INDIAN HEALTH SERVICE
INDIAN HEALTH CARE IMPROVEMENT FUND (IHCIF) WORKGROUP
FINAL REPORT

July 15, 2023

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INTRODUCTION

This is the final report of the Indian Health Service (IHS) Indian Health Care Improvement Fund (IHCIF) Workgroup established in January 2018. The Workgroup issued an interim report that included an initial set of recommendations, referred to as Phase I recommendations, in June 2018, and conducted their Phase II work from August 2018 to March 2019. This report provides the final conclusions and recommendations of the Workgroup[1], including a description of critical points determined to be notable to any discussion of Indian health care system funding needs but tangential to the Workgroup charge, which was focused solely on the formula used to allocate appropriations increases for the IHCIF.

The Indian Health Care Improvement Act (IHCIA) at 25 U.S.C. § 1621 authorizes the 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 consider the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances. For purposes of the IHCIF, the statute also states that available health resources considered in a resource deficiency calculation include IHS appropriations as well as health resources used by the IHS, a Tribe, or a Tribal Organization, including from Federal programs, private insurance, and programs of State or local governments—referred to as third party collections or alternate resources in this report.

The IHCIF Workgroup is committed to eliminating deficiencies in health status and resources of all Indian tribes. Continuous IHCIF increases—including increases to keep pace with the rising costs of pay, inflation, and population growth—would be needed to have a long-term impact on addressing resource needs across all IHS and Tribal health programs in the future. However, it is important to note that the IHCIF methodology does not address the full resources needed to truly eliminate the health status and resource deficiencies of all Indian tribes served by the IHS or a Tribal health program. Rather, the IHCIF formula seeks to fill the funding disparities as compared to a benchmark and it also seeks to equalize the resources available for health care among IHS and Tribal sites or improve equity within the system. The benchmark used has been a per capita spending amount; therefore, the IHCIF formula only seeks to ensure the amounts spent on Indian health care, including appropriations and third party collections, are equitable to amounts spent on the benchmark population.

The Workgroup's charge centers on reviewing the existing IHCIF formula and making recommendations for updating and improving the formula. This work supports efforts to address disparities, but it is not an all-encompassing solution. Potential solutions for addressing the full resources needed to truly eliminate the health status and resource deficiencies of all Indian tribes should continue to be evaluated in consultation with tribes as part of separate efforts, such as through the annual budget consultation and formulation process.

[1] While the IHCIF Workgroup identified consensus as a desired principle, the recommendations contained in this report reflect a majority concurrence from the Workgroup members. The differences that hampered reaching consensus are discussed throughout the report.

Background

A formula to allocate appropriations for the IHCIF was initially developed through the work of a Tribal/IHS Workgroup in 2000. This work included input from health economists, actuaries, and national Tribal consultation. The resulting formula that later became known as the Federal Disparity Index (FDI), or synonymously the Level of Need Funded (LNF), measures the LNF for IHS and Tribal facilities—also known as LNF Service Delivery Areas (LNF SDA) or operating units—relative to a benchmark level of funding. In other words, this formula determines the funding needed to achieve a benchmark level of resources, subtracts available resources, and results in an LNF percentage that describes the overall funding and deficiency level. The two main drivers affecting LNF SDA results include the population number used and alternate resources; however, all factors considered in the FDI, or LNF, methodology include:

- User Population;
- Health status deficiencies (using indices of mortality, life expectancy, morbidity, and poverty);
- Benchmark costs for mainstream plans (Federal Employee Health Benefit Program) adjusted annually for medical inflation;
- Geographic variations in cost of medical care including isolation and remoteness;
- Size of unit (correlated with operational economies and efficiency);
- Current funding available from IHS; and
- 25 percent factor for coverage by third parties such as Medicare, Medicaid, and private/employer insurance.

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 health 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.[2]

In late 2017, in recognition of the considerable changes in the health care environment since 2010, in response to Tribal requests, and because of the possibility of receiving a funding increase for the IHCIF in the final fiscal year (FY) 2018 appropriation, IHS determined it was appropriate to reconvene another IHCIF Tribal/IHS Workgroup to review the existing formula. The Workgroup was charged with making recommendations for updating and improving the formula and the data used in the formula. See the Workgroup charge at Appendix A.

