Indian Health Care Improvement Fund

GENERAL QUESTIONS

Q1: Why does IHS receive Indian Health Care Improvement Fund appropriations?
A1: 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 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.

Q2: Does the IHS receive IHCIF funding every year?
A2: No, the IHS does not receive IHCIF funding every year. The IHCIF has received funding increases in 10 of the last 19 fiscal years, i.e., since fiscal year (FY) 2000. The last new funding appropriated prior to FY 2018 funding was in FY 2012.

Q3: How much funding has IHS received FY 2000?
A3: Including the $72 million received in FY 2018, IHS has received approximately $258 million in IHCIF funding increases.

Q4: Are IHCIF funds provided for one year or are they recurring?
A4: Except in one year, all new funding has been allocated recurring to the Level of Need Funding Service Delivery Area level.

Q5: What is a Level of Need Funded (LNF) Service Delivery Area (SDA)?
A5: A LNF SDA is a term for an IHS or Tribal health care site/facility/program that should, if fully funded, assure a full range of medical services, onsite or by referral, to American Indians/Alaska Natives (AI/ANs) residing in a specific nearby geographic area. The Level of Need Funded (LNF) calculations and allocations therefore reflect the “local” granularity of the actual health care tribes/organizations.

Q6: Is a LNF SDA the same as a Purchased/Referred Care Delivery Area (PRCDA), formerly known as a Contract Health Service Delivery Area (CHSDA)?
A6: No, a LNF SDA is not the same as a PRCDA. A LNF SDA is the current terminology used to describe how the IHCIF will be allocated. LNF SDAs are based on facilities. A PRCDA are based on counties rather than facilities. In many cases, the LNF SDAs for a group of facilities is the same as the IHS Service Units.

Q7: What do you mean when you say Level of Need Funded (LNF)?
A7: A way to measure health care resource deficiency for all health care sites within the IHS/Tribal system. IHS calculates the resources needed, subtracts the resources available and this provides the funding deficiency. When expressed as a percentage this is the LNF percentage assigned to individual LNF Service Delivery Areas. LNF is also referred to as the Federal Disparity Index (FDI).

Q8: How are funds distributed?
A8: During the most recent distribution in fiscal Year (FY) 2012, funds were distributed by formula to LNF SDAs with the lowest LNF scores. Sites below 44.8% LNF received an allocation of the funding increase.

Q9: Will all severely underfunded sites qualify for IHCIF formula funds?
A9: Unfortunately, IHCIF funding available in FY 2018 ($72 million) is insufficient to reach all underfunded sites. The statute specifies that IHCIF funds go where deficiencies are greatest. The LNF methodology identifies resource deficiencies at more than 90 percent of IHS and Tribal health care sites totaling in excess of $5 billion. Thus, $72 million will reach only a fraction of sites and raise the overall IHS average LNF to less than 1 percent.

Q10: How many sites receive funding?
A10: This depends on the amount of funding available and the distribution methodology. For the last distribution of $11.9 million in FY 2012, 86 (31.7%) of the 271 LNF SDAs received funding.

Q11: What was the range of funding for Service Delivery Areas in FY 2012?
A11: Amounts allocated to LNF SDAs ranged from $1,000 to $1,303,877.

Q12: What is the difference between the Level of Need Funded (LNF) determination and the IHCIF distribution methodology?
A12: IHS calculates the LNF to determine the resources a site needs to reach a target funding level (i.e., a cost adjusted resource benchmark) tied to a standard package of health care services to be available at all sites. Actual IHS resources available at each site are compared to the needed resources to identify the sites with the greatest funding need, i.e., LNF funding gap between needed and available resources. The IHCIF distribution methodology allocates IHCIF funds in proportion to the LNF calculated funding gap. The number of sites qualifying for funds depends on the amount of IHCIF funds available.

Q13: How often does IHS update the LNF determination and the IHCIF distribution methodology?
A13: The data used in the LNF calculation have been updated periodically depending on IHCIF funding from Congress. An IHS-Tribal IHCIF Workgroup reviewed the LNF/IHCIF formula and provided a Workgroup report to IHS in 2010. The IHS initiated Tribal consultation in December 2010 and made a final decision not to change the formula in November 2011.

Q14: Where can I find documented information from the current and past reviews, and consultations?
A14: Documents are available on the IHS website on the IHCIF webpages at https://www.ihs.gov/ihcif/.

