DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

MAY 6 2013

Dear Tribal Leader:

I am writing to update you on the ongoing Tribal consultation to improve the Indian Health Service (IHS) Contract Health Services (CHS) program. I am pleased to share with you the third set of recommendations from the Director's Workgroup on Improving CHS (Workgroup).

The Agency has implemented the Workgroup's second series of seven recommendations since my letter to you on May 29, 2012. To date, the Agency has accomplished the following:

- Conducted Tribal consultation and implemented an optional set-aside of 2 percent of new CHS funds for prevention services that requires consultation with affected Tribes at the Area or Federal Service Unit level;
- Improved the methodology for estimating data on CHS deferrals and denials;
- Received Technical sub-committee recommendation to use the Federal Disparity Index (FDI) methodology to estimate unmet CHS need;
- Developed a standard CHS curriculum for orientation and CHS competency developed by a Federal/Tribal workgroup that can be provided in hard copy or electronically through the IHS.gov Web site that is accessible by Federal and Tribal staff;
- Established a CHS Listserv to serve as a forum to network with Federal/Tribal CHS experts;
- Designated CHS as a standing agenda item for National and Area Budget Formulation sessions;
- Revised the CHS Chapter of the *Indian Health Manual*, which is currently undergoing a formal review prior to publication;
- Partnered with IHS Nursing to implement CHS Case Management guidelines;

The Workgroup has examined all aspects of the CHS program, including, but not limited to, CHS staff training, budget enhancement, data collection for reporting and planning, and streamlining program controls. The eight recommendations that follow provide the third series of recommendations from the Workgroup.

ROUND III: RECOMMENDATION (1)

New CHS Funding

The Workgroup strongly recommends that all CHS programs be "held harmless," that base funding remain unchanged, and that future distribution of new CHS funding continue to be prioritized as follows:

- To cover medical inflation and population growth costs for CHS; and
- To utilize the current CHS distribution formula.

ROUND III: RECOMMENDATION (2)

Distribution Formula for New CHS Program Increase Funds

It is the recommendation of the Workgroup that the existing CHS distribution formula remain in place until after an assessment is completed that begins in FY 2014 of the impact of implementing the Affordable Care Act, Medicaid Expansion, and the Indian Health Care Improvement Act for future IHS budgets.

The Workgroup anticipates that these impacts have the potential to be significant and that future conditions and forces affecting the CHS program may differ significantly from those prevailing now. In the interim, pending the results of the impact assessment, the Workgroup agrees with IHS concurrence with Government Accountability Office (GAO) recommendations to develop certain technical improvements to data measures used in the current CHS formula. Specifically, the IHS should improve the accuracy of the hospital access measure by expanding from a yes/no measure to one that provides additional tiers reflecting levels of hospital care and a factor based on the hospital's isolation.

The Workgroup does not agree with the GAO recommendation to annually allocate all CHS funds by formula, including base funding. The Workgroup strongly feels that reallocation of stable base funding would be contrary to the Indian Self-Determination and Education Assistance Act (ISDEAA). The Workgroup believes that Tribal consultation has consistently established maintenance of current services (which includes annual adjustments to compensate for rising costs due to inflation and population growth) as the highest priority. The Workgroup does agree, however, that any new CHS program funding increases allocated to sites by the National CHS formula may be recalculated within an IHS Area, if the respective Tribes within the Area agree.

The Workgroup concludes that the existing CHS formula is acceptably suited at present to accomplish its original intent, and that the formula's simplicity is a significant side-benefit that permits a better understanding of it. While anticipated future developments may trigger consideration of significant changes to the CHS formula, it is premature at this time to

recommend significant changes, which would, at best, be based on speculation about future events and conditions. In FY 2015 or later, when the impacts of health care reform on the CHS program become clearer and a thorough analysis has been completed, the Workgroup recommends that the Agency conduct new Area and National Tribal Consultation sessions to receive input on options crafted to fit the future conditions.

The Workgroup recommends that a Subcommittee of the Workgroup convene in an appropriate manner no later than 30 days after release of the IHS resource deficiency report, which is due to Congress in the spring of 2013. Earlier Workgroup recommendations on measuring CHS unmet needs were adopted by the IHS. The Workgroup-recommended changes permit calculation of CHS resource deficiencies in that report for the first time. These new deficiency estimates in conjunction with improved measures of deferred and denied CHS cases should be evaluated by the Subcommittee for potential implications to the CHS formula and for potential system improvements arising from calculation and justification of the true CHS short falls.

The Workgroup further recommends that the IHS Director send a Tribal Leader Letter to encourage Tribes to participate in submitting CHS denial and deferral data for inclusion in the national CHS shortfall report. (As of FY 2013, 51 percent of Tribes voluntarily report on CHS data.) Workgroup members have agreed to assist with communicating the necessity of including Tribal CHS data to authenticate current national CHS shortfall estimates.

ROUND III: RECOMMENDATION (3)

Medicare-Like Rates for Non-Hospital Services

The Workgroup recommends the expansion of Medicare-Like Rates for non-Hospital services, provided that available funds are used to provide more services to address growing CHS shortfalls in Indian Country. Furthermore, as alternative payment methods are being considered by the Centers for Medicare & Medicaid Services (CMS) that affect the CHS program, the Workgroup recommends that consultation with Tribes be initiated. Nothing in this amendment shall be construed to alter the provisions of regulations published on June 4, 2007, by the Secretary at 72 Fed. Reg. 30706 et. seq., other than the provisions for payment described in reference to "the higher of Medicaid/Medicare payment rates" provision in the amendment.

