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NATIONAL INDIAN HEALTH BOARD

TESTIMONY ON, "FISCAL YEAR 2013 BUDGET REQUEST OF THE INDIAN HEALTH SERVICE AND OF THE OFFICE OF THE SPECIAL TRUSTEE FOR AMERICAN INDIANS"
MARCH 6, 2012, 2:00 PM

Chairman Young, Ranking Member Boren and Members of the Subcommittee, thank you for allowing me to be here today. My name is Rex Lee Jim, and I serve as the Vice President of the Navajo Nation and on the Executive Committee as Navajo Area Representative to the National Indian Health Board (NIHB)[1]. The NIHB, in service to the 566 federally recognized Tribes, offers the following written comments regarding the President's proposed FY 2013 budget for the Indian Health Service (IHS).

First, it cannot be overstated how thankful the NIHB is to this Congress for the passage of a 6% increase in funding to IHS for Fiscal Year (FY) 2012. Over the last three years, Congress and the Administration have made their commitments to Indian health and the fulfillment of the federal trust responsibility clear by ensuring that the IHS receives annual increases. As a result, IHS has been able to treat more patients than ever before, and American Indians and Alaska Natives (AI/ANs) have made small, but real gains in health status. NIHB applauds you for your dedication to upholding the sacred trust between the U.S. government and Tribes. Together, we must protect this recent progress.

In light of the current economic climate, the NIHB was relatively pleased to learn that, for the FY 2013 IHS budget, the Administration recommends a $115.9 million increase over the FY 2012 enacted IHS appropriations. Under the discretionary spending limits of the *Budget Control Act of 2011*, this 2.7% increase is significant. Where many other budget accounts saw deep cuts, this increase acknowledges the critical health needs of our tribal communities and represents the continued commitment to honor the federal government's legal obligation and sacred responsibility to provide health care to American Indians and Alaska Natives (AI/AN).

Yet, based on factors like population growth, medical inflation, and the possibility of cuts enacted through the sequestration process, this modest increase will, at most, only allow for the continuation of IHS current services. With exception of the Veteran's Administration, IHS is the only provider of direct care in the federal government, and funding levels should reflect its unique charge. Since IHS is currently funded, on average, at just 56.5% of need, this level of funding will not allow the agency to address the stark health disparities between AI/ANs and the U.S. general population. While we recognize the budget realities we face as a nation, the NIHB believes that a greater increase for the IHS is critically important and can be achieved. On behalf of the 566 Tribes, we urge this Congress to adopt funding levels for IHS more closely aligned with the FY 2013 National Tribal Budget Formulation Workgroup's recommendations.

[1] Established in 1972, the NIHB serves all federally recognized tribal governments by advocating for the improvement of health care delivery to AI/ANs, as well as upholding the federal government's trust responsibility to AI/ANs. We strive to advance the level and quality of health care and the adequacy of funding for health services that are operated by the IHS, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their Area. The NIHB is the only national organization solely devoted to the improvement of Indian health care on behalf of the Tribes.

National Tribal Budget Formulation Workgroup's Recommendations

The trust obligation to provide health care is paramount, and it is upon this foundation that the IHS National Tribal Budget Formulation Workgroup ("Workgroup") built its recommendations for the FY 2013 IHS budget. The Workgroup consists of tribal representatives from each of the 12 IHS Areas. Each year, this Workgroup consolidates all the IHS Areas' budget formulation recommendations; develops a consensus national tribal budget and health priorities document; and presents the recommendation to the U.S. Department of Health and Human Services (HHS).[2] The NIHB supports this government-to-government process and the final recommendations developed by the Workgroup.

