INDIAN HEALTH SERVICE CONTRACT HEALTH SERVICES

OUTREACH PROGRAM

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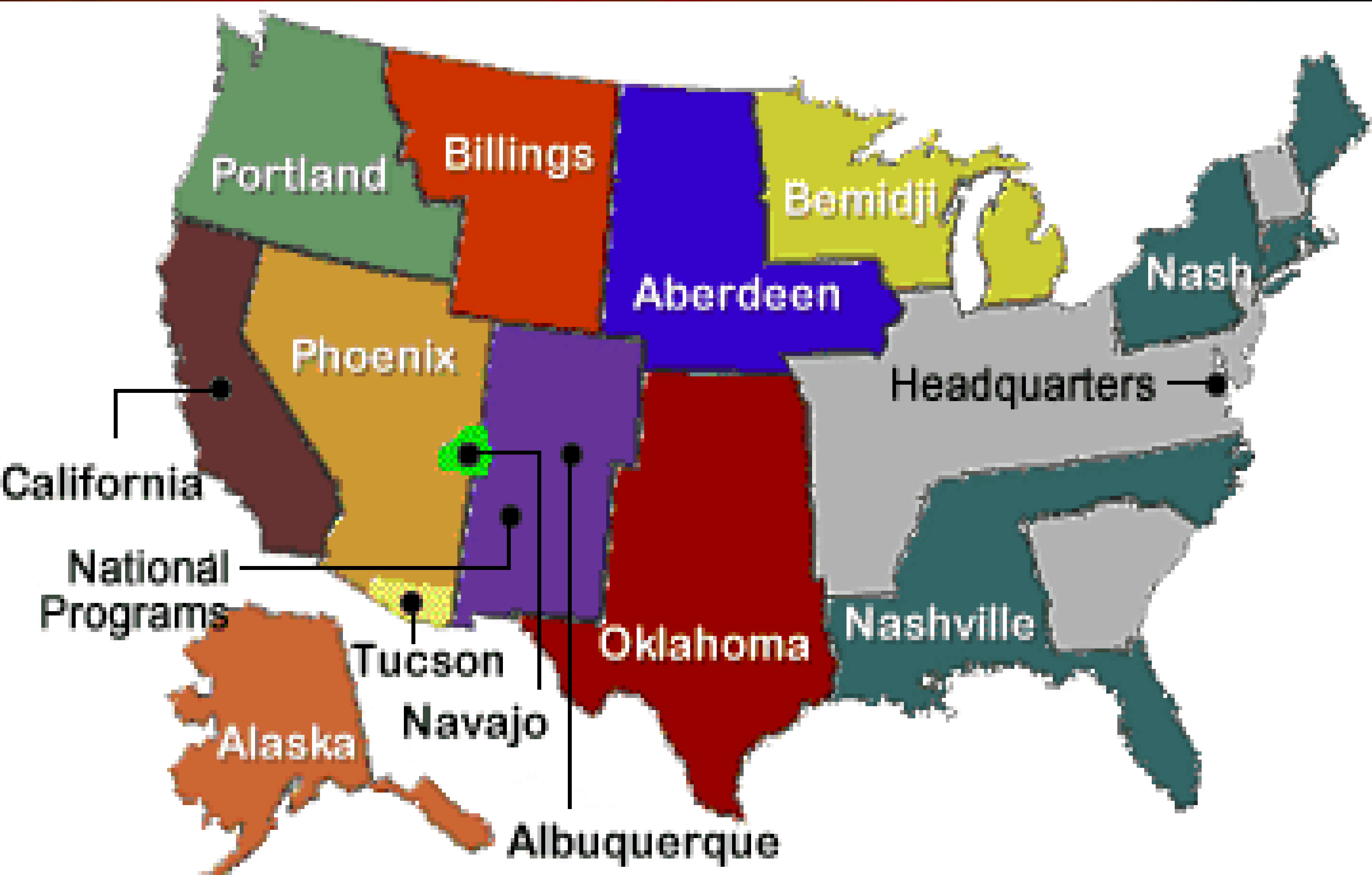
- Welcome
- Introductions
- Indian Health Service
- Contract Health Services

IHS NATIONAL AREAS



CONTRACT HEALTH SERVICES

- CONTRACT HEALTH SERVICES IS:

Health care purchased by the Indian Health Service (IHS) for eligible Indians from non IHS providers and facilities when direct services of appropriate types are not available or accessible.

