638 Toolkit

Considerations for Tribes Regarding Contracting or Compacting for Clinical Services from the Indian Health Service Under PL 93-638

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Chapter 1 – Purpose of the Toolkit

This document is intended to assist tribes in evaluating the feasibility of assuming the management of Indian Health Service (IHS) service units under an *Indian Self-Determination & Education Assistance Act* (ISDEAA—PL 93-638) Contract or Compact. Each tribe is unique and will therefore have unique considerations in this process. The purpose of the toolkit is to provide an initial outline of factors to consider in beginning the feasibility analysis. If a Tribe chooses to utilize ISDEAA, or if the Tribe chooses to have IHS manage their clinical services, either choice is an expression of tribal sovereignty. This document is not intended to make specific recommendations to particular tribes.

Brief Overview and Summary of Key Factors to Consider Include:

Community Demographics

- Number of eligible American Indians registered at the facility
- Number of new patients being registered per year
- Active user population (number of patients who have used the facility in the last 3 years)
- 2010 U. S. Census reports on community population and age distribution
- Tribal Enrollment data
- Population residing in the designated IHS Contract Health Service Delivery Area (CHSDA)
- Poverty rates

Health Status

The Northern Plains region has some of the greatest health disparities in the nation, including the highest age-adjusted death rate, the highest rates of infant and neonatal mortality, high rates of chronic diseases, and death rates from homicide and suicide and unintentional injury rates over twice the national average. These health disparities lead to higher costs of providing health services and need to be considered in the feasibility analysis. Key factors to consider include:

- The overall death rate in the population
- Prevalence (percentage of population with a particular disease) and death rate due to chronic diseases, including heart disease, cancer, diabetes, and chronic lung disease
- Prevalence and death rates due to acute conditions, including unintentional injuries, intentional injuries (homicide and suicide), and infant mortality

Role of Medicaid and Third Party Revenue

The operation of most service units operated by the IHS depends heavily on revenue received from third-party private and public insurance coverage of patients. As would be expected in a low income and young population, the coverage levels for Medicaid are typically very high. Current revenue generated by several sources needs to be calculated, including:

- Medicaid and Medicare
- Private Insurance

- Other sources

Contract Health Services

Due to significant health problems experienced among many IHS patients, Contract Health Services (CHS) funds are a key component for accessing services. CHS guidelines require that these funds be used as a payer of last resort and require the contract health provider to bill alternate resources whenever possible. Effective management of CHS resources requires the IHS or the tribe under ISDEAA management to register CHS patients for all alternate resources and to ensure the third party intermediary is effectively assigning payment to CHS only as the last recourse.

Current ISDEAA Contracted Services

All Tribes in the Northern Plains region currently manage ISDEAA contracts with the IHS to operate health programs, even if the service unit is directly operated by the IHS. Typical health programs that are often managed by tribes include:

- Community Health Representative (CHR) Program. CHRs work with the IHS service units to coordinate health care and to provide support and transportation for community members needing assistance.
- Alcohol and substance abuse programs
- Several other health programs are also managed by tribes under existing ISDEAA agreements

In considering the feasibility of assuming the management of IHS service units, it is important to examine the tribes' current ISDEAA budget and management history.

Current IHS Budget

The total annual budget for the operations of the service unit for the previous three fiscal years should be determined. These budget are typically relatively flat for the past three years, and they usually rely heavily on revenue from Medicaid and other third parties.

Contract Support Costs

A key consideration in the ISDEAA contracting process is the tribal Indirect Cost Rate (IDC) which is used to calculate Contract Support Costs (CSC) revenue, which tribes would be entitled to under the ISDEAA contract. Current median IDC rates for tribal contracts under the ISDEAA are approximately 28%. ***This means that tribes receive on average 28% more funding in their healthcare budgets than IHS-direct programs.*** If the tribes' IDC rate is low, it will need to be renegotiated prior to or during the ISDEAA process in order to maximize funding.

New Tribal Revenues

With an IDC rate consistent with national averages (approximately 28%), the tribes would be eligible for significant amounts of new revenue by contracting (Title I) or compacting (Title V) for the IHS service units. The tribes could also consider rolling current ISDEAA contracted services into a Title V Compact to promote and improve coordination of both clinical and non-clinical health services under one system.

Contractible Services Retained at IHS

Some services for which the tribe is eligible to contract might be better left with the IHS to manage. For example, sanitarians working in the Office of Environmental Health and Engineering (OEHE), Information Technology and the Resource and Patient Management System (RPMS) would require more resources and time investment than would be available under ISDEAA contracting. In addition, Area Office (AO) recruitment services for professional staff are typically better left at the AO due to limited resources via ISDEAA contracting for this service.

Patient Protection and Affordable Care Act Opportunities

New opportunities are available as the Patient Protection and Affordable Care Act (ACA) is implemented, including Medicaid expansion in most states, health insurance exchanges, Federally Qualified Health Center (FQHC) expansion, and Federal Employee Health Benefits (FEHB) opportunities under the reauthorization of the Indian Health Care Improvement Act (which was reauthorized as part of the ACA legislation). These opportunities need to be incorporated into the strategic planning and implementation of an ISDEAA contract for health services at Lower Brule. At the time of this report, South Dakota has decided not to expand Medicaid, but North Dakota and Minnesota are expanding Medicaid. Not expanding will have a negative impact on third party revenue for all IHS and tribal facilities in the state, and the tribes should continue their efforts in advocating for Medicaid expansion.

Facility Issues

Many IHS facilities are old and insufficient to meet the health services needs of the tribes. Often, much of the physical infrastructure needs to be improved and expanded to better meet the health needs of community members. New facilities that contain adequate space could be used to house clinic operations and other tribally-operated health services in a coordinated and co-located manner. Joint Venture opportunities with the IHS for new facilities have been limited in recent years. However, opportunities for creative financing exist under New Markets Tax Credits and related programs that can be combined with federal grants (e.g. HUD, etc.). A facilities development analysis will need to be conducted if the tribe determines that the current facility is inadequate.

Title I v Title V Considerations

If a tribe decides to proceed with an ISDEAA agreement, it will have to determine whether it is eligible for and prefers to use a Title V Self -Governance agreement or a Title I contract. Both self-determination (Title I) and self-governance (Title V) involve the transfer of responsibility for managing federal programs and funds that serve Indians from existing service providers to tribes. Tribal self-governance, however, is a step beyond self-determination, and it is founded on the government-to-government relationship between the federal government and a tribe and is designed to be more flexible for tribes than Title I contracting. More detail regarding the differences between Title I and Title V are provided in this document.

Federally Qualified Health Center Opportunities

Tribal “638” programs have an unprecedented opportunity to expand their capacities by securing Federally Qualified Health Center (FQHC) status and Community Health Center (CHC) funding. Key aspects of most IHS service units in the Northern Plains align with the

required HRSA FQHC program area requirements, including Governance, Service Area, Service Delivery Model, Quality Improvement, and Financial Management. FQHCs are authorized under Section 330 of the Public Health Service Act, and tribal 638 programs are eligible for FQHC / CHC grants. Although CHCs must see all patients regardless of race (not just AIs), the demographics in many Northern Plains tribes suggest that the clinic would see very few non-Indians as a CHC. Most IHS service units would be eligible for annual "330" grant funding of approximately $600K should the tribes pursue 638 contracting or compacting.

Timeline Summary and Next Steps

Following submission of a Letter of Intent to develop a contract or compact with the IHS, tribal leaders have many issues to consider when determining the timeline to contract or compact for the operation of the service unit. Generally, the ISDEAA proposal development and implementation of the necessary activities to transfer the clinic to tribal control can be achieved within 6 months following a determination by the Tribal Council and notification of IHS that the ISDEAA agreement is being pursued. Generally, the process can be divided into several stages. Many of these activities can often run concurrently:

1. **Feasibly assessment and tribal leadership decision stage**—The first part of the process in which the Tribal Council reviews the pros and cons of the proposed ISDEAA contract and determines the scope of the ISDEAA proposal. This may also include a determination of the appropriate contract or compact mechanism via a Title I or Title V agreement (this generally can be accomplished in 3 to 6 months).
2. **Prepare ISDEAA proposed agreement**—Depends on the size, scope and complexity of the proposed Program, Functions, Services and Activities (PFSAs) to be operated, but this generally can be achieved within 2-3 months if prioritized by the Tribal Council.
3. **Negotiate ISDEAA agreements with IHS**—Again, this depends on the size and scope of the project, but generally for a typical IHS service unit, this can be achieved in one to two months.
4. **Develop IPA/MOA agreements for federal employees**—This is normally the issue that consumes the most time in the development of an ISDEAA contract where significant numbers of existing federal employees are affected. Tribes normally choose to rely heavily on Interagency Personnel Agreements/Memorandum of Agreement (IPA/MOA) agreements for existing employees in transitions in which the Tribe will require difficult-to-recruit and highly-trained professional employees to provide the PFSAs under the new ISDEAA contract. The Tribe must determine early in the planning process which employees will be offered IPA/MOAs (typically recommended to offer all eligible federal employees and IPA or MOA), and the IHS is constrained by federal civil service and uniformed personnel rules throughout the transitions process and will require usually up to 4 to 6 months to counsel employees, prepare offers and take the necessary steps to relocate or go through the Reduction in Force (RIF) process for federal employees who choose not to accept or are ineligible for IPA or MOA positions with the Tribe. This is typically the most time-consuming process in an ISDEAA transition process for an existing IHS facility.

Chapter 2 – Background and Overview of Key Datasets

Overview of PL 93-638

Perhaps the most significant law affecting the provision of health services to the American Indian and Alaska Native (AI/AN) population is the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA, PL 93-638). This Act allows tribes to assume the management and control of healthcare programs from Indian Health Service (IHS) and to increase flexibility in healthcare program development. Under ISDEAA, tribes have the option to contract or compact with IHS to deliver health services using pre-existing IHS resources (formula-based shares tables determine funding for various IHS sites), third party reimbursements, grants, and other sources. Often, tribes develop their own non-profit healthcare corporations to provide services to their community, and as a result are eligible for grants and other types of funding not available to federal agencies like IHS.

Due to the increased revenue available to tribes under ISDEAA, "638 Tribes" are generally able to provide more services in their communities than they were able to under IHS control. Currently, over half of the IHS budget goes to 638 programs. Numerous tribes have improved access to healthcare services and increased flexibility of health programming for their communities.

