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Northwest Portland Area
Indian Health Board

# Priority One:

# The FY 2005 Indian Health Service Budget: Analysis and Recommendations

*March 8, 2004*

*15th Annual Report*
*March 4, 2004*

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# FY 2005 IHS Budget: Analysis and Recommendations

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## FY 2005 Indian Health Service Budget Analysis

### INTRODUCTION

The 15th Annual Northwest Portland Area Indian Health Board analysis of the Indian Health Service (IHS) Budget continues a tradition of close scrutiny of the IHS Budget that began in the 1980's. The character of budget formulation is vastly different for tribes than it is for the beneficiaries of other programs funded by the federal government. Trust responsibility and the government-to-government relationship between tribes and the federal government, by definition, requires a partnership in the development of the budget. Tribes welcome the continued commitment to joint development of the IHS budget under the Administration of President George W. Bush. The Northwest Portland Area Indian Health Board presented this budget analysis to tribes at its March 4, 2004 Budget meeting held this year in Portland, Oregon. Program increases totaling $228 million were added to the currents services increase requirement of $380 million for a total increase of $608 million recommended by the Northwest Portland Area Indian Health Board for the FY 2004 Indian Health Service budget. When compared to the Administration's request of just $46 million, the tragedy behind the numbers in this year's IHS budget becomes obvious.

Northwest Tribes and the Northwest Portland Area Indian Health Board see their role as presenting reasonable estimates of needs so these needs can be understood and appropriated their fair share of available funds. Each year the Board first discusses its priorities during its January Board Meeting and during the February meeting of the Affiliated Tribes of Northwest Indians. The Board then develops its analysis and presents it at a budget workshop conducted prior to the House Interior Appropriations hearing (if hearings are held) on the IHS budget. In addition to the Budget Analysis, the Board also prepares a Legislative Plan that presents official Board positions on the budget and other health legislation. The Legislative Plan is developed by the Board and presented for discussion and adoption through resolution by the Affiliated Tribes of Northwest Indians at its February meeting. The 2004 Northwest Portland Area Indian Health Board Legislative Plan and this budget analysis are the basis of the Board's lobbying activities (both are available at http://www.npaihb.org/legis/legisla.html ).

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

For the past seven years representatives from the Portland Area have joined Tribes nationwide in the IHS budget formulation process that includes direct service Tribes, Tribally operated programs, and urban programs. This group, commonly referred to as the I/T/U, meets annually to develop the IHS budget. The Northwest Tribes' long interest in the budget process allows them to

understand the complexity of developing the final approved appropriations. In the past, various Administrations have underestimated the need for funding the Indian Health Service. They have also often over estimated the amount of revenue received from collections from Medicare, Medicaid and third party collections. This analysis was first conceived as a reality check to the lack of integrity in past executive branch budgets. The analysis establishes criteria that are used to grade the President's budget request.

## Funding True Need:

The Northwest Portland Area Indian Health Board 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 Indian Health Service Budget Formulation Process and the FDI Workgroup have both established approximately $8-9 billion, as the approximate level of funding needed to meet the true health care needs of Indian people. This corroborates the long-held view that less than 50% of true need is funded by the Indian Health Service budget. If funded at $9 billion, an additional phased-in facilities cost of $9-10 billion would be needed to house the expanded health care services. This is sometimes stated as a $19 billion need-based budget, but in reality the annualized need after facilities are constructed is closer to $9-10 billion per year in 2004 dollars. A 10-year phase-in of the $19 billion budget can be achieved if the Congress and the Administration can commit to several years of sizeable increases.

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 so they can make their case to the Congress without fear of accusations of exaggerated estimates or double counting needs and challenge the true need. There is nothing to be gained by overestimating the funding required to meet the health care needs of Indian people. The Northwest Portland Area Indian Health Board invites discussion over every estimate presented in this analysis.

## Audience for this Analysis: Tribes, the Administration and the United States Congress.

Efforts have been made to identify pertinent issues that impact Northwest Tribes and to provide a meaningful discussion of each. This information is intended to assist leaders of each of our 43 member tribes in making their own analysis of the budget proposal and its impact on their respective communities. It is also intended to serve as a useful analysis for tribes nationwide since in nearly every case the interests of tribes nationwide are the interests of Northwest Tribes. It is only by making these views known that effective budget policy can be developed. The Northwest Portland Area Indian Health Board and Northwest Tribes actively participate in attempts to develop consensus positions on budget priorities.

This analysis is distributed to the Administration and to congressional committees who finalize the annual IHS budget. Although the analysis is prepared for the tribes of the Northwest, the analysis is now made available to tribes throughout the country. It is distributed to the National Indian Health Board, National Congress of American Indians, Tribal Self-Governance Advisory Committee, Alaska Native Health Board, California Rural Indian Health Board, Aberdeen Tribal Chairman's Association, Inter-Tribal Council of Arizona, Montana-Wyoming Health Board, and the United South and Eastern Tribes (USET). It was posted on the Board's website (at www.npaihb.org) on the same day it is published, March 4, 2004.

The long-term interests of Indian health programs (Tribal, IHS and Urban) are best served when tribes work together to inform the President and the Congress of our mutual needs and understandings. The Congress and the Administration must find common ground to maintain the purchasing power of health care resources, address unmet needs, and to facilitate service delivery that meets health objectives while maintaining fiscal discipline.

The President's FY 2005 request is less than 13% of the level needed to simply maintain the FY 2004 level of services. The Northwest Portland Area Indian Health Board estimates that approximately $380 million are needed to keep the current services provided in our health programs nationwide. Indian Health programs cannot afford to absorb such a large portion of mandatory cost increases year after year. The health and very lives of American Indian and Alaskan Natives are being put at risk by this chronic underfunding of the Indian Health Service budget. The most obvious effect of these lost revenues is fewer services and ultimately lower health status for American Indians and Alaska Natives. If tribes received mandatory cost increases there would be a decrease in the health disparities between the general population and American Indians and Alaska Natives.

Over the past 10 years Indian health programs have achieved program efficiencies. Health status has not declined dramatically despite funding shortfalls. Unfortunately, there is evidence that services have been cut despite the best efforts of Indian health programs. Further efficiencies in Indian health programs will be extremely difficult to attain. Cutting services for life threatening conditions are very likely, and in fact--some Northwest Tribes report that this is already the case in their programs.

## Restored Services will be cut due to inadequate funding

There is strong evidence that services will be cut due to inadequate funding. After the 10% increase approved in the last Clinton Budget of FY 2001 some services were restored. In FY 2001, the number of service denials declined for the first time since 1993. However, in FY 2003 the IHS deferred payment authorization for 148,523 recommended cases reached a new high and IHS funded programs denied care to 19,121 for cases that it determined not to be within medical priorities. These reported amounts **understate** the actual unmet need since many tribes no longer

report deferred services because of the expense involved in reporting. More disturbing is that many IHS users do not even visit IHS facilities because they know they will be denied services due to funding shortfalls. Last year denial and deferred services increased dramatically.

In Fy 2002, the first year of the Bush Administration, the IHS received a budget increase of just 5%. In 2003 3%, and in FY 2004 the increase was just 2.5%. The FY 2005 President's request is only 1.6%. The Northwest Portland Area Indian Health Board estimates lost purchasing power in the first three years of the Bush Administration at $600 million when the compounding effect of each year's absorption of mandatory cost increases is included in the estimate. The President's budget request is far less than what is needed to accomplish the stated goals of the Administration. It is very hard to argue that some of the management improvements have increased performance enough to cover these loses.

The unfunded amount for Catastrophic Health Emergency Fund cases totaled $12.5 million in FY 2003. 713 cases were funded and 700 were not due to lack of funding. It is estimated that millions of dollars in unreported cases exist since Indian health programs do not report cases once they know the funding has been exhausted during the fiscal year. Nearly every one of the 20 tribes in attendance at the March 4, 2004 Budget workshop reported that they are already at Priority One.

How will this funding gap be filled? Unfortunately, some believe increased revenues from tribes or from the Medicaid program are filling this gap. In 2003 every state planned cuts to its Medicaid program. Idaho and Oregon completely eliminated adult dental and vision services. Washington has proposed a benefit reduction and will implement cost sharing premiums, which American Indian and Alaska Native will have to pay if things stand with CMS. The number of American Indians and Alaska Natives who may lose their coverage is estimated to be as many as 2,400 in Oregon. Without Medicaid coverage, these people will seek out services at IHS and Tribally operated facilities.

In July 2003, The U.S. Commission on Civil Rights released a report that has become a landmark on the status of federal funding for Indian programs. The report, "A Quite Crisis," documents the harsh realities of life in Indian Country. The report discusses the United States' authority and obligation to provide programs and services to Native Americans have long been established in laws, treaties, jurisprudence, and the customary practices of nations. In short, the report finds a crisis in the persistence and growth of unmet funding needs of Indian programs and concludes that conditions in Indian Country could be greatly relieved if the federal government honored its treaty obligations and commitment to provide funding. The report offers eleven recommendations, which if implemented, would greatly improve the lives of Indian people. Two of those recommendations include exempting Indian programs from across-the-board rescissions and funding the unique needs of Indian Country (which includes funding the disparate health conditions of Indian people). Failure to fund anything less will only signify that

this Country's agreements with Indian nations and other legal rights are only empty promises.

There seems to be a misconception in the Congress and with the general public that Indian Tribes are getting rich by operating casinos. That myth must be dispelled. Tribes are not getting rich through gaming. Like state lotteries, proceeds from Indian gaming must be used for purposes like building houses, schools, roads and sewer and water systems; to fund the health care and educational systems; and, to develop a strong, diverse economic base for the future. Tribes like all elected governments have many competing needs for resources and often dedicate a portion of gaming revenue to health care as this is what they have had to do to prevent illness and deaths due to funding shortfalls in their health programs. The health funding needs are so critical in Indian Country that gaming revenue alone will not solve the problem.

This budget incorporates the recommendations of the Northwest Portland Area Indian Health Board for an IHS budget increase of $380 million or 12.8%. Program enhancements added to this total $228 million. The Northwest Portland Area Indian Health Board recommended increase of $608 million is required if the Administration is serious about addressing health disparities. The enhancements include small facility construction, pharmacy, Information Technology improvements and increases above current services for many of the line items in the budget. It adequately funds mandatory cost increases, addresses priority unmet needs for the Indian Health Service, and funds tribal homeland security, information technology and full funding for the tribal epidemiology centers. The estimated budget is to address the disparities in health status between the general population and the American Indian / Alaska Native population.

This year's analysis is dedicated to those who are suffering right now, just five months into FY 2004, in health programs that are already in priority one status. There a few members of Congress, some HHS bureaucrats, a reporter or two nationally that knows what the term means. No definition is offered here as American Indians and Alaska Natives face this challenge to their understanding of federal obligations to their tribes. Priority one means dishonor for all Americans and ill health for American Indians---this is beyond dispute for members of Northwest Tribes.

