INDIAN HEALTH SERVICE

INDIAN HEALTH CARE IMPROVEMENT FUND
WORKGROUP
INTERIM REPORT

June 2018

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EXECUTIVE SUMMARY

Congress established an Indian Health Care Improvement Fund (IHCIF) in the Indian Health Care Improvement Act (IHCIA) as one means for addressing resource disparities across the Indian health system. The fund is designed to consider many factors that result in resource gaps among the Indian Health Service (IHS) and Tribal sites or operating units. A formula is used to target IHCIF appropriations to the sites with the greatest need. The formula is the product of longstanding consultation with Tribes and recent efforts undertaken by the 2018 workgroup were necessary to re-evaluate the formula to determine what, if any, revisions are needed to factor in changes in the health care environment.

The IHCIF Workgroup convened four in-person meetings and several conference calls from January through May 2018 to develop their recommendations. The resulting Interim Report includes three major recommendations to incorporate into the IHCIF formula for use in allocating the fiscal year (FY) 2018 funding increase.

IHCIF Workgroup recommendations are summarized as follows:

1. **Change the Benchmark**: The existing formula uses the cost of Federal employee health insurance through the Federal Employees Health Benefits (FEHB) Program as a baseline for identifying a per capita cost for personal health care services expenditures.

   The IHCIF Workgroup recommends that the FEHB Program be replaced as the benchmark for identifying a per capita cost for personal health care services expenditures with the National Health Expenditures (NHE) data, with particular emphasis on the four categories that follow:
   - Category 1: Health Care Services in Traditional Settings
   - Category 2: Residential, Home, Nursing Facilities, etc.
   - Category 3: Dental Services
   - Category 4: Public Health (no public works)

2. **Update the Population Factor**: The IHCIF Workgroup recommends revising the standard user population factor (user count) currently used in the formula to add non-Purchased/Referred Care Delivery Area, formerly known as non-Contract Health Service Delivery Area, users to the national unduplicated user population.

3. **Revise the Alternate Resources Factor**: The current IHCIF formula calculates total funding available to an operating unit (site) by factoring in a standard 25 percent for alternate resources outside of IHS funding.

   The IHCIF Workgroup recommends changing the 25 percent estimate used for alternate resources to a site-specific coverage value (percent) based on IHS site level coverage data adjusted for program weighting, coverage gaps, payment gaps, and program component enrollments. For sites with missing or outdated enrollment data, the State average would be used. For sites whose coverage value exceeds the State average, the value would be capped at the State average.

INTRODUCTION AND BACKGROUND

The Indian Health Care Improvement Act (IHCIA) at 25 U.S.C. § 1621 authorizes the Indian Health Care Improvement Fund (IHCIF) for purposes of eliminating deficiencies in health status and resources of all Indian tribes, eliminating backlogs in health care services to Indians, meeting the health needs of Indians in an efficient and equitable manner, eliminating inequities in funding for both direct care and Purchased/Referred Care (PRC) programs, and augmenting health services where deficiencies are highest. The IHCIA specifies that the IHS take into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

A formula to allocate appropriations for the IHCIF was initially developed through the work of a Tribal/IHS Workgroup in 2000. The formula, which later became known as the Federal Disparity Index (FDI), or synonymously, the Level of Need Funded (LNF), measured the LNF for IHS and Tribal facilities relative to a benchmark level of funding. The formula was revisited once in 2010, prompted by the reauthorization of the IHCIA, which included an update to the IHCIF provision, expanding the list of services that the IHCIF may support, establishing a reporting requirement, and reaffirming that IHS must consider services and resources provided by Federal programs, private insurance, and programs of State and local governments. However, while technical improvements were made to the data used in the calculation, the IHS determined not to change the formula at that time.[1]

In late 2017, in recognition of the considerable changes in the health care environment since the 2010 Tribal consultation on the IHCIF, in response to Tribal requests, and because of the possibility of receiving a funding increase for the IHCIF in the final FY 2018 appropriation, IHS determined it appropriate to reconvene another IHCIF Tribal/IHS Workgroup (Workgroup) to review the existing formula and make recommendations for improvement. See Appendix C for the list of designated Workgroup members.

This report reflects the initial recommendations for a phased approach from the Workgroup for incorporation into the formula for use in allocating the FY 2018 funding increase and beyond.

CURRENT FORMULA OVERVIEW

The basic IHCIF formula is expressed mathematically as:

See Appendix D for a conceptual diagram of the existing formula.

[1] The Technical Evaluation of the Indian Health Care Improvement Fund methodology and data, dated March 12, 2010, is available on the IHS Web site at: www.ihs.gov/ihcif.

Funds Needed

The Funds Needed is based on a benchmark funding level, which is expressed as a per capita funding cost. The 2001 formula used the FEHB Program as the benchmark. The benchmark is adjusted for coverage differences, i.e., scope of FEHB Program benefits compared to IHS benefits, out-of-pocket costs, and American Indian and Alaska Native (AI/AN) demographic characteristics to yield an average per capita cost. This average per capita cost is reduced by 25 percent to account for insurance coverage (Medicare, Medicaid, and private insurance) of AI/ANs. Since 2001, the 25 percent adjustment for alternate resources was across-the-board due to lack of available data supporting local or regional differences.

Next, the average net cost is individualized to IHS and Tribal sites/operating units taking into account conditions that vary among the sites including size, remoteness, prevailing medical costs, and some variations in health status of the AI/AN users. These adjustments yield a unique site-specific cost forecast for each of the IHS and Tribal sites/operating units. Forecast site costs will exceed the IHS national average net cost at some sites and fall below the average at other sites.

Funds Available

The Funds Available is calculated using IHS appropriated funds, which are reduced to reflect the estimated portion that supports personal health services. This adjustment ensures that the amount of IHS funding available is comparable to the benchmark funding level, which is for a defined benefits package. Only the IHS appropriations that support visits to doctors, dentists, nurse practitioners, hospital care, and other health services provided to individual patients are used in the calculation of funds available to meet the benchmark. Each site's adjusted IHS funding is divided by its user population to result in a site-specific per capita amount.

Funding Deficiency

The site-specific per capita amount is then divided by the site-specific forecast cost (adjusted benchmark) to calculate the LNF at the site. The lower the percentage, the greater the funding disparity compared to the benchmark funding level.