ROUND III: RECOMMENDATION (4)

Statewide CHS Delivery Area (CHSDA) for North Dakota, South Dakota, and Arizona, per the Indian Health Care Improvement Act

The Workgroup recommends that this issue be addressed as an Agency regional issue for the time being, as the State of Arizona includes the Navajo Area IHS, Phoenix Area IHS, and Tucson Area IHS. Understanding that additional information is needed to provide a complete analysis related to eligibility and population growth and its subsequent potential impact on CHS, the

Workgroup further recommends that costs associated with implementation of these statewide CHSDAs must be tied to the availability of additional congressional appropriations specific for this purpose.

ROUND III: RECOMMENDATION (5)

Catastrophic Health Emergency Fund

The Workgroup has identified that a Subcommittee of the Workgroup be convened as soon as possible for a face-to-face meeting in June 2013 to address short- and long-term improvements for the CHEF, including consideration of the following:

- Establish a definitive listing of CHEF-covered services;
- Introduce options that would allow CHS programs to choose to be reimbursed at 100 percent once a case is completed, or receive a 50 percent advance payment;
- Determine if the 50 percent advance payment is an effective mechanism for encouraging applicants to submit completed paperwork quickly;
- Determine if the CHEF program should provide a higher percentage in advance, or set aside funds to cover the remaining 50 percent (based on the estimated total cost);
- Identify approaches that better distinguish true unmet need catastrophic cases currently not submitted for reimbursement due to the depletion of funds in the CHEF, or due to the inability of a small CHS program to meet the threshold requirement to access the CHEF;
- Determine if the CHEF program should establish different thresholds for each IHS Area to ensure that smaller CHS programs can better access the program;
- Identify ways that the IHS can assist smaller clinics and CHS programs with limited staffing to increase access to the CHEF program;
- Provide estimates of how lowering the CHEF threshold to $19,000 (as previously recommended) would affect the amount of funds needed to adequately fund the CHEF program; and
- Review the CHEF instructions to determine if additional items need to be considered (Will be provided by Ms. Terri Schmidt, Director, Division of Contract Care, ORAP).

ROUND III: RECOMMENDATION (6)

CHS Best Practices Sessions at the Area and National Levels

The Workgroup recommends that CHS continue to be a standing agenda item for annual Area and National Budget Formulation sessions, with active participation (either in person or remotely) by key IHS and Tribal Health Program staff; that CHS Best Practices be routinely shared during Area and National best practices conferences; and that the resulting materials be posted on the CHS Web page on the IHS.gov Web site.

ROUND III: RECOMMENDATION (7)

CHEF Training

The Workgroup recommends that the IHS establish consistent training on CHEF guidelines during the annual National IHS Director's Tribal Consultation Session, as well as making this training accessible via the IHS training portal. It is further recommended that all IHS Areas promote this training for both IHS-managed and tribally managed CHS programs.

ROUND III: RECOMMENDATION (8)

Use of CHS Funds for Prevention Services

The Workgroup concurs with the IHS Director's decision provided in the January 15, 2013-dated letter to Tribal Leaders, that allows, in consultation with Tribes, up to 2 percent of any new CHS funds at the IHS Service Unit or Area level for referrals for prevention services. This decision is only applicable to IHS-managed CHS programs and direct service sites.

I concur with the third series of Workgroup recommendations and am pleased with their continuing efforts to improve the IHS CHS program. I will keep you informed of their progress and any future recommendations. For your information, I have enclosed a copy of the Workgroup's charge, vision statement, guiding principles, and priorities. You are welcome to submit comments or recommendations by e-mail at consultation@ihs.gov, or by postal mail at the address below:

Yvette Roubideaux, M.D., M.P.H.
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

If you have any questions, please contact Mr. Carl Harper by phone at (301) 443-1553, or by e-mail at carl.harper@ihs.gov.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

Enclosure: Workgroup Charge, Vision Statement, Guiding Principles, and Priorities

Director's Workgroup on Improving Contract Health Services

I. CHARGE OF THE WORKGROUP

The charge of the Director's Workgroup on Improving Contract Health Services (Workgroup) is to provide recommendations to the Director, IHS, on strategies to improve the Agency's contract health services (CHS) program. The Workgroup will review input received to improve the CHS program; evaluate the existing formula for distributing CHS funds; and recommend improvements in the way CHS operations are conducted within the IHS and the Indian health system

II. VISION

To deliver culturally relevant, patient-centered, and medically appropriate CHS services to eligible American Indian and Alaska Native (AI/AN) patients.

III. WORKGROUP AIM STATEMENT

To implement Workgroup recommendations to improve CHS operations, data, oversight, and transparency.

Agency policies will ensure that CHS program services are:

- Reliable and accessible;
- Fully funded;
- Delivered in a culturally sensitive environment; and
- Coordinated and integrated across all elements of the Indian health system.

