NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Suislaw, & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
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Port Gamble S'Klallam Tribe
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Shoshone-Bannock Tribe
Siletz Tribe
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Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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DATE: June 23, 2010

TO: Tribal Leaders, Health Directors and Board Delegates

FROM: Jim Roberts, Policy Analyst

SUBJECT: CHS Meetings/Agendas

The attached information is an update on the status of the Contract Health Service (CHS) consultation that the IHS Director recently initiated.

As you are aware, on January 15, 2010, Dr. Yvette Roubideaux issued a "Dear Tribal Leader" letter requesting input on the CHS program. A subsequent letter was sent on June 8, 2010 by the IHS Director summarizing the comments received from that process into three broad categories: (1) more funding is needed for the CHS program; (2) the distribution of CHS funding needs to be reviewed; and (3) improvements are needed on how we do business with the CHS program.

To address the on-going CHS issues and the comments received following the Dear Tribal leader letters, the IHS Director will be convening a CHS Workgroup and CHS Listening Session. Dr. Roubideaux has appointed two representatives from each IHS Area to serve on the "IHS Director's Workgroup on Improving Contract Health Services." The CHS Workgroup will be meeting in Denver on June 24-25, 2010. The Portland Area representatives are Andy Joseph, Colville Tribes and Eric Metcalf, Coos, Lower Umpqua, Siuslaw Tribes; and will be supported by technical representatives Ed Fox, Squaxin Island and myself. A copy of the CHS Workgroup agenda is attached.

In addition, a CHS Listening Session and Best Practices meetings have been scheduled to be held on July 8-9, 2010, at the Hyatt Regency Crystal City in Crystal City, VA. I have attached a copy of the agenda for your planning purpose. I encourage Tribes to attend the listening session to provide their input and concerns with the CHS program. We have developed a CHS position paper for this meeting that is supported by a Board and ATNI resolutions. (See attached)

I will prepare an update for you all following the CHS workgroup and listening sessions. In the interim, if you have questions feel free to contact me at (503) 228-4185 or by email jroberts@npaihb.org.

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Quileute Tribe
Quinault Tribe
Samish Indian Nation
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Stillaguamish Tribe
Suquamish Tribe
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Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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March 19, 2010

Yvette Roubideaux, M.D., M.P.H
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Dear Dr. Roubideaux:

We are writing to provide you with our response to your letter dated, January 15, 2010, in which you request recommendation to improve the Contract Health Service (CHS) program. We were prepared to submit our recommendations as requested on March 15th, but wanted to offer our Tribe's additional time to submit their recommendations following your offer at last week's meeting with Portland Tribes, in which you offered additional time to develop recommendations. Your generosity to provide additional time is appreciated and did allow for additional comments to be received.

The attached position paper represents the views of Portland Area Tribes and was developed from previous Portland Area position statements, congressional testimony, and IHS Director Letters conveying concerns in the CHS program. This position paper will be adopted by a formal resolution of Portland Area tribes at our upcoming NPAIHB board meeting to be held on April 22, 2010.

We acknowledge your effort to address many longstanding issues in the CHS program. I believe you will find that Portland Area Tribes are willing to work hard on very difficult and complex issues to improve health programs for Tribes nationally. In this course, Portland Tribes only want their fair share while at the same time doing what is in the best interest of Indian health programs nationally. In this regard, our Board stands ready to assist you in this effort and we commend you for consulting with Tribes over these very complex issues.

If you should have any questions concerning any of our recommendations, feel free to contact me or Jim Roberts, NPAIHB Policy Analyst, at (503) 228-4185.

Sincerely,

Joe Finkbonner, RPh, MHA
Executive Director

Portland Area Tribes' Position Paper
Contract Health Service Program

March 19, 2010

Introduction

This position paper is prepared for the consideration by Portland Area Tribal leaders, Health Directors, and others to submit comments the Indian Health Service (IHS) Director's, Dr. Yvette Roubideaux, January 15, 2010 letter in which she announced a Tribal consultation process for the Contract Health Service (CHS) program. Dr. Roubideaux has requested Tribal input on issues affecting the CHS program, the CHS funding methodology, and ways to improve the way CHS programs conduct business.