Allocation of Funds

The IHS uses the LNF percentage to allocate IHCIF appropriations increases to IHS and Tribal facilities/service units. The methodology allocates funds to sites with the lowest LNF percentages. Congress has appropriated $259 million for the IHCIF in 10 fiscal years since FY 2000; prior to FY 2018, it was last funded in FY 2012. See Appendix E for a history of IHCIF appropriations.

2018 TRIBAL/IHS IHCIF WORKGROUP

Workgroup Charge

The 2018 Workgroup was charged by the IHS Acting Director to review the existing formula and make recommendations with consideration of the following questions:

1. Has the existing formula been effective in allocating IHCIF appropriations to meet the purpose/intent of the IHCIF?
2. What effect does the current health environment have on the formula?
3. Are the factors used in the formula appropriate in light of answers to questions 1 and 2?

Workgroup Meetings and Methods

The Workgroup conducted four face-to-face meetings with several teleconference calls held over a 16 week period. The initial meeting was held January 30-31, 2018, in Washington, DC, and focused on ensuring members had a good understanding of each of the factors used in the LNF and planning the Workgroup's approach to accomplishing its charge. A Tribal Co-Chair was elected by the Tribal members of the Workgroup; a Federal Co-Chair had already been designated by the Acting Director, IHS. The Workgroup agreed to work by consensus as much as possible.

The members engaged in discussion about several wide-ranging issues that could be addressed and options for improving the formula, and identified items for follow-up and analysis by technical experts. The primary follow-up actions were addressed by the designation of four sub-workgroups: 1) Per Person Benchmark; 2) User Counts; 3) PRC Dependency (later renamed Access to Care); and 4) Alternate Resources. Each of these sub-workgroup activities are described in greater detail later in this report, and Appendix C identifies the participants for each sub-workgroup.

The sub-workgroups were charged with developing and evaluating options specific to their topic and providing recommendations to the overall Workgroup. Each sub-workgroup convened through conference calls with the goal of having recommendations ready for the second face-to-face meeting, however, it became apparent that more extensive work and discussion would be necessary for the Access to Care and Alternate Resources sub-workgroups before they were ready to present recommendations to the larger Workgroup. Therefore, the approach was revised to have two sub-workgroups present at the second face-to-face meeting and the other two sub-workgroups present at the third face-to-face meeting.

The second face-to-face meeting was held on March 13-14, 2018, in Phoenix, Arizona. The Per Person Benchmark and User Counts sub-workgroups presented their recommendations to the larger workgroup. The third face-to-face meeting was held on April 12-13, 2018m in Denver, Colorado. The Access to Care and Alternate Resources sub-workgroups presented recommendations to the larger workgroup.

On March 23, 2018, the FY 2018 Omnibus appropriations were enacted, which included a $72 million funding increase for the IHS IHCIF in single year or annual funds. This action prompted the Workgroup to reconsider its timeline for completion of its work in order to ensure that full Tribal consultation could be accomplished and funds allocated and obligated by September 30, 2018. The Workgroup determined to divide its work into two phases: Phase 1 recommendations are targeted for incorporation into the formula and use in allocating the FY 2018 funding increase; and Phase 2 recommendations are targeted for completion in FY 2019.

The Workgroup identified May 17-18, 2018, as their final face-to-face meeting for the Phase 1 recommendations. The group met in Denver, Colorado, and reached agreement on three recommended improvements to the formula. In addition, the Workgroup discussed recommendations for the Tribal consultation process and for allocating the FY 2018 funding increase. Discussion on the Phase 1 recommendations follow in this report.

The meeting summaries are located on the IHCIF Workgroup website at https://www.ihs.gov/ihcif.

IHCIF SUB-WORKGROUPS

Per Person Benchmark Sub-workgroup

The Issue

There are several reasons to review the existing FEHB Program benchmark such as the fact that the existing benchmark is over fifteen years old and consists of an individual insurance model. There is also a Congressional request to re-examine the formula and use a new methodology for distributing new funding in FY 2018. The FEHB Program is a benefit which Congress is familiar with and is more relatable to the audience. However, it does not include the full range of health programs authorized under the IHCIA.

The IHCIF Per Person Benchmark Sub-workgroup was formed and tasked with four action items. The Sub-workgroup reviewed, analyzed, and provided recommendations to the IHCIF Workgroup on the following items:

1. Assess the rationale and impact of replacing the FEHB Program Blue Cross/Blue Shield (BC/BS) per user cost benchmark with a benchmark based on NHE (which is compiled with personal health care services).

2. Develop “side-by-side” LNF/IHCIF results under the original FEHB Program and proposed benchmarks.

3. Compare purposes and services for each IHS budget category (Budget Activity Program, e.g., PRC, etc.) with NHE definitions to determine to what degree IHS programs are

represented in the benchmark. Express as a percentage, e.g., Hospitals and Clinics 100 percent, Sanitation Facilities Construction 0 percent.

4. Compare services and programs authorized in the IHCIA to types of spending in the NHE. List major categories of un-funded IHCIA services that correspond to NHE spending. The Sub-workgroup determined that the authorizations passed by Congress in the IHCIA provisions align more closely with the NHE spending categories than mainstream insurance plans such as the FEHB Program BC/BS. That is, the FEHB Program, U.S. general population, and the IHS User population, and the original cost adjustment may not fully reflect the differences between the FEHB Program population and the IHS user population.

In January 2018, IHS updated the existing FEHB Program benchmark formula, and the result showed on average IHS Service Delivery Areas (SDAs) had 46.6 percent of needed resources (LNF) to provide health care services comparable to the FEHB Program. This assumed alternate resources at 25 percent, resources needed at $7,599 per person, and available IHS appropriations at $2,656; however, it does not include all of the IHCIA authorities that represent unfunded programs by Congress.

The NHE benchmark is broader and can be used to make funding comparisons against unfunded authorities in the IHCIA and IHS funded programs. It also compares the AI/AN population served to the U.S. population. However, the NHE is broad, high-level statistical information and is not used by other health care organizations for comparative purposes the way the IHS is considering using it. There is also a data lag of one to 1.5 years. The NHE may also be more challenging for making a link to a benchmark (which was actuarially determined) that is based on a defined set of health benefits. Finally, both the FEHB Program and NHE may not easily or fully correlate to the unique health care needs of Indian Country.

