IHS Indian Health Care Improvement Fund Workgroup Recommendations

TRIBAL CONSULTATION SESSION, JUNE 2018

Agenda

- Welcome – 5 minutes
- Review IHCIF formula background – 10 minutes
- Review IHCIF Workgroup recommendations – 20 minutes
- Questions, comments and input – 2 hours

IHCIF Formula Background - 25 U.S.C § 1621

LNF: Level of Need Funded

- Formula to measure the level of health status and resource deficiencies for IHS & Tribal facilities as a percentage related to a benchmark of funding

IHCIF: Indian Health Care Improvement Fund

- Resources expressly authorized to eliminate the deficiencies in health status and resources and allocated by formula to sites with greatest need (i.e, lowest LNF %)

Level of Need Funded – What is it?

- Calculates resource needs compared to cost of providing the IHS patient population with a benchmark benefits package (existing formula uses Federal Employee Health Benefit Program Blue Cross/Blue Shield insurance as the benchmark)
- LNF scores are calculated for 3 levels
  - Individually for 263 local level health care sites/operating units (service delivery areas)
  - Statistical total and average by IHS Area (no effect on formula allocations)
  - Statistical total and average for the whole IHS/Tribal system (no effect on formula allocations)
- Two primary purposes:
  - A benchmark to help justify IHS budget requests
  - Use to assist in allocation of IHCIF funding increases to local level service delivery areas

Rationale to Revise LNF Calculation

1. The original fixed percentage, developed in 2000-2001, does not reflect variations known to exist among states, regions, and sites.
2. The health care environment today is different than in 2000-2001. The original crude measure is considered by many to be less valid today than when developed in 2001.
3. Alternate resources have generally expanded, especially with Medicaid expansion and ACA private insurance (ACA subsidized premiums). Coverage among AI/ANs is greater and alternate resources make up a greater proportion of site operating budgets.
4. Detailed data documenting coverage (insurance enrollment rates) is available for most sites. More detailed data permit more detailed calculations.
5. The IHCIA statute requires the IHS to allocate IHCIF funds to the most under resourced sites. The real extent of resource deficiency at sites is not accurately reflected by a fixed percentage.

LNF: Level of Need Funded Methodology

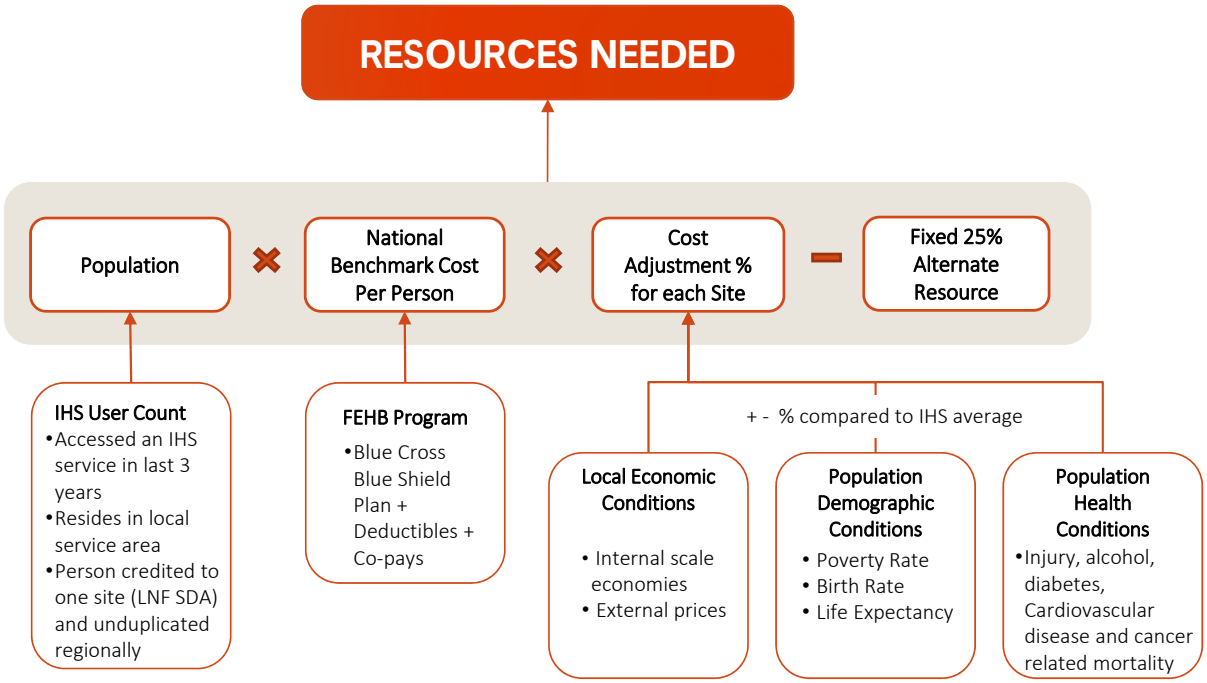
A set of data, resourcing goals, and calculations to measure health care resource deficiency (specified in § 1621) for all health care sites within the IHS/Tribal system

