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

Northwest Portland Area
Indian Health Board

The FY 2011 Indian Health Service Budget: Analysis and Recommendations

21th Annual Report
March 12, 2010

The recommendations in this report were reviewed and adopted by Portland Area Tribes at the 21st Annual All Tribes Meeting held in Portland, Oregon on March 11, 2010.

If you would like to make a contribution towards the production of this annual review of the Indian Health Service Budget, please make a check payable to:

NPAIHB /General Fund

Send your check to
Northwest Portland Area Indian Health Board
527 Hall St., Suite 300
Portland, OR 97201

Or consult our website at www.npaihb.org for information on how to donate to the Northwest Portland Area Indian Health Board.

Thank you

TABLE OF CONTENTS

Northwest Portland Area Indian Health Board

Introduction

This 21st Annual Northwest Portland Area Indian Health Board analysis of the Indian Health Service (IHS) budget continues a tradition of close scrutiny of the IHS budget that began in 1989. Northwest Tribes applaud the Administration for its continued support of Indian health programs. This year's budget marks the second year in a row that the IHS budget has received a respectable increase The scale of last year's increase (13%) and this year's request (8.7%) makes it clear that the Administration is listening to Tribes and that it recognizes the legacy of years of chronic underfunding that have *created* greater health disparities for Indian people. The Administration has proposed a freeze on non-security discretionary spending and future IHS budgets may not be as fortunate as the past two years. While Tribes understand the fiscal climate, they also recognize that their health programs have not kept pace with modern health care systems due to chronic underfunding and that this has contributed to the high health disparities seen in Tribal communities, and that it would be unjust to limit funding just as Tribes have begun to make gains in addressing disparities.

Budget formulation for tribes is vastly different 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 2011 IHS budget continues a positive maintenance of effort for a budget that has suffered a heavy burden of neglect over the past ten years. Following a FY 2001 increase of 10%, from FY 2002 to FY 2008 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. This gap has begun to be addressed in the last two budget increases of this Administration, however, additional funding is needed to address the growing health disparities of Indian people.

NPAIHB estimates it will take a $474 million increase in the FY 2011 budget to fund pay increases, inflation, and population growth in order to maintain current services. While the President's budget provides adequate funding to cover inflation and population growth, its distribution within the IHS accounts will not maintain current services as presented. Staffing new facilities and program expansions will absorb $217 million leaving only $137 million to cover NPAIHB's projected $328 million for inflation and population growth. Add to this the $146.1 contract support cost shortfall that is owed to those tribes that have assumed management of their own health care programs and the total is $474 million. An additional $120 million is needed. Alternatively, reallocating the President's $354 increase among the sub-accounts would also help cover the true costs of medical inflation and population growth.

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 is also 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 2010 NPAIHB Legislative Plan and this FY 2011 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.

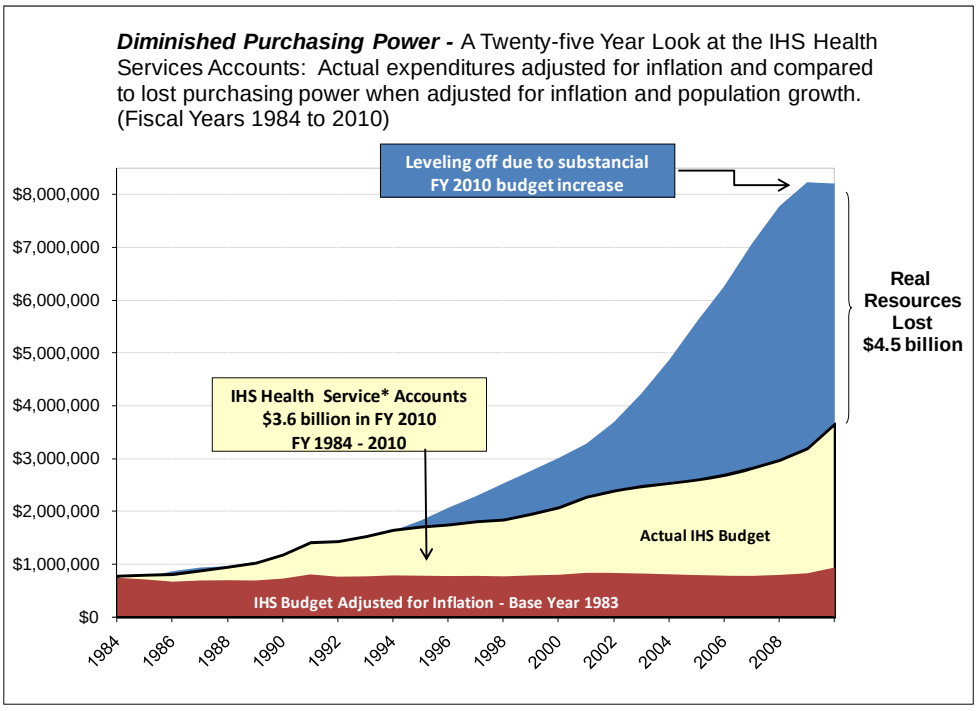
This analysis was first developed to serve as a reality check demonstrating the lack of integrity past executive branch budgets. Tribes are not without their own interest in advocating for budget increases, but this analysis presents unbiased estimates and objective data for that cause. The analysis 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 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-four 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 from 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 as 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 http://budget.house.gov/pres_budg.shtml
- The Budget for FY 2011 http://www.whitehouse.gov/omb/budget/ is the President's budget request of February 1, 2010. It is actually a set of documents with narrative and statistical information on the President's proposed budget for FY 2011.
- Congressional Budget Office (CBO http://www.cbo.gov/), The Budget and Economic Outlook: Fiscal Years 2010-2020, January, 2010 and Preliminary Analysis of the President's Budgetary Proposals for FY 2011, March 5, 2010. 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 2011, DHHS FY 2011 Budget In Brief, February 1, 2010 available at http://www.hhs.gov/asrt/ob/docbudget/2011budgetinbrief.pdf
- The Indian Health Service ,Congressional Justification of Estimates for Appropriations Committees Fiscal Year 2011 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 2011 Northwest Portland Area Indian Health Board Budget Analysis and Recommendations

The Northwest Portland Area Indian Health Board (NPAIHB) estimates that it will take at least $474 million to maintain current services (inflation and population growth) for IHS health programs in FY 2011. Of this amount, $146.1 million is recommended to fund the backlog of Contract Support Cost (CSC) that is owed to Tribes that have assumed programs under the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

Northwest Tribes further recommend $550 million in additional 'program' increases to address growing health needs and diminished services due to the lack of sufficient funding increases by the previous Administration. The President's respectable increase of $354 million is still less than one-half 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 2011 budget request provides $4.4 billion for the Indian Health Service (IHS), and is a $354 million increase, 8.7%, in funding above the FY 2010 enacted level. Taken together with last year's historic 14% increase, this year's request is noted and applauded by all Northwest Tribes. The last two years of budget increases are more than any increase in recent history. The increases exceed those of other agencies in the Department of Health and Human Services. While this action is significant in that it provides sufficient funding to maintain the current program, the effect of staffing new facilities and certain program increases, will result in less than adequate funding to cover mandatory costs of inflation and population growth in some programs. Congress can correct this by providing additional funding or reallocating staffing and certain program increases to cover these mandatory costs.

The generous Contract Health Service budgets of the last two years will allow some funding to be applied 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 reduce health disparities.

The President's request for Hospitals and Clinics includes a request of $44 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 $38.7 million, what might seem like an insignificant amount given the $354 million increase; however it absorbs over 22% of the available funding that the President makes available for pay costs, inflation, and staffing new facilities.

