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Northwest Portland Area
Indian Health Board

The FY 2009 Indian Health Service Budget: Analysis and Recommendations

19th Annual Report –
March 17, 2008

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Northwest Portland Area Indian Health Board

Introduction

The 19th Annual Northwest Portland Area Indian Health Board (NPAIHB or the Board) analysis of the Indian Health Service (IHS) Budget continues a tradition of close scrutiny of the IHS Budget that began in the 1980's. The nature of budget formulation is vastly different for tribes than it is for the beneficiaries of other programs funded by the federal government. The federal trust responsibility and the government-to-government relationship between tribes and the federal government, by definition, require a partnership in the development of the budget. The NPAIHB presented this budget analysis to tribes at its March 10, 2008 Annual All Tribes Budget meeting in Portland, Oregon.

The President's FY 2009 budget request for the IHS is perhaps the worst budget submission for the Agency in at least fifteen years. The President's proposed request for the IHS will decrease the Agency's budget by $21.3 million in FY 2009. There are twenty different budget sub activity line items for the IHS budget. The President's budget requests inadequate increases for eleven of those budget line items and either reduces or does not request an increase at all for the other nine budget line items. The overall budget proposes to reduce funding by $56.3 million in order to fund $35 million in current services and program increases. The net loss for the IHS budget is $21.3 million.

NPAIHB estimates it will take at least $355 million to fund pay increases, inflation, and population growth in order to maintain current services. We further recommend an additional $158 million to fund the backlog of Contract Support Costs that are owed to Tribes and to allow for new and expanded Tribal Self-Determination. We urge the Congress and the Administration to support increasing the IHS budget by $513 million in order to maintain current services and address the health disparities that American Indian and Alaska Natives face. The health and lives of American Indian and Alaskan Natives are being put at risk by this chronic under-funding of the IHS budget.

The fundamental budget principle for Northwest Tribes is that you must fund the current program in order to maintain the current level of services that are provided. This year's budget request does not include funding for cover the costs of pay act increases, inflation, or population growth. The budget balances $25 million of staffing for new facilities and $10 million to fund the Indian Health Care Improvement Fund by eliminating funding to the Urban Indian Health Programs and by decreasing funding for the Alcohol and Substance Abuse programs, the Indian Health Professions program, and Facilities accounts. Northwest Tribes support restoring most of the budget cuts with the exception of facilities construction. Northwest tribes do not support off-setting other important accounts of the program to restore the urban program. Congress must find a way to make this work.

Each year the Board first discusses their priorities during its January Quarterly Board Meeting and at the February meeting of the Affiliated Tribes of Northwest Indians. The Board then develops its analysis and conducts a budget workshop prior to the House and Senate Interior Appropriations hearings on the IHS budget. In addition to the Budget Analysis, the Board also prepares a Legislative Plan that presents official Board positions on the budget and other health legislation. The Legislative Plan is developed by the Board and presented for discussion and adoption through resolution at the January Board meeting, and again at the Affiliated Tribes of Northwest Indians at its February meeting. The 2008 NPAIHB Legislative Plan and this budget analysis are the basis of the Board's lobbying activities (both are available at www.npaihb.org).

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

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

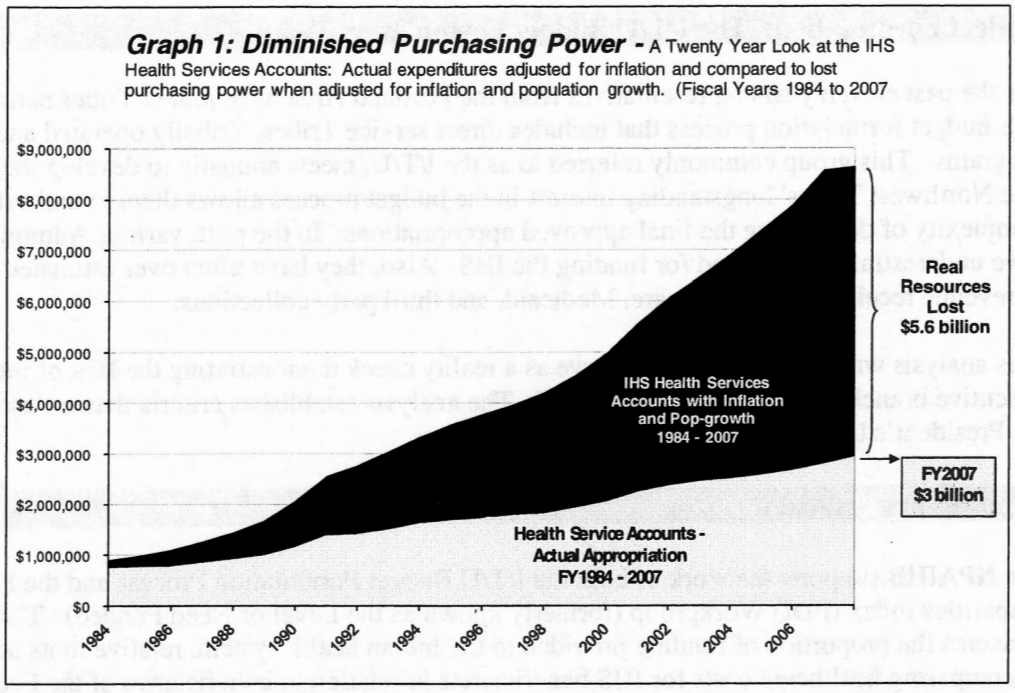
This analysis was first developed to serve as a reality check demonstrating the lack of integrity past executive branch budgets have experienced. The analysis establishes criteria that are used to grade the President's budget request.

Funding True Need:

The NPAIHB supports the work of both the I/T/U Budget Formulation Process and the Federal Disparities Index (FDI) Workgroup (formerly known as the Level of Need Funded). The 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. In 2002, per capita healthcare spending totaled $2,130 for AI/ANs, compared to $3,903 in other public sector financing programs serving the non-elderly population.

It is estimated by the FDI, that the IHS system is funded at less than 60% of its total need. To fully fund the clinical and wrap-around service needs of the Indian healthcare system, the IHS budget would need an additional $15 billion dollars. This estimate uses standard economic and actuarial forecasting methods that take into consideration actual inflation rates to measure growth and inflation. Instead, OMB routinely uses non-medical inflation estimates to calculate budget increases for the IHS budget, vastly underestimating true healthcare inflation rates. Applying the FDI to estimate the true health care needs of Indian people is $9-10 billion. This corroborates the long-held view that less than 50% of true need is funded by the IHS budget. If funded at $9 billion, an additional phased-in facilities cost of $9-10 billion would be needed to house the expanded health care services. This is sometimes stated as the Tribal needs-based budget

Rather, OMB and HHS should use actual medical inflations rates for measuring growth for IHS health programs—similar to those applied to Medicaid and Medicare. Compounded over the last twenty years, the IHS has received insufficient funding to cover population growth and the increasing cost of medical salaries, medical equipment, facility maintenance, and service administration (i.e. Contract Support Costs). This underestimation has seriously diminished the purchasing power of Tribal health programs.



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-two 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, had the accounts received adequate increases for inflation and population growth, that amount would be over $8 billion today. The NPAIHB conservatively estimates that the IHS budget has lost over $5.6 billion over the last twenty years.

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

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

This analysis is distributed to the Administration and to Congressional committees who finalize the annual IHS budget. Although the analysis is prepared for 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 will be posted on the Board's website (at www.npaihb.org) as soon at it is published so all tribes can consider its recommendations for their own use in the consultation process.

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

Acknowledgements

This analysis is based on over 19 years of contributions from delegates and staff of the NPAIHB including: Linda Holt, Chair; Pearl Capoeman-Baller, Julia Davis, former Chairs; Executive Directors: Doni Wilder (1990-1998) and now IHS Portland Area Office Director; Cheryle Kennedy (1998-2000); Ed Fox, Executive Director (2000-2005); current Director, Joe Finkbonner; and Jim Roberts, Policy Analyst.

- Senate Democratic (http://www.senate.gov/~budget/democratic/) and Republican http://www.senate.gov/~budget/republican/ Budget Committee publications.
- The House analysis is available at www.house.gov/budget/prezbudget.htm
- The Budget for FY 2009 www.whitehouse.gov/omb/budget/fy2009/ is the President's budget request of February 4, 2008. It is actually a set of documents with narrative and statistical information on the President's proposed budget for FY 2009.
- Congressional Budget Office (CBO http://www.cbo.gov/), The Budget and Economic Outlook: Fiscal Years 2009-2018, January, 2008 and Preliminary Analysis of the President's Budgetary Proposals for FY 2009, March 3, 2008. These documents examine the federal budget under different economic assumptions and provide estimates that are used for comparison to those of the President's Office of Management and Budget (OMB).
- Department of Health and Human Services Fiscal Year 2008, DHHS FY 2009 Budget In Brief, February 4, 2008 available at http://www.hhs.gov/budget/docbudget.htm
- The Indian Health Service, Justification of Estimates for Appropriations Committees Fiscal Year 2009 available at www.ihs.gov/AdminMngrResources/Budget/index.asp
- Additional information about the U.S. Budget is available at the Center on Budget and Policy Priorities: http://www.cbpp.org/pubs/fedbud.htm

The FY 2009 Northwest Portland Area Indian Health Board Budget Analysis and Recommendations

The Northwest Portland Area Indian Health Board (NPAIHB or the Board) estimates that it will take at least $355 million to maintain current services for IHS health programs in FY 2009. We further recommend an additional $158.2 million to fund the backlog of Contract Support Costs (CSC) that are owed to Tribes that have assumed programs under the Indian Self-Determination and Education Assistance Act (P.L. 93-638). The NPAIHB estimates that it will take at least $513.3 million just to maintain current services and fund past years CSC shortfalls. Northwest Tribal health directors further recommend $574.2 million in program increases to address growing health needs and diminished services due to lack of funding from past years.

The President's FY 2009 budget request provides $3.32 billion for the Indian Health Service (IHS), and is a $21.3 million decrease in funding from the FY 2008 enacted level. The request decreases certain IHS budget accounts by $56.3 million that is used to provide funding for staffing new facilities ($25 million) and fund $10 million for the Indian Health Care Improvement Fund (IHCIF). When the $35 million is subtracted from the $56.3 million decrease, it represents a net loss to the IHS budget by $21.3 million.

The most notable cut is the Urban Indian Health Program (UIHP), which has been zeroed out for the third straight year by the Bush Administration. Tribes nationally do not support this proposal by the President and have previously testified before Congress to restore the urban program funds. The Senate Committee on Indian Affairs supports the restoration of the urban program at a level of $40 million. Northwest Tribes recommend that there not be an offset of the President's proposed recommendations to restore the urban programs.

