

### 3. IHS Laws, Regulations, and Policies

#### *Contents*

3.1	Overview of IHS Laws, Regulations, and Policies .....	3-2
3.2	IHS Legislative Program Authority .....	3-2
3.2.1	The Snyder Act .....	3-2
3.2.2	Transfer Act .....	3-2
3.2.3	Public Law 86-121 .....	3-3
3.2.4	Indian Self-Determination and Education Assistance Act.....	3-3
3.2.5	Public Law 102-184 .....	3-3
3.2.6	Public Law 102-573 .....	3-4
3.2.7	Tribal Self-Governance Amendments of 2000 .....	3-4
3.3	Billing and Collection Authority .....	3-4
3.3.1	Indian Health Care Improvement Act (IHCIA) .....	3-4
3.3.2	Public Law 100-713 .....	3-6
3.3.3	IHS Medicare and Medicaid Third Party Revenue Legal Authorities.....	3-7
3.3.4	Tribal Reimbursement.....	3-7
3.3.5	Social Security Act, Title XXI, State Children’s Health Insurance Program (SCHIP) .....	3-8
3.3.6	Tribal Direct Reimbursement, Title IV, IHCIA.....	3-9
3.3.7	Benefit Improvement and Protection Act (BIPA).....	3-9
3.4	Statutory Bases of Liability-Fraud and Abuse .....	3-9
3.4.1	Federal Criminal and Civil Provisions.....	3-9
3.4.2	Emergency Medical Treatment and Active Labor Act (EMTALA) .....	3-11
3.4.3	“Prompt Pay” Statutes and Regulations.....	3-12

## **3.1 Overview of IHS Laws, Regulations, and Policies**

This section covers three major topics:

- (1) A summary of important laws that provide basic program legislative authority and appropriations to IHS.
- (2) The legislative authority for IHS to bill Medicare, Medicaid and receive reimbursements.
- (3) A list of laws and regulatory requirements that provide an overview of laws and penalties for improperly billing third-party payers for services provided to American Indians (AI) and/or beneficiaries.

Each facility should have a compliance plan adopted by the Governing Board, which outlines how the facility complies with the rules and regulation of Medicare and Medicaid and other third party payers.

For more information go to this website: <http://oig.hhs.gov>

## **3.2 IHS Legislative Program Authority**

### **3.2.1 The Snyder Act**

Public Law 67

67th Congress – November 2, 1921(25 U.S.C. 13) (42 Stat. 208)

This Act provides the broad legal basis for Federal expenditure of funds for health care for federally recognized Tribes, “for the relief of distress and conservation of health”. It provides legislative authorization for the Federal Health Program for American Indians and Alaska Natives, and is cited every year in the IHS budget appropriation. In order for Congress to appropriate or spend money, it must have legislative authority.

### **3.2.2 Transfer Act**

Public Law 83-568

83rd Congress – August 5, 1954 (U.S.C. 444-449)

This act transferred the Indian Health Programs from the Department of Interior to the Department of Health, Education, and Welfare, effective July 1, 1955.

### **3.2.3 Public Law 86-121**

86<sup>th</sup> Congress – July 31, 1959  
(U.S.C. 2001-2004) (73 Stat. 267-268, 68 Stat. 674)

This Act Amends P.L. 83-568, “Transfer Act,” to authorize the provisions of water and waste disposal facilities to Indian homes, lands, and communities. These activities are provided through the Office of Environmental Health and Sanitation of the IHS.

### **3.2.4 Indian Self-Determination and Education Assistance Act**

Public Law 93-638  
93<sup>rd</sup> Congress – January 4, 1975  
(25 U.S.C. 450-452-458, 20 U.S.C. 276, 25 U.S.C. 2001, 43 U.S.C. 1601)  
(88 Stat. 2203-2217)

This act:

- Authorizes the Secretary of HEW (now HHS) to enter into PL 93-638 contracts and grants with Indian Tribes and Tribal Organizations for the purpose of enabling such Tribes and Tribal Organizations to carry out any or all of the Secretary’s functions, authorities and responsibilities.
- Provides for the full participation of Indian Tribes in programs and services conducted by the Federal Government for Indians and to encourage the development of human resources of the American Indians and Alaska Natives
- Establishes a program of assistance to upgrade Indian education to support the rights of Indian Citizens to control their own educational activities, health activities, and for other purposes

### **3.2.5 Public Law 102-184**

102<sup>nd</sup> Congress – December 4, 1991 (25 U.S.C. 450) (105 Stat. 1278)

This law authorizes the Indian Health Service to undertake a study on the feasibility of including health care programs operated by the IHS under the authority of Tribal Self-governance.