The Final Enacted FY 2010 IHS Budget

The President signed the FY 2010 Interior appropriations bill on October 30, 2009, which provided $4.1 billion for the IHS budget. This historic increase provided a $471.3 million increase, or 13.2% over 2009, and is easily the largest increase in the past twenty-five years. The FY 2010 budget restored some of the budget neglect by the previous Administration and allowed some funding to be directed for program expansions. It provided one of the largest increases ever for the Contract Health Service program and restored funding for the Dental and Mental Health Services line items. A significant increase of $7 million was provided for the Urban Indian Health program, 20% more than the previous year. A record

increase of $116 million was provided for the Contract Support Cost line item and restored years of neglect for tribal contractors and compactors. While the FY 2010 is the best budget increase in twenty-five years, many health care analysts consider the decline in health care services a direct result of chronic under- funding of the Indian health system. In fact, a recent report indicates that health disparities have gotten significantly worse or have remained unchanged for AI/AN people.[1] Because of this, the Administration and Congress must continue to find ways to restore the lost purchasing power of the IHS budget.

Table No. 1: Indian Health Service Budget
Comparison of FY 2009, 2010, and Presidents FY 2011
(Dollars in Thousands)

Sub Sub Activity	Final Budget FY 2009	Final Budget FY 2010	Change Over FY 2009	Change Over FY 2009	President's FY 2011 Budget	Change Over FY 2010	Change Over FY 2010
SERVICES:							
Hospitals & Health Clinics	$ 1,597,777	$ 1,754,383	$ 156,606	9.8%	$ 1,893,292	$ 138,909	7.9%
Dental Services	$ 141,936	$ 152,634	$ 10,698	7.5%	$ 161,262	$ 8,628	5.7%
Mental Health	$ 67,748	$ 72,786	$ 5,038	7.4%	$ 77,076	$ 4,290	5.9%
Alcohol & Substance Abuse	$ 183,769	$ 194,409	$ 10,640	5.8%	$ 205,770	$ 11,361	5.8%
Contract Health Services	$ 634,477	$ 779,347	$ 144,870	22.8%	$ 862,765	$ 83,418	10.7%
Total, Clinical Services	*$ 2,625,707*	*$ 2,953,559*	*$ 327,852*	*12.5%*	*$ 3,200,165*	*$ 246,606*	8.3%
PREVENTIVE HEALTH:							
Public Health Nursing	$ 59,885	$ 64,071	$ 4,186	7.0%	$ 67,571	$ 3,500	5.5%
Health Education	$ 15,723	$ 16,682	$ 959	6.1%	$ 17,489	$ 807	4.8%
Comm. Health Reps	$ 57,796	$ 61,628	$ 3,832	6.6%	$ 63,991	$ 2,363	3.8%
Immunization AK	$ 1,823	$ 1,934	$ 111	6.1%	$ 2,009	$ 75	3.9%
Total, Preventative Health	*$ 135,227*	*$ 144,315*	*$ 9,088*	*6.7%*	*$ 151,060*	*$ 6,745*	4.7%
OTHER SERVICES:							
Urban Health	$ 36,189	$ 43,139	$ 6,950	19.2%	$ 45,502	$ 2,363	5.5%
Indian Health Professions	37,500	$ 40,743	$ 3,243	8.6%	$ 41,413	$ 670	1.6%
Tribal Management	2,586	$ 2,586	$ -	0.0%	$ 2,669	$ 83	3.2%
Direct Operation	65,345	$ 68,720	$ 3,375	5.2%	$ 69,845	$ 1,125	1.6%
Self Governance	6,004	$ 6,066	$ 62	1.0%	$ 6,201	$ 135	2.2%
Contract Support Costs	282,398	$ 398,490	$ 116,092	41.1%	$ 444,332	$ 45,842	11.5%
Total, Other Services	*$ 430,022*	*$ 559,744*	*$ 129,722*	30.2%	*$ 609,962*	*$ 50,218*	9.0%
TOTAL, SERVICES	***$ 3,190,956***	***$ 3,657,618***	***$ 466,662***	***14.6%***	***$ 3,961,187***	***$ 303,569***	***8.3%***
FACILITIES:							
Maintenance & Improvement	$ 53,915	$ 53,915	$ -	0.0%	$ 55,523	$ 1,608	3.0%
Sanitation Facilities Construction	95,857	$ 95,857	$ -	0.0%	$ 97,710	$ 1,853	1.9%
Hlth Care Facilities Construction	40,000	$ 29,234	$ (10,766)	-26.9%	$ 66,192	$ 36,958	126.4%
Facil. & Envir. Hlth Supp	178,329	$ 193,087	$ 14,758	8.3%	$ 202,106	$ 9,019	4.7%
Equipment	22,067	$ 22,664	$ 597	2.7%	$ 23,711	$ 1,047	4.6%
Total, Facilities	*$ 390,168*	*$ 394,757*	*$ 4,589*	1.2%	*$ 445,242*	*$ 50,485*	12.8%
TOTAL, IHS	***$ 3,581,124***	***$ 4,052,375***	***$ 471,251***	***13.2%***	***$ 4,406,429***	***$ 354,054***	***8.7%***

[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.

Preserving the Basic Health Program

The President's FY 2011 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. 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 2011 is $474 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. 23).

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 2011 an increase of at least $474 million (an increase of 12%) will be needed to maintain current services. In addition, Portland Area tribes recommend an additional **$550** 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 **25%** over last year's level (see Table 4 on page 14).

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

Mandatory Cost to Maintain Current Services	*Increase Needed*
CHS inflation estimated at 8.2%	$80,273
Health Services Account (not including CHS) inflation	$187,431
Contract Support Costs (unfunded)	$146,100
Population Growth (estimated at 2.1% of health services accounts)	$60,444
Total Mandatory Costs	$474,248

Note on Medical Inflation: Medical services inflation is between 5% - 10% in Northwest states of OR, WA, and ID. Health care and budget analysts understand that increases in medical spending reflect increases in the value of services and pharmaceuticals, and not simply general CPI inflation used to measure 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 14), 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 2011

Estimates for Contract Support Costs (CSC) use the IHS yearly CSC Shortfall report forecasting method that updates shortfall calculations based on actual figures in the FY 2010 appropriations. Since the FY 2010 CSC shortfall report is not available yet, CSC shortfall estimates are based on the FY 2009 shortfall report and the estimated program increases in FY 2010. There are other CSC changes at work as well. For instance, in 2010 IHS will now be recognizing additional CSC shortfalls from a Navajo expansion and a Cherokee expansion (Hastings) that occurred in FY 2009 and FY 2010. These expansions are estimated to total $15 million in additional CSC requirements. After taking account of these elements, plus the fact that 15% of the IHS program increases in FY 2010 will be require Tribes to administer the a larger portion of the IHS program (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 approximately $146.1 million for FY2010.

