



DEC 30 2010

Dear Tribal Leader:

I am writing to initiate a consultation on the Indian Health Care Improvement Fund (IHCIF) and its formula. The IHCIF was established to determine the overall level of need funded for Federal, Tribal, or Tribal organization health care facilities (facilities). A formula was established that assigned facilities a level of need funded percentage relative to funding spent for Federal employees for health insurance through the Federal Employees Health Benefits Program (FEHB). The average level of need funded for all facilities was determined to be 55 percent of the FEHB benchmark. Many facilities were funded at levels below that average. Each year since 2001, Congress has appropriated funding for facilities with the lowest percentage level of need funding, and to date, we have been able to raise all facilities to at least 46 percent of their estimated level of need. However, additional funding is needed to raise all facilities to the IHS average of 55 percent, which was the original goal after Tribal consultation on this issue.

I have heard about the IHCIF and its formula during my visits with Tribes. Some Tribes continue to advocate for more funding for their facilities and can quote their current level of need funded percentage according to the IHCIF formula. Some Tribes have raised concerns about the formula because their facilities do not receive IHCIF allocations, even though they feel their level of need is still significant. Other Tribes have commented that the data used to estimate their level of need funded needs to be changed. Therefore, it seems timely to consult with Tribes to see if we should continue to request funds for IHCIF and allocate those funds to the lowest funded facilities using the current formula until all facilities are at 55 percent, or if we should consider revising the formula now given concerns about the formula.

In addition, the recent reauthorization of the Indian Health Care Improvement Act (IHCIA) contains a provision that reauthorizes the IHCIF and includes the following 1) An updated list of services that the IHCIF may support; 2) a requirement to report on resource deficiencies for facilities in the IHS system and, if available, provide updates on "waiting lists" and Indians "turned away" due to resource deficiencies; and 3) a requirement that affirms the IHS must consider services and resources provided by any Federal programs, private insurance, and programs of State and local governments in the formula. These modifications to the IHCIF authorization make it clear that consultation is timely.

Given the concerns of Tribes and the new provisions in the IHCI A on the IHCIF, I am writing to initiate a consultation on the IHCIF and invite your input on the following topics:

- 1) **Should we change the IHCIF formula?** The original goal was to use the current formula to get all facilities to at least the IHS average. Approximately 150 of the 270 facilities are funded at less than the IHS average of 55 percent and approximately 75 facilities are funded at 46 percent. Should we update the formula now or wait until all facilities are at 55 percent? This question asks you to weigh the original intent of the IHCIF formula and its distribution methodology with current concerns and needs. Is it appropriate to alter the formula before all facilities reach 55 percent, or is it more important to modify the formula to reflect changes that have occurred since the formula was adopted 10 years ago? Your input on this question is very much appreciated.
- 2) **Should we make technical improvements to the current formula?** A joint IHS/Tribal data technical workgroup met in fiscal year (FY) 2009 and recommended updates to the formula that involve improvements in the data used in the formula, including user counts, the cost benchmark, site differences, data procedures, health status and alternate resources. A summary of these recommendations is attached and the workgroup's full report (101 pages) is available as an electronic copy by emailing a request to consultation@ihs.gov. We could make these technical improvements for the formula beginning in FY 2011 or FY 2012 without changing the basic formula as these mostly involve improvements in the data used in the formula. The proposed data improvements could alter the funding allocations by changing some level of need funded percentages. We do not know in advance how much the allocation would change. The technical improvements are intended to make the formula more accurate. Your input on this topic is appreciated.
- 3) **Should we make changes in the basic methodology of the formula?** The formula would need to be changed in a more fundamental manner to incorporate the changes in IHCI A. It would also need to be modified if Tribes want other changes, such as adding or deleting basic formula factors. Adding new factors, such as newly authorized services and benefits indicated in IHCI A, are likely to change the level of need funded percentages and may alter which facilities qualify to receive funds. Your input on whether more fundamental changes to the formula should be made is requested.
- 4) **How should we consult with Tribes on the questions above?** Our consultation options include holding national listening sessions/consultation sessions, forming an IHS/Tribal workgroup to make recommendations, and/or holding Area sessions and working with Area health boards/national Indian organizations/existing workgroups. I have attached a copy of the language from the recent IHCI A reauthorization relevant to the IHCIF. Please let me know your preferences on how to consult with Tribes on the issues raised above.

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Please provide your feedback in writing to me at the address below or electronically to the e-mail address consultation@ihs.gov by March 1, 2011. Thank you for your input on this important topic.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

Please send written comments by March 1, 2011 to:

Yvette Roubideaux, M.D., M.P.H.
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Summary of Technical Improvements Proposed for the Current Formula

User Counts. Currently, the formula counts an American Indian and Alaska Native (AIAN) as an active user if he/she obtains a medical service from an IHS, Tribal, or Tribal Organization health care delivery facility during the last three years and he/she lives within the facility's defined geographic catchment area. The Workgroup recommends that the formula retain this approach and that IHS improve the technical processes for un-duplicating user counts among IHS Areas. The Workgroup also recommends that the IHS consider whether Indian persons who access a direct care facility but live outside the facility's defined catchment area are counted or not counted in the IHCIF formula, or perhaps should be considered separately. People living outside the catchment area typically are ineligible for Contract Health Services and often access the direct care facility less frequently because of longer travel times.

