

Northwest Portland Area Indian Health Board

The FY 2016 Indian Health Service Budget: Analysis and Recommendations

25th Annual Report

March 25, 2015

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Thank you.

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**Northwest Portland Area Indian Health Board**

# Introduction

## 

This 25th Annual Northwest Portland Area Indian Health Board analysis of the Indian Health Service (IHS) budget continues a tradition of close scrutiny of the IHS budget that began in 1989.[[1]](#footnote-2) It is with a sense of celebration that this year’s twenty-fifth annual analysis examines a very good Presidential budget request. The sizeable increase (9.9%) makes this the second best budget during the Obama Administration. The President’s request will go a long way to restore the $175 million that was lost in the FY 2013 budget cycle. That funding was lost due to the Administration having to sequester the IHS budget because annual spending exceeded the spending caps contained in the Budget Control Act of 2010. If Congress funds the amount in President’s FY 2016 request, it will help to restore some of the lost IHS funding as a result of the budget sequester.

Budget formulation for tribes is vastly different than it is for advocates of other programs funded by the federal government. The federal trust responsibility and the government-to-government relationship between tribes and the federal government, by definition, require a partnership in the development of the budget. It has not always been easy for Tribes to return, year after year, to the budget consultation process, but years of faithfully making our case appears to have reached the ear of the President.

The President’s FY 2016 IHS budget continues a positive maintenance of effort for a budget that has suffered a heavy burden of neglect over the past twenty years. Following a FY 2001 increase of 10%, from FY 2002 to FY 2008 the average IHS budget increase was less than 2.5%. A growing population and medical inflation eroded the purchasing power of Indian health programs. Tribes were forced to redirect funding from economic development initiatives to supplement their health programs. Fortunately, expanding Medicaid and Children’s Health Insurance programs provided additional resources. There is no denying, however, that a huge and growing gap resulted in greater health care disparities between Indian people and the general population over the past ten years. This gap has begun to be addressed in the budget increases of this Administration; however, additional funding is needed to address the growing health disparities of Indian people.

NPAIHB estimates it will take a $297.2 million increase in the FY 2016 budget to fund pay increases, inflation, and population growth in order to maintain current services. While the President’s budget provides a $460 million increase, which is adequate to cover inflation and population growth, its distribution within the IHS accounts will not maintain current services as presented. Staffing new facilities and program expansions will absorb $313.3 million, leaving only $147 million ($460 million minus $313) to cover NPAIHB’s projected $297.2 million for inflation and population growth. This means that Tribes will have to absorb over $149 million ($297 minus remaining $147 million) in unfunded inflation and population growth. Or, Congress will have to provide this additional funding and the likelihood of this is not good in the current budget climate. Thus, NPAIHB recommends that the Congress reallocate the $100 million increase proposed for facilities construction and another $47 million that the Administration proposes for program increases to provide the $149 million in unfunded costs of inflation and population growth. If this is not done, then Tribes will have to cut health services to absorb these mandatory costs.

Each year the Board discusses their priorities during its January Quarterly Board Meeting and at the February meeting of the Affiliated Tribes of Northwest Indians. In addition to the Budget Analysis, the Board also prepares a Legislative Plan that presents official Board positions on the budget and other health legislation. The Legislative Plan is developed by the Board and is also presented for discussion and adoption through a resolution at the January Board meeting, and again at the Affiliated Tribes of Northwest Indians at its February meeting. The 2015 NPAIHB Legislative Plan and this FY 2016 budget analysis are the basis of the Board's lobbying activities (both are available at [www.npaihb.org](http://www.npaihb.org)).

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

For the past sixteen years representatives from the Portland Area have joined Tribes nationwide in the IHS budget formulation process that includes direct service Tribes, Tribally operated, and urban programs. This group is commonly referred to as the I/T/U budget formulation team, meets annually to develop the IHS budget recommendation. The Northwest Tribes' longstanding interest and active participation in the budget process allows them to understand the complexity of developing the final appropriations. In the past, various Administrations have underestimated the need for funding the IHS.

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

### **Funding True Need**

The NPAIHB supports the work of both the I/T/U Budget Formulation Process and the Federal Disparities Index (FDI) Workgroup (formerly known as the Level of Need Funded). The FDI measures the proportion of funding provided to the Indian health system, relative to its actual need, by comparing healthcare costs for IHS beneficiaries in relation to beneficiaries of the Federal Employee Health Benefits (FEHB) plan. This comparison uses actuarial methods that control for age, sex, and health status.

Applying the FDI to estimate the true health care needs of Indian people results in an annual budgetary need of $9-10 billion. This corroborates the long-held view that less than 50% of true need is funded by the IHS budget. If funded at $9 billion, an additional phased-in facilities cost of $9-10 billion would be needed to house the expanded health care services. This $19 to $20 billion is sometimes stated as the Tribal needs-based budget. To restate: about $9 to $10 billion is needed for the recurring budget and about the same amount for added facilities to support a fully funded IHS.

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

Throughout the years, this analysis has sought to maintain the integrity of its estimates by not inflating amounts in the manner of conventional negotiations. Tribal leaders want information that is reliable and accurate so they can make their case to the Congress in good conscience 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.

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

NPAIHB has identified pertinent issues that impact Northwest Tribes. This information will assist leaders from each of the forty-three Portland Area tribes in making their own analysis of the budget proposal and its impact on their respective communities. This will also serve as a useful analysis for tribes nationwide since in nearly every case the interests of tribes nationwide are the same as the interests of Northwest Tribes. It is only by making these views known that effective budget policy can be developed. The NPAIHB and Northwest Tribes actively participate in efforts to develop consensus positions on budget priorities.

The 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 to national Tribal organizations. It is posted on the NPAIHB website (at www.npaihb.org) as soon as it is published so all tribes can consider its recommendations for their own use in the consultation process.

The Congress and the Administration must find common ground to maintain the purchasing power of health care resources, address unmet needs, and facilitate service delivery that meets health objectives while maintaining fiscal discipline. NPAIHB’s IHS 2016 Budget Analysis and Legislative Plan are posted at [www.npaihb.org](http://www.npaihb.org).

### **Acknowledgements**

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

### **Sources:**

* Senate Democratic (<http://www.senate.gov/~budget/democratic/>) and Republican <http://www.senate.gov/~budget/republican/> Budget Committee publications.
* The House analysis is available at http://budget.house.gov/budgetanalysis/the-president-s-fy-2016-budget.htm
* The Budget for FY 2016 <http://www.whitehouse.gov/omb/budget/> is the President’s budget request of February 2, 2015. It is actually a set of documents with narrative and statistical information on the President’s proposed budget for FY 2016.
* Congressional Budget Office (CBO <http://www.cbo.gov/> ), “Updated Budget Projections FY 2015 to FY 2015”, <http://www.cbo.gov/publication/45471>; and “An Analysis of the President’s FY 2016 Budget” <http://www.cbo.gov/publication/49979>. 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 2016, HHS FY 2016 Budget In Brief, February 2, 2016 available at <http://www.hhs.gov/budget/>
* The Indian Health Service ,Congressional Justification of Estimates for Appropriations Committees Fiscal Year 2016 is available at: <http://www.ihs.gov/budgetformulation/congressionaljustifications/>
* Additional information about the U.S. Budget is available at the Center on Budget and Policy Priorities: <http://www.cbpp.org/pubs/fedbud.htm> .

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## The FY 2016 Northwest Portland Area Indian Health Board

## Budget Analysis and Recommendations

The Northwest Portland Area Indian Health Board (NPAIHB) estimates that it will take at least $297.2 million to maintain current services (inflation and population growth) for IHS health programs in FY 2016. We further recommend an additional $175 million to fund program increases (see p. 16) to address growing health needs and diminished services due to the lack of sufficient funding increases by previous Administrations. The President’s respectable increase of $460 million is still less than one-half of the $1 billion needed to maintain services *and* to also address health care deficiencies with an effort Northwest Tribes feel is appropriate to the level of need.

The President’s FY 2016 budget request provides $5.1 billion for the Indian Health Service (IHS), and is a $460 million increase, 9.9%, in funding above the FY 2015 enacted level. Taken together with the FY 2010 historic increase, this year’s respectable request is noted and applauded by all Northwest Tribes. The increase exceeds those of other agencies in the Department of Health and Human Services. While this action is significant in that it provides sufficient funding to maintain the current program, the effect of staffing new facilities and certain program increases will result in less than adequate funding to cover mandatory costs of inflation and population growth in some programs. Portland Area Tribes are cautious of this fact because the likelihood of this Congress to approve the entire President’s request in this difficult fiscal climate is not good. Therefore, Congress can correct this by providing additional funding or reallocating staffing, health facilities construction funds, and certain program increases to cover these mandatory costs.