In addition to discussing the pros and cons of each benchmark the Sub-workgroup developed and reviewed an analysis comparing the FEHB Program and the NHE. The NHE was stratified by the following categories:

Category 1: Health Care Services in Traditional Settings – Hospital care, professional services from private sector, and Federal government clinical services expenditures.

Category 2: Residential, Home, Nursing Facilities, etc. – Includes spending for school health, worksite health care, Medicaid home and community based waivers, residential mental health and substance abuse facilities, and other types of health care. Generally, these services are provided in non-traditional settings.

Category 3: Dental Services – Includes all estimates of spending for dental services.

Category 4: Public Health (no public works) – Provided services such as epidemiological surveillance, inoculations, immunization/vaccine services, disease prevention programs.

Category 5: New Health Care Facilities & Equipment – new construction put in place by the medical sector. Includes establishments engaged in providing health care, but does not include retail establishments that sell non-durable or durable medical goods. Equipment: comprised of the value of new capital equipment (including software) purchased or put in place by the medical sector.

The Sub-workgroup reviewed NHE data available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html. The Workgroup reached a consensus that IHS provided services similar to the NHE in categories 1-4. No consensus was reached about category 5 (new health care facilities and equipment) and it was decided to address this issue as part of the Workgroup's Phase II work.

The table below shows a comparison of the NHE to IHS per person expenditures. To provide similar expenditures for health care services, IHS would need to spend $9,726 per person (based on user population). This figure assumes that IHS provides or is authorized to provide services similar to those in NHE categories 1-4. IHS currently has two kinds of funding available for providing health care services, IHS appropriations and third party collections (alternate resources). The IHCIA requires IHS to look at alternate resources funding when determining LNF. Alternate resources calculations are discussed in a following section. IHS appropriations (or resources available) are approximately $2,809 per person.

COMPARISON OF NHE & IHS PER PERSON EXPENDITURES
Grouped for Potential New Benchmark Categories

Benchmark Categories -->		Category 1		Category 2		Category 3		Category 4		Category 5		Category NA	
Type of Expenditure	$ Per Person	Health Care Services in Traditional Settings	$ per person	Residential, Home, Nursing Facilites, etc	$ per person	Dental Services	$ per person	Public Health (no public works)	$ per person	New Health Care Facilities and Equipment	$ per person	Not Applicable to LNF	$ per person
NHE EXPENDITURES	10,348		$ 7,749		$1,329		$ 393		$ 255		$ 340		$ 284
ALTERNATE RESOURCES		25%	$ (1,937)	45%	$ (598)	10%	$ (39)	0%	$ -	0%	$ -		na
NET NHE BENCHMARK			$ 5,811		$ 731		$ 353		$ 255		$ 340		na
IHS EXPENDITURES			$ 2,411		$ 105		$ 117		$ 176		$ 89		$ 127
IHS LNF ESTIMATE			41%		14%		33%		69%		26%		na
UNMET NEED (billions)	$ 7.75		$ 5.73		$ 1.06		$ 0.40		$0.13		$0.42		

Notes
Estimates of alternate resources strongly affect LNF results. These are alternate resource estimates.

Summary

In summary, the Sub-workgroup concluded that the NHE provides a better approximation of the total health care need for the Indian health care system, particularly the unfunded authorities included in the IHCIA. Using the NHE benchmark would increase the overall need by approximately $3 billion compared to the FEHB Program benchmark, but would allow the inclusion of more authorities in the IHCIA.

This information was presented to the larger IHCIF Workgroup in Phoenix, AZ, on March 13, 2018. The Workgroup was supportive of the new methodology in general, pending additional questions. The Workgroup felt that the changes were practical, reasonable, and defensible. The new benchmark establishes an average and does not hurt or help any specific IHS Area in terms of funding. There was consensus to using NHE categories 1-4, with some reservations noted. Summarized reservations include the following:

- Two Areas (Phoenix, Bemidji) recommended using categories 1-3, but were not opposed to using category 4 (Public Health), as recommended by other Areas. General concerns included the fact that the categories have never been part of the LNF; and that local/regional factors can impact care, but overall, they were not opposed to inclusion.

- Two Areas (Navajo, California) were concerned about category 5 and whether this should be included and/or addressed by the Facilities Appropriation Advisory Board (FAAB). General concern was to assure that the IHCIF Workgroup was not being restrictive by not including all categories.

The NHE benchmark of $9,726, which captures non-traditional settings seen in traditional insurance plans, is approximately $2,100 more than FEHB Program at $7,599. Both are per person, gross cost benchmark estimates, if all data factors remain unchanged. Choosing the NHE would result in an increase in the overall LNF by approximately $3 billion. This figure would more accurately reflect the true LNF by incorporating a greater scope of health programs authorized in the IHCIA.

Recommendations

The Per Person Benchmark Sub-workgroup recommendations below were approved by the IHCIF Workgroup on April 12, 2018.

- Recommend adoption of the NHE Benchmark to replace FEHB Program Benchmark.
- NHE Benchmark should include 4 categories:
    - Category 1: Health Care Services in Traditional Settings
    - Category 2: Residential, Home, Nursing Facilities, etc.
    - Category 3: Dental Services
    - Category 4: Public Health (no public works)

User Count Sub-workgroup

The Issue

User counts are critical in the IHCIF methodology. User counts, because they represent numbers of patients receiving services, impact the formula results more than any other data variable. The current user count uses user population with regional un-duplication. Users in each region (IHS Area) are reviewed and duplicate users (a user being counted more than one time) are removed. The Sub-workgroup examined the data quality related to users, aggregation and un-duplication processes, and data rules for counting users.

The Sub-workgroup focused its work on rules and processes for counting users, rather than eligibility rules. Over a two month period the Sub-workgroup met four times (three times by conference call and once in person). Key issues identified by the Sub-workgroup were similar to those identified by the 2010 IHCIF Workgroup. These included how to avoid duplication in counting users, how to count individuals receiving services but residing outside their service delivery area (SDA), and how to ensure that AI/AN persons residing outside the geographic services areas or Purchased/Referred Care Delivery Areas (PRCDAs, also known as Contract Health Service Delivery Areas, CHSDAs) of any IHS Area, who are excluded from IHS user counts altogether (otherwise known as non-PRCDA or non-CHSDA users).

