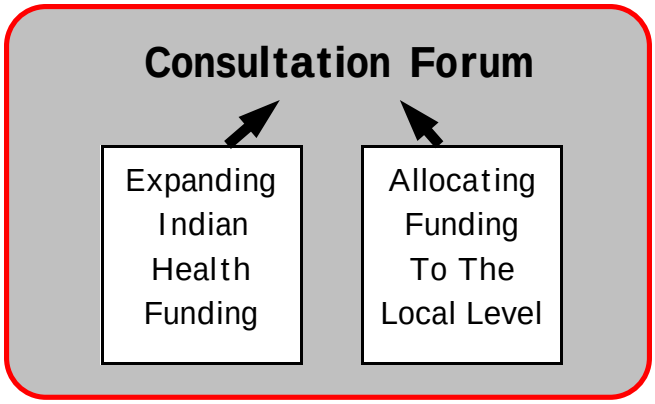
LNF Primer

The LNF Primer introduces the Level of Need Funded methodology and outlines the basics for review at the regional LNF consultation forums.

www.ihs.gov/nonmedicalprograms/lnf

2 Big Picture Issues



The LNF consultation forum is one among a number of ways to get tribal input to the policy making process. Input from 3 regional forums will go to the LNF work group which will make recommendations to the IHS. Both big picture issues (expanding total health funding for Indian health) and (allocating new funding among local Indian health programs) are important issues on which to comment.

The Background Facts

1. Indian people have long experienced disproportionately low health status and a large gap in health care resources compared to other Americans.
2. Federal statutes in the Indian Health Care Improvement Act call for "eliminating the deficiencies in health status and resources of all tribes".
3. The Congress requested a health status and resource deficiency report for each Indian tribe or service unit.
4. The IHS charged the Level of Need Funded (LNF) work group to develop the necessary methodology.
5. Among other budget enhancements, the Congress has appropriated $10 million in 2000 and $30 million in 2001 for the Indian Health Care Improvement Fund.
6. Congress directed that "The IHS should distribute the Indian Health Care Improvement Fund (IHCIF) in accordance with the Level of Need methodology to ensure that the most under-funded tribes are funded at more equitable levels."
7. The LNF work group will consider input from regional forums, correspondence to IHS, and other sources to make final recommendations for a methodology to allocate IHCIF funds.

The LNF Work Group

The LNF work group is a joint tribal-IHS committee. The work group charge was to develop a methodology including perspectives from Indian country. Members represent a mix of elected tribal officials, health care administrators and staff. The workgroup is not a substitute for consultation. Rather it is a vehicle for collecting and considering Indian views during policy development.

NAME	REPRESENTING
Jim Crouch Exec. Dir., California Rural Indian Health Board	California Area Tribes & Tribal co-chair
Reuben Howard Director, Pasqua Yaqui Tribal Health Department	Tucson Area Tribes
Howard Roach, Former IHS Administrator, Volunteer Lawton SU	Oklahoma Area Tribes
Bob Hall South Dakota Urban Indian Health	Urban Indian Projects
Orie Williams (replaces Carolyn Crowder, CEO NSHC) Executive VP, Yukon Kuskokwim Health Corp.	Alaska Area Tribes
Thomas John Diabetes and OTA Coordinator, USET	Nashville Area Tribes
Daniel Honahni, PhD. Hopi Tribe	Phoenix Area Tribes
Deanna Bauman Health Manager, Oneida Community Health Center	National Indian Health Board
Russ Vizina Director, Sault St. Marie Health Center & Human Svs.	Bemidji Area Tribes
Cliff Wiggins, Senior Operations Research Analyst, IHS	IHS co-chair & Office of Director, IHS
Taylor McKenzie, MD Vice-President, Navajo Nation	Navajo Area Tribes
Joyce Naseyowma Acting Executive Director, Albuquerque Area IHB	Albuquerque Area Tribes
Colleen Cawston Chairperson, Confederated Tribe of Colville	Portland Area Tribes
Greg Pyle Chief, Choctaw Nation of Oklahoma	Self-Governance Advisory Committee
Phillip Longie, Chairman, Spirit Lake Tribe	Aberdeen Area Tribes
Gordon Belcourt Exec. Dir., Montana-Wyoming Tribal Leaders Council	Billings Area Tribes

LNF is for Personal Health Services

The LNF methodology is based on a defined benefits package for personal medical services. Personal medical services are visits to doctors, dentists, nurse practitioners, hospital care, and other health services provided to individuals. This benchmark provides a recognized basis for determining whether Indian health funding for personal health services is deficient compared to other Americans. Using industry standard actuarial methods, **the study found that $2,980 per person is needed to assure benefits equivalent to those in a mainstream health plan**.

