AGENDA

IHS/Tribal Indian Health Care Improvement Fund Workgroup Meeting

January 30-31, 2018
Holiday Inn Washington DC-Central/White House
Mayors Room
1501 Rhode Island Ave., NW
Washington, DC

TUESDAY, JANUARY 30, 2018

9:00 am	Welcome and Invocation	Ms. Elizabeth Fowler *Deputy Director for Management Operations* *Indian Health Service*
9:10 am	IHS Leadership Opening Remarks and Introductions	Ms. Elizabeth Fowler *Deputy Director for Management Operations* *Indian Health Service*
9:30 am	Election of Tribal Co-Chair	Tribal Representatives
9:50 am	Review Agenda and Establish Ground Rules	Co-Chairs
10:15 am	Review of the IHCIF Purpose and Existing Formula	IHS Staff Mr. Cliff Wiggins
10:45 am	BREAK	
11:00 am	Review of the IHCIF Past Allocations • Discuss Formula Effectiveness • Identify Challenges	IHS Staff Workgroup
12:30 pm	LUNCH on your own	
1:30 pm	Discussion of the Current Health Care Environment Relative to the IHCIF Formula • Identify Changes Since the Formula was Established • Identify Future/External Influencing Factors	Workgroup
3:00 pm	BREAK	
3:15 pm	Develop Approach/Plan for Accomplishing Workgroup Charge	Workgroup
4:15 pm	Discussion and Work Session	Workgroup
5:30 pm	Adjourn for the day	

WEDNESDAY, JANUARY 31, 2018

8:30 am	Review Previous Day	Co-Chairs
9:00 am	Discussion and Work Session	Workgroup
10:30 am	BREAK	
10:45 am	Discussion and Work Session	Workgroup
12:30 pm	LUNCH on your own	
1:30 pm	Discussion and Work Session	Workgroup
3:00 pm	BREAK	
4:00 pm	Conclude Discussion and Identify Next Steps	Co-Chairs
5:00 pm	Adjourn Meeting	

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville, MD 20857

JAN 2 6 2018

TO: Indian Health Care Improvement Fund Workgroup

FROM: Acting Director

SUBJECT: Workgroup Charge

The Indian Health Service (IHS) Indian Health Care Improvement Fund (IHCIF) Workgroup is established to review the existing formula used to allocate appropriations to the IHCIF and make recommendations regarding the formula. The review should address the following questions:

(1) Has the existing formula been effective in allocating IHCIF appropriations to meet the purpose of the IHCIF as stated in the Indian Health Care Improvement Act?
(2) What effect does the current health care environment have on the formula?
(3) Are the factors used in the IHCIF formula appropriate in light of answers to questions 1 and 2? For example, is the Federal Employees Health Benefits Program the appropriate benchmark?

The IHCIF Workgroup should plan to complete its work by June 30, 2018. This is necessary to allow Tribal Consultation to be accomplished on the final recommendations with a decision to be made by September 1, 2018. We anticipate using the results to allocate any funding increases for the IHCIF that are included in the final fiscal year 2018 appropriations.

Thank you for your interest in serving on the IHCIF Workgroup and undertaking this important work.

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service

IHS/Tribal IHCIF Workgroup Representatives

Area	Tribal / Federal	Primary / Alternate	Name	Title	Tribe / Tribal Organization
Alaska	Tribal	Primary	Mr. James C. Roberts	Senior Executive, Intergovernmental Affairs	Alaska Native Tribal Health Consortium
Alaska	Tribal	Alternate	Mr. Luke Welles	Vice President of Finance	Arctic Slope Native Association
Alaska	Federal	Primary	Christopher Mandregan	Area Director	N/A
Alaska	Federal	Alternate	Evangelyn Dotomain	Executive Officer	N/A
Albuquerque	Tribal	Primary	Joe Garcia	Ohkay Owingeh Councilman	Ohkay Owingeh (San Juan Pueblo)
Albuquerque	Tribal	Alternate	TBD		
Albuquerque	Federal	Primary	John Rael	CEO, ABQ Svc Unit	N/A
Albuquerque	Federal	Alternate	Clinton K. Gropp	CEO, UMU Svc Unit	N/A
Bemidji	Tribal	Primary	Phyllis Davis	Tribal Council Member	Gun Lake Tribe
Bemidji	Tribal	Alternate	Matt Clay	Director of Health Services	Pokagon Band of Potawatomi
Bemidji	Tribal	Alternate	Jennifer Webster	Councilwoman, Oneida Business Committee	Oneida Nation
Bemidji	Federal	Primary	Jason Douglas	Statistician/Health Planner	N/A
Bemidji	Federal	Alternate	Keith Longie	Area Director	N/A
Billings	Tribal	Primary	Beau Mitchell	Council Member	Chippewa Cree Tribal Council of Rocky Boy Reservation
Billings	Tribal	Alternate	Clint Wagon	Chairman	Eastern Shoshone Business Council
Billings	Federal	Primary	Leslie Racine	Management Analyst	N/A
Billings	Federal	Alternate	Mary Godfrey	Financial Management Officer	N/A
California	Tribal	Primary	Chris Devers	Tribal Representative	Pauma Band of Luiseno Indians
California	Tribal	Alternate	Mark LeBeau, PhD	Chief Executive Director, CRIHB	Various CRIHB resolution Tribes
California	Federal	Primary	Steve Riggio	Deputy Director, CAO	N/A
California	Federal	Alternate	Christine Brennan	Statistician/Public Health Analyst	N/A
Great Plains	Tribal	Primary	David Flute	Chairman Sisseton Tribe	Sisseton Tribe
Great Plains	Tribal	Alternate	Jerilyn Church	Great Plains Tribal Chairman's Health Board	
Great Plains	Federal	Primary	Shelly Korbel	Budget Officer	N/A
Great Plains	Federal	Alternate	Alexia Gillis	Budget Analyst	N/A
Nashville	Tribal	Primary	Dr. Lynn Malerba	Chief	Mohegan Tribe of Connecticut
Nashville	Tribal	Alternate	Casey Cooper	CEO	Eastern Band of Cherokee Indians
Nashville	Federal	Primary	Mark Skinner	Executive Officer	N/A
Nashville	Federal	Alternate	Kristina Rogers	Statistician	N/A
Navajo	Tribal	Primary	Russell Begaye	President	Navajo Nation
Navajo	Tribal	Alternate	Dr. Glorinda Segay	Executive Director, Navajo Department of Health	Navajo Nation
Navajo	Federal	Primary	Dee Hutchison	Executive Officer	N/A
Navajo	Federal	Alternate	CAPT Brian K. Johnson	Acting Area Director	N/A

Area	Tribal / Federal	Primary / Alternate	Name	Title	Tribe / Tribal Organization
Oklahoma City	Tribal	Primary	Melissa Gower	Senior Advisor, Policy Analyst	Chickasaw Nation
Oklahoma City	Tribal	Alternate	Terri Parton	President, Wichita and Affiliated Tribes	Wichita and Affiliated Tribes
Oklahoma City	Federal	Primary	Ron Grinnell	Executive Officer	N/A
Oklahoma City	Federal	Alternate	Carla Despain	Director, Division of Financial Management	N/A
Phoenix	Tribal	Primary	Amber Torres	Chairman	Walker River Paiute
Phoenix	Tribal	Alternate	Rosemary Sullivan	Chairperson, Hualapai Tribe Health Advisory Board	Hualapai Tribe
Phoenix	Federal	Primary	Sheila Todecheenie	Supervisory Financial Management Specialist, Phoenix Indian Medical Center	N/A
Phoenix	Federal	Alternate	Desdamona Leslie	Financial Management Specialist/FATA, Whiteriver Indian Hospital	N/A
Portland	Tribal	Primary	Ms. Gail Hatcher	Vice-Chair	The Klamath Tribes
Portland	Tribal	Alternate	Mr. Steven Kutz	Tribal Council Member	Cowlitz Indian Tribe
Portland	Federal	Primary	Ann Arnett	Executive Officer	N/A
Portland	Federal	Alternate	Nichole Swanberg	Acting Financial Management Officer	N/A
Tucson	Tribal	Primary	CAPT Marc Fleetwood	Director of Facilities Engineering Planning & Economic Development Dept.	Tohono O'odham Nation
Tucson	Tribal	Alternate	Reuben Howard	Executive Director	Pascua Yaqui Tribe
Tucson	Federal	Primary	Vivian Draper	Area Financial Management Officer	N/A
Tucson	Federal	Alternate	Mark Bigbey	Area Executive Officer	N/A
Headquarters	Federal	Ex Officio	Jennifer Cooper	Acting Director, Office of Tribal Self-Governance	N/A
Headquarters	Federal	Ex Officio	Roselyn Tso	Acting Director, Office of Direct Services and Contracting Tribes	N/A
Headquarters	Federal	Ex Officio	CAPT Francis Frazier	Director, Office of Public Health Support	N/A
Headquarters	Federal	Ex Officio	Ann Church	Acting Director, Office of Finance and Accounting	N/A