Description of the Tribal Service Area

A significant amount of information regarding community demographics and the facility service area is available using several datasets, including:

- US Census
- IHS Resource and Patient Management System (RPMS)
- Tribal enrollment data
- Surveillance, Epidemiology and End Results (SEER)

The IHS typically tracks the number of eligible American Indians registered at the clinic and the number of new patients registering per year. The IHS measure of *active user population* measures the routine users of the facility over the last three years. IHS defines an *active user* of the facility as an eligible American Indian registered user that has used the facility at least once in the past three years and reported a home address in the community. Active Users, unlike clinic registrants, are not duplicated at other IHS facilities and are current active users of a facility.

Table 2.1
Sample IHS Active User Populations of the IHS Service Unit

Operating Unit	FY2010	FY2011	FY2012
Tribal Service Unit	2,020	2,080	2,080
Annual Increase		1.9%	0%
Area Office	120,000	122,000	124,000
Area Annual Increase		1.0%	1.0%
Annual Ambulatory Care Visits	19,632	19,096	19,287
Outpatient Visits per active user	9.71	9.18	9.27

Source of Data: IHS Area Office

Table 2.1 above shows a Sample IHS *active user* population for the past three years as reported by the IHS RPMS. These data can be compared to the 2010 U. S. Census reports to further validate the IHS active user count. However, it is not uncommon for tribal populations to be underestimated in the U. S. Census. The IHS Contract Health Service Delivery Area (CHSDA) also needs to be determined to better understand patient demographics and potential health services needs under CHS.

Demographics and Economic status

Typically, with high birth rates and high death rates, the age distribution of many reservation communities is extremely young—often with almost half of the total population under 20 years old. Median household income reported in the 2010 census is typically low with a significant number of households at or below the federal poverty level. A sample age distribution and gender table of tribal members is described in Table 2.2.

Table 2.2
Age and Sex Structure of Tribal Population

Age	Male	Female
0 to 9 years	X	Y
10 to 19	X	Y
20 to 29	X	Y
30 to 39	X	Y
40 to 49	X	Y
50 to 59	X	Y
60 to 79	X	Y
70 to 79	X	Y
over 80	X	Y
TOTAL		

Source- US Census

Health Status

Relatively small population numbers make it challenging to provide specific information on health status indicators on many reservation communities, however, American Indians, especially in the Aberdeen, Billings, and Bemidji Areas, have long experienced lower health status, lower life expectancy and greater disease burden when compared with other Americans. The Northern Plains American Indian population has some of the greatest health disparities in the nation including the highest age adjusted death rate, the highest rates of infant and neonatal mortality, and death rates from homicide and suicide and intentional injury rates over twice the national average.

Table 2.3 shows a sample table of the top ten causes of death for residents in a tribal population. The overall death rate of the population shown here is 2.4 times greater than in the state's white population. Heart disease, cancer, unintentional injuries, diabetes, and chronic lung disease are often among the leading causes of death in tribal communities. In addition, the death rate caused by most of these conditions occurs at a statistically significantly greater rate than in the non-Indian population.

Table 2.3

1990-2010 Top Ten Causes of Death for American Indians in the Sample Tribal Population

	Tribe	Rate per 100,000	Rate Ratio v. White Population (95% CI)	P-value*
	All Causes of Death	2031.0	**2.4 (1.8, 3.1)***	**<0.0005**
1	Diseases of Heart	462.3	1.9 (0.9, 3.2)	0.086
2	All Malignant Cancers	397.5	**2.1 (1.0, 3.7)***	**0.046**
	1. Lung Bronchus	139.2	2.1 (0.5, 5.5)	0.3
	2. Respiratory System	139.2	2.0 (0.4, 5.1)	0.4
	3. Digestive System	91.6	1.8 (0.4, 5.0)	0.4
3	Accidents / Injuries	160.5	**4.4 (2.1, 8.2)***	**<0.0005**
4	Diabetes Mellitus	126.6	**6.9 (1.3, 18.0)***	**0.025**
5	COPD	121.7	**3.1 (1.2, 6.7)***	**0.025**
6	Cerebrovascular Diseases	115.7	2.0 (0.3, 5.6)	0.5
7	Chronic Liver Disease/Cirrhosis	101.3	**18.8 (6.0, 43.4)***	**<0.0005**
8	Ill-Defined Conditions	89.7	**13.8 (3.4, 35.0)***	**0.001**
9	Kidney Disease	57.8	**6.1 (1.5, 17.0)***	**0.014**
10	Pneumonia / Influenza	37.6	1.3 (0.3, 4.4)	0.8

*P-value $\leq$ 0.05 is statistically significant greater death rate than white population.
Source: AI population Surveillance Research Program, National Cancer Institute SEER*Stat software (www.seer.cancer.gov/seerstat) version 7.0.4. Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Mortality - All Causes Of Death, Public-Use With County, Total U.S. for Expanded Races (1990-2002), National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2005. Underlying mortality data provided by NCHS (www.cdc.gov/nchs).

Tribal Epidemiology Centers are able to assist tribes in acquiring their data from the SEER database to demonstrate the leading causes of death in their communities. Table 2.4 is a sample table that shows the top presenting problems for the patients seen at the IHS facility from 2010-2012.

Table 2.4

Primary Reasons for Patient Visits to the IHS Health Center – FY2010-FY2012

Ambulatory Care Visits	2010	2011	2012	Average
Pharmacy	X	Y	Z	
General Primary Care	X	Y	Z	
Telephone	X	Y	Z	
Dental	X	Y	Z	
Pediatric	X	Y	Z	
Immunization	X	Y	Z	
Laboratory service	X	Y	Z	
Diabetic	X	Y	Z	

Pain Management	X	Y	Z	
Radiology	X	Y	Z	
Nurse Clinic	X	Y	Z	
Obstetrics (contract)	X	Y	Z	
All other visits	X	Y	Z	
TOTAL	**Total X**	**Total Y**	**Total Z**	**Total Ave**

Source: IHS Service Unit Operations Summary for 2010, 2011, 2012

Current 3rd Party Insurance Coverage Levels

The operation of most IHS and tribal facilities depends heavily on revenue received from 3rd party private and public insurance coverage of patients. Table 2.5 provides a sample pattern of insurance coverage for patients seen at an IHS facility.

Table 2.5
Sample Insurance Coverage Levels in IHS Facility User Population

Source of Coverage	Unduplicated Patient Count	% of active users
Medicaid - only	950	45.0%
Private Insurance - only	420	20.0%
Medicare A - only	15	0.7%
Medicare B - only	-	0.0%
Medicare Part A & B - only	40	1.9%
Medicare Part D	42	2.0%
Medicaid & Medicare	25	1.2%
Medicaid and Private Insurance	33	1.5%
Medicare and Private Insurance	36	1.7%
M & M and Private Insurance	6	0.3%
Total w/ 3rd Party Coverage	1,570	74.8%
Total 2011 Active users	2,100	100.0%

Source: IHS RPMS

As would be expected in a low income and very young population, the coverage levels for **Medicaid** are very high. Additionally, Medicaid contributes a significant percentage of all third party revenue at a typical IHS Health Center. .

Coverage levels for **Private Insurance** are typically lower, and total receipts from private payers usually accounts for a small percentage of the total third party reimbursements.

Medicare coverage and revenue can also be low with a small percentage of the population over 65 who are eligible for and enrolled in Medicare. Table 2.6 provides a sample distribution of annual third party revenue from Medicare, Medicaid, and Private Insurance.

Table 2.6
Sample Distribution of Annual Revenue from 3rd Party Billing based on Average Receipts from FY10 to FY12

3rd Party Revenue	3rd Party Collections	Percentage
Medicare	X	5%
Private Insurance	Y	15%
Medicaid	Z	80%
Total	Total	100%

Source: IHS Health Center / RPMS

Services Provided at the IHS Facility

Clinical services provided on the reservation may include primary care, pharmacy, dental, podiatry, optometry, on-site radiology support for routine radiology services, reference laboratory services, etc.

Staffing, especially professional recruitment is a challenge for many IHS facilities due to the common relative isolation of the practice environment. Table 2.7 provides a sample model for staffing vacancies to consider in the 638 process.

Table 2.7
Sample Approved Positions and Vacancies in the IHS facility

Staff Type	On Board	Vacant
Medical Provider	5	0
Nurse/ Med Assist	7	3
Pharmacy	3	1
Maintenance, Housekeeping and Supply	3	0
Administrative/IT support/HIS	5	4
Dental	0	4
Other	3	1
Total	**26**	**13**

Source: IHS Health Center staff roster

Communication between IHS staff and the Tribal Council is often perceived to be poor in many tribal communities. It is particularly important to improve communication during the review and evaluation and possible transition to tribal control.

Consideration: The Tribal Council should consider establishing communication protocols to include written and oral reports from the Clinic Staff to the Tribal Council on a monthly basis.

Contract Health Services

IHS clinics also operate IHS contract health programs to refer and pay for health services which cannot be provided in the facility. Table 2.8 below shows a sample of three years of CHS authorizations from an IHS facility.

Table 2.8

CHS Authorizations and Denials for IHS facility and Area.

	FY2010	FY2011	FY2012
Contract Health Service Authorizations			
Area Office	X	Y	Z
Local Service Unit	x	y	z
Local Service Unity - % of AO	x%	y%	z%
Contract Health Denials			
Local Service Unit	x	y	z
Aberdeen Area Office (all)	X	Y	Z
Lower Brule - % of AO	x%	y%	z%

Source: AO data

This data will demonstrate if there is a discrepancy in the percentage of CHS denials as compared to CHS authorizations for the local service unit as compared to the rest of the IHS Area.

Table 2.9 shows a sample of three years of budgets and expenditures for the IHS facility and the AO for CHS from FY2010 through 2012.

Table 2.9

Sample Contract Health Budgets and Expenditures for Local IHS Facility
FY2010 through FY2012

	FY2010	FY2011	FY2012
Budgets			
Local IHS Facility	$1,400,000	$1,500,000	$1,600,000
Area Office	$59,000,000	$60,000,000	$61,000,000
Expenditures			
Local IHS Facility	$1,400,000	$1,500,000	$1,600,000
Local IHS CHEF*	$130,000	$130,000	$130,000
Area Office	$59,000,000	$60,000,000	$61,000,000
Local Facility as a % of AO	2.59%	2.72%	2.43%

Source: AO CHS data
*CHEF—Catastrophic Health Emergency Fund

This table provides a comparison of the percentage of CHS funding for the local facility as compared to the IHS Area that can be compared with the percentage of User Population in the Area.

