

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

FY 2022 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 ongoing vital outpatient mental health counseling and access to dual diagnosis services, mental health crisis response and triage, case management services, community-based prevention programming, and outreach and health education activities. The MH/SS program supports the *IHS Strategic Plan Goal 2, Objective 2.2, to provide care that better meets the health care needs of American Indians and Alaska Native communities.* The most common MH/SS program model is an outpatient service staffed by one or more mental health professionals providing individual, family, and group psychotherapeutic services and case management. After hours emergency services are generally provided through local emergency departments and contracts with non-IHS hospitals and crisis centers. Inpatient services are generally purchased from non-IHS hospitals or provided by state or county hospitals providing mental health services. Intermediate level services such as group homes, transitional living support, intensive case management, and related activities are typically offered through state and local resources. Additionally, slightly more than one-half of the tribes administer and deliver their own mental health programs.

IHS continues to support tribal communities in their ability to address the mental health disparities experienced among the AI/AN population. IHS Mental Health initiatives and grant programs support the *IHS Strategic Plan Goal 1 that ensures comprehensive, culturally appropriate personal and public health services are available and accessible*. In partnership with tribal community partners, 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.

PROGRAM ACCOMPLISHMENTS

Suicide Prevention: Suicide rates among AI/ANs are historically higher than those of the total U.S. population. In 2018, the suicide rate for AI/AN adolescents and young adults has increased since 2003. AI/AN aged 15 to 34 (19.5 per 100,000) were 1.3 times higher than the national average for that age group (14.5 per 100,000). Suicide is the eighth leading cause of death among all AI/AN across all ages.[1] Strategies to address behavioral health, alcohol, substance use disorder, and suicide prevention require comprehensive clinical strategies, and approaches.

In 2017, AI/AN adolescents had the highest prevalence (16.3 percent) of major depressive episode with or without severe impairment compared to other ethnicities.[2] In addition in 2017, AI/AN adults had the highest prevalence (8.0 percent) of major depressive episode with or without severe impairment compared to other ethnicities.[3] Furthermore in 2017, AI/AN adults had the third highest prevalence (18.9 percent) of serious mental illness among U.S. adults compare to other ethnicities.[4]

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 2017–2022 National AI/AN Suicide Prevention Strategic Plan advances the 2012 National Suicide Strategic Plan with culturally relevant approaches and strategies specific for AI/AN communities.[5]

The IHS is initiating 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 through the use of a universal screening and associated clinical pathways to better understand local facility challenges, identify risk factors and target resources and services appropriately.

Ten percent of those who die by suicide had visited the emergency department within 2 months of death. In FY 2019, the IHS and the National Institute of Mental Health (NIMH) partnered by way of a Memorandum of Understanding (MOU) to address the high rates of suicide impacting the AI/AN communities. With this three year partnership (FY 2019- 2021), IHS and NIH will work together to implement the Ask Suicide Screening Questions (ASQ) and its accompanying toolkit for universal screening within IHS Emergency Departments (EDs) and Primary Care. The ASQ is a suicide screening resource developed by NIMH for medical settings to help nurses

[1] US Department of Health and Human Services, Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, June 8, 2018. Vital Signs: Trends in State Suicide Rates – United States, 1999-2016 and Circumstances Contributing to Suicide – 27 States, 2015.

[2] 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://nsduhweb.rti.org/respweb/homepage.cfm

[3] 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://nsduhweb.rti.org/respweb/homepage.cfm

[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://nsduhweb.rti.org/respweb/homepage.cfm

[5] Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2016) National Center for Injury Prevention and Control, CDC (producer). Available from http://www.cdc.gov/injury/wisqars/index.html

or physicians successfully identify individuals at risk for suicide. In FY 2019, IHS conducted a site visit and staff training on the ASQ, and partnered with IHS OIT to fully integrate the validated suicide risk screening instrument into the IHS electronic health records system for field implementation. In FY 2020, IHS began reviewing related surveillance data and released the ASQ screening and the associated suicide risk assessment to the field. The implementation of the ASQ has allowed for identification of crisis situations within the pilot sites and supported immediate response by the Area office to ensure quality of care. To date, the pilot sites have registered over 21,000 screenings completed. In addition, due to the impact of COVID-19, suicide screening has increased and has shown an increase in need for behavioral health services such as telehealth and virtual outreach to augment traditional service modalities. These efforts support several IHS Strategic Plan *including Goal 1 Objective 1.2 to build, strengthen, and sustain collaborative relationships and Goal 3, Objective 3.3 to modernize information technology and information systems to support data driven decisions*.

Zero Suicide Initiative:

In FY 2017, IHS received $3.6 million to fund 8 pilot IHS and tribal sites to participate in its first cohort of the Zero Suicide Initiative. The Zero Suicide" philosophy is a key concept of the National Strategy for Suicide Prevention (NSSP) and is a priority of the National Action Alliance for Suicide Prevention (Action Alliance). Zero Suicide focuses on developing 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. Furthermore, 80 percent of those who die by suicide had contact with a primary care provider within 1 year of suicide.

In FY 2020, ZSI projects trained over 1,015 Staff in evidence based suicide risk/assessment practices and over 8,000 patients received a positive suicide risk screening. Additionally, 100 percent of all ZSI projects established a Suicide Team and developed a Zero Suicide Work Plan.

IHS funds eight facilities in total, five tribal and three federal facilities, at $400,000 to implement the Zero Suicide Model within their healthcare system. Each project plan includes utilizing 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, increasing restriction of lethal means, implementing intensive case management, and initiating follow up with patients within 24 hours of transition of care. In year two all project sites have successfully established a Zero Suicide policy and have developed suicide risk screening procedures, clinical pathways, and data collection plans to enhance surveillance and analysis capabilities. Similar to other grant programs, the COVID-19 pandemic placed an unforeseen hardship on all facilities implementing Zero Suicide in their Emergency Departments. Accordingly, the IHS authorized ZSI grantees one additional project year to continue their approved project activities. The new end date for the ZSI grantees will be October 31, 2021.

Finally, in FY 2021, IHS anticipates funding an additional cohort of Zero Suicide grantees with a primary focus on promoting collaboration with the local, regional and federal health partners. These efforts support several IHS Strategic Plan *including Goal 1 Objective 1.2 to build, strengthen, and sustain collaborative relationships.*

Trauma-Informed Care: Trauma Informed Care supports the *IHS Strategic Goal 2, Objective 2.2, by providing care to better meet the health care needs of American Indian and Alaska Native communities*. IHS has worked to implement the principles of trauma informed care to ensure its system understands the prevalence and impact of trauma, facilitates healing, avoids re-traumatization, and focuses on strength and resilience. Developing and implementing a trauma informed care approach to address childhood trauma, including historical trauma, is necessary to comprehensively address the root causes of violence, suicide, depression, anxiety, self-harm, and chronic physical diseases.

In September 2016, the MH/SS and Improving Patient Care and the Johns Hopkins University developed the Pediatric Integrated Care Collaborative (PICC) pilot project. The PICC focused on increasing the quality and accessibility of child trauma services by integrating behavior and physical health services in patient-centered medical homes. Initially, ten PICC pilot sites were selected to attend in-person and virtual quality improvement learning collaborative sessions where they received tailored technical assistance to integrate trauma informed care into pediatric primary care. The goal of the pilot project was to harvest lessons learned that improve implementation of screening for trauma among the pediatric population, engaging families, and developing policy recommendations for the Indian health system. In FY 2019, IHS continued to support seven sites established in FY 2018, alongside the previously selected tribal and IHS sites to develop a quality improvement model. In addition, these supported sites completed site assessments, developed implementation plans and have shared best and promising practices for trauma informed care. In FY 2020, lessons learned from the PICC were used by IHS to incorporate into a new standalone trauma informed care policy in the Indian Health Manual, accompanied by on-demand online training for clinical and non-clinical staff.

In 2019, IHS continued to partner with the University of New Mexico (UNM) to develop an online training curriculum related to trauma and trauma-informed care tailored for IHS staff, clinical staff, and supervisors. UNM adapted the Creating Cultures of Trauma Informed Care (CCTIC) model to be culturally appropriate and for use within AI/AN communities. The training seeks to increase staff knowledge of the impact of historical trauma on American Indian/Alaska Native populations, the types of trauma, the impacts of trauma on physical and behavioral health, and the principles and implementation of Trauma Informed Care. The UNM CCTIC is now available as an online on-demand webinar series for clinical and non-clinical staff. The goal of the CCTIC is to facilitate organizational change built around five core values: safety, trustworthiness, choice, collaboration, and empowerment. Staff training focused on recognizing trauma and its impact, becoming trauma informed, treating trauma, and ensuring supervisors at all managerial levels understand the impact of trauma and historical trauma in employee performance, coworker relationships, and well-being. In FY 2021, IHS will expand the training to incorporate additional modules for healthcare professions.

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

In FY 2017, IHS received $6 million to launch the Behavioral health Integration Initiative, which is on a three-year funding cycle through FY 2020. BH2I supports *the IHS Strategic Goal 1, Objective 1.3, to increase access to quality health care services*. In FY 2020, IHS continued funding for 12 IHS, tribal, and urban Indian organizations to integrate behavioral health with

primary care services in their local health facilities. A primary goal of the BH2I is to formalize integration across the system, develop care teams, strengthen infrastructure, and enhance clinical processes including increased depression screenings in primary care clinics. Additionally, IHS contracted with a technical assistance (TA) provider to guide this pilot project through the implementation of their integrated care efforts with expertise from psychiatrists, primary care physicians, and social workers. The TA provider has also developed and implemented a cross-site evaluation of the BH2I initiative to help IHS determine the impact of BH2I. While the initiative focuses on increased implementation of depression screening in primary care clinics, this project will include additional measures that reflect organizational change for behavioral health integration beyond focusing solely on screening rates. Thus far, BH2I projects have reported successes such as new behavioral health integration policies and procedures including same day access to behavioral health providers within primary care and emergency room settings. Sites have also reported increased screening rates for depression, anxiety, trauma and early childhood development disabilities and reduction in wait times to see a mental health counselor and psychiatrist. In response to the COVID-19 pandemic, in FY 2020 IHS provided an additional year for all BH2I grantees. This final year will allow flexibility in the project period to complete proposed activities with a focus on meeting the needs of the community as well as developing sustainability plans for their work. In FY 2021, IHS will award approximately 15 new BH2I grantees, which will be on a five-year funding cycle through FY 2026. Additionally, IHS will contract with a technical assistance provider to support grantees with the implementation of integrated care efforts.

Reflective of the Agency's priority to raise the mental health of the AI/AN population, in FY 2020, IHS reported 41.1percent of AI/AN adults over the age of 18 screened for depression using a standardized screening assessment for depression. In FY 2020, this same measure was reported for youth ages 12-17 and data indicated 32.5 percent of eligible youth were screened for depression. For FY 2020, targets were based on prior year results and results indicate the targets were not met for both measures. The FY 2022 targets are set in consideration of the most recent results.

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. In FY 2021, IHS partnered with the Northwest Portland Indian Health Board to launch a free 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 allowing for an increase in access to care and support during the COVID-19 pandemic.

TeleBehavioral Health and Workforce Development: The IHS TeleBehavioral Health Center of Excellence (TBHCE) was established in 2009, utilizing funds from the Methamphetamine and Suicide Prevention Initiative, to assess the feasibility of providing behavioral health services via televideo. Due to the rural nature of many IHS and tribal facilities, I/T/U patients face many issues surrounding access to care, particularly specialty care. Providers working in these remote areas often face barriers to maintaining the required continuing education (CE) credits required for licensure and remaining up to date on current clinical guidelines. The TBHCE assists IHS, tribal, and urban Indian organizations providers and facilities in overcoming these challenges by providing a range of telebehavioral health services and virtual training. There are 26 sites receiving direct care services through the TBHCE. These services include, adult counseling, child counseling, family counseling, trauma/Post Traumatic Stress Disorder (PTSD) counseling, child psychiatry, adult psychiatry, and addiction psychiatry. In FY 2020, the TBHCE provided more than 4,627 hours of telebehavioral health services.

Additionally, the TBCHE hosted webinars designed to meet the specific training needs of IHS, Tribal, and Urban Indian (I/T/U) health care providers. 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 2020, TBHCE provided 56 webinars that resulted in 6,100 attendees and 2,124 people receiving CE hours or a certificate of attendance.

In FY 2020, to assist communities in their response and recovery efforts due to COVID-19, IHS hosted 36 webinar trainings with for I/T/U healthcare providers on topics such as adapting behavioral health care services, transitioning to telehealth services, compassion fatigue, self-care, cultural resilience, and supporting the mental health of healthcare providers. In FY 2021, IHS will support the new trauma informed care policy by developing on-demand online training for clinical and non-clinical staff. 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.

Finally, TBHCE developed and maintains the online IHS Essential Training on Pain and Addiction. In FY 2020, 355 I/T/U providers completed this five-hour training. Additionally, 289 I/T/U providers completed the TBHCE hosted Essential Training on Pain and Addiction Refresher course.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2018	$98,900,000
2019	$101,255,000
2020	$109,036,000
2021 Enacted	$115,107,000
2022 President's Budget	$124,622,000

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.

BUDGET REQUEST

The FY 2022 budget submission for Mental Health is $125 million, which is $10 million above the FY 2021 Enacted level.

FY 2021 Base Funding of $115 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 2021 Funding Increase of $10 million includes:

- Current Services: +$5 million for current services including:
    - Pay Costs +$3 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$349,000 – to fund inflationary costs of providing health care services.
    - Population Growth +$2 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.
- Staffing for New Facilities +$5 million - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$1,156,000	8
Naytahwaush Health Center (JV), Naytahwaush, MN	$46,000	0
NEACC (Salt River) Health Center, Scottsdale, AZ	$2,120,000	18
Ysleta Del Sur Health Center (JV), El Paso, TX	$288,000	3
Alternative Rural Health Center, Dilkon, AZ	$964,000	8
Grand Total:	**$4,574,000**	**37**

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2021 Target**	**FY 2022 Target**	**FY 2022 Target +/-FY 2021 Target**
65 Proportion of American Indian and Alaska Native	FY 2020: 41.1 %[6] Target:	49.4 %	42.9 %	-6.5 %

[6] Interim result.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
adults 18 and over who are screened for depression. (Outcome)	45.7 % (Target Not Met)			
85 Depression Screening ages 12-17. (Outcome)	FY 2020: 32.5 %[7] Target: 38.0 % (Target Not Met)	43.2 %	33.9 %	-9.3 %
MH-1 Increase Tele-behavioral health encounters nationally among American Indians and Alaska Natives (Output)	FY 2020: 60,696 Target: 21,860 (Target Exceeded)	46,000	48,000	+2,000
MH-2 Suicide Screen and Assessment (Outcome)	FY 2020: Result Expected Oct 1, 2021 Target: Set Baseline (Pending)	Maintain Baseline	Maintain Baseline	Maintain

GRANTS AWARDS

The proposed FY 2022 budget increases will be used, in part, for grants for IHS facilities, tribes, tribal organizations, and urban Indian organizations to develop innovative programs to address behavioral health services and deliver those services within and outside of the traditional health care system. The actual number of non-competitive grants are included below:

(whole dollars)	FY 2020 Final	FY 2021 Enacted	FY 2022 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

[7] Interim result.

AREA ALLOCATION

Mental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2020 Estimated			FY 2021 Estimated			FY 2021 Estimated			FY'22 +/- FY'21
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$74	$14,426	$14,500	$78	$15,229	$15,308	$84,663.07	$16,488	$16,573	$1,265
Albuquerque	1,771	3,228	4,999	1,869	3,408	5,277	2,024	3,689	5,713	$436
Bemidji	327	2,445	2,772	345	2,581	2,927	374	2,795	3,169	$242
Billings	2,610	1,563	4,173	2,755	1,650	4,405	2,983	1,786	4,769	$364
California	113	2,584	2,697	119	2,728	2,847	129	2,953	3,082	$235
Great Plains	7,148	3,115	10,264	7,546	3,289	10,835	8,170	3,561	11,731	$896
Nashville	326	2,828	3,153	344	2,985	3,329	372	3,232	3,604	$275
Navajo	9,056	8,130	17,186	9,560	8,583	18,143	10,350	9,293	19,643	$1,500
Oklahoma	3,139	15,535	18,674	3,314	16,400	19,714	3,588	17,755	21,343	$1,630
Phoenix	3,364	6,964	10,328	3,552	7,352	10,903	3,845	7,959	11,804	$901
Portland	499	4,531	5,031	527	4,784	5,311	571	5,179	5,750	$439
Tucson	12	1,817	1,829	12	1,919	1,931	13	2,077	2,090	$160
Headquarters	13,432	0	13,432	14,180		14,180	15,352	0	15,352	$1,172
Total, Mental	**$41,870**	**$67,166**	**$109,036**	**$44,202**	**$70,906**	**$115,107**	**$47,855**	**$76,768**	**$124,622**	**$9,515**

Note: FY 2021 and FY 2022 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 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$245,618	$251,360	$267,490	+$16,130
FTE*	222	232	244	+12

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

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

FY 2022 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Alcohol and 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. The ASAP addresses the IHS Strategic Plan *Goal 1, Objective 1.2 by building, strengthening, and sustaining collaborative relationships with I/T/Us and 1.3 increasing access to quality health care services*. These collaborative activities strive to integrate substance abuse treatment into primary care. For instance, the Substance Abuse and Suicide Prevention Program 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 general, AI/AN populations suffer disproportionately from substance use disorders (SUD) compared with other racial groups in the United States. Research has consistently found that AI/AN experience higher rates of substance use compared with the U.S. general population. Findings from the 2018 National Survey on Drug Use and Health (NSDUH) reported the rate of AI/ANs with an alcohol use disorder (7.2 percent) is higher than that of the total population (5.1 percent).[1] In 2017, the Centers for Disease Control and Prevention (CDC) reported that the AI/AN population had the second highest overdose rates from all opioids (15.7 deaths/ 100,000 population), and the highest rate from prescription opioids (7.2 deaths/100,000 population) during 2016-2017. The overall rate of overdose deaths for AI/ANs increased by 13 percent between 2015-2017. In 2017, the age-adjusted rate of drug overdose deaths was 9.6 percent higher than the rate for 2016. During that time, deaths rose more than 500 percent among AI/ANs. Due to

[1] https://www.samhsa.gov/data/sites/default/files/reports/rpt23246/1_AIAN_2020_01_14_508.pdf

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]

The services and functions of the IHS Alcohol and Substance Abuse program supports the IHS Strategic Plan *Goal 2, Objective 2.2 to provide care to better meet the health care needs of AI/AN communities and Goal 1 to ensure comprehensive, culturally appropriate services in the prevention, treatment and recovery of alcohol and substance use disorders*.

PROGRAM ACCOMPLISHMENTS

As alcohol and substance abuse treatment and prevention have transitioned from IHS direct care services to local community control via tribal contracting and compacting, IHS' role has 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. Integrating treatment into ambulatory health care offers immediate and same-day opportunities for health care providers to identify patients with substance use disorders, provide them with medical advice, help them communicate the health risks and consequences, obtain substance abuse consultations, and refer patients with more severe substance use-related problems to treatment.[3] One integration activity is the implementation of the Screening, Brief Intervention, Referral to Treatment (SBIRT) instrument. SBIRT is an early intervention and treatment service for people with substance use disorders 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. SBIRT is eligible for reimbursement from the Centers for Medicare and Medicaid Services (CMS). IHS has incorporated SBIRT as a national measure to be tracked and reported. In FY 2020, the SBIRT screening measure was utilized in 14.8 percent of the patient visits for those between ages 9 through 75. The target for this measure was 12.2 percent, therefore IHS efforts exceeded the expected percent of patients to be screened using the SBIRT. At the onset of the COVID-19 pandemic, IHS increased efforts to expand telehealth capacity across I/T/Us to continue coordination of treatment and services to patients. Additionally, IHS continues to monitor the SBIRT administered through telehealth methods. IHS continues to provide annual national training on SBIRT including guidelines for improved clinical documentation in the electronic health record. In FY 2020, IHS continues to increase efforts that broadly promote the SBIRT measure to achieve targets at the regional and local levels including a more focused education campaign on the importance of early detection and intervention using SBIRT screening among IHS operated programs. In addition, the IHS is actively working to expand local SBIRT measures to include a focus on substance use in women of childbearing age to assist in early identification and referral for treatment for risky use and to reduce illicit perinatal substance exposure for infants.

Increasing access to Medication Assisted Treatment (MAT): The Indian Health Service is committed to assuring access to Medication Assisted Treatment for patients struggling with Opioid Use Disorder (OUD). The IHS continues to host training sessions for clinicians to receive their Drug Addiction Treatment Act (DATA) 2000 waiver to prescribe buprenorphine and

[2] https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf
[3] U.S. Office of National Drug Control Policy. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.

in FY 2018 added buprenorphine-containing medication and injectable naltrexone to the IHS National Core Formulary. In FY20, the IHS continues to evaluate new long-acting MAT therapies for inclusion on the National Core Formulary and creates formulary briefs and technical assistance to incorporate these new treatments into practice. In June 2019, the IHS released the Special General Memorandum *Assuring Access to MAT* that requires Federal Indian Health Service Facilities to create an action plan to identify local MAT resources and coordinate patient access to these services when indicated to assure equitable access to MAT services. In addition, the IHS has created workforce development strategies that include SUD training for healthcare workers and technical assistance materials to support sites with creating integrated SUD approaches to care. These efforts have resulted in a 37 percent in buprenorphine prescriptions between 2018-2019.

To address challenges that limit access to recovery services in remote and rural IHS locations and villages, the IHS released an *Internet Eligible Controlled Substance Prescriber Designation (IECSP)* Policy in the Indian Health Manual (Chapter 38) to assure access to MAT using telemedicine models for remotely located Tribal members. In January 2020, an IHS telehealth toolkit for MAT services was created and shared on the ihs.gov/opioids website. These resources assist prescribers and sites with creating tele-MAT services and implementing provisions within the IECSP policy. Additionally, a webinar was hosted in February 2020 to describe available MAT resources and policies. 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* developed in collaboration with the American College of Obstetricians and Gynecologists' (ACOG) Committee on American Indian and Alaska Native Women's Health. 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* that includes clinical recommendations on the prevention and management of neonatal opioid withdrawal syndrome. These recommendations provide standards of care for screening, diagnosing, support, and treatment of pregnant mothers and infants affected by prenatal opioid exposure

The IHS has also partnered with the Northwest Portland Area Indian Health Board and the Clinician Consultation Center to facilitate I/T/U clinician access to free Substance 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 has expanded access to harm reduction interventions that include increased access to the opioid overdose reversal medication, naloxone. In 2015, the IHS signed a memorandum of agreement with the Bureau of Indian Affairs (BIA). The agreement allows IHS to provide BIA Law Enforcement Officers (LEO) with training and naloxone rescue kits for responding to incidents of opioid overdose. Between 2015 and 2017, this partnership trained and put naloxone in the hands of 324 BIA LEOs, who are often the first responders to incidents of opioid overdose in Tribal communities. In 2017, IHS turned the naloxone training program over to the BIA after certifying 48 BIA LEOs as naloxone trainers. The IHS continues to support this program by re-supplying naloxone rescue kits to BIA LEO first responders as needed. In 2019, IHS conducted first-responder train-the-trainer sessions on naloxone and harm reduction strategies for

community health workers from IHS and tribal sites from across the country. During that training 86 community workers were supplied with naloxone kits and certified to offer naloxone training within their local communities. The IHS also supports naloxone co-prescribing and has created sample collaborative practice agreements to engage pharmacists in naloxone distribution efforts and has hosted an IHS 'Grand Rounds' on naloxone co-prescribing to increase provider awareness of this life-saving procedure. A "First Responder Toolkit" that includes a training video, a law enforcement testimonial video, customizable forms, and a train-the trainer curriculum was created to support naloxone deployment in tribal communities. The IHS formally expanded access to naloxone in March 2018 through a policy titled "Prescribing and Dispensing of Naloxone to First Responders" that require IHS Federal pharmacies to provide naloxone to all Tribal law enforcement agencies and other trained first responders. These efforts have resulted in a 143 percent increase in naloxone procurement across IHS facilities that utilize the Prime Vendor.

The IHS has further adapted the toolkit and strategy to equip community first responders and paraprofessionals with training on opioid overdose response and naloxone. These expanded collaborations with local law enforcement and community first responders resulted in an initial pilot community-health naloxone train-the-trainer program to include naloxone distribution.

In addition to the naloxone distribution, the IHS expanded harm reduction strategies to include an evaluation of Safe Syringe Services. In FY 2020, IHS will develop and release a Safe Syringe Services toolkit that includes sample patient education pamphlets, a review of available resources, and information related to creating program financial sustainability. These expanded harm reduction services will support IHS Hepatitis C Elimination and HIV/AIDS efforts

Proper Pain Management, Opioid Stewardship and Training:
The IHS has created and released a comprehensive Opioid Stewardship workbook to assist sites with creating best practices surrounding safe opioid prescribing and increasing access to integrative pain treatments. The workbook 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 that evaluate trends in Morphine Milligram Equivalents versus a restricted focus on total opioid prescription fills. A total of fifteen opioid prescribing metric definitions have been proposed for inclusion in the IHS Opioid Prescribing dashboard. Finally, the Opioid Prescribing dashboard development phase was completed in FY 2020 with release and roll-out anticipated in FY 2021.

The IHS has also increased access to non-pharmacologic pain management approaches. The IHS has collaborated with the Defense Veterans Center for Integrated Pain Management to expand access to focused auricular acupuncture through the creation of sample credentialing and privileging processes, protocols, documentation standards, and sustainability recommendations. Access to additional integrative pain management strategies such as dry needling, deep tissue mobilization, and electrical stimulation have increased.

The IHS has created agency policy and clinical practice recommendations to improve patient outcomes and reduce unnecessary opioid exposure. In June 2014, the IHS implemented Indian Health Manual Chapter 30 policy titled *Chronic Non-Cancer Pain Management* to promote appropriate pain management with revision in 2018 to align with CDC *Guideline for Prescribing Opioids for Chronic Pain.* This policy will be revised in FY 20 to include enhanced recommendations related to de-prescribing and medical cannabis. The impact of Prescription Drug Monitoring Programs (PDMPs) on safe opioid prescribing is well documented. The IHS

implemented Chapter 32 *State Prescription Drug Monitoring Programs* requiring providers to check state PDMP data bases prior to prescribing opioids and requiring IHS federal pharmacies to report opioid prescribing data to these state PDMPs. Ongoing improvements to automate reporting electronic integration and audit reporting are planned for FY 2021. The IHS has also addressed acute pain prescribing through the development of clinical guidelines to assist dentists with selecting the safest pain control option. The *Recommendations for Management of Acute Dental Pain* will 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 has also created a robust workforce development strategy to include didactic training. In September 2019, the IHS launched its Pain Management and Opioid Use Disorder Continuing Medical Education webinar series. The IHS has hosted learning sessions in this series that include buprenorphine prescribing in pregnancy, dental acute pain management recommend as well as an auricular acupuncture-training program. Implementing an Integrated MAT Model-A Review of Resources, Assessment and Treatment of Pain and Co-occurring OUD In Individual with Serious Mental Illness, and Treatment of OUD in the ED, Should it be a Choice?

In May 2016, the IHS implemented a policy on mandatory opioid training requiring all federally controlled substance prescribers to complete the "IHS Essential Training on Pain and Addiction" with required refresher training every 3 years. This training is now available on demand with continuing medical education credits. The IHS released its Refresher training course in January 2018 including four sessions of its mandatory five-hour training course for providers on proper opioid prescribing. In FY 2019, 302 new clinicians completed this course. The mandate also includes an additional refresher training after three years. In FY 2019, 7251 clinicians completed the Essential Training on Pain and Addiction Refresher course. In FY 2020, course content was updated based on prescriber evaluation. These revisions include expanded modules on managing pain in special populations (e.g., older adults, pregnancy, SUD) as well as content on effective de-prescribing strategies.

Improved Communication Related to Opioid Strategies:
Enhanced communication during the opioid crisis response is vital to program development, policy implementation, and ongoing evaluation. The IHS created and released an Opioid Information Sheet that will serve 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 IHS HOPE Committee webpage that support a unified user experience in addition to publication of a quarterly opioid newsletter (https://www.ihs.gov/opioids/hope/).

In FY2020, the IHS expanded websites to include a new technical assistance page that will share best and promising practices related to clinical documentation, sample documentation templates and How-to guides, and links to clinician supports. Future content consolidation will include funding opportunities and promising clinical practices.

In FY 2020, IHS provided Pain Skills Intensive trainings in the Phoenix and Tucson Area and the Navajo Area. These trainings focus on assessment and treatment of myofascial pain, including non-pharmacological interventions. Additionally, they include the half-and-half DATA Waiver training for buprenorphine MAT. A total of 35 clinicians attended these trainings
In FY 2020, IHS provided three webinars that addressed pain management, opioids, and opioid misuse with a total of 326 attendees.

- Implementing an Integrated MAT Model-A Review of Resources
- Assessment and Treatment of Pain and Co-occurring OUD In Individual with Serious Mental Illness
- Treatment of OUD in the ED, Should it be a Choice?

The IHS has created agency policy and clinical practice recommendations to improve patient outcomes and reduce unnecessary opioid exposure. In June 2014, the IHS implemented IHM Chapter 30 policy titled Chronic Non-Cancer Pain Management to promote appropriate pain management. Finally, the Indian Health Service released new clinical guidelines to assist dentists with selecting the safest pain control options. The *Recommendations for Management of Acute Dental Pain* will limit opioid prescribing to 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 dosing of systemic analgesics based on anticipated operative pain.

Pain and Opioid Use Disorder Case Consultation Services: To provide ongoing clinical support for providers, IHS, in partnership with the University of New Mexico Pain Center, provides a weekly Chronic Pain and Opioid Management ECHO. ECHO is a case-based learning model in which consultation is offered through virtual clinics to primary care clinicians by an expert team to share knowledge and elevate the level of specialty care available to patients. In FY 2019, 178 IHS, tribal, and urban clinicians participated in 34 ECHO sessions with over 1,000 attendees.

Youth Regional Treatment Centers (YRTCs): YRTCs are facilities which provide medically managed care, including detoxification, and other essential treatment and recovery services to AI/AN youth experiencing substance use disorders.. 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 2020 all federal YRTCs in operation 18 months or longer have achieved accreditation status. COVID-19 significantly impacted service delivery across all YRTCs. In response to the challenges YRTCs experienced to maintain facility operations, YRTCs partnered with the IHS, SAMHSA's Office of Tribal Affairs and Policy and the Addiction Technology Transfer Center (ATTC) Network Coordinating Office to identify and develop response and recovery resources specific to YRTCs continuity of care. This document "Guidance for Caring for Patients in Youth Regional Treatment Centers During the COVID-19 Pandemic" was developed to support the delivery of care among the YRTCs during this ever-evolving situation.

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. To this end, ICP developed and posted a nine-session training series on FASD in AI/AN populations. ICP is currently piloting a four-hour, introductory course on FASD and another course on Autism Spectrum Disorder. The target audience of these trainings are Community Health Representatives, school staff, and other community members. In FY 2019, ICP produced a nine-session training series, Substance Use and the Adolescent Brain. The ICP also provides additional clinician supports. For example, clinicians can take advantage of the bi-weekly, Pediatric Neurodevelopmental & Behavioral Health Consultation Clinic. This virtual clinic is designed to help clinicians successfully diagnose, manage, and/or treat AI/AN youth with FASD, ASD, and other neurodevelopmental issues.

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

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

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

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

In April 2019, the IHS expanded collaboration with the Defense Veterans Center for Integrated Pain Management to explore feasibility of creating an IHS auricular acupuncture program utilizing the Veterans Health Administration Battlefield Acupuncture protocol. The IHS has created a pilot program that includes credentialing and privileging processes, clinical practice protocols, documentation standards, patient education materials, and a sustainability plan. The initial training session was hosted in November 2019 and 23 IHS clinicians were certified in this modality.

Ninety-six community-health workers completed training as naloxone trainers for their tribal communities in one week.

ASA Grant and Federal Award Programs

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. In particular, the IHS Community Opioid Intervention Pilot Program and the Substance Abuse and Suicide Prevention program (SASP) will support the IHS Strategic Plan Goal 1, Objective 1.2 to build, strengthen, and sustain collaborative relationships and Objective 1.3 to increase access to quality health care services.

IHS Community Opioid Intervention Pilot Program (COIPP): In FY 2021, IHS awarded $16 Million in funding to combat the opioid epidemic in American Indian and Alaska Native communities. The IHS Community Opioid Intervention Pilot program awarded 35 grants to support the development of innovative, locally-designed, culturally-appropriate prevention, treatment, recovery, and aftercare services for opioid use disorders. Awarded projects will focus on increasing public awareness and education about the impact of opioid use disorder on individuals, families and communities. Grantees will also 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 medication assisted treatment. The IHS Community Opioid Intervention Pilot is a three year program and part of the Department of Health and Human Services' five-point strategy to fight the opioid overdose epidemic in America.

Substance Abuse and Suicide Prevention Program (SASP): The SASP is a nationally-coordinated $31.97 million program providing funds for culturally appropriate substance use and suicide prevention programming in AI/AN communities. The program funds 174 projects. IHS administration of the SASP grants supports the HHS Strategic Plan, *Goal 2 to protect the health of Americans where they live, learn, work, and play*. In August of 2019, IHS initiated Tribal Consultation and an Urban Confer regarding behavioral health initiatives and the National Tribal Advisory Committee on Behavioral Health recommendations regarding the distribution of funding for the SASP program. In total 22 comments and recommendations were received and reviewed by IHS. On March 2, 2020, the IHS Director issued a decision to continue distribution the SASP program funds using a competitive grant mechanism.

However, due to the COVID-19 pandemic, the SASP notice of funding opportunity (NOFO) originally set to be released in Spring 2020, will be published in FY2021.

The goals of SASP are to:

1. Increase IHS, Tribal, and Urban (I/T/U) capacity to operate successful substance abuse prevention, treatment, and aftercare and/or suicide prevention, intervention, and postvention services through implementing community and organizational needs assessment and strategic plans;
2. Develop and foster data sharing systems among I/T/U behavioral health service providers to demonstrate efficacy and impact;
3. Identify and address suicide ideations, attempts, and contagions among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postvention strategies;
4. Identify and address substance use among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, treatment, and aftercare strategies;

5. Increase provider and community education on suicide and substance use by offering appropriate trainings; and
6. Promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance use.

SASP projects were awarded funding in at least one of four purpose areas and work to address the corresponding SASP goal listed above. SASP Purpose Areas are:

1. Community Needs Assessment and Strategic Planning;
2. Suicide Prevention, Intervention, and Postvention;
3. Substance Use Prevention, Treatment, and Aftercare; and
4. Generation Indigenous (Gen-I) Initiative Support.

Of the projects funded, 19 projects specifically focus on substance use prevention, treatment, and aftercare, while 107 focus on substance use and suicide prevention among Native youth. IHS established the Universal Alcohol Screening (UAS) as a national measure to increase screening and improve detection and intervention strategies among patients' ages 9 through 75 years of age. In FY 2020, 33.8 percent of eligible patients were screened for risky alcohol use. In 2020, the pandemic impacted IHS primary care and emergency departments clinical settings, therefore the IHS did not meet the expected screening target of 42.4.0 percent.

The SASP program had an anticipated project period ending on September 29, 2020. Due to the COVID-19 pandemic, the majority of the 174 SASP projects reduced and/or ceased activities. Only a limited number of projects continued to operate and did so according to their local, state, and federal guidelines for COVID-19 by modifying in-person activities to virtual events. In June 2020, the IHS requested and received a 1-year extension for all SASP grants from the Department of Health and Human Services (DHHS) due to the impact of COVID-19. The new end date for all SASP grants will be September 29, 2021.

In the fourth year, 100 percent of projects submitted progress reports as a requirement of funding. Positive strides in the delivery of substance use services have been accomplished and reported in preliminary data monitoring for SASP program activities. Successful outcomes during the fourth year of the program include expanded behavioral health services offered through school settings and home visiting with a total of 1,475 patients receiving care. Over 270 providers were trained in behavioral health integration with 163 of those providers located within a primary care setting. Project accomplishments include 67,168 individuals screen for suicide ideation, 54 percent of the SASP program suicide prevention projects implemented an enhanced process for suicide screening, and over 11,003 community members have been trained in suicide and/or substance use prevention. Fifty three percent of projects hosted a successful prevention education community event, and 59 percent reported their trainings to have expanded staff knowledge (a 12 percent increase from year 2). Twenty nine percent reported implementation and documentation of a system change. In addition, among projects supported, a total of 76,054 individuals received cultural services, a high percentage of projects have continued to offer integrated traditional healing into care, extended service hours, provision of follow-up care, new counseling and case management services. In summary, the SASP program continues to support tribes, tribal organizations, urban Indian organizations, and federal facilities offering care.

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, in the report the number of alcohol related deaths in the community of Gallup, New Mexico was addressed with the report stating, "these deaths underscore the urgent need for substance abuse treatment, residential services and detoxification services" in this community. In response, the IHS used the increased appropriated funds to address the urgent need in the city of Gallup, New Mexico. In addition to Gallup, New Mexico, IHS was aware of the urgent need for alcohol detoxification services in the Great Plains Area after the removal of liquor licenses and alcohol sales in White Clay, Nebraska, leading to the potential for increased mortality if services were unavailable for alcohol detoxification. As a result, funds were also made available to address this urgent need. The funds provided to Gallup, New Mexico and the Great Plains Area (specifically the Oglala Sioux Tribe) to address the need for social detoxification services were made available in FY 2017 through a competitive cooperative agreement. The funding announcement was released in FY 2017 and two projects were selected and funded. The project period is for 5 years and will run from September 15, 2017, to September 14, 2022. With the additional funding, the Gallup NM site reported detoxification services to 9,482 unique individuals with over 75 percent of those clients including males. In addition to services offered for monitoring, supervising and managing detoxification, this site has increased coordination and transportation with the Emergency Department; and established a contract with the Gallup Police Department to transport patients to the detoxification center. The Great Plains' site has used the funding to increase coordination with behavioral health programs, provide screenings and brief interventions to individuals incarcerated in jails, and serve as an immediate placement for individuals who are in need of treatment services following detoxification. In FY2020, the nearly 100 percent of individuals held in detoxification for more than two weeks were successfully admitted into a higher level of residential treatment care for their SUD.

While services were temporarily interrupted at the City of Gallup detoxification site, the PARD site in the Great Plains Area was able to continue operations. IHS continues to work with both sites to ensure each has adopted guidelines provided by the local and state health departments, and the Centers for Disease Control and Prevention.

YRTC Aftercare Pilot Project: In December 2017, IHS utilized $1.8 million to implement a pilot project for aftercare services for AI/AN youth discharged from residential substance abuse treatment. The Project focus is to identify appropriate aftercare services that can be culturally adapted to support AI/AN youth in their recovery journey once they leave YRTC care. Two YRTCs, Desert Sage Youth Wellness Center and Healing Lodge of the Seven Nations, were selected and to develop approaches to aftercare, recovery, and other support services for AI/AN youth that can be used across other YRTCs. These facilities are tasked with implementing best practices around effective reintegration processes while establishing a collaborative partnership community-based approach to reduce alcohol and substance use relapse. With the additional funding the two YRTCs have engaged tribal and urban programs that refer adolescents to the YRTCs, to identify best practices for aftercare. This has resulted in improved coordination around aftercare and case management, increased training of community supports for the adolescents, improved identification of transitional living, increased awareness of the use of social media, and improved follow-up with data collection after discharge. Best practices and lessons learned from the *YRTC Aftercare Pilot Project* will directly support discharge recommendations and guidance in the "Guidance for Caring for Patients in Youth Regional Treatment Centers During the COVID-19 Pandemic" document.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5

times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount	SASP	Gen I
2018	$224,188,000	($15,475,000)	($16,500,000)
2019	$234,421,000	($15,475,000)	($16,500,000)
2020	$245,618,000	($15,475,000)	($16,500,000)
2021 Enacted	$251,360,000	($15,475,000)	($16,500,000)
2022 President's Budget	$267,490,000	($15,475,000)	($16,500,000)

TRIBAL SHARES

Alcohol and Substance Abuse funds are subject to tribal shares and are transferred to tribes when they assume the responsibility for 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.

BUDGET REQUEST

The FY 2022 budget submission for Alcohol and Substance Abuse is $267 million, which is $16 million above the FY 2021 Enacted level.

FY 2021 Base Funding of $251 million – This funding will maintain the program's progress in addressing alcohol and substance abuse needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2021 Funding Increase of $16 million includes:

- Current Services: +$9 million for current services including:
    - Pay Costs +$4 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$790,000 – to fund inflationary costs of providing health care services.
    - Population Growth +$4 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

- Staffing for New Facilities: +$2 million - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$299,000	2
Naytahwaush Health Center (JV), Naytahwaush, MN	$23,000	0
NEACC (Salt River) Health Center, Scottsdale, AZ	$1,050,000	8
Ysleta Del Sur Health Center (JV), El Paso, TX	$113,000	1
Alternative Rural Health Center, Dilkon, AZ	$359,000	3
Grand Total:	**$1,844,000**	**14**

- Opioid Grants: +$5 million to expand the IHS Opioid Grant program to a total of $15 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 opioid use disorder activities.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2021 Target**	**FY 2022 Target**	**FY 2022 Target +/-FY 2021 Target**
10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). (Outcome)	FY 2020: 100 %[4] Target: 100 % (Target Met)	100 %	100 %	Maintain
80 Universal Alcohol Screening (Outcome)	FY 2020: 37.1 %[5] Target: 42.4 % (Target Not Met)	39.0 %	39.2 %	+0.2 %
82 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome)	FY 2020: 12.8 %[6] Target: 12.2 % (Target Not Met)	14.3 %	13.5 %	-0.8 %

[4] Interim result.

[5] Interim result.

[6] Interim result.

GRANTS AWARDS

(whole dollars)	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	143	178	178
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION

Alcohol and Substance Abuse

(dollars in thousands)

DISCRETIONARY	FY 2020 Estimated			FY 2021 Estimated			FY 2021 Estimated			FY'22 +/- FY'21
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$738	$33,579	$34,317	$756	$34,364	$35,120	$804	$36,569	$37,373	$2,254
Albuquerque	3,482	9,986	13,468	3,563	10,220	13,783	3,792	10,876	14,668	$884
Bemidji	2,216	8,788	11,004	2,268	8,993	11,262	2,414	9,571	11,984	$723
Billings	591	11,309	11,900	605	11,573	12,178	644	12,316	12,960	$781
California	3,921	14,600	18,520	4,012	14,941	18,953	4,270	15,900	20,170	$1,216
Great Plains	4,443	11,118	15,561	4,547	11,378	15,924	4,838	12,108	16,946	$1,022
Nashville	3,616	6,585	10,201	3,700	6,739	10,439	3,938	7,171	11,109	$670
Navajo	2,012	19,134	21,146	2,060	19,581	21,641	2,192	20,838	23,029	$1,389
Oklahoma	5,147	12,941	18,088	5,268	13,243	18,511	5,606	14,093	19,699	$1,188
Phoenix	8,532	11,171	19,702	8,731	11,432	20,163	9,291	12,165	21,457	$1,294
Portland	2,401	15,206	17,606	2,457	15,561	18,018	2,614	16,560	19,174	$1,156
Tucson	62	3,271	3,333	64	3,347	3,411	68	3,562	3,630	$219
Headquarters	50,770	0	50,770	51,957		51,957	55,291		55,291	$3,334
Total, ASA	**$87,932**	**$157,686**	**$245,618**	**$89,987**	**$161,373**	**$251,360**	**$95,762**	**$171,728**	**$267,490**	**$16,130**

Note: FY 2021 and FY 2022 are estimates.

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

(Dollars in thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$965,015	$975,856	$1,191,824	+$215,968
FTE*	85	89	91	+2

* PRC Funds are not used for Federal or Tribal Staff

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

FY 2022 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) (IHS Strategic Plan Goal 1). The Indian health system delivers care through direct care services provided in an IHS, Tribal or Urban Indian Health Program (I/T/U) facility (e.g., hospitals, clinics) and through PRC services delivered by non-IHS providers to increase access to quality health care services (IHS Strategic Plan 1.3). 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;

[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.

authorization of payment for each recommended medical service by a PRC authorizing official; medical necessity of the service and inclusion within the established Area IHS/Tribal medical/dental priorities; and full expenditure of all alternate resources (i.e., Medicare, Medicaid, 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 are defined as follows:

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

A PRC rate, a capitated rate based on Medicare payment methodology, is used to purchase care, and Medicare participating hospitals are required to accept this rate as payment in full for all hospital-based health care services (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 (*IHS Strategic Plan 1.3.4 – Increase access to quality community, direct, specialty, long-term care and support services, and referred health care services and identify barriers to care for AI/AN stakeholders*). 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) (*IHS Strategic Plan 3.2.7 – Develop policies, use tools, and apply models that ensure efficient use of assets and resources*). 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. This meets *the IHS Strategic Plan Goal 1: To ensure that comprehensive culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people. Objective 1.3 Increase access to quality health care services.*

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.

The PRC Program contracts with a fiscal intermediary (FI), currently Blue Cross/Blue Shield of New

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

Mexico, to ensure payments are made in accordance with IHS' payment policy, and coordinate benefits with other payers to maximize PRC resources.(*IHS Strategic Plan 3.2.7 – Develop policies, use tools, and apply models that ensure efficient use of assets and 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. (*IHS Strategic Plan 1.3 Increase access to quality health care services)*

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. This policy meets the (*IHS Strategic Plan 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce.)*

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 increased access to care by allowing I/T/Us to purchase additional services with these Medicare methodology capitated rates, referred to as PRC rates. PRC rates were originally referred to as Medicare-like rates (MLR) for hospital based services but are now identified as PRC rates. PRC rates are based on the Medicare payment methodology for all hospital based services, physician and non-hospital providers of supplies and services. The PRC rates rule (42 CFR 136 Subpart I) for physicians and non-hospital providers of supplies and services applies to I/T/Us but only to the extent the tribally-operated PRC 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 have allowed 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 2020, 93 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 2020, PRC programs denied and deferred an estimated $1,070,238,593 for an estimated 265,785 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 2020, 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.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	PRC	CHEF	Total
2018	$909,695,000	$53,000,000	$962,695,000
2019	$911,819,000	$53,000,000	$964,819,000
2020	$915,015,000	$53,000,000	$965,015,000
2021 Enacted	$922,856,000	$53,000,000	$975,856,000
2022 President's Budget	$1,138,824,000	$53,000,000	$1,191,824,000

BUDGET REQUEST

The FY 2022 budget submission for Purchased/Referred Care is $1 billion, which is $216 million above the FY 2021 Enacted Level.

