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