Feather River Tribal Health, Inc.

HEALTH INSURANCE CHANGES

Presented 1/11/14

http://www.frth.org

TOPICS TO BE ADDRESSED

- CHS
- Affordable Care Act
- Managed Care Expansion (Medi-Cal)
- CRIHB Care/CRIHB Options

Introduction to CHS

- Purpose of presentation is to ensure consistent information is provided to patients by FRTH staff
- Recognize the importance of understanding how the guidelines impact patient care
- Goal is to provide training & information to Tribal community and staff

Introduction to CHS

- Contract Health Service – CHS
  - Policy set by Chapter 3 of the Indian Health Service policy and procedure manual
  - 42 Code of Federal Regulations (CFR) Title 42
  - Complete manual is available at **www.ihs.gov**
  - Separate manual for exhibits
  - Funded annually by Congress – no guarantee of funding
  - FRTH records are audited for compliance

CHS - Introduction

- CHS is NOT an insurance – there are excluded items and levels of care
- CHS is the payor of last resort
- Requirements & Responsibility for program:
  - By FRTH
  - By Providers & Referral Providers
  - By Patients

Eligibility

- Verified Native Americans are eligible for any direct service offered by FRTH
  - Direct service is anything that is offered under the roof of an FRTH facility

Eligibility for CHS

- Must be documented CA Indian
- Must reside in service delivery area – unless member of 3 sponsoring Tribes – which allows for some limited services
- Must have a resource or show proof that you have applied for and been denied the resource (DNQ)

Pharmacy – In-House

- Effective 9/4/13 – FRTH opened the in-house pharmacy to all Native Americans
- CHS patients with or without a resource – no cost – as long as on formulary
- Direct patients with a resource – no cost as long as medication is covered by resource or on resource formulary

Pharmacy – In-House Continued

- Direct patients with no resource – must pay $3 fill fee per prescription + the actual cost of the medication
- Can fill a maximum of 5 scripts at one visit
- Cash or credit/debit card only – no checks are accepted
- No more one time fills for non-CHS patients since all Native patients have access – would be required to pay

Eligibility for CHS – cont'd

- CHS is not retro-active - Must be on CHS at the time of an event – e.g. a referral, ER visit, etc.
- Birth certificates are required for newborns within 6 weeks after birth in order to be eligible for direct care & CHS
- When child becomes adult, must apply for resource to be eligible for CHS

Levels of Care

- Level I – Emergent or Acute Urgent Care
- Level II – Preventative Care Svcs
- Level III – Primary & Secondary Svcs
- Level IV – Chronic/Extend Care Svcs
- Level V – Excluded Services