The FY 2021 Enacted base funding will provide for the following approximate services:

- 40,573 Inpatient admissions
- 942,316 Outpatient visits
- 45,320 Patient travel trips

FY 2022 Funding Increase of $226 million includes:

- Current Services: +$26 million for current services including:
  - Pay Costs: +$291,000 – to fund pay increases for Federal and Tribal employees.
  - Inflation: +$9 million – to fund inflationary costs of providing health care services.
  - Population Growth +$17 million – to address the impact of the additional services need arising from the growing AI/AN population. The IHS estimates the population growth rate will be 1.8 percent in CY 2022 based on state births and deaths data.

Purchased/Referred Care General Program Increase: The FY 2022 Funding increase of $190 million will provide for the following estimated increased services:

- 8,312 Inpatient admissions
- 195,465 Outpatient visits
- 10,086 Patient travel trips

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
PRC-2 Track IHS PRC referrals (Outcome)	FY 2020: 63.0 days Target: 60.0 days (Target Not Met but Improved)	60.0 days	60.0 days	Maintain
PRC-3 Track PRC self-referrals (Outcome)	FY 2020: 54.0 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 SERVICES	FY 2020 Estimated			FY 2021 Estimated			FY 2021 Estimated			FY '22 +/- FY '21
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$99,772	$99,772	$0	$100,893	$100,893	$0	$123,222	$123,222	$22,329
Albuquerque	26,870	18,595	45,465	27,172	18,804	45,976	33,185	22,965	56,150	$10,175
Bemidji	13,850	54,027	67,877	14,006	54,634	68,640	17,105	66,725	83,831	$15,191
Billings	43,661	21,108	64,769	44,152	21,345	65,496	53,923	26,069	79,991	$14,495
California	726	55,103	55,829	734	55,722	56,456	896	68,054	68,950	$12,494
Great Plains	67,266	23,362	90,628	68,021	23,625	91,646	83,075	28,853	111,929	$20,282
Nashville	6,148	34,618	40,767	6,217	35,007	41,225	7,593	42,755	50,348	$9,123
Navajo	57,704	45,449	103,153	58,352	45,959	104,312	71,266	56,131	127,397	$23,085
Oklahoma	45,852	74,850	120,702	46,368	75,691	122,058	56,629	92,442	149,071	$27,013
Phoenix	44,318	32,664	76,982	44,816	33,031	77,847	54,734	40,341	95,075	$17,228
Portland	13,188	93,444	106,633	13,337	94,494	107,831	16,288	115,407	131,695	$23,864
Tucson	279	21,192	21,471	282	21,430	21,713	345	26,173	26,518	$4,805
Headquarters	70,967	0	70,967	71,765		71,765	87,647		87,647	$15,882
Total, PRC	**$390,831**	**$574,184**	**$965,015**	**$395,222**	**$580,634**	**$975,856**	**$482,689**	**$709,135**	**$1,191,824**	**$215,968**

Note: FY 2021 and FY 2022 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

Services: 75-0390-0-1-551

INDIAN HEALTH CARE IMPROVEMENT FUND

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$72,280	$72,280	$317,306	+$245,026

Authorizing Legislation.....25 U.S.C. § 1621 of the Indian Health Care Improvement Act (IHCIA), as amended

FY 2022 Authorization..... Permanent

Allocation Method.....Direct Federal, P.L. 93-638 contracts and compacts, Tribal shares

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) at 25 U.S.C. § 1621 authorizes the Indian Health Care Improvement Fund (IHCIF) for purposes of eliminating deficiencies in health status and resources of all Indian tribes, eliminating backlogs in health care services to Indians, meeting the health needs of Indians in an efficient and equitable manner, eliminating inequities in funding for both direct care and Purchased/Referred Care (PRC) programs, and augmenting health services where deficiencies are highest. The IHCIA specifies that the IHS take into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances. The IHS received a total of $259 million in IHCIF resources from FY 2000 – FY 2018. Prior to the Omnibus Appropriations Act of 2018, which provided $72 million in a new IHCIF budget line, IHCIF increases were included in the Hospitals and Health Clinics budget line.

PROGRAM ACCOMPLISHMENTS

A formula to allocate appropriations for the IHCIF was initially developed through the work of a Tribal/IHS Workgroup in 2000. The formula, which later became known as the Federal Disparity Index (FDI), or synonymously, the Level of Need Funded (LNF), measured the LNF for IHS and Tribal facilities relative to a benchmark level of funding. The formula was revisited once in 2010, prompted by the reauthorization of the IHCIA, which included an update to the IHCIF provision, expanding the list of services that the IHCIF may support, establishing a reporting requirement, and reaffirming that IHS must consider services and resources provided by Federal programs, private insurance, and programs of State and local governments. While technical improvements were made to the data used in the calculation, the IHS did not to change the formula at that time.

In late 2017, in recognition of the considerable changes in the health care environment since the 2010 Tribal consultation on the IHCIF, in response to Tribal requests, and the funding increase for the IHCIF in the Consolidated Appropriations Act, 2018 (P.L. 115-141), IHS reconvened another IHCIF Tribal/IHS Workgroup (Workgroup) to review the existing formula and make recommendations for improvement.

The IHS updated the funding distribution formula based on the recommendations of the IHCIF workgroup, and allocated an additional $72 million in IHCIF resources to 40 sites across eight IHS Areas that were at or below a 34.84 percent Level of Need Funded.

FUNDING HISTORY

Fiscal Year	Amount*
2018	*$72,280,000*
2019	*$72,280,000*
2020	*$72,280,000*
2021 Enacted	*$72,280,000*
2022 President's Budget	*$317,306,000*

BUDGET REQUEST

The FY 2022 President's Budget requests a total of $317 million for the Indian Health Care Improvement Fund, an increase of +$245 million above the FY 2021 Enacted level.

The FY 2022 Funding Increase of $245 million includes:

- Current Services: +$2.5 million
    - Pay Costs +$913k – to fund pay increases for federal and Tribal employees.
    - Inflation +$312k – to fund inflationary costs of providing health care services.
    - Population Growth +$1.301 million – to fund the additional service needs arising from thegrowing AI/AN population. The projected growth rate is 1.8 percent in CY 2022 based on state births and deaths data.
- General Program Increase: +$242 million to significantly expand the reach of the Indian Health Care Improvement Fund, expanding access to direct health care services, and addressing resource disparities across the Indian health system.

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$177,928	$178,789	$192,588	+$13,799
FTE*	208	217	246	+29

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

SUMMARY OF THE BUDGET REQUEST

The FY 2022 Indian Health Service (IHS) Budget submission for Preventive Services the budget includes a total of $193 million, which is +$14 million above the FY 2021 Enacted level. This funding increase includes $5 million for staffing of new and replacement facilities and $8 million for current services costs.

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

- **Community Health Representatives** (CHRs) to help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members. In order to prioritize health care services and staffing of newly constructed facilities, the Budget discontinues the Community Health Representative program.

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

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 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$91,894	$92,736	$102,693	+$9,957
FTE*	188	197	226	+29

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

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

FY 2021 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

The PHN program aligns with the *IHS Strategic Plan FY 2019-2023 Goal 1 to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people by increasing access to quality health care services (Goal 1, objective 1.3).* The PHN Program funds provide critical support for direct health care services in the community which improve Americans' access to health care and expand choices of care and service *options (The HHS Strategic Plan FY 2018-2022, Goal 1: Reform, Strengthen, and Modernize the Nation's Health Care System, objective 1.3)*. PHNs support population-focused services to promote healthier communities through community based direct nursing services, community development, and health promotion and disease prevention activities. PHNs are licensed, professional nursing staff available to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they

transition from the hospital to home. The PHN expertise in communicable disease assessment, outreach, investigation, and, surveillance helps to manage and prevent the spread of communicable diseases. PHNs contribute to several agency's primary prevention efforts such as providing community immunization clinics, administering immunizations to homebound AI/AN individuals, and through public health education, inspiring AI/AN people to engage in healthy lifestyles and ultimately live longer lives. PHNs conduct nurse home visiting services via referral for such activities as follows:

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

PHNs perform a community assessment to identify high-risk populations and implement evidenced based interventions to address identified areas 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 with an emphasis on producing a good return on investments in terms of service(s) provided.

PROGRAM ACCOMPLISHMENTS

As part of the Agency's Public Health Response to the COVID-19 emergency, the PHN Program hosted the sharing of best practices, developed the agency's Recommendation for Home and Community Health Care Workers during COVID-19 Pandemic in March 2020, and shared tools and materials as they were developed to improve care response. As the COVID-19 pandemic spread, it became necessary to institute strategies to attempt to reduce transmission of the virus within AI/AN communities, the PHN Program encouraged compliance with CDC guidance(s) and recommended the creation of clear protocols which were communicated to staff and supervisors. For example, the implementation of protocol to prioritize home visits to provide services to the greatest need, if resources become strained by use of local PHN Program Priority, Intensity and Timeliness of follow up policy and procedures. PHNs are engulfed in the COVID-19 crisis by providing such services as contact investigation and surveillance of patients in the community. Several webinars have been hosted to share PHN specific electronic health record templates for COVID-19, case management via Icare to follow COVID 19 patient contacts for surveillance and supporting the agency's Contact Tracing Concept of Operations (CONOPs) which highlights the principles of establishing a contact tracing program. The Contact Tracing CONOPs aims to assist I/T/U communities to start organizing, developing, and/or refining their contact tracing capabilities in accordance with Federal, State, local, Tribal and other guidance. Towards the end of FY 2020, the PHNs prepared for a new phase against the pandemic, the implementation of the coronavirus vaccine. Existing best practices such as collaborating with a team that includes a designated point of contact for each tribe, the Primary Care Physicians and utilization of an established PHN patient referral system; and, tribal programs for assistance in monitoring patients was key in planning for vaccination administration. Hosting weekly calls with tribes to provide information and updates regarding plans for vaccination efforts, sharing of high risk elder list established prior to COVID pandemic, and planning to replicate prior PHN activity to high risk elders with influenza vaccines were used to define plans for administration of the COVID vaccine. Other established PHN avenues of services dictated plans for PHN COVID vaccination efforts such as home visitation for home bound elders and drive through influenza vaccines. Prior to COVID, PHN's were already visiting elders and others in the home for safety

and medication assessments. When influenza vaccines arrived PHN's began re-visiting known high risk elders and high risk patients with the help of the community health representative (CHR). The home visitations included providing up to date COVID information, safety COVID education, and planning for a home visit COVID vaccine once it became available.

The PHN Program aligns with the Agency's priorities and contributes to patient care coordination activities and access to quality, culturally competent care that aims to promote health and quality of life through a community population focused nurse visiting program which serves the patient and family in the home and in the community *(IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.3)*. The PHN Program assesses the services provided in meeting the agency's priority Government Performance and Results Act (GPRA) measures and integrates the Department's Strategic Goal to protect the health of Americans where they live, learn, work, and *play (HHS Strategic Plan FY 2018-2022, Goal 2, Objective 2.1, to empower people to make informed choices for healthier living). Using a variety of methods to educate the AI/AN population such as via individual and group patient education sessions, screening activities and referring high-risk patients, and immunizing individuals to prevent illnesses*, the PHN works to improve the overall wellness of Americans. Preventative health care informs populations, promotes healthy lifestyles and provides early treatment for illnesses. The PHN Data Mart report for FY 2020 reflects a total number of individual PHN patient related encounters was 391,738; PHN accomplishments in GPRA screening documented activities include the following encounter numbers:

- Tobacco Screening (2,921)
- Domestic Violence Screening (7,674)
- Depression Screening (8,530)
- Alcohol Screening (9,275)
- Adult Influenza Vaccines (47,766)

In 2020, the PHN Program continued efforts to meet the IHS's goal to decrease childhood obesity and prevent diabetes by supporting Baby Friendly re-designation by accomplishing the following activities: providing patient education, assessment and referral services for prenatal, postpartum and newborn clients during home visits, and utilizing a standardized PHN electronic health record template to document intervention *(IHS Strategic Plan FY 2019-2023, Goal 2 to promote excellence and quality through innovation of the Indian health system into an optimally performing organization, Objective 2.2: provide care to better meet the health care needs of AI/AN communities)*. The PHN data mart provides a mechanism to evaluate how the PHN program delivers this evidence-based prevention service of promoting breastfeeding during the nurse patient encounter. For FY 2020, there were a total of 8,086 PHN patient encounters related to the Baby Friendly Hospital Initiative. These patient encounters included 23,615 documented patient education topics provided by the PHN during prenatal, postpartum and newborn encounters, which included the following topics: breastfeeding, child health for the newborn, immunizations, family planning, sudden infant death syndrome, tobacco use/prevention, postpartum depression, formula feeding, and child health. As part of this initiative, IHS is encouraging clinicians in Indian Country to support policies and practices that foster breastfeeding as the exclusive feeding choice for infants during their first six months of life. By doing so, clinicians will reduce current and future medical problems and decrease health care costs. In 2019, the Clinton PHN Program, Clinton, OK, initiated a PHN best practice project to promote breastfeeding. The Clinton PHNs are addressing access to care by seeking lactation certification to support breastfeeding education services to patients in various settings including the home. They completed 90 hours of lactation management courses (60 hours of online education followed by 32 hours of classroom) to become International Board Certified Lactation Consultants (IBCLCs) specializing in breastfeeding management. They reached the goal to have all Clinton PHNs be IBCLC certified by October 2020.

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people by increasing access to quality health care services *(IHS Strategic Plan FY 2019-2023, Goal 1)*, the PHN Program continues to support caregivers of individuals suffering from dementia. Caregivers supported by the PHN program includes screening for depression, the effect of depression on daily life, and caregiver burden and frustration. For FY 2020, there have been 4,381 PHN encounters to patients with dementia, and services provided at these PHN encounters include the following:

- Immunizations (1,187)
- Medications (412)
- Communicable disease prevention (499)
- Life adaptation (590)
- Safety and fall prevention (216)
- Tobacco use prevention (118)

During these visits, patient encounters documented by the PHN included the following: medication, hypertension, dementia, diabetes, long term drug therapy, opioid dependence, and counseling. The goal to continue to implement these service in Tribal communities in 2021 and future efforts to adapt this intervention to deliver and sustain the program in AI/AN communities is ongoing.

The Pine Ridge PHN Mental Health Case Management Program was established to focus on suicide prevention in the local community during 2016 to 2018; and, this program will begin again in 2020-2021 This intervention serves as a best practice for improved health outcomes of high risk patients through a community case management model that utilized the PHN as a case manager. The program billed for this service, leveraging revenue to support services in the community; served to supplement data collection reports on the PHN data mart to report outcome; and, in FY 2019 collaborated to establish similar services at the Standing Rock Service Unit PHN Program. During FY 2020, this activity was shared as a best practice resource for the PHN grant program for tribal and urban grant recipients *(IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.2).*

In support of the Million Hearts campaign to prevent heart attacks and strokes, PHNs provided 21,353 patient encounters in FY2020 that encompassed patient education on tobacco cessation at 3,166, hypertension at 18,785, and sodium reduction at 1,599. Additional education provided during these PHN encounters include tobacco use, immunizations, diabetes, and medications.

PHNs provide services to enhance quality care and support patient safety during transitions of care settings by follow up on hospital discharges in an effort to decrease hospital readmissions. In FY 2020, PHNs documented patient encounters with patients who were discharged from the hospital and provided a total of 12,792 follow-up visits; some of these patients had multiple post discharge follow-up visits. Top patient education topics provided during these encounters include immunizations, community disease prevention, lifestyle adaptation and medication.

In FY 2019, the PHN Program aligned efforts to integrate Relationship Based Care (RBC) as a means of improving quality care and meeting the needs of the AI/AN population *(IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.2)*. To build, strengthen, and sustain collaborative relationships, RBC is linked to the 2019-2023 IHS Strategic Plan which is to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to the AI/AN people. Investing in a transformation of the program's culture will promote cost-savings with decreased cost burden of staff turnover and labor relations issues. Aggressive RBC training was put on hold due to the pandemic; however, to support staff retention and staff development, an evidenced based preceptorship program with proven training

materials, preceptor development, and an evidenced based repository of training material was initiated in 2020. In March 2020, the PHN Program hosted the Vermont Nurses in Partnership for a week long training in Albuquerque, New Mexico to establish evidence-based transition programs, competence validation, and experiential learning for the PHNs. In FY 2020 planning for ongoing training to support this activity will continue.

The PHN program continues to review the delivery of service for safe and quality standards of various accrediting bodies. This activity will focus on the Joint Commission to define the PHN services as an integrated IHS service for review and continued efforts to host webinars to share practices on safe and quality care with a focus on the Accreditation Association for Ambulatory Health Care survey. This activity will continue into FY 2021 to promote quality PHN services are provided in a safe manner. As the primary care system is foundational to achieving high-quality, accessible, efficient health care for AI/AN clients, expanded PHN engagement will be made to support the patient-centered medical home (PCMH) efforts to enhance quality care. PHN programs will engage in FY 2019-2020 efforts to meet the IHS national target of one hundred percent of IHS ambulatory care facilities achieving PCMH by 2021.

In 2019, the PHN program continued identification of interventions which targeted prevention of sexually transmitted diseases (STD) to improve quality care. In collaboration with the IHS STD Consultant (Office of the Public Health Service), this activity was monitored with the use of the PHN data mart tool as a performance measurement in support of practicing population based health management. The PHN data mart provides critical support in assessing improvement activities such as the provision of patient education, and the surveillance and treatment of STDs. Due to the pandemic, such planned activity as the PHN support of the Elimination of Hepatitis C and HIV/AIDS in Indian Country Initiative was minimized; however, the PHN data mart reports are available to monitor prevention, patient education and surveillance activities provided by PHNs.

In FY 2017, the PHN grant program awarded 9 grants; these awards have a narrow and defined area of focus, seeking to improve specific behavioral health outcomes and to support the efforts of AI/AN communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention services for individuals and their *families (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.2)*. The purpose of this IHS PHN grant is to improve specific behavioral health outcomes through a case management model with the PHN as a case manager. In addition to reducing the cost of health care, case management has worth in terms of improving rehabilitation, improving quality of life, increasing client satisfaction and compliance by promoting client self-determination. The community based case management model addresses the PHN scope of practice of working with individuals and families in a population-based practice to provide nursing care services in the community setting. Currently, there are 8 grant programs which are focusing on patient care services for behavioral health and coexisting conditions such as chronic disease management, maternal child health care, and medication patient education services. A PHN Consultant was hired (March 2020) to oversee the PHN grant program particularly to provide technical assistance and share best practice for replication. In FY 2020, the program increased coordination and collaboration with the local Behavioral Health Department to improve overall patient services.

The FY 2019 target for the PHN Program measure was 381,314 encounters. The final FY 2020 result of 391,738 patient encounters exceeded the target by 10,424 encounters, a 3 percent increase. The PHN impact during the COVID-19 pandemic is reflected in the top ten patient encounters addressing communicable disease and surveillance. Historically, data exporting processes have impacted the overall PHN performance outcome as several tribal programs have

migrated away from the IHS Patient Management System (RPMS) resulting in less visits being exported to the agency's National Data Warehouse database; however, in FY 2020 the pandemic crisis impacted the PHN workload with testing, patient monitoring and vaccine planning activities. The end result has been an increase in the number of PHN activities being reported in regards to services provided to address the COVID-19 crisis. In FY 2020, additional PHN data briefs are being created and posted on the PHN data mart to reflect the PHN activity in meeting several Agency goals (specific to COVID-19 crisis) and to supplement the PHN program's accomplishments report. These reports provide an avenue to monitor the PHN program's support of the health care delivery services in the community, and provides available data to inform I/T/U decision-making (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.3). In FY 2020, the updates to the PHN Documentation Manual was not completed due to heavy workload in responding to the pandemic. This will be a goal for FY 2021 and include in the manual PHN electronic health record templates and information on the PHN data mart reports to improve reporting of outcome.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2018	$84,043,000
2019	$86,354,000
2020	$91,984,000
2021 Enacted	$92,736,000
2022 President's Budget	$102,693,000

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.

BUDGET REQUEST

The FY 2022 budget submission for Public Health Nursing $103 million, which is $10 million above the FY 2021 Enacted level.

FY 2021 Base Funding of $93 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 2022 Funding Increase of $10 million includes:

- Current Services: +$5 million for current services including:
    - Pay Costs +$3 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$290,000 – to fund inflationary costs of providing health care services.

      Population Growth +$2 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

- Staffing for New Facilities: +$5 million to support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$658,000	3
Naytahwaush Health Center (JV), Naytahwaush, MN	$77,000	1
NEACC (Salt River) Health Center, Scottsdale, AZ	$3,288,000	21
Ysleta Del Sur Health Center (JV), El Paso, TX	$503,000	2
Alternative Rural Health Center, Dilkon, AZ	$782,000	5
Grand Total:	**$5,308,000**	**23**

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2021 Target**	**FY 2022 Target**	**FY 2022 Target +/-FY 2021 Target**
23 Public Health Nursing: Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals,	FY 2020: 391,738 Target: 381,314 (Target Exceeded)	330,000	411,325	+81,325

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
families and community groups. (Outcome)				

GRANTS AWARDS

(whole dollars)	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	8	8	10
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION

Public Health Nursing

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2020 Estimated			FY 2021 Estimated			FY 2021 Estimated			FY'22 +/- FY'21
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$138	$12,537	$12,675	$139	12,640	$12,778	$154	$13,997	$14,150	$1,372
Albuquerque	1,919	1,897	3,815	1,934	1,912	3,846	2,142	2,117	4,259	$413
Bemidji	34	2,661	2,695	34	2,683	2,717	38	2,971	3,009	$292
Billings	1,784	3,051	4,835	1,799	3,076	4,875	1,992	3,406	5,398	$523
California	14	1,270	1,284	14	1,281	1,295	16	1,418	1,434	$139
Great Plains	5,024	5,553	10,577	5,065	5,598	10,663	5,609	6,199	11,808	$1,145
Nashville	437	1,932	2,370	441	1,948	2,389	488	2,157	2,646	$257
Navajo	9,051	8,592	17,643	9,125	8,662	17,787	10,105	9,592	19,697	$1,910
Oklahoma	3,720	14,114	17,834	3,750	14,230	17,980	4,153	15,758	19,911	$1,931
Phoenix	4,241	5,815	10,056	4,276	5,863	10,138	4,735	6,492	11,227	$1,089
Portland	651	2,865	3,516	656	2,889	3,545	727	3,199	3,926	$381
Tucson	17	1,250	1,267	18	1,260	1,277	19	1,395	1,414	$137
Headquarters	3,416	0	3,416	3,444		3,444	3,814		3,814	$370
Total, PHN	**$30,446**	**$61,538**	**$91,984**	**$30,695**	**$62,041**	**$92,736**	**$33,991**	**$68,702**	**$102,693**	**$9,957**

Note: FY 2021 and FY 2022 are estimates.

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$20,925	$21,034	$22,164	+$1,130
FTE*	15	15	15	--

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

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

FY 2022 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.

In FY 2020, there was a decline of 19.49 percent or 594,453 patient visits from the previous year. COVID-19 along with staffing shortages significantly impacted provision of patient services, which was reflected in the decrease in documented patient education encounters for FY 2020. Data exporting processes have impacted the overall Health Education patient education encounters as several tribal programs have migrated away from the IHS Resource Patient Management System (RPMS), resulting in less encounters being exported to the agency's National Data Warehouse database. The end result of the migration has been a decrease in the number of Health Education patient education encounters being reported.

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.

PROGRAM ACCOMPLISHMENTS

Health education is weaved throughout the Indian health system, as it is essential for all patients and disseminated among each discipline. In response to the COVID-19 pandemic, health education materials were developed and disseminated, including patient education to mitigate risk of transmission, and shared best practices focused on prevention within the community. Critical patient contact occurred in clinical settings and community facilities to increase health knowledge, literacy, address myths, expand clinical outreach, and provide informal counseling, for patients. Both clinical and community-based services were tailored to meet the needs of the most rural communities.

Using a health education/health communications approach the following materials were developed in partnership with Johns Hopkins University (JHU) Center for American Indian Health (CAIH) aligning with the *IHS Strategic Plan* Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services.*

- COVID-19 Children's Storybooks for I/T/Us and purchased 7,500 copies for dissemination
- COVID-19 Pandemic health education/communication materials, included: 7 materials with IHS logo, 13 materials with cooperative agreement language, social media materials included 6 with IHS/HHS logos, 4 images with cooperative agreement language; Women's Health Week 4 materials; COVID-19 webinar materials 2 Town Halls (April 22 and 29).

In addition, the Health Education Program targeted the following activities in FY 2020 which aligns with the IHS Strategic Plan 2019-2023, Goal 1, *Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce.*

- Hosted a partners meeting, in collaboration with Phoenix Area HPDP/HE Consultant and Navajo Area to update the Physical Activity Kit (PAK). (IHS Strategic Plan Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce & 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services*)
- On boarded the new 'acting' Health Education Consultant. (IHS Strategic Plan Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce*)
- In collaboration with Phoenix Area Office Health Education Program, hosted a Native STAND virtual training workshop for 25 educators. Training facilitated by Northwest Portland Area Indian Health Board. (IHS Strategic Plan Goal, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce)*
- Collaborated with the National Health Promotion Disease Prevention Consultant in identifying 5 digital stories for cancer screening at the White Earth Health Center on January 8-9, 2020. (IHS Strategic Plan Goal 1, Objective 1.2 *Build, strengthen, and sustain collaborative relationships & 1.3 Increase access to quality health care services*)
- Developed and highlighted two blog posts *National Women's Health Week/Taking Time for Ourselves* and *National Men's Health Week/Prevention and Early Detection*. (IHS Strategic Plan Goal 1, Objective 1.2 *Build, strengthen, and sustain collaborative relationships & 1.3 Increase access to quality health care services*)
- Maintained a professional relationship with the Healthcare Partnership of Arizona to provide Basic Tobacco Intervention Skills for Native Communities and Basic Tobacco Intervention Skills for Native Communities Instructor Certification to increase

commercial tobacco cessation. (IHS Strategic Plan 2019-2023, Goal 1, Objective 1.2 *Build, strengthen, and sustain collaborative relationships)*

- Provided funding to Tribes and Service Units to address health disparities, including prevention of chronic diseases, and obesity though increased physical activity and diabetes prevention education, increased colorectal cancer screening, sexually transmitted disease education, commercial tobacco prevention and cessation education and access to health education services. (IHS Strategic Plan 2019-2023, Goal 1, Objective 1.2 *Build, strengthen, and sustain collaborative relationships)*
- Provided funding for Health Literacy Workshop for IHS Employees to improve knowledge and skills with use of plain language (IHS Strategic Plan Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce)*
- Release of the IHS Introduction to Health Literacy training video that was posted at the HHS Learning Management System. *(IHS Strategic Plan 2019-2023, Goal 1, Objective 1.1; Goal 3, Objective 3.1).*

In FY 2020, the National Patient Education Committee continued to collaborate with the Office of Information Technology to update the RPMS/Electronic Health Record (EHR) coding, to streamline the patient education documentation process (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.3 *Modernize information technology and information systems to support data driven decisions*; HHS Strategic Plan 2018-2022 Goal 5, Objective 5.4 *Protect the safety and integrity of our human, physical, and digital* assets). 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.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2018	$18,663,000
2019	$19,698,000
2020	$20,925,000
2021 Enacted	$21,034,000
2022 President's Budget	$22,164,000

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.

BUDGET REQUEST

The FY 2022 budget submission for Health Education of $22 million is $1 million above the FY 2021 Enacted level.

FY 2022 Funding Increase of $1 million includes:

- Current Services: +$1 million for current services including:
  - Pay Costs +$589,000 – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
  - Inflation +$63,000 – to fund inflationary costs of providing health care services.
  - Population Growth +$370,000 – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

- Staffing for New Facilities: +$108,000 - These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$108,000	1
Grand Total:	**$108,000**	**1**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
HE-1 Number of visits with Health/Patient Education (Output)	FY 2020: 2,454,977 visits Target: 0 visits (Target Exceeded)	0 visits	2,575,271 visits	+2,575,271 visits

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

AREA ALLOCATION

Health Education

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2020 Estimated			FY 2021 Estimated			FY 2022 Estimated			FY '22 +/- FY '21
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$35	$3,018	$3,053	$35	$3,034	$3,069	$37	$3,197	$3,233	$165
Albuquerque	298	1,020	1,318	299	1,025	1,325	315	1,080	1,396	$71
Bemidji	61	661	722	61	665	726	65	700	765	$39
Billings	241	1,115	1,356	242	1,120	1,363	255	1,181	1,436	$73
California	32	354	385	32	356	387	34	375	408	$21
Great Plains	346	1,861	2,207	348	1,871	2,219	367	1,971	2,338	$119
Nashville	171	712	883	171	716	887	181	754	935	$48
Navajo	38	3,315	3,353	38	3,332	3,371	40	3,511	3,552	$181
Oklahoma	780	2,433	3,213	784	2,446	3,230	826	2,577	3,404	$174
Phoenix	917	1,208	2,125	922	1,214	2,136	971	1,279	2,251	$115
Portland	105	974	1,079	106	979	1,084	111	1,031	1,142	$58
Tucson	4	259	263	4	260	265	4	274	279	$14
Headquarters	968		968	974		974	1,026		1,026	$52
Total, Hlth Ed	**$3,996**	**$16,929**	**$20,925**	**$4,017**	**$17,017**	**$21,034**	**$4,233**	**$17,931**	**$22,164**	**$1,130**

Note: FY 2021 and FY 2022 are estimates.

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$62,892	$62,892	$65,557	+$2,665
FTE*	5	5	5	--

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

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

FY 2022 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Community Health Representatives (CHRs) program began in 1968 and was established to meet the following four goals: (1) greater involvement of American Indian/Alaska Native (AI/AN) people in their own health and in the identification and treatment of their health problems; (2) greater understanding between AI/AN people and IHS staff; (3) improving cross-cultural communication between the AI/AN community and health service providers; and, (4) increasing basic health care and instruction in AI/AN homes and communities. The CHR programs supports the *HHS Strategic Plan Goal 2, Objective 2.1 and 2.2 to empower CHR patients to make informed choices for healthier living through the prevention, treatment, and control of communicable diseases and chronic conditions*.

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

CHRs are the frontline workforce focusing on improving Social Determinants of Health (SDoH) for underserved populations to decrease health inequities across the country using a place-based approach. 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. CHRs are trusted members of the community and serve as a link between the Indian health system, including associated health programs, and AI/AN patients and communities. Importantly, this community based delivery of care is provided in coordination with tribal health departments and programs, thereby *supporting IHS Strategic Plan Goal 1,*

Objective to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.

PROGRAM ACCOMPLISHMENTS

As CHR programs have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS's role has transitioned to providing support for training CHRs and providing technical assistance to expand cohesion and greater understanding of the full potential of CHRs to improve health, support individual and community development, and access to systems of care.

In FY 2020, CHR measures for all reporting categories exceeded targets in all (3) performance areas. Tribes who provided data reported 626,853 CHR patient contacts. This is an increase of 125,253 patient contacts above the target measure equating to a 25 percent increase. In addition, CHR reported patient contacts for visits made to patients with chronic diseases was 244,163. This is an increase of 42,763 patient contacts above the target measure for a 21 percent increase. IHS trained 376 CHRs through an online training platform on Basic CHR Series certificate and/or Advanced courses. This equates to an increase of 141 CHRs trained above the target measure for a 60 percent increase. Additionally, a total number of 9,762 completed courses were taken across all CHRs during FY 2020. Of the 376 CHRs, 56 completed the Basic CHR Series. Basic training provides CHRs with general health education to build and support an integrated sustainable CHR workforce with the aim to promote health and prevent disease and disability in AI/AN communities. CHRs are required to successfully complete the CHR web-based modules within one year of employment. Advanced training increases CHRs health knowledge on a variety of public health related topics designed to improve outreach capacity to meet Tribal health system and IHS national goals. CHRs must have completed three years of continuous service as a CHR to be eligible to take the advanced modules. Specialized training expands the CHRs knowledge base. Examples of specialized training include but are not limited to: Motivational Interviewing, Case Management, Maternal Child Health, Mental Health, Health Promotion and Disease Prevention, and CHR documentation training.

With "Protecting the Health of Americans Where They Live, Learn, Work and Play" as one of the priorities identified in the Department of Health and Human Services 2019-2023 Strategic Plan, IHS offered training to CHRs across the nation in the Family Spirit curriculum, an evidence-based maternal child health home visiting program with the goal of assisting paraprofessionals in their ability to help young parents learn skills to address emotional and behavioral functioning including substance abuse prevention. In addition, this training includes curriculum materials with positive parenting techniques and health promotion material to strengthen families.
The following is a summary of tasks for the Family Spirit Option Year 3 (2019-2020) contract:

1. Transferring the in-person training to a virtual format to accommodate COVID-19 Pandemic. Nineteen total participants.
2. Providing technical assistance support on a quarterly basis for all three cohorts from 2017, 2018, 2019, and 2020.
3. Family Spirit affiliate summary data for FY 2020 reports: 40 sites submitted at least 1 quarterly affiliate report; sites reported in 2020 that 111 trained home visitors completed 7,025 home visits and supported 1,772 children from ages newborn to 3 years old.

In response to the COVID-19 pandemic, the CHR program shifted gears and aided with mobilization, including implementation of virtual home visiting to mitigate risk of transmission, conducted community surveillance, and tailored community-based programs and services within their communities. The quick pivot in service delivery provided critical patient contact, coordination with health care providers, and enhanced contract tracing. CHR programs have

been highly engaged in COVID-19 response efforts in spite of Tribal government shut-downs to all but essential services and challenges related to providing service while maintaining social distancing and personal protective protocols.

In addition, to best position CHRs for COVID-19, the National CHR Program developed and submitted two guidance documents onto the IHS Quality Portal. (*Recommendation for Role and Response of Community Health Representatives/Community Health Workers during COVID-19 Pandemic*. May 6, 2020; *IHS COVID-19 Interim Guidance for Community Health Representatives/Community Health Workers Virtual Home Visits during the COVID-19 Pandemic*. May 21, 2020). In particular, the role and response outlined four key areas CHRs impact Tribal Communities: (IHS Strategic Plan Goal 3, Objective 3.1 *Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public*)

- Understand the disease and stay current with recommendations
- Communication
- Service coordination
- Empowerment

A four-part series of educational webinars to build capacity of Tribal CHR/CHW program staff and improve health within tribal Communities was developed. The IHS National CHR program was able to impact 1,057 participants during the month of May.

- COVID-19 101: Information & Impact in Tribal Communities
- Home Visiting During Social Distancing
- CHR COVID-19 Best Practices
- Individual & Community Resiliency

The CHR program targeted the following activities in FY 2020 which aligns with the IHS Strategic Plan 2019-2023, (Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce. Objective 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services)* all equipped CHRs to assist patients by increasing health knowledge and providing care to prevent avoidable hospital readmissions and emergency department visits. Additionally, the training allowed CHRs to be more effective in home visits, case finding and case management of patients with chronic health conditions.

- In February 2020, the IHS Division of Clinical and Community Services onboarded the Community Health Program Team Lead/Community Health Representative (CHR) Consultant. (IHS Strategic Plan Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce*)
- Partnered with Johns Hopkins University Center for American Indian Health to provide four CHW/CHR May Educational Seminar webinars for I/T/U community health professionals. (IHS Strategic Plan Goal 1, Objective 1.2 *Build, strengthen, and sustain collaborative relationships & 1.3 Increase access to quality health care services*)
- Participated in the Interdepartmental Health Equity Collaborative (IHEC) monthly operations and training meetings for CHW PATH Project. (IHS Strategic Plan Goal 2, Objective 2.2 *Prevent, treat, and control communicable diseases and chronic conditions*)
- Collaborated with the agency Community Health Aide Program (CHAP) designee to develop a contact tracing proposal for CHAP and CHR program staff. (IHS Strategic Plan

Goal 3, Objective 3.1 *Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public*)

- Partnered with University of New Mexico (UNM) via IHS Telebehavioral health for the development of a Community Health ECHO to raise awareness and build capacity of community level response of COVID-19 efforts for CHRs, community educators, and health promoters. (IHS Strategic Plan Goal 1, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce*)
- Participated in a bi-weekly networking call with Administration for Community Living, IHS Division of Nursing (Public Health Nurse Consultant) and IHS Elder Consultant on technical assistance and consultation with Native aging and elders in Tribal Communities. (IHS Strategic Plan Goal 3, Objective 3.1 *Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public*))

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2018	$61,888,000
2019	$62,613,000
2020	$62,892,000
2021 Enacted	$62,892,000
2022 President's Budget	$65,557,000

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.

BUDGET REQUEST

The FY 2022 budget submission for Community Health Representatives of $66 million is $3 million above the FY 2021 Enacted level.

FY 2022 Funding Increase of $3 million includes:

- Current Services: +$3 million for current services including:
  - Pay Costs +$ million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
  - Inflation +$252,000 – to fund inflationary costs of providing health care services.
  - Population Growth +$1 million - to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

Funding to be used as follows:

- For contracting, compacting and Tribal CHR programs to provide direct services, health promotion and disease prevention education services in homes and other community-based settings.
- For training, information technology costs, and special projects. Approximately 68 percent of this amount represents shares for Tribally-administered funds.
- The remaining 32 percent of federally-retained funds will support the following plans for FY 2022, but are not limited to:
  - Sustaining the CHR Basic and Refresher on-line training to support CHR skills and competencies.
  - Provide training, web management, listserv, and other program administrative, technical and logistical assistance to Tribes and Areas.
  - Continue health information technology development, refinement, and data support to enhance the CHR data application in RPMS and integration into the Electronic Health Record.
  - Train CHRs nationally on the CHR Patient Care Component (PCC) data system.
  - Continue efforts to integrate CHR's into the patient's health care team and medical home.
  - Share information on the use and benefits of the CHR Data Mart, an online tracking system which allows authorized local CHR Program staff to monitor exported CHR PCC patient data and workload management.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
CHR-1 Number of patient contacts (Output)	FY 2020: 626,853 patient contacts Target: 501,600 patient contacts (Target Exceeded)	0 patient contacts	653,181 patient contacts	+653,181 patient contacts

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
CHR-2 CHR patient contacts for Chronic Disease Services (Output)	FY 2020: 244,163 patient contacts Target: 201,400 patient contacts (Target Exceeded)	0 patient contacts	254,418 patient contacts	+254,418 patient contacts
CHR-3 Number of CHRs Trained (Output)	FY 2020: 376 CHRs Target: 235 CHRs (Target Exceeded)	0 CHRs	376 CHRs	+376 CHRs

AREA ALLOCATION

Community Health Representatives

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2020 Estimated			FY 2021 Estimated			FY 2022 Estimated			FY '22 +/- FY '21
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$51	$4,619	$4,670	$51	$4,619	$4,670	$53	$4,815	$4,868	$198
Albuquerque	40	3,632	3,672	40	3,632	3,672	42	3,786	3,828	$156
Bemidji	55	4,992	5,047	55	4,992	5,047	58	5,204	5,261	$214
Billings	51	4,620	4,671	51	4,620	4,671	53	4,815	4,869	$198
California	23	2,078	2,101	23	2,078	2,101	24	2,166	2,190	$89
Great Plains	262	7,199	7,461	262	7,199	7,461	273	7,504	7,777	$316
Nashville	278	3,297	3,576	278	3,297	3,576	290	3,437	3,727	$152
Navajo	79	7,145	7,224	79	7,145	7,224	82	7,448	7,530	$306
Oklahoma	104	9,415	9,519	104	9,415	9,519	108	9,814	9,922	$403
Phoenix	72	6,483	6,554	72	6,483	6,554	75	6,758	6,832	$278
Portland	54	4,857	4,911	54	4,857	4,911	56	5,062	5,119	$208
Tucson	23	2,040	2,063	23	2,040	2,063	23	2,127	2,150	$87
Headquarters	1,425	0	1,425	1,425		1,425	1,485		1,485	$60
Total, CHR	**$2,516**	**$60,376**	**$62,892**	**$2,516**	**$60,376**	**$62,892**	**$2,622**	**$62,935**	**$65,557**	**$2,665**

Note: FY 2021 and FY 2022 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 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$2,127	$2,127	$2,174	+$47
FTE*	--	--	--	--

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

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

FY 2022 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

Haemophilus Immunization (Hib) Program – The Hib Program started in 1989 with a targeted Haemophilus Influenzae type b prevention project in the Yukon Kuskokwim Delta and now 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 (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.3 *Increase access to quality health care services*; HHS Strategic Plan FY 2018-2022, Goal 2, Objective 2.2 *Prevent, treat, and control communicable diseases and chronic conditions*). 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 (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.3 *Modernize information technology and information systems to support data driven decisions*). In collaboration with statewide partners, the Hib Program advocates for continued access to affordable vaccine through public vaccine funding programs (HHS Strategic Plan 2018-2022, Goal 1, Objective 1.2 *Expand safe, high-quality healthcare options, and encourage innovation and competition*). 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 (IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.2 *Build, strengthen, and sustain collaborative relationships*). In alignment with the President's Management Agenda priority of information technology modernization (PMA Goal 5.3), 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 statewide.

The Hepatitis B Program and the Hib Program of the Alaska Native Tribal Health Consortium, in collaboration with Alaska Tribal Health Care System partners, provides clinical expertise and consultation, trainings, research, evaluation and surveillance with the goal to reduce the occurrence of infectious disease and improve access to healthcare in the Alaska Native population. The programs support immunization, patient screening, development of electronic health record reminders and systems, providing an infrastructure to maintain high 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). In patients with NAFLD that have nonalcoholic steatohepatitis (NASH) we have recently begun periodic screening and will be including these in future outcome measures. The Program promotes semi-annual screening of chronic hepatitis patients for both liver cancer and liver function (enzyme testing). The programs' activities support the IHS priorities on quality and partnerships as delineated in the IHS Strategic Plan.

Working with partners within the Alaska Tribal Health System to meet IHS Strategic Plan FY 2019-2023 and the HHS Strategic Plan FY 2018-2022 the programs provide both direct and telehealth patient care and health provider education to not only increase access to quality care, but also expand the options available (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.3 *Increase access to quality health care services,* IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.2 *Provide care to better meet the health care needs of American Indian and Alaska Native communities*, and HHS Strategic Plan 2018-2022, Goal 1, Objective 1.3 *Improve Americans' access to healthcare and expand choices of care and service options*). Both programs are actively engaged in preventing and treating communicable and chronic diseases (HHS Strategic Plan 2018-2022, Goal 2, Objective 2.2 *Prevent, treat, and control communicable diseases and chronic conditions*).

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. Due to the opioids crisis, new hepatitis C virus (HCV) infections have increased 69 percent from 2015-2018 compared to the 2011-2014 time period. In response to this crisis, 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 (IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.2 *Provide care to better meet the health care needs of American Indian and Alaska Native communities)* as well as performing provider in-person and webinar education seminars on treating hepatitis C to build capacity (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.3 *Increase access to quality health care services)*. The Program website (www.anthc.org/hep) provides online treatment documents and a treatment algorithm for Alaska Tribal healthcare providers. Also, Program staff conduct monthly Alaska HCV Extension for Community Healthcare Outcomes (ECHO) collaboratives providing remote assistance for hepatitis C case review and treatment recommendations. Since 2014, over 975 American Indian/Alaska Native persons have been treated for HCV through the Alaska Tribal Health System (HHS Strategic Plan 2018-2022, Goal 2, Objective 2.2 *Prevent, treat, and control communicable diseases and chronic conditions)*. The Program has two non-invasive elastography devices allows for the safe, non-invasive monitoring of liver disease progression without having to perform an invasive liver biopsy. One is a portable machine that is transported to field clinics thus reducing the need for patients to travel to Anchorage or alternative site for their care (HHS Strategic Plan 2018-2022, Goal 1, Objective 1.3 *Improve Americans' access to healthcare and expand choices of care and service options)*.

With the onset of COVID-19 pandemic, the Program is monitoring persons with liver disease who test positive for COVID-19 to track their health outcomes and assess any complications related to their liver disease.

In FY 2020:

- 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 96 percent (90 percent target).
- Overall, at least 74 percent of AI/ANs with either chronic hepatitis B (68 percent screened) or hepatitis C (78 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 maintain high vaccine coverage among Alaska Native people. Vaccine coverage data is collected for each Tribal region and measured in collaboration with regional Tribal health immunization coordinators (IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.1 *Create quality improvement capability at all levels of the organization)*. Technical consultation for the varying electronic health record (EHR) systems within each Tribal health organization is provided to support improved vaccine coverage for all Tribes. Statewide Alaska Native vaccine coverage rates (including influenza) are reported to IHS National Immunization Program for infants 3-27 months, 19-35 months, adolescents, adults. Flu vaccine coverage rates for healthcare personnel working at Tribal facilities are also reported to IHS National Immunization Program. Efforts pursuing information technology to advance capacity in maintaining high vaccine coverage rates include: participation as clinical experts on national EHR advisory workgroups regarding immunization-related product development; local advocacy for implementation of clinical decision support system (vaccine forecaster) in electronic health record systems; and collaboration with the State of Alaska immunization program in expanding coverage reporting capacity in the state's Immunization Information System (SIIS) (HHS Strategic Plan FY 2018-2022, Goal 5, Objective 5.3 *Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals)*. Improvement in vaccine

coverage relies on data capture and quality in electronic health record systems, facilitated by data interfaces, and in conjunction with clinical resources and training.

During FY 2020:

- Immunization Coverage for Alaska Natives age 19-35 months was 73 percent, which approaches the Healthy People 2020 goal of 80 percent for child vaccine coverage with 4:3:1:3*:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Var, 4 PCV).
- Achieved 90 percent coverage with full series Haemophilus influenza type b (Hib) vaccine in children age 19-35 months, which is much higher than the US all-races 2018 rate of 74.6 percent.
- Achieved 60 percent Tdap vaccine coverage in all patients 19 years and older who had received Tdap within the past 10 years.
- Achieved 82 percent pneumococcal vaccine coverage in patients 65 years and older who received pneumococcal vaccine in the past ever.
- Assisted Tribal facilities using new electronic health record (EHR) systems or the IHS EHR immunization package in maintaining or establishing interface connection with the State of Alaska Immunization Information System (SIIS) to share vaccine records.
    - Provided consultation with four facilities that implemented new EHRs on immunization documentation and facilitated SIIS interface implementation.
- Assisted IHS RPMS Immunization Advisory workgroup with gap analysis and provided associated consultation in preparation for IHS EHR transition to new clinical decision support system (vaccine forecaster).
- Collaborated with State of Alaska Immunization Program to improve capacity of Alaska SIIS in adult vaccine and flu vaccine coverage reporting; streamline processes for reporting 3-27 months, 19-35 months and adolescent's vaccine coverage.
    - New adult vaccine coverage report expands reporting capacity for a number of Tribal facilities; data was utilized for adult Tdap and pneumococcal vaccine measures for this budget submission.
    - New flu vaccine coverage report expands tracking of flu vaccine coverage critical for the 2020-21 flu season during the COVID-19 pandemic.
- Assisted Tribal facilities in utilization of Alaska SIIS patient reminder system.
- Assisted Tribal facilities throughout Alaska to implement new State policy and procedures associated with vaccine electronic inventory management, delivery systems and documentation.
- Engaging in early planning for COVID-19 vaccine, including collaboration with Alaska's State and Tribal stakeholders and supporting identification of key participants is critical for strategizing and plan implementation.

