NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

DATE: January 21, 2010

TO: Tribal Leaders, Health Directors, Board Delegates

FROM: Jim Roberts, Policy Analyst

SUBJECT: CHS Reform and Tribal Consultation

Please find attached a Dear Tribal leader letter, dated January 15, 2010, from Dr. Roubideaux announcing the beginning of a consultation process to reform the Indian Health Service Contract Health Service (CHS) program.

The process begins with a CHS Listening session that is scheduled for Thursday, February 11th and a CHS Best Practices meeting on February 12th in Arlington, Virginia. This is the same week as our Quarterly Board Meeting which is also being held in Arlington, VA.

On Thursday, February 11th, we end our Board meeting at noon and the CHS Listening session begins at 1:00 p.m. to 5:00 p.m. The CHS Best Practices meeting is on Friday, February 12th from 9:00 a.m. to 4:00 p.m. I know it will make for a long week, but I am hopeful that you will be able to stay over for the CHS meetings given the significance of the CHS program to Portland Area Tribes and since many of you will be in the area.

We will also include a session during the QBM to have a discussion on issues that should be brought up during the listening session and provided in a formal comment letter which is due by March 15, 2010. For your purpose, I have included a letter that the Board sent Dr. Roubideaux on the FY 2010 CHS program increase and testimony that we have prepared for past CHS hearings. I hope the information is helpful for the CHS Listening Session.

If you should have any questions concerning this material, please feel free to contact me at (503) 228-4185 or by email at jroberts@npaihb.org.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

JAN 15 2010

Dear Tribal Leader:

I am writing today to begin a formal **consultation with Tribes on how to reform the Contract Health Services (CHS) program** of the Indian Health Service (IHS). I am providing the following opportunities to provide input and to discuss how we can improve the CHS program:

1) Submit written input in response to this letter by March 15, 2010;
2) Attend a Tribal listening session on February 11, 2010, in Arlington, Virginia;
3) Attend our CHS Best Practices Meeting on February 12, 2010, in Arlington, Virginia;
4) Serve on a new CHS Workgroup to be scheduled in April 2010.

Please review the information below to learn more about the background and input that has led to the development of this plan to consult with Tribes on the CHS program. At the end of this letter, I provide details on how to participate in the above consultation activities.

I received input from Tribal leaders in response to my letter dated September 4, 2009, on top priorities for internal IHS reform and the CHS program was one of the top priorities for reform. I have also heard numerous comments from Tribal leaders at meetings during the past several months about the need to improve and change the CHS program. The concerns relate to two issues: the need for more CHS funding to pay for patient referrals for care outside the IHS system; and the need to improve the way we do business with the CHS program.

In terms of the need for more CHS funding, it is clear that the IHS and Tribal CHS programs often do not have enough CHS funding to pay for all the patient referrals that are medically necessary. As a result, the CHS program staff help determine if patients have alternate resources such as Medicare, Medicaid or private insurance to help pay for these referrals. The CHS regulations describe a process for paying for these referrals based on medical priorities. Unfortunately, the CHS funding is so limited in some facilities that only the most urgent referrals are approved for payment. This is frustrating for the patient, the healthcare providers, facility administration and staff, our partners in the private sector, and Tribal leadership. We all agree that we need more funding for the CHS program.

One area in which we need more input is on how to distribute CHS funding. CHS funding is distributed to IHS Service Units and Tribes in two ways: first, through the historical base funding for CHS for each CHS program; and second, through a formula developed in 2001 by an IHS and Tribal workgroup to be applied to annual CHS funding increases over the base funding. However, the formula for distribution of annual CHS funding increases over the base has rarely been used because there have been minimal or no CHS funding increases in the years since 2001. The 2001 workgroup felt that any changes to the historical base funding would be unfair because changes could potentially take resources away from some CHS programs to benefit others. They felt that all CHS programs should be "held harmless" and that the base funding should not

change. They did, however, believe that any new CHS funding increases should be distributed according to a formula that considered a facility's user population, inflation, regional and geographic cost variations, and access to care to the nearest healthcare facility. In addition to this national distribution formula, some Areas have developed additional methodologies to distribute funding within their IHS Area.

In the fiscal year (FY) 2010 budget, IHS will receive $779 million in CHS funding, of which $117 million is an increase over the base funding. This is the largest increase in CHS funding in recent history and will provide much needed resources to pay for medically necessary referrals for our patients. Of this amount, $17 million will be used for the CHEF program, and $100 million will be distributed using the 2001 formula. This will be the first year since 2001 that the formula for CHS funding increases will be used with a substantial amount of funding and its effectiveness can be fully assessed. Based on input I have received so far from Tribes, I have decided the best course of action for FY 2010 is to **apply the 2001 formula to the $100 million CHS funding increase and consult with Tribes during FY 2010 to determine if we need to make any adjustments or changes to the formula for FY 2011 and on.** Applying the formula to the FY 2010 CHS funding increase will really be the first time we can see the full outcomes and impact of the formula developed in 2001. Only then can we consider whether we need to change the formula or keep it the same.

In terms of the need to improve the way we do business with the CHS program, it is clear that we can do much more. I have heard much input from Tribes and our staff about how we can improve the program. The CHS program is a complex program with complicated rules and processes and it is often confusing for our patients. There is much we could do to educate our patients and our referral sources to reduce misunderstandings about payment rules and processes. We can do better at maximizing the use of third-party resources and negotiating better rates for the services we pay for in the private sector. We could do more to implement case management services to better coordinate care for our patients and we could do more to use cost saving measures such as telemedicine. Our implementation of the Electronic Health Record could help us with better continuity of care and better billing information. And we could develop better partnerships with our non-IHS care providers in the business we do with them for our CHS referrals. Of course, all changes we may make must be consistent with current CHS regulations and the limitations we have with the amount of funding available for CHS in the budget, but I do think there are things we can do to improve the way we do business with the CHS program.

I have also heard from Tribes and our staff that some of our CHS programs are actually doing well in many of these areas. However, there is little opportunity to share best practices among programs. Therefore, I would like to **convene a meeting in which IHS and Tribal program staff can share best practices in CHS programs.** This meeting will allow us to learn about what successful practices have already been used in our system, so that we can share them with other programs and use their ideas to change how we administer the CHS program in general.

In order to accomplish all of the above activities and provide opportunities for Tribes to consult further on these issues, I would like to invite you to participate in any of the following activities to provide input on the CHS program:

1) **Provide input in writing** – you are invited to submit input on how to change and improve the CHS program in writing in response to this letter. Please send your written input to me at 801 Thompson Avenue, Rockville, Maryland 20852 by March 15, 2010.
2) **Provide input in person** – I will hold a Tribal listening session on how to improve the CHS program on February 11, 2010 from 1:00 p.m. to 5:00 p.m. at the Holiday Inn National Airport, located at 2650 Jefferson Davis Highway, Arlington, Virginia 22202. I chose this date since the national budget work session will be held on the few days prior in Crystal City, Virginia. Unfortunately, we do not have travel funding available for this session.
3) **Attend the CHS Best Practices Meeting** on February 12, 2010 from 9:00 a.m. to 4:00 p.m. at the Holiday Inn National Airport, located at 2650 Jefferson Davis Highway, Arlington, Virginia 22202. The purpose of this meeting is to provide a forum for sharing best practices in conducting the business of the CHS program. If you would like to do a presentation on your program's best practices, please contact Mr. Carl Harper, Director, Office of Resource Access and Partnerships at (301) 443-1553 or carl.harper@ihs.gov. We will have a limited amount of travel funding available for speakers at this meeting on a first come, first serve basis.
4) **Serve on a new CHS workgroup** – I plan to invite one IHS and one Tribal representative from each IHS Area to serve on a workgroup that will review input collected during the above activities and to make recommendations for how to improve our CHS program and whether we need to change the formula for new CHS funding increases starting in FY 2011 and beyond. I would like to see a mix of Tribal elected officials and IHS/Tribal technical staff on the workgroup. The first meeting of the CHS workgroup will be in April 2010. Please send nominations for workgroup members for your IHS Area to your respective Area Director by February 16. Area Directors will submit nominations to me by March 1, 2010. I will announce the final workgroup membership list by March 15, 2010. After the workgroup meeting, I will forward any recommendations to all Tribes for review and comment before implementation.

I would like to thank you for your input so far on the CHS program and to thank you in advance for your participation in as many of the above activities as possible. I understand the importance and urgency of our efforts to improve and change the CHS program so that more American Indians and Alaska Natives who are served by our programs can get their medically necessary referrals paid for in a timely manner. If you have any questions, please contact Mr. Harper at (301) 443-1553 or carl.harper@ihs.gov.

Sincerely,

Yvette Roubideaux

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

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
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Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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SENT BY TELEFAX: (301) 443-4794 – Hardcopy via Federal Express

December 21, 2009

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

Dear Dr. Roubideaux:

We are writing to you concerning the FY 2010 Contract Health Service (CHS) funding decisions and to provide you with our recommendations following the Senate Committee on Indian Affairs' recent oversight hearing on chronic underfunding of the CHS program.

Our letter makes the following recommendations with discussion following: (1) we recommend that the IHS Director use the "2002 blended formula" when allocating the final FY 2010 CHS funding increase; (2) Portland Tribes recommend Tribal consultation on the continued use of the CHS funding formula, and (3) that the IHS Director convene a new CHS Workgroup to address how the IHS allocates CHS funding so that we effectively address the disparity between need and resources available for CHS.

The FY 2009 Congressional appropriation provided a $55.1 million increase for the CHS program. After applying mandatory pay costs, inflation, and population growth of $30.1 million, there remained $20.5 million that was available for distribution. It is the position of Portland Area Tribes that the $20.5 million should have been allocated using the formula in effect since 1994, or the "blended formula" that was used to distribute increases in FY 2001, FY 2002, and again in FY 2003. Instead the IHS allocated 75% of the remaining funds based on costs of health care, and 25% based on access to inpatient care. This resulted in approximately 18-40% less CHS funding being available for Portland Area Tribes.

