



Northwest Portland Area
Indian Health Board

The FY 2017 Indian Health Service Budget: Analysis and Recommendations

26th Annual Report
March 31, 2017

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Grading the President’s Proposed FY 2017 IHS Budget (Back Cover)

Northwest Portland Area Indian Health Board

Introduction

This 26th Annual Northwest Portland Area Indian Health Board (NPAIHB) analysis of the President's FY 2017 Indian Health Service (IHS) budget continues a tradition of close scrutiny of the IHS budget that began in 1989. The increase of \$377 million (7.9%) makes this the second best budget request of the Obama Administration. Overall it is a good budget, but for the most important line item, Purchased and Referred Care (PRC), it is insufficient to restore the \$46 million estimated need for a maintenance increase that was sacrificed (no increase) in the FY 2016 enacted budget and the additional \$62.3 million need in FY 2017 to fund inflation and population growth.

In addition, after paying for staffing costs and some new initiatives (program increases), a few important line items do not receive sufficient funding to maintain their current purchasing power. However, one has to say that the FY 2017 request is a budget that deserves to be enacted without any reductions in the requested funding levels. The most important change desired by Northwest Tribes is the addition to the President's request of sufficient funds to PRC to restore the nearly \$46 million lost in FY 2016.

The federal trust responsibility for health care and the government-to-government relationship between Tribes and the federal government, by definition, requires a partnership in the development of the budget. The President's FY 2017 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. There is no denying that budget shortfalls resulted in greater health care disparities between Indian people and the general population over the past fifteen years. This gap was addressed in the budget increases of this Administration, however, additional funding is needed for the health of American Indians and Alaska Natives (AI/AN).

NPAIHB estimates it will take a \$296.7 million increase in the FY 2017 budget to fund pay increases, inflation, and population growth in order to maintain current services. In addition, the FY 2016 increase to PRC of \$46 million that was eliminated in the enacted budget needs to be restored. Finally, the NPAIHB recommends an additional \$140 million in program increases. The total NPAIHB recommended increase of \$482.7 million is a 10% increase over the FY 2016 enacted budget. While the President's budget provides a \$377 million increase, it is not adequate to cover inflation and population growth. In addition, the distribution of the increase within the IHS accounts will not maintain current services as presented. PRC, in particular, has lost purchasing power over the last two years and this year's funding increase following flat funding in 2016 is inadequate despite the reasonable overall increase in the 2017 budget request.

The total budget authority requested for FY 2017 is \$5.2 billion, a 7.9% increase over FY 2016 compared to the 3.4% increase in the IHS enacted budget for 2016.

This NPAIHB FY 2017 budget analysis is available at (www.npaihb.org).

Budget Formulation: The IHS Budget Formulation Workgroup

For the past seventeen 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 Indian programs. This group, commonly referred to as the IHS Budget Formulation Workgroup, 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 over \$10 billion. This corroborates the long-held view that less than 50% of true need is funded by the IHS budget. If funded at \$10 billion, an additional phased-in facilities cost of \$9-10 billion would be needed to house the expanded health care services. This \$20 billion is sometimes stated as the Tribal needs-based budget. To restate: about \$10 billion is needed for the recurring budget and about the same amount for added facilities to support a fully funded IHS.

Northwest Tribes ask that the Office of Management and Budget (OMB) and HHS/IHS commit to using the same budget estimates for the IHS budget that they use for other financial and economic estimates. Medical inflation estimates are now a standard factor in budgetmaking for the agency and the use of accurate estimates is expected and appreciated by Tribes.

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. It 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 nationally 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 have traditionally considered treaty and trust responsibilities on a non-partisan basis and have worked to maintain the purchasing power of health care resources, address unmet needs with targeted increases, and facilitate service delivery improvements that achieve health objectives while maintaining fiscal discipline.

Acknowledgements

This analysis is based on over twenty-five years of contributions from delegates and staff of the NPAIHB including current and former Chairs : Andy Joseph Jr, Chair, Linda Holt, Pearl Capoeman-Baller, Julia Davis, and Executive Directors: Doni Wilder (1990-1998) Cheryle Kennedy (1998-2000); Ed Fox, (2000-2005); and current Director, Joe Finkbonner (2006-current); and Jim Roberts (2002-2016) and Laura Bird, Policy Analysts.

Sources:

- The House analysis is available at <http://budget.house.gov/fy2017/>
- The Budget for FY 2017 <http://www.whitehouse.gov/omb/budget/> is the President's budget request of February 2017.
- Congressional Budget Office (CBO <https://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 2017, HHS FY 2017 Budget In Brief, February 2, 2017 available at <http://www.hhs.gov/about/budget/index.html>.
- The Indian Health Service ,Congressional Justification of Estimates for Appropriations Committees Fiscal Year 2017 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/topics/federal-budget> .

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The FY 2017 Northwest Portland Area Indian Health Board Budget Analysis and Recommendations

The President's FY 2017 budget request provides \$5.2 billion for the Indian Health Service (IHS), and is a \$377 million increase, 7.9%, in funding above the FY 2016 enacted level. The hope is that the Congress will agree that this respectable budget is justified and deserves passage-even in a Presidential election year. If approved, FY 2017 would rank with the FY 2010 budget as one of the best of the Obama Administration's eight years in office. Since FY 2008 the IHS budget has increased by 54% thanks to bipartisan support and Presidential leadership.¹

NPAIHB estimates that it will take at least \$296.7 million to maintain current services (inflation and population growth) for IHS health programs in FY 2017 and provide funding for staffing and new initiatives. We further recommend an additional \$140 million to fund program increases to address growing health needs and diminished services due to the lack of sufficient funding increases in last year's budget.

The Final Enacted FY 2016 IHS Budget

The FY 2016 budget was a disappointment for Portland Area Tribes. While the 3.6% overall increase might be considered reasonable, the distribution of increases seemed haphazard and at odds with the recommendations of Tribes. The PRC increase proposed by the President was eliminated by the final budget agreement. Since the current year's budget remains the same as the \$914 million received in 2015 the predictable effect of medical inflation and the lack of increase for the 1.8% increase in the number of patients will be more denials for medically indicated health care services. The PRC's \$914 million FY 2016 budget will remain the same at \$914 million as it was in FY 2015. It seems irrational to provide no increase in PRC, while Congress decides to approve increases of \$20 million for Equipment, \$20 million for Maintenance and Improvement (M and I), and \$20 million for New Facilities Construction. A zero-dollar increase for PRC while approving \$20 million for each of these line items seems fickle and out of touch with with the Tribal and IHS Budget Formulation Workgroup recommendations. One could cynically say that, yes, Tribes requested these increases for Equipment and M and I, which is true, but it is not true that those increases are a higher priority than the PRC budget that the budget agreement choose to freeze at the 2015 level of funding.

No area of the IHS is hurt more by the unconscionable neglect of the PRC FY 2016 budget than the Portland Area. A \$108 million increase, 12% over FY 2016, is justified to restore the \$46 million in lost purchasing power of last year's neglect and fully fund medical inflation and population growth (\$62.3 million) in FY 2017. \$1.02 billion is the amount for PRC that should be approved by the Congress to correct the egregious unfairness in the 2016 enacted budget and maintain current services for tribal and federal purchase and referred care programs.

¹ Department of Health and Human Services Fiscal Year 2017, HHS FY 2017 Budget In Brief, February 2, 2017 available at <http://www.hhs.gov/about/budget/index.html>.

Budget Control Act 2011 & 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.

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.

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. A 2013 report indicates that health disparities have gotten significantly worse or have remained unchanged for AI/AN people.² The nature of the federal trust responsibility makes an exemption from sequestrations a moral obligation that no budget agreement can abrogate.

