Indian Health Service

Direct Care vs. Purchased/ Referred Care Eligibility and Resources

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How did we get here:

Snyder Act

Provides authority for the expenditure of such funds as Congress may appropriate for the benefit, care and assistance to Indians throughout the United States. Originally utilized by the Bureau of Indian Affairs at the Department of the Interior. At the date of enactment health care services were provided through this agency until 1955. This Act was never superseded, authority only transferred and expanded.

Indian Health Care Improvement Act - Public Law 94-437

The act 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 such programs. This Act expanded the Snyder Act authority. The Act became known as the “437” Act.

Transfer Act

Authorized the transfer of maintenance and operation of hospital and health facilities for Indians to the Public Health Service. This Transfer Act also encompassed all services related to the delivery of health care to Indian people. This was the beginning of specific directives on how such health care services were to be provided. i.e., through the construction of facilities.

Indian Health Facilities Act

Authorized funding for the construction of Indian health facilities to be used to assist in the construction of non-Federal community hospitals which service Indian and non-Indian patients. Such funding required consent of tribe. (https://www.ihs.gov/aboutihs/legislation/)

How did we get here continued:

Indian Sanitation Facilities Act of July 31, 1959 (Public Law 86-121)

This Act expanded both the Snyder Act and the Transfer Act to include, as part of the health care services to be provided to Indians, the provision of sanitation facilities and services. The Act includes authority to construct facilities and acquire land for sanitation purposes.

Self Determination Act

Congress recognized the importance of tribal decision-making in tribal affairs and the primacy of the nation-to-nation relationship between the United States and Tribes through the passage of the Indian Self-Determination and Education Assistance Act (ISDEAA) (Public Law 93-638) in 1975. Subsequent amendments to the ISDEAA strengthened the federal policies supporting tribal self-determination and self-governance. In 1992, Congress amended the ISDEAA to authorize a Tribal Self-Governance Demonstration Project within the IHS, giving federally-recognized Tribes the option of entering into self-governance compacts to gain more autonomy in the management and delivery of their health care programs. By 2000, Congress permanently authorized the IHS Tribal Self-Governance Program by creating Title V of the ISDEAA through Public Law 106-260.

The Indian Self-Determination and Education Assistance Act (ISDEAA), also known as Public Law 93-638, authorizes Indian Tribes and Tribal Organizations to contract for the administration and operation of certain Federal programs which provide services to Indian Tribes and their members. Under the ISDEAA, Tribes and Tribal Organizations have the option to either (1) administer programs and services the IHS would otherwise provide (referred to as Title I Self-Determination Contracting) or (2) assume control over health care programs and services that the IHS would otherwise provide (referred to as Title V Self-Governance Compacting or the TSGP).

Where do we begin – Direct Care Eligibility Determination

According to the Indian Health Manual Chapter 1 (Eligibility for Services), Part 2: 2-1.2 **PERSONS ELIGIBLE FOR IHS HEALTH CARE SERVICES**. A person may be regarded as eligible and within the scope of the IHS health care program if he or she is not-otherwise excluded by provision of law, and is:

American Indian and/or Alaska Native. American Indian and/or Alaska Native (AI/AN) descent and belongs to the Indian community served by the IHS program, as evidenced by such factors as:

- Membership, enrolled or otherwise, in an AI/AN Federally-recognized Tribe or Group under Federal supervision.
- Resides on tax-exempt land or owns restricted property.
- Actively participates in tribal affairs.
- Any other reasonable factor indicative of Indian descent.
- In case of doubt that an individual applying for care is within the scope of the program, as established in 42 C.F.R. § 136.12(b), and the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.

Dear Tribal Leader Letter from Dr. Trujillo dated January 10, 2000.

. . . the IHS is required to maintain services to Indian people based on the guidelines found in the current eligibility criteria at 42 Code of Federal Regulations (CFR),subparts A-G (1986). This regulation requires the IHS to serve all persons of Indian descent, regardless of tribal affiliation, who belong to the local Indian community. Therefore, we provide services to any persons of Indian descent who seek treatment at an IHS facility. We do not require a finding that they "belong to" the local Indian community. The eligibility regulation does not require a particular degree of Indian ancestry and does not define the term "Indian community".