Required to operate within appropriated funds. There is no authority to provide payment for services under the Contract Health Services (CHS) program unless funds are, **in fact**, available.

CONTRACT HEALTH SERVICES

CHS resources are a finite congressional appropriation.

CONTRACT HEALTH SERVICES ARE NOT

- An Entitlement Program
- An Insurance

USES OF CHS FUNDS

- CHS funds are used to supplement and compliment other health care resources available to eligible Indian people.

The funds are utilized in situations where:

1. No IHS direct care facility exists.
2. The direct care facility is incapable of providing required emergency specialty care.
3. The direct care facility has an overflow of medical care workload.

- CHS is limited to services that are medically indicated within the established medical priorities.
- If services are not authorized for payment they will be denied or deferred.

MEDICAL PRIORITIES

- The application of medical priorities of care is necessary to ensure that the funds provided are used to provide services that are authorized in accordance with IHS policy

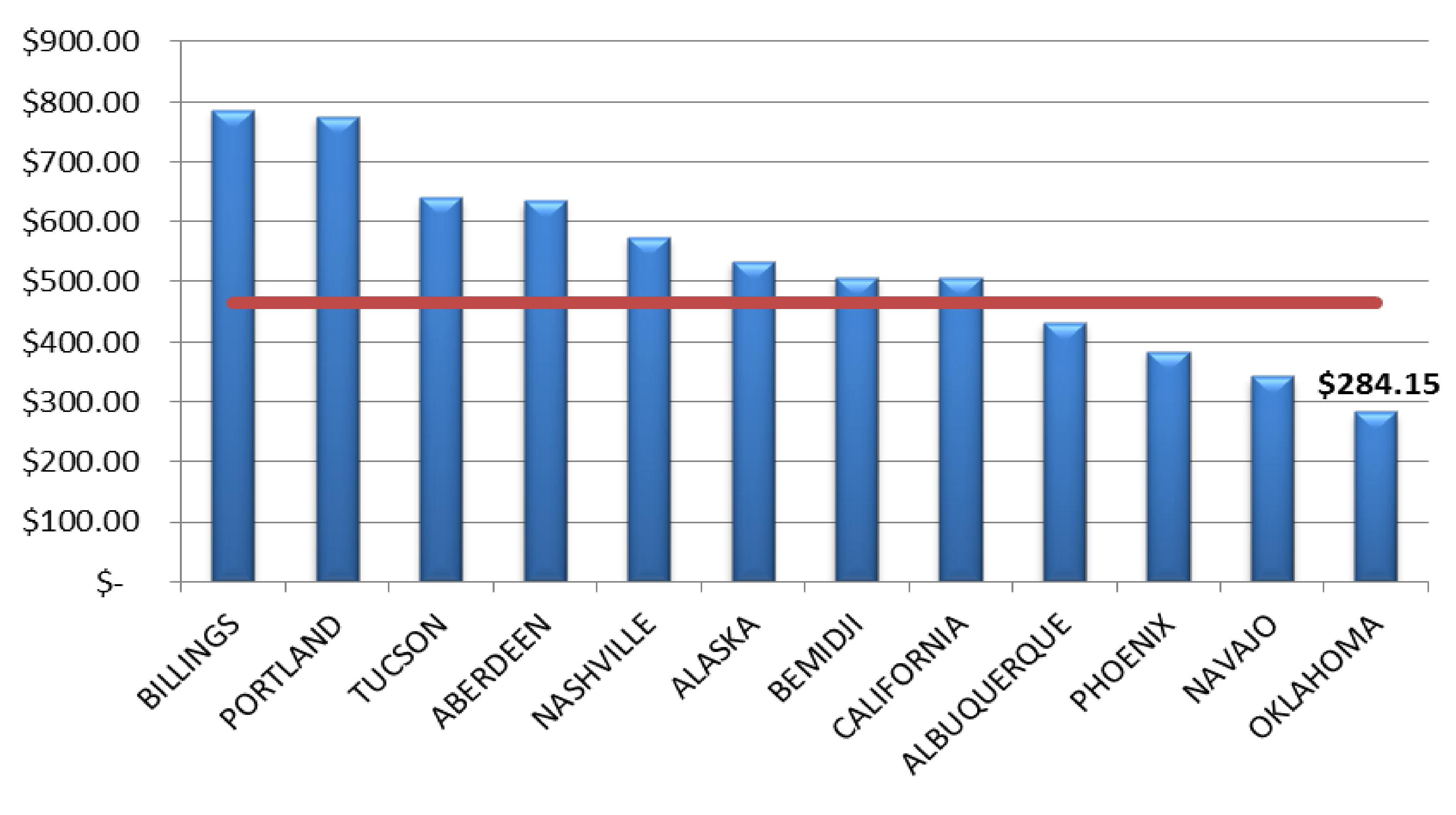
CHS REVIEW COMMITTEE

- CHS review committee reviews all referrals and emergency services (call-in)
  - Requests are reviewed, categorized and ranked in accordance with established medical priorities
- CHS staff obligate funds only to the extent of the resources available by issuing purchase orders (PO).
- The exception to these procedures are urgent referrals that require immediate review and if approved are expedited. The funding for these referrals are deducted from the weekly spending allowance.

FUNDING

- After ranking of requests, CHS staff obligates funds (issue purchase orders) in sequence of the highest to the lowest ranking and only to the extent of funding available for that review period.

- Available funding level for the review period is determined by prorating the service units quarterly funding level into a weekly spending plan.


CHS Funding Per Capita
(FY 2011 Funding and FY 2011 User Population)
By IHS Area
$900.00
$800.00
$700.00
$600.00
$500.00
$400.00
$300.00
$200.00
$100.00
$-
$284.15
BILLINGS
PORTLAND
TUCSON
ABERDEEN
NASHVILLE
ALASKA
BEMIDJI
CALIFORNIA
ALBUQUERQUE
PHOENIX
NAVAJO
OKLAHOMA
Per Capita for by Area
Per Capita for All IHS $464.35

ACCESSING CHS

Referral by IHS, Tribal Physician or Urban Program
Emergency Services (Call-in)

Referral

The patient presents to IHS/Tribal or Urban Facility and a referral is written by an IHS/Tribal/Urban provider for medically indicated care which cannot be provided directly through IHS.