Table 4: Indian Health Service Budget

Comparing Final FY 2010 to FY 2011 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 2010 Final**	**President's FY 2011 Request**	**Change**	**CPI Medical Care**	**Increase needed for Inflation**	**Increase needed for Pop. Growth**	**NPAIHB ESTIMATE FOR CURRENT SERVICES**
SERVICES:						2.1%	
Hospitals & Health Clinics	1,754,383	1,893,292	138,909	7.1% [a]	$ 124,561	$ 36,842	$ 161,403
Dental Services	152,634	161,262	8,628	3.2% [b]	$ 4,884	$ 3,205	$ 8,090
Mental Health	72,786	77,076	4,290	7.1% [a]	$ 5,168	$ 1,529	$ 6,696
Alcohol & Substance Abuse	194,409	205,770	11,361	7.1% [a]	$ 13,803	$ 4,083	$ 17,886
Contract Health Services	779,347	862,765	83,418	8.2% [d]	$ 63,906	$ 16,366	$ 80,273
Total, Clinical Services	*2,953,559*	*3,200,165*	*246,606*		*$ 212,323*	*$ 62,025*	*$ 274,348*
PREVENTIVE HEALTH:					4.70%		
Public Health Nursing	64,071	67,571	3,500	3.8% [c]	$ 2,435	$ 1,345	$ 3,780
Health Education	16,682	17,489	807	3.8% [c]	$ 634	$ 350	$ 984
Comm. Health Reps	61,628	63,991	2,363	3.8% [c]	$ 2,342	$ 1,294	$ 3,636
Immunization AK	1,934	2,009	75	3.8% [c]	$ 73	$ 41	$ 114
Total, Preventative Health	*144,315*	*151,060*	*6,745*		*$ 5,484*	*$ 3,031*	*$ 8,515*
OTHER SERVICES:					4%		
Urban Health	43,139	45,502	2,363	8.2% [d]	$ 3,537	$ 906	$ 4,443
Indian Health Professions	40,743	41,413	670	3.4% [e]	$ 1,385	$ 856	$ 2,241
Tribal Management	2,586	2,669	83	3.4% [e]	$ 88	$ 54	$ 142
Direct Operation	68,720	69,845	1,125	3.4% [e]	$ 2,336	$ 1,443	$ 3,780
Self Governance	6,066	6,201	135	3.4% [e]	$ 206	$ 127	$ 334
Contract Support Costs	398,490	444,332	45,842	3.4% [e]	$ 13,549	$ 8,368	$ 21,917
Total, Other Services	*559,744*	*609,962*	*50,218*		*$ 21,102*	*$ 11,755*	*$ 32,857*
TOTAL, SERVICES	*3,657,618*	*3,961,187*	*303,569*		*$ 238,909*	*$ 76,810*	*$ 315,719*
FACILITIES:							
Maintenance & Improvement	53,915	55,523	1,608	3.4% [e]	$ 1,833	$ -	$ 1,833
Sanitation Facilities Construction	95,857	97,710	1,853	3.4% [e]	$ 3,259	$ -	$ 3,259
Hlth Care Facilities Construction	29,234	66,192	36,958	3.4%	$ -	$ -	$ -
Facil. & Envir. Hlth Supp	193,087	202,106	9,019	3.4% [e]	$ 6,565	$ -	$ 6,565
Equipment	22,664	23,711	1,047	3.4% [e]	$ 771	$ -	$ 771
Total, Facilities	*394,757*	*445,242*	*50,485*		*$ 12,428*	*$ -*	*$ 12,428*
TOTAL, IHS	**4,052,375**	**4,406,429**	**354,054**		**$ 251,337**	**$ 76,810**	**$ 328,146**

Summary of Costs to maintain Current Services:

Contract Support Costs Shortfall Amount: [f]	$ 146,100	
Inflation & Population Growth:	$ 328,146	
Total Current Services:	$ 474,246	12%
Program Enhancements (see p. 18):	$ 550,000	
Total Current Services Budget:	**$ 1,024,246**	25%

Inflation Rates Calculated as follows:

[a] Hospital & Clinics inflation and Behavioral health line items are 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 CUSR0000SEMC04 Medcial Care Inflation (Other medical care professionals).

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

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

[f] 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.

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 increase of 12% to 25% 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 $83 million increase for CHS, but recommend more funding for the grossly underfunded Contract Health Service program to address the significant backlog of deferred services, and the growing number of denied services and for the Catastrophic Health Emergency Fund. 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. To accomplish this will require a significant increase in funding to increase the number of dental providers so that their workload is comparable with that of a dentist in the general population (see p. 20). Funding is also recommended for to develop a midlevel dental health provider, similar to the Dental Health Aide Therapist program in the Alaska Area, to practice throughout Indian Country. An additional $200 million is recommended for dental health needs in Indian Country.

Table No. 4b: IHS Budget Program Increases
(Dollars in Thousands)

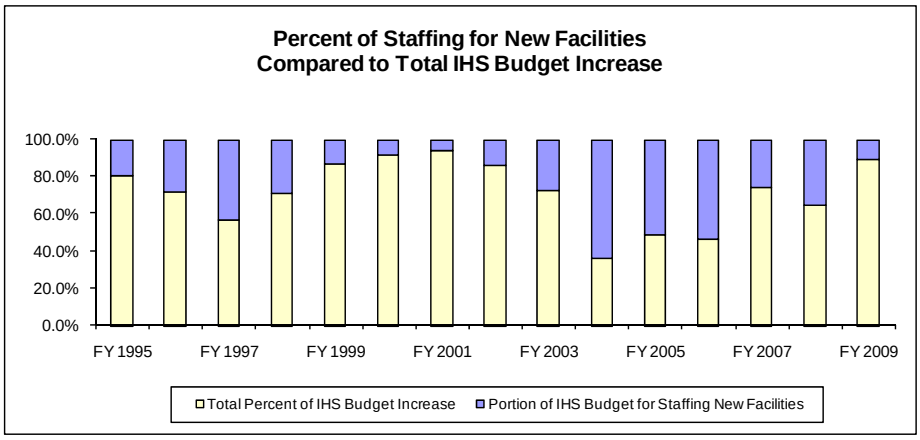
CHS Unfunded: Denied/Deferred Services	$ 173,000
CHS: Catestrophic Health Emergency Fund	$ 10,000
Dental Health	$ 200,000
Mental Health	$ 25,000
Alcohol and Substance Abuse	$ 40,000
Community Health Representatives	$ 2,000
Pharmacy	$ 35,000
Small Ambulatory Clinics, Joint Venture	$ 40,000
Maintenance & Improvement, Facilities	$ 25,000
Total, Program Increases:	**$ 550,000**

Facilities funding for small ambulatory clinics continues to be a high priority for the Portland Area. Unfortunately, the President budget does not request funding for the small ambulatory grant 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.

While ARRA funding provided $100 million for maintenance and improvement projects it also revealed that there are over $476 million in essential repairs need for IHS facilities (see p. 33). An additional $25 million is recommended to address this backlog of maintenance.

The balances of the increases are distributed for other high priority issues like behavior health programs and pharmaceuticals that have both required an increasing percentage of health program expenditures. As states of moved to contain costs in state budgets they cut back optional services in behavioral health programs and Tribes will no longer be able to rely on the Medicaid program to cover these costs.

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*
Joint Venture Place Holder	-	$ 9,843
Little Axe, OK - Absentee Shawnee Health Center	93	$ 8,981
New Town, ND - Elbowoods Health Center	88	$ 8,387
Ada, OK - Carl Albert Hospital	58	$ 6,532
Lakeport, CA - Lake County Tribal Health Ctr	31	$ 3,036
Eagle Butte, SD - Cheyenne River Health Center	20	$ 1,992
Total	**290**	**$ 38,771**

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

Table 6: Health Services Account FY 1993-FY 2010 (Dollars in Thousands)			
Year	**Approved Health Services Budget**	**Budget Needed w/Inflation & Pop-Growth Adjustment [1]**	**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
2010	$3,657,618	$3,449,532	($208,086)
		Total Real Resources Lost FY 1993-2009	**$2,876,229**

[1] Estimate from previous fiscal year's *NPAIHB Budget Analysis & Recommendations Report*.