FY 2017 IHS Budget

The FY 2016 budget provided \$4.8 billion for the Indian Health Service (IHS), which was a \$165 million increase over the FY 2015 enacted level. Simply looking at the overall increase does not take into account the net effects of including staffing for new facilities or other Congressional earmarks like new Tribes funding. The FY 2017 increase of \$377 million is an honest budget that maintains the purchasing power of health programs while targeting added funding for several initiatives that address critical needs identified by Tribal leaders in the budget formulation process; notably behavioral health in the Mental Health (35.4 % increase) and Alcohol and Substance Abuse (13.6% increase) line items. Tribes understand that a budget request is not the same as an approved budget, but the hope is there that needed funding to address pressing health issues is a possibility even in the politicized environment of 2016. The needs are real and the priorities of this budget are well chosen to address those needs.

² National Healthcare Disparities Report 2013, Agency for Healthcare Research and Quality, available: <http://www.ahrq.gov/research/findings/nhqrdr/nhqr13/index.html#>

Table No. 1: Indian Health Service Budget - Three Years Comparison of FY 2015, 2016, and President's FY 2017 (Dollars in Thousands)							
Sub Sub Activity	Final Budget FY 2015	Final Budget FY 2016	Change Over FY 2015	Percent Change	President's FY 2017 Budget	Change Over FY 2016	Percent Change
SERVICES:							
Hospitals & Health Clinics	\$ 1,836,789	\$ 1,857,225	\$ 20,436	1.1%	\$ 1,979,998	\$ 122,773	6.6%
Dental Services	\$ 173,982	\$ 178,286	\$ 4,304	2.5%	\$ 186,829	\$ 8,543	4.8%
Mental Health	\$ 81,145	\$ 82,100	\$ 955	1.2%	\$ 111,143	\$ 29,043	35.4%
Alcohol & Substance Abuse	\$ 190,981	\$ 205,305	\$ 14,324	7.5%	\$ 233,286	\$ 27,981	13.6%
Purchase and Referred Care	\$ 914,139	\$ 914,139	\$ -	0.0%	\$ 962,331	\$ 48,192	5.3%
<i>Total, Clinical Services</i>	\$ 3,197,036	\$ 3,237,055	\$ 40,019	1.3%	\$ 3,473,587	\$ 236,532	7.3%
PREVENTIVE HEALTH:	\$ -						
Public Health Nursing	\$ 75,640	\$ 76,623	\$ 983	1.3%	\$ 82,040	\$ 5,417	7.1%
Health Education	\$ 18,026	\$ 18,255	\$ 229	1.3%	\$ 19,545	\$ 1,290	7.1%
Comm. Health Reps	\$ 58,469	\$ 58,906	\$ 437	0.7%	\$ 62,428	\$ 3,522	6.0%
Immunization AK	\$ 1,826	\$ 1,950	\$ 124	6.8%	\$ 2,062	\$ 112	5.7%
<i>Total, Preventative Health</i>	\$ 153,961	\$ 155,734	\$ 1,773	1.2%	\$ 166,075	\$ 10,341	6.6%
OTHER SERVICES:	\$ -						
Urban Health	\$ 43,604	\$ 44,741	\$ 1,137	2.6%	\$ 48,157	\$ 3,416	7.6%
Indian Health Professions	\$ 48,342	\$ 48,342	\$ -	0.0%	\$ 49,345	\$ 1,003	2.1%
Tribal Management	\$ 2,442	\$ 2,442	\$ -	0.0%	\$ 2,488	\$ 46	1.9%
Direct Operation	\$ 68,065	\$ 72,338	\$ 4,273	6.3%	\$ 69,620	\$ (2,718)	-3.8%
Self Governance	\$ 5,727	\$ 5,735	\$ 8	0.1%	\$ 5,837	\$ 102	1.8%
Total Other Services	\$ 168,180	\$ 173,598	\$ 5,418	3.2%	\$ 175,447	\$ 1,849	1.1%
Services Total without CSC	\$ 3,519,177	\$ 3,566,387	\$ 47,210	1.3%	\$ 3,815,109	\$ 248,722	7.0%
Contract Support Costs	\$ 662,970	\$ 717,970	\$ 55,000	8.3%	\$ 800,000	\$ 82,030	11.4%
TOTAL, SERVICES including CSC	\$ 4,182,147	\$ 4,284,357	\$ 102,210	2.4%	\$ 4,615,109	\$ 330,752	7.7%
FACILITIES:	\$ -						
Maintenance & Improvement	\$ 53,614	\$ 73,614	\$ 20,000	37.3%	\$ 76,981	\$ 3,367	4.6%
Sanitation Facilities Construction	\$ 79,423	\$ 99,423	\$ 20,000	25.2%	\$ 103,036	\$ 3,613	3.6%
Hlth Care Facilities Construction	\$ 85,048	\$ 105,048	\$ 20,000	23.5%	\$ 132,377	\$ 27,329	26.0%
Facil. & Envir. Hlth Supp	\$ 219,612	\$ 222,610	\$ 2,998	1.4%	\$ 233,858	\$ 11,248	5.1%
Equipment	\$ 22,537	\$ 22,537	\$ -	0.0%	\$ 23,654	\$ 1,117	5.0%
<i>Total, Facilities</i>	\$ 460,234	\$ 523,232	\$ 62,998	13.7%	\$ 569,906	\$ 46,674	8.9%
TOTAL, IHS	\$ 4,642,381	\$ 4,807,589	\$ 165,208	3.6%	\$ 5,185,015	\$ 377,426	7.9%

Total Budget Authority

The Health Services Account, Contract Support Costs (CSC), and Facilities are now the three components of the Total Budget Authority for the Indian Health Services Budget.

Table 2 depicts the health services budget without CSC for the years FY 2015, FY 2016, and FY 2017. CSC is now mandatory funding and is no longer be included in the health services account.

Table 2 Budget Authority			
	FY 2015	FY2016	FY 2017
Health Services	\$3,519,177	\$3,566,387	\$3,815,109
Facilities	\$460,234	\$523,232	\$569,906
Contract Support Costs	\$662,970	\$717,970	\$800,000
Total, Program Increases:	\$4,642,381	\$4,807,589	\$5,185,015

Contract Support Costs (CSC)

CSC is a separate appropriation account enacted in FY 2016 as an indefinite discretionary budget authority. The proposed increase of \$82,030,000 above FY 2016 is an estimate of additional funds needed to ensure the full CSC need is funded for each Tribe. The estimate will be adjusted to reflect the amount necessary to fund the full CSC need when updated information is available. In FY 2018 and beyond, the Administration proposes to reclassify CSC as a mandatory, three-year appropriation with sufficient increases year over year to fully fund the estimated need for the program, for both the IHS and the Bureau of Indian Affairs which is consistent with Tribal consultation (CJ-4).

Facilities

\$570 million for all Facilities line items. This includes a large \$27 million increase for new facilities construction (26%).

Mandatory spending for Diabetes and Behavioral Health

Table 3 depicts mandatory spending for the ongoing Special Diabetes Program for Indians and the new Crisis Response and Behavioral Health initiatives.

Table 3 Mandatory Spending for Diabetes (SDPI) and Behavioral Health			
	FY 2015	FY2016	FY 2017
SDPI	\$150,000	\$150,000	\$150,000
Crisis Response	0	0	\$15,000
Behavioral Health Professions	0	0	\$10,000
Total	\$150,000	\$150,000	\$175,000

Preserving the Basic Health Program

The President's FY 2017 IHS budget provides adequate funding to preserve existing IHS programs. 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 with at least a 'maintenance level' budget should be the first budget principle, not an afterthought.

Tribes have maintained a trusting relationship, on a non-partisan basis, between Tribes who are concerned about improving the health status of their citizens, the Administration that is charged with that responsibility, and the Congress who considers the annual appropriations legislation. 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.

The Office of Management and Budget

The Office of Management and Budget (OMB), under President 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. OMB continues to refuse to meet directly with Tribal leaders. The OMB could open the process by sharing budget information in November before final distributions are made and prior to the budget submission, typically, the first Monday in February³. 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. 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 uphold 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 2018 budget suggests that treaties will be honored, promises will be kept, and the IHS will have a budget adequate to provide needed health services.

