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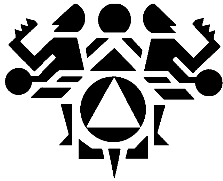

Northwest Portland Area
Indian Health Board

The FY 2010 Indian Health Service Budget: Analysis and Recommendations

20th Annual Report
June 10, 2009

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Northwest Portland Area Indian Health Board

Introduction

The 20th 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 1989. It is with a sense of celebration that this year's twentieth annual analysis examines the best Presidential budget request ever analyzed by Northwest Tribes. The scale of the increase (13%) and, as importantly, the priorities apparent in the distribution of funding increases across the budget line items, makes it clear that the Administration is listening to Tribes, that it recognizes the legacy of years of underfunding *creates* greater health disparities, and that the new Administration is committed to directing resources to well documented needs. Tribes recognize that when economic good times return that budgets will have to be balanced, that efficiencies have to be sought, that value has to be added by health programs that effectively apply what cultural traditions and modern medicine can accomplish for Indian health programs.

The nature of budget formulation is vastly different for tribes than it is for advocates 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. It has not always been easy for Tribes to return, year after year, to the budget consultation process, but years of faithfully making our case appears to have reached the ear of the President.

The President's FY 2010 budget assumes the heavy burden of recent neglect. Following a FY 2001 increase of 10%, from FY 2002 to FY 2007 the average IHS budget increase was less than 2.5%. A growing population and medical inflation eroded the purchasing power of Indian health programs. Tribes were forced to redirect funding from economic development initiatives to supplement their health programs. Fortunately, expanding Medicaid and Children's Health Insurance programs provided additional resources. There is no denying, however, that a huge and growing gap resulted in greater health care disparities between Indian people and the general population over the past eight years.

NPAIHB estimates it will take a $469 million increase in the FY 2010 budget to fund pay increases, inflation, and population growth in order to maintain current services. Fortunately, the President's FY 2010 request of $453 million, a 12.7% increase, is nearly sufficient to meet this year's mandatory cost increases. With the President's support earlier this year for a 7.5% increase in the IHS budget for FY 2009, and a $500 million IHS appropriation in the Recovery Act, most feel the stage is now set for real progress in Indian health programs. Northwest Tribes support and applaud each of these actions, but join most Tribes in questioning the wisdom of the allocation of 80% of ARRA funding to Tribes in just the two states of Alaska and South Dakota. The needs of Tribes in these two states are great, but so too are the needs in the 33 other states where federally recognized tribes are located.

Although the President has sought $107 million to meet the current need for existing contract support costs, a record increase for contract support costs, we recommend an additional $75 million to $100 million to allow for new and expanded Tribal Self-Determination contracting and compacting and to fund some continuing shortfalls for Contract Support Costs.

Each year the Board discusses their priorities during its January Quarterly Board Meeting and at the February meeting of the Affiliated Tribes of Northwest Indians. 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 2009 NPAIHB Legislative Plan and this FY 2010 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 twelve 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 is commonly referred to as the I/T/U budget formulation team and 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.

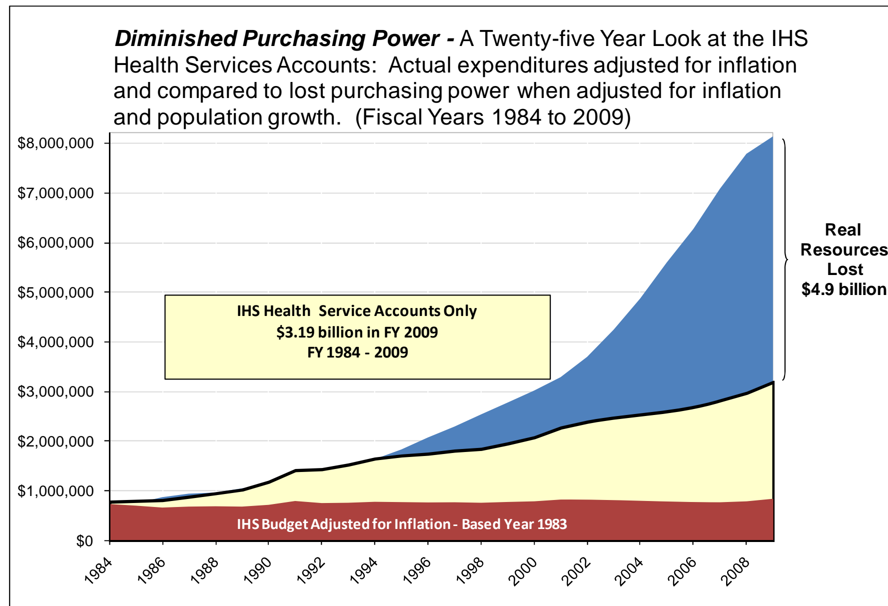
This analysis was first developed to serve as a reality check demonstrating the lack of integrity past executive branch budgets. Tribes are not without their own interest in advocating for budget increases, but this analysis presents unbiased estimates and objective data for that cause. The analysis also establishes criteria that are used to grade the President's budget request. These criteria are found at the end of the analysis in the form of a Report Card.

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 FDI measures the proportion of funding provided to the Indian health system, relative to its actual need, by comparing healthcare costs for IHS beneficiaries in relation to beneficiaries of the Federal Employee Health Benefits (FEHB) plan. This method uses actuarial methods that control for age, sex, and health status.

Applying the FDI to estimate the true health care needs of Indian people results in an annual budgetary need of $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 $19 to $20 billion is sometimes stated as the Tribal needs-based budget. To restate; about $9 to $10 billion is needed for the recurring budget and, coincidentally, about the same amount for added facilities to support a fully funded IHS.

Although this year's budget maintains purchasing power and allows for some program expansion, it appears that OMB continues the practice of utilizing a fictional(3%) rather than actual estimate of medical inflation. NW Tribes ask that OMB and HHS/IHS commit to using the same budget estimates for the IHS budget that they use for other financial and economic estimates.



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 graph above illustrates the diminished purchasing power of the IHS budget over the past twenty-three years. The graph demonstrates the compounding effect of multi-year funding shortfalls that have considerably eroded the IHS base budget. In 1984, the IHS health services accounts were slightly less than $1 billion, and had the accounts received adequate increases for inflation and population growth, that amount would be over $8 billion today. The NPAIHB conservatively estimates that over the last twenty years the IHS budget has lost nearly $6 billion in purchasing power.

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

NPAIHB has identified pertinent issues that impact Northwest Tribes. This information will assist leaders of each of the forty-three Portland Area 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 same as 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 Northwest tribes, it is made available to tribes throughout the country. It is distributed to all Area Health Boards within the Indian health system and national Tribal organizations. It is 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. NPAIHB's IHS 2010 Budget Analysis and Legislative Plan are posted at www.npaihb.org.

Acknowledgements

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

Sources:

- 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 2010 http://www.whitehouse.gov/omb/budget/ is the President's budget request of May, 7 2009. It is actually a set of documents with narrative and statistical information on the President's proposed budget for FY 2010.
- Congressional Budget Office (CBO http://www.cbo.gov/), The Budget and Economic Outlook: Fiscal Years 2009-2019, January, 2009 and Preliminary Analysis of the President's Budgetary Proposals for FY 2010, March 20, 2009. 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 2010, DHHS FY 2010 Budget In Brief, May 7, 2009 available at http://www.hhs.gov/budget/docbudget.htm
- The Indian Health Service ,Congressional Justification of Estimates for Appropriations Committees Fiscal Year 2010 is available at: http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/bf_cong_justifications.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 .

The FY 2010 Northwest Portland Area Indian Health Board Budget Analysis and Recommendations

The Northwest Portland Area Indian Health Board (NPAIHB or the Board) estimates that it will take at least $269 million to maintain current services for IHS health programs in FY 2010. We further recommend an additional $200 million to fund the backlog of Contract Support Costs (CSC) that is owed to Tribes that have assumed programs under the Indian Self-Determination and Education Assistance Act (P.L. 93-638). The NPAIHB estimates that it will take at least $469 million just to maintain current services and fund legally required payment for contract support costs for current and new requirements. Northwest Tribes further recommend $574.2 million in additional 'program' increases to address growing health needs and diminished services due to the lack of sufficient funding increases from the past eight years. The President's significant increase of $453 million is still less than ½ of the $1 billion needed to maintain services *and* also address health care deficiencies with an effort Northwest Tribes feel is appropriate to the level of need.

The President's FY 2010 budget request provides $ 4.034 billion for the Indian Health Service (IHS), and is a $453.5 million increase, 12.7%, in funding above the FY 2009 enacted level. This historic increase is noted and applauded by all Northwest Tribes. It is more than any increase in recent history, it is more than any other agency of the Department of Health and Human Services, it is significant in that it provides sufficient funding to maintain the current program, but to also apply some funding to finally increase our effort to reduce health disparities between American Indian /Alaska Natives and the general population. Finally, we are doing more than documenting those disparities; we can now direct funds to identified means to reduce them.

The President's request for Hospitals and Clinics includes a request of $45.6 million for the Indian Health Care Improvement Fund. This distribution of funds, if properly applied, promises to reduce some of the funding disparities between Indian health programs by lifting the funding level of programs that for historical and not well understood reasons are funded far below the average.

Staffing for new facilities will require $26 million this year, a significant amount, but the smallest percentage of the overall increase in the past 6 years thanks to the size of this year's budget increase.

The American Recovery and Reinvestment Act of 2009

The President and Congress passed an economic stimulus bill to provide jobs to aid economic recovery in Indian country. $85 million remains at IHS headquarters for national direction and national acquisition of equipment, and contractor services for EHR and telehealth projects. Fully two-thirds of the remaining $415 million in funding goes to two states, 45% to Alaska and 23% to South Dakota. Adding Arizona (10%) and New Mexico (5%) and we see that 82% of the funding, or $335 million goes to just 4 states.

Tribes in 24 states share the remaining 18% or $75 million of the $500 million IHS ARRA allocation. An additional $5 million in ambulances and equipment will be distributed nationally. The $500 million bill was hastily developed, without tribal consultation, with the result that its effect is small, but still noticeable for 80% of the nation's Tribes. The new construction facilities appropriation will also mean an obligation to fund staffing packages for these facilities in future IHS budgets.