DETERMINING THE LEVEL OF NEED FUNDED

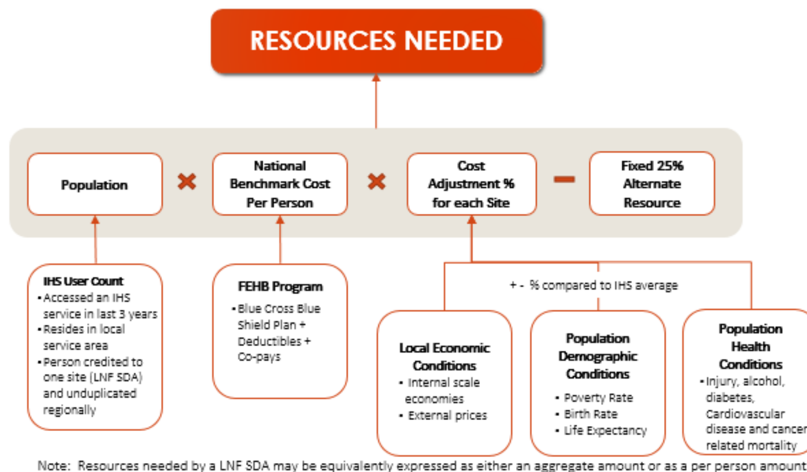
Q15: Why is the IHCIF calculated for LNF "Service Delivery Areas"?
A15: The IHCIF statute refers to tribes, which currently is composed of 573 federally recognized tribes. Tribes organize their health care systems differently. Some rely on IHS hospitals and clinics for direct care, contract or compact to operate IHS program, services, functions, or activities. Some smaller tribes, join a consortium that serves multiple tribes. Some authorize subsidiary organizations to operate

portions of their programs and rely on IHS for other parts. In the methodology a LNF Service Delivery Area (SDA) is a term for an IHS or Tribal health care site/facility/program that should, if fully funded, provide access to services, , onsite or by referral, to AI/AN residing in a specific nearby geographic area. The LNF calculations and allocations therefore reflect the "local" granularity of the actual health care tribes/organizations.

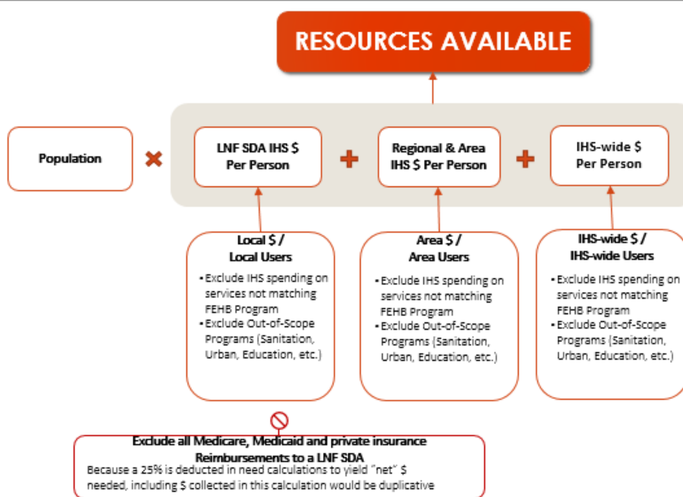
Q16: What factors go into determining the LNF?

A16: The factors include factors for resources Needed (i.e., a user count, cost benchmark, health status adjustment and location factors) and factors for resources Available (i.e., IHS funds, Non-Medical spending and Alternate Resources).

Existing Calculation of resources Needed



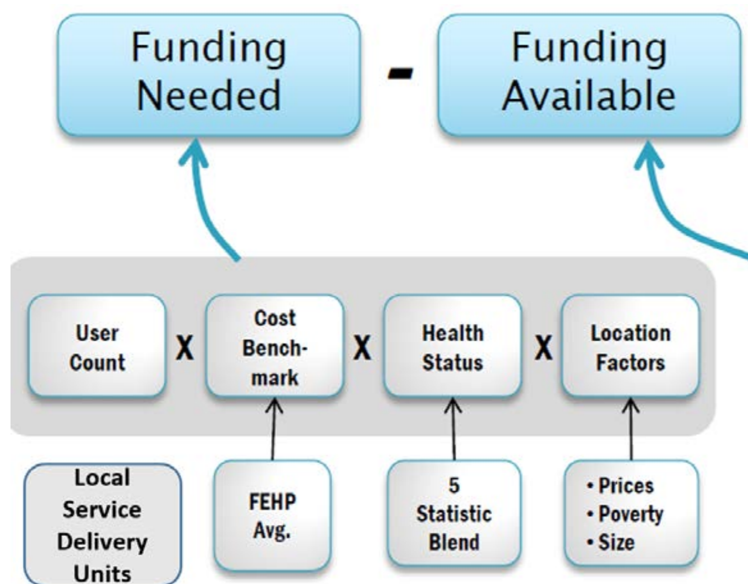
Existing Calculation of resources Available



