DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

ROBERT G. MCSWAIN

DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

OF THE

UNITED STATES CONGRESS

ON

CONTRACT HEALTH SERVICES

FOR THE

INDIAN HEALTH SERVICE

June 26, 2008

STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good Morning. I am Robert McSwain, Director of the Indian Health Service. Today I am accompanied by Dr. Richard Olson, Director of the Office of Clinical and Preventive Services, and Mr. Carl Harper, Director of the Office of Resource, Access and Partnerships. We are pleased to have the opportunity to testify on the Indian Health Service's Contract Health Services program.

Overview of Indian Health Service Program:

The Indian Health Service provides health services to nearly 1.9 million American Indians and Alaska Natives (AI/ANs). In carrying out this responsibility, the IHS maintains a unique relationship with more than 560 sovereign Tribal governments located in the most remote and harsh environments within the United States as well as in modern metropolitan locations such as Anchorage and Phoenix. This geographic diversity and major health disparities offer extraordinary opportunities and challenges to managing and delivering health services.

The IHS and Tribal programs provide a wide array of individual and public health services, including clinical, preventive, and environmental health services. In addition, medical care services are purchased from outside the IHS system through the Contract Health Services (CHS) program when the care is otherwise not available at IHS and Tribal facilities.

The IHS is committed to its mission to raise the physical, mental, social, and spiritual health of all AI/ANs to the highest level.

In FY 2008, the CHS program is funded at $579 million, and over 50% is administered by Tribes under Indian Self Determination contracts or compacts. Of the total funding the Tribal programs manage $302.9 million and the federal programs manage $276.4 million. CHS programs are administered locally through 163 IHS and Tribal Operating Units (OU). The funds are provided to the Area Offices which in turn provide resource distribution, program monitoring and evaluation activities, and technical support to Federal and Tribal OUs (local level) and health care facilities providing care.

CHS payments are made 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

Many of our patients have no health care coverage outside of that received from the IHS or tribal health programs. These patients often access needed care through local community hospital emergency rooms. The CHS program covers emergency services if they meet eligibility criteria. If the services do not meet eligibility criteria or CHS funds

are not available, the patient is responsible for the cost of care. Some patients are unable to pay for these services. Although these patients are eligible for direct IHS care, they may not meet the CHS eligibility regulations and many do not have an alternate resource to pay for their services.

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 medical care at nearly 700 different locations. Emergency room and inpatient care is provided in 46 locations, and a limited number of our largest medical facilities do provide secondary medical services. With the exception of a hospital in Alaska, IHS and Tribal hospitals have an average daily patient census of fewer than 45 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 are dependent on CHS for most of their health care needs. Those direct care programs with the most sophisticated capabilities have, per capita, the smallest CHS programs and visa versa. However, all of our facilities and programs are dependent on CHS for the medical services that they are unable to provide. The CHS program covers medical services on a priority system with the highest priority medical needs funded first.

It is important to understand that the CHS program does not function as an insurance program with a guaranteed benefit package. When CHS funding is depleted, CHS payments are not authorized. The CHS program only covers those services provided to

patients who meet CHS eligibility and regulatory requirements, and only when funds are available. Many facilities only have CHS funds available for more urgent and high priority cases and utilize a strict priority system to fund the most urgent cases first.

In some instances AI/AN patients go directly to community healthcare providers for care rather than through the CHS referral system for required prior authorization. Because community healthcare providers assume that IHS provides coverage and/or payment for AI/ANs, it is not uncommon for community healthcare providers to expect payment from the IHS or tribal CHS program regardless of eligibility, regulatory requirements, and/or CHS medical priorities. Patients who access non-emergency care without prior authorization/referral are responsible for payment for those services, regardless of CHS eligibility status.

Eligibility

In general, to be eligible for CHS, an individual must be of Indian descent from a federally recognized Tribe and belong to the Indian community served by a Contract Health Services Delivery Area (CHSDA). If the person moves away from their CHSDA, usually to a county contiguous to their home reservation, they are eligible for all direct care services available but are generally not eligible for CHS.