A referral does not authorize payment for medical care delivered, and some CHS medically indicated referrals are not within established or funded medical priorities and cannot be paid by CHS.

If services are approved, patient will be contacted by CHS with appointment information or they may contact their servicing CHS Office to find out the status of their referral.

All non-emergency care must be pre-authorized by CHS before receiving medical treatment in order for CHS to pay.

EMERGENCY SERVICES

- Patient, beneficiary/applicant, or medical provider shall, within 72 hours after beginning treatment, notify CHS and provide information to determine the relative medical need for the services.
- For an elderly or disabled person, this time may be extended to 30 days.
- The following supporting documentation is required (as applicable) and must be submitted prior to review in order to establish relative medical priority. This includes the following documentation:

  Emergency Room Report, History & Physical, Lab/X-ray results, Operative report & Discharge Summary.

FEDERAL APPEAL PROCESS

If services are denied, the patient may file an appeal. The IHS appeals process applies to IHS administered CHS programs, and is a 3 level process:

1. A request for reconsideration of the appeal by the Service Unit CEO.
2. A request for appeal to the Area Director (Oklahoma City Area Office).
3. A final appeal to the Director, IHS (Rockville, Maryland).

TRIBAL APPEALS

Tribes that have assumed their CHS program are required to provide their own administrative appeal procedures and IHS/CHS is not involved.

- If a tribal appeal is submitted to our office, it is forwarded to the appropriate tribal CHS office for processing.
- Our office will provide consultation to tribal CHS programs, as requested.

Questions?

ELIGIBILITY

- 1) Reside on or near a reservation or contract health service delivery area (CHSDA),
- 2) Member of tribe or tribes located on that reservation or CHSDA,
- 3) Maintain close economic and social ties with that tribe or tribes,
- 4) Student or transient who would otherwise be eligible at their permanent residence but who are temporarily absent from their residence,
  - a) students – full time attendance at programs of vocational, technical or academic institutions, including normal school breaks and for a period not to exceed 180 days after the completion of the course of study,
  - b) transients, persons who are in travel or are temporarily employed such as seasonal or migratory workers during their absence, and
- 5) Other persons who leave the CHSDA in which they are eligible and who are neither students or transients shall be eligible for CHS not to exceed 180 days from such departure

