

**COQUILLE INDIAN TRIBE
COMMUNITY HEALTH CENTER
CONTRACT HEALTH SERVICES
DELIVERY PLAN**

This service delivery plan has been developed by the Community Health Center with technical assistance from the Indian Health Services. The purpose of this plan is to establish administrative responsibilities associated with the Contract Health Services Program.

The Contract Health Service program is not an entitlement program and thus, when funds are insufficient to provide the volume of contract health services needed, priorities for service shall be determined on the basis of relative medical need.

1. PAYOR OF LAST RESORT

The Tribal Contract Health Service, acting on behalf of the Indian Health Service, is the payor of last resort for eligible Tribal members and tribal member's spouse, under these regulations, not withstanding any state or local law or regulation to the contrary. Accordingly, Tribal Contract Health Service will not be responsible for or authorize payment for Contract Health Service to the extent that:

- a) The Tribal member/Spouse is eligible for alternate resources; or
- b) The Tribal member/Spouse would be eligible for alternate resources if he or she were to apply for them.

The payor of last resort rule does not represent a change in the Contract Health Service program requirements. The Contract Health Service must first determine whether the patient applying for Contract Health Service funds is eligible. In addition, the Contract Health Service office must determine that the medical services requested for payment from Contract Health Service funds are within medical priorities.

2. ELIGIBILITY

A Tribal member/Spouse may request an application for Contract Health Services by calling (541) 888-4405 or (866) 862-7506 and one will be mailed to them. Once the application is returned, it will be reviewed by Contract Health to determine if eligibility requirements are met. Contract Health should enroll Tribal members/spouses within 72 hours of the receipt of a fully completed application. Applicants will be informed in writing of acceptance or denial.

To be eligible for Contract Health Services, an individual must meet the eligibility requirements listed in the Indian Health Service manual as well as the requirements of 42 CFR 36.61. The individual must:

- a) Be an enrolled member of the Coquille Indian Tribe and reside in the contract health service area; or
- b) Be a student or transient - Contract Health Service will be made available to students and transients who would be eligible for Contract Health Service at the place of their permanent residence within the contract health service area, but who are temporarily absent from their residence, as follows:
 - 1) College (undergraduate and graduate), vocational, technical or other academic education. A Tribal member who leaves an eligible service area to go directly to school and provides proof of enrollment.
 - 2) Transients (persons who are in travel or are temporarily employed, such as seasonal or migratory workers), during their absence from their place of residence.
 - 3) Other persons outside the contract health service area. Persons who leave the service area in which they are eligible for contract health service, and are neither students nor transients, will be eligible for contract health service for a period of up to one-hundred eighty (180) days from date of departure.
- c) Other [categories and conditions of] eligibility:
 - 1) Members of the Coquille Indian Tribe adopted by non-Indian parents, must meet all contract health service requirements to be eligible for care (e.g., reside in the contract health service area).
 - 2) Foster/Custodial Children - Coquille Indian Tribe children who are placed in foster care outside the contract health service area by order of a court of competent jurisdiction and who are eligible for contract health service at the time of the court order shall continue to be eligible for contract health service while in foster care.
 - 3) A non-Tribal member woman, pregnant with an eligible Tribal member's child who resides within the contract health service area is eligible for contract health service during pregnancy through post partum (usually 6 weeks). If unmarried, such a woman is eligible for contract health service if an eligible Tribal member provides the results of DNA testing that shows that he is the father of the unborn child, or such is determined by order of a court of competent jurisdiction. This will ensure health services to the unborn Indian child.