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

Immunization Measure	Age Group	Alaska Native coverage as of 8/18/2020
4:3:1:3*:3:1:4	19-35 months	73%
4:3:1:3:3:1	19-35 months	74%
3 Hib vaccines doses		90%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	92%

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

1+ HPV	13-17 years female	82%
Pneumococcal vaccine	65+ years	82%
Tdap	19 years and older	60%

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. Technical assistance to sites will continue to be addressed through coordinated efforts by the Hib Program, IHS, State, and Tribes. Vaccine coverage is measured.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2018	$2,058,000
2019	$2,127,000
2020	$2,127,000
2021 Enacted	$2,127,000
2022 President's Budget	$2,174,000

TRIBAL SHARES

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

BUDGET REQUEST

The FY 2022 budget submission for Alaska Immunization is $2 million, $47,000 above the FY 2021 Enacted level.

FY 2022 Funding Increase of $47,000 includes:

- Current Services: +$47,000 for current services including:
    - Inflation +$9,000 to cover inflationary costs of providing immunization services in Alaska.

- Population Growth +$38,000 – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

The FY 2022 funding will provide coordination of vaccine coverage reporting for Tribal facilities, training of Tribal immunization coordinators, and clinic staff in vaccine recommendations and documentation, consultation in the migration to alternate EHRs, and regular notification to hepatitis patients of the need to complete liver function screenings so that program clinicians can identify serious liver disease or liver cancer when it is at an early and treatable stage.

Hepatitis B Program – The program will conduct outpatient clinics five days a week at the Alaska Native Medical Center, travel to regional health centers to conduct outpatient clinics, and will continue its web-based application for video-conferencing (Adobe Connect) that is accessible to the statewide Alaska Tribal Health System (ATHS) audience to provide relevant clinical information to assist in the care and management of hepatitis and liver disease patients. Continue AK HCV ECHO (Extension for Community Healthcare Outcomes) virtual field clinics where primary care physicians collaborate with program staff for the treatment of hepatitis C cases. Annual field clinics will be conducted across Alaska to provide direct patient care, clinical updates to ATHS staff, and to recruit and conduct follow-up on participants enrolled in the program's research studies. Hepatitis A and Hepatitis B vaccine coverage for Alaska Natives will be measured. In addition, the total number of Alaska Native patients targeted and screened will be measured for hepatitis B, hepatitis C, and other liver disease that affects Alaska Natives.

Haemophilus Immunization (Hib) Program – The budget request will allow staff to provide continued expertise and support to regional Tribal programs on-site and for many partner locations, including rural and isolated locations. Funding of these activities allows maintenance of current program support of Alaska Tribal immunization activities, statewide and national immunization advocacy and technical support, and Area reporting to IHS Headquarters. Activities include the maintenance of statewide Alaska Native vaccine coverage rate reporting to IHS Headquarters during current phase of evolving electronic health record systems. Expanding quality of services through provision of technical support for electronic clinical decision support systems (vaccine forecaster), coverage reporting and patient reminder systems. In addition, 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.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output) [2]	FY 2020: 658 Screened Target:	600 Screened	600 Screened	Maintain

[2] Hepatitis Program (Known Cases Screened) Sum of known hepatitis B cases FY 2020: 963. Decline in hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
	600 Screened (Target Exceeded)			
AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output) [3]	FY 2020: 1416 Screened Target: 1300 Screened (Target Exceeded)	1300 Screened	1300 Screened	Maintain
AK-3 Other Liver Disease Patients Screened (Output) [4]	FY 2020: 260 Screened Target: 200 Screened (Target Exceeded)	200 Screened	300 Screened	+100 Screened
AK-4 Hepatitis A vaccination (Output) [5]	FY 2020: 86 % Target: 90% (Target Not Met)	90 %	90 %	Maintain
AK-5 Hepatitis B vaccinations (Output) [6]	FY 2020: 96 % 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 2020 Estimated			FY 2021 Estimated			FY 2021 Estimated			FY'22 +/- FY'21
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$2,127	$2,127	$0	$2,127	$2,127	$0	$2,174	$2,174	$47
Total, Imm AK	**$0**	**$2,127**	**$2,127**	**$0**	**$2,127**	**$2,127**	**$0**	**$2,174**	**$2,174**	**$47**

Note: FY 2021 and FY 2022 are estimates.

[3] Hepatitis Program (Known Cases Screened) Sum of known hepatitis C cases FY 2020: 1,799. New cases still increasing though the monthly rate decreased substantially for March and April because of the decrease in HCV screening due to COVID-19 and treatment of cases with no/mild fibrosis that no longer needed to be followed continued. Treated cases with advanced fibrosis/cirrhosis being followed indefinitely.

[4] Hepatitis Program (Known Cases Screened) Sum of known other liver disease cases FY 2020: 384. Other liver disease includes AIH and PBC (274 cases), plus the addition of NAFLD with NASH (110 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 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$57,684	$62,684	$100,000	+$37,316
FTE*	8	8	9	+1

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

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

FY 2022 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 American Indian/Alaska Native (AI/AN) people. The IHS OUIHP 2017-2021 Strategic Plan guides, supports, and improves access to high quality, culturally appropriate health care services for Urban AI/AN people. The OUIHP Strategic Plan aligns with the IHS Strategic Plan FY 2019-2023 to support health care solutions that fit the diverse circumstances of Urban AI/AN people and the tribal communities they serve. Urban Indian Organization Leaders provided input through the Urban Confer process to help inform the development of the IHS Strategic Plan. The IHS Strategic Plan will guide the work of OUIHP as we continue to strengthen our partnership with Urban Indian Organizations (UIOs) to address the three overarching goals of the IHS Strategic Plan to improve access to care, quality of care, and IHS management and operations.

The IHS enters into limited, competitive contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban AI/AN people in 22 states and 11 IHS Areas. These IHS contracts and grants with UIOs address the *IHS Strategic Plan Goal 1 by ensuring that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people*. Awarding of these contracts and grants to UIOs also addresses *HHS Strategic Plan Goal 2, to protect the health of Americans where they live, learn, work, and play*. UIOs define their scope of work and services based upon the service population, health status, and unmet needs of the Urban AI/AN community they serve. Each Urban Indian Organization is governed by a Board of Directors that must include at least 51 percent Urban AI/ANs.

UIOs provide unique access to quality health care and culturally appropriate services for Urban AI/AN people. The 41 UIOs are an integral part of the Indian health care system and serve as resources to both tribal and Urban AI/AN communities. Urban AI/AN people are often invisible in the urban setting and face unique challenges when accessing health care. A large proportion of Urban AI/AN people live in or near poverty and face multiple barriers such as the lack of quality

and culturally relevant health care services in cities. UIOs are an important support to Urban AI/AN people seeking to maintain their tribal values and cultures and serve as a safety net for Urban AI/AN patients. Social determinants of health play a key role in health and wellness, and UIOs address a wide range of factors contributing to improved health outcomes. For example, Urban AI/AN people in need of substance use disorder treatment commonly exhibit co-occurring disorders, and UIOs integrate behavioral health into primary care to offer health services within a culturally appropriate framework.

In Calendar Year 2019, UIOs provided 729,888 health care visits for 76,760 Urban AI/AN 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. UIOs vary in size and services – full ambulatory care, limited ambulatory care, outreach and referral, and residential and outpatient substance abuse treatment programs. 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.

Included in the above 41 UIOs funded through contracts and grants, are the following:

- Oklahoma City Indian Clinic and Indian Health Care Resource Center of Tulsa: These two urban sites, initially demonstration projects, are now permanent programs within the IHS's direct care program and must continue to qualify as an Urban Indian Organization under the IHCIA definition, 25 U.S.C. § 1660b.
- Former National Institute on Alcohol Abuse and Alcoholism Programs: As of FY 2020, the Urban Indian Health Program includes five UIOs that previously received grants originally awarded by the National Institute on Alcohol Abuse and Alcoholism (former-NIAAA program) and later administered by the IHS Alcohol and Substance Abuse Program (ASAP). OUIHP confirmed each of these former-NIAAA programs is an Urban Indian Organization as defined by the IHCIA and fully implemented the administrative transfer from ASAP to OUIHP, as authorized by IHCIA at 25 U.S.C. § 1660c – Urban NIAAA transferred programs. Congress approved the transfer of this funding from the ASAP budget to the Urban Indian Health budget line for FY 2020. These Urban Indian Organization contract awards address *HHS Strategic Plan Goal 2, Objective 2.3, to reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support*. The five UIOs provide high quality, culturally relevant prevention, early intervention, outpatient and residential substance abuse treatment services, and recovery support to meet the needs of Urban AI/AN communities they serve.

The other major Urban Indian Health focus areas and activities are:

- 4-in-1 Grant Program: In FY 2020, the OUIHP awarded 4-in-1 grants to 33 UIOs. The grantees are awarded for a three-year funding cycle from April 1, 2019 - March 31, 2022. These grants provide funding to UIOs 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 are required to participate in a national evaluation of the 4-in-1 grant program, which addresses *IHS Strategic Plan Goal 2 to promote excellence and quality through innovation of the Indian health system into an optimally performing organization*. The national evaluation includes reporting on the cultural interventions integrated into the 4-in-1 program activities, and practice based and evidence based approaches that are implemented to meet the needs of the Urban Indian service population. These grants expand *safe, high quality health care options, and encourage innovation and competition, which meets HHS Strategic Plan Goal 1, Objective 1.2.*

- Urban Indian Education and Research Organization Cooperative Agreement: Provides national education and research services for UIOs and OUIHP through a cooperative agreement. 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 meets *IHS Strategic Plan Goal 1, Objective 1.2, to build, strengthen, and sustain collaborative relationships.*
- Albuquerque Indian Dental Clinic: Provides dental services through the Albuquerque Area IHS Dental Program. These services address *the IHS Strategic Plan Goal 1 by ensuring that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people. The provision of dental services also addresses HHS Strategic Plan Goal 2, to protect the health of Americans where they live, learn, work, and play.*

UIOs are evaluated in accordance with the IHCIA requirements. The program is administered by OUIHP at IHS Headquarters. OUIHP integrates Enterprise Risk Management by annually reviewing Urban Indian Organization progress with set goals and objectives. The IHS Urban Indian Organization 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), Commission on Accreditation of Rehabilitation Facilities, and National Committee for Quality Assurance. In FY 2020, through an IHS contract with AAAHC, accreditation services were provided to 15 out of the 41 UIOs to meet *IHS Strategic Plan Goal 2, Objective 2.1, to create quality improvement capability at all levels of the organization; and HHS Strategic Plan Goal 1, to reform, strengthen, and modernize the Nation's health care system*.

PROGRAM ACCOMPLISHMENTS

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

From October 1, 2019, to September 30, 2020, the Urban Indian Organization FY 2020 GPRA cycle accomplishments included:

- 87 percent of the UIOs reported on 26 of the 26 performance measures;
- 76 percent of the UIOs reported through the Integrated Data Collection System Data Mart (IDCS DM);
- 12 (35 percent) have GPRA data specific to their health program available in IDCS DM;
- 9 UIOs reported through the Clinical Reporting System (7 of these programs reported both through IDCS DM and through CRS); and
- 4 UIOs reported manually using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records).

The IHS will proceed with plans to have all UIOs export data to the IHS NDW. This includes working with UIOs utilizing commercial off the shelf systems to export data to the NDW. The OUIHP will continue to work with the IHS National Patient Information Reporting System (NPIRS) staff to improve the export and accuracy of data for UIOs. The OUIHP, with the assistance of the IHS Office of Information Technology, will continue to provide training and technical assistance to UIOs on accurate and uniform data collection, so as to achieve standardization throughout the system. This work aligns with *IHS Strategic Plan Goal 1, Objective 2.1.1, to improve the transparency and the quality of data collected regarding health care services and program outcomes. It also aligns with HHS Strategic Plan Goal 5, Objective 5.3, to optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals*.

Design requirements for the IHS's IDCS DM, include an aggregate Urban report to provide the clinical measure results reported in the Outputs and Outcomes Table of the Urban program's budget narrative. IDCS DM data is only available at the service unit level and IHS is unable to view individual urban program data for some sites sending in data. An aggregate Urban report requires data from individual facility reports to produce national results. IHS will report data from aggregate Urban reports when available.

FY 2020 COVID-19 accomplishments include:

- OUIHP conducted three urban confer sessions on March 25, April 1, and April 29 to seek input on Coronavirus (COVID-19) funding decisions for resource distributions to UIOs. There were a total of 551 participants (187 participants from March 25, 252 participants from April 1, and 112 participants from April 29). The Urban Confer Satisfaction survey results indicated that participants were satisfied with information shared and topics discussed from sessions.
- OUIHP distributed funding in the amount of $103 million to 41 UIOs from the Families First Coronavirus Response Act; Coronavirus Aid, Relief, and Economic Security Act; and Paycheck Protection Program and Healthcare Enhancement Act for response and recovery to COVID-19.
- OUIHP approved Urban Emergency Funds totaling $200,000 to address costs incurred during the COVID-19 crisis. The Indian Health Center of Santa Clara Valley received $172,205, Oklahoma City Area received $18,645, American Indian Health Service of Chicago received $4,150, and $5,000 was used to procure personal protective equipment for 41 UIOs.
- OUIHP coordinated two distributions of cloth masks totaling 78,500 to UIOs for critical infrastructure employees working in office settings to help slow the spread of COVID-19.
- Furthermore, OUIHP received approval to utilize IHS Headquarters Managed COVID-19 funding for a cooperative agreement supplemental ($1 million per year for 2 years) to provide Public Health Support through education and services to 41 UIOs during the

pandemic. The supplemental was awarded on December 12, 2020 to the National Council of Urban Indian Health.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2018	$51,315,000
2019	$50,533,000
2020	$57,684,000
2021 Enacted	$62,684,000
2022 President's Budget	$100,000,000

BUDGET REQUEST

The FY 2022 budget submission for Urban Health is $100 million, which is $37 million above the FY 2021 Enacted Level.

FY 2021 Base Funding of $63 million – The base funding provides for the following:

- Improving Urban AI/AN access to health care to improve health outcomes in urban centers.
- Strengthening programs that serve Urban AI/AN people throughout the United States.
- Enhancing Urban Indian Organization 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 Urban Indian Organization programs and patient centered medical homes for Urban AI/AN individuals.
- Implementing and utilizing advanced health information technology.
- Expanding access to quality, culturally competent care for Urban AI/AN people through collaboration with other federal agencies.
- Implementing IHCIA authorities specific to UIOs.

FY 2022 Funding Increase of $37 million includes:

- Current Services: +$3 million for current services includes:

- Pay Costs +$2 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.

- Inflation +$403,000 – to fund inflationary costs of providing health care services.

- Population Growth +$1 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

- General Increase +$34 million to expand access to health care for urban AI/AN through the following activities:

  - Improving Urban AI/AN access to health care and expanding services across each type of UIO (residential substance abuse treatment center, outreach and referral, and limited and full ambulatory care).
  - Funding UIOs to provide culturally appropriate programming that meets the needs of their urban Indian patients.
  - Increasing funding to help UIOs recruit and retain medical and behavioral health providers, support staff training in technology, expand information technology, build internal capacity for expanding health services, facility improvements, and support UIO training programs.
  - Enhancing UIO third party revenue, implementing payment reforms such as the transition to a new prospective payment system; and supporting quality improvement efforts, research and data, training and technical assistance, and education, public relations, and marketing for UIOs.
  - Implementing and utilizing advanced health information technology; funding information technology infrastructure, staffing, and staff training; and telehealth.
  - Supporting ambulatory care UIOs to become certified patient-centered medical homes, which aligns with the triple aim of health care (improve the experience of care, improve the health of populations, and reduce costs).
  - Improving health care data, epidemiology, and population counts of AI/AN people residing in urban areas.
  - Expanding access to quality, culturally competent care for Urban AI/AN people through collaboration with local, state, and other federal agencies.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome)	FY 2019: 76,760 Target: 54,525 (Target Exceeded)	TBD	TBD	Maintain
UIHP-8 Percentage of AI/AN patients with diagnosed diabetes served by urban health	FY 2018: Result Expected December 31, 2021 Target: Set Baseline	Discontinued	Discontinued	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
programs that achieve good blood sugar control (Outcome)	(Pending)			
UIHP-9 Proportion of children, ages 2-5 years, with a BMI at or above the 95th percentile (Outcome)	FY 2018: Result Expected Dec 31, 2021 Target: Set Baseline (Pending)	Not Defined	Not Defined	Maintain
UIHP-10 Increase the number of diabetic AI/ANs that achieve blood pressure control (Outcome)	FY 2018: Result Expected Dec 31, 2021 Target: Set Baseline (Pending)	TBD	Not Defined	N/A
UIHP-11 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)	FY 2019: Result Expected Dec 31, 2021 Target: Set Baseline (Pending)	TBD	Not Defined	N/A

GRANTS AWARDS - Funding for UIOs for FY 2022 includes both grants and contracts awarded to the programs.

(whole dollars)	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	34	34	34
Average Award	$281,128	$281,128	$281,128
Range of Awards	$164,373 - $1,050,000	$164,373 - $1,050,000	$164,373 - $1,050,000

AREA ALLOCATION

Urban Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2020 Estimated			FY 2021 Estimated			FY 2022 Estimated			FY '21 +/- FY '20
	Federal	Urban	Total	Federal	Urban	Total	Federal	Urban	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$
Albuquerque	0	3,437	3,437	0	3,735	3,735	0	5,958	5,958	$2,223
Bemidji	0	5,197	5,197	0	5,647	5,647	0	9,009	9,009	$3,362
Billings	0	2,899	2,899	0	3,151	3,151	0	5,026	5,026	$1,876
California	0	7,941	7,941	0	8,629	8,629	0	13,766	13,766	$5,137
Great Plains	0	1,942	1,942	0	2,111	2,111	0	3,367	3,367	$1,257
Nashville	0	1,158	1,158	0	1,258	1,258	0	2,007	2,007	$749
Navajo	0	933	933	0	1,014	1,014	0	1,618	1,618	$604
Oklahoma	0	2,685	2,685	0	2,918	2,918	0	4,655	4,655	$1,737
Phoenix	0	3,193	3,193	0	3,470	3,470	0	5,536	5,536	$2,066
Portland	0	7,037	7,037	0	7,647	7,647	0	12,200	12,200	$4,552
Tucson	0	659	659	0	716	716	0	1,142	1,142	$426
Headquarters	0	20,603	20,603	0	22,389	22,389	0	35,718	35,718	$13,328
Total, Urban	**$0**	**$57,684**	**$57,684**	**$0**	**$62,684**	**$62,684**	**$0**	**$100,000**	**$100,000**	**$37,316**

Note: FY 2021 and FY 2022 are estimates.

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

INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$65,314	$67,314	$92,843	+$25,529
FTE*	14	14	14	--

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

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

FY 2022 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.

The IHP programs work synergistically and directly supports *IHS' FY 2019-2023 Strategic Plan, Goal 1, Objective 1.1 through the recruitment and retention of health care professionals to provide high-quality primary care and clinical preventive services to American Indians and Alaska Natives (AI/AN). The IHP programs also directly support the IHS Strategic Plan Goal 1, Objective 1.2 through critical support in continuing to strengthen collaborations between the IHS, Tribes/Tribal organizations, Urban Indian organizations (I/T/U) and the Health Resources and Services Administration (HRSA)* to increase the number of sites eligible to participate as National Health Service Corps (NHSC) approved sites for the NHSC Scholarship program and LRP.

PROGRAM ACCOMPLISHMENTS

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

- Recruiting well-qualified health care professionals through various sources: IHS Scholarship Recipients, Peace Corps, US Public Health Service Commissioned Corps, Uniformed Services University of the Health Sciences (USUHS), various social media networking sites and through Career Fair events conducted virtually due to the pandemic.
- Enhancement and update of the Career Opportunities webpages on the IHS.gov website.

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

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 online manuals, e-Newsletters, emails, and referral of graduates to recruiters have all been used to facilitate the 90 day scholar placement. In FY 2019, 42 percent of scholars had a hire letter within 90 days (target was 78 percent). Failure to meet this goal was primarily due to scholars not completing their licensing boards and finding positions within the 90 day period. The Scholarship program continues to seek new ways to assist IHS scholars to meet this requirement. Assuring scholars and loan repayment recipients meet their service obligation is another critical component of the IHP programs. Annual employment verification through personnel rosters and certification by Tribal employers assist in this process. Scholarship program and LRP databases allow staff to identify when health professionals are expected to complete their service obligation and allow for timely follow-up.

Loan Repayment Program (Section 108): The LRP is an invaluable tool for recruiting and retaining healthcare professionals by offering them the opportunity to reduce their student loan debts through service to Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding and up to an additional $5,000 per year to offset tax liability. Loan repayment recipients can extend their initial two-year contract on an annual basis until their original approved educational loan debt is paid.

In FY 2020, a total of 1,618 health professionals were receiving IHS loan repayment. This included 515 new two-year contracts, 538 one-year extension contracts and 565 health professionals starting the second year of their FY 2019 two-year contract.

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. In FY 2020, there were 381 "matched unfunded" applicants (including 94 nurses, 50 behavioral health providers, 9 dentists, 18 mid-level providers and 157 pharmacists, among others) and 133 "unmatched unfunded" health professionals (including 13 behavioral health providers, 9 dentists, 38 mid-level providers and 42 nurses among others). The inability to fund these 520 health professional applicants is a significant

challenge for the recruitment efforts of the agency. A more detailed breakout of loan repayment awards in FY 2020 by discipline is included in a table at the end of the narrative.

Scholarship Program (Sections 103 and 104) – Section 103 scholarships include the preparatory and pre-graduate scholarship programs that prepare students for health professions training programs. Graduate students and junior- and senior-level undergraduate students are given priority for funding for programs under Section 103, unless the section specifies otherwise. Section 104 includes the Health Professions Scholarship program, which provides financial support consisting of tuition, fees and a monthly stipend for AI/AN students from federally recognized Tribes enrolled in health profession or allied health profession programs. Students accepting funding for programs under Section 104 incur a service obligation and payback requirement. In FY 2020, there were 681 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 266 of these new scholarship applications were considered eligible for funding. The IHS Scholarship program was able to fund 88 new awards. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education. A total of 178 continuation awards were funded in FY 2020. A detailed breakout of scholarships awarded by discipline in FY 2020 is included in a table at the end of the narrative.

Extern Program (Section 105) - Section 105 of the IHCIA, is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. This program is open to IHS scholars and non-scholars. Students are employed up to 120 days annually, with most students working during the summer months. In FY 2019, the Extern Program funded a total of 34 student externs. A breakout of extern awards in FY 2019 by Area Offices is included in a table at the end of the narrative. In FY 2019, IHS implemented a new standard operating procedure that will actively recruit IHS Scholarship recipients into the Extern Program as well as offering Extern Program positions to non-Scholar health professional students. In FY 2020, the Extern Program was cancelled due to the pandemic situation.

FUNDING HISTORY

Fiscal Year	Amount
2018	$49,363,000
2019	$56,363,000
2020	$65,314,000
2021 Enacted	$67,314,000
2022 President's Budget	$92,843,000

BUDGET REQUEST

The FY 2022 budget submission for Indian Health Professions is $93 million, which is the $26 million above the FY 2021 Enacted Level.

FY 2022 Base Funding of $67 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 2022 Funding Increase of $26 million includes:

- Current Services: +$529,000 for current services including:
  - Pay Costs: +$6,000 – to fund pay increases for Federal employees.
  - Inflation: +$523,000 – to fund inflationary costs of providing health care services.
- Indian Health Professions Increase: +$25.0 million – to offer additional IHS Scholarship and Loan Repayment awards, which are a critical tool for recruitment and retention of health care professionals across the Indian health system. IHS currently receives more scholarship and loan repayments than the agency can fund each year.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome)	FY 2020: 67 % Target: 78 % (Target Not Met but Improved)	50 %	50 %	Maintain
IHP-1 Number of scholarship awards under section 103 (Output)	FY 2020: 48 Awards Target: 89 Awards (Target Not Met)	65 Awards	65 Awards	Maintain
IHP-2 Number of scholarship awards under section 104 (Output)	FY 2020: 218 Awards Target: 223 Awards (Target Not Met)	250 Awards	250 Awards	Maintain
IHP-3 Number of externs under section 105 (Output)	FY 2020: 34 Externs Target: 135 Externs (Target Not Met)	100 Externs	100 Externs	Maintain
IHP-4 Number of new 2 year contract awarded loan repayments under section 108 (Output)	FY 2020: 515 contracts Target: 465 contracts (Target Exceeded)	492 contracts	570 contracts	78 contracts
IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output)	FY 2020: 538 Awards Target: 360 Awards (Target Exceeded)	500 Awards	680 Awards	180 Awards
IHP-6 Total number of new awards	FY 2020: 565 awards Target:	465 awards	538 awards	73 awards

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
funded in previous fiscal year under section 108 (Outcome)	360 awards (Target Exceeded)			

* FY 2021 "Targets" include estimates based on complete FY 2020 funding cycle data.
** The "Number of Loan Repayments – Total" includes New Awards, Contract Extensions and Continuation Awards.

GRANTS AWARDS

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

(whole dollars)	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Quentin N. Burdick American Indians Into Nursing Program (Section 112) – CFDA No. 93.970			
Number of Awards	5	5	5
Average Award	$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 – In FY 2020, the IHS Scholarship Program made awards to the following disciplines:

Section 103 Pre-professional - 8 students				
Pre-Nursing	4		Pre-Pharmacy	4
Section 103 Pre-graduate – 40 students				
Pre-Dentistry	8		Pre-Optometry	2
Pre-Medicine	30			

Section 103 Pre-professional - 8 students				
Section 104 Health Professions - 218 students				
Counseling Psychology	3		Pharmacy	24
Dentistry	17		Physical Therapy	10
Chemical Dependency	2		Physician Assistant	19
Clinical Psychology	7		Optometry	15
Nurse Practitioner	5		Physician, Allopathic	46
Nurse, Baccalaureate Degree	17		Physician, Osteopathic	33
Nurse, Psychiatric	1		Podiatry	2
Nurse Midwife	3		Social Work	10
Nurse Anesthetist	4			

Loan Repayment Program Awards – In FY 2020, the IHS LRP made awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Behavioral Health	64	26	38	50
Dental*	100	33	67	9
Nurse	294	232	62	94
Optometrists	65	13	52	2
Pharmacists	145	35	110	157
Physician Assistants/ Advanced Practice Nurses	118	51	67	18
Physicians	125	41	84	7
Podiatrists	18	7	11	0
Rehabilitative Services	74	37	37	9
Other Professions	50	40	10	35
TOTAL	**1053**	**515**	**538**	**381**

* Includes Dentists and Dental Hygienists.

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Acupuncturist	2	0	Tribal Employee	619
Chiropractors	8	0	Civil Service	343
Dietetics/Nutrition	10	12	Commissioned Corps	81
Engineering	10	4	Urban Health Employees	10
Medical Laboratory Scientist	7	9		
Medical Technology	1	2		
Radiology Technicians	9	5		
Sanitarian	1	0		
Respiratory Therapists	2	3		
TOTAL	**50**	**35**	**Total**	**1053**

Extern Program Awards – In FY 2020, the IHS Extern Program was cancelled due to COVID-19.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$2,465	$2,465	$2,485	+$20
FTE*	--	--	--	--

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

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

FY 2022 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. (IHS Strategic Goal 1, Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce and Objective 1.2: Build, strengthen, and sustain collaborative relationships.) The TMG program has provided discretionary competitive grants to T/TO, to establish goals and performance measures for current health programs, assess current management capacity to determine if new components are appropriate, analyze programs to determine if T/TO management is practicable, and develop and enhance infrastructure systems to manage or organize PFSA. The nature of the TMG program allowed T/TO the option to enter or not enter into ISDEAA contracts/compact agreements which are equal expressions of self-determination. (IHS Strategic Goal 3, Objective 3.1: Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public.)

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.

The IHS Tribal Management Grants program supports the IHS Strategic Plan Goal 1 to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN by directly providing Tribes and Tribal organizations grant opportunities to develop systems, support financial management systems, and expand programs to increase access to preventive care services and quality health care.

PROGRAM ACCOMPLISHMENTS

Fiscal Year	New Funded Awards	*Cont: 2/3 Year	Total Award
FY 2017	16	3	$1,786,683
FY 2018	16	8	$2,235,271
FY 2019	11	15	$2,391,223
FY 2020	11	9	$1,802,826

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

- In FY 2020 the amount of awards decreased due to the COVID-19 pandemic. *Goal 1, Objective 1.1 – Recruit, develop, and retain a dedicated, competent, and caring workforce*.
- Provided technical assistance to potential applicants – *Goal 3, Objective 3.1 – Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public.*
- 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. – *Goal 1, Objective 1.2 – Build, strengthen, and sustain collaborative relationships.*

FUNDING HISTORY

Fiscal Year	Amount
2018	$2,465,000
2019	$2,165,000
2020	$2,465,000
2021 Enacted	$2,465,000
2022 President's Budget	$2,485,000

BUDGET REQUEST

The FY 2022 budget submission for Tribal Management Grants is +$2 million, which is +$20,000 above the FY 2021 Enacted Level.

FY 2022 Funding Increase of $20,000 includes:

Current Services: +$20,000 for current services including:

- Inflation +$20,000 – to fund inflationary costs.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2021 Target**	**FY 2022 Target**	**FY 2022 Target +/-FY 2021 Target**
TMG-1 Planning Grants (Output)	FY 2020: 0 planning grants Target: 1 planning grants (Target Exceeded)	0 planning grants	2 planning grants	+2 planning grants
TMG-2 Health Management Structure (HMS) grants (Output)	FY 2020: 9 HMS grants Target: 0 HMS grants (Target Exceeded)	0 HMS grants	9 HMS grants	+9 HMS grants

GRANTS AWARDS

(whole dollars)	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	20 Total Awards: 11 Noncompeting Continuations and 9 New	20 Total Awards: 11 Noncompeting Continuations and 9 New [1]	20 Total Awards: 11 Noncompeting Continuations and 9 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 2021 is an estimate will update when awarded.
[2] FY 2022 is an estimate will update when awarded.

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DIRECT OPERATIONS

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	71,558	$82,456	$107,788	+$25,332
FTE*	253	264	291	+27

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

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

FY 2022 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

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

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

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

Direct Operations funding supports all three goals of the IHS Strategic Plan. Recruitment, development, and retention of a dedicated, competent, and caring workforce (Goal 1, Access, Objective 1.1) is the foundation for improving quality (Goal 2) and strengthening management and operations (Goal 3). These funds are essential for sustaining a human resources program that can enhance and retain a workforce to carry out the agency's mission. The funds also support quality improvement capabilities (Goal 2, Quality, Objective 2.1) to ensure a quality healthcare program that promotes accountability, integrity, and stewardship. Woven through all of these components are the concerted efforts to continually strengthen IHS program management and operations through improved communication (Goal 3, Objective 3.1), secure and effective management of IHS's assets and resources (Goal 3, Objective 3.2), and modernization of information technology and systems to support data driven decisions (Goal 3, Objective 3.3).

PROGRAM ACCOMPLISHMENTS

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

To establish long term goals for quality implementation and outcomes, the IHS developed a five-year (2019-2023) Strategic Plan. The Strategic Plan was published in February 2019 after extensive gathering of stakeholder input. The IHS initiated Tribal Consultation and Urban Confer on the IHS Strategic Plan initial framework and formed an IHS Federal-Tribal Strategic Planning Workgroup to review all comments and recommend a list of final goals and objectives for IHS leadership review and approval. The plan promotes a culture of accountability, quality, and patient safety across the agency, and serves as a roadmap for continual quality improvement.

In December 2018, the Office of Quality (OQ) was formally established within the IHS Headquarters to continue elevation of and national coordination and oversight for quality across the IHS health care system. The focus of the OQ is to provide a structure to promote accountability and oversight through 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; improve patient safety and reduce all cause harm; and enterprise risk management to ensure that high risk agency systems and processes are identified, monitored, and mitigated. Through the national leadership of the OQ in FY 2019 and FY 2020, the IHS made significant strides in addressing priority areas for quality improvement including implementing credentialing and privileging software agency-wide; hiring an IHS credentialing program manager at headquarters; and awarding a new contract for an adverse events reporting and tracking system.

The IHS is committed to making improvements and ultimately to being removed from the Government Accountability Office (GAO) High Risk list. Although the IHS is still on the list, significant progress has been made. The GAO cited 14 open recommendations in the High Risk Reports. Of those 14 recommendations cited in the High Risk Reports, GAO closed 12 recommendations. In August 2020, the IHS requested GAO to close another recommendation regarding Quality Care.

Like other rural healthcare providers, the IHS historically has difficulties recruiting and retaining healthcare providers. To address these challenges, IHS continues to maximize the use of available recruitment and retention tools such as recruitment, retention, and relocation incentives; and use of Title 38 pay authorities. Most recently, the IHS worked to convert podiatrist salaries to Title 38 to aid in the recruitment and retention of these critical healthcare providers. The IHS has also increased its competitive stance in the healthcare labor market through Title 38 Special Salary Rate (SSR) pay tables and developed a new table for licensed practical nurses and dental hygienists who serve in our hospitals and health centers. Additionally, pay rates have been increased in Title 38 SSRs for physician assistants and optometrists to ensure we are able to offer competitive salaries.

To strengthen human resource management, the IHS implemented the Security Manager System. This system supports the entire life cycle of IHS's personnel security and suitability processes, to include capturing and managing background investigations. Security Manager has a customized workflow that ensures proper case management with a complete audit trail into the personnel security process. Use of this electronic system provides a simplified, streamlined, and standardized personnel security management process across the IHS.

In FY 2019, the IHS continued to expand the use of data analysis and visualization tools to enhance reporting and data-driven decisions. Building on the successful completion of the IHS 3rd Party Revenue Dashboard—a Qliksense based application developed to enhance reporting, trend analysis, and monitoring of third-party resources (e.g. Medicare and Medicaid) collected by federally-operated facilities—the IHS completed the "Follow the Money" Dashboard. This dashboard allows non-technical users to review funding status and spending data related to Purchased/Referred Care (PRC) instantly. Both applications democratize data previously held only in the proprietary accounting and reporting systems, Unified Financial Management System and Financial Business Intelligence System. Users are able to access data in a non-technical format that can be quickly sorted and compared by parameters such as type, Area, Service Unit, month, and fiscal year. This capability eliminates delays in accessing data through production financial systems, provides more financial information more widely, and reduces the requirement for a skilled financial analyst to produce labor intensive reports on demand, thereby freeing valuable time for value added analysis.

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

FUNDING HISTORY

Fiscal Year	Amount
2018	$72,338,000
2019	$70,788,000
2020	$71,538,000
2021 Enacted	$82,456,000
2022 President's Budget	$107,788,000

BUDGET REQUEST

The FY 2022 budget submission for Direct Operations is $108 million, which is the $25 million above the FY 2021 Enacted Level

FY 2022 Funding of $108 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:

- 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 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 2022 Funding Increase of $25 million includes:

- Current Services: +$3 million for current services including:
    - Pay Costs: +$3 million – to fund pay increases for Federal and Tribal employees.
    - Inflation +$156,000 – to fund inflationary costs.
- Direct Operations: +$23 million in additional Direct Operations funding is essential for sustaining and bolstering core capacity to promote the efficient and effective administration and oversight of national functions like financial management, human resources, grants management, acquisitions, ISDEAA contracting and compacting administration, contract support costs and tribal lease payment administration, performance management, and other administrative supports and systems.

  These resources would support critical hiring and systems needs at the national level, and within the IHS Area Offices. Current funding and staffing levels have led to delays in reporting, contracting, grant making, and hiring, and may lead to increased program risk.

  Increasing resources for these core management functions is vital for shoring up foundational capacity to support the IHS mission. Additional staff and resources are needed to maintain national and Area-level focus on fiscally responsible, accountable, and effective administration over inherently federal functions such as budget formulation and execution, policy management, workforce management and personnel security, acquisitions and grants management, Government Performance and Results Act and related performance management, and other key functions.

The IHS also faces increasing responsibilities associated with expansion of Indian Self-Determination, through which Tribal Health Programs operate over 60 percent of the IHS's appropriated resources. The IHS must have the necessary resources to provide technical assistance to Tribes and Tribal Organizations, and effectively manage ISDEAA contracts and compacts. Investments in these critical programs can mitigate the potential for missed deadlines with potentially large and recurring financial penalties, facilitate consistency in ISDEAA contract and compact terms to reduce legal risk, and ensure well-prepared and accurate reporting and negotiations.

AREA ALLOCATION

Direct Operations
(dollars in thousands)

DISCRETIONARY	FY 2020 Estimated			FY 2021 Estimated			FY 2022 Estimated			FY '21 +/- FY '20
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$36	$9,949	$9,985	$41	$11,467	$11,509	$54	$14,990	$15,045	$3,536
Albuquerque	873	656	1,529	1,006	756	1,762	1,316	988	2,304	$541
Bemidji	1,223	0	1,223	1,410		1,410	1,843		1,843	$433
Billings	1,930	70	2,000	2,225	80	2,305	2,908	105	3,013	$708
California	1,298	0	1,298	1,497		1,497	1,956		1,956	$460
Great Plains	2,136	0	2,136	2,462		2,462	3,219		3,219	$757
Nashville	899	1,664	2,563	1,036	1,918	2,955	1,355	2,508	3,862	$908
Navajo	2,684	0	2,684	3,094		3,094	4,044		4,044	$950
Oklahoma	1,591	3,763	5,354	1,834	4,337	6,171	2,397	5,670	8,067	$1,896
Phoenix	2,329	859	3,188	2,684	990	3,674	3,509	1,295	4,803	$1,129
Portland	1,676	1,424	3,100	1,932	1,641	3,573	2,526	2,145	4,671	$1,098
Tucson	597	0	597	689		689	900		900	$212
Headquarters	35,879	0	35,879	41,354		41,354	54,060		54,060	$12,705
Total, Direct Ops	**$53,153**	**$18,385**	**$71,538**	**$61,265**	**$21,191**	**$82,456**	**$80,087**	**$27,702**	**$107,789**	**$25,333**

Note: FY 2021 and FY 2022 are estimates.

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$5,806	$5,806	$5,990	+$184
FTE*	12	12	12	--

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

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

FY 2022 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Office of Tribal Self-Governance (OTSG) is responsible for a wide range of Agency functions that are critical to the IHS's *efforts to build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2) with American Indian and Alaska Native (AI/AN) nations, Tribal organizations, and other AI/AN groups*. The 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 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:

- Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS *that build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2) that increase access to quality health care services (Strategic Goal 1, Objective 1.3) and provides care to better meet the health care needs of American Indian and Alaska Native communities (Strategic Goal 2, Objective 2.2).*
- Participates in nation-to-nation negotiations of ISDEAA Title V Compacts and Funding Agreements and provides oversight of the Agency Lead Negotiators *to build, strengthen, and sustain collaborative relationships (Strategic Goal 1, Objective 1.2)*
- Reviews eligibility requirements for Tribes to participate in the TSGP and receives Self-Governance Planning and Negotiation Cooperative Agreements that will help to

promote excellence and quality through innovation of the Indian health system into an optimally performing organization (Strategic Goal 2, Objective 2.1) and to provide care to better meet the health care needs of American Indian and Alaska Natives communities (Strategic Goal 2, Objective 2.2).

- Provides resources and technical assistance to Tribes and Tribal organizations *to build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2)* for the implementation of Tribal self-governance.
- Provides TSGP training to Tribes, Tribal organizations, and Tribal groups *to build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2) that increase access to quality health care services (Strategic Plan, Goal 1, Objective 1.3*).
- Coordinates national Tribal self-governance meetings, including an annual consultation conference in partnership with the Department of the Interior, to promote the participation by all AI/AN Tribes in the IHS Tribal Self-Governance program *and improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public (Strategic Goal 3, Objective 3.1).*
- Develops, publishes, and presents information related to the IHS TSGP activities that will *build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2) with Tribes, Tribal organizations, state and local governmental agencies, and other interested parties to improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public (Strategic Goal 3, Objective 3.1).*
- Coordinates self-governance Tribal Delegation Meetings for IHS Headquarters and Area Senior officials to *build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2) that will provide care to better meet the health care needs of American Indian and Alaska Native communities (Strategic Goal 2, Objective 2.2) and improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public (Strategic Goal 3, Objective 3.1).*

PROGRAM ACCOMPLISHMENTS

The IHS TSGP has grown dramatically since the execution of the initial 14 compacts and funding agreements in 1994. In Fiscal Year (FY) 2020, IHS transferred approximately $2.6 billion of the total IHS budget appropriation to Tribes and Tribal organizations to support 105 ISDEAA self-governance compacts and 131 funding agreements.[1]

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

- Providing support for projects that assist Tribally operated health programs *that build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2)* to enhance information technology infrastructure *that create quality improvement capability at all levels of the*

[1] For FY 2021, 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.

organization (Strategic Goal 2, Objective 2.1) and prepare for meaningful use and other federal reporting *standards that modernize information technology and information systems to support data driven decisions (Strategic Goal 3, Objective 3.3)*

- Collaborating on crosscutting issues and processes including, but not limited to: program management issues; self-determination issues; Tribal shares methodologies; and emergency preparedness, response and security *to secure and effectively manage the assets and resources (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.2) and modernize information technology and information systems to support data driven decisions (Strategic Goal 3, Objective 3.3).* In FY 2020-2021, the IHS, in partnership with the Tribal Technical experts, updated the Tribal Self-Governance Program Negotiations Handbook – a resource and overview of the Title V Self-Governance negotiation process.
- Providing technical assistance, disseminating communication, and supporting the disbursement of funds related to Coronavirus (COVID-19) activities to Self-Governance Tribes to *build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2)*.

These services are deployed in accordance with strategic planning, are data driven, and support program integrity *that create quality improvement capability at all levels of the organization (IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.1)* through adherence to reporting requirements. The Office of Tribal Self-Governance Funds Management Database supports the delivery of services by improved access to data *through secure and effective management of assets and resources (Strategic Goal 3, Objective 3.2)* to evaluate performance and identify areas of process improvement *and modernize information technology and information systems to support data driven decisions (Strategic Goal 3, Objective 3.3).*

FUNDING HISTORY

Fiscal Year	Amount
2018	$5,806,000
2019	$4,806,000
2020	$5,806,000
2021 Enacted	$5,806,000
2022 President's Budget	$5,990,000

BUDGET REQUEST

The FY 2022 budget submission for Self-Governance is $6 million, which is the $184,000 above the FY 2021 Enacted Level.

FY 2021 Base 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 2022 Funding Increase of $184,000 includes:

- Current Services: +$184,000 for current services including:
  - Pay Costs: +$162,000 – to fund pay increases for Federal and Tribal employees.
  - Inflation: +$22,000 for inflationary costs of providing health care services.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2021 Target**	**FY 2022 Target**	**FY 2022 Target +/-FY 2021 Target**
TOHP-SP Implement recommendations from Tribes annually to improve the Tribal consultation process and IHS operations. (Output)	FY 2020 7 recommendations Target: 3 recommendations (Target Exceeded)	4 recommendations	4 recommendations	Maintain

GRANT AWARDS

(whole dollars)	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Planning Cooperative Agreements			
Number of Awards	1	5	5
Award Amount	$91,721	$120,000	$120,000
Negotiation Cooperative Agreements			
Number of Awards	3	5	5
Award Amount	$48,000	$48,000	$48,000

AREA ALLOCATION

Self-Governance

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2019 Final 1/			FY 2020 Estimated			FY 2021 Estimated			FY '21 +/- FY '20
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Albuquerque	0	0	0	0	0	0	0	0	0	$0
Bemidji	0	0	0	0	0	0	0	0	0	$0
Billings	0	0	0	0	0	0	0	0	0	$0
California	0	0	0	0	0	0	0	0	0	$0
Great Plains	0	0	0	0	0	0	0	0	0	$0
Nashville	0	0	0	0	0	0	0	0	0	$0
Navajo	0	0	0	0	0	0	0	0	0	$0
Oklahoma	0	0	0	0	0	0	0	0	0	$0
Phoenix	0	0	0	0	0	0	0	0	0	$0
Portland	0	0	0	0	0	0	0	0	0	$0
Tucson	0	0	0	0	0	0	0	0	0	$0
Headquarters	5,806	0	5,806	5,806	0	5,806	5,990	0	5,990	$184
Total, Self-Gov	**$5,806**	**0**	**$5,806**	**$5,806**	**0**	**$5,806**	**$5,990**	**0**	**$5,990**	**$184**

Note: FY 2021 and FY 2022 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 2020[1]	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021 PB
Medicare	$215,868	$215,868	$224,287	$8,419
Medicaid	$725,122	$725,122	$753,402	$28,280
M/M Total:	**$940,990**	**$940,990**	**$977,689**	$36,699
Private Insurance	$137,029	$137,029	$142,373	$5,344
VA Reimbursements	$6,391	$6,391	$6,640	$249
TOTAL :	**$1,084,410**	**$1,084,410**	**$1,126,702**	$42,292
FTE 1/	6,853	6,853	6,853	--

1/ FTE numbers reflect only federal staff and do not include increases in tribal staff.

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

PROGRAM DESCRIPTION

In 1976, the Indian Health Care Improvement Act (IHCIA) authorized the Indian Health Service (IHS) to collect Medicare and Medicaid (M&M) reimbursements for services provided in IHS facilities to patients with M&M eligibility. The IHCIA was later amended to allow IHS to collet Private Insurance (PI) reimbursements for services provided in IHS facilities for patients with PI. In 2010, the IHCIA was amended to authorize the IHS to be reimbursed by the Department of Veterans Affairs (VA) and the Department of Defense for services provided through the IHS to beneficiaries eligible for services from either Department. In 2012, the IHS and the VA signed an agreement under which VA agreed to reimburse IHS for direct care services provided through the IHS to eligible American Indian and Alaska Native (AI/AN) veterans.