## Acknowledgements

This analysis is based on over 15 years of contributions from delegates and staff of the Northwest Portland Area Indian Health Board including: Pearl Capoeman-Baller, Chair; Julia Davis, former Chair; former Executive Directors: Doni Wilder (1990-1998) and IHS Portland Area Office Director; Cheryle Kennedy (1998-2000); and, Ed Fox, Executive Director (2001-current) and Jim Roberts, Policy Analyst.

- Senate Democratic (http://www.senate.gov/~budget/democratic/) and Republican http://www.senate.gov/~budget/republican/ Budget Committee publications.
- The House analysis is available at www.house.gov/budget/prezbudget.htm
- The Budget for FY 2004 (http://www.whitehouse.gov/omb/budget/fy2004/ is the President's budget request of February 2, 2004. It is actually a set of documents with narrative and statistical information on the President's proposed budget for FY 2004.
- Congressional Budget Office (CBO http://www.cbo.gov/ ), The Economic and Budget Outlook: Fiscal Years 2004-2013, January, 2003 and Analysis of the President's Budgetary Proposals for FY 2005, March 2004 (not online as of March 1, 2004). 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 2004. DHHS FY 2004 Budget In Brief, February 3, 2004 available at http://www.hhs.gov/budget/docbudget.htm
- The Indian Health Service, Justification of Estimates for Appropriations Committees Fiscal Year 2005 available at www.ihs.gov/AdminMngrResources/Budget/index.asp
- Additional information about the U.S. Budget is available at the Center on Budget and Policy Priorities: http://www.cbpp.org/pubs/fedbud.htm


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# The FY 2005 Northwest Portland Area Indian Health Board Budget Analysis and Recommendations

The FY 2005 President's budget for the Indian Health Service (IHS) of $2.97 billion represents a slight increase of 1.6% ($45.6 million) over last year's amount. The President's request again falls short of the estimated $380 million it will take just to maintain current services. It will take an estimated $59.3 million just to cover pay costs and staffing for new facilities. This means that the $45.5 million increase has been quickly exhausted and will leave IHS and tribal health programs with no alternative other than to cut services.

**Figure 1. INDIAN HEALTH SERVICE BUDGET (000s)**
**Comparison of FY 2003, FY 2004 Final, and President's FY 2005 Request**

| | Actual FY 2003 | Final FY 2004 | Change Over FY 2003 | President's Budget FY 2005 | Over(under) FY 2004 Approp. |
|---|---|---|---|---|---|
| **SERVICES:** | | | | | |
| Hospitals & Health Clinics | 1,211,988 | 1,249,781 | 37,793 | 1,295,353 | (17,388) |
| Dental Health | 99,633 | 104,513 | 4,880 | 110,255 | 5,933 |
| Mental Health | 50,297 | 53,294 | 2,997 | 55,801 | 3,662 |
| Alcohol and Substance Abuse | 136,849 | 138,250 | 1,401 | 141,680 | 3,126 |
| Contract Health Services | 475,022 | 479,070 | 4,048 | 497,085 | 18,024 |
| | | | | | |
| Public Health Nursing | 39,616 | 42,581 | 2,965 | 45,576 | 3,496 |
| Health Education | 10,991 | 11,793 | 802 | 12,633 | 949 |
| Community Health Representatives | 50,444 | 50,996 | 552 | 52,383 | 1,189 |
| AK Immunization | 1,546 | 1,561 | 15 | 1,604 | 34 |
| | | | | | |
| Urban Health | 31323 | 31,619 | 296 | 32,410 | 245 |
| Indian Health Professions | 31,114 | 30,774 | (340) | 30,803 | 4,303 |
| Tribal Management | 2,390 | 2,376 | (14) | 2,376 | 16 |
| Direct Operations | 60,176 | 60,714 | 538 | 61,795 | (3,569) |
| Self Governance | 5,553 | 5,644 | 91 | 5,672 | 4,697 |
| Contract Support Costs | 268,974 | 267,398 | (1,576) | 267,398 | 1,760 |
| *Total, SERVICES* | *2,475,916* | *2,530,364* | *54,448* | *2,612,824* | *26,477* |
| **FACILITIES:** | | | | | |
| Maintenance and Improvement | 49,507 | 48,897 | (610) | 48,897 | (2,176) |
| Sanitation Facilities Construction | 93,217 | 93,015 | (202) | 103,158 | 20,958 |
| Health Care Facilities Construction | 81,585 | 94,554 | 12,969 | 41,745 | (11,638) |
| Facil and Env Hlth Support | 132,254 | 137,803 | 5,549 | 143,567 | 7,268 |
| Equipment | 17,182 | 17,081 | (101) | 17,081 | (888) |
| *Total, FACILITIES* | *373,745* | *391,350* | *17,605* | *354,448* | *13,524* |
| **Total, IHS** | **2,849,661** | **2,921,714** | **72,053** | **2,967,272** | **45,558** |

## The FY 2004 Indian Health Service Enacted Budget

In FY 2004 the Indian Health Service received only a $72 million budget increase. President Bush signed the Interior Appropriations Bill (P.L. 108-108) on November 10, 2003. The bill provided $2.96 billion for the IHS, which represented a $108.5 million increase (+3.7%) over the FY 2003 enacted amount. Unfortunately, $19.1 million was deducted from the $108.5 million to comply with a .646% across the board rescission approved by Congress. This represented, at the time, an $89.4 million increase. Further reductions occurred in January 2005, when Congress passed the Consolidated Appropriations Bill (P.L. 108-199) it included language that imposed an additional rescission for all non-defense discretionary programs. Thus, subjecting the IHS budget to another rescission of .59% or $17.3 million and reducing the $108.5 million increase down to $72 million. This provided a programmatic headache for IHS-funded health services since budgets had already been developed and 4 months of expenditures were incurred based on the higher amount approved in November.

**The Impact of two rescissions on the FY 2004 Indian Health Service Budget**

| **Action** | **Rescission** | |
|---|---|---|
| Approved by Interior Appropriations Committee | | $ 2,958,164 |
| H.R. 108-330: Sec. 334 Rescission November 2003 | $ (19,110) | |
| H.R. 2673: Sec. 168(b) Rescission January 2004 | $ (17,340) | |
| **Total Rescissions** | | $ (36,450) |
| **Final FY 2004 IHS Budget Total increase $72 million** | | **$ 2,921,714** |

Last year Portland Area Tribes estimated that it would take $360 million just to maintain current services in FY 2004. The FY 2004 budget increase of $72 million represented a 2.5% increase over FY 2003 and is estimated to fall short by $288 million. Pay cost increases, staffing for new facilities, and program increases alone will account for $73.3 million. There simply was no funding for all other inflation and population growth in the final IHS FY 2004 budget.

The approved FY 2004 IHS budget included only a 2.1% increase ($2.53 billion) for the Health Services Accounts and a 4.5% ($17.6 million) increase for health facilities. The Health Facilities Construction program did receive a sizeable increase of 13.6% ($12.9 million), however it will not benefit NW tribes at all. Portland Area tribes are supportive of using a new priorities list that includes the possibility of funding both facilities and staffing packages for NW tribes.

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

## FY 2005: Preserving the basic health program funded by the IHS budget

Unfortunately, the FY 2005 IHS budget falls far short of preserving the existing IHS programs. Tribes and IHS are focused on preserving the basic health care program funded by this budget. Preserving the purchasing power of the IHS base program should be the first budget principle, not an afterthought. How can unmet needs ever be addressed if the existing program is not maintained? Tribes have one overriding concern that is crucial to this discussion. There must be a trusting relationship between tribes who are concerned about improving their health status, the Administration that is charged with that responsibility, and the Congress who holds the purse strings. Tribes, IHS and Congress must continue to focus on the goals and objectives of the IHS program and assure that the necessary resources are available to continue to make improvements in health status. If the Administration is serious about addressing health disparities it must improve its commitment to adequate funding for the Indian Health Service. If it is not serious it should stop highlighting these disparities as if words are the same as action.

## The Office of Management and Budget

The Office of Management and Budget refuses to share vital budget information with tribes. The "who-struck-john" table that allows tribes to understand where budget cuts were made was still embargoed information as of this writing. This table should be public information. The OMB could open the process even further by sharing budget information prior to the first Monday in February. The continued embargo of the FY 2005 budget information allows the Administration to violate accepted standards of government-to-government consultation. Tribes have specifically requested that OMB allow the Department of Health and Human Services to share the OMB passback information with tribes so they can provide their comments to the Administration and the IHS to assist in preparation of its appeal to the Department and OMB. Sharing the final budget information with tribes would allow them to prepare their testimony for the oversight committees in a timely manner.

Tribes cannot be content with an under funded program that so deeply affects their communities. In the course of this budget review, the President's budget request is evaluated, major issues and concerns are identified and suggestions are provided that will benefit tribes and IHS. Recommendations for funding levels are also included. It is hoped that this document will be a valuable resource for the Administration, the Congress, and the congressional staff that are responsible for understanding the Indian Health Service Budget. The treaties, executive orders, and the legislation that tribes have fought so hard to achieve with the government of the United States remains the basic foundation of the unique status of health care for Indian people.

## Figure 2 Indian Health Service FY 2004 Budget

Markup Summary '(Dollar in Thousands)

This table compares the Pres. Request to Senate and House Marks and Omnibus Mark (enacted)