A Methodology for "wrap-around" is needed

Public health programs supplement personal health services in IHS' community-based approach to health care. These include sanitation facilities construction (clean water and waste disposal), community health representatives, public health nursing, public health education, and environmental monitoring and remediation — forms of municipal infrastructure which can be non-existent in remote areas of Indian country. Both personal and public health services are essential to improve Indian health status. The LNF work group left development of a wrap-around services methodology for a later time.

Elements of LNF Methodology

$2,980 Benchmark	**Annual cost per person for mainstream benefits package using actuarial model.**

- Average premium for a mainstream plan is $2,100 for persons < 65 years.
- $733 add-on for the elderly raises average costs to $2,833.
- $558 add-on for co-pays, deductibles raises average costs to $3, 391.
- Costs for Indians are assumed equal to costs for non-Indians of the same age and sex. Because fewer Indians are in costly older age brackets, the average cost is $2,645, $746 (-22%) for this younger population.
- The Indian population is sicker than the average.
  Add-on $509 (15%) to raise average costs to $3,153.
- More of the Indian population lives in lower cost rural locations.
  Deduct $173 (–6%) for a **average cost of $2,980**.
- Costs or each local operating unit may differ from the national average.

Adjust Benchmark for Size/Efficiency

Small size—less efficient—costs more than $2,980
Large size—more efficient—costs less than $2,980

- In-house costs depend on size—larger operating units enjoy cost savings.
- IHS staffing standards are based on this economy of scale assumption.
- The LNF actuary concluded that a size adjustment based on the staffing model was acceptable—"in the middle of industry experience."
- Based on this recommendation, the workgroup adopted a cost adjustment for local size at "**10% cost savings for each doubling of users.**"
- The size adjustment is applied only to in-house costs, not external costs.
- The break point is approximately 12,000 users—costs for units < 12,000 users are raised and costs for units > 12,000 are lowered to balance that the average benchmark cost of $2,980 is unchanged.

Adjust Benchmark for Prevailing Prices

Higher market prices—costs more than $2,980
Lower market prices—costs less than $2,980

- External costs depend on prevailing prices in the local / regional market to which patients are referred.
- Medical price index for counties is based on a blend of hospital wage data and physician practice costs—an index > 100% means higher purchase costs, an index <100% means lower than average costs.
- For each local unit, the price index for county to which most referrals are made is used. The price indices range from 85% in the lower 48 to 138% in Alaska.
- The external price adjustment is applied only to purchase costs, not in-house costs, in such a way that the average of $2,980 is unchanged.

Adjust Benchmark for Health Status

Worse—more services—costs more than $2,980
Better—less services—costs less than $2,980

- Costs depend on the sickness of users and the amount and complexity of services they need.
- $509 (15%) was added to the benchmark cost because Indians have lower health status than other Americans
- The actuary developed an index of health status of IHS areas using mortality rates, birth rates, and poverty rates for Indians.
- The status index affectively adjusts the add-on to exceed $509 in areas with low heath status and reduces to $509 add-on in areas with better health status.
- The adjustment is applied so that the average cost of $2,980 is unchanged.

Deduct $745 For Other Coverage

Statute requires consideration of other resources including Medicare, Medicaid, and Private Ins.

- Federal statute requires consideration of all resources in computing unmet funding needs for the Indian Health Care Improvement Fund.
- Local level data for other coverage are incomplete and imprecise.
- Extrapolation of a 10 year old survey of health care utilization and funding for 6,000 Indian households show approximately 25% is not from IHS.
- The LNF work group is philosophically apposed to counting other coverage, but agreed that global deduction of 25% ($745) is necessary because of statute.
- $745 per person is an average for all local operating units and will not reflect variations that may exist in alternate coverage at the local level.
- The resulting average net cost is $2,235 ($2,980-$745=$2,235).
- Actual net cost for individual local operating units can be higher or lower than $2,225 because of the benchmark cost are adjusted upward or downward for local conditions.