ALTERNATE RESOURCES

- Use of alternate resources is mandated by the IHS Payor of Last resort regulation, 42 CFR 136.61
  - Individual is required to apply for alternate resources
  - Refusal to apply, requires the denial of eligibility for CHS
- Medicaid – SoonerCare, Aged/Blind/Disabled Program, Medicare Supplemental Program, Breast & Cervical Cancer Program
- Medicare – Part A, B, C & D; End Stage Renal Disease (ESRD)
- Veteran Affairs (VA)
- Disability – Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).
  - Please also apply for Medicaid Title 19. Applications can be certified back to the date that Social Security Administration establishes the patient to be disabled as long as a Title 19 application was accepted at the same time.
- Insurance – Health, Sports, Liability & Worker's Compensation
- Victims of Crime Compensation Board (IHS is primary payor)

KANSAS CHSDA

Contract Health Services Delivery Areas (CHSDA) & Directory

- Kansas Service Units
  - Haskell
  - Holton
    - Tribal and Federal Programs

Oklahoma City Area Indian Health Service Kansas & Nebraska Contract Health Service Delivery Areas (CHSDAs)

Richardson, NE

Holton Service Unit

Brown

Doniphan

Jackson

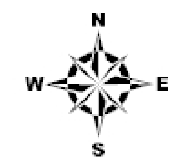
Haskell Service Unit

Douglas

Legend

Haskell Service Unit & CHSDA:
All Federally Recognized Tribes plus full-time Haskell Indian Nations University Students

Holton Service Unit:
CHSDAs within the Service Unit:
Kickapoo Nation CHSDA
Prairie Band Potawatomi Nation CHSDA
White Cloud CHSDA



Oklahoma City Area Indian Health Service
Division of Planning and Partnership Development
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Created by Julie Erb-Alvarez
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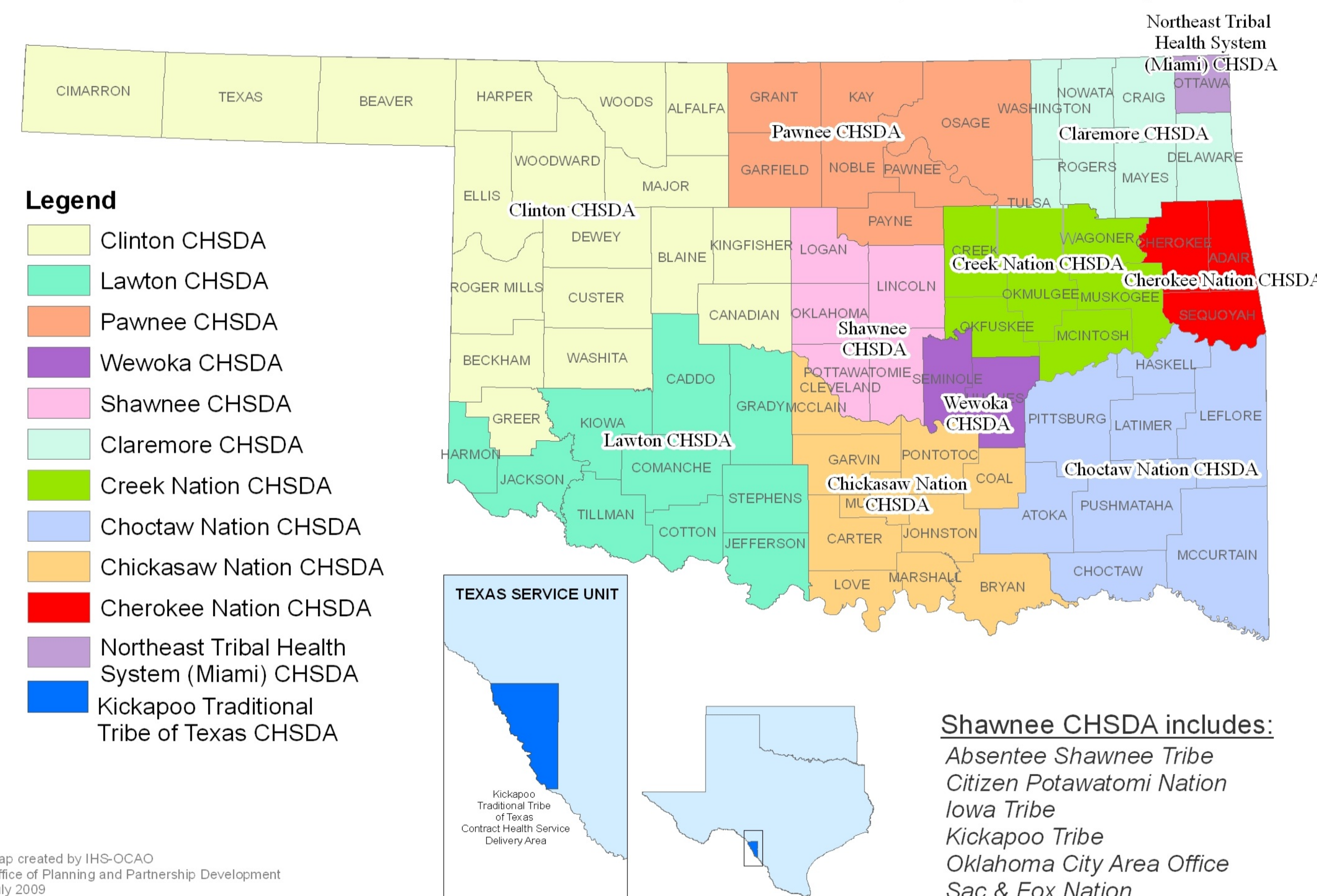
TEXAS CHSDA