For FY 2013, the Workgroup's recommendations were formally presented to the HHS on March 4, 2011, more than eleven months before the President presented his FY 2013 budget proposal to Congress. The Workgroup developed their recommendations based on the FY 2012 President's proposed budget. The recommendations focus on two types of needed increases:

1. **Current Services Increases and Binding Obligations:** *Preserving basic health care programs currently being funded.* Increases in current services are the budget increments needed to enable the Indian health care delivery system to continue operating at its current level. Current services comprise such items as federal and tribal pay cost increases; inflation; and funding for population growth. Also contained in this category are binding obligations that represent financial commitments previously made by IHS. These items must be funded in order to honor pledges made by the federal government. These binding obligations comprise of health care facilities construction, staffing for new and replacement facilities, and the shortfall in Contract Support Costs. Without these increases to base funding, the Indian health system would experience a *decrease* in its ability to care for the service population. In this economic climate, these increases are more important than ever. **For 2013, the Workgroup recommends an increase of $743 million for these items to maintain the existing level of services.**

2. **Program Increases:** *Significant program increases are required to address the overwhelming health needs in Indian Country.* The recommended increases are made in key IHS budget accounts to enable programs to improve and expand the services they provide to Indian patients. The IHS has long been plagued by woefully inadequate funding in all areas, a circumstance which has made it impossible to supply Indian people with the level of care they need and deserve, and to which they are entitled by treaty obligation. **The Workgroup recommends $688 million be added to identified program and facilities accounts.**

Below is a highlight of a few programs targeted by the Tribal Workgroup for vital increases.

[2] For copies of previous Workgroup recommendations, please visit the NIHB Budget Formulation page at http://www.nihb.org/legislative/budget_formulation.php.

Current Services: Inflation (Medical & Non-Medical) and Population Growth: Along with continued under-funding, IHS faces additional financial obstacles in its ability to provide care: inflation, both medical and non-medical, and population growth. Funding for IHS programs has not kept pace with inflation, while Medicaid and Medicare have accrued annual increases of 5% - 10%. The $59.9 million requested is needed to address the rising cost of providing health care and is based on the 1.5% non-medical inflation rate and 3.3% medical inflation rate identified by OMB. However, the actual inflation rate for different components of the IHS health delivery system is much greater. Thus, it is problematic that the President's FY 2013 request only contains an increase for medical inflation for only Contract Health Services. The National Tribal Budget Workgroup recommended that the rates of inflation applied to Hospitals & Clinics, Dental Health, Mental Health and Contract Health Services in developing the IHS budget should correspond to the appropriate components in the CPI, and that there should be parity in the calculation of inflation among HHS operating divisions. **The NIHB urges this Congress to consider the rates of inflation during the appropriations process and recommends a $59.9 million increase to address these costs.**

Additional funding is also needed to address the effects of population growth on IHS' ability to provide a continued level of care. IHS currently serves 2 million American Indians and Alaska Natives and this service population increases at an average rate of 1.9% annually.[3] The exclusion of population growth as a factor in the President's budget request puts the level of health care services into peril by reducing the availability of life-saving services for AI/ANs. **In accordance with the Workgroup's request, the NIHB proposes that $52.4 million be added to Current Services to account for population growth.**

Current Services: Federal and Tribal Pay Costs: The Workgroup recommended an $11 million increase for federal pay costs and a $13 million increase for tribal pay costs. However, the President's proposal contains a 1.7 percent pay raise for Commissioned Officers only at an increase of $2.4 million. The members of the National Tribal Budget Formulation Workgroup feel strongly that not only Commissioned Officers, but also Tribal and Federal IHS employees require a cost of living increase. **The NIHB recommends that Tribal and Federal IHS employees should be exempted from any federal employee pay freeze.**

Current Services: Contract Support Costs – Shortfall: Tribes in all Areas operate one or more such contracts. The ability of Tribes to successfully operate their own health care systems, from substance abuse programs to entire hospitals, depends upon the proper appropriation of Contract Support Costs (CSC). Full CSC funding honors the legal duty to pay these costs, and protects health care resources intended for service delivery. A year ago, the projection to fully fund CSC was $212 million and we currently await FY 2013 projections from IHS. **The NIHB supports the Workgroup's goal of full funding for CSC.**

