Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Opportunities to Increase Health Care Revenues

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Self-Governance Communication and Education

Increase Funding| IHS and Third Party

- Increase program funding from IHS.
- Increase Third Party Resources:
  - Medicare
  - Medicaid
  - CHIP
  - VA
  - Private Insurance (including Affordable Care Act)

IHS | Funding Increases

- IHS Budget increases.
- Assume additional Programs, Services, Function and Activities (PSFAs) retained by HIS.
- Take Area and HQ Shares.
- Update CSC:
  - Direct CSC.
  - Update indirect cost rate.
  - Proper accounting of expenditure of IHS funds can result in increased CSC.

Contract Support Costs | Third Party Revenues

- June 6, 2024 Supreme Court issues 5-4 decision in support of Tribes in *Becerra v. San Carlos Apache Tribe* and *Becerra v. Northern Arapaho Tribe.*
- Supreme Court rules that IHS must pay contract support costs (CSC) on third-party revenue in addition to the Secretarial amount.
- Tribes can recover CSC on third party revenues going forward but can also submit claims for past year non-payment of CSC on third party revenues.

CSC | Filing Past Claims

- Tribes can file claims for past-year nonpayment of CSC on third party revenues by the IHS.
- The applicable statute of limitations goes back six years, so Tribes could file claims as far back as FY or CY 2018.
- Documentation needed would include:
  - A copy of the Title I contract or Title V compact in effect for the claim years.
  - A copy of the funding agreement(s) in effect for the claim years.
  - The indirect cost rate agreement for each claim year.
  - Documentation showing how much third-party revenue the Tribe expended to provide health care in each claim year.
- Consult with legal counsel.

IHS | Section 105(*l*) Leases

- Section 105(*l*) of the ISDEAA ***requires*** the IHS and BIA to enter a lease with a T/TO for any facility owned or leased by the program used to carry out the ISDEAA scope of work.
- Not traditional “leases” but facility cost agreements for operational expenses associated with using the facility to administer services under an ISDEAA agreement.
- Payment amounts are based on full service lease fair market rental value, or on regulatory factors (rent, deprecation, operation and maintenance costs, interest, etc.) set out in 25 C.F.R. 900.70, or both.

Full Funding for 105(l) leases

- Historically, Congress paid these costs from general "Indian Health Services" account. This meant fluctuation of the lease payments could negatively impact services funding if 105(*l*) lease costs were higher than anticipated.
- FY 2021: Congress now appropriates 105(*l*) lease costs as a separate "indefinite discretionary" appropriation.
- Statute includes "such sums as may be necessary", but only contains a cost *estimate* in the "explanatory statement" accompanying the annual discretionary appropriation law.

Using Full 105(l) Funding to Help Finance Construction

- Tribes and tribal organizations now receive full funding for the Section 105(*l*) leases they enter into with the IHS regardless of any specific amount appropriated to the IHS.
- Since this is stable funding, Tribes and Tribal organizations will be able to use that funding stream to make construction loan payments. IHS has confirmed that it will pay principal and interest on 105(l) leases.
- Potential financing sources could include private lenders, as well as public entities like the USDA Direct and Guaranteed loan programs.
- The amount of the 105(l) lease covers depreciation as well as ongoing maintenance requirements. It is equivalent to a full service lease.

ISDEAA | Expand Scope and Billing

- Tribes can put programs in their Scope of Work even if IHS does not pay for them, like long term care.
- Expanding scope of work expands services you can bill to Third Party Resources like Medicaid and Medicare.
- Facilities used to support PFSAs may qualify for Section 105(l) leases.

ISDEAA | Services to Non-Beneficiaries

- Section 813(c) of the IHCIA authorizes T/TOs to determine to serve non-eligible individuals if no denial or diminution of services to eligible beneficiaries.
- Services to non-bens must be paid for by the non-ben (usually through third-party coverage like private insurance or Medicaid).
- Opportunities for innovative partnerships with Non-IHS Providers.

3rd Party Resources| Overview

- Enrolling patients in health coverage like Medicare, Medicaid and ACA insurance plans increases revenues for tribal programs, and saves IHS and tribal resources like PRC for other patient care.
- Payor of Last Resort rule requires all other forms of coverage to pay first before IHS funds are used.
- Enrolling patients in third party coverage gives them more flexible health care coverage.

Medicaid| Tribal Provisions

- Indians are exempt from premiums and cost-sharing in Medicaid.
- Trust resources exempt from the calculation of income for purposes of determining Medicaid eligibility.
- CMS reimburses States 100 percent of the cost of Medicaid services received through IHS/tribal facilities (100% FMAP).
- Tribal facilities are eligible to receive the IHS OMB rate for services provided to Indians.
- IHS is the payor of last resort, so Medicaid pays first.
- Special managed care protections for IHS/Tribal providers and Indians enrolled in Medicaid managed care plans.

Medicaid| Expand Benefits

- Every State's Medicaid plan is different and covers different optional services.
- Every State Medicaid Plan has special provisions for IHS and tribal providers. Some are better than others.
- The best plans generally allow IHS/tribal providers to bill for multiple encounters a day per patient at the IHS OMB encounter rates.