Medical services provided from CHS funds include emergency services and urgent care on nights and weekends, inpatient care, and specialty physician care not available on the reservation. They also include higher-level radiology and minimal laboratory services.

CHS funds also support durable medical equipment and other medical services that might not be available at the local Health Center. Table 2.10 below shows an example of the types of care supported by the CHS program.

Table 2.10
Sample Local Service Unit CHS Expenditures by Category

Category	FY2010	FY2011	FY2012
Medications	$X	$Y	$Z
Laboratory Services	$X	$Y	$Z
Radiology Services	$X	$Y	$Z
Emergency (facility & professional fees)	$X	$Y	$Z
Inpatient Hospital	$X	$Y	$Z
Outpatient Hospital or Surgery Center	$X	$Y	$Z
Physician Fees (specialty, etc.)	$X	$Y	$Z

Source: AO data

The Contract Health Program is used to supplement and support the care offered in the local Health Center. These services usually go to fund the highest priority cases consistent with IHS priority system for CHS. To extend and maximize the impact of very limited CHS resources requires compliance with extremely strict guidelines on priorities for care and CHS eligibility. Limited CHS resources have also been a source of patient dissatisfaction with IHS health care programs across the nation. CHS guidelines require that these funds be used as a payer of last resort and require the contract health provider to bill alternate resources whenever possible. Effective management of CHS resources requires the local service unit to register CHS patients for all alternate resources and to ensure the third party intermediary is effectively assigning payment to CHS only as the last recourse.

Tribally Provided Health Services

Tribal Health Departments currently manage numerous ISDEAA contracts with the IHS to operate several types of health programs, including the Community Health Representative (CHR) Program. CHRs work with the IHS Health Center to coordinate health care and to provide support and transportation for community members needing assistance. Tribes also frequently operate alcohol abuse prevention programs and substance abuse programs under ISDEAA contracts.

The tribally-managed health services should coordinate with the local IHS providers through regularly scheduled meetings to coordinate services in the community. Clinical and non-medical services should continue to be coordinated whether the local Health Center is managed by IHS or the tribe.

Consideration: Clinical and non-medical services should be coordinated whether the local Health Center is managed by IHS or the tribe.

Tribal Health Departments usually receive funding through existing ISDEAA Title I Contracts with the IHS. A sample summary of the FY12 IHS funding for the title I contract is in Table 2.11 below.

Table 2.11
Sample Local Title I ISDEAA Contract for Recurring Funding – FY2012

Activity	FY 2012
H&C	$X
Mental Health	$X
Alcohol	$X
CHR	$X
CSC (direct)	$X
Contract Health	$X
M&I	$X
Equipment	$X
Total	**$X**

Source: AO

Regional, Area Office and Headquarters Services

In addition to services provided directly by the tribe and Health Center on the reservation, the IHS provides additional services from the Regional Office of Environmental Health and Engineering (OEHE) offices, the Area Offices and Headquarters.

IHS typically provides Environmental Health Services directly to the communities from the OEHE Regional Office by the regional sanitarian or from the Area Office of Environmental Health Services. AO and Regional OEHE engineers also support the water, sewer, and waste management systems on reservations by providing planning and design support for the tribes to construct and improve these systems. Health Facility engineering support is also provided to the local facility director when needed from the OEHE at the AO.

The Area Offices and Headquarters also provide a wide array of administrative and support resources to the local Service Units for operations. Many of these functions, such as finance, personnel and contracting would be replaced with Tribally operated services in the event the tribe determined it wished to contract for the operation of the local health center, however some functions such as professional recruitment and information technology systems supporting the Clinic's electronic health record (RPMS/EHR) are very difficult and expensive to replace. Most tribes initially leave funding at the Area Offices and Headquarters to support continuation of these services from the IHS. These services and the tribal shares associated with each PFSA will be discussed in more detail in the succeeding chapters.

Chapter 3 - Community and Stakeholder Outreach

Community Surveys and Stakeholder Focus Groups

It is vitally important to ensure that there is community participation in the 638 process. With much misinformation regarding the process, community members may feel that it is not feasible for the tribe to operate its own clinic. Community surveys allow the tribe to gather information on community perspectives on several considerations, including:

- Level of satisfaction with current IHS services
- Perspectives on the tribe assuming management of the IHS facility under ISDEAA contracting or compacting
- Concerns regarding the process

In addition, focus groups allow for exchange of information in which questions regarding the 638 process can be addressed, and data can be collected regarding community concerns, hopes, and aspirations regarding the access to and provision of health services in the community.

Typical Findings—Community opinions could include:

- Community members are *dissatisfied* with the current level of their healthcare (access to care, referrals, customer service, follow-up) received at the local IHS facility
- Community members want *change*
- Community members may be unsure if their tribal leaders can provide the change

Typical Findings—Community perspectives could include:

- Community members may not know exactly what they want to change in terms of health programming and policy. Generally, however, they know that their healthcare is lacking, but they have little to compare it to.
- Community members may not know what the 638 process entails, and they may think that if the tribe takes over healthcare, the following will occur:
    - All IHS staff will be fired
    - They will lose healthcare
    - They will get a new clinic, new doctors and nurses, better services, and it will be a panacea

Consideration: Should a tribe decide to assume the management of the IHS clinic, community outreach meetings need to occur to educate tribal members about the "638" process and to answer questions they may have. This also provides an opportunity to gather community perspectives and to address potential concerns.

Chapter 4 – Determining Funding Available for PFSAs

Establishing a fair and equitable funding base for the first year of clinic operations under an ISDEAA agreement is of critical importance to the future success of any tribally-operated IHS funded health program. Since funding in subsequent years will be based primarily on the initial contract, the Tribe should ensure that all IHS resources at all levels expended (Service Unit, AO, Headquarters) in support of the local facility are made available to the tribe if they determine to move forward on contracting for tribal operation of the facility.

IHS Funding Methodologies and Processes for ISDEAA Contracts

When Programs, Functions, Services, and Activities (PFSAs) are contracted from the IHS, the Agency is required to provide to the tribe:

> *"Sec 106(a)(1) The amount of funding provided under the terms of self-determination contracts entered into pursuant to this Act shall not be less that the appropriate Secretary would have otherwise provided for the operation of the program or portions thereof for the period covered by the contract, without regard to any organizational level within the Department…"*
>
> *PL 93-638 as amended*

This funding normally includes funds from the service unit level and regional offices called the *program base* as well as associated funds from the Area Office or Headquarters level called tribal shares. In most cases the program base amount is relatively easily established based on the current budget and past historical spending patterns by the IHS for the PFSAs.

Once the base funding is established, the associated tribal shares from Headquarters and Area Office technical and administrative support are identified using formulas, which are usually based primarily on the number of active users of IHS services in the tribe. The IHS normally adopts these formulas after tribal consultation with the affected tribes. Tribes are offered the tribal share of funding associated with each PFSA for which they are eligible. If the service or PFSA is no longer desired from the IHS by the tribes, the tribal share funds are requested and added to the amount of the ISDEAA contract. In total these amounts from the Service Unit, Area Office and Headquarters are often referred to as the 106(a)(1) or *secretarial amount* of the ISDEAA contract. Tribes are also offered the option to leave tribal shares at the Area or Headquarters level and to continue to receive the same level of support that has previously been provided by Headquarters or Area. Tribes frequently leave support at Headquarters and Area Office to support professional recruiting and information technology services including the Resource and Patient Management System database (RPMS) and electronic health record hardware and software services, and IHS data warehouse services. Tribes may also choose to leave other services at the Area or Headquarters level for technical support or simply due to the fact that tribal shares are not sufficient to acquire a qualified employee to carry out the function which is necessary to support the local Health Center.

Once established in initial negotiations, this annual funding amount is adjusted each year for each sub-activity consistent with the amount and purpose of increases provided by Congress. In addition to amounts provided through the IHS base funding amounts, the Tribe is also eligible for funding for Contract Support Costs. Contract Support Costs (CSC) are based on the Tribe's Indirect Cost (IDC) Rate as well as negotiated amounts for direct contract support costs and pre-award and start-up costs. Negotiation of the CSC amounts can be time consuming and difficult, sometimes consuming as much time as the negotiation of the 106(a)(1) or secretarial amount for the contract. CSC funds account for about one dollar in four or 23% of total IHS funding for all IHS tribal ISDEAA contracts and compacts across the country. CSC funding also is quite variable as a percent of total award ranging from about 19.9% of the total awards in Aberdeen to over twice that rate of funding in some other IHS area like California area.

If a tribe *has an extremely low IDC rate*, which will not maximize the CSC, the Tribe would receive less funding than they would be entitled to under the contract.

Consideration: Each tribe should carefully consider its IDC cost structure, revise if needed, and exercise great care in the initial negotiation of CSC for the Local Health Center if the Tribal Council determines it wishes to proceed, as CSC funding can vary significantly, and once established cannot easily be renegotiated to provide greater equity to the Tribe.

PFSAs and Budgets from the service Unit

A sample total budget for the operations of an IHS Health Center for FY10 through FY12 is provided in Table 4.1 below. The IHS annual budgets have been relatively flat for the past three years and rely heavily on revenue from Medicaid and other third parties.

Table 4.1
Sample Revenue Sources and Trends for the Local IHS Health Center

	FY2010	FY2011	FY2012
Total IHS Recurring Revenue	X	Y	Z
Total IHS Non-Recurring Revenue	X	Y	Z
Total 3rd Party Revenue	X	Y	Z
Total Revenue	**X**	**Y**	**Z**
% Change from prior year		+/-%	+/-%
% Revenue from 3rd Party	X%	Y%	Z%

IHS appropriated funding has been relatively flat since 2010 (previous three fiscal years).

A sample of sources of funds for Local IHS Health Center Budgets are provided in table 4.2 below. In some cases, due to dependence on 3rd party revenue, IHS appropriated funding can represent less than 50% of the total budget.