Current Services: Health Care Facilities Construction 5-Year Plan: The Workgroup's recommendations include $343 million for previously approved health facility construction projects in accordance with the IHS Health Care Facilities FY 2012 Planned Construction Budget, referred to as the 5-Year Plan. Unfortunately, the Administration's request does not reflect this binding obligation. Rather, the President's FY 2013 Budget proposes a *decrease* to the Health Care Facilities Construction account. If the extensive, decades-long backlog of improvements and new construction continues to be ignored, the Indian Health System will

[3] IHS Fact Sheets: Indian Population (January 2011) at www.ihs.gov/PublicAffairs/IHSBrochure/Population.asp

never achieve parity with the U.S. general health system. **The NIHB supports a $343 million increase to the Health Care Facilities Construction 5-Year Plan.**

Program Increases: Contract Health Services: The contract health service (CHS) program serves a critical role in addressing the health care needs of Indian people. The CHS program exists because the IHS system lacks the capacity to provide directly all the health care needed by the IHS service population. In theory, CHS should be an effective and efficient way to purchase needed care – especially specialty care – which Indian health facilities are not equipped to provide. In reality, CHS is so grossly underfunded that Indian Country cannot purchase the quantity and types of care needed. As a consequence, many of our Indian patients are left with untreated and often painful conditions that, if addressed in a timely way, would improve quality of life at lower cost. **The Workgroup proposes an increase of $200 million for CHS.**

Program Increase: Hospitals & Clinics: Hospitals & Clinics (H&C) funding is a top Tribal budget priority representing additional opportunities to provide direct care, with more than half of the H&C budget transferred to the Tribes themselves. This funding supports essential personal health services, including inpatient care; routine and emergency ambulatory care; medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and patient therapy; and specialized programs for health conditions disproportionately affecting AI/ANs, such as diabetes, maternal and child health, women's health, elder health, and disease surveillance. **The Workgroup recommends a $219 million increase to H&C including:**

Indian Health Care Improvement Fund (IHCIF) - $45 million**:** The purpose of the IHCIF is to address deficiencies in health status and resources within the Indian Health System and to promote greater equity in health services among Indian Tribes. The IHCIF directs funding through the Federal Disparity Index to the lowest funded operating units.

Health Promotion and Disease Prevention (HPDP) - $30 million: The goal of the HPDP program is to create health AI/AN communities through programs focused on topics like diabetes, obesity, smoking cessation, cardiovascular disease, environmental quality, oral health, and traditional healing. A focus on cross-cutting issues, such as smoking and obesity, maximizes benefits by simultaneously reducing health risks for multiple conditions.

Information Technology (IT) - $30 million: Funding for IT invests in a burgeoning health IT infrastructure in the Indian Health System, as well as compliance with the HITECH Act and other new regulations. The transition from the ICD-9 to ICD-10 programs for medical diagnosis and inpatient procedure coding under Medicare and Medicaid is complex and must be completed by October 1, 2013. There has been no allocation to IHS to support this transition.

Program Increase: Behavioral Health: During the Budget Formulation process, the Workgroup identified behavioral health as its top ranked health priority. In concert with other health disparities, AI/ANs experience an alarmingly high incidence of mental and behavioral health disorders, including anxiety, substance abuse, and depression. In fact, they rank first among ethnic groups as likely to experience these types of disorders, with 23% of the AI/AN population reporting that they are frequently anxious or depressed. According to unpublished Indian Health

Service (IHS) data, suicide mortality is 73% greater in AI/AN population in IHS service areas compared to the general U.S. population.[4] These serious behavioral health issues profoundly impact individual and community health, both on and off reservation. Increased funding for Mental Health and Substance Abuse line items will allow individuals, families, and communities to begin to heal through clinical, emergency, and in-patient services; community-based prevention programming; child and family protection programs; and tele-behavioral health. **To be split equally between the two line items, the NIHB supports the Workgroup's proposal of an $80 million increase.**

Program Increase: Sanitation Facilities Construction: Currently 12% of AI/AN homes do not have an adequate potable water supply in comparison to 1% of homes for the U.S. general population.[5] The IHS Sanitation Facilities Construction (SFC) program provides potable water and waste disposal facilities and IHS reported that for every dollar IHS spends on sanitation facilities to serve eligible existing homes, at least a twentyfold return in health benefits is achieved.[6] **Due to the remaining need and success of this investment, the Workgroup recommends an $11 million increase**.

