

## **Director's Workgroup on Improving Purchased/Referred Care**

Sheraton Denver Downtown Hotel  
Tower Building Terrace Level / Columbine Room  
Denver, Colorado

**January 13-14, 2015**

### **Meeting Agenda**

#### **Tuesday, January 13**

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8:30 am	Welcome and Invocation	Cathy Chavers
	Roll Call and Introduction of New Members	Robert McSwain
9:15	Meeting Overview	Cathy Chavers
	<ul style="list-style-type: none"> <li>• Purchased/Referred Care (PRC) Workgroup Charge, Principles and Priorities</li> <li>• Objectives</li> <li>• Agenda</li> </ul>	Robert McSwain
9:45	PRC Program Update and Improvements	Felicia Roach
10:15	Break	
10:30	PRC Workgroup Recommendations Overview	Felicia Roach
	<ul style="list-style-type: none"> <li>• Round I, February 9, 2011</li> <li>• Round II, May 29, 2012</li> <li>• Round III, May 26, 2013</li> <li>• Catastrophic Health Emergency Fund</li> </ul>	
12:00 pm	Lunch	
1:30	Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital-Based Care	Terri Schmidt
	<ul style="list-style-type: none"> <li>• Overview</li> <li>• Discussion</li> </ul>	PRC Workgroup
3:30	Break	
5:00	Recess	

**Wednesday, January 14**

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8:30 am	Invocation	Cathy Chavers
	Summary of Day One	Robert McSwain
8:45	PRC Distribution Formula for Program Increases	Cliff Wiggins PRC Workgroup
10:30	Break	
10:45	Other Workgroup Recommendations	Cathy Chavers Robert McSwain
11:30	Lunch	
1:00 pm	Develop Workgroup Recommendations	Cathy Chavers Robert McSwain
3:00	Break	
3:15	Parking Lot Issues and Meeting Summary	
4:00	Adjourn	

# PRC ALLOCATIONS

## PRC Formula Refresher

1. PRC appropriations - 5 categories
2. PRC appropriations FY09 – FY14
3. PRC formula – 2 parts (general cost and hospital)
4. User Counts Measure
5. Price Variation Measure
6. Hospital Available Measure
7. Formula Per User Allocations by Site

## Options for Measures in the PRC Formula

8. User Count Measure – No proposals pending
9. Price Variation Measure – Option to replace ACCRA with Insurance “Exchange” data
10. Hospital Measure – Option to replace with 4 weighted “tiers”