Identify IHS Funds Available

Local IHS $ + a portion of area and IHS wide $ Less funds used for "wrap-around" programs

- Area offices report IHS funds based on actual budget allowances to each local operating unit.
- Added to local funding is a pro rata portion of area-wide funds ($/area users).
- Added to local funding is a pro rata portion of IHS-wide funds ($/area users).
- Deducted are funds spent on wrap-around programs (% is discounted for each budget account based on financial study by IHS).

Compute LNF % & Unmet Needs

Compare available funds to needed funds to get the percentage of need that is funded.

- Available $ / Needed $ = LNF %
  (IHS $ per user) / (Net cost per user)
- The average LNF % for FY 2000 was approximately 58%
- $258 million is needed to raise all local units to 60%.
- > $1.3 billion is needed reach 100%
- These findings are for personal health services only—not wrap-around—and for existing users of the system only—not other Indians who are eligible but may not access services because of distance or limited availability.

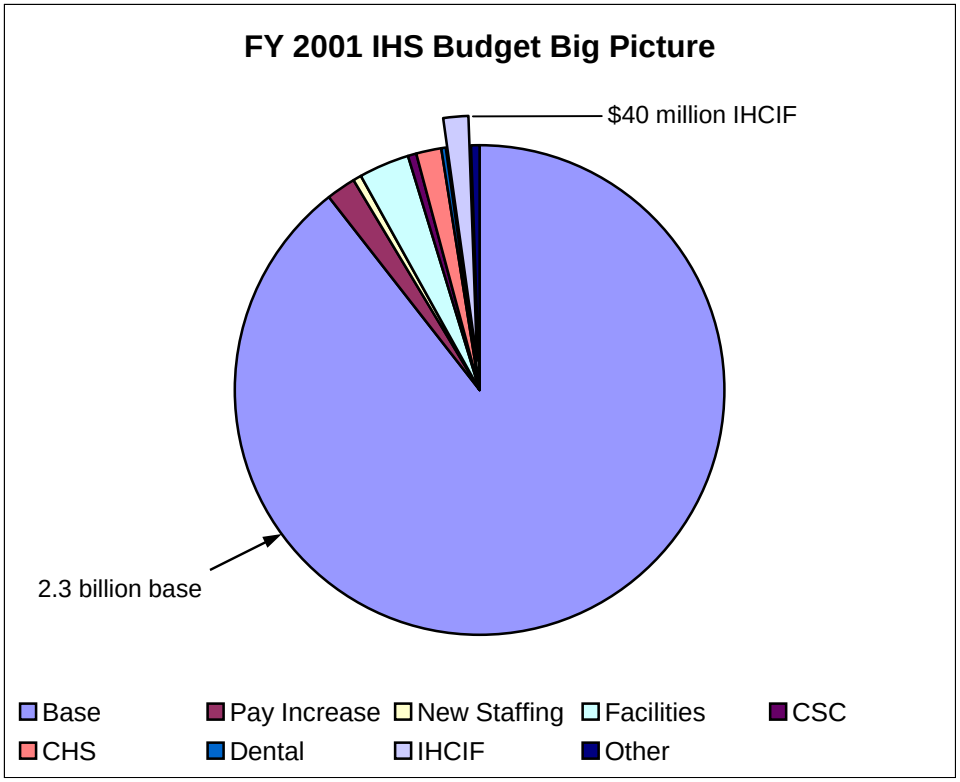
The IHCIF Formula

The language in statute says the IHCIF is for eliminating deficiencies with respect to those tribes with the highest levels of health status and resource deficiencies. The LNF work group discussed at length how to interpret this guidance. The work group recommended that tribes/operating units funded at less than the average for that year (approximately 60% in FY 2000) be eligible for receiving IHCIF funds.

The funds actually available for distribution in FY 2000 were insufficient to raise below average units to 60%—which required $258 million. Out of $10 million available, $9 million was distributed with the IHCIF formula and $1m was distributed with the CHS formula. Therefore, each eligible operating unit received approximately 3.5% of funds needed to raise it to 60% LNF ($9m/$258m=3.5%).