Federal Disparity Index (FDI) in a Nut Shell

The Federal Employees Health Plan Disparity Index (FDI) is an index comparing IHS funding to cost of insuring IHS AIAN users in a mainstream health insurance plan such as the Federal Employees Health Plan (FEHP). The index starts with an average benchmark cost for enrollees in FEHP. Because some characteristics of the IHS AIAN user population differ from FEHP enrollees in ways that affect health care costs, industry standard actuarial methods statistically adjust FEHP costs for characteristics found in the Indian population. These characteristics include demographic factors (age and sex), geographic variation in medical costs, size/scale of IHS/tribal health delivery sites, and poor health status of Indians in general and its variation place to place.

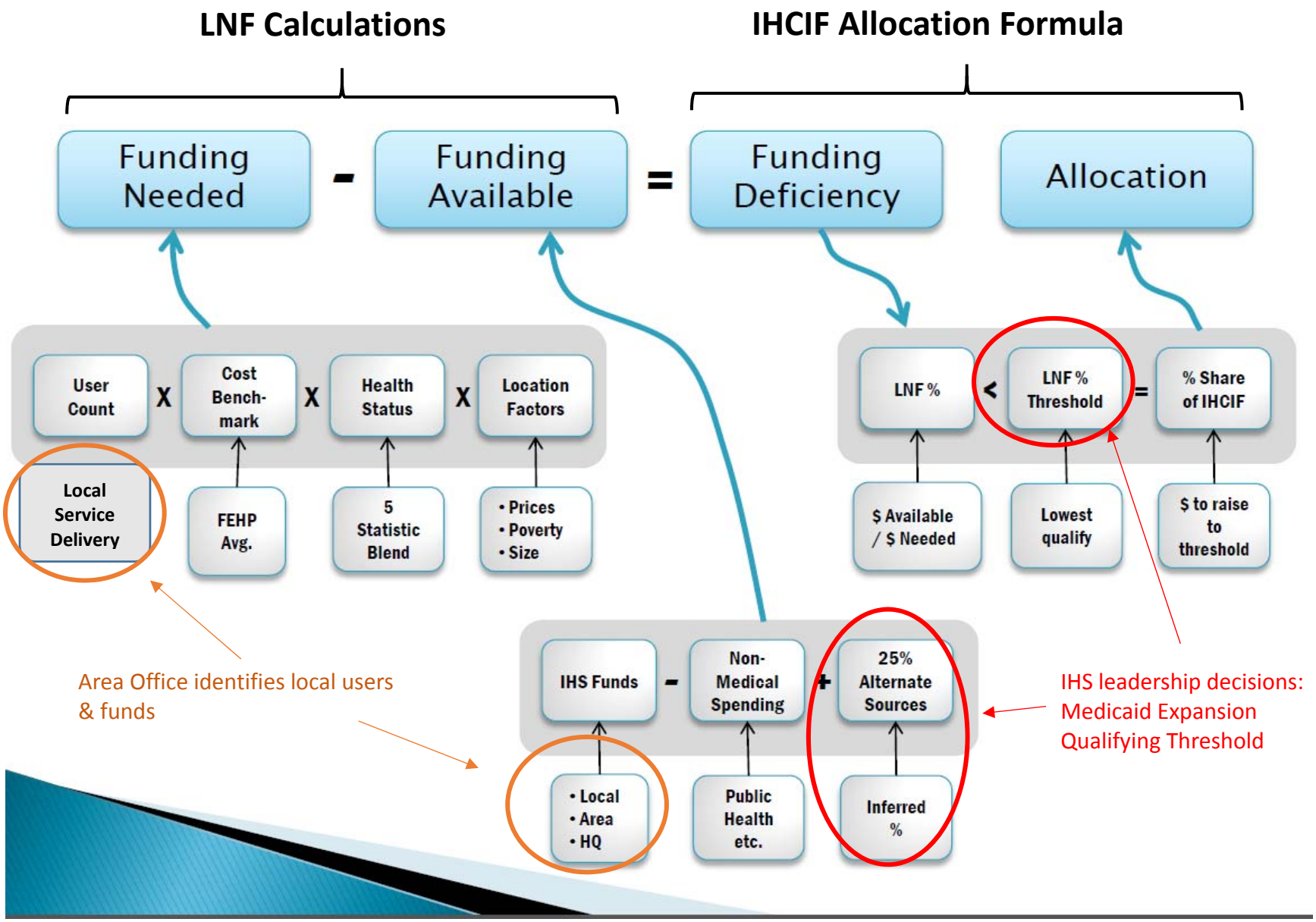
The FDI computation is accomplished in several steps.

1. The benchmark FEHP per capita cost is adjusted for coverage differences (scope of FEHP benefits compared to IHS benefits), out-of-pocket costs, AIAN demographic characteristics, less 25% for insurance coverage (Medicare, Medicaid, and private insurance) of AIANs. This yields an adjusted net cost of $3,079 per AIAN in 2006.
2. Next, the average net cost is individualized to 250 IHS and Tribal sites considering conditions that vary among the sites including size, remoteness, prevailing medical costs, and some variations in health status of AIAN users. These adjustments yield a unique site-specific cost forecast for each of the 250 IHS and Tribal sites. Forecast site costs will exceed the $3,079 IHS average at some sites and fall below the average at other sites.
3. Next, IHS funding at each site is adjusted to exclude spending on public health services which are not included in FEHP coverage. Each site's IHS funding is divided by the number of unduplicated users served at the site yielding a site-specific IHS funding per capita (an average of $1,610 per AIAN user in 2006).
4. Finally, each site's IHS funding per capita (step 3) is expressed as a percentage of the site's forecast cost (step 2). This ratio is known as the FDI percentage. A ratio of 60% means a site's funding is sufficient to cover only 60% of its users in an FEHP type health insurance plan. The lower the percentage, the greater the funding disparity compared to the FEHP benchmark.

Following guidelines in law, the IHS uses FDI results to allocate Indian Health Care Improvement Fund (IHCIF) appropriations to IHS and tribal sites. IHCIF appropriations are intended to reduce the degree of funding deficiency at IHS and Tribal sites as measured by the FDI ratio. The IHCIF formula is designed to reduce inequitable funding variations among sites by allocating more funds to sites with the lowest FDI ration (greatest funding disparity). Sites scoring above 60% receive no new IHCIF funds.

The FDI model accounts for important, but not all, factors that affect true costs of health care to Indians. Its value lies in systematic comparisons using industry recognized cost forecasts. The FDI is a statistical index that is valid for groups of AIAN served at the 250 IHS and Tribal sites. The FDI is not a valid basis to forecast costs for individual patients.

IHCIF Formula Conceptual Framework



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

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 IHCIA 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 IHCIA. 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 IHCIA, 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 IHCIA reauthorization relevant to the IHCIF. Please let me know your preferences on how to consult with Tribes on the issues raised above.

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.

(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.