The effect of phasing in staffing at new facilities is ever apparent in this year's President's request. Since the President did not request an increase for the IHS, in order to fund $25 million in new staffing, the Agency proposes to cut other Tribal budgets by $56.3 million! This clearly demonstrates the effect that phasing in staff at new facilities has on the IHS budget. In past years, staffing has taken approximately 50% of the IHS budget increase, while 550 tribes must split the balance. This year, the budgets of at least 560 tribes will be cut to cover the $25 million costs of staffing at one new facility.

Unless the Congress provides at least $513.3 million to maintain current services, the IHS and tribes will be forced to absorb mandatory costs of inflation, population growth, and administrative costs associated with unfunded Contract Support Costs. If these mandatory requirements are not funded, IHS and Tribal health programs will have to alternative but to cut health services. There simply is no other way to absorb these costs.

The Final Enacted FY 2008 IHS Budget

The President signed an omnibus appropriation package on December 26th that provided $3.39 billion for the IHS budget. As in past years, budget instructions required that a 1.56% rescission will be applied to the final appropriation. This meant that the IHS budget lost an additional $53 million. After the rescission was applied, the final budget for the IHS is $3.35 billion, which represents a $166 million increase over the FY 2007 enacted level. Last year, Northwest Tribes estimated that it would take at least $447 million to maintain current services. This estimate included $65 million for inflationary costs for the Contract Health Service (CHS) program, $174 million for inflation for other health and facilities accounts, $59 million for population growth, and $150 million in Contract Support Costs (CSC) to address past year's shortfalls and funding for expanded self-determination programs.

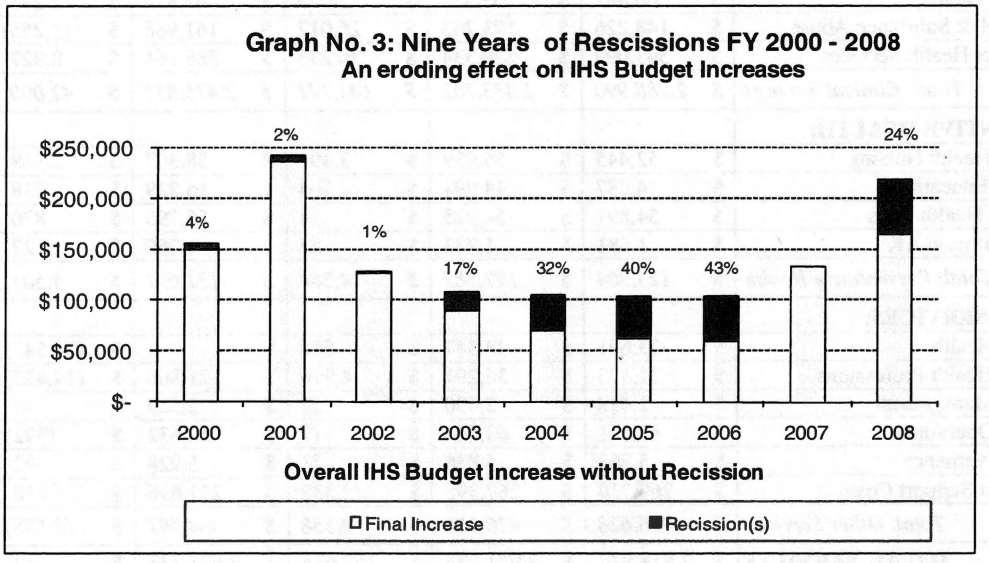
Table No. 1: Indian Health Service Budget Comparison of FY 2007, 2008, and Presidents FY 2009 (Dollars in Thousands)						
Sub Sub Activity	**Final Budget FY 2007**	**Final Budget FY 2008**	**Change Over FY 2007**	**President's FY 2009 Budget**	**Change Over FY 2008**	**Percent Change**
SERVICES:						
Hospitals & Health Clinics	$ 1,411,387	$ 1,484,016	$ 72,629	$ 1,521,934	$ 37,918	2.6%
Dental Services	$ 125,396	$ 133,637	$ 8,241	$ 137,944	$ 4,307	3.2%
Mental Health	$ 60,882	$ 63,531	$ 2,649	$ 65,824	$ 2,293	3.6%
Alcohol & Substance Abuse	$ 148,226	$ 173,243	$ 25,017	$ 161,988	$ (11,255)	-6.5%
Contract Health Services	$ 543,099	$ 579,334	$ 36,235	$ 588,161	$ 8,827	1.5%
Total, Clinical Services	*$ 2,288,990*	*$ 2,433,762*	*$ 144,771*	*$ 2,475,851*	*$ 42,090*	1.7%
PREVENTIVE HEALTH:						
Public Health Nursing	$ 52,445	$ 55,939	$ 3,494	$ 58,307	$ 2,368	4.2%
Health Education	$ 14,287	$ 14,991	$ 704	$ 15,229	$ 238	1.6%
Comm. Health Reps	$ 54,891	$ 54,925	$ 34	$ 55,795	$ 870	1.6%
Immunization AK	$ 1,681	$ 1,733	$ 52	$ 1,760	$ 27	1.6%
Total, Preventative Health	*$ 123,304*	*$ 127,587*	*$ 4,284*	*$ 131,091*	*$ 3,503*	2.7%
OTHER SERVICES:						
Urban Health	$ 33,691	$ 34,547	$ 856	$ -	$ (34,547)	-100.0%
Indian Health Professions	$ 31,375	$ 36,291	$ 4,916	$ 21,866	$ (14,425)	-39.7%
Tribal Management	$ 2,438	$ 2,490	$ 52	$ 2,529	$ 39	1.6%
Direct Operation	$ 63,631	$ 63,624	$ (7)	$ 62,632	$ (992)	-1.6%
Self Governance	$ 5,763	$ 5,836	$ 73	$ 5,928	$ 92	1.6%
Contract Support Costs	$ 269,730	$ 267,398	$ (2,332)	$ 271,636	$ 4,238	1.6%
Total, Other Services	*$ 406,628*	*$ 410,185*	*$ 3,558*	*$ 364,591*	*$ (45,595)*	-11.1%
TOTAL, SERVICES	$ 2,818,922	$ 2,971,533	$ 152,613	$ 2,971,533	$ (2)	0.0%
FACILITIES:						
Maintenance & Improvement	$ 54,668	$ 52,889	$ (1,779)	$ 52,889	$ -	0.0%
Sanitation Facilities Construction	$ 94,003	$ 94,253	$ 250	$ 94,253	$ -	0.0%
Hlth Care Facilities Construction	$ 25,664	$ 36,584	$ 10,920	$ 15,800	$ (20,784)	-56.8%
Facil. & Envir. Hlth Supp	$ 165,272	$ 169,638	$ 4,366	$ 169,105	$ (533)	-0.3%
Equipment	$ 21,619	$ 21,282	$ (337)	$ 21,282	$ -	0.0%
Total, Facilities	*$ 361,226*	*$ 374,646*	*$ 13,420*	*$ 353,329*	*$ (21,317)*	-5.7%
TOTAL, IHS	**$ 3,180,148**	**$ 3,346,179**	**$ 166,033**	**$ 3,324,862**	**$ (21,319)**	**-0.6%**

The final FY 2008 appropriation fell short by $281 million to maintain current services, which means Indian health programs will continue to have their base budgets eroded as they absorb the cost requirements of maintaining current services. Over the course of time this erosion effect has impacted the quality and quantity of services provided. Many health care analysts consider this decline in health care services as a direct result of chronic under- funding of the Indian health system. In fact, a recent report indicates a number of measures on which disparities are measured have gotten significantly worse or have remained unchanged for American Indians and Alaska Natives.[1]

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

The Effect of Rescissions on the Budget

Rescissions continue to have a growing effect on Indian health programs. Over the last six years, across the board reductions as a percentage of the approved IHS budget are growing at a disproportionate rate. In FY 2007, the IHS did not have a rescission because Congress passed a year-long continuing resolution. Beginning six years ago, rescissions were a mere one percent of the approved IHS budget increase. Three years ago, the rescissions cut into almost half of the approved IHS budget increase. Why aren't IHS health programs exempt from across-the-board reductions like the Veterans Administration (VA) programs? IHS health programs are subject to the same rates of medical inflation that VA programs are and are deserving of the same consideration. If the Administration and Congress are resolved to address Indian health disparities, they must restore past year's rescissions and exempt them from future cuts.



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

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

Preserving the basic health program funded by the IHS budget

The FY 2009 IHS budget completely fails to preserve the 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. How can unmet needs ever be addressed if the existing program is not maintained? Tribes have one overriding concern that is crucial to this discussion. There must be a trusting relationship between tribes who are concerned about improving their health status, the Administration that is charged with that responsibility, and the Congress who holds the purse strings. Tribes, IHS and Congress must continue to focus on the goals and objectives of the IHS program and assure that the necessary resources are available to continue to make improvements in health status. If the Administration is serious about addressing health disparities it must improve its commitment to adequate funding for the IHS and not simply refer to health disparities in reports and speeches.

The Office of Management and Budget

The Office of Management and Budget continues in its refusal to share vital budget information 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 is now embargoed information and OMB refuses to meet directly with tribal leaders. This table should be public information. The OMB could open the process even further by sharing budget information prior to the first Monday in February[2]. The continued embargo of the FY 2009 budget information allows the Administration to violate accepted standards of government-to-government consultation. Tribes have specifically requested that OMB allow the Department of Health and Human Services to share the OMB pass-back information with tribes so they can provide their comments to the Administration and the IHS to assist in preparation of its appeal to the Department and OMB. Sharing the final budget information with tribes would allow them to prepare their testimony for the oversight committees in a timely manner.

How can tribes effectively participate in the budget process if they are prohibited from having access to vital information in order to develop recommendations for Congress? Tribes cannot be content with an under funded program that has such a devastating effect on their communities. In the course of this budget review, the President's budget request is evaluated, major issues and concerns are identified, and suggestions are provided that will benefit tribes and IHS. Recommendations for funding levels are also included. Our goal is that this analysis will serve 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.

Current Services Budget: Maintaining the Current Health Program and the President's Proposed FY 2009 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 2009 is $513.3 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. 21).

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. Last year, the FY 2008 Consolidated Appropriations Act included up to a 3.75% pay act increase for Federal employees, which became effective on the first day of the first applicable pay period beginning on or after January 1, 2008.

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

The FY 2009 IHS budget decrease of $21.3 million erodes the base budget for Indian health programs. It is estimated that an increase of **$513.3 million** (an increase of 15%) will be needed to maintain current services in FY 2009. In addition, Portland Area tribes recommend an additional **$574.1** million for program enhancements to address the significant Indian health disparities and priority needs. This brings the total recommended amount to **$1 billion** or an increase of **32%** over last year's level (see Table 4 on page 19).

