DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

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Dear Tribal Leader:

I am providing you with my decision on the Diabetes Funding for Fiscal Year (FY) 2003 and a description of the funding formula methodology. The Balanced Budget Act of 1997 provides $150 million ($30 million each year for 5 years) for the Special Diabetes Program for Indians (SDPI) through FY 2002. The Consolidated Appropriations Act of 2001 (H-R. 4577) authorized an additional $70 million in FY 2001, $70 million in FY 2002, and $100 million in FY 2003. This letter outlines my decision on distribution of the FY 2003 funds. It is hoped that funding for the SDPI will continue beyond FY 2003.

I collaborated with Tribal Leaders, through the Tribal Leaders Diabetes Committee (TLDC) in authorizing Area consultations to obtain the Tribal Leaders' input for the final TLDC recommendations on distributing the special diabetes funding for FY 2003. Different opinions on the distribution of the funding were expressed during Area consultations. The TLDC submitted its final recommendations to me after the Area consultations were concluded.

I have carefully reviewed each Area's recommendations before making my decisions.

NATIONAL FUNDING DISTRIBUTION FORMULA

Tribal Leaders from seven Areas recommended keeping the national funding distribution formula the same as in FY 2002, while Tribal Leaders in five Areas provided other options for consideration. Suggestions included altering the disease burden allocation, eliminating or changing the Tribal size adjustment allocation, including data improvement funds as part of the national distribution formula, changing the percentage allocated to user-population, eliminating the use of mortality data, and including other factors such as the frontier and remoteness factors.

Tribal Leaders expressed their concern over the availability of current diabetes prevalence data and support the use of the most current data available to determine the final national funding distribution formula. Another concern was that diabetes mortality data is inaccurate and underrepresents the true mortality caused by diabetes. They suggest that this data not be used.

On April 12, a quorum of eight TLDC members met to finalize their recommendations based on the Area Tribal consultations. The TLDC submitted a tie vote - four "in favor" of, and four "against" keeping the national distribution formula the same as in FY 2002. The members submitted this result to me along with a message that as a group they could not reach a majority vote. The TLDC voted to continue the set-asides for the Urban Indian Health Programs and to keep the administrative and programs costs at the same amount as in FY 2002. Additionally, the TLDC voted to continue supporting the Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program at $1 million.

I have reviewed the TLDC recommendations as well as the Area consultations. I have also considered the fact that FY 2003 is the last year of funding for the SDPI.

RECOMMENDATIONS:

1. National Distribution Formula for FY 2003

   I recommend that in order to allow the SDPI grant programs to function with the least amount of disruption for the last year (the 6th), the IHS should maintain the same SDPI formula and fund distributions. This decision will allow our SDPI grants to maintain their programmatic and evaluation activities, spend a minimum amount of time writing new grant proposals for FY 2003, and put more energy toward planning for FY 2004 and beyond, should our funding continue.

   I have decided to allocate the FY 2003 diabetes funding totaling $93 million (after set-asides for urban diabetes grant programs and for administrative, data improvement and program support costs) to the IHS Areas. The $93 million will be allocated using the same formula as in FY 2002:

disease burden at 57.5 percent (defined as 75 percent prevalence and 25 percent mortality), user population count at 30 percent, and Tribal size adjustment at 12.5 percent. The Resource and Patient Management System data from FY 1998 will be used to calculate diabetes prevalence. Each IHS Area will conduct Tribal consultation to decide specific amounts for each diabetes grantee.

2. Set-Asides: Urban Programs, Administrative Funding and Program Support Costs

I have decided that the set-asides for FY 2002 will remain unchanged in FY 2003.

The Urban Indian Health Programs (UIHP) will be funded at the same level as in FY 2002. This funding represents 5 percent of the total $100 million funding. The UIHP have received grants on a national basis under the Title V authorities from the Indian Health Care Improvement Act. The amount provided gives the urban programs the opportunity to continue the diabetes related activities for Tribal individuals in urban settings.

Administrative funding and program support costs represent 3.8 percent of the total $100 million ($3.8 million), which is well below the 10 percent upper limit suggested for these activities in FY 2002. These funds will continue to be used to provide support for:

- data improvement and grants management activities at both the national and Area levels,
- programmatic support for the National Diabetes Program including data improvement,
- grants program evaluation (as required by Congress) and technical assistance, and
- support for Area diabetes programmatic activities.

These types of activities produce "outcomes" and data that are vital to convincing others to support the continuation of our funding. The administrative funds will also continue to be used to support activities of the TLDC.

3. National Diabetes Prevention Center

The TLDC has recommended continuing to support the activities of the National Diabetes Prevention Center (NDPC) as it has from FY 1997 to 2002 with the Balanced Budget Act funds. We will continue to fund the NDPC by providing $1 million to the CDC. The NDPC began providing service to American Indian and Alaska Native communities during the past 6 months through the development and dissemination of Tribal-specific diabetes community assessment and education tools.

I want to thank the members of the TLDC and all the Tribal Leaders and Indian health program representatives who participated in this year's regional and national consultation activities. The TLDC compiled the consultation issues from each Area, summarized and discussed all major concerns, and forwarded its national recommendations to me for final decision.

I look forward to continuing our collaboration on diabetes activities in the years to come.

Sincerely yours,

Michel E. Lincoln
Acting Director

Enclosure