Table No. 1: IHS American Recovery & Reinvestment Act Fund Projected Funding by Area							
ARRA ALLOCATION	Facilities Construction [1]	M & I [2]	Equipment [2]	Sanitation Construction [2]	Health Information Technology [3]	TOTAL ARRA FUNDING BY IHS AREA OFFICE	
	$ 227,000,000	$100,000,000	$ 20,000,000	$ 68,000,000	$ 85,000,000	$500,000,000	
IHS Area Office						Total	Percent of Subtotal
Aberdeen	$ 89,327,000 *	$ 15,210,000	$ 785,536	$ 5,907,000		$ 111,229,536	28%
Alaska	$ 137,673,000 *	$ 19,520,000	$ 984,570	$ 14,291,000		$ 172,468,570	43%
Albuquerque	$ -	$ 5,470,000	$ 535,842	$ 3,053,000		$ 9,058,842	2%
Bemidji	$ -	$ 4,970,000	$ 806,273	$ 1,918,000		$ 7,694,273	2%
Billings	$ -	$ 4,410,000	$ 456,066	$ 1,827,000		$ 6,693,066	2%
California	$ -	$ 3,020,000	$ 501,236	$ 4,068,000		$ 7,589,236	2%
Nashville	$ -	$ 3,500,000	$ 325,599	$ 3,083,000		$ 6,908,599	2%
Navajo	$ -	$ 13,450,000	$ 1,016,103	$ 15,078,000		$ 29,544,103	7%
Oklahoma	$ -	$ 8,490,000	$ 1,383,177	$ 8,074,000		$ 17,947,177	4%
Phoenix	$ -	$ 12,000,000	$ 888,408	$ 5,750,000		$ 18,638,408	5%
Portland	$ -	$ 4,410,000	$ 715,416	$ 2,237,000		$ 7,362,416	2%
Tucson	$ -	$ 2,550,000	$ 101,774	$ 1,714,000		$ 4,365,774	1%
Subtotal	*$ 227,000,000*	*$ 97,000,000*	*$ 8,500,000*	*$ 68,000,000*	*$ -*	*$ 399,500,000*	
Administrative hold (up to 5 percent)	$ -	$ 3,000,000	$ -	$ -	$ -		
FY 2010 Congressional Justification							
Administrative Costs					$ 4,250,000		
Hardware Acq.					$ 17,000,000		
Software Development					$ 21,250,000		
IHS-EHR (existing Contracts)					$ 42,500,000		
Replace 62 Ambulances			$ 5,000,000				
Computed Tomography Scanners (CT)			$ 6,500,000				
TOTAL:	$ 227,000,000	$ 100,000,000	$ 20,000,000	$ 68,000,000	*$ 85,000,000*	$ 500,000,000	

[1] Estimated allocation. As of 5/19/2009 the Indian Health Service had not reported the distribution for two projects to be funded (Nome, AK and Cheyenne River, SD). Estimate is based on percentage of proposed construction budgets to one another in the FY2010 facilities spending plan, and then applied to the $227 million.

[2] Source: Information provided during FAAB Teleconference call April 3, 2009.

[3] FY 2010 IHS Congressional Justification of Estimates for Appropriations Committee.

The ARRA provided $85 million for Health Information Technology. These funds will remain at headquarters to support the following: $61.4 million for Electronic Health Development and Deployment, $17 million for telehealth and network infrastructure, $2.5 million for personal health records, and $4 million for the management of these initiatives.

The ARRA provided $395 million for facilities: $227 million for two new facility construction projects: One at Hospital in Nome, Alaska and the other at Eagle Butte for the Cheyenne River Tribe in South Dakota. $68 million was allocated for Sanitation Facilities Construction and this was distributed using an existing formula. ARRA also provided $100 million for maintenance and improvement funding that included maintenance and facility upgrades. Tribes competed for area allocations of M&I. Finally, the ARRA included $20 million for medical equipment. Again an area allocation was used and tribes submitted proposals for the use of these funds.

The Final Enacted FY 2009 IHS Budget

The President signed an omnibus appropriation bill on March 11, 2009 that provided $3.58 billion for the FY 2009 IHS budget. This $235 million increase, or 7% over 2008, was easily the largest increase since FY 2001. Unfortunately it was than $370 million less than needed to cover last year's mandatory cost increases. The nearly 10% increase for CHS while, sufficient to cover one year's medical inflation, was just a down payment on making up for past year's miserable 3% increase. Likewise, the $15 million increase for contract support costs was higher than any year of the Bush Administration, but it was barely enough for new and expanded contracts and left largely untouched over $150 million in contract support cost shortfall.

Table No. 2: Indian Health Service Budget
Comparison of FY 2008, 2009, and Presidents FY 2010
(Dollars in Thousands)

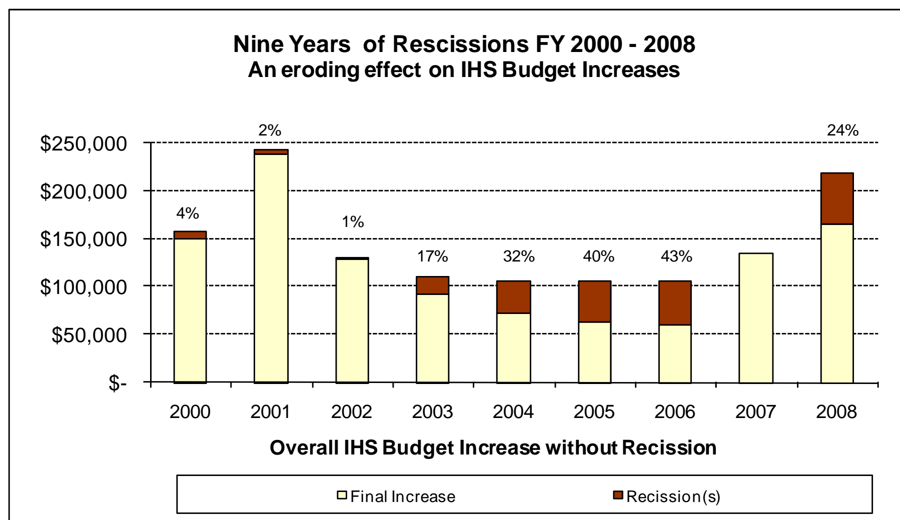
Sub Sub Activity	Final Budget FY 2008	Final Budget FY 2009	Change Over FY 2008	President's FY 2010 Budget	Change Over FY 2009	Percent Change
SERVICES:						
Hospitals & Health Clinics	$ 1,484,016	$ 1,597,777	$ 113,761	$ 1,751,883	$ 154,106	9.6%
Dental Services	$ 133,637	$ 141,936	$ 8,299	$ 151,384	$ 9,448	6.7%
Mental Health	$ 63,531	$ 67,748	$ 4,217	$ 72,786	$ 5,038	7.4%
Alcohol & Substance Abuse	$ 173,243	$ 183,769	$ 10,526	$ 194,409	$ 10,640	5.8%
Contract Health Services	$ 579,334	$ 634,477	$ 55,143	$ 779,347	$ 144,870	22.8%
Total, Clinical Services	*$ 2,433,762*	*$ 2,625,707*	*$ 191,946*	*$ 2,949,809*	*$ 324,102*	12.3%
PREVENTIVE HEALTH:						
Public Health Nursing	$ 55,939	$ 59,885	$ 3,946	$ 64,071	$ 4,186	7.0%
Health Education	$ 14,991	$ 15,723	$ 732	$ 16,682	$ 959	6.1%
Comm. Health Reps	$ 54,925	$ 57,796	$ 2,871	$ 61,628	$ 3,832	6.6%
Immunization AK	$ 1,733	$ 1,823	$ 90	$ 1,934	$ 111	6.1%
Total, Preventative Health	*$ 127,587*	*$ 135,227*	*$ 7,639*	*$ 144,315*	*$ 9,088*	6.7%
OTHER SERVICES:						
Urban Health	$ 34,547	$ 36,189	$ 1,642	$ 38,139	$ 1,950	5.4%
Indian Health Professions	$ 36,291	37,500	$ 1,209	$ 40,743	$ 3,243	8.6%
Tribal Management	$ 2,490	2,586	$ 96	$ 2,586	$ -	0.0%
Direct Operation	$ 63,624	65,345	$ 1,721	$ 68,720	$ 3,375	5.2%
Self Governance	$ 5,836	6,004	$ 168	$ 6,066	$ 62	1.0%
Contract Support Costs	$ 267,398	282,398	$ 15,000	$ 389,490	$ 107,092	37.9%
Total, Other Services	*$ 410,185*	*$ 430,022*	*$ 19,836*	*$ 545,744*	*$ 115,722*	26.9%
TOTAL, SERVICES	$ 2,971,533	$ 3,190,956	$ 219,421	$ 3,639,868	$ 448,912	14.1%
FACILITIES:						
Maintenance & Improvement	$ 52,889	$ 53,915	$ 1,026	$ 53,915	$ -	0.0%
Sanitation Facilities Construction	$ 94,253	95,857	$ 1,604	$ 95,857	$ -	0.0%
Hlth Care Facilities Construction	$ 36,584	40,000	$ 3,416	$ 29,234	$ (10,766)	-26.9%
Facil. & Envir. Hlth Supp	$ 169,638	178,329	$ 8,691	$ 193,087	$ 14,758	8.3%
Equipment	$ 21,282	22,067	$ 785	$ 22,664	$ 597	2.7%
Total, Facilities	*$ 374,646*	*$ 390,168*	*$ 15,522*	*$ 394,757*	*$ 4,589*	1.2%
TOTAL, IHS	**$ 3,346,179**	**$ 3,581,124**	**$ 234,943**	**$ 4,034,625**	**$ 453,501**	12.7%

The NPAIHB estimates that the final FY 2009 appropriation, although the best budget in eight years, fell short by $370 million to maintain current services, which means Indian health programs continue to have their base budgets eroded as they absorb the cost requirements of maintaining current services. Over the course of time this erosion effect has impacted the quality and quantity of services provided. Many health care analysts consider this decline in health care services as a direct result of chronic under- funding of the Indian health system. In fact, a recent report indicates a number of measures on which disparities are measured have gotten significantly worse or have remained unchanged for American Indians and Alaska Natives.[1]

The Effect of Rescissions on the Budget

Rescissions became a mindless, but common, budgetary tool in the last decade. The arbitrary nature of their effect on Indian health programs was particularly hurtful to programs, like health, that required more than inflation increases to maintain services. The contract support costs line item suffered actual reductions as across-the-board reductions hit even those line items that had not received an increase. It is hoped that this year's budget will not go through the routine again; passage and then revision to achieve a deal for final budget passage.

In FY 2007, the IHS did not have a rescission because Congress passed a year-long continuing resolution, but 2008 saw one of the largest ever. Beginning six years ago, rescissions were a mere one percent of the approved IHS budget increase. Four years ago, the rescissions cut into almost half of the approved IHS budget increase. If the Administration and Congress are resolved to address Indian health disparities, they must restore past year's rescissions and exempt them from future ones as they regularly did for Veteran's Health programs.



