Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

USET SOVEREIGNTY PROTECTION FUND

Nashville TN Office
711 Stewarts Ferry Pike, Ste. 100
Nashville TN 37214
P: (615) 872-7900
F: (615) 872-7417

Washington DC Office
400 North Capitol St., Ste. 585
Washington DC 20001
P: (202) 624-3550
F: (202) 393-5218

Transmitted via email to: consultation@ihs.gov

July 13, 2018

RADM Michael D. Weahkee
Acting Director
Indian Health Service
5600 Fishers Lane, Mail Stop 08E86
Rockville, MD 20857

Re: ***Comments on recommendations made by the Indian Health Care Improvement Fund Workgroup to revise the formula used to allocate funding increases appropriated for the Indian Health Care Improvement Fund***

Dear RADM Weahkee:

The Northwest Portland Area Indian Health Board (NPAIHB), the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF), and the 70 Tribal Nations our organizations represent collectively, submit the following written comments responding to the Indian Health Service's (IHS) June 8, 2018 Dear Tribal Leader Letter (DTLL) initiating tribal consultation on recommendations made by the Indian Health Care Improvement Fund (IHCIF) Workgroup to revise the formula.

Established in 1972, the NPAIHB is a non-profit, Tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, representing the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on health care issues. In the Portland Area, 75% of the total IHS funding is compacted or contracted and includes 6 federally operated service units, 17 Title I Tribes, 25 Title V Tribes, 3 urban facilities, and 3 treatment centers. NPAIHB works closely with the IHS Portland Area Office, operating a variety of important health programs on behalf of our member tribes, including the Northwest Tribal Epidemiology Center.

The USET SPF is a non-profit, inter-tribal organization representing 27 federally recognized Tribal Nations from Texas across to Florida and up to Maine. Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service, which contains 36 IHS and Tribal health care facilities. Our citizens receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

Background

Congress established the IHCIF in the Indian Health Care Improvement Act (IHCIA) as a means of addressing resource disparities across the Indian health system.[1] 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. On March 23, 2018, Fiscal Year (FY) 2018 Omnibus Appropriations were enacted and included a $72 million funding increase for the IHS IHCIF in a single year. Along with the increase, Congress suggested IHS and Tribal Nations re-examine the formula developed in 2000 to determine if revised distribution methodology was needed to distribute FY 2018 funding.[2] In January of 2018, IHS established the joint Tribal/federal workgroup to make recommendations on the IHCIF formula methodology. As the existing formula is not conducive to the needs and circumstances of Tribal Nations in the Nashville and Portland IHS Areas, NPAIHB and USET SPF have been actively engaged in the joint workgroup meetings and teleconferences in pursuit of a more equitable method of distribution. The last time Congress appropriated funds for the IHCIF was in FY 2012. The 2012 IHCIF allocation for the Portland Area totaled $881,000 and was distributed to 14 Tribal sites to raise their federal disparity index (FDI) threshold to 45.8%. In 2012, only one of the USET SPF Tribal Nations received funding at a mere $10,000 from the $11.9 million that was allocated.

IHCIF Workgroup

The joint Tribal/federal IHCIF Workgroup held four in-person meetings and several teleconference calls since January 2018. The Workgroup developed four sub-workgroups that were charged with developing options and providing recommendations to the overall Workgroup: 1) Per Person Benchmark; 2) User Counts; 3) Alternate Resources; and 4) Purchased and Referred Care (PRC) Dependency (later renamed Access to Care). The resulting IHCIF Interim Report includes three major recommendations to incorporate into the IHCIF formula for use in allocating the FY 2018 funding increase.

We are concerned that the Workgroup's decision-making process, a vote from each Area, was clearly divided between the majority of IHS Areas with hospitals and the minority of those without hospitals such as Nashville and Portland, on key issues. Although IHS has received and is considering recommendations through Tribal consultation on the IHCIF, IHS is ultimately responsible for authorizing the formula and policies that result in the distribution of the IHCIF across IHS Areas. The official role of the IHS agency as the authorizing federal entity is to determine how the funds shall be expended is of the utmost importance in addressing the glaring service deficiencies and funding inequities across the IHS delivery system, including those Tribal Nations faced by the Nashville and Portland IHS Areas due to limited IHS/Tribal hospital infrastructure.