IV. GUIDING PRINCIPLES

- No Workgroup actions or decisions will have the effect of waiving any Tribal Governmental rights, including treaty rights, sovereign immunity, or jurisdiction, nor absolve the United States of its Federal trust responsibility to provide and fully fund health care services for AI/AN people.
- Each Workgroup member makes a commitment to the Workgroup's charge and makes the time to engage in developing recommendations that will address the needs of eligible AI/AN patients in a fair and equitable manner.
- Each Workgroup member makes a commitment to be informed of all applicable CHS statutes, rules, regulations, and policies.

- Workgroup members pledge to build unity within the group for the benefit of eligible AI/AN people and overcome Area differences, including challenges related to CHS disparities.
- Workgroup recommendations will apply only to future formula funding distribution decisions and will not apply to the current CHS funding base.
- Each Workgroup member makes a commitment to reform that takes into consideration the reasons behind current policies and practices and the potential impact of future health reform changes.
- Each Workgroup member recognizes that future decisions may challenge traditional CHS practices.

V. OUTLINE OF PRIORITIES FOR IMMEDIATE AND LONG-TERM EFFECT

- Commission a study to quantify the unmet CHS need.
- Recommend a reporting process to document CHS referrals, denials, and deferred care to support justification of unmet need.
- Recommend data capture improvements that include capturing the cost burden for patients.
- Evaluate the effect of the fiscal year (FY) 2010 CHS funding increase on CHS unmet need in terms of return on investment for CHS direct services and investment into preventive services.
- Evaluate potential changes to the CHS program as a result of recent legislative actions and the enactment of the Affordable Care Act and permanent reauthorization of the Indian Health Care Improvement Act.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

JAN 15 2013

Dear Tribal Leader:

I am writing in follow-up to a letter I sent to you on August 2, 2012, requesting your consultation and input as to whether there should be a set-aside of Contract Health Services (CHS) program increases for referrals for prevention services. The Director's Workgroup on Improving CHS recommended this consultation.

Currently, when patients need services that are not available at the local health facility, those services may be purchased through referrals to private sector providers using CHS funding. However, at some health facilities, the amount of CHS funding available is not enough to fund all referrals. When funding does not meet the entire need, IHS CHS regulations require IHS-operated CHS programs to use a medical priority system to fund the most urgent referrals first. At some IHS health facilities, the amount of available CHS funding only allows funding medical priority 1 cases, or those that threaten life or limb. Increases in CHS funding in the past few years have allowed some IHS CHS programs to fund more than medical priority 1 cases. However, Tribes repeatedly express the need for the IHS to focus more on prevention, but prevention-type services, if not offered at the local IHS health facility, often fall into lower medical priorities and may not qualify to be funded as referrals by the IHS-operated CHS program. As a result, for some of our patients, referred care that includes prevention services may be deferred or denied, if funding is used for other more urgent medical priorities.

The Director's Workgroup on Improving CHS discussed the possibility of allowing Areas or local IHS Service Units to set-aside up to 2 percent of their CHS program fund increases to be used for referrals for prevention services if the IHS-operated CHS program is otherwise unable to fund these referrals through use of the medical priority system. This usually would be the case if the amount of CHS funding available could only fund medical priority 1 cases (life or limb referrals). This would allow some patients at an IHS Service Unit to get their preventive service referrals, such as mammograms or colonoscopies, approved for payment. Also, some Areas have discussed with Tribes setting aside a small portion of funding at each IHS Service Unit to contribute to funding an Area-wide contract that would provide preventive services to all IHS Service Units, such as a mobile mammography unit that travels to each IHS Service Unit on a regular basis.

The input received during this consultation was varied, but there was support for finding a way to fund more prevention, especially since preventing disease in the first place helps promote wellness and reduce health care costs in the long run. As a result, I have decided to accept the recommendation of the Director's Workgroup on Improving CHS. Therefore, Areas or IHS Service Units, in consultation with Tribes, can decide whether they want to set-aside up to 2 percent of their CHS program fund increases for prevention services for patients, either for individual referrals at the local IHS Service Unit, or for contribution to Area-wide prevention services available to all IHS Service Units.

Areas and IHS Services Units can continue to follow the current medical priority list or can adopt a set-aside as indicated. The most important part of this decision is that Area and local Tribal consultation and agreement on the decision is required.

It is important to note that this decision is specific only to IHS-operated facilities and CHS programs. Tribes that manage their own CHS programs under the Indian Self-Determination and Education Assistance Act (Public Law 93-638) follow CHS regulations but also have the ability to redesign Tribal CHS programs to meet their specific needs.

While this decision helps in the short-term, it is our goal to continue to make CHS funding a priority in the IHS budget formulation process to address the incredible need for referred care in many IHS and Tribal health care facilities. The work of the Director's Workgroup on Improving CHS has also helped us improve the way we conduct business in our CHS programs. Many of these improvements are making our process more efficient and patients are benefiting from more timely referrals, better case management and follow-up. These improvements are resulting in more patients getting their referrals approved, including some referrals beyond medical priority 1. We will continue to implement the recommendations of the Director's Workgroup on Improving CHS and I am looking forward to their next meeting in February where they will discuss the CHS distribution formula.