³ The first Monday in February is when the President is required to provide his budget to Congress.

Current Services Budget: Maintaining the Current Health Program and the President's Proposed FY 2017 IHS Budget

Current services estimates calculate mandatory cost increases necessary to maintain the current level of services. These “*mandatories*” are spending increases that are due to medical and general inflation, pay costs, staff for recently constructed facilities, and population growth. The 10% increases received in FY 2001 and 2010 are the only budgets that allowed Tribes to reduce PRC denials of services. The elimination of any increase in last year's enacted budget (FY 2016) will predictably increase the number of denials of health services. The NPAIHB estimates the current services need in FY 2017 is \$296.7 million. This is the amount necessary to fund inflation, population growth, and fully fund CSC. Anything less will increase 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 and the service is required to include the cost in its budget. Pay cost increases are costs that are precisely computed for federal employees. The IHS has also added reasonable Tribal pay estimates and reports these in the Congressional Justification.

The NPAIHB estimates that in FY 2017 an increase of at least \$296.7 million (an increase of 6.2%) will be needed to maintain current services. In addition, Portland Area Tribes recommend an additional **\$140** million for program enhancements to address the significant Indian health disparities and priority needs. Finally, \$46 million is needed to restore the PRC 2016 increase that was needed to maintain the 2015 level of services. This brings the total NPAIHB recommended amount to **\$482.7 million** or an increase of **10%** over last year's level.

FY 2017 Justification of Estimates

In the NPAIHB proposed budget (depicted in Table 4), 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. Finally, a 1.8% rate of growth (same as the IHS rate) is used to estimate population growth.

Contract Support Costs (CSC) is a vital component in FY 2017

Estimates for 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 2017. 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 be 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 less incentive to recalculate these amounts.

The President's budget request includes an \$800 million request, an \$82 million increase, and a proposal that Congress establish a mandatory appropriation for CSC. The proposal requests a three-year mandatory appropriation at stated dollar amounts for IHS. The President's budget also proposes that this measure go into effect beginning in FY 2018.

Table 4: Indian Health Service Budget
Comparing FY 2017 President's Request to Actual Current Services Needs
(Dollars in Thousands)

	A	B	C	D	E	F	G
					(D x A)	(1.8% x A)	(E + G)
					FY 2017 CURRENT SERVICE NEEDS		
Sub Sub Activity	FY 2016 Enacted Plan	President's FY 2017 Request	Change over FY 2016	Pct. of Change	CPI Medical Care	Increase needed for Inflation	Amount to Maintain in FY 2017
SERVICES:						1.8%	
Hospitals & Health Clinics	\$ 1,857,225	\$ 1,979,998	\$ 122,773	6.6%	3.36% ^a	\$ 62,403	\$ 33,430
Dental Services	\$ 178,286	\$ 186,829	\$ 8,543	4.8%	3.36% ^a	\$ 5,990	\$ 3,209
Mental Health	\$ 82,100	\$ 111,143	\$ 29,043	35.4%	3.36% ^a	\$ 2,759	\$ 1,478
Alcohol & Substance Abuse	\$ 205,305	\$ 233,286	\$ 27,981	13.6%	3.36% ^a	\$ 6,898	\$ 3,695
Purchased and Referred Care	\$ 914,139	\$ 962,331	\$ 48,192	5.3%	5.02% ^c	\$ 45,890	\$ 16,455
Total, Clinical Services	\$ 3,237,055	\$ 3,473,587	\$ 236,532	7.3%			
PREVENTIVE HEALTH:						4.7%	
Public Health Nursing	\$ 76,623	\$ 82,040	\$ 5,417	7.1%	3.36% ^a	\$ 2,575	\$ 1,379
Health Education	\$ 18,255	\$ 19,545	\$ 1,290	7.1%	3.36% ^a	\$ 613	\$ 329
Comm. Health Reps	\$ 58,906	\$ 62,428	\$ 3,522	6.0%	3.36% ^a	\$ 1,979	\$ 1,060
Immunization AK	\$ 1,950	\$ 2,062	\$ 112	5.7%	3.36% ^a	\$ 66	\$ 35
Total, Preventative Health	\$ 155,734	\$ 166,075	\$ 10,341	6.6%			
OTHER SERVICES:						4%	
Urban Health	\$ 44,741	\$ 48,157	\$ 3,416	7.6%	5.02% ^c	\$ 2,246	\$ 805
Indian Health Professions	\$ 48,342	\$ 49,345	\$ 1,003	2.1%	1.00% ^b	\$ 483	\$ 870
Tribal Management	\$ 2,442	\$ 2,488	\$ 46	1.9%	1.00% ^b	\$ 24	\$ 44
Direct Operation	\$ 72,338	\$ 69,620	\$ (2,718)	-3.8%	1.00% ^b	\$ 723	\$ 1,302
Self Governance	\$ 5,735	\$ 5,837	\$ 102	1.8%	2.43%	\$ 139	\$ 103
Total, Other Services	\$ 173,598	\$ 175,447	\$ 1,849				\$ 196,984
Contract Support Costs	\$ 717,970	\$ 800,000	\$ 82,030	11.4%		\$ -	\$ 82,030
TOTAL, SERVICES	\$ 4,284,357	\$ 4,615,109	\$ 330,752	7.7%		\$ -	\$ 279,014
FACILITIES:							
Maintenance & Improvement	\$ 73,614	\$ 76,981	\$ 3,367	4.6%	2.43%	\$ 1,789	\$ 1,325
Sanitation Facilities Construction	\$ 99,423	\$ 103,036	\$ 3,613	3.6%	2.43%	\$ 2,416	\$ 1,790
Hlth Care Facilities Construction	\$ 105,048	\$ 132,377	\$ 27,329	26.0%	0.00%	\$ -	\$ -
Facil. & Envir. Hlth Supp	\$ 222,610	\$ 233,858	\$ 11,248	5.1%	2.43%	\$ 5,409	\$ 4,007
Equipment	\$ 22,537	\$ 23,654	\$ 1,117	5.0%	2.43%	\$ 548	\$ 406
Total, Facilities	\$ 523,232	\$ 569,906	\$ 46,674			\$ 10,162	\$ 17,689
TOTAL, IHS	\$ 4,807,589	\$ 5,185,015	\$ 377,426		3.36%		\$ 296,703
Budget does not include \$150 million for Diabetes					Summary of Costs to maintain Current Services:		
Budget does include \$25 million increase for Behavioral health					PRC requires restoration of \$45.9 million from NO INCREASE of FY 2016	\$ 46,000	
					Inflation & Population Growth:	\$ 296,703	6.2%
<u>Inflation Rates Calculated as follows</u>					Program Increases	\$ 140,000	
^a Inflation calculated using CPI Series CUSR0000SAM2: Medical Care Services					Total Recommended Increase:	\$ 482,703	10%
^b Inflation calculated using CPI Series for General Inflation					President's Increase	\$ 252,426	
					Unfunded	\$ 230,277	

Portland Area Recommendations for Program Increases

Portland Area Tribes have considered 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. In past years 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 AI/AN people and the increased morbidity and years of productive life lost because of these disparities.

FY 2017 IHS Budget Recommended Program Increases (Dollars in Thousands)	
Increase Purchased and Referred Care and Catastrophic Health Emergency Fund (CHEF) to cover all denials and CHEF claims	\$ 30,000
Dental Health	\$ 20,000
Mental Health	\$ 15,000
Alcohol and Substance Abuse	\$ 20,000
Sanitation Facilities Construction	\$ 10,000
Maintenance and Improvement	\$ 10,000
Small Ambulatory Facilities	\$ 25,000
Urban Indian Health Program	\$ 10,000
Total, Program Increases:	\$140,000

Portland Area Tribes recommend program increases of \$140,000 for FY 2017. They also recommend more funding (\$30 million) for the Catastrophic Health Emergency Fund (CHEF) and the PRC program in order to address the significant backlog of deferred services and the growing number of denied services and CHEF claims. Portland Area Tribes recommend a substantial increase (\$20 million) 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. The well establish value of dental health aide therapists is an opportunity to stretch these dental funds even more as states see the logic of extending their practice authority.

