



SUMMARY OF CONTRACT HEALTH SERVICES TRENDS IN FUNDING

SERVICES PROVIDED

The Indian Health Service (IHS) provides two types of services: 1) direct health care services delivered by an IHS facility (*e.g.*, clinic, hospital) and 2) contract health services (CHS) delivered by a non-IHS facility or provider through contracts with the IHS. The CHS program is administered through the twelve IHS Area Offices, which collectively include 155 IHS and tribally operated service units. CHS funds are used to provide emergency or specialty care that is not available at IHS direct care facilities. CHS funds are also used for IHS Areas without IHS direct care facilities, if a direct care facility has an overflow of its medical care workload, and to supplement alternative resources. Services purchased through CHS include hospital, physician, outpatient, laboratory, dental, radiology, pharmacy, and transportation services.

The Catastrophic Health Emergency Fund (CHEF) is a component of CHS. CHEF pays for high cost cases over \$25,000. It is administered at the national level and cases are funded on a “first-come-first-served” basis until CHEF funds are depleted. If CHEF cannot cover a case, the responsibility for payment reverts back to the referring facility.

ELIGIBILITY REQUIREMENTS

The CHS eligibility requirements are stricter than those for receiving IHS direct care. To be eligible for CHS, an individual must: 1) be of Indian descent and belong to an Indian community (verified by tribal descendancy or census number) and 2) reside within his/her Tribal Contract Health Service Delivery Area (CHSDA), which includes trust land, the reservation, and neighboring counties. Other individuals eligible for CHS include: students who are temporarily absent from the CHSDA during full-time attendance at school; persons who are temporarily absent from CHSDA due to travel or employment; children placed in foster care outside of a CHSDA by court order; other Indian persons who reside in a CHSDA and are not tribal members but maintain “close social and economic ties” with the CHSDA tribe (*e.g.*, Indian individuals who are married to tribal members); and non-Indian women pregnant with a CHS-eligible individual’s child.

IHS is a “payer of last resort” for persons defined as eligible for CHS. As such, all individuals seeking CHS funds for care must apply for and utilize all alternate resources for which they are eligible, such as Medicare A and B, state Medicaid, state or other federal health programs, and private insurance. The IHS must be notified in advance of medical appointments and must authorize CHS funding before the provision of medical care. In emergency cases, IHS must be notified within 72 hours after the beginning of treatment (extended to 30 days for elderly and disabled persons).



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HISTORY AND INITIAL AUTHORIZATION

The IHS CHS program originated under the Department of the Interior, Bureau of Indian Affairs when the Johnson O'Malley Act of 1934 authorized the Secretary of the Interior to enter into health services contracts for American Indians and Alaska Natives. In 1955, the IHS was transferred to the Department of Health, Education, and Welfare. Funding for the CHS was initially authorized in the Snyder Act of 1921 (25 U.S.C. 13) and the Transfer Act of 1954 (P.L. 83-568; 42 U.S.C. 2001). As stated in 42 U.S.C. 2001: "In carrying out his functions, responsibilities, authorities, and duties under this subchapter, the Secretary [of Health and Human Services] is authorized, with the consent of the Indian people served, to contract with private or other non-Federal health agencies or organizations for the provision of health services to such people on a fee-for-service basis or on a prepayment or other similar basis."