## Other Allocation Related Issues – open discussion

11. Base Budgeting – GAO opposes
12. ACA effects on AIAN health resource needs

# 1) PRC Appropriations – 5 Categories

## FY 10 – FY 14

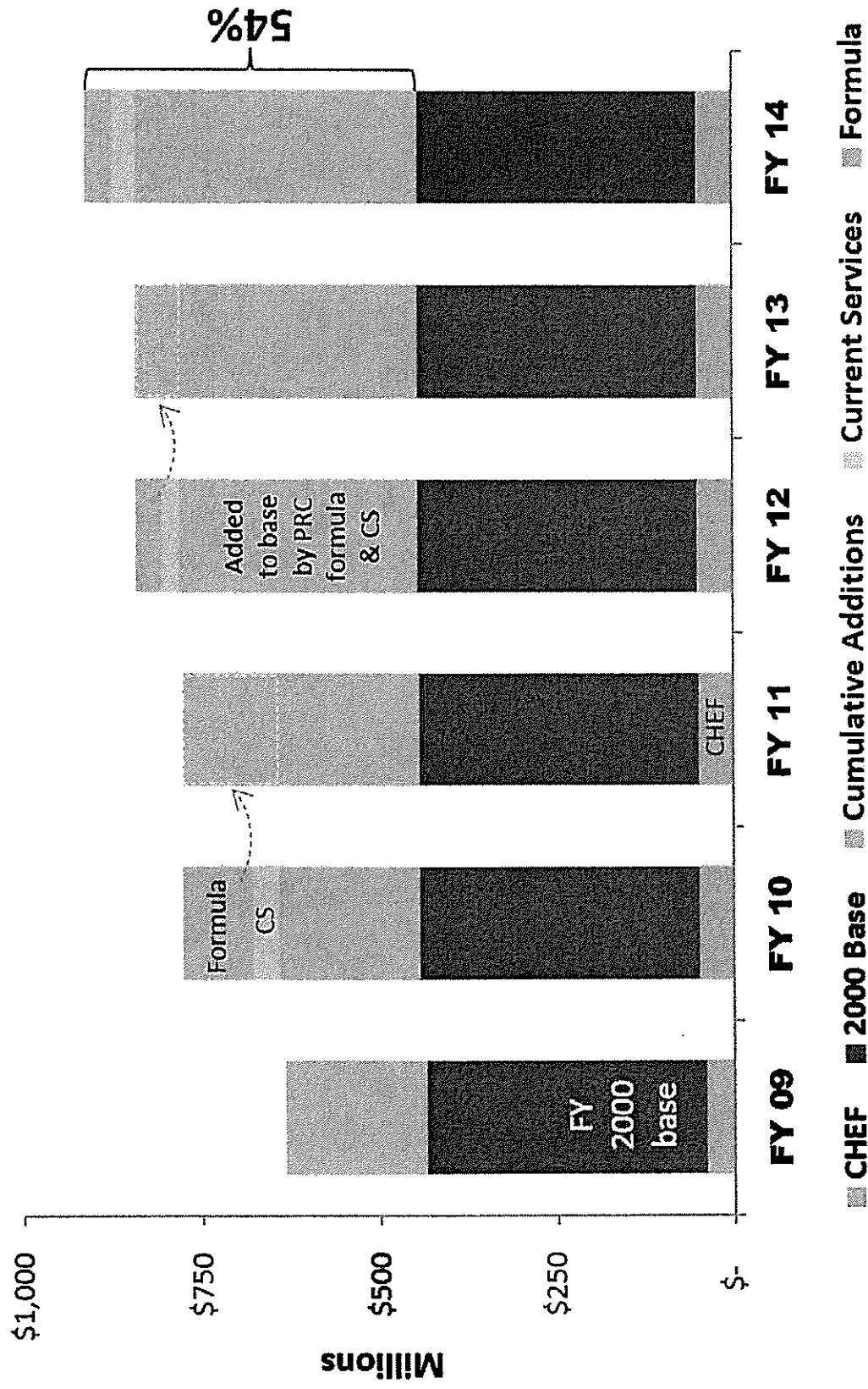
Millions

		Category	Purpose	Allocation	FY10	FY11	FY12	FY13	FY14
PRC	Base PRC	Stable base funds to maintain existing levels of PRC services	Recurring from prior year		\$594	\$732	\$732	\$794	\$794
	Current Services	Compensate for natural population growth and rising prices (inflation)	Proportional to inflation & pop. growth		\$36	\$0	\$26	\$0	\$35
	Congressional Earmarks	Designated for particular tribes or purposes (e.g. new tribe)	Earmarked – no discretion		\$1	\$0	\$0	\$0	\$0
	Program Expansion	Expand PRC services -- more services, fewer restrictions	2 Part PRC Formula		\$100	\$0	\$36	\$0	\$40
	CHEF	Reimburse catastrophic costs. Compensates for unpredictable costs.	Reimburse costs above specified cost threshold		\$48	\$48	\$51	\$51	\$51
TOTAL					\$779	\$779	\$843	\$843	\$879

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## 2) PRC Appropriations, Cumulative by type

Cumulatively since FY 2000, 54% of PRC \$ were allocated by PRC formula, inflation, and pop. growth calculations