Contract Health Services Delivery Area (CHSDA)

- Texas Service Unit – Eagle Pass
  Tribal CHS Program
  Kickapoo Traditional Tribe Of Texas

Nick Gonzales, Director
Eagle Pass, TX 78852
(830) 757-0322 Direct
(830) 757-9228 Fax

Oklahoma and Texas Contract Health Services Delivery Areas (CHSDAs)



OKLAHOMA CHSDA

- Contract Health Services Delivery Areas (CHSDA)
- CHS Directory

Questions?

MEDICARE

IHS has adopted the Medicare list of Hospital Acquired conditions, therefore, regulations preclude CHS from payment of these services. The Hospital Acquired Conditions are completely listed on the Medicare web site: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.

Some examples are:

- Pressure Ulcers
- Pneumonia
- Blood Incompatibility
- Manifestations of Poor Glycemic Control
- Post Surgical Abcess

Global Surgical Package

- The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services.
- The preoperative period included in the global fee for **major** surgery is 1 day.
- The postoperative period for **major** surgery is 90 days.
- The postoperative period for **minor** surgery is either 0 or 10 days depending on the procedure.

Global Surgical Package

The following services **are** included in the payment amount for a global surgery:

- Preoperative Visits
- Intraoperative Services
- Complications Following Surgery (Non surgical)
- Postoperative Visits – within the Global Period
- Removal of sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes
- Changes and removal of tracheostomy tubes.

Global Surgical Package

The following services <u>are not</u> included in the payment amount for a global surgery:

- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care.
- Visits unrelated to the diagnosis for which the surgical procedure is performed, (unless a complication of surgery)
- Treatment for the underlying condition or an added course of treatment which is not part of the normal recovery from surgery;
- Diagnostic tests and procedures, including diagnostic radiological procedures.

MEDICARE LIKE RATES (MLR)

Section 506 of the Medicare Modernization Act Requires Medicare participating providers to participate in the CHS program and charge no more than the Medicare-based rates to individuals eligible for CHS since July 5, 2007.

The methodology for coordination of benefits with other payors under section 506 is similar to the Medicare Secondary Payor Program.

MLR REQUIREMENTS

Requires Medicare-participating hospitals to accept MLR as payment in full from Indian Health Service, Tribal and Urban CHS programs for authorized CHS services

- CHS remains "*payor of last resort*"
- Does not affect lower contracted rates nor negate such contracts
- Does not "limit" existing rates less than MLR

PAYMENT PROCESS

- Purchase Order (PO) is issued for payment
  - Medicare Like Rates (MLR)
  - Federal Acquisition Regulation (FAR)
  - Requires *DUNS number and registration in *SAM
  - Established Eligibility with CHS
  - Emergency Services Notification (Call-In) (within 72 hours/30 days)
  - Approved Pre-Authorization (referral)
  - Exhaust Alternate Resources

*DUNS (Data Universal Number Systems Number)

*SAM (System for Award Management)

PAYMENT PROCESS

- PO Process for Providers
  - POs sent to providers for review
  - Attach claims, attach EOB (if applicable), and send copies to Fiscal Intermediary (FI) for processing and SU for files/audits
- FI
  - Blue Cross/Blue Shield of New Mexico is National FI
  - Examines documents and processes for payment and encourages electronic claim filing
  - If providers have questions – call FI (800) 225-0241
- Challenges Regarding Payment
  - Mismatching information, document type error, missing EOBR, changes in patient's insurance information, services provides are outside or exceed authorized date (s) of service

Questions?

Oklahoma City Area Office CHS Staff

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General CHS Information (405) 951-6075