IHS/Tribal IHCIF Workgroup
Sub-Groups

An IHS/Tribal workgroup is assessing the Indian Health Care Improvement Fund (IHCIF) formula. During wide ranging discussions about it, many issues were identified for follow-up and analysis by technical experts.

The charge for each sub-group is to investigate in greater detail the items listed for the group and to report the group's findings and recommendations back to the full workgroup for consideration. Time permitting, each sub-group also may identify related issues or options. Please summarize available factual data that underlie findings, implications, and recommendations. Please list pros and cons (e.g., rationale for support and non-support). Finally, determine whether any proposed changes to the IHCIF methodology are immediately feasible or not and any administrative and reporting burden that implementing changes would cause.

Four sub-groups have been established:

- Per Person Benchmark
- User Counts
- PRC Dependency
- Alternate Resources

Sub-Group: PER PERSON BENCHMARK

Sub-Group Members (*alphabetical by last name*):

Jennifer Cooper, HQ, Jennifer.Cooper@ihs.gov
Francis Frazier, HQ, Francis.Frazier@ihs.gov
Lynn Malerba, Nashville, lmalerba@moheganmail.com
Kasie Nichols, Oklahoma City, kasie.nichols@potawatomi.org
Jim Roberts, Alaska, jcroberts@anthc.org

Action	*Assigned to / Status*
Assess the rationale and impact of replacing the Federal Employee Health Plans (FEHP) per user cost benchmark with a benchmark based on national health care expenditures (personal health care services).	Team
Develop "side-by-side" LNF/IHCIF results under the original FEHP and proposed benchmarks.	Revised the LNF calculation model to optionally reference the National Health Expenditure (NHE) price benchmark. Side-by-side results can be produced quickly when NHE data are plugged into the model.
Compare purposes and services for each IHS budget category (BAP, e.g., PRC, etc.) with national health expenditure definitions to estimate correspondence or lack of correspondence. Express as a percentage, e.g., H&C 100%, Sanitation 0%	Team Reprogramed the LNF model to recalculate available IHS resources based on either the FEHP correspondence percentages or the NHE correspondence percentages when determined by the team.
Compare services and programs authorized in IHCIA to types of spending in the national health care expenditures. List major categories of un-funded IHCIA services that correspond to national health care spending. We anticipate that IHCIA mandates more closely correspond to national health care spending than mainstream insurance plans such as FEHP BC/BS. Consider analyses developed by the Budget Formulation workgroup or other sources.	Team

Sub-Group: USER COUNTS

Sub-Group Members (*alphabetical by last name*):

Ann Arnett, Portland, Ann.Arnett@ihs.gov
Chris Devers, California, ccdevers@gmail.com
Jason Douglas, Bemidji, jason.douglas@ihs.gov
Melissa Gower, Oklahoma City, melissa.gower@chickasaw.net
Kirk Greenway, HQ, Kirk.Greenway@ihs.gov
Ron Grinnell, Oklahoma City, ronald.grinnell@ihs.gov
Dee Hutchison, Navajo, dee.hutchison@ihs.gov
Steven Kutz, Portland, skutz.health@cowlitz.org
Robert Pittman, HQ, Robert.Pittman@ihs.gov
Leslie Racine, Billings, Leslie.Racine@ihs.gov
Jim Roberts, Alaska, jcroberts@anthc.org
Dee Sabattus, Nashville, dsabattus@usetinc.org
Sheila Todecheenie, Phoenix, Sheila.todecheenie@ihs.gov
Larry Voegele, Great Plains, lvoegele@poncatribe-ne.org

Action	*Assigned to / Status*
Assess the rationale and impact for modifying augmenting user counts now used in the methodology. List any implications if any of switching from an insurance plan benchmark to the national health care expenditure benchmark.	Team
Cross-walk "Non-CHSDA" users among 263 service delivery areas.	Kirk Greenway and Area Office staff. Created and provided to IHS additional data templates for 12 Areas to cross-walk Non-CHSDA counts among 263 local sites.
Prepare side-by-side results of base user count and base user count plus Non-CHSDA users	Cliff Wiggins Revised the LNF calculation model to optionally add Non-CHSDA counts. Side-by-side results can be produced quickly when data become available from IHS. In continuing dialogue with Mr. Greenway about IHS User counting algorithms. Provided comment and analysis of 2 types of Non-CHSDA algorithms.
Assess feasibility to augment each service delivery area user count with all or portion of Census based IHS "Service Population" counts. Cross-walk Service population counts among 263 service delivery areas.	Team, Kirk Greenway, and Area Office staff.
Prepare side-by-side results of base user count and base user count plus Service Population	Cliff Wiggins Revised the LNF model to recalculate by

counts (if practical) for 263 service delivery areas.	optionally adding Service Population increment counts. Side-by-side results can be produced quickly if/when data become available from IHS.
Assess the frequency that users (who are assigned to a service delivery area by place of residence) have encounters both in and outside the service delivery area facilities places. Is this problem isolated or prevalent? Assess feasibility for site of service counts versus residence based counts.	Kirk Greenway, etc. Continuing dialogue about IHS User counting algorithms. Analysis of 2 types of Non-CHSDA algorithms.