(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'.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

NOV 25 2011

Dear Tribal Leader:

The purpose of this letter is to inform you of my decisions on issues related to our consultation on the Indian Health Care Improvement Fund (IHCIF) and its formula. I sent you a letter on December 30, 2010, requesting input on this issue. My decisions are based on careful consideration of the input you have provided since I initiated this formal consultation. I also considered the reauthorization of the Indian Health Care Improvement Act (IHCIA), which contains a provision that reauthorizes the IHCIF and includes several modifications to the IHCIF as described in my December 30, 2010, letter.

The IHCIF is important because it measures the resources needed by Federal and Tribal health care programs. The IHCIF formula calculates a level of need percentage relative to health insurance costs for the Federal Employees Health Benefits Program (FEHB). If the Congress appropriates additional funding for the IHCIF, we use the formula to increase funding for programs with the greatest unmet needs. **I have decided not to change the IHCIF formula until all programs reach at least 55 percent of their estimated level of need, which was the original agreement.** Although the key factors in the formula will not change, we will continue to improve the data and refine calculations of resource deficiency.

As a part of continually improving the data to measure resource deficiency, a joint Tribal/Indian Health Service (IHS) data technical workgroup recommended some updates to data used in the IHCIF formula and some technical improvements to its calculations. I requested input on these recommendations and they were included as an attachment to my December 30, 2010, letter. The Tribal input indicated general agreement to adopt technical improvements related to counting procedures for users; making updates to the FEHB benchmark, the price and productivity measures, and the guidance on data collection; and evaluating the health status measures. The Tribal input indicated that there is less certainty about replacing the existing flat 25 percent alternate resource factor with new data that has emerged since 2001. **I have decided to approve the data and technical improvements to the formula and to continue to evaluate whether a prototype Medicaid spending index would be a possible replacement for the existing 25 percent alternate resource factor**. I would like to extend my sincere appreciation to the technical workgroup members who considered the myriad of technical details, addressed the difficult issues, and emerged with helpful recommendations for my consideration.

The last issue is related to expanding the IHCIF formula to include new types of services authorized in the IHCIA. The IHCIA updates the list of health care services that the IHCIF may support. The IHCIA did not include additional funding for the health care services, such as long term care, which is one of the new services listed. In general, the Tribal input on this issue indicated it is premature to expand the formula for unfunded authorities. **I have decided to defer expanding the IHCIF formula until funding is made available for newly authorized health services**. The implementation of new services would be a significant event and would require Tribal consultation.

Thank you for providing your input, which was obtained through multiple forums including submissions at consultation@ihs.gov, listening sessions, conferences, and meetings. I continue my commitment to carrying out the IHS mission in partnership with you, following the IHS Tribal Consultation Policy, and working on the priority to renew and strengthen the Agency's partnership with Tribes. Please feel free to visit the Tribal Consultation Web site on my Director's Corner at www.ihs.gov, where you can also access my December 30, 2010, letter.

Sincerely,

/Yvette Roubideaux/

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

Indian Health Service

Indian Health Care Improvement Fund

FY 2000 - FY 2017

Fiscal Year	Enacted Amount
2000	10,000,000
2001	30,000,000
2002	23,000,000
2003	26,212,000
2004	0
2005	11,094,000
2006	0
2007	0
2008	13,782,000
2009	15,000,000
2010	45,543,000
2011	0
2012	11,981,000
2013	0
2014	0
2015	0
2016	0
2017	0
TOTAL	186,612,000

FY 2012 ALLOCATION & EXPENDITURE GUIDANCE
for Indian Health Care Improvement Fund (IHCIF)

Allocation Methodology for FY 2012

The IHCIF formula targets funds to sites with the greatest resource deficiencies as measured in the Federal Disparity Index (FDI) methodology, last updated in 2010. Sites scoring less than 44.8% of the benchmark qualify for a portion of $11,980,800 allocated by this formula.

Allocation Table

"FY 2012 IHCIF Allocations" table shows the allocation of funds among qualifying sites. Allocations are listed in the column labeled "2012 IHCIF $.

Potential Adjustments Among Sites Within the IHS Area

The data collected IHS-wide for the IHCIF formula may incompletely account for complexities in the organization and operation of interdependent regional systems of health care. In practice, complex intra-network patterns of patient referral and usage are not fully reflected in data available. In such cases, the Area Office in consultation with affected sites, is permitted discretion to adjust allocations to account for additional local factors if adjustments are applied in a manner consistent with the language in Section 201 of the Indian Health Care Improvement Act, reauthorized 3/23/2010.

Purpose and Use of Funds - Section 201 of Indian Health Care Improvement Act (25 U.S.C. § 1621)

The Indian Health Care Improvement Fund is authorized in the Indian Health Care Improvement Act, amended in 2010, for "… eliminating deficiencies in health status and resources … eliminating backlogs in services … meeting needs in efficient equitable manner … eliminating inequities in funding … augmenting services where deficiencies are highest … ." The Act further specifies that the service take into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances. Text of permitted purposes and use of funds is detailed "Sec 121 IHCIF (25 USC 1621).

Recurring Distribution

The $11,980,000 FY 2012 IHCIF is distributed on a **recurring** basis.

2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide	1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%

Area	Qualify	Operating Unit (Site)	User Count	Need Benchmark per User	Available $ per User	FDI % Score	$ to Raise to 45.8%	2012 IHCIF $	Revised FDI % Score
Aberdeen		(SR-SU) Standing Rock	9,097	$ 4,186	$ 2,219	53.0%	$0	$ -	53.0%
Aberdeen		Cheyenne River	8,124	$ 4,108	$ 1,996	48.6%	$0	$ -	48.6%
Aberdeen		Crow Creek	3,819	$ 4,458	$ 2,006	45.0%	$138,481	$ 138,000	45.8%
Aberdeen		(F-SU) Flandreau	1,669	$ 4,562	$ 2,051	44.9%	$64,702	$ 65,000	45.8%
Aberdeen		(Y-SU) Yankton-Santee Of Nebra	1,018	$ 4,624	$ 5,220	100.0%	$0	$ -	100.0%
Aberdeen		Lower Brule	1,997	$ 4,562	$ 2,764	60.6%	$0	$ -	60.6%
Aberdeen		Northern Ponca	2,676	$ 4,435	$ 1,990	44.9%	$111,108	$ 111,000	45.8%
Aberdeen		Omaha	3,769	$ 4,435	$ 2,407	54.3%	$0	$ -	54.3%
Aberdeen		(PR-SU) Pine Ridge	21,067	$ 4,033	$ 2,259	56.0%	$0	$ -	56.0%
Aberdeen		Rapid City	13,867	$ 4,050	$ 1,815	44.8%	$547,615	$ 548,000	45.8%
Aberdeen		Rosebud	12,220	$ 4,124	$ 2,433	59.0%	$0	$ -	59.0%
Aberdeen		Sac & Fox	1,762	$ 4,539	$ 2,033	44.8%	$80,866	$ 81,000	45.8%
Aberdeen		Sisseton-Wahpeton	6,340	$ 4,308	$ 3,601	83.6%	$0	$ -	83.6%
Aberdeen		Spirit Lake (FT-SU)	5,322	$ 4,348	$ 1,953	44.9%	$203,307	$ 203,000	45.8%
Aberdeen		Three Affiliated (FB-SU)	5,605	$ 4,211	$ 1,997	47.4%	$0	$ -	47.4%
Aberdeen		Trenton	1,867	$ 4,491	$ 2,020	45.0%	$68,450	$ 68,000	45.8%
Aberdeen		Turtle Mountain	12,888	$ 4,038	$ 2,403	59.5%	$0	$ -	59.5%
Aberdeen		Winnebago	4,893	$ 4,279	$ 4,296	100.0%	$0	$ -	100.0%
Aberdeen		(Y-SU) Yankton-Wagner	3,903	$ 4,458	$ 2,474	55.5%	$0	$ -	55.5%
Aberdeen Area Sites In Total			**121,903**	**$ 4,191**	**$ 2,368**	**56.5%**	**$1,214,529**	**$1,214,000**	**56.7%**

LNF score last measured in 2010. Updates are scheduled for Fall 2012.