FRTH is only able to offer thru Level III

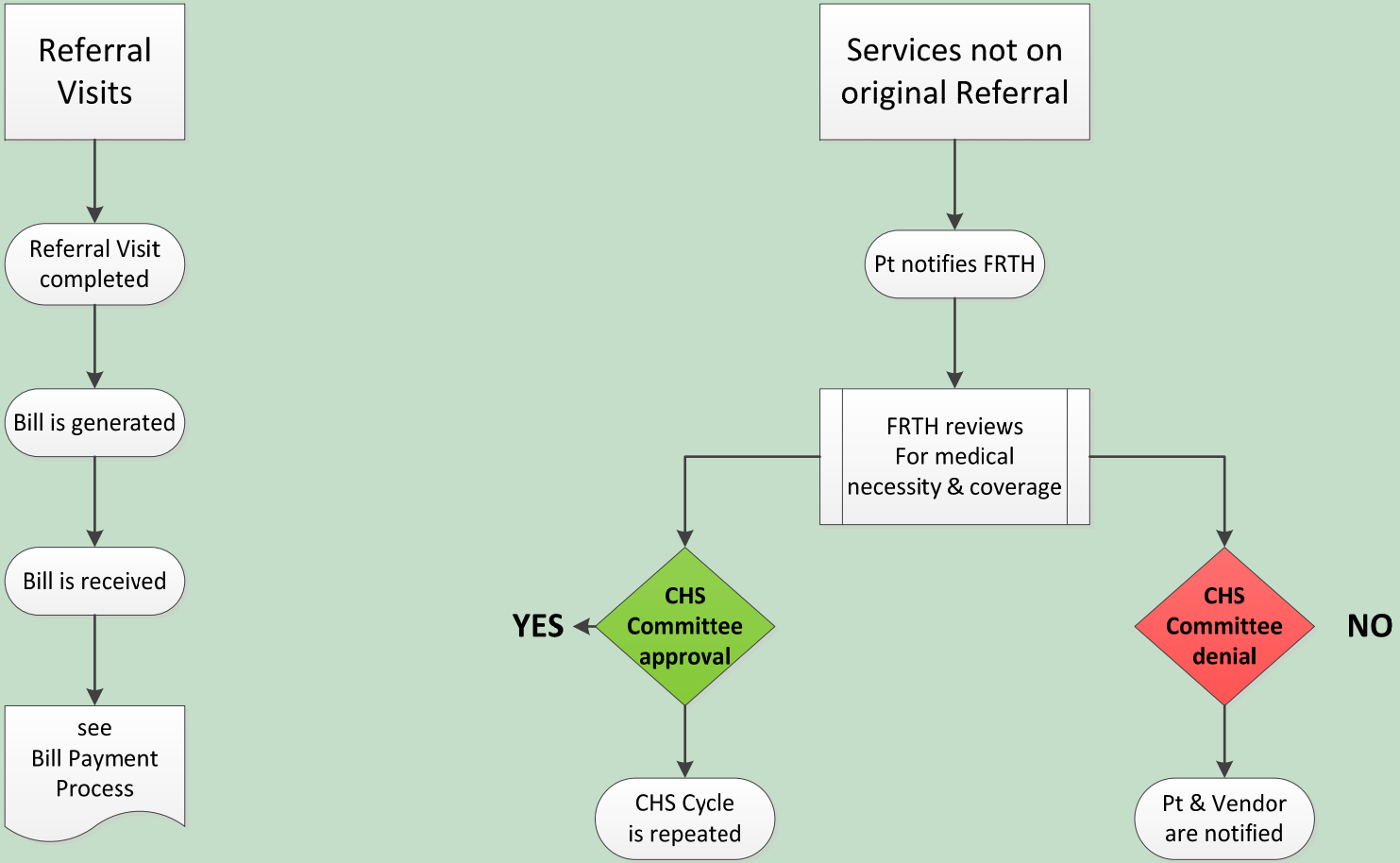
Requirements of CHS

- In order to use CHS there are patient responsibilities:
  - Be on CHS (active and in good standing) at time of event/referral/outside visit
  - Must be within medical priority for an ER visit
  - Must be within guidelines of referral or # of approved visits