In fiscal year (FY) 2020, $1 billion was collected from third party insurers, of which $941million was IHS Federal M&M collections and $137 million was collected from private insurers. The FY 2022 estimates above are based on the FY 2020 actual collections.

Public and private collections represent a significant portion of the IHS and Tribal health care delivery budgets. Some IHS health care facilities report that 60 percent or more of their yearly budget relies on revenue collected from third party payers. In order to fulfill the IHS Mission, IHS continues its efforts to improve the revenue generation process by following the IHS Strategic Plan FY 2019-2023 Goals and Objectives. Collection efforts from all third party payers by IHS facilities supports *IHS Strategic Plan Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services*

[1] Due to the effects of the COVID-19 pandemic, the FY 2020 actual collections of $1,084,410,000 was $109,567,000 below the FY 2020 estimated collections of $1,193,977,000.

are available and accessible to American Indian and Alaska Native people as well as Objective 1.3, Increase access to quality health care services.

Accreditation - In accordance with IHCIA authorization for collections, the IHS places the highest priority on meeting accreditation and certification standards for its healthcare facilities. Third party revenue is essential to maintaining facility accreditation, certification and standard of health care through organizations such as The Joint Commission and the Accreditation Association for Ambulatory Health Care. Third party collections are used to improve the delivery of and access to healthcare for American Indian and Alaska Native (AI/AN) people. This activity supports the IHS Strategic Plan Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization. Feedback obtained from accreditation organizations during the review process is used by IHS facilities to support *IHS Strategic Plan Objective 2.1, Create quality improvement capability at all levels of the organization.*

Monitoring – In addition to conference calls with IHS Areas, 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. Training of revenue cycle staff to use the dashboards effectively to identify areas for improvement began in FY 2018 and will continue in FY 2022. In FY 2022, IHS will focus on development and implementation of a standard site review/site assessment/site internal auditing template.

Impact of COVID-19 – COVID-19 created unprecedented financial stress on the I/T/U health system. Due to the effects of the pandemic, the actual FY 2020 collections of $1.1 billion were significantly less than the estimated collections of $1.2 billion. Pre-COVID-19, I/T/U healthcare facilities always faced unique challenges to ensuring their budgets met the needs of the communities they serve. Aside from IHS appropriations, third party collections are the main source of funding to I/T/U health care facilities. I/T/U revenues have declined because of the COVID-19 pandemic which has impacted the utilization of health care services and availability of third party payers. Strict public health driven social-distancing measures, curfews, and stay at home orders intended to prevent the risk of further infection have led IHS patients and health care facilities to cancel elective surgeries, and non-essential medical, surgical and dental procedures. Many AI/AN patients have also had to postpone care. As a result, overall face to face encounters decreased, and in addition some payers changed their payment methodology when visits were conducted via Telehealth technology. In addition, rising unemployment has forced many people off of private insurance, a small but reliable part of the I/T/U revenue stream. These are some of the variables that contributed to the decrease in overall Third Party Revenue. To more closely monitor revenue, IHS began a weekly Collection Monitoring Report/Analysis started in March, 2020 which has assisted in looking at the over all impacts of the Pandemic. The Provider Relief Fund authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act, has provided support to I/T/U providers, which has allowed I/T/U healthcare facilities to keep operating, The American Rescue Plan Act (ARPA) also provided $2 billion in critical funding to offset the impact of lost reimbursements across the I/T/U. The IHS has also benefitted from the Health Resources and Services Administration (HRSA) COVID-19 Uninsured Program Portal, allowing health care providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals on or after February 4, 2020 to submit claims for reimbursement. In addition, Centers for Medicare and Medicaid (CMS) regulatory waivers and flexibilities have also been helpful, especially in terms of expanding access to telehealth. However, despite these efforts, these measures have been not enough to match the pre-COVID-19 reimbursement

levels. Post-FY 2020, IHS will focus on evaluating the total net impact of COVID-19 on our revenue system and make adjustments as necessary to return to a healthy revenue stream.

In FY 2022, IHS will continue to strengthen its revenue generation policies and management practices, including internal controls, patient registration, patient benefits coordination, provider documentation training, certified procedural coding training, third party billing, electronic claims processing, accounts receivable, and debt management. Priority activities will include enhancement of third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes, compliance with Medicare and Medicaid, and industry standards and changes in operational processes. Improvements for IHS operated facilities are coordinated with concurrent enhancements in Purchased Referred Care business practices related to alternate resources. IHS will continue to develop and implement various tools including reports to analyze a facility's service population and identify opportunities to increase revenue. These efforts support *IHS Strategic Plan Goal 3: To strengthen IHS program management and operations, and specifically, Objective 3.2, Secure and effectively manage the assets and resources, as well as Objective 3.3, Modernize information technology and information systems to support data driven decisions.*

In addition, IHS continues to ensure compliance with statutory rules and regulations that impact third party collections directly and indirectly. Rules pertaining to the Medicare and Medicaid programs continue to have a direct impact on revenue generation. IHS reviews new policies and draft regulations prior to publication and provides feedback to CMS. After they are published IHS discusses the impacts with Tribal government representatives and urban programs. In addition, IHS has formed workgroups to maximize the positive impact for all IHS, Tribal, and Urban Indian health program facilities, such as the National Business Office Committee, which serves as a subcommittee to the National Council of Executive Officers. These efforts support the IHS Strategic Plan *Goal 3: To strengthen IHS program management and operations, and Goal 3, Objective 1.2 Build, strengthen and sustain collaborative relationships.*

Partnerships – IHS continues to develop and enhance partnerships with federal and state agencies in support of IHS Strategic Plan *Goal 1, Objective 1.2: Build, strengthen, and sustain collaborative relationships.* Enrollment and collections depend, in large part, on IHS's successful partnerships and relationships, state participation in Medicaid expansion, and awareness and willingness of IHS users to enroll in Medicaid and other programs. IHS continues to work with CMS and the state Medicaid agencies to identify patients who are eligible to enroll in M&M and the state Children's Health Insurance Programs. IHS also continues these partnerships in the implementation of provisions in the IHCIA, and the Children's Health Insurance Program Reauthorization Act. In FY2020 IHS senior leadership met directly with the National Association of State Medicaid Directors (NAMD) to exchange information and educate NAMD on the Indian health system.

In pursuit of better relationships with the states Medicaid programs, pursuant to CMS' State Health Official letter in January 2016 (SHO #16-002) IHS Areas have implemented care coordination agreements between IHS facilities and non-IHS providers, including urban Indian health care organizations for the purpose of facilitating 100 percent reimbursement to the states by Medicaid for payments they make to IHS and tribal health care providers when they treat IHS-eligible and Medicaid enrolled American Indian and Alaska Natives. Some states have committed to dedicate any cost savings to increasing services and access to care for Indians. In addition, IHS anticipates that in-network contracting with health plans may work for many facilities and is working with CMS to identify ways to provide informational resources for implementation.

Pursuant to health reform efforts, IHS is continuing to develop materials, presentations and stakeholder outreach for our federal, tribal and urban partners on what is needed to participate in the Medicare

Payment Reform/Quality Initiative efforts by CMS such as the Quality Payment Program (QPP). This includes data calls and working with Areas to determine IHS stakeholders that have reported or planning to report for future years. The IHS National QPP Working Group members collaborate with the Medicare and Medicaid Policy Committee (MMPC), the Tribal Technical Advisory Group (TTAG) and registry to support QPP efforts. Also, the IHS yearly reviews the Electronic Clinical Quality Measures (eCQMs) and selects new measures for 2022 if needed.

In addition, IHS collaborates with CMS and the Tribes on a number of matters, including implementation of and training regarding recent changes in legislation, eligibility policies, covered services policies, reimbursement policies and payment methodologies, claims processing, denials, training and use of information technology resources at IHS and Tribal sites to increase the enrollment of M&M eligible AI/AN patients. IHS continues to coordinate outreach, education, and training efforts in collaboration with other federal, state and Tribal partners. IHS continues to partner with CMS to provide a number of training sessions nationwide for Tribal and IHS employees, focusing on outreach and improving access to M&M programs. During the PHE, guidance and training has been provided online specifically updated in accordance with AMA and CMS rules, regulations, and waiver authorities. These training activities support the *IHS Strategic Plan Goal 1, Objective 1.1, Recruit, develop, and retain a dedicated, competent, and caring workforce and Goal 3, Objective 3.2: Secure and effectively manage the assets and resources*

Recently, and in accordance with 2015 Certified Health Information Technology Standards, IHS launched a collaborative initiative to train staff in the collection of voluntary Sexual Orientation and Gender Identity (SO/GI) data in order to identify essential health services. Collecting this data in electronic health records is essential to providing high-quality, patient-centered care. An opportunity for Two-Spirit and LGBTQ people to share information about their SO/GI in a welcoming and patient-centered environment opens the door to a more trusting patient-provider relationship and improved health outcomes for our patients. The training and collection of this data supports *IHS Strategic Plan Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.*

In December 2012, IHS and the Department of Veterans Affairs (VA) signed the VA/IHS National Reimbursement Agreement that facilitates reimbursement by the VA to the IHS and Tribal facilities for direct health care services provided to eligible AI/AN veterans. In January 2017, IHS renewed its interagency agreement with the VA to facilitate the use of the Veteran's Health Administration (VHA) Consolidated Mail Outpatient Pharmacy (CMOP) System by the IHS. The intent of this agreement is to cost-effectively expand clinical and support capabilities of participating facilities through use of VHA CMOP resources and by combining participating facilities' prescription needs with VHA's. Improved efficiencies were gained through more efficient and effective use of staff, reduction in medication error costs, and reduction in medication error litigation. In June 2018, the IHS and VA signed an amendment to the agreement that extends the period of the reimbursement agreement through June 30, 2022. This was a significant step in continuing to ensure implementation of Section 405 of the IHCIA. The agreement represents a positive partnership to support improved coordination of care and non-duplication of resources between IHS federal facilities and the VA and it paved the way for agreements negotiated between VA and tribal health programs. IHS will continue to work directly with the VA to implement billing and reimbursement practices to ensure IHS receives proper payment for care provided at IHS and Tribal facilities to AI/AN veterans. Recent changes that were added through amendments to the agreement were identifying Telehealth as a direct service and allowing the billing/reimbursement for the COVID- 19 Vaccinations and Antibody Treatment. Monitoring, auditing, and compliance with the agreement will continue to be a focus for in FY 2022. Current activities include but are not limited to exercising the additional Electronic Billing capabilities, working through system changes (VA) to ensure proper payment

proper denial, and assisting Tribes and IHS facilities in stabilizing their billing programs. These efforts focus on the IHS Strategic Plan *Objective 1.2: Build, strengthen, and sustain collaborative relationships.*

Training - IHS provides continuous training to 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. Programs are expected to ensure sufficient resources and training for staff to capture insurance in the Resource and Patient Management System (RPMS) system and bill accordingly. Area I/T/U staff are highly encouraged to participate in annual CMS trainings. IHS also hosts an annual Partnership Conference to provide the most current information related to finance, information technology, health information management, Purchased/Referred Care, and business office functions; special emphasis is also provided for the specific management needs of Tribes and urban programs. These training activities support the IHS Strategic Plan *Goal 1, Objective 1.1, Recruit, develop, and retain a dedicated, competent, and caring workforce and Goal 3, Objective 3.2: Secure and effectively manage the assets and resources.*

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

PROGRAM ACCOMPLISHMENTS

- With the Memorandum of Understanding and amended Reimbursement Agreement between the VA and IHS in place, IHS developed and executed an implementation plan to collect VA reimbursements at all IHS federal sites serving eligible Veterans. The VA has approximately 116 agreements with Tribal Health Programs in addition to the agreements at federal sites. In FY 2020 IHS implemented several amendments to the Reimbursement Agreement regarding telehealth, pharmacy and PRC – COVID-19 related testing and treatment. This partnership with the VA and implementation of VA reimbursement at IHS sites serve to support the IHS Strategic Plan Objective 1.2: Build, strengthen, and sustain collaborative relationships, *Goal 3, Objective 3.2, Secure and effectively manage the assets and resources and enables IHS to provide further services to local communities funded with these collections.*

  The IHS HQ has also entered into cooperative agreements since 2010 with organizations such as the National Indian Health Board and the National Congress of American Indians to coordinate and conduct consumer centered outreach and education, training and technical assistance on a national scale for the 573 Federally-recognized AI/AN Tribes, and Tribal organizations on the changes and authorities of the new legislation for the ACA and the IHCIA. The national organization partners have provided well over 100 training sessions and webinars for Tribes and tribal members, helped coordinate numerous enrollment events, created toolkits for youth and elders and offered technical assistance to AI/AN and non-AI/AN enrollment assisters. Through the IHS National Indian Health Outreach and Education (NIHOE) Initiative, the IHS continues to partner with national and regional Tribal/Indian organizations to educate consumers and tribal governments on the health care insurance options available, the process for enrollment, financial assistance, the exemption options for American Indians and Alaska Natives, eligibility determinations, the tribal employer mandate, and maximizing revenue. During FY 2020 IHS partnered under the NIHOE initiative to conduct several live outreach and enrollment trainings and during the COVID-19 pandemic, pivoted to online webinars and training specific to operating during the pandemic. In addition, IHS

was able to work with the NIHOE partners to modify the existing work plans to include activities related to COVID-19 response messaging. The NIHOE activities support IHS Strategic *Plan Goal 3, Objective 1.2 Build, strengthen and sustain collaborative relationships.*

- In June 2019, the IHS Office of Resource Access and Partnerships hosted a joint Partnership Conference with nearly 1000 I/T/U 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. The Business Office sessions focused on increasing efficiencies in the revenue cycle, business practices and productivity, and using reports to identify gaps in the revenue cycle. The Purchased/Referred Care (PRC) sessions included updates to the PRC Chapter of the *Indian Health Manual*, developments in automating Catastrophic Health Emergency Fund functions, and PRC referral best practices. The Health Information Management (HIM) sessions provide information and best practices on coding and auditing, the electronic health record, operational processes, privacy, and records management. Sessions were also available on leadership training, stress management, quality improvement, and wellness activities. Due to the COVID-19 pandemic, the July, 2020 partnership was postponed until July of 2021. As an interim solution, at the end of September and early October 2020, IHS partnered with CMS to offer 14 separate webinars on topics typically addressed during the annual Partnership conference. IHS was able to partner with CMS to arrange to offer several webinars on topics typically addressed during the annual conference.

- The IHS HQ provided Area Revenue Cycle training in FY 2017, FY 2018, FY 2019, FY 2020 to IHS revenue staff across the Agency. This training was also available to Tribal and urban program staff. Over 500 attendees have participated in the training, which covered aspects of the entire revenue cycle. This training focused on Third Party Billing and Accounts Management, and the Resource Patient Management System (RPMS) Process. In addition, IHS hosted an Accounts Reconciliation Workshop in FY 2019, which included finance and business office staff from every IHS Area. In FY 2020, several similar trainings were held, and additional ones scheduled but were postponed due to the COVID-19 pandemic.

- In FY 2019, the IHS revised and updated the Revenue Operations Manual (ROM). The ROM provides a system-wide reference resource available to all I/T/U facilities across the United States, to assist staff with all functions related to business operation procedures and processes. IHS developed training materials for the revised ROM and conducted webinars in FY 2021 to provide an overview of the revised ROM 2.0.

- IHS continued its strong partnership with Treasury Fiscal Services to further protect, control, and monitor all third party collections. Treasury mandates require that all Federal Agencies move towards an electronic environment for funds transfers and accountability of funds. In 2019, IHS, in Partnership with Treasury Fiscal Services, PNC Bank (Fiscal Agent) and other Financial Institution began laying the groundwork for converting all paper checks received by the Agency to be settled in a more secure and timely manner. In FY 2020 IHS continued to work towards a complete electronic patient account environment, and actually is surpassed industry standards in this arena. IHS has converted all Federal locations receiving paper check reimbursement (through PNC Lockboxes) to the ECP (Electronic Check Processing) system. This was completed in August, 2020. IHS has met and exceeded Treasury standards in this Conversion.

- In FY 2019 IHS drafted a Pharmacy Benefits Manager Contract Review Process in order to more efficiently review, respond, negotiate, and track contract offers, modifications, and amendments. In FY 2021, the process will be fully implemented.

- Finally, in FY 2021 IHS will update the Third Party Internal Controls Self-Assessment Tool questions and collaborate internally on the update of the IHS Debt Management Policy.

FY 2021 - 2022 Collections Estimates

The FY 2021 estimate of collections is based on FY 2020 actual collections. The FY 2022 amounts are estimated based on the FY 2020 actual collections, inflated by the average rate of annual increase from FY 2017 to FY 2020, by collection program.

***Medicare and Medicaid (M&M)* -- The FY 2022 Budget estimate assumes collections of $978 million, $37 million above FY 2020 collections:**

- ***Medicaid* – The FY 2022 budget estimate assumes collections of $753 million, $28 million above FY 2020 collections.** IHS continues to educate its users on the benefits of Medicaid enrollment. IHS continues to monitor its user population and insurance coverage and is making all possible efforts to maximize Medicaid enrollment in all States and to maintain current collection levels.

- ***Medicare*** – **The FY 2022 budget estimate assumes collections of $224 million, $8 million above FY 2020 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 2022 budget estimate assumes collections of $142 million, $5 million above FY 2020 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 2022 budget estimate assumes collections of $7 million, $249,000 above FY 2020 collections.**

The FY 2022 estimate is based on the FY 2020 estimated collections. The estimate includes actual collections received by IHS for Federal health programs. IHS and VA have agreed to continue to monitor FY 2021 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 2022 Performance Budget Submission to Congress

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Facilities

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$911,889	$917,888	$1,500,943	$583,055
FTE*	1,102	1,202	1,215	+13

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

SUMMARY OF THE FACILITIES BUDGET

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

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

BUDGET AUTHORITY

The FY 2022 budget submission for Facilities is $1,501 billion and is $583 million above the FY 2021 Enacted Level.

Maintenance & Improvement –The FY 2022 budget submission for Maintenance and Improvement is $223 million, which is $54 million above the FY 2021 Enacted Level. These funds are the primary source for providing maintenance, repair, and improvement of health care facilities. Specific objectives and program priorities to address the condition of facilities include:

- Providing routine maintenance and repairs to upkeep facilities at their current conditions;
- Achieving compliance with buildings and grounds accreditation standards of the Joint Commission or other applicable accreditation bodies;
- Providing improvements to facilities for enhanced patient access and care through larger M&I projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR), which is estimated at over $944.9 million 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 2022 budget submission for Sanitation Facilities Construction is $351 million, which is $155 million above the FY 2021 Enacted Level.

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

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

Health Care Facilities Construction – The FY 2022 budget submission for Health Care Facilities Construction is $526 million, which is $266 million above the FY 2021 Enacted Level.

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

- Phoenix Indian Medical Center, Phoenix, AZ
- Whiteriver Hospital, Whiteriver, AZ
- Gallup Indian Medical Center, Gallup, NM
- Bodaway Gap Health Center, The Gap, AZ
- Albuquerque Central Health Center, Albuquerque, NM
- Sells Health Center, Sells, AZ
- New and Replacement Staff Quarters
- Small Ambulatory
- Green Infrastructure

Facilities and Environmental Health Support (FEHS) – The FY 2022 budget submission for Facilities and Environmental Health Support is $300 million, which is $36 million above the FY 2021 Enacted Level.

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

FEHS funds provide for:

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

Equipment –The FY 2022 budget submission for Equipment is $101 million, which is $72 million above the FY 2021 Enacted Level.

These funds provide for:

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

COLLECTIONS

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

Quarters – The FY 2022 Quarters Return budget submission for Rent Collections is $12 million, which is $2 million above the FY 2021 Enacted Level for anticipated rental collections. FY 2020 rent collections were approximately $9 million and are projected to increase to approximately $10 million in FY 2021.

Collected funds are to be used for:

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

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$168,952	$168,952	$222,924	+$53,972
FTE*	--	--	--	--

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

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

FY 2022 Authorization.....Permanent

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

PROGRAM DESCRIPTION

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

Maintaining reliable and efficient buildings is an increasing challenge as existing health care facilities age and additional space is added into the real property inventory. The average age for IHS-owned health care facilities is approximately 37 years, whereas the average age, including recapitalization of private-sector hospital plants, is 9 to 10 years.[1] Many IHS and Tribal health care facilities are operating at or beyond capacity, and their designs are not efficient in the context of modern health care delivery. In addition, as existing health care facilities continue to age, the operational and maintenance costs increase.

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. Further, the administrators reported that maintaining aging buildings and equipment is a major challenge. Over one third of all IHS hospital deficiencies have

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

been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors.

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 BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2020, is $944.9 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.

The Facilities Management Program addresses the IHS Strategic Plan FY 2019-2023, Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and Objective 1.3: Increase access to quality health care services. Additionally, Facilities Program addresses the IHS Strategic Plan FY 2019-2023, Goal 3: To strengthen IHS program management and operations; Objective 3.2: Secure and effectively manage the assets and resources.

M&I Funds Allocation Method

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

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

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

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

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

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

Provision related to Demolition of hazardous, obsolete federal buildings, the inventory of this federal inventory continues to grow as does the potential liability.

IHS Strategic Plan and how the Facilities programs are implementing: 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 necessary to support health care delivery in the health care facilities and to modernize the health care facilities and staff quarters to expand access to quality health care services.

FUNDING HISTORY

Fiscal Year	Amount
2018	$167,527,000
2019	$167,527,000
2020	$168,952,000
2021 Enacted	$168,952,000
2022 President's Budget	$222,924,000

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.

BUDGET REQUEST

The FY 2022 budget submission for Maintenance and Improvement is $223 million, which is +$54 million above the FY 2021 Enacted Level.

FY 2022 Funding Increase of +$54 million includes:

Current Services: +$4 million for current services including:

- Inflation: +$931,000 – to fund inflationary costs of providing health care services.

- Population Growth +$3 million – to address the impact of the additional services need arising from the growing AI/AN. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

Maintenance and Improvement: +$50 million to support additional routine maintenance and repair, BEMAR, environmental compliance, and demolition projects across Indian Country.

The total $223 million funding request for FY 2022 would support:

- Approximately $105 million is the projected amount for routine maintenance and repair to sustain the condition of federal and Tribal healthcare facilities buildings. These funds will support facilities activities that are generally classified as those needed for 'sustainment' of existing facilities and provided to the IHS Area Offices and to Tribes for daily maintenance

activities and local projects to maintain the current state of health care facilities. These *Routine Maintenance Funds* may be used for Area and Tribal M&I projects to fund smaller elements of the backlog of work to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR) and program enhancements.

- Approximately $115 million would be available for major Area and Tribal M&I projects to reduce the BEMAR deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. The FY 2022 Budget Request continues funding critical projects to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR), accreditation standards, and program enhancements, all of which is essential to support health delivery.

- Approximately $3 million would be available for environmental compliance projects. The IHS places a high priority on meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. The IHS has currently identified approximately $8 million in environmental compliance tasks and included them in the BEMAR database.

- M&I funds, a portion from above categories retained by Headquarters, also provide resources for the demolition of IHS facilities that are no longer needed. The IHS has approximately 120 Federally-owned buildings that are vacant, excess, or obsolete. Many of these buildings are safety and security hazards. IHS plans for orderly demolition of some of these buildings, in concert with transferring others, reducing hazards and liability. Demolition Funds may be used in concert with environmental compliance funds as available for demolition of the Federal buildings to the extent that the proposed action reduces hazards, environmental concerns, or liability to the Indian Health Service. Since FY 2000 when funds were first set aside for the demolition of Federal buildings, associated demolition costs have risen significantly due to inflation, environmental regulations, recycling and landfill diversion requirements, abatement of hazardous material, etc. For example, many IHS locations are very remote which significantly increases the cost to haul the demolition waste off the reservation to approved landfills and recycling facilities.

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.

IHS targets the M&I funding, and supplements these funds with collections where available, towards major projects to reduce the BEMAR and improve the condition of existing Federal and Tribal healthcare sites. A few examples of these projects include: renovating/expanding pharmacy space, improvements to dental clinics to serve more users, remodeling reception/waiting areas, construction of CT suite and new digital radiology rooms, repaving parking lots, emergency department renovations, new heating-ventilation-air conditions systems, sustainability projects to reduce utility costs, etc. Continued investment in the BEMAR which is currently at $945 million, will enable IHS and the Tribes to maintain accreditation standards and delivery quality health care 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 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$193,577	$196,577	$351,445	+$154,868
FTE*	113	119	119	--

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

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

FY 2022 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. These outcomes support both the HHS and IHS Strategic Plans. (HHS Strategic Plan FY 2018 – 2022, Objective 2.2: "*Prevent, treat, and control communicable diseases and chronic conditions*" and IHS Strategic Plan FY 2019-2023, Objective 1.3: *Increase access to quality health care services.* Strategy 14, "*Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services…*").

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

Projects that provide sanitation facilities to existing homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS). The SDS is an inventory of the sanitation deficiencies of federally recognized AI/AN eligible homes and communities; the sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. These actions support Strategy 1, "*Improve the transparency and quality of data collected regarding health care service and program outcomes*" (IHS Strategic Plan FY 2019-2023, Objective 2.1: *Create*

quality improvement capability at all levels of the organization). Project selection is driven by objective evaluation criteria including health impact, existing deficiency level, adequacy of previous service, capital cost, local Tribal priority, operations and maintenance capacity of the receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined. The SDS priority position of each unfunded project is reevaluated with the Tribes in each Area annually.

Sanitation Facilities Construction (SFC) projects can be managed by IHS directly or by Tribes that elect to use the Title I or Title V authorization under P.L. 93-638, the Indian Self-Determination and Education Assistance Act. Sanitation facilities projects are carried out cooperatively with the Tribes that will be served, and construction is performed by either the IHS or the Tribes (IHS Strategic Plan FY 2019 – 2023, Objective 1.2: *Build, strengthen, and sustain collaborative relationships*). 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 (IHS Strategic Plan FY 2019 – 2023, Objective 1.2: *Build, strengthen, and sustain collaborative relationships*).

PROGRAM ACCOMPLISHMENTS

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

In FY 2020, IHS funded projects to provide service to 37,771 AI/AN homes. IHS also completed construction on 260 projects with an average project duration of 3.9 years. However, at the end of FY 2020 about 7,140, or 1.8 percent of all AI/AN homes tracked by IHS lacked water supply or wastewater disposal facilities; and, about 112,082 or approximately 28 percent of AI/AN homes tracked by IHS were in need of some form of sanitation facilities improvements. The individuals who live in homes without adequate sanitation facilities are at a higher risk for gastrointestinal disease,

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

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

The total sanitation facility need reported through SDS has increased approximately $0.52 billion or 20.2 percent from $2.57 billion to $3.09 billion from FY 2019 to FY 2020. In FY 2020, the Indian Health Service was appropriated $0.20 billion 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 IHS implementing a revised prioritization system to indicate the level of project planning. A "tier" system was introduced with the publication of the 2019 SDS Guidelines document. Projects considered "ready to fund" are assigned tier 1, while projects considered "engineering assessed" are assigned tier 2. Projects considered tier 3 are those that are only "preliminarily assessed"; previously many of these projects were not reported to Congress. In FY 2020, there was a total of $0.67 billion in tier 3 projects, resulting in an increase in the total sanitation facility need reported through SDS.

During FY 2020, 373 construction projects to address water supply and wastewater disposal needs were funded with a construction cost of $220 million using IHS and contributed funds. Once constructed, these sanitation facilities will benefit an estimated 143,000 AI/AN people and help avoid over 235,000 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 $259 million. Every $1 spent on water and sewer infrastructure will save $1.18 in avoided direct healthcare cost. These outcomes support Strategy 14, "Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services…". (IHS Strategic Plan FY 2019- 2023, Objective 1.3: Increase access to quality health care services).

In FY 2022, the SFC Program will continue to focus on improving quality of data reported through the SDS on the sanitation facility needs supporting AI/AN homes and communities (IHS Strategic Plan FY 2019-2023, Objective 2.1: *Create quality improvement capability at all levels of the organization*). These efforts will ensure the sanitation facilities needs included in SDS are:

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

Additionally, in FY 2022, the SFC Program will continue to focus on maintaining average construction project duration to 4.0 years. In order to achieve this outcome, funds will only be obligated to projects that have been certified by the SFC Program Areas as "ready to fund"; this means they have a well-defined scope, a detailed cost estimate, a completed preliminary design and that known potential risks to project construction, operation and maintenance have been considered and mitigated.

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

FUNDING HISTORY

Fiscal Year	Amount
2018	$192,033,000
2019	$192,033,000
2020	$193,577,000
2021 Enacted	$196,577,000
2022 President's Budget	$351,445,000

BUDGET REQUEST

The FY 2022 budget submission for Sanitation Facilities Construction is $351 million, which is $155 million above the FY 2021 Enacted Level.

FY 2022 Funding Increase of +$155 million includes:

- Current Services: +$5 million for current services including:
    - Pay Costs: +$2,000 – to fund pay increases for Federal employees.
    - Inflation: +$1 million – to fund inflationary costs of providing health care services.
    - Population Growth +$3 million – to address the impact of the additional services need arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.
- Sanitation Facilities Construction Increase: +$150.0 million – The disproportionate impact of the COVID-19 pandemic on Indian Country highlighted the critical need for potable water, water treatment systems, and solid waste systems in American Indian and Alaska Native communities. These additional resources will address the backlog in unfunded sanitation facilities construction projects reported annually to the Congress. The IHS expects that the additional resources would support potable water and sanitation improvements for approximately 38,184 eligible American Indian and Alaska Native homes.

The total of $351 million funding request for FY 2022 would support:

- Approximately $267 million would support prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time, or (b) are served by sanitation facilities that are in need of some form of improvement. Another element of the distribution formula is a weight factor that favors Areas with larger numbers of AI/AN homes without water supply or sewer facilities, or without both.
- Approximately $80 million would 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. 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 ofHUD. These HUD housing grant programs for new homes should continue to incorporate funding for the sanitation facilities necessary for those homes. A portion 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.3 Priority will be given to projects under the BIA Housing Improvement Program (HIP) to serve new and like-new homes with the exception of "Category A" BIA HIP homes, which are considered existing homes and will be served with the funds described in the first bullet of this section.

In addition, up to $5 million may be used for projects to clean up open dump sites and upgrade solid waste sites that present a health hazard on Indian lands and Alaska Native lands, pursuant to the Indian Lands Open Dump Cleanup Act of 19944, and pending coordination with the EPA on oversight and evaluation of Tribal solid waste management programs.

- Approximately $4 million will support emergency and special projects:

    - Emergency projects 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.

Special projects include:

- Updating the inventory of open dumps currently identified in the IHS data system to ensure compliance with the requirements of the Indian Lands Open Dump Cleanup Act (PL103-399),

- Incorporating a geographical information system (GIS) functionality into the SFC Program data system.

    - The primary benefit of incorporating a GIS into the SFC Program's data system is to improve the Program's ability to access, store and update sanitation facilities composite as-built drawings. The graphical interface will allow for the collection, uploading and editing of field-collected data on installed sanitation facilities. It will allow users to update sanitation facilities as-built drawings for the purpose of aiding in needs identification, planning, design, construction, and technical assistance.

- Enhancements of the SFC Program data system to facilitate development of an improved user interface, reporting, and program oversight.

- Research studies, training, or other needs related to sanitation facilities construction.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
35 Number of new or like-new and existing AI/AN homes provided with sanitation facilities. (Outcome)	FY 2020: 37,771 Target: 37,045 (Target Exceeded)	40,400	44,000	+3,600

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
SFC-E Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. (Outcome)	FY 2020: 3.9 yrs Target: 4 yrs (Target Exceeded)	4 yrs	4 yrs	Maintain

GRANT AWARDS – This Program has no grant awards.

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$259,290	$259,290	$525,781	+$266,491
FTE*	--	--	--	--

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

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

FY 2022 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Care Facilities Construction (HCFC) funds provide optimum availability of functional, modern IHS and tribally operated health care facilities and where required staff quarters. The IHS is authorized to construct health care facilities and staff quarters, support Tribal construction of facilities under the Joint Venture Construction Program (JVCP), provide construction funding for Tribal projects Under the Small Ambulatory Program (SAP), and provide funding to construct new and replacement dental units.

The construction and modernization of IHS infrastructure through the health care facilities construction program helps ensure the IHS commitment to the Department of Health and Human Services Strategic Objectives 1.2: Expand safe, high-quality healthcare options, and encourage innovation and competition; and 1.3: Improve Americans' access to healthcare and expand choice of care and service options. 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 HFCPS ranks proposals using factors reflecting the total amount of space needed, age and condition of the existing health care facility, if any, degree of isolation of the population to be served in the proposed health care facility, and availability of alternate health care resources. The remaining health care facilities projects on the HFCPS list, including those partially funded, total approximately $2.00 billion as of January 2021. The reauthorization of the Indian Health Care Improvement Act (IHCIA) includes a provision, "any project established under the construction priority system in effect on the date of enactment of the Act of 2009 shall not be affected by any change in the construction priority system taking place after that date…" Total need for the HCFC Program is approximately

$15 billion for expanded and active authority facility types according to *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*.

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

The Small Ambulatory Program (SAP) provides funding for small Tribal health care facilities. The SAP is authorized by Section 306 of the Indian Health Care Improvement Act, Public Law 94-437, and projects are competitively selected for funding as funds are appropriated. 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.

These three programs implement the IHS Strategic Plan Goal 1 by increasing access to culturally appropriate health care services for American Indian and Alaska Native people. IHS Strategic Plan Goal 2 is supported when a new facility is completed. A new facility is designed to meet the demand for health services from a growing population by providing more healthcare providers and exam rooms, dentists and dental chairs, improved imaging systems, and expanded services such as eye care and audiology. Each new facility includes a component to address behavioral health issues. Administration staff is increased to strengthen management, collections and bring health care quality expertise to the replacement facility. Each facility also incorporates additional space for Tribal health programs which complements IHS programs and how the HCFC programs are implementing.

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. Tribes typically provide land, at no cost to the Federal Government, for the new or replacement health care facility.

During FY 2020, no facility was completed, but all of the remaining projects on the grandfathered priority list progressed toward completion.

The FY 2020 appropriation completed funding for the Rapid City Health Center in Rapid City, SD; Alamo Health Center, Alamo, NM: Pueblo Pintado Health Center, Pueblo Pintado, AZ and contributed to the Whiteriver Hospital, Whiteriver, AZ; Bodaway Gap Health Center, The Gap, AZ; and Albuquerque West Health Center, Albuquerque, NM.

The FY 2020 appropriation also contributed $25 million to the IHS SAP and $10 million to the Staff Quarters Program. The selection and agreements to award the funds will be compete in May 2021.

The FY 2021 appropriation completed funding for the Albuquerque West Health Center, Albuquerque, NM and contributed to the Whiteriver Hospital, Whiteriver, AZ; Bodaway Gap Health Center, The Gap, AZ; Albuquerque Central Health Center, Albuquerque, NM and Sells Alternative Rural Hospital, Sells, AZ projects.

The FY 2021 appropriation also contributed $25 million to the IHS SAP and $10 million to the Staff Quarters Program. The selection and agreements to award the funds is beginning in late FY 2021.

The JVCP has saved the Federal Government over $1 billion dollars in capital expenses 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.

FUNDING HISTORY

Fiscal Year	Amount
2018	$243,480,000
2019	$243,480,000
2020	$259,290,000
2021 Enacted	$259,290,000
2022 President's Budget	$525,781,000

BUDGET REQUEST

The FY 2022 budget submission for Health Care Facilities Construction is $526 million, which is $266 million above the FY 2021 Enacted Level.

FY 2022 Funding Increase of +$266 million includes:

Current Services of +$603,000 including:

- Inflation +$603,000 to fund inflationary costs of providing health care services.

Health Care Facilities Construction: +$266 million - to support the remaining projects on the 1993 IHS Health Care Facilities Construction Priority List. These health care facilities will improve access to direct health care services.

The total $526 million funding request for FY 2022 would support:

Phoenix Indian Medical Center, Phoenix, AZ $70 million

These funds will be used to begin design of the facility and possibly purchase land if the site evaluation requires. The new Phoenix Indian Medical Center Health Care System is planned to decentralize a substantial portion of the primary care services workload to three new satellite facilities. The three satellite facilities are located in the southwest valley, the southeast valley, and in the northeast valley. The satellite facilities are located closer to the user's communities to provide more access to care. A new Central facility will be a major resource to the satellite facilities. The Central facility will be designed and equipped with full telemedicine support and visiting professionals to provide specialty care services, and will continue to serve as a referral hospital for specialty consultation and procedures.

Whiteriver Hospital, Whiteriver, AZ $100 million

These funds will be used to continue construction of the replacement hospital. It will serve a projected user population of 36,113 providing 67,000 primary care provider visits and 101,200outpatient visits annually. This project also includes an estimated 144 staff quarters for health care professionals serving at the facility.

Gallup Indian Medical Center, Gallup, NM $68 million

These funds will be used to provide infrastructure and purchase land for the facility. The proposed replacement Gallup Indian Medical Center will provide comprehensive inpatient, ambulatory, behavioral, and preventive health services for the Gallup Service Unit. The projects will also provide specialty care and inpatient care services to support other Navajo Area service units.

Bodaway Gap Health Center, The Gap, AZ $30 million

These funds will be used to complete construction of the 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.

Albuquerque Central Health Center, Albuquerque, NM $75 million

These funds will be used for construction of the health center located in central Albuquerque, NM. The Health Center will serve a projected user population of 15,500 generating 59,300 primary care provider visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.

Sells Health Center, Sells, AZ $120 million

These funds will continue construction of the health center and staff quarters in the Sells, AZ. The Sells Health Center will consist of approximately 210,000 GSF of space. The Health Center will serve a projected user population of 21,400 generating 38,200 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.

New and Replacement Staff Quarters $25 million

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.

Small Ambulatory $33 million

These resources would support up 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.

Green Infrastructure: $5 million

The Indian Health Service will use these funds to incorporate green infrastructure

and the most 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.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/- FY 2021 Target
36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome)	FY 2020: 0 projects Target: 0 projects (Target Met)	0 projects	1 project	+1 project
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 2020: 0 projects Target: 0 projects (Target Met)	0 projects	1 project	+1 project

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 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$261,983	$263,982	$300,153	+$36,171
FTE*	989	1,044	1,096	+52

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
Detail Breakout of FEHS Activity	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$261,983	$263,982	$300,153	+$36,171
Facilities Support	*$160,371*	*$161,635*	*$183,170*	*$21,535*
Environmental Health Support	*$84,220*	*$84,882*	*$96,191*	*$11,309*
Office of Environmental Health and Engineering Support	*$17,392*	*$17,464*	*$20,792*	*$3,327*
FTE	989	1,044	1,096	+52
Facilities Support	*559*	590	619	29
Environmental Health Support	*361*	381	400	19
Office of Environmental Health and Engineering Support	*69*	73	77	4

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 2022 Authorization.....Permanent

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

SUMMARY OF PROGRAMS

Facilities and Environmental Health Support Account (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs directly and indirectly support all of the IHS facilities performance measures and improved access to quality health services. The programs and staff at the IHS Headquarters, Area Office, and Service Unit levels work collaboratively with Tribes and other agencies to promote and provide access to

improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities. These activities are aligned in sub-activities: Facilities Support, Environmental Health Support, and Office of Environmental Health and Engineering Support. In addition to personnel salary and benefits costs, funding under this activity is used for utilities, certain non-medical supplies and personal property, and biomedical equipment repair.

The IHS may use a limited amount of these FEHS funds for centrally charged assessments that benefit the staff and activities funded through the Indian Health Facilities appropriations. To date, the majority of IHS's assessments have been paid through the Indian Health Services appropriation; however, the amount of assessment costs have exceeded the amount of funds available within Services. In order to continue the emphasis on direct patient care, these FEHS funds that provide other types of administrative support for the Facilities appropriation may share in appropriate assessment charges proportionate to the underlying activities. For example, a centrally managed assessment for payroll services that is charged by the number of employees may be proportionately paid under both the Services and Facilities appropriations according to the number of staff supported by each appropriation.

FACILITIES SUPPORT

PROGRAM DESCRIPTION

Facilities Support Account (FS) provides funding for Area and Service Unit staff for facilities-related management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement health facilities projects. The sub-activity directly supports the IHS Strategic Plan FY 2019-2023 priorities: (1) People - Recruit, develop, and retain a dedicated, competent, caring workforce collaborating to achieve the IHS mission; (2) Partnerships- Build, strengthen, and sustain collaborative relationships that advance the IHS mission; (3) Quality- Excellence in everything we do to assure a high-performing Indian health system; and (4) Resources- Secure and effectively manage the assets needed to promote the IHS mission.

The IHS owns approximately 10,245,000 square feet of facilities (totaling 2,122 buildings) and 1,775 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 168 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. Accomplishments include supporting health delivery through the attainment of accreditation and the maintenance of the environment of care of buildings, utility systems, life safety systems, and medical equipment.

Adequate facilities/maintenance staffing both at the Area Offices and service units are paramount to maintain accreditation, for the continuity of health services, and ensuring that major building systems function correctly. Workload for the facilities and biomedical staff has continued to increase to meet the Agency's emphasis on accreditation standards and supporting program enhancements/expansion, which is predominately funded with collections.

The Facilities Management Program addresses the IHS Strategic Plan FY 2019-2023, Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and Objective 1.3: Increase access to quality health care services. Additionally, Facilities Program addresses the IHS Strategic Plan FY 2019-2023, Goal 3: To strengthen IHS program management and operations; Objective 3.2: Secure and effectively manage the assets and resources.

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

PROGRAM ACCOMPLISHMENTS

Maintaining effective and efficient healthcare buildings and equipment improve the ease and access to care, facilitate successful behavioral health services, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment to deliver services. This is all integral to quality health care for AI/ANs.

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 coronavirus/COVID-19 medical services.

In FY 2020, total utility costs were $15 million and total utility costs per Gross Square Feet (GSF) were $2.86/GSF. In FY 2022, the total utility cost is expected to be $15 million reflecting a 2.0 percent annual increase. The cost per GSF is expected to rise to approximately $3.02/GSF. IHS makes conscious efforts to help stem the growth in utility costs to ensure appropriations are sufficient to fund these needs. For example, IHS 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, IHS seeks opportunities to fund renewable energy systems at IHS and tribally owned installations. For example, a current project is installing additional solar panels at the Fort Yuma Health Care Center in Yuma, Arizona, which has the potential to make the site net zero electricity.

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. More than 70 percent of these IHS and Tribal staff live and work in Tribal communities; another 20 percent provide regional services to Tribes or IHS facilities; and less than 10 percent of our staff are administrative managers. AI/ANs face hazards in their environments that affect their health status, including communities in remote and isolated locations, severe climatic conditions, limited availability of safe housing, lack of safe water supply, and lack of public health and safety legislation (e.g., lack of local solid waste ordinances, vehicle safety laws, or food safety laws). In accordance with congressional direction, these funds are distributed to the Areas based upon the workload and need associated with the two programs noted below.

- Sanitation Facilities Construction Program (SFC) – This program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated for SFC to provide safe water supply and waste disposal facilities for AI/AN people and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced. 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. The absence of clean water to sanitation facilities for tribal households exacerbate concern for the Indian Health Service Clinical Health Care program; further decreasing the quality of life for AI/ANs. Efforts by other public health specialists such as nutritionists and public health nurses are much more effective when safe water and adequate wastewater disposal systems are available in the home. In addition, the availability of such facilities is of fundamental importance to social and economic development, which leads to an improved quality of life and an improved sense of well-being.

  The SFC Program works collaboratively with tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply and waste disposal systems as soon as possible (IHS Strategic Plan FY 2019 – 2023, Objective 1.2: Build, strengthen, and sustain collaborative relationships) . Under this program in FY 2020, staff managed and/or provided professional engineering services for 545 new sanitation projects with a total cost of over $302 million, including IHS funds and contributions from Tribes and other agencies. 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. Services funded include management of staff, pre-planning, consultation with Tribes, coordination with other federal, state and local governmental entities, identifying supplemental funding outside of IHS, developing local policies and guidelines with Tribal consultation, developing agreements with Tribes and others for each

[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.

project, providing professional engineering design and/or construction services for water supply and waste disposal facilities, assuring environmental and historical preservation procedures are followed, and assisting Tribes where the Tribes provide construction management.
Consistent with the 1994 Congressional set aside for "…tribal training on the operation and maintenance of sanitation facilities," $1 million of these support funds are used for technical assistance, training, and guidance to Indian families and communities regarding the operation and maintenance of water supply and sewage disposal facilities.

In accordance with the Indian Health Care Improvement Act, the staff annually updates its inventory of sanitation facilities deficiencies for existing Indian occupied homes.[2] This is accomplished through extensive consultation with Tribes. The SFC staff also develops and updates an inventory of all open dump sites on Indian lands as required under the Indian Lands Open Dump Cleanup Act.[3] Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation facilities construction projects.

- Environmental Health Services (EHS) – National priority areas include: food safety, children's environments, healthy homes, vector borne and communicable disease, and safe drinking water. The EHS Program identifies environmental hazards and risk factors in Tribal communities and proposes control measures to prevent adverse health effects. The EHS Program monitors and investigates disease and injury. The program provides inspections to identify environmental hazards in homes, healthcare facilities, food service establishments, Head Start centers, and many other types of Tribal establishments. In addition, EHS provides training, technical assistance, and cooperative agreements to enhance the capacity of Tribal communities to address environmental health issues. *HHS Strategic Plan Goal 2, 3 and 5 (see goal descriptions below)*

  EHS provides access to public health services to AI/ANs. Examples include referrals for home investigations to reduce environmental triggers for asthma patients; home investigations to reduce exposure to lead-based paint or other lead hazards (including drinking water sources) for patients with elevated blood-lead levels; animal bite investigations in Tribal communities and potential patient exposure to rabies virus; home investigations to address fall risk for elderly and other patients at risk for falls; and referrals for investigation of community disease outbreaks from multiple patient exposures to contaminated food or water. *HHS Strategic Plan Goal 2 and 3 (see goal descriptions below)*

  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 (motor vehicle-related, falls, burns, drowning, poisoning) and intentional injuries (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. *HHS Strategic Plan Goal 2 and 3 (see goal descriptions below)*

[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

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. *HHS Strategic Plan Goal 2 and 3 (see goal descriptions below)*

- *HHS Strategic Plan Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play by: Preventing and Controlling communicable and environmental diseases; and Preparing for and responding to public health emergencies.*
- *HHS Strategic Plan Goal 3: Strengthen the Economic and Social Well-Being of Americans across the Lifespan by Safeguarding the public against preventable injuries and violence or their results.*
- *HHS Strategic Goal 5: Promoting Effective and Efficient Management and Stewardship.*

PROGRAM ACCOMPLISHMENTS

Environmental Health Services (EHS) staff have been involved with all aspects and at all levels of the National COVID-19 Pandemic response. The Division of Environmental Health Services has collaborated with Federal partners such as, National Indian Gaming Commission, Centers for Disease Control and Prevention, Department of the Interior, and the Bureau of Indian Education by serving as Subject Matter Experts for policy and guidance on the reopening of Tribal gaming facilities and tribal schools nationally. EHS staff remain focused on the community-based environmental health services by assisting tribal operations and businesses plan and prepare to reopen during COVID-19. EHS staff throughout the Indian Health Service are serving in critical leadership positions of the COVID-19 response. For example, many Environmental Health staff serve as Incident Commanders, Safety Officers, Emergency Management Points-of-Contact, Logistics Chief, and Liaisons to state and local emergency management entities.

