Purchased/Referred Care (PRC) Workgroup Update

Of the 12 Indian Health Service (IHS) Areas across the U.S. that support health services to Tribes, California (CA) is one of four that is designated as “PRC Dependent” or “Access to Care” deficient.

Eight IHS Areas have inpatient facilities funded by the IHS.

The Access to Care deficient designation applies to Areas that have no-to-few hospitals funded by the IHS.

Tribal Health Programs in CA must purchase all inpatient and other specialty care services for their AIAN patients using severely limited PRC funds.

In June of 2012, the Government Accountability Office issued a report finding that:

"…per capita PRC funding was sometimes not related to Areas' dependence on PRC for the provision of IHS-funded inpatient services. For example, California received a level of per capita funding that was in the lower half of the range for all Areas, while AIANs in that area rely entirely on PRC for their IHS-funded inpatient services because there are no IHS or Tribally operated hospitals... IHS can improve the equity of how it allocates program increase funds to Areas through improvements in its implementation of the PRC Allocation Formula [by refining among other factors]…the access to care factor to account for differences in available health care services at IHS and Tribally operated facilities."

The October 12, 2021 article entitled Hospital and Surgery Costs notes:

Hospital costs averaged $2,607 per day throughout the U.S., with California ($3,726 per day) just edging out Oregon ($3,271) for most expensive.

2018 Average Costs for Common Surgeries

- Heart valve replacement: $170,000
- Heart bypass: $123,000
- Spinal fusion: $110,000
- Hip replacement: $40,364
- Knee replacement: $35,000

- The funds allocated for PRC in CA was:
  - $55.8M in 2020
  - $56.4M in 2021
  - $68.9M in 2022

A critically important need exists in moving the Access to Care Factor from the Service Expansion category to the Maintain Current Services category in the PRC Funding Distribution Formula.

This will increase the potential for Tribes and THPs in Areas with no-to-little access to IHS funded hospitals to receive a more equitable level of funding for inpatient and specialty care services.

Tribes in CA have never received the amount of PRC funds that they need and AIAN patients are aware of this fact. As a result, many patients that warrant inpatient or other specialty care do not seek care through the PRC program. Thus, tracking deferred PRC services in CA is difficult.

5 PRC CATEGORIES AND ALLOCATION METHODS

	Funding Category	Purpose	Allocation Method	Comment
PRC	Recurring Base GAO - Base Funding	Stable funds for programs	Replenished annually	No formula calculation
PRC	Maintain Current Services* GAO - Annual Adjustment	Compensate for lost buying power due to population growth and inflation	Calculated in proportion to population and inflation growth	Fixed % to each PRC site
PRC	Congressional Earmarks*	Designated for particular tribes or purposes (e.g., new tribe)	Earmarked to each newly recognized tribe	Designated in appropriation text
PRC	Service Expansion* GAO - Program Increases	Expand services proportional to need	2-Part PRC Formula	Needs based calculation
CHEF	CHEF	Limited to catastrophic costs	Reimburse high cost cases	Requires documentation

* Allocated only if additional PRC funds are annually appropriated for this purpose

CA Area Tribal PRC Workgroup representatives met with a representative of the Northwest Portland Area Indian Health Board on March 18, 2022.

We exchanged PRC programmatic information and further committed to work together to move the Access to Care factor up in the PRC funding methodology.

If a majority of representatives in Areas that have access to IHS/Tribal hospitals attempt to dismantle the Access to Care factor or change it to their benefit, we discussed moving back to a position of no movement of the factor.

We would like to hear from Tribal leaders and Tribal clinic directors.