IHS Clinical Administration 101

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IHS Mission

- To raise the physical, mental, social, and spiritual health of American Indian and Alaska Natives to the highest level

IHS Foundation

- To uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures
- To honor and protect the inherent sovereign rights of Tribes

Agency Priorities

1. To renew and strengthen our partnership with tribes
2. To reform the IHS
3. To improve the quality of and access to care
4. To make all our work accountable, transparent, fair and inclusive

Early History

- Trust relationship established by treaties and supreme court decisions
- Responsibility transferred from War Department to Bureau of Indian Affairs

Transfer Act

- Studies of health conditions in Indian people in the early 1900's eventually led to the Indian Health Service Transfer Act in 1954

- This transferred healthcare responsibilities from the BIA to the Department of Health Education and Welfare (later the DHHS) and formed the IHS

Indian Self Determination

- Indian Self Determination and Education Assistance Act of 1975, aka Public Law 93-638
- Created a mechanism for the Federal government to make contracts and grants with Indian tribes, similar to those with states
- The implication for healthcare was that tribes can develop and implement healthcare in a way that they see best for their community

IHS in California- a slightly different path

- Indian health care in California has developed different that in other parts of the country
- There was not any significant Federal Indian health presence in California (other than 3 sanitariums that operated briefly in early 1990's)
- Most of the early California Indian health care was organized at the community level, as more tribes regained their Federal recognition

Today's Indian Health Service nationally

- Active user population of just over 2 million in the United States , 565 tribes
- Annual budget $4.05 billion (appropriated)
- Facilities:
  - Hospitals: 28 Federal and 17 tribal
  - Health clinics/stations: 94 Federal and 521 tribal
  - 34 urban Indian facilities

Organization

- Currently an Operating Division (subordinate agency) of the Department of Health and Human Services
- IHS divided into 12 administrative Areas, of which the California Area is one (includes a small contract program in Honolulu)

Indian Health Service/ California Area Office

- 4 offices: Office of Area Director, Office of Management Support, Office of Public Health, Office of Environmental Health and Engineering, 5 EHO/E field offices
- Office of Public Health (OPH) has dentist, 3 nurses, 1 APN, 1 PA, 1 statisticians and other admin (IT is under OPH)
- About 100 staff

California Area healthcare programs

- 58 PL-638 contractors
- 29 tribal health programs that provide direct healthcare services
- 6 urban clinics provide direct healthcare services
- 4 adult substance abuse residential treatment centers

Patient care- size

- 80,000 active users at THP and about 6,000 urban Indian users
- About 700 clinical staff throughout the Area

Scope of services

- Of the 35 health programs that provide direct service, almost all provide dental, most provide BH
- 12 have pharmacies, and some provide other ancillary services
- All hospital care provided through Contract Health Service

Questions about mission/function/organization?

Federal budget

- Discretionary
- 3 year budget process, starts with Agency, goes to Department, then to Congress

FY10 CAO Budget Overview

- Grand Total for Area Office = $210 million

- Major categories:
  - Tribal direct clinical = $88 million
  - Contract care = $40 million
  - Contract support cost = $37 million
  - Engineering/ EH = $12.5 million
  - Urban = $7.3 million
  - Area Office = $2.5 million

Distribution

- Based upon active users, some other historical
- Some non-competitive and non-competitive grants

Third party

- Important source of revenue for direct tribal and urban Indian health programs
- IHS-wide 3rd – party collections accounts for about 20% of total budget
- Current IHS/CMS MOA rate is $295 per encounter, can have up to two encounters if different category

The challenge

- IHS patients receive an average of $2500 for healthcare per patient, less than half that of other Federal beneficiaries
- About ½ estimated need

Questions about budget?

Accreditation

- 10 tribal and 1 urban health program AAAHC accredited, 1 Joint Commission
- 2 alcohol programs are Commission of the Accreditation of Rehabilitation Faciltities (CARF) accredited

- Do not have a mock survey review team, but can provide targeted technical support

Risk Management/ Medicolegal

- Federal Tort Claims Act (FTCA) of 1946 originally passed as a mechanism to allow citizens to sue the Federal government for negligent torts (Empire State Building crash)

- For the Federal employee, this means the Federal government will defend an employee that commits an act of negligence, or omission, if within the scope of employment

FTCA Basics

- Coverage for employees and “personal contractors”
- Generally does not cover locums or trainees
- Scope of employment means doing what employed to do (helps if in PD) and doing it at usual location

FTCA

- Scope of employment means that deliberate acts not covered, e.g. assault
- Serves as “exclusive remedy” (cannot sue provider separately)
- Statute of limitations is two years

FTCA FAQs

- **<u>From 25 Code of Federal Regulations FAQs:</u>**
  - 900.187 Does FTCA apply to a self-determination contract if FTCA is not referenced in the contract? – Yes
  - Does FTCA coverage extend to services provided under a staff privileges agreement with a non-IHS facility where the agreement requires a health care practitioner to provide reciprocal services to the general population – Yes
  - Does FTCA coverage extend to the contractor's health care practitioners providing services to private patients on a fee-for-services basis when such personnel (not the self-determination contractor) receive the fee? - Yes

FTCA doubtful for:

- Care provided to non-beneficiaries unless there is a “joint determination” clause in PL 93-638 contract/compact
- Services provided in the community as volunteer (school team doctor)
- Services provided at a school, or other non IHS funded agency should have MOU

Role of supplemental coverage

- Department of Justice has the last word, so err on side of caution
- Supplemental coverage advisable for situations in previous slide other grey areas

Need more information?