It is the position of Portland Area Tribes—and others nationally—that the 2001 CHS Workgroup *proposed funding methodology* has never been officially adopted by the Indian Health Service (IHS). This is evident following the development of the *proposed methodology* when in FY 2001 and FY 2002, there were CHS funding increases of $34.9 million and $15 million respectively, and the IHS Director, Dr. Michael Trujillo, decided to use a blended formula to allocate the funding increases. This was done in order to alleviate many of the "fairness" concerns associated with the new proposed methodology. The IHS Director allocated on a non-recurring basis one-half of the funding using the existing CHS formula (1994 formula) and the other half using the 2001 workgroup recommendations.

The gravity of this of this questionable policy will be felt considerably in FY 2010, in which Congress has provided a $144.8 million increase for the CHS program. Our estimates indicate that the Portland Area will receive approximately 27% ($1.6 million) less funding in FY 2010 if the same formula is applied that was used in FY 2009. Our analysis indicates that the effect of not using the 1994 formula is that following the FY 2001 and FY 2002 decisions, the Portland Area has lost over $50 million when formula changes are compounded through FY 2009.

In FY 2003, the IHS Director, Dr. Charles Grim, made permanent this funding decision by allocating the $49.9 on a recurring basis using the "2002 formula."[1] The 2002 formula in place was the blended formula. Dr. Grim also announced that in the future, "he planned," to use the 2001 workgroup formula. While this letter indicated the IHS Director's intention, it did not explicitly adopt the formula as a final policy for future use. Certainly, Dr. Trujillo never officially adopted it in light of his use of a blended formula when allocating funding increases in FY 2001 and FY 2002. Arguably, Dr. Grim didn't adopt it in practice since in FY 2003 he allocated the CHS funds using the "2002 blended formula."

Portland Area Tribes do not believe that new CHS formula has never been officially adopted through the use of a "Dear Tribal Leader" letter, which is the common practice of the IHS when making substantive policy changes. In fact the IHS Director's decision letters in FY 2001 and FY 2002 state the following:

> *"I support the Workgroup's strong recommendation to convene a follow-up Workgroup to address these issues," and; "..the decision regarding recurring allocation can be deliberated more comprehensively with contemporary and agreed upon data. By using this approach, it is my hope that we will continue our dialogue on the outstanding issues related to the disparity between need and the resources available for CHS."* [2]
>
> *Dr. Michael Trujillo, IHS Director*

These statements indicate that the IHS Director intended to continue to work to refine the CHS formula. There has not been a CHS funding increase sufficient until FY 2009 for the IHS to apply the new formulary components, in which the Agency allocated a $20.1 million increase using the proposed 2001 Workgroup formula. Because the formula has never officially been adopted, the IHS should have conducted Tribal Consultation to determine if the Tribes would prefer to use the blended formula implemented by previous IHS Directors when there were CHS funding increases in 2001, 2002, and 2003 or use the 2001 Workgroup proposal. Thus, we recommend that you use the "2002 blended formula" when making final the FY 2010 CHS funding increase.

During the CHS hearing you testified that you would seek Tribal input about the continued use of CHS funding formulas. It is our position that the CHS formula decision is not a closed case, and that you should seek consultation with Tribes nationally on this issue. We further recommend that you convene a new CHS workgroup to address how the IHS allocates CHS funding so that we effectively address the disparity between need and resources available for CHS. We further recommend that the Agency take into consideration all available resources related to CHS including third party collections such as

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[1] See "Dear Tribal Leader Letter", by Dr. Charles Grim, IHS Director, dated April 10, 2003.
[2] See "Dear Tribal Leader Letter", by Dr. Michael H. Trujillo, IHS Director, dated June 7. 2001 and December 31, 2001.

Medicare, Medicaid, CHIP, and private insurance collections. Contrary to what many believe, this data is available and must be used to achieve CHS funding equity.

Our recommendations are consistent with your testimony about how it is important to consult and partner with Tribes about making important changes in the CHS program, including funding distribution. If you should have questions concerning our recommendations, feel free to contact Jim Roberts, Policy Analyst, at (503) 228-4185 or by email at jroberts@npaihb.org.

We look forward to partnering with you on our recommendations.

Sincerely,

Joe Finkbonner, RPh, MHA
Executive Director

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RESOLUTION #09-01-01

Recommend the IHS Director Reconvene the CHS Workgroup to Revise the Contract Health Service Formula

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents forty-three federally recognized Tribes in Idaho, Oregon, and Washington and is dedicated to assisting to promoting the health needs and concerns of Indian people in the Northwest; and

WHEREAS, the Northwest Portland Area Indian Health Board is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, the Contract Health Services (CHS) is the most important budget line item for Portland Area Tribes and other Indian Health Service (IHS) Areas (California, Nashville, Bemidji) that do not have inpatient care and must purchase specialty care from the private sector; and

WHEREAS, in 2002 a CHS Workgroup appointed by the IHS Director developed a new CHS formula that requires (1) Congressional earmarks, new Tribes funding, and CHEF requirements must be met first; (2) any remaining amount is used to fund CHS inflation requirements, and; (3) if there is a balance after funding inflation, it is to be distributed using the new formula recommendations; and

WHEREAS, the former CHS distribution methodology was made up of three components with a percentage appropriated to each as follows: (1) Workload and Cost – 20 percent; (2) Years of Productive Life Loss – 40 percent, and; (3) CHS dependency – 40 percent. The former methodology carried a greater weight for CHS dependency than the new formula, which resulted in more funding for CHS-dependent Areas.

WHEREAS, the new CHS dependence component was adopted because it was felt that the former component was not related to the population being served, did not recognize that all Areas have some degree of CHS dependence, did not consistently measure for CHS dependence, and was distorted when applied to the operating unit level data; and

WHEREAS, the new formula component results in significantly less funding for CHS dependent Areas due to the fact that there is less weighted value given to the new variable to measure CHS dependence; and

WHEREAS, the new formula requires that inflation be funded prior to allocating any remaining funds under its requirements and if an inadequate inflation factor is used, it can create a superficial surplus of CHS funds to be allocated under the new formula. It is not fair for any Tribe to receive less funding than what is needed to fund true inflation; and

WHEREAS, one of the recommendations by the CHS Workgroup was the IHS Director should revisit the formula to evaluate its implementation following several years of implementation and make adjustments as needed and recommended by Tribal leaders in order to improve its application.

NOW THEREFORE BE IT RESOLVED, that the Northwest Portland Area Indian Health Board recommends that the IHS Director reconvene the CHS Workgroup to revisit the new CHS formula as recommended by the 2002 CHS Workgroup Report.

CERTIFICATION

NO. 09-01-01

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 29 for, 0 against, 0 abstain on October 16, 2008.

Chairman

10-16-08
Date

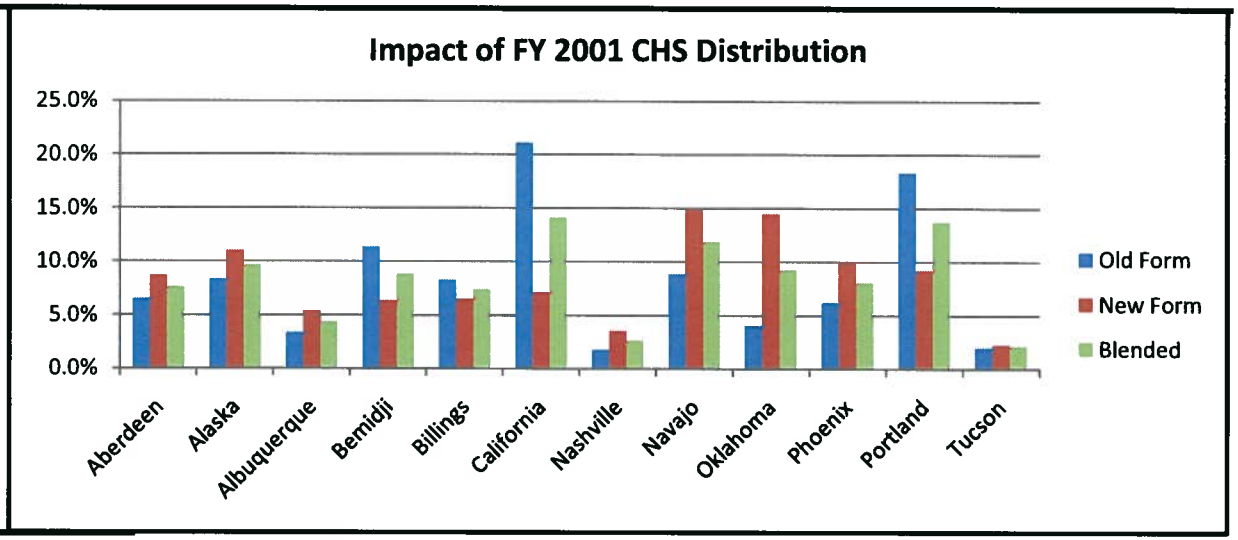
Secretary

CHS FORMULA WORKING PAPERS

PLEASE NOTE: These working papers were not included with the letter sent to Dr. Roubideaux. If you have questions or need an explanation of the worksheets, please contact Jim Roberts at (503) 228-4185 or by email at jroberts@npaihb.org.