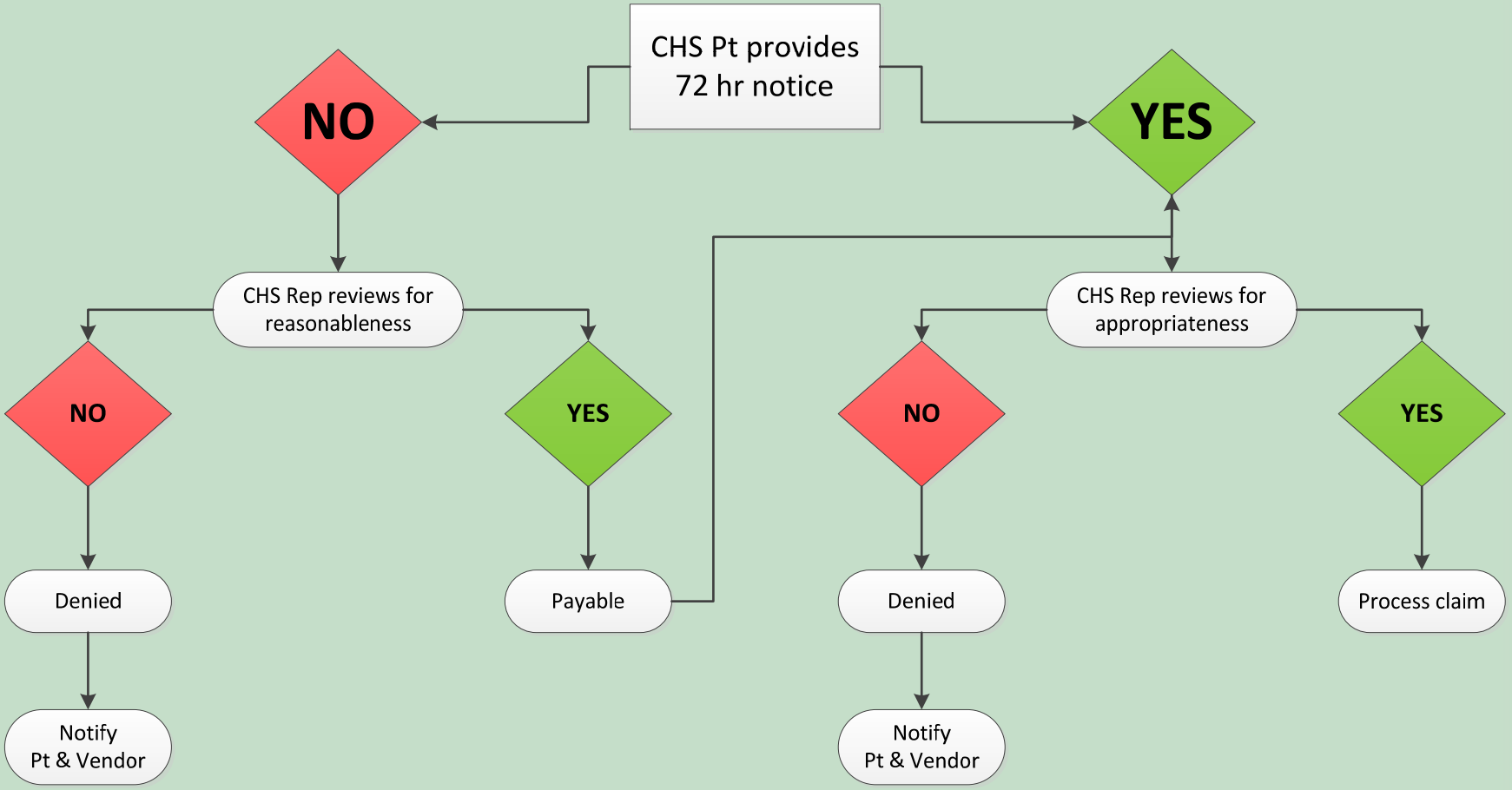
Referrals

- CHS must be active & good standing at time of referral
- Must be within the approved # of authorized visits
- Only good for 6 months
