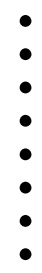
527 S.W. Hall Street, Suite 300
Portland, OR 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
www.npaihb.org

Northwest Portland Area
Indian Health Board

The FY 2008 Indian Health Service Budget: Analysis and Recommendations

18th Annual Report –
Revised: April 13, 2007



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Grading the President's Proposed FY 2008 IHS Budget (Back Cover)

Northwest Portland Area Indian Health Board

FY 2008 Indian Health Service Budget Analysis

The 18th Annual Northwest Portland Area Indian Health Board (NPAIHB or the Board) analysis of the Indian Health Service (IHS) Budget continues a tradition of close scrutiny of the IHS Budget that began in the 1980's. The nature of budget formulation is vastly different for tribes than it is for the beneficiaries of other programs funded by the federal government. The federal trust responsibility and the government-to-government relationship between tribes and the federal government, by definition, require a partnership in the development of the budget. Tribes welcome the continued commitment to joint development of the IHS budget under the Administration of President George W. Bush. The NPAIHB presented this budget analysis to tribes at its March 16, 2007 Annual Budget meeting in Portland, Oregon.

An Administration's budget is a statement of its policies and priorities. This year's final FY 2008 IHS budget will only provide a 2.8% increase over the FY 2007 enacted level for Indian health programs. As in past years, the President and members of the Administration meet will defend this as a very good budget given the current fiscal realities of this country. It will be reasoned that when compared to other discretionary funded programs that the IHS budget did quite well. This argument is based on poor reasoning because the IHS budget is not like other discretionary programs. In effect it is like the Medicaid program and should be funded at the approximate level. Unlike any other agency within Health and Human Services, the IHS provides direct medical care and is subject to much higher rates of inflation than other discretionary programs. Why on one hand would you fund a similar health program like Medicaid at 8% and only fund the IHS at 2.8 percent? When adequate funding is not provided, ultimately services have to be cut. When the significant health disparities of Indian people are taken into consideration and the need to fund medical inflation, the IHS budget is deserving of increases that allow it to meet its need. One thing is clear: the lack of significant increases to fund the real costs of health programs indicate that Indian health care is not an important policy or priority for this Administration.

Arguably, the President's budget provides acceptable increases for IHS budget line items; however it does so at the expense of again eliminating the Urban Indian Health Program and cutting some facilities accounts. The President proposes to eliminate a key component of the IHS system that provides health care services to over 605,000 people. The Senate Committee on Indian Affairs supports the restoration of funding for the urban Indian health programs, with no offset to the proposed budget. Congress must find a way to make this work. Northwest tribes do not support making cuts in other important areas of the program to restore the urban program. Congress requested the IHS to revise its facilities priority system in FY 2001, however, the Agency has yet to complete its revision. It makes fiscal sense to continue the delay of new construction until the revision of the priority system is complete.

Tribes do not to concede that the President's request is a reasonable given the current fiscal realities. Tribes fear that the Congress will once again take the President's request and make changes to suit the priorities of their own constituencies, and secondly that they will once again apply an across the board reduction to meet artificial budget targets, which have no correlation to health care priorities. In FY 2007, Congress applied "fixed cost decreases" to the IHS budget, which have the same effect of recessions. Tribes want the budget increased, and are alert to the danger of Congressional cuts hiding behind the word rescission and fixed cost decreases.

Each year the Board first discusses their priorities during its January Quarterly Board Meeting and at the February meeting of the Affiliated Tribes of Northwest Indians. The Board then develops its analysis and conducts a budget workshop prior to the House and Senate Interior Appropriations hearings (if hearings are held) on the IHS budget. In addition to the Budget Analysis, the Board also prepares a Legislative Plan that presents official Board positions on the budget and other health legislation. The Legislative Plan is developed by the Board and presented for discussion and adoption through resolution at the January Board meeting, and again at the Affiliated Tribes of Northwest Indians at its February meeting. The 2007 NPAIHB Legislative Plan and this budget analysis are the basis of the Board's lobbying activities (both are available at www.npaihb.org).

Budget Formulation: The I/T/U Budget Formulation Team

For the past ten years representatives from the Portland Area have joined Tribes nationwide in the IHS budget formulation process that includes direct service Tribes, Tribally operated and urban programs. This group commonly referred to as the I/T/U, meets annually to develop the IHS budget. The Northwest Tribes' longstanding interest in the budget process allows them to understand the complexity of developing the final approved appropriations. In the past, various Administrations have underestimated the need for funding the IHS. Also, they have often over estimated the amount of revenue received from Medicare, Medicaid, and third party collections.

This analysis was first developed to serve as a reality check demonstrating the lack of integrity past executive branch budgets have experienced. The analysis establishes criteria that are used to grade the President's budget request.

Funding True Need:

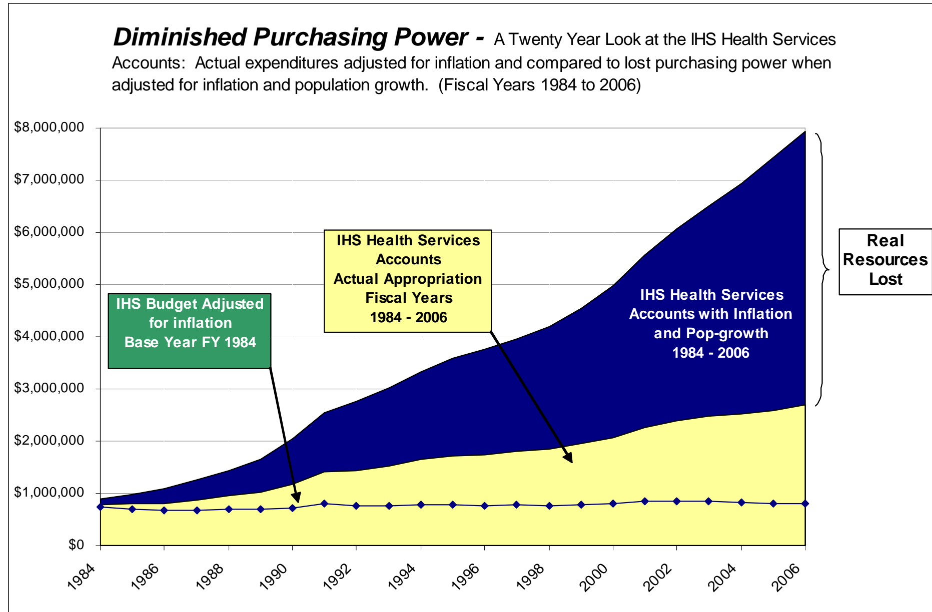
The NPAIHB supports the work of both the I/T/U Budget Formulation Process and the Federal Disparities Index (FDI) Workgroup (formerly known as the Level of Need Funded). The IHS Budget Formulation Process and the FDI Workgroup have both established that the approximate level of funding necessary to meet the true health care needs of Indian people is $9-10 billion. This corroborates the long-held view that less than 50% of true need is funded by the IHS budget. If funded at $9 billion, an additional phased-in facilities cost of $9-10 billion would be needed to house the expanded health care services. This is sometimes stated as a $20 billion need-based budget, but in reality the annualized need after facilities are constructed is closer to $10 billion per year in 2007 dollars. A ten-year phase-in of the $20 billion budget can be achieved if Congress and the Administration can commit to several years of sizeable increases.[1]

Throughout the years, this analysis has sought to maintain the integrity of its estimates by not inflating amounts in the manner of conventional negotiations. Tribal leaders want information that is reliable and accurate so they can make their case to the Congress in good consciousness without fear of accusations of exaggerated estimates or inflated needs. There is nothing to be gained by overestimating the funding required to meet the health care needs of Indian people. The NPAIHB invites discussion over every estimate presented in this analysis.

The following graph illustrates the diminished purchasing power of the IHS budget over the past twenty-two years. The graph demonstrates the compounding effect of multi-year funding

[1] For more discussion on the "IHS Needs Based Budget," see: The True Health Care Needs of American Indians and Alaska Natives, Northwest Portland Area Indian Health Board, June 2003: available at www.npaihb.org.

shortfalls that have considerably eroded the IHS base budget. In 1984, the IHS health services accounts were slightly less than $1 billion, had the accounts received adequate increases for inflation and population growth, that amount would be over $7 billion today. The NPAIHB conservatively estimates that the IHS budget has lost over $2.7 billion over the last fourteen years.



Audience for this Analysis: Tribes, the Administration and the United States Congress

Efforts have been made to identify pertinent issues that impact Northwest Tribes, and provide a meaningful discussion of each. This information will assist leaders of each of our forty-three member tribes in making their own analysis of the budget proposal and its impact on their respective communities. This will also serve as a useful analysis for tribes nationwide since in nearly every case the interests of tribes nationwide are the interests of Northwest Tribes. It is only by making these views known that effective budget policy can be developed. The NPAIHB and Northwest Tribes actively participate in efforts to develop consensus positions on budget priorities.

This analysis is distributed to the Administration and to congressional committees who finalize the annual IHS budget. Although the analysis is prepared for the tribes of the Northwest, the analysis is now made available to tribes throughout the country. It is distributed to the National Indian Health Board, National Congress of American Indians, Tribal Self-Governance Advisory Committee, Alaska Native Health Board, California Rural Indian Health Board, Aberdeen Tribal Chairman's Association, Inter-Tribal Council of Arizona, Montana-Wyoming Health Board, and the United South and Eastern Tribes. It will be posted on the Board's website (at www.npaihb.org) as soon at it is published so all tribes can consider its recommendations for their own use in the consultation process.

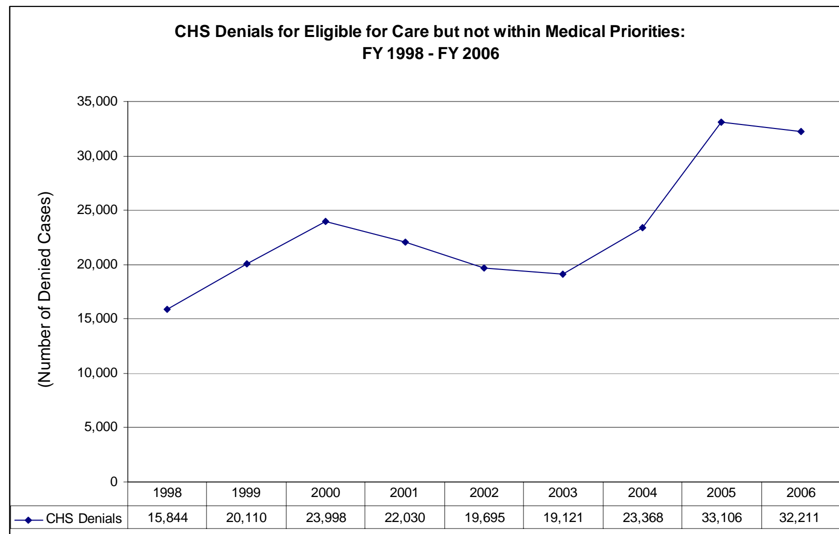
The Congress and the Administration must find common ground to maintain the purchasing power of health care resources, address unmet needs, and facilitate service delivery that meets health objectives while maintaining fiscal discipline.

The NPAIHB estimates it will take $447.6 million to maintain the current level of services provided in our health programs nationwide. Indian Health programs cannot afford to absorb such a large portion of mandatory cost increases year after year. The health and lives of American Indian and Alaskan Natives are being put at risk by this chronic under-funding of the IHS budget. The most obvious effect of these lost revenues is fewer services and ultimately lower health status for American Indians and Alaska Natives. If tribes received mandatory cost increases there would be a decrease in the health disparities between the general population and American Indians and Alaska Natives.

Unfortunately, there is evidence that services have been cut despite the best efforts of Indian health programs. Further efficiencies in Indian health programs will be extremely difficult to attain. Cutting services for life threatening conditions are very likely, and in fact--some Northwest Tribes report that this is already the case in their programs.

Restored Services will be cut due to inadequate funding

There is strong evidence that services will be cut due to inadequate funding. While the denied services for the Contract Health Service program fell for the first time in five years, the deferred services continued to climb. Denied services are those cases that are within the medical priorities for care, however there simply was not enough funding to cover the case. Thus the patient had to go without care. Deferred services are those cases that are not within the medical priorities since there is not enough CHS funding and are left untreated.



In FY 2001, a significant increase for the Contract Health Service (CHS) program allowed some services to be restored. In 2001, the number of Contract Health Service denials declined for the first time since 1993. In FY 2005, the IHS deferred payment for 158,784 recommended cases totaling $152 million. This is the highest amount that deferred payments in the CHS program have ever been. For the first time in five years these numbers dropped, however these reported amounts **understate** the actual unmet need since many tribes no longer report denied or deferred services because of the expense involved in reporting. More disturbing is that many IHS users do not even visit IHS facilities because they know they will be denied services due to funding shortfalls.

The unfunded amount for Catastrophic Health Emergency Fund (CHEF) cases totaled $19.6 million in FY 2006. There were 671 approved CHEF cases; an additional 872 were not approved due to lack of funding. It is estimated that millions of dollars in unreported cases exist since Indian health programs do not report cases once they know the funding has been exhausted during the fiscal year. In the Northwest, many Tribal health programs begin their year in Priority One status as they spend current year apportions to clear the backlog of denied and deferred services from the previous fiscal year. Others noted that they have shifted economic development funds to their contract health program to avoid Priority One status. Tribes should not have to sacrifice their economic development to fund the federal obligation for health care services.