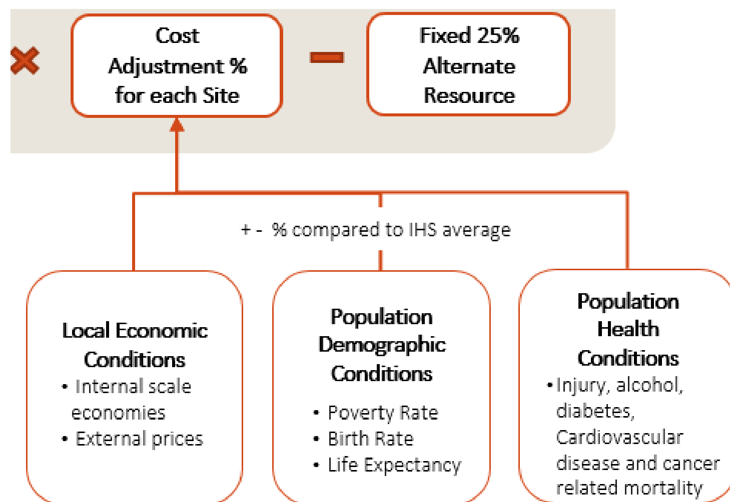
Q17: What user count (population) is currently being used (based on the 2012 Tribal consultation)?
A17: The LNF methodology calculates resources needed by AI/AN populations residing in the geographic service areas defined for IHS and Tribal health care facilities and programs. The user population (unduplicated within each IHS Area) is the count of AI/AN individual's receiving health care services from the IHS or Tribe during the most recent 36 months. AI/ANs residing in urban areas located within IHS service area boundaries, who go to an IHS or tribal program are included in user counts. AI/ANs who obtain services from an Urban Indian Health Program are not included in IHS and Tribal user counts, unless the individual also obtains services from an IHS or Tribal facility. The population of AI/ANs potentially eligible for IHS services in certain states may be higher than the actual user count.

Q18: What cost benchmark is currently being used?
A18: The Federal Employee Health Benefit (FEHB) Program Blue Cross and Blue Shield (BC/BS) Plans has been the benchmark. This includes all costs to provide the insurance coverage for the federal employee (e.g., government cost, premiums, co-pays, etc.).

Q19: What factors are associated with cost adjustments for the benchmark at the SDA level?
A19: In the past the cost adjustment factors were represented on the graphic as "Health Status" and "Location Factors".

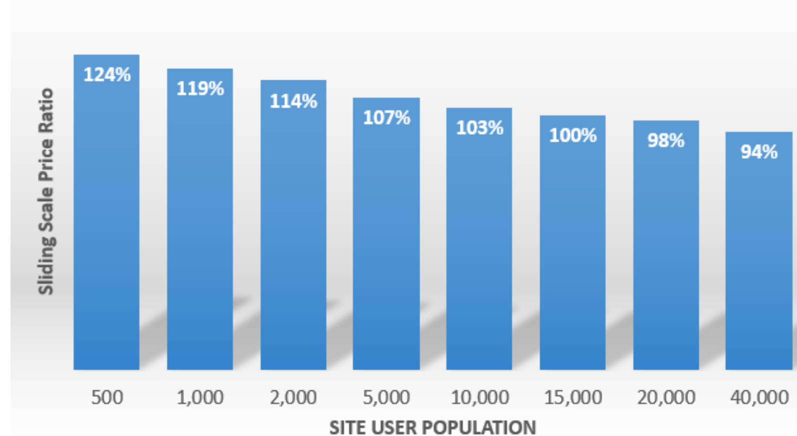


To make it easier to understand the cost adjustment is now shown as three conditions in the new graphic: local economic conditions (previously called location factors), population demographic conditions, and population health conditions.



Q20: Explain the Local Economic (or location) Conditions?

A20: Economic factors adjust resource allocations to reflect business and operating conditions, looking at internal scale economics (including organization size) and external prices. Internal scale economics assumes, smaller health care organizations (LNF SDA) often experience disproportionately higher costs. The LNF formula has an adjustment to account for economies of scale, providing an increased adjustment to the local benchmark cost. The increment follows a mathematical curve rather than a straight-line proportion. The maximum increment applies to organizations serving less than 500 people.



External prices looks at prevailing health care prices. Data for these costs is gathered from the County level health care price indices (Source: C2ER.com - Council for Community and Economic Research). County price indices are mapped to LNF SDAs, often by selecting the centroid of a multi-county LNF SDA. These factors compensate for price variation in health care costs that vary geographically place to place. That is, among populations equal in all other respects, incrementally more IHCIF allocations go to populations located in places with disproportionately high prevailing health care prices. Location based price statistics in the model are derived from Centers for Medicare & Medicaid Services/Office of Management and Budget (CMS/OMB) reimbursement ratios for Alaska and Lower 48 States.

Q21: Explain the population demographic conditions?
A21: Population demographic conditions reflect population conditions which include: birth rates, life expectancy and poverty-rates. Poverty-rates for Areas are published by IHS in the Trends in Indian Health book and apply within an Area, but vary among Areas, like health status. For this reason, Poverty is calculated in same way as health status adjustments in the same calculation module.