Per-Person Benchmark

The existing per-person benchmark is determined by utilizing 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 FEHB benchmark is an average per capita cost that is adjusted for coverage differences such as the scope of the FEHB benefits compared to IHS benefits, out-of-pocket costs, and AI/AN demographic information. This average per capita cost is then reduced by 25 percent to account for alternate resources (Medicare, Medicaid, and private insurance) of AI/ANs. Upon determining the per capita costs, overall costs are individualized to IHS and Tribal

[1] 25 U.S. Code § 1621
[2] Department of the Interior, Environment, and Related Agencies Appropriations Act Explanatory Statement, 2018

operating units considering conditions that vary among the sites (size, remoteness, prevailing medical costs, and health status of AI/AN users). Although the FEHB benchmark has been the easiest means to justify spending levels to Congress, it is over fifteen years old and has failed to adequately depict the services provided through the Indian health system.

The Per Person Benchmark Sub-Workgroup was tasked with assessing the rationale and impact of replacing the FEHB Program with a benchmark based on the National Health Expenditure (NHE). The Sub-workgroup compared services and programs authorized in the IHCIA to types of spending in the NHE. The Sub-workgroup determined that the authorizations in the IHCIA provisions aligned more closely with the NHE spending categories than mainstream insurance plans, such as the FEHB Program. Both the NHE and FEHB are per person, gross cost benchmark estimates.

The NHE would result in a $9,726 per person (based on user population) benchmark, which is approximately $2,100 per person more than the FEHB benchmark at $7,515. At present funding levels, IHS appropriations (or resources available) are approximately $2,809 per person. The Sub-Workgroup concluded that the NHE provides a better approximation of the total health care need for the Indian health care system, particularly with unfunded IHCIA authorities. The NHE benchmark is also broader and can be used to make funding comparisons against unfunded IHCIA authorities and IHS funded programs.

Therefore, the Workgroup recommended that the FEHB Program benchmark be replaced with the NHE benchmark, with particular emphasis on the four 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 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, immunizations/vaccine services, disease prevention programs.

The Sub-workgroup did not reach a consensus on Category 5 for New Health Care Facilities and Equipment because of concerns regarding the impact it may have on current facilities appropriations and calculation of need. As a result, this category was not included in the NHE benchmark.

USET SPF and NPAIHB fully support the NHE as a baseline for calculating the benchmark for the IHCIF in place of the FEHB Program benchmark. The FEHB does not include the full range of health programs authorized under the IHCIA. At $9,726 per person, the NHE benchmark provides a better approximation of the total health care need for AI/ANs, as well as the traditional and non-traditional services provided by the Indian health system. Not only will the change in benchmark have implications for the IHCIF, it will also present a more accurate picture to Congress regarding the federal government's total unfunded obligation within IHS.

User Count

The existing formula currently uses the standard user population factor (user count). The user count represents the number of patients receiving services and impacts the formula results more than any other data variable. The current user count uses user population with regional un-duplication. The user population is comprised of the AI/ANs who actually received IHS services during the most recent 36-month period. AI/ANs who reside in another IHS or Tribal service area are only counted once in the service delivery area where they reside. AI/ANs residing outside of any IHS or Tribal service area (non-PRCDA users) are excluded from user population counts. Users in each IHS Area are reviewed and duplicate users (a user being counted more than one time) are removed.

The Workgroup recommended that IHS utilize user population and not service population in order to count the actual users of IHS/Tribal operated sites. The Workgroup also recommended that the user count be changed to the national un-duplication methodology from the regional un-duplication methodology. Using the national un-duplication user population provides a much more accurate user population as an individual AI/AN user is only counted once in the IHS system. User counts are a critical part of the IHCIF methodology. USET SPF and NPAIHB support the national un-duplication of user population because it considers all users across the country and eliminates duplicate users across IHS Areas. We believe it is a more accurate user count.

In addition, the Workgroup recommended adding non-PRC Delivery Area (PRCDA) users to the national unduplicated user population. The addition of non-PRCDA users was proposed because approximately 49,000 AI/AN patients are not included in the current user population, as they reside outside of a service delivery area or PRCDA. USET SPF and NPAIHB support the addition of non-PRCDA users to the national unduplicated user population to account, as many of the AI/AN patients in our Areas are currently excluded from the user population. This will more accurately depict the AI/AN patients accessing services through Indian Health Service, Tribal, and Urban facilities (I/T/Us).