The NPAIHB recommends an increase of 14% or $447.6 million over the final FY 2007 joint resolution to fund current services and maintain the program. NPAIHB further recommends program enhancements above current services in the amount of $416 million. The NPAIHB recommended total increase for current services and program increases is $863.6 million. This amount is required if the Administration is serious about addressing health disparities of Indian people. The enhancements include small facility construction, pharmacy, information technology improvements, and increases above current services for certain line items in the budget. It adequately funds mandatory cost increases and addresses unmet needs for the IHS, and addresses disparities in health status between the general population and the American Indian/Alaska Native (AI/AN) population.

This year's analysis continues to be dedicated to those who are suffering right now, just six months into FY 2007, in health programs that are already in Priority One status.

Acknowledgements

This analysis is based on over 18 years of contributions from delegates and staff of the NPAIHB including: Linda Holt, Chair; Pearl Capoeman-Baller, Julia Davis, former Chairs; Executive Directors: Doni Wilder (1990-1998) and now IHS Portland Area Office Director; Cheryle Kennedy (1998-2000); Ed Fox, Executive Director (2000-2005); current Director, Joe Finkbonner; and Jim Roberts, Policy Analyst.

- Senate Democratic (http://www.senate.gov/~budget/democratic/) and Republican http://www.senate.gov/~budget/republican/ Budget Committee publications.
- The House analysis is available at www.house.gov/budget/prezbudget.htm
- The Budget for FY 2008 www.whitehouse.gov/omb/budget/fy2007/ is the President's budget request of February 7, 2005. It is actually a set of documents with narrative and statistical information on the President's proposed budget for FY 2006.
- Congressional Budget Office (CBO http://www.cbo.gov/), The Budget and Economic Outlook: Fiscal Years 2008-2017, January, 2007 and Preliminary Analysis of the President's Budgetary Proposals for FY 2008, March 2007. These documents examine the federal budget under different economic assumptions and provide estimates that are used for comparison to those of the President's Office of Management and Budget (OMB).
- Department of Health and Human Services Fiscal Year 2008, DHHS FY 2008 Budget In Brief, February 6, 2006 available at http://www.hhs.gov/budget/docbudget.htm
- The Indian Health Service, Justification of Estimates for Appropriations Committees Fiscal Year 2008 available at www.ihs.gov/AdminMngrResources/Budget/index.asp
- Additional information about the U.S. Budget is available at the Center on Budget and Policy Priorities: http://www.cbpp.org/pubs/fedbud.htm

Northwest Portland Area Indian Health Board 527 SW Hall Street, Suite 300 Portland, Oregon 97201	Phone: 503-228-4185 Fax: 503-228-8182 Web Address www.npaihb.org
Chair, Linda Holt, Council Member, Suquamish Tribe	Executive Committee: Linda Holt, Chair (Suquamish Tribe), Andy Joseph, Vice Chair (Confederated Tribes of Colville), Stella Washines, Secretary (Yakama Nation), Janice Clements, Treasurer, Confederated Tribes of Warm Springs), Pearl Capoeman Baller (Quinault Nation)

The FY 2008 Northwest Portland Area Indian Health Board Budget Analysis and Recommendations

It is important to note that most references and estimates regarding the IHS budget us the President's Budget released on February 5, 2007 as a baseline. The estimates presented in this report use the final budget resolution (P.L. 110-5) as its baseline for projecting its costs and estimates.

The President's FY 2008 budget request provides $3.27 billion for the Indian Health Service (IHS), an increase of $90.6 million over the final FY 2007 joint resolution. The Northwest Portland Area Indian Health Board (NPAIHB or the Board) estimates that it will take at least $447.6 million to maintain current services for IHS health programs in FY 2008. This means that the President's request will fall short by over $357 million in unfunded mandatory costs. Funding mandatory costs of inflation, population growth, and pay costs are a requirement in sustaining the current levels of health care.

The President's budget includes $147.5 million in current services and program increases and proposes to restore $64.1 million in base funding to the FY 2007 continuing resolution. The $64.1 million in restored funding is included since inflation is not included in the continuing resolution and without restoration of FY 2007 and FY 2008 levels of inflation; current service levels could not be maintained. The Administration's proposed increases are based on the previous continuing resolution and will surely be adjusted since Congress approved a $134.8 million increase for the IHS in FY 2007.

Once again, the President proposes the elimination the Urban Indian Health Program. Tribes nationally do not support this proposal by the President and have testified before Congress to restore the urban program funds. The Senate Committee on Indian Affairs supports the restoration of the urban program and indicates additional funding should be provided to restore the program. There should not be an offset of the proposed budget to restore the program. Like last year, the Administration is purposely trying to dupe Tribes into thinking they have been provided a reasonable budget, an increase of 6.9% as reported in the IHS Congressional Justification, only to have Congress make cuts in other important areas of the program to restore what the President did not fund.

The costs for phasing in staffing at new facilities ($19.1 million) will leave only $71.5 million to cover the mandatory costs of pay costs, inflation, and population growth. As mentioned previously, these components alone are estimated to be $447.6 million. This means the IHS and Tribal health programs will have to absorb over $357 million in unfunded mandatory costs. How will IHS and Tribes find the resources to absorb these costs? The answer is quite simple, Indian health programs will ultimately cut health services to Indian people to absorb this budget shortfall.

Table No. 1: Indian Health Service Budget
Comparison of FY 2006, 2007, and Presidents FY 2008
(Dollars in Thousands)

Sub Sub Activity	Final Enacted FY 2006	Final Joint Budget Resolution	Change Over FY 2006	President's FY 2008 Budget	Change Over FY 2007	Percent Change
SERVICES:		*P.L. 110-5*				
Hospitals & Health Clinics	$ 1,339,539	$ 1,442,455	$ 102,916	$ 1,493,534	$ 51,079	3.5%
Dental Services	$ 117,731	$ 126,882	$ 9,151	$ 135,755	$ 8,873	7.0%
Mental Health	$ 58,455	$ 61,656	$ 3,201	$ 64,538	$ 2,882	4.7%
Alcohol & Substance Abuse	$ 143,198	$ 150,511	$ 7,313	$ 161,988	$ 11,477	7.6%
Contract Health Services	$ 517,297	$ 517,297	$ -	$ 569,515	$ 52,218	10.1%
Total, Clinical Services	*$ 2,176,220*	*$ 2,298,801*	*$ 122,581*	*$ 2,425,330*	*$ 126,529*	5.5%
PREVENTIVE HEALTH:						
Public Health Nursing	$ 48,959	$ 53,015	$ 4,056	$ 56,825	$ 3,810	7.2%
Health Education	$ 13,584	$ 14,479	$ 895	$ 15,229	$ 750	5.2%
Comm. Health Reps	$ 52,946	$ 55,744	$ 2,798	$ 55,795	$ 51	0.1%
Immunization AK	$ 1,621	$ 1,706	$ 85	$ 1,760	$ 54	3.2%
Total, Preventative Health	*$ 117,110*	*$ 124,944*	*$ 7,834*	*$ 129,609*	*$ 4,665*	3.7%
OTHER SERVICES:						
Urban Health	$ 32,744	$ 33,951	$ 1,207	$ -	$ (33,951)	-100.0%
Indian Health Professions	$ 31,039	$ 31,676	$ 637	$ 31,866	$ 190	0.6%
Tribal Management	$ 2,394	$ 2,485	$ 91	$ 2,529	$ 44	1.8%
Direct Operation	$ 62,194	$ 63,793	$ 1,599	$ 64,632	$ 839	1.3%
Self Governance	$ 5,668	$ 5,842	$ 174	$ 5,928	$ 86	1.5%
Contract Support Costs	$ 264,730	$ 264,730	$ -	$ 271,636	$ 6,906	2.6%
Total, Other Services	*$ 398,769*	*$ 402,477*	*$ 3,708*	*$ 376,591*	*$ (25,886)*	-6.4%
TOTAL, SERVICES	$ 2,692,099	$ 2,826,222	$ 134,123	$ 2,931,530	$ 105,308	3.7%
FACILITIES:						
Maintenance & Improvement	$ 51,633	$ 52,668	$ 1,035	$ 51,936	$ (732)	-1.4%
Sanitation Facilities Construction	$ 92,143	$ 94,003	$ 1,860	$ 88,500	$ (5,503)	-5.9%
Hlth Care Facilities Construction	$ 37,779	$ 24,303	$ (13,476)	$ 12,664	$ (11,639)	-47.9%
Facil. & Envir. Hlth Supp	$ 150,709	$ 161,333	$ 10,624	$ 164,826	$ 3,493	2.2%
Equipment	$ 20,947	$ 21,619	$ 672	$ 21,270	$ (349)	-1.6%
Total, Facilities	*$ 353,211*	*$ 353,926*	*$ 715*	*$ 339,196*	*$ (14,730)*	-4.2%
TOTAL, IHS	**$ 3,045,310**	**$ 3,180,148**	**$ 134,838**	**$ 3,270,726**	**$ 90,578**	**2.8%**

The Final Enacted FY 2007 IHS Budget

The fourth and final Continuing Resolution funds government operations through the end of the current fiscal year September 30, 2007. The joint resolution (P.L. 110-5) passed by Congress was signed by the President on February 15, 2007, which provides $3.18 billion for the IHS, an increase of $90.6 million. The law required the IHS to provide the House and Senate Appropriations Committees an operating plan within 30 days after passage of P.L. 110-5. The details of this spending plan are just now becoming available and it does not look good for one of the most important programs within the Indian health system—the Contract Health Services (CHS) program.

While the IHS budget has received an overall increase of 4.4%, there is **no increase for the CHS program**. The reason for this is due to the way the final continuing resolution (H.J. Res. 20) is structured. The resolution requires the Agency to apply its increase based on the language of the FY 2006 appropriation, which caps the level of funding for the CHS program. The final enacted FY 2006 amount was capped at $499.3 million for CHS and an additional $18 million for the Catastrophic Health Emergency Fund (CHEF). The Agency's operating plan held the FY 2007 CHS funding levels to these FY 2006 thresholds. This means there is no increase in the CHS program to cover inflationary costs, which are significant. In fact, the inflation costs associated with the CHS program are much more significant than the inflationary costs associated with other IHS budget line items. This is an unfortunate circumstance and it seems that the Department and Office of Management and Budget (OMB) are not supportive of the CHS program otherwise they would have found a way to get the CHS program an increase in FY 2007.

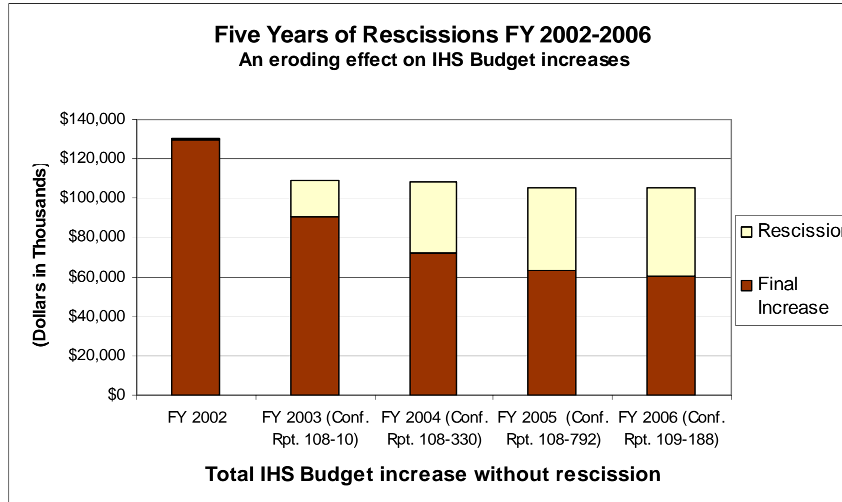
The Hospital and Clinics (7.7%), Dental (7.8%), Public Health Nursing (8.3%), and others received significant percentage increases over FY 2006 levels—yet the CHS program will receive no increase. This makes absolutely no sense whatsoever since the CHS program is subject to much higher inflation rates due to purchasing specialty care services from the private sector. It demonstrates a lack of understanding on behalf of the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB) concerning the CHS program. It seems that their expectation is that the CHS budget is complimented or co-mingled with the other IHS programs and can share in the significant increases of the other IHS budget line items. In most instances, IHS does not reprogram funding from other programs to the CHS program. Tribes most obviously do not reprogram funds, since their CHS funding is generally inadequate.

In FY 2007, the NPAIHB estimated that it would take $436 million to maintain current services; anything less ultimately means a cut in health care services provided to American Indian and Alaska Native people. There is simply no way for Tribes to acquire additional resources to cover the costs of maintaining current services without reducing the current levels of care or cutting other programs like education, social services, law enforcement, or economic development programs. The FY 2007 IHS appropriation falls short by $301 million.

