

Contract Health Services



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MEDICAL PROVIDERS' BEST PRACTICES

Agency Priorities



- **To renew and strengthen our partnership with tribes**
- **Reform IHS**
- **To improve the quality of and access to care**
- **To make all our work accountable, transparent, fair and inclusive**

Contract Health Services

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- CHS Defined
- CHS Eligibility Requirements
- CHS Claims Processing
- CHS Funding
- IHS Medical Priorities
- CHEF

Contract Health Services

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As defined in 42CFR136:

“Contract Health Services means health services provided at the expense of the Indian Health Service from public or private sector medical or hospital facilities other than those of the Service.”

To better understand CHS, we must first define Direct Care...

IHS Direct Care

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- **Direct Care is care provided at an IHS or Tribal facility.** A patient requesting direct care must provide proof of enrolled membership; or, proof that he/she descends from an enrolled member, of a federally recognized tribe
- **There are 566 U.S. Federally Recognized Tribes.**
 - ✦ Tribes are recognized by Federal recognition statute or through the Bureau of Indian Affairs (BIA) administrative recognition process

CHS Requirements

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- CHS funds are used in situations where the direct care element is incapable of providing required emergency and/or specialty care. CHS funds are used to compliment and supplement other health care resources available to eligible Indian people
- CHS funds **may not** be expended for services that are reasonably accessible and available at IHS facilities
(IHS Physician determination)
- CHS is not an entitlement program and a CHS referral is not an implication care will be paid; it is a referral for medical services
- Authorization of services is dependent on appropriations
- IHS pays for authorized CHS care only after all other alternate resources are exhausted, including an available IHS facility

CHS Residence Requirement

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- To be CHS eligible a patient must be a member, or a descendant of an enrolled member, of a federally recognized tribe; **and** **permanently** reside on a reservation within a Contract Health Service Delivery Area (CHSDA); or
 - Do not reside on a reservation but reside within a CHSDA and:
 - Are members of the tribe located on that reservation; or
 - Maintain close economic and social ties with that tribe
 - **CHSDA**: consists of a county which includes all or part of a reservation, and any county or counties which have a common boundary with the reservation

California as a CHSDA...

California as a Contract Health Service Delivery Area – 25 USC 1680

- The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura **shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State**
- Originally defined on September 30, 1976, P.L. 94-437
- IHCA, permanently authorized March 23, 2010



Notification Requirements

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- **Emergent Care:** Notify the appropriate IHS/CHS ordering official within 72 hours after the beginning of treatment or admission to a health care facility. Providers can notify the appropriate CHS program on behalf of the patient
 - Elderly (65 yrs of age or older) and disabled are allowed 30 days to notify IHS/CHS
- **Non-Emergent Care:** Notify IHS/CHS prior to receiving medical care and services

All CHS requests must comply with the Notification Requirements, including Students and Transients.

Alternate Resource Requirement

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- **42 CFR 136.61 establishes IHS as the “Payor of Last Resort”.**
 - ✦ IHS will not be responsible for or authorize payment for CHS to the extent that:
 - The person would be eligible for Alternate Resources if he/she were to apply for them. (not required to expend personal resources)
 - ✦ ***Alternate Resources*** means health care resources other than those of the IHS. Such resources include Medicare, Medicaid, private health insurance, VA, and state or local health care

All CHS requests must comply with the use of Alternate Resources, including Students & Transients.

CHS - Emergent Care

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- **42 CFR 136, Subpart C – Contract Health Services**
 - **§136.21 Definitions**
 - ✦ *“(f) Emergency means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.”*

CHS Committee

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- **IHS or Tribal CHS Committees determine the CHS Medical Priority of Care, approval, and denial of all CHS requests for care**
 - At a minimum the CHS Committee consists of Clinical Director, Administrative Officer, Nursing or Utilization Review Nurse and CHS staff
 - CHS Committee meetings are held at least once weekly, most committees meet 3-5 times per week

Other CHS Eligible Persons

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- **Students and Transients**

- CHS may be available to students and transients who would be eligible for CHS at the place of their permanent residence within a CHSDA, but are temporarily absent from their residence. Must still comply with all other CHS requirements

- ✦ **Transients:** People who are temporarily employed such as seasonal or migratory workers, during their absence

- ✦ **Students:** During **full time** attendance at programs of vocational, technical, or academic education

- In addition, persons who leave a CHSDA (in which they were CHS eligible) may be eligible for CHS for a period of 180 days from such departure

All of the above must still comply with all other CHS requirements.

