

FY 2011 TRIBAL BUDGET RECOMMENDATIONS TO THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Standing on Principles:

A New Era in Tribal Government Relations

“The National Congress of American Indians does hereby declare of State of Emergency for Indian health programs; and...urge(s) Congress to provide emergency funding to deal with the Indian Health Care Crisis.”

National Congress of American Indians Resolution
Resolution PHX-08-030
October 2008

“So let me be clear, I believe treaty commitments are paramount law, I will fulfill those commitments as President of the United States. That’s why I’ve cosponsored the Indian Health Care Improvement Act and that’s why I am fighting to ensure full funding for Indian Health Care Services...”

Then-Senator Barack Obama
Crow Agency, Montana
May 19, 2008

Presented by:

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Executive Summary

The time for change is now – the federal government must embark in a new era of relations with American Indian/Alaska Native (AI/AN) Tribes. Our nation must finally address the well documented legal and moral obligations to build stronger and healthier Tribal communities. The FY 2011 Tribal Budget recommended increase of \$2.1 billion is a necessary first step toward meeting the overwhelming \$21.8 billion (adjusted for inflation over a three-year period based on Medicare inflation rate) needed to bring parity in health care for AI/AN. ***While the rest of the nation is actively debating health care reform, the Tribal community has for years been trying to play “catch up.”***

At the 2008 Annual Session of the National Congress of American Indians, the Tribes passed Resolution PHX-08-030 “***Declaring a State of Emergency for Indian Health***” across Indian country. The 2 million Native American voices must be heard. Tribal leadership across the country, in multiple forums, are sounding the drum beat – our elders and our children deserve better than third world levels of health care. Many of our people are dying, many suffer needlessly from preventable chronic diseases, and many of our youth are losing hope as evidenced by the troubling statistics of increased rates of suicide and substance abuse. Our Indian Health system must be revitalized and modernized – the neglect of the past decades must be addressed. Justifiable estimates show that full funding to meet just the basic primary health care demands in FY 2011 will cost nearly \$9.22 billion. An additional \$2.16 billion is needed to address public health programs, including health promotion/disease prevention to reduce future chronic care costs. A necessary investment in infrastructure and facilities, including health clinics, hospitals and sanitation projects, is estimated to cost another \$8.77 billion in one-time costs. Full funding for a viable Indian Health Service program will cost a total of \$21 billion. The sacrifice of 400+ million acres of land in exchange for adequate health care and education benefits must be recognized and honored.

Tribes have acted in good faith in the past 11 years to send Tribal representatives to participate in the DHHS Indian Health Services budget formulation process. Laborious hours have been spent establishing health funding priorities, aligned with tearful testimonies which tell the numerous stories of the tremendous health care needs in remote Alaskan villages, in isolated Indian reservations, and among the Indians displaced to urban areas. Year after year, Tribal requests for funding increases to address these health disparities have been set aside, and America’s first citizens have been left with a system of rationed health care, limited Priority One contract health services, no elder health care, little funding to address dental, optometry, behavioral health, and almost no funding for preventative health services to address our top health priority areas. These good faith efforts to communicate these very real funding gaps must be honored by urgent action.

“Too often, Washington has paid lip service to working with tribes while taking a one-size-fits-all approach with tribal communities across the nation. That will change when I am President of the United States.”

Then Senator Barack Obama
October 25, 2008

No longer are Tribes willing to just “go through the motions” – we must see change, real change which demonstrates that the U. S. government is sincere in its desire to eliminate the health disparities separating its first citizens from the rest of our neighbors. We implore this new Administration to take the first steps by supporting the \$2.1 billion increase for FY 2011, and by targeting full funding by 2021 to finally eliminate the health disparities for Indians. We ask that this Administration stand on its principles, with the highest of honor befitting this great nation, so that together we can make strong and healthy AI/AN Tribal communities a reality.

Tribal Budget Formulation Process

Each year, the Indian Health Service (IHS) budget is developed using a budget formulation process that involves the IHS direct operated programs, tribally-operated programs, and Urban Indian health programs, commonly referred to as the I/T/U. Representatives from each of the 12 IHS Areas serve on the I/T/U budget work team to discuss their health and budget priorities and develop funding recommendations. The work team, along with the IHS headquarters and national organizations, come together to develop consensus on the IHS budget priorities for that year, and to present their recommendations to the Department of Health & Human Services (HHS).

For the last seven years the IHS Tribal Budget Formulation Work Group has been denied the opportunity to consult with the Office of Management and Budget (OMB) about our budget recommendations. In this new era of Tribal Government relations, the Tribes expect that the OMB will bring transparency to the budget formulation process and engage with the Tribes on ensuring Tribal budget priorities are reflected in the 2011 President's Budget recommendations. Tribal leadership, including the Tribal Budget Formulation Team Co-chairs and Co-Chairs of the National Tribal organizations are ready to meet directly with the OMB Director to engage in meaningful negotiations on Tribal health budget priorities.

Standing on the Principles for Stronger Tribal Communities

We believe that change has come to America. We know it! American Indians and Alaska Natives continue to pay close attention to President Obama's consistent actions and commitment to improving the lives of America's Indigenous People.

We are standing with the President on his *Principles for Stronger Tribal Communities*: including, sovereignty, tribal-Federal relations and the trust responsibility.

President Obama acknowledges that *"Perhaps more than anyone else, the Native American community faces huge challenges that have been ignored by*

Washington for too long. It is time to empower Native Americans in the development of the national policy agenda"

"...So let me be clear, I believe treaty commitments are paramount law, I will fulfill those commitments as President of the United States. That's why I've cosponsored the Indian Health Care Improvement Act and that's why I am fighting to ensure full funding for Indian Health Care Services..."

Then Senator Barack Obama
Crow Agency, Montana
May 19, 2008

*Barack Obama's Principles for Stronger Tribal Communities
January 18, 2008*

We enter the budget formulation process for 2011 with renewed hope and the belief that our recommendations will be respected and will have an impact on the President's 2011 budget request for the Indian Health Service (IHS). This is a significant departure from previous years expectations when the Tribes consistently came before the Department with detailed and

supported budget requests only to find that the resulting budgets bore little resemblance to the Tribal requests and recommendations. Our renewed hope is based on the words, actions and commitments of President Obama. For example, President Obama voted in the Senate to provide an additional \$1 billion for IHS to address the abhorrent health disparities in Indian Country. Additionally, he was an original cosponsor of the Indian Health Care Improvement Act of 2007 which mandates modernization of the Indian health care system and strengthens urban Indian health facilities. President Obama also fought against the Bush Administration's attempt to eliminate urban health care for Indians not living in reservation communities and he opposed a federal land acquisition program that would have diverted funds from the Special Diabetes Program for Indians and the Alcohol and Substance Abuse program. The President also consistently states that he supports sufficient funding for IHS and he demonstrated this most recently with the release of his FY 2010 budget in which he recommended a substantial funding increase significantly higher than years past.

Momentous harbingers of hope are found in the President's "Principles for Stronger Tribal Communities." President Obama outlines three:

1. Sovereignty;
2. Tribal-Federal, Government-to-Government Relations (Consultation and Inclusion)
3. Honoring Trust Responsibility.

It is in this spirit and optimistically standing side-by-side with the President on these Principles that we are here today representing the Tribes of this nation to provide their health priorities and funding recommendations for inclusion in the President's FY 2011 budget for the Indian Health Service.

Federal Trust Responsibility: Legal & Historical Roots

The provision of health services to AI/ANs is the direct result of treaties and executive orders that were made between the United States and Indian Tribes. This federal trust responsibility forms the

"Barack Obama recognizes that honoring the government-to-government relationship requires fulfillment of the United States' trust responsibility to tribes and individual Indians."

Principles for Stronger Tribal Communities

basis of providing health care to AI/AN people. This relationship has been reaffirmed by judicial decisions, executive orders, and congressional law. US Senator Byron Dorgan (ND), Chairman of the Senate Committee on Indian Affairs often describes health care delivery in many Indian communities as "rationing," and says it is "shameful" given the federal government's treaty commitments and trust obligations.

Overview of Indian Health System

The Indian Health Service is responsible for providing health care to all enrolled members of the more than 562 federally recognized Indian tribes, bands, and Alaska Native villages in the US.¹

The AI/AN health care delivery system consists of 594 health care facilities across the country, including 49 hospitals, 579 ambulatory facilities (231 health centers, five school-based health

centers, 133 health stations, 34 urban Indian health program, and 176 Alaska Native village clinics). These health care facilities can be grouped into three categories: those operated directly by IHS, those operated by the tribes through a Tribal Health Authority (THA) by contract or compact with IHS, and those providing services to urban AI/ANs (individuals not residing on or near an Indian reservation).

There is no consistent health benefits package across Indian country. Some Tribes operate their health facilities, some Tribes rely on the Indian Health Service to operate their facilities, and those Tribes without facilities rely on Contract Health Services (CHS) with private clinics or hospitals to provide care. What is consistent, however, is that there is an overwhelming lack of funding to support even the basic health care demands in all three delivery models. Along with ambulatory primary care services, Tribal, IHS or Contract Care facilities may offer inpatient care, sporadic medical specialties, traditional healing practices, dental care, child and emergency dental care, mental health care, limited eye care, and substance abuse assessment or treatment programs. Many tribes are also served by community health (e.g., childhood immunizations, home visits) and environmental health (e.g., sanitation, injury prevention) programs, which may be administered by the IHS or the THA. Specialty services and types of medical care that are not available at a given facility are often purchased from providers in the private sector through a contract health service (CHS) program. Due to lack of adequate funding, the IHS and THAs apply stringent eligibility criteria to determine which patients qualify for CHS funding. The severely limited pool of CHS dollars also means that most CHS programs limit reimbursement to those diagnostic or therapeutic services that are needed to prevent the immediate death or serious impairment of the health of the patient. Long lists of denied or deferred CHS care are commonplace at all IHS and Tribal facilities.