The generous Purchased and Referred Care (PRC) budgets of the last fiscal years will allow some funding to be applied to finally increase our effort to reduce health disparities between American Indian /Alaska Natives (AI/AN) and the general population. Finally, we are doing more than documenting those disparities; we can now direct funds to reduce health disparities.

### **The Final Enacted FY 2015 IHS Budget**

The FY 2010 budget provided an historic increase of $471.3 million, or 13.2% over 2009, and is easily the largest increase in the history of the agency. The FY 2010 budget restored some of the budget neglect by the previous Administration and allowed some funding to be directed for program expansions. It provided one of the largest increases ever for the Purchased and Referred Care (PRC) program and restored funding for the Dental and Mental Health Services line items. A significant increase of $7 million was also provided for the Urban Indian Health program, 20% more than the previous year. A record increase of $116 million was provided for the Contract Support Cost line item and restored years of neglect for tribal contractors and compactors. While the FY 2010 budget may have been the best in history of the Indian Health Service, its effect was reduced and health gains marginalized in FY 2013 when the IHS budget was sequestered and lost $175.7 million due the Administration’s budget sequester.

Budget Control Act & 2013 Sequester

The Budget Control Act of 2011 (BCA) requires the federal deficit to be reduced by $2.3 trillion over 10 years. The BCA sets spending targets and if they are not met requires budget sequestration by the Administration to make across the board spending cuts. This is important for Indian health programs because at least $26.4 billion of the proposed cuts must be made from non-defense discretionary programs. Since the IHS appropriation comes entirely from discretionary funding, the BCA sequestration will have an adverse impact IHS programs. If Congress fails to enact legislation negating the government-wide sequestration in future years, the IHS budget will be subject to across the board spending reductions. **Following the final FY 2013 sequestration, the IHS appropriation lost $175.7 million.** This lost funding will take years for the Administration and Congress to address in order to make Tribal government’s health budgets whole and in turn the AI/AN people they serve.

The BCA disproportionately targets discretionary spending and Tribes repeatedly inform Congress that the IHS appropriations are not “discretionary” by their mere classification in the appropriations process. IHS funding is provided in fulfillment of the United States federal trust responsibility based on treaty obligations that the United States Congress entered into with Indian Tribes. It is important that the Administration and Congress recognize that it passed a Declaration of National Indian Health Policy, in which the Congress declares it the policy of the United States—“in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.” To reduce IHS funding would be an abrogation of this policy passed by Congress and signed by this President.

The Congress and Administration should not play the “blame game” about who is at fault for the IHS sequester since each has the ability to exempt IHS from this requirement. Because of the federal trust responsibility and the chronic and severe underfunding of the Indian health system—along with the significant health disparities of Indian people—the Congress and Administration must exempt the IHS appropriation from discretionary funding budget reductions, and; enact an amendment to the Budget Control Act of 2011 to fully exempt the IHS budget from future sequestrations. The nature of the federal trust responsibility makes this a moral and ethical obligation—it is the right thing to do.

FY 2015 IHS Budget

The FY 2015 omnibus budget provided $4.64 billion for the Indian Health Service (IHS), which is a $207.9 million increase over the FY 2014 enacted level. The Congress supported the IHS budget by providing an additional $8.2 million over the President’s request. Despite this slight increase the allocation of the overall IHS budget was not good and likely the second worse budget for Tribes during the Obama Administration. Of course, the worst budget was the FY 2013 budget that lost $175.7 million to the budget sequestration process. Most analysts review the IHS budget simply by the final amount of funding provided by Congress. But the final amount does not take into account the net effects of including staffing for new facilities or other Congressional earmarks like new Tribes funding. While the overall program increase may be $207.8 million in FY 2015, the net amount available for 566 federally-recognized Tribes is less than $129 million (see Table 1). The $75.5 million needed for Contract Supports costs exacerbates this effect, and really makes only $53.5 million available to fund current service requirements of inflation and population growth.

While health disparities are improving for the United States, many health care analysts believe the stagnation or decline in health care services to be a direct result of persistent and chronic under- funding of the Indian health system. In fact, a recent report indicates that health disparities have gotten significantly worse or have remained unchanged for AI/AN people.[[2]](#footnote-3) Because of this, the Administration and Congress must continue to find ways to restore the lost purchasing power of over $4.2 billion to the IHS budget (see Table No. 6).



### **Preserving the Basic Health Program**

The President’s FY 2016 IHS budget provides adequate funding to preserve and partially restore existing IHS programs. However the allocation of the increase will not do so unless Congress reallocates the requested funding to fund inflation and population growth. A basic budget principle, Northwest Tribes have always focused on preserving the basic health care program funded by this budget. Preserving the purchasing power of the IHS base program should be the first budget principle, not an afterthought. Tribes have one overriding concern that is crucial to this discussion. There must be a trusting relationship between tribes who are concerned about improving their health status, the Administration that is charged with that responsibility, and the Congress who holds the purse strings. Tribes, IHS, and Congress must continue to focus on the goals and objectives of the IHS program and assure that the necessary resources are available to continue to make improvements in health status. If the Administration is serious about addressing health disparities it must continue with the commitment demonstrated in this budget to provide sustained funding increases for the IHS. Tribes stand ready to show results when resources are sufficient to address long recognized needs.



## The Office of Management and Budget

The Office of Management and Budget, under President Barack Obama, has demonstrated a new willingness to meet with Tribes. Many years ago, OMB shared a “who-struck-john” table that allowed tribes to understand where budget cuts were made. This allowed tribes to direct their advocacy to key decision makers by providing them with information about the funding requirements of IHS and tribal health programs. This information became embargoed information under the Bush Administration and OMB refused to meet directly with tribal leaders. The OMB could open the process even further by sharing budget information prior to the budget submission, typically, the first Monday in February[[3]](#footnote-4). Tribes have specifically requested that OMB allow the Department of Health and Human Services to share the November OMB pass-back information with tribes so they can provide their comments to the Administration and the IHS to assist in preparation of its appeal to the Department and OMB. Sharing the final budget information with tribes would allow them to prepare their testimony for the oversight committees in a timely manner and honors the government to government relationship.

How can tribes effectively participate in the budget process if they are prohibited from having access to vital information in order to develop recommendations for Congress? In the course of this budget review, the President’s budget request is evaluated, major issues and concerns are identified, and suggestions are provided that will benefit tribes and IHS. Recommendations for funding levels are also included. Our goal is that this analysis serves as a valuable resource for the Administration, Congress, and the Congressional staff that are responsible for developing the IHS Budget. The treaties, executive orders, and the legislation that tribes have fought so hard to achieve with the government of the United States remain the foundation of the unique status of health care for Indian people. The promise of this year’s budget and consultation for the FY 2016 budget suggests that treaties will be honored, promises will be kept, and the IHS will have a budget adequate enough to provide needed health services to our members.

### **Current Services Budget: Maintaining the Current Health Program and**

### **the President’s Proposed FY 2016 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 and 2010 are the only budgets that allowed tribes to reduce Purchase and Referred Care (PRC) denials of services. The NPAIHB estimates the current services need in FY 2016 is $297 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.

There are a number of ways to compute current services. The IHS estimates pay cost increases and reports this separate from inflation. The reason has less to do with budget presentation and more with the simple fact that Congress passes a pay act each year. Pay cost increases are costs that are precisely computed for federal employees. The IHS has also added reasonable tribal pay estimates and reports these. The pay act is legislation that requires compliance, no matter how long it may take the President to act on pay cost increases.

The NPAIHB estimates that in FY 2016 an increase of at least $297.2 (an increase of 6.3%) will be needed to maintain current services. In addition, Portland Area tribes recommend an additional **$175** million for program enhancements to address the significant Indian health disparities and priority needs. This brings the total recommended amount to **$472.2 million** or an increase of **10%** over last year’s level (see Table 4 on page 16).

## FY 2016 Justification of Estimates

In the NPAIHB proposed budget (Table No. 4, page 16), pay act costs are not displayed separately from general and medical inflation. Personnel inflation is a part of the overall inflation adjustment and does not need special treatment for the purposes of calculating a current services budget. The estimates presented in this analysis extrapolate medical related series of the Consumer Price Index (CPI) as they relate to IHS budget account activity. For example, inflation for the Hospital and Clinic Services is measured using the Hospital and Related Services series of the CPI, which measures inpatient and outpatient hospital related care only. Footnotes are included in the spreadsheet to indicate which CPI series have been used to measure inflation for budget sub-sub activity. A reference on where to locate CPI series is included as a footnote. Extrapolating CPI medical indices is a standard economic forecasting method that allows accurate and defensible estimates that are tied to real costs, though OMB has routinely applied non-medical related inflation rates to the IHS budget, which underestimate the true funding need for health care programs. The Urban program line item is estimated using the CPI chained index for Medical Care Services and includes prescription drugs, non-prescription and medical supplies, physician services, dental services, eyeglasses and eye care, and services by other medical professionals. Finally, the facilities account uses the general CPI inflation index. Finally, 1.8% rate of growth (same as the IHS rate) is used to estimate population growth.

