DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

YVETTE ROUBIDEAUX, M.D., M.P.H.

DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

OF THE

UNITED STATES CONGRESS

OVERSIGHT HEARING ON

CONTRACT HEALTH SERVICES

December 3, 2009

STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good Morning. I am Dr. Yvette Roubideaux, Director of the Indian Health Service. Today I am accompanied by Randy Grinnell, Deputy Director of Indian Health Service, and Carl Harper, Director, Office of Resource Access and Partnerships. I am pleased to have the opportunity to testify on the Indian Health Service's (IHS) Contract Health Services program (CHS).

Overview of Indian Health Service Program

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Service because it is a health care system that was established to meet the federal trust responsibility to provide health care to American Indians and Alaska Natives. The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban operated facilities and programs based on treaties, judicial determinations, and acts of Congress. This Indian health system provides services to nearly 1.5 million American Indians and Alaska Natives through hospitals, health centers, and clinics located in 35 States, often representing the only source of health care for many American Indian and Alaska Native individuals, especially for those who live in the most remote and poverty-stricken areas of the United States. IHS provides a wide array of clinical, preventive, and public health services, within a single system for American Indians and Alaska Natives. The purchase of health care from private providers through the Contract Health Services program

is also an integral component of the health system for services unavailable in IHS and Tribal facilities or, in some cases, in lieu of IHS or Tribal health care programs.

Overview of the Contract Health Services Program

The Contract Health Services (CHS) program serves a critical function in the IHS since patients often have medical needs that cannot be met with available services in our facilities. IHS provides direct care in its system of hospitals, clinics and health stations based on what resources, providers and equipment are available to each facility with our annual appropriation for direct services. The CHS program was developed to purchase additional health care services for patients when the local facility is unable to provide needed services. Our health care providers identify needs for referrals based on medical need, and then we review what resources might be available to pay for this referral either through the CHS program or through other third party resources. Many programs report funding these referrals, however, can be a challenge because their CHS annual budget does not cover all referrals. Therefore, the CHS program has been designed to pay first for urgent medical referrals.

Based on preliminary Area and Service Unit reports, we estimate that approximately $360 million services were denied and deferred in 2008. In FY 2009, the CHS program was funded at $635 million, with over 50 percent administered by Tribes under Indian Self Determination contracts or compacts. In FY 2010 the CHS budget is $779 million, an increase of $144 million or 23 percent. CHS programs are administered locally through 163 IHS and Tribal Operating Units (OU). The funds are provided to the 12 IHS Area Offices

which in turn provide resource distribution, program monitoring and evaluation activities, and technical support to Federal and Tribal OUs (local level). Less than 2 percent of CHS funds are retained at Headquarters to administer the Fiscal Intermediary contract and Quality Assurance Fund.

CHS payments, within budget limitations, may be made for referrals to community healthcare providers in situations where:

- There is a designated service area where no IHS or Tribal direct care facility exists;
- The direct care facility does not provide the required health care services;
- The direct care facility has more demand for services than it has capacity to provide; and/or
- The patient must be taken to the nearest Emergency Services facility with a valid medical emergency.

Referring patients to the CHS program depends on the direct services available in a particular IHS or tribal facility. The CHS and direct care programs are complementary; some locations with larger IHS eligible populations have facilities, equipment, and staff to provide more sophisticated medical care. IHS and Tribes provide direct medical care at nearly 700 different locations. Emergency room and inpatient care is provided directly in 46 locations, and a limited number of our largest medical facilities do provide secondary medical services (such as family practice medicine) but none provide tertiary care (such as burn units or specialized care). With the exception of one hospital in Alaska, IHS and Tribal hospitals have an average daily patient census of fewer than 45 patients, most with a census of 5 or

fewer patients. Twenty of the hospitals have operating rooms. In locations where there is no access to inpatient, emergency or specialty care in IHS or tribal healthcare facilities, patients must depend on CHS to address their health care needs. Those direct care programs with the most sophisticated capabilities have, per capita, the smallest CHS programs and vice versa. However, all of our facilities and programs are dependent on CHS and third party coverage among IHS beneficiaries for the medical services that they are unable to provide.