ED'S PROJECTIONS: 12/3/2009

	2001 Workgroup	Pro Rata	Blended
Aberdeen	8.25%	11.68%	7.38%
Alaska	11.07%	10.74%	9.70%
Albuquerque	5.44%	5.03%	4.40%
Bemidji	6.31%	7.07%	8.83%
Billings	6.08%	8.47%	7.18%
California	7.75%	5.25%	14.42%
Nashville	3.48%	4.14%	2.62%
Navajo	15.51%	11.76%	12.17%
Oklahoma	14.91%	12.77%	9.45%
Phoenix	10.14%	8.75%	8.17%
Portland	8.85%	11.79%	13.59%
Tucson	2.20%	2.55%	2.10%
	100.00%	100.00%	100.00%



CHS Increase 2001

Distribution:	**$**	**40,000,000**
Less CHEF	$	(3,000,000)
Less Ketchikan	$	(140,000)
New Tribes	$	(1,000,000)
Recission	$	(949,863)
TOTAL AVAIL:	**$**	**34,910,137**

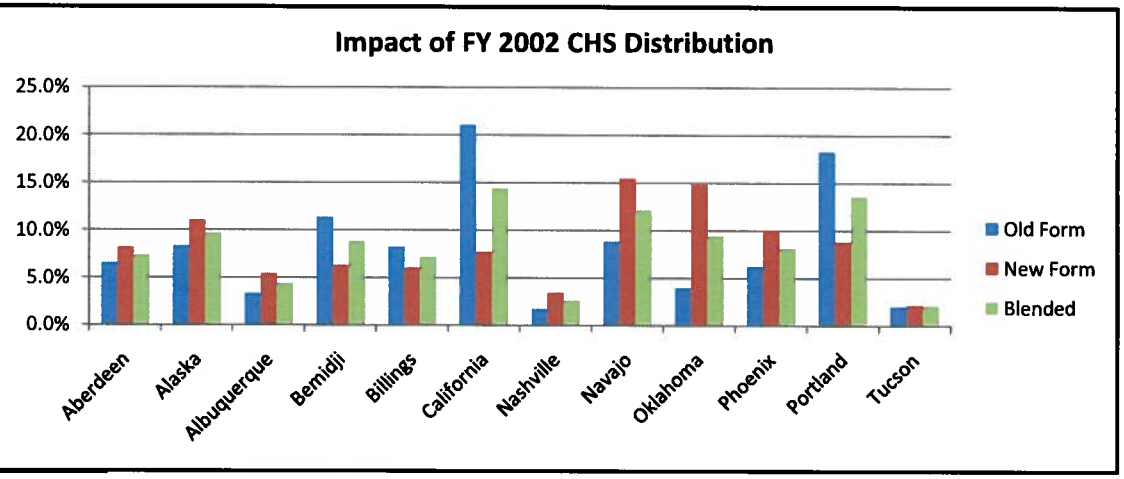
Summary of Changes for Portland Area:

Old Formula vs. New Formula:	$	3,179,834	-49.7%
Old Formula vs. Blended:	$	1,589,917	-24.9%

	(AA)		(BB)		AA & BB		FY 2001 TOTAL PROPOSED CHS FUNDING			
	Old Methodology	% of Total	New Formula	% of Total	Mid Point	% of Total	FY 2000 Base*	Old Formula	New Formula	Blended Formula
Aberdeen	$ 2,277,832	6.5%	$ 3,036,282	8.7%	$ 2,657,057	7.6%	$39,668,286	$ 41,946,118	$ 42,704,568	$ 42,325,343
Alaska	$ 2,907,000	8.3%	$ 3,846,688	11.0%	$ 3,376,844	9.7%	$36,307,812	$ 39,214,812	$ 40,154,500	$ 39,684,656
Albuquerque	$ 1,170,988	3.4%	$ 1,877,892	5.4%	$ 1,524,440	4.4%	$17,100,220	$ 18,271,208	$ 18,978,112	$ 18,624,660
Bemidji	$ 3,956,510	11.3%	$ 2,220,507	6.4%	$ 3,088,509	8.8%	$20,504,183	$ 24,460,693	$ 22,724,690	$ 23,592,691
Billings	$ 2,887,402	8.3%	$ 2,278,432	6.5%	$ 2,582,917	7.4%	$30,782,366	$ 33,669,768	$ 33,060,798	$ 33,365,283
California	$ 7,356,586	21.1%	$ 2,495,640	7.1%	$ 4,926,113	14.1%	$5,388,574	$ 12,745,160	$ 7,884,214	$ 10,314,687
Nashville	$ 612,474	1.8%	$ 1,241,492	3.6%	$ 926,983	2.7%	$15,191,134	$ 15,803,608	$ 16,432,626	$ 16,118,117
Navajo	$ 3,085,873	8.8%	$ 5,202,762	14.9%	$ 4,144,318	11.9%	$37,712,465	$ 40,798,338	$ 42,915,227	$ 41,856,782
Oklahoma	$ 1,398,667	4.0%	$ 5,059,119	14.5%	$ 3,228,893	9.2%	$44,326,011	$ 45,724,678	$ 49,385,130	$ 47,554,904
Phoenix	$ 2,165,663	6.2%	$ 3,472,055	9.9%	$ 2,818,859	8.1%	$28,962,282	$ 31,127,945	$ 32,434,337	$ 31,781,141
Portland	$ 6,394,348	18.3%	$ 3,214,514	9.2%	$ 4,804,431	13.8%	$36,509,685	$ 42,904,033	$ 39,724,199	$ 41,314,116
Tucson	$ 696,794	2.0%	$ 787,863	2.3%	$ 742,329	2.1%	$9,193,943	$ 9,890,737	$ 9,981,806	$ 9,936,271
HQ Reserve		0.0%	$ 176,891	0.5%	$ 88,446	0.3%			$ 176,891	$ 88,446
	$ 34,910,137	100%	$ 34,910,137	100%	$ 34,910,137	100%	$ 321,646,960	$ 356,557,097	$ 356,557,097	$ 356,557,097

ED'S PROJECTIONS: 12/3/2009

	2001 Workgroup	Pro Rata	Blended
Aberdeen	8.25%	11.68%	7.38%
Alaska	11.07%	10.74%	9.70%
Albuquerque	5.44%	5.03%	4.40%
Bemidji	6.31%	7.07%	8.83%
Billings	6.08%	8.47%	7.18%
California	7.75%	5.25%	14.42%
Nashville	3.48%	4.14%	2.62%
Navajo	15.51%	11.76%	12.17%
Oklahoma	14.91%	12.77%	9.45%
Phoenix	10.14%	8.75%	8.17%
Portland	8.85%	11.79%	13.59%
Tucson	2.20%	2.55%	2.10%
	100.00%	100.00%	100.00%



CHS Increase 2002

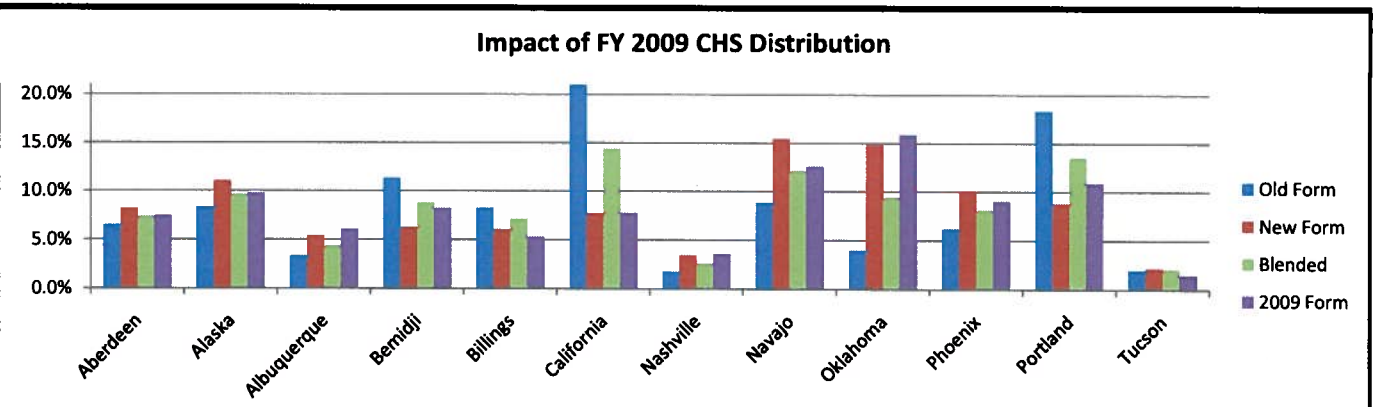
Distribution:	**$**	**49,900,000**	($34.9 million from FY 2001 non-recurring; $15 million increase from FY 2002 non-recurring)
New Tribes	$	(900,000)	
TOTAL AVAIL:	**$**	**49,000,000**	

Summary of Changes for Portland Area:

				YTD Loss
Old Formula vs. New Formula:	$	4,653,000	-51.8%	$ 7,832,834
Old Formula vs. Blended:	$	2,326,500	-25.9%	$ 3,916,417

	(AA)		(BB)		AA & BB		FY 2002 TOTAL PROPOSED CHS FUNDING			
	Old Formula	% of Total	New Formula	% of Total	Mid Point	% of Total	FY 2001 Base*	Old Formula	New Formula	Blended Formula
Aberdeen	$ 3,197,000	6.5%	$ 4,025,000	8.2%	$ 3,611,000	7.4%	$ 42,325,343	$ 45,522,343	$ 46,350,343	$ 45,936,343
Alaska	$ 4,080,000	8.3%	$ 5,406,000	11.0%	$ 4,743,000	9.7%	$ 39,684,656	$ 43,764,656	$ 45,090,656	$ 44,427,656
Albuquerque	$ 1,644,000	3.4%	$ 2,657,000	5.4%	$ 2,150,500	4.4%	$ 18,624,660	$ 20,268,660	$ 21,281,660	$ 20,775,160
Bemidji	$ 5,553,000	11.3%	$ 3,080,000	6.3%	$ 4,316,500	8.8%	$ 23,592,691	$ 29,145,691	$ 26,672,691	$ 27,909,191
Billings	$ 4,053,000	8.3%	$ 2,967,000	6.1%	$ 3,510,000	7.2%	$ 33,365,283	$ 37,418,283	$ 36,332,283	$ 36,875,283
California	$ 10,326,000	21.1%	$ 3,783,000	7.7%	$ 7,054,500	14.4%	$ 10,314,687	$ 20,640,687	$ 14,097,687	$ 17,369,187
Nashville	$ 860,000	1.8%	$ 1,698,000	3.5%	$ 1,279,000	2.6%	$ 16,118,117	$ 16,978,117	$ 17,816,117	$ 17,397,117
Navajo	$ 4,331,000	8.8%	$ 7,572,000	15.5%	$ 5,951,500	12.1%	$ 41,856,782	$ 46,187,782	$ 49,428,782	$ 47,808,282
Oklahoma	$ 1,963,000	4.0%	$ 7,280,000	14.9%	$ 4,621,500	9.4%	$ 47,554,904	$ 49,517,904	$ 54,834,904	$ 52,176,404
Phoenix	$ 3,040,000	6.2%	$ 4,949,000	10.1%	$ 3,994,500	8.2%	$ 31,781,141	$ 34,821,141	$ 36,730,141	$ 35,775,641
Portland	$ 8,975,000	18.3%	$ 4,322,000	8.8%	$ 6,648,500	13.6%	$ 41,314,116	$ 50,289,116	$ 45,636,116	$ 47,962,616
Tucson	$ 978,000	2.0%	$ 1,074,000	2.2%	$ 1,026,000	2.1%	$ 9,936,271	$ 10,914,271	$ 11,010,271	$ 10,962,271
HQ Reserve		0.0%	$ 187,000	0.4%	$ 93,500	0.2%			$ 187,000	$ 93,500
	$ 49,000,000	**100%**	**$ 49,000,000**	**100%**	**$ 49,000,000**	**100%**	**$ 356,468,651**	**$ 405,468,651**	**$ 405,468,651**	**$ 405,468,651**