There are 34 Urban Indian Health Programs (UIHP) that provide health services to AI/AN beneficiaries. Urban Indians are our brothers, sisters, cousins, or ourselves as we move between our tribal homes and the urban centers for work, to pursue education, or to advocate on behalf of all AI/ANs. Although AI/ANs were originally forced to urban locations during the Termination and Relocation era due to economic pressures and the federal policy at the time, now most AI/ANs transition between their tribal homes and the urban centers depending upon their needs and the needs of their families. The UIHP is there to provide health care for AI/ANs when they live in urban setting, thus helping to form a complete circle of care with tribal and IHS health providers.

Fulfilling its role in the circle of care for AI/ANs, the UIHP provides culturally competent, non-duplicative health services to 140,000 people annually.² The clinics and programs of the UIHP perform a number of critical functions within the Indian health system, including:

- overcoming cultural barriers and developing culturally appropriate best practices
- saving costs by providing preventative health service to Urban Indians
- UIHPs provide chronic disease health services
- UIHPs reduce costs to other parts of the I/T/U system by forming a complete network of care for AI/ANs and ensuring AI/ANs in urban settings have proper health care so they do not have to return to their tribal homes in medical crisis
- UIHPs are a key provider to many uninsured Urban Indians who are unlikely go to a non-Native or non-IHS facility for health care services

Statistics reflect a critical need for health promotion and disease prevention activities in Indian country. Provisions of the IHCIA reauthorization, when passed into law, would address this need.

- The Centers for Disease Control reported suicide rates for AI/AN youth and young adults ages 15 to 34 years old are 2.2 times higher than the U.S. population average, 21.7 per 100,000 vs. 10.0 per 100,000, respectively. Moreover, suicide is the second leading cause of death for this AI/AN age range.³
- Indians are 550% more likely to die from alcoholism, 200% more likely to die from diabetes, and 150% more likely to suffer accidental death compared with other groups.⁴

Among other problems, this results in reduced access to screening services and contributes to increased cancer mortality. Data from the 2008 IHS GPRA Summary Report indicates that only 45% AI/AN women between 52 and 64 years of age have had a mammogram within the past two years.

Targeting programs such as Diabetes & Cancer prevention, promotion of Holistic Wellness under Behavioral programs, Maternal Child Health programs, safety programs to prevent injuries, self-care management and regular health screening, among others is key to reducing long-term cost of high-acuity medical treatment and expensive chronic care in our Native population.

FY 2011 Budget Recommendations

CURRENT SERVICES

Our first goal is to maintain services and prevent further erosion of funding for Indian health programs, especially in the face of recent dramatic increases in operating costs as a result of the national energy crisis. The following budget request will maintain and prevent decreasing American Indian and Alaska Native (AI/AN) access to adequate health services, allowing us to move forward and not backward, in eliminating health disparities among AI/ANs. The Current Services Increases budget outlined below is essential for maintaining the base funding for the IHS programs. Similarly, the Program Services Increases budget is necessary to maintain current levels of access to care. Explained in more detail below, both types of funding are equally crucial if any progress is to be made in addressing our healthcare priorities included in this document.

AIAN Health Care Funding Need – An Aggregate Cost Estimate

GROSS COST ESTIMATES

Source of funding is not estimated

<i>Need for Existing Users at I/T Sites</i>	<i>Need Expanded for Eligible AIAN at I/T/U Sites*</i>
1,482,000	2,000,000

SERVICES

	\$ Per Capita	Billions	Billions
Medical Services	\$ 4,612	\$ 6.84	\$ 9.22
Medical services and supplies provided by health care professionals; Surgical and anesthesia services provided by health care professionals; services provided by a hospital or other facility, and ambulance services; Emergency services/accidents; Mental health and substance abuse benefits; Prescription drug benefits	Based on 2008 FDI benchmark (\$4,100) inflated to 2011 @4% per year	\$ per capita * Users	\$ per capita * Eligible AIAN
Dental & Vision Services	\$ 483	\$ 0.72	\$ 0.97
Dental and vision services and supplies as covered in the Federal Employees Dental and Vision Insurance Program	2008 BCBS PPO Vision (\$87) and Dental benchmarks (\$342) inflated to 2011 @4% per year	\$ per capita * Users	\$ per capita * Eligible AIAN
Community & Public Health	\$ 1,082	\$ 1.60	\$ 2.16
Public health nursing, community health representatives, environmental health services, sanitation facilities, and supplemental services such as exercise hearing, infant car seats, and traditional healing.	19% of IHS \$ is spent on Public Health. Applying this ratio, \$1,082 per capita = (.19/.81*\$4612).	\$ per capita * Users	\$ per capita * Eligible AIAN
Total Annualized Services	\$ 6,176	\$ 9.15	\$ 12.35

FACILITIES

	\$ Per Capita	Billions	Billions
Facility Upgrades Upfront Cost	<i>na</i>	\$ 6.50	\$ 8.77
Annualized for 30yr useful life		\$ 0.38	\$ 0.51
IHS assessed facilities condition (old, outdated, inadequate) and has estimated a one-time cost of \$6.5b to upgrade and modernize. A 30yr useful life assumption is used to estimate the annualized cost (assuming 4% interest) of the upgrades.			

TOTAL

	Billions	Billions
Total Annualized Services + 1-Time Upfront Facilities Upgrades	\$ 15.65	\$ 21.12

Gross costs for mainstream health care to AIAN and facilities upgrades are based on typical cost factors. The actual costs that would be experienced among I/TAU sites would vary. Gross costs are estimated expenses without specifying sources of payment. Under current law, a portion of gross costs would be paid by Medicare, Medicaid, and private insurance depending on the # of AIAN eligible - which varies place-to-place and time-to-time. The extent that gross costs would be offset is not precisely known. For certain planning assumptions, IHS assumes a crude 25% nation-wide.

*Crudely—AIANs residing in service areas, including urban areas, discounted for AIAN already partially served by IT sites.

Pay Costs: (both Federal & Tribal): The Tribal and Urban Indian leadership requests \$26.9 million for “Federal Pay Cost” increases. This enables the IHS to fund the mandated pay increases of Federal employees for FY 2011. Tribal and Urban Indian leaders request an additional \$29.2 million to allow Tribally-operated and Urban health programs to provide comparable pay raises to their own staff.

Inflation: It is clear that funding for the IHS has not kept up with inflation. Health facilities have been especially hit financially with uncontrolled energy costs which affects not only operating costs but also supply, labor, transportation, construction, equipment, pharmaceutical, and contracted healthcare costs. While mandatory programs such as Medicaid and Medicare have accrued annual increases of 5-10% to keep pace with inflation, the IHS has never received comparable increases. Our budget recommendation includes \$63.3 million critically needed to address the increased cost of providing health services due to inflation. The inflation rate now used by the Federal Office of Management and Budget (OMB) is insufficient to address the actual inflationary costs experienced by I/T/U programs. Funding to make up for the true medical inflation rate is especially crucial to programs dependent upon Contract Health Services (CHS) funding. The CHS program is most vulnerable to inflation pressures affecting rising pharmaceutical costs and purchased inpatient and outpatient hospital care. An additional \$54.8 million is requested to address the actual inflation rates expected in FY 2011 for the CHS program.

Contract Support Costs: One of President Obama's Principles for Stronger Indian Communities is acknowledging and strengthening Tribal Self-Determination. Successful demonstration of Tribal Self Governance has been showcased in those Areas where Tribes have assumed the management of their own health care systems in a customer-owner health deliver model. This model is one that promotes an environment which is less paternalistic and sets the stage for self care management which will have better outcomes when targeting health promotion and disease prevention performance objectives. The choice of Tribes to operate their own health care system and their ability to be successful in this endeavor is due in no small part to the availability of Contract Support Costs.

Successful Tribal Health Organizations rely on Contract Support Costs (CSC) as a vital foundation to develop the administrative infrastructure needed to successfully operate IHS programs. The present underfunding of CSC creates a disincentive for Tribes to compact or contract, and diminishes available healthcare funding, as limited program funds must be used to absorb this shortfall. Adequate CSC funding will assure that Tribes, under the authority of their contracts and compacts with the IHS, have the resources necessary to deliver the highest quality healthcare services to their members without sacrificing program dollars. It has been demonstrated that Tribal programs have increased the quality and level of services in their health systems fairly significantly over IHS-operated direct service programs. Failing to adequately fund "Contract Support Costs" defeats the very program that most appears to improve health conditions for AI/ANs. We strongly urge consideration of this line item, and recommend \$170.1 million to alleviate the CSC shortfall for current contracting and compacting Tribes.