Background

Between 2001 and 2010, there has been approximately $250 million in program funding increases in the Contract Health Service (CHS) program. The CHS increases are distributed using a CHS formula that takes into consideration such things as workload, inflation costs, and CHS dependency.[1] In 2001, IHS Director, Dr. Michael Trujillo formed a workgroup to provide recommendations to improve the formula and potential improvements to how CHS funding is allocated. The CHS formula is very important to those *CHS Dependent* Areas that do not have hospitals and must purchase all specialty and inpatient care from private sector hospitals and other providers. The 2001 workgroup formula has been controversial since it gives a lower weight for *CHS dependency* than the previous formula.[2]

The previous CHS formula (also referred to as the 1994 formula) was a response to the need to recognize the unique situation of *CHS Dependent Areas* in the same manner that facilities-dependent areas are recognized with funding from the hospital and clinic line items. Portland Area Tribes were unified in their position to retain the 1994 CHS formula. The position of Portland Tribes was that the 2001 workgroup formula did not have a strong enough factor for CHS dependency. The manner in which cost is measured is also suspect and was likely chosen because it was readily available. The 2001 workgroup formula uses the American Chamber of Commerce Research Association (ACCRA) Cost of Living Index. The location points used in the ACCRA index may not correlate with the locations of Portland Area Tribes, nor may they be indicative of costs in reservation settings.

The controversy around the formula is evident when in FY 2001 and FY 2002, there were CHS funding increases of $34.9 million and $15 million respectively, and the IHS Director decided to use a *blended formula* to allocate the increases. This was done in order to alleviate many of the "fairness" concerns associated with the 2001 workgroup formula.[3] The IHS Director allocated on a non-recurring basis one-

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[1] The 1994 formula also included Years of Productive Life Loss, however was removed by the 2001 Workgroup since it did not relate to cost of treating disease, but rather reflected cost of disease to society (lost wages & taxes).

[2] The previous CHS distribution formula was made up of three components, and a percentage of the appropriated funding was allotted on each component as follows:(a) Workload/Cost - 20 percent; (b) Years of Product Life Loss – 40 percent, and; (c) CHS Dependency – 40 percent. The new CHS formula lowered the weighting for CHS dependency by applying a 25% weighting to user population.

[3] See "Dear Tribal Leader Letter", by Dr. Michael H. Trujillo, IHS Director, dated June 7. 2001 and December 31, 2001.

half of the funding using the old CHS formula and the other half using the new 2001 workgroup formula. Below are concerns of Portland Area Tribal leaders and Health Directors regarding the CHS program and the CHS formula:

1. The CHS Formula Must be Reconsidered

It is the position of Portland Area Tribes that the 2001 CHS Workgroup proposed funding methodology has never been officially adopted through tribal consultation by IHS. This is evident following the development of the proposed methodology when in FY 2001 and FY 2002, there were CHS funding increases of $34.9 million and $15 million respectively, and the IHS Director (Dr. Michael Trujillo) decided to use a *blended formula* to allocate the funding increases. This was done in to alleviate many of the "fairness" concerns associated with the new proposed methodology. The IHS Director allocated on a non-recurring basis one-half of the funding using the existing CHS formula (1994 formula) and the other half using the 2001 workgroup recommendations.

In FY 2003, the IHS Director (Dr. Charles Grim) continued this funding decision by allocating the $49.9 on a recurring basis using the "2002 blended formula."[4] Dr. Grim also announced that in the future, "he planned," to use the 2001 workgroup formula. A decision that Portland Area tribes feel was made without adequate Tribal consultation, especially given the fact that in the last three fiscal years a *blended formula* was used to make CHS allocations. While this letter indicated the IHS Director's intention, IHS did not explicitly adopt the formula as a final policy for future use. Certainly, Dr. Trujillo never officially adopted it in light of his use of a blended formula when allocating funding increases in FY 2001 and FY 2002.

Portland Area Tribes do not believe that the 2001 CHS formula has been officially adopted through the use of a "Dear Tribal Leader" letter, which is the common practice of the IHS when making substantive policy changes. In fact the IHS Director's decision letters in FY 2001 and FY 2002 states the following:

> *"I support the Workgroup's strong recommendation to convene a follow-up Workgroup to address these issues," and; "..the decision regarding recurring allocation can be deliberated more comprehensively with contemporary and agreed upon data. By using this approach, it is my hope that we will continue our dialogue on the outstanding issues related to the disparity between need and the resources available for CHS."* [5]
>
> *Dr. Michael Trujillo, IHS Director*

These statements indicate that the previous IHS Director intended to continue to refine the CHS formula. Because the formula has never officially been adopted, the IHS should have conducted Tribal Consultation to determine if the Tribes would prefer to use the blended formula implemented by previous IHS Directors when there were CHS funding increases in 2001, 2002, and 2003 or adopt the new Workgroup proposal. Thus, we recommend that additional Tribal consultation occur before any continued use of the 2001 workgroup formula.

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[4] See "Dear Tribal Leader Letter", by Dr. Charles Grim, IHS Director, dated April 10, 2003.

[5] See "Dear Tribal Leader Letter", by Dr. Michael H. Trujillo, IHS Director, dated June 7. 2001 and December 31, 2001.