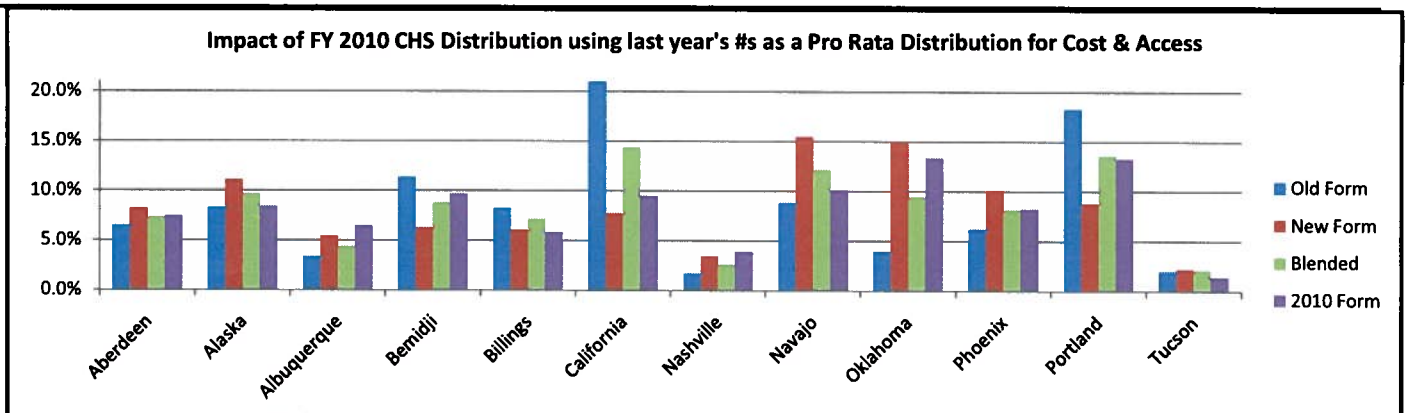
CHS Increase:	**$**	**55,143,000**
Pay Costs	$	23,000
Pop Growth	$	8,543,000
Inflation	$	21,577,000
New Tribes	$	-
CHEF	$	4,421,000
Subtotal,	$	34,564,000
TOTAL AVAIL:	**$**	**20,579,000**
Less FI/Reserve:	$	391,000
Actual Distrib:	**$**	**20,188,000**



	FY 2008 Base (ADL - 5/11/09)	% of CHS Budget	Current Services: Pop Growth Increase	Current Services: Inflation Increase	Current Services: Total	FY 2009 Adj Base	Funding Increase: 75% on Cost	Funding Increase: 25% on Access	Funding Increase: Total Increase	FY 2009 Total
Aberdeen	62,965,143	11.39%	$ 973,145	$ 2,457,866	$ 3,431,012	$ 66,396,155	$ 1,152,478	$ 387,395	$ 1,539,873	**$ 67,936,028**
Alaska	57,895,999	10.47%	$ 894,800	$ 2,259,991	$ 3,154,791	$ 61,050,790	$ 1,790,702	$ 226,384	$ 2,017,086	**$ 63,067,876**
Albuq	27,107,079	4.90%	$ 418,948	$ 1,058,134	$ 1,477,082	$ 28,584,161	$ 844,808	$ 404,198	$ 1,249,006	**$ 29,833,167**
Bemidji	38,095,014	6.89%	$ 588,770	$ 1,487,052	$ 2,075,822	$ 40,170,836	$ 968,066	$ 729,131	$ 1,697,197	**$ 41,868,033**
Billings	45,631,488	8.26%	$ 705,248	$ 1,781,241	$ 2,486,490	$ 48,117,978	$ 711,071	$ 382,415	$ 1,093,486	**$ 49,211,464**
California	28,280,641	5.12%	$ 437,086	$ 1,103,945	$ 1,541,031	$ 29,821,672	$ 833,152	$ 765,438	$ 1,598,590	**$ 31,420,262**
Nashville	22,288,969	4.03%	$ 344,483	$ 870,058	$ 1,214,540	$ 23,503,509	$ 480,551	$ 259,054	$ 739,605	**$ 24,243,114**
Navajo	63,397,710	11.47%	$ 979,831	$ 2,474,752	$ 3,454,583	$ 66,852,293	$ 2,437,813	$ 147,745	$ 2,585,558	**$ 69,437,851**
Oklahoma	68,792,633	12.45%	$ 1,063,211	$ 2,685,345	$ 3,748,555	$ 72,541,188	$ 2,950,585	$ 311,712	$ 3,262,297	**$ 75,803,485**
Phoenix	47,133,423	8.53%	$ 728,461	$ 1,839,870	$ 2,568,331	$ 49,701,754	$ 1,556,792	$ 303,570	$ 1,860,362	**$ 51,562,116**
Portland	63,503,636	11.49%	$ 981,468	$ 2,478,887	$ 3,460,354	$ 66,963,990	$ 1,163,922	$ 1,069,325	$ 2,233,247	**$ 69,197,237**
Tucson	13,723,875	2.48%	$ 212,107	$ 535,716	$ 747,823	$ 14,471,698	$ 251,060	$ 60,632	$ 311,692	**$ 14,783,390**
HQ Reserve	13,939,756	2.52%	$ 215,443	$ 544,143	$ 759,586	$ 14,699,342	$ 293,249	$ 97,751	$ 391,000	$ 15,090,342
TOTAL	**552,755,366**	**100.0%**	**$ 8,543,000**	**$ 21,577,000**	**$ 30,120,000**	**$ 582,875,366**	**$ 15,434,249**	**$ 5,144,750**	**$ 20,578,999**	**$ 603,454,365**
									CHEF	$ 30,999,800
										$ 634,454,165

	(AA) Old Formula	% of Total	(BB) New Formula	% of Total	AA & BB Mid Point	% of Total	FY 2009 TOTAL PROPOSED CHS FUNDING: FY 2009 Adj Base	Old Formula	New Formula	Blended Formula
Aberdeen	$ 1,317,164	6.5%	$ 1,658,300	8.2%	$ 1,487,732	7.4%	$ 66,396,155	$ 67,713,319	$ 68,054,455	$ 67,883,887
Alaska	$ 1,680,960	8.3%	$ 2,227,272	11.0%	$ 1,954,116	9.7%	$ 61,050,790	$ 62,731,750	$ 63,278,062	$ 63,004,906
Albuquerque	$ 677,328	3.4%	$ 1,094,684	5.4%	$ 886,006	4.4%	$ 28,584,161	$ 29,261,489	$ 29,678,845	$ 29,470,167
Bemidji	$ 2,287,836	11.3%	$ 1,268,960	6.3%	$ 1,778,398	8.8%	$ 40,170,836	$ 42,458,672	$ 41,439,796	$ 41,949,234
Billings	$ 1,669,836	8.3%	$ 1,222,404	6.1%	$ 1,446,120	7.2%	$ 48,117,978	$ 49,787,814	$ 49,340,382	$ 49,564,098
California	$ 4,254,312	21.1%	$ 1,558,596	7.7%	$ 2,906,454	14.4%	$ 29,821,672	$ 34,075,984	$ 31,380,268	$ 32,728,126
Nashville	$ 354,320	1.8%	$ 699,576	3.5%	$ 526,948	2.6%	$ 23,503,509	$ 23,857,829	$ 24,203,085	$ 24,030,457
Navajo	$ 1,784,372	8.8%	$ 3,119,664	15.5%	$ 2,452,018	12.1%	$ 66,852,293	$ 68,636,665	$ 69,971,957	$ 69,304,311
Oklahoma	$ 808,756	4.0%	$ 2,999,360	14.9%	$ 1,904,058	9.4%	$ 72,541,188	$ 73,349,944	$ 75,540,548	$ 74,445,246
Phoenix	$ 1,252,480	6.2%	$ 2,038,988	10.1%	$ 1,645,734	8.2%	$ 49,701,754	$ 50,954,234	$ 51,740,742	$ 51,347,488
Portland	$ 3,697,700	18.3%	$ 1,780,664	8.8%	$ 2,739,182	13.6%	$ 66,963,990	$ 70,661,690	$ 68,744,654	$ 69,703,172
Tucson	$ 402,936	2.0%	$ 442,488	2.2%	$ 422,712	2.1%	$ 14,471,698	$ 14,874,634	$ 14,914,186	$ 14,894,410
HQ Reserve		0.0%	$ 77,044	0.4%	$ 38,522	0.2%			$ 77,044	$ 38,522
	$ 20,188,000	**100%**	**$ 20,188,000**	**100%**	**$ 20,188,000**	**100%**	**$ 568,176,024**	**$ 588,364,024**	**$ 588,364,024**	**$ 588,364,024**

CHS Increase:	**$**	**144,870,000**
Pay Costs	$	11,000
Pop Growth	$	9,517,000
Inflation	$	17,360,000
New Tribes	$	982,000
CHEF	$	17,000,000
Subtotal,	$	44,870,000
TOTAL AVAIL:	**$**	**100,000,000**
Less FI/Reserve:	$	-
Actual Distrib:	**$**	**100,000,000**



