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Memorandum

January 9, 2015

TO: Joe Finkbonner, Executive Director
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

FROM: Geoff Strommer & Starla Roels
HOBBS, STRAUS, DEAN & WALKER, LLP

RE: ***Tribal Use of Third Party Revenues***

In November, the Office of Inspector General issued an alert urging tribes and tribal organizations to ensure that funds paid through Indian Self-Determination and Education Assistance (ISDEAA) agreements and Medicare and Medicaid (M/M) and Children's Health Insurance Program (CHIP) reimbursements are properly allocated and spent. You asked us to prepare a summary of the types of third party revenues that tribes and tribal organizations (hereinafter collectively referred to as "Tribes") can generate under their ISDEAA agreements and limitations on how such funds can be allocated and spent.

Introduction

As health care providers responsible for health care under ISDEAA agreements with the Indian Health Service (IHS), Tribes are authorized to seek reimbursements for services from M/M, CHIP and other third-party payors, such as private health insurance companies. We explain that authority and its history in more detail below, as it is important for understanding how such reimbursements can now be used.

We primarily discuss the following types of third-party reimbursements[1] that Tribes can pursue relative to the health care services they provide under their ISDEAA agreements:

1. *Medicare* (federal program covering individuals over 65 years of age, and younger based on certain disabilities);
2. *Medicaid* (state-administered federal program covering individuals and families with low incomes);

[1] In this memorandum, we use the terms "third-party revenues," "third-party collections," and "third-party reimbursements" to collectively refer to a Tribe's ability to seek reimbursement for services provided to individuals who have alternative health care coverage.

3. *CHIP* (state-administered federal program offering free or low-cost health coverage for eligible children and sometimes other family members or pregnant women);
4. *Private health care insurance*;
5. *Tortfeasors* (collections from tortfeasors and other liable third parties, such as under the Federal Medical Care Recovery Act);
6. *Catastrophic Health Emergency Fund (CHEF)* (funds administered by the IHS to partially reimburse Tribes for high-cost patient medical expenditures for catastrophic illnesses and events); and
7. *Veterans Administration* (such as reimbursements the VA makes to Tribes under a coordination/reimbursement agreement).

Discussion

Use of Third-Party Reimbursements, Generally

The ability to collect M/M and other third-party reimbursements, and how such collections may be expended, depends in some measure on provider type, facility type, relevant program and other factors. Understanding the history of M/M collections is important to understanding how such collections and other third-party revenues may be expended by Tribes.

Prior to enactment of the IHCIA in 1976, IHS facilities could not collect reimbursements from M/M.[2] Title IV of the IHCIA added Section 1880 to the Social Security Act (SSA), making a hospital or skilled nursing facility of the IHS, whether operated by the IHS or Tribes, eligible for Medicare payments.[3] Congress later amended Section 1880 of the SSA to extend payment under Medicare Part B to a hospital or an ambulatory care clinic that is operated by the IHS or Tribes.[4] Title IV of the IHCIA also added Section 1911 to the SSA to authorize Medicaid payments to a facility of the IHS (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under a State plan).[5] To broadly summarize, these changes generally authorized facilities of the IHS, whether operated by the IHS or Tribes,[6] to collect M/M reimbursements, which were largely required to be placed in an

[2] Special legislation was needed because Sections 1814(c) and 1835(d) of the Social Security Act (SSA), 42 U.S.C. §§ 1395f(c) and 1395n(d), prohibited Medicare reimbursement to federal providers of health services, such as the IHS.

[3] 42 U.S.C. § 1395qq.

[4] *Id.* § 1395qq(e).

[5] *Id.* § 1396j.

[6] The 1996 Memorandum of Agreement between the IHS and the Health Care Finance Administration (now the Centers for Medicare and Medicaid Services) allows a tribally-owned or leased facility to elect status as a "facility of the IHS" for purposes of M/M reimbursement.