2. CHS Funding and Formula Considerations

It is the position of Portland Area Tribes that funding issues associated with the CHS program should not be evaluated without addressing the overall funding received from the Hospitals and Clinics line item. The reason for this has to do with *CHS dependency*. The previous 1994 CHS formula was a response to the need to recognize the unique situation of *CHS dependency* in the same way that facilities-dependent areas are recognized. This type of formula should have been retained. The Portland Area has always recognized that its share of the Hospitals and Clinics line item is less than its user population would predict. For example, the Alaska Area makes up 9% of the total IHS user population, while receiving over 16% of the hospitals and clinics funding.[6] Comparatively, the Portland Area with 7% of the IHS user population receives less than 4% of the hospitals and clinics funding. As well, *CHS dependent* Areas cannot generate third party reimbursements on the same level as those areas that have inpatient care with greater medical staff.

The lower operating efficiencies of smaller health programs associated with *CHS dependent* Areas also predicts that they should receive a higher than user share percentage of total CHS spending. Smaller health systems do not have the same capacity as larger sized systems nor do they have the critical staffing packages that can generate third party collections. Those IHS Areas that have hospital based health systems (Aberdeen, Alaska, Phoenix, Oklahoma) can often provide specialty care and inpatient health services that *CHS dependent* Area (California, Bemidji, Nashville, Portland) must purchase from private sector hospitals. Moreover, those Areas with hospitals have staffing packages that can bill Medicare and Medicaid thereby preserving critical CHS funding for those patients that do not have public or private health coverage or in cases where the IHS hospital may not be able to provide the service.[7] In turn, hospital based Areas are then able to use the third-party collections to expand health services. *CHS dependent* Areas cannot internalize the same costs that inpatient systems can, nor can they bill for such services to expand care, thus increasing their need for CHS funds.

CHS Dependency: Portland Area Tribes do not believe that the 2001 workgroup formula has a strong enough factor for dependency. The Portland Area must insist that any CHS formula include a stronger factor for *CHS dependency*. The 2001 workgroup was too quick to give up on this concept and the decision to weight user population by a 1.25 factor as a measure of CHS dependency is not valid and distorts the reality that Areas such as Portland and California are far more dependent than this factor indicates. If it were true, then the Portland Area would certainly have a greater than 4% share of the Hospitals and Clinics line item. It is not clear that the access factor can be corrected by adding to the 1.25 factor for "access." Perhaps the 50% referral threshold could be changed so an operating unit with greater in-house hospital care is not treated the same as Portland or California programs that purchase 100% of hospital care. Not properly or accurately weighing CHS dependency is grossly unfair.

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[6] Based on FY 2009 Final IHS User Population Report, December 18, 2009; and FY 2010 IHS National Apportionment Tables 1-14.

[7] It is established that 60% of the IHS User Population over the age 55 are enrolled in Medicare; and that approximately 58% of AI/AI children and 28% of AI/AN adults are Medicaid enrollees that reside in IHS Areas. See *American Indian and Alaska Native Medicare Program and Policy Statistics*, (p. 24), October 31, 2009 and *American Indian and Alaska Native Medicaid Program and Policy Data*, (p. 14-15), February 28, 2010, both reports prepared for the Centers for Medicare & Medicaid Tribal Technical Advisory Group, prepared by the California Rural Indian Health Board.

User Population: *CHS dependent* Areas are particularly disadvantaged since they are not able to capture all of their potential active users relative to those Areas that have inpatient hospitals. Consequently, *CHS dependent* Areas like California and Portland suffer from an undercount in user population. For example, some areas, such as Alaska, Phoenix and Oklahoma, capture nearly all of their urban Indian population in their user counts, the Portland Area does not. Some areas, again such as Alaska and Oklahoma capture every resident in the state in a CHSDA, the Portland, Bemidji, and Nashville Areas do not. Adjustments that account for uniqueness in determining user population must be considered in any CHS formula.

Third Party Collections: Third party collections available from Medicare, Medicaid, and CHIP must also be factored in the CHS formula. The availability of revenue from third party collections alleviates CHS dependency when compared to those Areas that do not have hospital based staffing packages to provide services and generate revenue through Medicare, Medicaid, and other private collections. Medicare, Medicaid, and CHIP collection data are available from the states and from CMS and should be utilized in determining CHS need. Recent reports completed by the California Rural Indian Health Board document AI/AN participation in the Medicare, Medicaid, and CHIP programs and the glaring disparity in third party collections associated with hospital based IHS Areas and those that are *CHS dependent*. The Agency and IHS Director can no longer ignore these glaring data disparities in resource allocation in either FDI used to allocate the IHCIF or in the CHS formula.