- 4) A non-Tribal member of an eligible member's household who resides within the contract health service area is eligible for contract health service if it is determined by a Physician that services are necessary to control a public health hazard or an acute infectious disease that constitutes a public health hazard.
- 5) A non-Tribal member spouse[or domestic partner] of an eligible Tribal member who resides within the contract health service area, and has been legally married to [or a partner of] a Tribal Member for a minimum of one year. In the case of a divorce [or the dissolution of a domestic partnership,] the non-Tribal Member spouse [or domestic partner] will be eligible for a period of one hundred eighty (180) days after the date of divorce [or dissolution of the partnership].
- 6) A non-Tribal member child adopted by a Tribal member or placed into a permanent guardianship under the supervision of a Tribal member, subject to the other provisions of this policy. Children qualifying under this policy shall remain eligible until the limiting age of nineteen years. However a dependent adopted child may continue to be eligible for contract health coverage after age 19, provided that the adoptee is a full-time student at an accredited school, and primarily dependent upon the Tribal member adoptive parent, guardian or custodian for support and maintenance, is unmarried and is under the limiting age of 25 years. When the child reaches either limiting age, eligibility will end on the child's birthday. If the child does not maintain full-time educational status or graduates, coverage will end independent of the limiting age stated in this paragraph.
- 7) A non Tribal Member who meets all of the following criteria and other applicable provisions of this policy: (a) was a party to a marriage or domestic partnership with a Coquille Tribal member for over thirty years, (b) divorced or annulled the marriage to that Tribal member, (c) had a documented psychiatric disorder throughout the time of the divorce or annulment that rendered him or her not of sound mind or judgment, (d) files a request for eligibility for Contract Health coverage within 24 months of the divorce or annulment, (e) is not a party to any litigation adverse to the Tribe or any Tribally-owned entity, (f) owes no money to the Tribe or any Tribally-owned entity, (g) has no history of Coquille Contract Health policy violations, and (h) has not entered a new marriage or domestic partnership.

- 8) It is the responsibility of the Tribal member/Spouse to notify Contract Health Service immediately whenever there is a change of address, employment or family composition. No appeal will be allowed if a failure to notify Contract Health Services of these events results in a denial for payment of service

3. CONTRACT SERVICE DELIVERY AREA

The Oregon counties of Coos, Curry, Douglas, Lane and Jackson.

4. NOTIFICATION AND AUTHORIZATION FOR CONTRACT HEALTH SERVICES

No payment will be made for medical care and services unless the requirements listed below have been met and a purchase order for care and service has been issued by the Tribe's Contract Health Services Department.

- a) Non-emergency cases - Eligible Tribal members/spouse, eligible non-Tribal members, an individual or agency acting on behalf of the eligible person, or the medical care provider shall, prior to providing medical care and services, notify the Contract Health Department of the need for services and requested services. They must provide all of the necessary information to determine the medical need for the services and the individual's eligibility.

Eligible individuals who are referred by a physician to other medical care providers (physician, laboratory, radiology, physical therapy, etc.) must notify contract health services and receive authorization.

- b) Emergency cases - Eligible Tribal members/spouse, eligible non-Tribal members an individual or agency acting on behalf of the eligible person, or the medical care provider shall, within 72 hours after the beginning of treatment or after admissions or treatment and provide information to determine the relative medical need for the service. Must be a life threatening condition.

The cost of medical care at an emergency facility is three or four times greater than the cost of medical care at non-emergency facilities. Therefore, authorization for service of **non-emergency/acutely urgent care** at an **emergency facility will be denied**. Examples of authorization for emergency care (Level I) is listed in Paragraph 5(b) of this document.

- c) Notification Requirements - The above notification requirements apply to all categories of eligible individuals, which include students, transients, persons who leave the service area and residents who live in the service area.

- d) Authorization Denial - Eligible individual whose request for contract health services was denied due to the level of service requested and funding will be placed on a deferred services list. These individuals will be granted authorization as funds become available based on medical priority and cost.

5. LEVEL OF SERVICE AND DEFERRED SERVICES

Contract Health Services started out providing medical care at Level II and dental services at Level III plus some deferred services. Due to Tribal members utilizing alternate resources and good management of Contract Health Services, based on the recommendation of Tribal Council, the levels of care were increased on February 1, 1995. Since that time Contract Health Services has been able to provide medical care at Level III and dental services at Level IV plus some deferred services. Should we experience a high demand for service and an increase in cost, the level of service could be reduced to Level I and deferred services suspended. However, if we experience a lower than expected utilization and/or lower cost, the level of services could be increased and deferred services provided.

- a) EMERGENT/ACUTELY URGENT MEDICAL CARE SERVICES - LEVEL I

Definition: Diagnostic or therapeutic **services which are necessary to prevent the immediate death or serious impairment** of the 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.

If you are not sure it is an emergency, you can call the Coquille Indian Tribe Community Health Center, your Physician, or the "My Nurse 24-7" nurse call service and explain the problem. They can inform you whether the problem requires you going to an emergency facility. Payment for emergency room care that is **NOT necessary to prevent immediate death or serious impairment** of the health of the individual may be denied if attempts to determine the severity of the problem (i.e. calling the health center, your physician or the nurse call line) were not made.