Contract Support Costs a vital component in FY 2016

Estimates for Contract Support Costs (CSC) use the IHS yearly CSC shortfall report amount and forecasting methods that update shortfall report calculations based on actual figures provided by IHS for FY 2015. There are other CSC changes at work as well now that the Administration has agreed to fully pay CSC payments on Indian Self-Determination contracts and compacts. Under this full funding environment there will Tribes that want to expand their self-determination contracting opportunities as well as new Tribes that will want to enter into new self-determination agreements. There are also existing self-determination contractors that are in the process of recalculating and renegotiating their direct and indirect contracts support costs. Previously, since the Administration did not pay full CSC payments, there was little incentive to recalculate these amounts. Under a full funding environment there is now an incentive to do this. In FY 2015, IHS estimated that it would need to program $10 million to fund these ongoing costs. Than in late August and September 2015, the IHS announced it would need to reprogram more than the $10 million, and began consultations with Tribes to reprogram $48 million. The final amount ended up being approximately $25 million.

In order to avoid this miscalculation and to avoid the dangerous policy discussions that Contract Support Costs erodes the available funding for program increases, it would be best to estimate the amount needed for new and expanded Self-determination contracts and build in a contingency in case the IHS estimate is short. IHS estimates the need to be $55 million in FY 2016, and NPAIHB estimates an additional $11.9 million will be needed based on simple inflationary growth. Finally, the President’s budget request includes a proposal that Congress establish a mandatory appropriation for contract support costs. The proposal requests a three-year mandatory appropriation at stated dollar amounts for IHS with up to 2% of the sums so designated to be available for IHS’ administrative activities. The President's Budget also proposes that this measure go into effect beginning in FY 2017. NPAIHB and Portland Area Tribes are very supportive of the Administration’s proposal with exception of the 2% set-aside for IHS’ administrative activities. We believe there are alternatives for the IHS to cover these administrative costs. We encourage the appropriations Committees to continue to work with the Administration and Tribes to refine this proposal.



**Portland Area Recommendations for Program Increases**

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

The proposed increase above current services raises the Portland Area request to a level that may not be politically feasible (from the basic current services amount of 6.4% to 10% with these program increases), however, highlighting these priorities is necessary for Congress to see that other health areas are in need of increases above current service levels.

Although Portland Area Tribes are pleased with the President’s request of $70.3 million increase for Purchased and Referred Care, they recommend more funding for the grossly underfunded PRC program in order to address the significant backlog of deferred services, and the growing number of denied services. Portland Area Tribes also recommend a substantial increase to address the growing oral health needs and dental professional shortage in Indian Country. Tribal health directors stressed the importance of having good oral health; and how it is a prerequisite for making good nutritional choices that determine future health outcomes.

For the same reasons that IHS has recommended an additional $25 million for a behavioral health youth initiative, Portland Area Tribes recommend additional funding to address similar mental health and alcohol substance abuse issues for adults. The new youth behavioral initiative has been long needed; we also must do more to address similar issue for our Tribal adult population.

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The facilities Sanitation and Maintenance & Improvement (M&I) Programs are integral components of the IHS facilities program. IHS and Tribes carry out sanitation and related functions to provide potable water and waste disposal facilities throughout Indian Country. Almost 13 percent (53,200) AI/AN homes are without safe water or adequate wastewater disposal facilities. AI/AN people who live in those homes are at a higher risk for gastrointestinal disease, respiratory disease and other chronic diseases. The M&I program maintains and repairs existing IHS and Tribal health facilities. These programs have not received an increase worthy of being called adequate since FY 2006.

Finally, the Urban Indian Program, which was not provided an increase in the President’s FY 2016 budget, deserves more consideration for additional resources. NPAIHB recommends in addition to the $2.9 million for inflation and population growth, an additional $10 million, to assist urban health programs meet the growing demand for health services in urban areas across Indian Country.

**The Effect of Staffing New IHS Facilities on the Budget Increase**

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

The graph above illustrates the significance of staffing new facilities on the IHS budget increase. Staffing packages for new facilities are like pay act costs in two respects:

1. They come ‘off the top,’ (i.e. they are distributed before other increases), and;
2. They are recurring appropriations.

Northwest Tribes frequently ask: Why did our health program receive a 1% increase in funding this year when we were told there was a 5% increase for the IHS budget? In FY 2004, the IHS received a 2.1% increase, however, Portland Area Tribes realized less than a 1% increase in their health care budgets. In FY 2004, the new staffing was over 60% of the IHS budget increase. In FY 2005 and FY 2006, new staffing costs consumed over 50% of the increase.

In FY 2011, the overall IHS increase was $16.8 million, with $38 million requested for staffing, and the final operating plan amount was $25 million. In FY 2013 (year of sequester) the IHS budget was cut by $175 million, and the amount provided for staffing was $53 million. In these years, IHS cut Tribal program budgets in order to provide for funding to new facilities.

In FY 2016, $17.8 million is needed for staffing of new facilities at the Southern California Youth Regional Treatment Center (YRTC), the Choctaw Alternative Rural Health Center, and a replacement facility at Ft. Yuma. These ‘new staffing packages’ become recurring appropriations and are often more than the amounts applied to other mandatory costs.



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



Table 6 above demonstrates the loss of real resources in the Health Services Account due to increases that have been inadequate to pay for costs due to inflation (medical and general) and population growth. Inflation and population figures presented in Table 6 are based on the NPAIHB previous year’s analysis to fund current services. The loss of purchasing power over the past fifteen years is conservatively estimated at $4 billion. It is difficult to estimate how much collections from Medicaid (and to a lesser extent Medicare) have reduced these shortfalls. One reason for the difficulty is that collections estimates are understated in each year of the IHS budget justification because only IHS facilities’ collections are reported. Table 6 illustrates the annual and cumulative impact of annual under-funding of mandatory cost increases.

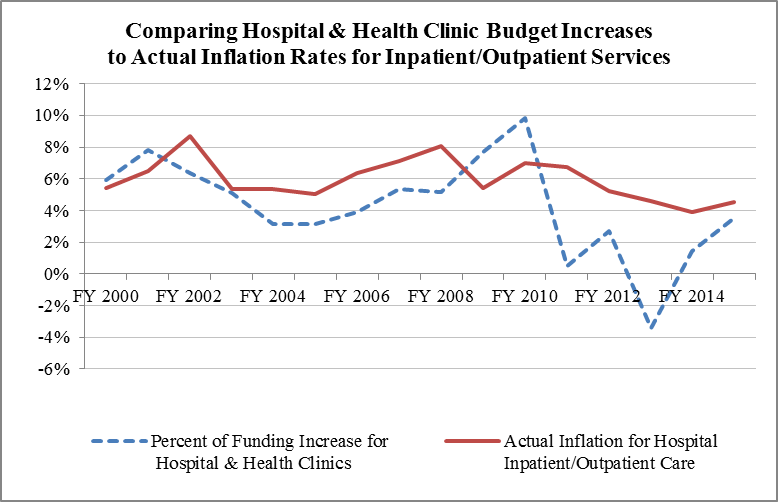
The following section reviews the IHS budget at the ‘sub-sub-activity’ level for the health services account. The number in the parenthesis is the page number in the Congressional Justification for the IHS FY 2016 budget.

**Hospitals and Clinics (CJ-55)**



The Hospitals and Clinics (H&C) line item would receive $1.94 billion under the Administration’s request, a proposed increase of $99.5 million or 5.4% over the enacted FY 2015 budget. NPAIHB estimates that $166.5 million is needed to maintain current services. After the effects of staffing and program increases are factored, the President’s request will fall short by over $36.9 million. The proposed program increases include $10 million to fund IHS business office improvements to increase third party collections. An additional $10 million is requested to fund health information technology (HIT) improvements associated with electronic health records (EHR) in order to meet Stage 3 meaningful use requirements. Portland Area tribes agree the $10 million is needed for health IT, but recommend that the $10 million request for business office improvements be denied by Congress. Especially since the President’s request is not adequate to maintain current services for the H&C account.