The Effect of Rescissions on the Budget

Last year, IHS appropriations did not see the effect of rescission as in previous years. The House approved Interior Bill and the Senate Interior Appropriation Subcommittee recommendations included "fixed cost decreases" in the IHS' FY 2007 appropriation. While these are not rescissions, the effect on the IHS appropriation is the same. It reduces the base budget amounts of the IHS that most likely will never be restored; and impacts the prospect of budget formulation

for years to come. Last year, the medical care programs for the Veterans Administration were exempt from the DOD rescission. IHS health programs, on the same basis as Veterans health programs, should be exempt from across-the-board reductions. The veteran's health programs are exempt from cuts due to the escalating costs of providing health care and the growing number of veterans returning from Iraq. IHS health programs are subject to the same rates of medical inflation that Veteran's programs are and should be given the same consideration. Moreover, many Indian veterans returning from Iraq will not travel the great distances to receive care at a Veteran's facility. They will present to receive services at an IHS or tribal facility. On this basis, IHS and tribal programs should be treated equally and be exempt from across the board cuts.



Unfortunately, Congress continues the use of rescissions to deal with spending caps in the appropriations process. These rescissions have had a significant impact and a growing effect on the IHS appropriations over the last five years. The reductions as a percentage of the approved IHS budget are growing at a disproportionate rate. Five years ago, the rescissions were a mere one percent of the approved IHS budget increase. In FY 2006, the rescissions will eat up almost half of the approved IHS budget increase. Members of Congress and the President can now have it both ways; they can first say they supported increases and then go on to say (after elections) that they supported fiscal responsibility by cutting funding. This year, the NPAIHB requested members of the Senate Committee on Indian Affairs include a recommendation to exempt Indian health programs from across the board cuts. Unfortunately, the recommendation was not included in the Committee's FY 2007 View and Estimates letter to the Senate Budget Committee.

The information that follows describes how insufficient funding has created funding shortfalls that threaten health care services for American Indian and Alaska Native people.

Preserving the basic health program funded by the IHS budget

The FY 2008 IHS budget falls far short of preserving the existing IHS programs. Tribes and IHS are focused on preserving the basic health care program funded by this budget. Preserving the purchasing power of the IHS base program should be the first budget principle, not an afterthought. How can unmet needs ever be addressed if the existing program is not maintained? Tribes have one overriding concern that is crucial to this discussion. There must be a trusting relationship between tribes who are concerned about improving their health status, the Administration that is charged with that responsibility, and the Congress who holds the purse

strings. Tribes, IHS and Congress must continue to focus on the goals and objectives of the IHS program and assure that the necessary resources are available to continue to make improvements in health status. If the Administration is serious about addressing health disparities it must improve its commitment to adequate funding for the IHS. If it is not serious it should stop highlighting these disparities as if words are the same as action.

The Office of Management and Budget

The Office of Management and Budget continues in its refusal to share vital budget information with Tribes. Five years ago, OMB shared a "who-struck-john" table that allowed tribes to understand where budget cuts were made. This allowed tribes to direct their budget advocacy to key decision makers by providing them with information about the funding requirements of IHS and tribal health programs. This information is now embargoed information and OMB refuses to meeting directly with tribal leaders. This table should be public information. The OMB could open the process even further by sharing budget information prior to the first Monday in February[2]. The continued embargo of the FY 2008 budget information allows the Administration to violate accepted standards of government-to-government consultation. Tribes have specifically requested that OMB allow the Department of Health and Human Services to share the OMB pass-back information with tribes so they can provide their comments to the Administration and the IHS to assist in preparation of its appeal to the Department and OMB. Sharing the final budget information with tribes would allow them to prepare their testimony for the oversight committees in a timely manner.

How can tribes effectively participate in the budget process if they are prohibited from having access to vital information in order to develop recommendations for Congress? Tribes cannot be content with an under funded program that has such a devastating effect on their communities. In the course of this budget review, the President's budget request is evaluated, major issues and concerns are identified, and suggestions are provided that will benefit tribes and IHS. Recommendations for funding levels are also included. It is our goal that this document will be a valuable resource for the Administration, Congress, and the congressional staff that are responsible for understanding the IHS Budget. The treaties, executive orders, and the legislation that tribes have fought so hard to achieve with the government of the United States remain the basic foundation of the unique status of health care for Indian people.

Current Services Budget: Maintaining the Current Health Program and the President's Proposed FY 2008 IHS Budget

Current services estimates' calculate mandatory costs increases necessary to maintain the current level of services. These *"mandatories"* are unavoidable and include medical and general inflation, pay costs, staff for recently constructed facilities and population growth. The 10% increase received in FY 2001 was the last budget that allowed tribes to reduce denials of services. The NPAIHB estimates a FY 2008 current services need of $419.8 million. This is the amount necessary to fund inflation, population growth, and fully fund contract support costs. Anything less will continue the trend of denied health care services as illustrated above.

[2] The first Monday in February is when the President is required to provide his budget to Congress.

There are a number of ways to compute current services. The IHS estimates pay cost increases and reports this separate from inflation. The reason has less to do with budget presentation and more with the simple fact that Congress passes a pay act each year. Pay cost increases are costs that are precisely computed for federal employees. The IHS has also added reasonable tribal pay estimates and also reports these. The pay act is legislation that requires compliance, no matter how long it may take the President to act on pay cost increases. Last year, the President's signed budget included a 2.1 percent overall average pay act increase for Federal employees, which became effective on the first day of the first applicable pay period beginning on or after January 1, 2007.

This year's final FY 2008 IHS budget increase of $90.6 million (an increase of 2.8%) is far short of the **$447.6** million needed to maintain current services. In addition, Portland Area tribes are recommending an additional **$416** million for program enhancements to address the significant health Indian health disparities and priority needs. This brings the total recommended increase to **$863.6** million or 27% over last year's level (see Table 4 on page 19).

Table No. 3: Summary of Mandatory Cost Increases (Current Services)	
Mandatory Cost	***Increase needed to maintain current services (1,000s)***
CHS inflation estimated at 12.5%	$64,662
Health Services Account (not including CHS) inflation estimated at 8.3%)	$173,547
Contract Support Costs (unfunded amount)	$150,000
Population Growth (estimated at 2.1% of health services accounts)	$59,351
Total Mandatory Costs	$447,560

Note on Medical Inflation: Medical Inflation is estimated between 8% - 14% in the Northwest states of Oregon, Washington and Idaho. Health care analysts understand that increases in medical spending reflect increases in the value of services and pharmaceuticals and not simply inflation as measured for most goods and services. Spending in Medicare will increase by 14% and Medicaid by 8.3% in FY 2007. NPAIHB assumes Indian health programs will not achieve the same level of cost containment due to the lack of large group purchasing

In the NPAIHB proposed budget (Table 4, page 18), pay act costs are not displayed separately from general and medical inflation costs. Personnel inflation is a part of the overall inflation adjustment and does not need special treatment for the purposes of calculating a current services budget. The proposed budget recommendations apply a 6.6% inflation adjustment in FY 2008 for the hospital services. This is consistent with the inflation rate used by the Congressional Budget Office to estimate growth in the Medicaid program.[3] The Preventative Health and Other Services apply a 4.7% inflation adjustment consistent with the CPI chained medical services index. The

[3] "The Budget & Economic Outlook: Fiscal Years 2007 to 2016," Congressional Budget Office, available online: www.cbo.gov.

Urban Indian health program applies a 10% inflation adjustment since it has not had any real increases in past years. Finally, the facilities accounts use a 4% inflation adjustment consistent with the CPI chained other medical services index.

The estimate for Contract Support Cost (CSC) need takes into consideration the continuing shortfalls reflected in the annual IHS CSC Shortfall Report. The estimate also takes into consideration the indirect cost rates associated with tribes assuming programs under P.L. 93-638, which are not entirely reflected in the CSC shortfall report. Finally, there are tribes willing to assume programs under P.L. 93-638 however they are reluctant to do so without adequate CSC funding. If the IHS was funded at a level to maintain current services, the CSC need would be much greater.

These inflation estimates are added to the FY 2008 budget to determine the amount needed to maintain current services.

Table No. 4: Indian Health Service Budget
Comparing President's FY 2008 Request to Current Services Estimates
(Dollars in Thousands)

	A	B	C	D	E	F
				CURRENT SERVICES ESTIAMTES		
Sub Sub Activity	**FY 2007 Final Joint Budget Resolution**	**President's FY 2008 Request**	**Change Over CR FY 2007**	**Increase[1] needed for Inflation**	**Increase[2] needed for Pop. Growth**	**NPAIHB ESTIMATE FOR INFLATION**
SERVICES:	*P.L. 110-5*			**6.6%**	**2.1%**	
Hospitals & Health Clinics	$ 1,442,455	$ 1,493,534	$ 51,079	$ 95,202	$ 30,292	$ 125,494
Dental Services	$ 126,882	$ 135,755	$ 8,873	$ 8,374	$ 2,665	$ 11,039
Mental Health	$ 61,656	$ 64,538	$ 2,882	$ 4,069	$ 1,295	$ 5,364
Alcohol & Substance Abuse	$ 150,511	$ 161,988	$ 11,477	$ 9,934	$ 3,161	$ 13,094
Contract Health Services	$ 517,297	$ 569,515	$ 52,218	$ 64,662	$ 10,863	$ 75,525
Total, Clinical Services	*$ 2,298,801*	*$ 2,425,330*	*$ 126,529*	*$ 182,241*	*$ 48,275*	*$ 230,516*
PREVENTIVE HEALTH:				**4.70%**		
Public Health Nursing	$ 53,015	$ 56,825	$ 3,810	$ 2,492	$ 1,113	$ 3,605
Health Education	$ 14,479	$ 15,229	$ 750	$ 681	$ 304	$ 985
Comm. Health Reps	$ 55,744	$ 55,795	$ 51	$ 2,620	$ 1,171	$ 3,791
Immunization AK	$ 1,706	$ 1,760	$ 54	$ 80	$ 36	$ 116
Total, Preventative Health	*$ 124,944*	*$ 129,609*	*$ 4,665*	*$ 5,872*	*$ 2,624*	*$ 8,496*
OTHER SERVICES:				**4%**		
Urban Health	$ 33,951	$ -	$ (33,951)	$ 3,395	$ 713	$ 38,059 [3]
Indian Health Professions	$ 31,676	$ 31,866	$ 190	$ 1,267	$ 665	$ 1,932
Tribal Management	$ 2,485	$ 2,529	$ 44	$ 99	$ 52	$ 152
Direct Operation	$ 63,793	$ 64,632	$ 839	$ 2,552	$ 1,340	$ 3,891
Self Governance	$ 5,842	$ 5,928	$ 86	$ 234	$ 123	$ 356
Contract Support Costs	$ 264,730	$ 271,636	$ 6,906	$ 10,589	$ 5,559	$ - [4]
Total, Other Services	*$ 402,477*	*$ 376,591*	*$ (25,886)*	*$ 18,136*	*$ 8,452*	*$ 44,391*
TOTAL, SERVICES	$ 2,826,222	$ 2,931,530	$ 105,308	$ 206,250	$ 59,351	$ 283,403
FACILITIES:						
Maintenance & Improvement	$ 52,668	$ 51,936	$ (732)	$ 2,107		$ 2,107
Sanitation Facilities Construction	$ 94,003	$ 88,500	$ (5,503)	$ 3,760		$ 3,760
Hlth Care Facilities Construction	$ 24,303	$ 12,664	$ (11,639)	$ 972		$ 972
Facil. & Envir. Hlth Supp	$ 161,333	$ 164,826	$ 3,493	$ 6,453		$ 6,453
Equipment	$ 21,619	$ 21,270	$ (349)	$ 865		$ 865
Total, Facilities	*$ 353,926*	*$ 339,196*	*$ (14,730)*	*$ 14,157*	*$ -*	*$ 14,157*
TOTAL, IHS	**$ 3,180,148**	**$ 3,270,726**	**$ 90,578**	**$ 220,407**	**$ 59,351**	**$ 297,560**

Summary of Costs to maintain Current Services:

Contract Support Costs Shortfall Amount:	$ 150,000
Inflation & Population Growth:	$ 297,560
Total, Maintain Current Services:	$ 447,560 [5]
Program Enhancements (see p. 18):	$ 416,000
Total, Recommended Budget:	**$ 863,560** [5]

[1] Inflation Calculated: Clinical Services 6.6% consistent with CBO estimate for Medicaid; Preventative Health 4.7% consistent with Medical Services chained CPI Series SUUR0000SAM2; Other Services 4% consistent with Other Medical Services chained CPI Series SUUR0000SAM0. CHS inflation is calculated at 12.5% due to increased cost of purchasing specialty care services from private sector.

[2] Computed at 2.1% of Health Services Total.

[3] Inflation for Urban Health Program is calculated at 10% due to lack of any real increases in past years and no increase in FY 2007.

[4] Contract Support Costs (CSC) inflation is calculated at 4% and reported here to demonstrate its need however is not added to the total Increase for Inflation Column (Column F). Instead the IHS CSC Shortfall Report total is used which includes an inflation component and past year's shortfalls.

[5] Does not include $10,589 million for inflation or $5,559 for population growth (see Footnote No. 3)

Tribal Recommendations for Program Increases

Portland Tribes debated various program increases (or program enhancements) that they felt were essential to address high priority health needs. Portland tribes recommended more funding for the grossly under-funded Contract Health Service program in order to address the significant backlog of deferred services, the growing number of denied services, and more funding for the Catastrophic Health Emergency Fund. Sustaining the efforts of health promotion and disease prevention (HP/DP) programs are a concern for Northwest tribes. Thus, Portland tribes recommended more funding for Community Health Representatives, Health Education, Public Health Nursing, and establishment of a separate fund to support HP/DP activities. Facilities funding for small ambulatory clinics continues to be a high priority for the Portland area. Tribes are locked out of the current facility construction priority system and continue to advocate for alternative ways to build health facilities. The small ambulatory construction program allows this. The balances of the increases are distributed in a basic manner for other high priority issues like information technology and pharmaceuticals. The requirements of Indian people participating in the Medicare Part D program are a concern for Tribal health directors. The requirements of premiums and co-payments mean Indian people will not enroll in the Part D program and additional funding is needed for CHS programs to cover these costs.