Some problems can be taken care of at home if given proper instructions by a Health Provider. If it is a normal working day, and your Physician determines it to be an emergency and can be treated at his facility rather than a hospital emergency room, he will instruct you to come in. There is usually less waiting time in a Physician's office than an emergency room facility.

If you have an insurance that requires that you see your Primary Care Physician (PCP) and you go to an emergency facility, they are required to contact your Physician for approval. If your PCP does not determine it to be an actual emergency, he does not have to authorize treatment and payment would be denied.

Categories of Services for Emergency included (random order):

- * Emergency room cares for emergent/urgent medical conditions, surgical conditions or acute trauma.
- * Emergency inpatient cares for emergent/urgent medical conditions, surgical conditions or acute trauma.
- * Renal dialysis, acute and chronic.
- * Emergency psychiatric care involving suicidal persons or those who are a serious threat to themselves or others.
- * Services and procedures necessary for the evaluation of potentially life threatening illnesses or conditions.
- * Obstetrical deliveries and acute perinatal care.
- * Neonatal care.

b) Examples of diagnoses that usually require emergent/acute/urgent care services (not an all inclusive list)

Airway Obstruction	Gunshot wounds	Pulmonary edema
Abscess		Puncture or stab wounds
Amputation, traumatic	Head injury	
Arrhythmias	Heat exhaustion	
Asthma, acute	Hemorrhage	Rape, alleged, examination
	Hernia, ruptured	Renal lithiasis, acute
Burns	Hypertension crisis	Renal failure, acute
Coma	Lacerations	
Concussion		Sepsis
Congestive heart failure, decompensated	Meningitis	Shock
	Migraine, acute	Spinal column injuries
	Musculoskeletal trauma	Suicide attempt
Dehydration, severe	Myocardial, acute	
Diabetic ketoacidosis		
Drowning, near	Obstetrical emergencies	Urinary retention,

obstruction

Embolism, cerebral or peripheral Encephalitis Eye diseases, acute Eye injuries	Pancreatitis Pelvic inflammatory disease Peritonitis Pneumonia, acute
Flail chest Fractures	Poisoning Pulmonary embolism

c) PREVENTIVE CARE SERVICES - LEVEL II

Definition: Primary health care that is aimed at the prevention of long-term disability. This includes services proven effective in avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention).

Categories of Services Included (random order):

- * Routine prenatal care
- * Non-urgent prevention ambulatory care (primary prevention)
- * Screening for known disease entities (secondary prevention)
- * Public health intervention
- * Specialized medications ordered by a physician (prescription)

d) Examples of diagnosis:

Cancer screening
Diabetes maintenance
Eye glasses, refractions *
Family planning services
Hemophilus prophylaxis
Hepatitis prophylaxis
HIV testing
Hypertensive screening, diagnosis and control
Immunizations
Laboratory services supporting primary care evaluations
Mammography
Periodic health exams of infants, children and adults
Pregnancy and infant care
Routine PAP smears/colposcopy
Sexually transmitted diseases, testing and treatment
Tuberculosis screening, prophylaxis, and treatment
Vision examinations *

X-ray services supporting primary care evaluations

* Limited Service

e) PRIMARY AND SECONDARY CARE - LEVEL III

Definition: Inpatient and outpatient care services that 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 includes services that may not be available at many IHS facilities and/or may require specialty consultation. Level III referrals should be approved by the local CHS committee or clinical director before the services are rendered.

Categories of Services Included (random order):

- * Scheduled/unscheduled ambulatory services for non-emergent conditions.
- * Specialty consultations in surgery, medicine, obstetrics, gynecology, pediatrics, ophthalmology, ENT, orthopedics.
- * Elective, routine surgery commonly performed in community hospitals.
- * Diagnostic evaluations for non-acute conditions.
- * CT scans/MRI
- * Cardiology referral (non-acute)
- * Hearing aides
- * Orthotics
- * Physical therapy
- * Podiatry
- * Tonsillectomy

f) DENTAL

Effective July 1, 2007, each Tribal member will have \$1,500.00 annually for dental expenditures. Cosmetic procedures are excluded on dental. Cosmetic procedures include (but are not limited to) dental implants and whitening.