Population Growth: According to information provided by the National Center for Health Statistics, birth-death records indicate that the AI/AN population is increasing at approximately 1.5% per year. This increase translates to approximately 30,000 new patients entering the Indian health care system annually. We recommend \$42.9 million to meet new demands produced by population growth. Failure to fund medical costs related to population growth translates into further erosion of existing health care dollars to meet current demand for services.

Health Care Facilities Construction: Facilities, both Tribal and IHS, have suffered long-term neglect for both existing structures and by not addressing the demand for new or expanded facilities. The current average age of an IHS facility is 33 years. The continuing "pause" on

facility construction has delayed attempts to address the aging healthcare facilities within the IHS system. We recommend \$281.3 million, allowing the IHS to replace its priority healthcare facilities with modern facilities and to significantly expand capacity at its most overcrowded sites. In additional \$60 million is requested for the Joint Venture program to allow Tribes to leverage federal resources with tribal funds to construct necessary health facilities. We also recommend that that the Department support the development of new innovative facilities construction program by providing \$140 million for an Area Distribution Construction Fund as a way of accelerating the completion of the 100+ years of backlog in health facility construction.

Staffing for New Facilities: \$25 million is requested to fund staffing and operating costs for new facilities scheduled to open in FY 2011. Investments made in the construction of healthcare facilities must be accompanied by the necessary resources to meet the updated staffing and operating costs.

Restoration of FY 2008 Rescissions and Sequestration: Not only have we not realized increases to meet real inflationary costs, Tribes have been subjected to across the board rescissions in funding in years past. The Tribal budget request recommends restoring the FY 2008 across-the-board rescission in the amount of \$53.5 million. Rescissions erode the funding base of the IHS budget and cannot be recovered unless the Department recommends this restoration. Tribal and Urban Indian leaders vigorously request an exemption for the IHS budget to any rescissions that are passed down by Health and Human Services.

PROGRAM INCREASES

Hospital & Clinics: We recommend \$500 million to support IHS and tribal programs in the treatment and care of chronic diseases, including diabetes, cancer, and heart disease, as well as sustained programs for health promotion and disease prevention to reduce future demand for chronic care in these disease categories.

Indian Health Care Improvement Fund: From the amount recommended above, we recommend that \$10 million be made available for the Indian Health Care Improvement Fund (IHCIF). The IHS is funded at approximately 60% of need. IHCIF funds are appropriated by Congress to reduce disparities and resource deficiencies between units within the IHS system. The funding formula targets funding deficiencies measured by the Federal Disparity Index. The FDI model was developed through national Tribal consultation, by a Tribal/IHS workgroup, health economists, and actuaries.

The disproportionately high rates of AI/AN morbidity, mortality, and disability are greatly exacerbated by disparate healthcare resources. Though there are significant needs for all IHS units, the most under-funded units require immediate attention. The additional \$10 million requested in FY 2011 will begin to reduce disparities for the most deficient units, and will provide greater equity in funding, but does not eliminate the \$15 billion system-wide deficiency identified by the FDI methodology.

Information Technology: The Indian Health Services and Tribal Health Authorities must be modernized to the technology standards of the mainstream health care industry. \$30 million is recommended for “Information Technology” within the H&C budget. It is critical that we develop the infrastructure and support systems needed to implement Electronic Health Records

(EHR) and telemedicine capabilities in the I/T/U system. Many Tribal communities are located at great geographic distance from specialists or inpatient facilities. Tribal leaders consistently voice the need for improved inter-connectivity. Advanced information technology services cannot be supported using existing outdated hardware and software. It is a priority for the Indian health system to develop uniform data collection to enhance surveillance, reporting, accountability, and to vigilantly bill third party resources when appropriate. Moving to a nationwide Electronic Health Record system will produce vast improvements in care and efficiencies in administration of health care delivery systems. While tribal leaders are cognizant that many budgets are being consolidated, this is one area that must receive increased funding to keep projects moving forward.

Dental Health: Adult dental care is almost non-existent in most Tribal communities. Limited funds are targeted for children and, when lucky, for adult emergency care, usually in the form of tooth extractions. The FY 2011 budget recommendation includes an increase of \$30 million for the “Dental Health” budget. Dental conditions are deplorable in Indian Country, and are recognized in the health industry to be a cause of significant health problems. AI/ANs have among the highest rates of tooth decay and gum disease in the US. Dental services are extremely limited, for example, routine procedures such as root canals and dentures services are not available to Tribal members. It is not uncommon for facilities to ration or defer dental care when funds are low. Nationally in 2008, the IHS GPRA Summary Report indicated only 25% of AI/AN people have access to dental care. This is substantially below our Healthy People 2010 goal of 40%. To address this, we recommend that the IHS assist Tribes in developing their own expanded duty dental auxiliaries.

Mental Health: Depression and other mental health diseases continue to destroy the sanctity of countless AI/AN families. Generational trauma relating to displacement of families to reservations, past overt discrimination by the larger society, extreme poverty conditions, high rates of substance and/or sexual abuse, as examples, are a tragic reality for many Tribal communities. Behavioral health services are inadequate to meet the present and growing needs of mental health disorders. Psychological services are necessary to improve outreach, education, crises intervention and the treatment of mental illness such as depression. Stronger action and intervention is necessary. To address this, additional funding in the amount of \$20.6 million is requested to enable IHS and AI/AN Tribal governments to provide culturally appropriate mental health services in a more timely and efficient manner consistent with current health problems. Wellness cannot be achieved without will, and will is not possible without a healthy outlook on life.

Alcohol and Substance Abuse Program: It has long been established that alcohol and substance abuse is a prevalent society affliction within Tribal communities. Last year’s budget increase provided for increased services and community interventions, yet the overwhelming demand for alcoholism and substance abuse treatment, aftercare prevention continues to be a major issue. This disease is associated with injuries, accidental death, domestic violence, suicide and other chronic health and social problems. Methamphetamine and inhalant abuse have reached epidemic proportions on reservations and some Alaskan villages. The Tribal budget recommendation for FY 2011 includes an increase of \$19.6 million to target Alcohol and Substance abuse programs and aggressive community-based prevention activities.

Contract Health Services: In the FY 2011 budget recommendation, Tribes have recommended a modest increase of \$500 million for Contract Health Services (CHS). The Senate Committee on Indian Affairs *Views and Estimates* letter on the FY 2010 budget reports that the documented need for the CHS program in Indian Country easily exceeds \$1 billion. At present, less than one-half of the CHS need is being met, leaving too many Indian people without access to necessary medical services. Many tribally-operated health programs no longer report deferred or denied services because of the expense associated with tracking and reporting un-provided services. More disturbing is that many IHS users avoid treatment of curable diseases and do not even visit health facilities, because they know they will be denied services due to funding shortfalls.

Within the Indian Health delivery system, CHS funds are used in situations where: (1) no IHS direct-care facility exists and health services are provided by a contracted private facility, (2) the direct-care facility has a limited scope of services and is incapable of providing the required emergency and/or specialty care, or (3) the direct-care facility has an overflow of medical care workload and must divert immediate care demands. In order to budget the limited CHS resources, the agency must apply stringent eligibility rules and use a medical necessity-based priority system. Non-emergency services must be pre-authorized and are limited based on pre-determined priority levels of care. CHS policies dictate that emergency services are only authorized if notification is provided within 72 hours of the patient's admission for emergency treatment creating an artificial barrier to access for health care. In all CHS cases, reimbursement for emergency care is not guaranteed and many patients find themselves facing collection agencies when their cases are denied due to lack of available CHS funding. The authorized health care priorities funded by CHS differ from facility to facility and fluctuates throughout the fiscal year based on the amount of funds available and the volume of demand. Insufficient funding in the CHS program causes most IHS and Tribal health programs to fund only "Priority One" services:

Priority One - Emergent/Acutely Urgent Care Services: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available. "Priority One" represents those diagnoses and treatments of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.

In areas where there are no hospitals, many Tribes begin the year in "Priority One" status because they obligate new fiscal year funds to clear the previous year's denied or deferred cases. Often Tribal members in CHS dependent service areas live by the dictum "don't get sick before June", although some areas have modified this to "don't get sick before March" because there won't be contract health dollars available to pay for care.

Urban Program: Tribes support a FY 2011 budget recommendation to increase the health care budget for the Urban Indian Health Program (UIHP) by a nominal \$10 million. Former President Bush's FY2009 budget argued that AI/AN living in urban centers could seek care from HRSA operated Community Health Centers (CHC) and any other local, state, and federal health resources; however, this position ignores the substantial barriers to care faced by urban AI/AN. The National Association of Community Health Centers has consistently stated that, since 2006 when the President Bush first proposed the elimination of the UIHP, the HRSA CHC grantees

have neither the funds nor the expertise to absorb the 150,000 patients annually served by UIHP clinics.

UIHP clinics are the only health care providers in urban centers providing culturally appropriate Indian health services. Without this program AI/AN living in urban centers would most likely return to their home reservations to seek care—often times delaying necessary care for months (if not years) until they return home, when their conditions worsen and the cost of treatment is substantially higher. No study or consultation has ever taken place addressing the impact that the total elimination of the UIHP would have upon Tribal programs. The UIHP represents approximately 1% of the Indian Health Services; and it is a necessary and congressionally-mandated program supporting the demand on the overall Native health system. Continuing attempts to eliminate the UIHP sends a troubling message: that the Administration seeks to substantially rescind its legal Trust responsibility. This FY 2010 budget recommendation to continue to fund the UIHP reaffirms the Trust relationship between the Federal government and Native American peoples.