Table No. 3: Summary of Mandatory Cost Increases (Current Services)

Mandatory Cost	*Increase needed to maintain current services (1,000s)*
CHS inflation estimated at 12.5%	$69,520
Health Services Account (not including CHS) inflation estimated at 8.3%)	$223,128
Contract Support Costs (unfunded amount)	$158,261
Population Growth (estimated at 2.1% of health services accounts)	$62,402
Total Mandatory Costs	$513,311

Note on Medical Inflation: Medical Inflation is estimated between 5% - 10% in the Northwest states of Oregon, Washington and Idaho. Health care analysts understand that increases in medical spending reflect increases in the value of services and pharmaceuticals and not simply inflation as measured for most goods and services. Spending in Medicare will increase by 7% and Medicaid by 6.8% in FY 2009. NPAIHB assumes Indian health programs will not achieve the same level of cost containment due to the lack of large group purchasing

Justification for Estimates

In the NPAIHB proposed budget (Table 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. Estimates for Contract Support Costs (CSC) use the IHS yearly CSC Shortfall report amount. 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.

Table No. 4: Indian Health Service Budget
Comparing President's FY 2009 Request to Current Services Estimates
(Dollars in Thousands)

	A	B	C	D	E	F	G
				CURRENT SERVICES ESTIAMTES			
Sub Sub Activity	**Final FY 2008**	**President's FY 2009 Request**	**Change**	**CPI Medical Care**	**Increase[1] needed for Inflation**	**Increase[2] needed for Pop. Growth**	**NPAIHB ESTIMATE FOR INFLATION**
SERVICES:							
Hospitals & Health Clinics	$ 1,484,016	$ 1,521,934	$ 37,918	8.1% [a]	$ 120,205	$ 31,164	$ 151,370
Dental Services	$ 133,637	$ 137,944	$ 4,307	5.8% [b]	$ 7,751	$ 2,806	$ 10,557
Mental Health	$ 63,531	$ 65,824	$ 2,293	4.9% [c]	$ 3,113	$ 1,334	$ 4,447
Alcohol & Substance Abuse	$ 173,243	$ 161,988	$ (11,255)	4.9% [c]	$ 8,489	$ 3,638	$ 23,382
Contract Health Services	$ 579,334	$ 588,161	$ 8,827	9.9% [d]	$ 57,354	$ 12,166	$ 69,520
Total, Clinical Services	*$ 2,433,762*	*$ 2,475,851*	*$ 42,090*		*$ 196,912*	*$ 51,109*	*$ 259,276*
PREVENTIVE HEALTH:							
Public Health Nursing	$ 55,939	$ 58,307	$ 2,368	4.9% [c]	$ 2,741	$ 1,175	$ 3,916
Health Education	$ 14,991	$ 15,229	$ 238	4.9% [c]	$ 735	$ 315	$ 1,049
Comm. Health Reps	$ 54,925	$ 55,795	$ 870	4.9% [c]	$ 2,691	$ 1,153	$ 3,845
Immunization AK	$ 1,733	$ 1,760	$ 27	4.9% [c]	$ 85	$ 36	$ 121
Total, Preventative Health	*$ 127,587*	*$ 131,091*	*$ 3,504*		*$ 6,252*	*$ 2,679*	*$ 8,931*
OTHER SERVICES:							
Urban Health	$ 34,547	$ -	$ (34,547)	5.9% [e]	$ 2,038	$ 725	$ 37,311
Indian Health Professions	$ 36,291	$ 21,866	$ (14,425)	3.6% [f]	$ 1,306	$ 762	$ 16,494
Tribal Management	$ 2,490	$ 2,529	$ 39	3.6% [f]	$ 90	$ 52	$ 142
Direct Operation	$ 63,624	$ 62,632	$ (992)	3.6% [f]	$ 2,290	$ 1,336	$ 4,619
Self Governance	$ 5,836	$ 5,928	$ 92	3.6% [f]	$ 210	$ 123	$ 333
Contract Support Costs	$ 267,398	$ 271,636	$ 4,238	3.6% [f]	$ 9,626	$ 5,615	$ 15,242
Total, Other Services	*$ 410,185*	*$ 364,591*	*$ (45,595)*		*$ 15,561*	*$ 8,614*	*$ 74,139*
TOTAL, SERVICES	$ 2,971,533	$ 2,971,533	$ -		$ 218,725	$ 62,402	$ 342,347
FACILITIES:							
Maintenance & Improvement	$ 52,889	$ 52,889	$ -	3.6% [e]	$ 1,904	$ -	$ 1,904
Sanitation Facilities Constructio	$ 94,253	$ 94,253	$ -	3.6% [e]	$ 3,393	$ -	$ 3,393
Hlth Care Facilities Constructio	$ 36,584	$ 15,800	$ (20,784)	0.0%	$ -	$ -	$ -
Facil. & Envir. Hlth Supp	$ 169,638	$ 169,105	$ (533)	3.6% [e]	$ 6,107	$ -	$ 6,640
Equipment	$ 21,282	$ 21,282	$ -	3.6% [e]	$ 766	$ -	$ 766
Total, Facilities	*$ 374,646*	*$ 353,329*	*$ (21,317)*		*$ 12,170*	*$ -	*$ 12,703*
TOTAL, IHS	**$ 3,346,179**	**$ 3,324,862**	**$ (21,317)**		**$ 230,896**	**$ 62,402**	**$ 355,050**

Summary of Costs to maintain Current Services:

Contract Support Costs Shortfall Amount[1]:	$ 158,261	
Inflation & Population Growth:	$ 355,050	
Program Enhancements (see p. 18):	$ 574,192	17%
Total Current Services Budget:	**$ 1,087,503**	32%

Inflation Rates Calculated as follows:

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

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

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

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

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

[f] Inflation calculated using CPI Series SUUR0000SA0: Chained Consumer Price Index all goods.

[1] Source: *FY 2007 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 debated various program increases (or program enhancements) that they felt were essential to address the desperate health disparities and high priority health needs that many of their programs face. There was a spirited discussion on keeping these recommendations within the bounds of political feasibility versus putting forth recommendation based on true need and how this would be accepted in this fiscal environment. Everyone who participated felt that the funding increases for the line items listed were far short of what was needed. It was decided to highlight the program increases given the significant health disparities of American Indian and Alaska Native people and the years of productive life lost because of these disparities.

The proposed increase above current services raises the Portland Area request to a level that may not be politically feasible (from the basic current services amount of 15% to 32% with these program increases), however, highlighting these priorities is necessary for Congress to see that other health areas are in need of increases above current services levels.

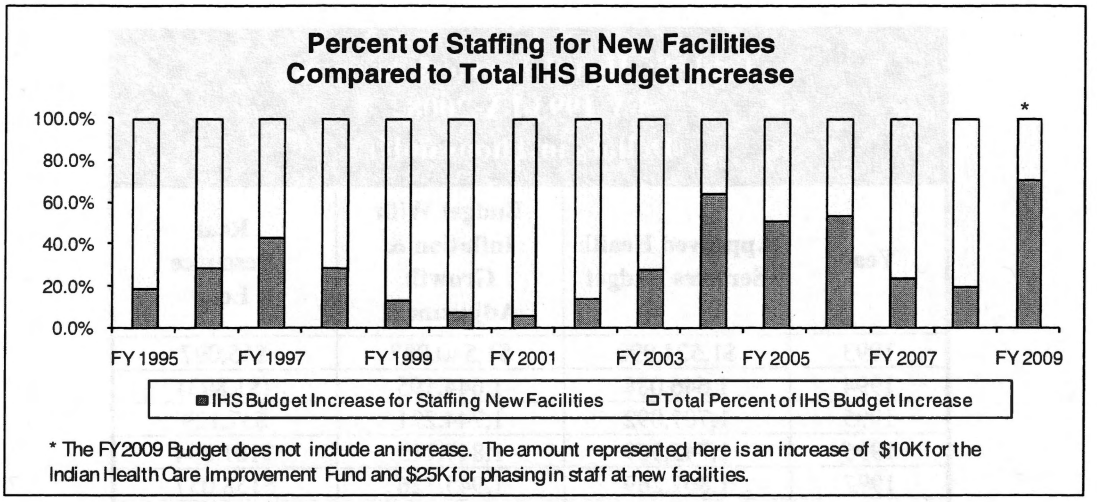
Portland Area Tribes recommended more funding for the grossly underfunded Contract Health Service program in order to address the significant backlog of deferred services, the growing number of denied services, and more funding for the Catastrophic Health Emergency Fund. Portland Area Tribes also recommend a substantial increase to address the growing oral health needs and dental professional shortage in Indian Country. Tribal health directors stressed the importance of having good oral health; and how it is a prerequisite for making good nutritional choices that determine future health outcomes.

Sustaining the efforts of health promotion and disease prevention (HP/DP) programs are a concern for Northwest tribes. Thus, Portland tribes recommend more funding for Community Health Representatives, Health Education, Public Health Nursing, and establishment of a separate fund to support HP/DP activities. Facilities funding for small ambulatory clinics continues to be a high priority for the Portland Area. 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. The balances of the increases are distributed in a basic manner for other high priority issues like information technology and pharmaceuticals.

Table No. 5: IHS Budget Program Increases
(Dollars in Thousands)

CHS Unfunded: Denied/Deferred Services and Catestropic Health Emergency Fund	$ 183,000
Dental Health	$ 180,000
Mental Health	$ 18,882
Alcohol and Substance Abuse	$ 31,470
Public Health Nursing	$ 5,245
Health Education	$ 5,245
Community Health Representatives	$ 10,490
Self Governance	$ 5,180
Pharmacy	$ 31,080
Information Technology	$ 20,720
Sanitation Facilities Construction	$ 20,720
Small Ambulatory Clinics, Joint Venture	$ 41,440
Maintenance & Improvement, Facilities	$ 5,180
Guaranteed Loan Program	$ 15,540
Total, Program Increases:	**$ 574,192**

Staffing for new 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 maintain (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.

This year, the FY 2009 IHS budget was decreased by $21.3 million, yet a new facility within the IHS system will receive $25 million for new staffing. Clearly, the Agency proposes to cut the health budgets of 560 Tribes in order to fund staffing packages. If the President did not include the amount in his request, the only way to cover these costs was cut current services budgets of other Tribes.