### **3.2.6 Public Law 102-573**

102<sup>nd</sup> Congress – October 29, 1992 (25 U.S.C. 1601) (106 Stat. 4526)

This law amends the

- Indian Health Care Improvement Act, P.L. 94-437, reauthorizing it through fiscal year 2000, adding programs and providing specific programs and administrative guidance in certain programs and activities.
- Indian Self-Determination and Education Assistance Act, P.L. 93-638, by extending Title III authority (Self Governance), for a Tribal Self-Governance Demonstration Project by IHS.

### **3.2.7 Tribal Self-Governance Amendments of 2000**

Public Law 106-260 August 18, 2000 (114 Stat. 711)

These amendments include the establishment of

- Title V of the Indian Self-Determination Education and Assistance Act to make Self-Governance permanent within IHS
- Title VI to study the feasibility of expanding self-governance to non-IHS programs and activities within the Department of Health and Human Services

## **3.3 Billing and Collection Authority**

This section covers laws associated with billing and collections of third-party revenue for the IHS.

### **3.3.1 Indian Health Care Improvement Act (IHCIA)**

Public Law 94-437

94<sup>th</sup> Congress – September 30, 1976 (25 U.S.C. 1601-1675, 40 U.S.C. 276, 42 U.S.C. 2004-1395-1396) (90 Stat. 1400-1414)

The Indian Health Care Improvement Act (IHCIA) implements the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian Health Programs and encouraging maximum participation of Indians in these programs.

IHCIA includes nine major Titles that strengthen health care to American Indian (AI) and Alaskan Native (AN) people.

Title IV, Access to Health Services, covers the basic authorities for collection of third party revenue in the IHS. It also includes copies of amendments to Title XVIII, Medicare and Title XIX, Medicaid, and the legal Authority for billing Medicare and Medicaid. .

Title II, Section 206, covers the right of IHS to recovery from third party payers to the same extent that non-governmental providers of services would be eligible to receive reimbursement.

**§ 1621e. Reimbursement from certain third parties of costs of health services** (Release date: 2004-09-20)

**(a) Right of recovery**

Except as provided in subsection (f) of this section, the United States, an Indian tribe, or a tribal organization shall have the right to recover the reasonable expenses incurred by the Secretary, an Indian tribe, or a tribal organization in providing health services, through the Service, an Indian tribe, or a tribal organization, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such expenses if –

- (1) such services had been provided by a nongovernmental provider, and
- (2) such individual had been required to pay such expenses and did pay such expenses.

**(b) Recovery against State with workers' compensation laws or no-fault automobile accident insurance program**

Subsection (a) of this section shall provide a right of recovery against any State only if the injury, illness, or disability for which health services were provided is covered under –

- (1) workers' compensation laws, or
- (2) a no-fault automobile accident insurance plan or program.

**(c) Prohibition of State law or contract provision impeding right of recovery**

No law of any State, or of any political subdivision of a State, and no provision of any contract entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or a tribal organization under subsection (a) of this section.

**(d) Right to damages**

No action taken by the United States, an Indian tribe, or a tribal organization to enforce the right of recovery provided under subsection (a) of this section shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

**(e) Intervention or separate civil action**

The United States, an Indian tribe, or a tribal organization may enforce the right of recovery provided under subsection (a) of this section by –

- (1) intervening or joining in any civil action or proceeding brought –
  - (A) by the individual for whom health services were provided by the Secretary, an Indian tribe, or a tribal organization, or
  - (B) by any representative or heirs of such individual, or
- (2) instituting a separate civil action, after providing to such individual, or to the representative or heirs of such individual, notice of the intention of the United States, an Indian tribe, or a tribal organization to institute a separate civil action.

**(f) Right of recovery for services when self-insurance plan provides coverage**

The United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization.

**3.3.2 Public Law 100-713**

100<sup>th</sup> Congress – November 23, 1988  
(U.S.C. 1601) (102 Stat. 4784)

This Law

- Reauthorized the Indian Health Care Improvement Act (IHCIA) and modified and/or expanded some of the 1976 IHCIA provisions.
- Established the Indian Health Service as an Agency of the Public Health Service.

### **3.3.3 IHS Medicare and Medicaid Third Party Revenue Legal Authorities**

In 1976, Congress enacted title IV of the Indian Health Care Improvement Act (IHCIA) and amended Title XVIII, Medicare, and Title XIX, Medicaid, of the Social Security Act (SSA), allowing IHS to bill for medical services provided by IHS facilities to Indians eligible for Medicare or Medicaid.