The Workgroup conducted their work in two phases. Phase I resulted in an interim report submitted in June 2018 that provided three recommendations regarding the benchmark, population count, and alternate resources. See the Workgroup's interim report at Appendix B. Phase II resulted in this final report that describes the Workgroup's continued evaluation of additional potential revisions to the IHCIF formula and recommendation to maintain all three Phase I recommendations.

[2] 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.

The IHS has received a total of $259 million for the IHCIF from FY 2000-FY 2018. Within this time period, the most recent funding increase distributions occurred in FY 2012 and FY 2018. The FY 2012 distribution used the original formula with technical data improvements. At that time, the IHS national LNF average was 56 percent, and a total of $12 million was distributed to 86 LNF SDA with a LNF of 44.8 percent or less. The FY 2018 distribution used an updated formula methodology based on the Workgroup's recommendations from Phase I, which included an updated benchmark. See the Conceptual Diagram of the IHCIF Formula at Appendix C. The most recent IHS national LNF average based on the updated formula is 48.6 percent. A $72 million congressional appropriation increase for the IHCIF was distributed to 40 LNF SDA with a LNF below 34.8 percent. This means that the LNF SDA with the lowest LNF percentages received a funding increase that raised them to an LNF of 34.8 percent.

Based on the data in FY 2018, the gross resources needed for all 280 LNF SDA was estimated to be $16 billion. This is not the full resource level needed to eliminate the health status and resource deficiencies of all Indian tribes; rather, it is the calculated resource level necessary to achieve funding parity across Indian health programs using the National Health Expenditure benchmark. Using the IHCIF formula, the calculated benchmark funding level of $16 billion minus the available funding totaling $11 billion (inclusive of $5 billion from appropriated resources and $6 billion from estimated alternate resources) derives a funding deficiency of approximately $5 billion.

PHASE I RECOMMENDATIONS SUMMARY

Per Person Benchmark:

- Recommendation: Replace the Federal Employee Health Benefit (FEHB) Program with the following 4 categories of the National Health Expenditure (NHE):
  - 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)
- Rationale: The benchmark should not be less than what is spent on everyone else in the US and the NHE is a better approximation of the total health care need for the Indian health care system, particularly the unfunded authorizations in the IHCIA.
- Result
  - FEHB Program per user cost (national average): $7,599
  - NHE per user cost (national average): $9,726

User Count:

- Recommendation: Replace official User Population with User Population adjusted for national un-duplication and addition of non-Purchased/Referred Care Delivery Area (non-PRCDA, formerly known as non-Contract Health Services Delivery Area) users.
- Rationale: IHS now has the ability to un-duplicate users at the national level, which was not the case when the formula was initiated in 2000. Using national un-duplication ensures that each user is only counted once across the IHS. Including the non-PRCDA users ensures that patients who meet all of the criteria to be counted in the official user population except the residency requirement within a PRCDA are counted, since it means

the operating unit is expending resources on these patients. These two adjustments result in a higher level of accuracy for use in the formula.

- Result
  - FY 2017 IHS User Population: 1,638,687
  - FY 2017 IHS User Population adjusted for national un-duplication and addition of non-PRDCA users: 1,666,230

Alternate Resources:

- Recommendation: Replace the 25 percent fixed calculation with an operating unit-specific alternate resource coverage value (percent) based on coverage data at the IHS operating unit level adjusted for program weighting, coverage gaps, payment gaps, and program component enrollments. For operating units with missing or outdated alternate resource enrollment data, the State average will be used. For operating units whose coverage value exceeds the State average, the value will be capped at the State average.
- Rationale: When the current 25 percent across the board alternate resources factor was developed and incorporated into the existing formula, data on alternate resources coverage was limited. There is greater availability and better accuracy in coverage data now. Using the data available specific to the operating unit level improves the accuracy of the calculation.
- Result
  - FY 2017 alternate resource factor: 25 percent across the board
  - Recommended alternate resource factor: operating unit specific (national average ranging from 35 percent to 38 percent).