	FY 2009 Base (HQ Rpt CHS Dist)	% of CHS Budget	Current Services: Pop Growth Increase	Current Services: Inflation Increase	Current Services: Total	FY 2010 Adj Base	Funding Increase: 75% on Cost	Funding Increase: 25% on Access	Funding Increase: Total Increase	FY 2010 Total
Aberdeen	67,932,811	11.26%	$ 1,071,360	$ 1,954,272	$ 3,025,632	$ 70,958,443	$ 5,612,055	$ 1,882,477	$ 7,494,532	$ **78,452,975**
Alaska	63,065,563	10.45%	$ 994,599	$ 1,814,252	$ 2,808,851	$ 65,874,414	$ 7,351,254	$ 1,100,073	$ 8,451,327	$ **74,325,741**
Albuq	29,830,959	4.94%	$ 470,460	$ 858,169	$ 1,328,629	$ 31,159,588	$ 4,551,993	$ 1,964,128	$ 6,516,121	$ **37,675,709**
Bemidji	41,868,282	6.94%	$ 660,299	$ 1,204,455	$ 1,864,754	$ 43,733,036	$ 6,185,421	$ 3,543,083	$ 9,728,504	$ **53,461,540**
Billings	49,214,400	8.16%	$ 776,154	$ 1,415,786	$ 2,191,940	$ 51,406,340	$ 3,985,201	$ 1,858,278	$ 5,843,479	$ **57,249,819**
California	31,420,785	5.21%	$ 495,533	$ 903,904	$ 1,399,438	$ 32,820,223	$ 5,826,049	$ 3,719,510	$ 9,545,559	$ **42,365,781**
Nashville	24,243,805	4.02%	$ 382,346	$ 697,439	$ 1,079,785	$ 25,323,590	$ 2,695,485	$ 1,258,827	$ 3,954,312	$ **30,259,902** *
Navajo	69,437,474	11.51%	$ 1,095,090	$ 1,997,558	$ 3,092,647	$ 72,530,121	$ 9,423,046	$ 717,941	$ 10,140,986	$ **82,671,108**
Oklahoma	75,806,573	12.56%	$ 1,195,536	$ 2,180,782	$ 3,376,318	$ 79,182,891	$ 11,889,416	$ 1,514,709	$ 13,404,125	$ **92,587,016**
Phoenix	51,563,659	8.54%	$ 813,204	$ 1,483,369	$ 2,296,573	$ 53,860,232	$ 6,780,075	$ 1,475,145	$ 8,255,219	$ **62,115,451**
Portland	69,197,424	11.47%	$ 1,091,304	$ 1,990,652	$ 3,081,956	$ 72,279,380	$ 8,139,051	$ 5,196,195	$ 13,335,246	$ **85,614,626**
Tucson	14,782,651	2.45%	$ 233,135	$ 425,263	$ 658,398	$ 15,441,049	$ 1,135,959	$ 294,630	$ 1,430,589	$ **16,871,639**
HQ Reserve	15,089,780	2.50%	$ 237,979	$ 434,099	$ 672,078	$ 15,761,858	$ 1,899,995	$ 475,004	$ 2,374,999	$ **18,136,856**
TOTAL	**603,454,166**	**100.0%**	$ **9,517,000**	$ **17,360,000**	$ **26,877,000**	$ **630,331,166**	$ **75,474,999**	$ **25,000,000**	$ **100,474,999**	$ **731,788,165**
			Balance to be Distributed (less $988,000 New Tribes Funding):		*$ 117,011,000*				CHEF	$ 30,999,800
			(Less CHEF increase of $17 million & Pay Costs of $11K):		*$ 100,000,000*		$ **75,000,000**	$ **25,000,000**		$ **762,787,965**

	(AA) Old Formula	(AA) % of Total	(BB) New Formula	(BB) % of Total	AA & BB Mid Point	AA & BB % of Total	FY 2009 TOTAL PROPOSED CHS FUNDING: FY 2009 Adj Base	Old Formula	New Formula	Blended Formula
Aberdeen	$ 6,524,490	6.5%	$ 8,214,286	8.2%	$ 7,369,388	7.4%	$ 70,958,443	$ 77,482,933	$ 79,172,729	$ 78,327,831
Alaska	$ 8,326,531	8.3%	$ 11,032,653	11.0%	$ 9,679,592	9.7%	$ 65,874,414	$ 74,200,945	$ 76,907,068	$ 75,554,006
Albuquerque	$ 3,355,102	3.4%	$ 5,422,449	5.4%	$ 4,388,776	4.4%	$ 31,159,588	$ 34,514,690	$ 36,582,037	$ 35,548,363
Bemidji	$ 11,332,653	11.3%	$ 6,285,714	6.3%	$ 8,809,184	8.8%	$ 43,733,036	$ 55,065,689	$ 50,018,751	$ 52,542,220
Billings	$ 8,271,429	8.3%	$ 6,055,102	6.1%	$ 7,163,265	7.2%	$ 51,406,340	$ 59,677,769	$ 57,461,442	$ 58,569,605
California	$ 21,073,469	21.1%	$ 7,720,408	7.7%	$ 14,396,939	14.4%	$ 32,820,223	$ 53,893,692	$ 40,540,631	$ 47,217,161
Nashville	$ 1,755,102	1.8%	$ 3,465,306	3.5%	$ 2,610,204	2.6%	$ 25,323,590	$ 27,078,692	$ 28,788,896	$ 27,933,794
Navajo	$ 8,838,776	8.8%	$ 15,453,061	15.5%	$ 12,145,918	12.1%	$ 72,530,121	$ 81,368,897	$ 87,983,183	$ 84,676,040
Oklahoma	$ 4,006,122	4.0%	$ 14,857,143	14.9%	$ 9,431,633	9.4%	$ 79,182,891	$ 83,189,014	$ 94,040,034	$ 88,614,524
Phoenix	$ 6,204,082	6.2%	$ 10,100,000	10.1%	$ 8,152,041	8.2%	$ 53,860,232	$ 60,064,313	$ 63,960,232	$ 62,012,273
Portland	$ 18,316,327	18.3%	$ 8,820,408	8.8%	$ 13,568,367	13.6%	$ 72,279,380	$ 90,595,706	$ 81,099,788	$ 85,847,747
Tucson	$ 1,995,918	2.0%	$ 2,191,837	2.2%	$ 2,093,878	2.1%	$ 15,441,049	$ 17,436,968	$ 17,632,886	$ 17,534,927
HQ Reserve		0.0%	$ 381,633	0.4%	$ 190,816	0.2%			$ 381,633	$ 190,816
	$ **100,000,000**	**100%**	$ **100,000,000**	**100%**	$ **100,000,000**	**100%**	$ **614,569,308**	$ **714,569,308**	$ **714,569,308**	$ **714,569,308**

AS PRESENTED IN THE FY 2009 CONGRESSIONAL JUSTIFICATION

SERVICES	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate	Change 08 to 09	CJ Proposed Distribution	(ProRata) OLD FORM.	Actual Increase	Actual Distribution	Change based on Old Form.
Aberdeen	$ 61,862,196	$ 64,240,876	$ 65,450,212	$ 1,209,336	11.9%	$ *1,317,235*	$ 1,539,873	7.6%	$222,638
Alaska	$ 58,328,195	$ 58,055,245	$ 59,148,136	$ 1,092,891	10.7%	$ *1,681,074*	$ 2,017,086	10.0%	$336,012
Albuquerque	$ 26,180,121	$ 27,180,365	$ 27,692,036	$ 511,671	5.0%	$ *677,164*	$ 1,249,006	6.2%	$571,842
Bemidji	$ 36,965,837	$ 37,975,832	$ 38,690,728	$ 714,896	7.0%	$ *2,287,989*	$ 1,697,197	8.4%	($590,792)
Billings	$ 46,714,154	$ 47,051,006	$ 47,936,743	$ 885,737	8.7%	$ *1,669,740*	$ 1,093,486	5.4%	($576,254)
California	$ 26,667,050	$ 27,762,039	$ 28,284,661	$ 522,622	5.1%	$ *4,254,201*	$ 1,598,590	7.9%	($2,655,611)
Nashville	$ 23,203,588	$ 22,451,926	$ 22,874,584	$ 422,658	4.1%	$ *354,184*	$ 739,605	3.7%	$385,421
Navajo	$ 62,075,461	$ 63,568,337	$ 64,765,013	$ 1,196,676	11.7%	$ *1,784,513*	$ 2,585,558	12.8%	$801,045
Oklahoma	$ 68,242,971	$ 68,490,272	$ 69,779,603	$ 1,289,331	12.6%	$ *808,828*	$ 3,262,297	16.2%	$2,453,469
Phoenix	$ 46,076,121	$ 47,464,522	$ 48,358,043	$ 893,521	8.8%	$ *1,252,370*	$ 1,860,362	9.2%	$607,992
Portland	$ 63,409,424	$ 63,638,208	$ 64,836,199	$ 1,197,991	11.7%	$ *3,697,754*	$ 2,233,247	11.1%	($1,464,507)
Tucson	$ 13,227,555	$ 14,060,039	$ 14,324,720	$ 264,681	2.6%	$ *402,945*	$ 311,692	1.5%	($91,253)
Subtotal, Areas	$ *532,952,673*	$ *541,938,667*	$ *552,140,678*	$ *10,202,011*	*100.0%*	$ *20,187,999*	$ 20,187,999	100.0%	
Headquarters	$ 10,146,327	$ 10,816,698	$ 11,020,323	$ 203,625					
Undistributed Funds - CHEF	$ -	$ 26,578,800	$ 25,000,000						
Total, CHS	$ 543,099,000	$ 579,334,166	$ 588,161,000						