| | PRESIDENT'S BUDGET | HOUSE MARK July 17, 2003 | SENATE MARK Sept. 23, 2003 | ENACTED |
|---|---|---|---|---|
| **FY 2003 Appropriation** | **2,849,661** | **2,849,661** | **2,849,661** | **2,849,661** |
| **CURRENT SERVICES:** | | | | |
| Pay Cost | 19,551 | 23,847 | 35,547 | 12,750 |
| Tribal Pay Cost | 15,996 | 20,001 | 0 | 23,459 |
| Staffing for New Facilities | 25,462 | 16,737 | 25,462 | 23,064 |
| Contract Support Cost | 0 | 2,500 | 0 | 0 |
| *Health Care Facilities Construction* | | | | |
| Pinon, AZ - Hlth Clinic | 21,573 | 19,577 | 0 | 19,577 |
| Red Mesa, AZ - Hlth Clinic | 30,000 | 30,000 | 0 | 30,000 |
| St. Paul, AK - Hlth Clinic | 0 | 6,520 | 0 | 6,520 |
| Metlakatla, AD - Hlth Clinic | 14,511 | 9,205 | 0 | 9,205 |
| Sisseton, SD - Hlth Clinic | 3,863 | 17,960 | 0 | 17,960 |
| Eagle Butte, SD - Hlth Clinic | 0 | 2,800 | 0 | 2,800 |
| Bethal, AK - Hlth Clinic | 0 | 5,000 | 0 | 0 |
| Dental Units | 0 | 1,000 | 0 | 0 |
| Regional Youth Treatment | 0 | 0 | 0 | 3,672 |
| *Sub-Total Hlth Facilities Const.* | *69,947* | *92,062* | *0* | *89,734* |
| Health Facilties Construction | -2,053 | | 10,392 | |
| **Sub-Total, Current Services** | **58,956** | **63,085** | **71,401** | **59,273** |
| **PROGRAM INCREASES:** | | | | |
| IHCIF | 0 | 2,500 | 0 | -2,500 |
| Contract Health Services | 24,916 | 0 | 15,000 | 7,000 |
| Lawton, OK Hospital | 0 | 1,500 | 0 | 0 |
| Dental Health Volunteer Program | 0 | 251 | 0 | 0 |
| Maintenance & Improvement | 0 | 2,176 | 0 | 0 |
| Equipment | 0 | 1,000 | 0 | 0 |
| Urban Indian Hlth Programs | 0 | 446 | 0 | |
| Restore Base Program Funding | 0 | 31,317 | 0 | |
| Management/IT Restoration | 0 | 30,170 | 0 | |
| Uniform Financial Mgmt System | 0 | 6,436 | 0 | |
| Direct Operations | 0 | 4,864 | 0 | |
| Health Facilties Construction | 0 | 22,115 | 0 | |
| Sanitation | 20,000 | 0 | 0 | |
| AK Telemedicine | 0 | 0 | 500 | |
| Mobile Woman's Hlth Unit | 0 | 0 | 850 | 850 |
| ANTHC Equipment | 0 | 0 | 300 | 0 |
| King Cove Staffing - AK | 0 | 0 | 0 | 500 |
| **Sub-Total, Program Increases** | **44,916** | **102,775** | **16,650** | **5,850** |
| **PROGRAM DECREASES:** | | | | |
| Admin/Mgmt Reductions | -21,334 | 0 | 0 | |
| Information Technology | -9,282 | 0 | 0 | |
| Self-Governance Reduction | 0 | -4,536 | 0 | 0 |
| Indian Hlth Professions | 0 | -4,259 | 0 | |
| Contract Health Services | 0 | -15,000 | 0 | |
| Sanitation Facilities | 0 | -20,000 | 0 | |
| **Sub-Total, Program decreases** | **-30,616** | **-43,795** | **0** | **0** |
| **Total Net Change** | **73,256** | **98,981** | **88,051** | **72,053** |
| **GRAND TOTAL** | **$2,922,917** | **$2,948,642** | **$2,937,712** | **$2,921,714** |

## Medicare and Medicaid Collections

The Bush Administration has engaged tribes by establishing a partnership with the Centers for Medicare and Medicaid (CMS). Collections are an important source of revenue for Indian health programs. The 2003 decision by CMS to formally adopt the Tribal Technical Advisory Group (TTAG) as an advisory committee to the Agency demonstrates a strong commitment, but more must be done to reach out to tribes and improve access to Medicare, Medicaid, and SCHIP programs. In 2002 the Indian Health Service and CMS signed an agreement that exempts Indian health programs from the prospective payment system (OPPS) that would have raised administrative costs and decreased revenue for IHS and tribal programs. The CMS has recently indicated that it will allow tribes to make an electronic group payment of the premiums for the Medicare program. This will facilitate participation in the program. There are good signs that CMS / IHS / and tribes can work to improve access to CMS programs.

Tribes in the Northwest have repeatedly stated their preference for full funding of the health needs of American Indians and Alaska Natives by fully funding the Indian Health Service over grants or increases in Medicare and Medicaid collections. However, most tribes are reconciled to the fact that all revenue sources must be pursued until some type of entitlement to full funding is secured through the IHS budget. The past two years' reductions in state Medicaid programs do call into question the wisdom of relying on this uncertain source of income. NW tribal leaders again call on the Congress to consider making Indian health an entitlement similar to the Medicare program promise to those over 65.

Since 2002, states have been responding to extremely difficult fiscal conditions. As revenues have fallen, spending on Medicaid has increased, and states have increasingly focused on Medicaid as a key component of their efforts to balance their budgets. Over the past three years, states have employed several different strategies to reduce the growth in their Medicaid spending, from reducing provider payments to restricting eligibility and benefits and increasing beneficiary co-payments. While these actions have helped states balance their budgets, they will have detrimental impact American Indian beneficiaries and the Indian health providers who serve them. Tribes support the renewal of the $20 billion temporary increase in federal funding to the Medicaid program.

The Medicaid program could be a more effective means of financing Indian health programs if it would exempt American Indians and Alaska Natives from cost sharing including co-pays, premiums and any other form of cost sharing. It makes little sense to Indian people to sign up for a health program that charges them for health care services that their tribe gave up lands and other considerations to secure for all generations. The practical effect is that they will not sign up for Medicaid and the IHS funded programs will end up paying all the costs of their health care. If this becomes the case, CMS will save the federal government millions of dollars, but renege on rights guaranteed by law and treaties. The Administration or Secretary of

HHS could easily exempt American Indians and Alaska Natives from these cost sharing requirements.

In recent years the Administration and the CMS have worked to improve Medicaid collections. Fair reimbursements have allowed tribal and Indian Health Service collections to increase. CMS Native American Contacts (NACs) have been assigned to key regions of the CMS and they have helped to improve the relationship between tribes, states and the agency. Unfortunately, the cost (to tribes) of attending meetings with states is not reimbursed by the CMS (as it is for states) and this means many tribes participate infrequently. CMS should pay its share for the costs of meetings related to Medicaid at the state as well as federal level. This year the NPAIHB spent over $15,000 on CMS and tribal meetings in Washington, DC and Baltimore Maryland; fortunately the cost of travel to DC will now be reimbursed for official representatives to the CMS TTAG.

## Current Services Budget: Maintaining the Current Health Program and the President's Proposed FY 2004 IHS Budget

This year's FY 2005 IHS budget request of $45.6 million (an increase of 1.6%) overall is far short of the $380 million needed just to maintain current services. In addition, Portland Area tribes are recommending an additional $228 million for program increases to addresses priority needs. This brings the total recommended increase to 18.8% or $556 million (see table 1 below).

Current services estimates' calculate mandatory costs increases necessary to maintain the current level of services. These mandatories are unavoidable and include medical and general inflation, pay costs, staff for recently constructed facilities and population growth. The 10% increase received in FY 2001 was the last budget that allowed tribes to reduce denials of services. The Northwest Portland Area Indian Health Board estimates a FY 2005 current services need of $379,830,000. This is the amount necessary to fund inflation and population growth and fully fund contract support costs.

| Table 1. Comparing President's FY 2004 Request to Current Services Budget | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Omnibus FY 2004** | **President's Request 05** | **Change over FY 2004** | **Increase for Inflation** | | **Current Services** | **(President's is Less)** |
| SERVICES: | 11-Nov-03 | 02-Feb-04 | | | | | |
| Hospitals & Clinics | $1,249,781 | $1,295,353 | $45,572 | $99,982 | | $1,349,763 | -$54,410 |
| Dental Health | 104,513 | 110,255 | 5,742 | $8,361 | | $112,874 | -2,619 |
| Mental Health | 53,294 | 55,801 | 2,507 | $4,264 | | $57,558 | -1,757 |
| Alcohol Substance Abuse | 138,250 | 141,680 | 3,430 | $11,060 | | $149,310 | -7,630 |
| Contract Health Services | 479,070 | 497,085 | 18,015 | 59,884 | | $538,954 | -41,869 |
| | | | | | | | |
| Public Health Nursing | 42,581 | 45,576 | 2,995 | $3,406 | | $45,987 | -411 |
| Health Education | 11,793 | 12,633 | 840 | $943 | | $12,736 | -103 |
| CHRs | 50,996 | 52,383 | 1,387 | $4,080 | | $55,076 | -2,693 |
| AK Immunization | 1,561 | 1,604 | 43 | $125 | | $1,686 | |
| | | | | | | | |
| Urban Health | 31,619 | 32,410 | 791 | 3,952 | | $35,571 | -3,161 |
| Health Professions | 30,774 | 30,803 | 29 | 1,231 | | $32,005 | -1,202 |
| Tribal Management | 2,376 | 2,376 | 0 | 95 | | $2,471 | -95 |
| Direct Operations | 60,714 | 61,795 | 1,081 | 2,429 | | $63,143 | -1,348 |
| Self Governance | 5,644 | 5,672 | 28 | 226 | | $5,870 | -198 |
| Contract Support Costs | 267,398 | 267,398 | 0 | 10,696 | [1] | $278,094 | -10,696 |
| *Total, SERVICES* | *$2,530,364* | *$2,612,824* | *$82,460* | *$210,734* | | *$2,741,098* | *-$128,274* |
| | | | 0 | | | | |
| FACILITIES: | | | 0 | | | | |
| Maint. & Improvement | 48,897 | 48,897 | 0 | 1,956 | | $50,853 | -1,956 |
| Sanitation Facilities Construction | 93,015 | 103,158 | 10,143 | 3,721 | | $96,736 | 6,422 |
| Health Care Facilities Construction | 94,554 | 41,745 | -52,809 | 3,782 | | $98,336 | -56,591 |
| Facil & Env Hlth Support | 137,803 | 143,567 | 5,764 | 5,512 | | $143,315 | 252 |
| Equipment | 17,081 | 17,081 | 0 | 683 | | 17,869 | -683 |
| *Total, FACILITIES* | *$391,350* | *$354,448* | *-36,902* | *$15,654* | | *$407,109* | *-$52,556* |
| | | | | ~~Increase~~ | | - | ~~Difference~~ |
| **Total, IHS** | **$2,921,714** | **$2,967,272** | **$45,558** | **$215,692** | | **$3,148,207** | **-$170,134** |
| | | | | **Other Increases** | | | Difference |
| | | | **Population Growth** | 53,138 | | 53,138 | 53,138 |
| | | | **Contract Support Cost** | 111,000 | [1] | 111,000 | 111,000 |
| | | | **subtotal** | ~~164,138~~ | | ~~164,138~~ | ~~164,138~~ |
| | | | **Program Enhancements** | | | 228,000 | |
| **Totals** | **$2,921,714** | **$2,967,272** | **$45,558** | **$379,830** | | **$556,275** | -$334,272 |
| | | **Percent of Increase:** | **1.56%** | **12.80%** | | **18.75%** | |

[1]Contract Support Costs (CSC) are calculated for inflation at 4% however the amount is not calculated as part of the total Increase for Inflation. CSC estimate of $111,000 is provided by the Office of Tribal Activities and includes inflation and shortfalls.

| **Table 2: Mandatory Cost Increases (Current Services)** | |
|---|---|
| *Mandatory Cost* | *Increase needed to maintain current services (1,000s)* |
| CHS inflation estimated at 12.5% | $ 59,884 |
| Health Services Account (not including CHS) inflation estimated at 7.5% | $ 140,154 |
| Facilities account inflation estimated at 4% increase | $ 15,654 |
| Contract Support Costs (unfunded amount) | $ 111,000 |
| Population Growth | $ 53,138 |
| Total Mandatory Costs | $ 379,830 |

Note on Medical Inflation: Medical Inflation is estimated at between 8 to 14% in the Northwest states of Oregon, Washington and Idaho. Health care analysts understand that increases in medical spending reflect increases in the value of services and pharmaceuticals and not simply inflation as measured for most goods and services. Medicare and Medicaid will increase their spending by 9% in FY 2005, but NPAIHB assumes Indian health programs will not achieve the same level of cost containment due to the lack of large group purchasing power.