IHS Response: The IHS engaged in Tribal consultation on the recommendations and based on the input received from the consultation approved and implemented two of the recommendations: the per person benchmark and user count recommendations. Through Tribal consultation, concerns were raised about the third recommendation: using the site specific IHS data on alternate resource coverage without an opportunity for Tribes to validate their data. Therefore, the IHS used statewide alternate resource coverage averages from the American Community Survey data for the FY 2018 IHCIF distribution only, and instructed the Workgroup to review and consider the Tribal consultation input about the third recommendation as part of its Phase II work.[3]

PHASE II WORK

The Workgroup initiated its Phase II work in August 2018 and held its final face-to-face meeting in March 2019. The Phase II work focus areas included items that required additional discussion from Phase I and items raised during the Tribal consultation period. The Workgroup determined to approach the work through the Subgroups established during the Phase I work. The following list comprises the Phase II items undertaken by the Workgroup and the Subgroups assigned to address them.

[3] A letter to Tribal Leaders dated August 17, 2018, provides IHS decisions on the FY 2018 IHCIF formula in response to the Workgroup's Phase I recommendations after Tribal consultation.

Benchmark Subgroup

- Facility factor

User Count Subgroup

- User Population fractionalization

Alternate Resources Subgroup

- Validation of operating unit-specific alternate resource enrollment data, which was a concern raised during Tribal consultation of the Phase I recommendations and not used in the formula to allocate the FY 2018 IHCIF funding increase
- Discounting Medicaid for coverage gaps

Access to Care Subgroup

- Purchased/Referred Care (PRC) Dependency Factor
- Distance factor – i.e., distance to a level II[4] facility or to an IHS facility
- Program size – determining if there is a better way to support this Tribal size adjustment factor
- Facility Type factor – using the IHS Standard Code Book
- Cost of care

BENCHMARK SUBGROUP

The Benchmark Subgroup was assigned to review the potential of incorporating a facility factor into the formula. The Subgroup consulted with IHS subject matter experts in the IHS Office of Environmental Health and Engineering as they considered what type of facility factor would be feasible. The discussion focused on the feasibility of using available mechanisms, such as the facility condition index or the Health Systems Planning (HSP) system, to measure the gap between facility infrastructure need and available resources.

Workgroup conclusion: The facility condition index is based on self-reported data and is likely not comparable across facilities and Areas. To use HSP would require running the HSP for every facility and the workload or effort required is not practical or feasible to accomplish.

USER COUNT SUBGROUP

The User Count Subgroup was assigned to review the fractionalization of IHS's user population. Fractionalization is a process to count a percentage of the user population for each Service

[4] A level II health facility has 24-hour immediate coverage by general surgeons that can initiate comprehensive care for all injured patients. The Subgroup used the American Trauma Society (ATS) definition of a Level II Trauma Center, which is available on the ATS Website at https://www.amtrauma.org/page/traumalevels. See page 10.

Delivery Area that provides health care services to a patient. The existing process maintained in Phase I, only allows an individual to be counted in one location based on the person's place of residence. The Subgroup discussed these existing processes and data sources to determine feasibility of a revised process that would enable a patient who has been seen by more than one facility to be counted for each Service Delivery Area visited.

Workgroup conclusion: Fractionalization of user population would provide the most accurate count of users by site. However, IHS has not yet achieved the ability to determine fractionalization. The workgroup encourages IHS to continue to work towards this goal for consideration in future work to review the IHCIF formula.

ALTERNATE RESOURCES SUBGROUP

The Alternate Resources Subgroup was assigned to revisit the Workgroup's Phase I recommendation to use operating unit-specific enrollment data and in the absence of data or in cases where the data is outdated to use the State average. In addition, the Subgroup was assigned to assess whether there was a method to address gaps in Medicaid coverage, since Medicaid-covered services vary from State to State and such coverage gaps contribute to an Indian Tribe's resource deficiencies.