One of the largest IHS appropriations is for the Contract Health Services Program, which is a restricted category of funding under direct IHS operation, and it must be spent to

purchase care in the private sector for health care services not available directly from the Local IHS Health Center. If contracted by the Tribe under ISDEAA, these resources could be utilized in a more flexible manner; however it is very likely that Tribes will need to maintain the current priorities for care in the initial years of the ISDEAA contract until management experience and additional resources have been obtained with CHS.

Table 4.2
Sample Funding for Local IHS Health Center by Source

Fiscal Year	2012		
Funding Source / Activity	**Recurring**	**Non-Recurring**	**Total**
H&C	$1,268,778	$(18,819)	$1,249,959
ASAP	$2,670		$2,670
PHN	$93,104		$93,104
HEALTH ED	$89,462		$89,462
CHS	$1,681,008		$1,681,008
CHEF		$133,210	$133,210
FMCRA		$5,000	$5,000
PY MEDICARE		$9,156	$9,156
CY MEDICARE		$83,685	$83,685
PY MEDICAID		$6,174	$6,174
CY MEDICAID		$1,858,463	$1,858,463
PY PRIVATE INS		$51,944	$51,944
CY PRIVATE INS		$323,100	$323,100
EHS	$47,445		$47,445
FAC SUPP	$91,759		$91,759
EQUIP	-	$11,789	$11,789
M&I	-	$42,218	$42,218
TOTAL	$3,274,226	$2,505,921	**$5,780,147**

Source: IHS AO

PFSAs and Budgets from Area Office

The Area Office can provide information on Tribal Shares. If the Tribe decides to contract for operation of the Local IHS Health Center, it would normally also include supporting PFSAs currently provided by the Area Office, and these PFSAs would no longer be required in support of the Clinic operations. This would make the tribal shares that support these resources available as well.

Tribes may wish to retain some these services at the AO and Headquarters to provide support for ongoing local operations. Generally, tribes leave full funding for professional recruitment assistance, and electronic health records at both Area Office and Headquarters. In some other cases, tribes select certain other services such as planning and evaluation or contract health support to acquire other Area services, which may be of use to the Tribe. Normally, a full review of all PFSAs would be completed during the contracting negotiation process with a determination which PFSAs will be contracted at that time.

In addition to the funding to support AO Office of Information Technology (OIT) services and the Health Center EHR remaining at the Area Office, the tribe may also choose to retain additional shares at the Area to support professional recruiting or other Area wide PFSAs. Below is a list of AO PFSAs that can be contracted:

- Area Director
- Financial Resources
- Property and Supply
- Human Resources
- Information Technology
- Division of Acquisition Management
- Planning and Evaluation
- Maternal and Child Health
- Behavioral Health
- Epidemiology
- Diabetes Program
- Etc.

If compacted under a Title V compact agreement, 100% the amount of the AO tribal shares would be available in the *initial year* of the compact (not phased in). Under Title I contracting, there is a phased-in process for the tribe to acquire these funds.

Headquarters Tribal Shares

In addition to Area Tribal Shares, there are shares which may be available to the Tribe from Headquarters. Headquarters Tribal share amounts are computed using the national TSA formula. Line items for Headquarters Tribal Shares include:

- Hospitals and Clinics (H & C)
- H & C Recruitment
- Dental Health
- Mental Health
- Alcohol and Substance Abuse
- Contract Health Services
- Public Health Nursing
- Health Education
- Community Health Representatives (CHR)
- Direct Operations
- Office of Information Technology Direct Operations
- Etc.

Contract Support Costs

Contract Support Costs (CSC) is another formula-based category of IHS funding that has become increasingly important to tribal contractors. The Contact Support Cost funding stream has been a high priority of Tribes and the IHS, and Congress has provided large increases to fully fund the CSC requirements in several recent appropriations. For the past two years, large increases to the funding nationally for CSC have raised it to $471,000,000

or the third largest appropriation line in the IHS budget after Hospitals and Clinics and Contract Health Services.

Consideration for Indirect Costs Rate: Prior to or simultaneously with the negotiation of an ISDEAA contract, it would be very important for the Tribe to review its IDC rate and to make adjustments as necessary to improve the CSC recovery under new and existing ISDEAA agreements.

Current median rates for IDC rates for tribal contracts under the ISDEAA are approximately 28%.

Chapter 5 – Current Health Policy Considerations

IHS appropriations and sequestration

The Indian Health Service and the entire Federal Government is in a period of uncertainty that may continue well into subsequent fiscal years. The Budget Control Act of 2011 that was enacted to raise the debt ceiling had provisions that automatically sequestered (or cut) 5.2% of the IHS budget automatically for FY 2013. These provisions will continue to be in force for the foreseeable future. Unless amended, these provisions could cause extensive funding reductions to all IHS programs across Indian Country for programs that are both tribally operated and directly operated by the IHS. While it may be timely for a Tribe to move forward with planning for an ISDEAA contract, it may be prudent to delay the final decision for implementation of the contract until after there is some certainty regarding the outcome of Congressional action on continuation of the budget sequestration and the FY14 federal appropriation. It is difficult to predict exactly if and when these budget issues will be resolved, however some additional clarity may be provided in the coming months.

Patient Protection and Affordable Care Act (ACA) opportunities

Countering the decidedly negative outlook in the Federal Appropriations environment are several positive enhancements in the Patient Protection and Affordable Care Act (ACA) that will provide significant additional 3rd party resources to support Tribal 638 Health Centers when implemented in early 2014. Among others, these changes will extend Medicaid coverage to a significant portion of patients who are currently without any third party coverage. The ACA also provides additional options for Tribe to offer additional private coverage on a highly subsidized basis[1] for any remaining adults on the reservation (with incomes under 400% of poverty) that would be without coverage.

Tribes across the nation are currently engaged in active development of tribal sponsorship programs under the provisions of the ACA. Current estimates from tribes at the front of this effort indicate that the tribes expect $3 to $6 dollars in additional third party revenue and Contract Health Services (CHS) savings for each dollar invested in health insurance premiums purchased through ACA insurance exchanges/marketplace. This potential source of additional revenue is difficult to quantify accurately at this time, however the potential for revenue enhancements and savings would accrue to the local Health Center only if it is under tribal management.

Medicaid Expansion

In the Northern Plains, North Dakota and Minnesota have decided to expand Medicaid. This is good news for tribes on those states and will provide significant expansion of third party coverage for patients that receive services in IHS or tribal 638 service units. Unfortunately, as of the date of this report, the South Dakota legislature has decided not to

[1] Subsidy levels are 96% for those below 150% of poverty, 83% for 150% to 200% of poverty level, 72% at 200,250% and a gradual progression to 35% at 400% of poverty level.

expand Medicaid. Listed here are some key data points related to *Medicaid Impact and Expansion in South Dakota:*

- South Dakota reports that in State FY 2006, 36% of it Medicaid population was American Indian (AI), and AIs accounted for 26% of its total expenditures
- 36,355 AI beneficiaries make it the *fourth largest Indian Medicaid* population in the country
- Total expenditures were estimated to be between $185 and $200 million in 2006
- 38% of South Dakota's AIs have no health insurance

How many AIs will be newly insured under Medicaid Expansion nationally?
Medicaid Participation Rates, the percent of those eligible who are enrolled, are difficult to estimate, and no good estimate for 'take-up' exists for AIs. "Take-up" can be defined in several ways, depending on the program and population in question. Generally speaking, it is a participation rate, ranging from 0 to 100%, and it measures the fraction of people who are eligible for a program who choose to enroll. Factors that have been shown to impact take-up include the benefits of the program to the intended beneficiaries, information available to the potential enrollee, transaction costs in enrolling, and stigma.

It is possible to estimate the maximum number of newly eligible AIs, but actual numbers will depend on each state's Medicaid program and the success of outreach and education efforts. Nationally, 300,000 to 350,000 newly eligible AI/ANs appears to be a good range for upper level estimates. 487,000 of the uninsured AI/ANs in the 33 states with IHS-funded programs are under 133% of the federal poverty level according the *November 2012 33 State AIAN ACS Report* by Fox-Boerner.

Nationally, 100,000 to 150,000 of currently eligible, but not enrolled AIs, raise the expansion total to about 500,000 AIs on Medicaid if each state were to expand.

Consideration: Tribal Leadership in South Dakota should continue and expand efforts to advocate for Medicaid expansion. Medicaid expansion would significantly improve third-party revenue for Tribal and IHS Health Centers and would increase access to services. Tribes should also encourage community members to enroll in Medicaid and Medicare if eligible.

Health Insurance Exchanges / Marketplaces

Health Insurance Exchanges / Marketplaces to be implemented in January of 2014 are a key vehicle for Tribes to access additional resources under the Affordable Care Act. These exchanges will allow the Tribes to assist *any tribal member* to enroll in the expanded Medicaid or Children's Health Insurance Plan (CHIP), as well as allow tribal members to access private health insurance provided through the health exchanges with large subsidies available to cover of the premiums for all individuals and families.

The law prohibits charging co-insurance or deductibles to American Indian enrollees and requires payment of reasonable charges for services provided in IHS or tribally operated systems. This will allow Tribal Health Centers to collect 100% reimbursement for services provided to tribal members who are enrolled in these plans, providing a substantial new

revenue stream to the Tribal programs. In addition, the law permits Tribes to *pay the premium on behalf of tribal members* using IHS Health Center funds or 3rd party revenue. With an enrollment period opening monthly for American Indians, this would permit the selection of enrollees by the tribe that are projected to need substantial care either in the Health Center or through the Contract Health Services program. Tribal members who are enrolled in insurance plans would allow the Tribal Health Center to recover funds *well in excess of the premium* for services provided to tribal members under these heavily subsidized insurance policies. In addition to the increases in income for the Tribal Health Centers, the expanded coverage will reduce the demand on Contract Health Service budgets and will allow for further expansion of CHS resources to add desired services which have previously been unavailable due to the CHS priority system.

The ACA also prevents cost sharing[2] at CHS or other providers, allowing Tribal members more choices and open access to care without incurring co-pays or deductibles at private sector facilities off the reservation.

Federal Employee Health Benefits Opportunity

Within the Indian Health Care Improvement Act (IHCIA), which was reauthorized as part of the ACA, are several provisions aimed at improving and increasing access to health care for American Indians and Alaska Natives. One specific provision in the law, Section 409, allows tribes to access to Federal Insurance, provides access to the Federal Employee Health Benefits (FEHB) program to any Tribe or tribal organization carrying out programs under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or an Urban Indian Organization carrying out programs under Title V of this Act.