Q22: What are the Population Health Conditions (Disease Factors) currently being used in the LNF?
A22: Disease factors adjust resource allocations to compensate for higher health care costs in populations with disproportionately poor health and reflect population conditions that merit separate prominence. That is, among populations equal in all other respects, incrementally more IHCIF allocations go to populations with a higher 5 statistic weighted blend that includes mortality rates for Injuries, Alcohol, Diabetes, Cardiovascular Disease, and Cancer. The adjustment is based on Area mortality statistics. Consequently, the adjustment is identical for each LNF SDA within an Area, but different Areas have different adjustments.

Q23: Explain the role of "IHS funds"?
A23: Resources available from the IHS (appropriated funds) are compared to resources needed for populations, e.g., per person. This compensates for variations in resources available from the IHS. That is, among populations equal in all other respects, incrementally more IHCIF allocations go to the populations with the lowest per capita IHS funding. The allocation increment depends on the IHCIF funding available. By law, only the least funded populations qualify for allocations. IHS available funding consists of 3 parts:
1) Local per capita funds – IHS funding expended locally that benefit the local population
2) Area per capita funds – IHS funding expended in the area that benefit Area populations
3) IHS-wide per capita funds – IHS funding expended nationally that benefit IHS-wide populations

Q24: Are all IHS funds counted as available for comparison to the benchmark?
A24: Almost all IHS funds are counted as available with respect to the IHCIF definitions of need. Most direct clinical services are counted, however even some clinical line items and not counted in their entirety of they do not align with the benchmark. For example, when compared to the FEHB Program benchmark, only 10% of the IHS dental program appropriation was used in the calculation since the dental benefit for the FEHB Program is limited. Other categories are excluded because of statutory prohibitions or purposes unrelated to health services defined for the IHCIF are:
1) Urban Indian Health Projects
2) Indian Health Professions (Scholarship and Loan Repayment)
3) Tribal Management Grants
4) Tribal Self-Governance Grants and Planning
5) Sanitation Projects

Q25: Explain the role of "alternate" resources?
A25: The statute defines resources available to include all resources not only resources provided by the IHS. Alternate resources available (e.g., Medicare, Medicaid and private insurance) are among the most important determinants in the resource allocation model. Alternate resources available are offset from the calculation of needed resources to yield the "net" resources needed to fully fund IHS programs. Alternate resources available to populations can vary significantly. This measure compensates for

variations in alternate resources available, e.g., greater alternate resources result in lower need for IHS resources.

Q26: When talking about alternate resources is the formula just looking at collections from Medicare, Medicaid and private insurance?
A26: When referring to alternate resources, IHS is trying to determine the impact of third-party resources on the benchmark cost for a specific LNF SDA. This would include possible collections for direct care services provided to a patient, cost savings to the IHS or Tribe when a patient is referred for care (the IHS or tribe would not receive any reimbursement but would save funds when Medicare, Medicaid or private insurance payed part or all of the medical bill) and when the patient self-refers for care with the cost payed for by their public or private insurance.

DISTRIBUTION METHODOLOGY

Q27: How were funds distributed in 2012?
A27: For the 2012 IHCIF distribution, LNF SDAs with a LNF score below 44.8% received funding to bring all LNF SDAs up to at least 44.8% of LNF. This resulted in 86 LNF SDAs receiving funding.

Q28: What are the advantages and disadvantages toward establishing a minimum and maximum funding distribution?
A28: A minimum amount (if, hypothetically, set at $50,000) would support practical measurable intervention / result, e.g., such as hiring 1 FTE. The raw calculation can sometimes yield allocation amounts that are too small for feasible interventions / results. A maximum amount (if, hypothetically, set at $5,000,000 per site for instance) would result in expanding the number of qualifying recipients.

Q29: Why are funds not distributed according to the tribal shares formula or by user population?
A29: The tribal shares formula and the IHCIF formula are guided by different statutes and purposes.

1) The tribal shares formula allocates funding by programs/services/functions/activities to a tribe in proportion to the resources benefiting each tribe – typically a per person calculation. The statutory intent is to transfer existing resources "as is", rather than alter resources available to each tribe.
2) The IHICF formula differs fundamentally. Rather than transfer "as is" resources, the intent is to allocate additional appropriated funds among populations in priority order reflecting "unmet need." The tribal shares formula splits existing resources proportionately among all tribes. The IHCIF first targets the neediest populations, e.g. a rising tide first floats the lowest boats.