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-57)

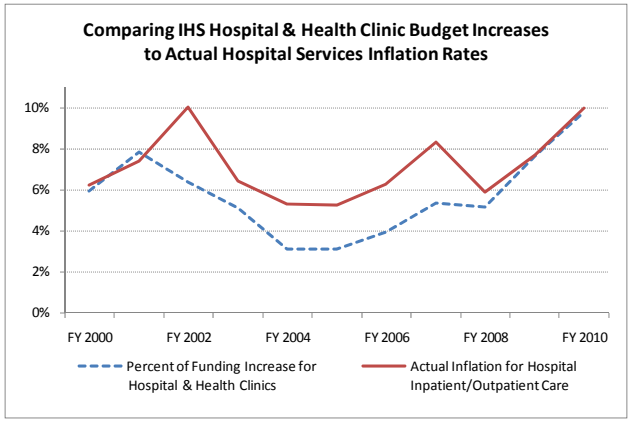
Table 7: Hospitals & Clinics (Dollars in Thousands)			
President Request:		**$**	**1,893,292**
FY 2010 Final Budget		$	1,754,383
President's Increase/Decrease	7.9%	$	138,909
Less Phasing-in Staff at New Facilities		*$*	*29,211*
Less Requested Program Expansions		*$*	*50,529*
Net Increase Available for Current Services		$	59,169
NPAIHB Estimate for Inflation & Pop Growth:		$	161,403
	Shortfall:	**$**	**(102,234)**

The Hospitals and Clinics (H&C) line item would receive $1.89 billion under the Administration's request, a proposed increase of $138.9 million or 7.9% over the enacted FY 2010 budget. NPAIHB estimates that $161.4 million is needed to maintain current services. The President's request will fall short by over $102 million due to the effect of staffing for new facilities and funding for the Indian Health Care Improvement Fund (IHCIF) are considered.

Staffing six new facilities will require $29.2 million. The President has also requested an additional $44 million for the IHCIF, $4 million for health IT, and $2.5 million for the chronic disease initiative. Once these amounts are subtracted from the President's increase, it only leaves $59.2 million to cover mandatory costs of inflation and population growth. An additional $102 million is needed or funding should be directed from the IHCIF to off-set the deficit. It is not likely that funding to phase in staffing at new facilities can be used, thus the IHCIF should be reduced.

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 $44 million for the IHCIF. Last year the agency conducted an evaluation of the methodology in order to update data and make technical improvements in computations used to distribute the IHCIF. The second phase of this process is to consult with Tribal leaders to determine whether the formula itself should be changed. Northwest Tribes support changes in the formula 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. This is contrary to the congressional intent of the IHCIF and must be corrected by the Agency.



Information Technology (CJ-75)

The FY 2011 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 2011 budget request for IT is $134.7 million, which is only a $4 million increase over FY 2010. The IHS information technology needs have been neglected

in the budget over the last ten years and more funding is needed, especially at P.L. 93-638 sites. It is noted that in 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 tele-health 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.

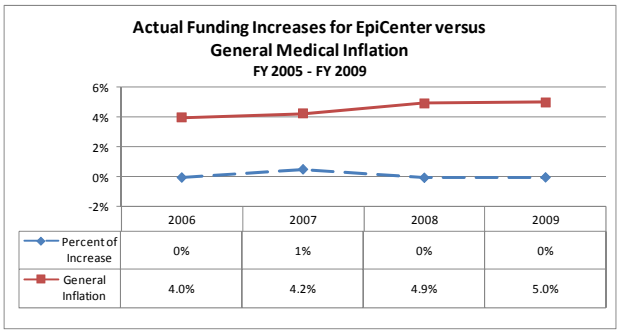
Epidemiology Centers: Recurring Funding Epidemiology Centers (CJ-71)

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

The Northwest Tribal Epidemiology Center (*The EpiCenter*), is located at the NPAIHB. It was the first tribal 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 Rural Indian Health Board
- 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 2011 proposed budget increase of about $208,000 will only fund pay increases and inflation at the twelve sites. The Administration's budget does not provide funding for any program increases.



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.

Dental Services (CJ-80)

Table 8: Dental Services
(Dollars in Thousands)

President Request:	**$**	**161,262**
FY 2010 Final Budget	$	152,634
President's Increase/Decrease	5.7%	$ 8,628
Less Phasing-in Staff at New Facilities		*$ 3,349*
Less Requested Program Expansions		*$ -*
Net Increase Available for Current Services		$ 5,279
NPAIHB Estimate for Inflation & Pop. Growth		$ 8,090
Shortfall:		**$ (2,811)**

The President's increase for Dental Health services is $8.6 million, a 5.7% increase over last year's level. NPAIHB estimates it will take at least $8.1 million to maintain current services. An additional $.28 million is needed to maintain current services in the IHS dental program.

The request includes $3.3 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 dental funding for the Portland Area. The total funding increase for the Oklahoma Area in FY 2011 will be approximately ten times greater than the increase for the Portland Area.

Despite a very good FY 2011 annual increase of 7.4%, 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. In FY 2010 Northwest states made cuts in Medicaid adult dental services and limited enrollment that will impact the ability of Portland Area Tribes to continue to address dental health services needs, let alone continue to increase services.

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 $200 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-83)

Table 9: Mental Health (Dollars in Thousands)		
President Request:	**$**	**77,076**
FY 2010 Final Budget	$	72,786
President's Increase/Decrease	5.9%	$ 4,290
Less Phasing in Staff at New Facilities		*$ 1,702*
Less Requested Program Expansions		*$ -*
Net Increase/Decrease for Current Services		$ 2,588
NPAIHB Estimate for Inflation & Pop. Growth:		$ 4,742
Shortfall:		**$ (2,154)**

The President requests $77.1 million to cover the mental health needs of IHS and tribal health programs. This is a $4.2 million increase, however, when the requirement to staff new facilities is factored, it only leaves $2.6 million to maintain current services. NPAIHB estimates that it will take $4.7 million to fund mandatory cost increases for inflation and population growth. An additional $2.1 million is needed to maintain the current levels of care for Indian Country.

Unfortunately, a modest 7.4% increase for mental health might come close to maintaining current services, however, it will fall short by over 44% when the effect of staffing is factored on the increase. Over 40% ($1.7 million) of the mental health increase will be needed to for staffing at three new facilities. The remaining $2.5 million represents less than half of what the NPAIHB recommends to fund current services. Approximately 30% 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.

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)

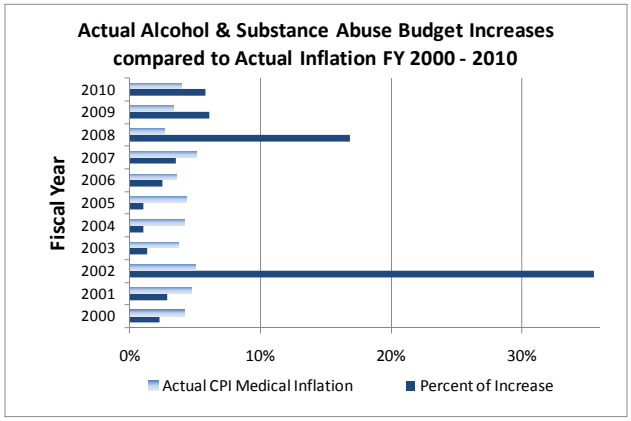
Table 10: Alcohol & Substance Abuse (Dollars in Thousands)			
President Request:		**$**	**205,770**
FY 2010 Final Budget		$	194,409
President's Increase/Decrease	5.8%	$	11,361
Less Phasing in Staff at New Facilities		*$*	-
Less Requested Program Expansions		*$*	*4,000*
Net Increase/Decrease for Current Services		$	7,361
NPAIHB Estimate for Inflation & Pop. Growth:		$	11,470
Shortfall:		**$**	**(4,109)**

The President's budget requests an increase of 5.8% for Alcohol and Substance abuse programs. Aside from last year, this is the largest increase in nine years, and will still fall over $7 million short of meeting mandatory cost increases. Tribes have often felt that this line item gets short-changed, in part, because it is primarily a tribally-operated program with less than 23% of funds going to federally operated programs.