EHS staff accomplishments reduce the need for direct healthcare services when environmentally related diseases and injuries are prevented. For example, the IHS Injury Prevention Program has been instrumental in reducing the injury mortality rate of AI/ANs by implementing a public health approach based upon effective strategies and initiatives to reduce the devastating burden of injuries. Preventing severe, debilitating injuries reduces the cost and need for healthcare service; however, the challenge remains that unintentional injuries are still the leading cause of death for AI/ANs ages 1-44.[5]

From 1997-2021 the TIPCAP funded 106 fulltime tribal injury prevention positions and provided over $34 million in funding. Through these efforts the IHS IPP has contributed to the 58 percent decrease in injury mortality rates since 1973 and continues to invest in preventing injuries in the first place, instead of treating the impacts of injury and violence through our health care delivery system.

4 Indian Health Focus: Injuries, 2017 Edition

President's Management Agenda Goal 3 Cross Agency Priority Goal – Developing a Workforce for the 21st Century.

The IEH Program provides extensive technical assistance and training to safety and facility management staff as well as the many inter-related medical program and leadership staff. These efforts have led to a reduction in the IHS total occupational injury case rate which has decreased from 4.35 injuries/100 employees in 2004 to 1.54 injuries/100 employees in 2019.

The IEH program supports healthcare management by providing local accreditation support including mock environment of care surveys in which regulatory requirements and conditions for general safety, environmental infection control, fire safety, and chemical safety are assessed and recommendations for corrective action are provided. The IEH Program works to foster multi-disciplinary engagement amongst all levels of the organization to improve transparency and efficiency.

Staff engage Tribal, county, and state public health and public safety officials in Tribal communities. For example, staff engage local Bureau of Indian Affairs law enforcement or Tribal police to enhance motor vehicle related injury prevention efforts through child safety seat interventions and enhanced police enforcement activities such as seat belt usage or driving under the influence checkpoints. Staff work extensively with Tribal, county, and state health departments on a variety of public health issues including response to foodborne (i.e., salmonellosis), vectorborne (i.e., bubonic plague, Rocky Mountain spotted fever, hantavirus), and waterborne (i.e. legionellosis) disease outbreaks. Other examples of collaboration include surveillance activities related to emerging diseases and public health emergency preparedness.

FUNDING HISTORY

Fiscal Year	Amount
2018	$240,758,000
2019	$252,060,000
2020	$261,983,000
2021 Enacted	$263,982,000
2022 President's Budget	$300,153,000

BUDGET REQUEST

The FY 2022 budget submission for Facilities and Environmental Health Support is $300 million, which is +$36 million above the FY 2021 Enacted Level.

FY 2022 Funding of +$300 million includes:

FY 2022 Funding Increase of +$36 million includes

- Current Services of +$13 million, including:
    - Pay Costs: +$7 million – to fund pay increases for Federal and Tribal employees.
    - Inflation +$1 million to fund inflationary costs of providing health care services.

- Population Growth +$5 million – to address the impact of the additional services need arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

Staffing for New Facilities +$10 million to fund staffing and operating costs for new and replacement projects. These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following tables display this request:

Staffing and Operating Costs for New/Replacement Facility	Amount	FTE/Pos
Yukon-Kuskokwim Primary Care Center (JV), Bethel, AK	$2,169,000	9
Naytahwaush Health Center (JV), Naytahwaush, MN	$95,000	1
NEACC (Salt River) Health Center, Scottsdale, AZ	$3,836,000	14
Ysleta Del Sur Health Center (JV)	$689,000	4
Alternative Rural Health Center, Dilkon, AZ	$3,195,000	14
Grand Total:	**$9,984,000**	**42**

These funds support a variety of critical facilities support and environmental health activities. A description of these activities along with program accomplishments is included below.

Facilities and Environmental Health Support: +$13 million to support the additional health care facilities construction, sanitation facilities construction, and maintenance and improvement projects proposed in the FY 2022 President's Budget, and to develop, coordinate, and upgrade Office of Environmental Health and Engineering data systems and dashboards.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
EHS-3 Injury Intervention: Occupant protection restraint use (Outcome)	FY 2020: 90% Target: 100%[6] (Target not met)	Discontinued	Discontinued	N/A
EHS-4 Environmental Surveillance (Outcome)	FY 2020: 90% Target: 100%[7] (Target not met)	Discontinued	Discontinued	N/A
EHS-5 Number of persons who received injury prevention training (Output)		154 trained	Maintain Baseline	N/A
EHS-6 Percent of food establishments with Certified Food		86.7%	Maintain Baseline	N/A

[6] Percent of all participating Areas distribute model practices and highlight challenges.

[7] Percent of all participating Areas distribute model practices and highlight challenges.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2021 Target	FY 2022 Target	FY 2022 Target +/-FY 2021 Target
Protection Manager (CFPM) (Output)				

In FY 2016, a national baseline was established for EHS-3 and EHS-4 at 64 percent and 5.1 percent, respectively. In FY 2018, 64 percent of drivers wore seat belts (EHS-3) and 3.4 percent of food borne illness risk factors were out of compliance (EHS-4). In FY 2019, 69.5 percent of drivers wore seat belts (EHS-3) and 3.5 percent of food borne illness risk factors were out of compliance (EHS-4). The FY 2020 target is based on 100 percent of all participating Areas distributing best practices and highlighting challenges to Tribes. *The FY 2020 targets are not comparable to FY 2019. FY 21 targets were set from FY 2020 WebEHRS data.

Performance Discussion

Injury Intervention: During the 2016-2020 performance cycle, in FY 2016, Area EHS Programs identified targeted communities from which a national baseline measure of seatbelt use was developed (64 percent). For the FY 2017 target, 8 of 10 (80 percent) of the Area programs implemented comprehensive interventions using at least three effective strategies to increase seatbelt usage rate in targeted Tribal communities. Examples include: developing or strengthening tribal seat belt laws, increasing partnerships with Tribal police, providing classroom curriculum for motor vehicle crash prevention at reservation schools. For the FY 2018 target, measure interim seat belt use to determine effectiveness of interventions and propose adjustments to interventions based on interim driver seat belt use findings. It was found that 64 percent of drivers wore seat belts (no change from the FY 2016 baseline year) and Areas modified their strategies to address identified intervention barriers. In FY 2019, Area programs conducted their final driver seat belt use rates. It was found that 69.5 percent of drivers used their seat belt. The results show an 8 percent increase in observed seat belt use when compared to the 64 percent baseline. In FY 2020, ninety percent of the Area programs shared their identified best practices and challenges with Tribes and EHS staff highlighted interventions which had the greatest impact in improving driver seat belt usage. The EHS programs are expected to incorporate the best practices to prevent injuries and deaths due to injuries. Best practices included enhanced trainings; effective interventions; and improved injury prevention outreach and collaboration with tribal partners. *IHS Strategic Plan Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people. Objective 1.3: Increase access to quality health care services.* HHS Strategic Plan FY 2019-2023, Goal 2.2.

Environmental Surveillance: During the 2016-2020 performance cycle, in FY 2016, Area EHS Programs identified targeted Tribal Head Start and non-residential day care establishments from which a national baseline of foodborne illness risk factors was calculated (5.1 percent). For the FY 2017 target, 10 of 10 (100 percent) of the Areas implemented and reported comprehensive interventions using at least three effective strategies to decrease food risk factor deficiencies at targeted Tribal Head Start and non-residential day care establishments. Examples include: developing and implementing active managerial control and corrective action plan processes with local operators, focusing food inspection surveys on targeted risk factors, and providing access to training through the IHS Online Food Handlers Training Course. For the FY 2018 target, conduct an interim assessment of poor employee health and hygiene foodborne illness risk factors to determine effectiveness of interventions and adjust interventions based on interim findings. It was found that 3.4 percent of food borne illness risk factors were out of compliance (a decrease from the FY 2016 baseline year) and Areas continued their comprehensive interventions. In FY 2019, Area programs conducted their final assessments and data collection and found that 3.5 percent of foodborne illness risk factors were out of compliance. The results showed a 31 percent

reduction in foodborne illness risk factors that were out of compliance when compared to the 5.1 percent baseline. In FY 2020. Ninety percent of the Area programs shared their identified best practices and challenges with Tribes. The EHS programs are expected to incorporate these best practices into their delivery of environmental health services. Best practices include conducting training, focused surveys, and audits based on identified deficiencies; and use of data to drive annual performance improvement; *IHS Strategic Plan Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people. Objective 1.3: Increase access to quality health care services.* HHS Strategic Plan FY 2019-2023, Goal 2.2.

The FY 2016 – 2020 EHS performance measures focused on reducing the risk of foodborne illness in children's environments and reducing the risk of motor vehicle-related injuries and deaths through increased use of seatbelts. Barriers that may have impacted the program's ability to meet these targets included competing local, regional and national priorities (e.g., COVID-19), staff turn-over, lapsed vacant positions, and a decentralized approach to program management that can result in non-standardized processes across the country. To help mitigate these barriers, EHS provided ongoing competency development through specialized training programs; strategic planning efforts that support uniform program management; and data management tools to support local staff.

In FY 2021-2025, a new performance cycle is established with two new measures. The EHS-5 measure is the number of persons who received injury prevention training. This measure focusses on the importance of injury prevention training in building the capacity of staff and tribes to prevent injuries and deaths due to injuries in tribal communities. In FY 2021, data from the web-based environmental health reporting system, WebEHRS, was used to report the number of people trained in injury prevention in FY 2020. Because of the focus on COVID-19 activities in FY 2020 and FY 2021, the target for FY2021 was determined to be to maintain the baseline number of 154 people trained.

The EHS-6 measure is the percent of food establishments with a Certified Food Protection Manager (CFPM). This measure uses WebEHRS to track the number of food service establishments (restaurants and kitchens within other establishments) with a Certified Food Protection Manager (CFPM). This performance measure focusses on a proven strategy in the reduction of foodborne illnesses and with aligns with the DEHS Operational Model and 10 essential environmental health services.

FY 2020 WebEHRS data was used to determine the baseline CFPM percent (86.7 percent). Because of the continuing focus on COVID-19, the FY 2021 target was determined to be to maintain the baseline percent (70) of food establishments with a CFPM present at time of inspection.

GRANT AWARDS

In FY 2020, the TIPCAP 2016-2020 Five year Funding cycle was completed. In FY 2021, the Injury Prevention Program solicited for TIPCAP Injury Prevention projects and awarded 27 Tribes (five year funding cycle) for $2.5 million per year.

OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT
PROGRAM DESCRIPTION

The IHS Office of Environmental Health and Engineering Support activity (OEHE) provides funds for executive management activities, personnel, contracts, contractors, and operating costs for the OEHE Headquarters. Personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, perform management functions and have responsibility for all construction contracting in excess of $150,000.

Management activities include**:**

- national policy development and implementation
- budget formulation, project review and approval
- congressional report preparation
- quality assurance (e.g., internal control reviews, Federal Managers Financial Integrity Act activities and other oversight)
- technical assistance (e.g., consultation and training)
- construction contracting
- long range planning
- meetings (with HHS, Tribes, and other federal agencies)
- recruitment and retention efforts.

Typical direct support functions are**:**

- Project officers and contracting officer representatives for health care facilities construction projects: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status.
- Staff support real property asset management requirements. These actions are to ensure management accountability and the efficient and economic use of federal real property.
- Staff serving as contracting officer representatives and project officers in support of data systems, cooperative agreements, inter-agency agreements, and community-based projects.

In accordance with appropriation committee direction, OEHE staff develop, maintain, and utilize data systems to distribute Facilities Appropriation resources to Area offices for facilities and environmental health activities and construction administration and management, based upon workload and need. Also, technical guidance, information, and training are provided throughout the IHS system in support of the Facilities Appropriation.

Office of Environmental Health and Engineering (OEHE) Support advances the HHS Strategic Plan Goal 1: Reform, Strengthen, and Modernize the Nation's Healthcare System by increasing access to healthcare and strengthening the healthcare workforce to meet diverse needs. OEHE Support advances the HHS Strategic Plan Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play by: Preventing and Controlling communicable and environmental diseases; and Preparing for and responding to public health emergencies. Additionally, OEHE Support furthers HHS Strategic Goal 5: Promoting Effective and Efficient Management and Stewardship.

PROGRAM ACCOMPLISHMENTS

The following are activities which focus on the IHS mission and priorities:

- review and approval of Program Justification Documents (PJDs) and Program Of Requirements (PORs)

- announcement and review of Joint Venture and Small Ambulatory projects
- awarding and monitoring contracts for all aspects of the Facilities Appropriation, including all types of construction contracts and 638 construction project agreements.
- OEHE coordinating construction, environmental health, and real property activities through the 12 Area Offices to ensure program consistency, to ensure the most effective use of resources across IHS, and to support field programs through budget preparation and required reporting, thus ensuring the most effective, accountable use of resources to improve access to quality healthcare services.

OEHE strengthens the overall management of IHS by reviewing and approving the planning documents for health care facilities construction projects called PJDs and PORs. OEHE also reviews joint venture and small ambulatory projects which address assessing health care and improving health care delivery. These programs include behavioral health services. These programs include behavioral health services. The OEHE facilities programs integrate strategic planning, performance, and program integrity into the office's daily business practices. One example is the Sanitation Facilities Construction Strategic planning efforts and identification of needs (Strategy 1, "*Improve the transparency and quality of data collected regarding health care service and program outcomes*" from IHS Strategic Plan FY 2019-2023, Objective 2.1: *Create quality improvement capability at all levels of the organization*). Implementation of this plan has improved project management, reduced project durations and transformed the data system used by IHS and federal partners to manage sanitation programs in Indian country. Another example is the Environmental Health program strategic visioning and the Ten Essential Environmental Health Services as a framework. Implementation of these initiatives is ongoing.

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

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$28,087	$29,087	$100,640	+$71,553
FTE*	--	--	--	--

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

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

FY 2022Authorization.....Permanent

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

PROGRAM DESCRIPTION

Equipment funds are used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at Indian Health Service (IHS) and Tribal healthcare facilities. It directly supports the Agency's priorities of Partnerships and Quality.

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health diagnosis. The IHS and Tribal health programs manage approximately 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $700 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 $100 million per year.

Many of the IHS hospital administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. Further, the administrators reported that maintaining aging buildings and equipment is a major challenge. Over one third of all IHS hospitals' deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors.

Equipment Funds Allocation Method

In FY 2021, 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 2021 funds support approximately $5 million for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS funding sources. Tribes and Tribal organizations will use these funds to serve approximately 500,000 patients with newly purchased medical equipment.

2. TRANSAM 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 2021 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 2021 funds support approximately $1 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 $23 million will be allocated to IHS and Tribal health care facilities to maintain existing and purchase new medical equipment, including the replacement of existing equipment used in diagnosing illnesses. The funding allocation is formula based.

The Facilities Management Program addresses the IHS Strategic Plan FY 2019-2023, Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and Objective 1.3: Increase access to quality health care services. Additionally, Facilities Program addresses the IHS Strategic Plan FY 2019-2023, Goal 3: To strengthen IHS program management and operations; Objective 3.2: Secure and effectively manage the assets and resources.

IHS Strategic Plan and how the Facilities programs are implementing: In consultation with Tribes and the Federal healthcare sites, IHS is allocating funding to the IHS Area Offices to replace and modernize medical equipment to support health care delivery and expand access to quality health care services.

[1] The IHS Facilities appropriation limits total expenditures up to $500,000 for equipment purchased through the TRANSAM Program.

FUNDING HISTORY

Fiscal Year	Amount
2018	$23,706,000
2019	$23,706,000
2020	$28,087,000
2021 Enacted	$29,087,000
2022 President's Budget	$100,640,000

BUDGET REQUEST

The FY 2022 budget submission for Equipment is $101 million, which is $72 million above the FY 2021 Enacted Level.

FY 2022 Funding Increase of +$72 million includes:

Current Services of +$640,000 including:

- Inflation: +$134,000 to fund inflationary costs of providing health care services.

- Population Growth: +$506,000 to address the impact of the additional services need arising from the growing AI/AN. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

- Equipment: +$71 million for maintenance and upgrades for existing medical equipment, and procurement of new medical equipment to replace units that are at the end of their useable lifecycle at IHS and Tribal healthcare facilities.

- Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment and systems to assure the best possible health diagnosis. IHS and Tribal health programs manage approximately 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $700 million.

- Today's medical devices and systems have an average life expectancy of approximately six to eight years. The average six year life cycle combined with rapid technological advancements means that medical equipment replacement is a continuous process that requires the replacement of aging equipment, and equipment that does not meet newer technological standards, to enhance the speed and accuracy of diagnosis and treatment. To replace equipment at IHS and Tribal health facilities at the end of its six-year life would require approximately $100 million per year, growing at an approximate 2 percent inflation rate per year. The FY 2022 funding request would be a substantial investment toward addressing critical equipment needs.

- Along with aging buildings, aging equipment presents challenges for maintaining accreditation, providing high quality care and ensuring patient safety. It also affects the recruitment and retention of high quality health care professionals. Having access to modern equipment and the ability to maintain skills and training on particular devices or equipment are important factors in our providers' decisions about working for IHS.

The total $101 million funding request for FY 2022 would support:

- Approximately $94 million for new and routine replacement medical equipment to over 1,500 federally and tribally-operated healthcare facilities;

- $5 million for new medical equipment in tribally-constructed health care facilities;

- $1 million for emergency generators at Tribal Health Programs located in areas impacted by de-energization events; and

- $500,000 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 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$9,100	$9,600	$11,500	+$1,900
FTE*	46	46	46	--

Quarters funds are not BA but are rents collected for quarters which are returned to the service unit for maintenance and operation costs. They fall under the Program Level Authority.
*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010; Public Law 98-473, Sec. 320, as amended

FY 2022 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.

The Facilities Management Program addresses the IHS Strategic Plan FY 2019-2023, Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and Objective 1.3: Increase access to quality health care services. Additionally, Facilities Program addresses the IHS Strategic Plan FY 2019-2023, Goal 3: To strengthen IHS program management and operations; Objective 3.2: Secure and effectively manage the assets and resources.

IHS Strategic Plan and how the Facilities programs are implementing: 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 necessary to support health care delivery in the health care facilities and to modernize the health care facilities and staff quarters to expand access to quality health care services.

FUNDING HISTORY

Fiscal Year	Amount
2018	$8,500,000
2019	$8,500,000
2020	$9,100,000
2021 Enacted	$9,600,000
2022 President's Budget	$11,500,000

BUDGET REQUEST

The FY 2022 Quarters Return budget submission for Rent Collections is $12 million, which is +$2 million above the FY 2021 Enacted Level for anticipated rental collections.

The IHS has increased the total number of quarters by about 6 percent since 2017, which is approximately 2 percent annually. In addition, the IHS updates rental rates for the Consumer Price Index (CPI) each year, per OMB Circular A-45. In FY 2020, the CPI was 3.5 percent.

As a result of the growth in the total number of quarters, and increasing rental rates, the IHS collections were approximately $9 million in FY 2020, and anticipates collections of approximately $10 million in FY 2021.

As a result, the FY 2022 IHS Budget includes anticipated collections of $12 million to address potential additional growth from FY 2021 to FY 2020.

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.).

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

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Indian Health Service
Contract Support Costs: 75-0344-0-1-551
CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$820,000	$916,000	$1,142,000	+$226,000
FTE*	--	--	--	--

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

FY 2022 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 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.

- *IHS Strategic Plan (SP) Goal 1, Objective 1.2, Building, strengthen, and sustain collaborative relationships;*

[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.

- *Strategic Goal 3, Objective 3.1, Improve communication within the organization with Tribes; and 3.2, Secure and effectively manage the assets and resources*

PROGRAM ACCOMPLISHMENTS

- Following is a summary CSC funds for FY 2016 – FY 2021, as of March 30, 2021:

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Appropriations*	$686,859,423	$714,642,272	$762,642,272	$822,227,000	$855,000,000	$916,000,000
Paid to Tribes	($678,005,883)	($723,655,002)	($770,457,690)	($800,409,997)	($796,842,674)	($599,802,517)
Balance*	$8,853,540	($9,021,730)	($7,815,418)	$21,817,003	$58,157,326	$316,197,483

* Funds remain in process for payment to tribes and/or pending final reconciliation with tribes to determine the 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 SP Goal 1, Objective 1.2.*

- IHS Headquarters reconciles CSC fund requests on a quarterly basis and allocates funds to each Area office to pay tribes. *IHS SP Goal 3, Objective 3.2*

- 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 SP Goal 3, Objective 3.3 – Modernize Information Technology and information systems to support data-driven decisions.*

- 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 SP Goal 3, Objective 3.3*

- IHS continues to make progress in resolving Contract Disputes Act claims from T/TO for additional CSC funding for prior years. As of August 17, 2020, the IHS has extended settlement offers on 1,567 of the 1,624 claims, with settlement payments of approximately $880 million that has been tentative or confirmed for payment from the Judgment Fund. *IHS SP Goal 3, Objective 3.1*

FUNDING HISTORY

Fiscal Year	Amount
2018	$762,642,000
2019	$822,227,000
2020	$820,000,000
2021 Enacted	$916,000,000
2022 President's Budget	$1,142,000,000

BUDGET REQUEST

The FY 2022 Budget submission for Contract Support Costs continues the indefinite discretionary appropriation established in FY 2016, with an estimated funding level of $1 billion, which is $226 million above the FY 2021 Enacted Level.

Contract Support Costs General Increase: +$226 million 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 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.

Contract Support Costs in FY 2023

The budget also proposes an advance appropriation for CSCs in FY 2023. In addition, the budget proposes that, beginning in FY 2023, that CSCs will continue to be funded through the Appropriations process but will be reclassified as mandatory funding. The FY 2023 Budget will include an updated score for FY 2023 CSC.

In 2012, the Supreme Court of the United States established a new funding entitlement for Tribal contractors and compactors when they ruled in *Salazar v. Ramah Navajo Chapter* that the Federal government is responsible for fully reimbursing actual contract support costs, regardless of the previous appropriations limit for this funding. In FY 2016, Congress provided an indefinite discretionary appropriation for contract support costs in the annual appropriations bill.

An indefinite discretionary appropriation allows IHS to fund contract support costs at the actual total funding need for the fiscal year, aligning the budget to the Supreme Court's decision in *Salazar v. Ramah Navajo Chapter*. This funding mechanism avoids the need to redirect funding that IHS would otherwise use to provide direct services to Tribes. These costs are more appropriately funded from mandatory appropriations, consistent with other indefinite authorities.

AREA ALLOCATION

CONTRACT SUPPORT COSTS

(dollars in thousands)

DISCRETIONARY	FY 2020 Estimated			Estimated			FY 2021 Estimated			FY '21 +/- FY '20
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$243,284	$243,284	$0	$271,766	$271,766	$0	$338,817	$338,817	$67,051
Albuquerque	0	20,288	20,288	0	22,663	22,663	0	28,255	28,255	$5,592
Bemidji	0	43,429	43,429	0	48,513	48,513	0	60,483	60,483	$11,969
Billings	0	15,246	15,246	0	17,031	17,031	0	21,233	21,233	$4,202
California	0	68,289	68,289	0	76,284	76,284	0	95,105	95,105	$18,821
Great Plains	0	7,799	7,799	0	8,713	8,713	0	10,862	10,862	$2,150
Nashville	0	35,349	35,349	0	39,488	39,488	0	49,230	49,230	$9,743
Navajo	0	64,740	64,740	0	72,319	72,319	0	90,162	90,162	$17,843
Oklahoma	0	123,871	123,871	0	138,373	138,373	0	172,513	172,513	$34,140
Phoenix	0	44,965	44,965	0	50,230	50,230	0	62,623	62,623	$12,393
Portland	0	62,819	62,819	0	70,174	70,174	0	87,488	87,488	$17,314
Tucson	0	26,040	26,040	0	29,089	29,089	0	36,266	36,266	$7,177
Headquarters	0	63,880	63,880	0	71,358	71,358	0	88,964	88,964	$17,606
Total, CSC	**$0**	**$820,000**	**$820,000**	**$0**	**$916,000**	**$916,000**	**$0**	**$1,142,000**	**$1,142,000**	**$226,000**

Note: FY 2021 and FY 2022 are estimates.

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ISDEAA 105*(l)* Leases

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Section 105(*l*) Leases: 75-0200-1-551
ISDEAA SECTION 105(*l*) LEASES

(Dollars in Thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$0	$101,000	$150,000	+$49,000
FTE*	--	--	--	--

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

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

FY 2022 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. 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 to 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, and quadrupled between FY 2018 and FY 2019. Because IHS has not had sufficient dedicated funding for leases, IHS has been forced to reprogram funds twice in FY 2019 totaling $62 million and once in FY 2018 totaling $25 million. A funding increase in FY 2020 temporarily reduced the likelihood of reprogramming, but absent a change, IHS will continue to divert increasing amounts of resources from direct services to pay for leases. IHS cannot legally reduce the amount of funds provided to self-determination Tribes and tribal organizations, so the only funds available for reprogramming come from Tribes that IHS serves directly.

The prevalence of Section 105(*l*) leases in FY 2017 was largely confined to the Alaska Area. However, by FY 2020, leases have proliferated throughout the IHS system and proposals have been received in 10 of 12 IHS Areas.

This new, separate funding source supports IHS Strategic Plan goals and objectives for increasing access to care by establishing a dedicated funding source for these required costs and preventing

the redirection of other IHS funds intended for health care services (*Goal 1, Access, Objective 1.3, Increase access to quality health care services*).

PROGRAM ACCOMPLISHMENTS

IHS has received 304 proposals in FY 2021 to date, with a current total of $128 million. This amount is likely to increase before the end of the fiscal year. At this funding level, costs are 21 times higher than in FY 2017.

Based on the exponential growth of Section 105(*l*) leases from 37 proposals totaling $6 million in FY 2017, to 76 proposals totaling $21 million in FY 2018, to 189 proposals totaling $85 million in FY 2019, and 296 proposals totaling $123 million in FY 2020, costs for future years are expected to continue growing as more Tribes and Tribal Organizations submit additional proposals.

In FY 2021, the IHS received an indefinite discretionary appropriation for section 105(*l*) leases, scored at $101 million. Funding for Village Built Clinics (VBCs) remains in the Hospitals and Health Clinics funding line. Unlike in prior years when section 105(*l*) lease costs were paid from the IHS lump sum appropriation for the Indian Health Services account, the IHS will not have to reallocate funding from other budget lines to address unanticipated lease proposals.

The IHS conducted Tribal Consultation and Urban Confer in FY 2018 and again in FY 2019 on short-term and long-term options for meeting requirements of the ISDEAA related to Section 105(*l*). Tribal and Urban Indian Organization feedback strongly recommended seeking additional resources, such as through a separate indefinite appropriation, and remained critical of any redirection of existing funding, which diminishes the Indian health system's ability to provide direct health care services. At the recommendation of Tribes and Tribal Organizations, the IHS established a technical subgroup to help collect and analyze information necessary for developing cost projections. The subgroup includes representatives from the IHS Tribal Self-Governance Advisory Committee, the IHS Direct Services Tribes Advisory Committee, the IHS Facilities Appropriation Advisory Board, the IHS National Tribal Budget Formulation Workgroup (NTBFW), and subject matter experts from the IHS. This subgroup operates under the auspices of the NTBFW and their on-going work is included in the IHS's annual Tribal Consultation and Urban Confer on the budget.

In accordance with FY 2021 appropriations language, IHS is working to finalize a planned approach for conducting Tribal Consultation to establish a consistent and transparent process for payment of Section 105(*l*) leases.

FUNDING HISTORY

Fiscal Year	Amount
2018	$0
2019	$0
2020	$0
2021 Final	$101,000,000
2022 President's Budget	$150,000,000

BUDGET REQUEST

The FY 2022 budget submission for ISDEAA Section 105(*l*) leases is $150 million, which is $49 million above the FY 2021 Enacted level.

Section 105(*l*) Lease Agreements in FY 2023

The budget also proposes an advance appropriation for ISDEAA Section 105(*l*) leases in FY 2023. In addition, the budget proposes that, beginning in FY 2023, that ISDEAA Section 105(*l*) lease will continue to be funded through the Appropriations process but will be reclassified as mandatory funding.

In March 2016, the *Maniilaq Association v. Burwell* decision established a new funding entitlement for Tribal contractors and compactors as authorized by section 105(*l*) of the ISDEAA. The court ruled that the Secretary must compensate reasonable costs to each Tribe or Tribal organization who enters into a section 105(*l*) lease agreement. The court also 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 health programs.

In FY 2021, Congress enacted an indefinite discretionary appropriation to fully fund these costs. An indefinite discretionary appropriation allows IHS to fund section 105(*l*) lease agreements at the actual total funding need for the fiscal year, aligning the budget to the court decisions in *Maniilaq Association v. Burwell*. This funding mechanism avoids the need to redirect funding that IHS would otherwise use to provide direct services to Tribes. These costs are more appropriately funded from mandatory appropriations, consistent with other indefinite authorities.

OUTPUTS / OUTCOMES -- There are no outputs/outcomes for this funding at this time.

GRANTS AWARDS -- The program does not award grants.

AREA ALLOCATION – Funds are allocated to Areas as ISDEAA Section 105(*l*) lease proposals are received and executed each fiscal year.

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Special Diabetes Program for Indians

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

(Dollars in thousands)

	FY 2020	FY 2021	FY 2022	
	Final	Enacted	President's Budget	FY 2022 +/- FY 2021
BA	$150,000	$150,000	$147,000	-$3,000
FTE*	111	111	111	--

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

Authorizing Legislation ..... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians (SDPI) to extend funding through FY 2011, the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013, the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014, the Protecting Access to Medicare Act of 2014 (P.L. 113-93; H.R. 4302) to extend funding through FY 2015. P.L. 114-10 – The Medicare Access and CHIP Reauthorization Act of 2015 authorized SDPI for FY 2016 and FY 2017, P.L. 115-63 — Disaster Tax Relief and Airport and Airway Extension Act authorized SDPI for the first quarter of FY 2018, and P.L. 115-96— Department of Homeland Security Blue Campaign Authorization Act of 2017 authorized SDPI for the second quarter of FY 2018, P.L. 115-123 – Bipartisan Budget Act of 2018 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.

FY 2022 Authorization..... Expires September 30, 2023

Allocation Method ..... Grants and Contracts

PROGRAM DESCRIPTION

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention to approximately 301 Indian Health Service (IHS), Tribal, and Urban (I/T/U) Indian health grant programs. Funds for SDPI were first authorized in FY 1998; as such, FY 2022 would be the 25th year of the SDPI. SDPI is currently authorized through September 30, 2023. 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. This mission aligns with *Goal 1 of the IHS Strategic Plan, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people and Objective 2.2 of the HHS Strategic Plan, Provide care to better meet the health care needs of American Indian and Alaska Native communities*. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, and approximately 301 SDPI grants and sub-grants at I/T/U sites across the country.

Target Population: American Indians and Alaska Natives

Diabetes and its complications are major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (14.7 percent) among all racial and ethnic groups in the United States, more than twice the rate of the non-Hispanic white population (7.5 percent).[1] In some AI/AN communities, more than half of adults 45 to 74 years of age have diagnosed diabetes, with prevalence rates reaching as high as 60 percent.[2]

Allocation Method

In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes among AI/ANs. The entities eligible to receive these grants were I/T/Us. The IHS distributes this funding to approximately 301 I/T/U sites annually through a process that includes Tribal consultation/Urban confer, development of a formula for distribution of funds, and a formal grant application and administrative process. *This process is consistent with IHS Strategic Plan Objective 1.2 to "build, strengthen, and sustain collaborative relationships*".

Strategy

The SDPI brings Tribes together to work toward a common purpose and share information and lessons learned. The Tribal Leaders Diabetes Committee, established in 1998, reviews information on the SDPI progress and provides recommendations on diabetes-related issues to the IHS Director. Through partnerships with federal agencies, private organizations, and an extensive I/T/U network, DDTP undertook one of the most strategic diabetes treatment and prevention efforts ever attempted in AI/AN communities and demonstrated the ability to design, manage, and measure a complex, long-term project to address this chronic condition. Because of the significant costs associated with treating diabetes, I/T/Us have used best and promising practices for their local SDPI funding to address the primary, secondary, and tertiary prevention

[1] Centers for Disease Control and Prevention (CDC). *National Diabetes Statistics Report 2020: Estimates of Diabetes and Its Burden in the United States.* Atlanta, GA: U.S. Department of Health and Human Services; 2020. *Available at*: https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

[2] Lee ET, Howard BV, Savage PJ, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45-74 years: the Strong Heart Study. *Diabetes Care*. 1995;18:599-610.

of diabetes and its complications. *These efforts increase the availability and accessibility of comprehensive, culturally appropriate personal and public health services to AI/AN people, which supports Goal 1 of the IHS Strategic Plan and Objective 1.3 of the HHS Strategic Plan.*

This collaborative approach supports the strategic planning process necessary to identify the goals and objectives needed to achieve the intended SDPI outcomes. As in *Objectives 1.2, 1.3, and 3.1 of the IHS Strategic Plan, the SDPI promotes collaboration and communication with Tribes and Urban Indian Organizations in the development of quality community-based diabetes prevention and treatment programs.*

PROGRAM ACCOMPLISHMENTS

SDPI: Two Major Components

As directed by Congress and Tribal consultation, the SDPI consists of two major components: (1) SDPI Grant Program; and (2) Diabetes data and program delivery infrastructure.

1. SDPI Grant Program

The SDPI grant program (formerly called the SDPI Community-Directed grant program) provides $138.7 million per year in grants and technical assistance for local diabetes treatment and prevention services at I/T/U health programs in 35 states. Each of the communities served by the SDPI grant program is unique in that its diabetes treatment and prevention needs and priorities are defined locally. Based on these local needs and priorities, the SDPI grant programs implement interventions to address the diabetes epidemic.

The Consolidated Appropriations Act of 2001 established statutory authority for SDPI to implement a best practices approach to diabetes treatment and prevention. As such, the SDPI has incorporated Indian Health Diabetes Best Practices into the SDPI grant application process used throughout AI/AN communities. This effort is used to promote excellence and quality within the SDPI programs, which aligns with the IHS Strategic Plan Goal 2. Grant programs are required to document the use of one SDPI Diabetes Best Practice,[3] corresponding evaluation measures, and progress in achieving program objectives in order to enhance accountability. Grantees receive training on how to collect, evaluate, and improve their data collection and use it to improve their outcome results.

Impact of the SDPI Grant Programs

SDPI funding has enabled staff and programs at the local and national levels to increase access to diabetes treatment and prevention services throughout the Indian health system. The following table demonstrates substantial increases in access to many activities and services:

[3] *Available at* https://www.ihs.gov/sdpi/sdpi-community-directed/diabetes-best-practices/

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 dieticians	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

At the same time that access to these diabetes services increased, key outcome measures for AI/ANs with diabetes showed improvement or maintenance at or near national targets. These results have been sustained throughout the inception of SDPI. Examples include:

- *Improving Blood Sugar Control*
  Blood sugar control among AI/ANs with diabetes served by the IHS has improved over time. The average blood sugar level (as measured by the A1C test) decreased from 9.0 percent in 1996 to 8.0 percent in 2020, nearing the A1C goal for most patients of less than 8 percent.
- *Improving Blood Lipid Levels*
  Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 89 mg/dL in 2020, surpassing the goal of less than 100 mg/dL.
- *Reducing Kidney Failure*
  The rate of new cases of kidney failure due to diabetes leading to dialysis declined by more than half (54 percent) in AI/AN people from 1996 to 2013. This is a much larger decline than in any other racial group in the US.[4]

2. Diabetes Data and Program Delivery Infrastructure

The IHS has used funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. The SDPI supports the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System in all 12 IHS Areas, which supports Objective 3.3 of the IHS Strategic Plan.

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 2020 Diabetes Audit included a review of 130,542 patient charts at 325 I/T/U health facilities. The Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national

[4] Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. MMWR Morb Mortal Wkly Rep 2017;66:26-32. DOI: http://dx.doi.org/10.15585/mmwr.mm6601e1.

levels, as well as enhance quality improvement capabilities across AI/AN communities. These innovative efforts align with Objective 2.1 of the IHS Strategic Plan. DDTP provides Diabetes Audit training through online and webinar formats. DDTP receives evaluations on all trainings provided to guide improvements for future sessions.

Key Performance/Accomplishments

Annual SDPI assessments have shown significant improvements in the availability of diabetes clinical care and community services provided over time when compared to the baseline SDPI assessment in 1997 (see table above titled "Diabetes treatment and prevention services available to AI/AN individuals").

Ongoing efforts to improve blood glucose, blood pressure, and cholesterol values will continue to reduce the risk for microvascular, as well as macrovascular complications (see "Outputs/Outcomes" table below).

Reporting

In addition to internal monitoring of the SDPI Grant Program, the DDTP has completed six SDPI Reports to Congress to document the progress made since 1997. The SDPI Reports to Congress are as follows:

- January 2000 Interim Report to Congress on SDPI;
- December 2004 Interim Report to Congress on SDPI;
- 2007 SDPI Report to Congress: On the Path To A Healthier Future;
- 2011 SDPI Report to Congress: Making Progress Toward A Healthier Future;
- 2014 SDPI Report to Congress: Changing the Course of Diabetes: Turning Hope into Reality; and
- 2020 SDPI Report to Congress: Changing the Course of Diabetes: Charting Remarkable Progress.

Following Tribal consultation, beginning in FY 2016, SDPI funding has been distributed as follows:

Special Diabetes Program for Indians – Total Yearly Costs

CATEGORY	Percentage of the total	(Dollars in Millions)
SDPI Grant Programs (272 Tribal and IHS grants, sub-grants, and technical assistance in FY 2020).	**86.8%**	**$127.6**
Administration of SDPI grants (includes program support funds to IHS Areas, Tribal Leaders Diabetes Committee, DDTP, Grants Management, evaluation support contracts, etc.)	**4%**	**5.9**
Urban Indian Health Program SDPI Grant Programs ($8.5M allocated to 29 grants and technical assistance in FY 2020)	**5.7%**	**8.4**
Funds to strengthen the Data Infrastructure of IHS	**3.5%**	**5.1**
TOTAL:	**100%**	**$147.0**

BUDGET REQUEST

The SDPI is currently authorized through September 30, 2023, under the Consolidated Appropriations Act, 2021. The FY 2022 funding level of $147 million reflects 2 percent mandatory sequestration. The distribution of funding is shown in the grant tables that follow. Please note that the numbers provided for FY 2022 are likely to change due to the start of the new SDPI grant cycle.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2021 Target**	**FY 2022 Target**	**FY 2022 Target +/-FY 2021 Target**
53 Controlled BP <140/90 (Outcome)	FY 2020: 52.3 %[5] Target: 60.5 % (Target Not Met)	59.1 %	57 %	-2.1 %
54 Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes (Intermediate Outcome)	FY 2020: 52.2 %[6] Target: 51.6 % (Target Exceeded)	49 %	56.8 %	+7.8 %
86 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)	FY 2020: 17.1 %[7] Target: 17.4 % (Target Exceeded)	16.8 %	15.6 %	-1.2 %

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 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Number of Awards	301 (includes sub-grants)	301 (includes sub-grants)	301 (includes sub-grants)
Average Award	$452,011	$452,011	$452,011
Range of Awards	$25,000 - $7,553,570	$25,000 - $7,553,570	$25,000 - $7,553,570

[5] Interim result.

[6] Interim result.

[7] Interim result.

FY 2022 State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2022 Annual Financial Assistance Awards					
State	State Name	FY 20 Total # Grant Programs	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
AK	Alaska	20	10,191,326	$10,191,326	$10,191,326
AL	Alabama	1	279,211	279,211	279,211
AZ	Arizona	28	28,915,564	28,915,564	28,915,564
CA	California	38	9,720,825	9,720,825	9,720,825
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
ME	Maine	5	543,580	543,580	543,580
MI	Michigan	12	2,363,824	2,363,824	2,363,824
MN	Minnesota	8	3,274,552	3,274,552	3,274,552
MS	Mississippi	1	1,256,112	1,256,112	1,256,112
MT	Montana	10	5,564,865	5,564,865	5,564,865
NE	Nebraska	5	1,931,172	1,931,172	1,931,172
NV	Nevada	14	5,203,730	5,203,730	5,203,730
NM	New Mexico	28	12,613,849	12,613,849	12,613,849
NY	New York	3	1,264,077	1,264,077	1,264,077
NC	North Carolina	1	1,351,228	1,351,228	1,351,228
ND	North Dakota	5	3,168,173	3,168,173	3,168,173
OK	Oklahoma	27	23,460,585	23,460,585	23,460,585
OR	Oregon	9	1,832,727	1,832,727	1,832,727
RI	Rhode Island	1	113,475	113,475	113,475
SC	South Carolina	1	163,399	163,399	163,399
SD	South Dakota	9	6,014,743	6,014,743	6,014,743
TN	Tennessee	1	130,001	130,001	130,001
TX	Texas	4	784,901	784,901	784,901
UT	Utah	5	2,051,292	2,051,292	2,051,292
WA	Washington	27	4,792,337	4,792,337	4,792,337
WI	Wisconsin	12	3,421,213	3,421,213	3,421,213
WY	Wyoming	2	1,032,196	1,032,196	1,032,196
	Total States	**301**	$136,055,369	$136,055,369	$136,055,369

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2022 Annual Financial Assistance Awards					
State	State Name	FY 20 Total # Grant Programs	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
	Indian Tribes*	**253**	$113,058,370	$113,058,370	$113,058,370

*This is the number of tribes that are primary grantees or sub-grantees.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2022 Performance Budget Submission to Congress

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Advance Appropriations

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Advance Appropriation

(Dollars in Thousands)

	FY 2022		FY 2023	
	President's Budget	FY 2022 +/- FY 2021	Advance Appropriation	FY 2023 +/- FY 2022
Total BA	$8,471,279	+$2,235,000	$8,971,279	+$500,000

Authorizing Legislation…….New authorization proposed for FY 2022 final appropriation

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

PROGRAM DESCRIPTION

An advance appropriation provides funding in one fiscal year that does not become available until subsequent fiscal years. Advance appropriations provide additional stability to programs funded through the annual appropriations process. Unlike the Veteran's Health Administration, which receives advance appropriations, and Medicare and Medicaid, which receive significant mandatory funding, at present, IHS receives the majority of its funding through the annual appropriations process which has complicated its delivery of services under continuing resolutions and during lapses in appropriations.

In September 2018, the Government Accountability Office published their report GAO-18-652, Indian Health Service: Considerations Related to Providing Advance Appropriation Authority[1]. In this study, the GAO highlighted the effects of budgetary uncertainty – Continuing Resolutions and lapses in appropriations – on health care programs and operations. The GAO highlighted negative impacts of budgetary uncertainty on provider recruitment and retention, administrative burden and costs, and financial effects on tribes.

In December 2018, appropriations for the IHS lapsed as part of the longest government shutdown in United States history. Under a government shutdown, IHS-operated health care operations are deemed "excepted" activities to protect life and property, and continue in the absence of funding. During the 35-day shutdown, the IHS took extraordinary steps to redirect carryover funding and third-party revenues to cover additional costs, including pay for health care professionals providing direct health care services, to the extent possible.

However, the IHS was unable to provide funding to Tribally-operated and Urban Indian Health programs, including Tribally-operated health programs that receive funding each January on a calendar-year payment cycle. Tribal and Urban Indian health programs are vulnerable to serious impacts from a lapse in appropriations. Many are unable to draw on reserves, or have little third-party revenue to rely on to maintain health care operations. In addition, a lapse in appropriations of the unprecedented duration experienced in FY 2019 made it all the more difficult for Tribes and Urban Indian health programs to maintain operations. As a result, programs reduced their hours, days or types of services, furloughed staff, faced staff resignations from hard-to-recruit positions, and as well as other impacts on patient care.

After the FY 2019 government shutdown, Tribal and Urban Indian Organization Leaders renewed their calls for Advance Appropriations for the IHS. The FY 2022 and FY 2023 Tribal Budget Recommendations include a request for advance appropriations for the IHS.

[1] https://www.gao.gov/assets/700/694625.pdf

Continuing resolutions also pose operational challenges for IHS, Tribally operated Health programs and Urban Indian Health programs. IHS has received full-year appropriations at the start of the fiscal year only once since 1997. Continuing resolutions can inhibit health programs' ability to make up-front purchases of medication and equipment, harm relationships with vendors due to funding unpredictability, and even result in higher costs on commercial loans.

IHS, Tribal and Urban Indian Health programs are faced with difficult decisions in the absence of a timely federal appropriation, including whether to reduce the level of care they provide to American Indian/Alaska Native patients. Advance Appropriations will support stable, reliable, and predictable resources for IHS, Tribal, and urban Indian health programs, providing the IHS parity with other federal direct health service providers.

BUDGET REQUEST

The IHS Advance Appropriation Request for FY 2023 is $9 billion, an increase of +$500 million above the FY 2022 President's Budget. These funds would become available on October 1, 2022, and would therefore score as an FY 2023 cost.

The FY 2023 request allows for an increase of:

- Current Services (+$207 million): Current Services funding offsets the rising cost of providing direct health care services, including tribal and federal pay costs, medical and non-medical inflation, and population growth. These resources help the IHS to maintain services at the prior year level by shoring up operating budgets of IHS, Tribal, and urban Indian health programs. For the FY 2023 Advance Appropriations estimate, the IHS uses the most recently available data that was also used to determine the FY 2022 President's Budget Current Service request.
    - Pay Costs $96.2 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing direct health care and related services.
    - Inflation $24.2 million – to fund inflationary costs of providing health care services.
    - Population Growth $86.7 million – to fund the additional service needs arising from the growing AI/AN population. The projected growth rate for FY 2023 is 1.8 percent, based on data used to calculate the growth rate for the FY 2022 President's Budget request.
- Staffing for New Facilities (+$39 million): These resources will support personnel and operating costs at eight new or expanded health care facilities, which will expand the availability of direct health care services for American Indian and Alaska Native Communities. Consistent with the approach taken in the FY 2022 President's Budget and prior years, IHS only requests funding for the portion of FY 2023 in which a facility will reach beneficial occupancy status.

