2019 Indian Health Service Partnership Conference

Spokane, Washington

INDIAN HEALTH MANUAL (IHM), PART 2 SERVICES TO INDIANS AND OTHERS

Chapter 3 – Purchased/Referred Care

Terri Schmidt, R.N., Director
Division of Contract Care
Office of Resource Access and Partnerships

PURPOSE & BACKGROUND

Initiated Tribal Consultation on Updating the PRC Chapter at the request of Tribes:

- May 18, 2018 – Initiated Tribal Consultation on Update
- May 18 – August 6, 2018 - Comment Period
- October 16-17, 2018 – Director's Workgroup on PRC reviewed and provided consensus of the proposed changes based on Tribal input and comment
  - IHS conducted:
    - Two All Tribes Conference Calls
    - A call with Director's Workgroup on Improving PRC
    - Four in-person Tribal Consultation sessions
  - IHS received 111 comments
- February 28, 2019 – Updated Indian Health Manual - PRC Chapter signed

SUMMARY OF CHANGES

2-3.1 Introduction

Removed reference to when funds are depleted to another section of the chapter as requested (GAO recommendation) addition of B. Scope.

Page 1

B. Scope. In accordance with 42 C.F.R. 136.3, this chapter contains operating procedures to assist officers and employees in carrying out their responsibilities, and are not regulations establishing program requirements which are binding upon members of the general public.

SUMMARY OF CHANGES

2-3.1 Introduction – E. Acronyms

Additions

Page 1 (10) CMS – Centers for Medicare and Medicaid Services

Page 1 (24) ORAP – Office of Resource Access and Partnerships

Page 1 (32) U.S. – United States

SUMMARY OF CHANGES

2-3.1 Introduction – F. Definitions

Alternate Resources – small wordsmithing changes.

Page 3

(1) Alternate Resources. Alternate resources means health care resources other than those of the Indian Health Service. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e., Medicare, Medicaid), State or local health care programs, and private insurance.

SUMMARY OF CHANGES

2-3.1 Introduction – F. Definitions

Additional language for clarity.

Page 3

(2) Appropriate Ordering Official. Appropriate ordering official means, unless otherwise specified by contract with the health care facility or provider, the ordering official for the purchased/referred care delivery area in which the individual requesting PRC or on whose behalf the services are requested, resides.

SUMMARY OF CHANGES

2-3.1 Introduction – F. Definitions

Additional language and citation for clarity.

Page 5

(16) Medical Referral. A referral for health care services that is not authorized for payment by PRC. A medical referral that becomes authorized for PRC becomes a PRC referral.

Page 5

(18) Purchased/Referred Care Delivery Area. The PRCDA means the geographic area within which PRC services will be made available by the IHS to members of an identified Indian community who reside in the area, subject to the provisions of 42 C.F.R. § 136 Subpart C.

SUMMARY OF CHANGES

2-3.1 Introduction – F. Definitions

Descendent of a Tribal Member – omitted not used in the chapter.

Page 5

(20) Notification of a Claim (see 42 C.F.R. § 136.202). For the purposes of part 136, and also 25 U.SC. § 1621s and 1646, the submission of a claim that meets the requirements of 42 C.F.R. § 136.24. Medical Referral. A referral for health care services that is not authorized for payment by PRC. A medical referral that becomes authorized for PRC becomes a PRC referral.

a. Such claims must be submitted within the applicable time frame specified by 42 C.F.R. § 136.24, or if applicable, 25 U.S.C. § 1646, and include information necessary to determine the relative medical need for the services and the individual's eligibility.

SUMMARY OF CHANGES

2-3.1 Introduction – F. Definitions – Cont.

Descendent of a Tribal Member – omitted not used in the chapter.

Cont. Page 6

b. The information submitted with the claim must be sufficient to:

(i) Identify the patient as eligible for IHS services (e.g., name, address, home or referring service unit, Tribal affiliation),

(ii) Identify the medical care provided (e.g., the date(s) of service, description of services), and

(iii) Verify prior authorization by the IHS for services provided (e.g., IHS purchase order number or medical referral form) or exemption from prior authorization (e.g., copies of pertinent clinical information for emergency care that was not prior-authorized).

SUMMARY OF CHANGES

2-3.1 Introduction – F. Definitions

Reservation added the phrase, including former reservations in Oklahoma, which was mistakenly left out of the revised chapter.