CHS FUNDING AND THE INCREASING COST OF HEALTH CARE

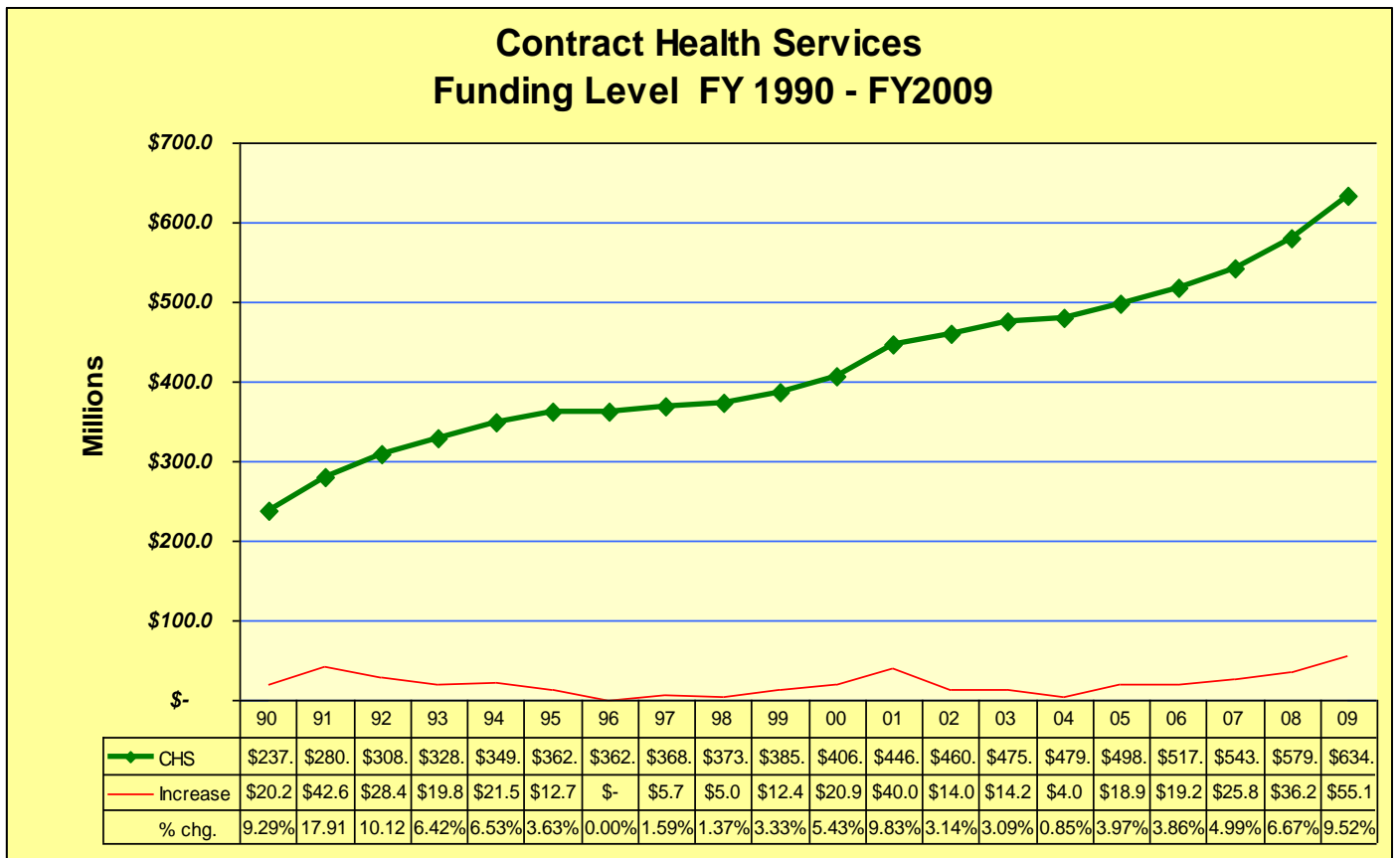
In general, the services provided by CHS have decreased in recent years because increases in the cost of care have far exceeded CHS budget increases. For example, from 2003 to 2008, CHS inpatient admissions declined by 4.0% from 14,847 to 14,205. At the same time, billed costs per admission increased 64.0% from \$16,345 to \$26,873. Similarly, from 2003 to 2008, CHS denials increased 88.0% from 19,121 to 35,953. During the same period, the cost of unfunded denials increased 296% from \$43,924,761 to \$130,113,907. In 2008 and 2009, only half of CHEF cases could be funded, and over 1000 cases went unfunded each year.