There are a number of ways to compute current services. The Indian Health Service usually estimates pay cost increases and reports this as separate from inflation. The reason for this has less to do with budget presentation and more with the simple fact that since Congress passes a pay act each year these are costs that are very precisely computed for federal employees. The Indian Health Service has also added reasonable tribal pay estimates and also reports these. The pay act is legislation that requires compliance, however long this compliance is delayed (It was March, 2004 before federal employees learned their 4.1% increase that was to start January 1, 2004 was effective).

In the Northwest Portland Area Indian Health Board proposed budget (Table 1), pay act costs are not displayed separately from general and medical inflation costs. Personnel inflation is a part of the overall inflation adjustment and does not need a special treatment for the purposes of calculating a current services budget. The proposed budget applies an 8% inflation adjustment in FY 2005 for the health services accounts. This amount is added to the FY 2004 budget as the estimated amount needed just to maintain current services. The CHS account has a separate adjustment of 12.5% percent since 100% of this line item is subject to medical inflation. The Urban line item is also estimated at 12.5% as a result of inflation and the lack of any real increases in past years. Contract Support Costs need is estimated at $111 million amount, the amount provided by the Office of Tribal Activities, and includes inflation and past year's shortfalls. Finally, the facilities account estimate uses a 4% adjustment since the inflation rate for facilities activities is similar to the general inflation rate.

## Unlike Medicare and Medicaid IHS Receives No Increase for Population Growth

Tribes have long testified that resources must increase to compensate for population growth just as they must increase for actual inflation costs. If one takes the American Indian population growth rate of 2.1% (the actual increase in 2003 user population) and multiple this by the health services account it results in a suggested increase of $53.1 million. There has been no additional funding to cover the population increase of approximately 17% between 1995 and 2004.

Population growth is built into the funding mechanisms for the Medicare and Medicaid budgets. Medicare is only now beginning to absorb the retiring baby boomers and growth will increase expenditures from $279 billion in FY 2004 to $340 billion in FY 2008. Medicaid expenditures increased by 12% in 2002. They are entitlement programs that automatically receive population growth increases. That is one reason why annual Medicaid and Medicare expenditures growth is estimated at 9% over the next five years. Medicaid will grow from $183 billion in FY 2005 to $348 billion in FY 2014 (CBO, January 2004).

If more participate, funds increase accordingly. It is inequitable that health services for American Indians and Alaska Natives are not likewise increased when the Indian population increases. Unlike Medicaid and Medicare, where spending increases are automatic to accommodate growth of enrollees, for the Indian Health Service budget population growth adjustments can only be secured by approving appropriations increases.

## Program Increases Recommended at the March 4, 2004 All Tribes Meeting: Increases above 'current services'

| **IHS budget program increases** | ($ thousands) |
|---|---|
| CHS Unfunded Need, Deferred Services, and Denials of CHEF | 55,000 |
| Mental Health | 18,000 |
| Alcohol and Substance Abuse | 15,000 |
| Public Health Nursing | 5,000 |
| Health Education | 5,000 |
| Community Health Representatives | 5,000 |
| Self Governance | 5,000 |
| Pharmacy | $30,000 |
| Information Technology | 20,000 |
| Sanitation Facilities Construction | 10,000 |
| Small Ambulatory Clinics | 25,000 |
| Joint Venture | 15,000 |
| M & I | 5,000 |
| Guaranteed Loan Program | 15,000 |
| $228 million recommended Total | $228,000 |

Portland Tribes debated various program increases that they felt were essential to address current priority needs. Facilities funding for small ambulatory clinics continues to be a high priority for the Portland area. The remainder of the increases are basic increases for high priority issues (line items) such as mental health, alcohol and substance abuse, public health nurses, Community Health Representatives, and health education. Many of these increases supported important components necessary to address long term care needs for the growing elders population in Indian communities. There was a spirited discussion on keeping the request within the bounds of political feasibility. Everyone who participated felt that the funding increases for the line items listed above were far short of what was needed. However, it was decided that they wanted to highlight these areas as key opportunities to make major improvements in health status. It was a very difficult decision not to add funding in every line item, but a decision was made to limit increases to what was felt might be politically feasible. It was noted that this increase above current services raises the Portland Area request to a level that may not be politically feasible (from the basic current services amount of 12.8 % to 18.8% with these program increases), but it was decided that highlighting these priorities was necessary to indicate to the Congress areas especially deserving of increases above current services levels. The one line item above that some felt may not be required in the Indian Health Service budget was homeland security since it should be funded in a separate appropriation for the new department of Homeland Security.

**Staffing for new facilities.**

**Table 3. Staffing New Facilities (Dollars in Thousands)**

| ***Facility*** | ***Staffing Cost*** |
|---|---|
| Westside, AZ Health Center | $4,083 |
| Dulce, NM Health Center | $3,424 |
| Metlakatla, AK Health Center | $3,280 |
| Piñon, AZ Health Center | $2,573 |
| Idabel, OK Health Center | $9,704 |
| **Total** | $23,064 |

Staffing the new facilities opening at the following locations--Westside, AZ; Dulce, NM; Metlakatla, AK; Pinon, AZ, and; Idabel, OK—will require $ 23,064 million in FY 2005. The ‘new staffing package’ becomes a recurring appropriation. This increase is more than the amount of money applied to other mandatories so its benefit to Indian Health Service programs calls into question the wisdom of building these facilities if funding is not available for current programs.

The significance of staffing new facilities is that it removes from distribution funds necessary to maintain current services. 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% or 2% increase in funding this year when we were told there was a 5 or 6% increase the Indian Health Service budget? (Note FY 2004 resulted in a meager 2.5% increase while Portland Area Tribes only realized a 1% increase.) One of the main reasons in past years for this apparent gap between the annual approved increases for the Indian Health Service Account and actual program level increases is the cost of staffing new facilities. These are obviously legitimate costs that must be provided when a new facility is built.

Unfortunately, the existing programs absorb the cost of mandatories for new facilities rather than an additional appropriation. As Table 4 (below) highlights, the staffing of new facilities has absorbed 27.6% of all increases in the IHS health services account over the past 11 years. For FY 2005 $23 million will go to staffing new facilities. This amount represents 51% of the budget increase for the entire IHS budget higher than the percentage in 1997; the year the Alaska Native Medical Center opened.

**Table 4. Percentage of Total IHS Increase Expended on Staffing for New Facilities**

| | |
|---|---|
| 1995 | 19.1% |
| 1996 | 28.3% |
| 1997 | 43.2% |
| 1998 | 28.7% |
| 1999 | 13.0% |
| 2000 | 8.0% |
| 2001 | 5.8% |
| 2002 | 14.2% |
| 2003 | 27.8% |
| 2004 | 64.0% |
| 2005 | 51.0% |
| **Average** | **27.6%** |

Once we subtract pay act costs and the costs of staffing newly opened facilities, there is simply no money left to maintain the current health care program. Since the President has requested only an overall $45.6 million increase, there is a balance of $22.6 million left for the rest of the IHS budget. Since the actual pay act increase will probably be 3.5% the balance will be less than one third the amount needed for federal and tribal employees pay increases.

## Health Services Account

### The Compounding Effect of Multi-year Funding Shortfalls

Table 5 demonstrates the loss of real resources in the Health Services Account due to increases that have been inadequate to pay for cost increases due to inflation (medical and general) and population growth (averaging 2.38% over this time period and an estimated 2.1% for FY 2005). Table 5 below illustrates the annual and cumulative impact of annual under-funding of mandatory cost increases.

**Table 5. Indian Health Services Account FY 1993-FY 2005**
**(Dollars in Thousands)**

| Year | Approved Health Services Budget | Budget With Inflation & Growth Adjustment | Real Resource Loss |
|---|---|---|---|
| 1993 | $1,524,990 | $1,540,087 | $15,097 |
| 1994 | 1,646,088 | 1,644,195 | -1,893 |
| 1995 | 1,707,092 | 1,744,221 | 37,129 |
| 1996 | 1,745,309 | 1,847,113 | 101,804 |
| 1997 | 1,807,269 | 1,945,326 | 138,057 |
| 1998 | 1,841,074 | 2,060,512 | 219,438 |
| 1999 | 1,950,322 | 2,274,992 | 324,670 |
| 2000 | 2,074,173 | 2,411,496 | 337,323 |
| 2001 | 2,265,663 | 2,610,497 | 344,834 |
| 2002 | 2,389,614 | 2,630,009 | 240,395 |
| 2003 | 2,475,916 | 2,644,996 | 169,080 |
| 2004 | 2,530,364 | 2,661,614 | 131,250 |
| 2005 | $2,612,824 | 2,821,850 | 209,026 |
| | | Total Real Resources Lost FY 1993-2004 | $2,266,211 |

The loss of purchasing power over the past twelve years is conservatively estimated at $2.26 billion.

It is difficult to estimate how much collections from Medicaid (and to a lesser extent Medicare) have reduced these shortfalls. One reason for the difficulty is that collections estimates are understated in each year of the IHS budget justification because only IHS facilities' collections are reported. It is clear that Medicaid collections have not grown in the Portland Area in the past two years. States nationwide are continuing to cut benefits and eligibility for the Medicaid program in an attempt to balance state budgets.

The following section reviews the IHS budget at the 'sub-subactivity' level for the health services account. The number in the parenthesis is the page number in the Congressional Justification for the Indian Health Service FY 2005 budget.

**Hospitals and Clinics (IHS 25)**

| Table 6. Hospitals and Clinics for FY 2005 (Dollars in Thousands) | | |
|---|---|---|
| President Request: $1,295,353 ($1.3 billion)<br>Increase/Decrease: 3.5% | | |
| NPAIHB Current Services Estimate: | $ | 1,349,763 |
| President's Proposed: | $ | 1,295,353 |
| Shortfall: | $ | 54,410 |

The Hospitals and Clinics line item would receive $1,295,353 under the Administration's request. The Administration's request is $54 million short of the amount needed to maintain services. Pay act cost increases total $36.2 million dollars and staffing new facilities requires an additional $23 million for a total increase of $59.4 million. The Administration's increase of $45.6 million will not even cover the cost of pay act and staffing costs.

This line item funds hospitals and many services some might expect to find under administrative costs such as information technology. In some Areas, funds that should be under contract health care are actually found in the H & C line item. The Portland Area receives far less per capita than most areas from this line item, under 5% of all funding despite Portland's nearly 6.7% share of users' population. There are logical reasons for this, most importantly, the lack of expensive hospitals in the Portland Area (one of two areas with no hospitals) and the high costs associated with service delivery in Alaska.