The IHCIF User Count Sub-workgroup was charged with looking at the impact of six factors related to user population. These factors were:

1. Assess the rationale and impact for modifying and/or augmenting user counts currently used in the methodology. List implications, if any, of switching from an insurance plan benchmark to the NHE benchmark.

2. Cross-walk those individuals who are called non-CHSDA users among 263 SDAs, because these individuals received services but are not counted in the user population.

3. Prepare side-by-side results of base user population and base user population plus non-CHSDA users.

4. Assess the feasibility to augment each SDA user count with all or a portion of Census-based IHS service population counts. Cross-walk service population counts among 263 SDAs.

5. Prepare side-by-side results of base user count and base user count plus service population counts (if practical) for the 263 SDAs.

6. Assess the frequency that users (who are assigned to a SDA by place of residence) have encounters both in and outside the assigned SDA facilities. Analyze whether this situation is relatively isolated or prevalent. Assess feasibility for site of service counts versus residence based counts.

Service Population vs User Population

The Sub-workgroup needed to determine what population to use when determining the user count.

Should IHS use service population or user population?

Service population: can be thought of as all AI/ANs who are eligible to use IHS services (i.e., eligible to receive direct or PRC services through an IHS, Tribal or Urban Indian health facility). In FY 2017, the service population was estimated at 2.2 million AI/ANs residing in a SDA consisting of counties "on" or "near" a Federal Indian reservation.

User population: can be thought of as those AI/ANs who actually receive IHS services. To be counted as part of the user population, a user must be an eligible AI/AN person who: a) registers at an IHS or Tribal delivery site; b) who resides in a county served by the delivery site; and c) who has obtained at least one personal health care service during the most recent 36 month period. Non-AI/AN persons are excluded. AI/AN persons who reside in another IHS or Tribal service area are only counted once – in the SDA in which they reside. Those AI/ANs residing outside of any IHS or Tribal service area (non-CHSDA users) are excluded from user population counts, even if they have recently received services.

The Sub-workgroup discussed several concerns with using service population. The service population is currently used for comparing historical budget figures. It is an algorithmic method that uses self-reported individual responses to the U.S. Census. IHS uses the year 2000, county-level bridged race file, to count how many eligible AI/ANs reside within the geographic area for which IHS is responsible (locations on or near reservations). This count includes AI/ANs who may or may not use IHS health services. Additionally, since the service population is not currently determined down to the SDA, which is used for the LNF calculation, IHS would have to either use an approximation for each SDA (such as using the same percentage as the user population for each SDA) or use significant time and staff to calculate the service population for each SDA.

Alternatively, using the user population to count users has some advantages and some concerns. The user population counts actual users of the IHS services and has been used in the IHCIF calculation for at least 17 years. There are three concerns with using the current user population calculation methodology: 1) a small number of users are counted more than once due to the current regional un-duplication methodology (i.e., those receiving service in more than one IHS Area); 2) some users are not counted at all (i.e., those living outside a service unit or CHSDA, referred to as non-CHSDA users); and 3) some patients visit more than one SDA for care, but only one SDA in the region (or Area) receives credit in the user count. Finally, user population only accounts for unmet needs of AI/ANs who are currently accessing services, not the unmet need for all AI/ANs.

Regional vs National Un-duplication of User Population

Historically, user population was derived using a regional un-duplication methodology. Regional un-duplication looked at all users in an IHS Area and eliminated duplicates when individuals are counted more than once in that Area. National un-duplication looks at all users across the country and not only eliminates duplicate user counts within an IHS Area, but eliminates duplicate users across IHS Areas. This provides a much more accurate user population, as an individual AI/AN user is only counted once in the IHS system.

Non-CHSDA Users

Should the user population continue to be used, the highest level of accuracy must be a high priority. To accomplish this, the number of users of IHS services that are not currently being counted in the user population must be examined. Approximately 49,000 AI/AN patients are presently not included in the current user population. These AI/AN patients meet all the criteria to be counted, except they reside outside any service unit or CHSDA.

Fractionalization

The current user population methodology allows an AI/AN patient to only be counted for user population at one facility. It is well known that individual AI/ANs are eligible to, and often receive care at more than one facility. All facilities providing services to the patient are expending resources to provide services to the patient, but only one is receiving funding from IHS appropriations for those services (note: the other facilities may be able to bill third party insurance to recover a portion or all of the cost of providing care for a specific visit). Fractionalization allows for all facilities providing services to a patient to receive some user population credit by allocating a portion of the user count among all facilities that provide services to the same AI/AN patient.

At this time, the Sub-workgroup is still evaluating fractionalization and ways to ensure that the data can be accurately measured to the SDA level. In summary, the Workgroup decided to continue to use user population, rather than service population, and to address the three areas of concern to the extent possible. The Workgroup recommended using national versus regional un-duplication for the IHCIF formula. The Workgroup also recommended adding the non-CHSDA user count that works with national un-duplication. At this time, the Workgroup is still evaluating fractionalization and ways to ensure that the data can be accurately measured to the SDA. It is recommended that fractionalization be considered in the Workgroup's Phase II work. Changing the benchmark does not appear to impact the user count.

Recommendation

The User Counts Sub-workgroup's recommendation was approved by the Workgroup on April 12, 2018.

- Revise the standard user population factor (user count) currently used in the formula to add non-CHSDA users to the national unduplicated user population.

Alternate Resources Sub-workgroup

The Issue

The IHCIF authorization, 25 U.S.C. § 1621, explicitly requires IHS to count available health resources to an Indian Tribe or tribal organization when determining the resource deficiencies for meeting the LNF. The current formula reduces the LNF benchmark by 25 percent to account for alternate resources. The existing formula assumes that if operating units were funded at the benchmark level, 25 percent of the available funding to support provision of health service would come from alternates resources (e.g., billing for Medicare, Medicaid, and private insurance). However, this assumption of set percentage for alternate resources is not valid given the varying levels of capacity to provide health care across the Indian health system. The IHS has also indicated that the Government Accountability Office (GAO) and Congress have inquired about the feasibility of the Agency to use more reliable data in lieu of the 25 percent default that is applied in the current methodology. The Sub-workgroup and technical staff proposed changing the measure for alternate resources based on Medicare and Medicaid eligibility for AI/ANs in each State where Indian health programs are located. The Sub-workgroup began its work by reviewing recent literature, data sources and/or studies of alternate resources available to AI/ANs and considered the feasibility of adopting or not adopting such measures; assessing IHS datasets as a source of potential "alternate resource eligibility codes" as indicators for each Area, State, or individual SDA; assessing State-maintained datasets as a source of potential alternate resource eligibility information; assessing Centers for Medicare & Medicaid Services (CMS) datasets as a source of potential alternate resource eligibility information; and seeking input from subject matter experts from Indian country for data sources, studies/projections that may be helpful.