From 1976 to 2001, the authority to receive Medicare reimbursements was limited to Medicare services provided in an IHS hospital or skilled nursing home. Today, IHS has full authority to bill Medicare for all covered services (excluding home health care, as covered in various amendments to existing authority).

Congress requires that Medicare and Medicaid reimbursements be placed in a special fund, to be used for the specific purpose of improving IHS facilities to meet the standards set out in the Medicare and Medicaid programs, including facility costs.

In order not to burden States with additional Medicaid expenditures, Congress provided 100% Federal reimbursement to States for reimbursements for services provided through an IHS facility to eligible Indian beneficiaries. [1905(b) of the SSA]

### **3.3.4 Tribal Reimbursement**

#### **Tribal reimbursement as facilities of IHS**

By Memorandum of Agreement (MOA) between the Indian Health Service (IHS) and the Center for Medicare and Medicaid Services (CMS) the 100% Federal reimbursement to States was expanded to include Medicaid covered services provided to Indian beneficiaries in 638 tribally operated programs. This MOA also allows these tribal operated programs to elect to receive Medicaid reimbursements at the all-inclusive rate published annually by IHS in the Federal Register.

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### **Tribal reimbursement as Federally Qualified Health Centers (FQHCs)**

As stated in the Public Health Service Act, Sec 330, tribes and tribal organizations and urban Indian programs have the option to receive Medicaid and Medicare reimbursements as Federally Qualified Health Centers (FQHCs) or as other Medicare or Medicaid provider types, if they qualify (e.g., home health, physician, clinic, nursing home, etc.).

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**Note:** IHS is not eligible for FQHC status, because it is a Federal facility.

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### **3.3.5 Social Security Act, Title XXI, State Children's Health Insurance Program (SCHIP)**

Congress established the **State Children's Health Insurance Program (SCHIP)** by creating Title XXI of the SSA as part of the Balance Budget Act of 1997.

SCHIP is designed to provide health insurance coverage to children who are not otherwise eligible for Medicaid or not covered by an employer sponsored health insurance plan.

- States can implement SCHIP by expanding their Medicaid program or by a separate program, such as through private insurance coverage.
- IHS utilizes its existing Medicaid and private insurance collection reimbursement authorities to receive reimbursements for SCHIP-covered provided services.

In January, 2001, the Department of Health and Human Services (HHS) published SCHIP regulations (42 CFR Parts 431, 433, 435, 436, and 457); where. 42 CFR 457.530 exempts AI/AN children from cost-sharing requirements under SCHIP.

In the preamble, HHS explained that the SCHIP statute imposes an affirmative obligation to address barriers to AI/AN enrollment and exempted AI/AN children from cost-sharing requirements because it determined cost-sharing acts as a barrier to AI/AN enrollment in SCHIP.

### 3.3.6 Tribal Direct Reimbursement, Title IV, IHCIA

On November 1, 2000, Congress enacted the Alaska Native and American Indian Direct Reimbursement Act, amending Section 405 of IHCIA. Prior to enactment, only four tribes were authorized to participate in the section 405 demonstration program and receive Medicare and Medicaid reimbursement directly.

This Act makes Section 405 permanent and authorizes tribal programs that operate IHS owned or leased facilities to receive reimbursements for Medicare and Medicaid directly without having the funds flow through the special fund.

### 3.3.7 Benefit Improvement and Protection Act (BIPA)

On December 15, 2000, Congress enacted Section 432 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA). This law authorizes hospitals and ambulatory care facilities that are operated by the IHS or tribes to bill for Medicare Part B physician services and other services (nurse practitioners, physician assistants, etc.) that are reimbursable under the Medicare Physician Fee schedule.

## 3.4 Statutory Bases of Liability-Fraud and Abuse

The following citations cover requirements related to proper coding and billing for services, and penalties for not complying with the rules and regulations of third-party payers.

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**Note:** The key principle is “*knowingly*,” or intentionally, engaging in these activities.

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### 3.4.1 Federal Criminal and Civil Provisions

#### A. Federal Criminal Provisions (42 U.S.C. § 1320A-7B)

##### 1. Prohibition of False Claims

False or Improper Claims (42 U.S.C. § 1320a-7a)

(a) I-civil money penalties of up to \$10,000 per item or service, plus an assessment of up to three times the amount claimed for each such item or service, may be imposed upon any person who presents or causes to be presented a claim for reimbursement from Medicare, Medicaid, or other “federal health care programs” that:

Knowingly and willfully making or causing to be made any false statement or representation of material fact in any claim or application for benefits under Medicare or Medicaid.