a. Calculate resources **NEEDED**
   (User Population) X (Per Person Cost Standards)

b. Calculate resources **AVAILABLE**
   (IHS Appropriations) + (Alternate Resources)

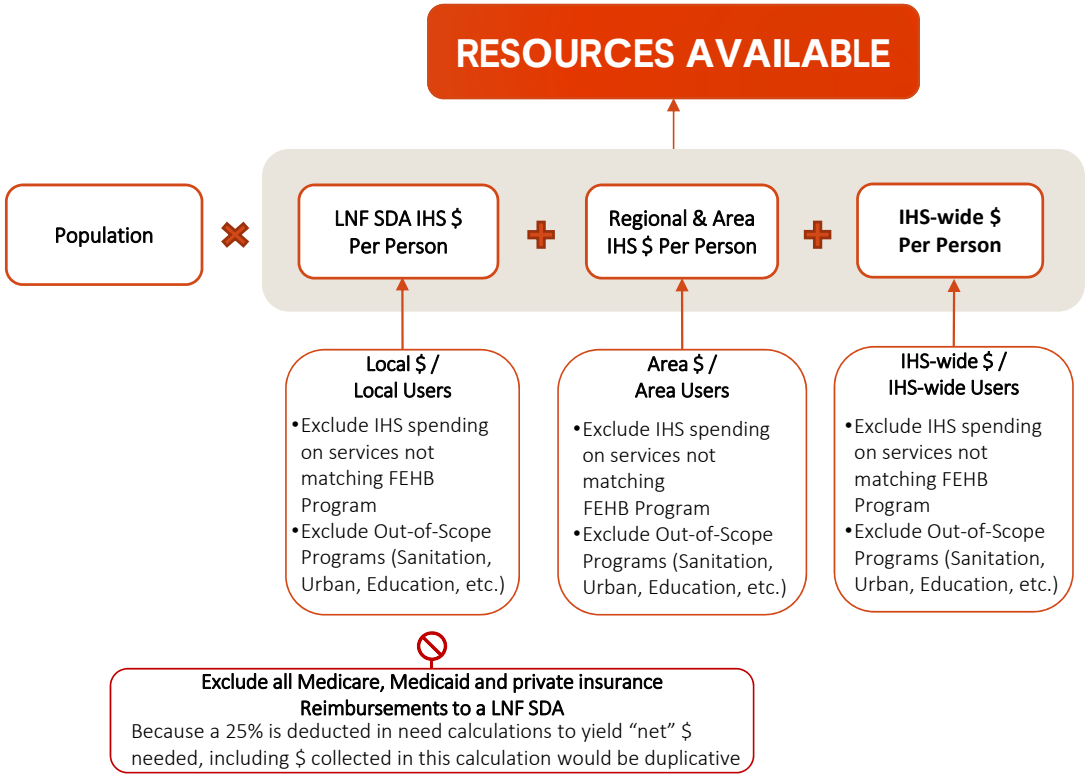
c. Calculate **LNF SCORE**
   (b / a = LNF %)

Existing Calculation of Resources Needed



Note: Resources needed by a LNF SDA may be equivalently expressed as either an aggregate amount or as a per person amount.

Existing Calculation of Resources Available



Note: Resources available to a LNF SDA may be equivalently expressed as either an aggregate amount or as a per person amount.