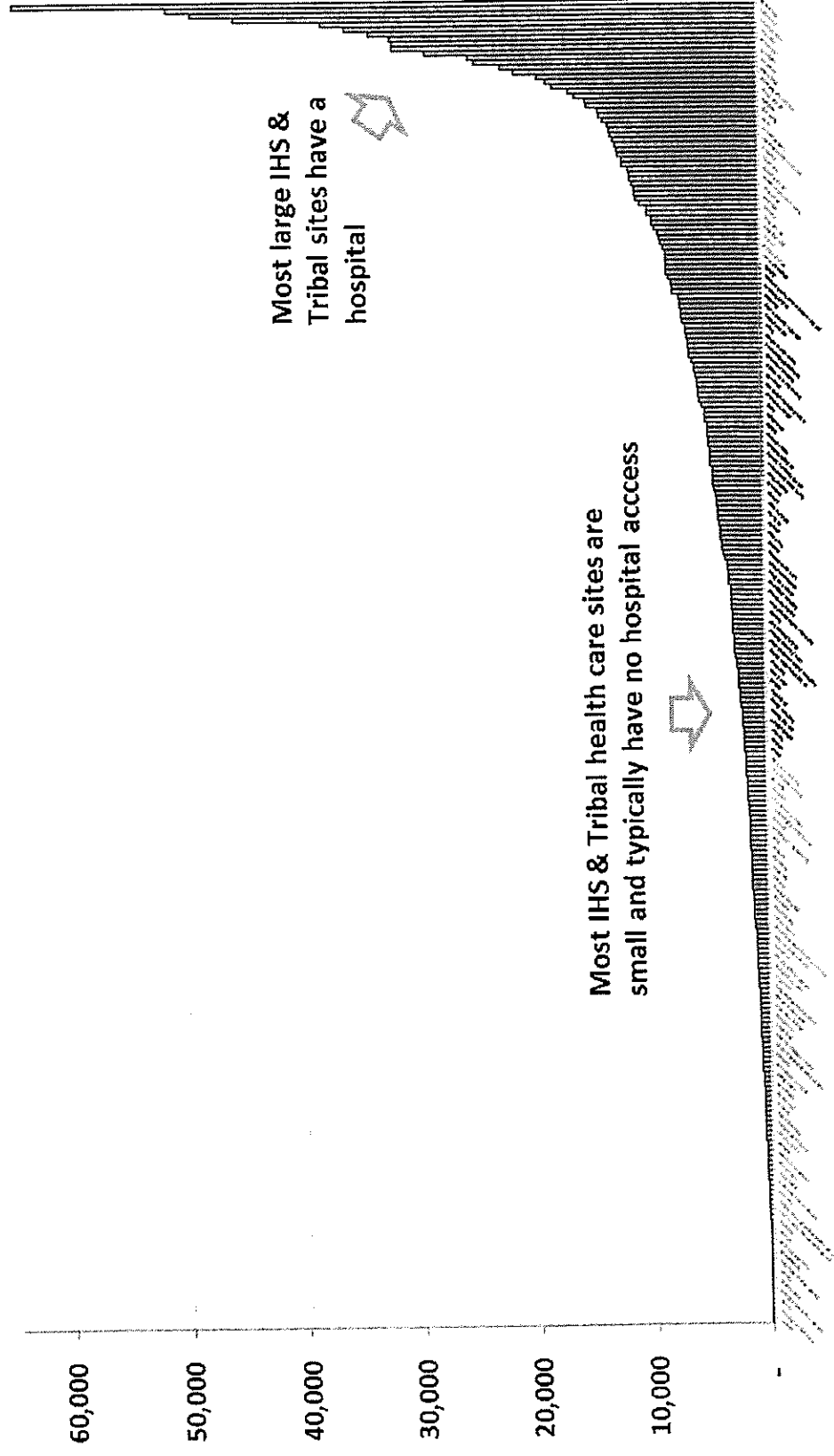


### 3) PRC Formula – 2 Parts

Part	Principle	Measures	Proportion	Allocation
<b>GENERAL COST PART</b>	Expected PRC costs are proportional to site patient counts adjusted (+ -) for price variation to equalize buying power for all	<ol style="list-style-type: none"> <li>1. Site User Count</li> <li>2. Health Care Price Index (ACCRA)</li> </ol>	$\frac{[\text{Site Users}] \times [\text{Site Price Index}]}{[\text{Total All Sites}]}$ $= [\text{Site Cost \%}]$	$[\text{Site Cost \%}] \times [75\% \text{ of PRC Expansion \$}]$ $= \text{Site Allocation}$
<b>INPATIENT SUPPLEMENT PART</b>	Expected PRC costs are higher where no IHS/tribal hospital is available for inpatient referrals	<p>Hospital Threshold</p> <ul style="list-style-type: none"> <li>• NO &lt;5 ADPL</li> <li>• YES &gt;5 ADPL</li> </ul>	<p>Same as above except include a site for the inpatient supplement <u>only</u> if its ADPL &lt; 5</p>	$[\text{Site Cost \%}] \times [25\% \text{ of PRC Expansion \$}] = \text{Site Allocation}$

