

***** SAMPLE TEMPLATE *****

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Re-designation of Purchased/Referred Care Delivery Area

AGENCY:: Indian Health Service

ACTION: Notice

SUMMARY: This notice advises the public that the Indian Health Service (IHS) is proposing to expand the geographic boundaries of the Service Delivery Area (SDA) for the [NAME OF TRIBE] ("The Tribe"). The Tribe's SDA is comprised of [name existing counties in Tribe's SDA]. These counties were designated as the Tribe's SDA when (describe when the PRCDA was established).

DATES: Comments must be received on or before [Federal Register insert 30 days after publication].

ADDRESSES: In commenting, please refer to file code [Federal Register insert file code number]. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a Comment" instructions.
2. By regular mail. You may mail written comments to the following address ONLY: Give the DRA Regulations Officer, Indian Health Service Address. Please allow sufficient time for mailed comments to be received before the close of the comment period.
3. By express or overnight mail. You may send written comments to the above address.
4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to the address above.

If you intend to deliver your comments to the address above, please call telephone number [enter DRA phone number] in advance to schedule your arrival with a staff member.

Comments will be made available for public inspection at the above address from 8:30 a.m. to 5:00 p.m., Monday - Friday, two weeks after publication of this notice.

SUPPLEMENTARY INFORMATION: Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment.

FOR FURTHER INFORMATION CONTACT: Director of the Office of Resource Access and Partnerships, Indian Health Service, 5600 Fisher Lane, 10E73, Rockville, Maryland 20857. Telephone number [enter number] (this is not a toll free number).

BACKGROUND: The IHS currently provides services under regulations codified at 42 CFR Part 136, Subparts A through C. Subpart C defines a Contract Health Service Delivery Area (CHSDA), now known as a Purchased/Referred Care Delivery Area (PRCDA), as the geographic area within which PRC will be made available by the IHS to members of an identified Indian community who reside in the area. Residence in a PRCDA by a person who is within the scope of the Indian health program, as set forth in 42 CFR 136.12, creates no legal entitlement to PRC but only potential eligibility for services. Services needed but not available at an IHS/Tribal facility are provided under the PRC program depending on the availability of funds, the person's relative medical priority, and the actual availability and accessibility of alternate resources in accordance with the regulations.

As applicable to the Tribe, these regulations provide that, unless otherwise designated, a Purchased/Referred Care Delivery Area (PRCDA) shall consist of a county which includes all or part of a reservation and any county or counties which have a common boundary with the reservation (42 CFR 136.22(a)(6)). The regulations also provide that after consultation with the Tribal governing body or bodies of these reservations included in the PRCDA, the Secretary may, from time to time, re-designate areas within the United States for inclusion in or exclusion from a PRCDA. The regulations require that certain criteria must be considered before any re-designation is made. The criteria are as follows:

- (1) The number of Indians residing in the area proposed to be so included or excluded;
- (2) Whether the Tribal governing body has determined that Indians residing in the area near the reservation are socially and economically affiliated with the Tribe;
- (3) The geographic proximity to the reservation of the area whose inclusion or exclusion is being considered; and
- (4) The level of funding which would be available for the provision of purchased/referred care.

Additionally, the regulations require that any re-designation of a PRCDA must be made in accordance with the procedures of the Administrative Procedure Act (5 U.S.C. 553). In compliance with this requirement, we are publishing this proposal and requesting public comment.

Pursuant to Tribal Resolution _____, dated _____, the Tribe requested the IHS to re-designate their current PRCDA, which incorporates [name of counties in existing PRCDA], to include [names of new counties to be added to PRCDA.]

In applying the aforementioned PRCDA re-designation criteria required by operative regulations criteria required by operative regulations 42 CFR 136.22, the following findings are made:

[PRCDA committee applies the Tribal specific facts to criteria (1) through (4) above.

- (1) By expanding, the Tribe estimates the current eligible population will be increased by [insert number].
- (2) The Tribe has determined that these [insert same number as above] individuals are socially and economically affiliated with the Tribe.
- (3) The expanded area including [insert all counties and states in the proposed PRCDA.
- (4) Generally, the Tribal members located in these counties in these states currently do not use the Indian health system for their PRC health care needs. The Tribe will use its existing Federal allocation for PRC funds to provide services to the expanded population. No additional financial resources will be allocated at this time by IHS to the Tribe to provide services to Tribal members residing in [expanded counties and states].