This methodology has the effect of targeting those units with the greatest deficiencies as required by statute. First, by targeting funds to units below average and, second, by awarding amounts in proportion to deficiency. For instance, if two units are similar with respect to size, price, health status, etc., then a unit funded at 40% LNF (20% below the 60% average) is twice as deficiency as a unit funded at 50% LNF (10% below the 60% average) and receives an allocation that is twice as large.

IHCIF is a small part of the budget picture



An example from the FY 2000 IHCIF

CHEYENNE RIVER OPERATING UNIT IN ABERDEEN AREA

Given Data

- 8,057 = 1998 user count
- $2,980 = National average cost per person (not including wrap-around costs)
- 33% = % Expenditures on purchased services, 67% = % expenditures in-house
- 91.9% = Cost index for purchasing health care in this geographic area
- 105.8% = Size cost index for in-house costs due to small or large size
- 108.7% = Aberdeen area cost index for health status above or below average

Cost Adjustment Calculations

- $905 per person for purchased services = 33% * 91.9% * $2,980
- $2,111 per person for in-house services = 67% * 105.8% * $2,980
- $3,015 per person total = $905 (purchase) + $2,111 (in-house)
- **$3,278 per person total** adjusted for health status = $3,015 * 108.7%
- **$2,533 per person net cost** = $3,278 - $745 Other resources (M&M&PI)

Existing Expenditures (for 8,057 users excluding wrap-around and collections)

- $1,043 per person = local IHS allowance (excludes $ for wrap-around)
- $203 per person = expenditures elsewhere in Aberdeen area on behalf of area users
- $54 per person = expenditures elsewhere in IHS on behalf of IHS users
- **$1,300 per person for OU users** = $1,043 + $203 + $54

LNF Calculation

- **39.7% Gross LNF** = $1,300 (expenditures) / $3,278 total cost (ignoring Medicare, Medicaid, PI spending on behalf of OU users)
- **51.3% Net LNF** = $1,300 / $2,533 net cost ($3,278 - $745 other)

IHCIF Allocation

- $1,769,516 = $ to raise LNF% from 51.3% to 60%
- $258,040,100 = aggregate $ to raise all locations to 60%
- 3.488% IHCIF fraction = $9,000,000 fund / $258,040,100 needed
- **$61,721 Allocation** = $1,769,516 needed for 60% * 3.488% IHCIF fraction

CHEYENNE RIV Unmet Needs

- **$20,410,008 Net Total Need** = 8,057 users * $2,533 net cost
- **$9,933,520 Net Unmet Need** = (100% - 51.3% LNF) * 8,057 users * $2,533 net cost

This is actual data and computations from the FY 2000 IHCIF methodology. A similar 1-page summary for all local operating units is available on the LNF website.

Issues Raised by Consultations So Far

- Comments both supporting and opposing the IHCIF formula have been received.
- Defining "most under-funded tribes" is very important for IHCIF allocation formula. The workgroup recommended allocating funds to tribes which are funded today at less than average (60%). After all tribes reached 60% the threshold would be raised, thereby expanding the number of participating tribes. With this approach, approximately 2/3 of tribes participate in the fund in FY 2000. If the definition is set to 100%, as some comments suggest, almost all tribes participate in the fund because all are under funded to some extent. The concern is whether this approach is consistent with the statute and whether funds would be spread too thinly to accomplish real improvements.
- Several comments point out that the LNF methodology explicitly excludes costs for infrastructure and "wrap-around" services. Both personal health services and "wrap-around" community health programs are important for raising health status of Indian people. IHS is proposing a new work group to develop a companion methodology for wrap-around programs. The effort will begin by convening a round table to define a process an approach for this methodology.
- Several comments suggest modifying the health status factor to:
  - include additional measures such as life expectancy,
  - refine the IHCIF formula so that health status contributes more to results, and
  - Use county health status data if feasible
- A number of tribes commented on the global deduction of $745 for other health care resources. Two concerns are typically raised. First, because health care is a federal responsibility based on treaties, the methodology should consider other resources as supplementing not supplanting IHS appropriations. Second, a single global amount will not reflect variations in other resources that may exist among local operating units.
- A number of concerns regarding data consistency and quality have been raised with respect to:
  - User Counts Data (unduplication and inclusion of users residing outside traditional service area boundaries)
  - Other Coverage Data (lack of local level data)
  - Regional/local price variations (possibility that rural cost factors may understate costs in extremely remote areas)
  - Health Status Data (county level data is preferred if available and feasible)
- A number of comments explore options to use the actuarial methodology to help formulate the IHS budget requests.

