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