Method

The Sub-workgroup held three conference calls and three sub-workgroup meetings.

The Sub-workgroup had the following question: *is it necessary to use the fixed rate (25 percent) or an alternate resource measure if actual data is available to document alternate resource coverage?*

The Sub-workgroup looked at possible resources for development of a new formula for alternate resources. These included the following:

- American Community Survey
- Kaiser Family Foundation report
- IHS National Data Warehouse (NDW)
- CMS information, and
- The IHS "4A" report. The IHS 4A report shows self-reported insurance coverage for IHS beneficiaries including Medicare, Medicaid, private insurance, and VA coverage.

The Sub-workgroup considered several issues and questions when trying to develop a more site specific alternate resource calculation. These included:

- How specific and reliable is the data,
- What is the impact of using a one size fits all percentage, and
- What is the possible positive and negative impact of removing the 25 percent for alternate resources?

The Workgroup concluded that the 25 percent estimate for alternate resources was a reasonable estimation, at the time, for offsetting alternate resources based on a study done in the 1990s. Unfortunately, using the 25 percent alternate resources rate across the board impacted funding allocation for some sites. Sites with higher collection rates benefited from the formula as it was capped at 25 percent and sites with lower collection rates (e.g., those in States with low Medicaid enrollment) might be disadvantaged by a fixed 25 percent alternate resources rate. Changing the formula using a variable rate based on local or regional data, would impact the allocation between operating units and make the allocation more reflective of the actual collections.

Section (d)(2) of the statute describes what must be considered for alternate resources:

> 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.

The Sub-workgroup decided to use the IHS NDW insurance status report for active users, by service unit to determine insurance coverage. The Sub-workgroup also recommended doing away with the fixed 25 percent alternate resource rate and only using the one factor from the IHS NDW for each service unit.

The Sub-workgroup also wanted to address outstanding questions including:

- Should there be a cap or no cap on alternate resources so as not to penalize locations doing better (or not) at accessing these resources?
- How should Tribal insurance (particularly Tribal self-insured employee benefits) be addressed in the formula (e.g., Tribal insurance is not billed by some IHS/Tribal sites)?
- Types of insurance coverage vary by State. Should the value for each payer source be adjusted to reflect actual value for the coverage?

The Sub-workgroup's progress and updates were presented the full Workgroup. The underlying assumptions for their work were to ensure that every available resource and the result are easily defendable and justifiable to Congress and to the GAO. The IHS's 2017 data on insurance status was used to value alternate resources for workgroup recommendations.

In valuing alternate resource categories, the Sub-workgroup recommended that resources not be counted when Tribes or Tribal members pay, including cost share, premiums, and employee

compensation, so these are discounted in the recommendation. Only resources from the Federal government programs are counted.

IHS 2016 and 2017 IHS Data

The data indicates 75 percent have coverage by Area and Service Unit, which is broken down by how many have Medicare coverage, Medicaid coverage, Private Insurance, and uninsured (or no data provided). In valuing the coverage, the Sub-workgroup considered the number and percentage of enrollees and the extent to which the coverage provides sufficient resources for a full-range of health care services, i.e., benchmark coverage. Preliminary results show:

a. Medicare Adjusted Actuarial Value: 55 percent
b. Medicaid Adjusted Actuarial Value: 100 percent
c. Private Insurance: 0 percent
d. Net Values (Insurance Coverage with Value)
    i) Medicare: 11.6 percent
    ii) Medicaid: 32.5 percent
    iii) Marketplace: 1.8 percent
    iv) Total 43.5 percent (effective net coverage percentage)

These results are recommended to be adjusted to ensure the SDAs who are successful at patient enrollments are not penalized for their success. The Sub-workgroup recommends that the coverage value be capped at the adjusted net State-wide average for those that exceed the average and use the actual adjusted net coverage if the operating unit is below the State-wide average.

The final adjustments to the methodology included the relative value of insurance types (weighting); enrollee premiums and cost-sharing amounts; gaps in covered services; deficiencies in payment amounts versus average costs of providing health services (i.e., payment-to-cost ratios); and the extent of enrollment in program components (e.g., Medicare Part A and B).[2]

Recommendation

The workgroup adopted the alternate resources valuation methodology, which was to apply the State-specific net coverage percentage or the actual adjusted net coverage of the SDA if it is below the State average to the IHCIF, as applicable. In addition, the IHCIF Workgroup agreed to use the State-specific net coverage percentage where the data is not available or has not been updated within a certain number of years. The workgroup felt this should only be used if:

1. Data at State level was accurate.
2. The Partial Valuing of Alternate Resources could be confirmed
3. Averages were used for units that cover more than one State
4. Modeling State average limits were used, and
5. Public Health available resources were not included, because they are non-existent.

[2] More information regarding the Alternate Resources Sub-workgroup's detailed work and presentations is available on the IHS Web site at: www.ihs.gov/ihcif.

The final recommendations were:
1. Use SDA level data, by State
2. Use State-specific net coverage if SDA level data is not available or has not been updated within a certain number of years
3. Cap SDA level data if it exceeds the State average to that SDA's State average
4. Use SDA level data if it falls below the SDA level data

Access to Care Sub-workgroup

The Issue

The charge of the Access to Care Sub-workgroup was to assess the rationale and impact for adding a PRC Dependency measure to the LNF methodology. The Sub-workgroup expressed some concern that existing "location based cost adjustments" insufficiently reflect true needs where hospitals and specialty care are inaccessible. Although not explicitly specified as part of this charge, the LNF calculation model includes another optional factor to address proposals made by some sub-workgroup members to reflect higher costs connected to distance and isolation that restrict IHS users' access to private providers and other non-IHS health care systems.