Cost Benchmark. Currently, the formula benchmarks per capita health care funding needs to average per capita costs of a blend of Federal Employee Health Program insurance plans. The Workgroup recommends that the formula retain this approach and that IHS apply technical improvements to fine tune the benchmark to reflect evolving health care practices.

Health Status. Currently, per capita health care funding estimates are scaled to reflect AIAN health status variations among States and IHS Areas. The Workgroup recommends the formula retain AIAN health status variations, but the IHS should evaluate substituting morbidity data, if practical, as an alternative to mortality data now used to scale funding estimates. Reliable morbidity data that measures occurrence of disease and lack of health would be a more direct indicator of variations in a population's need for health care services than mortality data.

Facility Differences. Currently, per capita health care funding estimates are scaled among local health care delivery facilities for local prices, local operational efficiencies, and local poverty. The Workgroup recommends the formula retain such local variations and the IHS should continue to refine the scaling factors to reflect any improved data that may become available.

Data Procedures. The data used in the current formula are collected from national, IHS Areas, States and individual sites. The Workgroup recommended no important changes in the data collection methods, but suggested that IHS refine and update technical manuals.

Alternate Resources. Because the law requires alternate resources be considered in the formula and because reliable alternate resources data were insufficient at the time the formula was adopted, the formula currently infers alternate resources for all individual facilities at a flat rate of 25 percent. The Workgroup recommends replacing the flat rate with a new statistical index of alternate resource potential to be created through a study linking IHS user data with expenditure data from the Centers for Medicare & Medicaid Services (CMS). The Workgroup does not propose to count alternate resources of AIAN individuals or to count third party reimbursements collected by individual health care delivery facilities. The Workgroup suggests both of those approaches have insurmountable practical difficulties and would introduce inappropriate disincentives for third party collections. Rather, CMS expenditures statistically linked to IHS users would broadly measure variations in alternate resource potential among States and IHS Areas in a more realistic manner than the current flat rate.

Sec. ~~201~~ 121 - Indian Health Care Improvement Fund: Amendment Enacted 3/23/2010

SEC. ~~201~~ 121. INDIAN HEALTH CARE IMPROVEMENT FUND.

(a) Use of Funds- The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of--

- (1) eliminating the deficiencies in health status and health resources of all Indian tribes;
- (2) eliminating backlogs in the provision of health care services to Indians;
- (3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;
- (4) eliminating inequities in funding for both direct care and contract health service programs; and
- (5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian tribes with the highest levels of health status deficiencies and resource deficiencies:
 - (A) Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.
 - (B) Preventive health, including mammography and other cancer screening.
 - (C) Dental care.
 - (D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.
 - (E) Emergency medical services.
 - (F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.
 - (G) Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.
 - (H) Home health care.
 - (I) Community health representatives.
 - (J) Maintenance and improvement.

Sec. ~~201~~ 121 - Indian Health Care Improvement Fund: Amendment Enacted 3/23/2010

(b) No Offset or Limitation- Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act or the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the `Snyder Act'), or any other provision of law.

(c) Allocation; Use-

(1) IN GENERAL- Funds appropriated under the authority of this section shall be allocated to Service units, Indian tribes, or tribal organizations. The funds allocated to each Indian tribe, tribal organization, or Service unit under this paragraph shall be used by the Indian tribe, tribal organization, or Service unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian tribe served by such Service unit, Indian tribe, or tribal organization.

(2) APPORTIONMENT OF ALLOCATED FUNDS- The apportionment of funds allocated to a Service unit, Indian tribe, or tribal organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes and tribal organizations.

(d) Provisions Relating to Health Status and Resource Deficiencies- For the purposes of this section, the following definitions apply:

(1) DEFINITION- The term `health status and resource deficiency' means the extent to which--

(A) the health status objectives set forth in sections 3(1) and 3(2) are not being achieved; and

(B) the Indian tribe or tribal organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

(2) AVAILABLE RESOURCES- The health resources available to an Indian tribe or tribal organization include health resources provided by the Service as well as health resources used by the Indian tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

(3) PROCESS FOR REVIEW OF DETERMINATIONS- The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian tribe or tribal organization.

(e) Eligibility for Funds- Tribal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

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(f) Report- By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service unit, including newly recognized or acknowledged Indian tribes. Such report shall set out--

(1) the methodology then in use by the Service for determining tribal health status and resource deficiencies, as well as the most recent application of that methodology;

(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service or a tribal health program;

(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service or a tribal health program; and

(4) an estimate of--

(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service unit, Indian tribe, or tribal organization;

(B) the number of Indians eligible for health services in each Service unit or Indian tribe or tribal organization; and

(C) the number of Indians using the Service resources made available to each Service unit, Indian tribe or tribal organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

(g) Inclusion in Base Budget- Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

(h) Clarification- Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

(i) Funding Designation- Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.