Accordingly, after considering the Tribe's request in light of the criteria specified in the regulations I am proposing to re-designate the PRCDA of the Tribe to consist of [names of all counties in PRCDA].

This notice does not contain reporting or recordkeeping requirements subject to prior approval by the Office of Management and Budget under the Paperwork reduction Act of 1980.

_____ [

[insert Director's name]
Director, Indian Health Service

Date

PROCESS FOR EXPANSION OR REDUCTION OF A PURCHASED/REFERRED CARE
DELIVERY AREA

1. Two Options to Request a Change in PRCDA

- A. Administrative
- B. Congressional

The Indian Health Service (IHS) and the Department of Health and Human Services (HHS) are not involved with this option

2. Administrative Option

The process to expand the PRCDA for a Tribe is described in the regulations and the Indian Health Manual. Since requests for expansion of a PRCDA are thoroughly reviewed, the material

should be clear.

A. The Tribe should provide the following types of information in writing to the Area Director:

- (1) A resolution in support of the PRCDA expansion.
- (2) State the county(s) proposed to be added or deleted from the existing PRCDA.
- (3) The number of Indians residing in the counties proposed to be included or excluded.
 - a. identify the number of members of the Tribe residing in each county.
 - b. identify the number of members of other Federally-recognized Tribes residing in each county.
- (4) Whether the Tribal governing body has determined that Indians residing in the proposed added county(s) are socially and economically affiliated with the Tribe; if the Tribe is granting close ties to members of other federally recognized Tribes, how many additional individuals will be eligible for PRC in each county to be added to the existing PRCDA?
- (5) The geographic proximity to the reservation of the county(s) whose inclusion or exclusion is being considered.
- (6) The level of funding which would be available for the provision of PRC if the requested expansion is approved.
- (7) The total number of new users.
- (8) The additional number of clinical work units.
- (9) The potential added costs.
- (10) The total resources already available.
- (11) The current level of need funded.
- (12) The anticipated decrease in level of need funded.

- (13) List the metropolitan areas that are included in the proposed expansion.
 - (14) List other Tribes whose PRCDA are included in the proposed expansion; identify by county the other Tribes whose PRCDA already include the counties which are in the proposed expansion.
 - (15) Other information which would support the request such as maps, narratives describing the Tribes' concerns, etc.
- B. The Area will analyze the proposal outlining positive and negative features, and will recommend acceptance or rejection over the signature of the Area Director to the Director, IHS. The Area should submit for Tribes that have a reservation a draft PRCDA re-designation Federal Register notice using the template developed by the Division of Regulatory Affairs.
- C. The Director, IHS will either approve or disapprove the requested change in a Tribe's PRCDA. However, for Tribes that have a reservation a decision of the Director, IHS to approve expansion of a Tribe's PRCDA will not be effective until the date a final rule is published in the Federal Register.

Note: Expanding a PRCDA does not automatically increase the funding to a Tribe.

GUIDELINES FOR ESTIMATING FINANCIAL IMPACT OF CREATING OR EXPANDING PURCHASED/REFERRED CARE DELIVERY AREA

1. Identify a Count of Eligible Purchased/Referred Care Beneficiaries. Determine the count of Indian people who will be eligible for Purchased/Referred Care (PRC) coverage in a new or expanded Purchased/Referred Care Delivery Area (PRCDA) (reside in the added Counties or portions of counties). Data considerations are:
 - A. All PRCDA correspondence with county and county subdivisions.
 - B. Census counts of American Indian/Alaska Native (AI/AN) for counties and subdivisions. Census counts are "self-identification" and may include members of Tribes that are not Federally-recognized. Adjustments may be necessary.
 - C. Are Tribal roles with place of residence available to help estimate potential PRC beneficiaries?
 - D. Enrollment lists if available.
 - E. Work closely with the Area Office Statistical/Planning office on the Areas and with Office of Program Statistics in Headquarters to estimate potential eligible beneficiaries.

2. Identify Subsets for PRC and Direct and PRC Only. Identify newly eligible PRC beneficiaries who get some health care services from existing IHS, Tribal, or Urban (I/T/U) hospitals/clinics. This combination is known as (PRC and Direct). The balance of beneficiaries [PRC Only] do not obtain services from I/T/U sites and rely on PRC to the extent their health care costs are not covered by alternate sources such as health care insurance; Medicare or Medicaid. Anticipated PRC costs for beneficiaries dependent on PRC exclusively can be higher than for those who obtain direct care services.
3. PRC and Direct Count. The PRC and Direct Count is that portion of newly PRC eligible count (#1) that obtains some services at I/T/U sites. Considerations:
 - A. Consult with the statistical office to obtain counts (if any) for AI/AN residing in the PRCDA who use IHS/Tribal/Urban direct care facilities.
 - B. Will these users continue to obtain direct care services after obtaining eligibility?