Page 6

(23) Reservation. Any Federally-recognized Indian Tribe's reservation, pueblo, colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq), and Indian allotments.

SUMMARY OF CHANGES

2-3.1 Introduction – F. Definitions

Tribal Health Program – Replaced Tribally-Operated Program and added language for clarity.

Page 7

(27) Tribal Health Program. The term "tribal health program" means an Indian Tribe or Tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the ISDEAA (25 U.S.C. § 5301 *et seq*).

SUMMARY OF CHANGES

2-3.1 Introduction – F. Definitions

Tribal Organization – added definition as requested by consultation.

Page 7

(29) Tribal Organization. Tribal Organization means the recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided, that in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian Tribe, the approval of each such Indian Tribe shall be a prerequisite to the letting or making of such contract or grant.

SUMMARY OF CHANGES

2-3.3 Purchased/Referred Care Delivery Areas – A. PRDCA

Addition

Page 10

A. Purchased/Referred Care Delivery Area (PRCDA). Currently the IHS provides services under regulations in effect on September 15, 1987 republished at 42 CFR Part 136, Subparts A-C, and may be changed only in accordance with the Administrative Procedures Act (5 U.S.C. 553). IHS personnel should understand and be able to explain that residence within a PRCDA by a person who is within the scope of the Indian health program, as set forth in 42 CFR 136.12 creates no legal entitlement to PRC but only potential eligibility for services.

SUMMARY OF CHANGES

2-3.3 Purchased/Referred Care Delivery Areas – A. PRDCA

Established PRCDAs – omitted the link to the web site as requested.

Page 10

C. Established Purchased/Referred Care Delivery Areas. Established PRCDA are listed in the Federal Register (FR) Notices. The current PRCDA Federal Register Notice can be found on the IHS PRC Web site. Deleted Link

SUMMARY OF CHANGES

2-3.4 Redesignation of A PRCDA – A. Re-designation Request

Requirements – (1) added citations for consultation.

Page 11

(1) The Area PRC Officer will analyze the request and will recommend acceptance or rejection of the request to the Area Director. For tribally-managed programs, analysis will be coordinated with the Area Tribal Project Officer for contracted programs or Self-Governance Coordinator for compacted programs. The Area is required to consult in accordance with 42 C.F.R. § 136.23(b).

SUMMARY OF CHANGES

2-3.5 Persons to Whom PRC Will be Provided – C. Insufficient Funds

(1) and (2) changed the format as requested – GAO recommendation.

Page 14

C. Insufficient Funds. When funds are insufficient to provide the volume of PRC services indicated as needed by the population residing in a PRCDA, priorities for service shall be determined on the basis of relative medical need.

(1) Manual Exhibit 2-3-B demonstrates the process for determining the disposition for a patient being considered for PRC funding.

(2) In the event that all PRC funds are depleted, referrals will be denied PRC payment or deferred. Medical referrals will still be made based on services needed by the patient. However, no payment or promise of payment can be made when there are no funds available. The Service Unit CEO will notify the Area Director when PRC funds are insufficient or depleted.

SUMMARY OF CHANGES

2-3.5 Persons to Whom PRC Will be Provided – D. Services

Removed the link to the Medical Priorities and provided a Manual Exhibit.

Page 14

C. Services. Any expenditure of PRC funds is limited to services that are medically indicated. See the Medical Priority list for services that may be included and those specifically excluded. The listing for PRC Medical Priorities can be found in Manual Exhibit 2-3-B. The listing for PRC Dental Levels of Care can be found in Manual Exhibit 2-3-C.

SUMMARY OF CHANGES

2-3.6 Eligibility Requirements – A. Documentation & B. Eligibility

Documentation Added Manual Exhibit 2-3-E.

B. Eligibility – added a citation and removed – must be eligible for direct care

Page 16

A. Documentation. An AI/AN claiming eligibility for PRC has the responsibility to furnish the CEO with verifiable documentation to substantiate the claim. Each facility should establish a policy on documentation.

