NPAIHB POLICY BRIEF

CHS Unfunded Need in FY 2007

PREPARED BY: NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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The Indian Health Service Contract Health Service Program: An Assessment of Unfunded Need

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Overview

The Indian healthcare system, which is comprised of the Indian Health Service, Tribes or Tribal Organizations, and Urban Indian Organizations (I/T/U), provides direct primary and preventive health care services to eligible patients. The Indian health system must routinely purchase specialized health services for their beneficiaries from public and private providers through the Contract Health Services (CHS) program. It is estimated that the unmet need for CHS resources is at least $333 million based on FY 2007 data and this figure could be significantly higher if all CHS data from Tribal programs were available. Many Tribally-operated health programs no longer report deferred or denied services because of the expense associated with tracking and reporting. More disturbing is that many IHS users do not even visit health facilities because they know they will be denied services due to funding shortfalls. Thus, the $301 million estimate is quite conservative and when added to the current IHS budget line item the CHS budget should be at least $800 million.

IHS Contract Health Service Program
Summary of Unfunded Need in FY 2007

Category	Number of Services	Estimated CHS Resource Need
Deferred Services within Medical Priorities	161,751	$179,058,357
Eligible But Care not within Medical Priorities	35,155	$38,916,032
Eligibile But Alternate Resources Available	66,045	$73,111,262
Emergency Notification Not within 72 Hours	8,033	$8,892,531
Non-Emergency No Prior Approval	19,259	$21,319,713
Patient Resides Outside CHSDA	9,642	$10,673,694
Unfunded CHEF Cases (actual amount)	895	$990,765
TOTAL:	**300,779**	**$332,962,353**

In order to budget the CHS resources so that as many services as possible can be provided, the agency applies stringent eligibility rules and uses a medical priority system. The regulations at 42 Code of Federal Regulations (CFR) Part 136 require that CHS services must be authorized or no payment will be made. Non-emergency services must be pre-authorized and emergency services are only authorized if notification is provided within 72 hours of the patient's admission for emergency treatment. The agency also has adopted the financial position that it is the Payer of Last Resort. This requires patients to exhaust all health care resources available to them from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. The IHS also negotiates contracts with providers to ensure competitive pricing for the services provided; however, there may be only one or a limited number of providers or vendors available to the local community. The CHS authorizing official from each I/T either approves or denies payment for an episode of care. If payment is approved, a purchase order is issued and provided to the private sector hospital.

CHS Priority System

CHS regulations permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of care needed. Because of insufficient funding in the CHS program, most IHS and Tribal health programs often begin the year at a Priority One level. If they do not begin the year at Priority One, they will move to this status by the second or third quarter of the fiscal year. These priorities are categorized into four Priority Levels and described as follows:

Priority One - Emergent/Acutely Urgent Care Services: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available. Priority One represents those diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.

Priority Two - Preventive Care Service: Primary health care that is aimed at the prevention of disease or disability. This includes services proven effective in avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention).

Priority Three - Chronic Primary and Secondary Care Services: Inpatient and outpatient care services that involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment-for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It includes services that may not be available at many IHS facilities and/or may require specialty consultation.

Priority Four - Chronic Tertiary Care Services: Inpatient and outpatient care services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, elective, and often require tertiary care facilities.

Estimating Resources for CHS

The IHS maintains a deferred and denied services report that is updated each year. The report is inclusive of CHS data from IHS direct operated health programs and may include limited data from Tribally-operated health programs. Unfortunately, the deferred/denied services report **understate** the true need of CHS resources due to the data limitations and the fact that many tribes no longer report deferred or denied services because of the expense involved in reporting. More disturbing is that many IHS users do not even visit health facilities because they know they will be denied services due to funding shortfalls. Although there are limitations with CHS data, an analysis can be conducted using the data that are available to assess the need for additional CHS resources. The effort of this analysis will under estimate need for additional CHS resources since the data are incomplete because not all tribally operated facilities report denial data to IHS headquarters, and not all requests for care are documented at the facilities that do report.