New Facilities	Amount	FTE/Tribal Positions
Naytahwaush Health Center (JV), Naytahwaush, MN	$13,159,000	95
NEACC (Salt River) Health Center, Scottsdale, AZ	$10,030,000	73
Phoenix Indian Medical Center Central, Phoenix, AZ	$451,000	6
Ysleta Del Sur Health Center (JV), El Paso, TX	$1,304,000	10
Alternative Rural Health Center, Dilkon, AZ	$6,465,000	47
Omak Clinic (JV), Omak, WA	$1,833,000	13
Elbowoods Memorial Health Center (JV), New Town, ND	$2,625,000	22

North Start Health Clinic (JV), Seward, AK	$3,500,000	20

- General Services Account Program Increase (+$254 million): The funding request for FY 2023 Advance Appropriations also includes an unallocated general program increase within the Services account. The IHS looks forward to working with Tribal and Urban Indian Organization Leaders and Congress to identify the highest priority uses for these funds.

INDIAN HEALTH SERVICE
FY 2023 Advance Appropriation
Detail of Changes
(Dollars in Thousands)

Sub IHS Activity	FY 2021 Enacted (P.L. 116-260)	FY 2022 President's Budget	FY 2023 Advance Appropriation				FY 2023 Advance Appropriations
			Current Services 1/	FY 2023 Staffing for New Facilities	Program Increases/ Adjustments	Subtotal of Changes	
SERVICES							
Hospitals & Health Clinics	2,238,087	2,703,574	115,059	29,920	0	144,979	**2,848,553**
Electronic Health Record System	34,500	284,500	0	0	0	0	**284,500**
Dental Services	214,687	287,326	11,076	3,361	0	14,437	**301,763**
Mental Health	115,107	124,622	4,941	1,181	0	6,122	**130,744**
Alcohol & Substance Abuse	251,360	267,490	9,286	560	0	9,846	**277,336**
Purchased/Referred Care	975,856	1,191,824	26,235	0	0	26,235	**1,218,059**
Indian Health Care Improvement Fund	72,280	317,306	2,526	0	0	2,526	**319,832**
Total, Clinical Services	3,901,877	5,176,642	169,123	35,022	0	204,145	**5,380,787**
Public Health Nursing	92,736	102,693	4,649	1,760	0	6,409	**109,102**
Health Education	21,034	22,164	1,022	0	0	1,022	**23,186**
Community Health Representatives	62,892	65,557	2,665	0	0	2,665	**68,222**
Immunization AK	2,127	2,174	47	0	0	47	**2,221**
Total, Preventive Health	178,789	192,588	8,383	1,760	0	10,143	**202,731**
Urban Health	62,684	100,000	3,002	0	0	3,002	**103,002**
Indian Health Professions	67,314	92,843	529	0	0	529	**93,372**
Tribal Management	2,465	2,485	20	0	0	20	**2,505**
Direct Operations	82,456	107,788	2,759	0	0	2,759	**110,547**
Self-Governance	5,806	5,990	184	0	0	184	**6,174**
Total, Other Services	220,725	309,106	6,494	1,760	0	6,494	**315,600**
General Program Increases	0	0	0	0	253,562	253,562	**253,562**
Total, Services	**4,301,391**	**5,678,336**	**177,506**	**36,782**	**253,562**	**474,344**	**6,152,680**
FACILITIES							
Maintenance & Improvement	168,952	222,924	3,972	0	0	3,972	**226,896**
Sanitation Facilities Construction	196,577	351,445	4,868	0	0	4,868	**356,313**
Health Care Facility Construction	259,290	525,781	603	0	0	603	**526,384**
Facility & Environmental Health Support	263,982	300,153	12,988	2,585	0	15,573	**315,726**
Equipment	29,087	100,640	640	0	0	640	**101,280**
Total, Facilities	917,888	1,500,943	23,071	2,585	0	25,656	**1,526,599**
Total, Services & Facilities	**5,219,279**	**7,179,279**	**200,577**	**39,367**	**253,562**	**500,000**	**7,679,279**
CONTRACT SUPPORT COSTS 2/							
Total, Contract Support Costs	**916,000**	**1,142,000**			**0**	**0**	**1,142,000**
SECTION 105(l) LEASES 2/							
Total Section 105(l) Leases	**101,000**	**150,000**			**0**	**0**	**150,000**
TOTAL, IHS BUDGET AUTHORITY	**6,236,279**	**8,471,279**	**200,577**	**39,367**	**253,562**	**500,000**	**8,971,279**

1/ Uses same current services estimate as FY 2022 President's Budget, given that FY 2023 economic assumptions and final FY 2021/FY 2022 data are not yet available.

2/ The FY 2022 President's Budget proposes to reclassify CSC and 105(l) lease costs as mandatory funding in FY 2023. The FY 2023 President's Budget will include an updated score for these costs.

INDIAN HEALTH SERVICE
STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES
FY 2023 Budget -- Estimates

(Dollars in Thousands)

	Naytahwaush, MN Naytahwaush Health Center (JV)		Scottsdale, AZ NEACC (Salt River) Health Center		Phoenix, AZ Phoenix Indian Medical Center Central		El Paso, TX Ysleta Del Sur Health Center (JV)		Dilkon, AZ Alternative Rural Health Center		Omak, WA Omak Clinic (JV)		New Town, ND Elbowoods Memorial Health Center (JV) [2]		Seward, AK North Star Health Clinic (JV) [2]				
Opening Date	September 2022		December 2021		December 2021		December 2021		December 2021		December 2021		July 2022		April 2022		**TOTAL**		
Sub Sub Activity	Pos	Amount	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount	Pos	Amount	Pos	Amount	Pos	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	70	$9,101	53	$6,647	6	$451	8	$891	37	$4,872	13	$1,833	22	$2,625	20	$3,500	104	125	$29,920
Dental Health	10	$1,409	9	$1,324	0	$0	1	$95	4	$533	0	$0	0	$0	0	$0	14	10	$3,361
Mental Health	5	$507	4	$424	0	$0	0	$57	2	$193	0	$0	0	$0	0	$0	6	5	$1,181
Alcohol & Substance Abuse	2	$256	1	$210	0	$0	0	$22	0	$72	0	$0	0	$0	0	$0	1	2	$560
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Clinical Services	87	$11,273	67	$8,605	6	$451	9	$1,065	43	$5,670	13	$1,833	22	$2,625	20	$3,500	125	142	$35,022
Public Health Nursing	5	$845	4	$658	0	$0	1	$101	1	$156	0	$0	0	$0	0	$0	6	5	$1,760
Health Education	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Community Health Representatives	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Preventive Health	5	$845	4	$658	0	$0	1	$101	1	$156	0	$0	0	$0	0	$0	6	5	$1,760
Total, Services	92	$12,118	71	$9,263	6	$451	10	$1,166	44	$5,826	13	$1,833	22	$2,625	20	$3,500	131	147	$36,782
Facilities Support	2	$926	2	$730	0	$0	0	$113	2	$524	0	$0	0	$0	0	$0	4	2	$2,293
Environmental Health Support	1	$115	0	$37	0	$0	0	$25	1	$115	0	$0	0	$0	0	$0	1	1	$292
Total, FEHS	3	$1,041	2	$767	0	$0	0	$138	3	$639	0	$0	0	$0	0	$0	5	3	$2,585
Total, Facilities	3	$1,041	2	$767	0	$0	0	$138	3	$639	0	$0	0	$0	0	$0	5	3	$2,585
Grand Total [1]	**95**	**$13,159**	**73**	**$10,030**	**6**	**$451**	**10**	**$1,304**	**47**	**$6,465**	**13**	**$1,833**	**22**	**$2,625**	**20**	**$3,500**	**136**	**150**	**$39,367**

[1] Includes Utilities

[2] These JVCPs are entering their planning phases and detailed budgets are not yet available. Preliminary estimates are included for budget planning purposes.

NEACC = Northeast Ambulatory Care Center

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2022 Performance Budget Submission to Congress

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Drug Budget

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2022

	Budget Authority (in Millions)				
	FY 2020		FY 2021[1]		FY 2022 President's Budget
	Final	Supplemental Funding	Enacted	Supplemental Funding	
Drug Resources by Function					
Prevention	33.794	0.000	34.233		35.179
Treatment	98.371	0.000	101.034		106.823
Total Drug Resources by Function	$132.165	$0.000	$135.267		$142.002
Drug Resources by Decision Unit					
Alcohol and Substance Abuse	128.518	0.000	131.645		138.380
Urban Indian Health Program	3.647	0.000	3.622		3.622
Total Drug Resources by Decision Unit	$132.165	$0.000	$135.267		$142.002
Drug Resources Personnel Summary					
Total FTEs (direct only)	171	-	171		171
Drug Resources as a Percent of Budget					
Agency Budget	$ 6,047.094	$ -	$6,236.279		$ 8,471.278
Drug Resources Percentage	2.19%	0.00%	2.17%		1.68%

[1] The American Rescue Plan Act provided $420 million for mental health and substance abuse prevention and treatment activities for IHS, Tribal, and urban Indian health programs. These funds have not yet been allocated, but the IHS anticipates a portion of the $420 million will support drug control activities.

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 substance abuse treatment and prevention services as part of this mission.

METHODOLOGY

The IHS includes the appropriation for Alcohol and Substance Abuse (excluding the amount designated as Adult Alcohol Treatment) and the portion of Urban Indian Health 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 2022, IHS requests $142.0 million for its drug control activities, a $6.7 million increase above the FY 2021 Enacted level.

Alcohol and Substance Abuse
FY 2022 Request: $138.4 million

In FY 2022, 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 opioid crisis and reduce the number of American's dying from dangerous drugs.

The Administration's ONDCP *Strategy* guides and expands Federal government efforts to reduce the size of the drug-using population through 1) prevention and education, 2) increasing access to treatment services for those suffering from substance use disorder, and 3) reducing the availability of dangerous drugs. 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, physical therapy, epidemiology, and injury prevention. The HOPE Committee work plan supports the HHS 5-Point Strategy to Combat the Opioid Crisis with a specific focus on 1) better pain management; 2) improving access to culturally relevant prevention, treatment, and recovery support services; 3) increasing availability and distribution of opioid overdose reversing drugs; and 4) improved public health data reporting and surveillance.

In addition to direct services, the IHS Alcohol and Substance Abuse grant and federal award program supports the IHS Strategic Plan *Goal 2, Objective 2.2 to provide care to better meet the*

health care needs of AI/AN communities and Goal 1 to ensure comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people. Particularly, in the prevention, treatment and recovery of alcohol and substance use disorders.

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. In particular, the IHS Opioid Grant Program and the Substance Abuse and Suicide Prevention program will support the IHS Strategic Plan Goal 1, *Objective 1.2 to build, strengthen, and sustain collaborative relationships and Objective 1.3 to increase access to quality health care services*.

IHS Opioid Grant Program: In FY 2021, IHS awarded a total of $16 Million in grants to combat the opioid crisis. IHS awarded thirty-five grants under the Community Opioid Intervention Pilot Project (COIPP) for AI/ANs targeted at opioid specific activities. This grant initiative has three objectives, 1) to increase public awareness and education about culturally-appropriate and family–centered opioid prevention, treatment and recovery practices and programs 2) creating comprehensive support teams to strengthen and empower AI/AN families, and finally 3) reducing the unmet treatment needs and opioid overdose related deaths through the use of Medication Assisted Treatment (MAT). Evaluation of the COIPP initiative will promote the documentation, and sharing of locally-designed, culturally-appropriate prevention, treatment, recovery, and aftercare services for opioid use disorders in AI/AN communities. The IHS COIPP is a three year program and part of the Department of Health and Human Services' five-point strategy to fight the opioid overdose epidemic in America.

IHS Substance Abuse and Suicide Prevention (SASP): The SASP is a nationally-coordinated grant program (formerly referred to as the Methamphetamine and Suicide Prevention Initiative (MSPI)) which focuses on substance abuse and suicide prevention providing intervention resources targeted to Tribes, Tribal programs, and Urban Indian communities with the greatest need for these programs. Due to the COVID-19 pandemic, the majority of the 174 SASP projects reduced and/or ceased activities. Only a limited number of projects continued to operate and did so according to their local, state, and federal guidelines for COVID-19 by modifying in-person activities to virtual events. In June 2020, the IHS requested and received a 1-year extension for all SASP grants from the Department of Health and Human Services (DHHS) due to the impact of COVID-19. The new end date for all SASP grants will be September 29, 2021.

Of the projects funded, 19 projects specifically focus on substance use prevention, treatment, and aftercare, while 107 focus on substance use and suicide prevention among Native youth. IHS established the Universal Alcohol Screening (UAS) as a national measure to increase screening and improve detection and intervention strategies among patients' ages 9 through 75 years of age. In FY 2020, 37.1 percent of eligible patients were screened for risky alcohol use, which is less than the IHS target of 42.4 percent.

All projects funded have a training objective to increase and expand the types of healthcare providers trained in SUD screening, assessment or treatment, including Brief Intervention and Motivational Interviewing. Projects also seek to hire additional behavioral health staff (i.e., licensed behavioral health providers and paraprofessionals, including but not limited to peer specialists, mental health technicians, and community health aides) specializing in child, adolescent, and family services. These new staff will be responsible for implementing project activities that address all of the required objectives listed.

Successful outcomes during the fourth year of the program include expanded behavioral health services offered through school settings and home visiting with a total of 1,475 patients receiving care. Over 270 providers were trained in behavioral health integration with 163 of those providers located within a primary care setting. Project accomplishments include 67,168 individuals screen for suicide ideation, 54 percent of the SASP program suicide prevention projects implemented an enhanced process for suicide screening, and over 11,003 community members have been trained in suicide and/or substance use prevention. Fifty three percent of projects hosted a successful prevention education community event. Twenty nine percent reported implementation and documentation of a system change. In addition, among projects supported, a total of 76,054 individuals received cultural services, a high percentage of projects have continued to offer integrated traditional healing into care, extended service hours, provision of follow-up care, new counseling and case management services. In summary, the SASP program continues to support tribes, tribal organizations, urban Indian organizations (UIOs), and federal facilities offering care.

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, in the report the number of alcohol related deaths in the community of Gallup, New Mexico was addressed with the report stating, "these deaths underscore the urgent need for substance abuse treatment, residential services and detoxification services" in this community. In response, the IHS used the increased appropriated funds to address the urgent need in the city of Gallup, New Mexico. In addition to Gallup, New Mexico, IHS was aware of the urgent need for alcohol detoxification services in the Great Plains Area after the removal of liquor licenses and alcohol sales in White Clay, Nebraska, leading to the potential for increased mortality if services were unavailable for alcohol detoxification. As a result, funds were also made available to address this urgent need. The funds provided to Gallup, New Mexico and the Great Plains Area (specifically the Oglala Sioux Tribe) to address the need for social detoxification services were made available in FY 2017 through a competitive cooperative agreement. The funding announcement was released in FY 2017 and two projects were selected and funded. The project period is for five years and will run from September 15, 2017, to September 14, 2022. With the additional funding, the Gallup NM site reported detoxification services to 9,482 unique individuals with over 75 percent of those clients including males. In addition to services offered for monitoring, supervising and managing detoxification, this site has increased coordination and transportation with the Emergency Department; and established a contract with the Gallup Police Department to transport patients to the detoxification center. The Great Plains' site has used the funding to increase coordination with behavioral health programs, provide screenings and brief interventions to individuals incarcerated in jails, and serve as an immediate placement for individuals who are in need of treatment services following detoxification. In FY 2020, nearly 100 percent of individuals held in detoxification for more than two weeks were successfully admitted into a higher level of residential treatment care for their SUD.

At the onset of the COVID-19 pandemic, services were temporarily interrupted at the City of Gallup detoxification site and the PARD site in the Great Plains Area. Services were temporarily disrupted due to tribal ordinances enforcing lockdowns and closures of tribal operations. Operations have since resumed and IHS continues to work with both sites to ensure each has adopted guidelines provided by the local and state health departments, and the Centers for Disease Control and Prevention.

Youth Regional Treatment Centers: The IHS YRTCs provide residential substance abuse and mental health treatment services to AI/AN youth. Congress established these YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California

Area. The YRTC in Northern California is expected to be operational in early 2021. The 12 currently funded YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values, and cultural identification. In FY 2020, all federal YRTCs in operation 18 months or longer have achieved and maintained accreditation status.

YRTC Aftercare Pilot Project: Two YRTC facilities, Desert Sage and the Healing Lodge of the 7 Nations are in the last year of an IHS supported aftercare pilot project. YRTCs have an important role in maintaining the health of patients after discharge. This aftercare pilot emphasized developing culture-based treatment that prevents alcohol and substance abuse relapse among youth discharged. While evaluations are in place, current data indicates that these programs have resulted in improved coordination around aftercare and case management, increased training of community supports for the adolescents, improved identification of transitional living, increased awareness of the use of social media, and improved follow-up with data collection after discharge. This pilot program will continue to support the YRTC's ability to support the IHS Strategic Plan *Goal 1 to ensure comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.* Particularly, in the recovery from alcohol and substance use disorders.

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.

Substance use disorders continue to rank high on the concern list of Tribal partners. IHS believes that a shift in emphasis to earlier intervention is required to be successful in reducing the consequences of substance use disorders. IHS proposes focusing on early intervention with adolescents and young adults and preventing further progression by recognizing and responding to the source of the abuse.

IHS continues to support the integration of substance use disorder treatment into primary care and emergency services through its activities to implement the *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.[1] One integration activity is Screening, Brief Intervention, and Referral to Treatment (SBIRT), which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders.

IHS 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 2020, the SBIRT was administered at 12.8 percent for AI/AN ages 9-75, exceeding the target of 12.2 percent screened. IHS promotes the use of this clinical process by training providers in clinical and community settings. IHS currently offers 10 SBIRT on-demand trainings. SBIRT is intended to meet the public health goal of reducing the harms and societal costs associated with risky use by reducing diseases, accidents, and injuries. As an additional resource, IHS developed an Alcohol and Substance Abuse Program webpage: https://www.ihs.gov/asap/providers/sbirt/.

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

The IHS requires all prescribers to conduct a full patient medical history and physical examination including 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 of use of 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/.

Patients treated for substance use disorders often present with a need to address co-occurring mental disorders. In FY 2017, the IHS Division of Behavioral Health awarded 12 new grantees through the Behavioral Health Integration Initiative (BH2I), a nationally-coordinated grant program that provides funding to Tribes, Tribal organizations, UIOs and federal facilities to plan, develop, implement and evaluate behavioral health integration with primary care. In FY 2020, IHS continued funding for 12 IHS, tribal, and UIOs to integrate behavioral health with primary care services in their local health facilities. A primary goal of the BH2I is to formalize integration across the system, develop care teams, strengthen infrastructure, and enhance clinical processes including increased depression screenings in primary care clinics. Additionally, IHS contracted with a technical assistance (TA) provider to guide this pilot project through the implementation of their integrated care efforts with expertise from psychiatrists, primary care physicians, and social workers. Thus far, BH2I projects have reported successes such as new behavioral health integration policies and procedures including same day access to behavioral health providers within primary care and emergency room settings. Sites have also reported increased screening rates for depression, anxiety, trauma and early childhood development disabilities and reduction in wait times to see a mental health counselor and psychiatrist. In response to the COVID-19 pandemic, in FY 2020 IHS provided an additional year for all BH2I grantees. This final year will allow flexibility in the project period to complete proposed activities with a focus on meeting the needs of the community as well as developing sustainability plans for their work. In FY 2021, IHS will award approximately 15 new BH2I grantees, which will be on a five-year funding cycle through FY 2026. Additionally, IHS will contract with a technical assistance provider to support grantees with the implementation of integrated care efforts.

Reducing the Number of Drug Overdose Deaths:

Increasing Access to MAT Services:

In June 2019, IHS released the Special General Memorandum *Assuring Access to MAT* that requires 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. Key components of these approaches include enhanced screening and early identification of Opioid Use Disorders; improved care coordination and patient referral for treatment; and workforce development strategies to increase education and resources surrounding using medications in the support of recovery.

The IHS has expanded access to harm reduction interventions that include increased access to the opioid overdose reversal medication, naloxone. 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* to require IHS Federal pharmacies to provide naloxone to Tribal law enforcement agencies and other trained first responders. A revision to Chapter 35 was released in 2020 to further expand first responder definitions to community members and to reduce administrative reporting requirements related to requests for resupply. The IHS has also created a naloxone toolkit for tribal communities that includes a culturally responsive training video and a digital story from two LEOs involved in a naloxone 'save'. This toolkit also contains a train the trainer curriculum and standardized forms to support first responder initiatives. The IHS has also created sample protocols and pharmacist collaborative practice agreements to expand access to co-prescribed naloxone for patients on long-term opioid therapy or at increased risk for opioid overdose. In November 2019, the IHS developed and released a health education video that shared best and promising practices surrounding naloxone distribution and the way IHS and the Red Lake Nation are responding to the opioid crisis. A companion video was released in August 2020 that shares basic information related to opioids, naloxone, treatment and prevention.

The IHS has further adapted the toolkit and strategy to equip community first responders and paraprofessionals with training on opioid overdose response and naloxone. These expanded collaborations with local law enforcement and community first responders resulted in an initial pilot community-health naloxone train-the-trainer program to include naloxone distribution.

In FY 2018, buprenorphine and suboxone were added to the IHS Core Formulary. Buprenorphine and suboxone are common medications used to treat opioid use disorder. With these added to the Core Formulary, all IHS facilities with pharmacies have these medications readily available for their patients. Data related to buprenorphine and suboxone will be captured in reporting tools that will support regional-level efforts to better monitor MAT and SUD treatment across IHS.

The IHS does face challenges in providing MAT in certain sectors within Indian Country. The rural and frontier nature of where American Indians/Alaska Natives live creates barriers to accessing health facilities. This is especially evident in Alaska where patients often only have access to a community health aide serving within a village-based clinic, 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. In December 2019, the IHS processed the first tribal clinician application to receive this designation.

In August 2019, ninety-six community-health workers completed training as naloxone trainers for their tribal communities in one week.

<u>Increase Mandatory Prescriber Education and Continuing Training on Best Practices and Current Clinical Guidelines:</u>

The IHS implemented the "Chronic Non-Cancer Pain Management Policy" to promote appropriate pain management as a primary prevention tool. In February 2018, IHS released a revised policy 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.

In May 2019, the IHS released its "*Recommendations for Management of Acute Dental Pain*" for prescribing opioids for acute pain secondary to common general dentistry conditions and procedures. These guideline 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.

The IHS has also implemented IHM Chapter 32 "State Prescription Drug Monitoring Programs" that establishes policy requirement for Federal facilities to participate with state-based Prescription Drug Monitoring Programs (PDMP). Controlled substance prescribers working in IHS federal-government-operated facilities must query state PDMP databases prior to prescribing opioids for pain treatment longer than seven days and periodically throughout chronic pain treatment. In FY 2019, IHS developed and released software programming to automate controlled substance dispensing reports to state-based PDMPs to near real-time reporting to improve the fidelity of IHS dispensing data in state PDMP databases. The IHS has been in preliminary planning and design discussions to evaluate feasibility of PDMP interoperability and integration into the IHS Electronic Health Record. These efforts support the IHS Strategic Plan *Goal 3, Objective 3.3 Modernize information technology and information systems to support data driven decisions.*

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* developed in collaboration with the American College of Obstetricians and Gynecologists' (ACOG) Committee on American Indian and Alaska Native Women's Health. 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* that includes clinical recommendations on the prevention and management of neonatal opioid withdrawal syndrome. These recommendations provide standards of care for screening, diagnosing, support, and treatment of pregnant mothers and infants affected by prenatal opioid exposure. In August 2019, the IHS developed and released two additional Clinical Reporting System measures to track implementation of the ACOG recommendations and substance use disorder screening in women of childbearing age.

Proper Pain Management and Opioid Stewardship Training:

The IHS has created and released a comprehensive Opioid Stewardship workbook to assist sites with creating best practices surrounding safe opioid prescribing recommendations and increasing access to integrative pain treatments. The workbook emphasizes utilizing opioid surveillance strategies to evaluate population health outcomes, target opioid interventions, enhance clinical decision support, and create professional practice evaluation strategies. In August 2019, the IHS

developed data definitions to support creation of an opioid prescribing surveillance dashboard that will assist with the analysis of opioid-related data on national and regional levels. The IHS opioid stewardship program evaluation considers metrics that evaluate trends in Morphine Milligram Equivalents versus a restricted focus on total opioid prescription fills, include analysis of risk reduction strategies with co-prescribed naloxone, and monitor patient conversion to chronic opioid therapy. These efforts support the IHS Strategic Plan *Goal 3, Objective 3.3 Modernize information technology and information systems to support data driven decisions.*

The IHS has also recently facilitated dedicated access to tele-consultation services for IHS clinicians to receive on-demand substance use expert recommendations and tailored clinical guidance for IHS healthcare providers of all experience levels. This service is also available to assist IHS health systems with creating clinic policies and procedures to support creation of integrated MAT services in IHS facilities.

In May 2016, the IHS implemented a policy on mandatory opioid training requiring all federally controlled substance prescribers to complete the "IHS Essential Training on Pain and Addiction" with required refresher training every 3 years. This training is now available on demand with continuing education credits. The IHS released its Refresher training course in January 2018, including four sessions of its mandatory five-hour training course for providers on proper opioid prescribing. In FY 2020, 355 participants completed this course. The mandate also includes an additional refresher training after three years. In FY 2020, 289 participants completed the Essential Training on Pain and Addiction Refresher course. This course will be updated in FY 2021.

The IHS has also created a robust workforce development strategy to include didactic training. In September 2019, the IHS launched its Pain Management and Opioid Use Disorder Continuing Medical Education series. The IHS has hosted learning sessions in this series that include buprenorphine prescribing in pregnancy as well as a live instructor-led auricular acupuncture-training program, implementation of MAT programs, management of co-occurring disorders, and initiating Buprenorphine in the acute care setting. Future session include an intensive training program related to the management of substance use disorders for advanced practice pharmacists and additional content surrounding integrated MAT models.

In FY 2020, IHS provided three webinars that addressed pain management and opioids, and opioid misuse with a total of 326 attendees.

- Implementing an Integrated MAT Model - A Review of Resources
- Assessment and Treatment of Pain and Co-Occurring Opioid Use Disorder in Individuals with Serious Mental Illness.
- Treatment of OUD in the ED, Should it be a Choice?

In FY 2020, IHS provided three on-demand trainings on Neonatal Opioid Withdrawal Syndrome (NOWS).

- Prenatal Opioid Exposure: Opioid Effects on the Developing Fetus and Neonatal Opioid Withdrawal Syndrome.
- Prenatal Opioid Exposure: Effects in Early Childhood
- Prenatal Opioid Exposure: Interventions

Enhanced communication during the opioid crisis response is vital to program development, policy implementation, and ongoing evaluation. The IHS created an Opioid Information Sheet

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.

The IHS collaborated in FY 2018 with the CDC to participate in the CDC Opioid Quality Improvement Collaborative to implement five opioid quality improvement measures at four IHS sites. Communication to employees and stakeholders involving best and promising practices and resources addressing pain management and addiction is achieved through our expanded internet presence. The IHS released a combined website for opioids in FY 2018 located at: www.ihs.gov/opioids.

In August 2020, the IHS released new clinical decision support tools for RPMS to assist providers in meeting documentation standards outlined in IHM, Part 3 – Chapter 30. The EHR reminders and dialogue note templates facilitate accurate and timely documentation to support patient care and the pain management policy. The tools also address OIG findings from a recent IHS prescribing review.

Increase Prescription Drug Monitoring Program (PDMP) Interoperability and Usage:

The IHS is working to improve public health data surveillance and reporting and has developed a data reporting system that will provide prescribing and diagnosis data on national and regional levels. This will enable IHS to track emerging trends, evaluate changes in prescribing practices, monitor overdose rates and emergency department utilization, and assess changes with access to MAT. The IHS will evaluate expanded partnerships and data-related resources with other Federal partners and Tribal Epidemiology Centers in FY 2019. These reporting and surveillance tools will strengthen IHS program management and operations by improving communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public Strategic Plan Goal 3, Objective 3.1 *Improve communication within the organization, Tribes, Urban Indian Organizations, and other stakeholders, and with the general public*.

Finally, in 2019 his hosted the National Combined Councils Meeting (NCC), an agency wide meeting which provides opportunities for multidisciplinary collaboration focusing on the clinical and administrative needs of the agency. In addition, this meeting offers an opportunity to provide continuing education trainings for healthcare providers, and previous session topics included: 1) Addressing the Opioid Crisis in Indian Country, 2) Exploring Best Practices in Chronic Pain Management, and 3) Evaluating Options for Creating and Sustaining Integrated Primary Care MAT Models. IHS also provided a 4.25 hour training, titled "Prescriber Data Waiver Training." This training session assisted participants with meeting the SAMHSA and DEA requirements to apply for a DATA waiver to prescribe buprenorphine in the treatment of opioid use disorder. Due to the COVID-19 pandemic, the 2020 NCC was cancelled however IHS will resume NCC meetings and activities in FY 2021.

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. IHS collaborated with the State of North Dakota to achieve 100 percent of IHS sites in the state (both Federal and Tribal) to be registered as DEA collectors. In FY 2019, the IHS expanded patient level disposal through the addition of 29 Federal Pharmacy sites as registered DEA controlled substance collectors. This included funding for supplies and technical assistance with DEA requirements.

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 2022 Request: $ 3.6 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. 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. UIOs that offer inpatient and outpatient substance use disorder treatment have become reliable referral sites for Tribes and Urban Indians. In FY 2022, IHS is proposing $3.6 million for the urban ONDCP budget.

AI/AN people who live in urban centers present a unique morbidity and mortality profile. Urban AI/AN populations suffer disproportionately higher mortality from certain causes in sharp contrast to mainstream society. These unique challenges require a targeted response. Existing UIOs see their efforts in health education, health promotion, and disease prevention as essential to impacting the behavioral contributors to poor health[2]:

- Alcohol-induced death rates are 2.8 times greater for urban AI/AN people than urban all races.
- Chronic liver disease death rates are 2.1 times greater for urban AI/AN people than urban all races.
- Accidents and external causes of death rates are 1.4 times greater for urban AI/AN people than urban all races.

Alcohol and drug-related deaths continue to plague urban AI/AN people. Alcohol-induced mortality rates for urban AI/AN 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 AI/AN people than for urban 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.[3]

Urban AI/AN populations are more likely to engage in health risk behaviors. Urban AI/AN people are more likely to report heavy or binge drinking than all-race populations and urban

[2] 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.
[3] Ibid.

AI/AN people are 1.7 times more likely to smoke cigarettes. Urban AI/AN people more often view themselves in poor or only fair health status, with 22.6 percent reporting fair/poor health as compared to 14.7 percent of all races reporting as fair/poor.

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 AI/AN people with fetal alcohol spectrum disorders. The IHS policy that 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 AI/AN 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 AI/AN people. Urban AI/AN people in need of substance use disorder treatment commonly exhibit co-occurring disorders. UIOs have recognized the need for more mental health and substance use disorder counselors to adequately address the needs presented by AI/AN 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 AI/AN 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. Affecting lifestyle changes among urban AI/AN families requires a culturally sensitive approach. UIOs have operated culturally appropriate initiatives to reduce health risk factors. The continued efforts of UIOs to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population.

The IHS has contracts and grants with 41 UIOs to provide health care and referral services for Urban Indians in 22 states. These IHS contracts and grants with UIOs address the *IHS Strategic Plan Goal 1 by ensuring that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people. Awarding of these contracts and grants to UIOs also addresses HHS Strategic Plan Goal 2, Objective 2.3, to reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support*. UIOs provide high quality, culturally relevant prevention, early intervention, outpatient and residential substance abuse treatment services, and recovery support to address the unmet needs of the Urban Indian communities they serve. Social determinants of health play a key role in health and wellness and UIOs are addressing a range of factors which contribute to improved health outcomes.

According to the most recent urban Indian data, 76,760 AI/AN patients access services through UIO programs. Also, UIOs performed 729,888 visits for AI/AN 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.

In FY 2020, the IHS Office of Urban Indian Health Programs awarded 4-in-1 grants to 33 UIOs. The grantees are awarded for a three-year funding cycle from April 1, 2019 - March 31, 2022. These grants provide funding to UIOs to make health care services more accessible for AI/ANs 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 are required to participate in a national evaluation of the 4-in-1 grant program, which addresses *IHS Strategic Plan Goal 2 to promote excellence and quality through innovation of the Indian health system into an optimally performing organization*. The national evaluation includes 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. *These grants expand safe, high quality healthcare options, and encourage innovation and competition, which meets HHS Strategic Plan Goal 1, Objective 1.2.*

PERFORMANCE

Information regarding the performance of the drug control efforts of IHS are based on agency GPRA/GPRAMA documents and other information that measure the agency's contribution to the *Strategy.*

In FY 2022, the IHS will track the number of unique patients receiving office-based MAT (buprenorphine or naltrexone) within the Indian Healthcare System. The IHS will continue to track the number of naloxone prescriptions as part of efforts to increase access to naloxone.

The table and accompanying text below represent highlights of IHS achievements during FY 2020, the latest year for which data are available. The selected performance measures reported in the table provide targets and results from both Tribally Operated Health Programs and Federally Administered Health Programs.

Indian Health Service		
Selected Measures of Performance	**FY 2020 Target**	**FY 2020 Achieved**
» Universal Alcohol Screening	42.4%	37.1%
» Accreditation rate for Youth Regional Treatment Centers in operation 18 months or more	100%	100%
» Report on number of emergency department patients who receive SUD intervention	40,781	44,451
» Report on number of SUD services in primary care clinics	145,006	137,907

To provide more comprehensive routine screening, IHS retired the alcohol screening measure for female patients and expanded the new alcohol screening measure to include all patients 9 through 75 years of age. The FY 2020 universal alcohol screening target of 42.4 percent was not met with final results achieving 37.1 percent screened.

The accreditation measure for YRTCs reflects an evaluation of the quality of care associated with accreditation status by either The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), state certification, or regional Tribal health authority

certification. For youth with substance use disorders, the YRTCs provide invaluable treatment services. In FY 2020, all YRTCs in operation 18 months or longer achieved accreditation status.

The IHS monitors two program measures on the number of SUD encounters provided in emergency departments and primary care clinics. The final results for the FY 2019 number of SUD encounters provided in emergency department was 44,451 while SUD encounters provided in primary care clinics totaled 137,907. IHS monitors the overall SUD encounters provided in all clinical settings across the health system to aid in promoting integrated substance use disorder services. The final results for FY 2020 SUD intervention services provided across all I/T/U clinics that report in the IHS national data warehouse was 718,873 encounters.

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Supplemental Tables

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INDIAN HEALTH SERVICE
Budget Authority by Object
(Dollars in Thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget	FY 2022 +/- FY 2021
[Object Class]				
Personnel compensation:				
Full-time permanent (11.1)	$438,956	$443,416	$550,852	$107,436
Other than full-time permanent (11.3)	$16,379	$16,551	$19,332	$2,781
Other personnel compensation (11.5)	$83,923	$85,192	$99,505	$14,313
Military personnel (11.7)	$81,588	$82,820	$84,706	$1,886
Special personnel services payments (11.8)	$281	$283	$330	$47
Subtotal personnel compensation	**$621,127**	**$628,262**	**$754,725**	**$126,463**
Civilian benefits (12.1)	$187,859	$189,741	$232,304	$42,563
Military benefits (12.2)	$12,780	$12,973	$13,268	$295
Benefits to former personnel (13.0)	$273	$277	$288	$11
Subtotal Pay Costs,	**$822,039**	**$831,253**	**$1,000,585**	**$169,332**
Travel and transportation of persons (21.0)	$24,968	$28,625	$43,954	$15,329
Transportation of things (22.0)	$6,365	$7,297	$7,428	$131
Rental payments to GSA (23.1)	$14,308	$16,403	$17,104	$701
Rental payments to others (23.2)	$5,567	$6,383	$6,655	$272
Communication, utilities, and misc. charges (23.3)	$19,885	$22,797	$24,287	$1,490
Printing and reproduction (24.0)	$82	$94	$95	$1
Other Contractual Services:				
Advisory and assistance services (25.1)	$2,102	$2,467	$90,182	$87,715
Other services (25.2)	$183,815	$210,735	$330,073	$119,338
Purchase of goods and services from government accounts (25.3)	$92,165	$105,663	$145,475	$39,812
Operation and maintenance of facilities (25.4)	$2,906	$3,332	$4,089	$757
Research and Development Contracts (25.5)	$0	$0	$0	$0
Medical care (25.6)	$221,874	$254,367	$554,714	$300,347
Operation and maintenance of equipment (25.7)	-$4,223	$12,770	$58,400	$45,630
Subsistence and support of persons (25.8)	$37,044	$42,470	$63,601	$21,131
AP Branch Services (25.9)	$108,935	$124,889	$225,732	$100,843
Subtotal Other Contractual Services	**$644,618**	**$756,693**	**$1,472,266**	**$715,573**
Supplies and materials (26.0)	$59,363	$68,055	$100,242	$32,187
Equipment (31.0)	$16,175	$18,544	$126,928	$108,384
Land and Structures (32.0)	$13,744	$15,756	$261,447	$245,691
Investments and Loans (33.0	$0	$0	$0	$0
Grants, subsidies, and contributions (41.0)	$3,805,316	$4,362,598	$5,259,487	$896,889
Insurance payments (42.0)	$332	$380	$396	$16
Interest and dividends (43.0)	$24	$28	$28	$0
Refunds (44.0)	-$7	$0	$0	$0
(91.0)	$326	$373	$377	$4
Subtotal Non-Pay Costs	**$4,611,066**	**$5,304,026**	**$7,320,694**	**$2,016,668**
Total Direct Obligations	**$5,433,105**	**$6,135,279**	**$8,321,279**	**$2,186,000**

Salary and Expenses INDIAN HEALTH SERVICE (Budget Authority in Thousands)			
Object Class	FY 2020 Final Level	FY 2021 Enacted Level	FY 2022 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$438,956	$443,416	$550,852
Other than full-time permanent (11.3)	$16,379	$16,551	$19,332
Other personnel compensation (11.5)	$83,923	$85,192	$99,505
Military personnel (11.7)	$81,588	$82,820	$84,706
Special personnel services payments (11.8)	$281	$283	$330
Subtotal personnel compensation	$621,127	$628,262	$754,725
Civilian benefits (12.1)	$187,859	$189,741	$232,304
Military benefits (12.2)	$12,780	$12,973	$13,628
Benefits to former personnel (13.0)	$273	$277	$288
Subtotal Pay Costs	$822,039	$831,253	$1,000,945
Travel (21.0)	$24,968	$28,625	$43,954
Transportation of things (22.0)	$6,365	$7,297	$7,428
Communication, utilities, and misc. charges (23.3)	$19,885	$22,797	$24,287
Printing and reproduction (24.0)	$82	$94	$95
Other Contractual Services:			
Advisory and assistance services (25.1)	$2,102	$2,467	$90,182
Other services (25.2)	$183,815	$210,734	$330,073
Purchase of goods and services from government accounts (25.3)	$92,165	$105,663	$145,475
Operation and maintenance of facilities (25.4)	$2,906	$3,332	$4,089
Research and Development Contracts (25.5)	$0	$0	$0
Medical care (25.6)	$221,874	$254,367	$554,714
Operation and maintenance of equipment (25.7)	-$4,223	$12,771	$58,400
Subsistence and support of persons (25.8)	$37,044	$42,470	$63,601
Subtotal Other Contractual Services	$535,683	$631,804	$1,246,534
Supplies and materials (26.0)	$59,361	$68,055	$100,242
Subtotal Non-Pay Costs	$646,344	$758,672	$1,422,540
Total Salary and Expenses			
Rental Payments to GSA(23.1)	$14,308	$16,403	$17,104
Rental Payments to Others(23.2)	$5,567	$6,383	$6,655
Grant Total, Salaries & Expenses and Rent	$1,488,258	$1,612,711	$2,447,244
Direct FTE 1/	8,298	8,692	9,515

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 2020 Final	FY 2021 Estimate	FY 2022 Estimate
Headquarters			
Sub-Total, Headquarters	686	716	768
Area Offices			
Alaska Area Office	284	257	263
Albuquerque Area Office	1,029	1,050	1,111
Bemidji Area Office	555	572	578
Billings Area Office	986	1,010	1,018
California Area Office	151	164	170
Great Plains Area Office	2,109	2,184	2,192
Nashville Area Office	184	195	202
Navajo Area Office	4,114	4,230	4,470
Oklahoma City Area Office	1,747	1,802	1,809
Phoenix Area Office	2,594	2,638	3,047
Portland Area Office	507	546	554
Tucson Area Office	245	221	226
Sub-Total, Area Offices	14,505	14,869	15,640
TOTAL FTES	15,191	15,585	16,408

INDIAN HEALTH SERVICE
DETAIL OF POSITIONS

(Dollars in Thousands)

	FY 2020 Final	FY 2021 Enacted	FY 2022 President's Budget
Total - ES	24	24	24
Total - ES Salaries	$4,453	$4,569	$4,688
GS/GM-15	451	468	497
GS/GM-14	414	419	445
GS/GM-13	523	581	617
GS-12	1,272	1,349	1,432
GS-11	1,437	1,426	1,514
GS-10	598	573	608
GS-9	1,105	1,081	1,147
GS-8	426	443	470
GS-7	1,294	1,293	1,372
GS-6	1,555	1,561	1,657
GS-5	1,905	1,857	1,971
GS-4	893	880	934
GS-3	147	130	138
GS-2	22	24	25
GS-1	0	0	0
Subtotal	12,042	12,085	12,827
Total - GS Salaries	$672,339	$679,471	$834,801
CO-08	0	3	3
CO-07	9	7	7
CO-06	284	280	295
CO-05	502	486	513
CO-04	524	534	563
CO-03	282	270	285
CO-02	12	8	8
CO-01	16	8	8
Subtotal	1,629	1,596	1,682
Total - CO Salaries	$94,368	$95,793	$97,974
Ungraded	1,275	1,288	1,344
Total - Ungraded Salaries	$50,606	$51,143	$62,834
Average ES level	ES	ES	ES
Average ES salary	$178	$182	$187
Average GS grade	8	9	9
Average GS salary	$66	$67	$68

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Significant Items in Committee Reports

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INDIAN HEALTH SERVICE
FY 2022 CONGRESSIONAL JUSTIFICATION
House Report 116-448
Significant Items

Advance Appropriations. - In the Further Consolidated Appropriations Act, 2020 (P.L. 116–94), the Committee directed IHS to examine its existing processes and determine what changes are needed to develop and manage an advance appropriation and report to the Committee within 180 days of enactment of that Act on necessary processes, and whether additional Congressional authority is required, to develop those processes. The Committee continues to direct IHS to examine its processes, determine needed changes and report to the Committee within 180 days of enactment of this Act. (p. 125)

Action taken or to be taken:

For the first time, the FY 2022 President's Budget proposes advance appropriations for the IHS. This proposal is consistent with the feedback we have heard from Tribal and Urban Indian Leaders over the last several years. It is also consistent with the findings of GAO Report GAO-18-652, Indian Health Service: Considerations Related to Providing Advance Appropriation Authority.

Advance appropriations will ensure a predictable funding source for the Indian health system, avoiding the negative consequences of funding delays under continuing resolutions, and lapses in funding during government shutdowns. With advance appropriations, the IHS could disburse funds more quickly, which could enable IHS, tribal, and urban Indian health program managers to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for American Indians and Alaska Natives.

This planning stability would reduce unnecessary contract and administrative costs. Funding continuity could also alleviate concerns from potential recruits, especially health care providers, about the stability of their employment. Events like the lapse in appropriations experienced in FY 2019 year undermine IHS's efforts to recruit and retain a quality workforce and provide a continuum of care that our patients deserve.

The IHS has examined the issue, and does not believe that any additional authority from Congress is necessary to develop and manage an advance appropriation, beyond the advance appropriation itself. The IHS financial management system and processes are fully equipped to manage an advance appropriation. IHS has also engaged with the Veteran's Health Administration to understand how the agency manages its advanced appropriation, and will leverage best practices learned from those discussions. The IHS is committed to working together with Congress to answer any questions, clarify any points, and provide any other assistance to support enactment of this critical proposal.

Current Services. - In fiscal year 2020, the Committee directed IHS to submit the actual estimated costs for current services based on the prior enacted level to the Committee each year at the same time IHS submits its annual budget justification. IHS did not provide this information for fiscal year 2021. The Committee again directs IHS to provide this information at the same time the annual budget justification is submitted. The recommendation includes the Federal portion of current services (p. 123).

Action taken or to be taken:

The FY 2022 Congressional funding request for Current Services is $207,070,000, which would fully fund pay cost, inflation, and population growth needs for IHS, Tribal, and urban Indian health programs in FY 2022. Please see the detailed Current Services request below:

Sub Activity	FY 2022/2023 Current Services Estimate			
	Pay Total	Inflation Total	Population Growth 1.8%	Current Services Total
SERVICES				
Hospitals & Health Clinics	65,609	7,607	41,843	115,059
Electronic Health Record	0	0	0	0
Dental Services	6,659	626	3,791	11,076
Mental Health	2,631	349	1,961	4,941
Alcohol & Substance Abuse	4,075	790	4,421	9,286
Purchased/Referred Care	291	8,577	17,367	26,235
Indian Health Care Improvement Fund	913	312	1,301	2,526
Total, Clinical Services	80,178	18,261	70,684	169,123
Public Health Nursing	2,703	290	1,656	4,649
Health Education	589	63	370	1,022
Comm. Health Reps	1,281	252	1,132	2,665
Immunization AK	0	9	38	47
Total, Preventive Health	4,573	614	3,196	8,383
Urban Health	1,561	403	1,038	3,002
Indian Health Professions	6	523	0	529
Tribal Management	0	20	0	20
Direct Operations	2,603	156	0	2,759
Self-Governance	162	22	0	184
Total, Other Services	4,332	1,124	1,038	6,494
Total, Services	89,083	19,999	74,918	184,000
FACILITIES				
Maintenance & Improvement	0	931	3,041	3,972
Sanitation Facilities Constr.	2	1,382	3,484	4,868
Health Care Fac. Constr.	0	603	0	603
Facil. & Envir. Hlth Supp.	7,131	1,141	4,716	12,988
Equipment	0	134	506	640
Total, Facilities	7,133	4,191	11,747	23,071
TOTAL, IHS	**96,216**	**24,190**	**86,665**	**207,071**

Urban Indian Health. The Committee expects the Service to continue including current services estimates for Urban Indian Health in annual budget requests. (p.131)

Action taken or to be taken:

The FY 2022 Congressional funding request for Current Services is $207,070,000, which includes $3 million for to fully fund pay costs, inflation, and population growth for Urban Indian Organizations.