2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide			1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%
Area	*Qualify*	*Operating Unit (Site)*	*User Count*	*Need Benchmark per User*	*Available $ per User*	*FDI % Score*	*$ to Raise to 45.8%*	*2012 IHCIF $*	*Revised FDI % Score*
Alaska		Aleutian Pribilof Islands Associat	1,065	$ 5,406	$ 5,779	100.0%	$0	$ -	100.0%
Alaska		Arctic Slope Native Association	4,462	$ 5,297	$ 3,844	72.6%	$0	$ -	72.6%
Alaska		Bristol Bay Area Health	5,790	$ 5,288	$ 5,065	95.8%	$0	$ -	95.8%
Alaska		Chugachmiut Tribe	1,767	$ 5,401	$ 3,977	73.6%	$0	$ -	73.6%
Alaska		Copper River Native Associaton	692	$ 5,357	$ 5,512	100.0%	$0	$ -	100.0%
Alaska		Eastern Aleutian Tribe	1042	$ 5,496	$ 4,978	90.6%	$0	$ -	90.6%
Alaska		Kenaitze Indian Tribe	2,614	$ 4,619	$ 2,114	45.8%	$3,028	$ 3,000	45.8%
Alaska		Ketchikan Indian Community	2,751	$ 5,357	$ 2,913	54.4%	$0	$ -	54.4%
Alaska		Kodiak Area Native Assoc.	2,279	$ 5,357	$ 4,079	76.1%	$0	$ -	76.1%
Alaska		Maniilaq Association	7,096	$ 4,989	$ 5,333	100.0%	$0	$ -	100.0%
Alaska		Metlakatla Indian Community	1,412	$ 5,501	$ 4,639	84.3%	$0	$ -	84.3%
Alaska		Misc. Anchorage Tribes	416	$ 4,619	$ 4,706	100.0%	$0	$ -	100.0%
Alaska		Ninilchik Traditional Council	1,445	$ 4,665	$ 2,089	44.8%	$68,666	$ 69,000	45.8%
Alaska		Norton Sound Health Corp.	8,269	$ 5,182	$ 3,372	65.1%	$0	$ -	65.1%
Alaska		Seldovia Village Tribe	1,379	$ 4,663	$ 2,088	44.8%	$65,193	$ 65,000	45.8%
Alaska		Southcentral Foundation	45,375	$ 4,385	$ 2,208	50.3%	$0	$ -	50.3%
Alaska		Southeast Alaska Regional Healt	12,535	$ 5,182	$ 3,767	72.7%	$0	$ -	72.7%
Alaska		Tanana Chiefs Conference	12,933	$ 4,989	$ 2,862	57.4%	$0	$ -	57.4%
Alaska		Yukon Kuskokwim Health Corp.	24,976	$ 5,024	$ 2,468	49.1%	$0	$ -	49.1%
Alaska Area Sites In Total			**138,298**	**$ 4,867**	**$ 3,020**	**62.1%**	**$136,887**	**$137,000**	**62.1%**

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2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide			1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%
Area	Qualify	*Operating Unit (Site)*	*User Count*	*Need Benchmark per User*	*Available $ per User*	*FDI % Score*	*$ to Raise to 45.8%*	*2012 IHCIF $*	*Revised FDI % Score*
Albuquerque		(ZR-SU) Ramah	2,001	$ 3,027	$ 2,661	87.9%	$0	$ -	87.9%
Albuquerque		(ZR-SU) Zuni	8,772	$ 3,549	$ 1,903	53.6%	$0	$ -	53.6%
Albuquerque		Acoma-Canoncito-Laguna	11,193	$ 3,381	$ 1,697	50.2%	$0	$ -	50.2%
Albuquerque		Albuquerque	31,734	$ 3,424	$ 1,537	44.9%	$996,439	$ 996,000	45.8%
Albuquerque		Jicarilla	3,623	$ 3,860	$ 2,364	61.2%	$0	$ -	61.2%
Albuquerque		Mescalero	4,625	$ 3,592	$ 1,788	49.8%	$0	$ -	49.8%
Albuquerque		Santa Fe	14,890	$ 3,381	$ 1,846	54.6%	$0	$ -	54.6%
Albuquerque		So Colorado Ute	5,757	$ 3,653	$ 1,642	44.9%	$182,073	$ 182,000	45.8%
Albuquerque		Taos	2,168	$ 3,801	$ 2,040	53.7%	$0	$ -	53.7%
Albuquerque		Ysleta Del Sur	1,183	$ 3,772	$ 2,675	70.9%	$0	$ -	70.9%
Albuquerque Area Sites In Total			**85,946**	**$ 3,472**	**$ 1,759**	**50.7%**	**$1,178,511**	**$1,178,000**	**51.1%**

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2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide			1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%
Area	Qualify	*Operating Unit (Site)*	*User Count*	*Need Benchmark per User*	*Available $ per User*	*FDI % Score*	*$ to Raise to 45.8%*	*2012 IHCIF $*	*Revised FDI % Score*
Bemidji		Bad River	1,839	$ 4,272	$ 1,915	44.8%	$76,754	$ 77,000	45.8%
Bemidji		Bay Mills	1,300	$ 3,940	$ 1,773	45.0%	$41,272	$ 41,000	45.8%
Bemidji		Bois Forte/Nett Lake (T-V)	1,384	$ 4,230	$ 1,955	46.2%	$0	$ -	46.2%
Bemidji		Fond Du Lac (T-V)	6,707	$ 3,914	$ 1,753	44.8%	$268,054	$ 268,000	45.8%
Bemidji		Forest County	1,225	$ 3,988	$ 1,786	44.8%	$49,882	$ 50,000	45.8%
Bemidji		Grand Portage	416	$ 3,725	$ 2,366	63.5%	$0	$ -	63.5%
Bemidji		Grand Traverse (T-V)	1,590	$ 3,940	$ 1,974	50.1%	$0	$ -	50.1%
Bemidji		Greater Leech Lake	10,324	$ 3,685	$ 1,654	44.9%	$343,492	$ 343,000	45.8%
Bemidji		Greater Red Lake	7,628	$ 3,698	$ 2,301	62.2%	$0	$ -	62.2%
Bemidji		Greater White Earth	8,055	$ 3,751	$ 1,746	46.6%	$0	$ -	46.6%
Bemidji		Gun Lake	230	$ 3,725	$ 2,841	76.3%	$0	$ -	76.3%
Bemidji		Hannahville	771	$ 4,242	$ 2,160	50.9%	$0	$ -	50.9%
Bemidji		Ho-Chunk	4,472	$ 3,982	$ 1,789	44.9%	$157,122	$ 157,000	45.8%
Bemidji		Huron Potawatomi	553	$ 4,351	$ 2,343	53.8%	$0	$ -	53.8%
Bemidji		Keweenaw Bay (T-V)	1,752	$ 4,272	$ 1,919	44.9%	$66,091	$ 66,000	45.8%
Bemidji		Lac Courte Oreilles	3,448	$ 4,151	$ 1,863	44.9%	$130,981	$ 131,000	45.8%
Bemidji		Lac Du Flambeau	2,780	$ 4,151	$ 1,867	45.0%	$94,102	$ 94,000	45.8%
Bemidji		Lac Vieux Desert	432	$ 3,725	$ 3,069	82.4%	$0	$ -	82.4%
Bemidji		Little River Ottawa	1,267	$ 3,725	$ 1,669	44.8%	$47,340	$ 47,000	45.8%
Bemidji		Little Traverse Odawa	2,667	$ 3,876	$ 1,737	44.8%	$101,244	$ 101,000	45.8%
Bemidji		Lower Sioux	837	$ 4,270	$ 1,914	44.8%	$34,938	$ 35,000	45.8%
Bemidji		Menominee	6,916	$ 3,904	$ 1,748	44.8%	$275,699	$ 276,000	45.8%
Bemidji		Mille Lacs (T-V)	2,297	$ 4,141	$ 1,862	45.0%	$80,494	$ 80,000	45.8%
Bemidji		Oneida (T-V)	11,765	$ 3,466	$ 1,552	44.8%	$417,705	$ 418,000	45.8%
Bemidji		Pokagon Potawatomi	1,297	$ 3,725	$ 2,992	80.3%	$0	$ -	80.3%
Bemidji		Prairie Island	441	$ 4,270	$ 2,011	47.1%	$0	$ -	47.1%
Bemidji		Red Cliff	1,672	$ 4,272	$ 1,920	44.9%	$60,831	$ 61,000	45.8%
Bemidji		Saginaw Chippewa	2,970	$ 3,876	$ 1,737	44.8%	$112,128	$ 112,000	45.8%
Bemidji		Saulte Sainte Marie (T-V)	10,950	$ 3,541	$ 1,589	44.9%	$357,592	$ 358,000	45.8%