Table No. 5: IHS Budget Program Increases (Dollars in Thousands)	
CHS Unfunded: Denied/Deferred Services & Catestropic Health Emergency Fund	$ 183,000
Mental Health	$ 18,000
Alcohol and Substance Abuse	$ 30,000
Public Health Nursing	$ 5,000
Health Education	$ 5,000
Community Health Representatives	$ 10,000
Self Governance	$ 5,000
Pharmacy	$ 30,000
Information Technology	$ 20,000
Sanitation Facilities Construction	$ 20,000
Small Ambulatory Clinics, Joint Venture	$ 40,000
Maintenance & Improvement, Facilities	$ 5,000
Guaranteed Loan Program	$ 15,000
Medicare Part D	$ 20,000
Health Promotion & Disease Prevention	$ 10,000
Total, Recommended Program Increases:	**$ 416,000**

There was a spirited discussion on keeping the request within the bounds of political feasibility versus putting forth recommendation based on true need and how this would be accepted given the current fiscal environment. Everyone who participated felt that the funding increases for the line items listed were far short of what was needed. It was decided to highlight the program increases given the significant health disparities of American Indian and Alaska Native people and the years of

productive life lost as a consequence of these disparities. It is noted this increase above current services raises the Portland Area request to a level that may not be politically feasible (from the basic current services amount of 14.1% to 21.6% with these program increases), however highlighting these priorities is necessary for Congress to see that other health areas are in need of increases above current services levels.

Staffing for new facilities

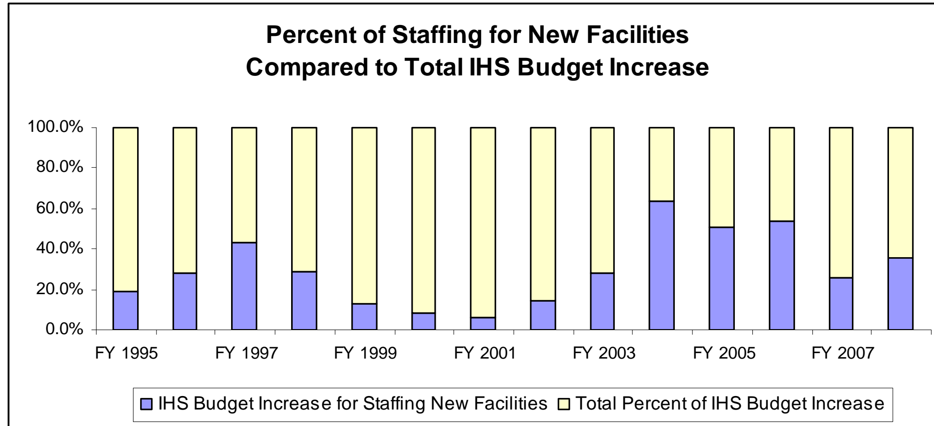
The staffing requirements for newly constructed health facilities have always been a concern for tribes in the Portland Area and other IHS Areas that are dependent on CHS funding to provide health care. The inequities associated with health facilities construction provides a significant amount of resources to Areas that are fortunate to score well under the Health Facilities Construction Priority System (HFCPS). Unfortunately, the HFCPS is fundamentally flawed and provides a disproportionate share of resources to only a few of the IHS Areas—while Areas like Portland, California, and Bemidji must rely on the chronically under-funded CHS program. In the FY 2001 Interior Appropriations Act, Congress requested the IHS to revise the HFCPS so it would be equitable for distributing health resources to address the needs of all tribes. It has been over six years since this request and the IHS has still not responded the Congressional request to revise the HFCPS.

Table 6: Staffing New Facilities (Dollars in Thousands)

Facility	*Staffing Cost*
Clinton, OK Health Center	$7,227
Red Mesa, AZ Health Center	$14,622
Sisseton, SD Health Center	$9,477
St. Paul, AK Health Center	$875
Total	$32,201

Staffing the new facilities opening at the following locations—Clinton, OK; Red Mesa, AZ; Sisseton, SD; and St. Paul, AK—will require $32.2 million in FY 2007. The 'new staffing package' becomes a recurring appropriation. The increase associated with staffing for new facilities is more than the amount applied to other mandatories so its benefit to IHS programs calls into question the wisdom of building these facilities if funding is not available to maintain current programs. How can you continue to build new facilities when you can not even maintain the current level of care in the facilities you have?

The significance of staffing new facilities is that it removes funds necessary to maintain current services. Staffing packages for new facilities are like pay act costs in two respects: (1) They come 'off the top,' (i.e., they are distributed before other increases); and (2) They are recurring appropriations. Northwest Tribes frequently ask: Why did our health program receive a 1% increase in funding this year when we were told there was a 2% or 3% increase for the IHS budget? In FY 2004, the IHS received a 2.1% increase; however Portland Area Tribes realized less than a 1% increase in their health care budgets. In FY 2004, the new staffing was over 60% of the IHS budget increase. In FY 2005 and FY 2006, new staffing costs consumed over 50% of the increase. As the graph illustrates below, the reason for this gap between the annual approved increases for the IHS accounts and actual program level increases is the cost of staffing new facilities.



Staffing costs are obviously legitimate costs that must be provided when a new facility is built. Unfortunately, the existing programs absorb the cost of mandatories for new facilities rather than an additional appropriation. As Table 7 (below) highlights, the staffing of new facilities has received 29.7% of all increases in the IHS health services account over the past 12 years. In FY 2007, $32.2 million will go to staffing new facilities. If scheduled new facilities construction proceeds as planned, it is estimated that this percentage will continue to rise to over 50% of the overall IHS budget in FY 2007 through 2010. Northwest tribes—and many tribes nationally—do not support this level of funding for staffing when there is not enough funding to maintain current services.

Table 7: Percentage of Total IHS Increase Expended on Staffing New Facilities

Fiscal Year	*Staffing Cost*
FY 1995	19.1%
FY 1996	28.3%
FY 1997	43.2%
FY 1998	28.7%
FY 1999	13.0%
FY 2000	8.0%
FY 2001	5.8%
FY 2002	14.2%
FY 2003	27.8%
FY 2004	64.0%
FY 2005	51.0%
FY 2006	53.5%
FY 2007	25.9%
FY 2008	35.6%

Health Services Account

The Compounding Effect of Multi-year Funding Shortfalls

Table 8 below demonstrates the loss of real resources in the Health Services Account due to increases that have been inadequate to pay for costs due to inflation (medical and general) and population growth. Inflation and population figures presented in Table 8 are based on the NPAIHB previous year's analysis to fund current services. The loss of purchasing power over the past fourteen years is conservatively estimated at $2.55 billion. It is difficult to estimate how much collections from Medicaid (and to a lesser extent Medicare) have reduced these shortfalls. One reason for the difficulty is that collections estimates are understated in each year of the IHS budget justification because only IHS facilities' collections are reported. Table 8 illustrates the annual and cumulative impact of annual under-funding of mandatory cost increases. This information is depicted graphically on page 7 of this document.

Table 8: Health Services Account
FY 1993-FY 2008
(Dollars in Thousands)

Year	Approved Health Services Budget	Budget With Inflation & Growth Adjustment	Real Resource Loss
1993	$1,524,990	$1,540,087	$15,097
1994	1,646,088	1,644,195	($1,893)
1995	1,707,092	1,744,221	$37,129
1996	1,745,309	1,847,113	$101,804
1997	1,807,269	1,945,326	$138,057
1998	1,841,074	2,060,512	$219,438
1999	1,950,322	2,274,992	$324,670
2000	2,074,173	2,411,496	$337,323
2001	2,265,663	2,610,497	$344,834
2002	2,389,614	2,630,009	$240,395
2003	2,475,916	2,644,996	$169,080
2004	2,530,364	2,661,614	$131,250
2005	$2,596,492	2,804,211	$207,719
2006	$2,692,099	2,880,546	$188,447
2007	$2,826,222	2,922,906	$96,684
	Total Real Resources Lost FY 1993-2007		$2,550,034

The following section reviews the IHS budget at the 'sub-sub-activity' level for the health services account. The number in the parenthesis is the page number in the Congressional Justification for the IHS FY 2008 budget.

Hospitals and Clinics (CJ-71)

The Hospitals and Clinics line item would receive $1.5 billion under the Administration's request, a proposed increase of 3.5% over the final FY 2007 joint resolution. NPAIHB estimates that $125.5 million is needed to maintain current services. The President's request falls short by $51 million. The Administration's proposal will provide pay act cost increases of $27.9 million dollars and staffing new facilities will require an additional $10.8 million. This account will also receive $21.5 million for population growth and $16.2 million for inflation.

This line item funds hospitals, many services, and other administrative costs such as information technology as well as provides funding for Epidemiology Centers. In some Areas, funds that should be under contract health care are actually found in the H & C line item. The Portland Area receives far less per capita than most areas from this line item, under 5% of all funding despite Portland's nearly 7% share of the IHS user population.

Table 9: Hospitals & Clinics (Dollars in Thousands)			
President Request:	**$**		**1,493,534**
FY 2007 Final Resolution:		$	1,442,455
President's Increase/Decrease	3.5%	$	51,079
NPAIHB Estimate for Inflation & Pop Growth:		$	125,494
	Shortfall:	**$**	**74,415**

Epidemiology Centers

Permanent Funding for the Northwest Tribal Epidemiology Center (IHS 10)
IHS funds eleven Epidemiology Centers, ten tribal and one urban. One of these centers, the Northwest Tribal Epidemiology Center (*The EpiCenter*), is located in the Portland Area at the NPAIHB. *The EpiCenter* is providing epidemiological and programmatic assistance on a variety of health issues. It has taken the lead in helping Northwest Tribes work to achieve the Health Status Objectives specified in the Indian Health Care Improvement Act Amendments of 1992. The Epi-Centers include:

- Alaska Native Epi-Center, Anchorage, AK
- Great Lakes Inter-Tribal Epi-Center, Bemidji, MN
- Inter-Tribal Council Epi-Center, Phoenix, AZ
- Montana-Wyoming Tribal Leaders Council, Billings, MT
- Navajo Nation Division of Health, Window Rock, AZ
- National EpiCenter Program, Albuquerque, NM
- Northern Plains Epi-Center, Rapid City, SD
- NPAIHB Epi-Center, Portland, OR
- Oklahoma Area Epi-Center, Oklahoma City, OK
- United South and Eastern Tribal Epi-Center, Nashville, TN
- Seattle Indian Health Board Epi-Center, Seattle, WA

The Board recommends permanent funding for Tribal Epi-Centers at a level that will enable them to be fully functional epidemiological and surveillance centers. FY 2008 will mark the second year that Tribal Epi-centers will be funded an average of $400,000 per program. This level of funding does not provide for inflation and pay increases for the Epi-Centers and unless these programs receive funding increases, they will be compromised to retain the highly skilled

professionals in their programs. Previous increases have allowed the NPAIHB *EpiCenter* to be funded at a level that allows it to provide professional, high quality work for Indian health programs.

Dental Services (CJ-85)

The President's increase for Dental Health services is $8.8 million and is a 7% increase over the final budget resolution. NPAIHB estimates it will take at least $137.9 million to maintain current services. The President's request falls short by $11 million. The FY 2008 request includes $2.4 million to cover pay cost increases, $2.8 million for phasing-in new dental staff, inflation at $1.3 million, and $1.9 million for population growth.

Table 10: Dental Services (Dollars in Thousands)			
President Request:	**$**		**135,755**
FY 2007 Final Resolution:		$	126,882
President's Increase/Decrease	7.0%	$	8,873
NPAIHB Estimate for Inflation & Pop Growth:		$	11,039
	Shortfall:	**$**	**2,166**

Mental Health (CJ-89)

The President requests $64.5 million to cover the mental health and social services needs of IHS and tribal health programs. NPAIHB estimates indicate that it will take $67 million to cover the needs of Indian Country. The President's request falls short by $2.5 million to maintain current services. While the Administration will claim that mental health services received a 4.7% increase, it did not support restoring lost inflation from FY 2006 to FY 2007; it took Congressional action to support an increase of $2.9 million in FY 2007. The FY 2008 request includes $1.12 million to cover pay costs, $706,000 for inflation, $914,000 for population growth, and $618,000 to cover the costs of phasing in staffing at new facilities.

Table 10: Mental Health (Dollars in Thousands)			
President Request:	**$**		**64,538**
FY 2007 Final Resolution:		$	61,656
President's Increase/Decrease	4.7%	$	2,882
NPAIHB Estimate for Inflation & Pop Growth:		$	5,364
	Shortfall:	**$**	**2,482**

The mental health and social service needs of Indian Country are tremendous. The overall suicide rate for Indian people is 72% greater than the national average. Violence and trauma are also reported at alarming rates in tribal communities. The rate of violence for Indian youth aged 12-17 is 65% greater than the national average. These statistics are shocking and communicate the critical importance of mental health needs to be addressed in Indian Country. Pay costs and

new staffing packages will take 52% of the increase, leaving $1.6 million to cover the $1.9 million costs of inflation and population growth. None of the increase will provide expanded services for the growing mental health needs of Indian Country; they simply maintain the current program. By IHS' own account, the mental health needs throughout Indian Country are a growing concerns and a significant investment is needed to avoid the youth suicides and the effects of a similar tragedy that happened at Red Lake or Columbine high schools.