It is important to understand that the CHS program does not function as an insurance program with a guaranteed benefit package. The CHS program only covers those services provided to patients who meet CHS eligibility and other requirements, and only when funds are available. Many facilities have CHS funds available only for more urgent and high priority cases and all utilize a strict priority system to approve the most urgent cases first. When CHS funding is depleted, CHS payments are not authorized.

It is also important to note that when CHS funding is not available to authorize payment for a referral that does not mean that the referral is not medically necessary. If a medical provider identifies a need to refer a patient, we assume the referral is medically necessary. The challenge we have, in many cases, is finding funding to pay for these referrals with our annual appropriation for the CHS program.

Many of our patients have no health care coverage outside of services received from the IHS or Tribal health programs, approximately 40 percent based on the Resource Patient Management System patient registration enrollment data. However, many of these patients

access health care through local community hospital emergency rooms and in other ways. Some patients and community health care providers often believe that IHS does or should provide coverage and/or payments for all American Indians and Alaska Natives that present for services, so it is not uncommon for providers to expect payment from the IHS or Tribal CHS program even in cases where CHS requirements are not met or CHS funding is not available. Patients who access care without meeting CHS requirements are responsible for payment for those services. We constantly have to work with our health care provider partners in the private sector and our patients to educate them on our CHS requirements and procedures so that they better understand and can work with us in our efforts to fulfill our mission within available resources, including our CHS resources.

Distribution of CHS Funding Increases

CHS funding is used to maintain previously existing levels of CHS patient care services. This fixed amount is called **"BASE"** funding. This base funding was originally established based on health care needs and availability of resources for each designated population within an area and is not necessarily based on a funding formula. Consequently, the established historical funding base or "fixed amount" does not change over the years except for adjustments due to inflation and population growth if included in the annual appropriation.

In 2001, the CHS Allocation Workgroup (CHSAWG) comprised of IHS and Tribal representatives from the 12 IHS Areas developed a new formula to distribute funding beyond the base amount made available for CHS in the annual IHS appropriation. The Workgroup-

developed formula for allocation of new CHS funding emphasizes the four following factors:

- Inflation funding based on each Area's base of the prevailing OMB inflation rate;
- User population to address population growth;
- Regional and geographical cost variances; and
- Access to care to the nearest healthcare facility

Any new CHS funding distribution to the Areas is based on this methodology, which is expressed mathematically as follows:

Inflation Funding	**= CHS Base for Operating Unit (OU)**	**x**	**% of OMB inflation rate**
Formula Funding	**=Active Users for OU x Cost Factor (Converted to proportionate percentage)**	**x**	**Access Factor**

As the new Director of the Indian Health Service, I have heard from tribes that one of their top priorities for internal IHS reform is to discuss improvements in the CHS program, which may include a discussion of how we distribute CHS program resources. I plan to ask tribes if they want to continue to use this 2001 formula for new program increases or whether they would like to discuss changes to the formula. I believe it is important to discuss any changes to the CHS program and its funding distribution in consultation and partnership with tribes. Any formula, or changes to it, may be more advantageous to some Areas compared with others. My primary concern is to assure that any proposed changes to the formula are as fair as possible to all our patients and health programs.

Reasons Services are Not Covered by CHS

The CHS requirements and how we conduct the business of the CHS program are important but complex matters and I would like to discuss them now in greater detail. The most common complaint we receive about the program is why we do not pay for all medical referrals. The most important principle that drives policy in this case is that IHS cannot incur costs which would exceed available resources. The CHS program follows a series of regulatory and other requirements to guide approval and payment of CHS services. Our medical providers identify medically necessary referrals. The CHS program determines whether IHS authorizes payment for such referrals.

Payment for contract health care services may be denied (and the referral care may be denied or deferred) for the following reasons:

1) Patient does not meet CHS eligibility requirements;

2) Patient is eligible for alternate resources and IHS is the payer of last resort;

3) Prior approval was not obtained for non-emergency services;

4) Notification was not made to the IHS or tribal program within the required time frames after emergency services were received (generally within 72 hours, or within 30 days in certain cases);

5) Services could have been provided at an IHS or Tribal facility; or

6) Services do not fall within medical priority levels for which funding is available.

