

# Summary of Questions and Comments from the Indian Health Care Improvement Fund Tribal Consultation Sessions as of July 9, 2018

## General Comments

Deliberations on a complicated formula can have unintended consequences.

Realizes need to make decision quickly due to need to get funding distributed, but don't make premature decisions.

No formula should be structured where some areas are on short end of the stick.

Support approach that does not pit tribe against tribe. Large Tribes versus Small Tribes.

Fair to revisit formula.

Most facilities are still funded for the same staffing levels they received when constructed (in some cases over 50 years ago).

Equitable distribution means everybody gets some funding. Apply an equality equation to the funding.

Think the numbers in calculations are totally wrong.

Need to look at being fair to every Area, and every Tribe. Needs to be fair and equitable.

Formula is not raising the LNF funding in the base. It is a one-time funding. (Note: this is incorrect. Funding is recurring once awarded).

Recommended the formula address the resources called for in the Rincon decision. Documented wide disparities in funding to California Tribes.

Use the old formula.

Use 50% of old formula and 50% of new formula.

Nobody knows how things are affected at the local level.

Should be a disbursement to all tribes, and then use a portion to most needy.

Tribes want to know how they are going to be affected by formula.

In 2012 sites with a LNF score under 44.8% were funded. IHS does not have a threshold at this point in time.

What is timeframe for Frequently Asked Questions: posted early next week. Will be trying to respond weekly with updates.

Why no charts with new formula? The old formula is posted to website. No current formula. Want discussion on overall comments and not pitting sites against each other.

Unless knowing the impact of formula, it's hard to make a decision.

Can we add a comparison chart between current formula and final results? *Response: We can look at doing that.*

This is kind of being fast-tracked. If tribes had more time to analyze information with staff specialists and bring back to tribal council to see if they have additional comments. This takes time. Need to follow the Consultation Policy. Chairs of Tribes have the say. To me you are consulting with only a 10<sup>th</sup> of the Tribes. This needs to be considered. It was a short notice. Our chairman did get the notice. Tribes need more time to be notified of changes. IHS  
*Response: IHS will share the information on the IHS Website and will share those comments received. Evaluation in Phase 2: after distribution of funds in FY 2018, look at planning next set of consultation sessions well in advance.*

What impact does \$72 million have? There is \$6,000 per person needed to make up the difference. We need to stop coming to meetings to argue over \$4.32 per person. People are dying. Let's get through this process and focus on the \$36 billion needed.

There is no perfect process. Workgroup has done what it can do.

What IHS is trying to do, have a condensed time frame? Appease the GAO.

Will IHS post transcripts on [ihs.gov/IHCIF](http://ihs.gov/IHCIF) of each IHCIF consultation or just a summary of each? When does IHS anticipate posting information related to comments brought forward at the consultation held last week in Phoenix? *Answer: This is a summary from all the consultations.*

Will IHCIF be allocated for 2018 using the existing formula? *Response: the FY 2018 allocation will be made using an updated formula incorporating any changes after Tribal consultation.*

Have the results (FDI scores) by operating unit been calculated using the workgroup recommendations? *Response: Not yet.*

What would be the process for a tribe to challenge the site-specific alternate resource data? *Response: Yes. The IHCIA 25 USC 1621(d)(3) allows for tribes to request a review of the LNF calculation related to the health status and resource deficiency.*

The statute requires private insurance be counted too for alternate resources. Why is this not included, but Medicare Part A and B are included (but not Medicare Part D due to lack of data). This unfairly rewards those Areas that have large staffing packaged and can provide and bill insurance related services. All statutory required services should be included in the alternate resources or none with the short IHS timeframe.

Need to address social determinants of health.

Health prevalence data should be included.

Regarding alcoholism used in health status, is data crosschecked? Alcoholism is the only behavioral health factor used. Is there consideration to use other health measures?

How is prevention addressed in formula? Need to capture prevention as a component of health care improvement. Is there a body currently addressing this?

Will the formula numbers be updated and recalculated annually or will the current scores be used for a set number of years? *Response: the plan is to update and rerun the formula more frequently, especially in years where IHS receives funding for the IHCIF.*

Should have had time to talk to Tribes.

Adding or enhancing a PRC dependency-like factor, a small tribal health facility user account factor and a factor accounting for tribal operating units in IHS areas that have no IHS or tribal hospitals.