Thank you for your input on this important matter. If you have any questions, please contact your respective Area Director for more information.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

AUG 2 2012

Dear Tribal Leader:

I am writing to update you on funding for the Indian Health Service (IHS) Contract Health Services (CHS) program. On May 29, I sent a letter to Tribal leaders to provide an update on our ongoing consultation to improve the CHS program. The letter included an update on the progress of the initial set of recommendations issued by the CHS workgroup. I also informed you of additional recommendations proposed by the CHS workgroup. The CHS workgroup has done an outstanding job of developing recommendations that are being be translated into specific, concrete actions to help us improve how we use funding to pay for referrals and care outside of our facilities.

CHS program funding increases remain one of the highest priorities of the IHS in our budget formulation process. As you know, the $117 million increase in fiscal year (FY) 2010 was the largest increase in CHS funding in the past twenty years. This year, the FY 2012 budget provided $843 million in CHS funding, which includes a $63.6 million increase compared to FY 2011. Of this amount, $3.5 million has been allocated to the Catastrophic Health Emergency Fund program that now totals $51.5 million.

The distribution of CHS funding in FY 2012 is based on a national distribution formula that was developed by an IHS and Tribal workgroup in 2001. The formula accounts for a facility's user population, inflation, regional and geographic cost variations, and access to care. The formula only applies to new CHS funding increases; CHS programs continue to receive CHS base funding each year. Additionally, some IHS Areas, in consultation with Tribes, have developed Area-specific CHS distribution methodologies. In 2010, the CHS workgroup reviewed the national distribution formula and recommended review of this formula after funds distribution through FY 2012.

I have provided for your review, a spreadsheet that summarizes the FY 2012 CHS funding distribution for each IHS Area (see Enclosure). The spreadsheet illustrates the recurring base funding from FY 2012, increases for medical inflation, a "program increase", and a 0.16 percent rescission for FY 2012. The spreadsheet also shows the amount for reserve funds that pay for the fiscal intermediary to process claims and an emergency fund for CHS. Tribes who manage their own CHS program under Public Law 93-638 take their Tribal shares of these funds at the beginning of each fiscal year. The total amount of funding distributed to each IHS Area is also shown on the spreadsheet, including the percent increases from FY 2011. In FY 2012, the percent increases for all Areas compared to FY 2011 range from over 6 percent to 10 percent. This increase will help fund more CHS program referrals and increase access to care for the patients we serve.

I am grateful for the increased funding for the CHS program in this year's budget, and look forward to working with you to make needed improvements to this important resource.

If you have any questions, please contact Terri Schmidt by telephone at (301) 443-1547 or by e-mail at Terri.Schmidt@ihs.gov.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

Enclosure
FY 2012 Contract Health Services Appropriation

CONTRACT HEALTH SERVICES
FY 2012 CHS APPROPRIATION

	A	B	C	D	E	F	G
AREA OFFICE	FY 2011 RECURRING BASE	FY 2012 CHS INCREASE				Total Combined Increase Sum B to E	Total FY 2012 Allocations Sum A+ F	Percent Increase From 2011
		Medical Inflation 3.2%	CHS	CHEF	Recsission (0.16%)			
Aberdeen	78,981,101	2,692,925	3,163,000		(126,370)	5,729,555	$ 84,710,656	7.25%
Alaska	75,851,244	2,585,607	3,710,000		(121,362)	6,174,245	82,025,489	8.14%
Albuquerque	37,216,024	1,267,846	2,148,000		(59,546)	3,356,300	40,572,324	9.01%
Bemidji	52,412,948	1,786,964	3,059,000		(83,861)	4,762,103	57,175,051	9.08%
Billings	56,820,021	1,936,710	1,908,000		(90,912)	3,753,798	60,573,819	6.60%
California	40,810,798	1,392,634	2,808,000		(65,297)	4,135,337	44,946,135	10.13%
Nashville	30,183,183	1,028,253	1,390,000		(48,293)	2,369,960	32,553,143	7.85%
Navajo	85,064,880	2,900,073	4,513,000		(136,104)	7,276,969	92,341,849	8.55%
Oklahoma	95,353,262	3,251,975	5,845,000		(152,565)	8,944,410	104,297,672	9.38%
Phoenix	63,107,391	2,151,345	3,368,000		(100,972)	5,418,373	68,525,764	8.58%
Portland	83,293,779	2,840,175	3,886,000		(133,270)	6,592,905	89,886,684	7.91%
Tucson	17,002,021	579,016	547,000		(27,203)	1,098,813	18,100,834	6.46%
Sub Total	$ 716,096,652	$ 24,413,523	$ 36,345,000		$ (1,145,755)	$ 59,612,768	$ 775,709,420	8.32%
CHS Reserve	15,926,348	544,077	3,154		(25,482)	521,749	16,448,097	3.27%
CHEF	47,904,000			3,590,246	(76,646)	3,513,600	51,417,600	6.58%
Grand Total	$ 779,927,000	$ 24,957,600	$ 36,348,154	$ 3,590,246	(1,247,883)	$ 63,648,117	$ 843,575,117	8.16%

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

MAY 29 2012

Dear Tribal Leader:

I am writing to update you on our ongoing Tribal consultation to improve the Indian Health Service (IHS) Contract Health Services (CHS) program. I am pleased to share with you the second set of recommendations from the Director's Workgroup on Improving Contract Health Services (Workgroup).