When the individual is not eligible for CHS, the IHS cannot pay for the referred medical care, even when it is medically necessary, and the patient and provider must be informed that CHS funds are not available. The CHS program educates patients on the eligibility

requirements for CHS, by interviewing them, posting the eligibility criteria in the patient waiting rooms, and in the local newspapers. The CHS program assists these patients by trying to find the needed healthcare services within the community at no cost or minimal cost to them. Patients who are not CHS eligible are responsible for their health care expenses. Some non-IHS providers have expectations that IHS will be the primary payer for all AI/AN patients, which has led to strained relationships with local community healthcare providers when patients are denied CHS which often leaves them without compensation.

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, SCHIP, 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.

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 CMS to provide outreach and education to the populations we serve to ensure that eligible patients are signed up for Medicare, Medicaid, and SCHIP. Recently, the IHS launched a nationwide awareness initiative entitled "Resource Smart." This is an

outreach program that trains staff and patients to maximize the enrollment of eligible AI/ANs in CMS and private insurance programs. By enrolling in these programs, this frees up existing funds to be used for CHS referrals/payments. An important component of this initiative is to increase the placement of State Medicaid eligibility workers at IHS health care facilities instead of our patients having to travel great distances to apply for Medicaid.

Medical Priorities

CHS regulations permit the establishment of medical priorities to rank which referrals or requests for payment will be funded. Area-wide priorities and routine management of funds are used to try to maintain an equivalent level of services throughout the year and take into consideration the availability of services and accessibility to a facility within the Indian healthcare system. There are five categories of care within the medical priority system: ranging from Emergency (threat to life, limb and senses) to chronic care services.

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

II. Preventive Care Services e.g., diagnostic tests, lab, xrays

III. Primary and Secondary Care Services e.g., family practice medicine, chronic disease management

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

V. Excluded Services - unless determined to be a Medicare covered service the program would pay for the services

Services not Covered by CHS:

Payment for contract health care services may be denied for the following reasons:

1) Patient does not meet CHS Eligibility requirements;

2) Patient eligible for Alternate Resources;

3) No Prior Approval for non-emergency services;

4) No notification within 72 hours of emergency services or 30 days in some cases;

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

6) Not within medical priority. When the services are not within the medical priority levels for which funding is available they must be denied.

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

Distribution of CHS Funding Increases

The IHS works hard to ensure fairness in distributing CHS funding increases. In FY 2001 the IHS Director formed a CHS Allocation Workgroup that included IHS and Tribal representatives to develop a distribution methodology for increases in appropriations of CHS funds. The workgroup's focus was on distributing any potential CHS funding increases in an equitable manner.

The CHS allocation methodology emphasizes four main elements:

- Inflation funding based on each Area's base at the prevailing OMB inflation rate
- User Population
- Relative regional cost of purchasing services
- Access to care – those Areas with or without I/T/U facilities

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 $25,000, which is capped by Statute. Prior to FY 2008, the CHEF was funded at $18 million and typically was depleted before the end of the fiscal year. The CHEF is funded at $27 million in FY 2008. The CHEF cases are funded on a "first-come-first served" basis. In FY 2007, the CHEF program provided funds for 738 high cost cases in amounts ranging from $26,000 to $1,000,000.

When CHEF cannot cover a particular high cost case, the responsibility for payment reverts back to the referral facility for payment purposes.

Unified Financial Management System

The IHS is successfully implementing a new accounting system (UFMS) in accordance with Departmental policy. In the past, the CHS program has experienced some challenges in paying providers but we expect the 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.

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 at the

"Medicare-like Rates." These rates are about 60-70% 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 AI/ANs, than would otherwise be the case. Since the regulation became effective in July of 2007, I have heard from several Tribes experiencing increased purchasing power due to payment savings, and expect the Medicare-like Rate payment savings to continue. However, the Federal programs have experienced less savings as most already had negotiated provider contracts with payment rates at, or near, the level of the Medicare rates, but benefit from the guarantee of reasonable rates that the regulation provides. Area Office CHS staffs continue their efforts to negotiate contracts with providers with the most cost-effective payment rates possible.

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