Validation of Operating Unit-specific Alternate Resource Enrollment Data

The Subgroup discussed available sources, such as the American Community Survey (ACS) and the IHS National Data Warehouse (NDW), for identifying the best alternate resource enrollment data. Information from the ACS had been used by the IHS when applying the IHCIF formula for the FY 2018 distribution due to concerns raised by Tribal leaders during Tribal consultation regarding the accuracy of IHS data in the NDW. In response to those prior data accuracy concerns, the Subgroup consulted with IHS experts from the IHS Office of Public Health Support to better understand data available through the IHS NDW. The IHS data was described as being substantially complete with data reported directly by IHS and Tribal health programs, which would provide a better reflection of enrollment data for the population served than the ACS data collected and maintained by the US Census Bureau.

Workgroup conclusion: Data from the IHS NDW should be used in the IHCIF formula for calculating alternate resources, rather than information from the ACS. To facilitate the highest degree of accuracy, the IHS should provide specific guidance to sites regarding how to validate or update their data, and provide specific outreach to sites without recent data. If a Tribe does not provide data in response to update requests, the IHS will use the statewide alternate resources coverage average from the ACS.

Discounting Medicaid for Coverage Gaps

The Subgroup reviewed net coverage for each insurance type: Medicaid, Medicare, and private insurance. The overall principle was to identify potential alternate resource discounts and weighting adjustments that could be addressed with readily available data and would also be equitable, easily implementable, rational, and defensible. In addition, the Subgroup emphasized

the fact that the alternate resources factor used in the IHCIF formula is based on insurance enrollment data and not on actual third party funding collected or the costs associated with the billing and collection process.

- Medicaid: Coverage gaps were identified in comparison to a standard benefit package. Optional coverages were reviewed and available data was discussed for valuing and discounting differing services, for example adult dental is valued and factored into the discount. Due to significant variations in coverage, the Workgroup discussed concerns about additional services not covered by Medicaid that would ideally be considered in the formula. However, it was acknowledged that significant work would be needed to identify a more comprehensive set of gaps for ensuring Medicaid is not over-valued in the formula.

- Medicare: Discounts were identified according to factors such as cost-sharing (copays), deductibles, premiums for Part B and Part D, coverage gaps in long-term services and supports, etc. Individuals identified as being dual eligible for Medicare and Medicaid were not added back into this enrollment data set.

- Private Insurance: Only the resources provided by the federal government were considered for inclusion. Private and employment-based insurance was discounted since it is viewed as resources of the individual and not from the federal government. Marketplace data is limited and a small factor is included based on federal government contributions.

Workgroup conclusion: Medicaid coverage gaps should be addressed where readily available data can clearly support discounting. However, the IHS should continue to explore mechanisms to review and develop these discounts more in the future. To ensure that only resources provided by the federal government are considered in the formula, discounts should be applied for coverage paid by non-federal sources such as private and employment-based insurance and Medicare copays, deductibles, premiums, etc.

ACCESS TO CARE SUBGROUP

The Access to Care Subgroup was assigned five items to review. Most were carried over from the Phase I work, reflecting topics for which the Workgroup was unable to reach consensus and thus tabled for further discussion during Phase II.

PRC Dependency

PRC Dependency is linked strongly to access to care in locations where there are small to no IHS and/or Tribal hospital facilities nearby, particularly where no inpatient IHS/Tribal hospitals are available. The Workgroup consulted with the IHS PRC program on available data that could be used to factor PRC into the formula. Consideration included, but was not limited to, PRC denial

data and the PRC Fiscal Intermediary (FI)[5] data on actual care purchased. The denial data was problematic because it is collected annually through the unmet need data call and therefore reflects self-reported data. Also, Tribal sites are not required to report and IHS estimates 70 percent of Tribal data is not reported each year. The FI data focused on the cost of inpatient care purchased. In comparing the direct care costs incurred by IHS and Tribal sites to PRC-purchased care at the time of the Workgroup's discussion, the national average cost per admission for direct care was $13,223 while the PRC average was $9,499. In addition, the FI data was incomplete because only 16 Tribes used the FI for payment processing.

Workgroup conclusion: The data that could be used to establish PRC denials and the PRC FI content are not available for all sites and are not reliable; i.e., there is no validation performed and IHS cannot confirm consistency in reporting. The Workgroup encourages IHS to focus on improving unmet need reporting with a validation process.

