

Summary of Questions and Comments on the IHS-Tribal Indian Health Care Improvement Fund (IHCIF) Workgroup Recommendations. Tribal Consultation Period June 6, 2018 through July 13, 2018.

Tribal Consultation on the IHS-Tribal IHCIF Workgroup recommendations was initiated through a Dear Tribal Leader Letter on June 8 to end July 13th. Three in-person Tribal consultations were held (June 14, 28 and 29) and one conference call was held on June 21st. Comments were also received at the United South and Eastern Tribes Meeting (June 19). Twenty-five written comments were received by mail or e-mail.

GENERAL COMMENTS

- We have reviewed in detail each of these recommendations and concur with the Workgroup. All three of these changes are based upon reliable data and improve the quantification of need and identification of funding disparities with greater precision than the prior methodology. None of these recommendations add new elements to the formula, but merely improve existing elements of the formula, which is a sound approach, given the aggressive timeframe.
- Realizes need to make decision quickly due to need to get funding distributed, but don't make premature decisions.
- Most facilities are still funded for the same staffing levels they received when constructed (in some cases over 50 years ago).
- This is kind of being fast-tracked. It would be good 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 10th 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. *Response: IHS realizes that the notice for the in-person meetings was less than desired. As many Tribal leaders were unable to attend the in-person meetings, IHS had conference lines for the meetings and also scheduled a separate conference call to allow for additional participation. IHS also shared information on the IHCIF Website, provided a Questions and Answers document and posted comments received to date. For Phase II Workgroup Activities (after distribution of funds in FY 2018), IHS will plan the Tribal consultation meeting(s) well in advance and provide notice to tribal leaders.*
- 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.
- Will IHS post transcripts on ihs.gov/IHCIF for each IHCIF consultation or just a summary of each? When does IHS anticipate posting information related to comments brought forward at the consultation held in Phoenix? *Response: IHS posted a summary of the comments and questions from all the consultations on the IHCIF webpage.*

- The statute requires private insurance be counted 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 packages and who 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 funding such as inflation and pay cost with the Indian Healthcare Improvement Fund allocations will more readily accomplish parity in resources.
- The three core recommendations that you've described that the workgroup is making for Phase 1 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 intends to do further study on some other ideas which I think we fully support.
- The official role of the IHS agency as the authorizing federal entity is to determine how the funds shall be expended is of the utmost importance in addressing the glaring service deficiencies and funding inequities across the IHS delivery system, including those Tribal Nations faced by the IHS Areas due to limited IHS/Tribal hospital infrastructure.
- IHS is urged to make annual budget requests for funds in the IHCIF just as it does for mandatories.
- What would be the process for a tribe to challenge the site-specific alternate resource data? *Response: There is a process to request a review of the LNF calculation. If a tribe can show that an error was made in the overall formula or in their specific SDA calculation, they can request that a review be done. This review process does not allow for submission of new data not previously submitted or the request of a change in the overall formula.*

IHCIF WORKGROUP

- Concerned about the workgroup decision-making process, a vote from each Area, was clearly divided between the majority of IHS Areas with hospitals and the minority of those without hospitals on key issues.
- Support approach that does not pit tribe against tribe. Large Tribes versus Small Tribes.

IHCIF METHODOLOGY

- Target the 2018 IHCIF allocation to sites with the lowest LNF, and for each site to receive the calculated amount, no matter how large or small.
- Should be a disbursement to all tribes, and then use a portion to most needy.
- 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.
- In 2012 sites with a LNF score under 44.8% were funded. IHS does not have a threshold at this point in time.
- Legacy of historical allocation methodologies from the days before Self-Governance, when IHS was responsible for operating the entire system. When IHS was the only health care provider, funding followed new facilities in order to support Federal staffing packages. With Tribes taking over their health care systems, providing their own facilities, and redesigning services to meet the health needs of their communities, it is no longer effective to remain tethered to the past by prioritizing funding for facility staffing above all else, creating funding winners and losers and exacerbating the embedded disparities. Rather, funding allocations should be provided per user so that life-saving services are available more uniformly throughout Indian Country. The IHCIF provides a methodology for this much needed per user funding.