## Epidemiology Centers

**Permanent Funding for the Northwest Tribal Epidemiology Center**

IHS funds 6 Epidemiology Centers, five tribal and one urban. One of these centers, the Northwest Tribal Epidemiology Center (*The EpiCenter*), is located in the Portland Area at the Northwest Portland Area Indian Health Board. *The EpiCenter* is providing epidemiological and programmatic assistance on a variety of health issues. It has taken the lead in helping Northwest Tribes work to achieve the Health Status Objectives specified in the Indian Health Care Improvement Act Amendments of 1992. The other centers are in Nashville, Phoenix, Anchorage, the Bemidji Area and the Seattle Indian Health Board.

The Board would like *The EpiCenter* to be funded at a level that will enable it to be a fully functional epidemiology center. *The EpiCenter* should be funded at

$550,000 to allow it to provide professional, high quality work for Indian health programs. The Centers for Disease Control and Public Health should continue to use its authority to assign personnel, such as medical epidemiologists, to the tribal epidemiology centers. The Northwest Portland Area Indian Health Board supports the President's request of a $2.5 million increase for Epi-Centers. Last year the Board passed a joint resolution with the California Rural Indian Health Board supporting an EpiCenter in California developed by California Tribes. There may be some merit in having an EpiCenter in each area, but this need must compete with others in the Indian Health Service budget.

## The Indian Health Care Improvement Act Goals

The Indian Health Care Improvement Act Amendments of 1992 authorized the Indian Health Improvement Fund plus additional initiatives to address the unmet health needs of Indian communities. The Level of Need Funded (LNF) methodology, now termed the Federal Employees Health Benefit Package Disparity Index (FDI), has been used to distribute funds appropriated to the fund. Tribes expect some appropriation to be included each year to raise tribes' funding level. In FY 2003 $18 million was distributed to the 55 lowest funded tribes (actually operating units) by the direction of Congress, not the workgroup. This suggests that the Congress feels it is the responsibility of Tribes to raise the lowest funded programs by redistributing increases from existing programs. Northwest Tribes disagree and feel that Congress and the President have the responsibility to raise the level of need funded to 100%.

## HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that IHS and tribal health programs comply with national standards for electronic health care transactions and protect the security and privacy of health data. The FY 2003 budget appropriation included $850,000 to implement the new privacy standards. Of major importance in the HIPAA legislation is the issue of data and transaction standardization—a mandate very few healthcare providers can sidestep if they bill third parties for services provided to patients. There is no funding in FY 2005 to comply with the special requirements of HIPAA. This un-funded mandate deserves and ongoing appropriations until it is fully implemented.

**Dental Services (IHS 53)**

| Table 7. Dental Health (Dollars in Thousands) | |
|---|---|
| President's Request: $110,255<br>Increase/Decrease: 5.2% | |
| NPAIHB Current Services Estimate | $8,361 |
| President's Proposed Increase | $5,742 |
| Shortfall | $2,619 |

The President's increase of $5,742 million is not enough to maintain current services since $1,934 will cover pay cost increases and $3,808 million is for phasing-in of new dental staff at Westside, AZ; Dulce, NM; Metlakatla, AK; Pinon, AZ, and; Idabel, OK. Thus, the entire increase is only slated to cover those costs and nothing more will be available to address health disparities or non-personnel related inflation. It is also an insufficient increase in a year when states like Idaho and Oregon have eliminated adult dental from their Medicaid programs, which will mean additional users to the IHS system. Over the past 4 years progress has been made in overcoming the abysmal dental health of American Indians and Alaska Natives. As noted in the budget justification (p. IHS-54), Indian people have disease rates 2 to 10 times that of the general population. Dental programs are unparalleled in their ability to provide efficient and effective health care services to the patients who need dental care. The Board has one of the seven Dental Support Centers that provide consultation services to area health programs.

**Mental Health (IHS 59)**

| Table 8. Mental Health (Dollars in Thousands) | |
|---|---|
| President's Request: $55,801<br>Increase/Decrease: 4.5% | |
| NPAIHB Current Services Estimate | $4,264 |
| President's Proposed Increase | $2,507 |
| Shortfall | $1,757 |

This increase to $55.8 million represents a better increase than other IHS budget functions. The Mental Health line item received a similar increase in FY 2004. Tribes appreciate the attention to this important area. Suicides occur more frequently (72% higher) and among younger people in the Indian population with the age group 15-24 having the highest rate. This is a shocking statistic. Consider that the highest rate for non-natives is for individuals over 74 years and one can conclude that a horrendous loss of productive years needs to be addressed

in a concerted effort. New staffing packages will take 60% of the increase and cost $1.5 million in FY 2005.

**Alcohol and Substance Abuse (IHS 67)**

| Table 9. Alcohol & Substance Abuse (Dollars in Thousands) | |
|---|---|
| President's Request: $141,680<br>Increase/Decrease: 2.4% | |
| NPAIHB Current Services Estimate | $11,060 |
| President's Proposed Increase | $3,430 |
| Shortfall | $7,630 |

Alcohol and substance abuse continues to be the highest priority for tribal leaders and health directors during the IHS budget formulation process. Last year's President's request for this item was less than a 1% increase. This year's request is 2.4% above last year's level, however, it falls drastically short of the needs of Indian Country. Rates for illicit drug use and alcohol abuse are highest for American Indian than any other racial/ethnic groups. This is unfortunate since many feel that substance abuse is the cause of many of the maladies that face Indian people. Despite some gains the NPAIHB estimates alcohol and substance abuse is more than 50% higher than the non-Indian rates. Unfortunately, little help will be coming from the President's FY 2005 budget request. The President's proposed increase of $3.4 million will only cover pay costs, with nothing more to maintain or expand services.

**Contract Health Services (IHS 55)**

| Table 10. Contract Health Services (Dollars in Thousands) | |
|---|---|
| President's Request: $497,085<br>Increase/Decrease: 3.6% | |
| NPAIHB Current Services Estimate | $59,884 |
| President's Proposed Increase | $18,014 |
| Shortfall | $41,870 |

This year's requested increase of $18 million is a reasonable percentage of the overall increase, but far short of need. The $41 million shortfall means referrals for dental services and specialty care will be curtailed. It means tribes will fall into PRIORITY ONE in the winter instead of spring of the year. CHS funding is the most critical line item for Tribes in the Northwest. The Northwest Portland Area Indian Health Board estimates $59.8 million is needed to maintain the current level of services purchased with Contract Health Service (CHS) dollars.

The FY 2001 increase, requested by President Clinton, of $40 million was the first time since 1992 that CHS received an increase sufficient to fund population growth and the medical inflation rate. This year's request is far short ($41.9 million short) of the amount needed to fund inflation and population growth. Congress should note that there are no pay costs included in CHS yet surely the providers who sell their care services to Indian health program are as deserving of pay cost increases as federal workers. In many cases these increases would go to small town practitioners and rural hospitals. CHS purchases of health care is a very efficient method that contributes to rural economies. CHS is a much more efficient method of providing care than building new hospitals, but its reward is insufficient funding increases.

CHS represents about 15% of the total health services account. In the Northwest it represents over 20% of the Portland Area Office's budget. The consequence of eleven years of un-funded inflationary increases has been declining services for tribes who depend upon Contract Health Services to support inpatient and specialty care. IHS areas like the Portland Area (with no hospitals) are particularly hurt by the lack of sufficient increases to cover medical care inflation. There is only so much that can be done to restrict medical priorities. Rationing and erosion of service has been a constant problem, particularly for CHS program. The Portland Area strongly supports distribution of CHS dollars with a formula that recognizes that some areas are strongly dependent on this funding source. The new formula for CHS distribution was not supported by NW tribes.

**Table 11. Lost Purchasing Power 1993 to 2004 for Contract Health Services Line Item (CHS)**

| Year | Approved Budget | Medical Inflation Need | Un-funded medical inflation | Un-funded Population Growth | Total un-funded (000s) |
|---|---|---|---|---|---|
| *1992* | $308,589 | | | | |
| 1993 | $328,394 | $331,425 | $3,031 | $6,480 | $9,511 |
| 1994 | $349,848 | $354,260 | $4,412 | $6,896 | $11,308 |
| 1995 | $362,564 | $373,635 | $11,071 | $7,347 | $18,418 |
| 1996 | $362,564 | $390,428 | $27,864 | $7,614 | $35,478 |
| 1997 | $368,325 | $406,744 | $38,419 | $7,614 | $46,032 |
| 1998 | $373,375 | $419,433 | $46,058 | $7,735 | $53,793 |
| 1999 | $385,801 | $438,218 | $52,417 | $7,841 | $60,258 |
| 2000 | $406,000 | $414,350 | $8,350 | $8,102 | $16,452 |
| 2001 | $445,773 | $444,570 | ($1,203) | $8,526 | $13,096 |
| 2002 | $460,776 | $490,350 | $29,574 | $9,240 | $51,036 |
| 2003 | $475,022 | $518,373 | $43,351 | $9,500 | $52,851 |
| 2004 | $479,070 | $536,558 | $57,488 | $9,581 | $67,070 |
| **Thirteen Year Total:** | | | $320,832 | $96,476 | $435,303 |

Contract Health Services is the program most vulnerable to inflation pressures. Between FY 1992 and FY 2004, the NPAIHB estimates that nearly 1/2 **billion** dollars has been lost to inflation in the CHS program nationally. Unfunded medical inflation alone exceeds approved increases by $320 million. When population growth is included, approximately *$435* million in purchasing power has been lost as depicted in the Table 11 above.

**Table 12. Budget History of CHS Funding FY 1996 to FY 2004 (Dollars in Thousands)**

| | CHS Approved | Increase over Previous Year | Percent of Increase |
|---|---|---|---|
| 1996 | $362,564 | $ - | |
| 1997 | $368,325 | $5,761 | 1.56% |
| 1998 | $373,375 | $5,050 | 1.35% |
| 1999 | $385,801 | $12,426 | 3.22% |
| 2000 | $406,756 | $20,955 | 5.15% |
| 2001 | $445,773 | $39,017 | 8.75% |
| 2002 | 460,776 | $15,003 | 3.26% |
| 2003 | 475,022 | $14,246 | 3.00% |
| 2004 | 479,070 | $4,048 | 0.84% |
| 2005 | 497,085 | $18,015 | 3.62% |
| | | **Ten Year Total:** | **3.16%** |

Table 12 charts the past 10 years funding for CHS. The increase has been about 3% each year while medical inflation rate experienced in the Northwest is approximately 10% over the past decade. CHS should receive medical inflation adjustments at least equal to the Medicaid program (estimated at 6.5% for the years 2002 to 2007) since both purchase care from private providers. Since the FY 2004 approved appropriation was $479 million, a fair inflation adjustment would total $59.8 million for FY 2005. The President has requested an amount that is not sufficient to protect real resources that continue to be lost to medical inflation.