Maintenance and Improvement: Tribes are increasingly concerned about the inadequacy of funding for the maintenance and improvement (M&I) routine expenses and specific projects related to Federal and Tribally-owned health care facilities. Base M&I funding to sustain the facilities in their current condition is estimated at \$80 million annually. In addition, the backlog of maintenance projects is currently estimated by IHS to be \$371 million. A minimal increase of \$20 million is recommended to address these two categories of need. M&I funds support and enhance the delivery of healthcare and preventative health services, and protects investments in real property from costly deterioration. Tribes recommend that increased funding be allocated to M&I to prolong the usable lifespan of federal and Tribal health care facilities.

Sanitation Facilities Construction: The Tribal recommendation for FY 2011 includes an increase of \$35 million for “Sanitation Facilities Construction”. Availability of adequate plumbing systems in homes has proven to have a direct correlation with prevention of diseases. Currently, 12% of AI/AN homes do not have an adequate potable water supply. In most cases, sanitation construction projects ensure a central water or waste point within AI/AN communities. Our request is minimal given that it would only cover water and waste-haul systems – not piped water and sewer for all AI/AN homes.

Facilities and Environmental Health Support: The level of funding for Facilities Support (FS) and Environment Health Support (EHS) has stayed relatively flat or received small annual increases (less than 2%). With the rising cost of salaries and double digit annual increases in energy costs, this funding line is not keeping pace with inflation. We recommend an increase of \$12 million for FS and EHS. FS supports utility costs and maintenance personnel to operate hospitals and clinics. EHS supports engineering services for the sanitation facilities program and for monitoring the safety of the community environmental health services.

FY 2011 National Budget Worksheet

		Recommended
FY 2010 President's Budget		4,000,000,000
Total \$ Increment to Spread Among Items		2,094,245,000
Balance Of Increment To Spread		0
CURRENT SERVICES*	747,045,000	947,045,000
Federal Pay Costs	26,900,000	26,900,000
Tribal Pay Costs	29,200,000	29,200,000
Inflation	63,300,000	63,300,000
Additional Medical Inflation	54,800,000	54,800,000
Population Growth	42,900,000	42,900,000
New Staffing for New/Replacement Facilities	25,000,000	25,000,000
Contract Support Costs	170,100,000	170,100,000
Health Care Facilities Construction	281,324,000	281,324,000
Joint Venture		60,000,000
Area Distribution		140,000,000
Restoration of FY 2007 Rescission (none)		
Restoration of FY 2008 Rescission @ 1.56%	53,521,000	53,521,000
PROGRAM INCREASES BY BUDGET LINE ITEM	82,000,000	1,147,200,000
Hospitals & Clinics		500,000,000
Indian Health Care Improvement Fund *		*
Information Technology *		*
Dental		30,000,000
Mental Health		20,600,000
Alcohol and Substance Abuse		19,600,000
Contract Health Services		500,000,000
Public Health Nursing		0
Health Education		0
Community Health Representatives		0
Alaska Immunization		0
Urban Indian Health		10,000,000
Indian Health Professions		0
Tribal Management		0
Direct Operations		0
Self-Governance		0
Contract Support Costs		0
Maintenance & Improvement	20,000,000	20,000,000
Sanitation Facilities Construction	35,000,000	35,000,000
Health Care Fac. Constr. Authorities	15,000,000	0
Facilities & Environmental Health Support	12,000,000	12,000,000
F&FEHS No & So CA YRTC		
SUBTOTAL Current Services + Program Increases	829,045,000	2,094,245,000
BASE APPROPRIATION	3,346,179,000	4,000,000,000
GRAND TOTAL	4,175,224,000	6,094,245,000

* Funding is recommended for the IHCIF and IT to be funded as a subset of Hospitals & Clinics Funding

2011 Tribal National Health Care Priorities

Investing in the needs based budget is a critical first step to addressing Tribal health care priorities. The following priorities target the most immediate health disparities among AI/AN people. The need to address these disparities is acknowledged in President Obama's Principles for Stronger Tribal Communities.⁵

2011 Tribal National Health Care Priorities

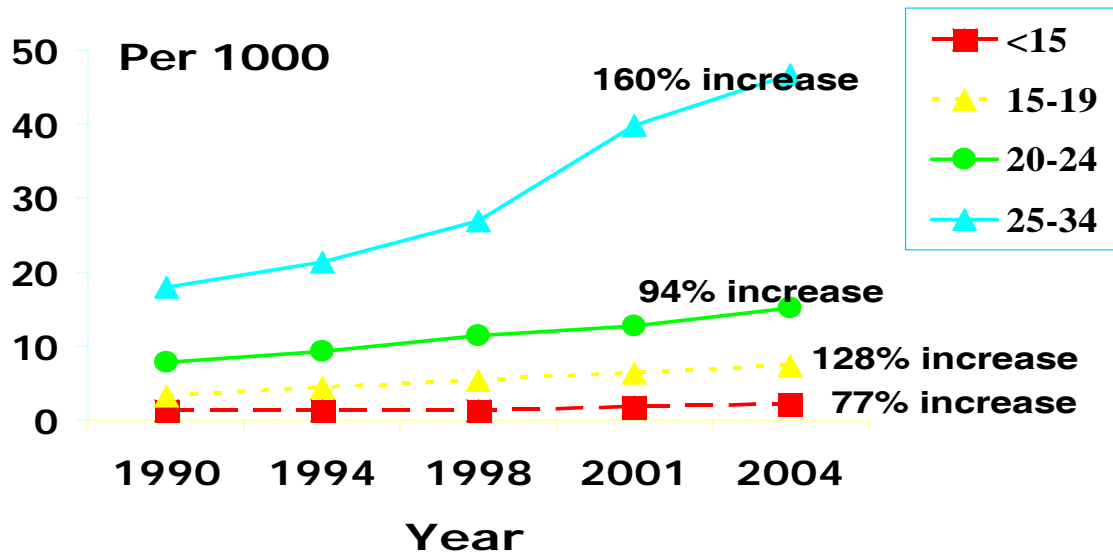
1. Diabetes
2. Cancer
3. Behavioral Health/Alcohol/Substance Abuse/Mental Health
4. Cardiovascular Disease/Heart Disease/Stroke
5. Health Promotion/Disease Prevention
6. Injuries/Injury Prevention
7. Maternal and Child Health
8. Dental Health
9. Water and Sanitation
10. Respiratory/Pulmonary

Below are descriptions and brief narratives for each of the Tribal national health priorities:

1. Diabetes⁶

Diabetes continues to rank as the number one national health focus priority for Tribes. The rates of diabetes for AI/ANs are the highest in the U.S., with rates of diagnosed diabetes in adults as high as 60 percent in some of our communities. Between 1997 and 2004, the prevalence of diabetes increased by 45 percent in all major regions (all ages) served by the Indian Health Service (IHS). The highest rate of increase has occurred among AI/AN young adults aged 25-34 years, with a 160 percent increase from 1990-2004. Alarmingly, type 2 diabetes rose 128% in AI/AN adolescents 15-19 years old.

Prevalence of diagnosed diabetes among children and young people, by age group, 1990-2004



The prevalence of diabetes in AI/ANs under the age of 35 increased by 133% between 1990 and 2004. In 2003, approximately 70% of AI/ANs over 35 had both diabetes and hypertension. Diabetes mortality is more than 3 times higher in the AI/AN population than in the general U.S. population (1999-2001). Complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general U.S. population. For instance, in 2000 in New Mexico, the age-adjusted lower-extremity amputation rate was 3.5 times higher for AI/ANs with diabetes than for non-Hispanic whites. In 2001, the age-adjusted ESRD incidence among American Indians in the Southwest was 2.4 times that of persons with diabetes in the U.S. In 2002, one in every four (24.8 percent) AI/AN elders over age 65 years had coronary heart disease.

The prevalence of diabetes varies among different tribes, but is increasing in all IHS Areas. A recent analysis of the IHS system patient data for AI/ANs under age 35 years showed that the prevalence rate of diagnosed diabetes *doubled* in just 10 years—rising from 8.5 cases per 1,000 people in 1994 to 17.1 cases per 1,000 in 2004. These data are based on the 60% of AI/ANs who used the IHS system for health care services during the 10-year period. Therefore, the effective rate of the remaining 40% could show even higher rates.

Although more recent data is not available yet to show what improvements have been made as a result of recently implemented diabetes treatment and preventions programs, there is general consensus among Tribal leaders that more funds are needed to successfully address this high priority disease burden in Indian country.

2. Cancer

Cancer is the second leading cause of death among American Indians and Alaska Natives over the age of 45.^{7, 8} Cancer mortality rates among men and women in the Northern Plains and Alaska areas are significantly higher than US rates.⁹ Late diagnosis is a major contributor to cancer related mortality for AI/ANs. After being diagnosed with cancer, access to needed services through I/T/U programs and contract health providers in the private sector can be complicated and overwhelming. Policies related to patient referral processes, contract care eligibility, and access to various pharmaceutical interventions creates added challenges in the coordination of cancer care for AI/ANs. Efforts to prevent certain cancers are needed including smoking cessation and promoting and providing access to routine early screening.