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2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide			**1,500,044**	**$ 3,613**	**$ 2,023**	**56.0%**	**$11,980,800**		**56.2%**
Area	***Qualify***	***Operating Unit (Site)***	***User Count***	***Need Benchmark per User***	***Available $ per User***	***FDI % Score***	***$ to Raise to 45.8%***	***2012 IHCIF $***	***Revised FDI % Score***
Bemidji		Shakopee	863	$ 4,270	$ 1,913	44.8%	$37,293	$ 37,000	45.8%
Bemidji		Sokaogon	405	$ 3,725	$ 2,456	65.9%	$0	$ -	65.9%
Bemidji		St Croix	1,640	$ 4,272	$ 1,917	44.9%	$65,710	$ 66,000	45.8%
Bemidji		Stockbridge-Munsee	1,561	$ 4,215	$ 2,109	50.0%	$0	$ -	50.0%
Bemidji		Upper Sioux	328	$ 4,270	$ 2,302	53.9%	$0	$ -	53.9%
Bemidji Area Sites In Total			**102,782**	**$ 3,831**	**$ 1,815**	**47.4%**	**$2,818,721**	**$2,818,000**	**48.1%**

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2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide			1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%
Area	*Qualify*	*Operating Unit (Site)*	*User Count*	*Need Benchmark per User*	*Available $ per User*	*FDI % Score*	*$ to Raise to 45.8%*	*2012 IHCIF $*	*Revised FDI % Score*
Billings		Blackfeet	11,204	$ 3,882	$ 2,390	61.6%	$0	$ -	61.6%
Billings		Crow	13,439	$ 3,848	$ 2,305	59.9%	$0	$ -	59.9%
Billings		Flathead	10,752	$ 4,904	$ 2,206	45.0%	$431,122	$ 431,000	45.8%
Billings		Ft Belknap	4,885	$ 4,124	$ 2,749	66.7%	$0	$ -	66.7%
Billings		Ft Peck	8,608	$ 3,969	$ 2,221	56.0%	$0	$ -	56.0%
Billings		No. Cheyenne	6,494	$ 4,094	$ 2,674	65.3%	$0	$ -	65.3%
Billings		Rocky Boy	4,703	$ 4,297	$ 2,464	57.3%	$0	$ -	57.3%
Billings		Wind River	10,778	$ 3,847	$ 1,751	45.5%	$119,433	$ 119,000	45.8%
Billings Area Sites In Total			**70,863**	**$ 4,100**	**$ 2,284**	**55.7%**	**$550,554**	**$550,000**	**55.9%**

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2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide			1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%
Area	Qualify	Operating Unit (Site)	User Count	Need Benchmark per User	Available $ per User	FDI % Score	$ to Raise to 45.8%	2012 IHCIF $	Revised FDI % Score
California		(CRIHB) Ione Band of Miwok	68	$ 4,178	$ 1,877	44.9%	$2,474	$ 2,000	45.6%
California		(CRIHB) Graton Rancheria	281	$ 4,178	$ 1,869	44.7%	$12,474	$ 12,000	45.8%
California		(CRIHB) MACT	1,996	$ 3,799	$ 2,068	54.4%	$0	$ -	54.4%
California		(CRIHB) Shingle Springs	1,004	$ 4,128	$ 1,848	44.8%	$42,459	$ 42,000	45.8%
California		(CRIHB) Sonoma County	4,547	$ 3,527	$ 1,705	48.3%	$0	$ -	48.3%
California		(CRIHB) United Indian Health Se	7,919	$ 3,297	$ 1,481	44.9%	$228,491	$ 228,000	45.8%
California		(CRIHB) Warner Mountain	124	$ 4,178	$ 4,616	100.0%	$0	$ -	100.0%
California		(CTHP) Consolidated	1,910	$ 3,865	$ 2,225	57.6%	$0	$ -	57.6%
California		(CTHP) Coyote Valley Tribal Cou	117	$ 4,576	$ 2,055	44.9%	$4,799	$ 5,000	45.8%
California		(CTHP) Guidiville Indian Rancher	52	$ 4,576	$ 3,694	80.7%	$0	$ -	80.7%
California		(CTHP) Hopland Band of Pomo I	219	$ 4,576	$ 2,053	44.9%	$9,336	$ 9,000	45.8%
California		(CTHP) Pinoleville Band of Pomc	67	$ 4,576	$ 2,056	44.9%	$2,687	$ 3,000	45.9%
California		(CTHP) Sherwood Valley Band o	218	$ 4,361	$ 1,959	44.9%	$8,420	$ 8,000	45.8%
California		(CVIHP) - Central Valley	6,903	$ 3,342	$ 1,499	44.8%	$219,362	$ 219,000	45.8%
California		(CVIHP) Cold Springs Tribal Cour	215	$ 3,862	$ 1,730	44.8%	$8,470	$ 8,000	45.7%
California		(LCIHP) Scotts Valley Band of Po	69	$ 4,361	$ 3,850	88.3%	$0	$ -	88.3%
California		(SCIHP) Lytton Rancheria	124	$ 3,981	$ 1,817	45.7%	$711	$ 1,000	45.9%
California		Cabezon	6	$ 3,629	$ 19,098	100.0%	$0	$ -	100.0%
California		Chapa De	5,646	$ 3,387	$ 1,517	44.8%	$195,652	$ 196,000	45.8%
California		Colusa	98	$ 3,981	$ 3,148	79.1%	$0	$ -	79.1%
California		Feather River	4,324	$ 3,441	$ 1,544	44.9%	$138,581	$ 139,000	45.8%
California		Greenville	1,252	$ 3,761	$ 1,688	44.9%	$42,650	$ 43,000	45.8%
California		Hoopa	2,749	$ 3,611	$ 2,084	57.7%	$0	$ -	57.7%
California		Indian Health Council	4,549	$ 3,507	$ 2,141	61.0%	$0	$ -	61.0%
California		Karuk	1,822	$ 3,841	$ 2,010	52.3%	$0	$ -	52.3%
California		Lake County	1,908	$ 3,841	$ 2,996	78.0%	$0	$ -	78.0%
California		Modoc	167	$ 4,132	$ 4,793	100.0%	$0	$ -	100.0%
California		Northern Valley	2,158	$ 3,751	$ 1,682	44.8%	$77,062	$ 77,000	45.8%
California		Pit River	908	$ 3,965	$ 2,533	63.9%	$0	$ -	63.9%