Establishing Native American Descent through Ancestry

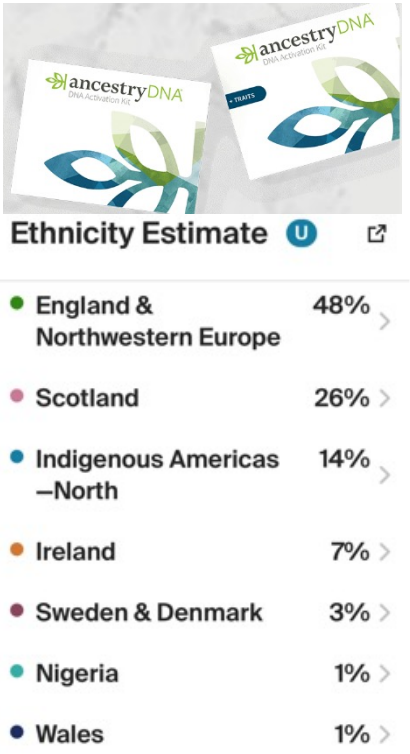
When establishing descent from an Indian tribe for membership and enrollment purposes, the individual must provide genealogical documentation.

The documentation must prove that the individual lineally descends from an ancestor who was a member of the federally recognized tribe from which the individual claims descent.

A DNA test **DOES NOT** provide this, it gives you a starting point.

To determine if you are eligible for membership in a federally recognized tribe - contact the tribe, or tribes, you claim ancestry from.

It is the individual tribes who set tribal enrollment requirements.



Purchased/Referred Care (PRC) Eligibility Determination

According to the Indian Health Manual Chapter 3 (Purchased/Referred Care), Part 2: 2-3.6 **ELIGIBITLY REQUIRMENTS**. A person may be regarded as eligible and within the scope of the IHS health care program if he or she is not-otherwise excluded by provision of law, and is:

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.

Eligibility. Eligibility for PRC is governed by 42 C.F.R. § 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 [42 C.F.R. § 136.23(e)]. To be eligible for PRC, individuals must be eligible for direct care as defined in 42 C.F.R. § 136.12 and either:

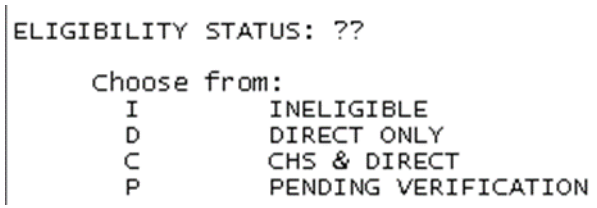
- reside within the U.S. on a Federally recognized Indian reservation; or
- reside within a PRCDA and;
  - are members of the Tribe or Tribes located on that reservation; or
  - maintain close economic and social ties with that Tribe or Tribes.

https://www.ihs.gov/ihm/pc/part-2/chapter-3-purchased-referred-care/#2-3.6

In terms of PRC eligibility for eligible descendants:

“Indian descendants living on the reservation are eligible for PRC if they meet all the other PRC requirements. Indian descendants residing off the reservation may be eligible if they meet certain conditions. Pursuant to 42 C.F.R. 136.23 (a)(2)(i) and (ii), if not residing on the reservation such individuals must live within the PRCDA and (1) be members of the tribe(s) located on the associated reservation or (2) "maintain close economic and social ties with that tribe or tribes."”

Knowing the eligibility status:



Ineligible – Not eligible for services, except in a limited capacity. [i.e. Services will be made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child, but only during the period of her pregnancy through postpartum (generally about six weeks after delivery, unless the provider determines there are pregnancy induced health care problems that do not resolve by six weeks.]

Direct only - health services provided at any Tribal/Federal facility.

CHS (PRC) / Direct – medical/dental care provided away from a Tribal/Federal facility. PRC is not an entitlement program and an IHS referral does not imply the care will be paid. If IHS is requested to pay, then a patient must meet the residency requirements, notification requirements, medical priority, and use of alternate resources.

Pending Verification – Pending status waiting on the necessary documentation required to complete eligibility. Allotted 30 days (upon initial request for services) at which time their individual status will be changed to "Ineligible". This could vary depending on local policy.

https://www.ihs.gov/ihm/pc/part-2/p2c6/#2-6.4A

Gate Keepers: Patient Registration

Instrumental for giving a first impression for the organization.

Complete and accurate patient registration is crucial to a medical practice's bottom line.

Because circumstances and policies change often, staff should confirm and update patient demographics and insurance information at each visit.