Eligibility

In general, to be eligible for CHS, an individual must be of Indian descent from a federally

recognized Tribe, belong to and live in the Indian community served by the local facilities and programs, or maintain close economic and social ties with said Indian community in a Contract Health Services Delivery Area (CHSDA). If the person moves away from their CHSDA, even to a county contiguous to their home reservation, they are eligible for all available direct care services but are generally not eligible for CHS. Given the limited amount of funding available for CHS, the CHSDA rules were implemented to ensure that the funding for CHS was prioritized for patients that live in the specified areas.

When the individual is not eligible for CHS, the IHS cannot pay for referred medical care, even when it is medically necessary, and the patient and provider must be informed of this circumstance. The CHS program educates patients on the eligibility requirements for CHS, by interviewing them and by posting the eligibility criteria in the patient waiting rooms and in the local newspapers. The CHS program assists these patients by attempting to locate available healthcare services within the community at no cost or minimal cost to them. Patients who do not meet CHS eligibility requirements are responsible for their health care expenses from other providers. If patients have other healthcare resources, such as Medicare, Medicaid or private insurance, the third party insurer must pay for the services because IHS is the payer of last resort. CHS programs work with the patient to determine if those other resources can pay for referrals. Some non-IHS providers have expectations that IHS will be the primary payer for all American Indian and Alaska Native patients, whether or not they are eligible to receive care through the CHS program. This can lead to strained relationships with local community health care providers when payment for medical services are denied by the CHS program leaving the non-IHS providers without compensation if a patient does not

have alternate healthcare resources such as insurance. While we do everything we can to inform local health care providers of the process for authorization of CHS payments for medical referrals from IHS, misunderstandings sometimes still occur.

Payor of Last Resort Rule

By regulation, the Indian Health Service is the payor of last resort (42 C.F.R.136.61), and therefore the CHS program must ensure that all alternate resources that are available and accessible such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), private insurance, etc., are used before CHS funds can be expended. IHS and Tribal facilities are also considered an alternate resource; therefore, CHS funds may not be expended for services reasonably accessible and available at IHS or tribal facilities. As a part of our business practices, both patients and outside healthcare providers are informed of the payor of last resort rule, as well as other CHS requirements, and we work with all patients to identify any third party or alternate resources to help pay for their referrals. This is particularly important when we do not have CHS funding available – patients can still obtain referred services using their other health coverage. This is why we encourage our providers to identify the need for referrals based on medical necessity, not on availability of funding. Sometimes a patient can be scheduled for a referral by IHS with an understanding that their health insurance, Medicare, Medicaid, or the CHIP will pay for it when we don't have CHS funding or the patient is not eligible for CHS funding.

Maximizing Alternate Resources

The CHS program maximizes the use of alternate resources, such as Medicare and Medicaid,

which increases the program's purchasing power of existing dollars. The IHS works closely with the Centers for Medicare & Medicaid Services (CMS) to provide outreach and education to the populations we serve to ensure that eligible patients are signed up for Medicare, Medicaid, and CHIP. On February 4, 2009 the President signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3). CHIPRA provides $100 million over five years to fund outreach and enrollment efforts that increase coverage of eligible children in Medicaid and CHIP. Ten percent of these funds are set aside for grants to the IHS providers, Urban Indian Organizations, and certain Tribes and Tribal organizations that operate their own health programs for outreach to, and enrollment of, children who are Indians. The IHS trains staff and educates patients to maximize the enrollment of eligible American Indian and Alaska Natives in CMS and private insurance programs. Enrolling patients in these programs frees up existing funds to be used for CHS referrals/payments.

Medical Priorities

CHS regulations permit the establishment of medical priorities that rank referrals or requests for payment when funding is limited, as is frequently the case. There are five categories of care within the medical priority system: ranging from Emergency (threat to life, limb and senses) to chronic care services. Medical Priority V is considered Excluded Services and would not normally be funded. The medical priority categories are as follows:

1.. Emergency – threat to life, limb, senses e.g., auto accidents, cardiac episodes

2.. Preventive Care Services e.g., diagnostic tests, lab, x-rays

3.. Primary and Secondary Care Services e.g., family practice medicine, chronic

disease management

4.. Chronic Tertiary and Extended Care Services e.g., skilled nursing care

It is important to note that this priority system is only used to rank referrals in order of medical priority for payment when resources are limited. It does not imply that these referrals are not medically necessary. It assures that we are targeting limited resources to the patients most in need of care based on their medical condition, not other factors.