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2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide			1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%
Area	*Qualify*	*Operating Unit (Site)*	*User Count*	*Need Benchmark per User*	*Available $ per User*	*FDI % Score*	*$ to Raise to 45.8%*	*2012 IHCIF $*	*Revised FDI % Score*
California		Quartz Valley	168	$ 3,981	$ 1,787	44.9%	$6,028	$ 6,000	45.8%
California		Redding Rancheria	3,097	$ 3,611	$ 2,557	70.8%	$0	$ -	70.8%
California		Riverside/San Bernardino	12,784	$ 3,089	$ 1,868	60.5%	$0	$ -	60.5%
California		Round Valley	1,212	$ 3,965	$ 1,846	46.6%	$0	$ -	46.6%
California		Santa Ynez	927	$ 4,279	$ 1,922	44.9%	$34,811	$ 35,000	45.8%
California		Southern Indian Health Council	2,591	$ 3,678	$ 2,406	65.4%	$0	$ -	65.4%
California		Susanville	1,015	$ 3,965	$ 1,973	49.8%	$0	$ -	49.8%
California		Sycuan	114	$ 4,132	$ 3,486	84.4%	$0	$ -	84.4%
California		Table Mountain	33	$ 3,862	$ 4,044	100.0%	$0	$ -	100.0%
California		Toiyabe	2,747	$ 3,611	$ 2,037	56.4%	$0	$ -	56.4%
California		Tule River	2,426	$ 3,609	$ 2,232	61.8%	$0	$ -	61.8%
California		Tuolumne Me-WUK	148	$ 3,981	$ 1,817	45.7%	$849	$ 1,000	45.8%
California Area Sites In Total			**78,682**	**$ 3,510**	**$ 1,895**	**54.0%**	**$1,035,318**	**$1,034,000**	**54.4%**

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2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide		1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%

Area	Qualify	Operating Unit (Site)	User Count	Need Benchmark per User	Available $ per User	FDI % Score	$ to Raise to 45.8%	2012 IHCIF $	Revised FDI % Score
Nashville		Alabama-Coushatta	806	$ 3,677	$ 2,276	61.9%	$0	$ -	61.9%
Nashville		Catawba	1,255	$ 3,486	$ 2,326	66.7%	$0	$ -	66.7%
Nashville		Cayuga	61	$ 3,494	$ 5,007	100.0%	$0	$ -	100.0%
Nashville		Cherokee	10,642	$ 3,388	$ 2,300	67.9%	$0	$ -	67.9%
Nashville		Chitimacha	498	$ 3,750	$ 2,229	59.4%	$0	$ -	59.4%
Nashville		Choctaw	9,258	$ 3,371	$ 2,042	60.6%	$0	$ -	60.6%
Nashville		Coushatta	480	$ 3,901	$ 2,088	53.5%	$0	$ -	53.5%
Nashville		Houlton Band of Maliseet	424	$ 3,359	$ 3,433	100.0%	$0	$ -	100.0%
Nashville		Jena Band of Choctaw	146	$ 3,901	$ 2,480	63.6%	$0	$ -	63.6%
Nashville		Manlius (Onondaga)	428	$ 3,547	$ 3,564	100.0%	$0	$ -	100.0%
Nashville		Mashpee Wampanoag	1,422	$ 4,271	$ 2,702	63.3%	$0	$ -	63.3%
Nashville		Miccosukee	762	$ 4,096	$ 2,957	72.2%	$0	$ -	72.2%
Nashville		Micmac	468	$ 3,901	$ 3,710	95.1%	$0	$ -	95.1%
Nashville		Mohegan	1,306	$ 4,096	$ 1,907	46.6%	$0	$ -	46.6%
Nashville		Narragansett	669	$ 4,373	$ 3,073	70.3%	$0	$ -	70.3%
Nashville		Oneida	1,840	$ 3,677	$ 1,946	52.9%	$0	$ -	52.9%
Nashville		Passamaquoddy-Ind. Township	743	$ 3,563	$ 2,891	81.1%	$0	$ -	81.1%
Nashville		Passamaquoddy-Pleasant Pt.	970	$ 3,635	$ 3,113	85.6%	$0	$ -	85.6%
Nashville		Penobscot	1,342	$ 3,563	$ 2,748	77.1%	$0	$ -	77.1%
Nashville		Pequot	931	$ 3,739	$ 1,937	51.8%	$0	$ -	51.8%
Nashville		Poarch Creek	2,269	$ 3,653	$ 1,942	53.2%	$0	$ -	53.2%
Nashville		Seminole	4,293	$ 3,758	$ 1,968	52.4%	$0	$ -	52.4%
Nashville		Seneca	4,043	$ 3,381	$ 2,576	76.2%	$0	$ -	76.2%
Nashville		St. Regis Mohawk	4,592	$ 3,498	$ 1,715	49.0%	$0	$ -	49.0%
Nashville		Tunica-Biloxi	329	$ 3,901	$ 1,755	45.0%	$10,452	$ 10,000	45.8%
Nashville		Tuscarora	1,201	$ 3,864	$ 2,278	58.9%	$0	$ -	58.9%
Nashville		Wampanoag of Gayhead	313	$ 4,373	$ 2,900	66.3%	$0	$ -	66.3%
Nashville Area Sites In Total			**51,491**	**$ 3,574**	**$ 2,180**	**61.0%**	**$10,452**	**$10,000**	**61.0%**

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2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide		1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%

Area	Qualify	Operating Unit (Site)	User Count	Need Benchmark per User	Available $ per User	FDI % Score	$ to Raise to 45.8%	2012 IHCIF $	Revised FDI % Score
Navajo		(C-SU) Chinle	16,335	$ 3,235	$ 1,643	50.8%	$0	$ -	50.8%
Navajo		(C-SU) Pinon	9,297	$ 3,376	$ 1,643	48.7%	$0	$ -	48.7%
Navajo		(C-SU) Tsaile	8,148	$ 3,376	$ 1,643	48.7%	$0	$ -	48.7%
Navajo		(CR-SU) Crownpoint	14,772	$ 3,217	$ 1,576	49.0%	$0	$ -	49.0%
Navajo		(CR-SU) Pueblo Pintado/Cuba	6,808	$ 3,491	$ 1,576	45.1%	$155,571	$ 156,000	45.8%
Navajo		(FD-SU) Fort Defiance	18,252	$ 3,235	$ 2,129	65.8%	$0	$ -	65.8%
Navajo		(FD-SU) Ganado	12,132	$ 3,235	$ 2,129	65.8%	$0	$ -	65.8%
Navajo		(G-SU) Gallup	31,532	$ 3,100	$ 1,938	62.5%	$0	$ -	62.5%
Navajo		(G-SU) Tohatchi	7,612	$ 3,389	$ 1,938	57.2%	$0	$ -	57.2%
Navajo		(G-SU) Nahata Dziil	2,717	$ 3,413	$ 1,938	56.8%	$0	$ -	56.8%
Navajo		(K-SU) Inscription House	3,349	$ 3,546	$ 1,590	44.8%	$114,179	$ 114,000	45.8%
Navajo		(K-SU) Kayenta	11,292	$ 3,376	$ 1,517	44.9%	$331,281	$ 331,000	45.8%
Navajo		(K-SU) Monument Valley	2,569	$ 3,546	$ 1,590	44.8%	$87,999	$ 88,000	45.8%
Navajo		(K-SU) Navajo Mountain	238	$ 3,621	$ 1,620	44.8%	$8,978	$ 9,000	45.8%
Navajo		(S-SU) Dzilth Na O Dith Hle	5,543	$ 3,552	$ 1,947	54.8%	$0	$ -	54.8%
Navajo		(S-SU) Shiprock	37,685	$ 3,123	$ 1,947	62.3%	$0	$ -	62.3%
Navajo		(S-SU) Red Mesa	3,038	$ 3,731	$ 1,947	52.2%	$0	$ -	52.2%
Navajo		(S-SU) Utah Navajo	6,234	$ 3,552	$ 1,947	54.8%	$0	$ -	54.8%
Navajo		(T-SU) Tuba City	28,634	$ 3,100	$ 1,827	58.9%	$0	$ -	58.9%
Navajo		(W-SU) Dilkon	6,784	$ 3,539	$ 1,585	44.8%	$245,582	$ 246,000	45.8%
Navajo		(W-SU) Leupp	3,955	$ 3,546	$ 1,588	44.8%	$143,650	$ 144,000	45.8%
Navajo		(W-SU) Winslow	5,405	$ 3,539	$ 1,585	44.8%	$195,684	$ 196,000	45.8%
Navajo Area Sites In Total			**242,331**	**$ 3,264**	**$ 1,825**	**55.9%**	**$1,282,923**	**$1,284,000**	**56.1%**