Additional Resources

Visit the IHCIF Workgroup Web site at: https://www.ihs.gov/ihcif/federal-tribal-ihcif-workgroup/

Online materials include:

- A more detailed explanation of the IHCIF
- Workgroup meeting summaries and materials

IHCIF Workgroup Recommendations

- The Workgroup
  - Comprised of one primary/one alternate Tribal representative and one primary/one alternate Federal representative from each IHS Area
  - Tribal Co-chair: Jim Roberts Federal Co-chair: Elizabeth Fowler
  - Charged with reviewing the existing IHCIF formula and making recommendations to the formula by considering whether the formula has been effective in meeting the stated purpose of the IHCIF in the Indian Health Care Improvement Act and the effect of the current health care environment on the formula.
- Methods
  - Four in-person meetings between January and May 2018; conference calls in between
  - Established four Sub-workgroups: three to look at established components of the formula and one to look at an additional factor.
- Final Interim Recommendations – revise three components as Phase I work and consider the additional factor as part of Phase II work

Workgroup Recommendations

PER PERSON BENCHMARK:

- Recommendation: Replace the Federal Employee Health Benefit (FEHB) Program with the National Health Expenditure (NHE), including 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)
- 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

Workgroup Recommendations

USER COUNT:

- Recommendation: Replace official User Population with User Population, adjusted for national un-duplication and addition of non-PRCDA (non-CHSDA) users.
- Rationale: IHS now has the ability to un-duplicate users at the national level, which wasn't 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-CHSDA users ensures that patients who meet all of the criteria to be counted in the official user population except the residency requirement within a CHSDA 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-CHSDA users: 1,666,230

Workgroup Recommendations

ALTERNATE RESOURCES:

- Recommendation: Replace the 25% fixed calculation with a operating unit-specific coverage value (percent) based on IHS operating unit level coverage data adjusted for program weighting, coverage gaps, payment gaps, and program component enrollments. For operating units with missing or outdated 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% 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% across the board
  - Recommended alternate resource factor: operating unit specific (national average ranging from 35% to 38%).

Key Concepts Related to Alternate Resources

- The alternate resource deduction in the LNF formula includes more than collections. It includes:
  - Collections - Payments made to IHS/Tribes for services provided to Medicare, Medicaid, and private insurance covered AI/ANs
  - Costs Avoided - Payments to others for services provided outside IHS to Medicare, Medicaid, and private insurance covered AI/ANs.
- The proposed LNF formula uses third party enrollment and average reimbursement costs to calculate estimated collections and cost avoidance. IHS and Tribal Sites:
  - Capture user (individual) enrollment status for Medicare, Medicaid, Private Insurance, and other less common types
  - Most sites regularly export alternate resource enrollment data to the IHS National Data Warehouse.

Key Concepts Related to Alternate Resources (Continued)

- Using National Data Warehouse data enrollment totals and rates by state, IHS Area, and IHS Service Unit can be tabulated for each third party coverage type (e.g., Medicaid)
- Service Unit data can be cross walked to Service Delivery Area for LNF calculations.
- The total alternate resources to be collected and avoided can be calculated when IHS has:
  - SDA Enrollment data for Medicare, Medicaid and private insurance, and
  - The average third party payment per person for each type of coverage
- The LNF SDA specific mix of reimbursements and cost avoidance varies according to the mix of onsite services and referrals.

Key Concepts Related to Alternate Resources (Continued)

- Only alternate resources from the federal government are included in the LNF alternate resource calculation.
- For LNF calculations, the portion of costs paid by individuals, their employer (e.g. employee compensation), or by Tribes, are not deducted from needed resources.
- For instance, only 47% of Medicare payments derive from a federal source whereas 94% of Medicaid payments come from federal sources. This means that the full alternate resource amount is not used, but a reduced amount is used representing only the federal portion of the calculation. Example: [Site Medicaid coverage rate] X [56% weight] X [94% actuarial value]
- While the calculations have not been finalized at the LNF SDA level, some preliminary results are available. Based on these preliminary findings, it is estimated an IHS average deduction for alternate resources will be between 35% and 38% (compared to the current 25%). SDA percentages will vary above and below the IHS average.

Key Concepts Related to Alternate Resources (Continued)

Adjustments to the alternate resource calculation for missing data or high reimbursement rates.

- IHS is using enrollment data submitted to the National Data Warehouse (NDW). While all IHS and many tribal sites report enrollment data, some tribal sites do not have up-to-date or no information in the NDW. In those SDAs without data, IHS will use the state average (from the American Community Survey) for the alternate resources calculation.
- The Workgroup also wanted to make sure SDAs with high reimbursement rates were not penalized for effective enrollment activities. Those SDAs with higher than the State average will be capped at the state average for the alternate resource calculation.