Q30: Why don't locations without access to an IHS hospital receive a higher score or a portion of the funding similar to the PRC distribution methodology?
A30: The LNF/IHCIF methodology is a blend of comprehensive cost measures (size and cost indices for instance) some of which are correlated with hospital availability. The PRC methodology targets gaps in inpatient care availability. The LNF/IHCIF methodology targets gaps measured more comprehensively across the complete range of necessary health care. For example, national health expenditure statistics show that inpatient spending is only 30% of total health care spending overall. Therefore, the inpatient category composes only 30% of all needed resources in the LNF too. Most IHS/Tribal hospitals provide

limited inpatient care and refer most complex cases to other hospitals using Purchased/Referred Care (PRC) funding. Costs for complex admissions makeup a high proportion of total inpatient costs. This means an available IHS hospital accounts for only about 15% of the resources measured by the LNF methodology. The balance, 85% of LNF resources are needed for the complete range of health care services including the inpatient cases referred outside the hospital. Thus, an available IHS/Tribal hospital accounts for only 15% of inpatient resources onsite -- the remaining 15% balance for such a hospital is needed for PRC referrals. Together, onsite and referral make up 30% for inpatient overall costs. Moreover, where an IHS/Tribal hospital is not accessible, the LNF methodology calculates the full 30% for inpatient care as referral care. This means on average, the LNF calculates the full 30% of the benchmark (~$2,870 inpatient costs per person) regardless of whether a hospital is present or not. The only meaningful distinction is that funds needed by an IHS/Tribal hospital are a mix of H&C and PRC categories, whereas funds are needed exclusively in PRC for LNF SDAs without a hospital.

IHS-TRIBAL IHCIF WORKGROUP RECOMMENDATIONS

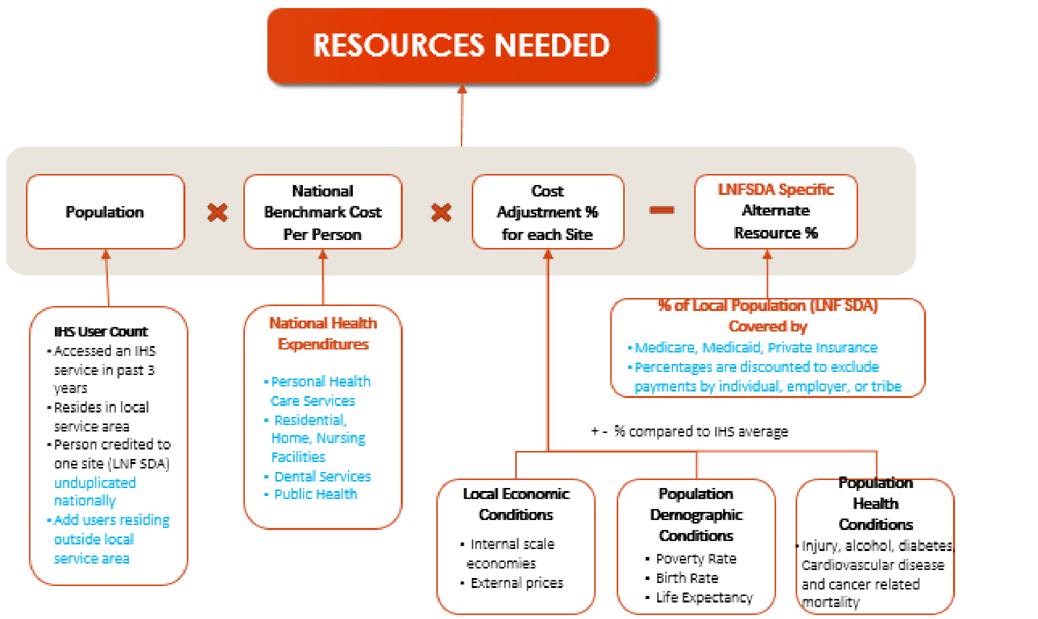
Q31: How were the members of the IHS-Tribal IHCIF Workgroup selected?
A31: The IHS Acting Director sent out a Dear Tribal Leader Letter on November 13, 2017 asking each IHS Area Director to appoint a Federal and a Tribal member to the workgroup. Tribal leaders interested in being a primary or alternate Tribal representative were asked to contact their local Area Director by December 1, 2017.

Q32: Who are the members of the Workgroup?
A32: The list of IHS and Tribal members is available on the IHCIF webpage at www.ihs.gov/ihcif/.