The Agency has implemented the Workgroup's first four recommendations since my letter to you on February 9, 2011. To date the Agency has accomplished the following:

- Formed a technical subcommittee charged with calculating total current CHS need and estimates of future CHS need;
- Conducted 12 Area Work Sessions to review current CHS policies and procedures and developed recommendations to improve CHS business practices (including IHS and Tribal best practices);
- Used the existing formula for distribution of new CHS funds; and
- Concurred with a recommendation that the IHS Budget Formulation Workgroup apply the true medical inflation index (Inpatient and Outpatient components from the Consumer Price Index) for new CHS increases within the current Agency Budget line item.

The Workgroup has continued to review the CHS program and in the past year have had two meetings and one conference call. Building on the feedback provided at these meetings, the Unmet Need Technical Workgroup and Area Work Sessions continued their work to develop recommendations for improving the CHS program. The seven recommendations that follow provide the second in a series of recommendations from the Workgroup.

ROUND II: RECOMMENDATION (1)

Evaluate Tribal Support for Set-Aside of Future CHS Program Increases for Health Prevention and Screening Services

The Workgroup recommends that the IHS evaluate Tribal support for setting aside a certain percentage of future CHS program increases for health prevention and screening services.

The IHS should conduct Tribal consultation to gather input, including what percentage would be appropriate for such a set-aside. The Workgroup believes that doing so will reduce disease and care delivery costs among Tribal populations and promote wellness in accordance with Tribal health priorities.

ROUND II: RECOMMENDATION (2)

Measuring CHS Unmet Need

The Workgroup deliberated this issue extensively. A technical subcommittee was created to work with Tribal and IHS technical experts to consider options, including the potential for alignment with established IHS methodologies such as the Federal Disparity Index (FDI), alignment with benchmarks that may exist for other Federal programs, or actuarial studies. The current CHS priority system generally does not include prevention services and behavioral health services, which external benchmarks generally cover.

The technical subcommittee ultimately proposed a new approach guided by the following goals:

Validity:	must be scientific and objective
Unbiased:	must be appropriate and acceptable for Federal and Tribal CHS programs
Practical:	must be relatively simple and non-burdensome to implement by providers and staff
Timely:	must be implementable in the near future
Affordable:	must be relatively low-cost.

Short-Term Options

2.a - Implement planned improvements to CHS deferral and denial data collection systems for CHS programs operated by the IHS (with the option for CHS programs operated by Tribes) to improve calculations of each program's CHS unmet need within the context of current policies.

2.b - Statistically separate CHS unmet need data from total unmet need data already calculated in the FDI methodology for each Federal and Tribal operating unit. The FDI calculation currently captures funding needs that are missed in CHS deferral and denial data. It also calculates

full funding for all American Indians and Alaska Natives now served by each operating unit as if each individual was universally eligible for full health care benefits. Provide both calculations (2.a and 2.b) to Federal and Tribal operating units for local validation and comment. Permit operating units to justify revising the FDI statistical mix of direct care and CHS unmet need considering local circumstances and conditions.

Long-Term Options

2.c - Develop new methodology for calculation of "*Additional CHS Unmet Need*," which targets American Indian and Alaska Native (AI/AN) people living in IHS and Tribal service delivery areas who are not currently accessing these health care programs and AI/AN people who come from locations outside the service delivery areas to seek medical services from IHS and Tribal direct care facilities.

The Workgroup suggests a benchmark calculation comparable to the one proposed in 2.b, adapted as appropriate, for these populations.

2.d - Develop a process to calculate the additional CHS funding needed to implement new Affordable Care Act-specific authorities and categories of health care services (such as amendments to the Indian Health Care Improvement Act (IHCIA) related to long–term care). Consider the recommendations of any IHS or Tribal group already examining new authorities and implementation options. Identify any portions of the new service categories which would be more economical and effective if purchased.

ROUND II: RECOMMENDATION (3)

Improve System-Wide Training, Orientation, and Processes

The Workgroup recommends that the IHS develop an implementation plan and timelines for the following actions:

- Develop a standard CHS curriculum for orientation and training on CHS rules, regulations, policies, and procedures for medical staff, CHS program staff, and external provider staff;
- Develop customer service performance guidelines and training for CHS staff;
- Provide "How to Deal with Difficult Patients" training to CHS staff;
- Create a formal CHS network of CHS subject matter experts, including Tribal liaisons, to promote best practices;
- Conduct forums on CHS best practices at the national, regional, and Area levels;
- Conduct CHS listening sessions in conjunction with the annual Area IHS Budget Formulation sessions and include a CHS update at the national IHS Budget Formulation sessions; and

- Provide targeted education and outreach about the Catastrophic Health Emergency Fund (CHEF) program, particularly among smaller clinics and CHS programs. Elevate the focus on CHEF training in the context of other training on CHS. Involve Tribal representatives in delivering education. Provide more training onsite and via Webinars to reach programs that lack the funding for extensive staff travel.