Distance Factor

The concept of a distance factor focused on availability of a certain level or type of care in terms of how far patients need to travel to obtain that care. The Subgroup discussed distance to the nearest IHS/Tribal facility. Another topic brought forward was distance to any level II[6] care facility—i.e. a health facility with 24-hour immediate coverage by general surgeons that can initiate comprehensive care for all injured patients. The IHS performed research on the latter topic and produced a list of sites and their distances to a level II trauma facility.

Workgroup conclusion: The data is interesting but it is not clear how it can be used as a factor in the formula. The IHCIF is not intended to address gaps in access to a level II trauma facility and the funds that support this care are likely PRC funds, which have a separate, established allocation formula.

Program Size

The IHCIF formula includes an adjustment for small healthcare facilities/programs in acknowledgment of the higher costs incurred in comparison to larger facilities as a result of the loss of economies of scale. During Phase I, the Workgroup reviewed this program size adjustment and considered whether to modify it to apply a greater adjustment for small facilities. However, it was decided to defer further discussion until Phase II, when additional work could be done to validate the higher costs incurred. In Phase II, the Access to Care Subgroup was not able to provide additional support for the higher costs.

Workgroup conclusion: No modification to the adjustment already included in the formula should be made until there is data to support an update.

[5] The FI is the fiscal agent contracted by IHS to provide and implement a system to process PRC medical, dental and behavioral health claims for payment.

[6] The Subgroup used the American Trauma Society (ATS) definition of a Level II Trauma Center, which is available on the ATS Website at https://www.amtrauma.org/page/traumalevels.

Facility Type Factor

The Subgroup considered whether access to care could be defined by type of facility. The IHS Standard Code Book is intended to identify each federal and Tribal facility by type. However, IHS cannot confirm the accuracy of the data, i.e., how often is it updated. In addition, the scope of services by facility type is not comparable across the Areas.

Workgroup conclusion: Facility type is not a viable method to uniformly define access or lack of access to care.

Cost of Care

The Subgroup proposed that the local costs of providing or purchasing care impacts access to care. The Workgroup discussed the fact that these costs were already addressed within the local price index used for site level calculations and were addressed to some extent in the program size adjustment.

Workgroup conclusion: The formula already factors in local costs of care and there is not a need to adjust further.

WORKGROUP DISCUSSION – BIFURCATING THE FORMULA

The Workgroup's final discussion item focused on whether the formula should be modified to place more emphasis on health status deficiency. This was raised because of the authorizing language for the IHCIF, which states the IHCIF was established for purposes of eliminating deficiencies in health status and resources of all Indian tribes. The Workgroup first reviewed a sensitivity analysis performed by IHS in order to understand how much of an impact the health status factors in the current formula have on results. The analysis showed that the health status factors used in the existing formula do not have a significant effect on the formula results. This led the Workgroup to consider other possible changes in the formula and in the allocation method. The Workgroup noted that the outcome of the FY 2018 distribution of IHCIF funds resulted in four Areas receiving no funding increases and the discussion that ensued centered on how to ensure all Areas receive an allocation of IHCIF. As options were identified, such as Congress appropriating additional funds to the IHCIF annually, the possibility of bifurcating (i.e. dividing the formula into two parts) the formula, similar to the PRC formula, became the central discussion point.

The Workgroup first considered options for allocating a portion of the IHCIF to all Areas using one method, such as user population or Area average LNF, and allocating the remaining portion using the LNF formula. Simulations of these options were prepared where 75 percent of the FY 2018 IHCIF increase was allocated to all Areas and 25 percent was allocated using the formula. The Workgroup did not reach agreement on either of these options. The discussion was redirected to the feasibility of bifurcating the formula based on resource deficiency and health status deficiency.

At the Workgroup's final Phase II meeting, IHS presented options for bifurcating the formula into a resource deficiency component and a health status deficiency component. The options for the health status deficiency component included health status only, hospital access, or a 50/50 blend of both. There was considerable discussion about the proposed bifurcation methods, both regarding the health status deficiency data to use and the weighting of each component, i.e., the percent of funds that would be allocated based on resource deficiency and the percent of funds to be allocated based on health status deficiency.