AS PRESENTED IN THE FY 2010 CONGRESSIONAL JUSTIFICATION

Discretionary SERVICES	FY 2008 Actual	FY 2009 Omnibus	FY 2010 Estimate	FY 2010 +/- FY 2009	CJ Proposed Distribution	(ProRata) OLD FORM.	Actual Increase	Actual Distribution	Change based on Old Form.
Aberdeen	$ 62,965,125	$ 68,477,842	$ 82,904,097	$ 14,426,255	11.7%	$ 6,400,872	$ 7,494,532	7.6%	$1,093,660
Alaska	$ 57,895,982	$ 62,964,886	$ 76,229,724	$ 13,264,838	10.7%	$ 8,168,879	$ 8,451,327	8.6%	$282,448
Albuquerque	$ 27,107,071	$ 29,480,347	$ 35,690,984	$ 6,210,636	5.0%	$ 3,290,561	$ 6,516,121	6.6%	$3,225,560
Bemidji	$ 38,095,003	$ 41,430,293	$ 50,158,430	$ 8,728,137	7.1%	$ 11,118,078	$ 9,728,504	9.9%	($1,389,574)
Billings	$ 45,631,475	$ 49,626,598	$ 60,081,453	$ 10,454,855	8.5%	$ 8,113,808	$ 5,843,479	6.0%	($2,270,329)
California	$ 28,280,633	$ 30,756,656	$ 37,236,174	$ 6,479,517	5.2%	$ 20,672,537	$ 9,545,559	9.7%	($11,126,978)
Nashville	$ 22,288,963	$ 24,240,404	$ 29,347,140	$ 5,106,736	4.1%	$ 1,721,096	$ 3,954,312	4.0%	$2,233,216
Navajo	$ 63,397,692	$ 68,948,281	$ 83,473,643	$ 14,525,362	11.8%	$ 8,671,525	$ 10,140,986	10.3%	$1,469,461
Oklahoma	$ 68,813,330	$ 74,838,069	$ 90,604,235	$ 15,766,166	12.8%	$ 3,930,355	$ 13,404,125	13.7%	$9,473,770
Phoenix	$ 47,140,406	$ 51,267,639	$ 62,068,213	$ 10,800,574	8.7%	$ 6,085,669	$ 8,255,219	8.4%	$2,169,550
Portland	$ 63,536,321	$ 69,099,047	$ 83,656,171	$ 14,557,124	11.8%	$ 17,968,579	$ 13,335,246	13.6%	($4,633,332)
Tucson	$ 13,723,871	$ 14,925,422	$ 18,069,767	$ 3,144,345	2.5%	$ 1,958,041	$ 1,430,589	1.5%	($527,452)
Subtotal, Areas	$ *538,875,872*	$ *586,055,484*	$ *709,520,031*	$ *123,464,545*	100.0%	$ 98,100,000	$ 98,100,000	100.0%	
Headquarters	$ 13,879,328	$ 17,421,514	$ 21,826,969	$ 4,405,455			2374999		
CHEF	$ 26,578,800	$ 31,000,000	$ 48,000,000	$ 17,000,000					
Total, CHS	$ 579,334,000	$ 634,477,000	$ 779,347,000	$ 144,870,000			$ 100,474,999		

Testimony for the Record
Northwest Portland Area Indian Health Board

Before:

Senate Committee on Indian Affairs

"Promises Made, Promises Broken: The Impact of Chronic Underfunding of Contract Health Services"

December 3, 2009

Chairman Dorgan, Vice-Chair Barrasso, and members of the Committee, thank you for this opportunity to provide our testify for the record and for conducting this very important hearing on "Promises Made, Promises Broken: The Impact of Chronic Underfunding of Contract Health Services."

The Northwest Portland Area Indian Health Board (NPAIHB) was established in 1972, as a P.L. 93-638 tribal organization that represents forty-three federally recognized Tribes in the states of Idaho, Oregon, and Washington.[1] The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts policy and budget analysis, manages a Tribal epidemiology center, and operates health promotion and disease prevention programs. Our Board is dedicated to improving the health status and quality of life of all American Indian and Alaska Native (AI/AN) people.

I. Federal Trust Relationship

The United States and the federal government have a duty and an obligation—acknowledged in treaties, Executive Orders, statutes, and court decisions—to provide for the health and welfare of Indian Tribes and their members. In order to fulfill this legal obligation to Tribes, it has long been the policy of the United States to provide health care to AI/ANs through a system of the Indian Health Service programs, Tribal health programs, and urban clinics. These services are provided to members of 567 federally-recognized tribes in the United States, located in thirty-five different states.

II. Indian Health Disparities

The Indian Health Care Improvement Act (IHCIA) declares this Nation's policy to elevate the health status of the AI/AN people to a level at parity with the general U.S. population. Over the last thirty years the IHS and Tribes have made great strides to improve the health status of Indian people through the development of preventative, primary-care, and community-based public health services. Examples are seen in the reductions of certain health problems between 1972-74 and 2000-2002: gastrointestinal disease mortality reduced 91 percent, tuberculosis mortality reduced 80 percent, cervical cancer reduced 76 percent, and maternal mortality reduced 64 percent; with the average death rate from all causes dropping 29 percent.[2]

Unfortunately, while Tribes have been successful at reducing the burden of certain health problems, there is strong evidence that other types of diseases are on the rise for Indian people. For example, national data for Indian people compared to the U.S. all races rates indicate they are 770 percent more likely to die from alcoholism, 650 percent greater to die from tuberculosis, 420 percent greater to die

[1] As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, 25 U.S.C., Section 450(b) a Tribal organization is a legally established governing body of any Indian tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.

[2] FY 2000-2001 Regional Differences Report, Indian Health Service, available: www.ihs.gov.

from diabetes complications, 91 percent greater to die from suicide, and 52 percent more likely to die from pneumonia and influenza.[3] Northwest data indicates a growing gap between the AI/AN death rate and that for the general population. In 1994, average life expectancy at birth for AI/ANs born in Washington State was 74.8 years, and is 2.8 years less than the life expectancy for the general population. For 2000-2002, AI/AN life expectancy were at 74 years and the disparity gap had risen to 4 years compared to the general population. The infant mortality rate for AI/AN in the Northwest declined from 20.0 per 1,000 live births per year in 1985-1988 to 7.7 per 1,000 in 1993-1996, and then showed an increasing trend, rising to 10.5 per 1,000 in 2001.[4]

What is alarming about this data is the fact that there is evidence that the data may actually ***underestimate*** the true burden of disease among AI/ANs because, nationally and in the Northwest, people who classify themselves as AI/AN are often misclassified on death certificates. Unfortunately, it is safe to say that the improvements for the period of 1955 to 1995 have slowed; and that the disparity between AI/AN and the general population has grown. Factors such as obesity and increasing rates of diabetes contribute to the failure to reduce disparities.

III. Portland Area Tribes

The IHS Portland Area Office provides access to health care for forty-three federally recognized Tribes in the states of Idaho, Oregon, and Washington. Fifty-five different health facilities provide an array of health services to an estimated 167,000 AI/AN people. A range of health services are provided through thirty-nine outpatient health centers, thirteen health stations and preventive health programs, and three urban programs. The health centers provide a wide range of clinical services and are open forty hours each week. Health stations provide a limited range of clinical services and usually operate less than forty hours per week. Preventive programs offer counselor and referral services. The three urban programs provide direct medical care in addition to outreach and referral services.

Twenty-nine of the health centers are tribally operated, while ten are federally operated. One of the health stations is federally operated, while the remaining thirteen are tribally operated. There has been a decline in direct care outpatient visits in the Portland Area falling from 954,375 visits reported in FY 2006, down to 736,025 in FY 2007. This decline is attributed to the meager CHS budget increases as many services were likely reduced to absorb costs of inflation and population growth. There are no hospitals in the Portland Area, therefore inpatient and specialty care services that are not available in health facilities must be purchased through the CHS program. This is an important distinction that

[3] Jon Perez, Testimony before the U.S. Commission on Civil Rights, briefing, Albuquerque, NM, Oct. 17, 2003.
[4] American Indian Health Care Delivery Plan 2005, American Indian Health Commission of Washington State, available at: www.aihc-wa.org.

makes IHS Areas like the California, Bemidji, Nashville, and Portland Areas highly reliant on the CHS budget—and are commonly referred to as "***CHS Dependent***" Areas.[5]

IV. The IHS Contract Health Service Program

The IHS Contract Health Service (CHS) program originated under the Department of Interior, Bureau of Indian Affairs (BIA) when authority to enter into health services contracts for AI/ANs was provided under the Johnson O'Malley Act of 1934. The program was continued when responsibility for Indian health was transferred from the BIA to the Department of Health, Education, and Welfare in 1955 when IHS was established. The CHS program is used to supplement and complement other health care resources available to eligible AI/ANs. The CHS program is administered through twelve IHS Area Offices that include 163 IHS and Tribal service units. The CHS program purchases health care services for IHS beneficiaries from non-IHS providers. Purchasing health care services from non-IHS providers is essential to the overall IHS health care delivery system, as many IHS hospitals and clinics cannot provide these services. These services are critical for Tribes that do not have access to needed clinical services. The CHS funds are used in situations where:

1. No IHS direct care facility exists,
2. The direct care facility cannot provide the required emergency or specialty services,
3. The direct care facility has an overflow of medical care workload.

The CHS budget supports essential healthcare services from non-IHS or Tribal facilities and include, but is not limited to, inpatient and outpatient care, routine and emergency ambulatory care, medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, and physical therapy. Some additional services include treatment and services for diabetes, cancer, heart disease, injuries, mental health, domestic violence, maternal and child health, elder care, refractions, ultrasound examinations, dental hygiene, orthopedic services, and transportation. The agency applies stringent eligibility rules and uses a medical priority system in order to budget CHS resources so that as many services as possible can be provided.

The regulations at 42 CFR, Part 136 require that CHS services must be authorized or no payment will be made. Non-emergency services must be pre-authorized and emergency services are only authorized if notification is provided within 72 hours of the patient's admission for emergency treatment. The agency also has adopted the financial position that it is the Payer of Last Resort. This requires patients to exhaust all health care resources available to them from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. The IHS also negotiates contracts with providers to ensure competitive pricing for the services provided; however, there may be only one

[5] ***CHS Dependent*** Areas are those Areas of the IHS that rely on the CHS program for all of their inpatient care which include the California and Portland Areas, and; for nearly all their inpatient care in the Bemidji and Nashville Areas.

or a limited number of providers or vendors available to the local community. The CHS authorizing official from each IHS or Tribal health program either approves or denies payment for an episode of care. If payment is approved, a purchase order is issued and provided to the private sector hospital. CHS regulations permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of care needed. Because of insufficient funding in the CHS program, many IHS and Tribal health programs begin the year at a Priority One level.[6]

V. CHS Funding

The CHS budget is the most important budget item for Northwest Tribes since there are no hospitals in the Portland Area. CHS dependent Areas lack facilities infrastructure to deliver health services and have no choice but to purchase inpatient and specialty care from the private sector. Nationally, the CHS program represents 19 percent of the total health services account. In the Northwest, the CHS program represents 30 percent of the Portland Area Office's budget. This makes the CHS budget the most critical budget line item for Portland Area Tribes. Our estimates indicate that the CHS program has lost at least $732 million due to unfunded medical inflation and population growth since 1992.[7] This has resulted in rationing of health care services using the CHS medical priority system, in which most patients in the Portland Area cannot receive care unless they are in a Priority One status. In FY 2008, this under-funding resulted in a backlog of over 300,000 health services that were not provided because there simply was not enough funding. These services were not provided because they did not fall within the medical priorities, administrative processes were not followed, or a patient had moved outside of the CHSDA.[8] What is most concerning is that the patients requiring CHs services continue to need care. The patients are put onto a "denied/deferred" services status and when health programs receive funding for the new fiscal year, most health programs begin clearing this backlog of service.