Additional Budget Recommendations

In addition to the Workgroup's recommendations, the NIHB would like to provide additional recommendations regarding the IHS budget.

Protect IHS Budget from rollbacks, freezes, rescissions, and sequestration

As a discretionary budget line, the IHS budget is subject to the across the board cuts to discretionary funding. Indian Country is thankful for the support of Congress and the Administration in recent years for significant increases to the IHS budget. However, the IHS budget has been subject to proposed budget cuts in the past. This was detrimental not only to an agency budget, but on the lives and well being of AI/ANs. Today, the IHS budget is funded on average at approximately half the level of need. Any budget cuts, in any form, will have harmful affects on the health care delivery to AI/ANs and will result in an increased loss of life. The NIHB asks the Subcommittee to work to exempt the Indian Health Service from any cuts, freezes, or rescissions.

With the deleterious effects of cuts still fresh in our minds, NIHB is very concerned about sequestration. Should sequestration occur, the two IHS budget accounts are capped at 2% in potential cuts under the *Budget Control Act of 2011*; however, the consequences of these reductions will be tangible, deadly, and rob the IHS of recent modest gains in health status. Due to factors like medical inflation and population growth, even small cuts have a large impact. Further, the IHS is the only federal provider of direct care to not be fully spared from this process. This must change. If this Congress cannot avoid sequestration through alternate methods of deficit reduction, the NIHB implores this Congress to make the IHS exempt from this process.

Create a long-term investment plan to fully fund IHS Total Need

[4] Fiscal Year 2013 Indian Health Service – Justification of Estimates for Appropriations Committee, Department of Health and Human Services, pg. CJ – 83.
[5] IHS Fact Sheets: Safe Water and Waste Disposal Facilities (January 2011) at http://info.ihs.gov/SafeWater.asp
[6] *Id.*

Tribes have long asked for full funding of the IHS. Developing and implementing a plan to achieve funding parity is critical to the future of Indian health and to fulfilling the United Status's trust responsibility to AI/AN people. The funding disparities between the IHS and other federal health care expenditures programs still exists and in 2010, IHS spending for medical care was $2,741 per user in comparison to the average of federal health care expenditure of $7,239 per person.[7] Tribes and the NIHB ask the federal government to design and implement a true full funding plan for the IHS.

Conclusion

Although our nation has been faced with a new budget reality since the National Tribal Budget Formulation Workgroup met to develop its request for FY 2013, its recommendations remain relevant. These funding levels speak to the binding commitments, both historic and recent, the federal government has made to Tribes, and to the desperate health status of First Americans. NIHB asks that this Subcommittee give deep consideration to the true needs of the IHS, as well as Indian Country, and the federal trust responsibility to AI/ANs. The nation's debt is a pressing issue, but a solution must not be achieved through broken promises.

I thank the Subcommittee for its time and for the opportunity to present this testimony. I am happy to answer any questions.

[7] IHS Fact Sheets: IHS Year 2012 Profile (January 2012) available at: http://www.ihs.gov/PublicAffairs/IHSBrochure/Profile.asp

THE INDIAN HEALTH SERVICE'S FY 2013 BUDGET RECOMMENDATIONS

Current Services Increases

	Tribal Workgroup FY 2013 Proposal[1]	President's FY2013 Request
Federal Pay Costs	$10,935,000	$2,412,000
Tribal Pay Costs	13,417,000	0
Inflation	59,977,000	33,987,000
Population Growth	52,466,000	0
Staffing for New/Replacement Facilities	50,000,000	49,236,000
Contract Support Cost – Shortfall	212,592,000	5,009,000
Health Care Facilities Construction 5-Year Plan	343,596,000	0
Total Current Services & Binding Obligations	**$742,983,000**	**$85,637,000**