FAQ

Why do we need the LNF methodology?

Congress directed IHS to report health care funding deficiencies for tribes. The LNF methodology was developed following guidelines in federal statute. The Congress also directed the IHS to allocate IHCIF funds using the LNF methodology.

Will the methodology result in funding decreases?

No. The methodology is designed to identify additional funding needs and allocate additional funds to places with the greatest needs. There are no plans to redistribute existing funding.

Does the LNF study recommend replacing the IHS with a insurance plan?

No. The LNF study uses a typical mainstream health plan as a reference to compare funding needs of Indian people with health funding available to persons covered by insurance plans. Using that standard, the study found a large gap in needed funding. Neither the LNF work group nor the IHS has proposed moving towards an insurance model. Rather, work group members say that local programs can design operate their own health programs if sufficiently funded.

Are Urban Indians included in the IHCIF?

No. The LNF study identified 4 sub-groups of eligible Indians to which the methodology may be applied. One of these groups was urban Indians residing in 34 cities with existing urban projects. The LNF methodology could be applied to Urban funding allocations if that is desired.

How does the LNF findings compare to the tribal budget formulation process?

The LNF study addresses a rather narrow question: "what amount of funding is necessary to make Indian health funding comparable to mainstream health plans." The tribal budget formulation process uses a much broader definition which includes personal health services, all wrap-around programs, and additional health services not now provided. While the funding benchmark in the LNF study was explicitly developed to allow "apples-to-apples" comparisons, the tribal budget formulation process use larger spending benchmarks from Medicaid which include programs not part of typical health plans. Also, the tribal budget includes expanding users from 1.4 to 1.8 million including 332,000 urban Indians. Finally, the tribal budget includes an additional $8 billion for infrastructure expansion and improvement that is not assumed in the "apples-to-apples" LNF study.

Are LNF findings inconsistent with the tribal developed budget request?

Not necessarily. The deficiencies identified in the LNF methodology are substantially smaller, but this largely due to the narrow scope of LNF which focuses only on personal health care as compared to the broad and comprehensive definitions used in the tribal budget process.

Glossary of terms

Active User—A eligible Indian individual who has obtained health care services at least once during the past 3 years.

Actuarial/Actuary—A science that uses statistics and mathematics to forecast risks of certain events, such as sickness or death, in defined populations. Actuaries help determine the insurance premiums to cover costs that are likely for a covered beneficiary group with certain characteristics such as age, sex, occupation, etc.

Age Adjustment—a method for considering average characteristics of populations whose age structure is different than a reference population. The LNF assumes costs for Indians are equal to costs for non-Indians of the same age and sex. The average cost is different, not because individuals cost less, but because fewer Indians are currently in the more costly age brackets.

Allowances—The official delegation of amount of spending authority to Areas and local operating units—the equivalent of transfers of funds.

Area—One of 12 geographic regions in which local operating units are grouped for administrative purposes.

Area-wide—costs incurred or managed at the area office for the whole area.

Base—Amount of funding that is recurring year to year. Base funding typically will decrease only if Congress reduces the IHS budget.

Benchmark—The standard adopted as a baseline for measuring variations. In the LNF study the cost benchmark for FY 1999 was $2,980 per person based on average costs of FEHBP plans adjusted for risk characteristics of Indian people.

Benefits Package—An array of personal health care services, such as hospitalization, physician visits, medications, etc. that are defined as covered in mainstream plans.

Budget Enhancements—Additions to IHS budget compared to the previous year.

CHS—Contract Health Services. A budget account for paying for purchased health care services.

CHSDA—Contract Health Services Delivery Area. A county or group of counties in which resident Indians are eligible for contract health services coverage.

Crossover—the extent that persons residing in one service area get health care services in another service area.

CSC—Contract Support Costs. Ordinary and expected costs of overhead and administration connected to a contracted IHS program.