For the same reasons that IHS has recommended an additional funding 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 issues for our Tribal adult population. Last year's increases for facilities accounts, M and I was helpful, but more is needed in this long neglected line item. Portland Area Tribes insist, once again, that small ambulatory facilities have a source of funds to support the new facility construction needs of smaller Tribes who cannot compete in the current new facilities construction priority system.

Finally, the Urban Indian Health Program (UIHP) is provided an increase in the President's FY 2017 budget. NPAIHB once again recommends in addition to the \$3 million for inflation and population

growth, an additional \$10 million, to assist UIHPs meet the growing demand for health services in urban areas across Indian Country.

Portland Area American Indian and Alaska Native Population

Portland Area's overall American Indian and Alaska Native (AI/AN) population is 343,675 with Washington's 196,026, Oregon's 110,852, and Idaho's 36,797. The American Community Survey (ACS) estimate for AI/ANs with Access to IHS is 95,113 for the Portland Area (compared to the 3-year active IHS user population of 105,000) with Washington's estimate 54,481, Oregon's 27,543, and Idaho's 13,089.

The ACS estimates now contain important and timely information regarding the AI/AN population, including income and insurance status. Its annual survey, also combined to produce 5-year estimates give an accurate 'estimate' of income, insurance, and access to Indian Health Programs. Data released January 26, 2016 depicted a growing population (faster than general population growth) and one with increased enrollment in the Medicaid program.

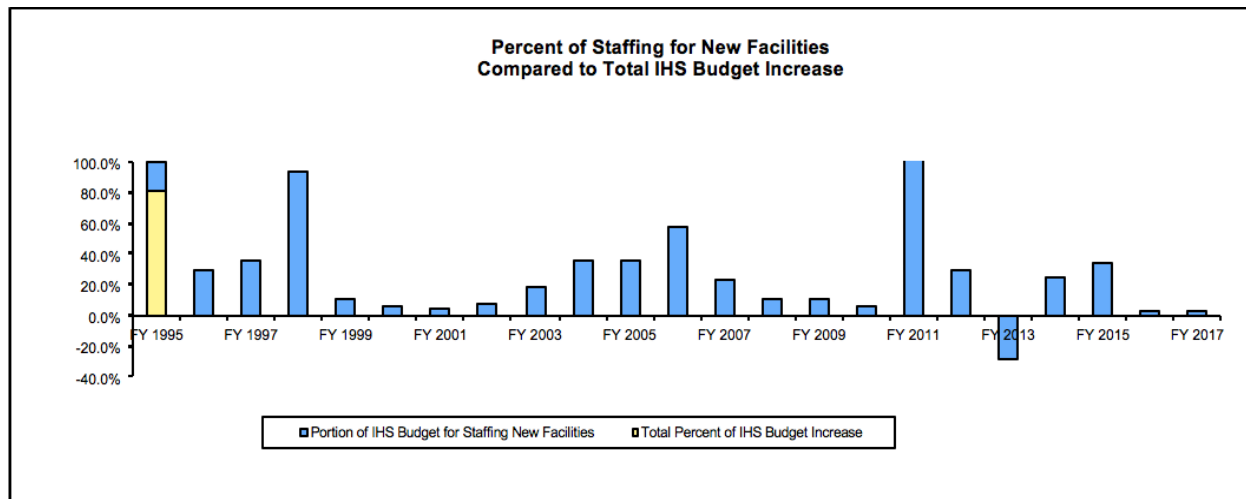
Table 5. Estimates of the Portland Area American Indian and Alaska Native population and Medicaid enrollment by Access to Indian Health Programs.

American Indian Alaska Native Population by Medicaid Enrollment by Access to IHS			2014	2013	2012	2012 to 2014 change	% increase
Washington	AIAN Population		196,026	192,836	188,077	7,949	4%
	IHS	Yes	54,481	54,217	52,420	2,061	4%
		No	141,545	138,619	135,657	5,888	4%
	Medicaid	Yes	61,534	57,512	55,346	6,188	11%
		IHS Yes	17,329	16,304	15,279	2,050	13%
		No	44,205	41,208	40,067	4,138	10%
Oregon	AIAN Population		110,852	108,560	108,539	2,313	2%
	IHS	Yes	27,543	26,845	25,270	2,273	9%
		No	83,309	81,715	83,269	40	0%
	Medicaid	Yes	36,239	31,722	31,198	5,041	16%
		IHS Yes	8,608	7,457	6,806	1,802	26%
		No	27,631	24,265	24,392	3,239	13%
Idaho	AIAN Population		36,797	36,483	34,994	1,803	5%
	IHS	Yes	13,089	13,491	12,811	278	2%
		No	23,708	22,992	22,183	1,525	7%
	Medicaid	Yes	9,461	9,043	8,705	756	9%
		IHS Yes	2,920	2,726	2,802	118	4%
		No	6,541	6,317	5,903	638	11%
Portland Area	AIAN Population		343,675	337,879	331,610	12,065	4%
	IHS	Yes	95,113	94,553	90,501	4,612	5%
		No	248,562	243,326	241,109	7,453	3%
	Medicaid	Yes	107,234	98,277	95,249	11,985	13%
		IHS Yes	28,857	26,487	24,887	3,970	16%
		No	78,377	71,790	70,362	8,015	11%

Table 5 indicates Medicaid enrollment increased by 13% since 2012 and for those with access to IHS Medicaid enrollment, increased by at least 4,000 or 16%. Of the estimated 2014 AI/AN Medicaid Portland Area enrollment of 107,234, those AI/AN with Access to IHS totaled 28,857 for the Portland Area, with Washington's estimate at 17,329, Oregon's at 8,608, and Idaho's at 2,920. Roughly 1/3 of those with Medicaid also have access to IHS health care services.

Congressional directives prohibit increased revenues from Medicaid from being considered as an offset to IHS funding, but many feel this year's flat funding of PRC was due, in part, to the view that revenues from Medicaid had increased dramatically. As the table above depicts, there were increases in enrollment in Medicaid in the Portland Area states, but not dramatic increases. The overall 16% increase in Medicaid enrollment is a testament to the hard work of Tribes and their outreach and enrollment partners. They should be praised, not punished with a zero increase in the PRC budget. This could have tragic consequences in states, like Idaho, that did not expand Medicaid and where enrollment only rose 4%.

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? Over many years, new staffing costs have 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 2017, \$33 million is needed for staffing of new facilities at the Northern California Youth Regional Treatment Center (YRTC), Kayenta, and the Choctaw and Muskogee and Flandreau Health Centers. These ‘new staffing packages’ become recurring appropriations.

Table 6: FY 2017 Staffing New Facilities (Dollars in Thousands)		
Facility	FTEs	Staffing Cost
Northern California YRTC	36	\$ 3,403
Muskogee Creek Nation Health Center, Joint Venture	94	\$ 10,743
Flandreau Health Center	55	\$ 6,297
Kayenta	1	\$ 182
Choctaw Nation Joint Venture	96	\$ 12,375
Total	282	\$ 33,000

Health Services Account

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 2017 budget.

Hospitals and Clinics (CJ-56)

Table 7: Hospitals & Clinics (Dollars in Thousands)			
President 2017 Request:	\$		1,979,998
FY 2016 Final Budget	\$		1,857,225
President's Increase/Decrease	6.6%	\$	122,773
Less Phasing-in Staff at New Facilities		\$	20,078
Less Resources for Program Increases		\$	39,000
Net Increase Available for Current Services		\$	63,695
NPAIHB Current Services Estimate for Inflation & Pop Growth:		\$	95,833
Shortfall:	\$		(32,138)

The Hospitals and Clinics (H&C) line item would receive \$1.98 billion under the Administration’s request, a proposed increase of \$122.7 million or 6.6% over the enacted FY 2017 budget. NPAIHB estimates that \$95.8 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 \$32.1 million. The proposed program increases include an additional \$20 million 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 \$20 million is needed for health IT.