Table 6: Staffing New Facilities (Dollars in Thousands)

Facility	*Staffing Cost*
Joint Venture Project Staffing	$ 4,044
Lawton, OK	$ 10,874
PIMC Ambulatory Center	$ 10,082
Total	**$ 25,000**

For FY 2009, $4 million is needed to staff new facilities built under the Joint Venture Program, $10.9 million is needed to phase in staffing at Lawton, OK, and $10.1 million is required to staff the new Phoenix Indian Ambulatory Medical Center. These 'new staffing packages' become recurring appropriations and are more than the amounts applied to other mandatory costs. It calls into question the feasibility of building new facilities if funding is not available to maintain current programs. How can you continue to build new facilities when the current levels of care can't be maintained in the facilities you have?

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

Table 8: Health Services Account FY 1993-FY 2008 (Dollars in Thousands)			
Year	**Approved Health Services Budget**	**Budget With Inflation & Growth Adjustment**	**Real Resource Loss**
1993	$1,524,990	$1,540,087	$15,097
1994	1,646,088	1,644,195	($1,893)
1995	1,707,092	1,744,221	$37,129
1996	1,745,309	1,847,113	$101,804
1997	1,807,269	1,945,326	$138,057
1998	1,841,074	2,060,512	$219,438
1999	1,950,322	2,274,992	$324,670
2000	2,074,173	2,411,496	$337,323
2001	2,265,663	2,610,497	$344,834
2002	2,389,614	2,630,009	$240,395
2003	2,475,916	2,644,996	$169,080
2004	2,530,364	2,661,614	$131,250
2005	$2,596,492	2,804,211	$207,719
2006	$2,692,099	2,880,546	$188,447
2007	$2,818,922	2,976,748	$157,826
2008	$2,971,533	$3,102,325	$130,792
		Total Real Resources Lost FY 1993-2008	$2,741,968

Table 8 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 8 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 $2.74 billion. It is difficult to estimate how much collections from Medicaid (and to a lesser extent Medicare) have reduced these shortfalls. One reason for the difficulty is that collections estimates are understated in each year of the IHS budget justification because only IHS facilities' collections are reported.

Table 8 illustrates the annual and cumulative impact of annual under-funding of mandatory cost increases. This information is depicted graphically on page 7 of this document.

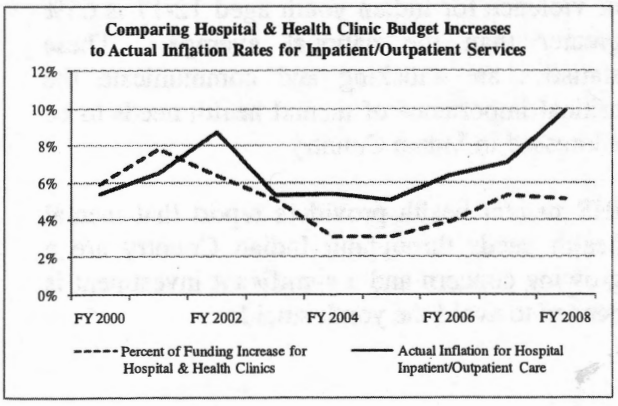
The following section reviews the IHS budget at the 'sub-sub-activity' level for the health services account. The number in the parenthesis is the page number in the Congressional Justification for the IHS FY 2009 budget.

Hospitals and Clinics (CJ-56)

Table 9: Hospitals & Clinics (Dollars in Thousands)		
President Request:	**$**	**1,521,934**
FY 2008 Final Budget	$	1,484,016
President's Increase/Decrease	2.6%	$ 37,918
NPAIHB Estimate for Inflation & Pop Growth		$ 151,370
	Shortfall:	**$ 113,452**

The Hospitals and Clinics line item would receive $1.52 billion under the Administration's request, a proposed increase of 2.6% over the enacted FY 2008 budget. NPAIHB estimates that $1.64 billion is needed to maintain current services. The President's request falls short by $113.5 million. The Administration's proposal does not provide funding to cover the estimated $65 (FY 2008 levels) million needed for pay act increases, population growth, or inflation. The request provides $17.9 million for staffing new facilities and $10 million for the Indian Health Care Improvement Fund (IHCIF).

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. Portland Area Tribes only receive 4.5% of H&C funding despite its 7% share of the IHS user population.



Epidemiology Centers:
Permanent Funding for the Northwest Tribal Epidemiology Center (CJ-71)

IHS funds eleven Epidemiology Centers, ten tribal and one urban. The Northwest Tribal Epidemiology Center (*The EpiCenter*), is located at the NPAIHB. The *EpiCenter* provides epidemiological and programmatic assistance on a variety of health issues. It has taken the lead in helping Northwest Tribes work to achieve the health status objectives specified in the Indian Health Care Improvement Act Amendments of 1992. The Epi-Centers include:

- Alaska Native Epi-Center,
- Great Lakes Inter-Tribal Epi-Center
- Inter-Tribal Council Epi-Center
- MT-WY Tribal Leaders Council
- Navajo Nation Division of Health,
- National EpiCenter Program
- Northern Plains Epi-Center
- NPAIHB Epi-Center
- Oklahoma Area Epi-Center
- United South and Eastern Tribal Epi-Center
- Seattle Indian Health Board Epi-Center

The Board recommends permanent funding for Tribal Epi-Centers at a level that will enable them to be fully functional epidemiological and surveillance centers. The FY 2009 proposed budget will provide each EpiCenter with approximately $414,300; a minimal increase of only $43,000. This level of funding does not provide an adequate increase to cover the costs of inflation, pay increases, and program growth for the Epi-Centers. 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 Epi-Centers.

Dental Services (CJ-75)

Table 10: Dental Services (Dollars in Thousands)			
President Request:	**$**		**137,944**
FY 2008 Final Budget	$		133,637
President's Increase/Decrease	3.2%	$	4,307
NPAIHB Estimate for Inflation & Pop. Growth		$	10,557
	Shortfall:	**$**	**6,250**

The President's increase for Dental Health services is a mere $8.8 million, a 3.2% increase over last year's level. NPAIHB estimates it will take at least $10.7 million to maintain current services. The President's request falls short by $6.2 million. The FY 2009 request does not provide funding for an estimated $5.6 million (FY 2008 levels) needed for pay costs, inflation, and population growth. The request includes $2.2 million to phase in staffing at new facilities.

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

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

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

Mental Health (CJ-80)

Table 11: Mental Health (Dollars in Thousands)			
President Request:	**$**		**65,824**
FY 2008 Final Budget	$		63,531
President's Increase/Decrease	3.6%	$	2,293
NPAIHB Estimate for Inflation & Pop. Growth		$	4,447
	Shortfall:	**$**	**2,154**

The President requests $65.8 million to cover the mental health needs of IHS and tribal health programs. NPAIHB estimates it will take $67.9 million to cover the needs of Indian Country. The FY 2009 request does not include funding for pay costs, inflation, or population growth, however, requests $1.3 million to cover the costs of phasing in staffing at new facilities. The President's request falls short by $2.2 million to maintain current services.

Phasing in new staff will take 56% of the meager increase that the President has requested. In FY 2008, IHS funded pay costs, inflation, and population growth at $2.8 million for mental health services. The President's budget does not provide additional funding to expand mental health services in Indian Country.

While the Administration will claim that mental health services have received reasonable increases over the last three years, it is not enough to address the tremendous mental health needs of Indian Country. The suicide rate for Indian people is 72% greater than the national average. Violence and trauma are also reported at alarming rates in tribal communities. The rate of violence for Indian youth aged 12-17 is 65% greater than the national average. These statistics are shocking and communicate the critical importance of mental health needs to be addressed in Indian Country.

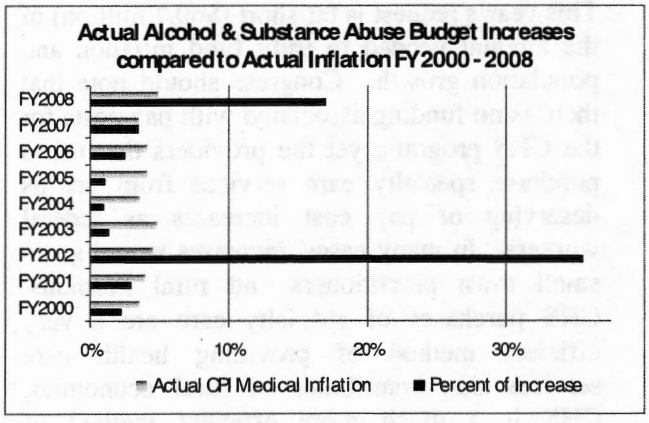
IHS mental health providers report that mental health needs throughout Indian Country are a growing concern and a significant investment is needed to avoid the youth suicides.

Alcohol & Substance Abuse (CJ-86)

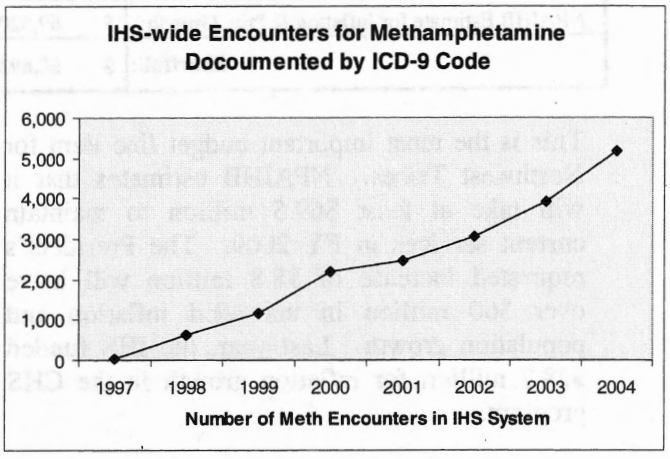
Table 12: Alcohol & Substance Abuse (Dollars in Thousands)			
President Request:		$	**161,988**
FY 2008 Final Budget		$	173,243
President's Increase/Decrease	-6.5%	$	(11,255)
NPAIHB Estimate for Inflation & Pop. Growth		$	12,127
	Shortfall:	**$**	**34,637**

The President's request proposes to cut alcohol and substance abuse services by $11.3 million in FY 2009. The request provides $161.9 million, which falls short of maintaining current services by $34.6 million. This recommendation restores the $11.2 million cut by the President and adds $12.1 to cover unfunded pay costs, inflation, and population growth. Last year, pay costs, inflation, and population growth were calculated to be $10.3 million.

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



Over the past eight years, the Administration's request has been less than adequate to fund inflation and population growth. The significant increases in FY 2002 and 2008 are a result of Congressional action and not at the request of the President. In FY 2002, Congress provided $30 million in non-recurring funding to address alcohol and substance abuse issues in Indian Country. Last year, Congress provided an additional $13.8 million in non-recurring funds to address methamphetamine prevention and treatment activities.