Accreditation Emergencies. - The Committee has heard complaints that not all funds appropriated for accreditation purposes are being distributed. Therefore, the Committee expects IHS to submit, within 90 days of enactment of this Act, a full accounting of the funds provided for accreditation emergencies in fiscal years 2018, 2019, 2020, and 2021, including the amount and purpose of funds allocated to each facility.

The Committee is concerned about financial losses from loss of CMS accreditation or of the requirement to divert patients at Service-operated facilities. The Committee considers the loss or imminent loss of accreditation to be an emergency. Funds allocated to a facility may be made available to Tribes newly assuming operation of such facilities pursuant to the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA) and shall be used by such Tribes to cover replacement of third-party revenues lost as a result of decertification, replacement of third-party carryover funds expended to respond to decertification, and reasonable costs of achieving recertification, including recruitment costs necessary to stabilize staffing.

Additionally, the Committee continues to urge IHS to develop new strategies to improve how IHS programs, including those operated by Tribes under ISDEAA, can be supported to avoid these challenges and to refocus on both the quality of health care delivery and the improvement in health outcomes for, and health status of, Indian health program beneficiaries. This requires full Tribal consultation and the participation of the Department of Health and Human Services, Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services, and State Medicaid and State Children's Health Insurance programs. (p. 127)

Action taken or to be taken:

Since our last response to this report language in the FY 2021 Congressional Justification, the IHS has taken a number of steps to develop and implement new strategies to avoid future accreditation challenges.

FY 2021 Activities to Date

- **Strategic Plan Implementation**. The IHS Strategic Plan, which includes the elements of the IHS Quality Framework, is now formally assessed for implementation. The IHS Strategic Plan has focused IHS programs and activities on improving quality, safety, and sustained compliance across the IHS healthcare system.

FY 2020 Activities

- **Current Accreditation Status**. The IHS has supported facilities in all 12 IHS Areas to achieve and maintain The Joint Commission (TJC) and Accreditation Association for Ambulatory Health Centers (AAAHC) accreditation standards and Centers for Medicare and Medicaid (CMS) regulations for IHS Hospitals, Health Centers, Behavioral Health facilities, and Critical Assess Hospitals (CAH).

    - The IHS has also directed that all ambulatory care facilities attain Patient Centered Medical Home (PCMH) designation by the end of calendar year 2021.

- As of September, 2020 100 percent of all IHS hospitals and CAHs have achieved and maintained CMS conditions of participation, 21 of 24 hospitals and CAHs have TJC accreditation, and 12 of 24 hospitals and CAHs have PCMH designation, and 90 percent of the IHS Health Centers and 50 percent of IHS hospitals with ambulatory care services have attained PCMH designation

- **Credentialing and Privileging**. The IHS implemented a credentialing and privileging software in all IHS healthcare facilities and are currently optimizing the system. The credentialing process evaluates the qualifications and practice history of a provider such as education, training, residency, and licensing. Privileging authorizes a healthcare practitioner to practice within a specified scope of patient care services.

- **IHS Safety Tracking & Response**. The IHS transitioned to the IHS Safety Tracking & Response (I-STAR), a system for reporting adverse events, which replaces the legacy WebCident platform. The legacy WebCident system was originally developed in 2002, and was intended for only tracking worker injury reporting. After a phased rollout of I-STAR, including a pilot session, the system has now successfully launched across the Agency, offering improved reporting of patient safety data and increased analytic capability.

- **IHS Infection Prevention and Control**. The IHS Infection Prevention and Control program developed resources for CEO oversight of infection control programs. As part of this effort, the program provided presentations on common infection control accreditation findings. The program also worked with the I-STAR team to incorporate infection control breaches and adverse incidents within the new reporting system.

    - The Infection Prevention and Control coordinator facilitated American Hospital Association Certified Healthcare Environmental Services (EVS) Training which promotes standardization of evidence based infection control best management practices throughout the IHS.

    - The IHS also collaborated with CDC to provide infection control training to IHS areas to help meet industry standards for infection control, including sterilization and decontamination of surgical instruments used in patient care within hospitals, ambulatory care and dental facilities.

- **Wait Time Standards**. The IHS continues to monitor wait time standards for both the Emergency Department (ED) and Primary Care Visits. The ED wait time consists of two measures that align with industry standards:

    - 1) Median Time from ED Arrival Time to ED Departure Time for discharged ED patients of 120 minutes or less; and

    - 2) "Left Without Being Seen" rate of two percent or less.

  The IHS has seen improvements in ED wait times since the measure went live. Improving patient wait times ensures that timely primary care is available and accessible to IHS patients. These steps are in direct response to the GAO recommendation to improve oversight of patient wait times, which is closed as of March 2020.

- **Quality Assurance Risk Management Committee**. The IHS established the Quality Assurance Risk Management Committee (QARMC) to provide 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. The QARMC also performs 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 IHS is preparing the requested report on the uses of the Accreditation Emergency Funds and expects to transmit the report to Congress in the coming months.

Staffing for New Facilities. In fiscal year 2020, Congress indicated IHS is expected to detail the transfer of Staffing for New Facilities funding into the base amount for each facility in its annual budget justification. IHS did not include this for fiscal year 2021. Congress again directs IHS to include this information in future budget justifications. (p. 125)

Action taken or to be taken:

To better display the base funding amounts for staffing for new facilities, the below table includes an additional Funding History display that shows the total funds provided for each facility, by year. Once a project reaches beneficial occupancy status and receives its staffing package, those staffing funds become part of that facility's recurring base.

INDIAN HEALTH SERVICE

STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES

FY 2022 Budget -- Estimates

(Dollars in Thousands)

	Bethel, AK		Naytahwaush, MN		Scottsdale, AZ		Phoenix, AZ		El Paso, TX		Dilkon, AZ		Omak, WA		New Town, ND		Seward, AK				
	Yukon-Kuskokwim Primary Care Center (JV)		Naytahwaush Health Center (JV)		NEACC (Salt River) Health Center		Phoenix Indian Medical Center Central		Ysleta Del Sur Health Center (JV)		Alternative Rural Health Center		Omak Clinic (JV)		Elbowoods Memorial Health Center (JV) [2]		North Star Health Clinic (JV) [2]				
Opening Date	April 2021		September 2022		December 2021		December 2021		December 2021		December 2021		December 2021		July 2022		April 2022		**TOTAL**		
Sub Sub Activity	Pos	Amount	Pos	Amount	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount	Pos	Amount	Pos	Amount	Pos	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	71	$13,021	6	$827	265	$33,234	30	$2,254	38	$4,455	183	$24,363	67	$9,167	8	$875	20	$3,500	516	172	$91,696
Dental Health	12	$1,676	1	$128	44	$6,618	0	$0	4	$475	19	$2,666	0	$0	0	$0	0	$0	67	13	$11,563
Mental Health	8	$1,156	0	$46	18	$2,120	0	$0	3	$288	8	$964	0	$0	0	$0	0	$0	29	8	$4,574
Alcohol & Substance Abuse	2	$299	0	$23	8	$1,050	0	$0	1	$113	3	$359	0	$0	0	$0	0	$0	12	2	$1,844
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Clinical Services	93	$16,152	7	$1,024	335	$43,022	30	$2,254	46	$5,331	213	$28,352	67	$9,167	8	$875	20	$3,500	624	195	$109,677
Public Health Nursing	3	$658	1	$77	21	$3,288	0	$0	3	$503	5	$782	0	$0	0	$0	0	$0	29	4	$5,308
Health Education	1	$108	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	1	$108
Community Health Representatives	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Preventive Health	4	$766	1	$77	21	$3,288	0	$0	3	$503	5	$782	0	$0	0	$0	0	$0	29	5	$5,416
Total, Services	97	$16,918	8	$1,101	356	$46,310	30	$2,254	49	$5,834	218	$29,134	67	$9,167	8	$875	20	$3,500	653	200	$115,093
Facilities Support	7	$1,815	1	$84	12	$3,649	0	$0	3	$563	10	$2,619	0	$0	0	$0	0	$0	25	8	$8,730
Environmental Health Support	2	$354	0	$11	2	$187	0	$0	1	$126	4	$576	0	$0	0	$0	0	$0	7	2	$1,254
Total, FEHS	9	$2,169	1	$95	14	$3,836	0	$0	4	$689	14	$3,195	0	$0	0	$0	0	$0	32	10	$9,984
Total, Facilities	9	$2,169	1	$95	14	$3,836	0	$0	4	$689	14	$3,195	0	$0	0	$0	0	$0	32	10	$9,984
Grand Total[1]	**106**	**$19,087**	**9**	**$1,196**	**370**	**$50,146**	**30**	**$2,254**	**53**	**$6,523**	**232**	**$32,329**	**67**	**$9,167**	**8**	**$875**	**20**	**$3,500**	**685**	**210**	**$125,077**

[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.

NEACC = Northeast Ambulatory Care Center

Funding History

FY 2019	$57,270	$0	$0	$0	$0	$0	$0	$0	$0	$57,270
FY 2020	$0	$0	$0	$0	$3,287	$0	$0	$0	$0	$3,287
FY 2021	$19,094	$0	$0	$0	-$3,287	$0	$0	$0	$0	$15,807
FY 2022 President's Budget	$19,087	$1,196	$50,146	$2,254	$6,523	$32,329	$9,167	$875	$3,500	$125,077
FY 2023 Advance Appropriation	$0	$13,159	$10,030	$451	$1,304	$6,465	$1,833	$2,625	$3,500	$39,367

Electronic Dental Record. The Committee is concerned that the entire $2,000,000 provided in fiscal year 2020 was not directed towards EDR at additional dental centers. Therefore, the Committee directs IHS to submit an accounting of fiscal year 2020 funds and expects IHS to use the fiscal year 2021 funds only for EDR. In addition, IHS is directed to expand its efforts in planning and developing greater data and information exchange between the IHS EHR system and the EDR system. (p. 129)

Action taken or to be taken:

The +$2 million for the Electronic Dental Record appropriated in the Consolidated Appropriations Act of 2020, and the Consolidated Appropriations Act of 2021 were used only for the Electronic Dental Record and were not distributed as tribal shares.

FY 2020 funds supported:

- New Electronic Dental Record Implementation at 9 Sites ($906k)
- Electronic Health Record Program Enhancements, including key consent forms, quality review, and other reports ($615k),
- Electronic Dental Record Upgrade Support for 64 sites ($400k), and
- Other activities including developing new Electronic Dental Record technology and training ($179k).

The FY 2020 activities include some base resources, in addition to the +$2 million increase.

FY 2021 funds are supporting:

- New Electronic Dental Record Implementation at 9-11 Sites ($1.2m)
- Electronic Health Record Program Enhancements, including charting, note taking, and quality review enhancements ($350k),
- Electronic Dental Record Upgrade Support for 108 sites ($750k), and
- Other activities including developing new Electronic Dental Record technology and training ($200k).

These amounts are estimates and may change.

Indian Health Care Improvement Act. It has been over nine years since the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), yet many of the provisions in the law remain unfunded. Tribes have specifically requested that priority areas for funding focus on diabetes treatment and prevention, behavioral health, and health professions. The Committee requests that the Service provide, no later than 90 days after enactment of this Act, a detailed plan with specific dollars identified to fully fund and implement the IHCIA. (p. 132)

Action taken or to be taken:

The Indian Health Care Improvement Act (IHCIA) is the cornerstone legal authority for the provision of health care to American Indian and Alaska Natives. The authorization was made permanent as part of the Patient Protection and Affordable Care Act (P.L. 111-148) on March 23, 2010.

The IHCIA includes a number of authorizations, and a list of those sections is included in Appendix A. Estimating the cost of fully funding those provisions would be a significant endeavor, requiring

significant tribal consultation and urban confer. It would also be a resource intensive process that would likely require additional appropriations to conduct appropriately.

However, the IHS has several existing methodologies of estimating funding need that can be used as a proxy to estimate the funding needed for the various authorized sections of the IHCIA. Those measures include:

- Indian Health Care Improvement Fund Workgroup Interim Report. The 2018 Indian Health Care Improvement Fund Formula identified a total funding need of over $16 billion for health care and related services to American Indians and Alaska Natives. This estimate does not take into account facilities funding needs, or funding needs for major projects, like Electronic Health Record modernization.

- Indian Health Service and Tribal Health Care Facilities' Needs Assessment. Every five years, the IHS transmits the *Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*. This report describes the comprehensive, national, ranked list of all health care facilities needs for the IHS, Indian tribes, and tribal organizations. The most recent version of this plan was completed in FY 2016, and identifies a $14.5 billion funding need for health care facilities in Indian Country.

    - This estimate includes the $2.1 billion needed to complete the 1993 Health Care Facilities Construction Priority List.
    - It also includes the top 5 Tribally-prioritized facility types newly authorized in the IHCIA, listed below. These five facility types total $4.3 billion of the $14.5 billion total.
        - Inpatient mental health/behavioral health and alcohol substance abuse program facilities,
        - Long-term care facilities – Clinical,
        - Long-term care facilities – Non-clinical,
        - Specialty Medical Services facilities, and
        - Dialysis facilities.

- Annual Report on Sanitation Deficiency Levels for Indian Homes and Communities. Each year, the IHS transmits the *Annual Report on Sanitation Deficiency Levels for Indian Homes and Communities to Congress*. The information in this report to Congress is used by the Indian Health Service (IHS) to establish budgetary funding requests and to allocate funding resources received. Additionally, the United States (U.S.) Environmental Protection Agency (EPA), the U.S. Department of Agriculture Rural Development, and the U.S. Department of the Interior's Bureau of Reclamation utilize the information contained in this report to aid in the implementation of their programs that support tribal water, sewer, and solid waste infrastructure. The current Feasible Project Cost Estimate from the IHS Sanitation Deficiency System totals nearly $1 billion, and the total cost of all projects in the Sanitation Deficiency System is over $2.5 billion.

- Backlog of Essential Maintenance and Repair (BEMAR). The IHS maintains and regularly updates the BEMAR for IHS and Tribal health programs. The total BEMAR is $945 million.

Payment for Tribal Leases. The Committee recommends an indefinite appropriation estimated to be $101,000,000 for Payment for Tribal Leases incurred by the agency as required by law. The bill includes language making such sums as are necessary to meet the Federal government's full legal obligation and

prohibits the transfer of funds to any other account for any other purpose. The Committee expects IHS to consult with Indian tribes on the implementation of this new budget line.

Action taken or to be taken:

See response under Payment for Tribal Leases in Joint Explanatory Statement Significant Items section.

Health Care Facilities Construction. IHS did not provide an accurate 5-year spend plan to the Committee in a timely manner. Going forward the Committee expects IHS to submit an accurate, updated 5-year spend plan at the same time the annual budget justification is submitted to Congress. (p. 133-134)

Action taken or to be taken:

An accurate 5-year Facilities Plan that reflects the FY 2022 President's Budget funding levels and policies is included in the OPDIV-Specific chapter of the FY 2022 Congressional Justification.

Green Infrastructure. The Committee directs IHS to submit a report to the Committee within 90 days of enactment of this Act explaining how it proposes to use the funds provided for green infrastructure and renewable energy.

Action taken or to be taken:

The IHS will support the following green infrastructure activities with the $5 million provided in the Consolidated Appropriations Act, 2021:

- Southcentral Foundation LED Conversion for Building 119,
- Southcentral Foundation LED Conversation for Building 122,
- Village Clinic Energy Retrofits,
- Prairie Band Potawatomi Nation Solar and Water Project,
- Pascua Yaqui Tribe Lighting, Solar Water Heater, and Solar Energy Project,
- Packer Energy Renovation,
- Pechanga Indian Health Clinic Solar Energy Project,
- MCAT Health Board Carport Solar Energy Project,
- Cass Lake Geothermal Energy Project,
- White Earth Geothermal Energy,
- Torres Martinez Clinic Solar Energy,
- Sacramento Native American Health Clinic Solar and Recharging Project, and
- Cass Lake Geothermal Energy Project.

Electronic Health Record. - The Committees recognize the need for a new electronic health record system to improve the overall interoperability, efficiency, and security of the Service's information technology system. The Committees also note that the Service has not completed directives on this topic included in previous fiscal years and solicited in hearings. The Committees direct the Service to report back within 120 days of enactment of this Act with a list of Tribes that currently maintain their own non-RPMS electronic health record systems along with cost estimates required for those Tribes to implement, maintain, and make any necessary upgrades to these systems. Further directions and limitations on expenditures are provided in the bill. The Committees understand that many Tribes recently upgraded their systems to be compatible with the new Veterans Affairs' system, and that these systems must be compatible with any new IHS system to the maximum extent practicable. It is the Committees' expectation that the Service will be able to use the compiled information gathered during this recent effort with Veterans Affairs to inform both the Service and the Committees on which Tribes use their own system and the estimated costs. (p. 78-79)

Action taken or to be taken:

As part of its Health Information Technology Modernization initiative the IHS has designed a brief data call requesting information from Tribes that currently maintain their own non-RPMS electronic health record systems, as directed by the Joint Explanatory Statement (P.L. 116-260). The IHS is currently working through Departmental policies for data collection, and expects to distribute the data call shortly.

Consistent with the IHS's current authorities, the IHS cannot require Tribal health programs to respond to the data call. However, the Agency will request that Tribal health programs voluntarily complete it to the best of their ability.

The IHS will compile information received from Tribal health programs, and provide that information in a Report to Congress.

Payments for Tribal Leases. The bill includes language establishing an indefinite appropriation for payment of Tribal leases under section 105(1) of the Indian Self-Determination and Education Assistance Act, which are estimated to be $101,000,000 in fiscal year 2021. The new account provides additional budget authority to fully fund such costs without the need for reprogramming, if actual costs exceed the current estimate. IHS is reminded of the directive to continue to seek a longer-term solution, as contained in the explanatory statement accompanying Public Law 116-94. Further direction is provided in the bill under Title IV of this division. (p. 80)

Action taken or to be taken:

The FY 2022 President's Budget proposes to shift funding for Tribal Lease Payment and Contract Support Costs to an annual mandatory indefinite appropriation beginning in FY 2023.

- Section 105(*l*) Lease Agreements. In March 2016, the *Maniilaq Association v. Burwell* decision established a new funding entitlement for Tribal contractors and compactors as authorized by section 105(*l*) of the ISDEAA. The court ruled that the Secretary must compensate reasonable

costs to each Tribe or Tribal organization who enters into a section 105(*l*) lease agreement. The court also 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 health programs.

  - In FY 2021, Congress enacted an indefinite discretionary appropriation to fully fund these costs. An indefinite discretionary appropriation allows IHS to fund section 105(*l*) lease agreements at the actual total funding need for the fiscal year, aligning the budget to the court decisions in *Maniilaq Association v. Burwell*. This funding mechanism avoids the need to redirect funding that IHS would otherwise use to provide direct services to Tribes.

  - These costs are more appropriately funded from mandatory appropriations, consistent with other indefinite authorities.

- Contract Support Costs. In 2012, the Supreme Court of the United States established a new funding entitlement for Tribal contractors and compactors when they ruled in *Salazar v. Ramah Navajo Chapter* that the Federal government is responsible for fully reimbursing actual contract support costs, regardless of the previous appropriations limit for this funding. In FY 2016, Congress provided an indefinite discretionary appropriation for contract support costs in the annual appropriations bill.

  - An indefinite discretionary appropriation allows IHS to fund contract support costs at the actual total funding need for the fiscal year, aligning the budget to the Supreme Court's decision in *Salazar v. Ramah Navajo Chapter*. This funding mechanism avoids the need to redirect funding that IHS would otherwise use to provide direct services to Tribes.

  - These costs are more appropriately funded from mandatory appropriations, consistent with other indefinite authorities.

Payments for Tribal Leases. The agreement incorporates the fiscal year 2021 budget proposal to create separate appropriations accounts for 105(1) Tribal payments along with a general provision directing the Bureau of Indian Affairs and the Indian Health Service to develop guidelines regarding lease costs. The Committees strongly encourage both Departments to engage in meaningful dialogue with one another and Tribes to coalesce around a process to develop policy guidance. (p. 6)

The Committees also note that payments for 105(1) leases directly resulting from decisions in the case of Maniilaq Ass'n v. Burwell in both 2014 (72 F. Supp. 3d 227 (D.D.C. 2014)) and 2016 (70 F. Supp. 3d 243 (D.D.C. 2016)) appear to create an entitlement to compensation for 105(1) leases that is typically not funded through discretionary appropriations, and the Committees encourage discussion regarding the funding classification to continue.

The Committees are aware of recent litigation in Federal courts regarding what constitutes reasonable lease costs under the 105(1) program. As part of the consultation required by language in Title IV of this Act, the Indian Health Service and the Department of the Interior are expected to consult with Tribes and Tribal organizations regarding agency regulations and policies that determine the amount of space and other standards necessary to carry out federal programs under a section 105(1) lease, and to ensure that such regulations and policies are consistent, transparent and clearly communicated to affected Tribes. The Service and the Department are expected to periodically update the Committees on the status of the consultation. (p. 6)

Action taken or to be taken:

The IHS is working to comply with the Tribal Lease Payments bill and report language, which is also consistent with feedback we have received from Tribal Leaders. We have had an initial discussion with the Bureau of Indian Affairs to understand their thinking on how to proceed. We plan to finalize a timeline and approach for tribal consultation in the coming weeks, and will keep the Committees apprised on progress.

Senate Report 116-123 Requirements. IHS is expected to comply with the instructions and requirements at the beginning of this division and in House Report 116-448, unless otherwise specified below. Language contained in Senate Report 116-123 regarding the Alaska Comprehensive Forensic Training Academy, first aid kit enhancements, prescription drug monitoring, and teledermatology is restated.

- **First Aid Kit Enhancements**.—The Committee is aware that first aid products endorsed by the Department of Defense's Committee on Tactical Combat Casualty Care [CoTCCC] help to reduce death or trauma as a result of bleeding. The Committee believe these products could help the Service save lives, especially in rural areas where it might take significant time to transport a patient to a hospital and/or healthcare facility for appropriate treatment. Accordingly, the Committee encourages the Service to analyze incorporating CoTCCC's hemostatic dressing of choice in healthcare facilities and vehicles and provide a report to the Committee within 90 days of enactment of this act.

  Action taken or to be taken:

  The use of hemostatic dressings is an element of the standard of care in the initial management of trauma patients and should be included, along with basic education around the use of such materials, as standard equipment for rural EMS and ED inventories. IHS will provide a recommendation to IHS, tribal, and Urban facilities for EMS and ED to consider adding these materials for EMS and ED use.

- **Prescription Drug Monitoring**.—The Committee is concerned that IHS and Tribally operated health facilities are not participating in State Prescription Drug Monitoring Programs and emergency department information exchanges. The Committee strongly encourages these facilities to participate in these programs. Accordingly, within 90 days of enactment of this act, the Service shall provide the Committee with a report outlining by State such facilities that are participating and those that are not and any issues preventing facilities from uploading data to these programs or exchanges.

  Action taken or to be taken:

  Although there is no federal law requiring IHS to report to state PDMPs, in June of 2016 IHS implemented Indian Health Manual Part 3 Chapter 32 "State Prescription Drug Monitoring Program", which requires all IHS federal pharmacies to report controlled prescriptions to their respective state PDMPs.

  Currently all IHS Federal Facilities, with pharmacies, report to the state PDMP, in the state where they are located. In addition, in May 2019, IHS released PDMP reporting software that reports to state PDMPs automatically, when a prescription is filled, in near real time.

  IHS does not track the participation of Tribally-operated health facilities with State PDMPs.

  A list of all IHS facilities with pharmacies, and the State PDMPs they report to is included below.

IHS FACILITIES REPORTING TO
STATE PRESCRIPTION DRUG MONITORING PROGRAMS
(Represents 100% of IHS Facilities with Pharmacies)

FACILITY	STATE	IHS AREA
Four Corners Regional Health Center	Arizona	Navajo
Chinle PHS Hospital/Ambulatory	Arizona	Navajo
Cibecue Health Station	Arizona	Phoenix
Hopi Health Care Center	Arizona	Phoenix
Inscription House Clinic	Arizona	Navajo
Kayenta Health Center	Arizona	Navajo
Parker PHS Hospital/Ambulatory	Arizona	Phoenix
Peach Springs Health Center	Arizona	Phoenix
Phoenix Indian Medical Center	Arizona	Phoenix
Pinon Health Center	Arizona	Navajo
Supai Canyon Health Station	Arizona	Phoenix
Tsaile Health Center	Arizona	Navajo
Whiteriver PHS Hospital/Ambulatory	Arizona	Phoenix
Fort Yuma Health Center	California	Phoenix
Ute Mountain Health Center	Colorado	Albuquerque
Ft Hall Indian Health Center	Idaho	Portland
Haskell Indian Health Center	Kansas	Oklahoma
Cass Lake Hospital	Minnesota	Bemidji
Naytahwaush Field Clinic	Minnesota	Bemidji
Pine Point Clinic	Minnesota	Bemidji
Red Lake Hospital	Minnesota	Bemidji
White Earth Health Center	Minnesota	Bemidji
Blackfeet Community Hospital	Montana	Billings
Chief Redstone Health Clinic	Montana	Billings
Crow/Northern Cheyenne Hospital	Montana	Billings
Eagle Child Health Station Clinic (Hays)	Montana	Billings
Fort Belknap PHS Hospital	Montana	Billings
Heart Butte Clinic	Montana	Billings
Lame Deer Health Center	Montana	Billings
Lodge Grass Clinic	Montana	Billings
Pryor Clinic	Montana	Billings
Verne E. Gibbs Health Center	Montana	Billings
Fort McDermitt Health Station	Nevada	Phoenix
Southern Bands Health Clinic	Nevada	Phoenix
Acoma-Canoncito-Laguna (ACL) Hospital	New Mexico	Albuquerque

CONTINUED: IHS FACILITIES REPORTING TO
STATE PRESCRIPTION DRUG MONITORING PROGRAMS
(Represents 100% of IHS-Operated Pharmacies)

FACILITY	STATE	IHS AREA
Albuquerque Indian Health Center	New Mexico	Albuquerque
Cochiti Health Station	New Mexico	Albuquerque
Crownpoint Health Care Facility Pharmacy	New Mexico	Navajo
Dzilth-NA-O-Dith-Hle Health Center	New Mexico	Navajo
Gallup Indian Medical Center	New Mexico	Navajo
Jicarilla Apache Health Care Facility (Dulce)	New Mexico	Albuquerque
Mescalero Hospital/Ambulatory	New Mexico	Albuquerque
Northern Navajo Medical Center	New Mexico	Navajo
Santa Ana Health Station	New Mexico	Albuquerque
Santa Clara Health Center	New Mexico	Albuquerque
Santa Fe Hospital/Ambulatory	New Mexico	Albuquerque
Taos Picuris Health Center	New Mexico	Albuquerque
Thoreau PHS Health Center	New Mexico	Navajo
Tohatchi Health Center	New Mexico	Navajo
Zia Pueblo Health Station	New Mexico	Albuquerque
Zuni Comprehensive Community Health Center	New Mexico	Albuquerque
Quentin N. Burdick Memorial Health Care Facility	North Dakota	Great Plains
Fort Yates Hospital	North Dakota	Great Plains
Lawton Indian Hospital	Oklahoma	Oklahoma
Anadarko Indian Health Center	Oklahoma	Oklahoma
Carnegie Indian Health Center	Oklahoma	Oklahoma
Claremore Indian Hospital	Oklahoma	Oklahoma
Clinton Indian Health Center	Oklahoma	Oklahoma
El Reno Indian Health Center	Oklahoma	Oklahoma
Pawnee Indian Health Center	Oklahoma	Oklahoma
Watonga Indian Health Center	Oklahoma	Oklahoma
Wewoka Indian Health Center	Oklahoma	Oklahoma
Warm Springs Health & Wellness Center	Oregon	Portland
Western Oregon - Chemawa Indian Healthc Center	Oregon	Portland
Catawba PHS Health Center	South Carolina	Nashville
Fort Thompson Health Center	South Dakota	Great Plains
Eagle Butte Hospital/Ambulatory	South Dakota	Great Plains
Lower Brule Health Center	South Dakota	Great Plains
Pine Ridge Hospital/Ambulatory	South Dakota	Great Plains

CONTINUED: IHS FACILITIES REPORTING TO
STATE PRESCRIPTION DRUG MONITORING PROGRAMS
(Represents 100% of IHS-Operated Pharmacies)

FACILITY	STATE	IHS AREA
Rapid City Hospital/Ambulatory	South Dakota	Great Plains
Rosebud Hospital/Ambulatory	South Dakota	Great Plains
Wagner Clinic	South Dakota	Great Plains
Woodrow Wilson Keeble Memorial Health Care Center	South Dakota	Great Plains
Fort Duchesne Health Center	Utah	Phoenix
Colville Indian Health Center	Washington	Portland
David C. Wynecoop Memorial Clinic	Washington	Portland
Yakama Indian Health Service	Washington	Portland
Fort Washakie Health Center	Wyoming	Billings

- **Teledermatology**.—The Committee recognizes the value of telehealth technology to expand access to critical healthcare services and to help address the impacts of provider shortages across the Service. The Committee recognizes that access to specialty programs like tele-dermatology help fill important gaps in the Service to diagnose and treat disease and encourages the Service to expand access to these programs and make needed equipment investments, such as mobile high definition cameras, to support them.

  Action taken or to be taken:

  Less than 10 percent of all dermatologists practice in rural areas while 40 percent practice in the 100 densest US areas.[1] According to the American Academy of Dermatology, the ideal dermatologist to population ratio is 3.5 per 100,000 (although the appropriate ratio has never been validated) and the mean dermatologist to population ratio of rural counties is 423 per 100,000 people.[1] However, 88 percent of rural counties have zero dermatologists.[1] The 26 Native American majority counties have no dermatologists.[1]

  The IHS has considered potential options for expanding tele-dermatology. One cost-effective solution could be to expand the tele-dermatology capacity of the Phoenix Indian Medical Center as well as leveraging private dermatologists who are willing to provide tele-dermatology services pro bono. Long-term solutions like targeted recruiting efforts, and the purchase of mobile high definition cameras would likely require additional resources.

  [1]Vaidya T et al. "Socioeconomic and Geographic Barriers to Dermatology Care in Urban and Rural US Populations," J Am Acad Dermatol Feb 2018: 406-408.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2022 Performance Budget Submission to Congress

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Operating Division-Specific Requirements

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Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, April 15, 2021

Type of Facility	TOTAL	IHS Total	TRIBAL Total	TRIBAL Title I [a]	TRIBAL Title V [b]
Service Units	172	54	118		
Hospitals	46	24	22	3	19
Ambulatory	637	86	549	135	414
Health Centers	368	49	317	99	218
School Health Centers	20	12	8	0	8
Health Stations	103	25	78	29	49
Alaska Village Clinics	146	0	146	7	139

[a] Operated under P.L. 93-638, Self Determination Contracts
[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2020 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**15,545**	**25,351**	**40,896**
Alaska	*	12,259	12,259
Albuquerque	728	1	729
Bemidji	134	*	134
Billings	840	*	840
California	*	*	0
Great Plains	2,300	*	2,300
Nashville	*	786	786
Navajo	6,189	4,384	10,573
Oklahoma	1,262	6,921	8,183
Phoenix	4,092	840	4,932
Portland	*	*	0
Tucson	*	160	160

* No direct inpatient facilities in FY 2020

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**4,960,696**	**8,038,897**	**12,999,593**
Alaska	**	1,684,339	1,684,339
Albuquerque	444,669	158,446	603,115
Bemidji	249,922	481,153	731,075
Billings	338,339	141,234	479,573
California	1,438	273,065	274,503
Great Plains	869,111	225,178	1,094,289
Nashville	20,146	487,803	507,949
Navajo	1,452,643	790,800	2,243,443
Oklahoma	661,545	2,418,781	3,080,326
Phoenix	677,675	523,512	1,201,187
Portland	245,208	614,308	859,916
Tucson	**	240,278	240,278

** No IHS facilities in FY 2020

INDIAN HEALTH SERVICE
Immunization Expenditures[1]

	FY 2018 Estimate	FY 2019 Estimate	FY 2020 Estimate	FY 2021 Estimate	FY 2022 Estimate	Increase or Decrease
Infants, ≤2 yrs†	$18,370,977	$17,637,372	$16,999,814	$27,697,493	$30,729,864	+$3,032,371
Children, 4 yrs*	--	--	--	$1,903,618	$2,181,400	+$277,782
Children, 11 yrs*	--	--	--	$2,638,457	$3,058,125	+$419,668
Children, 16 yrs*	--	--	--	$492,106	$592,244	+$100,138
Influenza, 3-18 yrs*	--	--	--	$7,011,952	$8,208,396	+$1,196,444
Adolescents, 13-17 yrs**	$14,416,586	$14,539,873	$14,751,715	--	--	--
HPV vaccine, Female 19-26 yrs	$3,365,850	$1,888,480	$2,234,867	$1,661,872	$4,362,851	+$2,700,979
HPV Vaccine, Males 19-26 yrs†	$3,617,239	$3,007,340	$3,471,040	$8,348,651	$11,371,327	+$3,022,676
Tdap, 19+ yrs	$4,986,405	$5,642,763	$6,881,091	$8,011,379	$14,506,783	+$6,495,404
Hepatitis B for diabetics, 19-59 yrs	$3,458,933	$5,001,855	$2,596,434	$983,972	$368,495	-$615,477
Influenza, 19+ yrs	$25,865,678	$26,722,962	$26,869,430	$28,389,102	$31,572,305	+$3,183,203
Zoster, 50+ yrs†	$634,156	$749,722	$600,430	$5,072,640	$10,710,516	+$5,637,876
Pneumococcal (PPSV23), 65+ yrs	$826,614	$1,263,179	$367,796	$1,766,053	$2,836,502	+$1,070,449
Pneumococcal (PCV13), 65+ yrs§	$5,105,479	$6,107,426	$6,676,690	$7,371,107	--	-$7,371,107
COVID-19, 16+ yrs	--	--	--	--	--	--
Monitoring	$132,057	$137,207	$138,579	$143,984	$149,599	+$5,615
TOTAL	$80,779,974	$82,698,180	$81,587,886	$101,492,384	$120,648,412	+$19,156,028

†Expanded age range beginning with FY 2021 estimate
*Newly added stratified measures beginning FY 2021 for improved capture and accuracy of estimates among these patient groups
**Retired aggregate measure replaced with newly added stratified measures as indicated
§PCV13 vaccine no longer recommended beginning FY2022

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Because the cost of vaccines for children < 19 years of age is covered by the Vaccines for Children (VFC) program, only the costs for vaccine administration, which are not covered by the VFC program, are included for this age group. Vaccine administration fees were based on an average of the CMS Maximum Regional Charges for vaccine administration, multiplied by the number of doses of vaccine routinely recommended for each age group (e.g., 25 total vaccine doses for children ≤ 2 yrs).

Estimated immunization expenditures include projected costs for routine, on-schedule immunizations among core patient demographic groups based on current age-appropriate

1. The immunization estimates do not include the Hepatitis B and Haemophilus Immunization (AK) program; estimates for these immunizations are included under the Immunization Alaska budget.

immunization schedules. Other individuals outside these core patient groups may be regular recipients of immunizations (e.g., health care workers; patients at specific increased risk for certain vaccine-preventable diseases). However, there is not currently a methodology to accurately estimate the size or vaccination coverage rates for all of these patient groups. Therefore, some special patient groups are excluded from these expenditure estimates.

Costs for monitoring of immunization coverage were also included and represent a 1.039 percent increase over the FY 2021 estimate:

- FY 2018 Estimated Costs = FY 2017 cost plus 3.9 percent
- FY 2019 Estimated Costs = FY 2018 cost plus 3.9 percent
- FY 2020 Estimated Costs = FY 2019 cost plus 1.0 percent
- FY 2021 Estimated Costs = FY 2020 cost plus 1.0 percent
- FY 2022 Estimated Costs = FY 2021 cost plus 1.0 percent

For FY 2022, $120,498,813 is estimated for vaccine costs, and $149,599 for immunization monitoring costs, for a total of $120,648,412 estimated for all immunization expenditures. This represents a $19,156,028 increase from the FY 2021 estimate attributable to changes in vaccine costs, shifting population sizes among age categories targeted for immunization, and progress towards immunization coverage goals aligned with Healthy People 2030 targets (i.e., fewer individuals still needing vaccination which translates to reduced forecasted costs). Calculations for the costs included as part of the FY 2022 estimated immunization costs were based on the assumptions outlined in the table below:

	Estimated User Population (FY 2020)	Coverage Goal†	Current Coverage*	No. to be vaccinated	Vaccine costs (per dose)**	Admin fee (per dose)§	No. of doses per patient	Total Immun. expenditures per patient	Total
Infants, ≤2 yrs	59,554	80%	NA	47,643	$0.00	$25.80	25	$645.00	$30,729,864.00
Children, 4 yrs	26,422	80%	NA	21,138	$0.00	$25.80	4	$103.20	$2,181,400.32
Children, 11 yrs	29,633	80%	NA	23,706	$0.00	$25.80	5	$129.00	$3,058,125.60
Children, 16 yrs	28,694	80%	NA	22,955	$0.00	$25.80	1	$25.80	$592,244.16
Influenza, 3-18 years	454,507	70%	NA	318,155	$0.00	$25.80	1	$25.80	$8,208,396.42
HPV Females, 19-26 yrs	109,720	60%	55%	5,486	$239.29	$25.80	3	$795.27	$4,362,851.22
HPV Males, 19-26 yrs	84,110	60%	43%	14,299	$239.29	$25.80	3	$795.27	$11,371,327.15
Tdap, 19+ yrs	1,153,832	90%	69%	24,2305	$34.07	$25.80	1	$59.87	$14,506,783.59
Hepatitis B for diabetics, 19-59 yrs	119,000	57%	55%	2,380	$25.81	$25.80	3	$154.83	$368,495.40
Influenza, 19+ yrs	1,153,832	70%	NA	807,682	$13.29	$25.80	1	$39.09	$31,572,305.02
Zoster, 50+ yrs	416,104	60%	50%	41,610	$102.90	$25.80	2	$257.40	$10,710,516.96
Pneumococcal (PPSV23) 65+yrs	174,988	90%	77%	22,748	$98.89	$25.80	1	$124.69	$2,836,502.98
COVID-19, 16+yrs[α]	NA	NA	UNK	UNK	NA	NA	NA	NA	NA
Vaccine Costs									$120,498,813
Monitoring									$149,599
Total Costs									$120,648,412

† Based on Healthy People 2030, where applicable.

*****Coverage estimates based on most current coverage levels available (FY 2021 Quarter 1); coverage estimates for diabetics ages 19-59 years includes those patients immune to Hepatitis B for reasons other than immunization; HPV estimate is based on 3 dose series; coverage listed as 'NA' either not applicable due to age-related cohort turnover each year or recurring annual immunization requirement each year (i.e., influenza); coverage estimate noted as 'UNK' is currently unknown and unavailable.
******Cost per dose for routine childhood vaccines administered up to and including age 18 are covered by the Vaccines for Children program; cost per dose determined from the CDC Adult Vaccine Price List dated April 1, 2021. Lowest published price is generally used where multiple products or formulations are available.
https://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/index.html
§Based on an average of the state CMS Maximum Regional Charges for Vaccine administration.
[α]FY 2022 will the first full year of administering the COVID-19 vaccine(s). Due to the rapidly evolving COVID-19 vaccine landscape, a full year estimate is currently unavailable.

Overall, the estimated costs above reflect projected costs for routine, on-schedule immunizations but with caveats:

1. Other individuals outside these core patient groups are regular recipients of immunizations (e.g., immunization for health care workers and those at specific risk for other vaccine-preventable diseases). However, there is not currently a methodology to estimate the size of these groups to effectively track vaccination coverage rates.
2. The CMS Maximum Regional Charges for Vaccine administration was used to estimate indirect costs because there is no specific methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations system-wide, or operation of the overall immunization program.