Staffing three new facilities will require $9.2 million for the H&C account. Once the facility amounts and business office and HIT are subtracted from the President’s increase, it only leaves $79.5 million to cover mandatory costs of inflation and population growth. An additional $36 million is needed or



should be re-directed from the $100 million increase for facilities construction to off-set the deficit.

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

Information Technology (CJ-75)

The FY 2016 budget request documents a true need for investment in IHS health information technology (HIT). IT will be an important component of quality improvements and potentially cost savings so it is wise to provide a clear documentation of IHS IT activities. The IHS maintains that the current budget request ensures that the budget needs for IT are independent of direct clinical care funds. The FY 2016 budget request for IT is $182.2 million, which is only a $10 million increase over FY 2015. The IHS information technology needs have been neglected in the budget over the last twenty years and more funding is needed, especially at P.L. 93-638 sites. Portland Area tribes support the increase of $10 million and certainly this amount is warranted given the enormous evolution of HIT in the private sector health care system.

### It is noted that in FY 2009, IT received $85 million in ARRA funding. $61.4 million of this funding is dedicated to Electronic Health Record development and deployment. $17 million will be spent on tele-health and related network infrastructure including 228 routers and router memory upgrades, the purchase of licenses, digital radiology units, backup power supplies, and network improvements. In addition, the Alaska and Aberdeen areas will have specific allocations. Aberdeen will receive specific videoconferencing support (Aberdeen Area Project). Alaska will receive funding for an Area Office protected network.

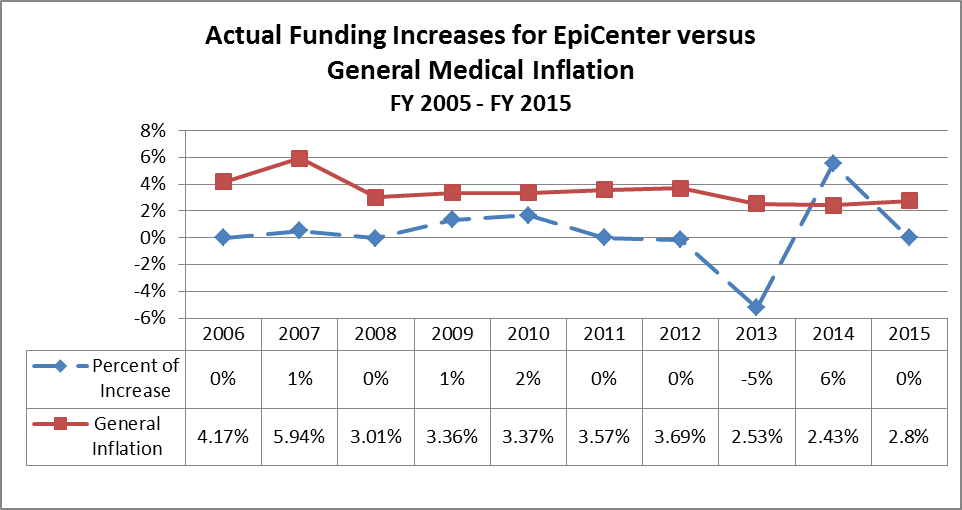
#### Epidemiology Centers: Recurring Funding Epidemiology Centers (CJ-67)

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

The Northwest Tribal Epidemiology Center (*The EpiCenter*), is located at the NPAIHB. It was the first tribal EpiCenter in the nation and is now a well-established part of the health research, health promotion and disease prevention efforts of Northwest Tribes. The *EpiCenter* provides epidemiological and programmatic assistance on a variety of health issues. The 12 Tribal Epi-Centers (TECs) are:

* Northwest Tribal Epidemiology Center
* Albuquerque Area Southwest Tribal Epidemiology Center
* California Tribal Epidemiology Center (California Rural Indian Health Board)
* Alaska Native Epidemiology Center,
* Great Lakes Inter-Tribal Epidemiology Center
* Inter-Tribal Council of Arizona Tribal Epidemiology Center
* Rocky Mountain Tribal Epidemiology Center (MT-WY Tribal Leaders Council)
* Navajo Epidemiology Cent r (Nation Division of Health),
* Northern Plains Tribal Epidemiology Center (Great Plains Tribal Chairmen’s Health Board)
* Oklahoma City Area Tribal Epidemiology Center
* United South and Eastern Tribal Epidemiology Center
* Urban Indian Health Institute Tribal Epidemiology Center

The Board recommends permanent funding for Tribal EpiCenters at a level that will enable them to be fully functional epidemiological and surveillance centers. There is no proposed increase for Tribal Epicenters in FY 2016 despite the fact that funding for the most part over the last ten years has remained flat. In FY 2011 and FY 2012 the base budget of the Epicenters was eroded due to Congressional rescissions in the appropriations process. In FY 2013 the Epicenter budget was reduced by over $245,000 due to the Administration sequester. The large increase in FY 2014 depicted in the graph below simply restored the Epicenter budget to its original level in FY 2012 prior to the sequester.



The current level of funding does not provide an adequate increase to cover the costs of inflation, pay increases, and program growth for the EpiCenters. Tribal EpiCenters conduct distinct public health functions and corresponding activities, ranging from population based public health surveillance, local, national and regional infrastructure and capacity building, to infectious disease outbreak response. In contrast to the fifty state operated public health departments, local public health departments, and federal departments, there are only 12 Tribal epidemiology centers to execute these functions for 565 Tribes, uncounted Tribal organizations, and 33 urban Indian health organizations.

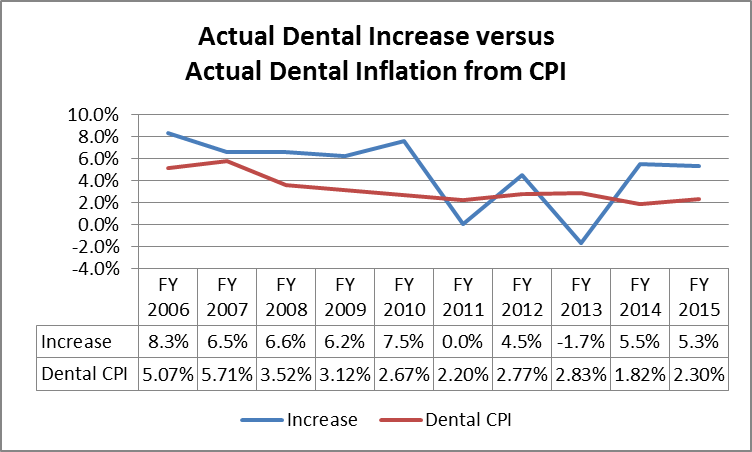
Unless these programs receive adequate funding increases, they will be challenged to retain the highly skilled professionals in their programs. Previous increases have allowed the NPAIHB *EpiCenter* to be funded at a level that allows it to provide professional, high quality work for Indian health programs. NPAIHB recommends that each Tribal EpiCenter receive at least $1 million annually to consistently provide services in the range that is needed. In order to fully handle data requests from Tribes NPAIHB could easily use six statisticians, full time, and three additional epidemiologists. Fully funding the TECs at a reasonable rate would allow important surveillance and epidemiology work to be completed on behalf of and alongside the tribes in each Area.

### **Dental Services (CJ-78)**



The President’s increase for Dental Health services is $7.5 million, a 4.3% increase over last year’s level. NPAIHB estimates it will take at least $8 million to maintain current services. Staffing costs of $1.7 million for new facilities will reduce the overall increase down to $5.7 million. The President’s request will be short $2.2 million. The President’s request includes $3.3 million to phase in staffing at new facilities.

While dental inflation is slowing down, The FY 2011 rescission and FY 2013 sequester have reduced the IHS dental services budget. The very good FY 2012 annual increase of 4.5%, for the dental program is still not adequate to meet the tremendous oral health needs of Indian Country. Many Portland Area Tribes increased their dental services in FY 2014, but none received increases for their increased staffing since their expansions were funded with non-IHS funds. While the ACA provides insurance coverage and Medicaid has restored dental services, many AI/AN still do not have access due to many private practice dentists not seeing Medicaid patients.



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 of $.2 million to maintain current services, Northwest Tribes further recommend an additional $20 million to address the significant dental health disparities in Tribal communities. The importance of oral health is that it impacts self-esteem for children, prevents problems in eating and speaking, and results in good nutritional options for adults. On the other hand, it is now widely recognized that poor dental health leads to increase morbidity and mortality.

### **Mental Health (CJ-84)**

The President requests $84.5 million to cover the mental health needs of IHS and tribal health programs. This is an increase of $3.3 million (4.1%) over last year’s budget. The President’s request is close to maintaining current services. However, when the requirement to staff new facilities is factored, the budget leaves only $2.9 million to maintain current services. NPAIHB estimates that it will take $3.4 million to fund mandatory cost increases for inflation and population growth. An additional $525,000 is needed to maintain the current levels of care for Indian Country.