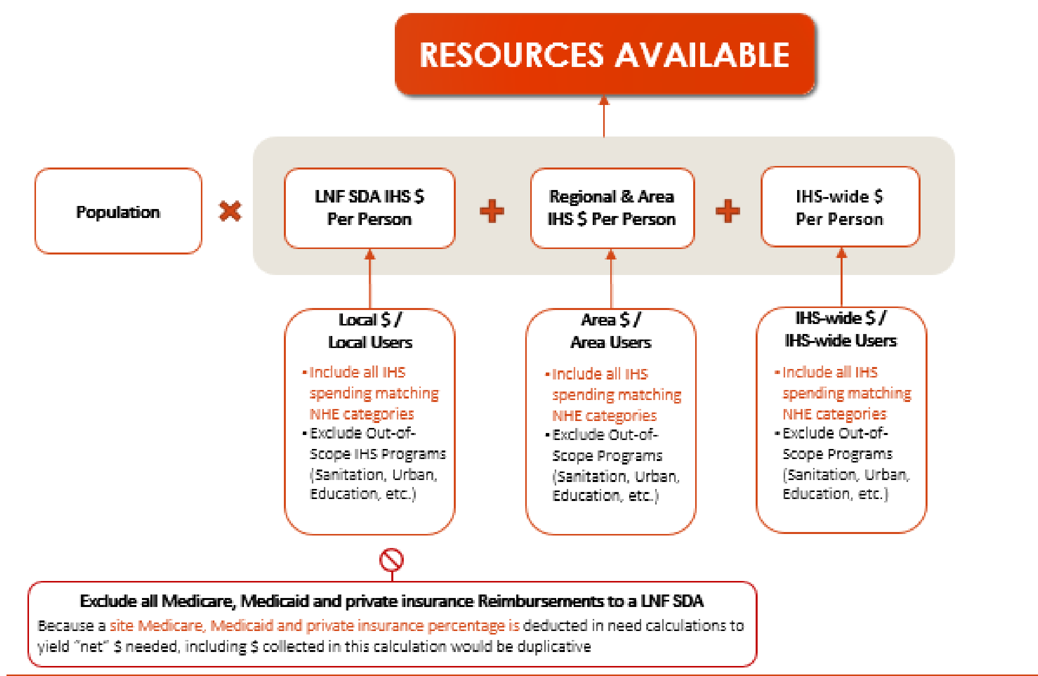
Q33: What are the Workgroup recommendations for FY 2018 LNF determination and the IHCIF distribution methodology?
A33: The Workgroup proposed revisions include:

1) Replace the FEHB Program insurance benchmark with a broader, comprehensive benchmark derived from National Health Expenditures (NHE) data (Categories 1-4). This expands the categories of IHS funds that are counted as available and includes authorized, but unfunded, programs in the LNF calculations.
2) Change the existing user count using regional unduplication to national unduplication (to get a more accurate user count) and add non-resident AI/ANs who use IHS/Tribal programs to the User Count (non-Purchased/Referred Care Delivery Area users). Non-resident means AI/AN persons who reside outside boundaries of IHS service areas who are not included in routine user counts.
3) Replace the flat 25% alternate resource discount with a more precise estimate (see explanation below) that varies among populations based on Medicare enrollment, Medicaid enrollment, and Private Insurance enrollment.

Proposed Calculation of resources Needed



Proposed Calculation of resources Available



Q34: How would changing the benchmark from the FEHB Program to the NHE impact the LNF nationally?

A34: Changing the benchmark from the FEHB Program to the NHE is expected to significantly increase the LNF. Using FEHB Program as the benchmark, the anticipated national average per person total needed is $7,599 (for FY 2017). Changing to the NHE will allow IHS to include clinical programs (e.g.,

dental) that are not fully comparable to the FEHB Program benchmark and to include authorized but unfunded provisions of the IHCIA (e.g., long term care). Using the NHE as the benchmark would raise the 2017 national average per person total needed to approximately $9,726. With over $1.6 million IHS active users this increase the LNF by over $3.5 billion for IHS and Tribal programs.

Q35: How would changing the benchmark from the FEHB Program to the NHE impact the LNF SDAs Level of Needed Funded percentages?
A35: While the rank order for possible IHCIF awards would not change, using the NHE as the benchmark would reduce the LNF percentage for all sites. But it is important to remember that other recommendations changes can impact the LNF as well.

Q36: What is the impact on the user population on changing from regional unduplication to national unduplication of user counts?
A36: This would create a more accurate user count by reducing the number of individuals counted in more than one Area (duplicates). This would cause a slight reduction in the overall user count.

Q37: What is the impact of adding non-resident AI/ANs who use IHS/Tribal programs to the user count?
A37: There are approximately 49,000 active users who are not being counted in the user count because they do not reside in the Purchased/Referred Care Delivery Area (PRCDA), formerly known as a Contract Health Service Delivery Area (CHSDA). Adding these users would increase the user count and lead to a more accurate count of total users.

Q38: Does a patient who is seen in more than one facility get counted for each LNF SDA visited?
A38: The current process and the proposed Phase I process only allows an individual to be counted in one location, based on the person's place of residence. We realize that all LNF SDA that a person-visits expend resources to provide health care services to the individual. The Workgroup discussed this issue and will be exploring a process to count a percentage of the user population for each LNF SDA that provides care to the individual (a process called fractionalization). This will be discussed in the Phase II discussions beginning in August or September 2018.