The President request seems adequate to fund current services, however, $4 million will be needed for a new competitive grant program to expand access to quality substance abuse treatment services. The goal of this new initiative will be to develop evidence-based and practice-based culturally competent treatment services. An additional $4.1 million will be needed to fund mandatory costs of inflation and population growth.

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.

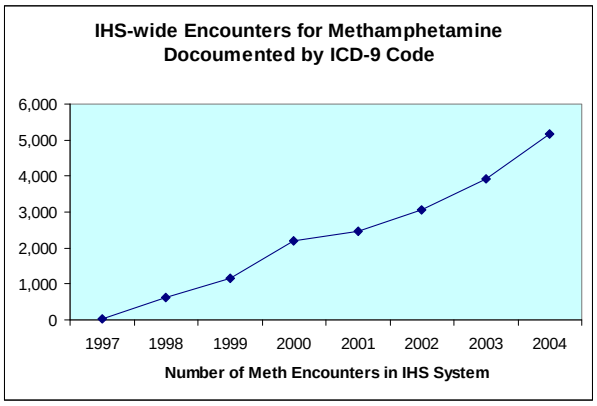
Alcohol and substance abuse continues to be one of the highest priorities identified by tribal leaders and health directors during the IHS budget formulation process. The latest data available to IHS indicates that alcoholism mortality rates in tribal communities have increased significantly since 1992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



During the previous Administration, budget requests were 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 and youth suicide activities, and another $16.4 million in FY 2009. There is no increase for this initiative in

FY 2011. In FY 2010 President Obama and the Congress provided a $11 million increase for alcohol and substance abuse programs.

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

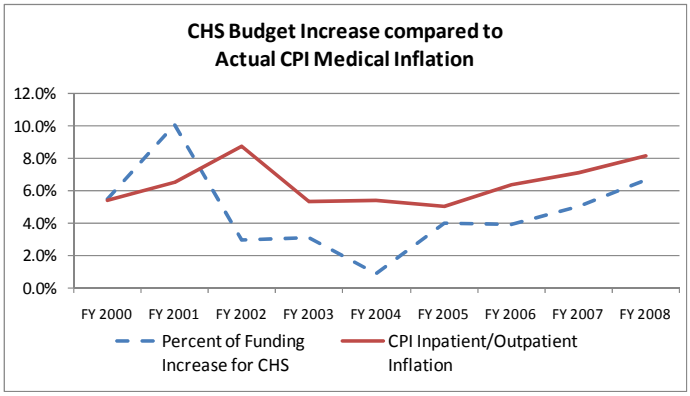


The methamphetamine issue in Indian Country continues to be a burden on Tribal health programs. In 1997, the IHS began collecting methamphetamine patient encounter data. The first year the Agency recorded thirty-one patient visits that were methamphetamine related. In 1998, methamphetamine patient visits 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-94)

Table 11: Contract Health Services (Dollars in Thousands)		
President Request:	**$**	**862,765**
FY 2010 Final Budget	$	779,347
President's Increase/Decrease	10.7%	$ 83,418
Less Phasing in Staff at New Facilities		*$ -*
Less Requested CHEF Program Expansion		*$ 5,000*
Net Increase/Decrease for Current Services		$ 78,418
NPAIHB Estimate for Inflation & Pop. Growth:		$ 80,273
Shortfall:		**$ (1,855)**

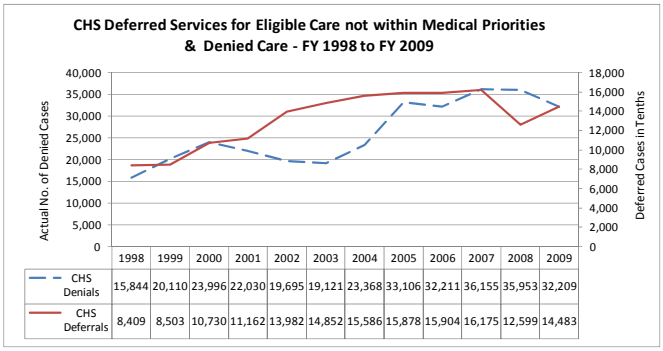
The President's request for Contract Health Services (CHS) over the last two years (often called Contract Care) is without a doubt of historic significance in its potential to make a positive impact on the health of AI/AN people. The FY 2011 budget marks the second year of a very positive increase for the CHS program. CHS is the most important budget line item for Northwest Tribes. NPAIHB estimates that it will take $80.3 million to maintain current services in FY 2011. The President's requested increase of $83.4 million is sufficient to address inflation and population growth, however, not enough to restore 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). In FY 2007, the CHS program began paying Medicare-like rates for services purchased from inpatient hospitals. There was a significant decrease in deferred services resulting from implementing this new statutory requirement. The benefit of Medicare-like rates has been short-lived as CHS deferred services (within medical priorities but not funding available) are on the rise once again. 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	2009
CHS Denials	15,844	20,110	23,996	22,030	19,695	19,121	23,368	33,106	32,211	36,155	35,953	32,209
CHS Deferrals	8,409	8,503	10,730	11,162	13,982	14,852	15,586	15,878	15,904	16,175	12,599	14,483

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 CHS request continues the recognition in 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 21.3% of the total FY 2010 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-operated or by the IHS.

In the Northwest, it represents over 40% of the total Portland Area Office allowance. The consequence past years of under-funded inflationary and population growth 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 2010, the NPAIHB estimates that over **$644 billion** has been lost to inflation in the CHS program nationally. This number was much higher but due to the significant budget increase for CHS in FY 2010, some funding has been restored. Unfunded medical inflation alone exceeds $479 million, while unfunded population growth totals $166 million—representing over $644 million in lost purchasing power as depicted in the Table 12 below.

Table 12: Contract Health Services (CHS) Lost Purchasing Power 1993 - 2010 (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
FY 2010	$ 779,347	$ 678,890	$ (100,457)	$ 13,324	$ (87,133)
		19 Year Total:	**$ 479,152**	**$ 165,844**	**$ 644,996**

The CHS Program and Medicaid

Table 13 charts fourteen years of funding for the CHS program compared to Medicaid. The CHS program has been brought into closer alignment with Medicaid program increases due to the 22.8% increase received in FY 2010. Prior to this, the CHS program lagged considerably behind Medicaid program increases. The CHS program is very similar to the Medicaid program. It provides services to an underserved population that often require 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 Compared to Medicaid FY 1996 to FY 2010 (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%
FY 2010	$ 779,347	$ 144,870	22.8%	9.9%
		14-Year Average:	5.4%	7.7%

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 $330 million is needed to address unmet care in the CHS program.

Catastrophic Health Emergency Fund (CJ-97)

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 2010 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.

Northwest Tribes urged the Congress to consider fully funding CHEF 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. In FY 2010, the CHEF was increased by $21.7. This year's President's request for CHEF is $53 million, a $5 million increase over FY 2010, which doubles the CHEF in just two years. Thanks to this increase, the availability of cost savings with Medicare-like rates, and the vigorous application of the alternative resources (like Medicaid), CHEF funding should be available throughout the year.

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.

Table No. 14: Catestrophic Health Emergency Fund FY 1998 - FY 2008				
Fiscal Year	CHEF Funded Cases		CHEF Unfunded Cases	
	No. of Cases	Funded Amount	No. of Cases	Unfunded Amount
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
2009	1,223	$ 31,000,000	1,065	$ 23,999,000

As the President and Congress have moved toward fully funding 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.