Examples of prohibited conduct:

- Billing for services not rendered.
- Misrepresenting the services actually rendered.
- Falsely certifying that certain services were medically necessary.
- Presenting or causing to be presented a claim for physicians' services, knowing that the individual who furnished the services was not a licensed physician.

## **2. Prohibition of False Statements**

Knowingly and willfully making or causing to be made, or inducing or causing to be induced, the making of any false statements of material facts with regard to an institution's compliance with conditions of participation for the purposes of certification.

## **3. Intent Standard**

For the statute to be violated, the individual must have known the claims were false at the time he was making the claims (*United States v. Laughlin*, 26 F.3d 1523 (10th Cir. 1994))

## **4. Penalties**

The offenses described above are felonies punishable by up to five years imprisonment, and/or \$25,000 in fines.

# **B. Federal Civil Provisions (31 U.S.C. § 3729(A))**

## **1. Civil False Claims Act**

Prohibited Conduct

- (1) The *knowing filing* of a false or fraudulent claim for payment to the United States,
  - (2) The *knowing use* of a false record or statement to obtain payment on a false or fraudulent claim,
- OR*
- (3) The *conspiracy* to defraud the United States by getting a false or fraudulent claim allowed or paid.

### 3.4.2 Emergency Medical Treatment and Active Labor Act (EMTALA)

IHS **must comply** with the Emergency Medical Treatment and Active Labor Act (EMTALA), as follows.

#### **IHS facilities:**

- Hospitals are responsible for ensuring that any physician, (including on-call physicians) responds within a reasonable period of time.
- Hospitals must have policies and procedures in place to handle particular specialty conditions beyond the capabilities of the Emergency Room (ER) physician.
- A central log must be maintained on each individual who comes to the ER seeking emergency medical treatment. The log should track the care provided to the individual.

#### **Medicare hospitals:**

- If an individual comes to the Emergency Room (ER) and a request is made by that individual or his or her representative for examination or treatment of a medical condition by qualified hospital personnel, the hospital must provide an appropriate Medical Screening Examination (MSE) within the capability of the ER to determine if an emergency condition exists.
- Every individual coming to the ER must be provided an MSE beyond initial triage. Triage is not the equivalent to an MSE.
- The MSE must be the same MSE that the hospital would perform on any individual with similar signs and symptoms, regardless of their ability to pay.
- The hospital must provide stabilizing care, such that the patient's condition would not deteriorate.
- The hospital may transfer patients only for services or care not available in that hospital.
- The facility must obtain a written informed refusal of medical exam, treatment, and/or transfer from the patient or patient family.
- The facility must report any "suspect" transfer, which occurs when a recipient hospital has reason to believe it may have received an individual who was transferred in an unstable emergency medical condition from another facility.

### 3.4.3 “Prompt Pay” Statutes and Regulations

The **Prompt Payment Final Rule (5 CFR Part 1315)** requires Executive departments and agencies to pay commercial obligations within certain time periods and to pay interest penalties when payments are late.

On June 17, 1998, the Office of Management and Budget (OMB) requested comment on proposed revisions to the OMB Circular A-125, “Prompt Payment.” The Circular was revised to reflect the increased use of electronic commerce in the Federal government and the private sector, and to reflect the requirements of the **Debt Collection Improvement Act (DCIA) of 1996**. OMB issued final revisions to Circular A-125 on September 29, 1999.

State-specific regulations are available at this website:

[http://www.naic.org/state\\_web\\_map.htm](http://www.naic.org/state_web_map.htm)

The following table provides a summary of the status/terms of the law by State, as of 2005.

State	Status/Terms of Law
Alabama	Clean claims must be paid within 45 working days for HMO claims. Electronic clean claims are paid within 30 days and clean paper claims are paid within 35 days.
Alaska	Claims must be paid within 30 days
Arizona	Clean claims must be paid within 30 days or interest payments required (usually about 10%)
Arkansas	Clean electronic claims must be paid or denied in 30 calendar days, paper in 45. 12% per annum late penalty fee.
California	Claims must be paid within 45 working days for an HMO, 30 days for a health service plan. Interest accrues at 15% per annum
Colorado	Claims must be paid in 30 days if submitted electronically, 45 if paper. Penalty is 10% annually.
Connecticut	Claims must be paid within 45 working days. Interest accrues at 15% per annum
Delaware	Clean claims must be paid in 45 days.
District of Columbia	None at the present although a 40 day timeframe has been proposed
Florida	Clean HMO claims must be paid in 35 days, non-HMO in 45 days. Claims where information was requested must be paid in 120 days. Interest penalty is 10% per year.
Georgia	Claims must be paid within 15 working days. Interest accrues at 18% per annum
Hawaii	Clean paper claims must be paid in 30 days; electronic claims with 15 days. Interest accrues at 15% per annum. Commissioner may impose fines