Unfortunately, a modest 7.4% increase for mental health might come close to maintaining current services; however, it will fall short by over 44% when the effect of staffing is factored on the increase. Over 40% ($1.7 million) of the mental health increase will be needed to for staffing at three new facilities. The remaining $2.5 million represents less than half of what the NPAIHB recommends to fund current services. Approximately 30% of the total increase will go to the Oklahoma Area in order to fully staff the programs of the new facilities while the rest of the country’s mental health programs wait for funding increases.

IHS mental health providers report that mental health needs throughout Indian Country are a growing concern. A significant investment is needed to avoid youth suicides, domestic violence, and other manifestations of mental health disparities. Violence and trauma are also reported at alarming rates in tribal communities. The rate of violence for Indian youth aged 12-17 is 65% greater than the national average. The suicide rate among AI/AN adolescents and young adults ages 15 to 34 (31 per 100,000) is 2.5 times higher than the national average for that age group (12.2 per 100,000). These statistics are shocking and communicate the critical importance of mental health needs to be addressed in Indian Country. It is unfortunate in a year where state after state has cut back services, in a year where increases have been proposed in many areas of health care services, that mental health services will not receive an increase sufficient to maintain the current program.

Despite a dismal funding outlook, recent congressionally approved increases have allowed tribes to develop innovative behavioral health projects. The NPAIHB has developed an area-wide proposal based on a long planning process that developed a suicide prevention coalition that focuses on prevention and awareness of how tribes can work together to prevent suicides. In addition to the amount recommended to maintain current services, Portland Area Tribes recommend an additional $15 million to address mental health needs throughout Indian Country.

**Alcohol & Substance Abuse (CJ-89)**



The President’s budget requests a historic increase of 18.9% for Alcohol and Substance abuse programs. This is one of the largest increases in the history of the alcohol and substance abuse program. While the increase is sizeable, it will not allow for current services to be maintained unless Congress changes the distribution. Tribes have often felt that this line item gets short-changed, in part, because it is primarily a tribally-operated program with less than 23% of funds going to federally operated programs.

In FY 2016, NPAIHB estimates that it will take $4.7 million to fund current services. The President proposed increase of $36 million seems adequate to fund current services, however, $3 million is needed to fund staffing at new facilities and $25 million is needed for the Tribal Behavioral Health Initiative for Native Youth (TBHINY). That leaves only $3.4 million to maintain the current levels of care in the program. The President’s request will fall short by $4.7 million. NPAIHB recommends that Congress provide this funding before approving any program increases within this line item.

Given the President’s sizeable increase, there is still adequate funding to establish TBHINY initiative. IHS justifies the new program on the basis that Tribal leaders advocated for additional resources to address negative health, education, and economic disparities in Indian Country. In response, IHS and SAMHSA are collaborating on the TBHINY program. It is noted that Portland Area Tribes support the goals of this program but also recommend that current services be funded first before developing other new initiatives. Otherwise the resources used to create a new program will result in unmet needs in other areas of the alcohol and substance abuse program.

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

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

During past Administrations, budget requests were less than adequate to fund inflation and population growth. The significant increases in FY 2002 and 2008 are a result of Congressional action and not at the request of the President. In FY 2002, Congress provided $30 million in non-recurring funding to address alcohol and substance abuse issues in Indian Country. In FY 2008, Congress provided an additional $13.8 million to address methamphetamine prevention and treatment and youth suicide activities, and another $16.4 million in FY 2009. In FY 2010 President Obama and the Congress provided a $11 million increase for alcohol and substance abuse programs.

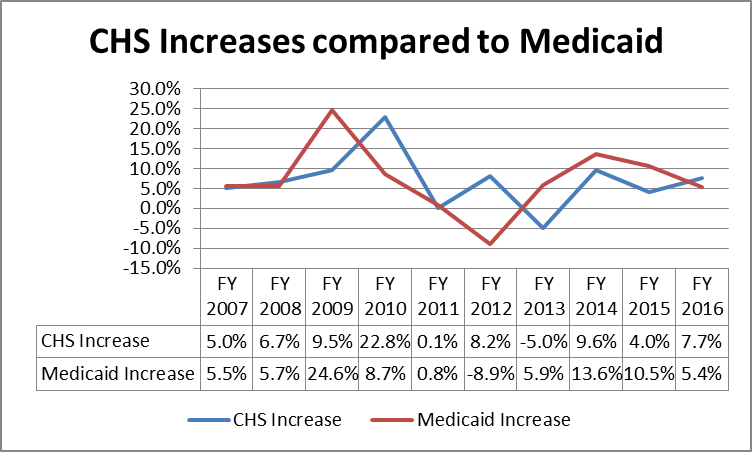
By relying on Tribes to develop these programs it is more likely that they will be relevant, effective, and long lasting. Northwest Tribes are developing programs that are likely to be effective since they are developed with local conditions in mind.

**Purchased and Referred Care (CJ-97)**



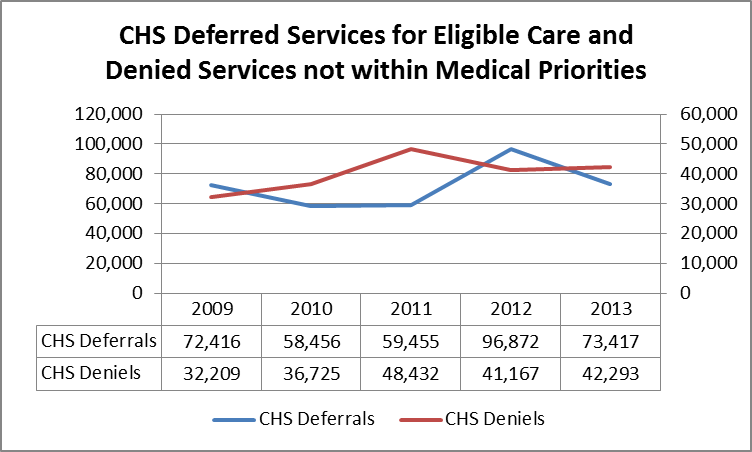
The President’s request for Purchased and Referred Care (PRC)[[4]](#footnote-5) over the past two years is, without doubt, of historic significance in its potential to make a positive impact on the health of AI/AN people. The FY 2016 budget marks the third year of a very positive increase for the PRC program. This follows very good increases in FY 2012 and FY 2014, however caution that the 2014 increase followed the sequester, and the PRC budget lost $42.3 million in its base budget. PRC is the most important budget line item for Northwest Tribes. NPAIHB estimates that it will take $62.3 million to maintain current services in FY 2016. The President’s requested increase of $70.3 million is sufficient to address inflation and population growth, however, not as proposed by the Administration.

The President requests only $35.3 million for inflation and a $25.5 million for program increases. NPAIHB recommends that the Congress reallocate the program expansion dollars to cover the full costs of PRC inflation and population growth. Otherwise, Tribes will have to absorb these costs as the Agency plays its shell game to reprogram base budget dollars to cover the program expansion.



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

Many tribal programs used to begin their new fiscal year on “Priority One” levels or in the winter instead of spring of the fiscal year. In FY 2001 and again in FY 2010, IHS received a significant CHS/PRC increase that was sufficient to fund population growth and medical inflation and for the first time since 1993 tribes saw the level of PRC denials begin to fall (graph below). In FY 2007, the PRC program began paying Medicare-like rates for services purchased from inpatient hospitals. There was a significant decrease in deferred services resulting from implementing this new statutory requirement. The benefit of Medicare-like rates has been short-lived as PRC deferred services (within medical priorities but no funding available) are on the rise once again. This means that many patients will go without care unless life or limb is at risk, and only then will they receive health care.



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. PRC purchases of specialty care are a very efficient method of providing health care services that contributes to rural economies. PRC is a much more efficient method of providing care than building, staffing, and maintaining new hospitals.

This year’s PRC request continues the recognition of the ability of a well-funded PRC program to provide efficient and effective health care services according to priorities established by Tribes themselves. The PRC appropriation is 22% of the total FY 2015 Health Services account. While small when compared to the 44% of the health services account that is in the Hospitals and Clinics line item, it is a critical component of every Indian health program, tribally-operated or by the IHS.

In the Northwest, the PRC line item represents over 25% of the total Portland Area Office allowance. The consequence of past years of under-funded inflationary and population growth costs is degraded services for tribes who depend upon Purchased and Referred Care to support inpatient, outpatient, and specialty care services. IHS Areas like the Portland Area (which has 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 PRC programs.