Workgroup Recommendations

ACCESS TO CARE

- Recommendation: PRC dependency, Distance, facility condition, program size
- Rationale: At this time the workgroup could not reach consensus on these issues or needed additional information on the impact of these possible changes, considering the progressive timeline.
- Result
  - These items will be reviewed and considered in Phase II in FY 2019

Workgroup Recommendations - Summary

1. USER COUNT:
   - User population, national un-duplication, addition of non-CHSDA users

2. PER USER COST BENCHMARK:
   - Replace the Federal Employee Health Benefit Program with the National Health Expenditure, including 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)

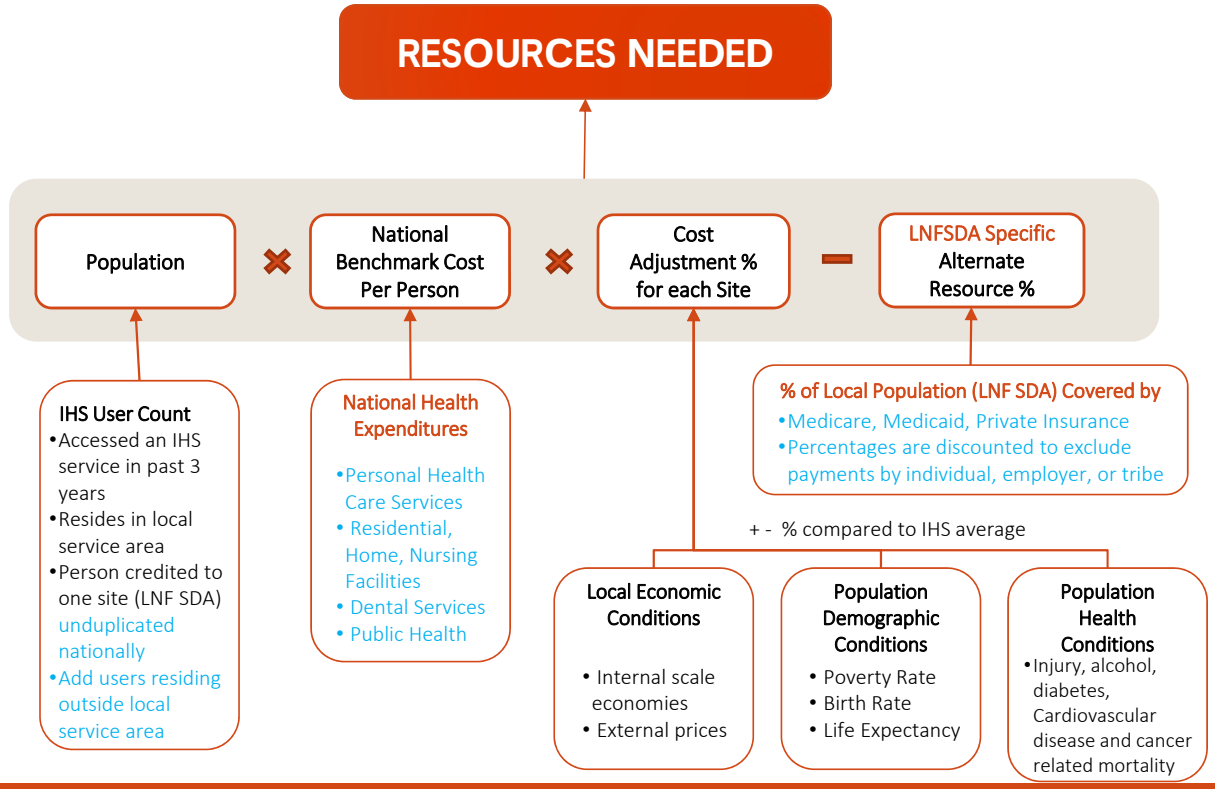
Workgroup Recommendations - Summary

3. ALTERNATE RESOURCES:
   - Replace the 25% fixed calculation with 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 will be used. For sites whose coverage value exceeds the State average, the value will be capped at the State average.