Members of Congress can't have it both ways; they can't say they supported increases for the IHS budget and then go on to say that they supported fiscal responsibility by cutting funding. Congressional members must clearly convey their support for Indian health programs by specifically requesting that IHS programs be exempt from across the board cuts when finalizing appropriations.

[1] National Healthcare Disparities Report 2007, Agency for Healthcare Research and Quality, available: www. http://www.ahrq.gov/qual/nhdr07/nhdr07.pdfahrq.gov/qual/nhdr07/nhdr07.pdf.

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

The President's FY 2010 IHS budget begins to set the standard on how to preserve and partially restore existing IHS programs. As a basic budget principle, Northwest Tribes have always 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. For the first time in nine years, unmet needs may be addressed with the resources provided in the ARRA, the recently enacted FY 2009 budget, and the proposed 2010 budget.

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 continue with the commitment demonstrated in this budget to provide sustained funding increases for the IHS. Tribes stand ready to show results when resources are sufficient to address long recognized needs.

The Office of Management and Budget

The Office of Management and Budget, under President Barack Obama, has demonstrated a new willingness to meet with Tribes. Many 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 advocacy to key decision makers by providing them with information about the funding requirements of IHS and tribal health programs. This information became embargoed information under the Bush Administration and OMB refused to meet directly with tribal leaders. The OMB could open the process even further by sharing budget information prior to the budget submission, typically, the first Monday in February[2]. Tribes have specifically requested that OMB allow the Department of Health and Human Services to share the November 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 and honors the government to government relationship.

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? 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. Our goal is that this analysis serves as a valuable resource for the Administration, Congress, and the Congressional staff that are responsible for developing 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 foundation of the unique status of health care for Indian people. The promise of this year's budget and consultation for the FY 2011 budget suggests that treaties will be honored, promises will be kept, and the IHS will have a budget adequate enough to provide needed health services to our members.

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

Current Services Budget: Maintaining the Current Health Program and the President's Proposed FY 2010 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 the current services need in FY 2010 is $469.7 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 (see graph on p. 25).

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 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.

The NPAIHB estimates that in FY 2010 an increase of at least $469.7 million (an increase of 13%) will be needed to maintain current services. In addition, Portland Area tribes recommend an additional **$574.1** million for program enhancements to address the significant Indian health disparities and priority needs. This brings the total recommended amount to **$1 billion** or an increase of **28%** over last year's level (see Table 4 on page 16).

Table No. 3: Summary of Mandatory Cost Increases to Maintain Current Services in FY 2010

Mandatory Cost	***Increase needed to maintain current services (1,000s)***
CHS inflation estimated at 7%	$44,413
Health Services Account (not including CHS) inflation	$158,358
Contract Support Costs (unfunded amount)	$200,000
Population Growth (estimated at 2.1% of health services accounts)	$67,010
Total Mandatory Costs	$469,781

Note on Medical Inflation: Medical Inflation is estimated between 5% - 10% 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 7% and Medicaid by 6.8% in FY 2009. NPAIHB assumes Indian health programs will not achieve the same level of cost containment due to the lack of large group purchasing

Justification for Estimates

In the NPAIHB proposed budget (Table No. 4, page 16), pay act costs are not displayed separately from general and medical inflation. 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 estimates presented in this analysis extrapolate medical related series of the Consumer Price Index (CPI) as they relate to IHS budget account activity. For example, inflation for the Hospital and Clinic Services is measured using the Hospital and Related Services series of the CPI, which measures inpatient and outpatient hospital related care only. Footnotes are included in the spreadsheet to indicate which CPI series have been used to measure inflation for budget sub-sub activity. A reference on where to locate CPI series is included as a footnote. Extrapolating CPI medical indices is a standard economic forecasting method that allows accurate and defensible estimates that are tied to real costs, though OMB has routinely applied non-medical related inflation rates to the IHS budget, which underestimate the true funding need for health care programs. The Urban program line item is estimated using the CPI chained index for Medical Care Services and includes prescription drugs, non-prescription and medical supplies, physician services, dental services, eyeglasses and eye care, and services by other medical professionals. Finally, the facilities account uses the general CPI inflation index. Finally, 2.1% rate of growth (same as the IHS rate) is used to estimate population growth.

Contract Support Costs a vital component in FY 2010

Estimates for Contract Support Costs (CSC) use the IHS yearly CSC Shortfall report amount and forecasting methods that update shortfall report calculations based on actual figures in the FY 2009 Omnibus appropriations (since IHS shortfall estimates were based on President Bush's FY 2009 request and far lower than final approved funding). There are other CSC changes at work as well. For instance, in 2009 IHS will now be recognizing additional CSC shortfalls from a Navajo expansion and a Cherokee expansion (Hastings) that both occurred last year, together totaling close to $15 million in additional CSC requirements. In FY 2009 IHS will also be correcting an error in its past reports that understated indirect CSC shortfalls by about $6 million. After taking account of these elements, plus the fact that 15% of the IHS program increases in the Omnibus will be required for Tribes to administer the contracted portions of those program increases (this is because 60% of the increases will go into 638 contracts/compacts, and the average CSC percentage is 25% of that sum), results in a shortfall of roughly $160M for FY2009.

If an additional $350 million ($453 million increase, less $107 million for CSC) in program increases are projected in FY 2010, this produces another $50 million in CSC requirements. Add inflation, plus only a small amount for new contracting, and the 2010 projection easily exceeds $200 million. Clearly, fully funding IHS's CSC requirements in FY2010 will cost at least $200 million. (This does not include any additional burden on the Tribes from temporarily operating some of the programs funded under the ARRA.)

Table No. 4: Indian Health Service Budget

Comparing FY 2009 to FY 2010 Current Services Estimates

(Dollars in Thousands)

	A	B	C	D	E (D x A)	F (2.1% x A)	G (E + G)
				CURRENT SERVICES ESTIMATES			
Sub Sub Activity	**FY 2009 Enacted (H.R. 1105)**	**President's FY 2010 Request**	**Change**	**CPI Medical Care**	**Increase needed for Inflation**	**Increase needed for Pop. Growth**	**NPAIHB ESTIMATE FOR INFLATION**
SERVICES:							
Hospitals & Health Clinics	$ 1,597,777	$ 1,751,883	$ 154,106	6.7% [a]	$ 107,051	$ 33,553	$ 140,604
Dental Services	141,936.00	$ 151,384	$ 9,448	4.7% [b]	$ 6,671	$ 2,981	$ 9,652
Mental Health	67,748.00	$ 72,786	$ 5,038	4.9% [c]	$ 3,320	$ 1,423	$ 4,742
Alcohol & Substance Abuse	183,769.00	$ 194,409	$ 10,640	4.9% [c]	$ 9,005	$ 3,859	$ 12,864
Contract Health Services	634,477.00	$ 779,347	$ 144,870	7.0% [d]	$ 44,413	$ 13,324	$ 57,737
Total, Clinical Services	*$ 2,625,707*	*$ 2,949,809*	*$ 324,102*		*$ 170,460*	*$ 55,140*	*$ 225,600*
PREVENTIVE HEALTH:							
Public Health Nursing	$ 59,885	$ 64,071	$ 4,186	4.9% [c]	$ 2,934	$ 1,258	$ 4,192
Health Education	15,723	16,682	$ 959	4.9% [c]	$ 770	$ 330	$ 1,101
Comm. Health Reps	57,796	61,628	$ 3,832	3.8% [c]	$ 2,196	$ 1,214	$ 3,410
Immunization AK	1,823	1,934	$ 111	3.8% [c]	$ 69	$ 38	$ 108
Total, Preventative Health	*$ 135,227*	*$ 144,315*	*$ 9,088*		*$ 5,970*	*$ 2,840*	*$ 8,810*
OTHER SERVICES:							
Urban Health	$ 36,189	$ 38,139	$ 1,950	7.0% [d]	$ 2,533	$ 760	$ 3,293
Indian Health Professions	37,500	40,743	$ 3,243	3.2% [f]	$ 1,200	$ 788	$ 1,988
Tribal Management	2,586	2,586	$ -	3.2% [f]	$ 83	$ 54	$ 137
Direct Operation	65,345	68,720	$ 3,375	3.2% [f]	$ 2,091	$ 1,372	$ 3,463
Self Governance	6,004	6,066	$ 62	3.2% [f]	$ 192	$ 126	$ 318
Contract Support Costs	282,398	389,490	$ 107,092	3.2% [f]	$ 9,037	$ 5,930	$ 14,967
Total, Other Services	*$ 430,022*	*$ 545,744*	*$ 115,722*		*$ 15,136*	*$ 9,030*	*$ 24,166*
TOTAL, SERVICES	$ 3,190,956	$ 3,639,868	$ (448,912)		$ 191,566	$ 67,010	$ 258,576
FACILITIES:							
Maintenance & Improvement	$ 53,915	$ 53,915	$ -	3.2% [e]	$ 1,725	$ -	$ 1,725
Sanitation Facilities Construct	95,857	$ 95,857	$ -	3.2% [e]	$ 3,067	$ -	$ 3,067
Hlth Care Facilities Constructi	40,000	$ 29,234	$ (10,766)	3.2%	$ -	$ -	$ -
Facil. & Envir. Hlth Supp	178,329	$ 193,087	$ 14,758	3.2% [e]	$ 5,707	$ -	$ 5,707
Equipment	22,067	$ 22,664	$ 597	3.2% [e]	$ 706	$ -	$ 706
Total, Facilities	*$ 390,168*	*$ 394,757*	*$ 4,589*		*$ 11,205*	*$ -*	*$ 11,205*
TOTAL, IHS	**$ 3,581,124**	**$ 4,034,625**	**$ 453,501**		**$ 202,771**	**$ 67,010**	**$ 269,781**

Summary of Costs to maintain Current Services:

Contract Support Costs Shortfall Amount:	$ 200,000	
Inflation & Population Growth:	$ 269,781	
Program Enhancements (see p. 18):	$ 574,200	16%
Total Current Services Budget:	**$ 1,043,981**	29%

Inflation Rates Calculated as follows:

[a] Hospital & Clinics inflation calculated using CPI Series CUSR0000SEMD: Hospital & Related Services (inpatient and outpatient related costs).

[b] Dental inflation calculated using CPI Series CUSR0000SEMC02: Dental Services.

[c] Inflation calculated using CPI Series CUSR0000SAM Medcial Care Inflation (medical care commodities, medical care services, and hospital & related services).

[d] CHS inflation calculated using CPI Series CUSR0000SS5703: Hospital Outpatient Services.

[e] Urban Indian Inflation calculated using CPI Series CUSR0000SAM2: Medical Care Services (Prescription drugs, non-prescription and medical supplies, physician services, dental services, eyeglasses and eyecare, and services by other medical profressionsals)

[f] Inflation calculated using CPI Series SUUR0000SA0: Chained Medical Care Index all goods and services.