Program Increases

Hospitals & Clinics	$219,170,000	$5,000,000
Indian Health Care Improvement Fund	45,000,000	0
Information Technology	30,000,000	5,000,000
Health Promotion Disease Prevention	30,000,000	0
Dental	21,000,000	1,000,000
Mental Health	40,000,000	0
Alcohol and Substance Abuse	40,000,000	0
Contract Health Services	200,000,000	20,000,000
Urban Indian Health	7,500,000	0
Direct Operations	8,200,000	1,115,000
Contract Support Costs (New & Expanded)	12,000,000	--
Facilities Maintenance & Improvement	11,500,000	1,749,000
Sanitation Facilities Construction	10,700,000	*0*
Health Care Facilities Construction	10,400,000	*(3,559,000)*
Small Ambulatory Program	4,500,000	0
Equipment	1,800,000	0
Total Program Expansion	**$688,030,000**	**$30,314,000**
Total Increases	**$1,431,013,000**	**$115,949,000**

[1] Note: this chart represents a summary of the National Tribal Budget Workgroup's recommendations. See appendix A for the full National Tribal Budget Recommendation table.

APPENDIX A: EXCERPT OF NATIONAL TRIBAL BUDGET RECOMMENDATIONS FOR FY 2013

Executive Summary

Introduction

"This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."

- The Constitution of the United States, Article VI

The federal budget is a moral, as well as a fiscal document. The nation's budget priorities are a demonstration of its core values and, in the case of the Indian Health Service, of its commitment to addressing the health needs of American Indian and Alaska Native people. The budget request for IHS reflects the extent to which the United States honors its promises of justice, health and prosperity to Indian people. The provision of federal health services to American Indians and Alaska Natives (AI/ANs) is the direct result of treaties and executive orders that were made between the United States and Indian Tribes, and of two centuries of Supreme Court case law developed in the wake of those treaties. Through the cession of lands and the execution of treaties, the federal government took on a trust responsibility to provide for the health and welfare of Indian peoples. It is this federal trust responsibility that is the foundation for the provision of federally funded health care to all enrolled members of the 565 federally recognized Indian Tribes, bands, and Alaska Native villages in the United States. The Snyder Act of 1921 provides the basic authority for health services provided by the federal government to American Indian and Alaska Natives. The Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450 *et. seq.*) allows Tribes to assume the administrative and program direction responsibilities that were previously carried out solely by the federal government. The Indian Health Care Improvement Act of 1976 (IHCIA) (25 U.S.C. §1601, *et. seq.*), the statutory basis of the Indian health care delivery, was permanently reauthorized in Title X of the Patient Protection and Affordable Care Act (Affordable Care Act)(Pub. L. 111-148), granting new authorities to Indian Health Service (IHS) and the Tribes.

Foundation for National Tribal Budget Recommendations

- U.S. treaties and laws requiring the U.S. government to provide health services to Indian people are grounded in the U.S. Constitution. The federal government has a constitutional obligation to fulfill this trust responsibility.

- Because of this trust responsibility, federal spending for the Indian Health Service is mandatory, not discretionary, spending. The Indian Health Service, like the Veteran's Administration, should be exempt from broad-based cuts in discretionary spending and budget rescissions.
- Although significant improvements in mortality and morbidity rates for AI/ANs have been and continue to be made by IHS, Tribal and Urban Indian health programs (I/T/Us or collectively, the

"Indian health system"), serious health disparities persist between AI/ANs and the general U.S. population, and in many areas of health the disparity gap is growing wider.

- In addition to significant health disparities, the Indian health system also faces significant funding disparities, both in per capita spending between IHS and other federal health care programs and within IHS, as reflected by differences in the Level of Need Funded (LNF) among IHS Areas and among sites within IHS Areas.

FY 2013 Budget Priorities & Recommendations

"Our native communities face problems that are serious, severe, and sometimes chronic… I intend to continue the long tradition of working together on this committee in a bipartisan manner to find solutions that will improve the lives and strengthen the futures of America's native people."

