

Analysis of Implementation of Section 405(c) of the Indian Health Care Improvement Act

Statement of the Problem

With enactment of the Patient Protection and Affordable Care Act (ACA) in March of 2010, the Departments of Defense (DoD) and Veterans Affairs (VA) became primary payers for services rendered by the Indian Health Service, Indian Tribes, and Tribal organizations to beneficiaries eligible for services from either Department. The effective date for this authority is March 23, 2010. To date, no functional mechanisms to process claims and reimbursements have been established by the three Departments involved – DoD, VA and Health and Human Services (HHS; parent agency of the IHS). Since some DoD or VA beneficiaries served by Indian health programs may also be enrolled in Medicaid and/or Medicare – and various requirements exist pertaining to Medicaid and Medicare being secondary payers to other liable payers – there is concern among Indian health programs, and potentially state Medicaid agencies, that compliance actions could result if they seek reimbursement from Medicaid and/or Medicare for services provided to these individuals due to the delay in implementation of Sec. 405(c).¹

Governing Provision

Section 405(c) of the Indian Health Care Improvement Act (IHCIA), as amended by the ACA, reads as follows:

(c) REIMBURSEMENT.—The [Indian Health] Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

Analysis

State Medicaid agencies and the Medicare program typically require providers, including Indian health programs, to bill other liable payers prior to billing Medicaid or Medicare, as Medicaid is generally considered the payer of last resort², except for Indian health programs³, and Medicare, in many instances, is considered a secondary payer.⁴

A compliance concern arises in circumstances under which an IHS beneficiary is a veteran or an active duty member of DoD and is also enrolled in Medicaid (or Medicare) and obtains a health service from an Indian health program. Prior to the Sec. 405(c) amendment to the IHCIA, unless there was a specific written agreement between the Indian health program and one of the Departments, the claim would have been properly sent to Medicaid (or Medicare) without

¹ Indian health programs are also concerned about the potential loss of additional revenues due to a delay in implementing this provision as well as the potential reduction in revenues if Medicaid and/or Medicare begin rejecting IHS and Tribal claims and assert that these other Departments are now primary payers.

² See <http://www.cms.gov/ThirdPartyLiability/>.

³ See ACA Sec. 2901(b) which states that programs operated by IHS, Tribes, Tribal organizations and urban Indian organizations are payers of last resort, notwithstanding any Federal, State, or local law to the contrary.

⁴ See <http://www.cms.gov/transmittals/downloads/R25MSP.pdf>.

tendering it first to the VA or DoD because these Departments asserted they were payers of last resort. Now, the Departments are obligated to pay Indian health programs, but no mechanism is in place to file claims and receive payment. Thus, there is a concern that claims sent to Medicaid or Medicare for such an individual without first exhausting these other payers may be found to be out of compliance with Medicaid or Medicare secondary payment rules.

To the extent this occurs – whether at the time of initial claim submission or in a future audit of State Medicaid agencies or Indian health programs – Indian health programs could find themselves without an ability to collect from any source for services rendered. This would leave the Indian health programs with not only a loss of potential new revenues (from VA and DoD) but an actual reduction in revenues from prior levels (where such claims had previously been paid by Medicare or Medicaid). Such an outcome would be directly counter to the Congressional intent in enacting IHCIA Sec. 405(c).⁵

Prior Comments from NIHB and TTAG to Federal Agencies

Indian Country has encouraged establishment of DoD and VA billing/payment procedures since the ACA was enacted. The National Indian Health Board and the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS)⁶ previously provided comments to the Department of Health and Human Services and the Indian Health Service regarding the need for the rapid implementation of Sec. 405(c) of the IHCIA. Individual Tribes and other Tribal organizations have also urged such action. Shown below are the portions of the previously-filed comments which pertain to implementation of Sec. 405(c).

July 2010

Section 405(c) – DVA and DoD reimbursements. This subsection requires the Department of Veterans Affairs and the Department of Defense to reimburse IHS and Tribal health programs when those Indian programs provide health services to DVA and DoD beneficiaries. IHS should immediately set up billing and payment procedures with DVA and DoD, as this reimbursement requirement is intended to provide additional revenue to both IHS-operated and Tribally-operated programs. Putting a billing/payment procedure in effect very soon will reduce the number of retroactive claims that must be processed beginning on March 23, 2010, when the provision became effective.

— Letter from NIHB and TTAG to Secretary Sebelius and IHS Director Roubideaux, July 1, 2010, page 4, regarding ACA/IHCIA implementation priorities.