Sub-Group: PRC DEPENDENCY

Sub-Group Members (*alphabetical by last name*):

Melissa Gower, Oklahoma City, melissa.gower@chickasaw.net
Dee Hutchison, Navajo, dee.hutchison@ihs.gov
Liz Fowler, HQ, Elizabeth.Fowler@ihs.gov
Steven Kutz, Portland, skutz.health@cowlitz.org
Mark LeBeau, California, Mark.LeBeau@crihb.org
Rita Neuman, Billings, Rita.Neuman@ihs.gov
Dee Sabattus, Nashville, dsabattus@usetinc.org
Larry Voegele, Great Plains, lvoegele@poncatribe-ne.org

Action	*Assigned to / Status*
Assess the rationale and impact for adding PRC Dependency type indicator to the LNF methodology. The workgroup expressed some concern that existing "location based cost adjustments" insufficiently reflect true needs where hospitals are inaccessible.	Team
Identify objective indicators (data) of PRC dependency and the weight such indicator should have among all "location based cost adjustments" NOTE: Although not explicitly specified as part of this charge, the LNF calculation model was revised to include another optional factor to address proposals made by some work group members to reflect higher costs connected to distance, isolation, that restrict IHS users access to private providers and other non-IHS health care systems.	Team A) LACK IHS HOSPITAL ACCESS: Revised the LNF model to recalculate by optionally adding a PRC-dependency factor. An obvious candidate is the lack of access to an IHS/Tribal Hospital which is currently part of the PRC resource allocation formula. The revised LNF model can handle either the PRC factor as is (yes or no for the whole SDA), or refined to identify the SDA population % without Hospital access. B) RESTRICTED ACCESS TO PRIVATE PROVIDERS: A second "Reduced Access" indicator was added as an option to the LNF calculation model. The indicator would measure the % of population in each SDA with: • Unrestricted Access – % of SDA Population in or near Urban places • Reduced Access - % of SDA Population in small towns or rural places • Wholly Restricted Access - % of SDA Population in remote and isolated areas

	A data collection template for all 263 SDAs (12 Areas) was provided if IHS chooses to collect this data. Side by side LNF results can be generated quickly if/when data become available.
Identify implications of a 2 bucket allocation approach (e.g., a set aside for PRC dependent sites) compared to a single bucket approach augmented for PRC dependency.	Team

Sub-Group: ALTERNATE RESOURCES (non-IHS Funding)

Sub-Group Members (*alphabetical by last name*):

Ann Church, HQ, Ann.Church@ihs.gov
Chris Devers, California, ccdevers@gmail.com
Sarah Freeman, Portland, sksullivan16@gmail.com
Melissa Gower, Oklahoma City, melissa.gower@chickasaw.net
Clinton Gropp, Albuquerque, Clinton.Gropp@ihs.gov
Dee Hutchison, Navajo, dee.hutchison@ihs.gov
Desdemona Leslie, Phoenix, desdemona.leslie@ihs.gov
Doneg McDonough, Technical Advisor, DonegMcD@outlook.com
Laura Platero, Portland, lplatero@npaihb.org
Jim Roberts, Alaska, jcroberts@anthc.org

Action	*Assigned to / Status*
Section 1621 statute explicitly requires counting all sources of services or resources available to AIANs. Technical staff proposed augmenting the measure of alternate resources based on State Medicaid Eligibility and survey data showing the percentage of AIANs in each state covered by alternate resources. Assess options and implications, both technical and contextual, e.g., political for revising the LNF/IHCIF model.	Team
Review recent literature, data sources and/or studies of alternate resources available to AIANs. Consider the feasibility of adopting or not adopting such measures.	Team
Assess IHS datasets as a source of potential alternate resource eligibility codes for potential indicators for each Area, State, or individual service delivery area.	Team
Assess state maintain datasets as a source of potential alternate resource eligibility information.	Team
Assess CMS datasets as a source of potential alternate resource eligibility information.	Team
Seek input from "subject matter experts" from Indian country for data sources, studies/projections that may be helpful, and input in general.	Team