ROUND II: RECOMMENDATION (4)

Review and Update Part 2, Chapter 3, "Contract Health Services" of the *Indian Health Manual*

The Workgroup recommends the creation of a new Workgroup subcommittee that includes Area CHS Officers and Tribal CHS staff to develop recommendations on improvements to Part 2, Chapter 3 of the *Indian Health Manual.*

These recommended improvements will include, but not be limited to the following:

- Definitions;
- Eligibility;
- CHS Notification requirements;
- The "Five-Day Rule" as it applies to issuing CHS payment denials;
- Revisions to improve the content and level of comprehension of CHS denial and deferral decisions;
- CHS medical priority system (including dental medical priorities);
- CHS case review team policies, procedures, and submission guidelines;
- CHS appeal process; and
- CHEF definitions, policies, and procedures.

ROUND II: RECOMMENDATION (5)

Improve CHS Case Management

The Workgroup recommends that the IHS develop an implementation plan, including timelines, for actions for the following:

- Develop CHS case management performance guidelines and annual CHS case management training for CHS staff;
- Develop guidelines for the structure of case management teams; and
- Integrate the Improving Patient Care model for improvement processes within the CHS program.

ROUND II: RECOMMENDATION (6)

Improve Electronic Processing and Web-Based Access to CHS

The Workgroup recommends development of an Agency-developed CHS repository on the IHS intra-net that would include CHS information, best practices, upcoming training, and schedules.

ROUND II: RECOMMENDATION (7)

CHEF Program Review

The Workgroup recommends a review of the CHEF program and the development of recommendations on process improvements and updates to CHEF guidelines that will ensure IHS and Tribal CHS programs have full access to the CHEF reimbursement fund in the most reliable and equitable manner.

Some areas of consideration are as follows:

- Establish a definitive listing of CHEF-covered services;
- Introduce options that would allow CHS programs to choose to be reimbursed at 100 percent once a case is completed or receive a 50 percent advance payment;
- Determine if the 50 percent advance payment is an effective mechanism for encouraging applicants to submit completed paperwork quickly;
- Determine if the CHEF program should provide a higher percentage in advance or set aside funds to cover the remaining 50 percent (based on the estimated total cost);
- Identify approaches that better distinguish true unmet need catastrophic cases currently not submitted for reimbursement due to the depletion of funds in the CHEF or due to the inability of a small CHS program to meet the threshold requirement to access the CHEF;
- Determine if the CHEF program should establish different thresholds for each IHS Area to ensure that smaller CHS programs can better access the program;
- Identify ways that the IHS can assist smaller clinics and CHS programs with limited staffing to increase access to the CHEF program.
- Provide estimates of how lowering the CHEF threshold to $19,000 (as previously recommended) would affect the amount of funds needed to adequately fund the CHEF program.

I concur with Workgroup recommendations and am pleased with their continuing effort in determining ways to improve the IHS CHS program.

In 2013, the Workgroup will begin an in-depth review of the impact of the funding methodology to distribute new CHS funds. I will keep you informed of their efforts and any future recommendations.

For your information, I have enclosed a copy of the Workgroup's charge, vision, aim statement, guiding principles and priorities.

If you have any questions, please contact Mr. Carl Harper by phone at (301) 443-1553, or by e-mail at carl.harper@ihs.gov.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

Enclosure: Workgroup Charge, Vision Statement, Guiding Principles and Priorities

Director's Workgroup on Improving Contract Health Services

I. CHARGE OF THE WORKGROUP

The charge of the Director's Workgroup on Improving Contract Health Services (Workgroup) is to provide recommendations to the Director, IHS, on strategies to improve the Agency's contract health services (CHS) program. The Workgroup will review input received to improve the CHS program; evaluate the existing formula for distributing CHS funds; and recommend improvements in the way CHS operations are conducted within the IHS and the Indian health system

II. VISION

To deliver culturally relevant, patient-centered, and medically appropriate CHS services to eligible American Indian and Alaska Native (AI/AN) patients.

III. WORKGROUP AIM STATEMENT

To implement Workgroup recommendations to improve CHS operations, data, oversight, and transparency.

Agency policies will ensure that CHS program services are:

- Reliable and accessible;
- Fully funded;
- Delivered in a culturally sensitive environment; and
- Coordinated and integrated across all elements of the Indian health system.

IV. GUIDING PRINCIPLES

- No Workgroup actions or decisions will have the effect of waiving any Tribal Governmental rights, including treaty rights, sovereign immunity, or jurisdiction, nor absolve the United States of its Federal trust responsibility to provide and fully fund health care services for AI/AN people.
- Each Workgroup member makes a commitment to the Workgroup's charge and makes the time to engage in developing recommendations that will address the needs of eligible AI/AN patients in a fair and equitable manner.
- Each Workgroup member makes a commitment to be informed of all applicable CHS statutes, rules, regulations, and policies.

- Workgroup members pledge to build unity within the group for the benefit of eligible AI/AN people and overcome Area differences, including challenges related to CHS disparities.
- Workgroup recommendations will apply only to future formula funding distribution decisions and will not apply to the current CHS funding base.
- Each Workgroup member makes a commitment to reform that takes into consideration the reasons behind current policies and practices and the potential impact of future health reform changes.
- Each Workgroup member recognizes that future decisions may challenge traditional CHS practices.