IHS "special fund" and used to make improvements necessary to achieve compliance with M/M participation/accreditation standards.[7]

Section 401(c)(1) of the IHCIA carries forward the special fund limitations for a "facility of the Service" receiving M/M reimbursements. It requires that any such reimbursements first be used "for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title."[8] Any amounts in excess are then to be used for reducing health resource deficiencies, and may include expenditures for assisted living services, home and community-based services, hospice, and long-term care.[9]

However, Section 401(c)(2) exempts tribal health programs that elect a direct billing option under Section 401(d) from the special fund limitations. Section 401(d)(1) specifically provides authority to Tribes to directly bill M/M and CHIP and any other third-party payer.[10]

For Tribes that exercise that option and elect to directly bill and collect reimbursement from M/M and CHIP, those reimbursements no longer have to be placed in a special fund and are no longer subject to the limitations on use described in Section 401(c).[11] Instead, M/M and CHIP funds that are collected under the direct billing authority of Section 401(d) must be used as provided in Section 401(d)(2)(A), which specifically requires that M/M and CHIP reimbursements be used for any of the following purposes:[12]

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[7] Congress amended the SSA several times (*e.g.*, in 2000, 2003 and 2005) to authorize collection under Part B without the special fund limitation, which was first extended to 2010 and then that "sunset date" was repealed by the Affordable Care Act, P.L. 111-148 (Mar. 23, 2010). Thus, this collection authority is permanent.

[8] 25 U.S.C. § 1641(c).

[9] *Id.*

[10] *Id.* § 1641(d)(1).

[11] Some Tribes have instead elected to bill M/M under their authority to do so as a Federally Qualified Health Center (FQHC). ISDEAA Tribes have the option of accessing FQHC payment rates for Medicaid through Section 1905(*l*)(2)(B) of the SSA, 42 U.S.C. § 1396d(*l*)(2)(B), and for Medicare under Section 1861(aa)(4) of the SSA, 42 U.S.C. § 1395x(aa)(4). Issues related to the use of third-party revenues by Tribes billing under their FQHC authority are beyond the scope of this memorandum.

[12] Section 401(d)(2)(A), 25 U.S.C. § 1641(d)(2)(A), provides in full:

> Each tribal health program making the election described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly by that program for items and services furnished [without the funds going through the special fund], except that all amounts so reimbursed shall be used by the tribal health program that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and tribal health programs, any health care-related purpose (including coverage for a service or service within a contract health service delivery area or any portion of a contract health service delivery

- As necessary to achieve or maintain compliance with the requirements applicable to the M/M and CHIP programs; or
- Health care services; or
- Improvements in health facilities or health programs; or
- Any "health-related purpose;" or
- To otherwise achieve the objectives of Section 3 of the IHCIA.[13]

These same use provisions in Section 401(d)(2)(A) also apply to all third-party collections—not just M/M and CHIP—for services provided to non-beneficiaries under Section 813(c)(2) of the IHCIA. Section 813 authorizes Tribes to provide services to non-eligible individuals at tribally operated facilities. With respect to use of collections received for services provided to such non-eligible individuals, Section 813(c)(3) provides that "amounts collected under [Section 813(c)] . . . shall be used for the purposes listed in section 401(d)(2)."[14]

There may be open legal questions, though, about whether Section 401(d)(2)(A) also governs use of other third-party reimbursements collected by Tribes for services to eligible beneficiaries (*e.g.*, services not covered by Section 813). The questions hinge primarily on one's interpretation of Section 207 of the IHCIA.[15] Section 207 pertains to crediting of reimbursements, lists certain "programs" that are covered by its provisions, and says that reimbursements recovered or received under those programs "may be used as provided in section 401."[16]

Before it was amended by the reauthorization, Section 207(a) provided that all reimbursements received or recovered under authority of the IHCIA, or any other provision of law, except for CHEF, M/M, and Section 813 reimbursements, shall be retained by the IHS or Tribes and be available for the facilities, and to carry out IHS and tribal programs to provide health services to Indians. This included reimbursements from private health insurers and other third payers under Section 206 of the IHCIA.[17] As amended by the reauthorization, Section 207(a) provides that all reimbursements received or recovered under any programs listed under Section 207(b), except for CHEF and Section 813 reimbursements, may be used as provided in Section 401. The "programs" listed in Section 207(b) are: (1) M/M and CHIP; (2) the IHCIA including Section 813; (3) the Federal Medical Care Recovery Act (P.L. 87-693; and (4) any other provision of law.