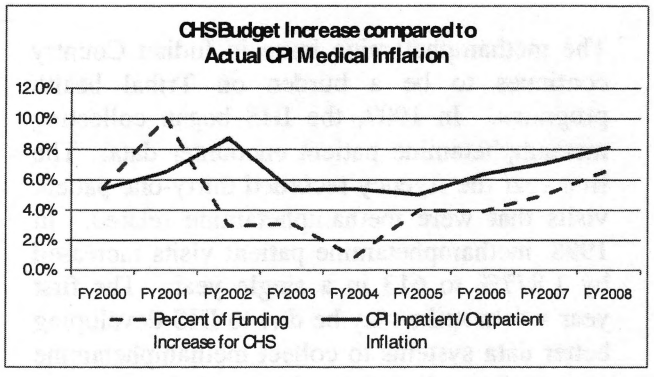


The methamphetamine issue in Indian Country continues to be a burden on Tribal health programs. In 1997, the IHS began collecting methamphetamine patient encounter data. The first year the Agency recorded thirty-one patient visits that were methamphetamine related. In 1998, methamphetamine patient visits 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. The IHS Portland Area Office manages a behavioral health fund for those Tribes that continue to receive behavioral health services directly from the Agency. Last year, 90% of the behavioral heath payments were to purchase specialty services due to methamphetamine related cases. The increased costs of health care and the growing methamphetamine use have many tribal leaders across Indian Country concerned that tribes do not have the necessary resources to deal with this epidemic.

Contract Health Services (CJ-92)

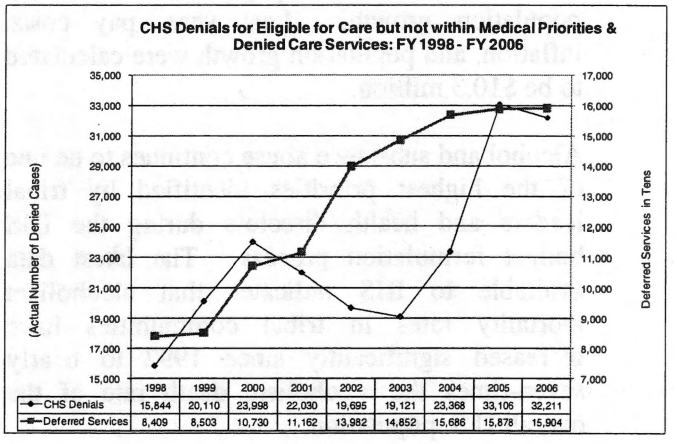
Table 13: Contract Health Services (Dollars in Thousands)		
President Request:	**$**	**588,161**
FY 2008 Final Budget	$	579,334
President's Increase/Decrease	1.5%	$ 8,827
NPAIHB Estimate for Inflation & Pop. Growth:		$ 69,520
	Shortfall:	**$ 60,693**

This is the most important budget line item for Northwest Tribes. NPAIHB estimates that it will take at least $69.5 million to maintain current services in FY 2009. The President's requested increase of $8.8 million will leave over $60 million in unfunded inflation and population growth. Last year, the IHS funded $28.7 million for inflation growth in the CHS program.



The Administration's requests have routinely requested less than what is needed to fund CHS inflation and population growth. Why are the Administration's requests generally less than 5% for such an important account, when the requests averaged over the last nine years for Hospitals and Clinics exceed 5% and 7% for Dental services? CHS dependent Areas lack facilities infrastructure to deliver services and have no choice but to purchase specialty care from the private sector using CHS funds. The CHS line item is subject to the same inflation rates for inpatient and outpatient services as the Hospital and Clinics line item. In fact, it could be argued that the CHS line item is subject to higher rates of inflation since it is used to purchase specialty care services. It is more expensive to purchase such services than if delivered in existing facilities.

Many tribal programs will begin the new fiscal year already on "Priority One" levels or in the winter instead of spring of the fiscal year. In FY 2001, President Clinton requested a significant CHS increase that was sufficient to fund population growth and medical inflation and for the first time since 1993 tribes saw the level of CHS denials begin to fall (graph below). While CHS denials (not within medical priorities) may be falling, CHS deferred services (within medical priorities but not funding available) are on the rise. This means that many patients will go without care unless life or limb test apply, and only then will they receive necessary health care.



This year's request is far short ($60.7 million) of the amount needed to truly fund inflation and population growth. Congress should note that there is no funding associated with pay costs for the CHS program, yet the providers that tribes purchase specialty care services from are as deserving of pay cost increases as federal workers. In many cases, increases would go to small town practitioners and rural hospitals. CHS purchases of specialty care are a very efficient method of providing health care services that contributes to rural economies. CHS is a much more efficient method of providing care than building, staffing, and maintaining new hospitals.

Table 14: Contract Health Services (CHS) Lost Purchasing Power 1993 - 2009 (Dollars in Thousands)					
Year	**Approved Budget**	**Required CHS Budget with Medical Inflaton**	**Un-funded Medical Inflation**	**Un-funded Population Growth**	**Total Unfunded**
FY 1992	$ 308,589	(Base Year)			
FY 1993	$ 328,394	$ 331,425	$ 3,031	$ 6,480	$ 9,511
FY 1994	$ 349,848	$ 354,260	$ 4,412	$ 6,896	$ 11,308
FY 1995	$ 362,564	$ 373,635	$ 11,071	$ 7,347	$ 18,418
FY 1996	$ 362,564	$ 390,428	$ 27,864	$ 7,614	$ 35,478
FY 1997	$ 368,325	$ 406,744	$ 38,419	$ 7,614	$ 46,033
FY 1998	$ 373,375	$ 419,433	$ 46,058	$ 7,735	$ 53,793
FY 1999	$ 385,801	$ 438,218	$ 52,417	$ 7,841	$ 60,258
FY 2000	$ 406,000	$ 414,350	$ 8,350	$ 8,102	$ 16,452
FY 2001	$ 445,773	$ 444,570	$ (1,203)	$ 8,526	$ 7,323
FY 2002	$ 460,776	$ 490,350	$ 29,574	$ 9,240	$ 38,814
FY 2003	$ 475,022	$ 518,373	$ 43,351	$ 9,500	$ 52,851
FY 2004	$ 479,070	$ 536,558	$ 57,488	$ 9,581	$ 67,069
FY 2005	$ 498,068	$ 557,836	$ 59,768	$ 9,961	$ 69,729
FY 2006	$ 517,297	$ 581,959	$ 64,662	$ 10,346	$ 75,008
FY 2007	$ 543,099	$ 605,714	$ 62,615	$ 11,405	$ 74,020
FY 2008	$ 579,334	$ 648,854	$ 69,520	$ 12,166	$ 81,686
FY 2009	$ 588,161	$ 636,688	$ 48,527	$ 12,166	$ 60,693
Seventeen Year Total:			**$ 625,924**	**$ 152,520**	**$ 778,444**

The CHS budget is approximately 19% of the total FY 2009 Health Services accounts. In the Northwest, it represents over 23% of the total Portland Area Office budget. The consequence of seventeen years of under-funded inflationary costs has declined 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 new formula currently used for CHS distribution.

The CHS program is also extremely vulnerable to inflation pressures. Between FY 1992 and FY 2009, the NPAIHB estimates that over **three-quarters of a billion** dollars have been lost to inflation in the CHS program nationally. Unfunded medical inflation alone exceeds $625.9 million, while unfunded population growth totals $152.5 million—representing over $738 million in lost purchasing power as depicted in the Table 14 above.

The CHS Program and Medicaid

Table 15. CHS Budget History FY 1996 to FY 2008 (Dollars in Thousands)				
Year	CHS Approved Budget	Increase over Previous Year	Percent of Increase	Compared to Medicaid Increase
FY 1996	$ 362,564	(Base Year)		
FY 1997	$ 368,325	$ 5,761	1.6%	4.1%
FY 1998	$ 373,375	$ 5,050	1.4%	5.7%
FY 1999	$ 385,801	$ 12,426	3.3%	7.1%
FY 2000	$ 406,756	$ 20,955	5.4%	9.1%
FY 2001	$ 445,773	$ 39,017	9.6%	11.7%
FY 2002	$ 460,776	$ 15,003	3.4%	13.0%
FY 2003	$ 475,022	$ 14,246	3.1%	11.6%
FY 2004	$ 479,070	$ 4,048	0.9%	9.7%
FY 2005	$ 497,085	$ 18,015	3.8%	4.0%
FY 2006	$ 517,297	$ 20,212	4.1%	5.8%
FY 2007	$ 543,099	$ 25,802	5.0%	6.7%
FY 2008	$ 579,334	$ 36,235	6.7%	6.8%
		13-Year Average:	3.7%	7.3%

Table 15 charts the past thirteen years of funding for the CHS program. The CHS increase has averaged 3.7% each year while medical inflation rate experienced in the Northwest is approximately 10% over the past decade. The CHS program is very similar to the Medicaid program. It provides services to an underserved population that often requires similar services. In fact, Congress intended the IHS and Tribal health programs to have access to Medicaid resources when in 1976, it authorized the Indian health system to be reimbursed for Medicaid related services.

CHS should receive medical inflation adjustments at least equal to the Medicaid program (projected to be 6.8 in FY 2009)[3] since both purchase care from private providers. The President's request of $8.8 million is insufficient to protect real resources that continue to be lost to unfunded medical inflation and population growth. 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.

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 2006 there were 158,784 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 33,106 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.'g 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 $960 to these numbers estimates that an additional $301 million is needed to address unmet care in the CHS program.

[3] HHS 2009 Budget in Brief, p. 61, available www.hhs.gov.

Catastrophic Health Emergency Fund (CHEF)

The CHS budget includes a Catastrophic Health Emergency Fund (CHEF) of $25 million, which is intended to protect the daily administration of local CHS programs from overwhelming expenditures for catastrophic health cases. This fund is a lifesaver for Indian health programs. Its purpose is to fund catastrophic health care cases with large expenses. Northwest Tribes urge the Congress to consider fully funding CHEF and consider increasing this amount to $36 million since these cases are all well-documented and critical to the financial stability of the small programs that exist in the Portland Area and many other IHS Areas.

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

In FY 2006[4], there were 671 CHEF claims totaling $17.7 million that were paid before the CHEF was depleted. An additional $871 CHEF cases totaling $19.5 million went unpaid and were absorbed by local CHS budgets. This is an increase of only 70 cases over the previous fiscal year. The actual unfunded need is certainly greater than $19.5 million because the fund is usually depleted by the third quarter of the fiscal year. Tribal health directors understand this and may not make application to the CHEF since they know there is no money to cover the costs of a catastrophic case. Otherwise, these numbers would be much higher.