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Grand Total for All Sites IHS-Wide			1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%
Area	Qualify	*Operating Unit (Site)*	*User Count*	*Need Benchmark per User*	*Available $ per User*	*FDI % Score*	*$ to Raise to 45.8%*	*2012 IHCIF $*	*Revised FDI % Score*
Oklahoma		Abs Shawnee	7,584	$ 3,206	$ 2,093	65.3%	$0	$ -	65.3%
Oklahoma		Cherokee/Tahlequah	84,796	$ 3,093	$ 1,479	47.8%	$0	$ -	47.8%
Oklahoma		Chickasaw	31,545	$ 3,096	$ 2,418	78.1%	$0	$ -	78.1%
Oklahoma		Choctaw	35,725	$ 3,092	$ 1,869	60.4%	$0	$ -	60.4%
Oklahoma		Citizen Potawatomi	13,776	$ 3,095	$ 1,386	44.8%	$435,749	$ 436,000	45.8%
Oklahoma		Claremore	49,057	$ 3,024	$ 1,359	44.9%	$1,303,877	$ 1,304,000	45.8%
Oklahoma		Clinton	9,661	$ 3,387	$ 2,148	63.4%	$0	$ -	63.4%
Oklahoma		Creek	17,782	$ 3,091	$ 1,738	56.2%	$0	$ -	56.2%
Oklahoma		Haskell	3,577	$ 3,528	$ 1,615	45.8%	$1,852	$ 2,000	45.8%
Oklahoma		White Coud OU	662	$ 3,332	$ 1,785	53.6%	$0	$ -	53.6%
Oklahoma		Iowa Of Oklahoma	960	$ 3,417	$ 1,533	44.9%	$30,620	$ 31,000	45.8%
Oklahoma		Kaw	1,404	$ 3,663	$ 1,857	50.7%	$0	$ -	50.7%
Oklahoma		Kickapoo Of Kansas	789	$ 3,349	$ 1,755	52.4%	$0	$ -	52.4%
Oklahoma		Kickapoo Of Oklahoma	6,278	$ 3,344	$ 1,497	44.8%	$214,510	$ 215,000	45.8%
Oklahoma		Kickapoo Of Texas	225	$ 3,847	$ 5,820	100.0%	$0	$ -	100.0%
Oklahoma		Lawton	22,235	$ 3,026	$ 1,840	60.8%	$0	$ -	60.8%
Oklahoma		Miami Consortium	3,142	$ 3,597	$ 1,868	51.9%	$0	$ -	51.9%
Oklahoma		Pawnee	9,676	$ 3,181	$ 1,889	59.4%	$0	$ -	59.4%
Oklahoma		Ponca Tribe Of Oklahoma	3,633	$ 3,532	$ 1,860	52.7%	$0	$ -	52.7%
Oklahoma		Prairie Band Pottawatomi	1,538	$ 3,400	$ 1,750	51.5%	$0	$ -	51.5%
Oklahoma		Sac And Fox Of Oklahoma	4,974	$ 3,417	$ 1,530	44.8%	$173,822	$ 174,000	45.8%
Oklahoma		Wewoka	8,487	$ 3,129	$ 1,401	44.8%	$271,716	$ 272,000	45.8%
Oklahoma		Wyandotte / E Shawnee	1,417	$ 3,392	$ 1,524	44.9%	$40,956	$ 41,000	45.8%
Oklahoma Area Sites In Total			**318,923**	**$ 3,126**	**$ 1,696**	**54.3%**	**$2,473,103**	**$2,475,000**	**54.5%**

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2012 Indian Health Care Improvement Fund Allocation - Final

Grand Total for All Sites IHS-Wide			1,500,044	$ 3,613	$ 2,023	56.0%	$11,980,800		56.2%
Area	*Qualify*	*Operating Unit (Site)*	*User Count*	*Need Benchmark per User*	*Available $ per User*	*FDI % Score*	*$ to Raise to 45.8%*	*2012 IHCIF $*	*Revised FDI % Score*
Phoenix		(CR-SU) Colorado River	6,006	$ 3,534	$ 3,397	96.1%	$0	$ -	96.1%
Phoenix		(CR-SU) Peach Springs/Supai	2,578	$ 3,773	$ 3,366	89.2%	$0	$ -	89.2%
Phoenix		(DV-SU) Owyhee	1,275	$ 4,071	$ 7,356	100.0%	$0	$ -	100.0%
Phoenix		(E-SU) Duckwater	148	$ 4,247	$ 10,354	100.0%	$0	$ -	100.0%
Phoenix		(E-SU) Elko	2,214	$ 3,982	$ 2,652	66.6%	$0	$ -	66.6%
Phoenix		(E-SU) Ely	341	$ 4,223	$ 4,248	100.0%	$0	$ -	100.0%
Phoenix		(S-SU) Fallon/Lovelock/Yomba	1,851	$ 4,071	$ 2,178	53.5%	$0	$ -	53.5%
Phoenix		(S-SU) Ft. Mcdermitt	643	$ 4,247	$ 2,458	57.9%	$0	$ -	57.9%
Phoenix		(S-SU) Las Vegas/Moapa	2,725	$ 3,920	$ 1,759	44.9%	$97,372	$ 97,000	45.8%
Phoenix		(S-SU) Pyramid Lake	1,790	$ 4,071	$ 1,823	44.8%	$74,282	$ 74,000	45.8%
Phoenix		(S-SU) Reno-Sparks/Nevada Urb	4,176	$ 3,761	$ 1,962	52.2%	$0	$ -	52.2%
Phoenix		(S-SU) Schurz/Walker River	846	$ 4,248	$ 7,034	100.0%	$0	$ -	100.0%
Phoenix		(S-SU) Washoe	2,354	$ 3,982	$ 2,440	61.3%	$0	$ -	61.3%
Phoenix		(S-SU) Yerington	632	$ 4,247	$ 3,574	84.2%	$0	$ -	84.2%
Phoenix		Ft. Yuma	3,869	$ 3,773	$ 2,618	69.4%	$0	$ -	69.4%
Phoenix		Gila River	24,458	$ 3,064	$ 1,556	50.8%	$0	$ -	50.8%
Phoenix		Keams Canyon/Hopi	6,398	$ 3,609	$ 3,400	94.2%	$0	$ -	94.2%
Phoenix		Paiute Tribe-Utah	798	$ 3,912	$ 3,238	82.8%	$0	$ -	82.8%
Phoenix		Phoenix SU	64,384	$ 3,049	$ 1,625	53.3%	$0	$ -	53.3%
Phoenix		San Carlos	11,801	$ 3,371	$ 1,525	45.2%	$225,236	$ 225,000	45.8%
Phoenix		Uintah-Ouray	3,989	$ 3,752	$ 2,359	62.9%	$0	$ -	62.9%
Phoenix		Whiteriver	15,890	$ 3,271	$ 1,775	54.3%	$0	$ -	54.3%
Phoenix Area Sites In Total			**159,166**	**$ 3,301**	**$ 1,985**	**60.1%**	**$396,890**	**$396,000**	**60.2%**

