IHCIF Per Person Benchmark Sub-Group

APRIL 12, 2018

Per Person Benchmark Sub-Group

Jim Roberts, Alaska

Lynn Malerba, Nashville

Dee Sabattus, Nashville

Sarah Sullivan, Portland

Kasie Nichols, Technical Advisor, OCA

Leslie Racine Billings

Laura Platero, Portland

Mary Godfrey, Billings

Jennifer Cooper, HQ

Francis Frazier, HQ

Kella With Horn, Great Plains

Mark Fleetwood, Tucson

John Rael, Albuquerque

Per Person Benchmark Sub-Workgroup Assigned Action & Status

Action	Assigned to / Status
Assess the rationale and impact of replacing the Federal Employee Health Plans (FEHP) per user cost benchmark with a benchmark based on national health care expenditures (personal health care services).	The NHE classification system is based on an accounting structure with a common set of definitions which allows comparison among categories over time, and is useful in analyzing a changing mix of medical services and products. Using the NHE may present a better picture on total need, particularly unfunded authorizations. Impact: possible $3.2B increase when compared to FEHP. (*See IHS-FHEP-NHE Analysis Excel Spreadsheet*)

Per Person Benchmark Sub-Workgroup Assigned Action & Status

Action	Assigned to / Status
Develop "side-by-side" LNF/IHCIF results under the original FEHP and proposed benchmarks.	Revised the LNF calculation model to optionally reference the National Health Expenditure (NHE) price benchmark. Side-by-side results can be produced quickly when NHE data are plugged into the model.
Compare purposes and services for each IHS budget category (BAP, e.g., PRC, etc.) with national health expenditure definitions to estimate correspondence or lack of correspondence. Express as a percentage, e.g., H&C 100%, Sanitation 0%	Reprogramed the LNF model to recalculate available IHS resources based on either the FEHP correspondence percentages or the NHE correspondence percentages when determined by the team. (*See New Benchmark Categories using NHE accounts Excel spreadsheet*)

Per Person Benchmark Sub-Workgroup Assigned Action & Status

Action	Assigned to / Status
Compare services and programs authorized in IHCIA to types of spending in the national health care expenditures. List major categories of un-funded IHCIA services that correspond to national health care spending. We anticipate that IHCIA mandates more closely correspond to national health care spending than mainstream insurance plans such as FEHP BC/BS.	Major categories of un-funded IHCIA services mapped to NHE. Explored options: • Information presented to IHCIF Workgroup on 3/13/18 in Phoenix, AZ • Core Services (personal health care) and Wrap-Around Services (total unmet need or gaps in services). • Sub-Group recommends using NHE Benchmark, Categories 1-4. Presented information to Federal-Tribal Workgroup on 3/13/18.

Additional Analysis using on NHE using categories 1-4 as a Combined Factor

Table i: COST BENCHMARK PER PERSON - 2017
Basis: US National Health Expenditures Data

Option A: NHE	% to Include	per Person	Comment
Cat1: Health Care in Traditional Settings	100%	$7,749	Include (IHCIF WG)
Cat2: Residential, Home Settings, Nursing Homes etc.	100%	$1,329	Include (IHCIF WG)
Cat3: Dental Care Services	100%	$393	Include (IHCIF WG)
Cat4: Public Health	100%	$255	Include (IHCIF WG)
Cat5: New Facilities & Equipment	0%	$340	Exclude (IHCIF WG)
Sum of NHE Categories		**$9,726**	NHE Categories 1 - 4
Option B: FEHP Insurance		*per Person*	
Premiums + Cost Shares Adjusted for AIAN		$7,515	Equivalent to NHE Category 1
Selected Benchmark		*per Person*	*Option A*
NHE Benchmark		$9,726	NHE sum: Cat1+Cat2+Cat3+Cat4
Adjustments		$0	None at this time
Adjusted Benchmark		$9,726	Per person gross cost benchmark
CMS/OMB All-Inclusive Rates for IHS		*Cost Rate*	*Ratio to L48 States*
Inpatient Day Rate - Lower 48		$2,933	100%
Inpatient Day Rate - Alaska		$3,235	110.30%
Outpatient Encounter Rate - Lower 48		$391	100%
Outpatient Encounter Rate - Alaska		$616	157.54%
Blended Rate Ratio (30% Inpatient, 70% Outpatient)			143.4%
State Variations (cost neutral overall)	*Population*	*Benchmarks*	*Ratio to US Average*
IHS - All States	1,638,687	**$9,726**	100%
Alaska only	166,146	**$13,357**	137.3%
Lower 48 states excluding Alaska	1,472,541	**$9,316**	95.8%
Ratio: Alaska to Lower 48		143.4%	
Alternate Resources[1] Pending***	*Fixed 25% Deduction*	*Variable Deduction by State (if > 25%)*	*Net Deduction Locally Adjusted (Economic + Health + Access)*
IHS Average Deduction	-$2,432	$0	-$2,432
Alaska Deduction	-$3,339	$0	-$3,035
Lower 48 States Deduction	-$2,329	$0	-$2,364
Ratio: Alaska to Lower 48	143.4%	0.0%	128.4%