LNF FORMULA

- Formula is not raising the LNF funding in the base. It is a one-time funding. *Response: 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.
- No formula should be structured where some areas are on short end of the stick.
- Fair to revisit formula.
- Tribes want to know how they are going to be affected by formula.
- 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.*

- 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.
- Deliberations on a complicated formula can have unintended consequences.
- 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.*
- 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 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.
- Have the results (FDI scores) by operating unit been calculated using the workgroup recommendations? *Response: The LNF or FDI percentages have not yet been calculated down to the SDA level (as of July 17, 2018). IHS is in the process of gathering needed additional user count data from the Areas to be able to run the calculations at the SDA level to include national un-duplicated and non-PRCDA users.*

PER PERSON BENCHMARK

- We are in support of the National Health Expenditure (NHE) in place of the Federal Employee Health Benefits (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.
- Fully support the NHE as a baseline for calculating the benchmark for the IHCIF. It will also present a more accurate picture to Congress regarding the federal government's total unfunded obligation within IHS.
- The NHE benchmark is broader and can be used to make comparisons against unfunded authorities in the IHCIA and IHS funded programs. The NHE benchmark more closely approximates the total healthcare need to all people in the U.S.; however, it still may be insufficient to estimate the need for Native populations which experience higher than National average risk (and cost) for certain ailments such as diabetes and pulmonary disease. The NHE model allows the inclusion of dental and vision services that were previously excluded in the FEHB model, as well as new services authorized in the amendments to the IHCIA.
- The agency will have a challenge in justifying and managing optics for why the new benchmark increases the overall need by approximately \$3 billion.
- 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

- It is imperative that this figure for the number of individuals at sites that are needing services be inclusive, without being duplicative, and capture all of these patients on which site is expending funds for care.
- What are PRCDA and CHSDA? *Response: PRCDA: Purchased & Referred Care Delivery Area, CHSDA: Contract Health Service Delivery Area.*
- We support the addition of non-PRCDA users to the national unduplicated user population.
- There are good things in formula like expanding CHSDA.
- Look at how counting user population differently. Have 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 an IHS or Tribal facility during the reporting period.*
- 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.
- How will the formula address patients that are receiving services in more than one operating unit? *Response: Service Delivery Area (SDA) or Operating Unit of residence will get the credit. Fractionalization will help by giving partial credit to each site the person visits (Fractionalization is being considered during Phase II).*
- 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.*
- Tribe requests that the Workgroup continue to evaluate fractionalization in Phase II to ensure that the data can be accurately measured at the service delivery area level. We support each facility serving an AI/AN patient to receive credit for expending resources to providing services, so that multiple facilities can receive IHS appropriations for those services.
- Recommend not using the Service Population as a measure for user counts.

ACCESS TO CARE

- Concerning the various proposals for “access to care” or “Purchased and Referred Care (PRC) Dependency,” there were no data presented to support additional changes to the formula. Specifically, there seemed to be a lack of understanding of the impact of the ‘Tribal size adjustment’ that is already part of the formula and that provides an overall 30 percent difference per user between the smallest and largest operating units (by user population).
- Some Areas don’t have hospitals.
- All Hospitals are not equal in the scope of services provided. The Government Accountability Office (GAO) recognized that the mere existence of a hospital is not satisfactory to account for relative access to care. In its High Risk Report of September 13, 2017, pages 20-21, the GAO recommended the IHS PRC formula consider “variations in levels of available hospital services in allocation formulas” rather than simply the existence of a hospital.
- 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.
- Technology has led to advances in medical care, but access to antiquated facilities should be recognized as diminished access to care.
- Transportation costs is important to be included.
- Encourage IHCIF Workgroup to continue to explore a factor that can be added to the IHCIF formula that reflects barriers to accessing care that includes such issues as travel distances, modes, and cost of travel, and isolation factors that restrict access to Level I or II trauma care.

ALTERNATE RESOURCES

- To continue to use an across-the-board 25% as a proxy will no longer be defensible, and the Workgroup has presented a reasonable adjustment to the formula to reflect actual resources available. Using the statewide rates of coverage as both a replacement for missing data, and as a cap is a good approach.
- That 25% alternate resource factor is probably not accurate.
- Recommend maintaining the 25% fixed alternate resource component for the FY 2018 IHCIF and that proposed recommendations be further evaluated in Phase II of the Workgroup charge.