- If provider wants add'l testing or visits – must notify CHS for approval

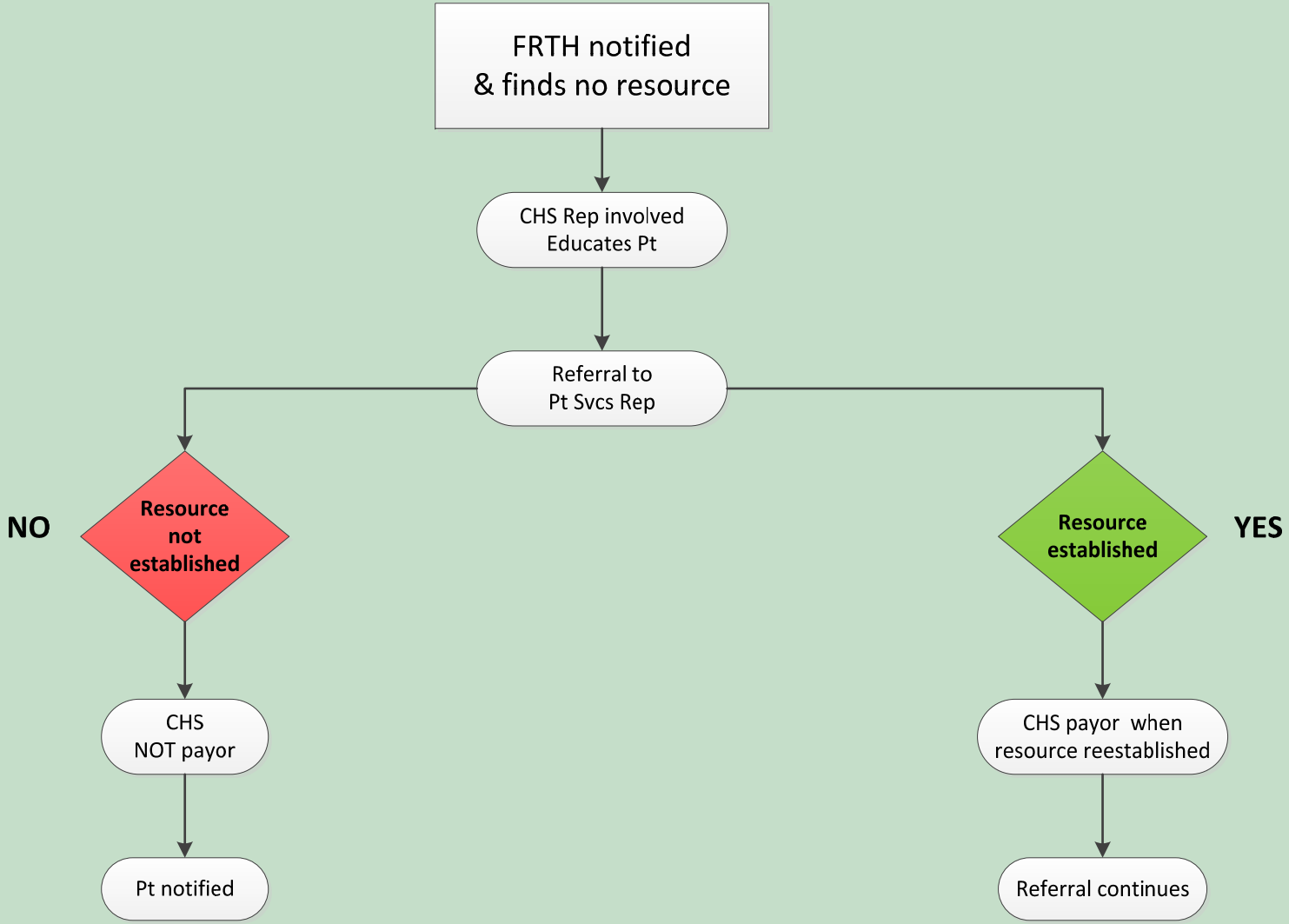
CHS Patient Goes for a Referral Appointment