If the medical condition does not meet medical priorities, the proposed care is identified as a CHS deferred service. In the event funds become available, the care may be provided at a later date. Again, the IHS cannot incur costs which would exceed the amount of available resources.

Unified Financial Management System (UFMS)

The IHS implemented the accounting system (UFMS) in accordance with HHS Departmental policy. Prior to implementation of UFMS, the CHS program experienced some challenges in paying providers for authorized referrals; but, we anticipate full implementation of UFMS will mitigate these issues. Making timely payments to community healthcare providers is a priority for us, and we continue to look for ways to improve the process. We provided training on this new system prior to implementation and continue to train our staff in not only this system but the overall management of the CHS program. It is important to note that the issue of not paying for referrals that are not authorized is a separate issue.

Catastrophic Health Emergency Fund (CHEF) – Purpose and Intent

The CHS program also includes a Catastrophic Health Emergency Fund which pays for high

cost cases over a threshold of $25,000, as authorized by the Indian Health Care Improvement Act (Public Law 94-437), as amended. In FY 2007, the CHEF was funded at $18 million and was depleted before the end of the fiscal year. In FY 2009, the CHEF program was funded at $31 million and provided funds for 1,223 high cost cases and was depleted in August. The CHEF is funded at $48 million in FY 2010, an increase of over 100 percent from the FY 2007 level. The CHEF cases are funded on a “first-come-first served” basis. When CHEF cannot cover a particular high cost case, the responsibility for payment reverts back to the referral facility for payment purposes.

Medicare-Like Rates (MLR)

The passage of Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a requirement that Medicare participating hospitals accept IHS, Tribal and Urban Indian Health programs’ reimbursement rates set forth in regulations and based on Medicare payment methodologies. As is the case for health programs of the Department of Defense and certain Department of Veterans Affairs health programs, rates are established by regulation based on what Medicare pays for similar services. These reimbursement rates are typically about 60-70% of full billed charges. These rates are established by regulation, based on what Medicare pays for similar services, and are typically about 60-70 percent of full billed charges. The individual physicians and other practitioners paid under Medicare Part B are not included in this provision. The savings derived from the Medicare-like rates allow Indian healthcare programs to purchase additional health care services for American Indians and Alaska Natives, than would otherwise be the case. Since the regulation became effective in July of 2007, we have heard

from several Tribes experiencing increased purchasing power due to payment savings, and expect the Medicare-like rate payment savings to continue. IHS Federally-operated programs have experienced fewer saving because most had already negotiated provider contracts with payment rates at, or near, the level of the Medicare rates. However, the federally-operated programs benefit from the guarantee of reasonable rates that the regulation provides. Area Office CHS staff continue their efforts to negotiate contracts with other providers not covered by the MLR to achieve the most cost-effective payment rates possible.

We realize the importance of making maximum use of available CHS funding and we are focused on improvements in the ways we do business in the overall CHS program. We work to ensure that staff maximizes the use of alternate resources, assist eligible patient to enroll in other types of health coverage, apply the Medicare-like rates, negotiate lower reimbursement rates for services not covered under MLR, and apply medical priorities and other CHS requirements strictly and fairly. For many years, the program also has implemented managed care practices in an effort to maximize resources. We focus our efforts on cost-effective strategies for our CHS cases such as improved case management and utilization of telemedicine. We are working diligently to recruit and retain providers to provide more direct care in our facilities, thus reducing the demand on CHS. We are also working to improve the CHS systems and processes by utilizing the electronic health record and the new UFMS system. And, we continue to build partnerships with our non-IHS healthcare providers through local and national meetings. I also look forward to consulting with tribes on how to improve the CHS program now that they have formally indicated to me that it is a priority for Internal IHS reform.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify on the Contract Health Services programs serving American Indians and Alaska Natives. We will be happy to answer any questions that you may have.