[1] Source: *FY 2009 IHS Contract Support Costs Shortfall Report* - amount required to address past year's CSC funding shortfall and growth for new and expanded Self-Determiniation and Self-Governance agreements and Estimates calculated on program increases of $350 million.

Tribal Recommendations for Program Increases

Portland Area Tribes have debated various program increases (or program enhancements) that they feel are essential to address the desperate health disparities and high priority health needs that their programs face. Spirited discussions on keeping these recommendations within the bounds of political feasibility often compete with recommendations based on true need. Everyone feels the funding increases for the line items listed here are far short of what was actually needed. It was decided, however, to highlight these program increases given the significant health disparities of American Indian and Alaska Native people and the increased morbidity and years of productive life lost because of these disparities.

The proposed 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 15% to 28% 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 service levels.

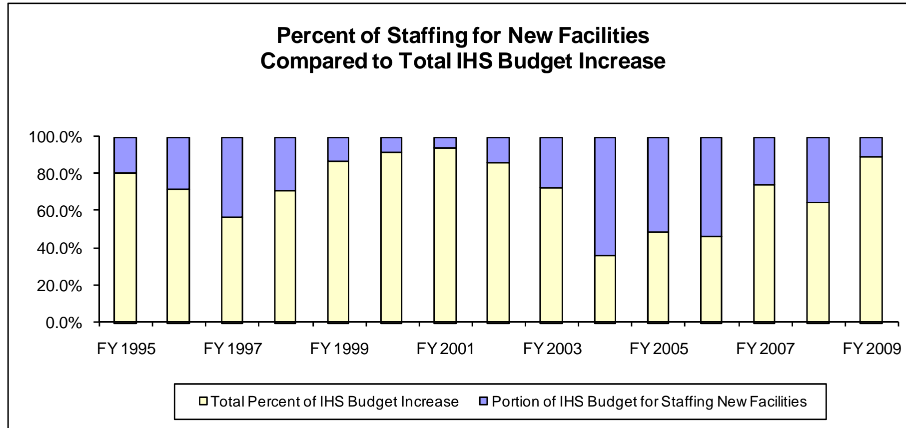
Portland Area Tribes are pleased with the President's request of $144.9 million increase for CHS, but recommend more funding for the grossly underfunded Contract Health Service program in order to address the significant backlog of deferred services, and the growing number of denied services.. Portland Area Tribes also recommend a substantial increase to address the growing oral health needs and dental professional shortage in Indian Country. Tribal health directors stressed the importance of having good oral health; and how it is a prerequisite for making good nutritional choices that determine future health outcomes.

Sustaining the efforts of health promotion and disease prevention (HP/DP) programs are a concern for Northwest tribes. Thus, Portland tribes recommend 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. Unfortunately, the President has not requested funding for the small ambulatory program. Tribes are locked out of the current facility construction priority system and continue to advocate for alternative methods to build health facilities. The small ambulatory construction program allows this. Unfortunately, the ARRA's stimulus package for the IHS did not include any funding for small ambulatory facilities in its $227 million appropriation.

The balances of the increases are distributed for other high priority issues like information technology and pharmaceuticals that have both required an increasing percentage of health program expenditures.

Table No. 4b: IHS Budget Program Increases (Dollars in Thousands)	
CHS Unfunded: Denied/Deferred Services and Catestropic Health Emergency Fund	$ 183,000
Dental Health	$ 180,000
Mental Health	$ 18,882
Alcohol and Substance Abuse	$ 31,470
Public Health Nursing	$ 5,245
Health Education	$ 5,245
Community Health Representatives	$ 10,490
Self Governance	$ 5,180
Pharmacy	$ 31,080
Information Technology	$ 20,720
Sanitation Facilities Construction	$ 20,720
Small Ambulatory Clinics, Joint Venture	$ 41,440
Maintenance & Improvement, Facilities	$ 5,180
Guaranteed Loan Program	$ 15,540
Total, Program Increases:	**$ 574,192**

Staffing for New IHS 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 inequity of facilities construction funding provides a disproportionate share of funding to a few select communities. The significance of facilities funding, both for construction and staffing new facilities, is that it removes funds necessary to maintain current services (pay costs, inflation, and population growth) from the IHS budget increase.

The graph above illustrates the significance of staffing new facilities on the IHS budget increase. 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 5% 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.

In FY 2010, $26.8 million is need for staffing of new facilities at the Absentee Shawnee Health Center, the Santee Health Center, the Carl Albert Hospital in Ada, OK, and the Lake County Tribal Health Center in Lakeport CA. These 'new staffing packages' become recurring appropriations and are often more than the amounts applied to other mandatory costs.

Table 5: Staffing New Facilities (Dollars in Thousands)

Facility	*FTEs*	*Staffing Cost*
Little Axe, OK - New Joint Venture	31	$ 2,914
Santee, NE - New Joint Venture	37	$ 3,622
Ada, OK - Replacement Joint Venture	173	$ 18,874
Lakeport, CA - New Joint Venture	15	$ 1,456
Total	**256**	**$ 26,866**

Health Services Account:
The Compounding Effect of Multi-year Funding Shortfalls

Table 6: Health Services Account FY 1993-FY 2009 (Dollars in Thousands)			
Year	**Approved Health Services Budget**	**Budget w/Inflation & Pop-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	$2,818,922	2,976,748	$157,826
2008	$2,971,533	$3,102,325	$130,792
2009	$3,190,956	$3,533,303	$342,347
		Total Real Resources Lost FY 1993-2009	**$3,084,315**

Table 6 above 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 6 are based on the NPAIHB previous year's analysis to fund current services. The loss of purchasing power over the past fifteen years is conservatively estimated at $3 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 6 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.

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 2010 budget.

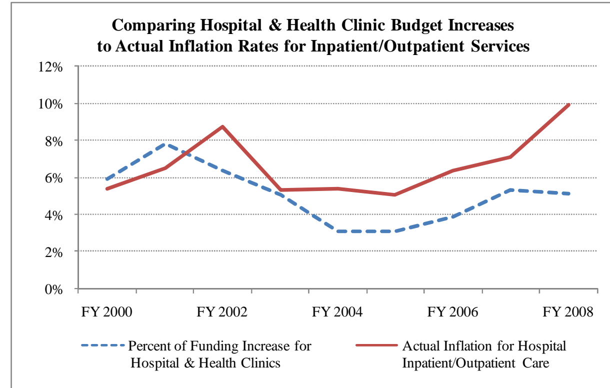
Hospitals and Clinics (CJ-59)

Table 7: Hospitals & Clinics (Dollars in Thousands)			
President Request:	**$**		**1,751,883**
FY 2009 Final Budget	$		1,597,777
President's Increase/Decrease	9.6%	$	154,106
Less Phasing-in Staff at New Facilities		$	12,806
Net Increase Available for Current Services		$	141,300
NPAIHB Estimate for Inflation & Pop Growth:		$	140,604
Shortfall:		**$**	**(696)**

The Hospitals and Clinics (H&C) line item would receive $1.75 billion under the Administration's request, a proposed increase of $154 million or 9.6% over the enacted FY 2009 budget. NPAIHB estimates that a $140 million is needed to maintain current services, but this does not include the funding earmarked for the Indian Health Care Improvement Fund. The President's request appears to be sufficient to maintain and even expand services for most programs. This is the first time in eight years that this can be said for this all-important line item of the IHS budget.

This line item supports inpatient and outpatient care, routine and emergency ambulatory care, and medical support services. In some Areas, funds that should be under contract health care are actually found in this line item. Over the last seven years this very important budget line item has been diminished due to inadequate budget increases. The Portland Area receives far less per capita than most areas from this line item that includes nearly 50% of the Health Service Account. Portland Area Tribes only receive 4.7% of the non-Headquarters share of H&C funding despite its 7% share of the IHS user population. This reflects the high cost of operating hospitals for other areas and the lack of any hospitals in the Portland Area. Alaska receives 17.2% of H&C funding due to the high cost of care in Alaska and the high cost of operating the Alaska Native Medical Center and many small hospitals in Alaska.

The Administration's proposal includes over $45 million for the IHCIF and calls on the agency to "conduct a thorough evaluation of the methodology and data sources utilized to distribute the IHCIF and …take action to improve and refine the formula if necessary." Northwest Tribes support this recommendation since the IHCIF does not take into consideration all resources like third-party collections, facilities infrastructure, and other wrap-around services when computing the funding disparity indices of Tribes and allocating the IHCIF.



Epidemiology Centers: Recurring Funding Epidemiology Centers (CJ-71)

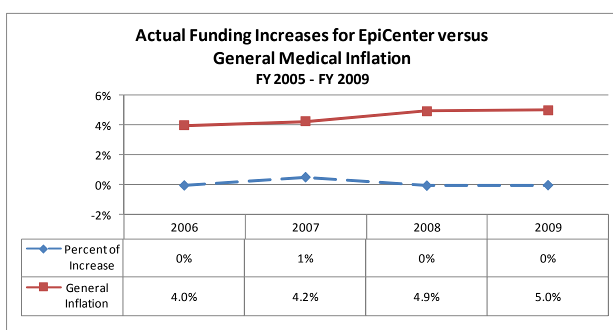
IHS proposes funding for thirteen Epidemiology Centers, eleven tribal, one urban located at the Seattle Indian Health Board and one national center in Albuquerque.

The Northwest Tribal Epidemiology Center (*The EpiCenter*), is located at the NPAIHB. It was the first EpiCenter in the nation and is now a well established part of the health research, health promotion and disease prevention efforts of Northwest Tribes. The *EpiCenter* provides epidemiological and programmatic assistance on a variety of health issues. The Epi-Centers include:

- Northwest Tribal Epidemiology Center
- California Area Epidemiology Center and the California Rural Indian Health Board (new funding for an existing Epi-Center).
- Alaska Native Epi-Center,
- Great Lakes Inter-Tribal Epi-Center
- Inter-Tribal Council Epi-Center
- MT-WY Tribal Leaders Council
- Navajo Nation Division of Health,
- Northern Plains Epi-Center

- Oklahoma Area Epi-Center
- United South and Eastern Tribal Epi-Center
- National Centers: Urban and IHS
- Seattle Indian Health Board Epi-Center
- National EpiCenter Program

The Board recommends permanent funding for Tribal EpiCenters at a level that will enable them to be fully functional epidemiological and surveillance centers. The FY 2010 proposed budget increase of about $450,000 will provide $350,000 in funding for the California Epi-Center.