The Portland Area strongly supports distribution of PRC dollars with a formula that recognizes that some areas are strongly dependent on this funding source. Northwest tribes did not support the formula that was developed without consensus in 2001. Since most areas are not PRC dependent, a workgroup process runs the risk of allowing the ‘majority’ to redistribute funds from the areas who depend on a formula that accurately reflects this dependence to the ‘minority’ who are not PRC dependent. The Portland Area is not Hospitals and Clinics ‘dependent’ and does not expect to receive a share of that line item that is proportionate to the user population of the Portland Area. It is hoped that Tribes would likewise understand that their share of PRC funding is likely to be less than their user population percentage since they are not contract care dependent. The PRC program is also extremely vulnerable to inflation pressures. Between FY 1992 and FY 2015, the NPAIHB estimates that over **$749 million** has been lost to inflation in the PRC program nationally. This number was much higher but due to the significant budget increase for PRC in FY 2001 and 2010, some funding has been restored. Unfunded medical inflation alone exceeds $597 million, while unfunded population growth totals $152 million—representing over $749 million in lost purchasing power as depicted in the Table 12.

**The PRC Program and Medicaid**

Table 13 charts fourteen years of funding for the PRC program compared to Medicaid. The PRC program has been brought into closer alignment with Medicaid program increases due to the 22.8% increase received in FY 2010. Prior to this, the PRC program lagged considerably behind Medicaid program increases. The PRC program is very similar to the Medicaid program. It provides services to an underserved population that often require similar services. In fact, Congress intended the IHS and Tribal health programs to have access to Medicaid resources when in 1976, it authorized the Indian health system to be reimbursed for Medicaid related services. PRC should receive medical inflation adjustments at least equal to the Medicaid program (projected to be 10.5% in FY 2015) since both purchase care from private providers



Medicaid's enrollment growth rate is projected at 1.8% over the next five years and is less than the projected increase in the Indian population (2%); so population growth does not justify the higher rate of growth for Medicaid. Surely no one believes that the relatively small Indian health system is able to secure better rates from providers than the Medicare and Medicaid programs. In 2003 the Medicare Modernization Act authorized Medicare-like rates for PRC programs. After a long delay, IHS funded programs gained access to Medicare-like rates in July 2007. This has moderated increases in FY 2008 and FY 2009, but future increases will be somewhere between those approved my Medicare for Hospitals and those faced by all health care providers for specialty care provided outside the hospital setting.



**PRC Unmet Need**

The IHS maintains a deferred and denied services report that is updated each year. By applying an average PRC outpatient cost to the deferred and denied services figures an estimate can be calculated for unmet PRC need. In 2013 there were 73,417 deferred services, with an estimated cost of $322 million. Deferred services are those within the PRC medical priorities (usually Priority One or Two), but for which there was not enough funding to cover the costs of care. There were an additional 42,293 denied services, estimated to cost $186 million, determined not to be within the medical priorities (Priority One). Clearly the unmet PRC need is well over $400 million.

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

**Catastrophic Health Emergency Fund**

**(CJ-99)**

The PRC budget includes a Catastrophic Health Emergency Fund (CHEF) which is intended to protect the daily administration of local PRC programs from expenditures for catastrophic health cases. This fund is a lifesaver for Indian health programs. Its purpose is to fund catastrophic health care cases with large expenses.

The current FY 2016 threshold is $25,000 before a case is considered for funding. The Catastrophic Health Emergency Fund is an important source of funds for programs that experience high cost cases. These cases place a tremendous financial and ethical burden on a Service Unit or a tribe if the case occurs near the end of the year after the Fund has been exhausted.

Northwest Tribes have always urged the Congress to consider fully funding CHEF since these cases are all well-documented and critical to the financial stability of the small programs that exist in the Portland Area and many other IHS Areas. In FY 2012, the CHEF was increased to $51 million. Following the Administration budget sequester this amount fell to $48.9 million. This year’s President’s request for CHEF is $51.5 million, a slight increase over FY 2015. The availability of cost savings with Medicare-like rates, and the vigorous application of the alternative resources (like Medicaid), CHEF funding should be available throughout the year.

Portland Area Tribes strongly urge Congress to fully fund CHEF since the impact of not funding it impacts Indian Health programs more than any other line activity in the budget.



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

### **Public Health Nursing (CJ-104)**



The President’s request for Public Health Nurses (PHNs) is $3.9 million, an increase of 5.2% over last year’s amount. With $500,000 for staffing new facilities, the balance is 3.4 million remaining and is sufficient to fund current services. NPAIHB estimates that it will take $3.2 million to maintain the current program. NPAIHB commends the Administration for requesting adequate funding for this sub-account.

PHNs are at the center of many tribal community based health services including home visits. Disease surveillance, direct therapy; and group education comprise 40% of the PHNs time. The growing elderly population has required an increase in home visits by PHNs. The increasing threats of pandemic flu and bioterrorism have also brought additional planning 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.

Another significant amount of time of PHNs is dedicated to maternal and child health promotion. The important work being done to lower infant mortality and Sudden Unexplained Infant Death Syndrome (SUIDS) cannot be maintained if funding falls below the rate of inflation. SIDS/SUIDS awareness campaigns have resulted in a lower rate of infant deaths, yet it is still the greatest cause of infant mortality among Indians, with rates that are the highest of any group in the United States. Many tribes are now involved in focused maternal and infant health projects including an effort by Washington tribes with support from the NPAIHB and the American Indian Health Commission for Washington State.

**Health Education (CJ-109)**



The President’s request for Health Education is $1.1 million in FY 2016. NPAIHB estimates that it will take $762,000 to maintain current services. The President’s request approximates this need, even when staffing of $96,000 is factored. The President’s budget is adequate to fund inflation and population growth.

The Health Education program communicates the importance and on-going need for comprehensive clinical and community health education programs. It ensures education to patients, works with hospitals, clinics, and community education programs to integrate IHS patient education protocols and code systems. PHNs provided approximately 390,556 individual patient encounters for health activities and nursing services to AI/AN patients. This program continues to support national measures of maternal-child health, such as childhood immunizations, prenatal visits, postpartum visits, childhood obesity prevention through breastfeeding promotion and the Baby Friendly Hospital Initiative, as well as domestic violence screening through collaboration with related federal, state, local, and private programs.

### **Community Health Representatives (CJ-113)**

The President’s request for the Community Health Representatives (CHRs) program is $62.4 million, a 6.7% increase over last year’s level. NPAIHB estimates that it will take at least $2.5 million to maintain current services. The FY 2016 increase of $3.9 million is adequate to maintain the current levels of care provided by CHRs. There are no staffing or program increase requirements in the FY 2016 request. This allows the entire amount of $3.9 million to cover inflation and population growth. The Administration is commended for adequately funding the current service needs of the CHR program.



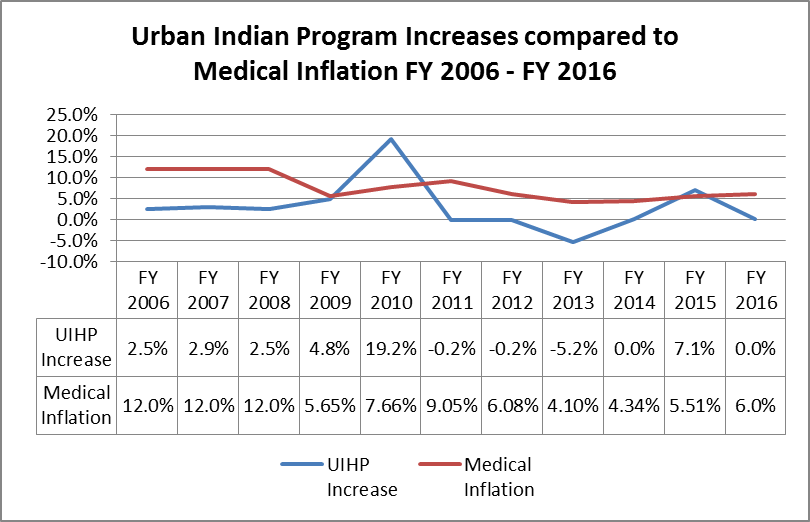
The CHR program maximizes health resources by providing basic medical knowledge about health promotion and disease prevention in the communities. Increased training for CHRs has made them effective partners on the health care team. CHRs are at the forefront of much of the preventive health that needs 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)**



It is unfortunate that the Urban Indian Health Program does not get the respect it deserves in the President’s FY 2016 budget. The Urban Indian health Programs (UIHP), with exception of FY 2010 and FY 2015, has never received an increase adequate to keep up with inflation let alone population growth over the past ten years. Past Administrations have recommended eliminating all of the funding for Urban Indian Health Programs and Portland Area Tribes have vehemently opposed ending this vital component of the Indian health care system.