3. Behavioral Health/Alcohol/Substance Abuse/Mental Health

Tribal leaders agree that behavioral health is a serious healthcare priority, pointing out that the availability of culturally appropriate emergency, outpatient, and inpatient psychiatric services are limited due to chronic under-funding. Psychological services are necessary to improve outreach, education, crises intervention, and the treatment of mental illness such as depression, unresolved childhood trauma, schizophrenia, and factors contributing to suicide and violence.

- a) *Alcohol & Substance Use* - Alcohol and substance abuse continues to be a major issue and correlates to injuries, domestic violence, and other behavioral health problems in tribal communities. The impact of these issues on individual health status is evident. Liver disease is the sixth leading cause of death for all AI/ANs, especially effecting individuals 35 years and older.¹⁰ In 2007, American Indians/Alaska Natives aged 12 years or older had the highest rate of current illicit drug use. (12.6%). This population is also more likely than other racial groups to have some form of alcohol use disorder (28.3%).¹¹ Tribes make continued efforts to address prevention, treatment, and aftercare services within their communities. Under-staffed, frontline professionals are often faced with the need to address co-existing behavioral and mental health disorders. Medical staff are overwhelmed with inebriated emergency room cases crowding their understaffed ER facilities and often this becomes a deterrent in our ability to retain medical staff at our hospitals and urgent care clinics.
- b) *Methamphetamines* - Tribal officials also report an increase in methamphetamine use in many areas of the country. Highly aggressive prevention and intervention services are demanded because of the severe influence of this drug on human behavior and the neurological and physical damages caused by this drug. The extent of the problem is difficult to ascertain because the present ICD-9 coding in the IHS data system includes 'amphetamine,' not 'methamphetamine' indicators. However, some recent surveys suggest at least 30% of AI/AN youth have experimented with methamphetamine¹² Furthermore, from 2000 – 2005 there were approximately 58,000 medical and behavioral health visits to IHS facilities for amphetamine-related problems at a cost of over \$11 million.¹³ Some large scale methamphetamine distribution networks specifically target Indian reservations¹⁴ and Tribal leaders across the country express urgency regarding the need to assess the extent of the problem of increasing methamphetamine use among AI/AN populations.¹⁵

- c) *Suicide* - Suicide is a sensitive issue, but one that is of great concern in AI/AN communities. According to one estimate¹⁶, the 1998 suicide rate among AI/AN was 13.4 per 100,000, representing an 8.1% increase from 1990 and a substantial departure from the target rate for Health People 2010. National suicide rates for AI/ANs have consistently been over twice the U.S. national average for all races and even higher for young Indian males. IHS service population data indicate that suicide is an even greater problem among AI/AN youth and males. Among AI/ANs ages 10-to-34 years, suicide is the second leading cause of death.¹⁷ Current reports indicate these trends are not abating.^{18, 19}

4. Cardiovascular Disease/Heart Disease/Stroke

With the increasing prevalence in AI/AN communities of risk factors for CVD, such as diabetes and high blood pressure, the burden of CVD in tribal communities is expected to increase, a literal health care ticking time bomb. This has made this chronic disease our fourth national health priority. Diseases of the cardiovascular system are responsible for over 40% of deaths in the US general population and low-income and minority populations carry a disproportionately high burden of death and disability.²⁰ In 2001, heart disease was the leading cause of death among all AI/AN people (accounting for 20% of all deaths) and stroke was the fifth leading cause of death (accounting for 5% of all deaths).²¹ More AI/AN men and women over the age of 45 currently die of CVD than any other single disease. While CVD mortality has decreased in the last several decades for the U.S. population as a whole, rates are rising among AI/ANs and now exceed those of the general population.²² Heart disease mortality declined 43% in the general US population in the last 30 years, but only declined 4% in the Native population.²³

CVD is a major and increasing component of both inpatient and outpatient medical expenditures by the IHS and tribal health programs. Almost all advanced heart disease must be referred to specialists outside the IHS system, and this is either not available, or if available, is accomplished at considerable expense. Most IHS beneficiaries live in rural areas and access to specialty treatment is difficult to obtain. When AI/AN patients enter an Emergency Room for CVD emergencies, they often are faced with bills that they are unable to pay and are taken to collections.

5. Health Promotion and Disease Prevention

Tribes have long been concerned with the lack for resources available to provide effective overall Health Promotion and Disease Prevention (HP/DP) programs, which ranks as our fifth health focus priority. Current funding limitations require that almost all resources go toward expensive treatment of diseases. Tribes firmly believe that holistic, culturally appropriate health promotion and disease prevention (HP/DP) programs can save lives, reduce health disparities, and when adequately funded, significantly improve the quality of life of AI/ANs. The prevention focus areas for the IHS are:

- Asthma
- Diabetes
- Nutrition
- Obesity
- Physical Activity and Exercise
- Tobacco Cessation
- Access to Health Care
- Cardiovascular Disease
- Environmental Quality
- Immunization
- Injury and Violence
- Mental Health

- Oral Health
- Responsible Sexual Behavior
- Substance Abuse
- Traditional Healing

Prevention is cost effective. Despite limited financial resources, IHS has made great progress in many healthcare domains by providing holistic preventative care. Primary prevention efforts are crucial to this effort, and ongoing resources and expertise must be committed to the provision of long-range HP/DP services. Physical fitness, tobacco cessation programs, and early screening initiatives can reduce current levels of diabetes, cardiovascular disease, and cancer. Given the significant cost of treating critical health outcomes (i.e. diabetes, HIV, heart disease), public health research has found a variety of wellness programs to be cost effective, including diabetes prevention programs, STD/HIV prevention, and tobacco cessation.

Focusing on wellness is good public health practice and reflects Tribes' traditional cultural values. To proactively address each of these issues, strategies are needed to expand the prevention capacity of the Indian health care delivery system. Tribes cite a variety of effective strategies, including: community-based health education, patient case management, screening and early detection campaigns, training for healthcare professionals, and incorporating traditional healing approaches to improve wellness. Traditional, culturally-appropriate prevention programs must be recognized as "best practice" by state and federal agencies. Holistic prevention activities integrate the physical, emotional, spiritual, and social dimensions of health behavior and self-care.

6. Injuries/Injury Prevention

Among ethnic groups in the US, AI/AN children experience the highest rates of injury mortality and morbidity and this has led to ranking this as our sixth national priority. While injury mortality rates for AI/AN children have decreased during the past quarter century, it still remains almost double the rate for all children in the US.²⁴ Although rates of injury death have dropped considerably during the past 25 years, they remain disproportionately high among AI/AN children for the most common causes of injury.²⁵ Fatality rates for motor vehicle occupant injuries are 3 times higher for AI/AN children than for Caucasian and African American children.^{24, 26} Some of the recognized important risk factors for unintentional injury mortality among AI/AN children include poverty, alcohol abuse, substandard housing, limited access to emergency medical services, rural residences, and low seat belt use rates. The high rates of injury-related death and disability make it especially important to emphasize and intensify injury prevention efforts within this population. Overall AI/AN have an injury rate nearly twice that of all races and motor vehicle crashes cause the greatest amount of injury deaths.^{27, 28} Of special concern is that suicide and assaults have become more visible as rapidly emerging injury prevention issues. This alarming data suggests the need for comprehensive and collaborative efforts by tribes with the IHS, the Bureau of Indian Affairs (BIA) and other state and county public health and law enforcement entities.

7. Maternal and Child Health

The need to seek the long-term proven benefits of effective Maternal and Child Health (MCH) programs on the overall health of a population has led Tribes to make this our seventh health

focus priority need. Successful maternal and child health services will help reduce the numbers of children diagnosed with Fetal Alcohol Syndrome, Fetal Alcohol Effect and other developmental disabilities.²⁹ Early MCH care has been shown to be effective in reducing obesity in the AI/AN youth population.^{30, 31, 32} Wellness efforts in Tribal communities that have positive results have focused on breastfeeding, childhood nutrition, dental care, physical activity, education, parent-child interactions and obesity prevention programs.³³ Breastfeeding has been shown to improve both the health of the mother and the infant and would increase the impact of preventing the onset of diabetes, obesity, some types of cancers, and many other health problems.^{34, 35} Enhancing breastfeeding support to improve the duration of breastfeeding would serve to save health care costs in the long term. Public health efforts have been focused on improving the overall pre-conception health of AI/AN women between the ages of 15 and 44 in order to improve pregnancy-related outcomes.³⁶ Access to prenatal care is limited and AI/AN women typically initiate their first prenatal visit later in their pregnancy and complete fewer doctors' visits than their counterparts in the general population. On average 65 percent of AI/AN women start prenatal care in the first trimester, while in the general population, the corresponding number is 83 percent.³⁷

8. Dental

Dental health needs rank as the eighth national Tribal health priority. The Dental Health program is primarily limited to children and for adults typically only provides emergency care, if anything at all. The Indian Health Service Dental Program is challenged to provide these limited dental services to an increasing population with some of the highest rates of tooth decay and gum disease in the US.