3. CHS Workgroup Process

Any workgroup that examines proposed changes for the CHS program and formula should include equal representation from each of the twelve IHS Areas. The decision making process should also be based on a consensus process that is not bound by any time limitations. The process used by the 2001 workgroup was terribly flawed as it pitted Areas against Areas and was based on a majority rule. Since those IHS Areas classified as *CHS dependent* were usually in the minority, the outcome of the vote resulted in the damaging changes that were made in the CHS formula.[8] There was not consistent representation in the number of voting members participating in the process, meeting announcements and materials were not consistently shared, and when materials were shared time constraints prohibited due diligence in reviewing and developing positions—all which contributed to an unfair and unequal process in 2001. This underscores the Portland Area position that any decision to use the 2001 workgroup formula should be revisited and continued use of the 2001 workgroup formula requires additional Tribal consultation.

4. Establish a Workgroup to examine the distribution of funding for Hospitals & Clinics

The Portland Area gets less than its fair share of the $1.8 billion in Hospital and Clinics funding; and far less than its share of facilities construction and facilities support funding. The CHS formula should not have been changed unless the method of distributing Hospital and Clinics, Facilities Construction, and other support line items were also changed. Portland Area Tribes support

[8] See NPAIHB letter to IHS Director, Dr. Michael Trujillo, dated March 22, 2001.

establishing a workgroup to conduct a comprehensive review of all funding received by the IHS that would also include a gap analysis in the levels of health care provided across the IHS system. These gaps are a direct result of the varying levels of IHS funding, facilities infrastructure, staffing packages, and third-party collections that result in varying levels of basic, intermediate, tertiary health care in the IHS system. The workgroup would be charged with providing recommendations to reallocate resources so that consistent levels of care can be provided to Indian people across the IHS system. This recommendation is consistent with the health reform goals currently being deliberated by Congress and the Administration to increase access to health care and improve the quality to care for all Americans. This should also extend to AI/AN people served by the IHS system.

5. CHS Budget and Medical Inflation

It is generally accepted that the main challenge in the CHS program is that there is not enough funding. The CHS budget is the most important IHS budget line item for Northwest Tribes since there are no hospitals in the Portland Area and that the CHS program represents 40 percent of the Portland Area's health services budget. Nationally, the CHS program represents 19 percent of the total health services account. Because of this, Northwest Tribes have tracked the CHS budget over a long period of time. Portland Area Tribes estimate that the CHS budget has lost over $600 million in unfunded medical inflation and population growth since FY 1992.[9] This has resulted in rationing of health care services using the CHS medical priority system, in which most patients in the Portland Area cannot receive care unless they are in a Priority One status. In FY 2009, this resulted in over 100,000 denied or deferred services nationally in the CHS program.[10]

One of the reasons that the CHS budget has eroded so badly is due to the fact that the Agency, and/or the Department, and/or the Administration, and/or the Congress have all failed to either request or appropriate adequate CHS funding to cover mandatory inflation and population inflation increases. The CHS program is more vulnerable to inflation pressures than any other program in the Indian health system. CHS budget increases have averaged 4.5 percent over the last ten years, despite the fact that medical inflation has exceeded 10 percent in many of these years. Similar public insurance programs like Medicaid obtain budget increases that are based on actual medical inflation. The Medicaid program has averaged an annual budget increase of 7.5 percent over the same period.

The IHS Director must stress with the Department, OMB, and the Administration that the CHS program should receive medical inflation adjustments equal to the Medicaid program since both provide similar services and purchase care from the private sector. Surely, the relatively small Indian Health Program is not able to secure better rates from providers than the Medicare and Medicaid programs. It is reasonable to expect that Medicaid program inflation rates will exceed 10 percent in FY 2010. It seems clear that CHS, while an efficient alternative to building hospitals and

[9] See *NPAIHB 21st Annual FY 2011 IHS Budget Analysis & Recommendations* (page 24), March 12, 2010. Available at: www.npaihb.org.

[10] See FY 2009 IHS Denied, Deferred, CHEF Services report, available from the IHS Headquarters CHS Program, Rockville, MD.

specialty clinics, is subject to higher rates of inflation than the rest of the IHS budget and should be provided with an appropriate increase annually.

In summary, this paper represents the position of Northwest Tribes who stand ready to assist the IHS Director to work to bring positive changes to the CHS program and funding methodology. Northwest Tribes are confident that the IHS Director will follow the practice of being sure that true consultation is obtained prior to making final decisions affecting the CHS program.

The last two years and the President's proposed FY 2011 budget mark positive changes for Indian health funding. We all share in that success if we distribute the record increases fairly. For the Portland Area, where over 40% of the funding for actual health care delivery comes from the 'contract care' line item; the IHS Director's decisions will be critical. The previous developed 2001 workgroup formula does not meet the test of fairness in the way it was developed or the results that it produces. The Northwest Portland Area Indian Health Board is ready, willing, and able to work on a new formula that will meet the needs of all tribes. Until an acceptable formula is developed, the current formula should be used to distribute CHS dollars.

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