The FY 2009 CHS budget was \$634 million, which included an increase of \$55 million over FY 2008 levels (a 9.5% increase). The proposed FY 2010 budget for CHS is \$779 million and if passed by Congress, would be the largest increase in the last two decades. The FY 2010 proposed CHS budget includes an increase of \$144 million (23%) over FY 2009 funding levels.



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CHS FUNDING LEVELS SINCE 1990

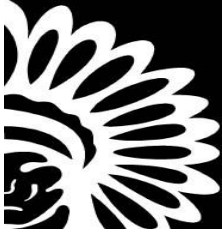




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IHS AREA FUNDING LEVELS FOR CHS (IN MILLIONS OF DOLLARS)

AREA	2004	2005	2006	2007	2008	2009
Aberdeen	\$50.1	\$51.8	\$54.5	\$61.1	\$63.5	\$67.9
Alaska	\$49.4	\$51.5	\$53.2	\$55.2	\$58.0	\$63.1
Albuquerque	\$23.0	\$24.0	\$24.9	\$25.8	\$27.4	\$29.8
Bemidji	\$32.3	\$33.6	\$34.8	\$36.1	\$38.2	\$41.9
Billings	\$40.7	\$41.9	\$43.1	\$44.7	\$46.5	\$49.2
California	\$23.0	\$24.4	\$25.5	\$26.4	\$28.3	\$31.4
Nashville	\$18.9	\$19.6	\$20.6	\$21.3	\$22.4	\$24.2
Navajo	\$53.7	\$56.3	\$58.3	\$60.4	\$63.8	\$69.4
Oklahoma	\$54.3	\$56.8	\$59.6	\$65.1	\$69.1	\$75.8
Phoenix	\$39.9	\$41.8	\$43.5	\$45.1	\$47.6	\$51.6
Portland	\$54.4	\$56.2	\$58.3	\$60.5	\$63.6	\$69.2
Tucson	\$12.1	\$12.5	\$12.9	\$13.4	\$13.9	\$14.8
Reserve	\$9.6	\$9.8	\$10.3	\$10.0	\$10.5	\$15.1
CHEF	\$17.8	\$17.8	\$17.7	\$18.0	\$26.6	\$31.0
TOTAL	\$479.2	\$498.0	\$517.2	\$543.1	\$579.4	\$634.4



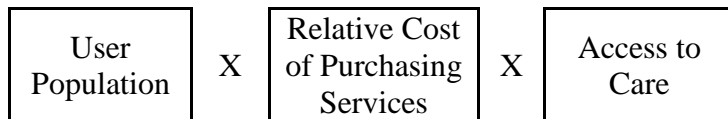
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CHS AREA DISTRIBUTION METHODOLOGY

Base Funding: When CHS was first established, the distribution of funds to IHS Areas was based on the health care needs for each designated population within an Area. However, there was no particular funding formula, and there is currently no specific information available from IHS detailing the initial base distribution methodology. Annual increases in funding for current CHS services (*i.e.*, funding increases for population growth and inflation) are allocated according to the original base distribution.

Additional Funding: 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 (see chart below). Funds are then distributed to operating units proportionally based on their results from the new formula. This formula however only goes into effect if funding to CHS exceeds the base funding. Over the last several years, funding increases for CHS have rarely exceeded base funding. However, in 2009 this increase did occur, and the new formula was applied. If the proposed 2010 budget increase is enacted, then the formula would again be used.