Among AI/AN adults, the rate of periodontal disease is 2.5 times greater than in the general US population.³⁸ While this is alarming, dental decay among children is even more significant. AI/AN children between the ages of 2 and 4 have a rate of tooth decay that is 5 times the US average.³⁹ 79% percent of AI/AN children aged 2–5 years, have tooth decay, with 60% of these children having severe early childhood caries (baby bottle tooth decay).^{38,39} 87% percent of children, aged 6–14 years, have a history of decay—twice the rate of dental caries experienced by the general US population and 91% percent of AI/AN young people between 15–19 years have caries.³⁸ Overall, 68% of AI/AN children have untreated dental caries, 33% of school children report missing school because of dental pain, and 25% report avoiding laughing or smiling because of the way their teeth look.³⁸

Lack of funding for dental services continues to restrict care. Basic dental services, such as dental emergency care, education and prevention, and basic restorative care are not available to most AI/AN people. The dental program recommends a three directional approach involving community education, facility construction, and recruiting.⁴⁰ Community education covers continuous Dental Health Promotion and Disease Prevention awareness within communities along with excellent one-on-one dental patient education. The IHS Dental Program acknowledges that quality dental care must use quality materials applied with quality dental equipment, housed in a quality facility and surrounded by quality housing for providers and their families.⁴¹ Recruiting consumes most of the Area Dental Program's efforts because qualified dentists are in short supply nationwide, approximately 40 percent of dental positions in community health centers are currently vacant.⁴²

The Tribally-initiated DENTEX Dental Health Aide Therapist (DHAT) program in Alaska is an example of successful needs-based innovation.⁴³ The DENTEX program trains DHATs as mid-level providers in order to enhance access to dental services in rural Alaska. DHATs focus on prevention, pain and infection relief, and basic restorative services. The World Health Organization cites 42 countries that currently use DHATs. The DHAT program in Alaska was modeled after other DHAT programs throughout the world including those from New Zealand, the United Kingdom, and Canada.⁴⁴ The DHAT program's service statistics demonstrate that DHATs are improving access to year-round oral health care for individuals who previously could see a dentist only a few weeks each year.⁴¹ This program is an excellent solution to meeting the overwhelming demand for dental care within Indian country.

9. Water and Sanitation

Our ninth Tribal health priority is the availability of basic water and sanitation facilities in Tribal communities. The availability of adequate plumbing systems in homes has a direct correlation with the prevention of gastrointestinal diseases, respiratory and skin infections.⁴⁵ Despite tremendous efforts to improve water and sanitation facilities across Indian Country, approximately 11% of AI/AN homes still lack safe water in the home.⁴⁶ The provision of water and sanitation facilities to existing homes and communities is a critical part of preventative health as well as essential to meeting the growing demands of new construction for homes and health facilities. Sanitation facilities construction needs for tribes are prioritized and funded by IHS using a database called Sanitation Deficiency System (SDS) which contains needed water, sewer, and solid waste projects for all existing homes.⁴⁷ At the end of FY 2008, the total sanitation facilities unmet needs for all tribes was \$2.59 billion, which consisted of feasible projects in the amount of \$1.18 billion and economically unfeasible projects in the amount of \$1.41 billion. A project is considered unfeasible if the cost to construct the sanitation facilities is greater than \$47,000 per home for projects located in New Mexico or Utah and \$48,000 per home for projects located in Arizona.⁴⁸ In Alaska, most projects focus on safe community water access points and safe waste dumping facilities; in a large number of Alaskan communities, piped water and sewer to homes will never be a reality.

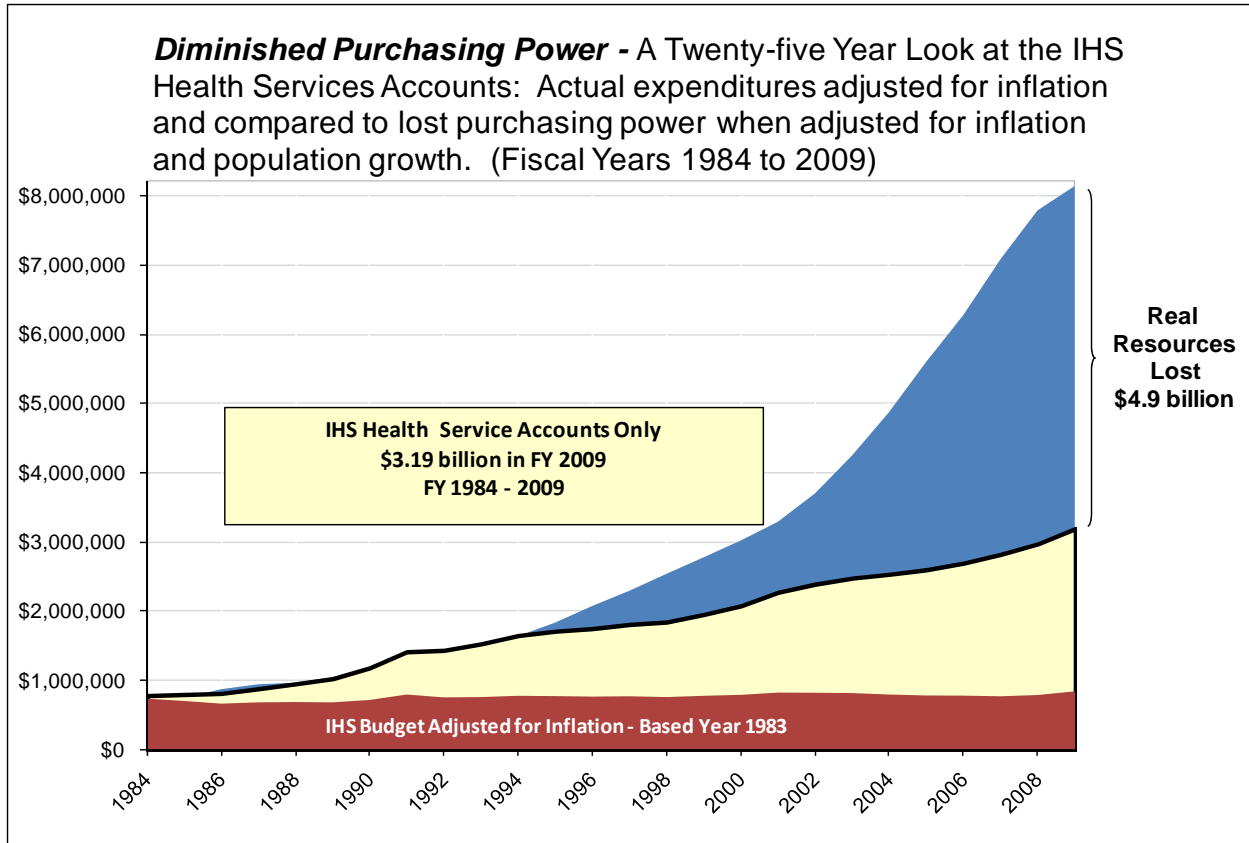
10. Respiratory/Pulmonary

The IHS reports that asthma is a serious condition and that the number of people with asthma is increasing.⁴⁹ This has raised this chronic care concern to our tenth national health priority. In the clinical setting, the IHS, Tribal and Urban Indian (I/T/U) health care programs stress the importance of following the recommended guidelines for the diagnosis, treatment and management of asthma tailored to fit the severity of the illness.⁵⁰ Furthermore, there is a need to increase efforts to educate patients, families and communities on practical steps to reduce the exacerbating environmental risk factors.⁵¹

Diminished Purchasing Power

The graph below illustrates that in FY 1984 the IHS health service accounts (does not include facilities) were funded at \$777 million. In FY 1993 the budget totaled \$1.5 billion. For the subsequent 16 year period ending FY 2009, the budget for health services has increased to only \$3.2 billion. If this budget were to keep pace with inflation and population growth factors alone, this amount should be at least \$8.1 billion. This graph illustrates the rapidly escalating divide that

has emerged between: (1) the actual IHS budget; (2) the IHS budget adjusted for inflation, and; (3) the purchasing power of the budget accounting for medical inflation and population growth. As demonstrated, the IHS budget has suffered a cumulative loss of \$4.9 billion in purchasing power from 1984 to 2008.



To address this shortfall, the I/T/U workgroup has developed budget recommendations for FY 2011 totaling \$2.1 billion. While conservative, the funds included in this recommendation will offer the IHS the ability to provide AI/ANs with access to quality primary and secondary healthcare, basic preventative services, and to begin to build some of the infrastructure needed to support those services. The following budget accounts for the actual inflationary costs experienced by I/T/U programs, population growth, the staffing needs of new facilities, and the long-needed backlog of facility construction.

One example of inflationary increases being accounted for in this budget recommendation is the substantial increases in energy costs which directly and indirectly impact operational expenses. Rising energy costs impact transportation of patients to clinics and other services, heating and electrical costs, and medical supply costs. In Alaska, Maniilaq Health Center in Kotzebue, Alaska, which serves approximately 8,500 people in 12 villages in an area the size of Indiana, estimates an increase in energy cost from last fiscal year at \$2.1 million. Eastern Aleutian Tribes, Inc. serves eight villages along the Aleutian Chain has experienced increases in transportation fuels costs of 35% resulting in some clinics closing intermittently and reductions in some services. Bristol Bay Area Health Corporation serving Dillingham and 34 villages in Southwest Alaska has also experienced increased due to energy costs that required them to lay off 18 employees and reduce hours for six employees, but they still expect a \$1 million increase

in energy expense from last fiscal year. These noted energy costs increases translate into unfortunate decreases in patient care through the diminished purchasing power of funding for Indian health care. It is not fair to Indian health care that they must redirect funding from direct patient services to rising costs of providing health care because of the lack of true inflationary increases provided for Indian health care.