This process immediately puts many Portland Area Tribes into a Priority One status at the beginning of each fiscal year. Postponing treatment often results in higher costs once a patient is finally able to receive care. In other instances patients will quit reporting to Tribal health facilities because they know that the health program is in a Priority One status and funding is limited. They know their required health care services may be denied or deferred, so they don't seek health care. Because of this, the data used to estimate denied/deferred services is often incomplete and can never accurately estimate the complete level of unfunded CHS need.

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[6] CHS Prioritized Levels of Care available at: www.ihs.gov/NonMedicalPrograms/chs/index.cfm

[7] "The FY 2010 IHS Budget: Analysis and Recommendations," p. 25, June 10, 2009, available at: www.npaihb.org.

[8] 42 CFR Part 136, Subparts A–C. Subpart C defines a Contract Health Service Delivery Area (CHSDA) as the geographic area within which contract health services will be made available by the IHS to members of an identified Indian community.

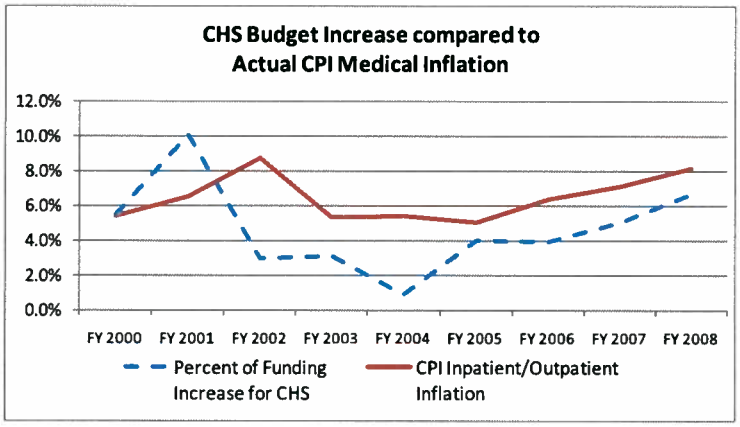
Table 12: Contract Health Services (CHS) Lost Purchasing Power 1993 - 2009 (Dollars in Thousands)					
Year	Approved Budget	Required CHS Budget with Medical Inflaton	Un-funded Medical Inflation	Un-funded Population Growth	Total Unfunded
FY 1992	$ 308,589	(Base Year)			
FY 1993	$ 328,394	$ 331,425	$ 3,031	$ 6,480	$ 9,511
FY 1994	$ 349,848	$ 354,260	$ 4,412	$ 6,896	$ 11,308
FY 1995	$ 362,564	$ 373,635	$ 11,071	$ 7,347	$ 18,418
FY 1996	$ 362,564	$ 390,428	$ 27,864	$ 7,614	$ 35,478
FY 1997	$ 368,325	$ 406,744	$ 38,419	$ 7,614	$ 46,033
FY 1998	$ 373,375	$ 419,433	$ 46,058	$ 7,735	$ 53,793
FY 1999	$ 385,801	$ 438,218	$ 52,417	$ 7,841	$ 60,258
FY 2000	$ 406,000	$ 414,350	$ 8,350	$ 8,102	$ 16,452
FY 2001	$ 445,773	$ 444,570	$ (1,203)	$ 8,526	$ 7,323
FY 2002	$ 460,776	$ 490,350	$ 29,574	$ 9,240	$ 38,814
FY 2003	$ 475,022	$ 518,373	$ 43,351	$ 9,500	$ 52,851
FY 2004	$ 479,070	$ 536,558	$ 57,488	$ 9,581	$ 67,069
FY 2005	$ 498,068	$ 557,836	$ 59,768	$ 9,961	$ 69,729
FY 2006	$ 517,297	$ 581,959	$ 64,662	$ 10,346	$ 75,008
FY 2007	$ 543,099	$ 605,714	$ 62,615	$ 11,405	$ 74,020
FY 2008	$ 579,334	$ 648,854	$ 69,520	$ 12,166	$ 81,686
FY 2009	$ 634,477	$ 636,688	$ 2,211	$ 12,166	$ 14,377
		Eighteen Year Total:	$ 579,608	$ 152,520	$ 732,128

There are at least two ways to calculate the amount of additional funding needed in the CHS program. The first is to take the IHS denied/deferred services reports and apply an average outpatient cost to the number of services. Last year, 300,779 unfunded services would have been approved had adequate funding been available. Applying an average outpatient rate of $1,107 to these services estimates that an additional $333 million was needed for the CHS program in FY 2008. Adding this amount to the approved FY 2010 CHS budget indicates that minimally, the CHS program needs at least $1.1 billion. Another method of calculating additional funding needed in the CHS program, is to estimate the unfunded inflation and population growth over a period and apply that amount to the current funding level. Since 1992, we estimate that the CHS program has not received adequate funding for mandatory cost of inflation ($579.6 million) and population growth ($152.5 million) and that the CHS budget should be at least $1.5 billion in FY 2010.[9]

The reason the CHS budget has eroded so badly is due to the fact that the Administration—or IHS—has not requested adequate increases; or that the Congress have failed to provide adequate increasese to cover inflation and population growth. The CHS program is more vulnerable to inflation pressures than any other program in the Indian health system. CHS budget increases have averaged 4.5 percent over

[9] The FY 2010 CHS budget is $779.3 million + our estimates for unfunded inflation $579.6 million + unfunded population growth $152.5 million equals a CHS budget of at least $1.5 million in FY 2010.

the last ten years, despite the fact that medical inflation has exceeded 10 percent in many of these years. Similar public health programs like Medicaid obtain budget increases that are based on actual medical inflation estimates. The Medicaid program has averaged an annual budget increase of 7.5 percent over the same period. The CHS program should receive medical inflation adjustments equal to the Medicaid program since both provide similar services and purchase care from the private sector. Medicaid's enrollment in FY 2008 grew by 2.2 percent and is comparable to the growth rate of 2.1 percent for IHS, so population growth alone does not justify the higher inflation rate for Medicaid. Surely, the relatively small Indian Health Program is not able to secure better rates from providers than the Medicare and Medicaid programs. It is reasonable to expect that Medicaid program inflation rates will exceed 12 percent in FY 2010. It seems clear that CHS, while an efficient alternative to building hospitals and specialty clinics, is subject to higher rates of inflation than the rest of the IHS budget and should be provided with an appropriate budget increase annually.



Almost all Tribes in the Northwest contribute Tribal resources to complement their health budgets and most often for the CHS program. Tribes in the Northwest see resources needed for economic development and other priorities increasingly absorbed by health care expenses in violation of treaty obligations of the federal government to provide for these health care services. If Tribes do not provide these resources the situation would be drastically worse and Congress must be aware of this.

VI. Denied/Deferred Services

The IHS maintains a deferred and denied services report that is updated each year. The report is inclusive of CHS data from IHS direct operated health programs and includes limited data from Tribally-operated health programs. Unfortunately, the denied/deferred services report **understates** the true need of CHS resources due to the data limitations and the fact that many tribes no longer report deferred or denied services because of the expense involved in tracking. More disturbing is that many IHS users do not even visit health facilities because they know they will be denied services due to funding shortfalls. Thus, using the denied/deferral report to estimate funding shortfalls in the CHS

program is not always appropriate because it under represents the amount of funding required to address unmet need.

IHS FY 2007 CONTRACT HEALTH SERVICE PROGRAM
DEFERRED & DENIED SERVICES REPORT
ALL AREA OFFICES
January 22, 2008

IHS AREA	A	Denied Service Categories								
	A Deferred Services Within Med Priorities	B Eligible But Care Not Within Med. Priority	C Eligible But Alternate Resource Available	D Patient Ineligible for CHS	E Emergency-Notification Not Within 72 Hours	F Non-Emergency No Prior Approval	G Patient Resides Outside CHSDA	H IHS Facility Available & Accessible	I All Other Denials	TOTAL
Aberdeen	*7,895*	9,116	17,463	2,409	774	3,357	2,565	3,969	1,398	41,051
Alaska	*2,785*	*1,463*	5,472	602	129	3,459	464	1,389	478	13,456
Albuquerque	*3,383*	2,078	4,448	223	220	66	1,180	186	256	8,657
Bemidji	*2,278*	572	1,909	872	964	1,930	617	626	1,811	9,301
Billings	*14,319*	6,707	4,740	1,227	236	3,577	1,529	3,118	187	21,321
California	*2,123*	318	1,308	352	303	274	25	13	7,532	10,125
Nashville	*1,927*	2,650	237	234	362	412	137	218	103	4,353
Navajo	*75,673*	2,654	16,247	229	1,311	523	602	2,026	2,779	26,371
Oklahoma	*45,159*	*5,069*	1,313	89	1,262	2,961	856	2,869	8,381	22,798
Phoenix	*2,720*	1,941	9,457	546	922	906	1,307	1,538	922	17,539
Portland	*3,389*	*2,562*	1,916	1,525	1,425	3,440	187	500	0	11,555
Tucson	*100*	*25*	1,535	93	125	14	173	1	11	1,977
TOTALS	***161,751***	***35,155***	***66,045***	***8,401***	***8,033***	***20,919***	***9,642***	***16,453***	***23,858***	***188,504***