Rather than rely on "yes" or "no" answers from the patient, ask open-ended questions that require a full response, and therefore ensure you're getting the most up-to-date information

Accurate registration helps keep patient data complete and clean as it moves throughout the organization; includes PRC.

PRC relies on what is updated in registration which populates to the purchase orders and denials.

Patient Registration lays the foundation for successfully generating revenue.

A few functions/responsibilities of Patient Registration are:

- Promotes a Positive facility image for the entire patient visit;
- Interviews patients to obtain demographic and eligibility information;
- Responsible for verifying eligibility information from various resources, including payer portals;
- Gathers required signatures and documents from the patient in a timely manner;
- Updates within the RPMS system, or BPRM application, all information regarding the patient;
- Often responsible for obtaining prior-authorizations (pre-certification, pre-determination, pre-approval) for certain procedures, and documenting information appropriately;
- Refers patients to Benefits Coordinator when no evidence of insurance is provided;
- “Check In” process establishes the visit in the Electronic Health Record (EHR). This also establishes the “Account”; Identifies Coordination of Benefits (COB);
- Sequences insurance appropriately;
- 50% of claim information comes from data input by the Patient Registration Staff. Data integrity is key to efficient revenue return; and,
- Collects information for reporting on quality measures.

Patient Registration continued

Through the Registration function, the patient's visit record is created, updated, and maintained, ensuring data integrity for required reporting, billing and compliance purposes.

Incomplete and/or inaccurate collection of information from the patient will adversely affect other departments by delaying various processes and creating more manual interventions (re-works) by the Business Office (BO), Health Information Management (HIM), and Purchased Referred Care (PRC).

https://www.ihs.gov/sites/businessoffice/themes/responsive2017/display_objects/documents/ROM_Part2.pdf

Segregation of Duties

The Indian Health Service (IHS) is responsible for securing information that it collects, records, transmits, and uses in the performance of its mission. Since this information includes Agency-sensitive information, such as personnel and financial records as well as individually identifiable health information, it is necessary to establish the conditions and rules under which the IHS electronic systems and networks will operate to ensure the confidentiality, integrity, and availability of the information.

Best practice for analyzing segregation of duties needs an internal control process for employee access to financial information, patient demographics, familial health records, any material maintained within the health information system.

Familial Definition: father, mother, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half-brother, half-sister.

Anyone who has direct relationships outside of work could meet this definition.

Impacts and effects - samples

DIRECT CARE

No update means loss revenue

No prescreen results in possible loss in revenue

No update of current/accurate information causes loss of revenue and rework or delays in billing

No prior authorization impacts revenue

No record of what transpired or completed results in inaccurate information; no trail of occurrence for others to verify current status of demographic and 3rd party.

PRC – PURCHASED/REFERRED CARE

No update of 3rd party information – PRC makes incorrect eligibility decisions.

No prescreen – PRC pays unnecessary costs.

No update of current/accurate information means PRC issues an unnecessary POs and Denials

When alternate resource not updated, creates delays for PRC providers to bill timely (timely filing).

Claim pends causing delays of processing payment; due to difference of 3rd party information, no term dates or effective dates or change of insurer

Patients referred with Out of Network provider and no prior authorization causes PRC to pay for unnecessary costs.

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DIRECT CARE

No updates or changes to mailing address causes notification of important information to be delayed

No updates to physical location of home results in unnecessary home visits by PHN or CHRs with important information or follow up

No updates to telephone #s result in no patient contact with important patient information by all disciplines

PRC – PURCHASED/REFERRED CARE

Patients in need of transports or durable medical equipment; with no enrollment to an alternate resource means PRC may pay unnecessary costs.

Pended claims at the fiscal intermediary due to alternate resources – alternate resource not updated or changed to reflect current coverage; a lot of rework for PRC to re-verify.

No updates to addresses results in returned mail (hundreds) PRC trying to make contact with denial notice which has an appeal timeline

Physical location of home not updated may results in inaccurate PRC decision, which is an eligibility factor for PRC – Residency.

Community of residence may have changed which affects a facility user population count. May mean you lose out on PRC funds. PRC funds is distributed based on user pop.

Educate Yourselves and Others

Wider prospective of the mission and goals.

What is your role and responsibility? How can you make a difference?

Why it is important to have patients provide the information?

Be a “Champ” at interviewing and gather all information which must be updated.

Learn as much about other programs within your facilities to answer questions appropriately or to direct patients to correct departments/individuals. Especially PRC regulations/eligibility, guidance and protocols.