September 2010

The TTAG is very concerned about the delay in undertaking any substantive implementation work for two significant reasons:

- *First, the absence of billing arrangements with these departments means that IHS and tribal programs are losing meaningful revenue collection opportunities. All services our programs have provided on/after March 23, 2010, to DoD and DVA beneficiaries are due for payment, but without billing arrangements, our programs*

⁵ “Reforming the Indian Health Care System,” Senator Dorgan, July 7, 2009, page 7.

⁶ Sec. 5006(e) of the American Recovery and Reinvestment Act codifies in statute, at sections 1902(a)(73) and 2107(e)(1)(C) of the Social Security Act, the requirement for the Secretary of Health and Human Services to maintain a Tribal Technical Advisory Group within CMS and the requirement that States seek advice from Tribes on a regular and ongoing basis where one or more Indian health program or urban Indian organization furnishes health care services.

cannot yet collect the sums due. The more time that passes without such arrangements, the greater will be the administrative burden to have back claims submitted and paid. The opportunity to collect revenue from these departments – as Congress intended – must be actively pursued.

- *Second, the TTAG is concerned that where Indian beneficiaries enrolled in Medicaid are also eligible for DoD or DVA services, Medicaid programs may begin rejecting IHS and tribal claims and assert that these other Departments are now the primary payers. Should this occur, our programs would experience reductions in third-party collections and have to devote greater administrative staff time to claims processing.*

– Letter from TTAG to Dr. Yvette Roubideaux, IHS Director, and Paul Dioguardi, HHS Intergovernmental Relations, September 20, 2010, page 2, regarding implementation of Sec. 405(c).

January 2011

Reimbursement by VA for Services Provided by an Indian Health Provider. Section IV.B.6 of the MOU provides the barest acknowledgement and framework for fulfilling the new duty of VA to reimburse the IHS, an Indian Tribe or Tribal organization —where services are provided through the Service, an Indian Tribe, or a Tribal organization to beneficiaries eligible for services from [VA], notwithstanding any other provision of law. □13 The responsibility to provide reimbursement became effective March 23, 2010, with the passage of the ACA. To date it has not been implemented.

The failure to implement the reimbursement provision of the law is troublesome on at least two levels. First, it deprives Indian health providers of the resources necessary to expand the scope of services they can provide to AI/AN veterans. Secondly, it raises potential compliance issues. Medicaid is generally the payer of last resort, except for Indian health programs. Typically, Medicaid programs require providers to bill all other potential payers, such as Medicare and VA, prior to billing Medicaid. For example, the Alaska Medicaid program provider billing manuals spell out expressly how claims for Medicaid enrollees who are also veterans eligible for VA benefits are to be handled. It requires the provider to —[b]ill VA first and receive a formal denial (in writing) from VA or receive a Medicaid Denial Letter. □14 Failure to comply with billing requirements can lead to serious audit and compliance issues for providers, including Indian health providers...

– Letter from NIHB to Dr. Yvette Roubideaux, January 3, 2011, page 10, responding to the IHS Dear Tribal Leader letter regarding the draft Memorandum of Understanding between the Department of Veterans Affairs and the IHS.

Establishing a Functional and Efficient Billing Mechanism

Given the statutory requirements applicable to Indian health programs and the recently stated

intention of the Department of Veterans Affairs to move forward⁷, establishing a functional and efficient billing mechanism between the Departments and the Indian health programs can be achieved in a reasonably short period of time if (1) all parties are included in the implementation process and (2) all parties are actively and sufficiently engaged. Three areas central to establishing a functional and efficient billing mechanism are: (1) option for electronic claims filing; (2) determination of payment rates; and (3) eligibility for services.

Electronic Claims Filing

In establishing a functional mechanism for Indian health programs to seek reimbursement from the VA and DoD, it will be critical that the billing mechanisms permit electronic filing of claims and attachments to the claims. This will greatly simplify the administrative challenges related to (a) Indian health programs submitting claims to the Departments for services rendered as far back as March 23, 2010; (b) Indian health programs reimbursing State Medicaid programs and Medicare to the extent those programs previously paid for services to DoD and VA beneficiaries; and (c) efficient processing of future claims.

Section 206(h) of the amended IHCIA addresses this issue and requires payment regardless of the form of submission so long as it meets certain standards. It reads:

(h) NONAPPLICABILITY OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian tribe or tribal organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

This provision permits Indian health programs to submit claims to a payer without regard to the billing system established by the payer if the Indian health program complies with the format required for submission of Medicare claims. As such, the option of using standardized claims forms (such as CMS1500 for professional fee claims and CMS1450 for hospital and facility claims) and electronic filing is available to Indian health programs in filing claims to any payer, including DoD and VA. Building on the Medicare billing infrastructure would greatly facilitate the implementation of a functional and efficient billing mechanism.