New Funding Formula Recommended in 2001



PER CAPITA EXPENDITURES BY IHS AREA

The original base distribution for funding allocations to IHS Areas has not changed since the origination of the CHS program. As a result, there may be differences today between IHS Areas in the *per capita* expenditure for individuals receiving services. It is important to note that the active user population is the number of individuals eligible for direct care. The number of individuals utilizing CHS may be smaller because the eligibility requirements for CHS are stricter than those for direct care (see “Eligibility Requirements” above). However, the exact numbers of CHS-eligible individuals are not available. As a result, the *per capita* expenditure statistics shown below are not entirely accurate. They are derived by dividing the total CHS budget for each Area by the active user population, which is the number of individuals eligible for direct care (not CHS). However, these data provide a rough estimate of the differences between IHS Areas in *per capita* expenditure. The most recent data available for user population were from FY 2008, and so expenditure data from that year were used in the calculations.



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User Population and Expenditures by IHS Area (FY 2008)

Area	Active User Population	CHS Expenditures	Total Expenditures**	Per Capita Expenditures	
				CHS	Total
Aberdeen	120,639	\$62,965,125	\$259,998,890	\$521.93	\$2,155.18
Alaska	136,065	\$57,895,982	\$452,007,193	\$425.50	\$3,321.99
Albuquerque	85,778	\$27,107,071	\$138,206,461	\$316.01	\$1,611.21
Bemidji*	101,022	\$38,095,003	\$154,773,249	\$377.10	\$1,532.07
Billings	70,507	\$45,631,475	\$148,546,485	\$647.19	\$2,106.83
California*	77,532	\$28,280,633	\$136,846,648	\$364.76	\$1,765.03
Nashville*	51,399	\$22,288,963	\$106,393,245	\$433.65	\$2,069.95
Navajo	239,814	\$63,397,692	\$368,899,312	\$264.36	\$1,538.27
Oklahoma	316,940	\$68,813,330	\$431,827,762	\$217.12	\$1,362.49
Phoenix	156,803	\$47,140,406	\$253,220,261	\$300.63	\$1,614.89
Portland*	101,690	\$63,536,321	\$204,973,588	\$624.80	\$2,015.67
Tucson	25,234	\$13,723,871	\$43,449,607	\$543.86	\$1,721.87

*These Areas do not have an IHS hospital. As a result, they may be more reliant on CHS for specialty services than Areas with IHS hospitals. The presence or absence of an IHS hospital in an Area is included in the new formula developed in 2001, although this formula only applies to CHS budget increases beyond the base distribution. The base CHS distribution does not account for the presence or absence of an IHS hospital.

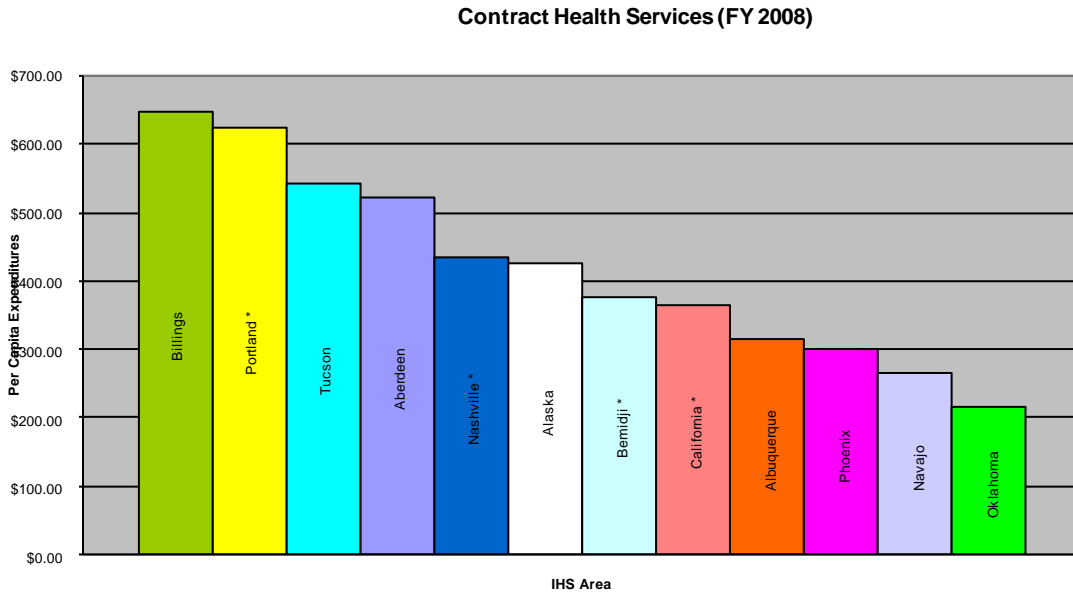
**Total IHS expenditures by Area are not directly available. This variable was calculated by adding all of the individual Area allocations for: hospitals and health clinics, dental services, mental health services, alcohol and substance abuse treatment, contract health services, public health nursing, health education, the community health representatives program, urban health services, direct operations, and contract support. The actual total IHS expenditures may not be same as the "Total IHS expenditures" shown here, which is a calculated sum of individual IHS program Area allocations.



