SHINGLE SPRINGS BAND OF MIWOK INDIANS

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RESOLUTION 2016-42

SUBJECT: APPROVAL OF AMENDMENTS TO THE CONTRACT HEALTH SERVICES PROGRAM POLICY B.

WHEREAS, the Shingle Springs Band of Miwok Indians (the "Tribe") is a federally recognized Indian tribe eligible for the special programs and services provided by the United States to Indians because of their status as Indians and is recognized as possessing powers of self-government; and

WHEREAS, the Shingle Springs Tribal Council is the duly-elected governing body of the Tribe and is authorized to act on behalf of the Tribe; and

WHEREAS, the Tribe operates the Shingle Springs Tribal Health Program ("SSTHP"), located on the Shingle Springs Rancheria; and

WHEREAS, Contract Health Services (CHS) funds are available to assist Tribal members obtain medical, dental and some hospital services that cannot be provided at the SSTHP; and

WHEREAS, the CHS Program Policy was approved to establish the rules and eligibility requirements in order to receive CHS funds; and

WHEREAS, the Tribal Council now desires to amend the CHS Program Policy B in order to specifically include off-label treatments on the list of non-covered services; and

WHEREAS, the Tribal Council has reviewed the attached amended CHS Program Policy B and has determined that it is consistent with the Tribe's goals for the CHS program.

NOW THEREFORE, BE IT RESOLVED that the Tribal Council hereby approves the attached amended "Contract Health Services Program Policy B" and authorizes the Chairman or his designee to execute any and all documents and agreements necessary as may be required to give effect to the transaction, herein contemplated, and to take such other actions as may hereby be necessary and appropriate to carry out the obligations thereunder.

BE IT FURTHER RESOLVED that this resolution will take effect immediately.

BE IT FURTHER RESOLVED that a copy of the Policy shall be mailed to all current CHS recipients and that all current recipients shall not be required re-sign the Policy Certification.

CERTIFICATION

As a duly-elected official of the Shingle Springs Band of Miwok Indians, I do hereby certify that, at a meeting duly called, noticed, and convened on the 26th day of May, 2016 at which time a quorum of 7 was present, this resolution was duly adopted by a vote of 7 FOR, 0 AGAINST, 0 ABSTAINED, and said resolution has not been rescinded or amended in any form.

Chairperson — May 26, 2016 Date

ATTEST:

Secretary — May 26, 2016 Date

Shingle Springs Band of Miwok Indians
Shingle Springs Health and Wellness Clinic
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Contract Health Services Program Policy B

Contract Health Service (CHS) B funds are received through the Shingle Springs Band of Miwok Indians (Tribe). CHS B program monies are for the purpose of assisting eligible Indian people with medical, dental and some hospital services that cannot be provided at the Shingle Springs Tribal Health Program (SSTHP), and only after CHS A funds have already been exhausted.

CHS is not an entitlement program, but operated only as funds are available. The SSTHP CHS program supplements direct care services at the SSTHP clinic and emergency services.

It is important to understand that only the CHS Coordinator can authorize payments for CHS care. Authorization is required for all non-emergency services and follow-up visits. All non-emergency cases must be seen at the SSTHP clinic. Those who are not referred by SSTHP to outside providers will not be eligible for assistance under the SSTHP CHS program. CHS program requirements and process are below:

Section A. Eligibility

Proof of eligibility is in **FOUR** parts: Tribal Membership, Application, Orientation, and Alternate Resources.

1. **Tribal Membership must be proved by**:
   a. Enrollment in the Shingle Springs Band of Miwok Indians. Proof of enrollment can be shown by providing a valid Tribal ID card.
   b. Babies, who have not yet had an opportunity to be enrolled in the Tribe, are eligible for services if a parent provides his/her enrollment card as evidence of the child's heritage.

2. **Application**
   a. Current applications must be on file for individuals requesting payment of medical or dental bills. These applications are reviewed as necessary and must be updated on an annual basis. Failure to complete an application and provide necessary documentation for Contract Health Services may result in non-payment by the SSTHP CHS Program.

3. **Orientation**
   a. Applicants must attend an orientation on CHS at the Tribe's clinic prior to any medical or dental services being paid for by the CHS program.
   b. As of the effective date of this policy all current CHS recipients must attend an orientation on CHS prior to July 1, 2014, or CHS services will be terminated.