- Encourage use of 25%, until further discussion down the road. Some states have managed care organizations, which don't always work for tribal organizations.
- Those more aggressive with 3rd 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 the formula.
- The formula disproportionately impacts tribes that do not have hospitals and specialty care at our IHS clinics or Tribal facilities.
- Not discounting what Tribes have to pay.
- It conflicts with modernizations made during the permanent authorization of IHClA that prohibit funding offsets based on the amount IHS and Tribally operated sites are able to generate in alternate resources.
- Penalizing tribes who conduct extensive outreach and enrollment in Medicaid and Medicare and Collect third-party revenue in addition to patient care is contrary to the federal treaty and trust obligations of the U.S.
- Our biggest concern is the lack of information provided to the tribe to make sound recommendation(s) on our own data to help us understand the direct impact. We would like full copies of the data IHS is using to calculate the IHS state averages for our Area and additional time to confirm the data and completely comprehend the impacts to the tribe when IHS state averages are used.
- Some SDAs cross state lines. The state coverage average may not be an accurate reflection of the SDA alternate resource coverage.
- 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.
- Not all hospitals are created equal. Services are provided to 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/>.*
- 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.

- Leveraging limited resources through collections is a necessity when Congress continues to underfund the IHS. Tribal Nations in the Portland Area rely heavily on alternate resources, such as Medicaid and Medicare, to provide specialty care to patients. Penalizing savvy Tribal Nations who conduct extensive outreach and enrollment in Medicaid and Medicare and collect third-party revenue in addition to patient care is contrary to the federal treaty and trust obligations of the U.S.
- Complexity is imbedded in the alternate resources calculation. First, not all operating units provide the same services and second, third-party resources vary greatly across states as demonstrated by Medicaid expansion. Because of the differences in services provided at each operating unit, alternate resources credited to the individual are not always available to the Tribe or Tribal organization.
- The proposed inclusion of Medicare in the alternate resources calculation will not be accurate for some Areas. There needs to be an adjustment to Medicare enrollment for Areas isolating only those active users who use it for services at an IHS/Tribally operated site/unit and that can be verified by an IHS/Tribally operated site/unit.
- Question the veracity of using statewide averages for those operating units with missing or outdated enrollment data. This could penalize those operating units when their actual coverage data might be lower than the statewide average.
- It is inconsistent policy to include Medicaid expansion and Affordable Care Act (ACA) impacts into the IHCIF formula, but not the PRC formula.

ALTERNATE RESOURCES DATA REVIEW PROCESSES

- Due to lack of information provided by IHS, we are unsure how the change to alternate resources will impact the Tribal Nations in our Area (Portland Area). We do not believe that adequate site-specific information and supporting data was provided to the Workgroup and Tribal Nations to provide a comprehensive explanation of the major change to the alternate resources factor of the formula.
- Each Tribal Nation needs time to look at their site-specific enrollment data for accuracy and to determine how this change will impact their IHCIF funding allocation.
- Upon compiling site-specific data, Tribal Nations should be afforded the opportunity to review and approve data retrieved from the national data warehouse prior to it being utilized within the formula calculations.

- It is critical to maintain the ability to use state average data or site-specific operating unit data when NDW data is missing or is inaccurate.
- We do not believe that adequate site-specific information and supporting data was provided to the Workgroup and Tribal Nations to provide a comprehensive explanation of the major change to the alternate resources factor of the formula.
- An operating unit (Tribe or Tribal organization) should also have an opportunity to address or appeal this issue before allocations of the IHCIF are finalized. The Workgroup recommendation should also include and describe a procedure to allow a Tribe or tribal organization to petition the IHS Director for a review of any determination about its alternate resources or other factors of measuring resource deficiency in the IHCIF methodology.
- Frustrated with annual request for Priority level I denials. Some tribes supplement PRC with tribal resources so the priority I denials aren't really accurate.
- IHS should be alert to situations where seemingly erroneous Alternate Resource rates are evident. In such instances the more specific, but complicated, formula may be in error.
- We are concerned that the sources of data are not as complete or accurate as they should be before implementing the Workgroup's recommendations.
- 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.