The President proposes $43.6 million for the UIHP and does not include an increase of any type. NPAIHB estimates that it will take at least $2.9 million to maintain current services in the UIHP; thus, the President’s budget will fall short by this amount. It does not stand to reason why the Administration would bolster the urban health programs with a 7.1% increase in FY 2015 and not continue to maintain the program.



The urban health programs provide over 928,000 health services to an eligible population of over 650,000 urban Indian people living in thirty-four locations across the United States. Many Indian people were relocated in the 1950s and 60s from reservations to cities in an attempt to assimilate them via mainstream educational and training opportunities. The basis for the provision of health services to the urban Indian population is a direct result of the federal government’s early assimilation policies.

When Indian people return to reservations to receive health services they could actually cost the federal and state governments and tribal health programs more money to treat. Therefore, it is vital that Congress continue to support urban Indian health programs. NPAIHB recommends that the UIHPs be provided a budget increase adequate to maintain current services.

### **Indian Health Professions (CJ-128)**



Unfortunately the Administration did not support Indian health professions at the same level it did last year. While last year’s budget increase also included $10 million to pay back funding that was reprogrammed to cover unfunded Contract Support Costs, it also included a program increase of $9.8 million for the Indian Health Professions program.

This year’s request does not include an increase for the Indian Health Professions program. NPAIHB estimates that it will take at least $2.1 million to maintain the scholarship program in FY 2016. The President’s request will fall short by $2.1 million. Last year’s budget request recognized the importance of addressing the severe human resource needs of IHS-funded health programs by requesting a $9.8 million after the CSC restoration. Developing health professionals will be very important as this nation prepares itself for services expansion that will come with health reform. The Indian health system has high vacancies in many of its health professions and will need to begin to grow and train its own work force to keep pace with the rest of the nation. Otherwise, vacancy rates will become even higher.

The Indian Health professionals 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. NPAIHB commends the Administration for including a legislative proposal of tax relief for IHS Scholarship and Loan Repayment Program recipients. This is consistent with other health profession loan programs in the federal government.

Last year’s budget was a start in the right direction, but more needs to be done in FY 2016. In addition, many believe not enough is being done to address the tremendous need for nurses, not only in the United States, but particularly in the Indian health system.

**Tribal Management (CJ-134)**



The President requests $2.4 million for Tribal Management, which is the same amount that was funded last year. The President’s request does not provide an increase for the Tribal Management program. NPAIHB recommends that $103,000 be provided to maintain current services. NPAIHB believes the funding for this program could easily be doubled and the scope of its funded activities expanded. The President and Congress have not funded any increases for this line item in a number of years with the result that it has become a program with few resources. In fact, there is less funding in FY 2015 than four years earlier when the budget for this program was $2.6 million.

The Tribal Management 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 that are carrying out Self-Determination programs and working to develop capacity of Indian managed programs.

### **Direct Operations (CJ-138)**



The Direct Operations line item funds the cost of management at IHS headquarters and the twelve Area Offices. This year the President’s request proposes a slight increase in Direct Operations funding by $273,000. NPAIHB estimates that $2.9 million will be needed to maintain current services. Thus, the President’s request falls short by $2.6 million.

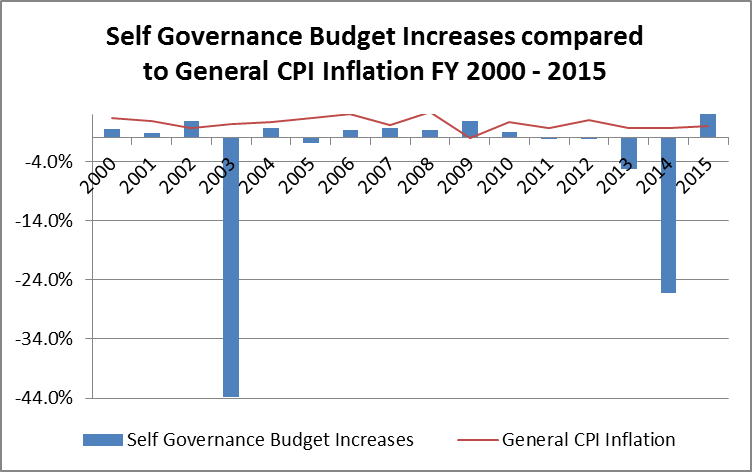
The Direct Operations budget supports overall management of the IHS to ensure effective support for the IHS mission. This includes oversight of financial, human, facilities, information and support resources and systems. Recent projections by IHS indicate that a significant portion of their workforce will be eligible for retirement in the next few years. This budget line item will be important to finance succession planning activities and workforce development in order to meet the Agency’s future needs.

The IHS Congressional Justification also explains the Direct Operations budget is critical for the agency to continue to implement the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA). The past two years have seen IHS and Tribes focus on helping IHS beneficiaries during the Health Insurance Marketplace open enrollment periods and helping Tribal members who can enroll monthly throughout the entire year as a special benefit of the ACA. IHS also explains that the Direct Operation budget is critical to improving the human resources management system. These are such important functions that the IHS should receive more funding to conduct these activities.

**Self-Governance (CJ 142)**



The President’s request for the Self-Governance item is $5.7 million and is less than a one-half percent increase; or $8,000 more than last year’s budget. NPAIHB estimates that it will take at least an additional $242,000 to maintain current services in FY 2016. This will result in a $234,000 shortfall in unfunded mandatory costs. While this may not seem like much, six years ago, Congress reduced the Self Governance line item by $4.7 million, a loss of over 43% from the previous year. Tribes have continually recommended that this funding be restored to the FY 2002 level with appropriate adjustments to restore full funding. In FY 2002, the Self-Governance office budget was $9.8 million. Had the FY 2002 amount been maintained and received general CPI inflation, the budget for the Self-Governance office should be approximately $13 million in FY 2015.



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 $3 billion of the total $4.6 billion 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-146)**

As mentioned on page 15 of this document, the Indian Self-Determination and Education Assistance Act of 1975 authorized Tribes to enter into contracts or self-governance compacts to manage federal programs previously administered by the IHS. The well-documented achievements of the Indian self-determination policies have consistently improved service delivery, increased service levels, and strengthened Tribal governments, institutions, and services for Indian people. Every Administration since 1975 has embraced this policy and Congress has repeatedly affirmed it through extensive amendments to strengthen the Self-Determination Act in 1988 and 1994.



This year’s FY 2016 request of a $55 million increase for Contract Support Costs (CSC) continues a new chapter for Indian Self-Determination. In past years the Administration did not fully fund CSC payments to Tribes nor did Congress provide adequate funding because seemingly the Administration never requested it. Otherwise the full amounts to pay CSC would have been included in the President’s requests.

The FY 2016 President’s request for CSC is $718 million, an increase of $55 million over the FY 2015 level. Estimates for Contract Support Costs (CSC) use the IHS yearly CSC shortfall report amounts and forecasting methods that update shortfall report calculations based on actual figures provided by IHS for FY 2015. There are other CSC changes at work as well now that the Administration has agreed to fully pay CSC payments on Indian Self-Determination contracts and compacts. Under this full funding environment there will Tribes that want to expand their self-determination contracting opportunities, as well as new Tribes that will want to enter into new self-determination agreements. There are also existing self-determination contractors that are in the process of recalculating and renegotiating their direct and indirect contracts support costs.

Previously, since the Administration did not pay full CSC payments, there was little incentive to recalculate these amounts. Under a full funding environment there is now an incentive to do this. In FY 2015, IHS estimated that it would need to program $10 million to fund these ongoing costs. Then in late August and September 2015, the IHS announced it would need to reprogram more than the $10 million, and began consultations with Tribes to reprogram $48 million. The final amount ended up being approximately $25 million.

In order to avoid this miscalculation and to avoid the dangerous policy discussions that Contract Support Costs erodes the available funding for program increases, it would be best to estimate the amount needed for new and expanded Self-determination contracts and build in a contingency in case the IHS estimate is short. IHS estimates the need to be $55 million in FY 2016, and NPAIHB estimates an additional $11.9 million will be needed based on simple inflationary growth.

Finally, the President’s budget request includes a proposal that Congress establish a mandatory appropriation for contract support costs. The proposal requests a three-year mandatory appropriation at stated dollar amounts for IHS with up to 2% of the sums so designated to be available for IHS’ administrative activities. The President's Budget also proposes that this measure go into effect beginning in FY 2017. NPAIHB and Portland Area Tribes are very supportive of the Administration’s proposal with exception of the 2% set-aside for IHS’ administrative activities. We believe there are alternatives for the IHS to cover these administrative costs. We encourage the appropriations Committees to continue to work with the Administration and Tribes to refine this proposal.