While some tribes advocate for funding based on need and other tribes prefer supporting proportional increases to historical funding, we actually believe that increases based on historical funding and Indian Healthcare Improvement Fund increases, which are needs-based fund, are not mutually exclusive and in fact we truly believe augmenting mandatory such as inflation and pay cost with the Indian Healthcare Improvement Fund allocations will more readily accomplish parity in resources.

We all know that virtually every site and every facility is severely underfunded in the Indian health system and that goes without saying. There are nuances and unique situations with every geographic region and then even within regions and areas there are nuances within those areas. IHS needs to come up with a formula that addresses as many of those unique scenarios as we can possibly embody in one formula and still make it understandable.

The three core recommendations that you've described today that the workgroup is making for Phase 1 I think are solid. I think, from our perspective, they improve the formula and they're all three based on solid data which we truly appreciate. I understand the workgroup it tends to do further study on some other ideas which I, you know, I think we fully support.

The formula itself is of course designed to help with addressing resource deficiencies but it's not meant to substitute for any of the other formulas that are used for funding allocations across IHS.

### **Per Person Benchmark**

We are in support of the National Health Expenditure (NHE) in place of the FEHB Program benchmark because the FEHB does not include the full range of health programs authorized under the Indian Health Care Improvement Act (IHCIA). NHE benchmark because it provides a better approximation of the total health care need for the Indian health care system and increases the overall need by approximately \$3 billion compared to the FEHB benchmark and allows for the inclusion of IHCIA authorities.

Is it possible to be considered in more than one benchmark?

Why was Blue Cross/Blue Shield selected as the Benchmark in the old formula? *Response: it was a nationwide program that law makers were familiar with that covered most of the health care programs IHS provided.*

## **User Count**

There are good things in formula like expanding CHSDA.

Look at how counting user population differently. Has heard no assurances that this will not roll over in general distribution of regular IHS funding cycle.

Does user count include Urban Indians? *Response: urban Indians are only included if they visit a nonurban facility.*

Support national un-duplication and adding non-CHSDA users. Need better understanding of data on their population. Want to review data used. Have resistance, because tribes do not know the impact.

What are PRCDA and CHSDA? *Response: PRCDA: Purchased & Referred Care Delivery Area, CHSDA: Contract Health Service Delivery Area.*

How will the formula address patients that are receiving services in more than one operating unit? *Response: Operating Unit of residence will get the credit. Fractionalization will help by giving partial credit to each site the person visits (Phase II activity).*

Are tribal members who reside in Hawaii, under the California Area, in which services are provided through a contracted facility counted in the user population? *Response: If an eligible beneficiary receives services and is not residing in a CHSDA they are not currently counted. Under the new formula, these non-CHSDA users should be counted, if their data is submitted to the National Data Warehouse.*

How are you able to follow a patient who may go from a PRCDA under one tribe (RPMS) and end up moving into a separate PRCDA under another tribe (NextGen)? How do you ensure a patient is unduplicated? *Response: IHS uses the most recent residence data.*

Using non-duplication is good.

What happens to the user count when the whole state becomes a CHSDA? *Response: the user count increases as the non-CHSDA user count decreases.*

## **Access to Care**

Some Areas don't have hospitals.

Staffing issues. Hard time recruiting specialists.

The PRC folks who wanted equalizers did not agree. Look at national benchmark related to Medicare and Medicaid. If you are female with lump, you do not get into care as soon. No hospitals or access to specialty care. Mental Health specialty needed, but those providers don't accept Medicaid. Workgroup has not been able to factor in Medicare or Medicaid side of things. This area does not have hospital or specialists. PRC is not a factor.

Can't speak to formula at this time. Face recruitment issues, substance abuse and mental health issues. Will push for Hospitals in California.

Services availability needs to be included in access to care.

Recommend hiring a health economist to quantify impacts of social determinants on health.

Transportation costs is important to be included.

### **Alternate Resources**

Those more aggressive with 3<sup>rd</sup> party billing are being penalized.

Since we have no hospitals there is no Medicare Part A revenue coming in.

Private Insurance is not included in formula.

Not discounting what Tribes have to pay.

How does it address sites not exporting data to the National Data Warehouse? *Response: Looking at enrollment data, if no data submitted use state average. Enrollment data refers to Medicare and Medicaid enrollment.*

Each site is so unique. Want to provide one story. Medicaid and Medicare data. OBGYN referrals provided but providers don't accept their insurance. This may impact formula.