Senator Daniel Akaka (D-HI), Chairman

Senate Indian Affairs Committee, February 7, 2011

The National Tribal Budget Formulation Workgroup offers the following budget recommendations for FY 2013:

Top Budget Priorities

- Hold Indian health programs harmless and **protect prior year and proposed FY11 and FY12 increases** from budget roll-backs, freezes and rescissions. We have been encouraged by the increased investments made in Indian health in Fiscal Years 2008, 2009 and 2010 and greatly appreciate President Obama's proposed increases for FY 2011 and 2012, but are equally concerned that efforts by Congress and the Administration to reduce the overall size of the federal budget may jeopardize the progress made in recent years to address severe and chronic health and funding disparities in Indian country.

- Make a commitment to a multi-year funding agreement to **fully fund the IHS Total Need of $22.1 billion over the next 10 years**. It will take an additional $1.6 billion per year over the next ten years for the IHS budget to grow sufficiently to meet the total $22.1 billion health care need in Indian country. Developing and implementing a plan to achieve funding parity is critical to the future of Indian health and to fulfilling the United States' trust responsibility to AI/AN people. See "AI/AN Needs Based Funding Aggregate Cost Estimate" table and "Percent of Increase Required to Achieve Full Funding in 10 Years - $22.1 Billion" chart included in the Appendix.

- Increase the IHS budget for FY 2013 by **$1.431 billion in "must have" spending** over the FY 2012 President's Budget Request to a **total of $6.054 billion**.

- **Fully fund Current Services** (Federal & Tribal Pay Costs, Medical & Non-Medical Inflation and Population Growth) at +$136.795 million **and other Binding Obligations** (New Staffing for New/Replacement Facilities, Contract Support Cost - Shortfall and Health Care Facilities Construction 5-Year Plan) at +$606.188 million for a total of +$742.983 million.

- Increase funding for Hospitals & Clinics by $219.17 million over the FY 2012 President's Budget Request to a total of $2.18 billion.

- Increase funding for Contract Health Services by $200 million over the FY 2012 President's Budget Request, plus an additional +$30 million for the Catastrophic Health Emergency Fund (CHEF) for a total of $1.17 billion.

Other Budget Priorities

- Services Increases of $621.230 million to include:
    - $200 million for Contract Health Services and $30 million for CHEF
    - $80 million for Behavioral Health (Mental Health $40 million & Alcohol and Substance Abuse $40 million, with 50% of new Alcohol and Substance Abuse funding targeted to youth)
    - $75 million in Hospitals & Clinics (H&C) funding for New/Expanded programs
    - $45 million in Hospitals & Clinics funding for the Indian Health Care Improvement Fund (IHCIF)
    - $32 million in Hospitals & Clinics funding for Chronic Diseases (Diabetes, Cancer, Cardiovascular Disease)
    - $30 million in Hospitals & Clinics funding for Health Promotion and Disease Prevention
    - $30 million in Hospitals & Clinics funding for Information Technology

- Facilities Increases of $66.800 million to include:
    - $20.0 million for Health Facilities & Environmental Support
    - $18.2 million for Health Care Facilities Construction
    - $11.5 million for Maintenance & Improvement
    - $10.7 million for Sanitation Facilities Construction

These increases are needed to address funding disparities between the Indian Health Service and other federal health programs as illustrated below and in the "2010 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita" chart included in the Appendix to these National Tribal Budget Recommendations:

Medicare spending per beneficiary	$11,018	(2009)
Veterans medical spending per user	$7,154	(2010)
National Health Expenditures per capita	$6,909	(2010)
Medicaid spending per enrollee	$5,841	(2008)
Federal Employee Health Benefits per enrollee	$4,817	(2009)
Indian Health Service spending per user - all	**$3,348**	**(2010)**
Indian Health Service spending per user – medical care	$2,741	(2010)

These increases are necessary to address funding disparities within the Indian Health Service, as the Level of Need Funded (LNF) varies widely across and among IHS sites. The Area LNF funded ranged from 50.0% for the Bemidji Area to 62.2% for the Alaska Area for FY 2010. Among all IHS sites, the LNF ranged from a low of 44.7% to a high of 100%, with an average LNF of 56.5%. In December 2010, IHS estimated that it would cost $217 million to raise all IHS sites to a minimum LNF of 55% and $394 million to reach a minimum of 65%. See "Average LNF Score for IHS Areas – FY 2010" chart in the Appendix. The chart shows average Level of Need Funded (LNF) scores by Area. It is important to note that the national IHCIF formula applies to LNF scores of individual sites. Area average scores have no impact on IHCIF allocations, and are included here simply to illustrate that we are a long way from 100% LNF.

