IHCIF User Count Sub-Group

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User Count Sub-Group

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User Count Sub-Group Charge

- 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.
- Cross-walk “Non-CHSDA” users among 263 service delivery areas.
- Prepare side-by-side results of base user count and base user count plus Non-CHSDA users

User Count Sub-Group Charge (Con't)

- 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.
- Prepare side-by-side results of base user count and base user count plus Service Population counts (if practical) for 263 service delivery areas.
- 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.

2010 Technical Workgroup – Un-duplication

- User count shapes the formula results more than any other data.
- Duplicates –Thought to be less than 5%
  - Implies duplicate funding
  - Small overall impact since numbers are low and IHCIF are less than 2% of what is needed
- Recommendation
  - Consider going form Are un-duplication to IHS-wide un-duplication
  - Would have to address user counts for individuals with multiple addresses
  - Factional assignment reflecting frequency and intensity of use is possible

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2010 Technical Workgroup – Persons outside IHS Service Areas

- Persons residing outside IHS service areas, often but not always in adjacent urban counties, obtain services for which costs are not recognized in the IHCIF formula.
- Recommendation: Policy issue touching on urban Indians, open door policy and direct vs CHS eligibility.

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2010 Technical Workgroup – Standard Codes for IHCIF Operating Units

- Historical Service Units do not always correspond with delivery system (Service Delivery Areas).
- Develop standard code book table linking older Service Units and communities codes to IHCIF “Operating unit” codes. User counts for operating units could be automatically tabulated.

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2010 Technical Workgroup – Tabulations

- IHS and Area offices track a variety of health status and utilization indicators that depend on population counts in the denominator.
- Recommendation: Identify how these changes will be applied for other purposes.

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User Population and Unduplication

User Population

- The user population is those patients that receive direct or contract healthcare from inpatient stay, outpatient visit, or a direct dental visit at an IHS or tribal facility during the previous three years.
- The user also must live within a Purchased Referred Care Service Delivery Area (PRCSDA)

Unduplication

- Individuals can go to multiple sites for care.
- There are methodologies/statistical methods to count these individuals.
- Historically, these counts have been done at the Area level.
- Can now do national unduplication.

Fractionalization

- Allow all service delivery areas providing health care services to get some user count credit

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Non-CHSDA Users

Non-CHSDA Users

- Purpose: to include individuals receiving health care services who are not being counted.
- For either scenario need to know the boundary units of each Service Delivery Area Service Unit, counties, etc.

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Non-CHSDA Users – Scenario 1

Scenario 1

- Assigned to a community that is assigned to a Service Unit with an ASU code ending in 00.
- Not inside of a service unit (therefore not in a PRCDA or CHSDA). Counting only non-Service Unit Users
- They meet all criteria of being a user.
  - Active
  - Workload reportable visit in the last 3 years,
  - Indian, Beneficiary Category Code or blood quantum or Tribe code from a federally recognized Tribe.
- This scenario shows 10 regions that have communities that have non-CHSDA.
- Navajo and Tucson do not have any non-CHSDAs.
- There are some in Alaska.
- Urban Indians might be included in these counts.

Non-CHSDA Users – Scenario 1

Examples

- In the Oklahoma City Area there are individuals traveling from across the border in Arkansas, Kansas and Texas. Historically, these individuals are eligible for health care services, however, they have not been included in the user population because they did not live in a CHSDA.
- Alaska – Most of the non-Service Unit users have two distinct codes. One is Alaska Unspecified. The other is Alaska Unknown (146 patients). May be a data quality issue.

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Scenario 1. If not resident in any community in any CHSDA nationally	
AREA	TOTAL
ALASKA	376
ALBUQUERQUE	959
BEMIDJI	8,916
BILLINGS	3,550
CALIFORNIA	1,886
GREAT PLAINS	6,918
NASHVILLE	3,706
NAVAJO	-
OKLAHOMA CITY	16,170
PHOENIX	2,580
PORTLAND	4,217
TUCSON	-
	49,278
These people went to a facility in the named Area,	
did not belong to a community in a PRCDA or CHSDA nationwide,	
therefore did not receive regionally unduplicated user credit	

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Non-CHSDA Users – Scenario 2

Scenario 2

- Active AI/AN residing in a non-urban CHSDA.
- ASU does not end in 00.
- Reside in another Area.
- Unlike scenario 1, they are not reported where they reside.
- They are reported in each Area (can be more than one Area).
- **You could think of these patients being visitors to the Area.**
- ALBQ, PHX, NAV standout because interlaced with visitors and crossover.
- Highly likely individuals are duplicates by definition. For example, if a person is counted for user credit in Navajo Area and also visit Phoenix Area, there would be one count for Phoenix Area.
- All 12 Areas included in this scenario.

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Scenario 2. If in a community outside the CHSDAs of that area	
AREA	TOTAL
ALASKA	2,903
ALBUQUERQUE	14,008
BEMIDJI	2,223
BILLINGS	4,486
CALIFORNIA	3,794
GREAT PLAINS	6,035
NASHVILLE	1,621
NAVAJO	34,438
OKLAHOMA CITY	6,975
PHOENIX	39,861
PORTLAND	5,885
TUCSON	4,557
	126,786
These people went to a facility in the named Area, did not belong to a community in a PRCDA or CHSDA of that area, therefore did not receive regionally unduplicated user credit	

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Service Population

Service Population

- Service Population is not the same as the Census Population.
- It is based on the year 2000 bridged race file.
- Use Service Unit Geography to determine where the Service Unit is and then using a county-level bridged race file count how many eligible AI/ANs reside within the geographic area for which IHS is responsible (locations on or near reservations).
- May or may not use IHS health services.
- Migration not a factor.
- Algorithmic method.
- Uses rules based on individual responses to the National Health Interview Survey (by Census).
- Uses Census definition of Indian
- Allows us to compare to historical budget figures
- Two possible tools to look at service population

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Service Population – Method 1

Method 1 – simple calculation method

- Determine percent of user population of the Area for each service delivery area.
- Take the Area Service Population and multiply by the percentage of the user population.
- Worked for all service delivery areas except for those in Alaska.

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Service Population – Method 2

Method 2

- If know where SDAs are and use a more intensive calculation, you get better result, but one Area is less impacted than the other Areas.

Other Methods

User Population vs Service Population vs Hybrid

For Consideration

- Using user population is the most conservative alternative for unmet need (those users that we know the most about).
- Is it better to set priority for that population or is it better to blend that population with the larger population.
- Previous workgroup felt IHS should target the known system and its unmet need.
- Historically, the IHCIF priority was members and descendants of federally recognized tribes, which is different than the urban definition.
- Census definition of Indian is less strict than IHCIA. In urban areas this may lead to error in urban counties.