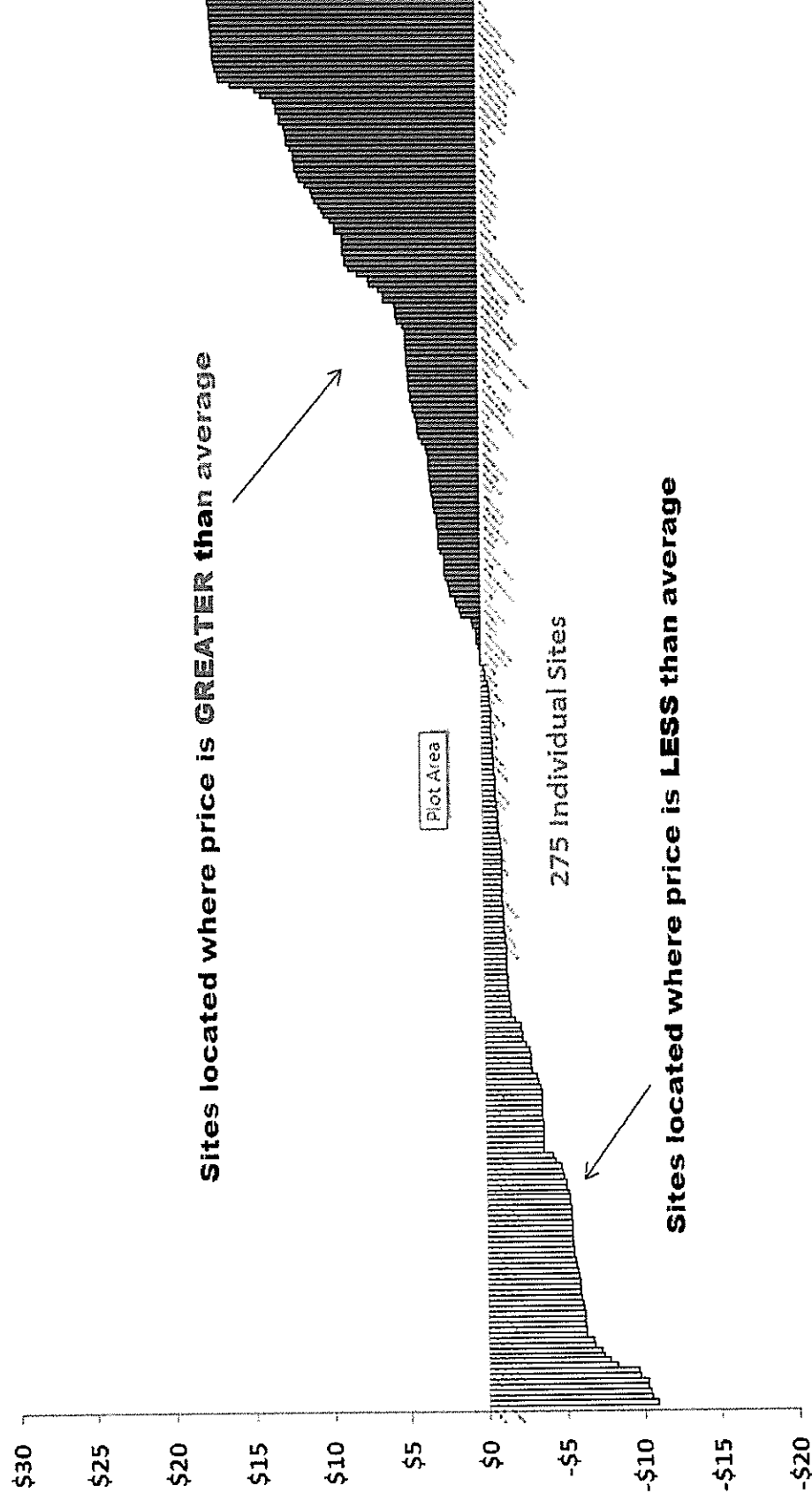
## 4) Measure 1 – Site User Counts

Site User Counts Sorted Low to High



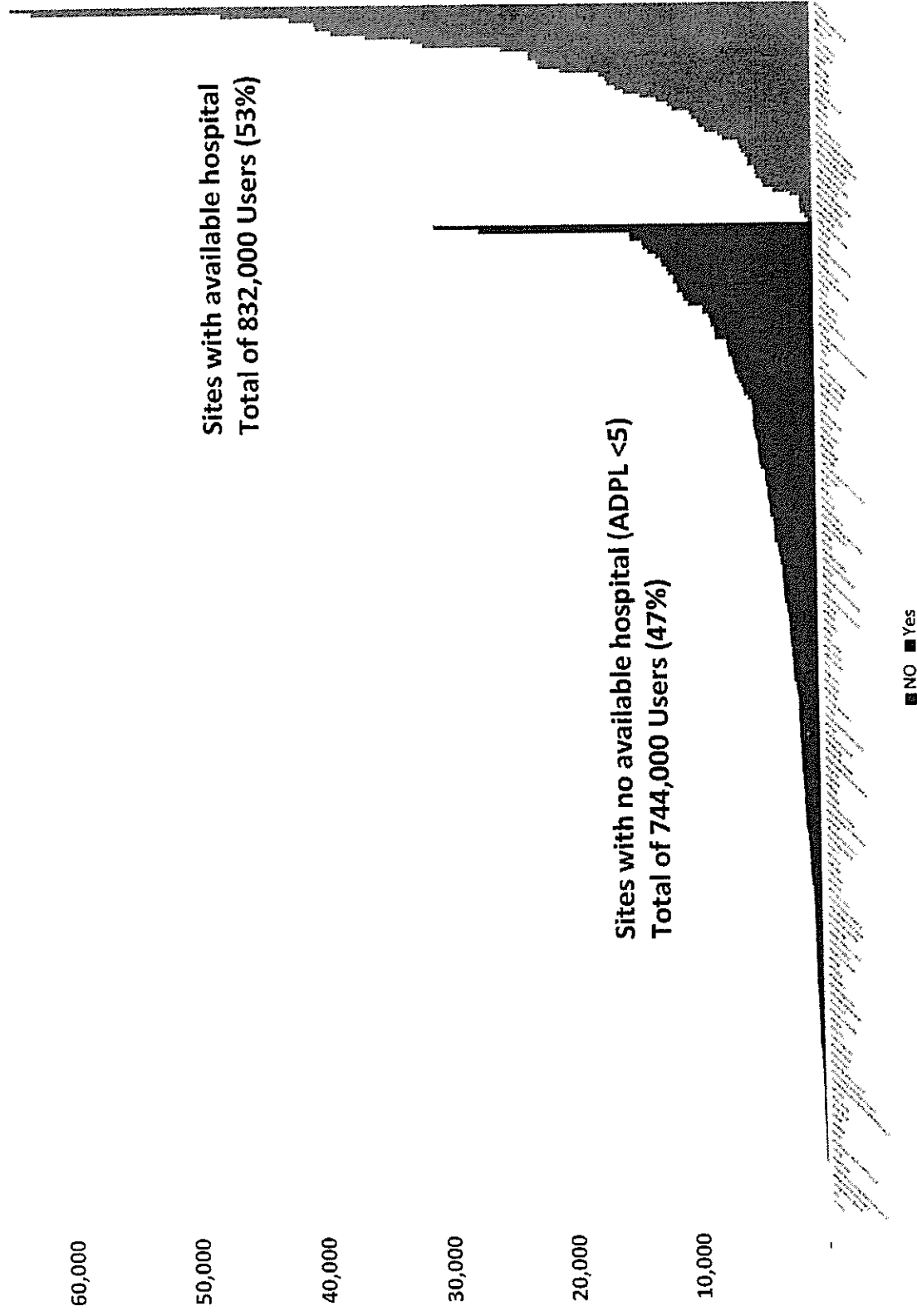