Page 16 & 17

B. Eligibility. Eligibility for PRC is governed by 42 CFR 136.23. The PRC program is not an entitlement program and thus, when funds are insufficient to provide the volume of PRC needed, services shall be determined on the basis of relative medical need in accordance with established medical priorities [42CFR 136.23(e)]. To be eligible for PRC, an individual must be eligible for direct care as defined in 42 C.F.R. § 136.12 and either:

SUMMARY OF CHANGES

2-3.6 Eligibility Requirements – D. Full-time Student

Added language for clarity.

Page 17

(1) Full time student programs such as high school (except for BIE Boarding Schools), college (undergraduate and graduate) vocational, technical, or other academic education, during their attendance and normal school breaks. The service unit where the student was eligible for PRC prior to leaving for school is responsible for the student. These students remain eligible after the completion of the courses of study up to 180 days. After 180 days has elapsed the student is no longer eligible for PRC.

Page 18

(2) At all BIE Boarding Schools, PRC is provided for students during their full-time attendance, by the Area where the boarding school is located. Included are BIA off-reservation schools such as:

SUMMARY OF CHANGES

2-3.6 Eligibility Requirements – F. Persons in Custody

Persons in Custody – added language and citations for clarity.

Page 18

F. Persons in Custody. The cost of medical and related health services for eligible beneficiaries in custody of non-Indian law enforcement agencies is not the responsibility of the IHS, but is the responsibility of that particular agency. Persons in the custody of Bureau of Indian Affairs or tribal law enforcement agencies, including custodial services provided through contract, shall be eligible for services provided through the IHS, on the same basis, and for the same level of care, as other beneficiaries. IHS does not provide the same health services in each area served and services provided will depend upon the facilities and services available (42 C.F.R. § 136.11(c)).

SUMMARY OF CHANGES

2-3.7 Purchased/Referred Care Medical Priorities

Removed the link and added Manual Exhibit for Medical Priorities.

Page 21

Regulations, 42 C.F.R. § 136.23(e), permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of PRC indicated as needed by the population residing in a PRCDA. The IHS medical and dental priorities health priorities are found Manual Exhibits 2-3-B and 2-3-C.

SUMMARY OF CHANGES

2-3.8 Payor of Last Resort Requirements – A. Payor of Last Resort

Removed the reference to charity programs.

Page 22

(3) The AI/AN would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for PRC or other health services, from the IHS or IHS programs.

SUMMARY OF CHANGES

2-3.8 Payor of Last Resort Requirements – D. Failure to Follow Alternate Resource Procedures

Failure to follow alternate resources – changed from 10 to 30 days as requested.

Page 23

(1) When the patient willfully or intentionally fails to apply or fails to complete an alternate resource application. The facility staff will provide written notice to patients that if an alternate resource application is not completed, or if the patient does not contact the facility staff for assistance in completing the application within 30 days after the receipt of the notice, a PRC denial letter will be issued. If an alternate resource program issues a denial because the applicant failed to apply or failed to complete the application and the PRC file is well documented with attempts to assist the applicant, the PRC office should issue a PRC denial to the patient and a copy should be forwarded to the provider.

SUMMARY OF CHANGES

2-3.8 Payor of Last Resort Requirements – G. Alternate Resources

Added, must be used before PRC and added language for clarity added statement that - IHS considers insurance purchased under 25 U.S.C. § 1642 to be an alternate resource under the payor of last resort rule.

Page 24 & 25

G. Alternate Resources. All IHS or Tribal facilities that are available and accessible to an individual must be used before PRC. IHS considers the list of alternate resources included in 42 C.F.R. § 136.61(c) to be exemplary and not exhaustive, other alternate resources to pay for private sector services would include, but not be limited to, Veterans programs, Vocational Rehabilitation, Children's Rehabilitative Services, Local or Private Insurance, State Programs and Crime Victims Act. See 42 C.F.R. § 136.61(c). IHS considers insurance purchased under 25 U.S.C. § 1642 to be an alternate resource under the payor of last resort rule. A charity or indigent care program offered by a provider of services is not considered an alternate resource if the provider of services is absorbing the full cost of the care, but the charity or indigent care program will be considered an alternate resource if it receives reimbursement for the costs of providing such care from state resources or other institutions.

SUMMARY OF CHANGES

2-3.8 Payor of Last Resort Requirements – G. Alternate Resources - Cont.

Added, must be used before PRC and added language for clarity added statement that - IHS considers insurance purchased under 25 U.S.C. § 1642 to be an alternate resource under the payor of last resort rule.