Workgroup's Conclusions on Bifurcation

The Workgroup was unable to reach consensus on a specific recommendation for bifurcation, although a majority of Workgroup members were in agreement with using the health status and distance factor presented by IHS and an 80/20 split, i.e., 80 percent of funds allocated based on resource deficiency and 20 percent based on health status deficiency. However, the Workgroup supports the concept of bifurcation in general. The use of a bifurcated formula could result in more sites sharing in any future distribution of funds. In addition, the use of a bifurcation formula could better address the health disparity/deficiency purpose of the IHCIF. Therefore, the Workgroup remands the concept of bifurcation to the IHS for determination.

WORKGROUP CONSIDERATIONS – ADDITIONAL IDEAS CONSIDERED BUT NOT ADOPTED

All IHS Areas made recommendations to the Indian Health Care Improvement Fund (IHCIF) methodology development process that may or may not have been included in the final IHCIF formula. However, all issues and recommendations were discussed by the full Workgroup. Where consensus or majority agreement could not be reached, the outcome of these deliberations were reported to the IHS Director for consideration to modify the final IHCIF formula. Generally, these recommendations by the various Areas were not included because they were controversial and consensus could not be reached. Or, implementation of the recommendations was not reasonable due to data or other limitations. Important to note is that the Workgroup made tremendous effort to address all the issues recommended by Workgroup members.

While the full Workgroup did not recommend adoption of all IHCIF formula revision ideas raised during Workgroup discussions, nor did the Agency adopt them into the 2018 formula update, the Workgroup wanted to document these issues in this final report. These additional concepts and recommendations include:

- Adding a factor and/or enhanced adjustment for small Tribal facilities and/or small Tribal size (tribal size adjustment);
- Consideration for those IHS Areas with limited or no access to the IHS Health Care Facilities Construction Priority System regarding funding for hospitals, health centers, staffing quarters, etc.;
- Utilization of a PRC Dependency Factor;
- How to weight providing health care in high cost Tribal areas;

- Consideration for the distance between Tribal primary care facilities and the nearest IHS/Tribal hospital;
- Consideration for the distance between Tribal primary care facilities and the nearest IHS or private sector hospital; and also, consideration of the types of services provided in those facilities;
- Adjustments to address the cost of travel or distance to IHS/Tribal hospitals;
- Adjustments to address the cost of travel or distance to inpatient or specialty care IHS or non-tribal hospitals;
- Consideration for those IHS Areas and/or sites who excel at Medicaid enrollment (i.e. sites with higher than average enrollment rates);
- Consideration for replacing user population with the number of patients seen in a facility, which may more accurately reflect the workload a facility experiences; and
- Documented comparisons between how IHS and Tribes provide services with how the private sector provides services are lacking and could help refine a benchmark.

The Workgroup felt it was important to document these items for future work on the Indian Health Care Improvement Fund.

WORKGROUP FINAL RECOMMENDATIONS

The Workgroup provides the following final recommendations to the IHS.

1. Benchmark. Maintain the Phase I recommendation to use the NHE data for categories 1-4.

2. User Count. Maintain the Phase I recommendation to adjust IHS's official user population count for national un-duplication and addition of non-PRCDA users, without adjusting for fractionalization. However, IHS should continue to work on fractionalization of the user population.

3. Alternate Resources. Maintain the Phase I recommendation to use IHS site-specific alternate resource enrollment data, with valuing and discounting; and to use the State average when a site's alternate resource data is missing or outdated. However, IHS should reach out to those sites with missing or outdated data and provide an opportunity for them to validate or update their information. This will ensure even greater accuracy in the alternate resources factor used in the formula.

See the Conceptual Diagram of the IHCIF Formula at Appendix C.