PHASE II DISCUSSION

GENERAL

- Quality Improvement Project: We have a distribution formula which is an output. What is the outcome? It 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 II examine how it can be done.
- Do we need to do an evaluation on the IHCIF?
- Most of what was punted to phase II is what could not be agreed upon. A lot of recommendations that were brought forward were not embraced. Potential for inclusion in Phase II 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.

BENCHMARK

- We specifically recommend further review of the existing Resources Needed portion of the formula, the Cost Adjustment section. This section includes adjustments to the benchmark for economic, demographic and health conditions.
- We agree that the NHE Category 5 (New Health Care Facilities and Equipment) needs to be addressed in Phase II.
- The NHE does not include a consideration for “Category 5 – New Health care Facilities & Equipment” in the determination of need. As a result, replacement of antiquated equipment, or the need to build a new facility is not considered in the estimate of “healthcare needs”, which depresses the realistic number.

PRC DEPENDENCY

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

DISTANCE AND FACILITY FACTOR

- Recommend a Facility Differences or Facility Efficiency factor be included for Areas without IHS hospitals, not on the IHS Health facilities Construction Priority List, and with limited access to the IHS Joint Venture Construction Program.
- The California Area has received zero funding from IHS Facilities construction program. Number of facilities being built are not in California Area. 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.?
- In Phase II, 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.
- In regard to possible incorporation of facilities backlog in the IHCIF in some way, we would be extremely concerned at the prospect of relying upon IHS data for this element. The IHS Health Center Facilities Construction priority list has been closed for over two decades. The Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) is not a full accounting

of the maintenance and improvement backlog, as a lack of resources at the local level (for both IHS and Tribal sites) often precludes regular updates.

- Since Joint Venture Construction Program (JVCP) is competitive and based upon need factors, we also strongly disagree with penalization of sites that have successfully completed JVCP projects.
- We support a small tribal nation add-on factor. The current formula does not account for the size of a facility, which may have the same degree of funding shortages as a larger facility.

USER COUNT

- We would strongly recommend that the workgroup work in the future to quantify the total need for AI/AN, regardless of whether or not they are a recent recipient of Indian health services. Barriers to care and lack of access to care can depress the current patient population, and if the IHCIF calculation is used to justify additional appropriations from Congress, the true need should be represented.
- Would like to see fractionalization of user count in Phase II.
- Recommend Workgroup continue to evaluate fractionalization to ensure that the data can be accurately measured at the service delivery area.
- Concern about the concept of fractionalization of the user population in the future. Facilities that “share” patients should negotiate a mutually acceptable method to share resources based upon local circumstances.
- It is true that while all facilities providing services to a single patient are expending resources only one is receiving funding from IHS appropriations for those services. Most facilities are also able to bill 3rd party resources to recover a portion or all of the cost of providing care for that patient’s specific visit, even if they do not receive direct resources from the IHS to serve that patient. Allocation of 3rd party collections should be split along with the associated IHS resources if fractionalization is adopted in the user count formula component.
- Evaluate fractionalization in Phase II to ensure that the data can be accurately measured at the service delivery area level. We support each facility serving an AI/AN patient to receive credit for expending resources to providing services, so that multiple facilities can receive IHS appropriations for those services.

ALTERNATE RESOURCES

- Recommend maintaining the 25% fixed alternate resource component for the FY 2018 IHCIF and that proposed recommendations be further evaluated in Phase II of the Workgroup charge.
- While we understand the argument regarding the exclusion of private insurance from alternate resources because it should not be counted as a federal resource, there is no consideration for Areas with large staffing packages who benefit from additional revenue from such insurance, which is indirectly related to funding that they receive from IHS. We ask that this be taken into consideration during Phase II.

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?
- Small Tribal Nation Add-on Factor. The current formula does not account for the size of a facility, which may have the same degree of funding shortages as a larger facility. We recommend that the Workgroup consider this factor in future formula recommendations.