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Area	*Qualify*	*Operating Unit (Site)*	*User Count*	*Need Benchmark per User*	*Available $ per User*	*FDI % Score*	*$ to Raise to 45.8%*	*2012 IHCIF $*	*Revised FDI % Score*
Portland		Burns Paiute	208	$ 8,998	$ 5,123	56.9%	$0	$ -	56.9%
Portland		Chehalis	1,278	$ 4,142	$ 1,861	44.9%	$46,173	$ 46,000	45.8%
Portland		Coeur d'Alene	4,681	$ 3,532	$ 1,587	44.9%	$141,852	$ 142,000	45.8%
Portland		Colville	8,076	$ 3,535	$ 1,900	53.8%	$0	$ -	53.8%
Portland		Coos, L Umpqua, Suislaw	741	$ 4,353	$ 2,968	68.2%	$0	$ -	68.2%
Portland		Coquille	1,045	$ 4,294	$ 2,430	56.6%	$0	$ -	56.6%
Portland		Cow Creek	2,305	$ 3,928	$ 1,759	44.8%	$92,363	$ 92,000	45.8%
Portland		Cowlitz	1,689	$ 4,353	$ 1,949	44.8%	$74,923	$ 75,000	45.8%
Portland		Grand Ronde	3,535	$ 3,723	$ 2,353	63.2%	$0	$ -	63.2%
Portland		Hoh	30	$ 4,619	$ 4,375	94.7%	$0	$ -	94.7%
Portland		Jamestown S'Klallam	357	$ 4,590	$ 2,961	64.5%	$0	$ -	64.5%
Portland		Kalispel	410	$ 4,590	$ 2,063	44.9%	$16,086	$ 16,000	45.8%
Portland		Klamath	2,775	$ 3,723	$ 2,524	67.8%	$0	$ -	67.8%
Portland		Kootenai	178	$ 4,026	$ 3,535	87.8%	$0	$ -	87.8%
Portland		Lower Elwha	799	$ 4,490	$ 2,406	53.6%	$0	$ -	53.6%
Portland		Lummi	4,321	$ 3,779	$ 1,962	51.9%	$0	$ -	51.9%
Portland		Makah	2,092	$ 4,053	$ 2,131	52.6%	$0	$ -	52.6%
Portland		Muckleshoot	4,328	$ 3,779	$ 1,692	44.8%	$166,191	$ 166,000	45.8%
Portland		Nez Perce	3,626	$ 3,702	$ 2,404	64.9%	$0	$ -	64.9%
Portland		Nisqually	1,339	$ 4,142	$ 1,860	44.9%	$49,720	$ 50,000	45.8%
Portland		Nooksack	1,013	$ 4,490	$ 2,044	45.5%	$12,390	$ 12,000	45.8%
Portland		Nw Band Of Shoshoni	39	$ 3,536	$ 7,966	100.0%	$0	$ -	100.0%
Portland		Port Gamble	1,499	$ 4,142	$ 1,860	44.9%	$56,341	$ 56,000	45.8%
Portland		Puyallup	8,098	$ 3,483	$ 1,776	51.0%	$0	$ -	51.0%
Portland		Quileute	668	$ 4,590	$ 2,099	45.7%	$2,244	$ 2,000	45.8%
Portland		Quinault	2,531	$ 3,962	$ 2,467	62.3%	$0	$ -	62.3%
Portland		Samish	521	$ 4,590	$ 2,096	45.7%	$3,465	$ 3,000	45.8%
Portland		Sauk-Suiattle	76	$ 4,590	$ 6,652	100.0%	$0	$ -	100.0%
Portland		Shoalwater Bay	440	$ 4,619	$ 5,303	100.0%	$0	$ -	100.0%

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Portland		Shoshone-Bannock	6,169	$ 3,295	$ 1,963	59.6%	$0	$ -	59.6%
Portland		Siletz	5,085	$ 3,501	$ 1,810	51.7%	$0	$ -	51.7%
Portland		Skokomish	761	$ 4,513	$ 2,854	63.2%	$0	$ -	63.2%
Portland		Snoqualmie	325	$ 4,590	$ 2,339	51.0%	$0	$ -	51.0%
Portland		Spokane	1,651	$ 4,142	$ 2,883	69.6%	$0	$ -	69.6%
Portland		Squaxin Island	715	$ 4,619	$ 4,240	91.8%	$0	$ -	91.8%
Portland		Stillaguamish	127	$ 4,590	$ 2,346	51.1%	$0	$ -	51.1%
Portland		Suquamish	542	$ 4,590	$ 3,267	71.2%	$0	$ -	71.2%
Portland		Swinomish	1,125	$ 4,590	$ 2,587	56.3%	$0	$ -	56.3%
Portland		Tulalip	4,755	$ 3,779	$ 1,693	44.8%	$179,160	$ 179,000	45.8%
Portland		Umatilla	3,018	$ 3,723	$ 2,518	67.6%	$0	$ -	67.6%
Portland		Upper Skagit	570	$ 4,590	$ 2,058	44.8%	$25,234	$ 25,000	45.8%
Portland		Warm Springs	5,454	$ 3,501	$ 2,637	75.3%	$0	$ -	75.3%
Portland		Western Oregon (Chemawa)	2,809	$ 3,723	$ 1,699	45.6%	$16,768	$ 17,000	45.8%
Portland		Yakama	12,293	$ 3,535	$ 1,694	47.9%	$0	$ -	47.9%
Portland Area Sites In Total			**104,097**	**$ 3,758**	**$ 2,062**	**54.9%**	**$882,911**	**$881,000**	**55.1%**

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Area	Qualify	*Operating Unit (Site)*	*User Count*	*Need Benchmark per User*	*Available $ per User*	*FDI % Score*	*$ to Raise to 45.8%*	*2012 IHCIF $*	*Revised FDI % Score*
Tucson		Tohono O'Odham	19,015	$ 3,371	$ 1,864	55.3%	$0	$ -	55.3%
Tucson		Yaqui	6,547	$ 3,661	$ 2,090	57.1%	$0	$ -	57.1%
Tucson Area Sites In Total			**25,562**	**$ 3,445**	**$ 1,922**	**55.8%**	**$0**	**$0**	**55.8%**
Grand Total for All Sites			**1,500,044**	**$ 3,613**	**$ 2,023**	**56.0%**	**$11,980,800**	**$11,977,000**	**56.2%**

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Summarized responses to the November 13, 2017, Dear Tribal Leader letter requesting feedback and recommendations on topics for the IHS/Tribal IHCIF Workgroup's consideration:

- Closely review the formula to ensure equitable distribution of funding that meets the goals/purpose of the IHCIF.
- Use valid and reliable data to determine the variations between service allocations.
- Adopt a new cost of living factor that recognizes variations between states/IHS Areas.
- Use valid and reliable health status factors and measures that relate to the fund. For example, why is the health status factor so heavily weighted in the formula and what is its relationship to the goals of the fund?
- Why aren't actual Medicaid payments required for participation in the fund since all IHS and Tribally-run programs know the amount of their Medicaid payments?
- Why is the national poverty rate utilized when it's well known that it underreports poverty in high cost areas? The formula should only use proven measures that reflect the reality faced by service areas.
- Does the active user population actually measure the patient population of Tribal health programs? Purchased/Referred Care (PRC) population and/or a workload measure should be used to better capture patient population (e.g. some Tribal health programs have high active user counts but few users consider the Tribal clinic their "medical home").
- Consider areas that rely heavily on PRC funds due to the lack of or extremely limited access to IHS run or sponsored hospitals and IHS Joint Venture Construction projects. Are these types of inequities captured in the formula?
- The 2011 IHCIF formula update deferred expansion to include new types of services authorized under the IHCIA. Consider whether it may be more advantageous to recommend specific/targeted increases for unfunded services authorized in the IHCIA (e.g. long-term care) rather than through new increases to the IHCIF.
- Ensure the IHCIF Workgroup is able to identify and utilize technical support of their choice, including Tribal technical advisors to prepare materials, conduct analyses, and draft proposals, papers, and reports.
- When updating data for the current/existing formula, use the recent recommendations and IHS changes to user population numbers resulting from adjustments to PRC service delivery area expansions.
- Provide a draft/example distribution of funds using updated data in the current formula to assist with identifying missing factors or considerations for the formula.
- IHS should share data updates and formula considerations with all Tribes as soon as possible.
- Ensure thorough Tribal Consultation and the Rincon decision are adequately addressed in the formula distribution methodology.
- Engage in Tribal Consultation as early as possible, prior to any decision on changes, and share Consultation results and Agency decisions in an expedited manner.