Needs Based Budget

The IHS enacted budget for FY 2009 totals \$3.58 billion, which is on average about 50% percent of the level of funding needed to meet the health care needs of AI/AN people. The IHS budget increases have regularly not been sufficient to maintain current services considering inflation, population increase, and pay act increases. These mandatory costs must be covered therefore Tribes have no alternative but to cut the level of health services in order to absorb these costs. This continuing saga thwarts advancements in the health care available in Indian Country and exacerbates the health disparities facing AI/ANs communities.

To address this shortfall, IHS, Tribal, and urban programs conducted annual consultation meetings and developed a ten year needs based budget (NBB) totaling \$21 billion to be phased in over ten years. This proposed budget ensures the IHS ability to provide AI/ANs with access to quality primary and secondary health and basic preventative services, and the modernized infrastructure necessary to effectively support those services. The NBB includes dollars to adequately support contract health services (CHS), facilities expansion, and services expansion which allocates funding to address health priorities. To continue funding current services and allow for modest increases in FY 2011 for some program expansion, the NBB proposes a \$2.1 billion increase in addition to the base amount of \$3.58 billion (FY 2009 enacted budget). To expand programs and services to meet the health care needs, the NBB proposes \$12.4 billion in total annualized services to be phased in over the next ten years. \$8.7 billion is dedicated to facilities expansion to accommodate the growth in health services resulting from sizable program increases that would be achieved by investing in the Tribal needs based budget.

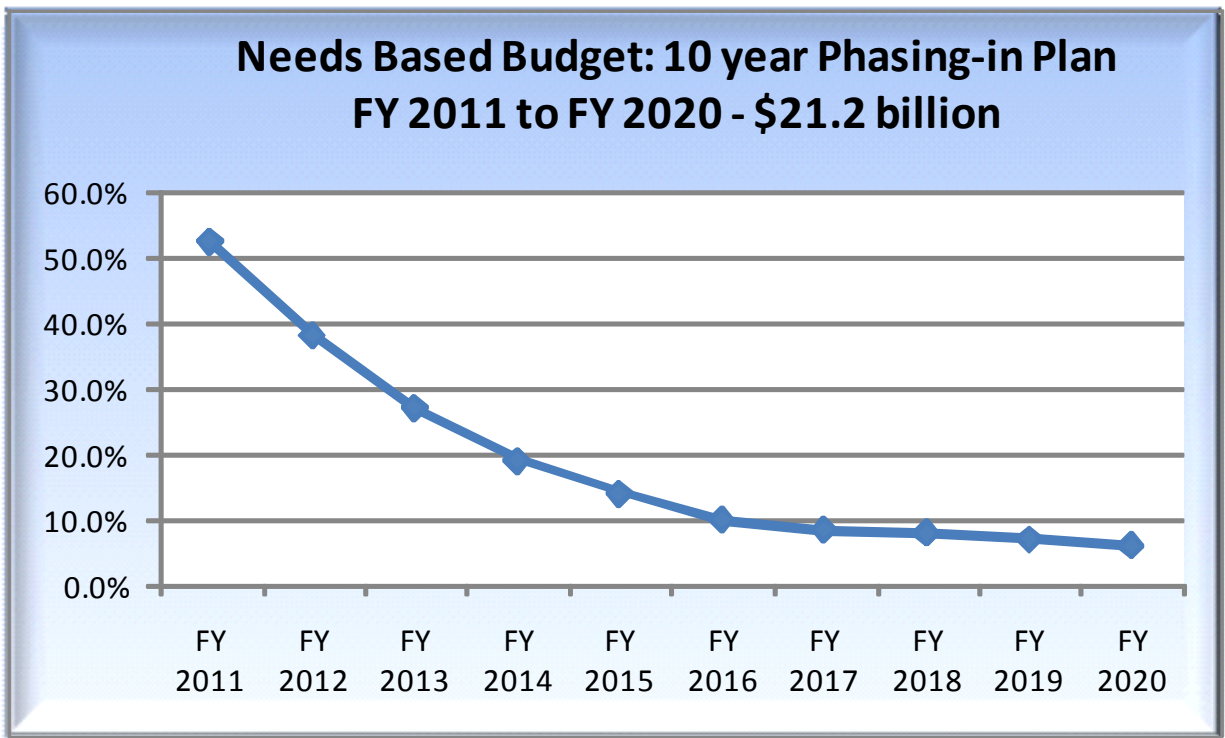
The IHS Budget Formulation Workgroup understands that this is a sizable increase that might not seem politically feasible in these tough economic times. However, this request is consistent with the Administration's commitment to honor the federal trust responsibility to provide health care for AI/AN people. President Obama, in his own words has stated, "...that honoring the government-to-government relationship requires fulfillment of the United States' trust responsibility to tribes and individual Indians." We respect President Obama's sincerity in making these statements as evidenced by his record in the Senate, when he voted and worked to provide the IHS a \$1 billion increase to address health disparities and provide adequate health care to AI/AN people. We believe our President is committed to uphold his statement and will be supportive of our request.

“...that honoring the government-to-government relationship requires fulfillment of the United States’ trust responsibility to tribes and individual Indians.”
President Barack Obama

A Ten Year Plan: Phasing in of the Needs Based Budget

The IHS Budget Workgroup and Tribes understand that immediately funding the total NBB of \$21 billion is unlikely in an environment of equally important competing national priorities such as the War in Iraq, balancing the budget, and the current national economic crisis. Furthermore, we recognize that even if we were provided the full level of proposed funding in one year, the IHS and Tribal health programs do not have the adequate health infrastructure necessary to accommodate immediately expanded services.

To address this in a responsible manner, the Tribes have developed a 10-Year Phased Funding Plan for the NBB. The 10-Year Plan would require a sizable increase in the first two years, but the increases thereafter will be moderate. The most significant aspect of the 10-Year Plan, however, is that it will involve a multiple year commitment of several years by the Congress and the Administration to enact a budget designed to impact significant improvement in the health status of AI/AN people.



The chart demonstrates that if the first year increase of \$2.1 billion in FY 2011 is appropriated, the following year's increases would decline gradually until they approximate 6% in FY 2020. This amount thereafter would be tied to actual medical inflation. The increase proposed in the first year is justified when considering the \$4.9 billion lost to inflation over the last twenty-five years. Beginning in FY 2012, increases in funding would taper down and adjust for inflation and population growth with occasional standard proposals for services and facility enhancements. With facility needs addressed and initial funding to propel the development and institutionalization of health services for chronic diseases, prevention, and behavioral health, maintaining current services for each year can be the focus. Failing to address the need for initial costs in FY 2011 will continue to weaken of Indian health services at an exponential rate. The

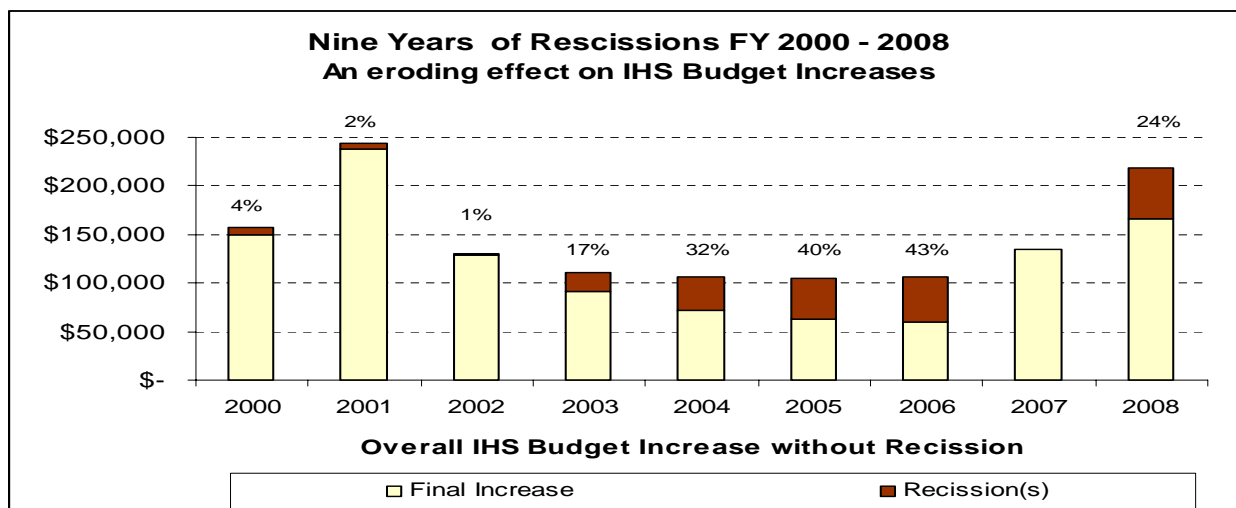
cumulative lost purchasing power over the last two decades has had immeasurable damage, now only repairable by committing to fully fund the health needs outlined in the Needs Based Budget.

With the 10-Year Plan and commitment to improve AI/AN health status, the AI/AN burden on medical services provided by the government may decrease over time. Indian individuals eligible for Medicaid services will increasingly choose care through the programs funded by the IHS budget. The improvements in overall AI/AN health status and achieving levels to that of the rest of the United States population will also decrease the medical costs related to access to care and preventative and behavioral health services that is so affecting Indian communities today.