Deductibles, Co-pays—Amount not covered by insurance premiums that are typically paid out-of-pocket. The LNF study assumes Indian people are not responsible for these costs.

Depreciation—A method for accounting for annual costs of a long-lived asset, such as a facility. For instance, a portion of one-time facility construction costs are

Glossary of terms—continued

charged/depreciated on annual basis over the life of the facility.

Disparity Indices—A special type of index that expressly compares a population against a reference population. Differences, such as gaps in health status of Indians relative to US All Races, are termed disparities.

Earmarks—The term describing directives from Congress to use funds only for a specifically defined purpose.

Economies of Scale—savings are possible as the number of users increases. There may be a limit in which additional growth in size actually decreases efficiency.

External—The extent to which services are purchased from providers outside the system rather than by in-house employees.

FEHBP—Federal Employees Health Benefits Plan. The LNF study used benefits and costs of the FEHBP as a standard for comparing health care needs of Indian people.

H&C—Hospitals & Clinics. A budget account for general costs of medical services provided in-house usually in hospitals and health clinics.

HCFA—Health Care Financing Administration. HCFA oversees Federal Medicare and Medicaid programs.

Health Status Index—A scale that measures relative variations in health conditions for population groups. Health status indices are commonly based on incidence and prevalence of diseases, mortality rates, and underlying conditions such as poverty.

IHCIF—Indian Health Care Improvement Fund. A pool of additional federal appropriations established by statute to "eliminate the deficiencies in health status and resources for all tribes" by targeting those with the highest deficiencies. In FY 2000 the IHCIF was $10 million and in FY 2001 the IHCIF is $30 million additional.

IHS-wide—costs incurred or managed by IHS headquarters on behalf of the field.

In-house—The extent to which services are provided by the in-house employees rather than outside providers.

Input/Output Analysis—An analysis that quantifies the extent that a local population is served by multiple surrounding operating units (inputs) and the extent that the local unit serves persons from surrounding service areas (outputs). The analysis may help identify actual health resource consumption patterns among operating units.

Life Expectancy—The average life span for a population group.

LNF—Level of Need Funded. The extent to which resources are available for a mainstream package of personal health services (LNF does not measure need for infrastructure or wrap-around services.)

M&M—Medicare and Medicaid. Medicare is for the elderly. Medicaid is for the poor.

Medical Center—Referral hospital shared by several operating units.

Glossary of terms—continued

Operating Unit—Local units of the Indian health system that are independent, autonomous and are responsible for the personal health services to eligible Indians (the technical definition is extensive) residing in the service area.

Other Coverage—The extent to which health care services are paid from sources other than from the IHS.

PHCS—Personal health care services. These are ambulatory and inpatient medical services provided to individuals which are defined in a benefits package in mainstream health plans.

Price Index—A scale that measures relative variations in prices, typically among geographic regions, counties, or states. A high price index value means prices are higher compared to prices in other locations.

Resource Allocation—determining the amount of IHS funds provided to local operating units from IHS appropriation.

RRM—Resource Requirements Methodology. A staff planning model used by IHS to identify staff and resources for a new or replacement health care facility.

SAIAN—Survey of American Indians and Alaska Natives that examined health costs in detail for 6,000 households in 1988.

Service Area—The counties in which a operating unit provides services to eligible Indians residing there.

Set-aside—a portion of fund that is distributed or used differently than the balance.

Step-down—A method of allocating central or indirect costs to a particular center, purpose or location. In LNF, step-down of IHS-wide and Area-wide funds is typically proportional to the user counts.

Sub-Sub Activity—Term for IHS budget activities such as H&C, CHS, Dental, etc.

Unduplication—The method to identify and correct counts of users who may have multiple active charts in one or more operating units.

Utilization—Individuals using and receiving health care services from an operating unit of the system.

Weights—Quantitative factors in a formula that control the extent each formula element contributes to allocation results.

Workload—The count of encounters, visits, hospital days, etc. that measure the extent of services provided in local operating units.

Wrap-Around—Public health, community, and sanitation health programs and services that supplement medical services to individuals.

Years of Potential Life Lost—An index that measures pre-mature death compared to a reference life span such as 65 or 70 years of age. In populations with equal death rates, the YPLL is higher when deaths occur at younger ages.