- http://www.ihs.gov/RiskManagement/index.cfm

Questions on FTCA?

Contract Health Service (CHS) and Catastrophic funding

- For healthcare services that are not available as direct care

- Total California Area CHS funding is $41 million (not including CHEF), which is about $500 per active user, so very limited

42 CFR 136.23 (e)

- *Priorities for contract health services.* When funds are insufficient to provide the volume of contract health services indicated as needed by the population residing in a contract health service delivery area, priorities for service shall be determined on the basis of relative medical need

Requirement

- Tribes can develop their own medical priorities, but they should:
  - Be consistent with eligibility guidelines
  - Be fair
  - Be justifiable from a medical perspective
- IHS Medical Priorities are available as a guide

IHS Medical Priorities

- Level I- Emergent or acutely urgent care
- Level II- Preventive services
- Level III- Primary and secondary services
- Level IV- Chronic tertiary
- Level V- Excluded services are purely cosmetic or experimental

Level I - Emergent or acutely urgent

Examples:

- Fracture
- Acute congestive heart failure
- Pneumonia
- Suicide attempt
- Obstetrical emergencies
- Stroke
- Kidney stone
- Acute eye illness/trauma
- Rape examination

Level II – Preventive Services

Examples:

- Routine prenatal
- Mammography
- Colonoscopy
- Podiatric services for diabetics
- X-Ray services supporting primary care
- Optometry
- Immunizations
- HIV testing

Level III- Primary and Secondary Care Services

- Non-emergent specialty services
  - Ortho
  - Dermatology
  - Psychiatric
- Elective surgeries (non-acute)
  - Tonsillectomy
  - Ear tube placement
  - Non-acute gall bladder
  - Hernia repair
  - Back surgery
- Other non-emergent
  - Hearing aids
  - Eye glasses
  - Orthotics
  - Prosthetics
  - EEG
  - Palliative radiation

Level IV- Chronic Tertiary

- These are either non-essential, or high cost, or both
- Require close case management

Examples:

- Lithotripsy (kidney stone)
- Joint replacement
- Reconstructive surgery
- Obesity surgery

Level V- Excluded Services

Purely cosmetic:

- Tattoo
- Tattoo removal
- Dermabrasion
- Breast augmentation
- Face lift
- Tummy tuck
- Hair transplant

Experimental/non-established:

- Accupuncture
- Biofeedback
- In-vitro fertilization
- Hair analysis

CHS Committee

- Essential to provide oversight of limited resources
- Membership should include clinical director, nursing director or clinic manager, executive director, or designee, CHS officer
- Should meet on a regular basis (Federal sites require weekly)

CHS Committee (cont'd)

- Family members must recuse self
- Health board should review CHS priorities and policies, but leave CHS funding decisions to CHS Committee

Catastrophic Health Emergency Fund (CHEF)

History

- Initially established in 1987 “solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illness who are within the responsibility of IHS”

- In its present from since 1993

Purpose

- To meet the extraordinary high costs of catastrophic illness
- Catastrophic illness refer to conditions which are costly due to their intensity and or duration
- Examples include cancer, burns, premature births, cardiac disease, end stage renal disease, strokes, organ transplants, trauma and some mental disorders

Basic eligibility requirements

- Patient must be CHS eligible
- Must have “catastrophic illness”
- Rule of thumb… if threat to life or limb
- No alternate resources (Medicare, Medi-cal, VA, Tricare, private insurance)
- Threshold met, FY2011 it was lowered to $19,000 (but still $25,000 because still on FY 2010 budget)

Allowable Services and Costs examples

- Ambulance service
- Emergency department treatment
- Acute inpatient hospitalization
- Attending and consulting physicians

Allowable Services and Costs (cont'd)

- Reconstructive surgery to restore function
- Prosthetic devices
- Rehabilitative treatment up to 30 days after inpatient discharge
- Care in skilled nursing facility (up to allowable Medi-Cal or Medicare guidelines)

Specific guidelines

- Reimbursement only for same “episode of care”
- Inpatient costs (only) incurred in September can carry into new year
- CHEF reimbursement ends 90 days after discharge from first admission
- Readmission after the 90 days can be considered for subsequent CHEF

Specific guidelines (cont'd)

- Cases over $75,000 must include discharge summary and/or medical notes
- Incomplete cases are eligible for reimbursement at 50 percent
- Any efforts made for cost containment should be documented (it can only help case)
- "First come, first serve", not as much of an issue last year due to increase to $48 million

Specific guidelines (cont'd)

- Use of the checklist will assist in developing a refundable case

Questions about CHS or CHEF?