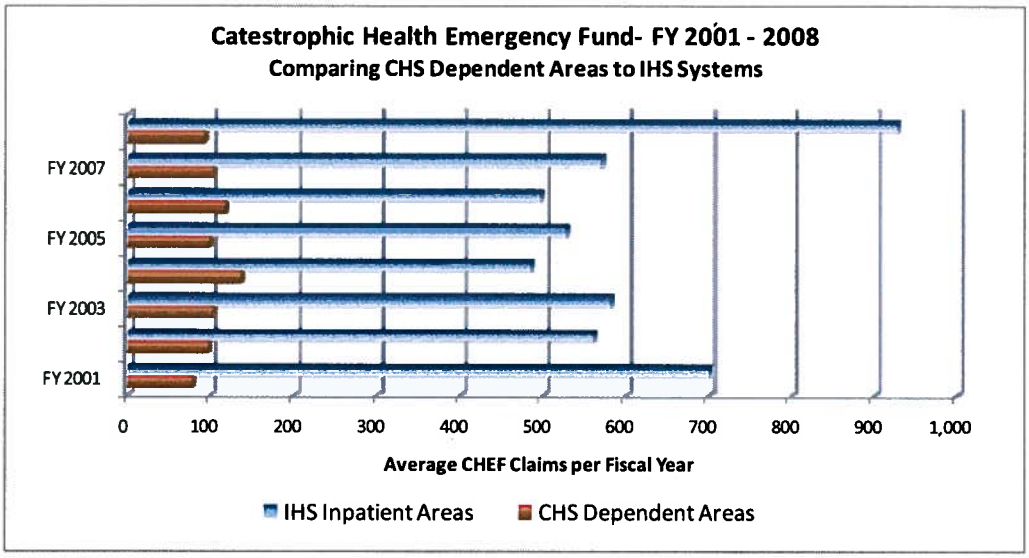
The denied/deferred service issue is a special concern for CHS dependent Areas. When a patient is not authorized to receive care; or does not report to a health clinic because they will be denied care, their visit will not be counted in IHS user population or workload reports. This is important, because user population and workload data drive many funding formulas to allocate IHS resources, including CHS funding. Those Areas with inpatient hospitals can generate more workload and users and internalize costs associated with providing care that would normally be purchased by CHS dependent Areas. Hospital based systems can provide care in some of these instances and get to count the patient visit in their user population and workload data. The effect of this is that CHS dependent Areas may not receive a fair share of resources if they cannot deliver the same level of care as those Areas that have inpatient care.

VII. Catastrophic Health Emergency Fund

The CHS program also includes a Catastrophic Health Emergency Fund (CHEF) that covers high cost cases and catastrophic illness. The term "catastrophic illness" refers to conditions that are costly by virtue of the intensity and/or duration of their treatment. Cancer, burns, high-risk births, cardiac disease, end-stage renal disease, strokes, trauma-related cases such as automobile accidents and gunshot wounds, and some mental disorders are examples of conditions that frequently require multiple or prolonged hospital stays and extensive treatment after discharge. The CHEF is used to help offset high cost CHS cases that meet a threshold of over $25,000 per incident. In FY 2008, the CHEF program provided funds

for 1,084 high cost cases totaling $26.7 million. For FY 2010 the CHEF fund has been increased to $48 million and should cover a higher level of catastrophic CHS claims.

One of the most fundamental distinctions in the IHS system is the dichotomy between those Areas that have hospitals and those that are CHS dependent. This division is a result of a decades old facility construction process that prioritizes dense populations in remote areas over small populations in mixed population areas. The priority for facility construction may have been logical at one time, however, over time has created two types Areas—those that are hospital based with expanded health services and those that are CHS dependent with limited ability to provide hospital like services. Unlike hospital based Areas that can provide specialty care services, CHS dependent Areas must purchase all specialty care utilizing CHS resources. The core issue is that IHS hospital level care can substitute for CHS purchased services in some Areas but not in others. Yet the annual distribution of CHS funds does not consider this fundamental exchange. This problem and the resulting reductions in access to care will continue as long as access to CHS funds are considered in isolation from access to directly provided hospital care. The impact of this problem is compounded in the CHS dependent Areas by organization structure and IHS policy on access to the CHEF. This inequity is depicted in the graph below comparing those CHS dependent Areas to those that have hospital based services. Clearly, the average CHEF claims for those CHS dependent Areas has lagged significantly behind those Areas that have hospital services.



CHS dependent Areas are disadvantaged in three fundamental ways. First they lack access to inpatient and specialty services such as radiology, specialty diagnostics, laboratory, and pharmacy services. These types of services tend to be associated with hospital based facilities. Comparatively, CHS dependent Areas have very few facilities with specialty services and limited pharmacy. In CHS dependent Areas access to services is restricted not only by the general underfunding, but also by the fragmentation of

resource into a large number of independently operated Tribal health programs. This can result in excess funds in one operating unit while other operating units are denying even life threatening care.

Lastly the relatively high threshold for access to CHEF disproportionably impacts CHS dependent Areas, where hospital services cannot be substituted for CHS coverage. This is because rational management of small CHS pools leads to policies that restrict high cost cases in favor of extending program activity to all four quarters of the year. One proof of this analysis is the persistent pattern of comparative CHEF utilization between two similarly sized IHS Areas one with hospital capacity and one without. A decade long comparative analysis of California Area and Billings Area CHEF utilization indicates a persistent rate for Billings Area that is 500 percent higher than that for the California Area.

CHS Funding Distribution Methodology

The most important issue for CHS dependent Areas is the distribution methodology used to allocate CHS resources. In 2001, a CHS Workgroup proposed a new distribution methodology that arguably has never been officially adopted by previous IHS Directors. The former CHS distribution methodology was made up of three components with a percentage appropriated to each as follows: (1) Workload and Cost – 20 percent; (2) Years of Productive Life Loss – 40 percent, and; (3) CHS dependency – 40 percent.

The former methodology carried a greater weight for CHS dependency than the new formula, which resulted in slightly more funding for CHS dependent Areas to deal with the unique circumstances of not having access to inpatient or specialty care. The previous formula's CHS dependency component was not adopted by the CHS Workgroup because it was felt that it did not adequately relate to the population being served, nor did it recognize that all Areas have some degree of CHS dependence, and was reportedly distorted when applied to operating unit level data. This position was not unanimous within the CHS Workgroup that developed the formula, with the previous formula components supported by those CHS Dependent Areas. Because the workgroup did not use a consensus process, the new changes were accepted based on a of majority support. Since there are only four CHS dependent Areas, defending the former CHS methodology was a losing proposition. The effect of the revised formula is that it will result in significantly less funding for CHS dependent Areas.

In 2001, understanding the contention of the newly proposed CHS funding methodology, the IHS Director decided to distribute the $34.9 million CHS funding increase on a non-recurring basis using a blended formula. One half of the funding was distributed using the existing formula at the time, and the other half was distributed using the Workgroup's *proposed* formula.[10] The following fiscal year (2002), the IHS Director again allocated on a non-recurring basis the FY 2001 increase ($34.9 million) and the FY 2002 increase ($15 million) "using the FY 2001 blended formula", which was *based on a blend of the*

[10] See "Dear Tribal Leader Letter", by Dr. Michael H. Trujillo, IHS Director, dated June 7. 2001.

former formula and the formula recommended by the 2001 CHS Workgroup.[11] Finally, in FY 2003, Dr. Charles Grim, IHS Director, made final the $49 million distribution by allocating the funds on a recurring basis using the "FY 2002 formula".[12] The slight increase of $10 million that was provided by Congress in FY 2003 was not adequate to fully fund medical inflation; therefore the new formulary portion was not applied. While the IHS Director indicates his "plan was to distribute increases in the future" using the proposed formula, it leaves in question whether the CHS Workgroup proposed formula has ever been officially adopted by the IHS. Certainly, the previous IHS Directors never officially adopted it in light of their use of a blended formula when allocating funding increases in FY 2001, FY 2002, and FY 2003.

It is the position of Portland Area Tribes that new CHS formula has never been officially adopted through the use of "Dear Tribal Leader" letter that that is the common practice of the IHS when making substantive policy changes. In fact the IHS Director's decision letters in FY 2001 and FY 2002 state the following:

> "I support the Workgroup's strong recommendation to convene a follow-up Workgroup to address these issues," and; "..the decision regarding recurring allocation can be deliberated more comprehensively with contemporary and agreed upon data. By using this approach, it is my hope that we will continue our dialogue on the outstanding issues related to the disparity between need and the resources available for CHS."

The statements above indicate that then IHS Director, Dr. Michael Trujillo, intended to continue to work to refine the CHS formula. There has not been a CHS funding increase sufficient until FY 2009 for the IHS to apply the new formulary components, in which the Agency allocated a $20.1 million increase using the proposed 2001 Workgroup formula. Because the formula has never officially been adopted by the IHS, the IHS should have conducted Tribal Consultation to determine if the Tribes would prefer to use the blended formula adopted by previous IHS Directors when there were CHS funding increases in 2001, 2002, and 2003; or use the 2001 Workgroup proposal. It is the position of Portland Tribes that this is not a closed case and the IHS Director should consult with Portland Area Tribes over this matter.

Another concern related to the CHS funding methodology is the use of inflations rates that are not indicative of actual medical inflation. It is recommended that Congress direct the IHS to use actual medical inflation rates to purchase inpatient and outpatient hospital care when determining inflation amounts for CHS distributions to Tribes.

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[11] See "Dear Tribal Leader Letter", by Dr. Michael H. Trujillo, IHS Director, dated December 31, 2001.
[12] See "Dear Tribal Leader Letter", by Dr. Charles W. Grim, IHS Director, dated April 10, 2003.

VIII. Recommendations

1. It is the position of Portland Tribes that the proposed formula developed by the 2001 CHS Workgroup has not been officially adopted by the IHS and that the Agency should continue to consult with Tribes over its continued use. The IHS Director should also convene a new CHS Workgroup to revisit the CHS formula to consider the following:
    a. Alternate resources (Medicaid, Medicare, Private Insurance, and changes under health reform) when making CHS distributions.
    b. CHS Dependency
    c. Use of actual medical inflation when allocating CHS funding.

2. The unique circumstances of CHS Dependent Areas must be addressed by the IHS and Congress in national and internal health reform, otherwise these systems will continue to be plagued with chronic underfunding and may not be able to capitalize on health care coverage expansions that will come with health reform.

3. To address the lack of access to the CHEF, it is recommended that Congress consider establishing an intermediate risk pool for CHS dependent Areas.