The idea of allowing Tribes to participate in the FEHB Program was first introduced in 2000 when tribes began the process of reviewing and revising the IHCIA when it was up for renewal. Tribes' perceptions at the time were that the FEHB Program was a more cost effective alternative than purchasing health benefits for their employees in the insurance market. To be eligible to participate in the program, a Tribe, Tribal Organization or Urban Indian Organization simply must carry out a program under the Indian Self-Determination and Education Assistance Act. Therefore, this will remain an option for the Lower Brule Sioux Tribe to consider as it moves forward with its ISDA contract or compact.

Many recent analyses show that there appear to be more disadvantages than advantages; however, every tribe should conduct their own assessment to determine if the program is the right fit for them. Also, as a new opportunity, there is no track record of success or failures, and there are no best practices for tribes to consider in participating in FEHB.

While it appears to have the potential to be a cost effective solution, every tribe must evaluate the opportunity for themselves and determine whether it meets their specific needs.

Advantages and disadvantages of the FEHB opportunity are outlined in Table 5.1 below.

[2] This provision is limited to enrollees with income up to 300% of poverty level.

Table 5.1
Advantages and Disadvantages for Tribes in Participating in FEHB

Advantages	Disadvantages
• May be less expensive than the private insurance market • Employees may choose from multiple plans • No waiting periods • No pre-existing conditions limitations • Historically, on average, only a 6% annual increase • Widely accepted insurance plan with a long track record	• No control over plan management • No control over plan design • Only 2 Coverage Tiers, Single & Family • Some plans do not offer dental & vision • No control over annual increases • Tribe has to pay "at least" employer amount (72% on average) • No coverage for non-employed Tribal members • Rates set by Office of Personnel Management • May be more expensive • May be difficult to re-enter commercial market

Health Insurance Marketplace

When enrollment in the Marketplace starts in October 2013, Tribal health stakeholders and staff can assist patients in comparing private health insurance plans and to assist in determining eligibility for several low-cost and no-cost insurance affordability programs. These programs will be all in one place, with a single application.

The Marketplace at HealthCare.gov will have much more information than any health insurance website – as insurance companies will compete for patients business on a level and transparent playing field, with no hidden costs or misleading fine print.

Consideration: Tribal leadership should consider coordinating efforts to ensure that the maximum numbers of eligible community members are enrolled in new insurance opportunities provided by the ACA. This will increase revenue and improve access to health services.

Chapter 6 – Title I Contracting versus Title V Compacting

If the Tribal Council determines that it will proceed with an ISDEAA agreement, it will have to determine whether it is eligible for and prefers to use a Title V Self -Governance agreement or a Title I contract.

Title I vs. Title V

Both self-determination (Title I) and self-governance (Title V) involve the transfer of responsibility for managing Federal programs and funds that serve Indians from existing service providers to tribes. Tribal self-governance, however, is a step beyond self-determination, and it is founded on a government-to-government relationship between the federal government and a tribe. In recognition of this government-to-government relationship, Title V compacting is designed to be more flexible for tribes than Title I contracting. Title V expands the responsibilities that tribes may assume, minimizes federal oversight, and maximizes flexibility by including broad authority to redesign programs and reallocate resources to meet the needs of tribal communities. As mentioned previously, Title V provides a small amount of additional funding in tribal shares and accelerated full receipt of tribal share payment to eliminate "transitional" funding.

Similarities and Differences in Title I and Title V

Generally, Title V incorporates the protections and benefits of Title I, and, in some instances, adds enhancements. Specifically,

- Tribes are subject to the *same audit and record-keeping standards* under both Titles.
- Tribes are entitled to the *same level of funding* under both Titles, including direct program costs and contract support costs, without regard to the level of the agency where the functions are carried out (one exception to this rule has been that the IHS has not delayed the payment of Headquarters and Area Tribal shares due to a transition plan under Title V).
- Under Title V a tribe is *also entitled to grants* to negotiate a compact.
- Tribes receive the *same Federal Tort Claims Act coverage* under both Titles.
- Tribes have the *same access to Federal supply sources*, including property, supplies, and pharmaceuticals under both Titles.
- Under Title V, the Secretary is also required to provide goods and services to the tribe on a reimbursable basis.
- FTCA coverage and access to Federal supply sources may in fact improve under Title V, because the scope of the tribal program may be broader due to the authority to redesign and consolidate programs and to reallocate funds.
- Tribes have the same ability to retain and use interest, program income, and savings, and to carryover funds from one year to the next under both Titles.

Title V, however, has several unique features reflecting more flexibility and less Federal oversight:

- The Secretary has more discretion for rejecting a Tribe's proposal under Title I than Title V, which only allows rejection if the tribe cannot carry out the program in a manner that would not result in significant danger or risk to the public health.
- Under Title V, a Tribe has the ability to redesign and consolidate programs, and to reallocate funds amongst them without approval by the Secretary.
- Both Titles have similar standards for reassumption of a program due to "gross mismanagement" of funds, however, Title I allows for reassumption under more liberal circumstances than Title V regarding administration of the program.
- Under Title I, a Tribe is not subject to policies and guidance of the IHS; under Title V the Tribe is also not subject to regulations adopted by IHS except those adopted under Title V, provided eligibility cannot be impaired.

Requirement for Eligibility for Title V

Tribes must qualify for Title V participation by successfully completing a planning phase, requesting participation through a Tribal Resolution, and demonstrating financial stability.

Demonstrated Financial Stability and Financial Management Capacity. Title V provides that a Tribe must have "demonstrated for three years financial stability and financial management capacity." Tribes must demonstrate this capacity by having no uncorrected significant and material audit exceptions in their annual financial audits for the three years immediately preceding the Title V proposal. Title I contracting does not have this specific requirement.

Governance of the Health Center

It would be prudent for a Tribe to review the proposed governance structure of the ISDEAA facility to ensure that it provides accountability and open lines of communication to the Council while maintaining policies which would limit political intervention in the operation of the clinic. Several options may exist for the governance of the facility, including establishing a Tribal non-for-profit healthcare corporation, but the option which appears to hold the most promise for a smaller facility would be to organize a Health Committee of the Tribal Council composed primarily of membership of the Tribal Council and other key stakeholders with health care expertise. The Health Committee could function as a credentialing and quality assurance committee, and it could meet periodically with standing agenda items to include reports from the Clinical Director and current Health Director and other clinic professionals as needed.

Personnel issues-Federal Employees and IPAs and MOAs

Ensuring a well-trained, professionally qualified workforce will be perhaps the largest challenge for Tribes in the Northern Plains. Many IHS facilities have a large percentage of its approved professional positions vacant. Recruiting and retaining professional personnel to practice in isolated, rural settings to provide high quality, professionally delivered healthcare services is a challenge throughout Indian Country.

To assist in recruiting and retaining qualified health professionals, Tribes may choose to utilize federal employees from the civil service under an intergovernmental personnel agreement (IPA) or from the US Public health service under a memorandum of agreement (MOA). This option requires that the tribe, the employee, and the IHS all agree to provide the employee to the tribe to continue to carry out the responsibilities of their job in the health center once under tribal control. IPA and MOA agreements usually have a term of 2 years.

Under this arrangement federal employees continue to work for the federal government and are paid by the IHS. The cost of the employee, including all salary and benefits and some associated administrative costs are reimbursed to the IHS by the Tribe. Generally, Tribes have found IPAs and MOAs to be an invaluable tool when contracting to operate clinical services as recruiting physicians, dentists nurses pharmacist and other health professionals requires specific expertise and very long lead times and significant resources.

Tribes contracting under the ISDEAA for fully operating IHS clinical facilities have generally facilitated the transfer to tribal control by extending an offer for an IPA or MOA positions to all eligible federal employees at the initial time of the contract. Any federal employee not currently on probation or in a temporary position is eligible for and IPA or MOA.

Consideration: Tribes should be prepared to offer initial 2 year IPAs and MOAs to eligible employees. This action has proven successful in other transfers in stabilizing the work and recruiting environment during the transition to a tribally operated clinic.

Typically after the first year of tribal operation, the number of federal employees begins to decline. Depending on the incentives for direct hire offered by the tribe, the numbers of federal employees will usually decline to 20% to 40% of all employees within 4 to 5 years. Some tribes, however, continue to rely on the U. S. Public Health Service to recruit professional employees to fill medical officer, dental officer or pharmacists, and other highly skilled technical positions.

Tribes also may utilize the IHS professional recruitment web site and other tools at both headquarters and area office level provided they retain or leave resources at these levels to support professional recruitment functions. Most Tribes choose to do this for medical, nursing, dental and other hard to recruit positions.

Electronic Health Records and Enterprise Functions to support Health Center

Modern health care is becoming increasingly dependent on electronic health records to support the entire clinic operations. The IHS has implemented the RPMS-based electronic health records (EHR) across the entire agency, and the IHS has made this system available to tribal contractors if they choose to use it in tribally operated facilities.

IHS tribal share funding exists at all three levels of IHS to provide the Tribes with support for data management and reporting to IHS, server hardware support, RPMS platform for EHR and enterprise functions, and network support necessary to operate the RPMS and

transfer data to IHS national data warehouse, and data security for all patient data maintained on the IHS systems. These tribal shares are available for contracting, however for most Tribes, the required costs and considerable resources to maintain these functions are typically in excess of the funds received from IHS to replace the hardware, network infrastructure, and software to operate the EHR system, enterprise billing functions, and other software and network services and to continue to provide registration and workload data to the IHS national data warehouse.

Generally the users of RPMS rate the clinical functionality of the system very high, although the user interfaces and business intelligence functions are not as good as some commercial systems. Tribal users consistently rate the business office functions of the software as inadequate. Some tribes have replaced or are in process of replacing the RPMS system with off the shelf EHR systems. Those that have, however, expect to purchase the software with tribal resources and to spend significant revenue over what is recovered from the tribal shares (5 to 10 times) to support the system once operational. It is acknowledged generally that commercial EHR and billing software is significantly more expensive for tribal programs than RPMS provided through the IHS, but tribes often elect to use commercial software because they have projected that it will improve third party collections enough to justify the added capital and operational investment.