Cont. Page 25

G. Alternate Resources – Cont.

Individuals who receive funding to purchase health care coverage shall be required to use such funds for health care purposes and such coverage shall be considered an alternate resource.

SUMMARY OF CHANGES

2-3.8 Payor of Last Resort Requirements – H. Exception to the IHS Payor of Last Resort Rule – Tribal Self-Insurance

Added, Exception to the IHS Payor of Last Resort Rule – Tribal Self-Insurance with language requirements as a new section under the topic (1) and (2).

Page 25

H. Exception to the IHS Payor of Last Resort – Tribal Self-Insurance Plans. For purposes of IHS administered PRC programs, the Agency will not consider tribally-funded self-insured health plans to be alternate resources for purposes of the IHS' Payor of Last Resort Rule. IHS will assume that a Tribe does not wish for its self-insured plan to be an alternate resource for purposes of PRC and IHS will treat the plan accordingly, once IHS receives documentation to show that the plan is tribal self-insurance. IHS will only treat the Tribe's plan as an alternate resource for purposes of PRC if either of the following occurs:

SUMMARY OF CHANGES

2-3.8 Payor of Last Resort Requirements – H. Exception to the IHS Payor of Last Resort Rule – Tribal Self-Insurance – Cont.

Added, Exception to the IHS Payor of Last Resort Rule – Tribal Self-Insurance with language requirements as a new section under the topic (1) and (2).

Cont. Page 25

(1) IHS has not received documentation to show that the plan is tribal self-insurance, or

(2) IHS receives a tribal resolution from the Tribe's governing body, which clearly states that the Tribe would like IHS to treat the self-insured plan as an alternate resource for purposes of PRC.

SUMMARY OF CHANGES

2-3.8 Payor of Last Resort Requirements – H. Exception to the IHS Payor of Last Resort Rule – Tribal Self-Insurance – Cont.

Added, Exception to the IHS Payor of Last Resort Rule – Tribal Self-Insurance with language requirements as a new section under the topic (1) and (2).

Cont. Page 25

REMINDER: This process applies to IHS operated PRC programs. Tribes and Tribal organizations operating PRC programs may choose to follow this coordination process, or they may adopt a different process for addressing this issue.

To the extent any Tribal self-insurance plan has reinsurance or stop loss insurance from which claims are paid by entities other than the Tribe or Tribal organizations, such reinsurance or stop loss insurance shall not be considered Tribal self-insurance; provided that the fact that a Tribal self-insurance plan has reinsurance or stop loss insurance does not mean that the Tribal self-insurance shall be considered an alternate resource.

SUMMARY OF CHANGES

2-3.8 Payor of Last Resort Requirements – J. Medicaid Coordination

Added Medicaid Coordination as a separate section under the topic.

Page 27

J. Medicaid Coordination. AI/ANs with Medicaid who have ever received a service (e.g., a primary care, dental, behavioral health visit etc.) from the Indian Health Service, tribal health programs, or through a PRC referral are exempt from cost-sharing which includes copayments or coinsurance for Medicaid services. Therefore, there is no cost to the PRC program for Medicaid services provided. AI/ANs can self-attest that they have ever received services from IHS or a tribal health program.

SUMMARY OF CHANGES

2-3.8 Payor of Last Resort Requirements – K. Coordination of Other Benefits (Non-Medicaid)

Added Coordination of Other Benefits (Non-Medicaid) as a separate section under the topic.

Page 27

J. Coordination of Other Benefits (Non-Medicaid). When an alternate resource is identified that will require the IHS to pay a portion of the medical care costs, IHS will obligate the funds for the estimated balance, after alternate resource payment, with corresponding distribution of the form. In these situations, the obligating document, must clearly indicate that payment will not be processed and disbursed unless and until the provider has billed and received payment from the alternate resource. An explanation of benefits (EOB) or, in cases of denial from the alternate resource, a copy of the denial notice for the record.

SUMMARY OF CHANGES

2-3.9 Authorization for Purchased/Referred Care – C. Payments

PRC rates for services provided by Medicare participating hospitals – In the event a hospital is balance billing patients after PRC payment – omitted (iii), (iv) and (v) as requested.