Other CHS Eligible Persons

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- Non-Indian woman pregnant with an eligible Indian's child; duration of pregnancy & up to 6 weeks postpartum (proof required)
- Non-Indian member of an eligible Indian's household for public health hazard
- Adopted, foster & step-children up to 19 yrs of age (IHCIA)

Must still comply with all other CHS requirements

Eligibility of California Indians

25 USCS § 1679

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- (a)** In general. The following California Indians shall be eligible for health services provided by the Service:
- (1)** Any member of a recognized Indian tribe
 - (2)** Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—
 - (A)** is a member of the Indian community served by a local program of the Service, and
 - (B)** is regarded as an Indian by the community in which such descendant lives

IHCIA, permanently authorized March 23, 2010

Must still comply with all other CHS requirements

Eligibility of California Indians

25 USCS § 1679 (Continued)

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- (3) Any Indian who holds trust interest in public domain, national forest, or Indian reservations allotments in California
- (4) Any Indian in California who is listed on the plans for distribution of the assets of Rancherias and reservations located within the State of California under the Act of August 18, 1958 (72 Stat. 619), [unclassified], and any descendant of such an Indian

(b) Clarification Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986

IHCIA, permanently authorized March 23, 2010

Must still comply with all other CHS requirements

Reconsideration & Appeals

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- **Persons to whom contract health services are denied shall be notified of the denial in writing**
 - Shall notify applicant that within 30 days from the receipt of the denial:
 - ✦ May obtain a reconsideration by the appropriate CEO of the original denial; **the request must be in writing**
 - Federal Programs have 3 levels of appeal:
 - ✦ 1st level: CEO, Service Unit issuing the original denial
 - ✦ 2nd Level: Area Director
 - ✦ 3rd Level: Director, IHS, Rockville, MD
 - ✦ The decision of the Director, IHS shall constitute final administrative action
 - **Tribal facilities must define local levels of appeals**
 - **The California Area Director does not mitigate tribal CHS appeals**

Medicare Like Rates

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- **42CFR, Subpart D, 136.30** – Limitation on charges for services furnished by Medicare-Participating hospitals to Indians
 - Requires Medicare participating hospitals that provide inpatient hospital services to accept Medicare-Like Rates as **payment in full** when delivering services to CHS eligible patients who are referred to them by programs funded by the IHS
 - MLR for IHS/Federal Facilities is determined by the IHS Fiscal Intermediary, Blue Cross Blue Shield of NM.
 - Tribal Facilities may contract with the IHS FI or purchase their own software to determine the MLR
- **Became effective July 5, 2007**

Can CHS pay for your referral medical care? Find out in 3 stages.

Individual Qualifications

Stage 1 You are eligible if:

a) You are a member or descendent of a Federally recognized Tribe or have close ties acknowledged by the CHSDA Tribe*

and

b) You live on the reservation or, if you live outside the reservation, you live in a county of the CHSDA

Each Contract Health Service Delivery Area (CHSDA) covers a single Tribe or a few Tribes local to the area. You are ineligible for CHS elsewhere.*

and

c) You get prior approval for each case of needed medical service or give notice within 72 hours in emergency cases (30 days for elders & disabled)

No

for the above

Application is denied.

* There are a few narrowly defined exceptions. Ask CHS staff for more specifics about individual eligibility, CHSDA, or prior notice.

Relative Medical Priorities

Stage 2 Payment may be approved if:

a) The health care service that you need is medically necessary

– as indicated by medical documentation provided

b) The service is **not** available at an accessible IHS or Tribal facility

and

c) The facility's CHS committee determines that your case is within the current medical priorities of the facility

*Unfortunately, CHS funds often are not sufficient to pay for all needed services. When this happens, the committee considers each individual's medical condition to rank cases in relative medical priority. Cases with imminent threats to life, limb, or senses are ranked highest in priority. ***

d) CHS funds available are sufficient to pay for the service to be authorized

Yes

for all

No

for the above

Application is deferred.

** Ask CHS staff for more specifics. Sometimes deferred lower priority cases may be reconsidered later if funding permits.

Coordination and Payment

Stage 3 Approval, Billing, Payment

a) You must apply for any alternate resources for which you may be eligible – Medicare, Medicaid, insurance, etc.

then

b) A CHS purchase order is issued to a provider authorizing payment for services

then

c) IHS or Tribal staff and the authorized provider coordinate your medical care

then

d) The authorized provider bills and collects from your alternate resources

then

e) The authorized provider bills any unpaid balance to CHS for payment – because CHS is *payer of last resort*, it pays only for costs not paid by your alternate resources

Steps are completed in order

Provider is paid.

Specific services authorized within relative medical priorities may vary from time-to-time in response to changing supply and demand, especially to stretch diminished funds over the remainder of the fiscal year.