Alcohol and Substance Abuse (CJ-94)

The President requests a respectable increase for the Alcohol and Substance Abuse account. The requested increase of $11.4 million will leave $1.6 million in unfunded inflation and population growth. NPAIHB estimates that it will take at least $13 million to maintain current services. Alcohol and substance abuse continues to be one of the highest priority identified by tribal leaders and health directors during the IHS budget formulation process. The FY 2008 request includes $2.9 million for pay costs, $5.2 million for inflation, $2.2 million for population growth, and $2 million for phasing in staff at newly constructed health facilities.

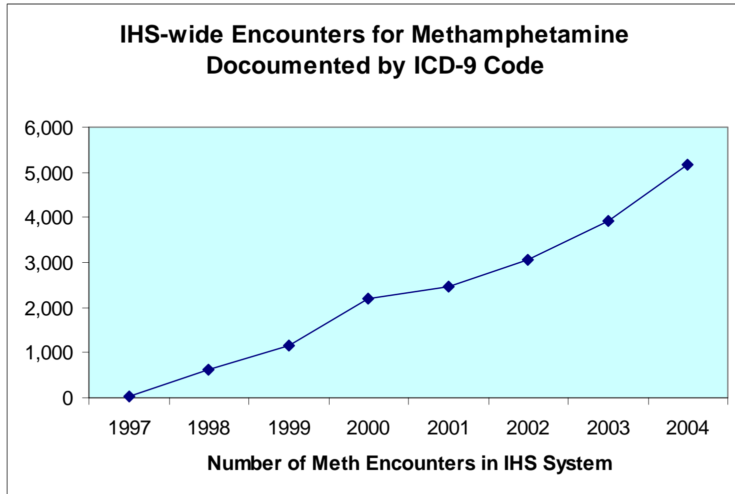
Table 11: Alcohol & Substance Abuse (Dollars in Thousands)

President Request:		**$**	**161,988**
FY 2007 Final Resolution:		$	150,511
President's Increase/Decrease	7.6%	$	11,477
NPAIHB Estimate for Inflation & Pop Growth:		$	13,094
	Shortfall:	**$**	**1,617**

The latest data available to IHS indicates that alcoholism mortality rates in some tribal communities have increased significantly since 1992 to nearly seven-times the alcoholism death rate of the overall U.S. population. In past years, the Administration's request for this line item has been less than adequate with an expectation that tribal programs will have access to SAMHSA funding to address alcohol and substance abuse needs. This expectation can no longer be applied since SAMHSA programs are not being funded as in previous years for FY 2008.

The methamphetamine issue in Indian Country has also reached an epidemic level. According to a recent study, treatment admissions of persons with primary methamphetamine use problems increased from 21,000 to 117,000 in 2003.[4] In 2004, 1.4 million persons aged twelve or older (.6% of the population) had used methamphetamine in the past year, and 600,000 (.2% of the population) had used it in the past month. These two groups represent a little less than 1% of the total population of the United States. The number of past month methamphetamine users who met criteria for illicit drug dependence or abuse in the past twelve months more than doubled in the past two years. In 2002, 164,000 people had reported being past month methamphetamine users; while in 2002, the number had jumped to 346,000. This data is alarming and is only for children twelve years or younger.

[4] National Survey on Drug Use and Health, "Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004. Available online: http://oas.samhsa.gov/2k5/meth/meth.htm, accessed March 3, 2006.



In 1997, the IHS began collecting methamphetamine patient encounter data. The first year the Agency recorded thirty-one patient visits that were methamphetamine related. In 1998, methamphetamine patient visits increased by 1,877% to 613 in a single year. The first year's data spike may be due to IHS developing better data systems to collect methamphetamine patient data. However, the trend demonstrates that IHS patient encounters for methamphetamine related visits are growing at an alarming rate. The IHS Portland Area Office manages a behavioral health fund for those Tribes that continue to receive behavioral health services directly from the Agency. Last year, 90% of the behavioral heath payments were to purchase specialty services due to methamphetamine related cases. The increased costs of health care and the growing methamphetamine use have many tribal leaders across Indian Country concerned that tribes do not have the necessary resources to deal with this epidemic.

Contract Health Services (CJ-100)

NPAIHB estimates that it will take at least $75.5 million to maintain current services in FY 2008. This means that the President's requested increase of $52.2 million will fall significantly short and those referrals for dental services and specialty care will not be reduced; and in fact will probably grow. The proposed increase will be used to cover the costs of inflation ($20.4 million) and population growth ($8.2 million) and $20.2 million will be used to restore unfunded inflation not included in the final FY 2007 apportion (see discussion below).

Table 12: Contract Health Services (Dollars in Thousands)			
President Request:	**$**		**569,515**
FY 2007 Final Resolution:		$	517,297
President's Increase/Decrease	10.1%	$	52,218
NPAIHB Estimate for Inflation & Pop Growth:		$	75,525
Shortfall:		**$**	**23,307**

This year's requested Contract Health Service (CHS) increase is $52.2 million and seems reasonable. It represents a proposed increase of 10.1% over the final joint resolution however, as previously mentioned (see p. 13) the CHS program has not currently received an increase for FY

2007. There is language in the FY 2007 emergency supplemental bills that will provide an additional $25.8 million for the CHS program ($18 million for the Catastrophic Health Emergency Fund and $7.8 million for CHS services). Taking into account this additional increase, the CHS program will only receive a 5% increase if FY 2007. The President has also indicated that he will veto the emergency spending bills which put the CHS program in further jeopardy in terms of an increase to cover the costs of inflation and population growth. If the CHS program is not provided a significant increase in FY 2008 its base budget will be eroded in the appropriation process and cause many to go without health services.

The emergency supplemental bill recommends $525.1 million in funding for the CHS program. If approved, it is only a 1.6% increase over the final resolution. The health services accounts averaged an overall increase of 5.6 percent. The President's FY 2007 request included a $37 million increase for the CHS program, so it is not known why a similar increase wasn't recommended to the Congress as it developed its funding thresholds in the emergency request. Why does the Administration only requests 5% for such an important account, when the request for Hospitals and Clinics, Dental, and others will receive an 8% increase? If CHS program were to be funded at those same levels, the proposed increase in the supplemental bills should be at least $28 to $39 million. The CHS line item is subject to the same inflation rates for inpatient and outpatient services as the Hospital and Clinics line item. In fact, it could be argued that the CHS line item is subject to higher rates of inflation since it is used to purchase specialty care services from the private sector.

Many tribal programs will begin the new fiscal year already on "Priority One" levels or in the winter instead of spring of the fiscal year. CHS funding is the most critical line item for Northwest tribes. The FY 2008 request includes $20.5 million for inflation and $8.2 million for population growth. In FY 2001, President Clinton requested a significant CHS increase that was sufficient to fund population growth and medical inflation and for the first time since 1993 tribes saw the level of CHS denials begin to fall (see Figure on page 8). This year's request is far short ($28.6 million) of the amount needed to truly fund inflation and population growth. Congress should note that there is no funding associated with pay costs for the CHS program, yet the providers that tribes purchase specialty care services from are as deserving of pay cost increases as federal workers. In many cases, increases would go to small town practitioners and rural hospitals. CHS purchases of specialty care are a very efficient method of providing health care services that contributes to rural economies. CHS is a much more efficient method of providing care than building, staffing, and maintaining new hospitals.

The CHS budget is approximately 24% of the total FY 2008 Health Services accounts. In the Northwest it represents over 20% of the total Portland Area Office's budget (Health Services, Preventative Health, Other Services, and Facilities). The consequence of sixteen years of unfunded inflationary increases has been declining services for tribes who depend upon Contract Health Services to support inpatient and specialty care. IHS areas like the Portland Area (with no hospitals) are particularly hurt by the lack of sufficient increases to cover medical care inflation. There is only so much that can be done to restrict medical priorities. Rationing and erosion of service has been a constant problem, particularly for CHS programs. The Portland Area strongly supports distribution of CHS dollars with a formula that recognizes that some areas are strongly dependent on this funding source. Northwest tribes did not support the new formula currently used for CHS distribution.

Table 14: Contract Health Services (CHS) Lost Purchasing Power 1993 - 2007 (Dollars in Thousands)					
Year	Approved Budget	Required CHS Budget with Medical Inflaton	Un-funded Medical Inflation	Un-funded Population Growth	Total Unfunded
FY 1992	$ 308,589	(Base Year)			
FY 1993	$ 328,394	$ 331,425	$ 3,031	$ 6,480	$ 9,511
FY 1994	$ 349,848	$ 354,260	$ 4,412	$ 6,896	$ 11,308
FY 1995	$ 362,564	$ 373,635	$ 11,071	$ 7,347	$ 18,418
FY 1996	$ 362,564	$ 390,428	$ 27,864	$ 7,614	$ 35,478
FY 1997	$ 368,325	$ 406,744	$ 38,419	$ 7,614	$ 46,033
FY 1998	$ 373,375	$ 419,433	$ 46,058	$ 7,735	$ 53,793
FY 1999	$ 385,801	$ 438,218	$ 52,417	$ 7,841	$ 60,258
FY 2000	$ 406,000	$ 414,350	$ 8,350	$ 8,102	$ 16,452
FY 2001	$ 445,773	$ 444,570	$ (1,203)	$ 8,526	$ 7,323
FY 2002	$ 460,776	$ 490,350	$ 29,574	$ 9,240	$ 38,814
FY 2003	$ 475,022	$ 518,373	$ 43,351	$ 9,500	$ 52,851
FY 2004	$ 479,070	$ 536,558	$ 57,488	$ 9,581	$ 67,069
FY 2005	$ 498,068	$ 557,836	$ 59,768	$ 9,961	$ 69,729
FY 2006	$ 517,297	$ 581,959	$ 64,662	$ 10,346	$ 75,008
FY 2007[1]	$ 520,548	$ 605,714	$ 85,166	$ 10,932	$ 96,098
FY 2008	$ 569,515	$ 637,857	$ 68,342	$ 11,960	$ 80,302
		Sixteen Year Total:	**$ 598,770**	**$ 127,715**	**$ 738,444**

[1] The FY 2007 Continuing Resolution amount was only $520.6 million. It is not known if $20.3 million to the CHS base budget will be restored during the FY 2008 appropriation.

Contract Health Services is the program most vulnerable to inflation pressures. Between FY 1992 and FY 2008, the NPAIHB estimates that over **three-quarters of a billion** dollars have been lost to inflation in the CHS program nationally. Unfunded medical inflation alone exceeds $598 million, while unfunded population growth is $127 million—representing over $738 million in lost purchasing power as depicted in the Table 14 above.

Table 15 charts the past twelve years funding for the CHS program. The increase has been about 3.6% each year while medical inflation rate experienced in the Northwest is approximately 10% over the past decade. CHS should receive medical inflation adjustments at least equal to the Medicaid program (projected to be 8.3%)[5] since both purchase care from private providers. The President has requested an amount that is not sufficient to protect real resources that continue to be lost to medical inflation. Medicaid's enrollment growth rate is projected at 1.8% over the next five years and is less than the projected increase in the Indian population (2%); so population growth does not justify the higher rate of growth for Medicaid. Surely no one believes that the relatively small Indian Health Program is able to secure better rates from providers than the Medicare and Medicaid programs.

Table 15. CHS Budget History
FY 1996 to FY 2007
(Dollars in Thousands)

Year	CHS Approved Budget	Increase over Previous Year	Percent of Increase	Comparison to Increase for Medicaid
FY 1996	$ 362,564	(Base Year)		
FY 1997	$ 368,325	$ 5,761	1.6%	4.1%
FY 1998	$ 373,375	$ 5,050	1.4%	5.7%
FY 1999	$ 385,801	$ 12,426	3.3%	7.1%
FY 2000	$ 406,756	$ 20,955	5.4%	9.1%
FY 2001	$ 445,773	$ 39,017	9.6%	11.7%
FY 2002	$ 460,776	$ 15,003	3.4%	13.0%
FY 2003	$ 475,022	$ 14,246	3.1%	11.6%
FY 2004	$ 479,070	$ 4,048	0.9%	9.7%
FY 2005	$ 497,085	$ 18,015	3.8%	4.0%
FY 2006	$ 517,297	$ 20,212	4.1%	0.6%
FY 2007	$ 517,297	$ -	0.0%	6.7%
		12-Year Average:	**3.0%**	**6.9%**

The Department and IHS should expedite the publication of regulations to implement Section 506 of the Medicare Modernization Act. This provision would require hospitals that participate in the Medicare program to accept Medicare-like rates as payment in full when providing services to individuals under the CHS program. This law would provide IHS programs with similar benefits enjoyed by of other Federal purchasers of health care. The Board assisted in the development of the implementation regulations almost two years ago; however the final regulations have not been published by IHS or CMS. It is conservatively estimated that the costs savings from implementation of Section 506 are $25 million per year. In the meantime, Tribes continue to drawdown on their CHS budgets paying much more than is needed. Unfortunately, it has taken the Administration and HHS over two years to implement this important cost saving provision—thereby costing the federal government, IHS and Tribally-operated health programs, and American taxpayers millions of dollars.