V. OUTLINE OF PRIORITIES FOR IMMEDIATE AND LONG-TERM EFFECT

- Commission a study to quantify the unmet CHS need.
- Recommend a reporting process to document CHS referrals, denials, and deferred care to support justification of unmet need.
- Recommend data capture improvements that include capturing the cost burden for patients.
- Evaluate the effect of the fiscal year (FY) 2010 CHS funding increase on CHS unmet need in terms of return on investment for CHS direct services and investment into preventive services.
- Evaluate potential changes to the CHS program as a result of recent legislative actions and the enactment of the Affordable Care Act and permanent reauthorization of the Indian Health Care Improvement Act.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

NOV 25 2011

Dear Tribal Leader:

The purpose of this letter is to inform you of my decisions on issues related to our consultation on the Indian Health Care Improvement Fund (IHCIF) and its formula. I sent you a letter on December 30, 2010, requesting input on this issue. My decisions are based on careful consideration of the input you have provided since I initiated this formal consultation. I also considered the reauthorization of the Indian Health Care Improvement Act (IHCIA), which contains a provision that reauthorizes the IHCIF and includes several modifications to the IHCIF as described in my December 30, 2010, letter.

The IHCIF is important because it measures the resources needed by Federal and Tribal health care programs. The IHCIF formula calculates a level of need percentage relative to health insurance costs for the Federal Employees Health Benefits Program (FEHB). If the Congress appropriates additional funding for the IHCIF, we use the formula to increase funding for programs with the greatest unmet needs. **I have decided not to change the IHCIF formula until all programs reach at least 55 percent of their estimated level of need, which was the original agreement.** Although the key factors in the formula will not change, we will continue to improve the data and refine calculations of resource deficiency.

As a part of continually improving the data to measure resource deficiency, a joint Tribal/Indian Health Service (IHS) data technical workgroup recommended some updates to data used in the IHCIF formula and some technical improvements to its calculations. I requested input on these recommendations and they were included as an attachment to my December 30, 2010, letter. The Tribal input indicated general agreement to adopt technical improvements related to counting procedures for users; making updates to the FEHB benchmark, the price and productivity measures, and the guidance on data collection; and evaluating the health status measures. The Tribal input indicated that there is less certainty about replacing the existing flat 25 percent alternate resource factor with new data that has emerged since 2001. **I have decided to approve the data and technical improvements to the formula and to continue to evaluate whether a prototype Medicaid spending index would be a possible replacement for the existing 25 percent alternate resource factor**. I would like to extend my sincere appreciation to the technical workgroup members who considered the myriad of technical details, addressed the difficult issues, and emerged with helpful recommendations for my consideration.

The last issue is related to expanding the IHCIF formula to include new types of services authorized in the IHCIA. The IHCIA updates the list of health care services that the IHCIF may support. The IHCIA did not include additional funding for the health care services, such as long term care, which is one of the new services listed. In general, the Tribal input on this issue indicated it is premature to expand the formula for unfunded authorities. **I have decided to defer expanding the IHCIF formula until funding is made available for newly authorized health services**. The implementation of new services would be a significant event and would require Tribal consultation.

Thank you for providing your input, which was obtained through multiple forums including submissions at consultation@ihs.gov, listening sessions, conferences, and meetings. I continue my commitment to carrying out the IHS mission in partnership with you, following the IHS Tribal Consultation Policy, and working on the priority to renew and strengthen the Agency's partnership with Tribes. Please feel free to visit the Tribal Consultation Web site on my Director's Corner at www.ihs.gov, where you can also access my December 30, 2010, letter.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

JAN 15 2010

Dear Tribal Leader:

I am writing today to begin a formal **consultation with Tribes on how to reform the Contract Health Services (CHS) program** of the Indian Health Service (IHS). I am providing the following opportunities to provide input and to discuss how we can improve the CHS program:

1) Submit written input in response to this letter by March 15, 2010;
2) Attend a Tribal listening session on February 11, 2010, in Arlington, Virginia;
3) Attend our CHS Best Practices Meeting on February 12, 2010, in Arlington, Virginia;
4) Serve on a new CHS Workgroup to be scheduled in April 2010.

Please review the information below to learn more about the background and input that has led to the development of this plan to consult with Tribes on the CHS program. At the end of this letter, I provide details on how to participate in the above consultation activities.

I received input from Tribal leaders in response to my letter dated September 4, 2009, on top priorities for internal IHS reform and the CHS program was one of the top priorities for reform. I have also heard numerous comments from Tribal leaders at meetings during the past several months about the need to improve and change the CHS program. The concerns relate to two issues: the need for more CHS funding to pay for patient referrals for care outside the IHS system; and the need to improve the way we do business with the CHS program.

In terms of the need for more CHS funding, it is clear that the IHS and Tribal CHS programs often do not have enough CHS funding to pay for all the patient referrals that are medically necessary. As a result, the CHS program staff help determine if patients have alternate resources such as Medicare, Medicaid or private insurance to help pay for these referrals. The CHS regulations describe a process for paying for these referrals based on medical priorities. Unfortunately, the CHS funding is so limited in some facilities that only the most urgent referrals are approved for payment. This is frustrating for the patient, the healthcare providers, facility administration and staff, our partners in the private sector, and Tribal leadership. We all agree that we need more funding for the CHS program.