<b>State</b>	<b>Status/Terms of Law</b>
Idaho	None. Department of Insurance will investigate abusive patterns
Illinois	Clean claims must be paid in 30 days. Interest accrues at 9% per annum.
Indiana	Claims must be paid in 45 days
Iowa	Clean claims must be paid in 30 days. Penalty will be 10% per annum.
Kansas	Claims will be paid in 30 days. Interest accrues at a rate of 1% per month
Kentucky	Claims must be paid or denied within 30 working days. Interest accrues at 12% per annum when 31-60 days late; 18% when 61-90 days late; and 21% when 91+ days late.
Louisiana	Claims submitted electronically must be paid within 25 days. Paper claims submitted in 45 days must be paid in 45 days; submitted after 45 days must be paid in 60 days. Penalty is 1% of unpaid balance.
Maine	Clean claims must be paid within 30 days. Interest accrues at 1.5% per month.
Maryland	Clean claims must be paid within 30 days. Interest accrues at monthly rates of 1.5% (31-60 days late), 2% (61-120 days late), and 2.5% (121+ days late)
Massachusetts	None. Division of Insurance will investigate abusive patterns.
Michigan	This law applies only to non-contracted providers; Claims must be paid in 60 days with an interest penalty of 12% per annum.
Minnesota	Clean claims must be paid in 30 days. Interest accrues at 1.5% per month if not paid or denied.
Mississippi	Clean claims must be paid within 45 days. Interest accrues at 1.5% per month.
Missouri	Claims must be acknowledged within 10 days and paid within 45 days. Once requested information is received, claims must be paid or denied in 15 days. Interest accrues at a monthly rate of 1%. After 40 processing days entitled to a per day penalty: the lesser of 1.2 value of the claim or \$20 per claim.
Montana	Clean claims must be paid within 30 days. Interest accrues at 18% per annum.
Nebraska	Claims must be paid or denied within 15 days of affirmation of liability.
Nevada	Claims must be paid in 30 days. Penalty interest accrues at rate set forth in Nevada.
New Hampshire	Clean paper claims must be paid in 45 days; electronic in 15 days. 1.5% monthly interest penalty.
New Jersey	Electronic claims must be paid within 30 days; paper claims with 40 days.
New Mexico	Clean claims must be paid within 30 days if electronic; 45 days if paper. Interest accrues at 1-1/2% per month.
New York	Claims must be paid within 45 days. Interest accrues at greater of 12% per year or corporate tax rate determined by the Commissioner. Fines up to \$500 per day may be imposed.

<b>State</b>	<b>Status/Terms of Law</b>
North Carolina	Claims must be paid or denied within 30 days. Annual interest penalty of 18%.
North Dakota	Claims must be paid within 15 days.
Ohio	Claims must be paid or denied within 30 days. Interest penalty of 18% per annum.
Oklahoma	Clean claims must be paid with 45 days. Penalty of 10% of claim as interest for late claims.
Oregon	Clean claims must be paid in 30 days. 12% interest penalty applies.
Pennsylvania	Clean claims must be paid in 45 days.
Rhode Island	None. Department of Insurance will investigate abusive patterns.
South Carolina	Group health insurers must pay claims in 60 days.
South Dakota	Electronic claims must be paid in 30 days; paper claims in 45.
Tennessee	Claims must be paid with 40 days. Interest accrues at 25% per annum.
Texas	Claims must be paid with 45 days (HMOs only). Interest accrues at 18% per annum.
Utah	Claims must be paid or denied in 30 days. Interest accrues at 18% per annum
Vermont	Claims must be paid or denied in 45 days. Interest penalty is 12% per annum
Virginia	Clean claims must be paid within 40 days
Washington	95% of the monthly volume of clean claims shall be paid in 30 days. 95% of the monthly volume of all claims shall be paid or denied within 60 days
West Virginia	Claims must be paid in 30 days if electronic; 40 days if paper. Interest and fines may apply. Interest penalty of 10% per year.
Wisconsin	If clean claims are not paid within 30 days, they are subject to a penalty interest rate of 12% per year
Wyoming	Claims must be paid within 45 days. Penalties and fines may accrue