Final Report
APPENDIX A: Workgroup Charge

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville, MD 20857

JAN 2 6 2018

TO: Indian Health Care Improvement Fund Workgroup

FROM: Acting Director

SUBJECT: Workgroup Charge

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

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

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

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

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

Final Report
APPENDIX B: Workgroup Interim Report

INDIAN HEALTH SERVICE

INDIAN HEALTH CARE IMPROVEMENT FUND
WORKGROUP
INTERIM REPORT

June 2018

INDIAN HEALTH SERVICE
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Interim Report

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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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Joe Finkbonner, Tribal

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Theresa Galvan, Navajo
Dee Sabattus, Nashville

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Lynn Malerba, Nashville
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John Rael, Albuquerque
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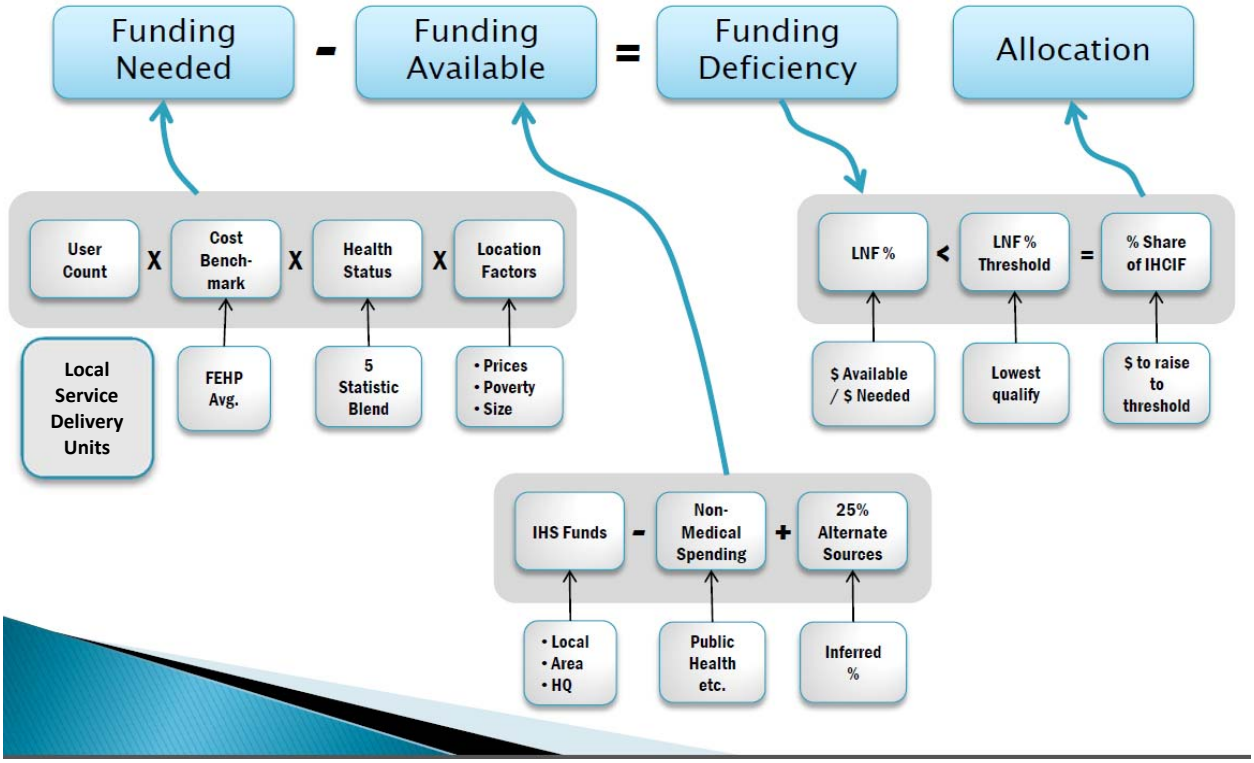
Leslie Racine, Billings
Dee Sabattus, Technical Advisor
Sarah Freeman Sullivan, Technical Advisor
Larry Voegele, Technical Advisor