The proposed level of funding still does not provide an adequate increase to cover the costs of inflation, pay increases, and program growth for the EpiCenters. Unless these programs receive adequate funding increases, they will be challenged 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. NPAIHB recommends a $75,000 increase be provided to each of the Tribal EpiCenters.

Information Technology

The FY 2010 budget request includes a more accurate picture of IHS infrastructure investment in Health Information Technology. IT will be an important component of quality improvements and potentially cost savings so it is wise to provide a clear documentation of IHS IT activities. The IHS maintains that the current budget request ensures that the budget needs for IT are independent of direct clinical care funds. The FY 2010 budget request for IT is $130,757,000, a $16,251,000 increase over FY 2009.

IT received $85 million in ARRA funding. $61.4 million of this funding is dedicated to Electronic Health Record development and deployment. $17 million will be spent on telehealth and related network infrastructure including 228 routers and router memory upgrades, the purchase of licenses, digital radiology units, backup power supplies, and network improvements. In addition the Alaska and Aberdeen areas will have specific allocations . Aberdeen will receive specific videoconferencing support (Aberdeen Area Project). Alaska will receive funding for an Area Office protected network.

Dental Services (CJ-80)

Table 8: Dental Services (Dollars in Thousands)			
President Request:	**$**		**151,384**
FY 2009 Final Budget	$		141,936
President's Increase/Decrease	6.7%	$	9,448
Less Phasing-in Staff at New Facilities		$	2,624
Net Increase Available for Current Services		$	6,824
NPAIHB Estimate for Inflation & Pop. Growth		$	9,652
Shortfall:		**$**	**2,828**

The President's increase for Dental Health services is $9.4 million, a 6.7% increase over last year's level. NPAIHB estimates it will take at least $9.6 million to maintain current services.

The request includes $2.6 million to phase in staffing at new facilities. $1.5 million of this increase in recurring funding is for the Oklahoma Area; a total increase that is equal to 25% of the annual funding for the Portland Area. The total funding increase for the Oklahoma Area in FY 2010 is $3.7 million, 10 times greater than the increase for the Portland Area.

Despite a healthy FY 2010 annual increase of 6.7%, the dental program is still not able to keep pace with inflation and population growth due to the need to fund new facility staffing increases with recurring dollars. Many Portland Area Tribes increased their dental services in FY

2009, but none received increases for their increased staffing since their expansions were funded with non-IHS funds.

Indian populations have the highest rates of oral health disease than any other population. Oral health surveys conducted by IHS indicate the following: 79% of children aged 2-4 years have dental caries; 68% of adults have untreated dental decay; 59% of adults have periodontal (gum) disease; 78% of adults 35-44 years and 98% of elders (55 or older) have at least one tooth removed because of decay, trauma, or gum disease.

These disparities are directly attributed to a lack of dental health funding and access to services. IHS dental providers have a patient load of 2,800 patients per provider, while general population providers have 1,500 patients per provider. Per capita spending for IHS dental services is $50 per patient, while $300 is spent in the general population.

In addition to the recommendation to maintain current services, Northwest Tribes further recommend an additional $180 million to address the significant dental health disparities in Tribal communities. The importance of oral health is that it impacts self-esteem for children, leads to problems eating and speaking, and results in good nutritional choices for adults. It now widely recognized that poor dental health leads to increase morbidity and mortality.

Mental Health (CJ-85)

Table 9: Mental Health (Dollars in Thousands)			
President Request:	**$**		**72,786**
FY 2009 Final Budget	$		67,748
President's Increase/Decrease	7.4%	$	5,038
Less Phasing in Staff at New Facilities		$	1,769
Net Increase/Decrease for Current Services		$	3,269
NPAIHB Estimate for Inflation & Pop. Growth:		$	4,742
Shortfall:		**$**	**1,473**

The President requests $72.786 million to cover the mental health needs of IHS and tribal health programs. This is a $5 million increase compared to the $4.7 million NPAIHB estimates it will take to keep pace with mandatory cost increases for Indian Country.

Unfortunately, what looks like a 7.4% increase, sufficient to maintain the current program and address some unmet needs, is actually far short of that needed to maintain the current program. $1.78 million or 35% of the $5 million increase will be needed for staffing at four new facilities. The remaining $2.2 million represents less than half of what the NPAIHB recommends to fund current services.

40% of the total increase will go to the Oklahoma Area in order to fully staff the programs of new facilities while the rest of the country's mental health programs wait for funding increases. The increase for Oklahoma is ten times the increase for the Portland Area. Only $195,129 was added to the Portland Area's allowance for FY 2010.

IHS mental health providers report that mental health needs throughout Indian Country are a growing concern. A significant investment is needed to avoid the youth suicides, domestic violence, and other manifestations of mental health disparities. 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. It is unfortunate in a year where state after state has cut back services, in a year where increases have been proposed in many areas of health care services, that mental health services will not receive an increase sufficient to maintain the current program.

Despite a dismal funding outlook, recent congressionally approved increases have allowed tribes to develop innovation behavioral health projects. The NPAIHB has developed an area-wide proposal based on a long planning process that developed a suicide prevention coalition that focuses on prevention and

awareness of how tribes can work together to prevent suicides.

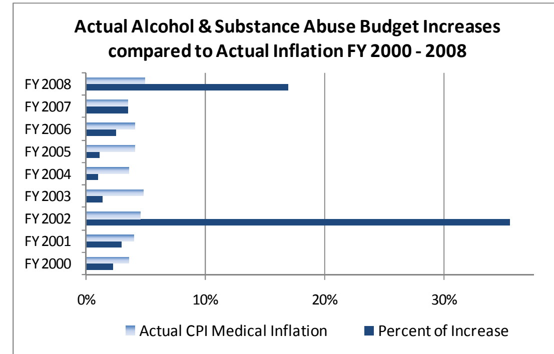
Alcohol & Substance Abuse (CJ-93)

Table 10: Alcohol & Substance Abuse (Dollars in Thousands)		
President Request:	**$**	**194,409**
FY 2009 Final Budget	$	183,769
President's Increase/Decrease	5.8%	$ 10,640
NPAIHB Estimate for Inflation & Pop. Growth:	$	12,864
Shortfall:	**$**	**2,224**

The President's budget requests an increase of 5.8% for Alcohol and Substance abuse programs. This is the largest increase in eight years, but it still falls $2.2 million short of meeting mandatory cost increases. Tribes have often felt that this line item was shortchanged, in part, because it is a tribal program with less than 10% of funds going to federally operated programs.

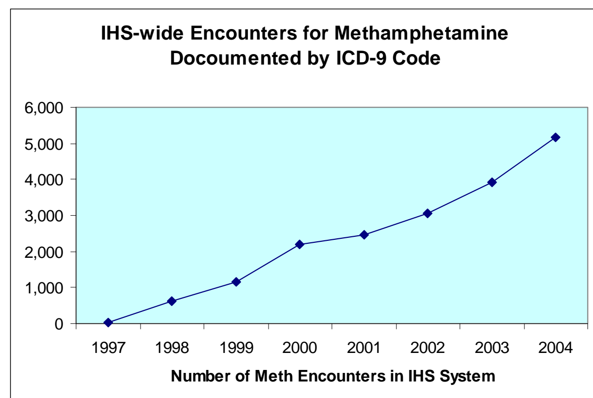
Future budgets should consider the fact that the Alcohol and Substance Abuse funding has grown slower than most other line items over the past eight years. As states cutback funding for alcohol and chemical dependency treatment, funding for tribally operated treatment centers will have increased difficulty providing space for Indian patients. Tribes have successfully developed their own youth and adult treatment centers with a mix of IHS, Tribal, and state funding, but the state funding is now in decline threatening the recent improvements in treatment services.

Alcohol and substance abuse continues to be one of the highest priorities identified by tribal leaders and health directors during the IHS budget formulation process. The latest data available to IHS indicates that alcoholism mortality rates in tribal communities have increased significantly since 1992 to nearly seven-times the alcoholism death rate of the overall U.S. population.



Over the past eight years, the Administration's request has been less than adequate to fund inflation and population growth. The significant increases in FY 2002 and 2008 are a result of Congressional action and not at the request of the President. In FY 2002, Congress provided $30 million in non-recurring funding to address alcohol and substance abuse issues in Indian Country. In FY 2008, Congress provided an additional $13.8 million to address methamphetamine prevention and treatment activities and another $16.4 million in FY 2009. There is no increase for this initiative in FY 2010. Tribal consultation recommended a distribution to Areas and then a competitive process for final distribution to tribes and tribal organizations. The total of $30 million in non-recurring funds should show positive results in addressing these twin scourges.

By relying on Tribes to develop these programs it is more likely that they will be relevant, effective, and long lasting. NW Tribes are developing programs that are likely to be effective since they are developed with local conditions in mind.



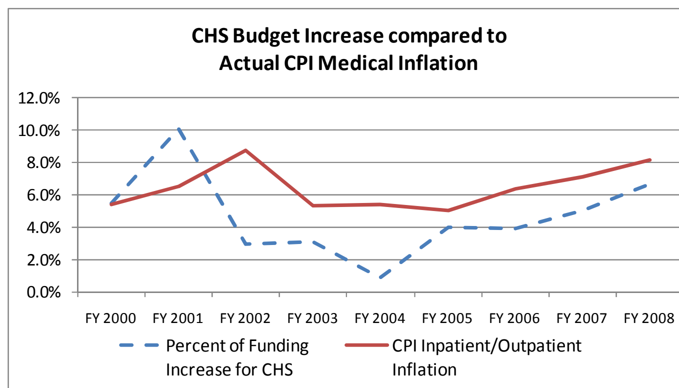
The methamphetamine issue in Indian Country continues to be a burden on Tribal health programs. In 1997, the IHS began collecting methamphetamine patient encounter data. The first year the Agency recorded thirty-one patient visits that were methamphetamine related. In 1998, methamphetamine patient visits 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. Last year, 90% of the behavioral health payments paid by the IHS Portland Area office behavioral health program were to purchase specialty services due to methamphetamine related cases. Growing methamphetamine use has many tribal leaders across Indian Country concerned that tribes do not have the necessary resources to deal with this epidemic.

Contract Health Services (CJ-99)

Table 11: Contract Health Services (Dollars in Thousands)			
President Request:	**$**		**779,347**
FY 2009 Final Budget	$		634,477
President's Increase/Decrease	22.8%	$	144,870
NPAIHB Estimate for Inflation & Pop. Growth:		$	57,737
Shortfall:		**$**	**(87,133)**

The President's request for Contract Health Service (CHS), often called Contract Care, is without a doubt of historic significance in its potential to make a positive impact on the health of American Indians and Alaska Natives.