Emergency Services



Referral in Process – Resource Lost



Contract Health Service Statistics for 12/13

- 2,630 CA Native American patients designated eligible for CHS
- 2,024 active CHS users (77%)

CHS Statistics – cont'd

- 1,746 registered members of 3 sponsoring Tribes eligible for CHS
- 889 Tribal members are currently active on CHS (51%)
  - Berry Creek = 266
  - Mooretown = 374
  - Enterprise = 249

CHS Statistics – cont'd

- # of active patients with CHS as their only resource = 121
- # of Members from 3 sponsoring Tribes residing outside service area = 68

CHS Statistics – cont'd

- Principal reasons for denials:
  1) Not eligible for CHS at time of service
  2) No referral for visit
  3) Billing amount less than $3.00
  4) No 72-hour notice
  5) Not a covered benefit
  6) Care not within medical priority

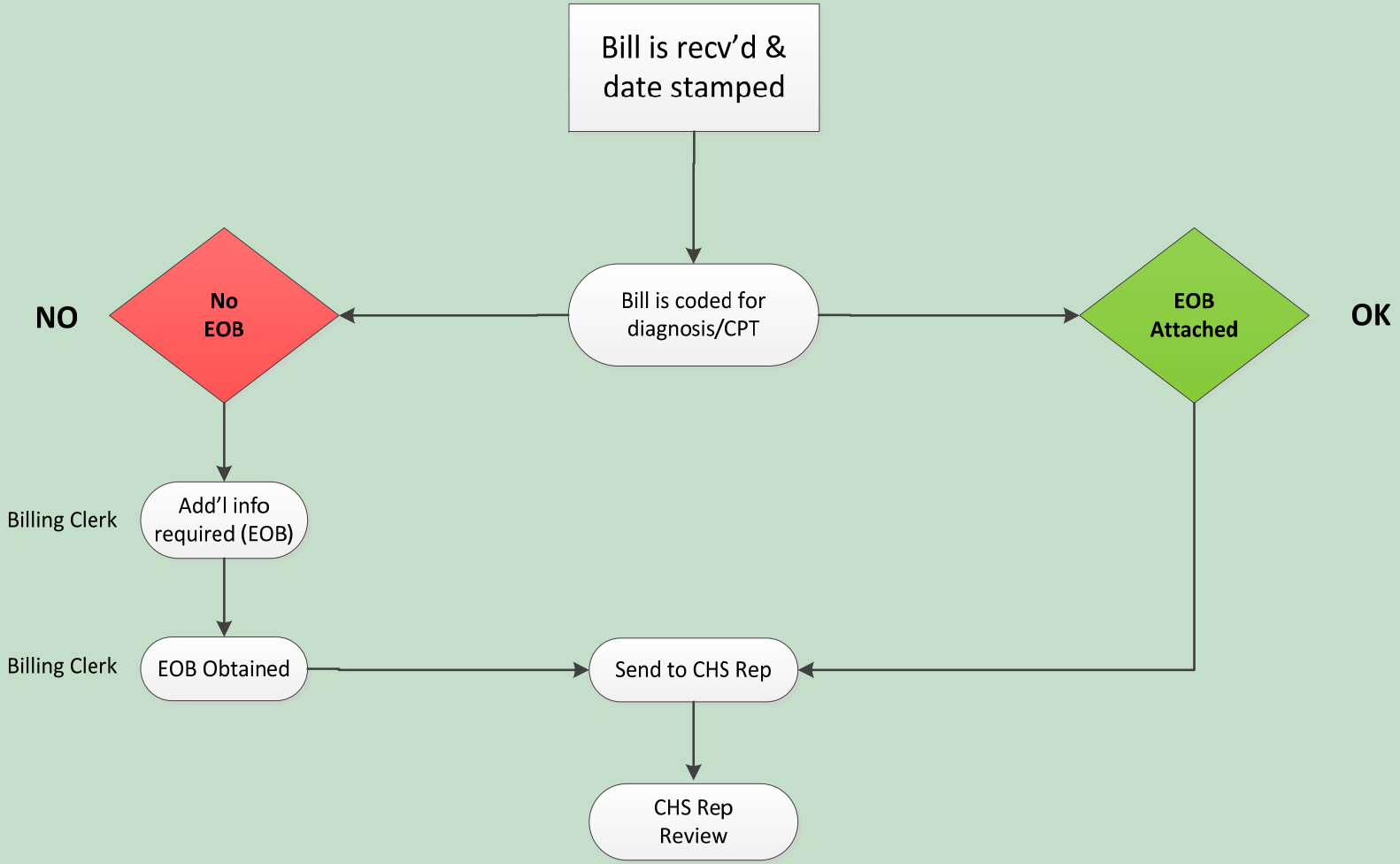
CHS

- Summary of Expenditures
  - Pharmacy – 35%
  - In-house specialty care – 19%
  - Hospital – 12% (limited coverage)
  - Outpatient Hospital – 12%
  - Outside Provider visits – 6%
  - Dental referrals – 3%
  - Eyeglasses – 3%