Unfortunately there are no evaluations or case studies available of the business or clinical benefits of replacing IHS RPMS software. Anecdotal information from tribal entities that have or are in process of replacing RPMS with commercial EHR software have indicated the transition is likely to take longer (2 to 3 times) and cost more (3 to 4 times) than anticipated in the original business analysis. In addition, the expected savings (and revenue) from IHS OIT/MIS tribal shares have also not generally materialized when planned as the tribal programs must continue to run RPMS in parallel with the newly implemented systems, often several years after implementation of the initial EHR, to provide support for some departments or activities not supported in the commercial EHR and enterprise software. Some tribal facilities have replace IHS EHR software with commercial EHR software at considerable expense—only to abandon the commercial software and return to the IHS EHR after the commercial software exceeded estimated expense and did not provide the promised enhanced functionality.

Finally, RPMS has been fully certified as an EHR, thus making its users who meet the other criteria, eligible for meaningful use incentive payments.

Consideration: Benefits of the IHS EHR by far outweigh any potential benefit that could be received by implementation of a commercial off the shelf EHR software, and the implementation process for commercial software imposes considerable risk on both clinical support and business office functions, and thus the revenue base of the clinic. Usually, Tribes should consider leaving all IHS Tribal Share amounts for MIS/IT/RPMS at all levels with the IHS.

Timelines

Generally, ISDEAA proposal development and implementation of the necessary activities to transfer the clinic to tribal control can be achieved within 6 months or less after a determination by the Tribal Council and notification of IHS that the ISDEAA agreement is being pursued. Sometimes disagreements with IHS or Congressional actions with appropriations (or more likely inactions) delay this process. In some years, tribes delay or accelerate the implementation of an ISDA agreement to take maximum advantage of a CSC appropriation to support the new ISDEAA contract. Generally, however, the process can be divided into several stages. Many of these activities can often run concurrently:

1. Feasibly assessment and tribal leadership decision stage—The first part of the process where the Tribal Council reviews the pros and cons of the proposed ISDEAA contract and determines the scope of the ISDEAA proposal. This may also include a determination of the appropriate contract mechanism via a Title I or Title V agreement (this generally can be accomplished in 3 to 6 months).
2. Prepare ISDEAA proposed agreement—Depends on the size, scope and complexity of the proposed PFSAs to be operated, but this generally can be achieved in 2-3 months or less if prioritized by the Tribal Council.
3. Negotiate ISDA agreements with IHS—Again, this depends on the size and scope of the project, but generally this can be achieved in one to two months.
4. Develop IPA/MOA agreements for federal employees—This is normally the issue that consumes the most time in the development of an ISDEAA contract where significant numbers of existing federal employees are affected. Tribes normally choose to rely heavily on IPA/MOA agreements for existing employees in transitions where the Tribe will require difficult to recruit and highly trained professional employees to provide the PFSA's under the new ISDEAA contract. The Tribe must determine early in the planning process which employees will be offered IPA/MOAs, although it is usually prudent to offer IPA/MOAs to all current IHS employees. The IHS is constrained by federal civil service and uniformed personnel rules throughout the transitions process and will require usually up to 4 to 6 months to counsel employees, prepare offers and take the necessary steps to relocate federal employees who choose not to accept or are ineligible for IPA or MOA positions with the Tribe. This is typically the most time-consuming process in an ISDEAA transition.

Summary of Differences between TITLE I Contract AND TITLE V Compact

P.L. 93-638 established two distinct Titles from which Tribes may assume PFSAs, including Title I, which is also referred to as Self-Determination or Contracting, and Title V, which is also referred to as Self-Governance or Compacting.

Since its origins in 1975, ISDEAA agreement under Title I and Title V have evolved. Many of the same provisions that exist in Self-Determination also exist under Self-Governance; however, there are some very distinct differences between the two. The chart below provides an overview and summary of these differences.

Activity	Title I	Title V
Eligibility	Federally Recognized Tribe or Tribal Organization, upon request by the Tribe via Tribal Resolution for Contracting. ISDEAA Sec. 102; 25 CFR Part 900, Subpart C	Federally Recognized Tribe or Tribal Organization who has successfully completed a planning phase, requested participation in Self Governance by resolution or other official action, and has demonstrated, for 3 fiscal years, financial stability and financial management capability. ISDEAA Sec. 503(c); 42 CFR Part 137, Sub part C
Documents required	"Model" Contract and Annual Funding Agreement (AFA) ISDEAA Sec. 108; 25 CFR Part 900, Subpart C	Compact and Funding Agreement (FA) (FA may be annual or multi-year) ISDEAA Sec. 504, 505 & 508; 42 CFR Part 137, Subparts D & E
PFSA	One or more PFSA's (or portions thereof) may be included in one model contract and AFA ISDEAA Sec. 102; 25 CFR Sec. 900.8	One or more PFSA's (or portions thereof) may be included in Title V Compact and FA. ISDEAA Sec. 504 & 505; 42 CFR Part 137, Subparts D & E
Structure of Agreement	Must follow the ISDEAA model Contract as listed in the statute. The Contract and AFA are for one PFSA , or more than one PFSA may be consolidated into on Contract. ISDEAA Sec. 108; 25 CFR Sec. 900.8	No model compact but some general and mandatory provisions identified in the ISDEAA. ISDEAA Sec. 506 & 506; 42 CFR Part 137, Subparts D & E
Monitoring performance	Generally, for routine monitoring the IHS is limited to not more than one performance monitoring visit per Contract; exception may apply.	No routine monitoring required for IHS No citation

	ISDEAA Sec. 108(c)(b)(7)(c)	
Redesign and Funding reallocation	May redesign PFSA's with IHS approval and may reallocate funding without IHS approval in accordance with the ISDEAA. ISDEAA Sec. 105(j) ISDEAA Sec. 106(o)	May redesign or consolidate the PFSA's and reallocate the funding without IHS approval in accordance with the ISDEAA. ISDEAA Sec. 505 & 506(e); 42 CFR Sec. 137.185
Retrocession	Tribe may choose to retrocede individual PFSA's or the entire Contract award. ISDEAA Sec. 105(e); 25 CFR Sec. 900.240-245	Tribe may choose to partially or fully retrocede. ISDEAA Sec. 506(f); 42 CFR Part 137, Subpart L
Reassumption	IHS may take over when there is a violation of rights or endangerment of the health, safety or welfare of any person or gross negligence or mismanagement in the handling or use of funds under the Contract. ISDEAA Sec. 109; 25 CFR Sec. 900.246-256	IHS may reassume operation of a PFSA and associated funding if there is a specific finding of imminent endangerment of the public health caused by an act or omission of the Tribe and the imminent endangerment arises out of failure to carry out the Compact of FA or there is gross mismanagement of the funds transferred by the Tribe by a Compact or FA. ISDEAA Sec. 506(a)(2)(A); 42 CFR Part 137, Subpart M
Federal review of Agreement	The Secretary (IHS Area Contracting Officer) must give written declination of a new Contract proposal or proposed amendment to an existing Contract within 90 days based on five ISDEAA criteria or the proposal or proposed amendment is deemed approved. ISDEAA Sec. 102(a)(2); 25 CFR Part 900, Subpart D & E	The Secretary (IHS Area Contracting Officer) must give written rejection of a Final Offer within 45 days or receipt based on one or more of the four ISDEAA criteria or the Final offer is deemed approved. ISDEAA Sec. 507(b) & (c); 42 CFR Part 137, Subpart H

Reporting	For mature Contracts, an annual single agency audit as required by the Single Agency Audit Act of 1984 and a brief annual program report. All other reporting requirements are negotiable. ISDEAA Sec. 5(a)(2); 25 CFR Part 900, Subpart G	Annual single agency audit as required by the Single Agency Audit Act of 1984 and Health Status Reports. ISDEAA Sec. 506(c) & 507(a)(1); 42 CFR Sec. 137.165-173 & 137.200-207
Adding Grants to Agreements	Cannot add grants to Title I Contracts or AFA's No citation	Statutorily mandated grants may be included. ISDEAA Sec. 505(b); 42 CFR Part 137, Subpart F
Payment Schedule	Quarterly, Semi-annual, Lump sum and other. ISDEAA Sec. 108(c)(b)(6)(B)	Lump sum, Semi-annual, or other periodic transfers. ISDEAA Sec. 508(a); 42 CFR Sec. 137.75-77
Funding Available for Planning and Negotiation	Tribal Management Grants are available for planning purposes but cannot be added to Contracts or AFA's. ISDEAA Sec. 103(a) & (b)	Planning and Negotiation Cooperative Agreements as available. (Note: Title V Tribes may apply for Tribal Management Grants; however, the grants may not be used for Self-Governance planning or negotiation activities.) ISDEAA Sec. 503(e); 42 CFR 137.24-26

Generally speaking, despite the initial requirements of a Compact, it affords Tribes more latitude overall in terms of reporting, program redesign, payment, performance monitoring and contract model.

Chapter 7 - Collaboration and New Revenue Opportunities

Health Resources and Services Administration (HRSA) opportunities

The following documentation will assist Tribes with an initial assessment of the readiness to apply for Federally Qualified Health Center (FQHC) status and Community Health Center (CHC) funding. FQHC is a reimbursement designation from the Bureau of Primary Health Care and the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. This designation is significant for several health programs funded under the Health Center Consolidation Act (Section 330 of the Public Health Service Act). FQHCs include all organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid. CHCs are a type of FQHC that receive "330" grants to provide services to underserved populations. In the United States, the CHC is the dominant model for federal grant funding for primary care in the country's health care safety net. Tribes that operate health centers under ISDEAA are eligible to become CHCs—IHS, as a federal agency, is not eligible for 330 funding.

Currently, Tribal 638 programs have an unprecedented opportunity to expand their capacities by securing FQHC "Look-Alike" status and CHC funding. The following outline will provide an analysis of key aspects of Tribal operations and an assessment of how current IHS service units align with the required HRSA Health Center program area requirements and expectations. These key program areas include Governance, Service Area, Service Delivery Model, Quality Improvement, and Financial Management. Each of these program areas will provide an assessment addressing the level or readiness for each key program area, as well as recommended key action steps that should be taken prior to applying for FQHC / CHC funding. Although CHCs must see all patients regardless of race (not just AIs), the demographics in Lower Brule suggest that the clinic would see very few non-Indians as a CHC.