Medicaid's enrollment growth rate (1.4%) over the next 5 years is less than the projected annual increase in the Indian population (2.1%) so population growth does not justify the higher rate of growth for Medicaid. Surely no one believes that the relatively small Indian Health Program is able to secure better rates from providers than the Medicare and Medicaid programs.

## Catastrophic Health Emergency Fund (CHEF)

The CHS budget includes a Catastrophic Health Emergency Fund (CHEF) of $18 million intended to protect the daily administration of local CHS programs from overwhelming expenditures for catastrophic health cases. This fund is a lifesaver for Indian health programs. Its purpose is to fund catastrophic health care cases with large expenses. Northwest Tribes urge the Congress to consider fully

funding CHEF since these cases are all well-documented need and critical to the financial stability of the small programs that exist in the Portland Area and many other Areas of the Indian Health Service.

The current FY 2004 threshold is $23,800 before a case is considered for funding. The Catastrophic Health Emergency Fund is an important source of funds for programs that experience high cost cases. These cases place a tremendous financial and ethical burden on a Service Unit or a tribe if the case occurs near the end of the year after the Fund has been exhausted.

In FY 2003, CHEF claims for $12.4 million for 700 cases went unpaid and were absorbed by local CHS budgets. The actual unfunded need is certainly greater than $12 million because the fund is usually depleted by the third quarter of the Fiscal Year. CHS deferred services include those cases within the CHS medical priority area however are deferred due to lack of funding. Portland Area Tribes strongly urge the Congress to fully fund CHEF since the impact of not funding it fully threatens Indian Health programs more than any other line activity in the budget.

The IHS in FY 2003 estimates that there are 143,523 deferred services totaling $91.2 million. There are another 19,121 eligible cases that are denied services because the care is not within the CHS medical priorities. Every year tribes simply do not submit claims since they know that in the last quarter claims are not likely to be approved.

## HIV /AIDS

The President has identified the HIV/AIDS epidemic as one of his highest health priorities in the United States and abroad, with a Presidential initiative to fund HIV/AIDS prevention in Africa. Unfortunately, the President's priority for addressing HIV/AIDS in Indian Country is not the same without any increase in funding in the FY 2005 IHS budget request. The IHS is committed to the primary prevention of HIV in American Indian communities through the dissemination of appropriate information and the development and nurturing of empowerment skills at both the individual and community levels.

### Public Health Nursing (IHS 83)

| Table 13. Public Health Nursing (Dollars in Thousands) | |
|---|---|
| President's Request: $45,476<br>Increase/Decrease: 6.6% | |
| NPAIHB Current Services Estimate | $3,406 |
| President's Proposed Increase | $2,995 |
| Shortfall | $411 |

Public Health Nurses (PHNs) are at the center of many community based health care services including home visits to provide: disease surveillance, direct therapy; and group education comprise 40% of the PHNs time. The growing elderly population has resulted in a 15% increase in home visits by PHNs. It is clear that this growing need requires greater than average increases if we are to meet this demand. A significant amount of time is dedicated to maternal and child health promotion. The important work being done to lower infant mortality and Sudden Infant Death Syndrome cannot be maintained if funding falls below the rate of inflation. SIDS awareness campaigns have resulted in a lower rate of infant deaths, yet it is still the greatest cause of infant mortality with rates that are the highest of any group in the United States. Over 70% of the President's increase will go toward staffing new facilities.

**Health Education (IHS 89)**

| Table 14. Health Education (Dollars in Thousands) | |
|---|---|
| President's Request: $12,633<br>Increase/Decrease: 6.6% | |
| NPAIHB Current Services Estimate | $943 |
| President's Proposed Increase | $840 |
| Shortfall | $103 |

Health Education holds the promise of reducing future expenditures. The request of $12,633,000 will cover pay act costs and staffing for new facilities. Patient education and youth health education programs will have to make do with less funding in FY 2005 after inflation takes its toll on funding. The National Institutes of Health have begun to work with tribes to implement culturally sensitive community-directed pilot cardiovascular disease prevention programs. Tribes look forward to accessing the resources of the important agency.

**Community Health Representatives (IHS 95)**

| Table 15. Community Health Representatives (Dollars in Thousands) | |
|---|---|
| President's Request: $52,383<br>Increase/Decrease: 2.6% | |
| NPAIHB Current Services Estimate | $4,080 |
| President's Proposed Increase | $1,387 |
| Shortfall | $2,693 |

The President proposes spending $52,383,000 for the Community Health Representatives (CHRs) Program. Increased training for CHRs has made them

effective partners on the health care team. CHRs are at the forefront of much of the preventive health that needs to be emphasized in Indian health programs. Unfortunately, the requested level of funding will result in cuts at the program level since it does not cover inflationary cost increases.

**Urban Health (IHS 107)**

| Table 16. Urban Health (Dollars in Thousands) | |
|---|---|
| President's Request: $32,410<br>Increase/Decrease: 2.4% | |
| NPAIHB Current Services Estimate | $3,952 |
| President's Proposed Increase | $791 |
| Shortfall | $3,161 |

The 34 Urban Health Programs serve a diverse patient base with tribal affiliation from around the country. Most American Indians and Alaska Natives are urban Indians (an estimated 57%) with approximately 605,000 American Indians or Alaska Natives are eligible to use Title V Urban Indian Programs. In some cities, however, such as Phoenix, Anchorage, Albuquerque and Seattle, far more urban Indians receive their care from IHS and tribally operated programs than Urban programs. There is no data to accurately describe the true need, but it is clearly grossly underfunded in the Indian Health Service budget. The availability of care in urban settings relieves the caseload at IHS/tribal programs and saves many from difficult transportation challenges. Medical inflation and past shortfalls require at least a 12.5% increase just to maintain services. In FY 2004 Urban Programs received less than a 1% increase. This year's increase of $791,000 will only cover pay cost increases, with no additional funding to cover current services. The request of just $32.4 million will mean that many more patients will be forced to travel great distances to secure care at their tribe or other Indian health programs.

**Indian Health Professions (IHS 115)**

| Table 17. Indian Health Professions (Dollars in Thousands) | |
|---|---|
| President's Request: $30,803<br>Increase/Decrease: 0.1% | |
| NPAIHB Current Services Estimate | $1,231 |
| President's Proposed Increase | $29 |
| Shortfall | $1,202 |

The Administration is only requesting $30.8 million, an increase of less than one-percent. This request does not make sense when the IHS is experiencing critical shortages of physicians, nurses, dentists, pharmacists and optometrists and a growing concern of other professions essential to staffing health facilities. The President's request is $1.2 million short of addressing these critical profession areas. The scholarship and loan repayment programs are vital to the IHS system developing its own human resource capital. The $29,000 increase will only cover pay act costs and will mean cuts in scholarships for students and what would have been future physicians and nurses for the IHS.

**Tribal Management (IHS 123 )**

| Table 18. Tribal Management (Dollars in Thousands) | |
|---|---|
| President's Request: $2,376<br>Increase/Decrease: 0.00% | |
| NPAIHB Current Services Estimate | $95 |
| President's Proposed Increase | $0 |
| Shortfall | $95 |

For the second straight year, the President is not requesting an increase for Tribal Management in FY 2004. This means the FY 2005 amount of $2.4 million is just $16,000 more than provided in FY 1998. Funding increases could be put to good use as tribes improve their management capacity. In FY 2002, just 25 grants were approved (13 new and 12 continuation grants). Clearly, there is a great need for the activities this program supports.

**Direct Operations (IHS 125)**

| Table 19. Direct Operations (Dollars in Thousands) | |
|---|---|
| President's Request: $61,795<br>Increase/Decrease: 1.7% | |
| NPAIHB Current Services Estimate | $2,429 |
| President's Proposed Increase | $1,081 |
| Shortfall | $1,348 |

Direct Operations includes the cost of management at IHS headquarters and the 12 area offices. This year the President has requested $61,795,000, an increase of 1.7% over last year. The increase of $1,081,000 will fund pay cost increases for federal, tribal, and urban staff.

**Self Governance (IHS 129)**

| Table 20. Self-Governance (Dollars in Thousands) | |
|---|---|
| President's Request: $5,672<br>Increase/Decrease: 0.5% | |
| NPAIHB Current Services Estimate | $452 |
| President's Proposed Increase | $28 |
| Shortfall | $424 |

The FY 2004 President's request attempted to restore $4.7 million to the Self-Governance account but was not successful. The FY 2004 enacted level is $5.6 million. The FY 2005 request of $5,672,000 is less than a one-percent increase and will only cover pay act increases. This office supports compacted tribes operating programs under the Tribal Self-Governance Amendments of 2000. This law, P. L. 106-260 established compacting as permanent, under the new Title V of P. L. 93-638.

**Contract Support Costs (IHS 121)**

| Table 21. Contract Support Costs (Dollars in Thousands) | |
|---|---|
| President's Request: $267,398<br>Increase/Decrease: 0% | |
| NPAIHB Current Services Estimate | $111,000 |
| President's Proposed Increase | $0 |
| Shortfall | $111,000 |

The President does not request an increase for Contract Support Costs in FY 2005. Last year CSC received a reduction of $1.5 million. Why? There was no reason: it was the accidental result of the two Congressional rescissions. Contract Support Costs funds are required for tribes to successfully manage their own programs. It is estimated that an increase of $111 million is needed to fully fund contract support costs. Currently, the IHS reports that tribes are funded at about 80 % of full funding, but this seems higher than the actual rate of funding. It also ignores previous year's unpaid Contact Support Costs.

Congress should appropriate adequate contract support cost funds to eliminate the ongoing shortfall. This continuing shortfall threatens to pit tribe against tribe as mature contractors are asked to absorb all inflationary increases in order to fund new contractors. Some tribes are told they will receive no contract support cost

funding if they take over additional programs because their level of contract support cost funding is greater than that of new tribal contractors. Each year's appropriations should contain some funds to protect existing self-determination contracts and compacts from erosion of their programs due to inflation.

The Northwest Portland Area Indian Health Board has participated in both the IHS and National Congress of American Indians' Contract Support Costs workgroups. The Northwest Portland Area Indian Health Board recommends that one-half of the CSC increase be reserved for ongoing contract support costs shortfall and the other half should be earmarked for new and expanded contracts and compacts. It is essential that tribes waiting to contract or compact be given hope of receiving the funding needed to make Self-Determination a reality. It is also essential that ongoing contracts receive the amount of funding they are entitled to receive.

## Medicaid, Medicare and Private Collections (IHS 137)

The budget justification states that the Administration assumes no increase in Medicare and Medicaid collections for FY 2005. This estimate may be accurate given severe cutbacks in the Medicaid program in some states. The current Medicaid all-inclusive rate is $206 for outpatient visits.