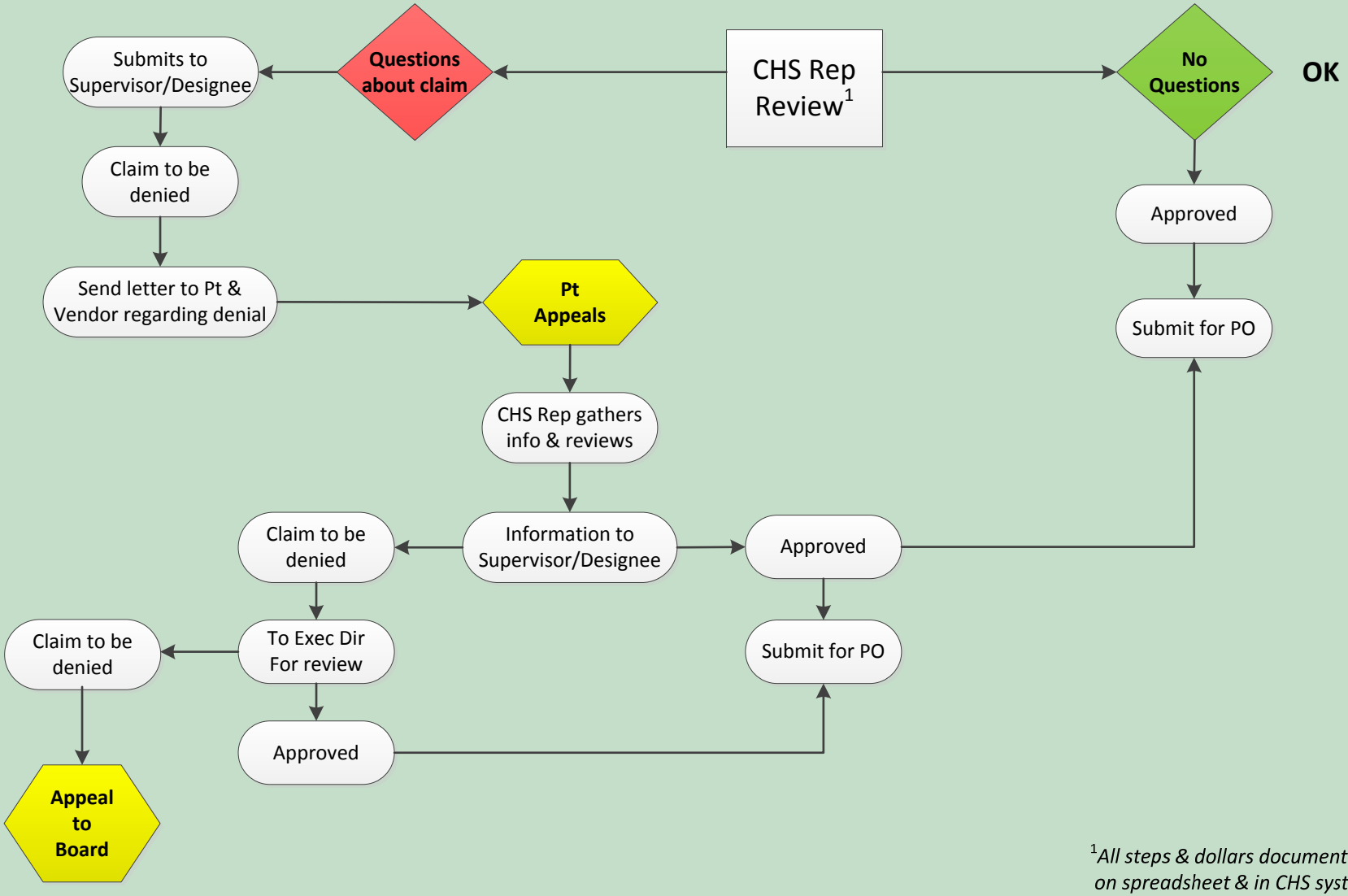
CHS

- Summary of Expenditures – cont'd
  - Ambulance – 2%
  - Physical Therapy – 2%
  - Xray/MRI – 2%
  - Lab – 2%
  - Durable Medical Equipment <1%
  - Hearing - <1%
  - Miscellaneous – 1%

CHS Pt Submits Bill for Payment



CHS Representative Review



[1]*All steps & dollars documented on spreadsheet & in CHS system*

Miscellaneous

- There are special levels of service available to 3 sponsoring Tribes – list included in available handout
- **Catastrophic diagnosis** – to protect all CHS patients, FRTH requires that the patient must get a payment resource in order to have diagnosis covered – e.g. cancer

Catastrophic Diagnosis

- Definition for CHS:
  - An illness that either requires lengthy hospitalization, extremely expensive therapies, or other care that would deplete a family's financial resources, unless covered by special medical insurance policies. Catastrophic illnesses are usually life-threatening and may leave significant residual disability.

Miscellaneous

- **Glasses** – one pair every 2 yrs based on change in prescription – contacts not covered - $300 maximum
  - Exceptions – children & diabetics, patients over age 65
- **Hearing aids** – one every 5 yrs - $1,500 per ear
- **DME** – must have medical necessity – anything over $500 must be approved by Board

Examples of Excluded Svcs

- Speech therapy
- Gastric Bypass
- Contacts
- Experimental therapy
- Over the counter meds/products
- Dental implants
- Motorized scooters/wheelchairs
- Cosmetic surgery
- Eye surgery that eliminates need for glasses

CHEF

- Catastrophic Health Emergency Fund
  - Threshold for payment is $25,000 – must be paid up front before considered for CHEF
  - Must submit to IHS for reimbursement for event
  - Pool of funds available for program is nationwide
  - Eligibility based on 1st come/1st served basis until funds run out for the year

CHEF

- Have not submitted any claims because no guarantee that there would be reimbursement – one claim could jeopardize CHS funds for all FRTH CHS patients