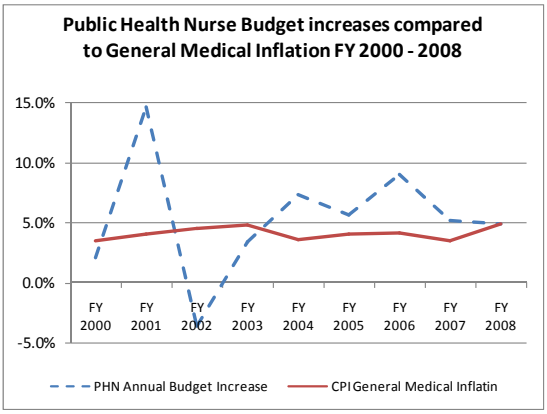
Public Health Nursing (CJ-103)

Table 15: Public Health Nursing (Dollars in Thousands)		
President Request:	**$**	**67,571**
FY 2010 Final Budget	$	64,071
President's Increase/Decrease	5.5%	$ 3,500
Less Phasing in Staff at New Facilities		$ 1,314
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 2,186
NPAIHB Estimate for Inflation & Pop. Growth		$ 3,780
	Shortfall:	**$ (1,594)**

The President's request for Public Health Nurses (PHNs) is $67.6 million, an increase of 6% over last year's amount. With $1.3 million for staffing at five new facilities, the $2.2 million remaining is not sufficient to maintain the current program. An additional $1.6 million is needed.

Over 22% of the increase is for the Oklahoma Area, while Portland Area Tribes will receive less than a 3% increase. 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-107)

Table 16: Health Education (Dollars in Thousands)		
President Request:	**$**	**17,489**
FY 2010 Final Budget	$	16,682
President's Increase/Decrease	4.8%	$ 807
Less Phasing in Staff at New Facilities		$ 192
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 615
NPAIHB Estimate for Inflation & Pop. Growth		$ 984
	Shortfall:	**$ (369)**

The President's request for Health Education is $17.5 million in FY 2010. NPAIHB estimates that it will take $984,000 to maintain current services. The President's request approximates this need, but not after adjusting for $192,000 that will be needed to staff two new facilities. After considering the staffing requirements, the President's request will fall short $369,000 of funding mandatory costs of inflation and population growth.

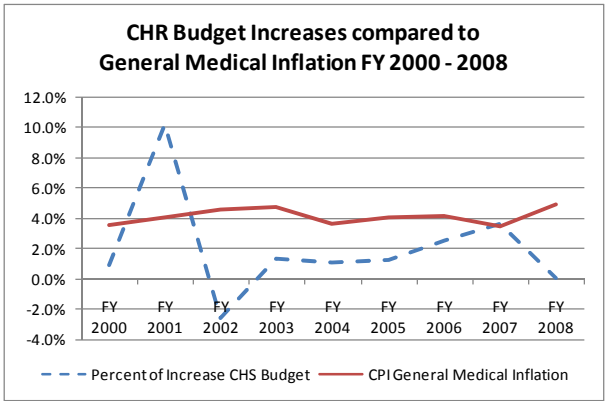
The Health Education program communicates the importance and on-going need for comprehensive clinical and community health education programs. It ensures education to patients, works with hospitals, clinics, and community education programs to integrate IHS patient education protocols and code systems. The number of health education visits has increased from approximately 777,000 provided in FY 2004 to over 2.3 million at the end of FY 2009. Clearly this demonstrates a commitment to improve health education access, increased health literacy, increased patient-provider communications, and ultimately better health outcomes.

Community Health Representatives (CJ-110)

Table 17: Community Health Representatives (Dollars in Thousands)		
President Request:	**$**	**63,991**
FY 2010 Final Budget	$	61,628
President's Increase/Decrease	3.8%	$ 2,363
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 2,363
NPAIHB Estimate for Inflation & Pop. Growth		$ 3,636
	Shortfall:	**$ (1,273)**

The President's request for the Community Health Representatives (CHRs) program is $64 million, a 3.8% increase over last year's level. NPAIHB estimates that it will take at least $3.6 million to maintain current services. The FY 2011 increase of $2.3 million, while not enough, will be targeted to cover pay costs ($621,000), inflation ($818,000), and population growth ($924,000). The President's request will fall short with a $1.2 million needed to cover mandatory costs increases.

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-123)

Table 18: Urban Indian Health Programs (Dollars in Thousands)		
President Request:	**$**	**45,502**
FY 2010 Final Budget	$	43,139
President's Increase/Decrease	5.5%	$ 2,363
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ 1,000
Net Increase/Decrease for Current Services		$ 1,363
NPAIHB Estimate for Inflation & Pop. Growth		$ 4,443
Shortfall:		**$ (3,080)**

The previous Administration 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. Under the proposed health reform proposals the UIHPs will become important health providers for AI/AN people. Many Indian people will qualify for coverage under proposed Medicaid expansions and subsidies offered through insurance exchanges. UIHP programs will serve a critical role in providing care to those Indian people that move between reservations and urban areas and Northwest Tribes support funding these programs.

The President proposes a $2.4 million increase for the UIHP. NPAIHB estimates that it will take at least $4.4 million to maintain current services in the UIHP, thus the President's budget will fall short by $3 million. The budget also proposes a $1 million initiative to improve the third party collections of urban Indian health clinics. This is a very important undertaking and should serve to improve the availability of resources to the UIHPs from Medicare, Medicaid, CHIP, and private insurance. The timing of this initiative is also important in the wake of preparing for health reform activities.

These programs provide over 928,000 health services to a user population of over 650,000 urban Indian people living in thirty-four locations across the United States. 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-130)

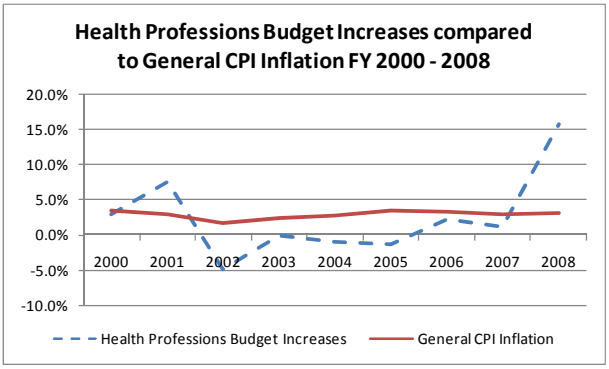
Table 19: Indian Health Professions (Dollars in Thousands)		
President Request:	**$**	**41,413**
FY 2010 Final Budget	$	40,743
President's Increase/Decrease	1.6%	$ 670
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 670
NPAIHB Estimate for Inflation & Pop. Growth		$ 2,241
Shortfall:		**$ (1,571)**

Unfortunately the Administration did not support Indian health professions at the same level it did last year. Last year, this program received an 8.6% increase, it highest increase in over ten years. This year's request provides a slight increase of $670,000. NPAIHB estimates that at least a $2.2 million increase is needed in order to support the growing demand in this program. The President's request will fall short by $1.6 million.

Last year's budget request recognized the importance of addressing the severe human resource needs of IHS-funded health programs by requesting a $3.2 million increase. Developing health professionals will be very important as this Country prepares itself for services expansion that will come with health reform. The Indian health system has high vacancies in many of its health professions and will need to begin to grow and train its own work force to keep pace with the rest of the Country. Otherwise, vacancy rates will become even higher.

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.



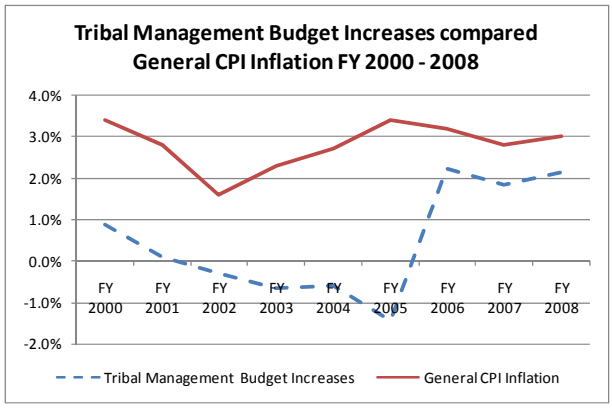
Last year's budget was a start in the right direction, but more needs to be done in FY 2011. In addition, many believe not enough is being done to address the tremendous need for nurses, not only in the United States, but particularly in the Indian health system.