Facilities that do not provide direct services or that do not have the ability to provide necessary direct care services must provide care through the purchase of services that are outside of the Indian healthcare system. This creates limitations on services that can be accessed due to funding constraints, PRC eligibility issues, and access to high quality of care providers that meet patient needs. In addition, for those areas that do not have access to facilities, it is not just the cost of purchasing care. The other ramification is that unlike other facilities, there is no revenue from billing so it is doubly problematic. This sub-workgroup determined that the real issue to address was access to care and changed the name of this sub-workgroup to Access to Care.

The top five priorities for the group include:

- Average cost of providing care regionally
- Distance from IHS and tribal facilities to high quality of care providers
- Access to the IHS Facilities Construction Priority Program to build and/or maintain health programs
- Capability of current programs to provide care and the level of services available
- Tribal size adjustment factor

Methods

Many of the issues discussed overlap with other sub-workgroup priorities. The average cost of providing care regionally involves the work done through the Per Person Benchmark Sub-workgroup. Medicaid expansion is addressed through the Alternate Resources Sub-workgroup

as well as the cost of providing care through the NHE adopted by the Per Person Benchmark Sub-workgroup. The group considered looking at Priority I denials for PRC services to help gauge cost of care; and while the data is available for federally run programs, data for Tribal programs is not regularly available for use in this formula.

Distance Factor

Distance from IHS and Tribal facilities to high quality of care providers was an issue that involved discussion on the level of services available at hospitals (level I, II, III, IV, V), and availability of care provided outside the Indian health system. While this topic is an important one, classification of IHS hospitals and access to reliable travel data would be time consuming and cumbersome to compile.

Facility Condition Factor

The IHS FAAB addresses access to the IHS Facilities Construction Priority Program; however, the larger workgroup felt it was important enough to consider the addition of a Facility Factor into the IHCIF formula. This factor would add consideration for facility condition and locations that cannot get on the facilities construction priority list or that have aging facilities where maintenance and improvement funds are available. The Workgroup decided that consideration of this issue would be determined in Phase II.

Level of Care Factor

Capability of current programs to provide information about health care services is available for federally operated locations, but Tribal locations do not share this information consistently. This issue was raised to establish a minimum standard of care that should be provided at each location for the type of program being run (PRC only, Direct Outpatient care or Direct Inpatient care). This task, while important, is outside the scope of this Workgroup and was not addressed with a solution.

Service Delivery Area Size Adjustment Factor

A Tribal size adjustment factor already exists in the formula, as much as 127 percent is currently used for the sites with below 2,000 users. However, the SDA size adjustment factor is the element that the group felt could have the most impact. While a SDA size adjustment was already included in the LNF calculation, the Sub-workgroup felt additional weighting of this factor was needed. It would increase the already adjusted internal economies of scale for SDAs with a user population smaller than 2,000 users. Smaller facilities experience costs exponentially greater than the small number of patients they are serving. Adjusting the weight for number of users would change the amount associated with what it cost to provide care to all individuals. Smaller locations are unable to see the financial advantage of economies of scale seen by larger locations. They are held to the same standards as larger program, but are limited in their ability to recoup the overhead costs and due to a small number of patients are unable to recoup the cost of services or to hire additional staff to run a health program. Smaller locations benefit from this

change and while it does impact larger programs by decreasing their price per person in relation to the benchmark, it does not have an impact on the larger formula.

Examples presented by the Sub-workgroup for an additional Tribal size adjustment:

- 0-500 = 137 percent or 133 percent above benchmark
- 500-1000 = 125 percent or 126 percent above benchmark
- 1000-2000 = 117 percent or 116 percent above benchmark
- Greater than 2000 = 99 percent under benchmark

The Sub-workgroup requested continued advocacy for 100 percent LNF. The Sub-workgroup requests further development of access to care factors and continuance to obtain Priority I PRC Denials in Phase II. Additionally, the Sub-workgroup recommended working alongside the IHS PRC Workgroup to explore whether a portion of PRC can be added into the IHCIF formula. Consideration should be given to:

1. Revise the SDA size adjustment to increase the weighting for smaller sites. The Workgroup discussion focused on ensuring that larger facilities were not harmed and on whether there are data supporting the amount of additional costs incurred by smaller facilities as a result of a loss of economies of scale, in addition to the adjustments already made in the existing formula.
2. Use the PRC dependency factor used in the PRC formula to identify sites without access to a hospital and adjust their LNF by 10 percentage points (reduce the percentage) to reflect a greater gap in funding for them. The Workgroup discussion of this recommendation focused on the best place to apply the adjustment, e.g., to the final LNF percentage or to the benchmark, and on whether 10 percentage points is an appropriate adjustment. Due to the discussion in the full Workgroup, there was not consensus on making the two revisions recommended by the Sub-workgroup in Phase I.

Recommendations & Summary

The IHCIF Workgroup is committed to eliminating deficiencies in health status and resources of all Indian tribes. Continuous IHCIF increases will have a long-term impact to close the need gap for all operating units in the future. Some of the recommendations considered by the Workgroup required additional discussion or reflected data issues to be resolved at a later date. The Workgroup anticipates it will continue its work for use in allocating potential FY 2019 or future funding increases. Therefore, the Workgroup proposes Phase I and Phase II recommendations to the existing IHCIF formula and funding allocation. The Workgroup also discussed recommendations for the Tribal consultation process including face-to-face sessions as part of the consultation plan. This approach will assist in clarifying the complexities of the formula and the changes recommended by the Workgroup to facilitate meaningful consultation.

CONCLUSION

Phase I Recommendations

The following recommendations were agreed to in consensus by the IHCIF Workgroup for incorporation into the formula for use in allocating the FY 2018 funding increase of $72 million.

Benchmark – update the benchmark to use the National Health Expenditures (NHE) per capita instead of the Federal Employees Health Benefits Program. However, the recommendation is to use only categories 1-4 of the NHE.

Population – revise the population number used in the calculation from official user population to the national unduplicated user population plus non-CHSDA users.

Alternate Resources – change the estimate used for alternate resources that assumed 25 percent of the benchmark is addressed through other insurance coverage to a site-specific coverage value (percent) based on IHS site level coverage data adjusted for program weighting, actuarial value of coverage, coverage gaps, payment gaps, and program component enrollments. For sites with missing or outdated enrollment data, the State average will be used. For sites whose coverage value exceeds the State average, the value will be capped at the State average. For sites below the State average, the site will be credited at the site's actual adjusted net coverage.