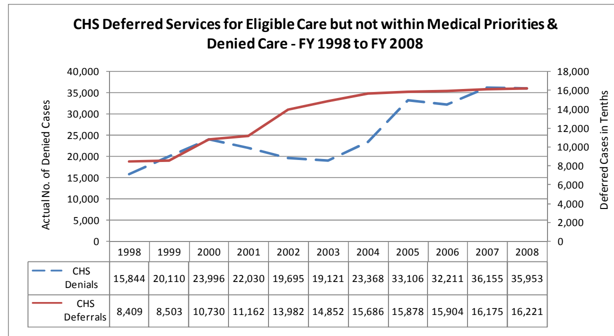
CHS is the most important budget line item for Northwest Tribes. NPAIHB estimates that it will take $58 million to maintain current services in FY 2010. The President's requested increase of $144.9 million is sufficient to not only address inflation, population growth, but also to restore some of the nearly $750 million in lost purchasing power of the past eight years.



Nationally, 48 % of CHS funds are for federally operated facilities and 52% are for tribally operated programs. CHS dependent Areas lack facilities infrastructure to deliver services and have no choice but to purchase specialty care from the private sector using CHS funds. 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. It is more

expensive to purchase such services than if delivered in existing facilities.

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. 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 (graph below). While CHS denials (not within medical priorities) may be falling, CHS deferred services (within medical priorities but not funding available) are on the rise. This means that many patients will go without care unless life or limb test apply, and only then will they receive necessary health care.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
CHS Denials	15,844	20,110	23,996	22,030	19,695	19,121	23,368	33,106	32,211	36,155	35,953
CHS Deferrals	8,409	8,503	10,730	11,162	13,982	14,852	15,686	15,878	15,904	16,175	16,221

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.

This year's requested increase is recognition of the ability of a well funded CHS program to provide efficient and effective health care services according to priorities established by Tribes themselves. The CHS appropriation is 17.4% of the total FY 2009 Health Services account. While small when compared to the 48% of the health services account that is in the Hospitals and Clinics line item it is a critical component of every Indian health program, tribally run or operated by the IHS.

In the Northwest, it represents over 23% of the total Portland Area Office allowance. The consequence of eight years of under-funded inflationary costs is degraded services for tribes who depend upon Contract Health Services to support inpatient, outpatient, and specialty care services. IHS areas like the Portland Area (with no hospitals) are particularly hurt by the lack of sufficient increases to cover medical care inflation and population growth. 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 formula that was developed without consensus in 2001. Since most areas are not CHS dependent a workgroup process runs the risk of allowing the 'majority' to redistribute funds from the areas who depend on a formula that accurately reflects this dependence to the 'minority' who are not CHS dependent. The Portland Area is not Hospitals and Clinics 'dependent' and does not expect to receive a share of that line item that is proportionate to the user population of the Portland Area. It is hoped that Tribes would likewise understand that their share of CHS funding is likely to be less than their user population percentage since they are not contract care dependent.

The CHS program is also extremely vulnerable to inflation pressures. Between FY 1992 and FY 2009, 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 $625.9 million, while unfunded population growth totals $152.5 million—representing over $778 million in lost purchasing power as depicted in the Table 12 above.

Table 12: Contract Health Services (CHS) Lost Purchasing Power 1993 - 2009 (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	$ 543,099	$ 605,714	$ 62,615	$ 11,405	$ 74,020
FY 2008	$ 579,334	$ 648,854	$ 69,520	$ 12,166	$ 81,686
FY 2009	$ 634,477	$ 636,688	$ 2,211	$ 12,166	$ 14,377
		Eighteen Year Total:	**$ 579,608**	**$ 152,520**	**$ 732,128**

The CHS Program and Medicaid

Table 13 charts fourteen years of funding for the CHS program. The CHS increase has averaged 4% each year while medical inflation rate experienced in the Northwest is approximately 8% over this same period. The CHS program is very similar to the Medicaid program. It provides services to an underserved population that often requires similar services. In fact, Congress intended the IHS and Tribal health programs to have access to Medicaid resources when in 1976, it authorized the Indian health system to be reimbursed for Medicaid related services.

CHS should receive medical inflation adjustments at least equal to the Medicaid program (projected to be 10.4% in FY 2010)[3] since both purchase care from private providers. 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. In 2003 the Medicare Modernization Act authorized Medicare-like rates for CHS programs. After a long delay, IHS funded programs' gained access to Medicare-like rates in July 2007. This has moderated increases in FY 2008 and FY 2009, but future increases will be somewhere between those approved my Medicare for Hospitals and those faced by all health care providers for specialty care provided outside the hospital setting.

[3] HHS 2010 Budget in Brief, p. 62, available www.hhs.gov.

Table 13. CHS Budget History FY 1996 to FY 2008 (Dollars in Thousands)				
Year	CHS Approved Budget	Increase over Previous Year	Percent of Increase	Compared to Medicaid Increase
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%	5.8%
FY 2007	$ 543,099	$ 25,802	5.0%	6.7%
FY 2008	$ 579,334	$ 36,235	6.7%	6.8%
FY 2009	$ 634,477	$ 55,143	9.5%	10.4%
		13-Year Average:	4.1%	7.5%

CHS Unmet Need

The IHS maintains a deferred and denied services report that is updated each year. By applying an average CHS outpatient cost to the deferred and denied services figures an estimate can be calculated for unmet CHS need. In 2008 there were 162,205 deferred services; Deferred services that are those within the CHS medical priorities (usually Priority One or Two), however, there was not enough funding to cover the costs of care. There were 35,953 denied services determined not to be within the medical priorities (Priority One).

Other types of denied services in the CHS program are also tracked in the denied service reports by the IHS. These categories represent policy and procedural decisions that typically disqualify an individual from 'covered care.' They include emergency visits not reported in 72 hours, non-emergency care with no prior approval, or patients that reside off the reservation. If adequate funding were available to the CHS program, these procedural denials would be covered services and should be included in projecting CHS funding shortfall.

Applying an average CHS inpatient cost of $1,107 to these numbers estimates that an additional $33 million is needed to address unmet care in the CHS program.

Catastrophic Health Emergency Fund (CHEF)

The CHS budget includes a Catastrophic Health Emergency Fund (CHEF) which is intended to protect the daily administration of local CHS programs from 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.

The current FY 2009 threshold is $25,000 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.

Last year Northwest Tribes urged the Congress to consider fully funding CHEF and consider increasing this amount to $36 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 President's request for CHEF is $48 million, a $21.4 million increase over FY 2008, nearly doubling CHEF funding in just two years. Thanks to this increase, to the availability of cost savings with Medicare-like rates, and the vigorous application of the alternative resources (like Medicaid), CHEF funding may be available throughout the year. The is more likely to be true if overall increases for the IHS budget approach the level recommended by the President for FY 2010.

Table No. 14: Catestrophic Health Emergency Fund FY 1998 - FY 2008				
Year	No. of Funded Cases	Funded Amt.	No. fo Unfunded Cases	Unfunded Amt.
1998	770	$ 12,000,000	501	$ 9,850,000
1999	710	$ 12,000,000	521	$ 10,713,047
2000	714	$ 12,000,000	675	$ 12,225,000
2001	805	$ 15,000,000	439	$ 8,165,000
2002	693	$ 15,000,000	570	$ 8,530,000
2003	718	$ 17,883,000	700	$ 12,359,000
2004	667	$ 17,778,206	756	$ 13,347,720
2005	694	$ 17,749,935	802	$ 17,971,608
2006	671	$ 17,735,176	872	$ 19,545,288
2007	738	$ 17,999,680	895	$ 20,058,448
2008	1,084	$ 26,578,800	1,096	$ 27,000,000

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.

Now that the President, with Congressional support, has fully funded CHEF it is time to call for a careful evaluation of the program with two goals: To insure that programs that need the funds get them and secondly, that all alternative resources are accessed before any distribution of CHEF funds. Since there is often uncertainty surrounding what bills and what patients are eligible for CHEF or alternate resources training should be provided to maximize the effectiveness of this funding source.

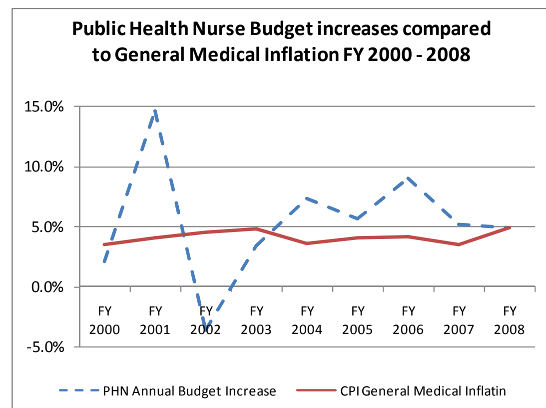
Public Health Nursing (CJ-108)

Table 15: Public Health Nursing (Dollars in Thousands)		
President Request:		**$ 64,071**
FY 2009 Final Budget		$ 59,885
President's Increase/Decrease	7.0%	$ 4,186
Less Phasing in Staff at New Facilities		$ 1,183
Net Increase/Decrease for Current Services		$ 3,003
NPAIHB Estimate for Inflation & Pop. Growth		$ 4,192
Shortfall:		**$ 1,189**

The President's request for Public Health Nurses (PHNs) is $64 million, an increase of 7% over last year's amount. With $1.2 million for staffing at four new facilities., the $2.9 million remaining is not sufficient to maintain the current program.

33% of the increase is for the Oklahoma Area. The Portland Area will receive an increase of just 2.85%. It is significant that although Public Health Nursing has enjoyed wide support, even in this year of a significant overall budget increase, PHN will not receive sufficient funding to maintain its existing program due to such a large percentage of the increase being directed to fully paying for new staffing at new facilities.

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 of PHN is dedicated to maternal and child health promotion. The important work being done to lower infant mortality and Sudden Infant Death Syndrome (SIDS) 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. Many tribes are now involved in focused maternal and infant health projects including an effort by Washington tribes with support from the NPAIHB and the American Indian Health Commission for Washington State.

Health Education (CJ-113)

Table 16: Health Education (Dollars in Thousands)		
President Request:	**$**	**16,682**
FY 2009 Final Budget	$	15,723
President's Increase/Decrease	6.1%	$ 959
NPAIHB Estimate for Inflation & Pop. Growth		$ 1,101
Shortfall:		**$ 142**

The President's request for Health Education is $16.7 million in FY 2009. NPAIHB estimates that it will take at least $1 million to maintain current services. The President's request approximates this need. Just $58,000 in funding will be used for staffing at one new facility, the Carl Albert Hospital.