Staffing new facilities will require \$20 million for the H&C account. Once the staffing and program increases for HIT are subtracted from the President’s increase, it only leaves \$63.7 million to cover mandatory costs of inflation and population growth.

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% of the non-Headquarters share of H&C funding (\$79.7 million) despite its 7% share of the IHS user population. This reflects the fact that there are no hospitals in the Portland Area. Alaska receives 19% of H&C funding (\$343 million) due to the high cost of care in Alaska and the high cost of operating the Alaska Native Medical Center and many smaller hospitals in Alaska.

Information Technology (CJ-75)

The FY 2017 budget request documents a true need for investment in IHS 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 2017 budget request for IT is \$202 million, which is a \$20 million increase over FY 2016 (a year that saw no increase in IT funding for 2015-- \$182.2 million). 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 \$20 million and certainly this amount is warranted given the enormous evolution of HIT in the private sector health care system. It is also recognized that non-IHS information systems adopted by some programs also deserve funding support.

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

IHS proposes modest funding increases 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 EpiCenters (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 Center (Nation Division of Health),
- Northern Plains Tribal Epidemiology Center (Great Plains Tribal Chairmen's Health Board)
- Southern Plains 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. The \$4.9 million request, a \$194,000 increase, for Tribal EpiCenters in FY 2017 ignores the fact that funding over the last ten years has remained flat. The current \$380,000 per EpiCenter funding compares to the \$440,000 average of 2006. 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 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 567 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, but only because some grant funds (notably the Special Diabetes Programs for Indians funds Northwest Tribes share with the EpiCenter), have been applied to the core functions of the EpiCenter.

In the past, the NPAIHB recommended that each Tribal EpiCenter receive at least \$1 million annually in core funding in order to consistently provide services needed. As an alternative way to secure more funding, IHS could depart from the 'equal is equitable' principle and provide added funding to some EpiCenters to become 'centers of excellence' in certain aspects of Epidemiology. 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-81)

Table 8: Dental Services (Dollars in Thousands)		
President Request:	\$	186,829
FY 2016 Final Budget	\$	178,286
President's Increase/Decrease	4.8%	\$ 8,543
Less Phasing-in Staff at New Facilities		\$ 2,637
Less Resources for Program Increases		\$ -
Net Increase Available for Current Services		\$ 5,906
NPAIHB Estimate for Inflation & Pop. Growth		\$ 9,200
President's Budget Shortfall:	\$	(3,294)

The President's increase for Dental Health services is \$8.5 million, a 4.8% increase over last year's level. NPAIHB estimates it will take at least \$9.2 million to maintain current services. Staffing costs of \$2.6 million for new facilities will reduce the overall increase down to \$5.9 million. The President's request is \$3.3 million less than needed to fund a maintenance budget.

The FY 2011 rescission and FY 2013 sequester have reduced the IHS dental services budget. Many Portland Area Tribes increased their dental services in FY 2015 and FY 2016, 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 since the majority of dentists are not accepting Medicaid patients. The Dental Health Aide Therapist initiative in Washington and Oregon will only partially address this need. Additional support from states in the form of Medicaid payment for DHAT services will be needed to fully take advantage of this new provider type.

Indian populations have the highest rates of oral health disease than any other population. Oral health surveys conducted by IHS indicate the following:

According to IHS (CJ-81), the demand for dental treatment remains high due to the high incidence of dental caries in AI/AN children. Over 80 percent of

AI/AN children ages 6-9 years suffer from dental caries, while less than 50 percent of the U.S. population ages 6-9 years have experienced cavities. In addition to this disparity in prevalence, there is a significant disparity in severity of dental disease. AI/AN children ages 2-5 years exhibit an average of six decayed teeth, while the same age group in the U.S. population averages one decayed tooth.

In addition to the recommendation of \$9.2 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-87)

The President requests \$111 million to cover the mental health needs of IHS and Tribal health programs. This is an increase of \$29 million (35.4%) over last year's budget. The President's request is close to maintaining current services. However, when the \$1.2 million required to staff new facilities is considered and \$25 million for program increases, the budget leaves only \$2.8 million to maintain current services. NPAIHB estimates that it will take \$4.2 million to fund mandatory cost increases for inflation and population growth. Program increases proposed by the Presidents means the request is adequate to meet current service needs and to address some unmet need.

Table 9: Mental Health (Dollars in Thousands)		
President Request:	\$	111,143
FY 2016 Final Budget	\$	82,100
President's Increase/Decrease	35.4%	\$ 29,043
Less Phasing in Staff at New Facilities	\$	1,231
Less Resources for Program Increases	\$	25,000
Net Increase/Decrease for Current Services	\$	2,812
NPAIHB Estimate for Inflation & Pop. Growth:	\$	4,236
President's Request is Adequate		

The Administration is to be commended for listening and acting on the expressed priority of Tribal leaders in the budget formulation process.

Program increases proposed by the President include:

Behavioral Health Integration: \$21.4 million would fund continued integration between medical care, behavioral health, and Tribal community organizations to provide the entire spectrum of prevention to impact health outcomes. (CJ-91)

Zero Suicide Initiative: \$3.6 million would fund implementation of pilot projects for the Zero Suicide Initiative in I/T/U organizations. (CJ-91)

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.

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.

Alcohol & Substance Abuse (CJ-93)

Table 10: Alcohol & Substance Abuse (Dollars in Thousands)		
President Request:	\$	233,286
FY 2016 Final Budget	\$	205,305
President's Increase/Decrease	13.6%	\$ 27,981
Less Phasing in Staff at New Facilities	\$	3,645
Less Resources for Program Increases	\$	16,800
Net Increase/Decrease for Current Services	\$	7,536
NPAIHB Estimate for Inflation & Pop. Growth:	\$	10,594
President's Budget Shortfall	\$	(3,058)

The President's budget requests an increase of 13.6% for Alcohol and Substance abuse programs. This is one of the larger increases in the history of the alcohol and substance abuse program. It includes \$16.8 million for program increases to fund significant new initiatives (see below).

In FY 2017, NPAIHB estimates that it will take \$10.6 million to fund current services. The President proposed increase of \$28 million is \$3 million less

than needed to fund current services since, in addition to new initiatives, \$3.6 million is needed to fund staffing at new facilities.

IHS notes that the new program is in response to Tribal leaders who advocated for additional resources to address negative health, education, and economic disparities in Indian Country. It is noted that Portland Area Tribes support the goals of this program when current services are funded first.

These program increases include:

Generation Indigenous Initiative: \$15 million would fund expansion of the Substance Use and Suicide Prevention Program (formerly known as the Methamphetamine and Suicide Prevention Initiative) to focus on hiring additional personnel to improve behavioral health services and prevention programming for AI/AN youth. (CJ-100)

Pilot Project Youth: \$1.8 million would fund the development of a pilot project to fill the gap in services and provide a continuum of care for AI/AN youth after they are discharged and return home from the Youth Regional Treatment Centers located at the local levels. (CJ- 99)

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.

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-104)

Table 11: Purchased & Referred Care (Dollars in Thousands)		
President Request:	\$	962,331
FY 2016 Final Budget	\$	914,139
President's Increase/Decrease	5.3%	\$ 48,192
Less Phasing in Staff at New Facilities		\$ -
Less Resources to restore 2016 purchasing power		\$ 45,900
Net Increase for Current Services		\$ 2,292
NPAIHB Estimate for Inflation & Pop. Growth:		\$ 62,344
President's Budget Shortfall:		\$ (60,052)

The PRC proposed increase of \$70 million for FY 2016 was, without explanation, eliminated in the enacted FY 2016 budget. \$45.9 million is needed just to restore the loss in 2016 purchasing power alone, not including population growth. \$60 million in additional funding is needed to maintain the purchasing power of the PRC budget and to restore 2016 current services and maintain that level in FY 2017.