History of the FQHCs

For more than 40 years, health centers in the United States have delivered comprehensive, high-quality, primary health care to patients regardless of their ability to pay. During that timeframe, health center grantees have established a tradition of providing care for people underserved by America's health care system: the poor, uninsured, and homeless; minorities; migrant and seasonal farmworkers; public housing residents; and people with limited English proficiency.

Federal support for entities that would later be called health centers began in 1962 with passage of the *Migrant Health Act*, which funded medical and support services for migrant and seasonal farmworkers and their family members. Two years later, the *Economic Opportunity Act* of 1964 provided Federal funds for two "neighborhood health centers," which were launched in 1965 by Jack Geiger and Count Gibson, physicians at Tufts University in Boston.

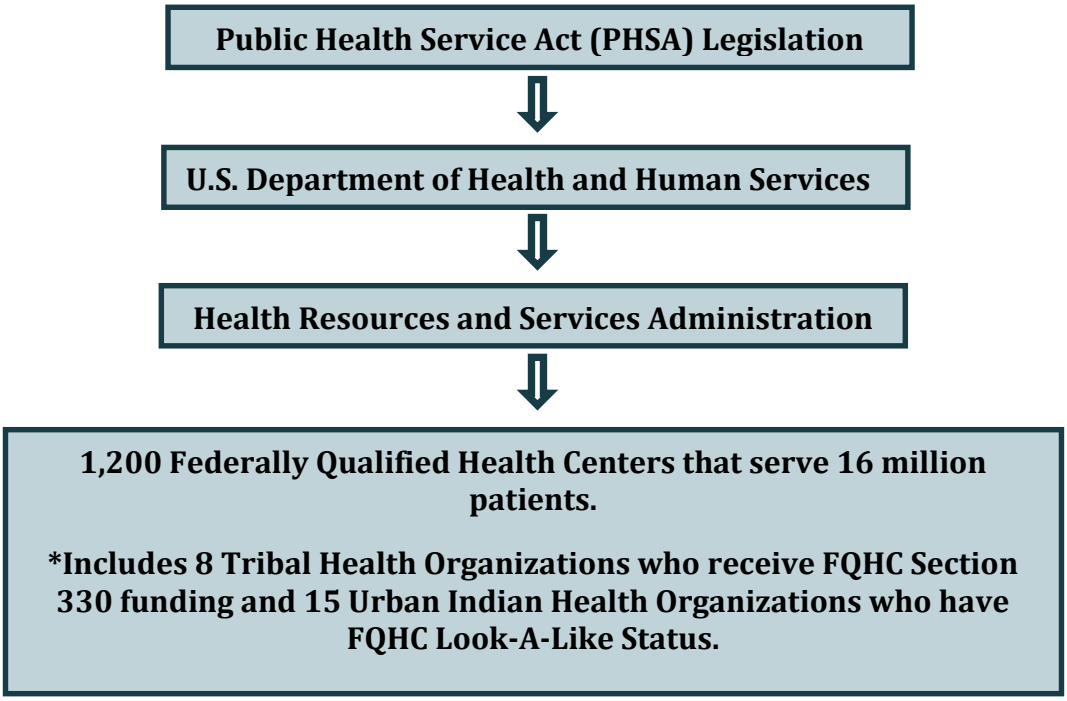
Those first two centers created an innovative new model of community-based, comprehensive primary health care that focused on outreach, disease prevention and patient education activities. The early centers also promoted local economic development,

job training, nutritional counseling, sanitation, and social services. Most importantly, they established one of the enduring principles of the program: respect for patients and communities and their involvement in the operation and direction of health centers.

In the mid-1970s, Congress permanently authorized neighborhood health centers as "community health centers" and "migrant health centers" under sections 329 and 330 of the *Public Health Service Act* (PHSA). Congress expanded the health center system in the later years of the 20th century. In 1987, the Health Care for the Homeless program was created by the *McKinney Homeless Assistance Act* and 3 years after that the Public Housing Primary Care program was established by the *Disadvantaged Minority Health Improvement Act* of 1990. Passage of the *Health Centers Consolidation Act* of 1996 brought authority for all four primary care programs (community, migrant, homeless, and public housing) under section 330 of the PHSA.

What is a Federally Qualified Health Center?

The Federally Qualified Health Center Program is funded through an appropriation under Section 330 of the PHSA, which is then managed by the following federal programs:



Federally Qualified Health Centers build on and complement other Federal and non-Federal health service efforts and fill major gaps where there are no existing programs or resources. For example, while the federal government and states broaden access to health care through financing streams such as Medicaid, Medicare, IHS, and CHIP, health centers ensure access to a comprehensive and regular source of care for the populations covered by these funding streams. This is of particular importance during a time when the proportion of physicians serving existing Medicaid and uninsured patients and those willing to accept new Medicaid or uninsured patients has continued to decline.

Accordingly, over 45 percent of health center patients are Medicaid, Medicare, CHIP, or other public insurance beneficiaries, and nearly 40 percent are uninsured. As funding and eligibility for health center services are not tied to individual patient characteristics (e.g., women or infants) or specific health conditions (e.g., diabetes or HIV/AIDS), health centers have the unique ability to reach certain underserved populations often excluded from existing federal, state, or private sector health funding streams such as non-elderly, non-disabled, low-income men.

Types of Federally Qualified Health Centers

- **Grant-Supported Federally Qualified Health Centers** are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act) and receive funds under the Health Center Program (Section 330 of the Public Health Service Act). These include:
  - **Community Health Centers*** serve a variety of underserved populations and areas, including American Indian reservation communities;
  - **Migrant Health Centers** serve migrant and seasonal agricultural workers;
  - **Healthcare for the Homeless Programs** reach out to homeless individuals and families and provide primary care and substance abuse services; and
  - **Public Housing Primary Care Programs** serve residents of public housing and are located in or adjacent to the communities they serve.
- **Federally Qualified Health Center Look-A-Likes** are health centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services (CMS) as meeting the definition of "health center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330. Tribal 638 health centers can be designated as FQHC Look-Alike programs.
- **Outpatient health programs/facilities operated by tribal organizations** (under the Indian Self-Determination Act, P.L. 96-638) or **urban Indian organizations** (under Title V of the Indian Health Care Improvement Act, P.L. 94-437).

*COMMUNITY HEALTH CENTER PROGRAM FUNDAMENTALS
▪ **Located in or serve high-need communities that are medically underserved.**
▪ **Governed by a community board composed of a majority (51%) of health center patients.**
▪ **Provide comprehensive primary health care services as well as supportive services (education, translation, transportation, etc.) that promote access to health care.**
▪ **Provide services available to all with fees adjusted based on ability to pay.**

HRSA Governance Requirements

In 1993, the *Omnibus Reconciliation Act* (OBRA) added Title V Urban Indian Health Programs and Tribal 638 Programs as eligible for FQHC designation. As a result, if Tribal Health Centers becomes tribally-managed under an ISDEAA agreement, it will be eligible for FQHC status, and it will be eligible for CHC funding ("330 grant"). Health Centers operated by a Tribe, Tribal Organization, or Urban Indian Health Organization who meet

all of the program requirements for operating a Federally Qualified Health Center receive an automatic designation of FQHC Look-a-Like status.

Health Centers operated by a Tribe, Tribal Organization, or Urban Indian Health Organization who meet all of the program requirements for operating a Federally Qualified Health Center receive an automatic designation of FQHC Look-a-Like status.

Outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Indian organization receiving funds under Title V of the Indian Health Care Improvement Act can become Health Centers by meeting program requirements and applying to HRSA for funding.

There are *two major governance requirements* for CHC funding:

Board Authority: Health center governing board maintains appropriate authority to oversee the operations of the center, including:

- Holding monthly meetings;
- Approval of the health center grant application and budget;
- Election/dismissal and performance evaluation of the health center CEO;
- Selection of services to be provided and the health center hours of operations;
- Measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and
- Establishment of general policies for the health center.

***Board Composition:** The health center governing board is composed of individuals, a majority of whom are being served by the center and, who as a group, represent the individuals being served by the center. Specifically:

- Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization;
- The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community; and
- No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.

***Note:* Tribal Health Centers and Urban Indian Health Organizations, upon a showing of good cause, may request a waiver for the patient majority requirement and other board requirements. Therefore, if a Tribe assumes the management of their Health Center under an ISDEAA contract or compact, the governing board of the 638 facility could also serve as the governing board for a combined 638/FQHC.**

HRSA Health Center Service Area Requirements

Community Health Centers provide high quality, culturally competent care to patients in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. More than half (52%) of all health centers serve rural populations, including some reservations. As the essential healthcare homes for some of the Nation's most vulnerable groups, they are delivering care where it is needed most.

Health Professional Shortage Area (HPSA) Designation

HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups or medical or other public facilities. **Tribes have an automatic HPSA designation.**

Medically Underserved Area (MUA)/Medically Underserved Population (MUP)

A Tribal Health Center or Urban Indian Clinic must meet the eligibility requirements for Federally Qualified Health Status at the time it submits an application to Health Resources Services Administration. One of the elements of eligibility is serving, in whole or in part, a federally-designated MUA or MUP.

A Medically Underserved Area (MUA) may be a whole county or a group of contiguous counties, a group or county or civil division or a group of urban census tracts in which residents have a shortage of personal health services.

A Medically Underserved Population (MUP) may include groups of persons who face economic, cultural or linguistic barriers to health care.

Service Area Overlap

HRSA is committed to increasing access to health care services to vulnerable and underserved populations, including expanding and adding new sites and services in communities with high unmet health care needs. This is true on many Indian reservations across the country, including the Northern Plains. To apply for CHC funding, entities / Tribes must demonstrate that there is a need for healthcare services in the area / reservation to support the designation of a new FQHC service delivery site. Tribal Health Centers and Urban Indian clinics must demonstrate collaboration and coordination of health care services with other area health care providers, including existing section 330 program grantees and/or FQHC Look-A-Likes through letters of support, Memoranda of Agreement / Understanding, and other formal documentation. For organizations that are serving the same, or a contiguous, area served by a section 330 program grantee or FQHC Look-A-Like, HRSA will conduct an analysis to determine the level of unmet need in the area to support an additional FQHC service delivery site.