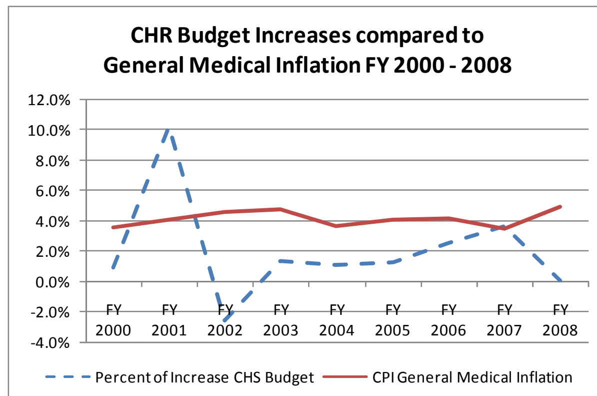
The Health Education program communicates the importance and on-going need for comprehensive clinical and community health education programs. It ensures education to patients, works with hospitals, clinics, and community education programs to integrate IHS patient education protocols and code systems.

Community Health Representatives (CJ-117)

Table 17: Community Health Representatives (Dollars in Thousands)		
President Request:	**$**	**61,628**
FY 2009 Final Budget	$	57,796
President's Increase/Decrease	6.6%	$ 3,832
NPAIHB Estimate for Inflation & Pop. Growth		$ 3,410
Shortfall:		**$ (422)**

The President's request for the Community Health Representatives (CHRs) program is $61.6 million, approximately the same amount NPAIHB estimates that it will take to fund current services.

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-133)

Table 18: Urban Indian Health (Dollars in Thousands)		
President Request:	**$**	**38,139**
FY 2009 Final Budget	$	36,189
President's Increase/Decrease	5%	$ 1,950
NPAIHB Estimate for Inflation & Pop. Growth		$ 3,293
Shortfall:		**$ 1,343**

President Bush proposed the elimination of the Urban Indian health Programs (UIHP) in FY 2007, 2008, and 2009. Tribes vehemently opposed ending this vital component of the Indian health care system. This year's nearly $2 million increase is needed; perhaps even more is justified. The UIHP has not received a respectable budget increase in the last eight years.

In FY 2006, these programs provided over 680,000 health services to a service population of more than 605,000 urban Indian people living in thirty-four locations across this country. Many Indian people in the 1950s and 60s were relocated from reservations to cities in an attempt to assimilate them via mainstream 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.

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. Therefore, it is vital that Congress continue to support urban Indian health programs.

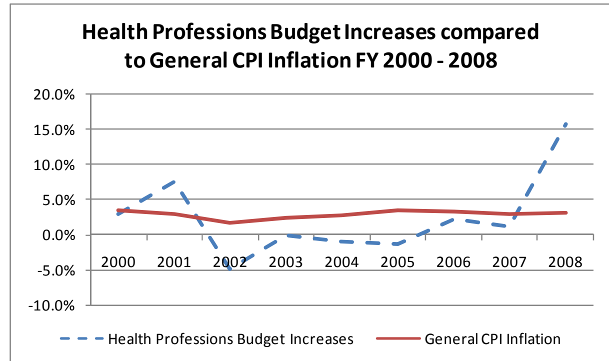
Indian Health Professions (CJ-140)

Table 19: Indian Health Professions (Dollars in Thousands)		
President Request:	**$**	**40,743**
FY 2009 Final Budget	$	37,500
President's Increase/Decrease	8.6%	$ 3,243
NPAIHB Estimate for Inflation & Pop. Growth		$ 1,988
Shortfall:		**$ (1,255)**

The Administration has recognized the importance of addressing the severe human resource needs of IHS-funded health programs by requesting an 8.6% increase for health professions.

This program was developed to meet the critical staffing shortages of physicians, nurses, dentists, pharmacists, and other professions essential to staffing health facilities. Its purpose is to recruit Indian people into the health professions, serving as a catalyst for workforce recruitment and development for IHS and tribal programs.

Last year the NPAIHB recommended a $30 million increase to this program. This year's budget request is a start in the right direction, but more needs to be done. In addition, many believe not enough is being done to address the need for nurses in the Indian health system.

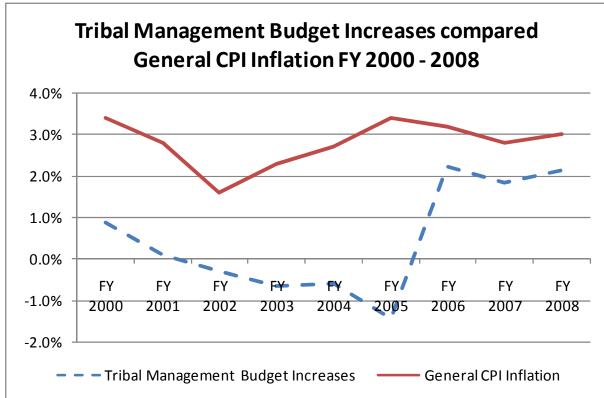


Tribal Management (CJ-154)

Table 20: Tribal Management (Dollars in Thousands)		
President Request:	**$**	**2,586**
FY 2009 Final Budget	$	2,586
President's Increase/Decrease	0.0%	$ -
NPAIHB Estimate for Inflation & Pop. Growth		$ 137
Shortfall:		**$ 137**

The President requests $2.5 million for Tribal Management, approximately the same amount as last year. NPAIHB recommends that $150,000 be provided to maintain current services. The President's request falls short by $103,000.

NPAIHB estimates that this program could easily be doubled and the scope of it funded activities expanded. The President and Congress have not funded any increases for this line item in a number of years with the result that it has become a program with few resources. 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. This program administers grants to tribes, and tribal organizations carrying out Self-Determination programs and works to develop management capacity of Indian managed programs.

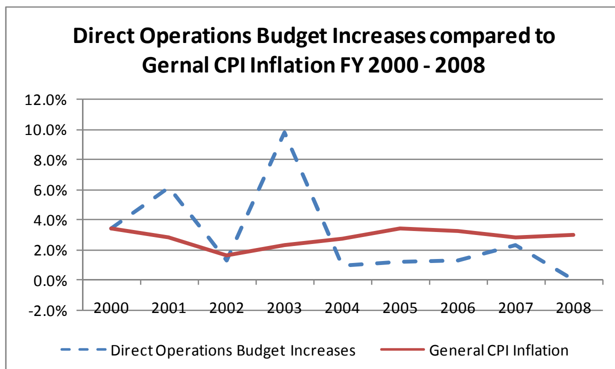


Direct Operations (CJ-158)

Table 21: Direct Operations (Dollars in Thousands)		
President Request:	**$**	**68,720**
FY 2009 Final Budget	$	65,345
President's Increase/Decrease	5.2%	$ 3,375
NPAIHB Estimate for Inflation & Pop. Growth		$ 3,463
Shortfall:		**$ 88**

The Direct Operations line item funds the cost of management at IHS headquarters and the twelve Area Offices. This year the President request proposes an increase in Direct Operations funding by $3.4 million. This is roughly the same amount recommended by the NPAIHB.

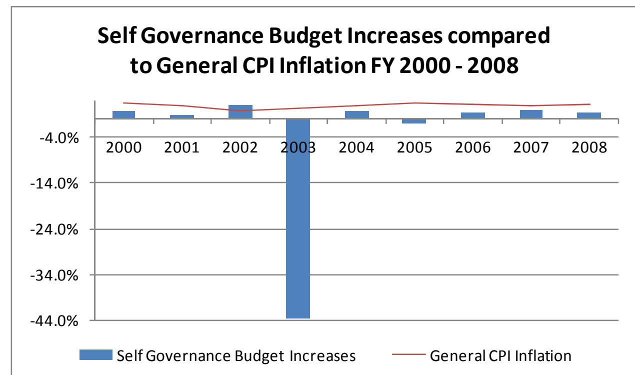
IHS indicates that in FY 2009 twenty-seven percent of its workforce will be eligible for retirement. This budget line item will be important to finance succession planning activities and workforce development in order to meet the Agency's future needs.



Self-Governance (CJ 161)

Table 22: Self Governance (Dollars in Thousands)		
President Request:	**$**	**6,066**
FY 2009 Final Budget	$	6,004
President's Increase/Decrease	1.0%	$ 62
NPAIHB Estimate for Inflation & Pop. Growth		$ 318
Shortfall:		**$ 256**

The President's request for the Self-Governance item is $6 million and is only 1% or $62,000 more than what was requested last year. NPAIHB estimates that it will take at least $318,000 to maintain current services in FY 2010. This leaves $256,000 in unfunded mandatory costs. While this may not seem like much, five 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 with appropriate adjustments to restore full funding.



The Self-Governance office supports Tribes operating programs under the Tribal Self-Governance Amendments of 2000. 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 $1.86 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.

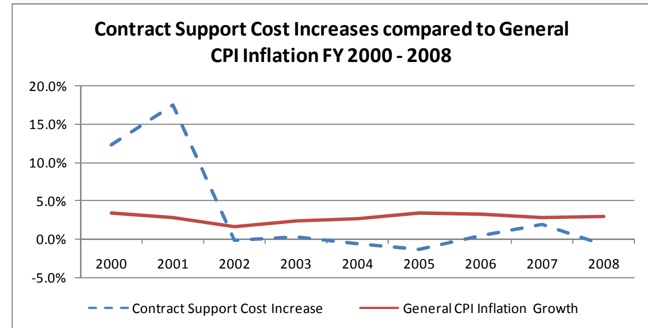
Contract Support Costs (CJ-154)

Table 23: Contract Support Costs (Dollars in Thousands)		
President Request:	**$**	**389,490**
FY 2009 Final Budget	$	282,398
President's Increase/Decrease	37.9%	$ 107,092
NPAIHB Estimate for Inflation & Pop. Growth		$ 14,967
Amt to Address Prior Year's Shortfall		$ 200,000
ESTIMATED NEED		*$ 214,967*
Shortfall:		**$ 107,875**

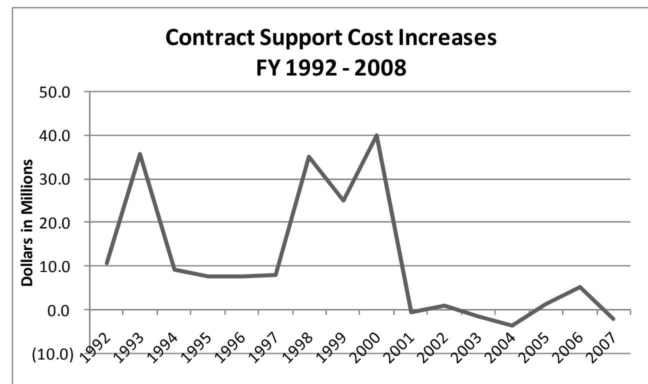
This year's FY 2010 request of a $107 million increase for Contract Support Costs signals an end to a sad chapter of neglect for Self-Determination. Contracting and compacting were seriously undermined from 2002 through 2008, by the failure to pass adequate funding increase to not only support existing contractors, but those who wanted to participate in self-determination. New contractors found themselves unfairly set up to fail when the IHS was unable to provide the level of contact support that was justified by the amount of activity taken over by tribes.