[5] The Budget and Economic Outlook: Fiscal Years 2008 to 2017, p. 55, Congressional Budget Office, January 2007.

Catastrophic Health Emergency Fund (CHEF)

The CHS budget includes a Catastrophic Health Emergency Fund (CHEF) of $18 million intended to protect the daily administration of local CHS programs from overwhelming expenditures for catastrophic health cases. This fund is a lifesaver for Indian health programs. Its purpose is to fund catastrophic health care cases with large expenses. Northwest Tribes urge the Congress to consider fully funding CHEF and consider increasing this amount to $24 million since these cases are all well-documented and critical to the financial stability of the small programs that exist in the Portland Area and many other IHS Areas.

The current FY 2007 threshold is $23,800 before a case is considered for funding. The Catastrophic Health Emergency Fund is an important source of funds for programs that experience high cost cases. These cases place a tremendous financial and ethical burden on a Service Unit or a tribe if the case occurs near the end of the year after the Fund has been exhausted.

In FY 2006[6], CHEF claims totaling $19.5 million for 872 cases went unpaid and were absorbed by local CHS budgets. This is an increase of only 70 cases over last year. The actual unfunded need is certainly greater than $19.5 million because the fund is usually depleted by the third quarter of the fiscal year. Indian patients understand this and quit reporting because they know there is no money to cover the costs associated with their care. Otherwise, these numbers would be much higher. CHS deferred services include those cases within the CHS medical priority area, however, are deferred due to lack of funding. Portland Area Tribes strongly urge Congress to fully fund CHEF since the impact of not funding it impacts Indian Health programs more than any other line activity in the budget. **NPAIHB recommend that the CHEF fund be increased to $24 million in FY 2008.** Based on FY 2006 data (the most current year data are available) the CHEF need is $37.3 million.

For FY 2006, the IHS estimates that there are 159,043 deferred services totaling $176 million. This is an increase of 259 cases over FY 2005. In addition, there were another 32,211 cases that meet the eligibility requirements for CHS services, but are denied because the care is not within the CHS medical priorities (Priority One). This is a 29% increase over the previous year. Every year tribes simply do not submit claims since they know that in the last quarter claims are not likely to be approved. Thus, this number could be significantly higher.

[6] FY 2006 is the most current year that CHEF data are available since expenditures are not reported until the following fiscal year.

Public Health Nursing (CJ-105)

The President's request for Public Health Nurses (PHNs) is $56.8 million and is commendable; a reported increase of 7.2% over the final FY 2007 joint resolution. NPAIHB estimates it will take $56.6 million to maintain current services. The President's request will adequately fund the true costs of current services and provide an additional $205,000 for program enhancements. The President's FY 2008 request includes $997,000 for pay costs, $504,000 for inflation, $786,000 for population growth, and $12 million for staffing new facilities.

Table 16: Public Health Nursing (Dollars in Thousands)			
President Request:	**$**		**56,825**
FY 2007 Final Resolution:		$	53,015
President's Increase/Decrease	7.2%	$	3,810
NPAIHB Estimate for Inflation & Pop Growth:		$	3,605
Shortfall:		**$**	**(205)**

PHNs are at the center of many community based health services including home visits to provide: disease surveillance, direct therapy; and group education comprise 40% of the PHNs time. The growing elderly population has resulted in an increase in home visits by PHNs. The growing threat of pandemic flu planning and bioterrorism has also brought additional responsibilities for the PHN program. PHNs are vital in the emergency planning arena through health surveillance and coordination with other local health jurisdictions. It is clear that this growing need will require greater than average increases. A significant amount of time is dedicated to maternal and child health promotion. The important work being done to lower infant mortality and Sudden Infant Death Syndrome cannot be maintained if funding falls below the rate of inflation. SIDS awareness campaigns have resulted in a lower rate of infant deaths, yet it is still the greatest cause of infant mortality with rates that are the highest of any group in the United States.

Health Education (CJ-108)

The President's request for Health Education is $15.2 million in FY 2008. NPAIHB estimates that it will take at least $985,000 to maintain current services. The President's request falls short by $235,000. This year's request includes $274,000 for pay costs, $188,000 for inflation, $215,000 for population growth, and $170,000 for staffing at new facilities.

Table 17: Health Education (Dollars in Thousands)			
President Request:	**$**		**15,229**
FY 2007 Final Resolution:		$	14,479
President's Increase/Decrease	5.2%	$	750
NPAIHB Estimate for Inflation & Pop Growth:		$	985
Shortfall:		**$**	**235**

In FY 2007, the President requested a 7% increase for Health Education with this year's request at approximately 5%. This demonstrates the continued commitment of the Department and the IHS Director to encourage health promotion and disease prevention programs. NPAIHB supports this initiative and recommends additional funding to address the $235,000 shortfall in this year's request.

The Health Education program communicates the importance and on-

going need for comprehensive clinical and community health education programs. It ensures education to patients, works with hospitals, clinics, and community education programs to integrate IHS patient education protocols and code systems.

Community Health Representatives (CJ-112)

The President's request for the Community Health Representatives (CHRs) program is only $55.8 million, approximately the same amount as requested last year. NPAIHB estimates that it will take at least $59.5 million to fund requirements of current services. No new staffing dollars are proposed for the CHR program. The FY 2008 increase includes $1.1 million for pay cost increases, $832,000 for inflation, and $827,000 to fund population growth. The President's request falls short of maintaining current services by $3.9 million in FY 2008.

Table 18: Community Health Representatives (Dollars in Thousands)			
President Request:		**$**	**55,795**
FY 2007 Final Resolution:		$	55,744
President's Increase/Decrease	0.1%	$	51
NPAIHB Estimate for Inflation & Pop Growth:		$	3,971
	Shortfall:	**$**	**3,920**

The CHR program maximizes health resources by providing basic medical knowledge about health promotion and disease prevention in the communities. Increased training for CHRs has made them effective partners on the health care team. CHRs are at the forefront of much of the preventive health that needs to be emphasized in Indian health programs. Unfortunately, the requested level of funding will result in cuts at the program level since it does not cover inflationary cost increases.

Urban Health (CJ-121)

For the second straight year, the President's FY 2008 proposes to eliminate the $34 million to fund the Urban Indian health Programs (UIHP) across the country. The Administration rationalizes that urban Indians—unlike other Indian people that live in isolated rural areas—have access to hospitals and other health services under Medicaid and other Federal, State and local health care programs, on the same basis as other Americans. NPAIHB recommends that the UIHP be restored by Congress and an additional $4.1 million be provided to fund the costs of maintaining current services. This is in part due to the fact that the UIHP has not received respectable budget increases in the last five years and if restored at the previous level will not receive an increase in FY 2008.

Table 19: Urban Health (Dollars in Thousands)			
President Request:		**$**	**-**
FY 2007 Final Resolution:		$	33,951
President's Increase/Decrease	-100.0%	$	(33,951)
NPAIHB Estimate for Inflation & Pop Growth:		$	38,059
	Shortfall:	**$**	**38,059**

The justification for eliminating the urban health program does not make sense when Secretary Leavitt's 500 Day Plan outlines priorities and two objectives for HHS are to *Eliminate Racial and Ethnic Health Disparities* and *Increase Access to Health Service for AI/ANs*. In FY 2006, these programs provided over 680,000 health services to more than 605,000 urban Indian people living in thirty-four locations across this country. The proposal to eliminate the urban health program will contribute to worsening the health disparities of Indian people and decrease access to health services.

Many Indian people in the 1950s and 60s were relocated from reservations to cities in order to receive educational and training opportunities. The basis for the provision of health services to the urban Indian population is a direct result of the federal government's early assimilation policies. The President's proposal to cut urban Indian health programs from the IHS budget means that these people will now go without receiving health services or some will return to already under-funded tribal clinics. The Administration and IHS justify the elimination of the urban program by indicating that people served in these programs have access to health services under Medicaid and from the Health Resources Services Administration's (HRSA) community health centers.

This assertion is simply is not true. Indian people are not able to navigate the social or community health center systems in an urban setting for a variety of reasons, such as receiving care from a culturally competent provider. When Indian people return to reservations to receive health services they could actually cost the federal and state governments and tribal health programs more money to treat. This will be the same situation when they present at local community health centers. Many will have gone without services for some time and will be in a greater need of care. They will require more services than if they had been treated earlier, resulting in increased costs. They may also enroll in other social service programs that will cost the Tribes and state programs more money.

The National Association of Community Health Centers has indicated that they simply lack the capacity to absorb the patient load resulting from the elimination of the UIHP. Many Urban Indian programs are designated as community health centers and will jeopardize their HRSA program if they loose IHS funding. In addition to health services, the UIHPs have leveraged their IHS resources to develop capacity in other areas of their program. They not only provide IHS services, but other services funded by SAMHSA, CDC, HRSA, states, and the private sector as well. These services are not just provided to AI/AN people, but to the overall community. By cutting urban programs, the Administration has compromised these other services and the very safety net that it indicates Indian people will be able to rely on.

Indian Health Professions (CJ-123)

The Administration's request for Indian Health Professions is $31.9 million, an increase of less than 1% over the final FY 2007 joint resolution. The President's request for Indian Health Professions simply does not make sense when the IHS is experiencing critical shortages of physicians, nurses, dentists, pharmacists, and optometrists, as well as a growing concern of other professions essential to staffing health facilities. The purpose of this program is to recruit Indian people into the health professions, and serves as a catalyst for the development of health professionals to work for IHS and tribal program. Thereby assisting Indian health programs to recruit, train, and develop staff to work in its own health programs and address critical health shortage areas.

Table 20: Indian Health Professions (Dollars in Thousands)			
President Request:		**$**	**31,866**
FY 2007 Final Resolution:		$	31,676
President's Increase/Decrease	0.6%	$	190
NPAIHB Estimate for Inflation & Pop Growth:		$	1,932
	Shortfall:	**$**	**1,742**

This year's increase of only $190,000 will not adequately cover the President's proposed $44,000 for pay cost increases and $608,000 for inflation. The NPAIHB estimates that current services for this account are $1.9 million with a total budget need of $33.6 million. The President's request is short by $1.7 million and is not sufficient to address the health personnel shortages of Indian Country. The scholarship and loan repayment programs are vital to the IHS system developing its own human resource capital and must be funded accordingly.

Tribal Management (CJ-129)

The President requests $2.5 million for the Tribal Management and is approximately the same amount as last year. This program administers grants to tribes, and tribal organizations carrying out Self-Determination and Self-Governance programs and works to develop management capacity of Indian managed programs.

Table 21: Tribal Management (Dollars in Thousands)			
President Request:		**$**	**2,529**
FY 2007 Final Resolution:		$	2,485
President's Increase/Decrease	1.8%	$	44
NPAIHB Estimate for Inflation & Pop Growth:		$	152
	Shortfall:	**$**	**108**

NPAIHB estimates that it will take $108,000 to maintain current services, over double the amount than the proposed increase of $44 thousand. Realistically, the current services estimate should be much higher since the President and Congress have not funded any increases for this line item in a number of years. FY 2006 was the first time in two years that an increase was proposed for the Tribal Management line item. In FY 2008, the President proposes restoring $44,000, and unless Congress approves the request, the Tribal Management budget will not have received an increase in over three years. This program is an essential component of the Self-Determination program and allows tribes to assess, evaluate, and develop their capacity to assume IHS programs. The President's increase of $44,000 will be used to cover the costs inflation. The President's request will fall short of maintaining current services by $108,000 and does not provide for any expansion of the current program.

Direct Operations (CJ-132)

The Direct Operations line item funds the cost of management at IHS headquarters and the twelve Area Offices. This year the President request includes $64.6 million, an increase of only $839,0000 over the final FY 2007 joint resolution. NPAIHB estimates that it will take at least $3.9 million to maintain current services for a total budget need of $67.7 million. The President's request will fall short by over $3 million to maintain current services. The proposed budget proposes to cover the costs of $1.3 million in pay costs and $369,000 for inflation.

Table 22: Direct Operation (Dollars in Thousands)			
President Request:	**$**		**64,632**
FY 2007 Final Resolution:		$	63,793
President's Increase/Decrease	1.3%	$	839
NPAIHB Estimate for Inflation & Pop Growth:		$	3,891
Shortfall:		**$**	**3,052**

Self-Governance (CJ 136)

The President's request for the Self-Governance item is only $5.9 million and is only $81,000 more than what was requested last year. NPAIHB estimates that it will take at least $356,000 in FY 2008 to maintain current services. This leaves $270,000 in unfunded mandatory costs in FY 2008. While this may not seem like much, three years ago, Congress reduced the Self Governance line item by $4.7 million, a loss of over 43% from the previous year. Tribes have continually recommended that this funding be restored to the FY 2002 level. The FY 2008 request for Self-Governance is an $86,000 increase that is supposed to cover proposed costs of $20,000 for pay cost increases and $164,000 for inflation. In FY 2008, the IHS will reserve a fund of $2.5 million for shortfall. These funds will address shortfalls in compact funding in cases where there can not be a direct transfer of funds from IHS to the tribes to fund Self-Governance compacts without jeopardizing the support to other IHS programs.

