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