No one really know how much is collected for Medicare and Medicaid, but at least the Administration does not inflate the estimates and then use the inflated estimates to justify lower increases in the IHS budget. The estimates are not worth restating here. One wonders why the Centers for Medicare and Medicaid cannot produce better figures since they are paying the bills. In addition, they are paying states 100% of the costs of American Indians and Alaska Natives. Surely, they know what the amount of the check they write total?

There are some indications that collections will not increase as much as estimated by the Administration because enrollment growth in Medicaid has stopped in Washington and is stable in Oregon over the past year. Many programs are reporting reluctance by American Indians and Alaska Natives to enroll in Medicaid because states have used the estate recovery process to force Medicaid patients' heirs to repay the costs of the deceased's medical treatment. In addition, CMS has recently denied Washington’s request to exempt American Indians from co-payments at the point of service. The Board and the American Indian Health Commission are working with the state to challenge this change in CMS policy.

## Changes in Medicare and Medicaid Rules Needed

The Centers for Medicare and Medicaid should work with states and tribes to insure that American Indians and Alaska Natives can choose Indian Health Programs as their providers. They should not be automatically assigned to managed care plans nor should they be required to pay co-payments or premiums.

## Special Diabetes Funding (IHS-141)

FY 2004 was the first year of the $150 million per year authorized for diabetes by the 107th Congress. Tribes are still waiting to hear how $27.4 million of this funding will be distributed. Spending on diabetes will result in program dollar savings in future years. Tribes welcome new resources for diabetes and hope to make these funds a recurring addition to the IHS budget until such time as they are not needed. These funds are a good investment. They are helping tribes nationwide to understand the magnitude of the burden of disease from diabetes and to develop interventions. They will likely save future spending on this disease. Improved health status depends on adequate appropriations. In some cases failing to maintain current services will result in the need for greater resources in the future. In addition to the human suffering it causes, diabetes is a financial drain on Indian health program resources. If prevention activities are successful, much suffering and expense will be avoided. Tribes are successfully developing programs to prevent and treat this serious disease that disproportionately impacts Indian people. The Northwest Portland Area Indian Health Board's *EpiCenter* is assisting tribes in this effort and continues to report on progress made by Northwest Tribes.

## Health Facilities Account (IHF-1)

### Maintenance and Improvement (M & I) (IHF-9)

Over the past 10 years (FY 1993-FY2002) there has been less than a 5% increase in M & I despite the fact that the inventory of space has increase appreciably (over 30% in the Portland Area). Many tribes have seen a decrease in their funding due to the lack of adequate increases to reflect the growth in new and expanded facilities. The current (2002) replacement value of facilities eligible for M & I is $2.37 billion. The capital assets of Indian health facilities must be protected from deteriorating due to lack of funding for routine maintenance.

The IHS Backlog of Essential Maintenance and Repair (BEMAR) survey for November 2002 estimates that there is a chronic backlog of $506 million in needed repairs to Indian health facilities. In FY 2002 $14,145,000 was available for program deficiencies identified by BEMAR. The Indian Health Service should continue to update this information to provide Congress with the basis for increased funding to address this need.

### Sanitation (IHF 13)

7.5 % of all AI/AN homes lack safe water in the home compared to less than 1% average nationally. In response, the President has requested a $20 million increase for sanitation facilities construction. This is a welcomed increase. Last year's congressional justification noted a backlog of sanitation projects

considered economically feasible exceeded $875 million. In FY 2001, the IHS estimated that an annual funding requirement of $77 million would be required to fulfill the objectives of the 10-year Sanitation Improvement Plan (for feasible projects). Only $53 million will be available for this in FY 2004. Portland Area tribes request an additional $20 million above current services need of $3.7 million to address the backlog of feasible projects.

**Health Facilities Construction (IHF 23)**
NW tribes need to look no father than the spending associated with facilities to understand why they will get virtually no increase in funding in FY 2005 if the President's budget is adopted. Facilities, especially hospitals, are expensive to build and their staffing packages more costly still. The Administration and Congress funded $82 million in FY 2003 while allowing contract health services to erode with funding 75% below the level needed to maintain services.

The cost of the Ft. Defiance Hospital through FY 2004 totaled $125 million---far above the initial estimate of $105 million. The Administration and Phoenix Area tribes have wisely not requested funding to continue planning for a much larger Phoenix Indian Hospital (no longer termed a hospital, but a system). The Alaska Native Medical Center provides a wonderful resource, both cultural and medical, for Alaska Natives, but hospitals' costs deserve careful review before any new hospital facility is authorized.

IHS is far behind in constructing ambulatory care facilities, yet the Administration ignores the highly successful alternative financing programs developed over the past several years. Last year only $5 million was appropriated to this fund. Over the past 20 years IHS has spent seven times as much on hospitals as it has on outpatient clinics. Northwest Tribes find this investment strategy inconsistent with the mission to elevate the health status to the highest possible level. Providing new or expanded outpatient facilities will have a greater impact on health status than constructing more hospitals.

The importance of adequate outpatient facilities must be continuously emphasized to the Indian Health Service. Before any new hospitals are built, especially in urban areas (the Ft. Defiance hospital is in a rural area) with excess hospital capacity, cost-benefit analyses should be conducted. It is expected that increased contract health service dollars can purchase more care than could be provided by expensive hospitals. As previously discussed, staffing new hospitals often requires that 25% to this year's 64% of any given year's total IHS budget increase be dedicated to staffing the new facilities. If the Congress is required to fund expensive hospitals and then fund expensive staffing packages, they often reduce the amounts they make available to maintain current services. For the Portland Area, this translates into funding increase on the range of 1 to 2% over the past 10 years. In FY 2003 and FY 2004 the increase is expected to be less than 1%; only a 1% increase to address medical inflation rates in excess of 10%!

**Alternative Methods of Acquiring Health Facilities**
Northwest Tribes have long encouraged more alternative methods to construct new facilities. These alternative methods of acquiring health facilities must be supported. There is such an enormous need that depending exclusively upon IHS appropriations for all health facility requirements is not realistic. The Indian Health Service and Tribes have developed a strategy that will greatly increase the number of new ambulatory health facilities constructed, but some IHS funding is required for this strategy of leveraging financing to work.

The Indian Health Care Improvement Amendments (Section 818 of P.L. 102-573) authorized joint venture projects in which a tribe plans and constructs a health facility and IHS provides the equipment, staffing and operations costs. The Administration requests no funds for additional projects. $20 million would fund 2 to 3 projects per year.

The Indian Health Care Improvement Act (Section 306 of P.L. 102-573) authorized a grant program for the construction, expansion and modernization of small ambulatory care facilities. This is a program that has long been needed to assist tribes to secure quality health care in isolated rural areas. In the Northwest this could mean replacing old, worn out trailers that serve as the health clinics in tribal communities. Small modern clinic facilities assist tribes to attract health care professionals, provide a health focus for the community, and where tribes are agreeable and resources available, can provide health care services to underserved non-Indian individuals in the community. $25,000,000 is recommended annually for this purpose for 4 to 10 projects a year. There is an excellent record of achievement that should be rewarded with increased appropriations.

The Northwest Portland Area Indian Health Board has also suggested that the Indian Health Service 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 Indian Health Service to fulfill its obligation. A loan guarantee would substantially reduce the debt service associated with financing facilities. A $15 million fund (possibly funded with government bonds) could support construction of 7 projects a year with tribes repaying their loans with Medicaid collections or other sources of revenue.

**Facilities and Environmental Health and Engineering Support (IHF-35)**
This line item consists of four subsidiary activities; facilities support, environmental health support, and the office of Environmental Health and Engineering support. The Board estimates a need of $5,290,000 to maintain current services, but the President has proposed an increase of $7,268,000 for the laudable goal in increasing health promotion projects.

**Equipment (IHF 55)**
The Administration requests $16.3 million (no increase) for Equipment. Indian Health Service estimates an inventory of $310 million in equipment with an

average estimated life expectancy of 6 years. New facilities, including facilities built with non-IHS funds would benefit from additional funding for the equipment line item. The equipment line item funds normal equipment replacement due to age and maintenance. A reasonable estimate is that Indian health programs will need an additional $18 million annually to cover needs for biomedical, facility and telecommunications equipment. This amount will only cover the cost of upgrades and will not cover the cost of equipment-even where that would be more cost effective in the long run.

# The FY 2005 IHS Budget in the Context of the New Budgetary Realities

It is worthwhile to consider the overall budgetary context in any analysis of the FY 2004 Indian Health Service budget. When President Clinton left office there was a budget surplus that was anticipated to continue to grow to $6 trillion over ten years. Unfortunately, the recent recession (2000-2003) combined with tax cuts and war spending associated with fighting terrorism and funding for homeland defense has completely reversed the expected revenue and spending picture. It is anticipated that deficit spending will continue over the next ten years. What is more compelling is that these assessments do not include three major costs because they are not included in the President's budget request but are very likely to happen and will require funding. These items include the cost of reconstruction of Iraq, the costs of tax relief (AMT) and tax credits that are not accounted for in the budget.

Table 22 below compares significant differences between the estimates of the Congressional Budget Office and President (OMB) over the next five years. As the table illustrates, there is likely to be deficit budgeting for the next five years.

**Table 22. Five-Year Budget Projections**

**Table 22. Annual Budget Surplus Projections (Billions $)**

| (Dollars in Billions) | FY 2004 | FY 2005 | FY 2006 | FY 2007 | FY 2008 | FY 2009 | Total |
|---|---|---|---|---|---|---|---|
| CBO Baseline Projections | ($477) | ($362) | ($269) | ($267) | ($278) | ($268) | ($1,921) |
| President's Budget Projections | ($521) | ($364) | ($268) | ($241) | ($239) | ($127) | ($1,760) |

**Source**: CBO - The Budget & Economic Outlook FY 2005-FY 2014;
Analytical Perspectives: Budget of U.S. Government, FY 2005

**Budget Realities**

For FY 2004, discretionary programs represent approximately one-third of the budget of the United States government. Debt interest will represent approximately 11 percent of the budget down from 15 percent just four years ago. Mandatory spending for Social Security Act programs like Medicare, Medicaid and other mandatory programs such as veterans programs represent over 53 percent of the budget. Debt interest will grow over the next four years from 18 percent in FY 2004 to over 20% of the overall budget in FY 2008.

**Discretionary Spending**

President Bush has proposed $818.4 billion in discretionary spending for FY 2005. This is only a $31.1 billion (3.9%) increase over last year's budget request. Defense discretionary programs will receive a $26.5 billion increase or 7.1%

above FY 2004. Funding for defense, homeland security, and international affairs stood at $344 billion in FY 2001. It now equals $535 billion in FY 2004, an increase of $191 billion—after accounting for inflation the increase is 56%. By contrast, funding for domestic discretionary programs outside of homeland security increased from $338 billion in FY 2001 to $392 billion in FY 2004—after accounting for inflation the increase of 10.3%.