## 5) Measure 2 – Price Variation

Adjustment to equalize per person buying power



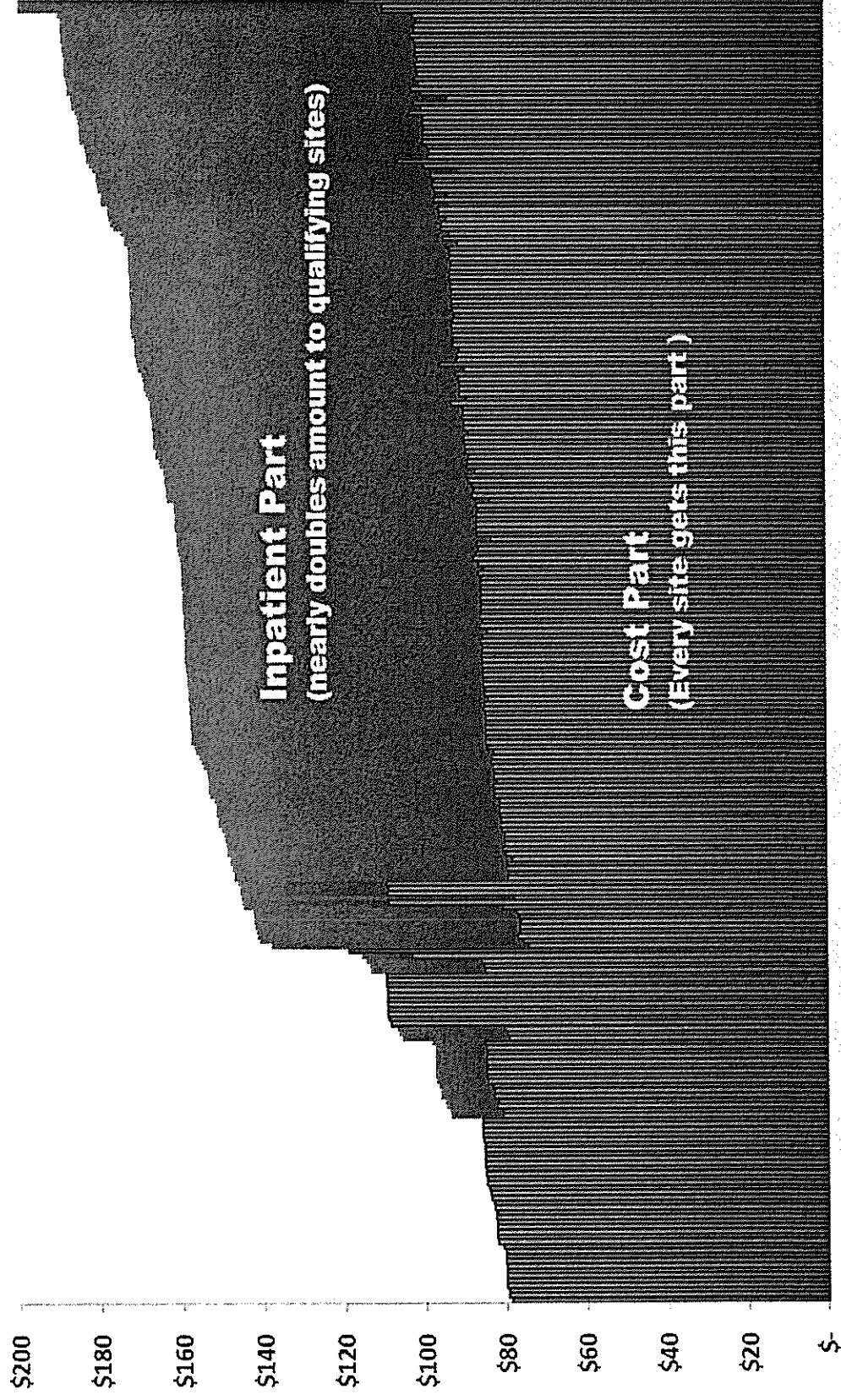


## 6) Measure 3 – Hospital Availability



## 7) PRC formula = Cost part + Inpatient part

Allocations per person by site (FY10 + FY12 + FY14)