Catastrophic Health Emergency Fund				
Year	# Cases	Funded Amt	# Cases	Unfunded Amt
1998	770	$12,000,000	501	$ 9,850,000
1999	710	$12,000,000	521	$ 10,713,047
2000	714	$12,000,000	675	$ 12,225,000
2001	805	$15,000,000	439	$ 8,165,000
2002	693	$15,000,000	570	$ 8,530,000
2003	718	$17,883,000	700	$ 12,359,000
2004	667	$17,778,206	756	$ 13,347,720
2005	694	$17,749,935	802	$ 17,971,608
2006	671	$17,735,176	872	$ 19,545,288

Portland Area Tribes strongly urge Congress fully fund CHEF since the impact of not funding it impacts Indian Health programs more than any other line activity in the budget. **NPAIHB recommends that the CHEF fund be increased to $38 million in FY 2009.** Based on FY 2006 data (the most current year data are available) the CHEF need is $37.3 million.

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

Public Health Nursing (CJ-101)

Table 16: Public Health Nursing (Dollars in Thousands)		
President Request:	**$**	**58,307**
FY 2008 Final Budget	$	55,939
President's Increase/Decrease	4.2%	$ 2,368
NPAIHB Estimate for Inflation & Pop. Growth		$ 3,916
Shortfall:		**$ 1,548**

The President's request for Public Health Nurses (PHNs) is $58.3 million, an increase of 4.2% over last year's amount. The request does not stipulate that any funding for pay costs, inflation, or population growth. The request does include $1.5 million for phasing in staff at new facilities. It is anticipated that the additional $886,000 will be used to offset some mandatory cost requirements. This will leave over $1.5 million in unfunded costs.

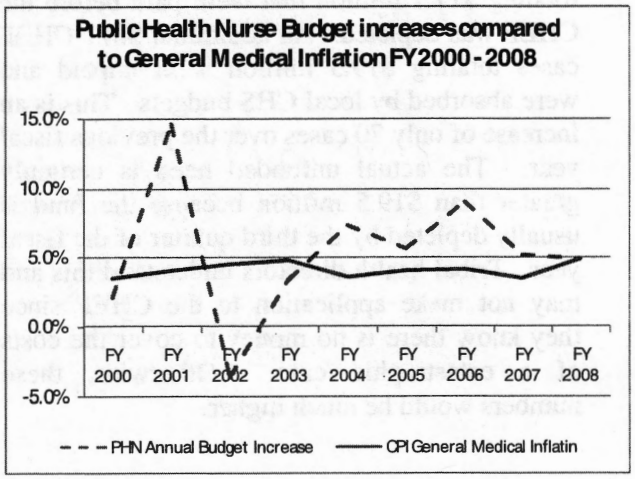
PHNs are at the center of many community based health services including home visits to provide: disease surveillance, direct therapy; and group education comprise 40% of the PHNs time. The growing elderly population has resulted in an increase in home visits by PHNs. The growing threat of pandemic flu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

Health Education (CJ-108)

Table 17: Health Education (Dollars in Thousands)		
President Request:	**$**	**15,229**
FY 2008 Final Budget	$	14,991
President's Increase/Decrease	1.6%	$ 238
NPAIHB Estimate for Inflation & Pop. Growth		$ 1,049
Shortfall:		**$ 811**

The President's request for Health Education is $15.2 million in FY 2009. NPAIHB estimates that it will take at least $1 million to maintain current services. The President's request falls short by $811,000. The request does specify how the $238,000 will be applied to pay act increase, population growth, or inflation. No funding will be used for staffing at new facilities.

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.



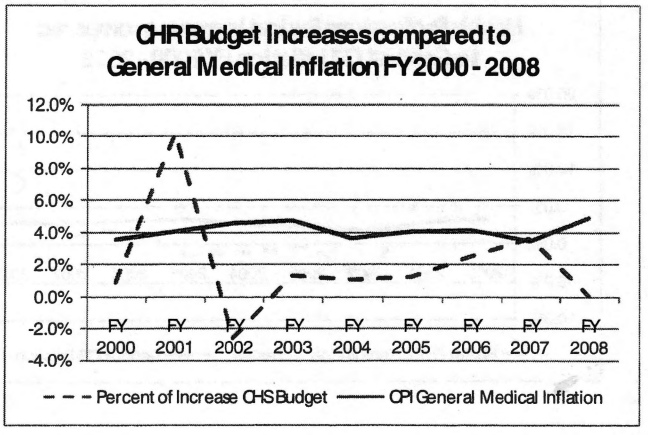
Over the last five years, the Administration has adequately funded this budget line item although it was decreased significantly in FY 2002. It demonstrates the commitment HHS' health promotion and disease prevention goals.

Community Health Representatives (CJ-113)

Table 18: Community Hlth Representatives (Dollars in Thousands)		
President Request:	$	55,795
FY 2008 Final Budget	$	54,925
President's Increase/Decrease	1.6%	$ 870
NPAIHB Estimate for Inflation & Pop. Growth		$ 3,845
Shortfall:		**$ 2,975**

The President's request for the Community Health Representatives (CHRs) program is only $55.7 million, approximately the same amount as requested last year. NPAIHB estimates that it will take at least $58.8 million to fund requirements of current services. This year's request includes a slight increase of $870,000 however there are no details on how it will be applied. The request does not indicate that funding is available for pay costs, inflation, or population growth. The President's request falls short of maintaining current services by $2.9 million in FY 2009.

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 19: Urban Indian Health (Dollars in Thousands)		
President Request:	$	-
FY 2008 Final Budget	$	34,547
President's Increase/Decrease	-100%	$ -
NPAIHB Estimate for Inflation & Pop. Growth		$ 37,311
Shortfall:		**$ 37,311**

For the third year, the President's FY 2009 eliminates the $34 million in funding to the Urban Indian health Programs (UIHP). The Administration rationalizes that urban Indians—unlike other Indian people that live in isolated rural areas—have access to other health services under Medicaid and other Federal and State health care programs, on the same basis as other Americans. NPAIHB recommends that the UIHP be restored by Congress and an additional $4.1 million be provided to fund the costs of maintaining current services. This is, in part, due to the fact that the UIHP has not received respectable budget increases in the last six years and when restored in FY 2008 did not receive an adequate increase to maintain current services or allow for population growth.

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

Many Indian people in the 1950s and 60s were relocated from reservations to cities in 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. The President's proposal to cut urban Indian health programs from the IHS budget means that these people will now go without receiving health services or some will return to already under-funded tribal clinics. The Administration and IHS justify the elimination of the urban program by indicating that people served in these programs have access to health services under Medicaid and from the Health Resources Services Administration's (HRSA) community health centers.

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

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

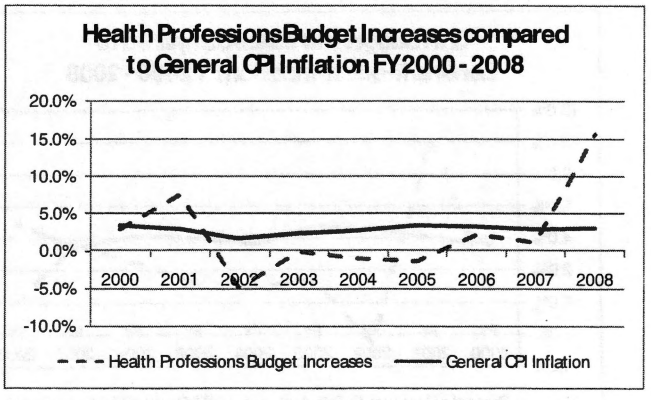
Indian Health Professions (CJ-132)

Table 20: Indian Health Professions (Dollars in Thousands)		
President Request:	**$**	**21,866**
FY 2008 Final Budget	$	36,291
President's Increase/Decrease	-39.7%	$ (14,425)
NPAIHB Estimate for Inflation & Pop. Growth		$ 16,494
Shortfall:		**$ 30,919**

The Administration's proposes to cut the Indian Health Professions program by $14.4 million. The justification for the cuts is that the IHS vacancy rates for many health professionals have remained unchanged since 2003. This is attributed to the fact that the IHS workforce is aging at an accelerated rate with many health providers retiring. If this program was ever needed the time is now.

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.

While this program did receive a decent increase in FY 2008, it has been underfunded over the last seven years. NPAIHB recommends that the $14.4 million cut be restored in addition to $16.5 million be provided to address growing staffing shortage areas. The total recommended increase is $30.9 million.

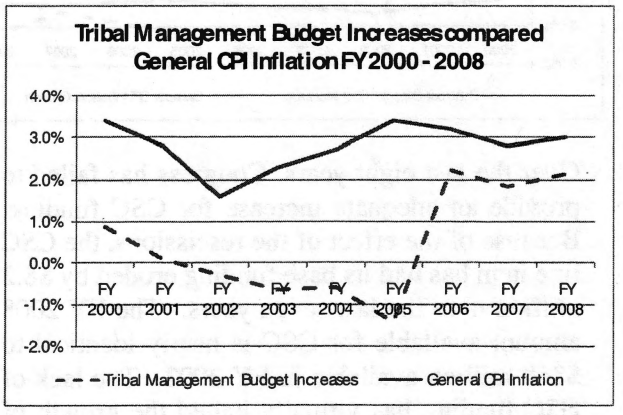


Tribal Management (CJ-139)

Table 21: Tribal Management (Dollars in Thousands)		
President Request:	**$**	**2,529**
FY 2008 Final Budget	$	2,490
President's Increase/Decrease	1.6%	$ 39
NPAIHB Estimate for Inflation & Pop. Growth		$ 142
Shortfall:		**$ 103**

The President requests $2.5 million for Tribal Management, approximately the same amount as last year. The request includes a slight increase of $39,000. The justification document does not indicate how the increase will be applied to cover pay costs, inflation, or population growth. NPAIHB recommends that $142,000 be provided to maintain current services. The President's request falls short by $103,000.

NPAIHB estimate should be much higher since the President and Congress have not funded any increases for this line item in a number of years. This program has received decreases in four out of the last ten years. This program is an essential component of the Self-Determination program and allows tribes to assess, evaluate, and develop their capacity to assume IHS programs. This program administers grants to tribes, and tribal organizations carrying out Self-Determination programs and works to develop management capacity of Indian managed programs. The President's increase of $39,000 is inadequate to cover the costs inflation.