APPENDIX D: Conceptual Diagram of Existing Formula



APPENDIX E: History of IHCIF Appropriations

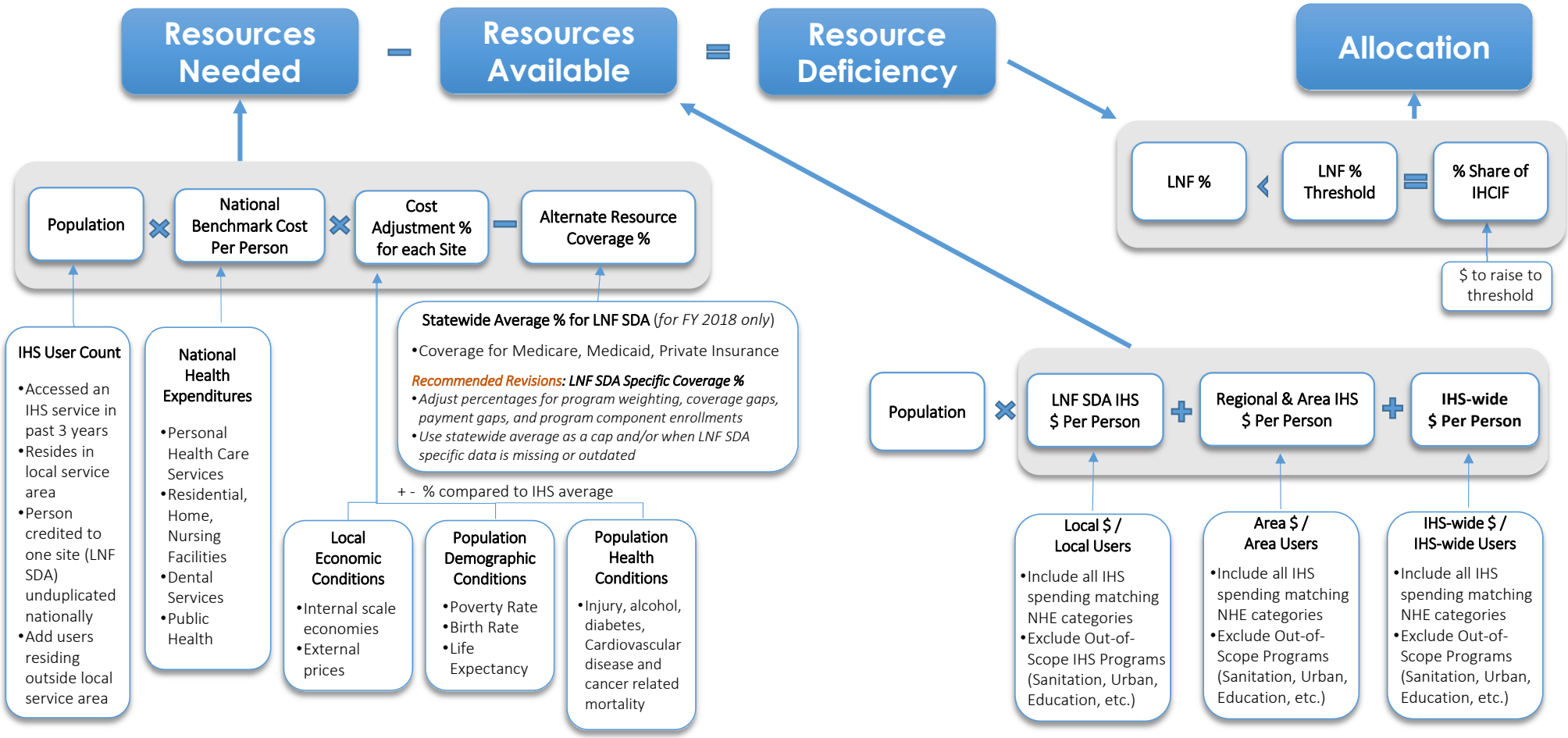
Indian Health Service
Indian Health Care Improvement Fund
Fiscal Year 2000 – Fiscal Year 2018

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

Final Report
APPENDIX C: Conceptual Diagram of the IHCIF Formula

Conceptual Diagram of the IHCIF Formula

(Reflects 2018 Revisions and *Recommended Revisions*)



Note: Resources needed by a Level of Need Funded (LNF) Service Delivery Area (SDA) may be equivalently expressed as either an aggregate amount or as a per person amount.