CHS RESOURCES

- Medi-Cal
- Medicare
- Private Insurance
- Gateway
- Healthy Families – rolled into new managed care
- Do Not Qualify (DNQ)

CHS Resources

- How do resources work?
  - Resources help FRTH defray the costs of the CHS program – by having a resource we are able to extend additional levels of care
  - Medicare Part A – only pays hospitalization
  - Medicare Part B & D – cost to patient
    - Need Medicare Part B for referrals to outside providers if not a covered CHS benefit

CHS Resources

- CRIHB Care/CRIHB Options
- Managed Care (Medi-Cal)
  - Not all levels of care are covered under Medi-Cal – having a secondary resource ensures the patient that they will not have any out of pocket costs
  - Medi/Medi – dual coverage of Medi-Cal and Medicare – ensures that patients will not have any out of pocket costs for items not covered – e.g. dental not covered by Medicare

CHS – RESOURCES RECENT CHANGES

- Path2Health rolled into Managed Care Medi-Cal
- CMSP – Need to reapply for Medi-Cal in order to continue eligibility for CHS
- CMSP DNQ – Need to reapply for Medi-Cal in order to be eligible for CHS

PENDING ISSUES THAT MAY IMPACT CHS

- Definition of Indian
- Implementation of Affordable Care Act – Covered California
- Implementation of Managed Care
- CRIHB Care/CRIHB Options - future
- Medicare-like rate for referrals

DEFINITION OF INDIAN

- Under the Affordable Care Act (ACA) 3 definitions were used:
  - Dept of Interior
  - Indian Health Care Improvement Act (IHCIA)
  - Internal Revenue Service

DEFINITION OF INDIAN

- Dept of Interior & IHCIA are very similar in definition and reflect how we do business
- IRS definition states specifically that the Indian must be from a federally recognized Tribe – this definition would not include special circumstances in CA – Descendants of CA Indian

DEFINITION OF INDIAN

- What does this mean?
  - Medi-Cal (CA) recognizes the definition used by IHCIA
  - IHS recognizes the definition used by IHCIA & Dept of Interior
  - Feds are aware of the problem – no solution has been approved by them at this time
  - Will require a Congressional fix

DEFINITION OF INDIAN

- Who would be impacted?
  - Native Americans that are Descendants of CA Indian that currently have CHS as their only resource – if their income is above 400% of the poverty level
  - This group may be required to purchase health care coverage under the ACA – failure to do so could result in a tax charge at the end of the year – unclear at this time

Affordable Care Act

- Creates a standard set of benefits for all plans offered through a health exchange
- Provides help for those with limited incomes to pay premiums offered by exchange
- Gives states the option to expand Medicaid (CA is taking advantage of this)

Affordable Care Act

- Helps people with pre-existing conditions to obtain coverage
- Allows young adults (up to age 26) be covered under their parent's health plan
- Creates exchanges where individuals & small businesses can buy health insurance
- Patients aged 18 – 64 years are eligible
- Can only enroll until 3/31/14 – would be effective 5/1/14 - after that must wait until next open enrollment (October/ November)

Affordable Care Act

- Native Americans from federally recognized Tribes can enroll at any time
- Members of Indian household have to follow the guidelines of the ACA – not exempt

Affordable Care Act

- For people that already have insurance:
  - Prohibits insurance companies from dropping coverage due to illness or pre-existing condition
  - Restricts caps on health coverage
  - Reduces out-of-pockets costs for preventative
  - Bans lifetime dollar limits on health coverage
  - Medicare patients do not need to do anything – could apply to Hi-Cap for supplemental coverage

Affordable Care Act

- Sets up a “Navigator” program that assists patients navigate through the different plans to determine which is best for them
- Sets up financial responsibilities for patients that currently are not covered
- Offers assistance programs (subsidies) to help pay for the premium – patient may be eligible for coverage at low or no cost
- Automatically identifies if you are eligible for Medi-Cal

IMPLEMENTATION OF AFFORDABLE CARE ACT (ACA)

- Went into effect January 1, 2014
- Sign-ups began in October 2013 for effective date 1/1/14
- Still working out the details of implementation
- Expands coverage for wellness & preventative care under Medicare
- Permanently authorized the IHCIA

