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INDIAN  
HEALTH  
BOARD**

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Cowlitz Tribe  
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March 1, 2011

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

Dear Dr. Roubideaux:

The Northwest Portland Area Indian Health Board is a P.L. 93-638 Tribal organization that represents health care issues of forty-three federally recognized Tribes in Idaho, Oregon, and Washington. We are responding to your December 30, 2011 letter, in which you have initiated Tribal consultation on the Indian Health Care Improvement Fund formula.

The Indian Health Service (IHS) has always been challenged by Tribes for its inequitable distribution of resources for health services and facilities. This distribution controversy reached a head in *Rincon Band of Mission Indians vs. Harris*, when a group of California Indians sought redress for disparate funding levels for Indian health care in the California Area.<sup>1</sup> Consequently, the Indian Health Care Improvement Fund (IHCIF) was established to correct IHS funding disparities by raising the level of funding and services provided to the neediest tribes. Since its inception, the system used to measure and rank Tribal needs has often been criticized for its weaknesses and inability to know whether the IHCIF is truly being distributed according to tribes' relative needs.

Portland Area Tribes also have concerns about the IHCIF and whether it has been effective at eliminating funding and services disparities that exist across the Indian health system. To this end, we appreciate the opportunity to address the four items outlined in your December 30<sup>th</sup> letter.

**1. Should we change the IHCIF formula?**

Our answer to this question is, yes. Portland Area Tribes position on this question is that the IHCIF should be changed to address the technical weaknesses unveiled by the IHCIF Data Workgroup. The Data Workgroup recommended making technical improvements in six key areas of the formula: (1) User Counts; (2) Cost Benchmark; (3) Health Status; (4) Facility Differences; (5) Data Procedures, and; (6) Alternate Resources. It is the position of Portland Area Tribes that the aforementioned areas must be improved in order to achieve the Congressional intent of the IHCIF and to effectively address funding and service inequities in the Indian health system.

<sup>1</sup> *Rincon Band of Mission Indians v. Harris*, 618 F.2d 569 (9th Cir. 1980).

Section 121 of the Indian Health Care Improvement Act (IHCIA) sets forth the authority to establish the IHCIF. Section 121 was amended to provide that funds appropriated for the IHCIF may be supplied to IHS or ISDEAA programs, with the apportionment of funds to be determined by IHS in consultation with affected tribes and tribal organizations. The amended Section 121 now states that one of the functions of the IHCIF is to eliminate inequities in funding for direct and Contract Health Service (CHS) programs. Section 121 also updates the requirement for IHS to file a health status and resource deficiency report to Congress and directs that, to the extent available, the report shall include information on waiting lists and the number of Indians turned away for services due to lack of resources.

One of the important changes for Section 121 is that it now defines "**health status and resource deficiency.**" Section 121(d)(2) now requires that for the purpose of determining health status and resource deficiencies that the IHS must take into account all available resources.

Section 121(d)(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].*" [Emphasis added]

Because the law now requires IHS to consider "*financing systems provided by any Federal programs, private insurance, and programs of State and local governments*" we believe that alternate resources must now be included in calculating the Federal Disparity Index (FDI) for Tribes. While the IHCIF Data Workgroup did not concur about the reliability of alternate resources data we believe this data can readily be made available through the Centers for Medicare & Medicaid Services (CMS) and state Medicaid programs. There is no denying the fact that these alternate resources do provide an advantage over those tribes that may not have the same capacity to provide similar levels of care and also generate third party reimbursements. Ignoring this fact in the IHCIF will only perpetuate funding and health service inequities that the IHCIF was established to address.

## 2. Should we make technical improvements to the current formula?

The IHCIF Data Workgroup has proposed technical improvements for some of the data elements used in the IHCIF formula. We agree that the formula components should be refined as recommended by the Workgroup. We also provide the following recommendations based on concerns expressed by Portland Area Tribes:

**User Counts.** The IHCIF Data Workgroup supports retaining user population as an approach to determine the FDI scores. We support this recommendation with the condition that the formula develop a system to un-duplicate user counts across all IHS Areas. Currently, user population is only unduplicated within respective IHS Areas. We also recommend that the IHS take into consideration CHS dependency factors. For example, if a person lives outside a CHSDA they often will not seek care and do not show up in a Tribe's user population. Comparatively at a direct care facility many services may be provided and result in the patient being included in that facility's user population.

The result is that user population at CHS dependent programs is restricted and held artificially low compared to those direct care facilities. This inequity should be compensated in the IHCIF.

*Cost Benchmark.* We support continuing the use of benchmark per capita funding comparisons relative to the average per capita costs of a blend of Federal Employee Health Program insurance plans. We recommend improving the services included in the benchmark package to reflect changing services provided in the private sector and recognize the new authorities included in the reauthorization of the IHCA. Our recommendation is consistent with that of the Workgroup, who concurred that IHS should make technical improvements to fine tune the benchmark to reflect evolving health care delivery system. The integration of behavioral health into primary care should also be factored in this process.

*Health Status.* We recommend additional work be put into refining the health status indicator in the formula. We believe that an index constructed from more relevant and current health status data would better reflect cost variations among the IHS Areas or operating unit sites. We agree with the Workgroup that 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 cost variations than mortality data.

*Data Procedures.* The Workgroup recommended no important changes in the data collection methods, but suggested that IHS refine and update technical manuals. We concur with this recommendation.

*Alternate Resources.* We do not support counting resources contributed by Tribal governments to their health programs. Please also see our discussion included above in Item No. 1. The measurement of alternate resources is the most critical issue that must be addressed in the IHCIF formula. We support replacing the 25 percent flat rate used in the formula with the actual collections data from Medicare, Medicaid, and CHIP. Alternatively, we are supportive of developing a new statistical index of alternate resources that could be created through an IHS-CMS expenditure data linkage.

**3. Should we make changes in the basic methodology of the formula?**

Please see our discussion included under Items No. 1 and No. 2 above.

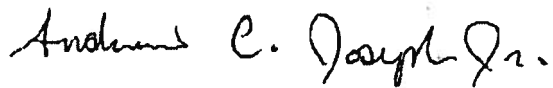
**4. How should we consult with Tribes on the questions above?**

We recommend that the IHS continue to use the IHCIF Data Workgroup to review the comments received through this Tribal consultation. The Workgroup should refine their recommendations based on the Tribal consultation comments and prepare a final report to the IHS Director. We recommend that the findings of this report be used to conduct Area or national listening sessions,

which can serve as the basis for the IHS Director to make her decision concerning changes in the IHCIF.

Thank you for the opportunity to provide our comments on the IHCIF formula. If you should have any questions, please feel free to contact Jim Roberts, Policy Analyst, at (503) 228-4185 or by email at [jroberts@npaihb.org](mailto:jroberts@npaihb.org).

Respectfully,

A handwritten signature in black ink that reads "Andrew C. Joseph, Jr." in a cursive style.

Andrew Joseph, Jr., Chairperson  
Northwest Portland Area Indian Health Board,  
Colville Tribal Council Member