The President's requested 2017 increase of \$48 million is not sufficient to address inflation and population growth. It does cover inflation, but not population growth estimates. It ignores the simple fact that there was no increase in 2016 while medical inflation eroding the purchasing power of the PRC program.

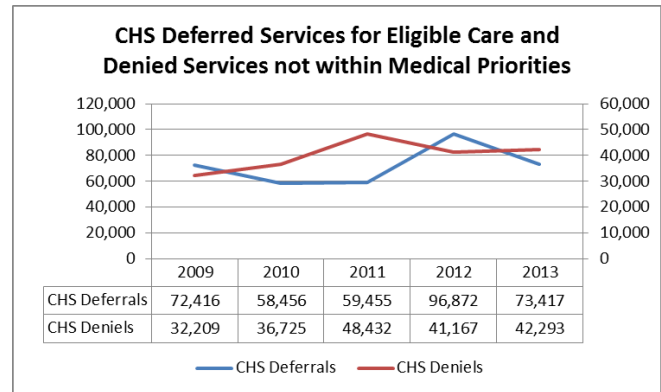
\$44.2 million of the increase will be distributed to the 10 Areas, with 11.5% of the increase to the Portland Area. Currently, the Portland Area receives 12% of the PRC funds allocated to the Areas; an estimated \$102 million in FY 2017. As noted above, this compares to the Portland Area's 4% share of the H and C budget. Alaska receives about 11% of PRC funding.

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 2017. Care. Otherwise, Tribes will have to absorb \$62.3 million in unfunded medical inflation and increases due to population growth. Another \$46

million is needed to restore last year's loss in purchasing power.

Nationally, 36% of PRC funds are for federally operated facilities and 64% 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 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. In 2017 Medicare-like rates for specialists will be implemented with a great deal of uncertainty about its affect on access and rates. Tribes realize that some providers may not accept patients if only Medicare rates are paid, but hopefully providers will accept this promising and simple billing option that could lower costs for all.



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 contribute 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 21% of the total FY 2017 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 30% 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 PRC 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 2017, the NPAIHB estimates that over **\$1.2 billion** 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 \$144 million—representing over \$ 1.2 billion in lost purchasing power as depicted in the Table 12.

The PRC Program and 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.

Table 12: Purchased & Referred Care (PRC) Lost Purchasing Power 1993 - 2017 (Dollars in Thousands)					
Year	Approved PRC Budget	Required PRC Budget with Medical Inflation	Un-funded Medical Inflation	Un-funded Population Growth	Total Unfunded
FY 1992	\$308,589	(Base Year)			
FY 1993	\$328,394	\$348,088	\$19,694	\$6,171.78	\$25,866
FY 1994	\$349,848	\$354,260	\$4,412	\$6,567.88	\$10,980
FY 1995	\$362,564	\$373,635	\$11,071	\$6,996.96	\$18,068
FY 1996	\$362,564	\$390,428	\$27,864	\$7,251.28	\$35,115
FY 1997	\$368,325	\$406,744	\$38,419	\$7,251.28	\$45,670
FY 1998	\$373,375	\$419,433	\$46,058	\$7,366.50	\$53,425
FY 1999	\$385,801	\$438,218	\$52,417	\$7,467.50	\$59,885
FY 2000	\$406,000	\$414,350	\$8,350	\$7,716.02	\$16,066
FY 2001	\$445,773	\$444,570	-\$1,203	\$8,120.00	\$6,917
FY 2002	\$460,776	\$490,350	\$29,574	\$8,915.46	\$38,489
FY 2003	\$475,022	\$518,373	\$43,351	\$9,215.52	\$52,567
FY 2004	\$479,070	\$536,558	\$57,488	\$9,500.44	\$66,988
FY 2005	\$498,068	\$557,836	\$59,768	\$9,581.40	\$69,349
FY 2006	\$517,297	\$581,959	\$64,662	\$9,961.36	\$74,623
FY 2007	\$543,099	\$605,714	\$62,615	\$10,345.94	\$72,961
FY 2008	\$579,334	\$614,094	\$34,760	\$10,861.98	\$45,622
FY 2009	\$634,477	\$672,546	\$38,069	\$11,586.68	\$49,655
FY 2010	\$779,347	\$826,108	\$46,761	\$12,689.54	\$59,450
FY 2011	\$779,927	\$826,723	\$46,796	\$15,586.94	\$62,383
FY 2012	\$843,575	\$894,190	\$50,615	\$15,598.54	\$66,213
FY 2013	\$801,258	\$849,333	\$48,075	\$16,871.50	\$64,947
FY 2014	\$878,575	\$931,290	\$52,715	\$16,025.16	\$68,740
FY 2015	\$914,139	\$959,846	\$45,707	\$17,571.50	\$63,278
FY 2016	\$914,139	\$950,705	\$36,566	\$18,282.78	\$54,848
FY 2017	\$962,331	\$994,665	\$32,334	\$18,282.78	\$50,617
Twenty-six Year Total:			\$597,369	\$144,878	\$1,232,724

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, but future increases will be somewhere between those approved by Medicare for Hospitals and those faced by all health care providers for specialty care provided outside the hospital setting. As noted above Medicare-like rate regulations covering specialist providers is being implemented in 2016 with uncertain impact as to rates and impact on access to care.

Table 13. CHS Budget History 1996-2017			
Year	CHS Approved Budget	Increase over Previous Year	Percent of Increase
FY 1996	\$ 362,564		
FY 1997	\$ 368,325	\$5,761	1.6%
FY 1998	\$ 373,375	\$5,050	1.4%
FY 1999	\$ 385,801	\$12,426	3.3%
FY 2000	\$ 406,756	\$20,955	5.4%
FY 2001	\$ 445,773	\$39,017	9.6%
FY 2002	\$ 460,776	\$15,003	3.4%
FY 2003	\$ 475,022	\$14,246	3.1%
FY 2004	\$ 479,070	\$4,048	0.9%
FY 2005	\$ 497,085	\$18,015	3.8%
FY 2006	\$ 517,297	\$20,212	4.1%
FY 2007	\$ 543,099	\$25,802	5.0%
FY 2008	\$ 579,334	\$36,235	6.7%
FY 2009	\$ 634,477	\$55,143	9.5%
FY 2010	\$ 779,347	\$144,870	22.8%
FY 2011	\$ 779,927	\$580	0.1%
FY 2012	\$ 843,575	\$63,648	8.2%
FY 2013	\$ 801,258	-\$42,317	-5.0%
FY 2016	\$ 878,575	\$77,317	9.6%
FY 2015	\$ 914,139	\$35,564	4.0%
FY 2016	\$ 914,139	\$0	0.0%
FY 2017	\$ 962,331	\$48,192	5.3%
22 year average:			4.7%

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).

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-106)

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 2017 threshold before a case is considered for funding is \$25,000, but will soon go to \$19,000 under a proposed regulation.⁴ The new regulation will be effective in 2017 and will reaffirm that CHEF is the payor of last resort. If IHS funds are used to purchase insurance in a self-insured Tribal employers plan it would also be the payor of last resort. 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 it fell to \$48.9 million. This year’s President’s request for CHEF is \$53 million, a \$1.5 million increase over FY 2016. 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.

⁴ 81 Fed. Reg. 4239-4243 (Jan. 26, 2016).