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that would otherwise be provided as a contract health service), or otherwise to achieve the objectives provided in section 3 of this Act.

[13] Section 3 is the broad declaration of National Indian Health Policy and aims to ensure the highest possible health status for Indian people, among other goals. 25 U.S.C. § 1602.

[14] *Id.* § 1680c(c)(3).

[15] *Id.* § 1621f.

[16] *Id.* § 1621f(a).

[17] *See* 25 U.S.C.A. § 1621(f) (Amendments: showing language prior to reauthorization in 2010).

One open legal question, for example, is whether Section 207's reference to "programs" includes third-party reimbursements collected by Tribes under the authority of Section 206 of the IHCIA, like payments made by private health insurance. There are different ways to interpret what Section 207 means by "programs" and the manner in which it encompasses other sections of the IHCIA. Another open question is whether the language in Section 207(a), saying that third-party reimbursements "may" be used as provided in Section 401, requires Tribes to use non-SSA related third-party reimbursements in the manner set out in Section 401(d)(2)(A).

We do not think it is necessary at this time to try to resolve these open questions, however, because regardless of whether collections from third-party insurers are subject to Section 207, and regardless of whether Section 207 requires compliance with Section 401(d)(2)(A), Tribes collecting third-party revenues under their ISDEAA agreements are still subject to the limitations on the use of those revenues imposed by the ISDEAA's provisions on "program income."

With respect to Title I self-determination contracts, Section 106(m) of the ISDEAA states in relevant part: "The program income earned by a tribal organization in the course of carrying out a self-determination contract—(1) shall be used by the tribal organization to further the general purpose of the contract."[18]

With respect to Title V self-governance compacts and FAs, Section 508(j) of the ISDEAA provides in relevant part:

> All Medicare, Medicaid, or other program income earned by an Indian tribe shall be treated as supplemental funding to that negotiated in the funding agreement. The Indian tribe may retain all such income and expend such funds in the current year or in future years except to the extent that the Indian Health Care Improvement Act (25 U.S.C. 1601, et seq.) provides otherwise for Medicare and Medicaid receipts.[19]

These provisions are applicable to all "program income," meaning that any third-party reimbursements received or recovered by Title I and Title V Tribes—M/M, CHIP, private insurance, etc.—must be used in furtherance of the Tribes' ISDEAA agreements with the IHS. This is generally understood to mean that the funds are to be used to supplement the funds the Tribes receive to carry out the health care-related programs, functions, services and activities assumed by the Tribes in their scopes of work.

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[18] 25 U.S.C. § 450j-1(m).

[19] *Id.* § 458aaa-7(j).

Other Considerations

1. Construction of New Facilities

There may be a question about whether third-party reimbursements that are subject to Section 401(d)(2)(A) may be used for new facility construction. The IHS appropriation for a number of years has included the following proviso governing use of M/M collected by the Secretary:

> *Provided further*, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act, except for those related to the planning, design, or construction of new facilities.[20]

While this proviso precludes IHS's expenditure of its M/M reimbursements for planning, design, or construction of new facilities, it does not by its terms apply to Tribes directly billing and collecting M/M under Section 401(d) of the IHCIA. A similar proviso in the appropriation applicable to Tribes does not include this restriction:

> *Provided further,* That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organization until expended.[21]

The IHS may nevertheless raise an issue about use of program income for planning, design or construction of new facilities, because new construction must be carried out under a separate construction contract and not under an AFA or FA.[22] Although the IHS may raise such an issue, Section 401(d)(2) is broadly written, to the extent it applies. The reference to "improvements to health care facilities and tribal health programs" in Section 401(d)(2) should not necessarily be read as a limitation[23] and could be reasonably read in context to include improvements in existing or new facilities.