Between FY 2002 through 2008, tribal contracting and compacting programs were seriously undermined by the failure to pass adequate funding increases to support existing contractors, as well as preclude those who wanted to participate in self-determination. New contractors found themselves unfairly set up to fail when the IHS was unable to provide the level of contact support that was justified by the amount of activity taken over by tribes. New contractors were coerced into signing their rights of full CSC recovery away in order for new contracts to be executed by the IHS.

### **Health Facilities Accounts (CJ-164)**

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### **Maintenance and Improvement (CJ-164)**

### The M&I program is the primary source of funding to maintain, repair, and improve existing IHS and Tribal healthcare facilities. This infrastructure is central to the IHS mission of being able to deliver and support healthcare services to AI/AN people. The M&I budget has not received adequate program and inflation increases to effectively maintain the physical condition of IHS-owned and many tribally-owned healthcare facilities. Compound this with the fact that there is a backlog of $465 million in essential maintenance and repairs (BEMAR), that the system continues to add more supportable space to its facilities M&I inventory, and that the average age of IHS health facilities is 34 years. One can immediately see that we are at a dangerous point of not being able to adequately maintain our health facilities.

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The President’s request for M&I is $89 million a worthy increase of $35 million (a 66% increase) over last year’s enacted budget. NPAIHB estimates that it will take at least $2.2 million to fund current services in the M&I program, but we also acknowledge that there is a $465 million backlog in BEMAR projects. In addition to the $2.2 million to maintain current services, NPAIHB recommends an additional $10 for M&I to address BEMAR projects. Recognizing the serious need for M&I funds in Indian Country, NPAIHB supports the President’s request and commends the Administration for requesting a $35 million increase for the M&I program.

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### **Sanitation (CJ-168)**



The FY 2016 budget requests $115.1 million for the Sanitation facilities program, a sizeable increase of $35.7 million and a 45% increase over last year. Due to the American Recovery and Reinvestment Act (ARRA) providing $68 million for Sanitation Facilities in FY 2009, past year’s budget requests have not included adequate funding for this program. This year’s increase of $35.7 million is a lofty increase that will fund sanitation projects throughout Indian Country.

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

### **Health Facilities Construction (CJ-172)**

Northwest tribes continue to support a moratorium on facilities construction until an equitable funding methodology can be implemented by the IHS. This position has been recommended for the past eight years so that savings from facilities construction can be redirected to the health services accounts. As noted throughout this analysis, facilities, especially hospitals are expensive to build and their staffing packages are more costly still. The Administration and Congress funded $88.6 million in FY 2005 while allowing Purchased and Referred Care to erode with funding 75% below the level needed to maintain services.

The current priority list was developed in 1991 and Tribes are locked out of accessing badly needed construction dollars unless their facility is 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.

The FY 2016 Health Facilities Construction budget requests $185 million for construction projects. This is an increase of $100 million in FY 2016. The consequence of such a large facilities construction request will be monumental in two to three years when the staffing packages follow the construction process. In FY 2019 and beyond, staffing for new facilities construction will likely absorb at least 50-60% of the overall IHS budget increase—if not more.

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### **Alternative Methods of Acquiring Health Facilities**

If new facilities construction dollars are included in the FY 2016 budget, some of these funds should go to alternative funding mechanisms. Northwest Tribes have long encouraged alternative methods to acquire 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 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, provide health care services to underserved non-Indian individuals in the community. An investment of $20 million would support four to ten projects a year. This program has an excellent record of achievement that should be rewarded with increased appropriations.

Northwest Tribes recommend that the IHS and

Congress includes appropriation language in the FY 2016 appropriation bill to allow staffing and equipment funding for the small ambulatory construction authorities (P.L. 102-573). This is necessary to realign the facilities construction program to provide consistent opportunities to address health facility construction needs throughout Indian Country. This recommendation is supported by the IHS National Budget Formulation Workgroup.

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

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### **Facilities and Environmental Health and Engineering Support (CJ-175)**



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 request of $226.9 million provides a $7.3 million increase over the FY 2015 level (a 3.3% increase). NPAIHB estimates that it will take at least $3.6 million to maintain current services in this program. Once $1.6 million is factored for staffing at new facilities, the President’s proposed increase is $5.6 million. This will leave a $3.6 needed to fund current services. NPAIHB recommends an increase of $3.6 million be provided to fund increased inflation costs and pay act increases.

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### **Equipment (CJ-181)**



The Administration’s request of $23.6 million includes an increase of $1 million (4.6% increase) over last year’s amount. NPAIHB estimates that it will take at least $953,000 to maintain current services in the Equipment program. The President’s budget is adequate to maintain current services in FY 2016.

IHS estimates an inventory of $500 million in equipment with an average estimated life expectancy of six years. New facilities, including facilities built with non-IHS funds could benefit from additional funding. The equipment line item funds normal equipment replacement due to age and maintenance. A reasonable estimate is that Indian health programs will need an additional $18 million annually to cover needs for biomedical, facility and tele-communications equipment

## Conclusion: The Purpose of this Report

This document and the Portland Area Tribes participation in discussion about the budget at the Affiliated Tribes of Northwest Indians, and meetings of the Northwest Portland Area Indian Health Board represents an effort by the NPAIHB to provide Tribes with an analysis of the Administration’s proposed IHS budget and is intended to identify issues that will impact or benefit all Northwest Tribes. While it is recognized that individual tribes will have their own particular issues and projects, it is hoped that tribes will also embrace the main budget and legislative issues identified in this document. Issues with broad support are most likely to achieve congressional action.

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

## *Evaluation Based on Budget Principles: Table 28*

Table 28 grades the President’s FY 2016 IHS budget against criteria (or principles) that the NPAIHB has developed and applied to budget analyses over the past 22 years. It is the Northwest Tribes’ attempt to make an inherently subjective process more objective. The NPAIHB stands ready to engage in an honest discussion over each aspect of this evaluation to clarify its position in the consultation over funding Indian health programs.

As noted above, the President’s proposed FY 2016 increase for the IHS is greater than nearly every other discretionary program. Nonetheless, the obligation to fund health services is not considered discretionary by Northwest tribes. This obligation is a long-standing legal and political responsibility embodied in the federal trust responsibility that that United States has with Indian Tribes.

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|  | Table 28: GRADING THE PRESIDENT’SPROPOSED FY 2011 IHS BUDGET | **President**  **Feb. 2, 2016** | **Senate** | **House** |
|  | *Criteria or Budget Principle* | *FY 2016*  *Grade* |  |  |
| 1 | Budget Information Shared with Tribes in Consultation Sessions Prior to release date of the first Monday in February. | D |  |  |
| 2 | Appropriate adjustment will be made to fully cover expected inflation. | C |  |  |
| 3 | Appropriate increases will be included to address population growth. | C |  |  |
| 4 | Appropriate adjustments will be made to fully fund tribal and federal employee compensation. | C |  |  |
| 5 | The Contract Health Service Budget will be increased to fully fund the need for deferred services. | D |  |  |
| 6 | Collection estimates are not represented as fulfilling the federal responsibility to fully fund the IHS budget. | D |  |  |
| 7 | Increases will be provided to address the goals of the Indian Health Care Improvement Act. | D |  |  |
| 8 | Full funding to support new facility staffing packages so they do not compete with resources to support current services or program expansion. | 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. | A |  |  |
| 11 | Adequately support maintenance of IHS and tribal health facilities. | B |  |  |
| 12 | The public announcements relating to the budget will honestly depict what is in the budget. | C |  |  |
| 13 | Provides adequate funding to reduce health disparities. | D |  |  |
| 14 | Honor the federal trust responsibility to provide health care services to American Indians and Alaska Natives. | D |  |  |
|  | **Overall Grade** | **C-** |  |  |

1. Comprehensive budget analysis reports were not completed between FY 2012 to FY 2015 due to timing in the release of the President’s budget to Congress. Rather, Policy Briefs provided a summary analysis of the President’s request in these years. Available at: [www.npaihb.org/policy/policybrief/](http://www.npaihb.org/policy/policybrief/) [↑](#footnote-ref-2)
2. National Healthcare Disparities Report 2013, Agency for Healthcare Research and Quality, available: [http://www.ahrq.gov/research/findings/nhqrdr/nhqr13/index.html#](http://www.ahrq.gov/research/findings/nhqrdr/nhqr13/index.html) [↑](#footnote-ref-3)
3. The first Monday in February is when the President is required to provide his budget to Congress. [↑](#footnote-ref-4)
4. Formally called the Contract Health Service (CHS) program; or ‘Contract Care’. [↑](#footnote-ref-5)