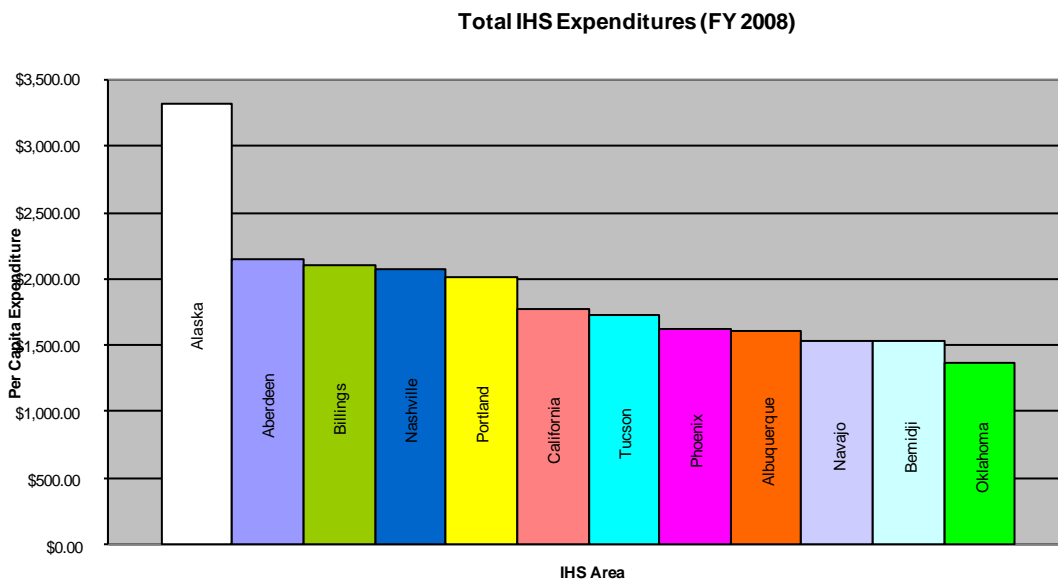
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Per Capita Expenditures by Area (FY 2008)

The *per capita* expenditures calculated above for FY 2008 are displayed here in graph form.



*Areas without an IHS hospital





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RESOURCES

Overview of CHS and eligibility requirements:

<http://www.ihs.gov/NonMedicalPrograms/dqwg/dqwg-section1-home.asp#1>

Budget data for CHS and other IHS programs:

http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/IHS_CJ_2010_Final_Submission.pdf

User population data (FY 2008):

<http://www.ihs.gov/FacilitiesServices/areaOffices/California/uploadedfiles/gpra/FY2008FinalUserPopulationMemo12182008a.pdf>

2008 IHS testimony on CHS to the Senate Committee on Indian Affairs:

<http://www.hhs.gov/asl/testify/2008/06/t20080626g.html>

Summary of CHEF regulations:

<http://www.ihs.gov/FacilitiesServices/AreaOffices/California/UploadedFiles/CATASTROPHIC-HEALTH-EMERGENCY-FUND.pdf>