IHCIF Funding Allocation - The Workgroup recommends that IHS use the formula in the same way as in previous years which focused the allocation to sites with an LNF under a target LNF and for each site to receive the calculated amount, no matter how small or large.

Phase II Recommendations – *For further study and potential revision for FY 2019*

The IHCIF Workgroup agreed that the following items required additional discussion or reflected data issues to be resolved that could not be accomplished in time for use in allocating the FY 2018 funding increase. Some reflect recommendations presented to the full Workgroup, but which were voted on without reaching consensus. Therefore, the IHCIF Workgroup will continue its work on these issues and develop Phase II recommendations for allocating an FY 2019 funding increase, should there be one.

PRC Dependency – further evaluate using the PRC dependency factor/access to IHS/Tribal hospital used in the PRC allocation formula. It was noted that such hospitals provide a widely varying scope of services.

Distance – evaluate a factor accounting for distance to a level II facility and/or transportation costs. Some operating units are quite large in geography, so such evaluation may need to be more granular.

Facility factor – facility condition index, and whether reliable data sets exist.

Program size – is there data to support the costs incurred by smaller facilities (those with a smaller user population) in addition to the program size adjustment already provided in the current formula

Fractionalization – fractionalization of users utilizing multiple IHS/Tribal facilities

Medicaid coverage gaps – Evaluate additional discounts to Medicaid coverage; identify Medicaid coverage gaps

IHCIF Funding Allocation - Minimum and Maximum Allocations – The last IHCIF allocation included very small amounts to some sites, e.g., less than $5,000, and some Workgroup members expressed that a minimum amount should be allocated in order to ensure the funds could have a certain level of benefit. The Department of Labor minimum salary of approximately $44,000 was suggested. After further discussion, the Workgroup did not recommend either a minimum or a maximum for distribution of funds.

APPENDIX A: Acronyms & Abbreviations

AI/AN	American Indian and Alaska Native
BC/BS	Blue Cross/Blue Shield
CHSDA	Contract Health Service Delivery Area
CMS	Centers for Medicare & Medicaid Services
FAAB	Facilities Appropriation Advisory Board
FDI	Federal Disparity Index
FEHB	Federal Employee Health Benefits
FY	Fiscal Year
GAO	Government Accountability Office
HQ	Headquarters
IHCIA	Indian Health Care Improvement Act
IHCIF	Indian Health Care Improvement Fund
IHS	Indian Health Service
LNF	Level of Need Funded
NDW	National Data Warehouse
NHE	National Health Expenditure
PRC	Purchased/Referred Care
PRCDA	Purchased/Referred Care Delivery Area
SDA	Service Delivery Area
SU	Service Unit
US	United States
VA	Veterans Administration

APPENDIX B: Glossary

Alternate Resources - The available and accessible IHS facilities and those non-IHS health care resources. Such resources include health care providers and institutions, and health care programs for payment of health services including but not limited to programs under Titles XVIII and XIX of the Social Security Act (i.e., Medicare, Medicaid), State and local health care programs and private insurance.

Contract Health Services (CHS) - Now known as Purchased/Referred Care. Health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service, e.g., dentists, physicians, hospitals, and ambulances.

Contract Health Services Delivery Area (now known as a Purchased/Referred Care Delivery Area) - Geographic area within which Purchased/Referred Care will be made available by the IHS to members of an identified Indian community who reside in the area. (Reference Federal Register, Vol. 72, No. 119 June 21, 2007.) The Federal Register provides the entire listing of Tribal PRC delivery areas for IHS; the entire State of Oklahoma is a PRC delivery area.

Federal Employees Health Benefits (FEHB) Program - Became effective in 1960. It is the largest employer-sponsored group health insurance program in the world, covering over 8 million Federal employees, retirees, former employees, family members, and former spouses.

National Health Expenditure (NHE) - Historical annual health spending in the U.S. by type of good or service delivered (hospital care, physician and clinical services, retail prescription drugs, etc.), source of funding for those services (private health insurance, Medicare, Medicaid, out-of-pocket spending, etc.) and by sponsor (businesses, households and governments).

Purchased/Referred Care - Formerly known as Contract Health Services. Health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service, e.g., dentists, physicians, hospitals, and ambulances.

Residence - In general usage, a person "resides" where he or she lives and makes his or her home as evidenced by acceptable proof of residency. In practice, these concepts can be very involved. Determinations will be made by the Service Unit Director based on the best information available, with the appeals procedure process as a protector of the individual's rights.

Service Delivery Area - Geographic area within which care will be made available by the IHS to members of an identified Indian community who reside in the Area.

Service Population - Based on the 2000 Census bridged-race file and consists of AI/ANs identified to be eligible for IHS services. Those AI/ANs eligible are estimated by counting AI/ANs who reside in geographic areas in which IHS has responsibilities (“on or near” reservations) and is comprised of approximately 58 percent of all AI/ANs residing in the U.S. These people may or may not use IHS health services. (Migration is not a factor when developing the IHS service population).

User population - The count of registered Indian patients that had at least one direct or contract inpatient stay or outpatient visit or a direct dental visit during the last three fiscal years. The user also must live within a Purchased/Referred Care Delivery Area.

Un-duplication - The NDW can receive multiple registrations for a given person if they visit more than one facility. In order to count a person only once in each IHS Area, a pre-established set of business rules are applied to un-duplicate the registration records which are used for User Population reporting purposes and have been reviewed and approved by HHS Headquarters, Division of Program Statistics.