Frequently Asked Questions:

1. QUESTION: Are Indian descendants eligible for PRC if they reside on a reservation?

Answer: Yes. See 42 C.F.R. 136.23 and 136.12

2. QUESTION: Why are Indian descendants not eligible for PRC off the reservation?

Answer: Indian descendants residing off the reservation may be eligible if they meet certain conditions. Pursuant to 42 C.F.R. 136.23 (a)(2)(i) and (ii), if not residing on the reservation such individuals must live within the PRCDA and (1) be members of the tribe(s) located on the associated reservation or (2) "maintain close economic and social ties with that tribe or tribes."

Also see 42 C.F.R.136.23(b) related to students and transients, and 42 C.F.R.136.23(d) for foster children placed off the reservation.

Frequently Asked Questions:

3. QUESTION: If 136.12 is mentioned in 136.23, does this mean Indians eligible for direct care are also automatically eligible for PRC?

Answer: No. In order to receive PRC, Indian beneficiaries must also meet the PRC eligibility requirements of 42 C.F.R. 136.23, 136.24 and 136.61.

4. QUESTION: Why do I have to apply for Alternate Resources?

Answer: This is required by 42 C.F.R. 136.61, Payor of last resort. Approval of PRC payment for services is considered after all other Alternate Resources (AR) are applied. Any patient who is potentially eligible is required to apply for the alternate resource.

Frequently Asked Questions:

5. QUESTION: 42 C.F.R. 136.12 states "to persons of Indian descent belonging to the Indian community served by the local facilities and program.", and "an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.", why do we have to provide direct care services to Indians that do not belong to the community?

Answer: The IHS adheres to an "Open Door" policy in which all Indian descendants are provided direct health care. See Dear Tribal Leader Letter from Dr. Trujillo dated January 10, 2000.

CFR Title 42, Section 136.21 – 136.25, Part 2, Chapter 3 Subpart C of the Indian Health Manual

1. Indian Decent: 42 CFR 136.23 – you must show proof of being an enrolled member or descendent of an enrolled member of a federally recognized tribe,

2. Residency: 42 CFR 136.23 – permanent residence on a reservation or you must have permanent residence in a CHSDA and as a member of that tribe; if you are not a member of that tribe – you must have close social and economic ties to that tribe or have certification of eligibility by that tribe. If you have been away from your CHSDA/reservation for more than 180 days, you are no longer eligible. Exception is students, transients, children placed by the tribe or through court orders outside of their CHSDA.

3. Medical Priority: 42 CFR 136.23 (e) – "Not all services are covered" referrals from the Indian Health Services for further care will be in accordance with established National PRC Medical Priorities and/or Area specific Medical Priorities. Occasionally, IHS providers refer cases outside of IHS facilities that are not necessarily covered, such as cosmetic plastic/reconstructive surgeries, orthodontics, bridges/crown, root canals, durable medical equipment, etc.

4. Notification/Prior Authorization: 42 CFR 136.24 – *Emergency care*, the patient or someone on behalf of the patient MUST notify an IHS facility within 72 hours of admission and/or outpatient services. *Non-Emergency,* you must obtain prior authorization prior to getting medical care. If you have a *follow up care* to the initial referral, you MUST go back to your primary care provider at the IHS to see whether you need to go back to the private hospital/physicians for care or IHS may take care of this in-house. Exception is 30 day notification for disabled and elderly.

ALTERNATE RESOURCES: 42 CFR 136.23 (f) states that IHS will not authorize payment for PRC to the extent that the patient/family **is** eligible for Alternate Resources, **upon application** or **would have been** eligible if they applied or made an effort to apply. There are various categories of alternate resources that a person may apply to and qualify for and depending on the circumstances at hand; such as; Medicare, Medicaid, Private Insurance and others: (**Priority to get everyone screened for Medicaid**)

IHS Facility Available: 42 CFR 136.23(a) IHS facility is considered an alternate resource; therefore PRC funds may not be for services reasonably accessible or available at the I/T/Us. Facility available capable of providing services within 90 minute one way.

- Veteran's Benefits
- Workman's Compensation – if injured on the job, they have to apply through their employer.

Other persons eligible for PRC

- Non-Indian woman pregnant with an eligible Indian's child for duration of pregnancy through postpartum.
- Non-Indian member of an eligible Indian's household for public health hazard.
- Adopted, foster & step children up to 19 years old.

QUESTIONS?


INDIAN HEALTH SERVICE
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