The current user population allows an AI/AN patient to only be counted for user population at one facility. Individual AI/ANs often receive care at more than one facility. All facilities are expending resources to provide those services to the patient, but only one is receiving funding from IHS appropriations for those services. The Workgroup recommended that fractionalization be considered in the next phase of the Workgroup. Fractionalization allows for all facilities providing services to a patient to receive some user population credit.

USET SPF and NPAIHB request that the Workgroup continue to evaluate fractionalization in Phase II to ensure that the data can be accurately measured at the service delivery area level. We support each facility serving an AI/AN patient to receive credit for expending resources to providing services, so that multiple facilities can receive IHS appropriations for those services.

Alternate Resources

The IHCIF authorization requires IHS to account for health resources available to a Tribal Nation when determining resource deficiencies. The current IHCIF formula calculates total funding available to an operating unit by factoring in a standard 25 percent reduction to account for alternate resources received by an IHS/Tribally operated site beyond IHS funding (Medicare, Medicaid, and private insurance). 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 alternate resources. Since 2001, the 25 percent adjustment for alternate resources was used across-the-board due to lack of available data

supporting local or regional differences. Congress and the Government Accountability Office (GAO) have requested that IHS use more reliable data in lieu of the 25 percent default that is applied in the current methodology.

The Workgroup recommended 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. However, it is unclear if this Workgroup recommendation would be based on enrollment data or the percentage of total benchmark that would come from alternate resources. For sites with missing or outdated enrollment data, the state average would be used. For sites with a coverage value that exceeds the state average, the value would be capped at the state average. The Sub-workgroup looked at various resources for development of a new alternate resources formula including: the American Community Survey, the Kaiser Family Foundation report, the IHS National Data Warehouse insurance status reports, CMS eligibility datasets, and the IHS 4A report. The final Workgroup recommendations on alternate resources were:

1. Use the service delivery area level data by state;
2. Use state-specific net coverage if the service delivery area level data is not available or has not been updated within a certain number of years;
3. Cap the service delivery area level data if it exceeds the state average to the service delivery area's state average;
4. Use the service delivery area level data if it falls below the service delivery area level data.

Although we are cognizant that IHS must consider alternate resources, based on statutory language in 25 U.S. Code § 1621 regarding the fund, it conflicts with modernizations made during the permanent authorization of IHCIA that prohibit funding offsets based on the amount IHS and Tribally operated sites are able to generate in alternate resources. Leveraging limited resources through collections is a necessity when Congress continues to underfund the IHS. Tribal Nations in the Nashville and Portland Areas rely heavily on alternate resources, such as Medicaid and Medicare, to provide specialty care to patients. Penalizing savvy Tribal Nations who conduct extensive outreach and enrollment in Medicaid and Medicare and collect third-party revenue in addition to patient care is contrary to the federal treaty and trust obligations of the U.S.

NPAIHB and USET SPF do not believe that reducing the Level of Need Funded (LNF) for the chronically underfunded Indian health system addresses funding deficiencies as intended through the Fund and only exacerbates it for some Tribal Nations and puts Tribal Nations at odds, fighting for limited resources. In the event that IHS must comply with statutory language, we recommend maintaining the 25% fixed alternate resource component for the FY 2018 IHCIF and that proposed recommendations be further evaluated in Phase II of the Workgroup charge. Due to a lack of information provided by IHS, we are unsure how the change to alternate resources will impact the Tribal Nations in our Areas. We do not believe that adequate site-specific information and supporting data was provided to the Workgroup and Tribal Nations to provide a comprehensive explanation of the major change to the alternate resources factor of the formula. Each Tribal Nation needs time to look at their site-specific enrollment data for accuracy and to determine how this change will impact their IHCIF funding allocation. Upon compiling site-specific data, Tribal Nations should be afforded the opportunity to review and approve data retrieved from the national data warehouse prior to it being utilized within the formula calculations. Additionally, we would like to fully understand the recommended adjustments for patients who are enrolled in Medicaid and Medicare but are not receiving services at the IHS/Tribally operated site/unit.