4. ACCESS TO CARE (Phase II):
   - PRC dependency, distance, facility condition, program size

5. DISTRIBUTION METHODOLOGY
   - Provide funding to those sites with the lowest LNF scores to raise the lowest score to a higher level
   - No minimum or maximum dollar amount for IHCIF awards

Proposed Calculation of Resources Needed



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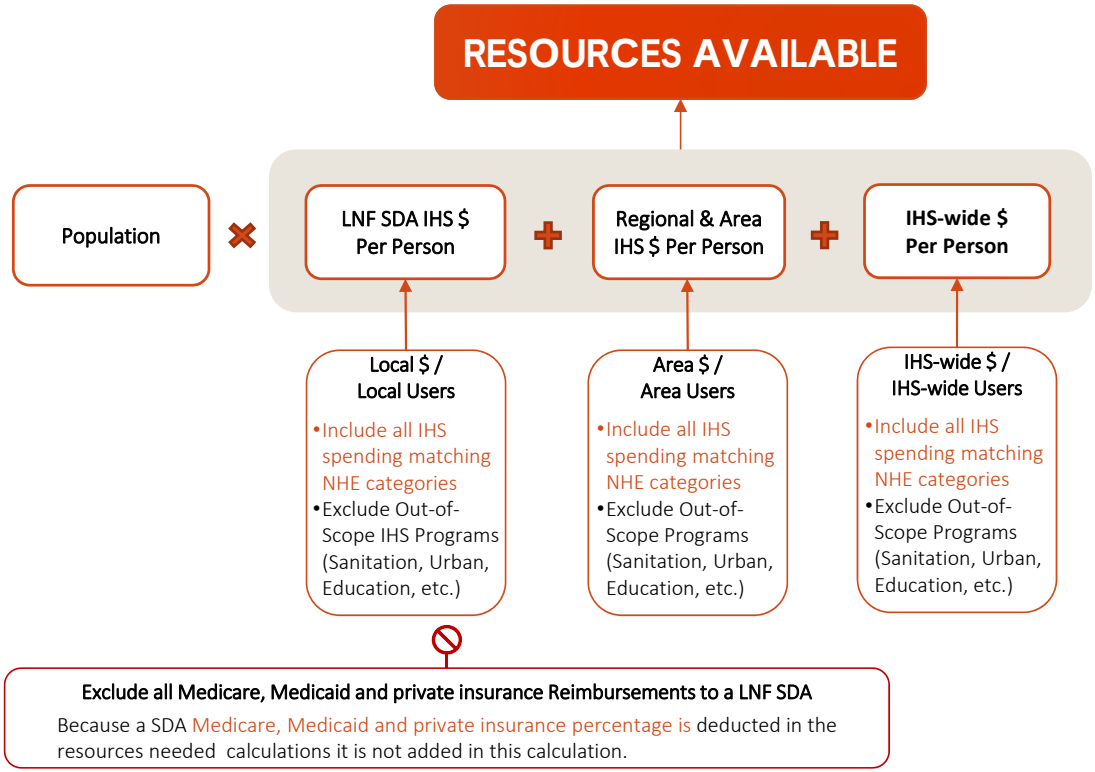
Proposed Calculation of Resources Available



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IHCIF Workgroup – Phase II

- The IHCIF Workgroup will continue to work on Phase II recommendations.
- Phase II focus areas include:
  - PRC dependency factor (priority I denials and transportation costs in particular)
  - Distance factor (to a certain type of facility)
  - Facility factor
  - Program size
  - Fractionalization (user population)
  - Medicaid coverage gaps
- The Workgroup is targeting completion of this work by the end of the calendar year in order to update the formula for use in allocating possible future funding increases for the IHCIF.

Next Steps

- Comments are due by Friday, July 13, 2018.
  - We are capturing comments today. They can also be submitted
  - by email to consultation@ihs.gov using Subject line "IHCIF Workgroup Recommendations Tribal Consultation"
  - by postal mail to RADM Michael Weahkee, Acting Director, 5600 Fishers Lane, MS 08E86, Rockville, MD 20857, ATTN: IHCIF Workgroup Recommendations Tribal Consultation.
- Once the comment period has ended, the Acting Director will review the comments and IHS's response with the IHCIF Workgroup and will issue a follow-up Dear Tribal Leader letter to provide a response to all Tribal leaders.
- IHS anticipates using the updated formula to allocate the $72 million appropriated in FY 2018 for the IHCIF. The target allocation date is early August.

Questions/Comments?