Last year, the CBO estimated the Iraq war could cost as much as $41 billion, however the costs turned out to be much higher. The Congressional Budget Office (CBO) estimates that the ongoing military operations in Iraq, Afghanistan, and the continuing war on terrorism could cost $280 billion over the next ten years. The Congress on October 29, 2003 passed the Emergency Supplemental Appropriations Act for the Reconstruction of Iraq and Afghanistan in the amount of $87 billion. The bill provides $18.6 billion for Iraq relief and reconstruction, while providing $1.2 billion for Afghanistan. These costs have exceeded the initial estimates of the war and will continue to have an impact on U.S. spending with a severe effect on discretionary spending. The President is expect to request a FY 2005 supplemental of $50 billion (above the budget submitted).

**Discretionary Spending for Indian Programs**

Federal spending on Indian programs is considered discretionary spending. This does not mean the U.S. government has no obligation to fund Indian programs, but it does mean that an annual appropriation is required to fund these programs, including the Indian Health Service budget. This year's HHS budget only includes $66.8 million, or 11.5%, for discretionary programs. The IHS budget ($2.97 million) represents less than 1% of the overall HHS budget ($580 billion) and 4.4% of the discretionary budget. Given the costs of the war in Iraq and the Administration's proposal to cut the deficit in half in five years, the prospect for discretionary programs does not look good.

**Appropriations Subcommittees**

There are thirteen appropriation subcommittees that consider funding bills. The Senate and House Interior Appropriation Committees develop the Bureau of Indian Affairs and the Indian Health Service budgets. IHS funds are transferred to the Department of Health and Human Services (similar to FDA funds from Agriculture to HHS). The Interior Appropriations Committee appropriates only 2% percent of all discretionary spending or about 5% of all non-defense discretionary spending. The Bush Administration's FY 2005 request for the Interior Appropriations Bill totals $20 billion in budget authority. This is the same amount as enacted in FY 2004. If this ends up being the 302 (b) allocation to the committee, the committee will be under severe constraints in allocating these small increases across the varied programs of the committee.

## The Indian Health Service Budget and Department of Health and Human Services

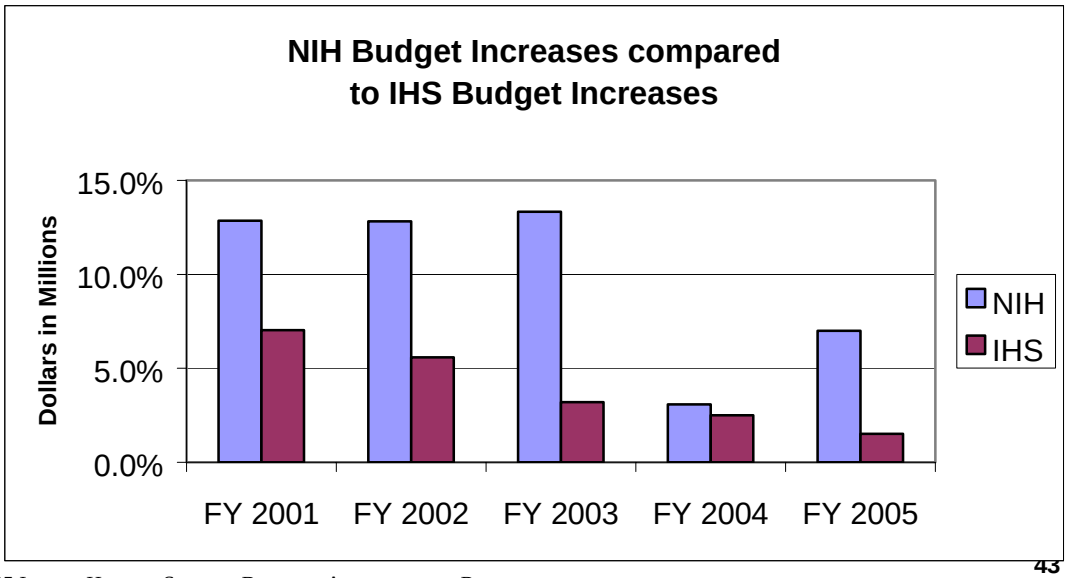
The FY 2005 Budget Authority of the Department of and Human Services totals approximately $580 billion. The enacted FY 2004 appropriation for the Indian Health Service budget totals $2.9 billion dollars. This means the Indian Health Service represents less than one percent (0.53%) of all spending by the Department. By comparison, Medicare represents $291 billion (50.2%) of all spending and Medicaid $182 billion (31.4%) of total spending by the Department of Health and Human Services in FY 2005. Table 23 below shows the IHS, the only agency whose only business is providing health care, lags behind most agencies that do not suffer from the effects of medical inflation eroding their core programs.

**Table 23. Five Health Care Agencies of the Department of Health and Human Resources**

| | FY 2000 | FY 2001 | FY 2002 | FY 2003 | FY 2004 | FY 2005 | FY 04 Change | 5-year Increase |
|---|---|---|---|---|---|---|---|---|
| **CDC** | $ 3,268 | $ 3,823 | $ 4,449 | $ 4,340 | $ 4,440 | $ 4,290 | -3.5% | 23.8% |
| **NIH** | $ 17,894 | $ 20,535 | $ 23,554 | $ 27,178 | $ 28,041 | $ 28,805 | 2.7% | 37.9% |
| **HRSA** | $ 4,795 | $ 6,304 | $ 6,209 | $ 7,017 | $ 7,188 | $ 6,578 | -9.3% | 27.1% |
| **IHS** | $ 2,421 | $ 2,604 | $ 2,758 | $ 2,849 | $ 2,922 | $ 2,967 | 1.5% | 18.4% |
| **SAMHSA** | $ 2,652 | $ 2,966 | $ 3,136 | $ 3,158 | $ 3,235 | $ 3,429 | 5.7% | 22.7% |

**Source**: DHHS FY 2004 Budget in Brief (Budget Authority numbers)

The chart below illustrates the National Institutes of Health (NIH) budget increases over the last four years as compared to the total budget for the Indian Health Services. It demonstrates the inequities in funding for Indian health within the Department of Health and Human Services. In FY 2002 and FY 2003 the increases alone for the NIH exceeded the total budget authority for the IHS!



The Department's discretionary program spending is just 11.4% ($68 billion in budget authority) of its total spending. Other discretionary programs in the Department include the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration. Table 23 shows the IHS, the only agency whose only business is providing health care, lags behind most agencies that do not suffer from the effects of medical inflation eroding their core programs.

**The Agenda of the Second Session of the 108th Congress**

The 108th Congress marks the first time since 1952 that the Republicans will control both the House and the Senate while having a Republican president. Despite nominal control of the government, it is once again unclear whether this Congress will pass a budget resolution since the Republicans do not have a veto-proof Senate. If there is a budget resolution it is likely there will be a reconciliation bill. Since such a bill only requires 51 votes for passage it is the likely vehicle for important agenda items of the Republican Party. If a reconciliation bill is introduced it could mean certain cost savings measures will be taken by Congress that will adversely effect Indian health programs. Reconciliation directives instruct various committees to meet budget targets through spending and tax saving measures.

The must-pass appropriation bills will be a key test of bipartisanship claims of President Bush. If he insists on his extremely low increase for non-defense spending (and he has House and Senate support for this), battles with the more moderate Senate could ensue. The Republicans in the Senate will have their own difficulties securing 60 votes to pass legislation.

The agenda for the second session of the 108th Congress includes few key budget items. The Administration's tax cutting proposals are becoming more difficult to justify, but a $50 billion supplemental for increase defense spending is likely. Republicans may want to review the recently passed Medicare Modernization Act

**The 1993 Government Performance and Results Act (GPRA)**

The Administration has taken unprecedented steps to reform the budget process by establishing systematic performance ratings like GPRA and the new Program Assessment Rating Tool (PART), which is intended to rate programs across the federal government. In 2002, agencies submit to the President and Congress annual reports that compare actual and target performance levels and explain any difference between them. The Indian Health Service scored better than most agencies and was judged 'moderately effective." The Indian Health Service included its FY 2004 Performance Plan as the same time as the budget justification. Hopefully, tribes will be asked again this year to work with IHS to formulate the FY 2004 Budget and GPRA performance plan. It remains to be seen what impact GPRA will have on funding decisions. As a general matter, tribes support performance budgeting, but with the cautionary note that goals

cannot be met without adequate funding. Many of the proposed IHS GPRA objectives reflect health status objectives proposed in Healthy People 2010.

**Conclusion: The Purpose of this Report**

This document and the Portland, Oregon budget workshop that was held March 4, 2004 represent an effort by the NPAIHB to provide tribes with an analysis of the Administration's proposed Indian Health Service budget and the pertinent legislation to assist them in their efforts to improve health care for their people. It 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 attract attention.

Budget formulation should be a participatory process. One of the best ways to develop such participation is for Tribes and the Indian Health Service 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 24 is based on these principles.

***Evaluation Based on Budget Principles: Table 24***

Table 24 grades the President's FY 2005 IHS budget against criteria (or principles) that the Northwest Portland Area Indian Health Board has developed and applied to budget analyses over the past four years. It is the Northwest Tribes' attempt to make an inherently subjective process more objective. The Northwest Portland Area Indian Health Board stands ready to engage in an honest debate over each aspect of this evaluation to clarify our position in the debate over funding Indian health programs. The President's overall score is between an F and a D- making it the worst budget since the first budget of the Clinton Administration in FY 1995. If enacted, it could be the worst budget increase in the history of the Indian Health Service. If enacted, Indian programs nationwide will reach priority one status earlier than any year of the past decade.

| | Table 24. GRADING THE PRESIDENT'S PROPOSED FY 2005 INDIAN HEALTH SERVICE BUDGET | President February 2, 2004 | Senate | House |
|---|---|---|---|---|
| | Criteria or Budget Principle | FY 2005 Grade | | |
| 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. | F | | |
| 3 | Appropriate increases will be included to address population growth | F | | |
| 4 | Appropriate adjustments will be made to fully fund tribal and federal employee compensation. | C- | | |
| 5 | The Contract Health Service Budget will be increased to fully fund the need for deferred services. | D+ | | |
| 6 | Collection estimates are not represented as fulfilling the federal responsibility to fully fund the IHS budget. | C- | | |
| 7 | Increases will be provided to address the goals of the Indian Health Care Improvement Act. | D- | | |
| 8 | Full funding will be included to support staff associated with new construction projects. | B | | |
| 9 | The Catastrophic Health Emergency (CHEF) Fund will be budgeted at a level to cover all qualifying cases. | C | | |
| 10 | Funding will be provided to cover Contract Support Costs for tribes electing to compact or contract their health care services. | F | | |
| 11 | Adequately support maintenance of IHS and tribal health facilities. | D- | | |
| 12 | The public announcements relating to the budget will honestly depict what is in the budget. | D | | |
| 13 | Provides adequate funding to reduce health disparities | F | | |
| 14 | Honor the federal trust responsibility to provide health care services to American Indians and Alaska Natives | D- | | |
| | I incomplete reverts to F in subsequent years | | | |