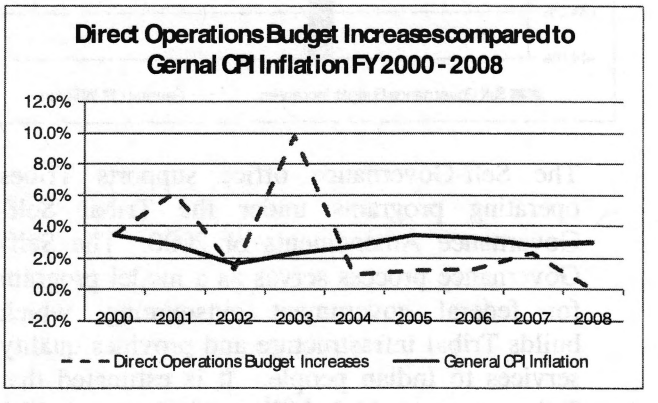
Direct Operations (CJ-144)

Table 22: Direct Operations (Dollars in Thousands)		
President Request:	**$**	**62,632**
FY 2008 Final Budget	$	63,624
President's Increase/Decrease	-1.6%	$ (992)
NPAIHB Estimate for Inflation & Pop. Growth		$ 4,619
Shortfall:		**$ 5,611**

The Direct Operations line item funds the cost of management at IHS headquarters and the twelve Area Offices. This year the President request proposes to cut Direct Operations funding by $992,000. The workload for supporting direct operation is not being reduced by Tribes assuming programs under Self-Determination and the funding decrease is not justified.

NPAIHB recommends restoring the $992,000 and providing an increase of $4.6 million to cover pay cost and inflation increases. The President's budget will fall short by $5.6 million to maintain current services.

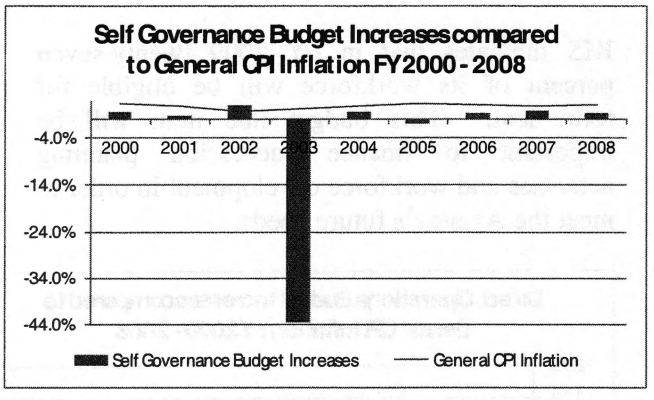
IHS indicates that in FY 2009 twenty-seven percent of its workforce will be eligible for retirement. This budget line item will be important to finance succession planning activities and workforce development in order to meet the Agency's future needs.



Self-Governance (CJ 148)

Table 23: Self Governance (Dollars in Thousands)		
President Request:	**$**	**5,928**
FY 2008 Final Budget	$	5,836
President's Increase/Decrease	1.6%	$ 92
NPAIHB Estimate for Inflation & Pop. Growth		$ 333
Shortfall:		**$ 241**

The President's request for the Self-Governance item is only $5.9 million and is only $92,000 more than what was requested last year. NPAIHB estimates that it will take at least $241,000 to maintain current services in FY 2009. This leaves $241,000 in unfunded mandatory costs. Last year, current services totaled $184,000, double what the President has requested this year. While this may not seem like much, four years ago, Congress reduced the Self Governance line item by $4.7 million, a loss of over 43% from the previous year. Tribes have continually recommended that this funding be restored to the FY 2002 level.

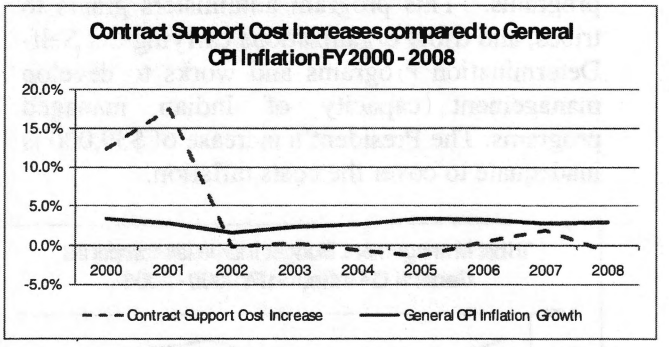


The Self-Governance office supports Tribes operating programs under the Tribal Self-Governance Amendments of 2000. The Self-Governance process serves as a model program for federal government outsourcing, which builds Tribal infrastructure and provides quality services to Indian people. It is estimated that Tribes operate $1.2 billion of the total IHS budget, and it is imperative that they receive the necessary resources to develop and build their administrative infrastructure and allow for new and expanded programs.

Contract Support Costs (CJ-154)

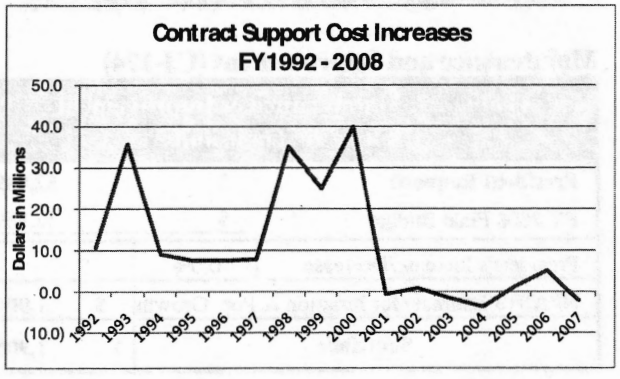
Table 24: Contract Support Costs (Dollars in Thousands)		
President Request:	**$**	**271,636**
FY 2008 Final Budget	$	267,398
President's Increase/Decrease	1.6%	$ 4,238
NPAIHB Estimate for Inflation & Pop. Growth		$ 15,242
Shortfall:		**$ 11,004**

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



Over the last eight years, Congress has failed to provide an adequate increase for CSC funding. Because of the effect of the rescissions, the CSC line item has had its base funding eroded by $8.2 million over the last seven years. The FY 2008 amount available for CSC is nearly identical to $268 million available in FY 2002. The lack of CSC funding has virtually halted the growth of Indian Self Determination.

The damaging cuts to CSC are contrary to the Administration's principles of government outsourcing. The FY 2009 proposed increase of $4.2 million will not come close to restoring lost funding to the CSC base. In fact, if there are rescissions in FY 2009, the meager increase will quickly turn into a decrease and erode the CSC base budget. The proposed increase will be directed for new and expanded P.L. 93-638 programs; and will require Tribes to waive their rights to CSC as a condition to the award of any new Self-Determination or Self-Governance agreements. This requirement has essentially stopped many Tribes from assuming programs under P.L. 93-638 and is contrary to the principles of Indian Self-Determination. **Congress should act to prohibit IHS' new waiver policy and address the funding of CSC for new initiatives.**



There is approximately $158 million in CSC shortfall that has accumulated over the years. This growing shortfall reflects the absence of any significant increases over the past six years. The continuing shortfall threatens to pit tribe against tribe as mature contractors are asked to absorb all inflationary increases in order to fund new contractors. There are two Portland Area tribes that would like an opportunity to assume programs from the IHS, however can not because of the lack of CSC funding and IHS' new CSC policy. **Congress must act to eliminate the backlog of $158 million in CSC funding shortfall.**

Medicaid, Medicare and Private Collections (CJ-158)

The President's FY 2009 budget proposes significant changes for the Medicare and Medicaid programs. Congress and the Administration have taken measures to reform these two 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 changes proposed by the President in FY 2009 will further complicate Indian participation in Medicare and Medicaid programs.

The President's budget forecasts a deficit of $407 billion in FY 2009. The proposed budget includes $208.2 billion in Medicare savings and proposes to reduce spending by $178 billion over the next five years. These reductions will reduce the average annual growth rate in Medicare spending from 7.2% to 5% over five years. The President's legislative proposals would reduce Medicare spending by $12.2 billion in FY 2009. Finally, the Administration proposes an additional $645 million in savings from administrative changes in FY 2009, and $4.7 billion over five years. These proposed changes in the Medicare program will undoubtedly impact the ability of IHS and Tribal programs to be reimbursed for Medicare related services.

Similar to Medicare, the President's FY 2009 budget also contains a number of changes for the Medicaid program. The President's FY 2009 budget proposes to reduce Medicaid spending by $17.4 billion over the next five years. The proposed budget includes three new regulatory proposals with savings of $0.8 billion over five years. The Administration has also proposed a series of regulatory changes that would reduce federal Medicaid spending by at least $12 billion. Many of these proposals were included in the FY 2008 budget. While the reductions in spending are a small, the changes will have negative implications for beneficiaries and shift costs to the states. States will respond by limiting or cutting services.

As the reductions in services and reimbursements occur in the Medicare and Medicaid programs, they will shift costs onto the Indian health system. Health Services that were once reimbursable may no longer be available. These reductions in resources available to the Indian health system would decrease the health services they can provide and cause a further decline in the health status of Indian people.

No one really knows how much is collected for Medicare and Medicaid, but at least the Administration does not inflate the estimates and then use the inflated estimates to justify lower increases in the IHS budget.

Special Diabetes Funding (CJ-160)

Congress, in approving an extension of the State Child Health Insurance Program (SCHIP) through May 31, 2009, also included a one-year extension for the SDPI program at its current funding level of $150 million through September 30, 2009. Prior to the extension, the SDPI programs were scheduled to expire on September 30, 2008.

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 over $1 million of their own diabetes allocation in improving Diabetes data reporting and information generation since the start of the SDPI.

Health Facilities Account (CJ-172)

Maintenance and Improvement (CJ-174)

Table 25: Maintenance & Improvement (Dollars in Thousands)		
President Request:	**$**	**52,889**
FY 2008 Final Budget	$	52,889
President's Increase/Decrease	0.0%	$ -
NPAIHB Estimate for Inflation & Pop. Growth		$ 1,904
Shortfall:		**$ 1,904**

Over the past 14 years (FY 1993-FY2008) there has been less than a 5% increase in Maintenance & Improvement (M&I) despite the fact that the inventory of space has increase appreciably (over 30% in the Portland Area). Many tribes have seen a decrease in their funding due to the lack of adequate increases to reflect the growth in new and expanded facilities. The replacement value of facilities eligible for M&I is $2.42 billion. The capital assets of Indian health facilities must be protected from deteriorating due to lack of funding for routine maintenance.

The IHS Backlog of Essential Maintenance and Repair (BEMAR) survey for October 2007 estimates that there is a backlog of $371 million in needed repairs to Indian health facilities. In FY 2002 $14.1 million was available for program

deficiencies identified by BEMAR. The IHS should continue to update this information to provide Congress with the basis for increased funding to address this need.