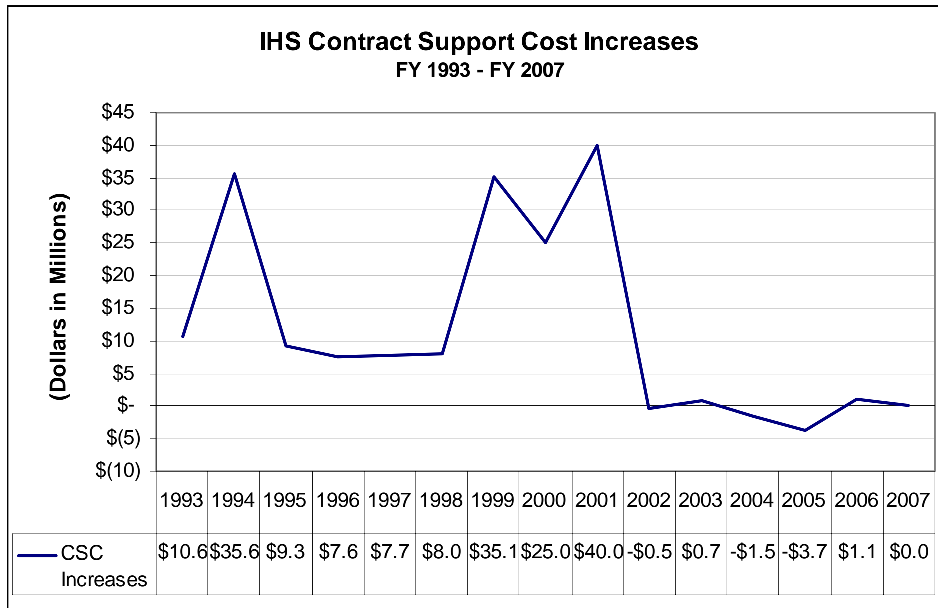
Table 23: Self Governance (Dollars in Thousands)			
President Request:	**$**		**5,928**
FY 2007 Final Resolution:		$	5,842
President's Increase/Decrease	1.5%	$	86
NPAIHB Estimate for Inflation & Pop Growth:		$	356
Shortfall:		**$**	**270**

The Self-Governance office supports compacted tribes operating programs under the Tribal Self-Governance Amendments of 2000. This law, P. L. 106-260 established compacting as permanent, under the new Title V of P. L. 93-638. The Self-Governance process serves as a model program for federal government outsourcing, which builds Tribal infrastructure and provides quality services to Indian people. It is estimated that Tribes operate $1.142 billion of the total IHS budget, and it is imperative that they receive the necessary resources to develop and build their administrative infrastructure and allow for new and expanded programs.

Contract Support Costs (CJ-140)

Table 24: Contract Support Costs (Dollars in Thousands)			
President Request:	**$**		**271,636**
FY 2007 Final Resolution:		$	264,730
President's Increase/Decrease	2.6%	$	6,906
NPAIHB Estimate for Inflation & Pop Growth:		$	16,148
Shortfall:		**$**	**9,242**

The Indian Self-Determination and Education Assistance Act of 1975 authorize Tribes to enter into contracts or self-governance compacts to manage federal programs previously administered by the IHS. The well-documented achievements of the Indian self-determination policies have consistently improved service delivery, increased service levels, and strengthened Tribal governments, institutions, and services for Indian people. Every Administration since 1975 has embraced this policy and Congress has repeatedly affirmed it through extensive amendments to strengthen the Self-Determination Act in 1988 and 1994. Once again, the President's budget fails to support the principles of Indian Self-Determination by not requesting adequate Contact Support Cost (CSC) funding.



In FY 2005, Congress failed to provide an increase for CSC for a second straight year. Because of the effect of the rescissions, the CSC line item has had its base funding eroded by over $6 million. The FY 2008 request of $271 million for CSC is not adequate to fund past year's shortfalls or provide necessary resources for Tribes to continue to manage health programs assumed from the Federal government. The President's budget falls short by $9.2 million to maintain inflation.

The damaging cuts to CSC are contrary to the Administration's principles of government outsourcing. The FY 2008 proposed increase of $5.5 million will not even restore the CSC funding base lost due to the fact that the Administration failed to request adequate CSC funds.

The proposed increase will be directed for new and expanded P.L. 93-638 programs; and will require Tribes to waive their rights to CSC as a condition to the award of any new Self-Determination or Self-Governance agreements. This requirement has essentially stopped many Tribes from assuming programs under P.L. 93-638 and is contrary to the principles of Indian Self-Determination. **Congress should act to prohibit IHS' new waiver policy and address the funding of CSC for new initiatives**.

There is approximately $150 million in CSC shortfall that has accumulated over the years. This growing shortfall reflects the absence of any significant increases over the past six years. In addition to the funding to maintain current services, **Congress must act to eliminate the backlog of $150 million in CSC funding shortfall.** The continuing shortfall threatens to pit tribe against tribe as mature contractors are asked to absorb all inflationary increases in order to fund new contractors. There are at least three Portland Area tribes that would like an opportunity to assume programs from the IHS, however can not because of the lack of CSC funding, IHS' new CSC policy.

Medicaid, Medicare and Private Collections (CJ-143)

Medicare and Medicaid programs have entered a period of change and will have a great impact on Indian health programs. Over the last two to three years, Congress and the Administration have take measures to reform these two programs that will have lasting effects on the Indian health system and its ability to enroll people in the programs and receive reimbursements.

The changes contained in the Medicare Modernization Act (MMA) and Deficit Reduction Act of 2006 (DRA) have had an impact on the ability of the IHS system to collect reimbursements under Medicaid. The MMA Part D program shifted pharmaceutical costs for dual-eligibles from Medicaid to Part D plans. Because of this, the IHS system lost significant resources in third party reimbursements. The effects of this shift are still not fully known because the data systems for IHS and CMS are not adequate to track utilization in the Part D program.

The effects of the DRA are starting to be felt with lower enrollment in Medicaid because of the documentation requirements for enrollment and re-determination. The DRA also allowed states to reduce access to services by allowing increased cost-sharing and premiums. While many states have not taken advantage of this flexibility it is expected that more will in FY 2008, thus effecting Indian health programs even though services provided to Indian is reimbursed at 100 FMAP. The DRA changes will have a very harmful effect on the Indian health system and affect Indian participation in Medicare and Medicaid, which is already low. The decreases in Medicaid enrollment will deprive chronically under-funded Indian health programs of vital Medicaid revenues.

These reductions in resources available to the Indian health system would decrease the health services they can provide and cause a further decline in the health status of Indian people.

No one really knows how much is collected for Medicare and Medicaid, but at least the Administration does not inflate the estimates and then use the inflated estimates to justify lower increases in the IHS budget. The estimates are not worth restating here. One wonders why the Centers for Medicare and Medicaid cannot produce better figures since they are paying the bills.

Special Diabetes Funding (CJ-146)

FY 2004 was the first year of the $150 million per year authorized for diabetes by the 107th Congress. In response to Congressional direction, the IHS developed and implemented a competitive grant program entitled, the Targeted Demonstration Project. The competitive grant program provides $24.7 million to focus on primary prevention of Type 2 diabetes and reduction of cardiovascular risk in American Indian people. A careful evaluation of this expenditure of over $100 million for a research project should be conducted annually to ensure the wise use of limited funds.

The Special Diabetes program will most surely result in program dollar savings in future years. Tribes welcome new resources for diabetes and hope to make these funds a recurring addition to the IHS budget until they are not needed. These funds are a good investment. They are helping tribes nationwide to understand the magnitude of the burden of disease from diabetes, and to develop effective interventions. They will likely save future spending on this disease. Improved health status depends on adequate appropriations. In some cases failing to maintain current services will result in the need for greater resources in the future. In addition to the human suffering it causes, diabetes is a financial drain on Indian health program resources. If prevention activities are successful, much suffering and expense will be avoided. Tribes are successfully developing programs to prevent and treat this serious disease that disproportionately impacts Indian people. The NPAIHB's *EpiCenter* is assisting tribes in this effort and continues to report on progress made by Northwest Tribes. Northwest tribes have invested over $1 million of their own diabetes allocation in improving Diabetes data reporting and information generation since the start of the SDPI.

Health Facilities Account (CJ-162)

Maintenance and Improvement (IHF-3)

Over the past 13 years (FY 1993-FY2007) there has been less than a 5% increase in Maintenance & Improvement (M&I) despite the fact that the inventory of space has increase appreciably (over 30% in the Portland Area). Many tribes have seen a decrease in their funding due to the lack of adequate increases to reflect the growth in new and expanded facilities. The current (2006) replacement value of facilities eligible for M&I is $2.42 billion. The capital assets of Indian health facilities must be protected from deteriorating due to lack of funding for routine maintenance.

The IHS Backlog of Essential Maintenance and Repair (BEMAR) survey for October 2006 estimates that there is a chronic backlog of $409 million in needed repairs to Indian health facilities. In FY 2002 $14.1 million was available for program deficiencies identified by BEMAR. The IHS should continue to update this information to provide Congress with the basis for increased funding to address this need.

The President's request for M&I is $51.9 million and is $318,000 less than the amount funding in the FY 2007 continuing resolution. The President's request does not restore unfunded inflation to most of the health facility accounts. It seems unreasonable to maintain that unfunded inflation in the continuing resolution be provided to health services and prevention accounts, however not provide that same justification for the facility maintenance accounts. The NPAIHB estimates that it will take at least $2.1 million to address the current M&I needs of Indian health facilities.

Sanitation (CJ-168)
Approximately 7.5% of all AI/AN homes lack safe water in the home compared to less than 1% average nationally. Unfortunately, the final FY 2007 joint resolution for Sanitation services only will decrease the program my $5.5 million even though the list of documented project needs totals $915 million. The President's FY 2008 request includes is only $88.5 million and proposes to cut $5.5 million from the final FY 2007 joint resolution amount. NPAIHB estimates that it will take at least $3.8 million to address the sanitation needs of Indian Country.

Health Facilities Construction (CJ-174)
Northwest tribes are on record as supporting the continued pause in new facilities construction. Last year this position was supported to redirect the savings to the health services accounts. This year Northwest tribes support the moratorium to redirect the savings to restore the urban Indian health program. As noted above, facilities, especially hospitals are expensive to build and their staffing packages more costly still. The Administration and Congress funded $88.6 million in FY 2005 while allowing Contract Health Services to erode with funding 75% below the level needed to maintain services.

The cost of the Ft. Defiance Hospital through FY 2004 totaled $125 million---far above the initial estimate of $105 million. The projected cost to build the Phoenix Indian Medical Center heath system, four different facilities, will be over $537 million. At the current rate of health facilities appropriations it will take at least 7-8 years to complete the PIMC projects. Thus, keeping the health facilities construction priority system locked for at least another decade. The current priority list was developed in 1991 and locks out Tribes from badly needed construction dollars unless you are one of the facilities on the current list. The Portland Area tribes continue to oppose any new facilities construction projects until the IHS completes its revision of the Health Facilities Construction Priority System.

Alternative Methods of Acquiring Health Facilities
If new facilities construction dollars are restored to the FY 2008 budget, some of these funds should go to alternative funding mechanisms. Northwest Tribes have long encouraged alternative methods to construct new facilities. These alternative methods of acquiring health facilities must be supported in an effort to meet the demand for primary care. There is such an enormous need that depending exclusively upon IHS appropriations for all health facility requirements is not realistic. The IHS and Tribes have developed a strategy that will greatly increase the number of new ambulatory health facilities constructed, but some IHS funding is required for this strategy of leveraging financing to work.

The Indian Health Care Improvement Amendments (Section 818 of P.L. 102-573) authorized joint venture projects in which a tribe plans and constructs a health facility and IHS provides the equipment, staffing and operations costs. The Administration requests no funds for additional projects. $20 million would fund two to three projects per year.

The Indian Health Care Improvement Act (Section 306 of P.L. 102-573) authorized a grant program for the construction, expansion and modernization of small ambulatory care facilities. This program assists tribes to secure quality health care in isolated rural areas. In the Northwest this could mean replacing old, worn out trailers that serve as the health clinics in tribal communities. Small modern clinic facilities assist tribes to attract health care professionals, provide a health focus for the community, and where tribes are agreeable and resources available, can provide health care services to underserved non-Indian individuals in the community. An investment of $25 million would

support four to ten projects a year. This program has an excellent record of achievement that should be rewarded with increased appropriations.

The NPAIHB has also suggested that the IHS secure authority to make loan guarantees for tribes who are seeking outside financing for health facilities. This would create another opportunity for tribes to build needed facilities rather than waiting for the IHS to fulfill its obligation. A loan guarantee would substantially reduce the debt service associated with financing facilities. A $15 million fund (possibly funded with government bonds) could support construction of seven projects a year with tribes repaying their loans with Medicaid collections or other sources of revenue.

Facilities and Environmental Health and Engineering Support (CJ-183)
This line item consists of four subsidiary activities; facilities support, environmental health support, and the office of Environmental Health and Engineering support. The FY 2007 continuing resolution included $161.3 million for this account. The President's FY 2008 request is $164.8 million, an increase of only $3.5 million over the final FY 2007 joint resolution. The NPAIHB estimates that it will take an increase of $6.5 million to maintain the current levels of service. The President's budget falls short by $6.1 million.