One area in which we need more input is on how to distribute CHS funding. CHS funding is distributed to IHS Service Units and Tribes in two ways: first, through the historical base funding for CHS for each CHS program; and second, through a formula developed in 2001 by an IHS and Tribal workgroup to be applied to annual CHS funding increases over the base funding. However, the formula for distribution of annual CHS funding increases over the base has rarely been used because there have been minimal or no CHS funding increases in the years since 2001. The 2001 workgroup felt that any changes to the historical base funding would be unfair because changes could potentially take resources away from some CHS programs to benefit others. They felt that all CHS programs should be "held harmless" and that the base funding should not

change. They did, however, believe that any new CHS funding increases should be distributed according to a formula that considered a facility's user population, inflation, regional and geographic cost variations, and access to care to the nearest healthcare facility. In addition to this national distribution formula, some Areas have developed additional methodologies to distribute funding within their IHS Area.

In the fiscal year (FY) 2010 budget, IHS will receive $779 million in CHS funding, of which $117 million is an increase over the base funding. This is the largest increase in CHS funding in recent history and will provide much needed resources to pay for medically necessary referrals for our patients. Of this amount, $17 million will be used for the CHEF program, and $100 million will be distributed using the 2001 formula. This will be the first year since 2001 that the formula for CHS funding increases will be used with a substantial amount of funding and its effectiveness can be fully assessed. Based on input I have received so far from Tribes, I have decided the best course of action for FY 2010 is to **apply the 2001 formula to the $100 million CHS funding increase and consult with Tribes during FY 2010 to determine if we need to make any adjustments or changes to the formula for FY 2011 and on.** Applying the formula to the FY 2010 CHS funding increase will really be the first time we can see the full outcomes and impact of the formula developed in 2001. Only then can we consider whether we need to change the formula or keep it the same.

In terms of the need to improve the way we do business with the CHS program, it is clear that we can do much more. I have heard much input from Tribes and our staff about how we can improve the program. The CHS program is a complex program with complicated rules and processes and it is often confusing for our patients. There is much we could do to educate our patients and our referral sources to reduce misunderstandings about payment rules and processes. We can do better at maximizing the use of third-party resources and negotiating better rates for the services we pay for in the private sector. We could do more to implement case management services to better coordinate care for our patients and we could do more to use cost saving measures such as telemedicine. Our implementation of the Electronic Health Record could help us with better continuity of care and better billing information. And we could develop better partnerships with our non-IHS care providers in the business we do with them for our CHS referrals. Of course, all changes we may make must be consistent with current CHS regulations and the limitations we have with the amount of funding available for CHS in the budget, but I do think there are things we can do to improve the way we do business with the CHS program.

I have also heard from Tribes and our staff that some of our CHS programs are actually doing well in many of these areas. However, there is little opportunity to share best practices among programs. Therefore, I would like to **convene a meeting in which IHS and Tribal program staff can share best practices in CHS programs.** This meeting will allow us to learn about what successful practices have already been used in our system, so that we can share them with other programs and use their ideas to change how we administer the CHS program in general.

In order to accomplish all of the above activities and provide opportunities for Tribes to consult further on these issues, I would like to invite you to participate in any of the following activities to provide input on the CHS program:

1) **Provide input in writing** – you are invited to submit input on how to change and improve the CHS program in writing in response to this letter. Please send your written input to me at 801 Thompson Avenue, Rockville, Maryland 20852 by March 15, 2010.
2) **Provide input in person** – I will hold a Tribal listening session on how to improve the CHS program on February 11, 2010 from 1:00 p.m. to 5:00 p.m. at the Holiday Inn National Airport, located at 2650 Jefferson Davis Highway, Arlington, Virginia 22202. I chose this date since the national budget work session will be held on the few days prior in Crystal City, Virginia. Unfortunately, we do not have travel funding available for this session.
3) **Attend the CHS Best Practices Meeting** on February 12, 2010 from 9:00 a.m. to 4:00 p.m. at the Holiday Inn National Airport, located at 2650 Jefferson Davis Highway, Arlington, Virginia 22202. The purpose of this meeting is to provide a forum for sharing best practices in conducting the business of the CHS program. If you would like to do a presentation on your program's best practices, please contact Mr. Carl Harper, Director, Office of Resource Access and Partnerships at (301) 443-1553 or carl.harper@ihs.gov. We will have a limited amount of travel funding available for speakers at this meeting on a first come, first serve basis.
4) **Serve on a new CHS workgroup** – I plan to invite one IHS and one Tribal representative from each IHS Area to serve on a workgroup that will review input collected during the above activities and to make recommendations for how to improve our CHS program and whether we need to change the formula for new CHS funding increases starting in FY 2011 and beyond. I would like to see a mix of Tribal elected officials and IHS/Tribal technical staff on the workgroup. The first meeting of the CHS workgroup will be in April 2010. Please send nominations for workgroup members for your IHS Area to your respective Area Director by February 16. Area Directors will submit nominations to me by March 1, 2010. I will announce the final workgroup membership list by March 15, 2010. After the workgroup meeting, I will forward any recommendations to all Tribes for review and comment before implementation.

I would like to thank you for your input so far on the CHS program and to thank you in advance for your participation in as many of the above activities as possible. I understand the importance and urgency of our efforts to improve and change the CHS program so that more American Indians and Alaska Natives who are served by our programs can get their medically necessary referrals paid for in a timely manner. If you have any questions, please contact Mr. Harper at (301) 443-1553 or carl.harper@ihs.gov.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director