Medicaid| Medicaid State Plans

- ***Five Encounters Per Day.*** Some states allow for five (5) encounters per day. Arizona, Oregon, Washington, and Virginia all allow five encounters per day.
- ***Multiple Encounters for Distinctly Different Diagnoses and/or Different Services.*** Some states do not specify how many encounters may be billed per day but allows for encounters on the same day if the services are categorically different and/or for distinct diagnoses. Wyoming, Montana, North Dakota.
- ***Pharmacy Billed at OMB Rate.*** Many States now authorize pharmacy services to be reimbursed at the IHS OMB rate.
  - One encounter rate payment per Medicaid beneficiary per day (Nebraska, North Dakota).
  - One encounter rate payment per Medicaid beneficiary per day at the IHS OMB rate except for high cost drugs which are reimbursed at cost (Arizona).
  - One encounter rate payment per prescription (Oregon, Wyoming).

Medicaid| Medicaid Waivers

- Several States have Section 1115 Demonstration Waivers that set special reimbursement rules for Indian Health Care Providers.
- Arizona's Demonstration Waiver authorizes payment to IHS and tribally operated facilities for services that were previously covered under Arizona's state plan, but are no longer covered.
- The Arizona Waiver provides that dental services provided at IHS and tribally operated facilities are not subject to the $1000 cap that normally applies to Medicaid dental services in the State.
- Four states have pending waivers that would allow IHS and tribal providers to bill Medicaid for traditional healing services – Arizona, California, Oregon and New Mexico.
- CMS is working on a traditional healing framework and has committed to a decision by the end of the year.

Medicaid| Billing Partnerships

- CMS State Health Official Letter #2016-002 and 2017 FAQs allow Tribes to enroll as Tribal Medicaid FQHCs and bill for services outside the four walls at the IHS OMB rates.
- Tribes can enter into contracts with other providers, including Urban Indian Programs, where the other provider provides the service to the AI/AN patient, and the Tribal program then bills Medicaid for the service at the IHS OMB rates.
- The Tribal program then reimburses the other provider at an agreed upon rate.

VA| Tribal Reimbursement Agreements

- The IHS and the VA have entered into a national MOU and a reimbursement agreement.
- Section 405(c) of the IHCIA requires VA to pay for health care for AI/AN veterans, primary to IHS and T/TOs, for all services “provided through” the IHS or T/TO health programs.
- Many T/TOs have entered into sharing/reimbursement agreements with the VA for direct care services.
- “PRC for Native Veterans Act” (Jan. 2021) clarified that VA must also reimburse for PRC (and not just during the COVID-19 emergency).

VA/Tribal Reimbursement Agreement

- On December 6, 2023 the VA and IHS entered into a new reimbursement agreement that includes PRC.
- VA has issued a template VA/Tribal Health Provider Agreement for the lower 48 States and requested comments by tribes by March 22, 2024.
- First draft VA/THP Agreement includes PRC but contains key differences from the IHS/VA agreement.
    - Preauthorization language removed.
    - Narrows scope of the Agreement.
    - expected soon.
- New draft of VA/THP Agreement expected soon.

Medicare| Overview

Medicare provides services to persons over 65 and disabled population.

- Part A – Hospital Insurance
- Part B – Medical Insurance
- Part C – Medicare Advantage Plans
- Part D – Prescription Drugs

Medicare| Premiums and Cost Sharing

- The Medicare program requires patients to pay premiums and cost-sharing to receive services.
- Part B premiums are $174.70, with higher premiums for higher incomes. There is an annual deducible of $240, and 20 percent coinsurance for most services. Part B also charges an additional late enrollment penalty.
- Part D premiums vary by plan, which also charge copayments and coinsurance.
- These patient costs can be a barrier of access to the Medicare program for AI/ANs who have a right to receive care from the IHS at no cost to them.

Paying for Medicare| Tribal Sponsorship

- Section 402 of the IHCIA authorizes tribes to use federal sources of funding (*e.g.*, PRC funding) to buy insurance coverage for their members in their service area.
- Tribes can use this authority to buy coverage for their members on the private market, or through the ACA marketplace.
- The tribal health provider then bills the plan for providing services to the member.
- In a well designed plan, the cost of buying coverage is less than what the plan pays.

Medicare| Tribal Sponsorship Part B Plans

- Tribes have the authority to sponsor (pay for) Medicare Part B premiums for their eligible patients.
- Tribes may also pay for late enrollment penalties.
- Section 402 of the Indian Health Care Improvement Act authorizes tribes to use federal funds to do so.
- Tribes must reimburse patients for Medicare Part B premiums. They cannot pay Medicare directly.
- Tribes can also pay any late enrollment penalties for their patients.

Medicare| Tribal Sponsorship Part D Plans

- Tribes have the authority to sponsor (pay for) Medicare Part D premiums for their eligible patients.
- Tribes can enter into contracts with Part D providers to reimburse them for services. Part D providers are required to use an Indian-specific contract addendum that protects tribal rights.
- Tribes may pay the Part D plans directly.
- Late enrollment penalties do not apply because IHS is considered creditable coverage for Part D.

Questions?

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For more information on the TSGAC Affordable Care Act/IHCIA Project, please visit the Health Reform website at: Health Reform - Tribal Self-Governance (tribalselfgov.org)

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