Tribal Management (CJ-141)

Table 20: Tribal Management (Dollars in Thousands)		
President Request:	**$**	**2,669**
FY 2010 Final Budget	$	2,586
President's Increase/Decrease	3.2%	$ 83
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 83
NPAIHB Estimate for Inflation & Pop. Growth		$ 142
Shortfall:		**$ (59)**

The President requests $2.7 million for Tribal Management, approximately the same amount as last year. NPAIHB recommends that $142,000 be provided to maintain current services. The President's request falls short by $59,000.

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.



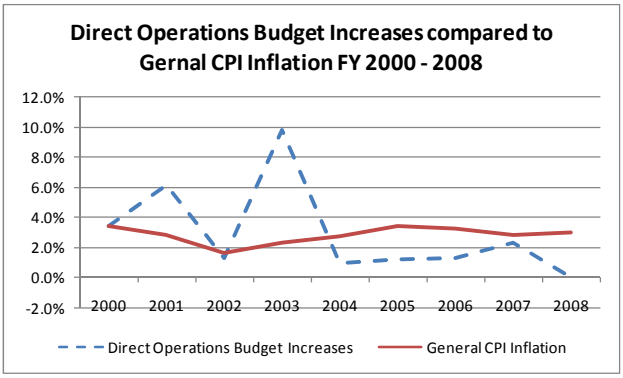
Direct Operations (CJ-145)

Table 21: Direct Operations (Dollars in Thousands)		
President Request:	**$**	**69,845**
FY 2010 Final Budget	$	68,720
President's Increase/Decrease	1.6%	$ 1,125
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 1,125
NPAIHB Estimate for Inflation & Pop. Growth		$ 3,780
Shortfall:		**$ (2,655)**

The Direct Operations line item funds the cost of management at IHS headquarters and the twelve Area Offices. This year the President request proposes a slight increase in Direct Operations funding by $1.1 million. NPAIHB estimates that $3.8 million will be needed to maintain current services. Thus, the President's request falls short by $2.6 million.

The Direct Operations budget supports overall management of the IHS to ensure effective support for the IHS mission. This includes oversight of financial, human, facilities, information and support resources and systems. Recent projections by IHS indicate that in FY 2009 twenty-seven percent of its workforce will be eligible for retirement. This

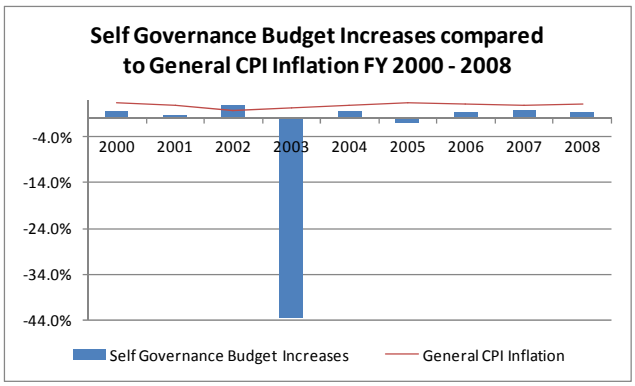
budget line item will be important to finance succession planning activities and workforce development in order to meet the Agency's future needs.



Self-Governance (CJ 148)

Table 22: Self-Governance (Dollars in Thousands)		
President Request:	**$**	**6,201**
FY 2010 Final Budget	$	6,066
President's Increase/Decrease	2.2%	$ 135
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 135
NPAIHB Estimate for Inflation & Pop. Growth		$ 334
Shortfall:		**$ (199)**

The President's request for the Self-Governance item is $6.2 million and is only 2% or $135,000 more than what was requested last year. NPAIHB estimates that it will take at least $334,000 to maintain current services in FY 2011. This will leave a $256,000 shortfall in unfunded mandatory costs. While this may not seem like much, six 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-151)

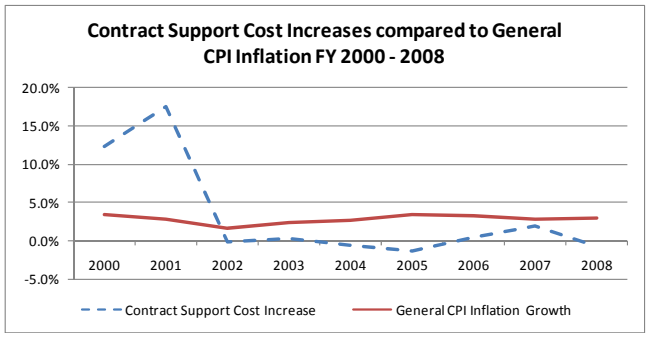
Table 23: Contract Support Costs (Dollars in Thousands)		
President Request:	**$**	**444,332**
FY 2010 Final Budget	$	398,490
President's Increase/Decrease	11.5%	$ 45,842
NPAIHB Estimate for Inflation & Pop. Growth		$ 21,917
Amt to Address Prior Year's Shortfall		$ 146,100
ESTIMATED NEED		*$ 168,017*
Shortfall:		**$ (122,175)**

This year's FY 2011 request of a $45.8 million increase for Contract Support Costs (CSC) continues the end of a sad chapter of neglect for Indian Self-Determination. Last year the President requested a $107 million increase for CSC with the Congress providing an additional $8 million. NPAIHB estimates that $21.9 million is needed to fund on-going CSC requirements of existing contractors and recommends that an additional $146.1 million be provided to reduce past year's CSC shortfall. This means that an additional $122 million is needed to address CSC needs in FY 2011.

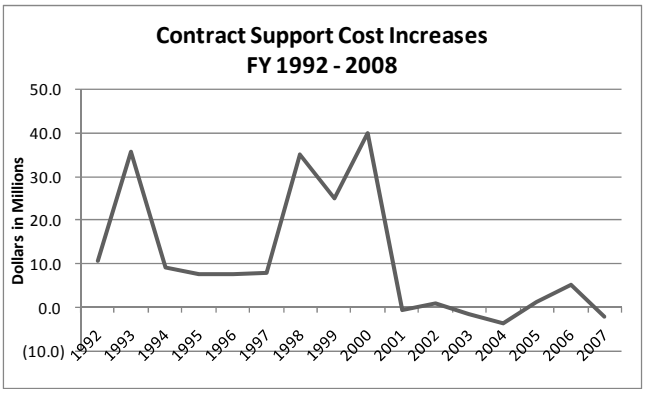
Between FY 2002 through 2008, tribal contracting and compacting programs were seriously undermined by the failure to pass adequate funding increases to support existing contractors, as well as preclude those who wanted to participate in self-determination. New contractors found themselves unfairly set 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. New contractors were coerced into signing their rights of full CSC recovery away in order for new contracts to be executed by the IHS.

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 six years later in FY 2008.



The lack of CSC funding virtually halted the growth of Indian Self Determination. The FY 2010 budget passed last year finally appropriated $398.5 million which together with this year's increase will greatly reduce the current CSC shortfall, but not the years of funding lost while the shortfall accumulated to over $100 million. The damaging cuts to CSC are contrary to past and current Congressional and Administration support of 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 & Private Collections (CJ-155)

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 expand Medicaid coverage up to 135% of Federal Poverty Level, 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 that have been passed by both the House and Senate. As well, NPAIHB has been working with national Indian organizations that have been involved in developing the Administration's health proposal to get past the current gridlock in the Senate.