[PRC Only Counts]. The PRC Only Count is derived from the total eligible count in #1, subtract the [PRC and Direct Count].

4. Net Counts Considering Other Coverage. Experience shows that some eligible AI/AN do not seek Federal IHS health care services - especially if health benefits are provided through their employers. There would be little financial impact by eligible AI/AN who do not use program. To reduce the eligible beneficiary counts by a percentage for expected non-use:
 - A. $[\text{NET PRC and Direct Count}] = 2.a) \times [100\%]$. Existing users have demonstrated they will seek IHS services and would likely continue seeking IHS services after PRCDA expansion. Unless exceptional circumstances warrant, the expected utilization factor is 100% for those already seeking services.
 - B. $[\text{NET PRC Only Count}] = [2.b] \times [\text{Utilization } 5]$. Use judgment to estimate a reasonable utilization percentage based insurance coverage, employment, or other related data. The judgment should consider actual experience if available, distance to source of care, employment rates, and other knowledge about the circumstances in the PRCDA that are reasonable factors in predicting utilization by newly eligible beneficiaries that have no direct services.
5. PRC Cost Benchmarks. There is no standard for PRC costs per person because there is no fixed set of benefits assured under all IHS PRC programs. The extent and scope of PRC costs varies at the local level. All PRC services (or payments) are rationed uniquely in each service unit and over time depending on funds availability. In lieu of a fixed standard, the cost benchmarks below are suggested as guidelines for estimating cost impacts.

The Federal Disparity Index (FDI) methodology computes a cost per person for a comprehensive personal health care services plan similar to that available to federal employees. It accounts for local regional cost variations, other factors such as health, and discounts for expected levels of reimbursement from other sources. The 2015 FDI estimate is \$4,817 per person annually net of

expected reimbursements and cost avoidance for Medicare, Medicaid, and PI.

In an existing PRCDA in which direct care services are also available, approximately 30% of medical services are purchased from outside sources. Such purchases are often paid from the PRC account. Therefore, the average portion of the FDI cost benchmark would be $.3 \times \$4,817 = \$1,445$ per user per year. But this national average masks wide variation at the local level. Purchase percentages range from 15% to 90% depending on the extent of services available at the I/T/U site. A more refined estimate will account for whether direct services are limited to ambulatory care or include some hospital care.

We further assume that most secondary and all tertiary care services would be obtained from private sources and paid under PRC. Choose an appropriate benchmark depending on the extent of direct care services available to the PRCDA:

A1. If Only Ambulatory Care is available at I/T/U sites:

$$[\text{PRC and Direct Cost}] = 40\% \times \$4,817 = \$1,927$$

Direct Ambulatory care is accessible. PRC will pay for hospital and most secondary and tertiary ambulatory care. Beneficiaries with access to I/T/U ambulatory care only will have higher PRC cost impact.

A2. If Both Ambulatory and Hospital Care are available at I/T/U sites:

$$[\text{PRC and Direct Cost}] = 20\% \times \$4,817 = \$963$$

Direct Hospital and Ambulatory care is accessible. PRC will pay for most secondary and tertiary care whether ambulatory or inpatient. Beneficiaries with access to I/T/U ambulatory care and hospital care will have lower than average cost.

B. If neither Ambulatory nor Hospital Care are available at I/T/U sites: $[\text{PRC Only Cost}] = 100\% \times \$4,817 = \$4,817$

6. Estimate Financial Impact. The financial impact is based on separate factors;

A. Financial Impact [CHS and Direct]:

If Only Ambulatory Direct Care is Available

$$[3a: \text{NET PRC and PRC Count}] \times [4a1: \$1,927] \text{ or}$$

If ambulatory and Hospital Direct Care are Available

$$[3a: \text{NET PRC and Direct Count}] \times [4a2: \$963]$$

B. Financial Impact [PRC Only]

$$[3b: \text{NET PRC Only Count}] \times [4b: \$4,817]$$

C. Total Financial Impact = A + B.