4. **Use of Alternate Resources:**
   a. Alternate resources are other sources of health care insurance or health care payment available and accessible. Persons are required by CHS regulation [42 CFR part 36 (C)] to apply for any and all available alternate resources prior to

being eligible for the CHS program. **For example, individuals must use or have been denied Medi-cal, Medicare, private insurance or other available health care coverage or programs before the STTHP CHS program can pay for services.** Persons who are eligible for an alternate resource and refuse to apply for, or refuse to use that alternate resource, will not be allowed to use the CHS Program.

Section B. CHS Covered Services

1. The maximum amount an individual may receive from the CHS program is $10,000 a year. The Tribal Health Board may approve by majority vote more money for individuals whose medical needs exceed $10,000.

2. **Private Insurance:** When an individual is enrolled in a private insurance plan, the SSTHP CHS program will pay the deductible and/or balance of the bill when the services have been referred by the SSTHP. If you belong to an HMO or Managed Care Systems, such as Kaiser, Health Net, PacifiCare, etc., it is required you see your primary care physician for services and coverage under your medical program for outside referrals.

3. **Payments received from alternate resources** by individuals must be paid to the health provider, if an individual spends the medical reimbursement, it will be the patient's responsibility to pay for that portion of the bill. The SSTHP CHS program may not pay any balance of the deductible unless provided with an explanation of benefits from the Insurance Company and a current bill for service(s).

   Alternate resources include, but are not limited to;

   -Medi-cal
   -Medicare
   -Private Insurance
   -California Children's program
   -Veteran's Administration
   -County and State health programs
   -automobile insurance if medical needs result from a motor vehicle accident

4. **Pre-Authorization Required**

   a. Authorization from SSTHP CHS Coordinator is required for all non-emergency services and follow-up care.
      - If you are referred to an outside provider and the initial visit is authorized, do not assume that your follow-up appointments are authorized. You must contact the CHS Coordinator for each follow-up visit, refill of a prescription, surgery or procedure to get approval for payment and a purchase order.
      - If you are referred out for services such as X-rays, lab tests, medications, other doctors or specialists, do not assume that it be automatically paid for by CHS. All follow-up visits, require pre-authorization or notification.
      - Do not assume that any provider will obtain the CHS authorization for you. It is the patient's responsibility to contact the CHS office for pre-approval and a purchase order for services.

   b. Emergency Room Exception to Pre-Authorization Requirement

   In the case of an emergency room visit, pre-authorization is not required. However the patient (or a family member) must give notification of the emergency room visit within 72 hours of the visit to receive CHS services. Elders and Disabled persons have 30 days from the date of the visit to give notification of the emergency room visit.

Note: All reported emergency room visits will be reviewed by the Clinic Manager. A **true emergency is** when a person's life, limb or organ is threatened in which a delay in care would be hazardous to life, or would result in serious and/or avoidable complications. **In those cases where a true emergency did not exist, such a problem that could have been handled during regular clinic hours, CHS may be denied.**

5. 90 Days to Submit Bills

In order to have preauthorized or emergency services reimbursed with CHS funds, all patient bills must be submitted to the CHS coordinator within 90 days of the date of billing.

Section C. Non-covered Services

1. Deferred Services

Deferred services are medical or dental services that do not fall within the SSTHP CHS priority levels of care, and are therefore not covered by CHS such as elective surgeries and experimental drugs, etc.

2. **Off-Label Treatments**

When a drug is used in a way that is different from that described in the FDA-approved drug label, it is said to be an "off-label" use. Off-label treatment is not covered by CHS.

3. SSTHP Medical Priority

a. The medical priority list (levels of care) is developed using Indian Health Services (IHS) guidelines, medical staff consultation and is approved by the Tribal Health Board. A medical priority is defined as Emergency and Urgent Care which must be done within 30 days to preserve life, limb, organ or function, and non-emergency care which if not done this fiscal year will result in permanent risk of life, limb, organ or function. Tertiary and experimental services are not available under the SSTHP CHS program.

b. Levels of care;

i. **Emergent or Acutely Urgent Care Services.** Medical Priority Level I-Emergent or Acutely Urgent Care Services are diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual necessitate the use of the most accessible health care available and capable of furnishing such services. Diagnosis and treatment of injuries or medical conditions that if left untreated, would result in uncertain but potentially grave outcomes.