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

Table No. 14: Catastrophic Health Emergency Fund FY 1998 - FY 2017				
Year	No. of Funded Cases	Funded Amt.	No. of Unfunded Cases	Unfunded Amt.
1998	770	\$ 12,000,000	501	\$ 9,850,000
1999	710	\$ 12,000,000	521	\$ 10,713,047
2000	714	\$ 12,000,000	675	\$ 12,225,000
2001	805	\$ 15,000,000	439	\$ 8,165,000
2002	693	\$ 15,000,000	570	\$ 8,530,000
2003	718	\$ 17,883,000	700	\$ 12,359,000
2004	667	\$ 17,778,206	756	\$ 13,347,720
2005	694	\$ 17,749,935	802	\$ 17,971,608
2006	671	\$ 17,735,176	872	\$ 19,545,288
2007	738	\$ 17,999,680	895	\$ 20,058,448
2008	1,084	\$ 26,578,800	1,096	\$ 27,000,000
2009	1,223	\$ 31,000,000	1,065	\$ 2,399,308
2010	1,747	\$ 48,000,000	869	\$ 14,849,157
2011	1,745	\$ 47,904,000	928	\$ 17,670,622
2012	1,879	\$ 51,416,800	641	\$ 13,664,304
2013	1,534	\$ 48,838,000	743	\$ 17,866,064
2014	1,534	\$ 51,500,000	744	\$ 17,866,065
2015	1,531	\$ 51,500,000	Mid September depleted	n/a
2016	n/a	\$ 51,500,000	n/a	n/a
2017	n/a	\$ 53,000,000	n/a	n/a

To insure that all alternative resources are accessed before any distribution of CHEF funds, alternate resources training should continue to be provided to maximize the effectiveness of this funding source.

Public Health Nursing (CJ-111)

Table 15: Public Health Nursing (Dollars in Thousands)		
President Request:	\$	82,040
FY 2016 Final Budget	\$	76,623
President's Increase/Decrease	7.1%	\$ 5,417
Less Phasing in Staff at New Facilities		\$ 1,689
Less Resources for Program Increases		\$ -
Net Increase/Decrease for Current Services		\$ 3,728
NPAIHB Estimate for Inflation & Pop. Growth:		\$ 3,954
President's Budget Shortfall		\$ (226)

The President's request for Public Health Nurses (PHNs) is \$82 million, an increase of 7.1% over last year's amount. With \$1.7 million for staffing new

facilities, the balance is not sufficient to fund current services. NPAIHB estimates that it will take \$3.9 million to maintain the current program.

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-117)

Table 16: Health Education (Dollars in Thousands)		
President Request:	\$	19,545
FY 2016 Final Budget	\$	18,255
President's Increase/Decrease	7.1%	\$ 1,290
Less Phasing in Staff at New Facilities		\$ 96
Less Resources for Program Increases		\$ -
Net Increase/Decrease for Current Services		\$ 1,194
NPAIHB Estimate for Inflation & Pop. Growth:		\$ 942
President's Request is Adequate:		\$ 252

The President's request for Health Education is \$19.5 million in FY 2017, an increase of 7.1% over last year's amount. NPAIHB estimates that it will

take \$1.2 to maintain current services. The President's request 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 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-121)

The President's request for the Community Health Representatives (CHRs) program is \$62.4 million, a 6.0% increase over last year's level. NPAIHB estimates that it will take at least \$3 million to maintain current services. The FY 2017 increase of \$3.5 million is adequate to maintain the current levels of care provided by CHRs. There are no staffing or program increase requirements in the FY 2017 request. This allows the entire amount of \$3.5 million to cover inflation and population growth. The Administration is commended for adequately funding the current service needs of the CHR program.

Table 17: Community Hlth Representatives (Dollars in Thousands)		
President Request:	\$	62,428
FY 2016 Final Budget	\$	58,906
President's Increase/Decrease	6.0%	\$ 3,522
<i>Less Phasing in Staff at New Facilities</i>		\$ -
<i>Less Resources for Program Increases</i>		\$ -
Net Increase/Decrease for Current Services		\$ 3,522
NPAIHB Estimate for Inflation & Pop. Growth:		\$ 3,040
President's Request is Adequate:		\$ 482

The CHR program maximizes health resources by providing basic medical knowledge about health

promotion and disease prevention in the communities. Increased online 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.

Urban Indian Health (CJ-131)

Table 18: Urban Health (Dollars in Thousands)		
President Request:	\$	48,157
FY 2016 Final Budget	\$	44,741
President's Increase/Decrease	7.6%	\$ 3,416
<i>Less Phasing in Staff at New Facilities</i>		\$ -
<i>Less Resources for Program Increases</i>		\$ -
Net Increase/Decrease for Current Services		\$ 3,416
NPAIHB Estimate for Inflation & Pop. Growth:		\$ 3,051
President's Request is Adequate:		\$ 365

The President's FY 2017 budget requests an increase that is adequate to keep up with inflation.

The President proposes \$48.1 million for the Urban Indian Health Program (UIHP). NPAIHB estimates that it will take \$3 million to maintain current services in the UIHP; thus, for this year alone, funding is adequate to maintain the current program, unfortunately more is needed to amend for past years of neglect.

The UIHPs provide over 1 million 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.

An adequately funded UIHP helps IHS and Tribal programs. When Indian people return to reservations to receive health services, that could be secured more conveniently in UIHPs, it could actually cost the federal and state governments and Tribal health programs more money to provide needed services. Therefore, it is vital that Congress

continue to support cost effective urban Indian health programs. NPAIHB recommends that the UIHPs be provided a budget increase that is not only adequate to maintain current services, but to meet the service level needs of these programs. IHS should develop reasonable estimates of this unmet need.

The President has requested legislation to extend the 100% Federal Medical Assistance Percentage to UIHPs (CJ-229). This is supported by Northwest Tribes by resolution at the Affiliated Tribes of Northwest Indians. The proposal promises to bring additional state and federal resources in support of UIHPs and should be considered and enacted by the Congress.

Indian Health Professions (CJ-137)

Table 19: Indian Health Professions (Dollars in Thousands)		
President Request:	\$	49,345
FY 2016 Final Budget	\$	48,342
President's Increase/Decrease	2.1%	\$ 1,003
<i>Less Phasing in Staff at New Facilities</i>	\$	-
<i>Less Resources for Program Increases</i>	\$	-
Net Increase/Decrease for Current Services	\$	1,003
NPAIHB Estimate for Inflation & Pop. Growth:	\$	1,354
President's Budget Request Shortfall:	\$	(351)

The President's FY 2017 budget requests an increase that is \$351,000 less than needed to maintain the current level of funding the health professions program. Developing health professionals will be very important as the expansion of health insurance coverage due to the Affordable Care Act increases the need for health care providers. The Indian health system has high vacancies in many of its health professions and will need to begin to grow and train its 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 once again 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. It is time for Congress to approve this requested legislation.

Last year's budget was a start in the right direction, but more needs to be done in FY 2017. 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-144)

Table 20: Tribal Management (Dollars in Thousands)		
President Request:	\$	2,488
FY 2016 Final Budget	\$	2,442
President's Increase/Decrease	1.9%	\$ 46
<i>Less Phasing in Staff at New Facilities</i>	\$	-
<i>Less Resources for Program Increases</i>	\$	-
Net Increase/Decrease for Current Services	\$	46
NPAIHB Estimate for Inflation & Pop. Growth:	\$	68
President's Budget Request Shortfall:	\$	(22)

The President requests \$2.5 million for Tribal Management, which is nearly the same amount that was funded last year. It is less than is needed to maintain current service funding. 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 2017 than five 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-148)

Table 21: Direct Operations (Dollars in Thousands)		
President Request:	\$	69,620
FY 2016 Final Budget	\$	72,338
President's Increase/Decrease	-3.8%	\$ (2,718)
Less Phasing in Staff at New Facilities	\$	-
Less Resources for Program Increases	\$	-
Net Increase/Decrease for Current Services	\$	(2,718)
NPAIHB Estimate for Inflation & Pop. Growth:	\$	2,025
President's Budget Request Shortfall:	\$	(4,743)

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 decrease in Direct Operations funding by \$2.7 million. NPAIHB estimates that \$2 million will be needed to maintain current services. Thus, the President's request falls short by \$4.7 million.