IHS FY 2007 CONTRACT HEALTH SERVICE PROGRAM
DEFERRED & DENIED SERVICES REPORT
ALL AREA OFFICES
January 22, 2008

IHS AREA	A Deferred Services Within Med Priorities	Denied Service Categories								
		B Eligible But Care Not Within Med. Priority	C Eligible But Alternate Resource Available	D Patient Ineligible for CHS	E Emergency-Notification Not Within 72 Hours	F Non-Emergency No Prior Approval	G Patient Resides Outside CHSDA	H IHS Facility Available & Accessible	I All Other Denials	TOTAL
Aberdeen	*7,895*	9,116	17,463	2,409	774	3,357	2,565	3,969	1,398	41,051
Alaska	*2,785*	*1,463*	5,472	602	129	3,459	464	1,389	478	13,456
Albuquerque	*3,383*	2,078	4,448	223	220	66	1,180	186	256	8,657
Bemidji	*2,278*	572	1,909	872	964	1,930	617	626	1,811	9,301
Billings	*14,319*	6,707	4,740	1,227	236	3,577	1,529	3,118	187	21,321
California	*2,123*	318	1,308	352	303	274	25	13	7,532	10,125
Nashville	*1,927*	2,650	237	234	362	412	137	218	103	4,353
Navajo	*75,673*	2,654	16,247	229	1,311	523	602	2,026	2,779	26,371
Oklahoma	*45,159*	*5,069*	1,313	89	1,262	2,961	856	2,869	8,381	22,798
Phoenix	*2,720*	1,941	9,457	546	922	906	1,307	1,538	922	17,539
Portland	*3,389*	*2,562*	1,916	1,525	1,425	3,440	187	500	0	11,555
Tucson	*100*	*25*	1,535	93	125	14	173	1	11	1,977
TOTALS	***161,751***	***35,155***	***66,045***	***8,401***	***8,033***	***20,919***	***9,642***	***16,453***	***23,858***	***188,504***

Column A – Deferred Services: Last year, the IHS deferred payment for 161,751 recommended cases totaling $179 million. This amount is computed by multiplying the average CHS outpatient cost of $1,107.00 times the number of deferred services. Deferred services that are those within the CHS medical priorities (usually Priority One or Two) however there simply was not enough funding the cover the costs of care. This is the highest amount that deferred payments in the CHS program have ever been.

Column B – Denied Services: In 2007, IHS programs denied care to 35,155 eligible cases, because they were determined not to be within medical priorities (Priority One). This is a 10% since 2005. Every year tribes simply do not submit claims since they know that in the last quarter claims are not likely to be approved. Thus, this number could be significantly higher.

Columns C, E, F, and G: Represent denied service categories that are generally not reflected in denied service reports by the IHS. These categories represent policy and procedural decisions that typically disqualify an individual from 'covered care', however they would be eligible if the CHS program was funded at an adequate level.

Column C – Alternate Resources: Represents individuals that were denied services because of the CHS payer of last resort or alternate resources rule. This simply means that an individual was eligible for services under another health program like Medicaid or another source; and does not mean that the individual would have received services had the resource not been available. The estimated funding to cover the CHS costs these individuals is $73 million.

Column E – No Emergency Notification: Represents individuals that needed to receive emergency or urgent care within the CHS medical priorities from a non-IHS provider however did not report their visit within the required 72 hours to the IHS or Tribal CHS program. Thus, payment authorization was denied. The estimated

funding to cover the CHS costs of these individuals is $9 million.

Column F – No Prior Approval: Represents individuals that received non-emergency services from a non-IHS provider and were within the medical priorities, however were denied payment authorization since they could have been delivered by an IHS provider. The estimated funding to cover the CHS costs of these individuals is $23 million.

Column G – Resides Outside CHSDA: Represents those individuals that requested CHS services but were denied because they reside outside of the Contract Health Service Delivery Area (CHSDA).[1] These are individuals that require services within the CHS medical priorities however may have been away from the reservation for more than 6 months or may not qualify for CHS funding for other reasons. The estimated funding to cover the CHS costs of these individuals is $11 million.

Finally, the Catastrophic Health Emergency Fund (CHEF) is intended to protect CHS programs from overwhelming expenditures for catastrophic health cases and ensure their financial stability. In FY 2007, there were 738 CHEF claims totaling $18 million. There were 895 cases totaling $20 million that went unpaid and were absorbed by local CHS budgets. The actual unfunded need is at least $20 million because the fund is usually depleted by the third quarter of the fiscal year and many Tribes stop making application to the CHEF once it has been depleted.

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