DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

APR 10 2003

Dear Tribal and Urban Indian Leaders:

Following the fiscal year (FY) 2003 budget apportionment distribution, I directed that full distribution of the amounts received be completed by March 28, 2003. In addition, I am announcing my decisions regarding the distribution of Alcohol and Substance Abuse (ASA) funds and Contract Health Services (CHS) funds under new distribution formulas recommended to me by joint Tribal and urban Indian organizations, and Indian Health Service (IHS) workgroups. Both of these allocations will now be provided on a recurring basis. Also, I am modifying the distribution of the Indian Health Care Improvement Fund (IHCIF) appropriation to continue reducing the funding disparity among Indian health system programs.

As a result of Tribal and urban consultation, and the outstanding efforts of the joint Tribal/urban/IHS Workgroup on alcohol and substance abuse, I have decided to accept the Workgroup's recommendation to use a new fund distribution formula to distribute the $15 million the Agency will receive (as a result of the passage on December 15, 2000, of legislation Senator Ted Stevens of Alaska introduced) for drug and alcohol prevention and treatment services for Tribes in the lower-48 States. The ASA Fund Distribution Formula resulted in the lowest level of disparity, on a per capita basis, in the amounts received under the previous formula. The new formula for distribution, on a recurring basis, considers four equally weighted factors: user population (including users from adjacent areas), the alcohol and substance abuse related mortality rates for the IHS Area regions, the poverty level of the regions, and the percentage of per capita alcohol and substance abuse funds below the 60th percentile level. As part of the distribution formula, I have also accepted the recommendation of a 5 percent set-aside for urban Indian alcohol and substance abuse prevention and treatment programs and a $1 million set-aside for information technology support for all Tribal and urban Indian programs. After all reductions and set-asides are applied, there is approximately $13 million that will be distributed to the 11 Area Offices. I also accepted the recommendation of the Workgroup for the National 5-year ASA Strategic Plan.

Regarding CHS program increases, I have decided to allocate the $49 million from the FY 2001 and FY 2002 increases available for distribution using the FY 2002 formula. This will maintain CHS funding levels from FY 2002 such that no Tribe will receive less than it did previously. Of the $14,246,555 increase for FY 2003 (the amount remaining after applying the mandated 0.65 percent rescission), $10 million is available for distribution after applying the congressionally directed $3 million increase for the Catastrophic Health Emergency Fund and setting aside $1,246,155 for new Tribes. These dollars will be distributed based on the formula recommended by the FY 2001 CHS Allocation Workgroup (CHSAWG), which also includes funding the Office of Management and Budget medical inflation rate before applying the new formula to the remaining funds. To address inflation as recommended by the CHSAWG would require approximately $17 million. Because the FY 2003 funds available for distribution are not

sufficient to fully fund medical inflation, the new formulary portion of the new methodology will not be applied this fiscal year, and the CHS recommendation results in a pro rata distribution of the $10 million to each Area's base CHS funding. My plan is to distribute increases in future years using the CHSAWG formula.

My third distribution decision applies to the FY 2003 IHCIF. The IHCIF formula, which was adopted after extensive national Tribal consultation, allocates funds to service units with the greatest resource deficiencies. The IHCIF formula is applied for FY 2003 using the same data used in FY 2002 to expedite release of IHCIF funds immediately. The qualifying threshold for IHCIF funds remains the same: scores of less than 60 percent on the Federal Disparity Index (FDI), which is an index of comparability with the Federal Employees Health Benefits Plan. Based on guidance and clarification from Congress, funding deficiencies in the lowest bracket (FDI scores of less than 40 percent) are given more emphasis in the 2003 IHCIF formula. As a result, $18 million (70 percent of the $26 million IHCIF) is distributed to 57 units in the lowest bracket. The formula allocates $8 million (30 percent of the fund) to 117 units in the next lowest bracket (scores between 40 percent and 60 percent). The additional IHCIF funds in 2003 will begin to reduce disparities for the most deficient units.

My appreciation is extended to your representatives and the workgroups who diligently worked on developing the recommendations over the past year. Their final recommendations are the result of numerous meetings, regionally and nationally, as well as the comments received during extended comment time frames. Enclosed with this letter are additional documents and information related to my decisions.

I remain grateful for your guidance and counsel regarding the challenge of meeting the health needs of our people within available resources. I look forward to continuing to work with you in improving the health of American Indian and Alaska Native people.

Sincerely yours,

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Enclosures