ii. **Preventive Services.** Medical Priority Level II-Preventive Services are distinguished from emergency care, sophisticated diagnostic procedures, treatment of acute conditions, and care primarily intended for symptomatic relief or chronic maintenance. Most services listed as Priority Level II are available at IHS direct care facilities. If no direct care capabilities are available at the IHS or Tribal direct care facility, preventative services can be purchased using CHS funds

iii. **Primary and Secondary Care Services.** Medical Priority Level III-Primary and Secondary Care Services include inpatient and outpatient care services. The inpatient and outpatient services involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It also includes services that may not be available at many IHS facilities and/or may require specialty consultation.

iv. **Chronic Tertiary and Extended Care Services.** Medical Priority Level IV - Chronic Tertiary and Extended Care Services are services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, are elective, and often require tertiary care facilities. These services are not readily available from direct care IHS facilities.

v. **Excluded Services.** Medical Priority Level V-Excluded Services includes cosmetic procedures and experimental and other procedures excluded from authorization for CHS payment. The list of Medical Priority Level V-Excluded Services is based upon the Centers for Medicare and Medicaid's (CMS) Medicare National Coverage Determinations Manual.

1. **Cosmetic Procedures.** The Tribe will not pay a claim for a potentially cosmetic procedure listed in Medical Priority Level V-Excluded Services, unless the Area CMO approval is obtained. This may be granted if one of the listed procedures, normally considered cosmetic, is necessary for proper mechanical function or psychological reasons.

2. **Experimental and other Excluded Procedures.** Payment for the excluded procedures listed in Medical Priority Level V-Excluded Services will not be paid by the Tribe, unless a formal exception has been granted by the IHS CMO (See IHS Circular No. 93-03, "Cosmetic and Experimental Procedures Review.")

3. **Payment for Direct Services.** Examples of direct care services that cannot be reimbursed with CHS funds are on-call hours, after hours or weekend pay, holiday coverage (e.g., for x-ray, laboratory, pharmacy).

4. <u>Common Reasons For Denial Of Contract Health Services</u>

- Person does not meet the eligibility requirements, or supply necessary documentation.
- Failure to obtain prior approval from CHS coordinator for non-emergency services.
- Failure to give notification of emergency services within 72 hours (30 days for elders and disabled persons).
- Medical problem is not within established SSTHP medical priorities (levels of care).
- The referral is not made by a Shingle Springs Tribal Health provider or doctor.

- Person is denied eligibility for alternate resources, Medi-cal or county medical services program due to person's failure to complete their paperwork, or not following through with instructions.
- Persons refusing to use alternative resources or be screened for alternative resources which may be available will not be allowed to use Contract Health Services.

5. Appeals

If a person is denied CHS payment for services, they may appeal the denial in writing within fifteen (15) working days after receipt of the denial letter. The appeal shall be sent to the SSTHP Clinic Manager to be reviewed. If the claim is again denied, an appeal shall be made within fifteen (15) working days after receipt of denial, to the Chairperson of the Tribal Health Board. The appeal to the Health Board must be in writing and include supporting documentation showing that the patient has complied with every part of this policy. The Health Board Chairperson shall decide whether sufficient documentation has been submitted in order for the appeal to be reviewed by the Health Board. The Health Board shall meet within thirty (30) days of receipt of the patient's appeal of the denial to consider the circumstance of the case. The Health Board shall notify the patient, in writing, within five (5) working days after the meeting, of the Health Board's decision regarding the patient's appeal. The identity of the patient shall remain anonymous during the Health Board appeal process. There shall be no appeal available past the Health Board; decisions of the Health Board shall be final.

CERTIFICATION

As a duly-elected official of the Shingle Springs Tribal band of Miwok Indians, I do hereby certify that, at a meeting duly called, noticed, and convened on the 26th day of May, 2016 at which time a quorum of 7 was present, this policy was duly adopted by a vote of 6 FOR, 0 AGAINST, 0 ABSTAINED, and said policy has not been rescinded or amended in any form.

Tribal Council Chairperson — May 26, 2016 — Date

ATTEST:

Tribal Council Secretary — May 26, 2016 — Date

I understand that it is my responsibility to comply with required guidelines of the SSTHP Contract Health Services Program if I am requesting financial assistance for any medical, dental, and emergency services. These guidelines have been reviewed and explained to me by the CHS Coordinator. I have received a copy of the CHS guidelines to read and keep for my records.

Patients Signature or Parent/Guardian if minor — Date