Eliminate Budget Rescissions and Sequestration for IHS

Tribal and Urban Indian leaders vigorously request an exemption for the IHS budget to any rescissions or sequestrations that are passed down by Health and Human Services.

Given the unique mission of the IHS as a direct health care provider, and consistent with other government health service agencies like the Department of Defense (DOD) and Veterans Health Administration (VA), the IHS should be exempt from congressional rescissions and Administration sequestration, as articulated through the Office of Management and Budget Circular A-11 (Section 20.3). Rescissions and sequestration equate to a reduction in healthcare delivery and mean elimination of health programs and turning away patients in need. The IHS health programs are subject to the same rates of medical inflation that VA and DOD programs, (yet do not receive increases consistent with these costs) and deserve the same consideration. The IHS programs also provide services to veterans that may not be able to travel great distances from reservations to VA hospitals to receive care. If the Administration and Congress are resolved to address Indian health disparities, they must restore past year’s rescissions and exempt them from future cuts.



***Standing on the Principles:
Indian Health Care Improvement Act Reauthorization***

“For more than fourteen years, Congress has failed to reauthorize the Indian Health Care Improvement Act and comprehensively modernize Native American health care services. This is unfair and unacceptable.

Today’s Native Americans are disproportionately suffering from debilitating illnesses, like diabetes, heart disease and stroke. The infant mortality rate is 150 percent higher for Native American infants than white infants, and the suicide rate for Native Americans is two and a half times the national rate. With these alarming statistics, improvements to Native American health care could not come at a more urgent time.”

Then Senator Barack Obama
January 18, 2008
US Senate Floor

The Indian Health Care Improvement Act (IHCIA) is the key legal authority for the provision of health care to American Indians and Alaska Natives (AI/ANs). The IHCIA was originally enacted in 1976 to address the deplorable health conditions in Indian Country. As Congress states in the findings of the IHCIA:

Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

Along with the Snyder Act of 1921, the IHCIA forms the statutory basis for the delivery of health care to AI/ANs, by the Indian Health Service (IHS).

It is necessary to reauthorize the IHCIA to officially extend the life of the IHCIA authorization and to update the law to reflect both the current needs of Indian health care and the modern methods of health care delivery.

The IHCIA contains a number of provisions that authorize appropriation of funds to support health care programs set forth in the law; however, the life of these provisions ended in fiscal year 2001. Fortunately, the Snyder Act of 1921 provides permanent authority for the appropriation of funds for Indian health, so Congress can and does continue to appropriate funds for these programs. The IHCIA needs to be reauthorized to supply the baseline authority for providing direct health care to AI/ANs.

Also, since Congress’s last comprehensive review of the IHCIA in 1992, the American health care delivery system has been revolutionized while the Indian health care system has not. For example, mainstream American health care has moved out of hospitals and into people's homes; focus on prevention has been recognized as both a priority and a treatment; and, coordinating mental health, substance abuse, domestic violence, and child abuse services into comprehensive

behavioral health programs is now standard practice. Reflecting these improvements in the IHCIA is a critical aspect of reauthorization.

The IHCIA reauthorization and reform would achieve many critical health system modernizations, such as;

- Establishing objectives for addressing health disparities of Indians as compared with other Americans.
- Enhancing the ability of the Indian Health Service (IHS) and Tribal health programs to attract and retain qualified Indian health care professionals.
- Updating and modernizing health delivery services, such as cancer screenings, home and community based services and long term care for the elderly and disabled.
- Provides innovative mechanisms for reducing the backlog in health facility needs.
- Establishing a continuum of care through integrated behavioral health programs both prevention and treatment –to address alcohol/substance abuse problems and the social service and mental health needs of Indian people.
- Facilitating greater decision-making regarding program operations and priorities at the local tribal level in order to improve services to Tribal populations.

Despite these modest, but important, proposed reforms, and despite the critical nature of the IHCIA as a baseline authority for Indian health care delivery, Indian Country has not seen the successful reauthorization of this law. President Obama stated his commitment to seeing this legislation reauthorized and we will need this Administration's active support to achieve this long-worked for goal.

Closing

Tribes across the nation believe that change has finally come to America. In fact, we are counting on it. We look to our President, along with his Administration, to stand on the principles which he has so astutely identified and chosen as a springboard for change in Indian country. Throughout this testimony we have documented the powerful, clearly stated insights and promises that President Obama has articulated throughout his political career. He highlights the need to strengthen American Indian communities; to achieve swift passage of the Indian Health Care Improvement Act reauthorization; to honor Trust responsibilities to the Tribes and to make significant increases in funding for Indian health care.

The President, through the US Department of Health and Human Services, has the opportunity to hold fast to past promises made by the U. S. government to the Tribes, and to demonstrate his own its faithfulness to principle by including the requested \$2.1 billion increase in funding for Indian health in the President's FY 2011 budget. A \$2.1 billion increase will allow, for the first time in many years, Tribes to realize demonstrable improvements in our struggling Indian Health Care delivery system.

These past 11 years, the 562 federally recognized Tribes in the United States have acted in good faith to be fully engaged and committed participants in the DHHS Tribal budget consultation process. The seemingly insurmountable, ever-increasing health disparities documented throughout Indian Country tell a compelling and undeniable story – the story that has been shared with the US Government for many years, years before opportunities were made for Tribes

to engage in the formal consultation process. The message has been consistent: *our people are suffering; our people need help; and our people have indisputably pre-paid for health care with land, lives and culture.* Our good faith efforts to communicate these very real funding gaps to address very basic Indian health care needs *must* be honored by *urgent action.*

As our the President stated in response to the impending health care crisis in America during the White House Health Care Reform Summit on March 5, 2009, "...healthcare reform cannot wait, it must not wait and it will not wait another year." This message resonates with Tribes across our great nation.... Indians are keenly aware that *our* people have been *well into a health care crisis for the past several decades.* Without a doubt, American's first citizens cannot wait another day, much less another year.

Citations:

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Attachment:

NATIONAL CONGRESS OF AMERICAN INDIANS

The National Congress of American Indians Resolution #PHX08030

TITLE: Declaring a State of Emergency for Indian Health

WHEREAS, we, the members of the National Congress of American Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants the inherent sovereign rights of our Indian nations, rights secured under Indian treaties and agreements with the United States, and all other rights and benefits to which we are entitled under the laws and Constitution of the United States, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the health, safety and welfare of the Indian people, do hereby establish and submit the following resolution; and

WHEREAS, the National Congress of American Indians (NCAI) was established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal governments; and

WHEREAS, over 1.7 million American Indians and Alaska Natives (AI/AN) living in the United States rely on the Indian Health Service (IHS) access to health care services; and

WHEREAS, AI/AN people have long experienced lower health status when compared with other Americans that include lower life expectancy and a disproportionate disease burden because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences; and

WHEREAS, given the higher health status enjoyed by most Americans, the lingering health disparities of AI/AN people is troubling with the most important factor associated with these health disparities is the inadequate funding for the Indian health care delivery system; and

WHEREAS, it is estimated that funding for Indian health needs in the United States is only provided at 5060% of its level of need with per capita expenditures for AI/AN people significantly less than other populations served by federal health programs, such as:

- Per capita expenditures for an AI/AN beneficiary served in the IHS is \$1,914 per year;
- Per capita expenditure for a Medicare beneficiary is \$5,915 per year;
- Per capita expenditure for a Medicaid beneficiary is \$3,879 per year;
- Per capita expenditure for a VA beneficiary is \$5,214 per year;
- Per capita expenditure for an inmate in the Bureau of Prisons is \$3,803 per year; and

WHEREAS, these health and funding disparities have resulted in a health care crisis for Tribal governments and AI/AN people in the United States.

NOW THEREFORE BE IT RESOLVED, that the NCAI does hereby urge the Congress to declare a

State of Emergency for Indian health programs; and
BE IT FURTHER RESOLVED, that the NCAI does hereby urge Congress to provide emergency funding to deal with the Indian health care crisis; and
BE IT FINALLY RESOLVED, that this resolution shall be the policy of NCAI until it is withdrawn or modified by subsequent resolution.

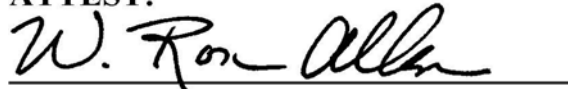
CERTIFICATION

The foregoing resolution was adopted by the General Assembly at the 2008 Annual Session of the National Congress of American Indians, held at the Phoenix Convention Center in Phoenix, Arizona on October 19-24, 2008, with a quorum present.



President

ATTEST:



Recording Secretary

FY 2011 Tribal Budget Formulation Workgroup Members:

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Albuquerque	Councilman Carleton Albert, Pueblo of Zuni Councilman Greg Mendez, Mescalero Apache Tribe
Bemidji	Co-Chair Gaiashkibos, Lac Courte Oreilles Band Terri Terrio, Stockbridge-Munsee Band
Billings	Co-Chair Daryl Red Eagle, Fort Peck Tribe Tracy King, Fort Belknap Tribe Donna Buckles-Whitmer, Assiniboine & Sioux Tribes of Fort Peck
California	Alternative Co-Chair Rachel Joseph, Lone Pine Crista Ray, SVPomo
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The National Tribal Budget Workgroup wishes to acknowledge and thank the members of the technical work group who assisted them in the preparation of this testimony:

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If your name was unintentionally omitted, the National Tribal Budget Workgroup apologizes.