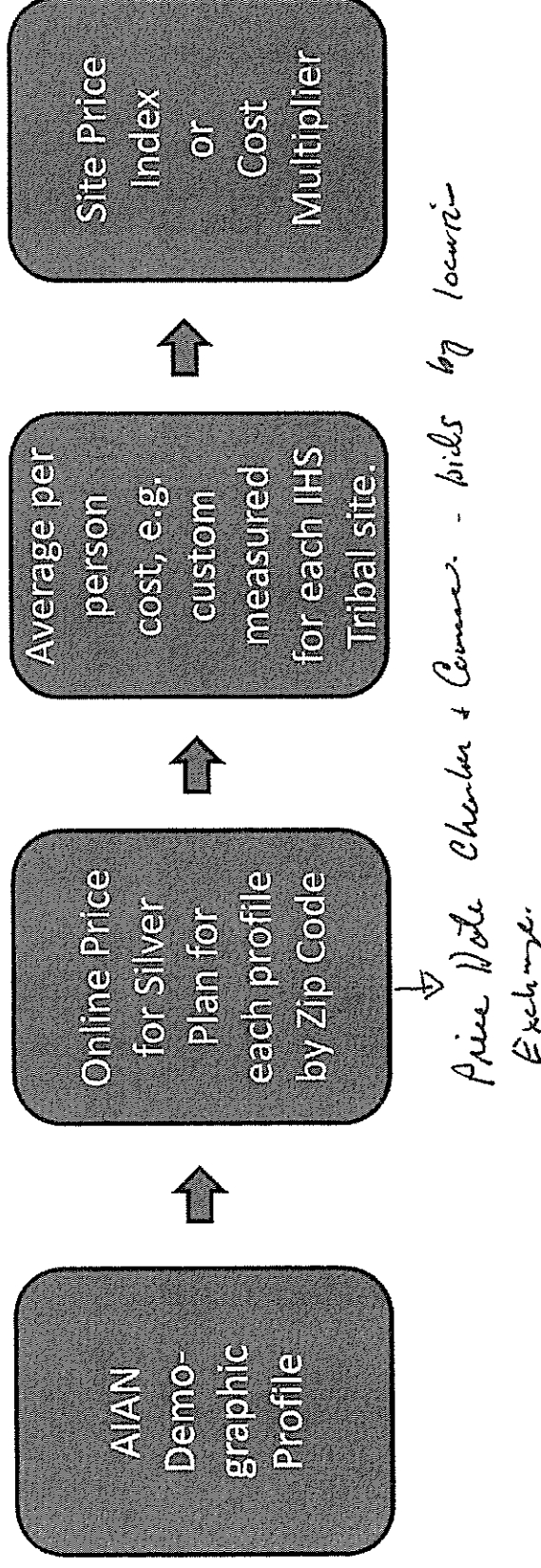


## **8) User Count Measurement Options**

- No formal proposals
- Discussion Issues
  - All AIAN individuals with a direct or PRC service in 36 months who reside in any defined CHSDA are counted
  - AIANs residing in a local CHSDA who are members of other tribes (not the local tribe) are counted but often are not individually eligible for PRC in the local.
  - Includes “urban” Indians only to the extent services are provided to such individuals counted in an IHS/Tribal direct care facility

## 9) Price Variation Measurement Options

- ACCRA data (self reported by some Chambers of Commerce) can be incomplete and is not highly regarded as precise or reliable.
- OPTION: replace with newly available price data from online health insurance market places (exchanges).
- Potential to reliably determine cost of full health care coverage customized for each individual IHS/Tribal site



## 10) Hospital Measurement Options

- GAO and others criticized this “all or nothing” measurement (5 ADPL) as crude and imprecise.
- On the other hand, results (see #7 above) demonstrate substantial effect on formula allocations.
- OPTION: replace with 4 weighted tiers
  - No Hospital (zero ADPL): 100% of users at these sites are included in the site’s supplemental inpatient calculation (unchanged)
  - Minimal Hospital (1 - 4 ADPL): 67% of users are included in the site’s supplemental inpatient calculation
  - Modest Hospital (5 – 9 ADPL): 33% of users are included in the supplemental inpatient calculation
  - Hospital (>10 ADPL): Site does not qualify for supplemental inpatient calculation

## **11) Historical Base Budgeting - discussion**

- GAO opposes
- Statutory Restrictions
  - Prohibits reductions for 638 contracts
  - 5% limit
- Advantages
  - Stable, predictable, lower fluctuations, less volatility
  - Simple to administer – less overhead
  - Less annual political conflicts about allocations
  - Budget formulation/justification principles
- Disadvantages
  - Slower to reflect rapidly changing conditions
  - Slower to remedy past discrepancies
  - Less incentive to innovate, complacency

## **12) Health reform & AIAN resource needs - discussion**

- Substantial in potential
  - Cost reductions and waivers for AIANs
  - Due to poverty, many AIANs qualify for cost reductions
  - Some tribes subsidize enrollment, many have not
  - slow to realize, 2-3 years for situation to stabilize
  - Not yet reliably measured, little data exists for AIANs
- State Medicaid expansion - Mixed
  - Big differences in resource opportunity for AIANs individually and IHS/Tribal sites serving them
- Online insurance comparison tools
  - Offer new options to reliably estimate actual cost of full coverage for AIANs that is equivalent to other Americans