Nashville Area and Portland Area Tribal Nations are concerned that the proposed inclusion of Medicare in the alternate resources calculation will not be accurate for our Areas. There needs to be an adjustment to Medicare enrollment for our Areas isolating only those active users who use it for services

at an IHS/Tribally operated site/unit and that can be verified by an IHS/Tribally operated site/unit. A clear majority of Tribal Nations in both the Nashville and Portland Areas do not bill for Medicare Part A because many Tribal Nations do not have hospitals or provide specialty care services. Nashville and Portland Area Tribal Nations will be at a disadvantage if there are no considerations or options for excluding Medicare Part A and possibly Part B for the Tribal Nations that do not bill for them. Therefore, including Medicare Part A and B would increase the alternate resources percentage for the Nashville and Portland Area Tribal Nations, therefore reducing consideration for IHCIF funds.

Section (d)(2) of the statute requires IHS to include the health resources available and used by an Indian tribe or tribal organization in the formula, "including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments."[3] While we understand the argument regarding the exclusion of private insurance from alternate resources because it should not be counted as a federal resource, there is no consideration for Areas with large staffing packages who benefit from additional revenue from such insurance, which is indirectly related to funding that they receive from IHS. We ask that this be taken into consideration during Phase II.

Phase 2 Workgroup Charges

The Workgroup agreed that the following items required additional discussion or reflected unresolved issues that could not be accomplished in time for use in allocating the FY 2018 funding increase. Some items reflect recommendations presented to the full Workgroup but voted upon without reaching consensus. Therefore, the Workgroup will continue its work on these issues and develop Phase II recommendations for allocating an FY 2019 funding increase, should one be appropriated.

1. **PRC Dependency:** further evaluate using the PRC dependency factor/access to IHS/Tribal hospitals used in the PRC allocation formula. It was noted that such hospitals provide a widely varying scope of services.

For a variety of reasons, including the underfunding of IHS, Tribal Nations, including many in the Nashville and Portland Areas, often lack requisite healthcare infrastructure to deliver a full range of services to patients. In these situations, there is no other option except to purchase care outside the Indian health system. At current funding levels, most PRC programs in our Areas are approving very limited services beyond medically emergent referrals, and less urgent routine or preventive care must be deferred or denied pending additional appropriations. The circumstances of PRC dependent Tribal Nations must be considered, as the Workgroup continues to review the formula.

2. **Distance and Facility factor:** evaluate a factor accounting for distance to a level II facility and/or transportation costs.

USET SPF Tribal Nations have access to just two Tribally-operated hospitals within the Nashville Area while Portland Area Tribal Nations do not have any access to IHS or Tribally-operated hospitals within the Northwest. Therefore, most AI/ANs in the Nashville and Portland Areas seek care from small, rural health clinics offering limited services. NPAIHB and USET SPF strongly recommend a systems efficiency factored be considered as the Workgroup continues to review the formula.

3. **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?

[3] 25 U.S. Code § 1621

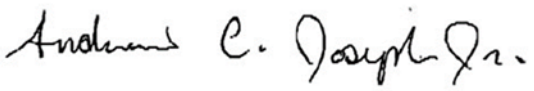
NPAIHB and USET SPF support a Small Tribal Nation Add-on factor. The current formula does not account for the size of a facility, which may have the same degree of funding shortages as a larger facility. We recommend that the Workgroup consider including a Small Tribal Nation Add-on within future formula recommendations. As demonstrated with the 2012 IHCIF allocation, the allocation awarded to smaller Tribal Nations is too small to have a measurable impact on the health services provided to beneficiaries. Similar Tribal size adjustments have been incorporated in other agency funding allocations that give an additional percentage to Tribal Nations with user populations less than a negotiated threshold.

Conclusion

We appreciate the opportunity to provide our input into the IHS IHCIF Workgroup recommendations and thank you for considering our written comments. NPAIHB and USET SPF understand that a final decision needs to be made in a short timeline to allocate funds, but it cannot be made prematurely. We request that IHS, as a trustee of Tribal Nations, ensure that the IHCIF formula changes result in an equitable funding distribution and that there are no unintended consequences. For additional information please contact USET SPF's Director of Policy and Legislative Affairs, Liz Malerba at (202) 624-3550 or lmalerba@usetinc.org or NPAIHB's Director of Government Affairs/Health Policy Analyst, Laura Platero at (503) 407-4082 or lplatero@npaihb.org.

Sincerely,

Kirk Francis, Sr.
President
United South and Eastern Tribes Sovereignty Protection Fund



Andy Joseph, Jr.
Chair
Northwest Portland Area Indian Health Board