These increases are also needed to address the erosion of health care funding by population growth and inflation, particularly the diminished purchasing power resulting from medical inflation rates for CHS (estimated at 11%-12% in 2010), pharmaceuticals and other health services that far exceed standard non-medical inflation rates (1.5% in 2010) and general other medical inflation (3.6% in 2010).

"The federal Indian programs that we fight hardest to fund were created to fulfill the trust responsibility between this Nation and its first people. Authority to fund these programs derives from three distinct provisions of the Constitution – the Indian Commerce Clause, the Treaty Clause and the Property Clause. This is not "nice to have" spending. That is "must have" spending to fulfill the trust responsibility founded in the Constitution."

Senator Lisa Murkowski (R-AK), Ranking Member

Subcommittee on Interior and the Environment

Senate Committee on Appropriations, January 27, 2011

FY 2013 National Tribal Budget Recommendation Table

		Recommendation
PLANNING BASE - FY 2012 President's Budget		**$4,623,808,000**
Total increase to be spread		**$1,431,013,000**
Current Services & Binding Obligations	**Subtotal**	**$742,983,000**
Current Services	**Subtotal**	**$136,795,000**
Federal Pay Costs [1]		$10,935,000
Tribal Pay Costs		$13,417,000
Inflation (medical & non-medical)		$59,977,000
Population Growth		$52,466,000
Binding Obligations	**Subtotal**	**$606,188,000**
Staffing New/Replacement Facilities [2]		$50,000,000
Contract Support Costs - Shortfall		$212,592,000
Health Care Facilities Construction 5-Year Plan		$343,596,000
Program Expansion Increases - Services	**Subtotal**	**$621,230,000**
Hospitals & Clinics	Subtotal	$219,170,000
Indian Health Care Improvement Fund		$45,000,000
Health Information Technology[3]		$30,000,000
Maternal Child Health		$6,500,000
Health Promotion/Disease Prevention		$30,000,000
Diabetes, Cancer, Heart Disease		$32,000,000
Hospitals & Clinics - New/Expanded		$75,670,000
Dental Services		$21,000,000
Mental Health		$40,000,000
Alcohol & Substance Abuse		$40,000,000
Contract Health Services		$200,000,000
Catastrophic Health Emergency Fund (CHEF)		$30,000,000
Public Health Nursing		$12,600,000
Health Education		$11,400,000
Community Health Representatives		$15,400,000
Urban Health		$7,500,000
Indian Health Professions		$3,300,000
Tribal Management Grant		$660,000
Direct Operations[5]		$8,200,000
Contract Support Costs - New/Expanded		$12,000,000
Program Expansion Increases - Facilities	**Subtotal**	**$66,800,000**
Maintenance & Improvements		$11,500,000
Sanitation Facilities Construction [6]		$10,700,000
Heath Care Facilities Construction (HCFC) Authorities		$10,400,000
Small Ambulatory		$4,500,000
Youth Regional Treatment Centers		$3,300,000
Facilities & Environmental Support		$20,000,000
Injury Prevention		$2,600,000
Equipment		$1,800,000
Ambulance		$2,000,000
TOTAL		**$6,054,821,000**

[1] Federal Pay Costs - to be adjusted if pay freeze is extended

[2] Staffing New Facilities - to be adjusted to cover total requirement

[3] Health IT - increase distributed first to tribes to assist in meeting Meaningful Use and ICD-10

[4] H&C New/Expanded - to address the health priorities established by each Area

[5] Direct Operations - placeholder to establish Nevada Area Office, if approved

[6] Sanitation Facilities Construction - increase on this line is over FY 2011 President's Budget