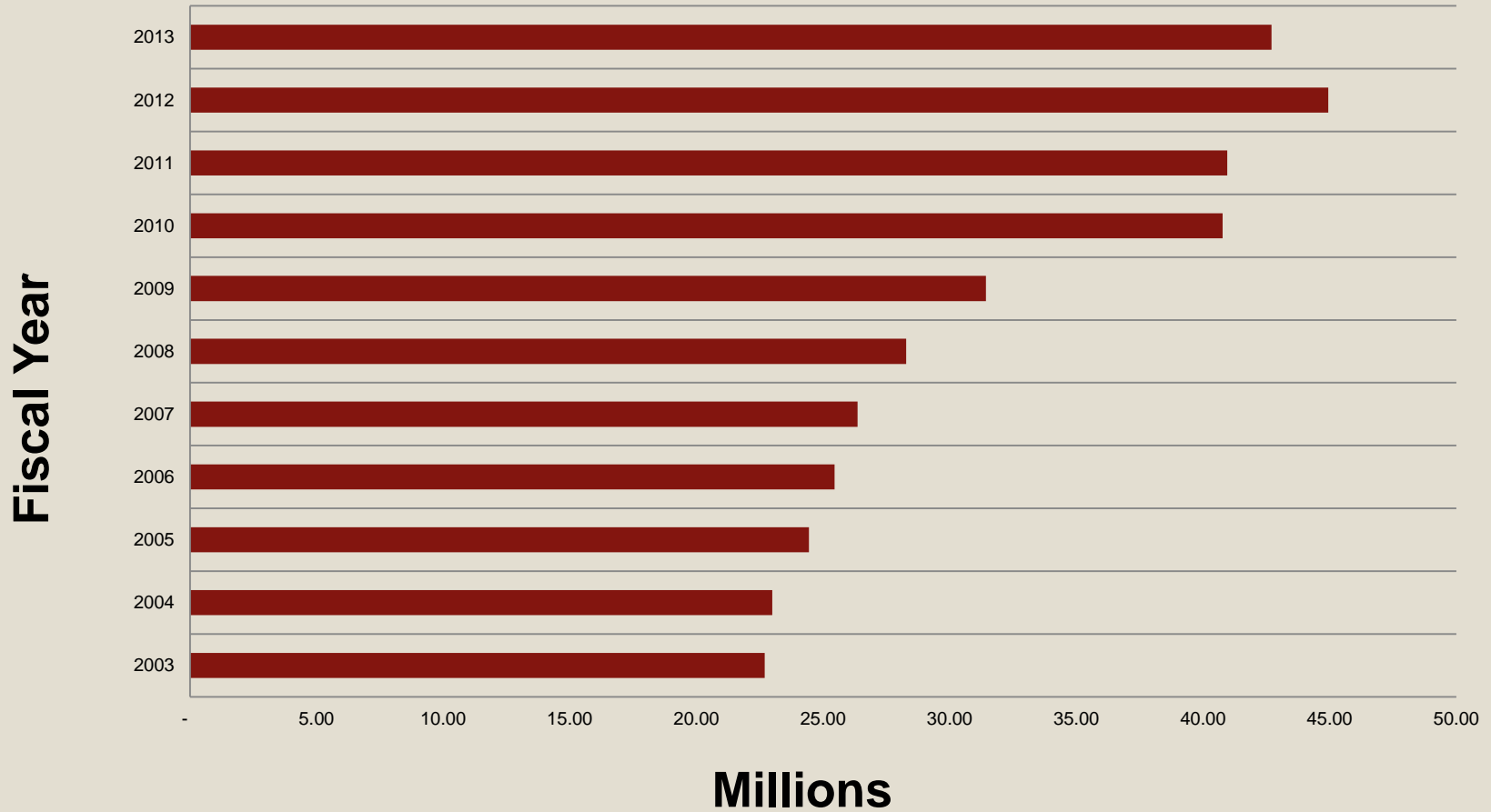
California CHS Funding

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- **Funds are distributed/shared among:**
 - **34 Tribal P.L. 93-638 CHS Programs**
- **FY 2012 allowance: \$45 million**
- **California Area distributes new CHS funds based on total active users**
- **Unmet Need – CHS financial needs**
 - Reporting supports budget justifications for CHS program

California CHS Funding

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Medical Priority Requirement

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- **Congressional funding is discretionary:** When funds are insufficient to provide the volume of CHS indicated as needed by the population residing in a CHSDA, priorities for services shall be determined on the basis of relative medical need. CHS Medical Priorities are determined by IHS or tribal providers/physicians.
 - **Priority I** – Emergent
 - **Priority II** – Chronic primary & secondary care services
 - **Priority III** – Preventive Care
 - **Priority IV** – Chronic Care Services
 - **Priority V** – Excluded (cosmetic and experimental)

All requests for CHS care must comply with the use of Medical Priorities, including Students and Transients.