FY 2020 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration									Tribal Health Administration									FY 2020 Final
	Clinical Services	EHR Modernization	Preventive Health	Indian Health Professions	Tribal Mgmt Grants	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Tribal Mgmt Grants	Management Training	Contract Support	Self Governance	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																			
Hospitals & Health Clinics	956,052	0	0	0	0	0	0	0	956,052	1,367,846	0	0	0	0	0	0	0	1,367,846	2,323,898
Electronic Health Record	0	8,000	0	0	0	0	0	0	8,000	0	0	0	0	0	0	0	0	8,000	8,000
Dental Health	80,763	0	0	0	0	0	0	0	83,609	126,993	0	0	0	0	0	0	0	126,993	210,602
Mental Health	41,110	0	0	0	0	0	0	0	41,110	67,144	0	0	0	0	0	0	0	67,144	109,036
Alcohol & Substance Abuse	71,498	0	0	0	0	0	0	0	71,498	157,736	0	0	0	0	0	0	0	157,736	245,618
Purchased/Referred Care	401,365	0	0	0	0	0	0	0	401,365	574,184	0	0	0	0	0	0	0	574,184	965,015
IHCIF	15,468	0	0	0	0	0	0	0	15,468	57,376	0	0	0	0	0	0	0	57,376	72,280
Subtotal (CS)	1,566,256	8,000	0	0	0	0	0	0	1,577,102	2,351,279	0	0	0	0	0	0	0	2,359,279	3,934,449
Public Health Nursing	0	0	29,792	0	0	0	0	0	29,792	0	61,528	0	0	0	0	0	0	61,528	91,984
Health Education	0	0	3,684	0	0	0	0	0	3,684	0	16,928	0	0	0	0	0	0	16,928	20,925
Community Health Repr.	0	0	1,602	0	0	0	0	0	1,602	0	60,345	0	0	0	0	0	0	60,345	62,892
Immunization AK	0	0	0	0	0	0	0	0	0	0	2,127	0	0	0	0	0	0	2,127	2,127
Subtotal (PH)	0	0	35,078	0	0	0	0	0	35,078	0	140,928	0	0	0	0	0	0	140,928	177,928
Urban Health Project	0	0	0	0	0	0	0	0	0	0	0	57,684	0	0	0	0	0	57,684	57,684
Indian Health Professions	0	0	0	56,363	0	0	0	0	56,363	0	0	0	0	0	0	0	0	0	65,314
Tribal Management	0	0	0	65	1,461	0	0	0	1,526	0	0	0	1,004	0	0	0	0	1,004	2,465
Direct Operations	0	0	0	0	0	52,029	0	0	52,029	0	0	0	0	18,412	0	0	0	18,412	71,558
Self-Governance	0	0	0	0	0	0	3,340	0	3,340	0	0	0	0	0	0	556	0	556	5,806
Subtotal (OS)	0	0	0	56,428	1,461	52,029	3,340	0	113,258	0	0	57,684	1,004	18,412	0	556	0	77,656	202,827
Total, Services	1,566,256	8,000	35,078	56,428	1,461	52,029	3,340	0	1,725,438	2,351,279	140,928	57,684	1,004	18,412	0	556	0	2,577,864	4,315,204
CONTRACT SUPPORT COST	0	0	0	0	0	0	0	0	0	0	0	0	0	0	820,000	0	0	820,000	820,000
FACILITIES																			
Maintenance & Improvement	0	0	0	0	0	0	0	74,727	74,727	0	0	0	0	0	0	0	94,225	94,225	168,952
Sanitation Facilities Constr.	0	0	0	0	0	0	0	67,752	67,752	0	0	0	0	0	0	0	125,825	125,825	193,577
Health Care Facs. Constr.	0	0	0	0	0	0	0	234,290	234,290	0	0	0	0	0	0	0	25,000	25,000	259,290
Facs. & Env. Health Sup	0	0	0	0	0	0	0	149,514	149,514	0	0	0	0	0	0	0	112,469	112,469	261,983
Equipment	0	0	0	0	0	0	0	13,426	13,426	0	0	0	0	0	0	0	14,661	14,661	28,087
Total, Facilities	0	0	0	0	0	0	0	539,709	539,709	0	0	0	0	0	0	0	372,180	372,180	911,890
TOTAL, IHS	1,566,256	8,000	35,078	56,428	1,461	52,029	3,340	539,709	2,265,146	2,351,279	140,928	57,684	1,004	18,412	820,000	0	372,180	3,770,044	6,047,094

FY 2021 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration										FY 2021 Enacted
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Tribal Mgmt Grants	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Tribal Mgmt Grants	Management Training	Self-Governance	Contract Support	Tribal Lease Payments	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																			
Hospitals & Health Clinics	920,749	0	0	0	0	0	0	920,749	1,317,338	0	0	0	0	0	0	0	0	1,317,338	2,238,087
Electronic Health Record	125,000	0	0	0	0	0	0	125,000	0	0	0	0	0	0	0	0	0	0	34,500
Dental Health	85,231	0	0	0	0	0	0	85,231	129,456	0	0	0	0	0	0	0	0	129,456	214,687
Mental Health	44,224	0	0	0	0	0	0	44,224	70,883	0	0	0	0	0	0	0	0	70,883	115,107
Alcohol & Substance Abuse	89,937	0	0	0	0	0	0	89,937	161,423	0	0	0	0	0	0	0	0	161,423	251,360
Purchased/Referred Care	395,222	0	0	0	0	0	0	395,222	580,634	0	0	0	0	0	0	0	0	580,634	975,856
IHCIF	14,904	0	0	0	0	0	0	14,904	57,376	0	0	0	0	0	0	0	0	57,376	72,280
Subtotal (CS)	1,675,266	0	0	0	0	0	0	1,675,266	2,317,111	0	0	0	0	0	0	0	0	2,317,111	3,901,877
Public Health Nursing	0	30,705	0	0	0	0	0	30,705	0	62,031	0	0	0	0	0	0	0	62,031	92,736
Health Education	0	4,017	0	0	0	0	0	4,017	0	17,017	0	0	0	0	0	0	0	17,017	21,034
Community Health Repr.	0	2,547	0	0	0	0	0	2,547	0	60,345	0	0	0	0	0	0	0	60,345	62,892
Immunization AK	0	0	0	0	0	0	0	0	0	2,127	0	0	0	0	0	0	0	2,127	2,127
Subtotal (PH)	0	37,270	0	0	0	0	0	37,270	0	141,518	0	0	0	0	0	0	0	141,519	178,789
Urban Health Project	0	0	0	0	0	0	0	0	0	0	62,684	0	0	0	0	0	0	62,684	62,684
Indian Health Professions	0	0	51,683	0	0	0	0	51,683	0	0	0	0	0	0	0	0	0	0	67,314
Tribal Management	0	0	0	0	1,461	0	0	1,461	0	0		1,004	0	0	0	0	0	1,004	2,465
Direct Operations	0	0	0	61,240	0	0	0	59,216	0	0	0	0	21,216	0	0	0	0	21,216	82,456
Self-Governance	0	0	0	0	0	5,250	0	5,250	0	0	0	0	0	556	0	0	0	556	5,806
Subtotal (OS)	0	0	51,683	61,240	1,461	5,250	0	117,610	0	0	62,684	1,004	21,216	556	0	0	0	85,460	220,725
Total, Services	1,675,266	37,270	51,683	61,240	1,461	5,250	0	1,830,146	2,317,111	141,518	62,684	1,004	21,216	556	0	0	0	2,544,090	4,301,391
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	916,000	0	0	916,000	916,000
TRIBAL LEASE PAYMENTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	101,000	0	101,000	101,000
FACILITIES																			
Maintenance & Improvement	0	0	0	0	0	0	74,727	74,727	0	0	0	0	0	0	0	0	94,225	94,225	168,952
Sanitation Facilities Constr.	0	0	0	0	0	0	68,802	68,802	0	0	0	0	0	0	0	0	127,775	127,775	196,577
Health Care Facs. Constr.	0	0	0	0	0	0	234,294	234,294	0	0	0	0	0	0	0	0	24,996	24,996	259,290
Facs. & Env. Health Sup	0	0	0	0	0	0	150,655	150,655	0	0	0	0	0	0	0	0	113,327	113,327	263,982
Equipment	0	0	0	0	0	0	13,904	13,904	0	0	0	0	0	0	0	0	15,183	15,183	29,087
Total, Facilities	0	0	0	0	0	0	542,382	542,382	0	0	0	0	0	0	0	0	375,506	375,506	917,888
TOTAL, IHS	1,675,266	37,270	51,683	61,240	1,461	5,250	542,382	2,372,528	2,317,111	141,518	62,684	1,004	21,216	556	916,000	0	375,506	3,835,596	6,236,279

FY 2022 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration									Tribal Health Administration										FY 2022 Pres Bud
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Tribal Mgmt Grants	Self-Governance	Special Diabetes Program for Indians	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Tribal Mgmt Grants	Self-Governance	Contract Support	ISDEA 105*(l)* Leases	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																				
Hospitals & Health Clinics	1,112,250	0	0	0	0	0	0	0	1,112,250	1,591,324	0	0	0	0	0	0	0	0	1,591,324	2,703,574
Electronic Health Record	284,500	0	0	0	0	0	0	0	284,500	0	0	0	0	0	0	0	0	0	0	284,500
Dental Health	114,068	0	0	0	0	0	0	0	114,068	173,258	0	0	0	0	0	0	0	0	173,258	287,326
Mental Health	47,880	0	0	0	0	0	0	0	47,880	76,742	0	0	0	0	0	0	0	0	76,742	124,622
Alcohol & Substance Abuse	95,708	0	0	0	0	0	0	0	95,708	171,782	0	0	0	0	0	0	0	0	171,782	267,490
Purchased/Referred Care	482,689	0	0	0	0	0	0	0	482,689	709,135	0	0	0	0	0	0	0	0	709,135	1,191,824
IHCIF	65,428	0	0	0	0	0	0	0	65,428	251,878	0	0	0	0	0	0	0	0	251,878	317,306
Subtotal (CS)	2,202,523	0	0	0	0	0	0	0	2,202,524	2,974,119	0	0	0	0	0	0	0	0	2,974,118	5,176,642
Public Health Nursing	0	34,002	0	0	0	0	0	0	34,002	0	68,691	0	0	0	0	0	0	0	68,691	102,693
Community Health	0	4,233	0	0	0	0	0	0	4,233	0	17,931	0	0	0		0	0	0	17,931	22,164
Health Education	0	2,655	0	0	0	0	0	0	2,655	0	62,902	0	0	0	0	0	0	0	62,902	65,557
Immunization AK	0	0	0	0	0	0	0	0	0	0	2,174	0	0	0	0	0	0	0	2,174	2,174
Subtotal (PH)	0	40,890	0	0	0	0	0	0	40,890	0	151,698	0	0	0	0	0	0	0	151,698	192,588
Urban Health Project	0	0	0	0	0	0	0	0	0	0	0	100,000	0	0	0	0	0	0	100,000	100,000
Indian Health Professions	0	0	51,683	0	0	0	0	0	51,683	0	0	0	0	0	0	0	0	0	0	92,843
Tribal Management	0	0	0	0	1,473	0	0	0	1,473	0	0	0	0	1,012	0	0	0	0	0	2,485
Direct Operations	0	0	0	80,055	0	0	0	0	80,055	0	0	0	27,734	0	0	0	0	0	27,734	107,789
Self-Governance	0	0	0	0	0	5,416	0	0	5,416	0	0	0	0	0	574	0	0	0	574	5,990
Subtotal (OS)	0	0	51,683	80,055	1,473	5,416	0	0	138,627	0	0	100,000	27,734	1,012	574	0	0	0	128,308	309,106
Total, Services	2,202,523	40,890	51,683	80,055	1,473	5,416	0	0	2,382,041	2,974,119	151,698	100,000	27,734	1,012	574	0	0	0	3,254,124	5,678,336
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,142,000	0	0	1,142,000	1,142,000
ISDEAA 105*(l)* Leases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		150,000	0	150,000	150,000
FACILITIES																				
Maintenance & Improvement	0	0	0	0	0	0	0	98,599	98,599	0	0	0	0	0	0	0	0	124,325	124,325	222,924
Sanitation Facilities Constr.	0	0	0	0	0	0	0	123,006	123,006	0	0	0	0	0	0	0	0	228,439	228,439	351,445
Health Care Facs. Constr.	0	0	0	0	0	0	0	475,096	475,096	0	0	0	0	0	0	0	0	50,685	50,685	525,781
Facs. & Env. Health Sup	0	0	0	0	0	0	0	171,297	171,297	0	0	0	0	0	0	0	0	128,856	128,856	300,153
Equipment	0	0	0	0	0	0	0	48,106	48,106	0	0	0	0	0	0	0	0	52,534	52,534	100,640
Total, Facilities	0	0	0	0	0	0	0	916,104	916,104	0	0	0	0	0	0	0	0	584,839	584,839	1,500,943
TOTAL, IHS	2,202,523	40,890	51,683	80,055	1,473	5,416	0	916,104	3,298,145	2,974,119	151,698	100,000	27,734	1,012	574	1,142,000	0	584,839	4,980,963	8,471,279

Pre-Decisional, Internal to HHS and OMB

FACILITY	Prior to FY 21 *	FY 21 Appro	FY 22 Est.	FY 23 Est.	FY 24 Est.	FY 25 Est.	Out years Est.	Total Cost **
Planning Studies	-				500	500	500	
Inpatient Facilities b/ c/								
PIMC, AZ, Health Care System 1/								
Central - Hospital & ACC	2,228	25,000	70,000	150,000	125,000	301,772	0	674,000
Whiteriver, AZ, Hospital 2/	25,000	60,000	100,000	100,000	175,000	0	0	460,000
Gallup, NM Hospital 3/	2,000	15,000	67,781	100,000	200,000	167,219	0	552,000
Outpatient Facilities b/ c/								
Bodaway Gap, AZ 7/	80,700	40,500	30,000	-			-	151,200
Albuquerque Health Care System								
Albuquerque West, NM 8/	145,353	18,790	-	-			-	164,143
Albuquerque Central, NM /9	734	20,000	75,000	100,000	0		-	195,734
Sells, AZ 3/ 9/	15,750	40,000	120,000	114,000	0		-	289,750
Small Ambulatory Program (Section 306) d/								
Small Health Clinics	84,273	25,000	33,000	-	-		-	
Staff Quarters Program 25 U.S.C. 13, Snyder Act e/								
Staff Quarters	26,000	10,000	25,000	-	-		-	
Green Infrastructure (CWA)								
Sustainability Projects	5,000	5,000	5,000	-	-		-	
Joint Venture Construction Program (Section 818e) f/								
TOTAL		259,290	525,781	564,000	500,500	469,491	500	2,319,562
UNFUNDED (FY 2021-Outyears) Priority Projects only								2,055,272

FISCAL YEAR 2022 DHHS LEGISLATIVE PROPOSAL
Indian Health Service

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.

While 2 U.S.C. § 906(e) ostensibly sets IHS's discretionary funding sequester level to 2% of its total, Section 251A(5), Implementing Discretionary Reductions, does not apply the special rules of Section 256; they are only used in Implementing Direct Spending Reductions (Section 251A(6)), which results in reductions in IHS's discretionary accounts on the same basis as other nonsecurity accounts. Inclusive of the 2% sequestered from the mandatory Special Diabetes Program for Indians (SDPI, limited to a 2% reduction), a total of $219.6 million was sequestered from IHS's budget, which was 5.1% of the resources appropriated in FY 2013 for Indian health programs.

Rationale: 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, interpretation of sequester policy (e.g., OMB's decision applying the 2% limitation only to the mandatory SDPI), as well as the availability of third party resources to ameliorate budget reductions to critical care areas. Additionally, the date in the fiscal year in which it is implemented will add to the effect of the impact. Notice earlier in the fiscal year would allow for a minimal impact, evenly reducing the reduction across 12 full months of the fiscal year, whereas later notice would impact operations more greatly.

An illustrative example is included below to demonstrate the impact of a sequestration on IHS. For the purposes of calculating the following estimate, a sequestration reduction percentage to IHS programs (excepting the SDPI program, which is capped at 2 percent) is assumed to be 7.5 percent, in the range of modest reduction levels, applied equally across IHS programs, projects or activities, as implemented in FY 2013. Using FY 2016 performance results as the base, a reduction of $267.5 million would be taken from the IHS's Appropriation, which would result in estimated impacts over the following selected measures:

Estimated Impact on Health Care Delivered by a National 7.5% Sequester Reduction

Comprehensive Cardiovascular Disease Assessment	
Number Carried out in FY 2016	30,040
Sequester Reduction	2,253
Number of Patients Who Receive Depression Screening	
Number Carried out in FY 2016	515,692
Sequester Reduction	38,677
Number of Patients Who Receive Colorectal Cancer Screening	
Number Carried out in FY 2016	165,056
Sequester Reduction	12,379
Number of Patients Who Receive Alcohol Screening: Fetal Alcohol Syndrome (FAS) Prevention Screening	
Number Carried out in FY 2016	205,952
Sequester Reduction	15,446
Number of Patients Who Receive Mammography Cancer Screening	
Number Carried out in FY 2016	55,808
Sequester Reduction	4,186

Number of AI/AN patients (age 19-35 months) who have received the combined childhood vaccination series	
Number Carried out in FY 2016	63,423
Sequester Reduction	4,757
Number of AI/AN patients (ages 18+) who have received the influenza vaccine	
Number Carried out in FY 2016	515,692
Sequester Reduction	38,677
Number of AI/AN patients who have received dental services	
Number Carried out in FY 2016	1,093,321
Sequester Reduction	81,999

Reference:

IHS FY 2016 Performance Report
https://www.ihs.gov/crs/includes/themes/responsive2017/display_objects/documents/gpra/2016_GPRAResults_CRS.pdf

IHS FY 2016 Performance Measurement Explanation
https://www.ihs.gov/crs/includes/themes/newihstheme/display_objects/documents/crsv16/GPRAMeasuresV161.pdf

Budget Impact: This is a budget related and discretionary proposal that was submitted by the IHS in previous years; however, it was not included in the President's FY 2021 Budget. 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.

Impact on Other Agencies: This is noted in the "Budget Impact" section of the proposal: While resulting in no change to IHS's funding, it would increase the amount of sequestered funding taken from remaining non-exempt agencies.

Other Data: None.

FISCAL YEAR 2022 HHS LEGISLATIVE PROPOSAL
Indian Health Service

Provide the Indian Health Service Discretionary Use of all Title 38 Personnel Authorities

Proposal: The Indian Health Service (IHS) is seeking the discretionary use of all United States Code Title 38 authorities under Part V, Chapter 74, "Veterans Health Administration – Personnel", that are primarily available to the Department of Veterans Affairs (VA) in relation to health care positions. The term "health care occupations" refers to positions, other than positions in the Senior Executive Service, that provide direct patient-care services or services incident to direct patient-care which would normally be covered by Title 5 of the United States Code.

Current Law: Title 38 Part V, Chapter 74, governs all aspects of personnel administration for the Veterans Health Administration (VHA) unless expressly overridden by another law or regulation. In many areas of personnel administration, the VHA is exempt from Title 5 laws and regulations by virtue of Title 38. The U.S. Office of Personnel Management (OPM), under the authority of section 1104 and 5371 of Title 5 of the United States Code, has authorized the Department of Health and Human Services (HHS) to use the Title 38 provisions pertaining to pay rates and systems, premium pay, classification, and hours of work. This delegation of authority is described in a delegation of authority between OPM and HHS – the latest version of which was effective March 6, 2019. If HHS, or an HHS Operating Division under the delegation of authority, chooses to use a Title 38 provision, the comparable authority under Title 5 is waived. However, 5 U.S.C. § 5371 does not provide authority to apply all personnel provisions of Title 38 in lieu of comparable Title 5 provisions.

Rationale: The IHS, as a primarily rural healthcare provider, has difficulty recruiting healthcare professionals. 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. The ability to use Title 38 for pay purposes as noted above is beneficial because the IHS can offer market pay to physicians, dentists, and podiatrists as well as special salary rates to individuals in other health care occupations. However, the IHS's use of these compensation authorities is not adequate by itself to compete with other public sector agencies and private sector organizations.

Typically, the private sector and the VHA can offer candidates better scheduling options and paid time off — particularly important benefits to providers who serve in remote and rural locations. The IHS faces specific public sector competition in the area of annual leave accrual. The VHA provides 1 day of annual leave per pay period for all (including new) physicians, dentists, podiatrists, optometrists, and chiropractors and 8 hours of annual leave accrual per pay period for all (including new) nurses, physician assistants, and expanded-function dental auxiliaries. Due to the limited scope of 5 U.S.C. § 5371, the IHS does not have the authority covered by 38 U.S.C. § 7421. "Personnel Administration: in general" that includes "leaves of absence of employees". Thus, when a candidate with just a few years of experience is choosing

between the IHS and the VHA, he or she will invariably choose the organization offering 1 day/8 hours of annual leave accrual per pay period, as opposed to just 4 or 6 hours of annual leave accrual per pay period that the IHS offers. Supervisors report anecdotally that the IHS has lost many candidates due to this difference in accrual rates.

In addition to better scheduling options and paid time off, the IHS is seeking access to other Title 38 authorities to increase its competitive stance in the healthcare labor market and to create a more efficient and effective human resources program. This would include the potential for instituting two-year probationary periods for staff appointed under Title 38 and to have jurisdiction over appeals for adverse actions involving professional conduct or competence pertaining to direct patient care and clinical competence instead of going through the Merit Systems Protection Board. Title 38 also exempts the VHA from collective bargaining and associated grievance procedures relating to issues concerning professional conduct competence, and peer review. In contrast, Title 5 permits the establishment of grievance procedures on any issue through the collective bargaining process.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment.

Impact on Other Agencies: Not applicable.

Other Data: None.

FISCAL YEAR 2022 DHHS LEGISLATIVE PROPOSAL
Indian Health Service

Facilities Renovation for Urban Indian Organizations to the Extent Authorized for Other Government Contractors

Proposal: Amend federal law to permit the Indian Health Service (IHS) to make funds available to IHS-funded Urban Indian Organizations (UIOs) for minor renovations to facilities or construction or expansion of facilities, including leased facilities, to the extent authorized for other government contractors. This would allow UIOs the full authority that exists for other Federal Acquisition Regulation (FAR) contractors.

Current Law: Current federal law at 25 U.S.C. § 1659 permits the IHS to make funds available to UIOs to make minor renovations to facilities or construction or expansion of facilities, including leased facilities, but only to assist UIOs in meeting or maintaining accreditation standards of The Joint Commission (TJC). Because of the specificity of the language in Section 1659, the IHS cannot award funds to an UIO to make minor renovations, construct or expand facilities, unless the UIO is doing so to meet or maintain accreditation specifically from TJC.

Rationale: The 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. An UIO is defined by 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 25 U.S.C. § 1653(a). UIOs provide unique access to culturally appropriate and quality health care for Urban Indians.

Currently, UIOs are seeking or maintaining accreditation from several health care accreditation organizations, including TJC, Accreditation Association for Ambulatory Healthcare (AAAHC), and Commission on Accreditation of Rehabilitation Facilities (CARF). Some UIOs have also achieved recognition as Patient Centered Medical Homes (PCMH), with additional UIOs currently working towards PCMH recognition, as well as AAAHC accreditation. In addition, some UIOs must meet standards from the Centers for Medicare & Medicaid Services and/or their respective state departments of health.

Expanding the current authority to be consistent with the authority for other government contractors, rather than limiting it under Section 1659 to TJC, would allow UIOs to make renovations, construction, or expansion of facilities necessary to improve the safety and quality of care provided to Urban Indian patients. Currently, only 1 out of the 41 UIOs maintain TJC accreditation.

A large proportion of Urban Indians live in or near the poverty level and thus face multiple barriers to obtaining access to quality and culturally relevant health care services in urban centers. They must overcome additional barriers to receiving appropriate care such as lack of culturally appropriate care, lack of respect, lack of visibility, transportation issues, and communication obstacles that often interfere with the delivery of high-quality health care to Urban Indians. Providing UIOs with broader authority, similar to other FAR contractors, to improve their health care facilities will assist in providing the high quality, safe, and culturally relevant health care for the Urban Indian population.

Budget Impact: This is a non-budget related and discretionary proposal.

Effective Date: Upon enactment.

Impact on Other Agencies: Not applicable.

Other Data: While there are a few other references in the Indian Health Care Improvement Act (IHCIA) to accreditation by TJC, there is no mention of other accreditation bodies in either the IHCIA or Indian Self-Determination Education Assistance Act (ISDEAA). In addition, the Department of Veterans Affairs' statutes do not make mention of specific accrediting bodies.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2022 Performance Budget Submission to Congress

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Self Determination

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Indian Health Service

Indian Self Determination

Indian Health Service Philosophy – The Indian Health Service (IHS) implements the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law (Pub. L. No.) 93-638, as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Accordingly, the IHS supports Tribal sovereignty: (1) by assisting Tribes in exercising their right to administer the IHS health programs, or portions thereof, and (2) by continuing to directly provide services to Tribes that choose the IHS as their health care provider. A Tribal decision to enter or not enter into ISDEAA agreements are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts – Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1975, the IHS has entered agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, over $4.2 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 219 Tribes and Tribal Organizations operating 249 contracts and annual funding agreements. Under Title V, IHS is party to 105 compacts and 131 funding agreements; through which approximately $2.6 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-five percent of federally recognized Tribes participate in Title V.

Indian Health Service
Self-Governance Funded Compacts FY 2022
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALABAMA	**4,397**	**170**	**156**	**767**	**5,491**
Poarch Band of Creek Indians	4,397	170	156	767	5,491
ALASKA	**440,432**	**48,094**	**57,102**	**176,306**	**721,934**
Alaska Native Tribal Health Consortium	36,389	20,270	11,946	21,771	90,376
Aleutian Pribilof Islands Association, Inc.	1,647	23	151	1,130	2,951
Arctic Slope Native Association, Ltd	23,009	2,542	3,374	7,894	36,819
Bristol Bay Area Health Corporation	21,673	1,126	2,269	9,593	34,661
Chickaloon Native Village	58	1	15	13	88
Chugachmiut	3,763	28	230	1,852	5,873
Copper River Native Association	5,601	412	497	1,954	8,463
Council of Athabascan Tribal Governments	1,806	148	102	1,247	3,303
Eastern Aleutian Tribes, Inc.	2,881	28	182	1,850	4,942
Kenaitze Indian Tribe, I.R.A.	12,056	1,121	407	5,180	18,764
Ketchikan Indian Community	5,107	197	564	3,463	9,332
Knik Tribal Council	73	1	11	10	94
Kodiak Area Native Association	6,982	147	467	2,771	10,367
Maniilaq Association	27,099	1,295	2,896	14,459	45,748
Metlakatla Indian Community	6,280	994	488	1,177	8,939
Mount Sanford Tribal Consortium	799	1	84	287	1,170
Native Village of Eklutna	179	2	6	63	249
Native Village of Eyak	913	37	91	243	1,284
Norton Sound Health Corporation	45,854	4,355	4,453	12,606	67,269
Seldovia Village Tribe	1,859	73	90	710	2,732
Southcentral Foundation	80,312	4,977	10,296	32,758	128,343
SouthEast Alaska Regional Health Consortium	36,322	2,023	3,662	16,970	58,977
Tanana Chiefs Conference	61,050	4,204	5,818	15,620	86,693
Yakutat Tlingit Tribe	1,164	9	3,093	1,610	5,875
Yukon-Kuskokwim Health Corporation	57,554	4,079	5,913	21,077	88,623
ARIZONA	**197,437**	**17,594**	**7,697**	**50,106**	**272,834**
Ak-Chin Indian Community	42	0	7	9	57
Gila River Indian Community	76,782	8,807	1,815	21,002	108,406
Pascua Yaqui Tribe	15,537	240	188	3,244	19,209
Salt River Pima-Maricopa Indian Community	5,625	64	268	2,418	8,374
Tohono O'Odham Nation	35,529	3,674	2,490	6,815	48,508
Tuba City Regional Health Care Corporation	41,520	3,676	2,114	9,141	56,451
Winslow Indian Health Care Center, Inc.	22,402	1,133	814	7,479	31,828
CALIFORNIA	**83,121**	**6,221**	**3,937**	**35,993**	**129,272**
Chapa-De Indian Health Program, Inc.	6,775	370	184	3,509	10,838
Consolidated Tribal Health Project, Inc.	3,924	105	105	1,502	5,636
Feather River Tribal Health, Inc.	5,944	1,526	168	1,946	9,583
Hoopa Valley Tribe	5,283	302	270	2,293	8,148
Indian Health Council, Inc.	8,655	289	284	3,727	12,954
Lake County Tribal Health Consortium, Inc	6,565	1,004	171	2,596	10,336
Karuk Tribe of California	3,102	208	94	1,471	4,876
Northern Valley Indian Health, Inc.	4,210	391	115	1,556	6,271
Pinoleville Pomo Nation	90	0	3	16	108
Redding Rancheria Tribe	8,073	792	589	3,432	12,886
Riverside-San Bernardino County Indian Health, Inc.	21,677	815	890	10,091	33,474
Rolling Hills Clinic	46	15	1	64	125
Santa Ynez Band of Chumash Mission Indians	1,819	94	35	645	2,593
Southern Indian Health Council, Inc.	5,247	226	866	2,402	8,741
Susanville Indian Rancheria	1,712	85	162	743	2,702

Indian Health Service
Self-Governance Funded Compacts FY 2022
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
CONNECTICUT	**2,477**	**71**	**0**	**694**	**3,242**
Mohegan Tribe of Indians of Connecticut	2,477	71	0	694	3,242
FLORIDA	**7,791**	**559**	**997**	**1,900**	**11,247**
Seminole Tribe of Florida	7,791	559	997	1,900	11,247
IDAHO	**15,947**	**843**	**1,933**	**5,910**	**24,633**
Coeur D'Alene Tribe	6,133	342	1,414	3,317	11,206
Kootenai Tribe of Idaho	663	29	79	283	1,054
Nez Perce Tribe	9,152	471	441	2,310	12,374
KANSAS	**6,007**	**136**	**21**	**1,439**	**7,603**
Iowa Tribe of Kansas and Nebraska	1,250	16	0	0	1,265
Prairie Band Potawatomi Nation	4,757	121	21	1,439	6,338
LOUISANA	**1,213**	**99**	**128**	**214**	**1,654**
Chitimacha Tribe of Louisiana	1,213	99	128	214	1,654
MAINE	**3,432**	**103**	**174**	**823**	**4,532**
Penobscot Indian Nation	3,432	103	174	823	4,532
MASSACHUSETTS	**714**	**32**	**225**	**0**	**971**
Wampanoag Tribe of Gay Head	714	32	225	0	971
MICHIGAN	**28,818**	**1,197**	**2,293**	**3,358**	**35,666**
Grand Traverse Band of Ottawa and Chippewa Indians	2,898	195	318	494	3,905
Keweenaw Bay Indian Community	3,447	274	835	527	5,082
Little River Band of Ottawa Indians	2,093	70	257	335	2,755
Match-E-Be-Nash-She-Wish Band of Pottawatomi	1,155	14	27	254	1,450
Nottawaseppi Huron Band Of The Potawatomi	1,778	88	55	206	2,126
Sault Ste. Marie Tribe of Chippewa Indians	17,448	556	800	1,543	20,347
MINNESOTA	**20,839**	**773**	**2,915**	**2,299**	**26,826**
Bois Forte Band of Chippewa Indians	2,677	90	413	608	3,789
Fond du Lac Band of Lake Superior Chippewa	12,136	483	1,256	798	14,672
Mille Lacs Band of Ojibwe	4,255	188	1,229	564	6,236
Shakopee Mdewakanton Sioux Community	1,771	11	17	329	2,129
MISSISSIPPI	**37,734**	**3,811**	**1,282**	**0**	**42,827**
Mississippi Band of Choctaw Indians	37,734	3,811	1,282	0	42,827
MONTANA	**33,548**	**1,643**	**1,900**	**4,657**	**41,748**
Chippewa Cree Tribe of the Rocky Boy's Reservation	10,564	831	1,084	2,378	14,857
Confederated Salish and Kootenai Tribes of the Flathead Nation	22,984	812	816	2,279	26,891
NEBRASKA	**17,599**	**2,572**	**1,702**	**2,926**	**24,799**
Winnebago Tribe of Nebraska	17,599	2,572	1,702	2,926	24,799
NEW MEXICO	**12,722**	**203**	**1,368**	**2,130**	**16,422**
Pueblo of Jemez	9,821	160	995	1,649	12,625
Pueblo of Sandia	1,982	39	155	238	2,415
Taos Pueblo	919	4	217	243	1,383
NEW YORK	**8,817**	**324**	**330**	**1,930**	**11,402**
St. Regis Mohawk Tribe	8,817	324	330	1,930	11,402
NEVADA	**28,734**	**1,258**	**2,243**	**7,587**	**39,822**
Duck Valley Shoshone-Paiute Tribes	6,957	476	794	1,864	10,091
Duckwater Shoshone Tribe	1,091	18	207	1,131	2,447
Ely Shoshone Tribe	1,347	15	65	418	1,845
Fort McDermitt Paiute and Shoshone Tribe	1,626	95	7	210	1,939
Las Vegas Paiute Tribe	3,466	65	123	310	3,964
Reno-Sparks Indian Colony	7,056	309	696	1,815	9,876
Washoe Tribe of Nevada and California	5,134	187	243	1,579	7,142
Yerington Paiute Tribe of Nevada	2,056	92	107	261	2,517
NORTH CAROLINA	**26,301**	**1,084**	**1,027**	**8,352**	**36,764**
Eastern Band of Cherokee Indians	26,301	1,084	1,027	8,352	36,764
NORTH DAKOTA	**11,006**	**292**	**1,579**	**1,171**	**14,048**
Spirit Lake Tribe	11,006	292	1,579	1,171	14,048

Indian Health Service
Self-Governance Funded Compacts FY 2022
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
OKLAHOMA	**485,361**	**60,935**	**42,330**	**98,833**	**687,459**
Absentee Shawnee Tribe of Oklahoma	18,166	1,626	1,995	8,315	30,101
Cherokee Nation	165,652	22,290	14,177	25,399	227,519
Chickasaw Nation	85,821	16,437	10,449	18,453	131,161
Choctaw Nation of Oklahoma	88,450	12,826	6,568	24,486	132,330
Citizen Potawatomi Nation	22,194	1,674	1,693	9,257	34,818
Kaw Nation of Oklahoma	2,915	107	218	689	3,930
Kickapoo Tribe of Oklahoma	9,977	162	299	1,612	12,051
Modoc Tribe of Oklahoma	51	50	6	15	121
Muscogee Creek Nation	51,912	4,612	5,848	4,440	66,813
Northeastern Tribal Health System	7,687	92	158	1,175	9,112
Osage Nation	12,907	100	382	1,968	15,356
Ponca Tribe of Oklahoma	6,090	66	244	844	7,244
Quapaw Tribe of Oklahoma	159	0	30	83	272
Sac and Fox Nation of Oklahoma	9,887	78	171	1,043	11,179
Seminole Nation of Oklahoma	498	709	51	253	1,511
Wyandotte Nation	2,996	104	40	799	3,940
OREGON	**32,382**	**976**	**2,903**	**12,174**	**48,435**
Confederated Tribes of Grand Ronde	7,627	115	590	2,453	10,785
Confederated Tribes of Siletz Indians of Oregon	8,123	211	787	4,258	13,378
Confederated Tribes of the Coos, Lower Umpqua & Siuslaw Indians	1,860	58	308	564	2,789
Confederated Tribes of the Umatilla Reservation	8,935	318	773	2,735	12,761
Coquille Indian Tribe	2,119	86	244	1,378	3,826
Cow Creek Band of Umpqua Tribe of Indians	3,719	188	201	787	4,895
UTAH	**7,869**	**66**	**1,847**	**3,425**	**13,208**
Utah Navajo Health System, Inc.	7,869	66	1,847	3,425	13,208
WASHINGTON	**61,489**	**2,663**	**3,053**	**22,079**	**89,284**
Cowlitz Indian Tribe	7,054	116	24	1,219	8,414
Jamestown S'Klallam Indian Tribe	1,313	57	97	506	1,973
Kalispel Tribe of Indians	1,117	53	23	88	1,281
Lower Elwha Klallam Tribe	1,923	87	115	464	2,589
Lummi Indian Nation	8,274	465	284	3,696	12,719
Makah Indian Tribe	4,026	265	320	1,388	5,999
Muckleshoot Tribe	7,444	269	221	3,709	11,643
Nisqually Indian Tribe	2,373	106	122	468	3,068
Port Gamble S'Klallam Tribe	2,698	143	150	2,045	5,036
Quinault Indian Nation	5,755	424	242	1,820	8,241
Samish Indian Nation	1,166	3	99	409	1,678
Shoalwater Bay Indian Tribe	1,825	41	309	846	3,020
Skokomish Indian Tribe	2,123	71	123	519	2,837
Squaxin Island Indian Tribe	2,830	171	218	1,155	4,373
Suquamish Tribe	1,780	24	163	945	2,912
Swinomish Indian Tribal Community	2,314	52	195	1,072	3,633
Tulalip Tribes of Washington	7,474	314	350	1,730	9,867
WISCONSIN	**35,287**	**1,486**	**2,550**	**4,629**	**43,952**
Forest County Potawatomi Community	2,010	218	778	379	3,385
Ho-Chunk Nation	8,261	551	939	863	10,614
Oneida Tribe of Indians of Wisconsin	21,699	526	330	2,614	25,169
Stockbridge-Munsee Community	3,317	192	504	773	4,785
Grand Total	**1,611,473**	**153,205**	**141,695**	**449,701**	**2,356,075**

Indian Health Service
FY 2022 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	465,670	13,459	9,397	57,102	176,306	721,934
ALBUQUERQUE	11,675	924	326	1,368	2,130	16,422
BEMIDJI	84,849	1,856	1,695	7,759	10,286	106,445
BILLINGS	32,400	1,882	909	1,900	4,657	41,748
CALIFORNIA	83,590	3,346	2,406	3,937	35,993	129,272
GREAT PLAINS	29,942	1,188	338	3,282	4,096	38,846
NASHVILLE	92,631	5,058	1,442	4,319	14,680	118,129
NAVAJO	72,514	2,119	2,032	4,776	20,045	101,487
OKLAHOMA	527,753	11,069	13,617	42,352	100,272	695,063
PHOENIX	117,778	1,930	1,603	4,333	31,015	156,660
PORTLAND	107,511	3,718	3,071	7,890	40,163	162,352
TUCSON	51,651	2,582	747	2,679	10,058	67,717
Total, IHS	**1,677,965**	**49,130**	**37,583**	**141,696**	**449,701**	**2,356,075**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2022 Performance Budget Submission to Congress

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Nonrecurring Expenses Fund

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Nonrecurring Expenses Fund
Indian Health Service

(Dollars in Thousands)

	FY 2020	FY 2021[1]	FY 2022
Notification [2]	$108,375	TBD	TBD

Authorizing Legislation:
Authorization…….Section 223 of Division G of the Consolidated Appropriations Act, 2008
Allocation Method……Direct Federal, Competitive Contract

Program Description and Accomplishments

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds 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.

Information Technology Accomplishments

The Indian Health Service (IHS) Health Information Technology (HIT) Program uses secure and reliable information technology (IT) in innovative ways to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. IHS HIT provides support for the IHS, Tribal, and Urban (I/T/U) programs that care for 2.6 million American Indian and Alaska Native (AI/AN) people across the Indian health system. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS HIT also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record (EHR) and more than eighty applications. The IHS HIT program 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, wiser spending of our health dollars, and healthier communities, economy, and country.

NEF funds have allowed IHS to make capital investments through the Health IT Systems and Support (HITSS) project, enabling targeted upgrades toward its quarterly release schedule for the IHS electronic health records system software applications. New upgrades/accomplishments include:

- **Improving Patient Care Program (IPC):** Made critical upgrades to the iCare capability, National Patient Information Reporting System (NPIRS), and Clinical Reporting System (CRS) as part of IPC to support field level quality improvement activities.

- **Bar Code Medication Administration (BCMA):** Continued implementation of a VA-developed BCMA solution, which is designed to prevent medication errors in healthcare settings and improve the quality and safety of medication administration, across the Indian health system.

[1] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.

[2] The projects described below are the current list of approved projects through FY 2021. Additional projects may be funded from the FY 2021 notification letter upon approval from OMB.

- **Emergency Department (ED) Whiteboard**: Developed and implemented the ED Whiteboard to facilitate the electronic tracking of patients. The ED Whiteboard will support clinical staff to avoid mistakes that could lead to patient safety issues.

- **Suicide Risk Assessment**: Created a report to track results of the RPMS Suicide Risk Assessment, which previously would have been a manual process of counting records. This allows sites to locally track their suicide intervention efforts, which may be used to report on grants, such as the Methamphetamine and Suicide Prevention Initiative (MSPI).

- **New Medicare Card Initiative Phases I & II**: Developed and implemented Phase 1 of NMCI facilitating the documentation in RPMS of newly issued Medicare Beneficiary ID numbers; began NMCI Phase II development work.

- **Windows 10 Infrastructure Upgrade**: Upgraded the EHR and HITSS components to support migration to modernized platform; successfully tested, on behalf of the Department of Veterans Affairs and IHS, VistA Imaging (VI) against Win10 and gained FDA approval to use VI across over 400 sites.

- **Medication Information Management, Prescription Drug Monitoring**: Development related to the Medication Information Management and Prescription Drug Monitoring program (PDMP). continued to support final phases for meeting the DEA regulations and HHS Office of National Coordinator (ONC) 2014 certification requirements for the IHS mandated project Electronic Prescribing of Controlled Substance (EPCS).

- **COVID-19 Disease Surveillance Reporting:** Developed a national disease surveillance dashboard that provided insights into COVID testing activity and status to over 300 federal, tribal and urban partners. Additional interface for reporting was developed to support the exchange of critical testing information with HHS.

- **Opioid Surveillance Dashboard:** An enterprise business intelligence solution was developed, for the HOPE committee, to promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and improve access to culturally appropriate treatment.

- **Business Intelligence/Business Analytics Security Framework:** Matured the enterprise security framework that manages, governs and enforces compliance with agency, privacy and program level security definitions, at the row or data column level. The security model promotes reusable solutions that meet national, area, service unit and individual facility reporting requirements.

- **2015 Certified Edition of RPMS:** The IHS Resource and Patient Management System (RPMS) has been certified by the Office of the National Coordinator for Health Information Technology (ONC). In announcing the RPMS 2015 Certified Health Information Technology (CHIT) certification, ONC stated that IHS "meets the certification criteria identified in 45 CFR 170 Subpart C of the 2015 Edition ONC Standards and Certification Criteria." This certification ensures that the IHS, Tribal, and Urban (I/T/U) sites that installed the upgraded software by October 3, 2020 will continue to participate in the Centers for Medicare & Medicaid Services' (CMS) Meaningful Use (MU) program and be eligible for Medicare/Medicaid incentive payments and/or avoid payment adjustments.

Facilities Accomplishments

The IHS Facility Construction Program has received $328.0 million for 38 projects funded by NEF allocations since 2015. One priority project, the Phoenix Indian Medical Center SE, Phoenix, AZ was completed. In addition, 95 staff quarters units and one dental unit was completed.

In total, IHS has obligated 74.5 percent of NEF Facilities funding for 38 projects. NEF Facilities funding has reduced the total IHS Health Care Facilities Construction Project Priority List by $64 million from FY 2015 through FY 2020. The IHS has also constructed an additional 85 Quarters units with NEF Facilities funding.

FY 2020 Budget Allocation

Facilities Activities ($69.5 million): The Indian Health Service (IHS) requests funding to address healthcare facilities construction needs, which directly affect the provision of quality health care and recruitment and retention of healthcare providers.

- Fort Washakie Health Center Expansion and Renovation ($2.5 million): This expansion and renovation project will provide 3,700 sq. ft. of additional space, and renovate 1,500 sq. ft. of existing space. It will create two new nursing stations, and increase the number of exam rooms to 33. This proposed facility construction would increase access to health care for the Wind River Service Unit. The additional exam rooms and renovation will make patient flow more efficient thereby allowing the clinic to provide services to more patients.

- Blackfeet Community Hospital Quarters ($6 million): This project will construct 16 staff quarters to provide housing to healthcare providers in Browning, MT. The Service Unit faces recruitment challenges due to lack of housing.

- Burdick Health Center Emergency Department Renovation ($5.8 million): This project will renovate and expand the existing emergency department, which does not meet standards for the volume of patients and requires a more functional floorplan. The facility is located in Belcourt, ND.

- Burdick Health Center Quarters ($5.9 million): This project will construct an apartment building to be used as staff quarters units in Belcourt, ND. The new apartment building will be a 20,000 sq. ft. single-story building with approximately 19 separate housing units.

- Sacred Oaks Healing Center ($2.3 million): The Sacred Oaks Healing Center is a co-ed residential treatment facility for youths ages 12-17 with substance abuse and co-occurring disorders. These projects will ensure that 24/7 operations will not be interrupted by power outages, trespassers, or flooding. The ultimate goal of this project is to prevent the evacuation of patients, which greatly hinders their healing process.

- Desert Sage Youth Wellness Center ($1.1 million): The Desert Sage Youth Wellness Center is a co-ed residential treatment facility for youths ages 12-17 with substance abuse and co-occurring disorders. These projects will ensure that 24/7 operations will not be interrupted by trespassers and provide additional power. The ultimate goal of this project is to prevent the evacuation of patients, which greatly hinders their healing process.

- Nevada Skies Youth Regional Treatment Center ($1 million): This project includes a redesigned parking lot and drainage to address runoff level, and a fence to make it usable for patients' activities and protection.

- Red Lake Hospital Expansion and Renovation ($20.4 million): This proposed expansion and renovation project is needed to ensure quality and comprehensive healthcare. The Hospital is currently completing the schematic planning phase for the expansion and renovation of the facility. The project will add 4,000 sq. ft. of new space and 42,410 sq. ft. of remodeled space. The project includes renovations and increased space for Primary care, Pediatric Clinic, Laboratory, Behavioral Health, Health Information, Business Office, Information Technology, Administration and Helipad.

- Lawton Pharmacy Expansion ($3 million): This project will modify the pharmacies at the Lawton facility to meet the new provisions in the USP 800 code. The inpatient pharmacy will be relocated to the main pharmacy and clean rooms will be added that meet the new ventilation requirements. Emergency power will be extended to the pharmacy. This will expand the pharmacy space to 4,000 sq. ft., consolidate all pharmacy functions, and ensure that the facility will meet Joint Commission requirements.

- Great Plains Area USP 795, USP 797, and USP 800 Pharmacy Requirements ($6 million): This project includes renovation to add required work areas such as a receiving area, hazardous med storage area, hazardous compounding room (negative buffer room, positive buffer room, anteroom), and segregated compounding area room. Space renovation will include adding/replacing flooring, suspended ceilings, cabinetry, and high-density shelving systems at the following facilities:
    - Quentin N. Burdick Memorial Health Care Facility, Belcourt, ND
    - Eagle Butte Hospital, Eagle Butte, SD
    - Pine Ridge Hospital, Pine Ridge, SD
    - Sioux San Hospital, Rapid City, SD
    - Rosebud PHS Indian Hospital, Rosebud, SD
    - Fort Yates Hospital, Fort Yates, ND
    - Woodrow Wilson Keeble Memorial Health Care Center, Sisseton, SD

- Rosebud Health Center Women's Department Expansion ($4.5 million): This project expands the outpatient and women's health departments for the Rosebud Health Care Facility in Rosebud, South Dakota. This project will ensure the availability of an adequately sized facility that meets current standards and requirements for outpatient clinical care per the IHS Architecture/Engineering Design Guide. Additional space to meet the current and projected patient load, and a floorplan conducive to proper healthcare, will be the major focus points of the project. The project will improve the overall condition of the outpatient clinic and women's health clinic within the Rosebud Hospital building.

- Vern Gibbs Health Center (Ft. Peck) Expansion and Renovation ($5.5 million): This project will relocate the dental and optometry departments into the new ancillary facility. The major change is incorporating the Improving Patient Care model into the existing clinic by creating three team rooms in close proximity to six exam rooms for each of the teams. The Administration and Business Offices will be consolidated to improve communication and streamline existing processes. The Behavioral Health Department will be placed in its own suite with a waiting area to ensure patient privacy and the Laboratory Department will be relocated into the space previously occupied by Dental, placing it directly adjacent to Public Health. The Dental Department will increase the number of chairs from five to ten.

- Gallup Indian Medical Center Fire Alarm Improvements ($3.5 million): This project will completely replace the system to meet current standards.

- Standing Rock Hospital Expansion and HVAC Replacement ($2.2 million): This project includes

construction of a 1,000 sq. ft. addition to the outpatient clinic waiting area, paving asphalt to the existing gravel parking lot by the dialysis entrance, and an HVAC upgrade to meet American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) standards for healthcare.

IT Activities ($38.9 million): These funds will be used to support critical IT infrastructure investments to improve the patient care, meet new requirements, consolidate disparate systems, and increase cybersecurity capacity and capabilities.

- Health Information Technology Systems and Support Capabilities Expansion ($27.1 million):
    - Quality Measures Development and Reporting ($3.8 million): This project will complete critical changes to existing IHS IT infrastructure to support new requirements for quality measures develop and data reporting. The IHS must make these changes to ensure that it can continue to receive revenue through CMS incentive-based quality programs.
    - Advancing Interoperability of Health Information ($15 million): These resources will support implementation of requirements for Certified Health Information Technology stemming from the 21st Century Cures Act.
    - Revenue Cycle Management ($0.5 million): These resources will support a comprehensive alternatives analysis and requirements definition project to improve technologies that support third party billing and accounts receivable processes for direct health care services.
    - Purchased/Referred Care (PRC) Tracking & Payment System ($0.5 million): These resources will support a comprehensive alternatives analysis and requirements definition project to modernize the technologies that support Purchased/Referred Care processes.
    - Population Health Analytics ($0.5 million): These resources will support a comprehensive alternatives analysis and requirements definition project for the modernization of technologies supporting population health management and analytics processes.
    - Centralized Platform & Data Standardization ($2.8 million): This project will standardize application data interfaces and platforms to support dashboard development for aggregated agency quality metrics from the National Data Warehouse. It will also align the Quality Metadata repository within the enterprise National Data Warehouse (NDW) to support quality and surveillance dashboarding and reporting. This would enhance visibility (surveillance, analytics, reporting) into several initiatives that include but are not limited to behavioral health, suicide risk reduction, opioid reporting and surveillance, clinical quality metrics, drug utilization, and disease management.
    - Opioid Prescribing Drug Monitoring ($1.5 million): This project will complete implementation efforts of both the core e-Prescribing system, as well as the mandated Electronic Prescribing of Controlled Substances (EPCS) functionality and processes. It will also to support the collection of pharmacy data and extension of the pharmacy data domain within the National Data Warehouse.
    - IHS Enterprise Business Intelligence Reporting Environment ($2.5 million): This project will improve the Qlik national reporting environment and ensure an ability to support ad hoc enterprise report requirements in support of mission critical reporting initiatives. Adoption of the Qlik business intelligence solution for analytics and reporting enables the

agency to quickly develop national reports that meet key stakeholder reporting requirements.

- Information Technology (IT) Operations Enhancements ($11.8 million):

    - Modernize Enterprise IT Services ($6.3 million): This project will improve the cloud capabilities of IHS Health Information Technology (HIT) systems and improve IT services to support direct patient care. This project is a high priority requirement on the roadmap to modernize the IHS electronic health record system, satisfies recommendations from the HHS Office of the Inspector General (OIG), and achieves Department data center consolidation goals. Expanding cloud capabilities enhances the cybersecurity capabilities of IHS and HIT systems and allows IHS to centralize and consolidate IT services.

    - Improve IT Service Management Maturity ($2.5 million): This project will mature IT Service Management (ITSM) capabilities and improve IT and HIT systems that support direct patient care. This project delivers consistent processes and centralizes ITSM capabilities to improve IHS IT services. This project also allows the IHS to develop a centralized capability to assist in stronger cybersecurity management of IHS IT and HIT systems.

    - Lifecycle Replacement of Critical Hardware ($3 million): This project will replace end-of-life network and data center hardware critical to HIT services that support direct patient care. IHS has thousands of devices that pose a significant cybersecurity risk, are operating beyond the manufacturer's supported lifecycle, and are no longer covered by warranties or service agreements. Additionally, these out of date devices pose a significant cybersecurity risk as they can no longer be patched or secured against threats. This project is part of a multi-year strategy to improve lifecycle management of all IHS hardware.

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