Q39: Did the Workgroup look at using service population rather than user population?
A39: Yes. The Workgroup discussed the possibility of using service population (individuals eligible for services) rather than user population (individuals who had received services within the last 3 years). There were a number of concerns with using service population including: the data is self-reported to the U.S. Census, the data is currently only available to the county level rather than the LNF SDA level, and LNF SDA near a large urban area could have a large service population disproportionate to their actual users. The Workgroup felt that using information on actual users (user population) provided a more accurate representation for LNF SDA for calculation of the LNF.

Q40: Why is the Workgroup proposing to change the 25% across-the-board alternate resource calculation?
A40: In the formula from 2012, a 25% alternate resources calculation was used for all LNF SDAs. This percentage has been used since that time because data on alternate resources was limited. The

Alternate Resources factor does need to be changed since it does not reflect changes to the healthcare system (e.g., Medicaid expansion) and does not reflect differences in alternate resources between LNF SDA locations. Using a single factor for all sites underestimates alternate resources for sites with high third party enrollment and overestimates alternate resources for sites with low third party enrollment.

Q41: Does IHS use third-party collection data to determine the alternate resource rate?
A41: While all federal and some Tribal locations report third-party reimbursement data to IHS, not all Tribal sites report this information. IHS does not require Tribal sites to report this data, so IHS cannot use IHS and Tribal reimbursements data for this calculation.

Q42: If IHS cannot use reimbursement data, what data is used?
A42: The Alternate Resources sub-workgroup recommended using third-party enrollment data as the alternative. Most IHS and tribal sites provide alternate resource enrollment data to the National Data Warehouse. If a site does not report enrollment data, a statewide average would be used.

Q43: Isn't it unfair to use Medicare enrollment data for LNF SDAs that do not include hospitals since they cannot bill for Medicare Part A?
A43: The formula also includes estimates for IHS and Tribal referrals and self-referrals for care. Medicare Part A enrollment is included because Medicare Part A is paying part or all the cost of inpatient stays (saving PRC funds), hospice care, skilled nursing facility care and some other health care when a patient is referred by the IHS or Tribal facility or when the patient self-referred for care. While the LNF SDA is not receiving any supplemental funding through collections, they are not having to expend resources for costs covered by Medicare Part A.

Q44: Why does the formula not include Medicare Part D and Veterans Health Administration coverage?
A44: The data for these two coverages is incomplete or non-verifiable and is not considered accurate enough to use in the formula at this time.

Q45: Why does the formula not include private insurance?
A45: The Alternate Resources sub-workgroup felt that only third-party coverage provided by the government should be included in the Alternate Resources calculation. Since private insurance is either earned by the employee (as part of the employment compensation package) or paid for directly by the individual, the sub-workgroup felt it should not be included in the calculation.

Q46: What other assumptions did the Alternate Resources make with developing the formula?
A46: The sub-workgroup wanted a formula that was rationale, reasonable, manageable, fair and equitable. The formula would not be a measure of collectability, but a measure of who is paying at what levels (offset). The sub-workgroup did not want to count resources that tribes or Tribal members pay (i.e., cost sharing, premiums, employee compensation/benefits and they would only count resources provided by the federal government.

Q47: What percentage of the IHS user population was enrolled in some type of insurance?
A47: Based on 2017 insurance enrollment data from the IHS National Data Warehouse (NDW), the Alternate Resources sub-group reported that approximately 74.1% of the user population were enrolled in some type of insurance. A total of 25.9% were either uninsured or had no insurance information reported to the NDW. Enrollment rates varied by IHS Area from a low of 60.2% to a high of 90.3%. Medicaid enrollment was the most common type of insurance.

Q48: What kind of analysis did the Alternate Resources sub-workgroup do to determine the value of Medicare and Medicaid coverage?
A48: The sub-workgroup compared Medicare and Medicaid to the National Health Expenditure benchmark to determine, at a national level, the value of the Medicare and Medicaid coverage (how well they matched up for Essential Health Benefits (EHB), Long-Term Care Services (LTCs) and Dental Services). They determined that the value of coverage for Medicare (Parts A, B and D) was 55% and for Medicaid it was 100%.

Q49: Why is it important to determine the value of health insurance coverage?
A49: It is important to be able to adjust the net value of health insurance coverage. As an example if a facility had 41.3% enrollment in Medicaid and 10.1% enrollment in Medicare and the value of coverage for Medicaid was 100% and for Medicare was 55% then the value of coverage for the site for these two insurance types would be 46.9% (Medicaid 41.3% x 100% and Medicare 10.1% x 55%).

Q50: Did the Alternate Resources sub-workgroup identify any potential concerns related to the alternate resource calculation?
A50: The sub-workgroup wanted to make sure that LNF SDAs that have higher-than-average enrollment percentages of the user population in third-party insurance were not penalized. This could be done by limiting the value of insurance coverage for a LNF SDA to the statewide average. This way sites with high enrollment are not penalized. Due to HIPAA issues, the workgroup was unable to see data for all LNF SDAs when developing their calculations. They requested IHS check the LNF SDA data to assure that it is accurate for use in the final calculations.