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[20] Consolidated and Further Continuing Appropriations Act, 2015, P.L. 113-235, Division F (Department of Interior, Environment and Related Agencies Appropriation Act, 2015).

[21] *Id.*

[22] *See* Section 105(m) of the ISDEAA, 25 U.S.C. § 450j(m), and Subpart J of the implementing regulations at 25 C.F.R. § 900.110 *et seq.* for Title I construction contracts and Section 509 of the ISDEAA, 25 U.S.C. § 458aaa-8, and Subpart N of the implementing regulations at 42 C.F.R. § 137.270 et seq. for Title V construction project agreements.

[23] The second sentence of Section 508(j) of the ISDEAA governing program income of Title V compactors allows use of M/M reimbursements unless the IHCIA provides otherwise.

2. Contract Limitations

Individual Tribes may have agreed to language in their Title I or Title V ISDEAA agreements that place different or additional limitations on their use of M/M and other third-party reimbursements, so Tribes should review the terms of their own agreements to determine what limitations might apply.

3. CHEF

One of the exceptions mentioned in Section 207 of the IHCIA is Section 202(a)(2) of the IHCIA, which pertains to amounts appropriated by Congress for the IHS's Catastrophic Health Emergency Fund (CHEF).[24] CHEF funds are designed to reimburse Tribes' purchased/referred care programs for catastrophic expenses. CHEF reimbursements received by Tribes are not subject to the broad usage provisions of section 401.[25] The IHCIA does not otherwise say how CHEF reimbursements must be expended by the recipient Tribes. In reviewing the IHS's Administrative Guidelines for the CHEF program, the IHS takes the position that CHEF funds are made available for expenditures on patients, solely for the purpose of meeting extraordinary medical costs, and that any amounts unused on an approved case (*e.g.*, spent on something else or not spent at all) must be returned to the IHS's CHEF account.

4. Veterans

Generally, the U.S. Department of Veterans Affairs (VA) is responsible for paying for health care services to veterans. Section 2901(b) of the Affordable Care Act (P.L. 111-148) clarified that the IHS and Tribes are the "payer of last resort," which now makes it clear that the VA must pay for at least some services provided by the IHS or Tribes to veterans.[26] We note that the 2012 Agreement between the VA and IHS states in Section VIII(C) that all reimbursements received under the agreement "shall be used as provided in 25 U.S.C. § 1641," which is Section 401 of the IHCIA. That agreement is specific to IHS-operated facilities and programs, individual reimbursement agreements that Tribes have with the VA may provide similar or different limitations on the use of the VA funding. Each Tribe would thus need to consider its own agreement with the VA.

5. State Laws

We have not researched whether there may be any limitations on expenditure of third-party collections (*e.g.*, medical lien laws, medical insurance payments) under state or local laws for certain types of third-party payments. Tribes may want to consider whether they have agreed to comply with any such laws or are subject to them.

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[24] 25 U.S.C. § 1621a.

[25] *Id.* § 1621f(a)(1).

[26] *Id.* § 1623(b).

Conclusion

The analysis included in this memorandum is intended to generally discuss various third-party reimbursements which Tribes are eligible to generate under Title I or V ISDEAA agreements. This memorandum is not intended to cover every type of third-party revenue that can be collected by Tribes. Individual Tribes may also be subject to additional or different limitations on the use of their third-party collections, than what is outlined above, as specific to their own circumstances.

I look forward to discussing these issues at the January 20 quarterly board meeting. If you have any questions prior to the meeting please do not hesitate to contact me at gstrommer@hobbsstraus.com (503-242-1745).