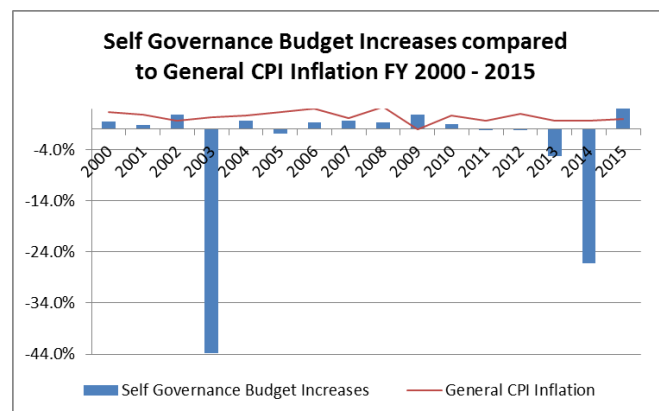
The Direct Operations budget supports overall management of the IHS to ensure effective support for the IHS mission. This includes oversight of financial, human, facilities, information and support resources and systems. Recent projections by IHS indicate that a significant portion of their workforce 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 (IHCA). 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 152)

Table 22: Self-Governance (Dollars in Thousands)		
President Request:	\$	5,837
FY 2016 Final Budget	\$	5,735
President's Increase/Decrease	1.8%	\$ 102
Less Phasing in Staff at New Facilities	\$	-
Less Resources for Program Increases	\$	-
Net Increase/Decrease for Current Services	\$	102
NPAIHB Estimate for Inflation & Pop. Growth:	\$	243
President's Budget Request Shortfall:	\$	(141)

The President's request for the Self-Governance item is \$5.8 million, a 1.8 percent increase; or \$102,000 more than last year's budget. NPAIHB estimates that it will take at least an additional \$243,000 to maintain current services in FY 2017. This will result in a shortfall in unfunded mandatory costs of \$141,000. While this may not seem like much, seven 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 \$13.5 million in FY 2017.



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. Tribes operate over \$3 billion of the total \$5

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-161)

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.

Table 23: Contract Support Costs (Dollars in Thousands)		
President Request:		\$ 800,000
FY 2016 Final Budget		\$ 720,000
President's Increase/Decrease	11.1%	\$ 80,000
Less Phasing in Staff at New Facilities		\$ -
Less Resources for Program Increases		\$ -
Net Increase/Decrease for Current Services		\$ 80,000
Funded at actual need:		\$ -

This year's FY 2017 request of a \$80 million increase for CSC continues a new and positive chapter for Indian Self-Determination.

The FY 2017 President's request for CSC is \$800,000 million, an increase of \$80 million over the FY 2016 level. Estimates for 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 2016. 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 be 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.

Finally, the President's budget request includes a proposal that Congress establish a mandatory appropriation for CSC. The proposal requests a three-year mandatory appropriation (CJ-4). The President's Budget also proposes that this measure go into effect beginning in FY 2018.

Health Facilities Accounts

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 received a rare increase last year of \$20 million, a significant increase.

This funding is essential for the maintenance of IHS-owned and many Tribally-owned healthcare facilities.

Table 24: Maintenance & Improvement (Dollars in Thousands)		
President Request:		\$ 76,981
FY 2016 Final Budget		\$ 73,614
President's Increase/Decrease	4.6%	\$ 3,367
Less Phasing in Staff at New Facilities		\$ -
Less Resources for Program Increases		\$ -
Net Increase/Decrease for Current Services		\$ 3,367
NPAIHB Estimate for Inflation & Pop. Growth:		\$ 3,114
President's Request is Adequate:		\$ 253

The President's request for M&I is \$77 million, an increase of \$3.3 million over last year's enacted budget). Recognizing the serious need for M&I funds in Indian Country, NPAIHB supports the President's request and commends the Administration for supporting a \$24 million increase for the M&I program over the past two years.

Sanitation (CJ-168)

Table 25: Sanitation (Dollars in Thousands)		
President Request:	\$	103,036
FY 2016 Final Budget	\$	99,423
President's Increase/Decrease	3.6%	\$ 3,613
Less Phasing in Staff at New Facilities		\$ -
Less Resources for Program Increases		\$ -
Net Increase/Decrease for Current Services		\$ 3,613
NPAIHB Estimate for Inflation & Pop. Growth:		\$ 4,206
President's Budget Request Shortfall	\$	(593)

The FY 2017 budget requests \$103 million for the Sanitation facilities program. The increase, following last year's \$20 million increase falls short of maintaining the purchasing power of the program.

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 over the past two years.

Health Facilities Construction (CJ-173)

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 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 2017 Health Facilities Construction budget requests \$132 million for construction projects. This is an increase of \$27 million in FY 2017. The NPAIHB does not support an increase unless it is designated as a \$25 million fund for small ambulatory facilities.

Table 26: Facilities Construction (Dollars in Thousands)		
President Request:	\$	132,377
FY 2016 Final Budget	\$	105,048
President's Increase/Decrease	26.0%	\$ 27,329
NPAIHB recommendation		\$ 105,048
President's Request is Adequate, but alternative programs should be funded	\$	-

Alternative Methods of Acquiring Health Facilities

If new facilities construction dollars are included in the FY 2017 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 strategies (Joint Venture and Small Ambulatory Funding) 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. In addition, staffing packages should be available to any new facility, regardless of how construction was funded.

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 include appropriation language in the FY 2017 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 \$25-\$30 million fund (possibly funded with government bonds) could support construction of ten projects a year with Tribes repaying their loans with Medicaid collections or other sources of revenue.

Facilities and Environmental Support (CJ-178)

Northwest Tribes support the many activities of this line item that includes many public health initiatives. Some thought should be given to moving these activities out of the Facilities account into a new Public Health Account. This would align with the HHS/Centers for Disease Control and Prevention focus on improving public health under health care reform.

Table 27: Facilities and Env Support (Dollars in Thousands)		
President Request:	\$	233,858
FY 2016 Final Budget	\$	222,610
President's Increase/Decrease	5.1%	\$ 11,248
Less Phasing in Staff at New Facilities		
Less Resources for Program Increases	\$	-
Net Increase/Decrease for Current Services	\$	11,248
NPAIHB Estimate for Inflation & Pop. Growth:	\$	9,416
President's Request is Adequate:	\$	1,832

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 \$233.9 million provides a \$11 million increase over the FY 2017 level that is adequate to maintain current services.

Equipment (CJ-187)

Table 28: Equipment (Dollars in Thousands)		
President Request:	\$	23,654
FY 2016 Final Budget	\$	22,537
President's Increase/Decrease	5.0%	\$ 1,117
Less Phasing in Staff at New Facilities	\$	-
Less Resources for Program Increases	\$	-
Net Increase/Decrease for Current Services	\$	1,117
NPAIHB Estimate for Inflation & Pop. Growth:	\$	953
President's Request is Adequate:	\$	164

The Administration's request of \$23.6 million includes an increase of \$1 million (5% increase) over last year's amount. NPAIHB estimates that it will take at least \$1 million to maintain current services in the Equipment program. The President's budget is adequate to maintain current services in FY 2017 after last year's \$20 million increase.

IHS estimates an inventory of over \$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 \$20 million annually to cover needs for biomedical, facility and telecommunications 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 29 is based on these principles.

Evaluation Based on Budget Principles: Table 29

Table 29 grades the President's FY 2017 IHS budget against criteria (or principles) that the NPAIHB has developed and applied to budget analyses over the past 26 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 2017 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.

	Table 29: GRADING THE PRESIDENT'S PROPOSED FY 2017 IHS BUDGET	President February 2017	Senate	House
	<i>Criteria or Budget Principle</i>	<i>FY 2017 Grade</i>		
1	Budget Information Shared with Tribes in Consultation Sessions Prior to release date of the first Monday in February.	C		
2	Appropriate adjustment will be made to fully cover expected inflation.	B		
3	Appropriate increases will be included to address population growth.	D		
4	Appropriate adjustments will be made to fully fund Tribal and federal employee compensation.	B		
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.	C		
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.	D		
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.	C		
	Overall Grade	C		