Determination of Payment Rates

The Director of the Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act⁸ and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), has the authority to establish rates annually for inpatient and outpatient medical care provided by IHS facilities for Medicare and Medicaid beneficiaries and beneficiaries of other Federal agencies. The rates established by the Director are also applicable for payment to Tribes and Tribe facilities for services rendered to Medicare and Medicaid beneficiaries and

⁷ The pending Memorandum of Understanding between the Department of Veterans Affairs and the Indian Health Service includes the following language: "VA and IHS agree to actively collaborate and coordinate... (6) To increase availability of services, in accordance with law, by the development of payment and reimbursement policies and mechanisms to: Support care delivered to eligible AI/AN Veterans served at VA and IHS."

⁸ 42 U.S.C. 248 and 249(b).

beneficiaries of other Federal agencies.⁹ The rates are published annually in the FEDERAL REGISTER.¹⁰ In addition to being a requirement of Federal law, the use of these rates for DoD and VA payments to Indian health programs will be convenient for all and obviate the need to establish other billing rates.¹¹

Eligibility for DoD and VA Services

Each Department possesses the information necessary to make a timely determination of “beneficiaries eligible for services from either such Department”, as called for in Sec. 405(c). Establishing a means for Indian health programs to access this information, either directly or through queries to the Departments, is an important component of a functional and efficient billing mechanism.

Potential Actions by CMS to Facilitate Implementation of IHCIA Sec. 405(c):

The following remedial actions, if undertaken by CMS, could serve to expedite implementation of Sec. 405(c) of the Indian Health Care Improvement Act (IHCIA), minimize the potential loss of revenues to Indian health programs, and reduce administrative and health service expenditures under Medicare and Medicaid.

1. Issuance of a guidance letter from CMS indicating that, due to the gap between enactment and implementation of Sec. 405(c), no compliance actions will be taken against a State Medicaid agency or an Indian Tribe or Tribal organization for seeking reimbursement from Medicaid or Medicare for services rendered to an individual who is also eligible for services from DoD or VA, and is enrolled in Medicare or Medicaid. The guidance letter would serve to avoid potential unintended consequences that may occur, such as a finding of noncompliance by CMS, because the reimbursement requirement of Section 405(c) has not been implemented by the Departments, thereby impeding the ability of Indian health programs to bill the Departments for services rendered to eligible individuals.
2. Communication by CMS urging the Secretaries of Defense (DoD), Veterans Affairs (VA) and Health and Human Services (HHS) to give priority attention to establishing procedures to implement IHCIA Sec. 405(c). This provision requires DoD and VA to reimburse the Indian Health Service (IHS), Indian Tribes and Tribal organizations (collectively “Indian health programs”) for health services provided to DoD and VA beneficiaries. CMS has a direct programmatic interest in speedy implementation of Sec. 405(c) because an individual who is both an IHS beneficiary and a beneficiary of DoD or VA may also be enrolled in Medicare or Medicaid. When an Indian health program provides health services to such an individual, the Medicare and Medicaid secondary payer rules are implicated.
3. Submission of any retroactive Medicare or Medicaid claims by CMS directly to the VA and DoD – for services rendered to eligible beneficiaries by the Indian health programs between March 23, 2010 and the date of implementation of Sec. 405(c) by VA and DoD – and holding the Indian health programs harmless for any potential differences between the revenues

⁹ For inpatient services provided to Medicare beneficiaries, the Medicare Part A inpatient rates are based on the Medicare prospective payment system.

¹⁰ The rates for calendar year 2010 appeared in 75 FED.REG. 34147 (June 16, 2010).

¹¹ The VA announced on December 10, 2010 it will begin using Medicare’s standard payment rates for certain medical procedures performed by non-VA providers on Feb. 16, 2011

<http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=2021>

secured by the Indian health programs from Medicare and Medicaid for services provided to these eligible beneficiaries and the revenues ultimately recaptured by CMS from VA and DoD.

Conclusion

Although the IHICIA does not make CMS responsible for establishing billing/payment procedures between DoD and VA and Indian health programs, there are implications to Medicare and Medicaid for the delay in implementation. The intersection of the Medicare and Medicaid program billing rules and Sec. 405(c) implementation gives CMS an interest in seeing that such procedures are put in place immediately. Further delay will only exacerbate the administrative challenges and costs already faced by Indian health programs, VA, DoD, State Medicaid agencies and CMS in assuring that services provided by Indian health programs to applicable beneficiaries on and after March 23, 2010, are paid by the correct payer. The issuance of a guidance letter by CMS, as well as the assistance of CMS in retroactive billing to VA and DoD, would serve to minimize potential unintended negative consequences related to the implementation of this provision.