



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](http://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](http://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](mailto:consultation@ihs.gov), or by postal mail at the address below:

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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](mailto:carl.harper@ihs.gov).

Sincerely,

/Yvette Roubideaux/

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

Director

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