



# SUMMARY OF CONTRACT HEALTH SERVICES TRIBAL RECOMMENDATIONS

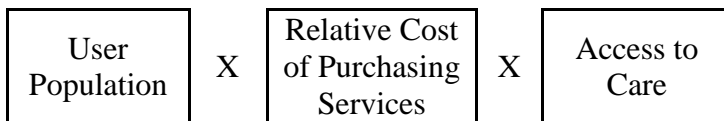
## SUMMARY

Within the last ten years, Indian Health Service (IHS) and Indian Country have been formulating ideas and suggestions on how best to reform Contract Health Services (CHS). Below is a list of these recommendations retrieved from the CHS allocation workgroup as well as testimony given during CHS reform hearings by the U.S. Senate Committee on Indian Affairs (SCIA).

## CHS WORKGROUP RECOMMENDATIONS

### New Funding Formula Recommended in 2001

The Contract Health Services Allocation Workgroup was established in 2001 and included tribal and IHS representatives from each IHS Area as well as the National Indian Health Board. The workgroup developed a new formula, which consists of three variables for each IHS operating unit: a) active user population, b) cost of purchasing health care services within a geographical area (based on the American Chamber of Commerce Research Association regional cost of living index), and c) whether or not there is access to an IHS funded hospital. These three variables are multiplied together to yield a result for each operating unit. New funds are then distributed to operating units proportionally based on their results from the new formula.



In addition to the new funding formula, the workgroup proposed:

- IHS use actual medical inflation rates to purchase inpatient and outpatient hospital care when determining inflation amounts for CHS distributions to tribes.
- \$110 million increase for CHS.



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## SCIA HEARING RECOMMENDATIONS

### Administrative Changes

- Reduce the administrative overhead within IHS including departmental-imposed administrative paperwork, systems, programs, etc., as well as limit the dollar amount of resources that may be utilized for administrative costs versus cost to directly fund healthcare.
- Remove the new CMS documentation requirements and accept tribal membership or Certificate of Degree of Indian Blood as proof of citizenship.
- Develop a congressionally mandated CHS Advisory Committee, of which 51% would be Tribal leaders. Other suggested members should be the IHS Director, the Chair of MedPAC, provider groups, and academics proficient in health system structural reform.

### Medicare-like Rates

- Pursue the most favorable rates at hospitals that have previously offered less than Medicare rates, and strategically identify and pursue other opportunities where lower rates may be negotiated.
- Separate hospitals in terms of those paying higher or lower than Medicare rates.
- Extend Medicare-like rates to the ambulatory setting.

### Third Party Reimbursements

- Develop a method of using third party reimbursements to fund additional providers in our clinics.

### Use Medical Inflation Rates

- The CHS program should receive medical inflation adjustments equal to the Medicaid program.



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### Workforce Shortages

- Work through the Medicare Graduate Medical Education Program to achieve lower health professional vacancy rates and improve infrastructure at direct care sites.
- Pursue the highest volume providers for contract negotiations, and use comparative cost and utilization data the FI makes available to strengthen its negotiating position.

### Other Recommendations

- Conduct field hearings in all IHS Areas.
- Create charity partnerships.
- GAO Report examining billing and reimbursement rates, the ability to access health care after-hours, and the number of unpaid medical bills of American Indian and Alaska Natives.
- Expand funded medical procedures to pay for other priorities such as preventive care services, cancer screenings, specialty consultations, and diagnostic evaluations.
- Require IHS to report annually on the medical consumer price index and to demonstrate that the full value is factored into the CHS budget request.
- Know in advance the utilization and costs data associated with target hospitals; obtaining Medicare information on the hospitals from the fiscal intermediary; combining purchasing power among areas to increase potential patient volumes; and conducting face-to-face meetings with hospital personnel to build and maintain ongoing positive business relationships.