*** Assume a fixed 25% deduction until IHCIF workgroup recommends replacement method/data.

1: Law specifies that other resources available to AIANs be considered in calculating resources needed for Indian health care. The estimate is calculated from state-by-state percentages of AIANs covered by Medicaid, Medicare, VA, and Tri-care multiplied by the applicable benchmark cost per person. This proxy estimate includes: 1) 3rd party reimbursements for "in-system" services provided to IHS users, and 2) costs avoided for "out-of-system" services to IHS users that otherwise must be paid from IHS appropriations.

Revised LNF based on NHE Benchmark

Option A: NHE Benchmark $9,726, which captures non-traditional settings seen in traditional service plans, and is approximately $2,000 more than Option B: FEHP $7,726. Reviewed CMS/OMB All-Inclusive Rates for IHS; State Variations, and Alternate Resources (Assumed a fixed 25% deduction until the IHCIF workgroup recommends replacement methodology/data).

Both are per person gross cost benchmark estimates, if all data factors unchanged. End result: changes benchmark substantially. Crude Calculation-overall level of need would increase by approximately $3.2 Billion. This figure would more accurately reflect the true level of need.

Additional Items Identified & Discussed Sub-Group Meeting on 4/3/18

- Marketing: it is important to be able to explain the difference compared to the previous LNF. Increasing the benchmark will lower everyone's level of need funded. We could potentially go back to an approximate average of 40%. We don't have the specifics of how a new LNF will re-draw the line.
- Resetting the Bar: Move from 50% to 40% range. Will not change rank order at all. By raising the threshold more Tribes will get funding. Again, relative ranking unchanged. Roughly the same Tribes will qualify for similar proportions of funding.
- What are the key optics that need to be identified? Very important for any rollout efforts. The Indian Health Care Improvement Act (IHCIA) authorized wrap around services (i.e. Nursing Home care, etc.), but the IHS was never funded for these authorizations. These services are added to the identified need.
- The NHE Benchmark more accurately reflects what the law has authorized.
- Alternate Resources (25%): Placeholder at this time. A change in percent of alternate resources will impact benchmark.

Facility Condition Factor

- Aging Facilities limit the capacity to deliver care to patients, and this needs to be accounted for somewhere in the LNF. What is the best way to represent this factor?
- Facilities issue was brought up at previous face-to-face meetings. There is a cost associated with the facility condition. Explore possibility of creating some type of a facility condition factor; looking at FAAB recommendations; developing a measure for facility condition based on the BEMAR Report.

- A facilities condition factor should not be incorporated into Category 5 and kept separate from the per person benchmark. The analysis and development would markedly delay overall benchmark progress. A facilities condition factor should be added to the local conditions part of the LNF.

Sub-Workgroup Summary

The sub-workgroup is supportive of new methodology in general, pending any additional questions. It is practical and defendable. The new benchmark establishes an average and does not hurt or help one specific Area in terms of funding. There is consensus using categories 1-4, with some reservations noted below.

Summarized Reservations include the following:

Two Areas (PHX, BEM) recommended using categories 1-3, but were not opposed to using Category 4 (Public Health).

Two Areas (NAV, CAO) were concerned about Facilities Appropriations Advisory Board (FAAB) Issues.

Recommendation to IHCIF Workgroup

- Recommend adoption of National Health Expenditure (NHE) Benchmark to replace Federal Employee Health Benefit (FEHB) Plan 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)
- Caveats
  - Aging Facilities limit the capacity to deliver care to patients, and this needs to be accounted for somewhere in the LNF. A facilities condition factor should be added to the local conditions part of the LNF. It should not be included in the benchmark.