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

Sanitation (CJ-180)

Table 26: Sanitation & Facilities (Dollars in Thousands)		
President Request:	**$**	**94,253**
FY 2008 Final Budget	$	94,253
President's Increase/Decrease	0.0%	$ -
NPAIHB Estimate for Inflation & Pop. Growth		$ 3,393
Shortfall:		**$ 3,393**

Approximately 7.5% of all AI/AN homes lack safe water in the home compared to less than 1% average nationally. The President's FY 2009 request does not provide an increase for Sanitation and Facilities and requests that same amount as funded in FY 2008. 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.

NPAIHB recommends an additional $3.4 million is needed to fund and maintain current services.

Health Facilities Construction (CJ-185)

Table 27: Facilities Construction (Dollars in Thousands)		
President Request:	**$**	**15,800**
FY 2008 Final Budget	$	36,584
President's Increase/Decrease	-56.8%	$ (20,784)
NPAIHB Estimate for Inflation & Pop. Growth		$ -
Shortfall:		**$ -**

Northwest tribes support a moratorium on facilities construction until an equitable funding methodology can be implemented by the IHS. This position has been recommended for the last three years so that savings from facilities construction can be redirected to the health services accounts. As noted previously, facilities, especially hospitals are expensive to build and their staffing packages 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 projected cost to build the Phoenix Indian Medical Center heath system, four different facilities, will be over $680 million. At the current rate of health facilities appropriations it will take at least 7-10 years to complete the PIMC projects. Thus, keeping the health facilities construction priority system locked for at least another decade. The current priority list was developed in 1991 and locks out Tribes from badly needed construction dollars unless you are one of the facilities on the current list. The Portland Area tribes continue to oppose any new facilities construction projects until the IHS completes its revision of the Health Facilities Construction Priority System.

Alternative Methods of Acquiring Health Facilities

If new facilities construction dollars are restored to the FY 2009 budget, some of these funds should go to alternative funding mechanisms. Northwest Tribes have long encouraged alternative methods to construct new facilities. These alternative methods of acquiring health facilities must be supported in an effort to meet the demand for primary care. There is such an

enormous need that depending exclusively upon IHS appropriations for all health facility requirements is not realistic. The IHS and Tribes have developed a strategy that will greatly increase the number of new ambulatory health facilities constructed, but some IHS funding is required for this strategy of leveraging financing to work.

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

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

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

Facilities and Environmental Health and Engineering Support (CJ-193)

Table 28: Facilities & Environmental Support (Dollars in Thousands)		
President Request:	**$**	**169,105**
FY 2008 Final Budget	$	169,638
President's Increase/Decrease	-0.3%	$ (533)
NPAIHB Estimate for Inflation & Pop. Growth		$ 6,640
Shortfall:		**$ 6,107**

This line item consists of three subsidiary activities: facilities support, environmental health support, and the office of Environmental Health and Engineering support. The President's proposes to cut this budget line item by $533,000. NPAIHB recommends that the $533,000 be restored and an additional $6.6 million be provided to fund increased inflation costs and pay act increases. The President's budget falls short by $6.1 million.

Equipment (CJ-205)

Table 29: Equipment (Dollars in Thousands)		
President Request:	**$**	**21,282**
FY 2008 Final Budget	$	21,282
President's Increase/Decrease	0.0%	$ -
NPAIHB Estimate for Inflation & Pop. Growth		$ 766
Shortfall:		**$ 766**

The Administration does not request an increase for Equipment in FY 2009. IHS estimates an inventory of $320 million in equipment with an average estimated life expectancy of six years. New facilities, including facilities built with non-IHS funds could benefit from additional funding. The equipment line item funds normal equipment replacement due to age and maintenance. A reasonable estimate is that Indian health programs will need an additional $18 million annually to cover needs for biomedical, facility and telecommunications equipment. NPAIHB recommends an additional $766,000 be provided for the Equipment line item.

The FY 2009 IHS Budget in the Context of Current Fiscal Realities

Table 30: Annual Budget Surplus Projections

	Fiscal Years (Dollars in Billions)											
	2007 Actual	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
President Budget Projections	$ (162)	$ (396)	$ (342)	$ (182)	$ (129)	$ (1)	$ (21)	$ (20)	$ (29)	$ (64)	$ (3)	$ 73

Source: CBO An Analysis of the President's Budgetary Proposals for FY 2009, available at: www.cbo.gov.

Deficit/Surplus Projections

It is worthwhile to consider the overall budgetary context in any analysis of the FY 2009 IHS budget. When President Clinton left office a budget surplus was anticipated to continue to grow to $6 trillion over ten years. Unfortunately, the recession from past years, combined with the war in Iraq, hurricane relief, and tax cuts have completely reversed this Country's future budget prospects. If enacted, the proposals in the President's budget will add $396 billion in 2008 and $342 billion in 2009 to the deficit. Under the President's proposals, the deficit would steadily diminish from 2009 to 2012, at which point it would balance. The CBO forecasts do not include military operations in Iraq and Afghanistan after 2009.

Table 30 estimates the budget deficit over the next ten years using information reported in the President's FY 2008 budget. The current budget deficit is $162 billion. As the table illustrates, the CBO anticipates deficit spending for the next five years. The President's budget proposes to a surplus by the year 2018 with critical changes in mandatory and discretionary funded programs.

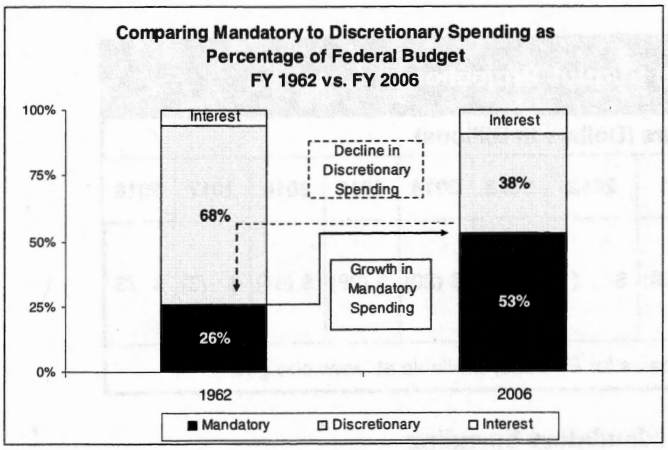
Mandatory Spending

If the President's budget proposals are enacted they will reduce mandatory spending by $143 billion over the next ten years. The largest reductions in mandatory spending would be in the Medicare program—totaling $481 billion over ten years. This proposal would freeze Medicare spending by 8% over the period. The President's budget would also lower by 50% the federal matching payments for expenditures by State Medicaid programs for targeted case management and administrative activities. These proposals would reduce outlays by $59 billion over a ten year period. The continuing costs of the War in Iraq and the Congress' commitment to get a handle on the deficit will prove challenging for Tribal health programs over the next two years.

Discretionary Spending

The President requests $1,067 billion in discretionary budget authority for FY 2009. By comparison, discretionary budget authority for 2008 will total $1,153 billion if the requested supplemental authority of $108 billion—$105 billion of which is for military operations and other activities in Iraq and Afghanistan—is enacted. So far this year, a total of $88 billion has been appropriated for those purposes. If funding for operations in Iraq and Afghanistan was excluded from the comparison, discretionary budget authority under the President's proposals would grow by about 3.8 percent, or $37 billion, from 2008 to 2009. Appropriations for defense would grow by 7.2 percent, and funding for homeland

security activities would rise by 7.8 percent. Other appropriations, in total, would be slightly below their level in 2008.



Discretionary Spending for Indian Programs

Federal spending on Indian programs is considered discretionary spending. This does not mean the U.S. government has no obligation to fund Indian programs, but it does mean that an annual appropriation is required to fund these programs, including the IHS budget. This year's FY 2009 HHS budget only includes $70.8 billion or 9.6% of its total budget for discretionary programs. This is the exact amount of discretionary budget that HHS had last year. This means that the FY 2009 HHS budget for discretionary spending is not growing as a percentage of its overall budget, which will make for tough budget times within the Department.

In FY 2009, the IHS budget ($3.32 billion) represents less than one-half percent of the overall HHS budget ($736.8 billion) and 4.7% of the discretionary portion of the HHS budget (again, the same amount as last year). Given the costs of the war in Iraq, hurricane relief efforts, and the Administration's proposal to cut the deficit, and other reform efforts to curtail mandatory spending--the prospect for discretionary programs does not look good in FY 2009 and beyond.

Conclusion: The Purpose of this Report

This document and the Portland Area All Tribes budget workshop that was held March 10, 2008 represent an effort by the NPAIHB to provide Tribes with an analysis of the Administration's proposed IHS budget and is intended to identify issues that will impact or benefit all Northwest Tribes. While it is recognized that individual tribes will have their own particular issues and projects, it is hoped that tribes will also embrace the main budget and legislative issues identified in this document. Issues with broad support are most likely to achieve congressional action.

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

Evaluation Based on Budget Principles: Table 31

Table 31 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 five years. It is the Northwest Tribes' attempt to make an inherently subjective process more objective. The NPAIHB stands ready to engage in an honest debate over each aspect of this evaluation to clarify our position in the debate over funding Indian health programs.

As noted above, the President's proposed FY 2009 increase for the IHS is greater than nearly every other discretionary program. Unfortunately, the obligation to fund health services is not considered discretionary by Northwest tribes. The President's grades reflect this view by Tribes. With many Tribal and IHS health programs beginning the new fiscal year on Priority One status they cannot give the President high marks for meeting the health care needs of Indian people.

	Table 31. GRADING THE PRESIDENT'S PROPOSED FY 2009 IHS BUDGET	President February 4, 2008	Senate	House
	Criteria or Budget Principle	FY 2009 Grade		
1	Budget Information Shared with Tribes in Consultation Sessions Prior to release date of the first Monday in February.	F		
2	Appropriate adjustment will be made to fully cover expected inflation.	F		
3	Appropriate increases will be included to address population growth.	F		
4	Appropriate adjustments will be made to fully fund tribal and federal employee compensation.	F		
5	The Contract Health Service Budget will be increased to fully fund the need for deferred services.	F		
6	Collection estimates are not represented as fulfilling the federal responsibility to fully fund the IHS budget.	C		
7	Increases will be provided to address the goals of the Indian Health Care Improvement Act.	F		
8	Full funding will be included to support staff associated with new construction projects.	F		
9	The Catastrophic Health Emergency (CHEF) Fund will be budgeted at a level to cover all qualifying cases.	C		
10	Funding will be provided to cover Contract Support Costs for tribes electing to compact or contract their health care services.	F		
11	Adequately support maintenance of IHS and tribal health facilities.	F		
12	The public announcements relating to the budget will honestly depict what is in the budget.	F		
13	Provides adequate funding to reduce health disparities.	F		
14	Honor the federal trust responsibility to provide health care services to American Indians and Alaska Natives.	F		
	Overall Grade	F		