IHS Medical Priorities

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- Because CHS level of funding is only a fraction of the need, an equitable and rational system is needed to prioritize the severity of injury and/or illness
- Tribal healthcare programs that elect to follow IHS regulation on medical priorities may use Indian Health Manual Exhibit 2-3-D as a guideline
- Deviations from IHS regulations should demonstrate fairness and equity, and be medically necessary

Level I

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- Emergent or acutely urgent healthcare services
- Necessary to prevent death, or serious impairment
- Examples:
 - Bone fractures
 - Acute pneumonia
 - Obstetrical deliveries and post-natal care
 - Acute psychiatric care of suicidal person
 - Acute cardiopulmonary problems
 - Acute renal failure
 - Bowel obstruction

Level II

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- Preventive healthcare services
- Aimed at preventing disease, or disease complications
- Many GPRA measures fit under Level II
- Examples:
 - Routine prenatal care
 - Immunizations
 - Screening exams, such as mammography, colonoscopies
 - Vision and hearing
 - Diagnostic procedures (X-ray, lab) supporting primary care

Level III

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- **Primary and secondary healthcare services**
- **For conditions that would lead to progressive loss of function if not treated**
- **Non-acute diagnoses**
- **Examples:**
 - Many specialty consultations in ophthalmology, ENT, dermatology, orthopedics, psychiatry, non-acute cardiology, pain medicine
 - Routine, elective surgeries such as gall bladder surgery, hernia repair, some back surgeries
 - Eyeglass refraction, hearing aids, orthotics

Level IV

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- **Chronic tertiary and extended healthcare services**
- **Not essential**
- **Low impact on morbidity and mortality**
- **High cost**
- **Examples:**
 - Obesity surgery
 - Joint replacement
 - Reconstructive surgery
 - Non-acute coronary bypass surgery
 - Pain medicine procedures

Level V

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- Excluded services
- Generally cosmetic, experimental/investigational clinical trials
- **Examples:**
 - Tattoo
 - Tattoo removal
 - Dermabrasion
 - Breast augmentation
 - Face lift
 - Custodial care
 - “Tummy tuck”
 - Experimental drugs or devices not approved by the U.S. Food and Drug Administration

Catastrophic Health Emergency Fund (CHEF) Background

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The Indian Health Care Amendments of 1988, P.L. 100-713 established the CHEF solely to meet the extraordinary medical costs associated with treating of victims of disasters or catastrophic illnesses who are within the responsibility of IHS and Tribal programs.

CHEF

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- **Catastrophic Health Emergency Fund (CHEF)**
 - CHEF is a Congressionally appropriated fund to partially cover the IHS portion of medical expenses for catastrophic illnesses and events falling within IHS responsibility
 - Administered by IHS Headquarters, Rockville, MD. IHS & Tribal facilities may submit CHS referral (1 episode of care) and request reimbursement of care/cost in excess of \$25,000
 - Access to the CHEF fund is on a cost reimbursement basis requiring IHS and Tribal CHS programs to first obligate and expend funds, and meet the CHEF threshold amount
 - ✦ May be reimbursed for amount exceeding the threshold as long as fund is not depleted
 - FY2012 CHEF Budget was \$51 million
 - FY2013 CHEF Budget is \$49 million

Reference

- **CHS Regulations:**

- Code of Federal Regulations (CFR)

- ✦ Title 42, Volume 1, Subchapter M – Indian Health Service

- Part 136 – Indian Health, Subpart C – Contract Health Services.

- **CHS Manual:**

- Indian Health Manual

- ✦ Part 2 – Services to Indians and Others

- Chapter 3 – Contract Health Service

- **The Indian Health Care Improvement Act**

- **CHS info on IHS website at <http://www.ihs.gov>**

Recap – Basic CHS Requirements

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Person requesting IHS to pay for CHS referred or self referred care must first meet these basic CHS requirements:

- Provide proof of enrollment in, or descendent from, an enrolled member of a federally recognized tribe, **and;**
- Permanently reside on a Reservation or CHSDA, **and;**
- Meet the CHS Medical Priority of Care (Emergent), **and;**
- For self referred care, patients must notify their local CHS program within 72 hours of receiving care (30 days for elderly and disabled), **and;**
- Insure all alternate resources for which they may be eligible, are exhausted, including the use of an available IHS facility

Questions?

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