The Indian Self-Determination and Education Assistance Act of 1975 authorized 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.

Over the eight years of the Bush Administration the IHS budget failed to provide an adequate increase for CSC funding. Because of the effect of the rescissions, the CSC line item had its base funding eroded by $8.2 million from FY 2002 to FY 2008. Incredibly, the FY 2002 appropriation for CSC was nearly identical the amount appropriated in FY 2008.



The lack of CSC funding virtually halted the growth of Indian Self Determination. The FY 2009 budget passed this year finally appropriated $15,000,000 which together with this year's increase will eliminate the current shortfall, but not the years of funding lost while the shortfall accumulated to over $100 million. The damaging cuts to CSC are contrary to the Congressional and Administrion's support of allowing Tribal Self-Determination.



In addition to the accumulated shortfall, there are tribes waiting to contract or compact, but do not because there is no funding for these new or expanded contracts. Congress should signal to tribes that it is willing to fund new contractors and that Congress understands that new contractors who should not be punished just because they are coming after the early contracting tribes.

Medicaid, Medicare and Private Collections (CJ-158)

Congress and the Administration have taken measures to reform the Medicare and Medicaid programs over the last five years. These changes will continue to have lasting effects on the Indian health system, on its ability to enroll people into the programs, and on its ability to increase reimbursements. The President has also promised sweeping health care reform that will keep, but alter the Medicaid program.

The Administration has thankfully understood that Medicare and Medicaid collections can never be used to offset IHS funding nor to justify lower increases in the IHS budget.

Health Care Reform

Northwest Tribes are carefully tracking the development of health care reform proposals and have provided the Congress and the Administration with detailed analysis and recommendations. There is a clear need for specific and detailed provisions relating to the Indian health care system that have to be incorporated into health care reform legislation.

The NPAIHB has provided Congressional committees working on health reform legislation with recommendation on how to improve opportunities for Indian health programs in health reform legislation. These recommendations are available at: www.npaihb.org/policy/health_reform_the_indian_health_system/.

Special Diabetes Funding (CJ-160)

Congress approved an extension of the SDPI program at its current funding level of $150 million through September 30, 2011. 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.

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 well 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-172)

Maintenance and Improvement (CJ-174)

Table 24: Maintenance & Improvement (Dollars in Thousands)		
President Request:	**$**	**53,915**
FY 2009 Final Budget	$	53,915
President's Increase/Decrease	0.0%	$ -
NPAIHB Estimate for Inflation & Pop. Growth		$ 1,725

Over the past 14 years (FY 1993-FY2008) 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 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 of April 24, 2009, estimates that there is a backlog of $476 million in needed repairs to Indian health facilities. While the ARRA appropriation of $100 million is expected to result in a decline of about $80 million in the BEMAR, there is still a considerable need for maintenance and repair funding for IHS and Tribal health facilities.

The President's request for M&I is $52.8 million; the same amount funded in FY 2008. The request does not include any funding for inflation or pay act increases. NPAIHB recommends that $1.9 million be provided to maintain current services. Additional funding should be considered by the Congress to address the $371 million needed for BEMAR.

Sanitation (CJ-180)

Table 25: Sanitation Facilities (Dollars in Thousands)		
President Request:	**$**	**95,857**
FY 2009 Final Budget	$	95,857
President's Increase/Decrease	0.0%	$ -
NPAIHB Estimate for Inflation & Pop. Growth	$	3,067
Shortfall:	**$**	**3,067**

The ARRA appropriated $68 million for Sanitation Facilities. The FY 2010 budget request has no increase for this line item as projects funded under ARRA work their way toward completion. It is expected the increases will resume once the ARRA projects are completed.

NPAIHB estimate of $3 million to maintain the current rate of completion of projects give a good sense of the magnitude of the ARRA projects. It should result in improvements in the health of Indian people in the most needy communities of the country.

Approximately 7.5% of all AI/AN homes lack safe water in the home compared to less than 1% average nationally. Sanitation is an integral component of disease management. Many health professionals credit health status improvements due to quality water, sewage disposal facilities, development of solid waste sites, and support for Indian water and sewage programs.

Health Facilities Construction (CJ-185)

Table 26: Facilities Construction (Dollars in Thousands)		
President Request:	**$**	**29,234**
FY 2009 Final Budget	$	40,000
President's Increase/Decrease	-26.9%	$ (10,766)
NPAIHB Estimate for Inflation & Pop. Growth	$	-
Shortfall:	**$**	**-**

Northwest tribes support a moratorium on facilities construction until an equitable funding methodology can be implemented by the IHS. This position has been recommended for the last four years so that savings from facilities construction can be redirected to the health services accounts. As noted previously, facilities, especially hospitals are expensive to build and their staffing packages are 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 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 2009 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 depends 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-193)

Table 27: Facilities & Environmental Support (Dollars in Thousands)		
President Request:	**$**	**193,087**
FY 2009 Final Budget	$	178,329
President's Increase/Decrease	8.3%	$ 14,758
NPAIHB Estimate for Inflation & Pop. Growth		$ 5,707
Shortfall:		**$ (9,051)**

This line item consists of three subsidiary activities: facilities support, environmental health support, and the office of Environmental Health and Engineering support. NPAIHB recommends be provided to fund increased inflation costs and pay act increases.

Equipment (CJ-205)

Table 28: Equipment (Dollars in Thousands)		
President Request:	**$**	**22,664**
FY 2009 Final Budget	$	22,067
President's Increase/Decrease	2.7%	$ 597
NPAIHB Estimate for Inflation & Pop. Growth		$ 706
Shortfall:		**$ 109**

The ARRA appropriated $20 million for medical equipment. The Administration does not request an increase for Equipment in FY 2010. 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.

The FY 2010 IHS Budget in the Context of Current Fiscal Realities

Table 29: Annual Fiscal Year Budget Projections - *Deficit/Surplus*										
President's Budget Projections	Fiscal Years - Dollars in Billions									
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Deficits	$1,617	$1,270	$1,043	$761	$743	$788	$797	$907	$949	$977
Source: CBO, "An Analysis of the President's Budgetary Proposals for FY 2010, available at www.cbo.gov.										

Deficit/Surplus Projections

It is worthwhile to consider the overall budgetary context in any analysis of the FY 2010 IHS budget. The $3.6 trillion dollar federal budget is in addition to the $789 billion stimulus bill (American Relief and Recovery Act ARRA).

When President Clinton left office the country enjoyed an annual $236 billion budget surplus. Unfortunately, the Bush Administration's tax cuts, combined with the war in Iraq and Afghanistan, and this year's stimulus spending passed in order to speed economic recovery, have completely reversed this Country's future budget prospects.

The Fiscal Year 2009 projected deficit is an astounding $1.7 trillion dollars and a $1.28 billion deficit is expected in 2010. At 12% of Gross Domestic Product (GDP) this year and next, borrowing to pay for accumulated deficits by the United States Government is expected to rise to 80% of GDP.

Table 29 estimates the budget deficit over the next ten years using information reported in the President's FY 2010 budget. While some might say the Obama Administration has ushered in a new era of profligate spending his budget proposals fit more closely with that of the Congressional Budget Office philosophy on budget deficits and the need for spending constraint when the current recession ends:

CBO Position on Deficits:

"Thus, the large deficits that CBO projects for the years after the economy has returned to full employment are more worrisome. Moreover, the sharp increase in debt this year and next raises the risk that investors might lose confidence in U.S. government debt as a safe haven. This risk heightens the importance of putting the budget on a sustainable path as the economy returns to full employment."

(CBO, May 2000).

As the table illustrates, the CBO anticipates deficit spending for the next five years. Like the President the CBO argues that it the high deficits have to be reduced. The President's budget proposes reductions in non-defense discretionary programs to meet the goal of reducing the annual deficit to just $761 billion by the end of his first term in 2012. The proposed increases for non-defense discretionary programs are less than $10 billion for each of the next four years with reductions planned for the following six years.

In other words the next seven to ten years will NOT be like this year with massive spending for discretionary programs. Indian health funding increases of more than 10% are still possible and fully justified, but the case must be made against other competing priorities that have their own advocates. The fact that the President has stated the goal of driving non-defense spending to its

lowest level in three generations is a cause for concern. Tribes should not take this year's increases and predictive of future years'. The case will have to be made for future investments in improving Indian health.

Discretionary Spending

The President requests $508 billion in non-defense and $533 billion in defense spending for a total of $1.04 trillion in discretionary budget authority for FY 2010. Non defense discretionary spending is about 4% of GDP, but the President's ten year projection is for it to decline to under 3% of GDP. He has stated that this will be lower than 1962 or any year since. This means discretionary program will come under severe budgetary restraints in the medium and long term.

Conclusion: The Purpose of this Report

This document and the Portland Area Tribes participation in discussion about the budget at the Affiliated Tribes of Northwest Indians, and meetings of the Northwest Portland Area Indian Health Board represents 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 31

Table 30 grades the President's FY 2009 IHS budget against criteria (or principles) that the NPAIHB has developed and applied to budget analyses over the past 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 2010 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.

	Table 30: GRADING THE PRESIDENT'S PROPOSED FY 2010 IHS BUDGET	President May 7, 2009	Senate	House
	Criteria or Budget Principle	*FY 2010 Grade*		
1	Budget Information Shared with Tribes in Consultation Sessions Prior to release date of the first Monday in February.	B		
2	Appropriate adjustment will be made to fully cover expected inflation.	B		
3	Appropriate increases will be included to address population growth.	A		
4	Appropriate adjustments will be made to fully fund tribal and federal employee compensation.	A		
5	The Contract Health Service Budget will be increased to fully fund the need for deferred services.	B		
6	Collection estimates are not represented as fulfilling the federal responsibility to fully fund the IHS budget.	B		
7	Increases will be provided to address the goals of the Indian Health Care Improvement Act.	B		
8	Full funding will be included to support staff associated with new construction projects.	B		
9	The Catastrophic Health Emergency (CHEF) Fund will be budgeted at a level to cover all qualifying cases.	A		
10	Funding will be provided to cover Contract Support Costs for tribes electing to compact or contract their health care services.	B		
11	Adequately support maintenance of IHS and tribal health facilities.	C		
12	The public announcements relating to the budget will honestly depict what is in the budget.	A		
13	Provides adequate funding to reduce health disparities.	B		
14	Honor the federal trust responsibility to provide health care services to American Indians and Alaska Natives.	B		
	Overall Grade	**B**		