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 Indian Health Care Improvement Act has been included in each chamber's health reform legislation. It is imperative that these two components remain in the health reform package if the Indian health system is to benefit from proposed public program expansions and subsidies that would be offered through insurance exchanges.

The NPAIHB has provided Congressional committees working on health reform legislation with recommendations 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 $2 million of their own diabetes allocation in improving Diabetes data reporting and information generation since the start of the SDPI.

Health Facilities Accounts (CJ-168)

Maintenance and Improvement (CJ-170)

Table 24: Maintenance & Improvement (Dollars in Thousands)		
President Request:	**$**	**55,523**
FY 2010 Final Budget	$	53,915
President's Increase/Decrease	3.0%	$ 1,608
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 1,608
NPAIHB Estimate for Inflation & Pop. Growth		$ 1,833
Shortfall:		**$ (225)**

Over the past fifteen years there has been less than a 5% increase in Maintenance & Improvement (M&I) funding 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 for IHS and Tribal health facilities. While administering the ARRA funds, the BEMAR increase by $104.2 million due to an increase in reporting of backlog of maintenance and repairs by Tribally-operated health facilities.

The President's request for M&I is $55.5 million a slight increase of $1.6 million (3%) over last year. NPAIHB estimates that it will take at least $1.8 million to fund current services in this program. An additional $225,000 is needed. Additionally, funding should be considered by the Congress to address the $476 million needed for BEMAR.

Sanitation (CJ-176)

Table 25: Sanitation Facilities Construction (Dollars in Thousands)		
President Request:	**$**	**97,710**
FY 2010 Final Budget	$	95,857
President's Increase/Decrease	1.9%	$ 1,853
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 1,853
NPAIHB Estimate for Inflation & Pop. Growth		$ 1,833
Shortfall:		**$20**

The FY 2011 budget requests $97.7 million for the Sanitation facilities program, a slight increase of $1.8 million. Due to ARRA providing $68 million for Sanitation Facilities, last year's budget request did not include an increase for this program. This year's increase of $1.8 million considered with no increase last year, means marginal activity for this program as ARRA projects work their way toward completion.

NPAIHB estimates that a $1.8 million increase is needed to fund critical potable water and waste disposal projects for Indian people. The President's request comes close to making this happen, however an additional $20,000 is needed.

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-181)

Table 26: Health Care Facilities Construction (Dollars in Thousands)		
President Request:	**$**	**66,192**
FY 2010 Final Budget	$	95,857
President's Increase/Decrease	30.5%	$29,234
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$29,234
NPAIHB Estimate for Inflation & Pop. Growth		$ -
	Shortfall:	**$29,234**

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 five years so that savings from facilities construction can be redirected to the health services accounts. As noted throughout this analysis, 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 included in the FY 2011 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.

Northwest Tribes recommend that the IHS and Congress includes appropriation language in the FY 2011 appropriation bill to allow staffing and equipment funding for the small ambulatory construction authorities (P.L. 102-573). This is necessary to realign the facilities construction program to provide consistent opportunities to address health facility construction needs throughout Indian Country. This recommendation is supported by the IHS National Budget Formulation Workgroup.

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-190)

Table 27: Facilities & Environmental Health Support (Dollars in Thousands)		
President Request:	**$**	**202,106**
FY 2010 Final Budget	$	193,087
President's Increase/Decrease	4.7%	$ 9,019
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 9,019
NPAIHB Estimate for Inflation & Pop. Growth		$ 6,565
	Shortfall:	**$2,454**

This line item consists of three subsidiary activities: facilities support, environmental health support, and the office of Environmental Health and Engineering support. NPAIHB recommends an increase of ^.6 million be provided to fund increased inflation costs and pay act increases. The President's budget request adequately funds these requirements.

Equipment (CJ-204)

Table 28: Equipment (Dollars in Thousands)		
President Request:	**$**	**23,711**
FY 2010 Final Budget	$	22,664
President's Increase/Decrease	4.6%	$ 1,047
Less Phasing in Staff at New Facilities		$ -
Less Requested Program Expansions		$ -
Net Increase/Decrease for Current Services		$ 1,047
NPAIHB Estimate for Inflation & Pop. Growth		$ 771
	Shortfall:	**$276**

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 tele-communications equipment

The FY 2011 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 Actual	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Deficits	-$1,414	-$1,349	-$980	-$650	-$539	-$475	-$480	-$521	-$525	-$542	-$649	-$687
Source: CBO, "An Analysis of the President's Budgetary Proposals for FY 2011, available at www.cbo.gov.												

Deficit/Surplus Projections

It is worthwhile to examine the overall budget picture in an analysis of the FY 2011 IHS budget. The deep recession that began two years ago seems to have ended at the end of 2009. Economic indicators such as new construction and unemployment have improved throughout 2009. The effect of the recession in Northwest appears to have lagged the rest of the country by about 6-12 months, so while the economic situation may be improving, its effect continue to be felt in Oregon and Washington.

Economic growth over the next few years will likely be very slow especially given the aftermath of the financial market collapse and economic recession. This means that revenues will likely grow very slowly due to jobs loss and taxes collected through employment, until consumers grow confidence to start spending and borrowing, and households regain lost wealth.

The federal fiscal outlook beyond this year is compelling with projected deficits to average about $600 billion per year over the 2011–2020 period. The table above illustrates that the Congressional Budget Office (CBO) projects deficit spending for the next ten years. Like the President, the CBO's Budget and Economic Outlook: Fiscal Years 2010 to 2020 argues that the high deficits have to be reduced.

The President has already proposed a three year freeze on non-security discretionary spending that is anticipated to yield $250 billion in savings over a ten year period. Indian health programs are funded out of this discretionary pool of funding, and while the IHS budget did not seem to be impacted by the discretionary freeze, it is suspect in the future. Tribes will have to be at their best to advocate and defend the IHS budget from meager increases, or worse cuts, in future budget years. Tribes should not take the past two year's increases as predictive of future. The case will have to be made for future investments in improving Indian health.

Discretionary Spending

For 2011, the President has requested $1.3 trillion in discretionary budget authority, an amount that is nearly identical to the total provided in 2010 if the requested supplemental funding is included. The CBO projects that total discretionary funding would drop over the following two years, to $1.2 trillion.

Total nondefense discretionary budget authority requested by the President would fall from $556 billion in 2010 to $537 billion in 2011. This is primarily due to restructuring educational Pell grants. Most programs in the non-defense discretionary category would receive about the same funding as appropriated for the previous year; however, programs the Administration classified as related to "security" would see a $14 billion increase.

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 20 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 2011 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 2011 IHS BUDGET	President Feb. 1, 2010	Senate	House
	Criteria or Budget Principle	*FY 2011 Grade*		
1	Budget Information Shared with Tribes in Consultation Sessions Prior to release date of the first Monday in February.			
2	Appropriate adjustment will be made to fully cover expected inflation.			
3	Appropriate increases will be included to address population growth.			
4	Appropriate adjustments will be made to fully fund tribal and federal employee compensation.			
5	The Contract Health Service Budget will be increased to fully fund the need for deferred services.			
6	Collection estimates are not represented as fulfilling the federal responsibility to fully fund the IHS budget.			
7	Increases will be provided to address the goals of the Indian Health Care Improvement Act.			
8	Full funding will be included to support staff associated with new construction projects.			
9	The Catastrophic Health Emergency (CHEF) Fund will be budgeted at a level to cover all qualifying cases.			
10	Funding will be provided to cover Contract Support Costs for tribes electing to compact or contract their health care services.			
11	Adequately support maintenance of IHS and tribal health facilities.			
12	The public announcements relating to the budget will honestly depict what is in the budget.			
13	Provides adequate funding to reduce health disparities.			
14	Honor the federal trust responsibility to provide health care services to American Indians and Alaska Natives.			
	Overall Grade			