Q51: How are Alternate Resources calculated when LNF SDAs cross state lines?
A51: The sub-workgroup proposed using averages for each state.

Q52: If after the comment period IHS believes the Alternate Resource calculation is not ready to be implemented for FY 2018, will IHS use the previous 25% or another percentage?
A52: The proposed change to the alternate resources component it the LNF calculation would look at available alternate resource enrollment data by LNF SDA (or State, if the LNF SDA data was unavailable). The data would be adjusted to reflect weighted averages based on coverage. LNF SDAs with high third-party enrollment would be capped at the state average. This change would lead to most LNF SDAs having alternate resource percentages between 30% and 41% rather than the current 25%. If the current proposed Alternate Resource calculation is not used, IHS would need to decide whether to use the current 25% or a higher figure that more accurately reflects current Alternate Resources.

Q53: Some states have Medicaid expansion while other states have severely limited Medicaid eligibility. Does the IHCIF formula account for this?
A53: Yes. The proposed alternate resource calculation explicitly depends on AI/AN Medicaid enrollment data. Typically, the percentage of AI/ANs enrolled in Medicaid is higher in states that expanded.
Q54: How do the recommendations impact Individual LNF Service Delivery Areas?
A54: The original LNF methodology and proposed revisions to it are derived from broad methodological principles, objective data, and uniform policy goals that fairly apply to all LNF SDAs. The workgroup did not examine potential outcomes for individual LNF SDAs. The workgroup examined aspects of the methodology that are important for broad classes of LNF SDAs. For instance, economic adjustments to compensate for regional variations in health care costs and health status were examined for geographic regions and IHS areas. The workgroup is advising the IHS on how to best to fairly represent the shared interests of all tribes and sites.
Q55: Did the workgroup propose establishing a minimum or maximum funding level for IHCIF awards?
A55: The workgroup did not propose a minimum or maximum allocation.

Q56: Where there other LNF formula issues that the workgroup still needs to discuss?
A56: Yes. There were a number of issues that the workgroup either needed additional information to decide or the workgroup was unable to reach a consensus on. Due to time constraints in getting FY 2018 funding distributed (before the end of the fiscal year), these issues were deferred for later discussion (Phase II). The workgroup will meet again to discuss these issues starting in late summer 2018. Any changes would be implemented in any IHCIF increase in FY 2019.

Q57: What are the categories to be discussed in Phase II?
A57: Phase II focus areas include:

1. PRC dependency factor (priority I denials and transportation costs in particular)
2. Distance factor (to a certain type of facility)
3. Facility factor
4. Program size
5. Fractionization (allocation of user population by LNF SDA inpatient and outpatient visits)
6. Medicaid coverage gaps

Q58: What is the deadline for providing comments?
A58: Comments are due by Friday, July 13, 2018.

Q59: Why is the Tribal consultation period only 30 days?
A59: The FY 2018 funding must be distributed and obligated before the end of the fiscal year.

Q60: How do I provide comments on the workgroup plan?
A60: Comments can be provided during the in-person consultation sessions, by e-mail, or by mail. In-person consultation sessions will occur on June 28th in Minneapolis, MN and June 29th in Seattle, WA. Please see the IHS Calendar at www.ihs.gov/IHSCalendar for additional details. E-mail comments to consultation@ihs.gov using Subject line "IHCIF Workgroup Recommendations Tribal Consultation". Comments by postal mail should be sent to RADM Michael Weahkee, Acting Director, 5600 Fishers Lane, MS 08E86, Rockville, MD 20857, ATTN: IHCIF Workgroup Recommendations Tribal Consultation.

Q61: What will happen once the comment period is closed?
A61: The IHS Acting Director, RADM Weahkee, will convene a conference call with the Workgroup to discuss the results of the Tribal consultation and his decisions for Phase I.

Q62: When will the final decision be released?
A62: After all comments have been received and reviewed, the IHS will make a decision regarding the Phase I recommendations. . Tribal leaders will be notified through a Dear Tribal Leader Letter.

Q63: When will FY 2018 awarded sites be notified?
A63: Sites are expected to receive funding in August 2018.

Q64: Can a Tribe challenge the results of the LNF calculation?
A64: Yes. The IHCIA 25 USC 1621(d)(3) allows for tribes to request a review of the LNF calculation related to the health status and resource deficiency.

Q65: Does this mean IHS will provide Alternate Resource data for Tribes to compare to their own collection data on alternate resources?
A65: No. IHS is not using actual collection data in the LNF calculation. IHS will be using enrollment data provided to the NDW to assure that all Tribes and Tribal Organizations are treated equally. A mechanism has been developed to provide an enrollment number for Tribes that have not submitted data to the NDW.