Encourage use of 25%, until further discussion down the road. Some states have managed care organizations, which don't always work for tribal organizations.

Not all hospitals are created equal. Serve members from hundreds of tribes at his facility. Elders with Medicare get stuck with half the bill. We are also not even talking about urban Indians. We need to make the system fair. It's also broader than what we are discussing today.

Working with state with 100% FMAP. When looking at Medicaid and Medicare and trying to enhance services for patients, don't want to be penalized within the formula. Don't want to penalize patients if looking outside the box.

Why is Medicare being included when most PRC programs do not bill Medicare and none bill Medicare Part A in the Northwest. *Response: see Question 32 in the Questions and Answers document at <https://www.ihs.gov/ihcif/ihcif-consultation/>.*

That 25% alternate resource factor is probably not accurate.

We do not believe that enough data has been provided to our tribes related to this major change to the formula. Each tribe needs time to look at their site-specific coverage data for accuracy and to determine how this change will impact their IHCIF funding allocation. We understand that the site-specific data will be pulled from the IHS National Data Warehouse, which is mainly limited to direct service tribal data. So, in most cases IHS would be using the state average for our tribally-operated clinics. Is this correct? We would like full copies of the data IHS is using to calculate the state averages for our Area and additional time to confirm the data and completely

comprehend the impacts on Portland Area tribes when site level coverage data is not available. We are not entirely assured that any third-party data will be accurate.

We would like to be assured through validated data that the alternate resources factor only accounts for Medicaid billing on active users seen in our facilities not AI/AN patients enrolled in Medicaid.

Portland Area Tribes are concerned that the proposed inclusion of Medicare in the alternate resources calculation will not be accurate for our area. There needs to be a breakdown of Medicare inpatient billing versus Medicare outpatient. Since we do not have hospitals in our area, Medicare inpatient costs should be excluded from the alternate resources formula. Portland Area Tribes do not bill for Medicare Part A because we do not have any hospitals. Medicare Part B revenues may also be calculated higher in the formula because of low access to specialty care. As a Portland Area Tribe, we will be at a disadvantage if there are no considerations or options for excluding Medicare Part A and possibly Part B for the tribes that do not bill for them. Therefore, emphasizing the issue that insurance coverage is not created equally and the utilization of Medicare Part A and B could drastically harm the Level of Need Funded (LNF) for Portland Area Tribes.

Frustrated with annual request for Priority level I denials. Some tribes supplements PRC with tribal resources so the priority I denials isn't really accurate.

## **Phase 2 Discussion**

Quality Improvement Project: output we have a distribution formula. What is the outcome? May be time to look at baseline measures? GPRA, sustainable service lines, increased PRC, improved patient flow. What is the tangible outcome? We need to take and measure. What sustained improvement did we see in IHS. Full circle from a quality improvement standpoint.

Recommendation - Phase 2 examine how it can be done.

Do we need to do an evaluation on the IHCIF?

Most of what was punted to phase 2 is what could not be agreed upon. A lot of recommendations that were brought forward were not embraced. Potential for inclusion in Phase 2 may be unlikely.

Don't raise the level of need unless the level of need is sustained. It must stay in base to sustain that level of need.

Facility efficiency Factor. Areas without hospitals, or not on construction list, limited access to joint ventures.

The California Area has received zero funding from IHS Facilities construction program. Number of facilities being built are not in California Area. A factor should be included that California Tribes should be assured that a factor is included in the formula.

As result of not receiving facilities, tribes have been forced to take on this responsibilities. California Area has expectation that some of these factors will be included in the formula.

Recruitment is a big issue for medical, dental, behavioral health. Level of funding makes it difficult to hold onto staff. Lack of housing for staff. Discussed mental health and access to care. The variables are being mentioned because they are all related.

Don't look away from factor in formula regarding health.

Is it possible that there is a "cross-border" consideration for those tribes who are impacted with distance, coverage, third party disparities etc.?

Would like to see fractionalization of user count in Phase II.

In Phase 2, a lot of the discussion will be about facility factors. We do have other formulas that address some of those types of resources. So part of what we've encountered in the workgroup discussions is making sure that we don't provide any negative impacts to existing funding resource allocations and that we take into consideration what the intent of this particular formula is.