Page 29

(1) PRC Rates for services furnished by Medicare-Participating Hospitals - 42 CFR 136 Subpart D Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), requires hospitals and critical access hospitals to participate in PRC programs. Section 506 directed the Secretary to set forth a payment methodology, payment rates, and admission practices through regulation for the PRC services provided by Medicare-participating hospitals. Any payments made under the PRC program are considered payment in full and the patients must not be billed for any remaining balance. See 42 CFR 482.29, 42 CFR 136.30 and also 25 U.S.C. 1621u.

SUMMARY OF CHANGES

2-3.9 Authorization for Purchased/Referred Care – C. Payments - Cont.

PRC rates for services provided by Medicare participating hospitals – In the event a hospital is balance billing patients after PRC payment – omitted (iii), (iv) and (v) as requested.

Cont. Page 29

a. In the event a hospital is balance billing patients after PRC payment.

(i) Notify the hospital of the law, if the hospital refuses to comply.

(ii) Notify the Area PRC Officer who will notify the Regional CMS Native American Contact (NAC).

SUMMARY OF CHANGES

2-3.10 Electronic Signatures – A. Electronic Signature for PRC Purchase Order

Electronic Signatures - Corrected the name of Pub. L. 106-229.

Page 32

A. Electronic Signature for PRC Purchase Order. Pub. L. 106-229 (Electronic Signatures in Global and National Commerce Act) provides for the use of electronic signatures. The electronic signature promotes the use of electronic contract formation, signatures, and record keeping in private commerce by establishing legal equivalence between:

SUMMARY OF CHANGES

2-3.11 Payment Denials and Appeals – E. Tribal Appeal Process – Title I and V

Tribal Appeal Process – Title I and V Programs – (1) added, IHS will use Tribal Medical Priorities if provided.

Page 34

(1) The Area Director and the Director, IHS, will follow the IHS regulations and interpretations to adjudicate claims but will adopt tribal standards for close economic and social ties, medical priority and high cost case management, as applicable.

SUMMARY OF CHANGES

2-3.12 Management of Purchased/Referred Care Fund – B. Use of PRC Funds for Staff Administering the PRC Program

This was an addition to the Chapter to meet a GAO recommendation.

Page 34

B. Use of PRC Funds for Staff Administering the PRC Program. PRC funds may be used for staff administrating the PRC program at administrative levels, including for the support of HQ and Area positions. PRC funds may be used for staff at the service unit level PRC programs as long as the following conditions are met:

SUMMARY OF CHANGES

2-3.12 Management of Purchased/Referred Care Fund – B. Use of PRC Funds for Staff Administering the PRC Program

This was an addition to the Chapter to meet a GAO recommendation.

Page 37

(1) The PRC program is purchasing care beyond Medical Priority II and using funds for PRC staff does not preclude payment for Priority II throughout the year; and

Page 38

(2) The PRC program reports the following information to the Area Director annually: the medical priority level the program is purchasing; the number, grade level and salary of full or part time employees supported by PRC funds; and the number of any denied and deferred services for Priority II care; and

(3) The Area Director reports by October 10, annually to the Director, DCC, ORAP, for each Area Service Unit, the following information: medical priority level each program is purchasing; the number, grade level and salary of full or part time employees supported by PRC funds; and the number of denied and deferred services for Priority II care.

SUMMARY OF CHANGES

2-3.21 Prompt Action on Payment of Claims Also Known As The PRC "Five-Day Rule"

Omitted Notification of a Claim as requested as it was duplicated information already provided earlier in the chapter

SUMMARY OF CHANGES

2-3.21 Prompt Action on Payment of Claims Also Known As The PRC "Five-Day Rule" – B. Failure to Timely Respond

Failure to Timely Respond – added language for clarity.

Page 45

B. Failure to Timely Respond. If IHS fails to respond to a notification of a claim that contains the information required by 42 C.F.R. § 136.24, IHS shall accept the claim as a valid claim for PRC services. The Notification of a Claim must include sufficient information so that IHS may make a decision about a claim. IHS will not adjudicate a Notification of a Claim that does not contain the information from the individual, or as applicable, the provider or supplier, necessary to make a decision.

QUESTIONS?

CONTACT INFORMATION

Terri Schmidt

Director, Division of Contract Care

Office of Resource Access and Partnerships

E-mail: Terri.Schmidt@ihs.gov

QUESTIONS?