APPENDIX C: Designated Workgroup and Sub-workgroup Members

Tribal Co-Chair: James Roberts **Federal Co-Chair: Elizabeth Fowler**

Area	Tribal / Federal	Primary / Alternate	Name	Title	Tribe / Tribal Organization
Alaska	Tribal	Primary	James Roberts	Senior Executive, Intergovernmental Affairs	Alaska Native Tribal Health Consortium
Alaska	Tribal	Alternate	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	Federal	Primary	CDR John Rael	Chief Executive Officer, Albuquerque Service Unit	N/A
Albuquerque	Federal	Alternate	CDR Clinton K. Gropp	Chief Executive Officer, Ute Mountain Ute Health Center	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	Richard Brannan	Chief Executive Officer	Northern Arapaho Tribe
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	Dr. Mark LeBeau	Chief Executive Director, California Rural Indian Health Board (CRIHB)	Various CRIHB resolution Tribes
California	Federal	Primary	Christine Brennan	Statistician/Public Health Analyst	N/A

Area	Tribal / Federal	Primary / Alternate	Name	Title	Tribe / Tribal Organization
California	Federal	Alternate	Steve Riggio	Deputy Director	N/A
Great Plains	Tribal	Primary	David Flute	Chairman Sisseton Tribe	Sisseton Tribe
Great Plains	Tribal	Alternate	Jerilyn Church	Chief Executive Officer	Great Plains Tribal Chairman's Health Board
Great Plains	Federal	Primary	Shelly Korbel	Budget Officer	N/A
Great Plains	Federal	Alternate	Kella With Horn	Budget Analyst	N/A
Nashville	Tribal	Primary	Dr. Lynn Malerba	Chief	Mohegan Tribe of Connecticut
Nashville	Tribal	Alternate	Casey Cooper	Chief Executive Officer	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 Johnson	Acting Area Director	N/A
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	Desdemona Leslie	Financial Management Specialist, Whiteriver Indian Hospital	N/A
Portland	Tribal	Primary	Gail Hatcher	Vice-Chair	The Klamath Tribes
Portland	Tribal	Alternate	Steven Kutz	Tribal Council Member	Cowlitz Indian Tribe

Area	Tribal / Federal	Primary / Alternate	Name	Title	Tribe / Tribal Organization
Portland	Federal	Primary	CAPT 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	Primary	Elizabeth Fowler	Deputy Director for Management Operations	N/A
Headquarters	Federal	Alternate	RADM Kevin Meeks	Deputy Director for Field Operations	N/A
Headquarters	Federal	Ex Officio	Jennifer Cooper	Director, Office of Tribal Self-Governance	N/A
Headquarters	Federal	Ex Officio	Roselyn Tso	Director, Office of Direct Services and Contracting Tribes	N/A
Headquarters	Federal	Ex Officio	Francis Frazier	Director, Office of Public Health Support	N/A
Headquarters	Federal	Ex Officio	Robert Pittman	Acting Deputy Director, Office of Public Health Support	N/A
Headquarters	Federal	Ex Officio	Ann Church	Acting Director, Office of Finance and Accounting	N/A

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Christina Francisco, Federal, HQ
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David Larson, Tribal, Bemidji
Joe Finkbonner, Tribal

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Theresa Galvan, Navajo
Dee Sabattus, Nashville

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Francis Frazier, HQ
Mary Godfrey, Billings
Lynn Malerba, Nashville
Kasie Nichols, Technical Advisor
Leslie Racine, Billings
John Rael, Albuquerque
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Sarah Freeman Sullivan, Technical Advisor
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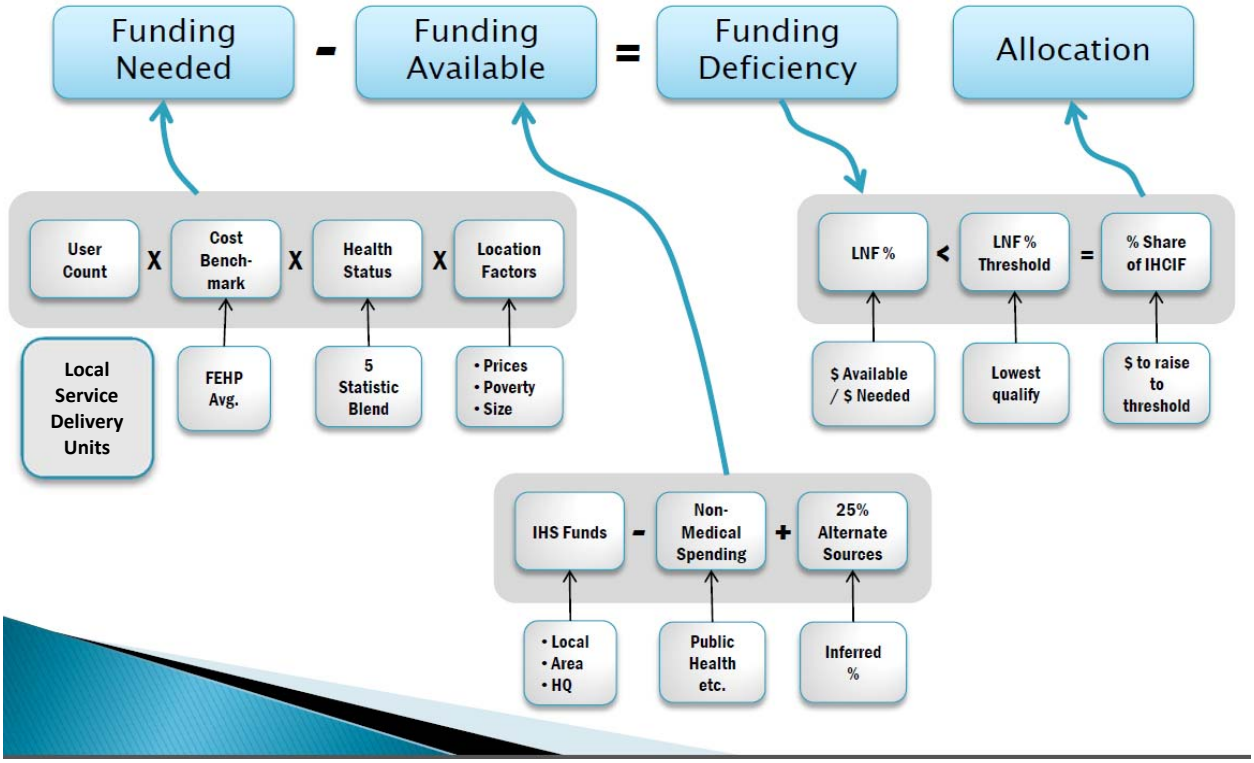
APPENDIX D: Conceptual Diagram of Existing Formula



APPENDIX E: History of IHCIF Appropriations

Indian Health Service
Indian Health Care Improvement Fund
Fiscal Year 2000 – Fiscal Year 2018

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
2018	72,280,000
TOTAL	258,892,000