Affordable Care Act

- Native Americans from federally recognized Tribes can apply for exemption from ACA
- What can you do if not from a federally recognized Tribe?
  - Can apply for a hardship exemption – must meet certain criteria:
    - Individual would have to pay > 8% of their income for health insurance
    - People with income below threshold for filing taxes
    - People who qualify for religious exemption
    - Undocumented immigrants

Affordable Care Act Exemptions – con't

- People that are incarcerated
- Members of non federally recognized Native Americans need to apply for hardship exemption:
- Can be done online
- By phone
- By paper
- Native Americans will be required to have an exemption number from IRS – in process

Affordable Care Act

- Unknowns:
  - Could require Native Americans making more than 400% of Poverty level to purchase coverage – failure to do so could result in a tax penalty at the end of the year
  - Still working out the details on implementation
  - Definition of Indian could have an impact
  - CHS is a limited resource – not everything covered

Affordable Care Act

- Consideration –
  - Might be eligible for a low cost or no cost insurance through ACA for individual or family
  - Would help to cover gaps that CHS might not cover – e.g. catastrophic diagnosis
  - Ability to buy insurance anytime for federally recognized Tribal members
  - Must wait for open enrollment for non-federally recognized Tribal members
  - Need to make payment in order to have coverage

Affordable Care Act

- Could impact CHS as an alternate resource – CHS is payor of last resort – could be required to apply for no cost coverage
  - $95 penalty or 1% of income – whichever is greater -1st year
  - $325 penalty or 2% of income –whichever is greater – 2nd year

IMPLEMENTATION OF MEDI-CAL EXPANSION

- Scheduled began 11/1/13
- Also known as Managed Care
- Medi-Cal managed care health plans will have their own doctors, specialists, pharmacies & hospitals
- Patient will have the ability to choose their health plan

Managed Care

- Notices were mailed out to eligible individuals in October 2013
- Patients will need to determine who they want for their carrier
- In our service area 2 plans will be offered:
  - CA Health & Wellness
  - Anthem Blue Cross

Managed Care

- Can contact Outreach or Patient Services staff at FRTH in order to learn more about the process and selection of FRTH as the provider
- If patient fails to respond to either notice, carrier was assigned to them
- Effective 11/1/13 – patients MUST bring their new benefit card and Medi-Cal eligibility card at time of visit

Managed Care

- If patient has received card and has different provider, can switch to FRTH – contact Outreach or Patient Services at 530-534-5394
- State will no longer oversee healthcare -only Medi-Cal eligibility
- Patients would only go to county regarding eligibility
- Patient must now deal directly with the healthcare plans re level of services covered e.g. if pay cash for med – will need to be reimbursed by plan provider – not CHS

Managed Care

- Frequently Asked Questions for program are available for those that are interested
- Includes info on:
  - What is covered,
  - Whether they can continue to see their current provider
  - Already scheduled procedures
  - Eligibility

Managed Care - CHANGES

- Effective 1/1/14 – behavioral health services will be a covered service for Medi-Cal patients
- Effective 5/1/14 – some adult dental services will be covered for Medi-Cal patients
- There are still some carve-outs – Gateway, Cancer Detection, Family Pact
- Health plans provide transportation for some services w/prior arrangements

CRIHB CARE/CRIHB OPTIONS

- Proposed as solution to lost optional benefits back in 2009
- Provides THPs ability to bill for uncompensated care
- Approved by CMS April 5, 2013
- Allows eligible Native American patients with Medi-Cal as a resource to access some lost benefits

CRIHB Care/CRIHB Options

- Allows billing for services provided as a direct service under the “roof”
- For FRTH would allow us to bill again for:
  - Adult Dental
  - Adult BHS
  - Podiatry
  - Acupuncture

CRIHB Care/CRIHB Options

- Allows FRTH to use funds received to expand services (for example Pharmacy)
- Problems:
  - Program just extended through 12/31/14 – what happens after that?

MEDICARE-LIKE RATES FOR REFERRALS

- Currently have Medicare-like rates for hospitalizations
  - Any hospital that accepts Medicare as a resource cannot charge more than the Medicare-like rate for Native American patients that do not have a resource
  - Impacts CHS – patients with no resource need to have procedures done at a facility that accepts Medicare as a resource

QUESTIONS?

- For more information, please contact:
- Outreach/Patient Services Departments at FRTH:
  - 530-534-5394
  - Online – please visit www.frth.org and connect to the various links