Equipment (CJ-186)
The Administration requests $21.3 for Equipment, a decrease of $80,000 from the FY 2007 continuing resolution. IHS estimates an inventory of $320 million in equipment with an average estimated life expectancy of six years. New facilities, including facilities built with non-IHS funds could benefit from additional funding. The equipment line item funds normal equipment replacement due to age and maintenance. A reasonable estimate is that Indian health programs will need an additional $18 million annually to cover needs for biomedical, facility and telecommunications equipment. This amount will only cover the cost of upgrades and will not cover the cost of equipment-even where that would be more cost effective in the long run.

The FY 2008 IHS Budget in the Context of Current Fiscal Realities

It is worthwhile to consider the overall budgetary context in any analysis of the FY 2008 IHS budget. When President Clinton left office there was a budget surplus that was anticipated to continue to grow to $6 trillion over ten years. Unfortunately, the recession from past years, combined with the war in Iraq, hurricane relief, and tax cuts have completely reversed this Country's future budget prospects. If enacted, the proposals in the President's budget will add $37 billion to the deficit this year by reducing revenues by $9 billion and boosting outlays by $28 billion (mostly for military operations in Iraq and Afghanistan). The effect of this would be a federal deficit of $214 billion in FY 2007.

Table 25: Annual Budget Surplus Projections

	Fiscal Years (Dollars in Billions)											
	2006 Actual	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
President Budget Projections	$ (248)	$ (214)	$ 226	$ (215)	$ (169)	$ (149)	$ (31)	$ (74)	$ (64)	$ (53)	$ (70)	$ (10)

Source: CBO An Analysis of the President's Budgetary Proposals for FY 2008, available at: www.cbo.gov.

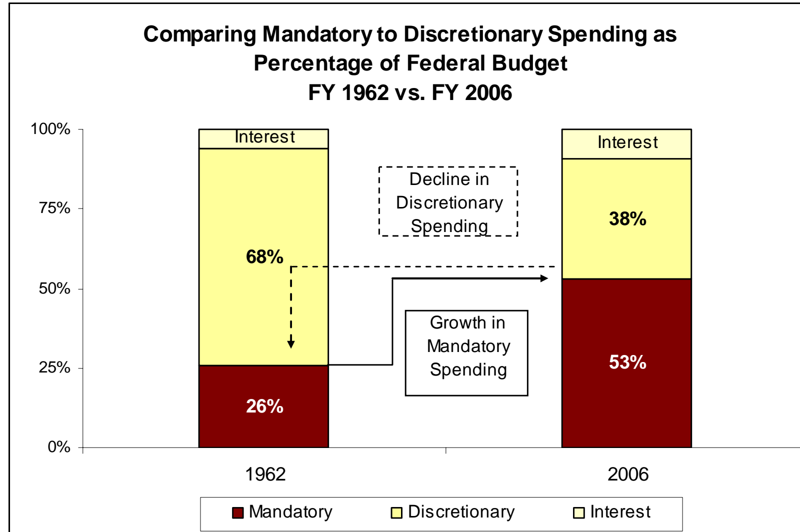
Table 25 estimates the budget deficit over the next ten years using information reported in the President's FY 2008 budget. The current budget deficit is $248 billion. As the table illustrates, the CBO anticipates deficit spending for the next ten years. The President's budget proposes to reduce the deficit to near balance by the year 2017 with critical changes in mandatory and discretionary funded programs.

Budget Realities

If the President's budget proposals are enacted they will reduce mandatory spending by $34 billion (0.4 percent) over the next five years. The proposals will also cut non-discretionary spending by 6.8% if Congress approves many of the President's budget proposals. For FY 2007, discretionary programs represent approximately one-third (37%) of the budget of the United States government. Mandatory spending for Social Security Act programs like Medicare, Medicaid and other mandatory programs such as veterans programs represent over 54% of the budget. Debt interest is projected to stay approximately the same over the next five years, growing to 11% in FY 2010. The continuing costs of the War in Iraq and the Congress' commitment to get a handle on the deficit will prove challenging for Tribal health programs over the next two years.

Discretionary Spending

In FY 2007, Congress approved $951 billion in discretionary budget authority, including $70 billion for military operations in Iraq and Afghanistan. In addition, the Administration has requested another $103 billion in supplemental funding in FY 2007 (nearly $100 billion for wartime operations and an additional $3 billion for hurricane relief). If the supplemental funding request is approved by Congress, it will bring the total FY 2007 discretionary budget to $1,054 billion, an increase of $58 billion over the FY 2006 level (5.8% increase).



For FY 2008, the President proposes $1,078 billion in discretionary budget authority which is $24 billion more than the current enacted FY 2007 level and the pending supplemental request. The President's discretionary proposal would provide $646 billion for national defense and $432 billion for non-defense programs (source of IHS funding). The defense request includes $142 billion for war related operations and in Iraq and Afghanistan. Since September 2001, Congress and the President have provided approximately $417 billion in appropriations to fight the War in Iraq and other DOD related activities.[7]

The costs of the war have exceeded the initial estimates, the unforeseen circumstances of hurricane relief, and the President's proposal to reduce the deficit to $10 billion over the next ten years will make it very difficult for discretionary funded programs to receive increases in future years.

Discretionary Spending for Indian Programs

Federal spending on Indian programs is considered discretionary spending. This does not mean the U.S. government has no obligation to fund Indian programs, but it does mean that an annual appropriation is required to fund these programs, including the IHS budget. This year's FY 2008 HHS budget only includes $67.6 billion or 9.6% of its total budget for discretionary programs. Last year, HHS budget request included 10.5% of its total budget for discretionary programs. This means that the FY 2008 HHS budget for discretionary spending is shrinking as a percentage of its overall budget, which will make for tough budget times within the Department.

In FY 2008, the IHS budget ($3.17 billion) represents one-half percent of the overall HHS budget ($627.3 billion) and 4.7% of the discretionary portion of the HHS budget. Given the costs of the war in Iraq, hurricane relief efforts, and the Administration's proposal to cut the deficit, and other reform efforts to curtail mandatory spending--the prospect for discretionary programs does not look good in FY 2008 and beyond.

[7] Congressional Budget Office, www.cbo.gov.

Appropriations Subcommittees

Last year, the House has reorganized its appropriation subcommittee structure from thirteen down to ten subcommittees. The House Interior Subcommittee has responsibility for the IHS appropriation and has also picked up the responsibility of appropriations for the Environmental Protection Agency. It was not expected that the environmental issues would compete directly with Indian health care programs. During these tough budget times and the competition of resources to stay within Congressional spending caps, this may not be true anymore.

The Senate continues to have its twelve appropriations committees. The Senate and House Interior Appropriation Committees develop the Bureau of Indian Affairs and the IHS budgets. IHS funds are transferred to the Department of Health and Human Services (similar to FDA funds from Agriculture to HHS). In past years, the Interior Appropriations Committee appropriated an average of 2% percent of all discretionary spending or about 5% of all non-defense discretionary spending. The Bush Administration's FY 2008 request for the Interior Appropriations Bill totals $19 billion in budget authority. This is a $970 million decrease from the FY 2007 enacted level. If this ends up being the 302(b) allocation to the Interior Appropriation Committee, the Committee will be under severe pressure to cut spending across the varied programs under its jurisdiction.

The Indian Health Service Budget and The Department of Health and Human Services

The FY 2008 Budget Authority of the Department of and Health and Human Services (HHS) totals approximately $697.3 billion. The final enacted FY 2007 appropriation for the IHS budget totals $3.18 billion dollars and represents less than one percent of all spending by the Department. By comparison, Medicare represents $436.3 billion (69%) of all spending and Medicaid $191.8 billion (30%) of total spending within HHS in FY 2007.

Although the IHS FY 2007 increase compares favorably to other HHS agencies, Table 26 below shows the IHS, as the only direct medical provider within HHS, lags behind all but one agency (SAMHSA) in budget increases over the last eight years. The 7.8% increase for the Medicaid program is easy to understand since it faces the same significant medical inflation costs that the IHS has to deal with. What is not understandable is why the IHS has not received the same level of increases over the eight year period. These unfunded inflationary costs have eroded the core health care program of the IHS.

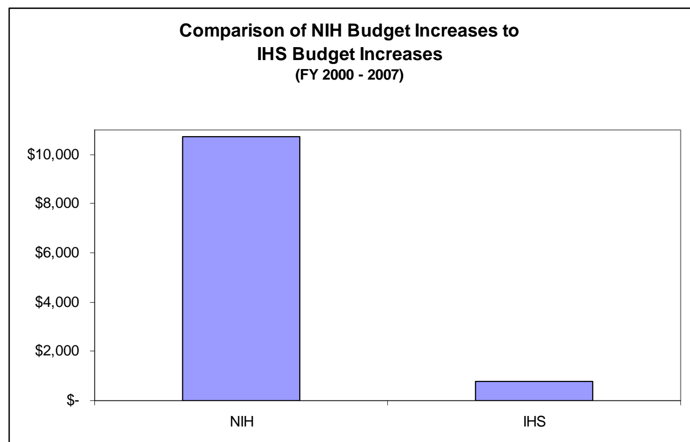
Table 26: Five Health Care Agencies of HHS

Agency	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 06 versus FY 07	8-Year Avg. Increase
CDC	$ 3,268	$ 3,823	$ 4,449	$ 4,340	$ 4,440	$ 4,776	$ 6,390	$ 5,812	-9.0%	9.4%
Medicaid	$ 117,921	$ 129,374	$ 147,512	$ 160,693	$ 176,231	$ 181,720	$ 192,334	$ 199,287	3.6%	7.8%
NIH	$ 17,894	$ 20,535	$ 23,554	$ 27,178	$ 28,041	$ 28,805	$ 28,509	$ 28,618	0.4%	7.2%
HRSA	$ 4,795	$ 6,304	$ 6,209	$ 7,017	$ 7,188	$ 6,904	$ 6,093	$ 6,109	0.3%	4.3%
IHS	$ 2,421	$ 2,604	$ 2,758	$ 2,849	$ 2,922	$ 2,985	$ 3,045	$ 3,180	4.4%	4.0%
SAMHSA	$ 2,652	$ 2,966	$ 3,136	$ 3,158	$ 3,235	$ 3,391	$ 3,203	$ 3,205	0.1%	2.9%

NIH Program Increases compared with IHS

The chart below illustrates the National Institutes of Health (NIH) budget increases over the last seven years as compared to the increases received for the IHS. Over the last eight years, the NIH has received $11 billion in budget increases, while the IHS has only received $759 million—a difference of 93 percent.

The Department's discretionary program spending is just 10.5% ($67.1 billion in budget authority) of its total spending. Other discretionary programs in the Department include the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration.



Conclusion: The Purpose of this Report

This document and the Portland, Oregon budget workshop that was held March 16, 2007 represent an effort by the NPAIHB to provide Tribes with an analysis of the Administration's proposed IHS budget and is intended to identify issues that will impact or benefit all Northwest Tribes. While it is recognized that individual tribes will have their own particular issues and projects, it is hoped that tribes will also embrace the main budget and legislative issues identified in this document. Issues with broad support are most likely to achieve congressional action.

Budget formulation should be a participatory process. One of the best ways to develop such participation is for Tribes and the IHS to agree on common principles and determine the cost of achieving those objectives. It is the connection between budget principles and funding that can bring Tribes and IHS together on the budget. The evaluation of this budget in Table 27 is based on these principles.

Evaluation Based on Budget Principles: Table 27

Table 27 grades the President's FY 2008 IHS budget against criteria (or principles) that the NPAIHB has developed and applied to budget analyses over the past five years. It is the Northwest Tribes' attempt to make an inherently subjective process more objective. The NPAIHB stands ready to engage in an honest debate over each aspect of this evaluation to clarify our position in the debate over funding Indian health programs.

As noted above, the President's proposed FY 2008 increase for the IHS is greater than nearly every other discretionary program. Unfortunately, the obligation to fund health services is not considered discretionary by Northwest tribes. The President's grades reflect this view by Tribes. With many Tribal and IHS health programs beginning the new fiscal year on Priority One status they cannot give the President high marks for meeting the health care needs of Indian people.

	Table 27. GRADING THE PRESIDENT'S PROPOSED FY 2008 IHS BUDGET	**President** February 5, 2007	**Senate**	**House**
	Criteria or Budget Principle	FY 2008 Grade		
1	Budget Information Shared with Tribes in Consultation Sessions Prior to release date of the first Monday in February.	F		
2	Appropriate adjustment will be made to fully cover expected inflation.	D		
3	Appropriate increases will be included to address population growth.	C		
4	Appropriate adjustments will be made to fully fund tribal and federal employee compensation.	C		
5	The Contract Health Service Budget will be increased to fully fund the need for deferred services.	F		
6	Collection estimates are not represented as fulfilling the federal responsibility to fully fund the IHS budget.	F		
7	Increases will be provided to address the goals of the Indian Health Care Improvement Act.	C		
8	Full funding will be included to support staff associated with new construction projects.	C		
9	The Catastrophic Health Emergency (CHEF) Fund will be budgeted at a level to cover all qualifying cases.	D		
10	Funding will be provided to cover Contract Support Costs for tribes electing to compact or contract their health care services.	F		
11	Adequately support maintenance of IHS and tribal health facilities.	F		
12	The public announcements relating to the budget will honestly depict what is in the budget.	F		
13	Provides adequate funding to reduce health disparities.	F		
14	Honor the federal trust responsibility to provide health care services to American Indians and Alaska Natives.	F		
	Overall Grade	F		