Consideration: If a Tribe moves forward with an ISDEAA Contract or Compact, they should consider working with HRSA to coordinate a planning grant to consider applying for a "330" CHC grant. The grant amounts are approximately $600K per year and will increase resources to expand services for Tribal community members.

HRSA Service Delivery Model

The HRSA Community Health Center Model

Community Health Centers are free-standing clinics that provide medical, dental, behavioral health, substance abuse, outreach, prevention and chronic disease management, and medications to uninsured and vulnerable populations (eg: homeless) without regard for the patient's ability to pay for their care. Quality health care is delivered in a culturally appropriate manner to best serve American Indians/Alaska Natives, Spanish-speaking residents, and immigrants.

Who does a Health Center Serve?

Federally Qualified Health Centers (FQHCs) serve people of all ages. Nearly 39% of patients are without health insurance, along with others who have Medicaid (35%), Medicare (8%), and private insurance (16%). FQHCs serve people who are challenged to afford their co-pays or other health care expenses. FQHCs are designed to serve people of all races and ethnicities. FQHCs also serve migrant and seasonal farm workers, homeless, and public housing residents.

Health Center Patients, 2007

Type of Insurance	Percent	Number
Uninsured	39%	6,205,660
Medicaid	35%	5,675,125
Medicare	8%	1,221,840
Other Public	3%	466,228
Private Insurance	16%	2,507,987

How are Health Center patients charged for services?

While an FQHC must provide services to anyone regardless of their ability to pay, it is not a free clinic. Services are offered on a Sliding Fee Scale based on the patient's annual income and family size. For patients whose incomes fall below 100% of federal poverty, there is no cost for their care. Patients whose incomes fall between 100% - 200% federal poverty receive significant discounts for their care. No unpaid bills are ever sent to collections. *Tribal 638* ***FQHC Look-Alike programs*** *do not have to see all patients—they can focus solely on the AI population if they choose.*

Federal Poverty Level

Family Size	100% Poverty	200% Poverty
1	$10,830	$21,660
2	$14,750	$29,140
3	$18,310	$36,620
4	$22,050	$44,100

Other Benefits to Receiving Care at a Health Center:

- Medicare deductibles are waived for patients who receive care at a Health Center.
- Patients can access free and low-cost medications through the Health Center's 340B Drug Program.
- Children and seniors can often receive free immunizations.
- Tribal members may be able to schedule appointments during evening and weekend hours to avoid having to take time off work to see the doctor.
- The Health Center can be staffed with American Indian staff and providers and translation services are available for other languages. Traditional healing services unique to the AI population may be offered. Citizenship is not required to receive care.
- The Health Center may offer walk-in appointments for homeless patients and offer assistance linking patients with food, shelter, housing, clothing, employment and income services, and other social programs.

Primary Care Services

Federally Qualified Health Centers must provide certain primary care services or ensure a direct referral is in place for patients to access the service. The following chart provides a list of the primary care services that are required for applying for FQHC status and funding.

Required FQHC Health Center Services		
Clinical Services		**Do you currently provide this service? (Yes or No)**
1	General Primary Medical Care	
2	Diagnostic Laboratory	
3	Diagnostic X-Ray	
4	Screenings	
	• Cancer	
	• Communicable diseases	
	• Cholesterol	
	• Blood lead test for elevated blood lead level	
	• Pediatric vision, hearing, and dental	

5	Emergency Medical Services		
6	Voluntary Family Planning		
7	Immunizations		
8	Well Child Services		
9	Gynecological Care		
10	Obstetrical Care		
11	Prenatal and Perinatal Services		
12	Preventive Dental		
13	Referral to Mental Health *(Health Clinic does <u>not</u> pay for the services)*		
14	Referral to Substance Abuse *(Health Clinic does <u>not</u> pay for the services)*		
15	Referral to Specialty Services *(Health Clinic does <u>not</u> pay for the services)*		
16	Pharmacy		
17	Substance Abuse services *(Required only for FQHCs receiving funding for Health Care for the Homeless; optional for other grantees)*		
	• Detoxification		
	• Outpatient treatment		
	• Residential treatment		
	• Rehabilitation (non hospital settings)		
18	If the health center provides <u>pharmacy services</u> either on-site or through an off-site provider that it owns or manages…		
	a	Has a clinical committee established a formulary to insure cost-effective prescribing?	
	b	Is there a policy regarding acceptance, stocking, logging, and recording of dispensed sample medications?	
19	Regarding referrals to specialists:		
	a	What is the level of specialist availability for referrals?	
	b	Are there written procedures and tracking mechanisms in place for specialty referrals?	
	c	Is there a system for following-up on missed specialty care appointments?	

Required FQHC Health Center Services			
Non-Clinical Services			**Do you currently provide this service? (Yes or No)**
1	Case Management, including counseling, referral, and follow-up:		
1.a.	Counseling/Assessment		
1.b.	Referral		
1.c.	Follow-up/Discharge Planning		
1.d.	Eligibility Assistance		
2	Health Education		
3	Outreach		
4	Transportation		
5	For health centers providing translation services *(Required only for FQHCs serving a substantial number of patients with limited English proficiency; optional for other grantees.)*		Y/N
	a	Does the type of interpretation/translation services provided appear to be appropriate for the size/needs of the grantee (e.g., bilingual providers, onsite interpreter, language telephone line)?	
	b	Are the Registration Form, Sliding Fee Scale, and other pertinent documents provided to patients in the appropriate languages?	
6	Substance Abuse related Harm/Risk Reduction services—e.g., educational materials, nicotine gum/patches. *(Required only for FQHCs receiving funding for Health Care for the Homeless; optional for other grantees.)*		
7	For all required services (listed above) that are provided by an outside organization/provider, either through agreement or formal referral:		Y/N
	a	Is a contract or written agreement (e.g., MOA/MOU) in place with the outside organization/provider that at minimum describes services and fees or the manner by which the referral will be made and managed, and the process for referring patients back to the grantee for appropriate follow-up care?	
	b	For formal referral arrangements, is the health center appropriately tracking and providing follow-up care for referred patients?	

	c	Does the outside organization/provider offer the service to health center patients based on the health center's sliding fee discount schedule?	
	d	Is the service is available equally to all health center patients, regardless of ability to pay?	
	e	Has the license of the outside provider been verified?	
	f	Has the certification of the lead provider been verified?	

Clinic Operations

CLINIC OPERATIONS - Eligibility				
Requirements			**Questions**	**Y/N**
1		Health center must assure that no patient will be denied services due to their inability to pay for such services.	Are all health center patients provided services regardless of ability to pay?	
			Are there signs in the lobby and at the exit/cashier's desk or other mechanisms for communicating the availability of discounts for eligible low-income persons?	
			Is the clinic willing to provide services to non-Native people?	
2		Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. Under this system:	Does the health center's sliding fee schedule cover the cost of all types of visits, procedures, lab tests, and other ancillary services within the approved scope of project?	
			Is the sliding fee schedule based on a schedule of fees or payments that is consistent with locally prevailing rates or charges and designed to cover the reasonable costs of operation?	
			Does the health center have a written policy for the sliding fee discount schedule that is applied equally to all patients?	
3	a	Individuals and families with annual incomes at or below 100% of the Federal poverty level must receive a full discount. (Only nominal fees may be charged.)	Do individuals and families below 100% of poverty receive a full discount, other than perhaps nominal fees?	

	b	Individuals and families with incomes between 100% and 200% of poverty must be charged a fee in accordance with a sliding discount policy based on family size and income.	Are individuals and families between 100% and 200% of poverty charged a fee according to a sliding fee discount policy based on family size and income?	---
	c	Individuals and families with incomes over 200% of poverty may not receive discounts.	Are individuals and families above 200% of poverty charged a non-discounted rate?	---

CLINIC OPERATIONS – Performance Improvement – After Hours Operations			
			Response
1		What mechanisms/arrangements does the grantee have for after-hours coverage (e.g., does it include the health center clinicians, does it use other community clinicians)?	
2		Do all patients receive a written or verbal explanation regarding the procedures for accessing emergency medical/dental care after hours?	
3		Does the general phone system provide information on how to access emergency care after hours?	
4		Is the written information and/or phone message about accessing care after hours provided in the appropriate languages?	
5		Is the answering service and/or provider able to communicate in the appropriate languages to serve the population?	
6		Does the coverage system have established mechanisms for patients needing care to be seen in an appropriate location and assure timely follow-up by health center clinicians for patients seen after-hours?	
Hospital Privileges			
1		Do the formal written agreements with the hospital(s) address:	
	a	Compensation for services rendered?	
	b	Admission notification?	
	c	Discharge follow-up?	
	d	Exchange of information?	
2		When physicians do not follow patients in the hospital, how is continuity of care ensured?	
Provider Credentialing and Privileging			
1	a	Is there a formal provider credentialing and privileging process (for insurance companies and other third-party payors as well as clinical privileges)?	
	b	Has the Board approved this process?	
	c	Are providers required to complete the privileging process before starting to see patients?	

Quality Improvement

As a Federally Qualified Health Center, a Tribe will be required to have an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. These functions will assist the Health Center in assuring high quality health care services. The QI/QA program must include:

- A clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;
- Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall:
    - Be conducted by physicians or by other licensed health professionals under the supervision of physicians;
    - Be based on the systematic collection and evaluation of patient records; and
    - Identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.

HRSA Financial Management

As a Community Health Center, the health center must maintain accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separate functions appropriate to organizational size to safeguard assets and maintain financial stability. The health center must assure an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report.

The health center must also have the appropriate systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit, and collection policies and procedures. The health center is required to develop a budget that reflects the costs of operations, expenses, and revenues (including the CHC grant) necessary to accomplish the service delivery plan, including the number of patients to be served. The health center also must have systems in place that accurately collect and organize data for program reporting and that support management decision-making.

These processes will already be in place to varying degrees at a tribally-managed 638 Health Center, and meeting the HRSA requirements for services provision, quality improvement, and financial management will not be a barrier to accessing the HRSA CHC grant should a tribe decide to pursue this funding opportunity in addition to the ISDEAA funding agreement.

Conclusion

The **"638 Toolkit: Considerations for Tribes Regarding Contracting or Compacting for Clinical Services from the Indian Health Service Under PL 93-638"** was funded by a grant from the Helmsley Charitable Trust to the Sanford Health Foundation. It was prepared by a consulting team including Dr. Donald Warne, MD, MPH.

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