Tribal Members/Spouses are required to obtain a purchase order number prior to all dental appointments.

All Coos County Contract Health Service enrollees are required to use the Confederated Tribes of the Coos, Lower Umpqua and Siuslaw (CLUS) Dental Clinic as their Primary dental provider.

g) DEFERRED SERVICES

Definition: Deferred services must be elective, not emergent or urgent. The service requested must be within Indian Health Services priorities. Procedures that are not listed as one of the priorities will not be considered for deferred services. These services are usually not available until the end of the year based on funds available.

6. DENIALS AND APPEALS

If a person is denied Contract Health Services, or if the medical provider may reasonably think Indian Health Service will be a party to payment, both the patient and the provider shall be notified in writing of the denial with a statement containing all the reasons for the denial.

Any appeal for a denial must be made in writing by the patient or his guardian/representative within thirty (30) days from the date of receipt of a denial. The applicant:

- a) May request a reconsideration by the Medical Director or other uninvolved licensed physician if the Medical Director is the patient's Primary Care Provider (PCP). The Medical Director will have 30 days from receipt of appeal in which to respond in writing. A request for reconsideration must contain additional information not previously submitted, or
- b) May appeal the original denial, or denial on reconsideration, by the Medical Director to the Health & Human Services Administrator, if there is additional information on which to base reconsideration within 30 days of receipt of Medical Director's written response. The Health and Human Services Administrator must provide a written response within 30 days of receipt of the second appeal.
- c) File an "*intent to appeal*" within 10 days of receipt of denial from the Health and Human Services Administrator, to the Tribal Executive Director who will appoint an advocate to assist with the final appeal. The sole purpose of the navigator/ facilitator is to explain and help the Tribal Member/Spouse navigate the appeal process and assist with writing the appeal letter. Advocates must

be unpaid volunteers, but, when not serving as advocate, may otherwise be employed by the Tribe or any Tribal entity. No funds will be specifically appropriated or allocated to pay for the advocate's services or costs incurred. Executive Director will have 10 days in which to appoint an advocate and contact the patient or guardian/representative. Within 30 days of appointment of advocate, an appeal must be submitted to the Contract Health Review Panel.

- d) This appeal of denial of the Health and Human Services Administrator to the Contract Health Review Panel will constitute the final level of appeal and this decision will be final. Patient or guardian/representative will be notified in writing of the Contract Health Review Panel's decision within 30 days of receipt of appeal.

In the event the Health & Human Services Administrator, upholds the Medical Director's denial, (either the original denial or a denial after reconsideration), the applicant must be notified in writing of the denial. The applicant may appeal the Health & Human Services Administrator's denial to the Contract Health Review Panel.

The Contract Health Review Panel shall have three members, whom are appointed and removed by majority vote of the Tribal Council. If not sooner removed, appointed members shall serve for one year, but shall continue to serve until replaced or removed. At least one member shall be a physician, nurse practitioner, or nurse. A second member must be a Tribal Council member. A third member must be employed by the Coquille Indian Tribal Community Health Center. Decisions of the Contract Health Review Panel shall be made by majority vote. The decision of the Contract Health Review Panel shall be final for the Tribe.

Failure to follow these procedures may result in denial of your request for reconsideration or appeal.

The Contract Health Services regulations currently in effect only allow reconsideration by the Medical Director, an appeal to the Health & Human Services Administrator and a final appeal to the Contract Health Review Panel. All appeals will be based on the existing written medical record and the record of previous denials, the applicant's appeal request and any other documentary evidence provided by the applicant or the Contract Health Department.

The stages of review again are:

- Request for reconsideration of the Medical Director's denial
- Appeal to the Health & Human Services Administrator
- File an "intent to appeal" to CIT Executive Director
- Appeal of Health & Human Services Administrator's denial to the Contract Health Review Panel

Addresses:

1. Medical Director
Coquille Indian Tribe
Community Health Center
P.O. Box 3190
Coos Bay, OR 97420-0407

2. Health & Human Services Administrator
Coquille Indian Tribe
Community Health Center
P.O. Box 3190
Coos Bay, OR 97420

3. Coquille Indian Tribe Executive Director
3050 Tremont
North Bend, OR 97459

4. Contract Health Review Panel
Coquille Indian Tribe
P.O. Box 3190
Coos Bay, OR 97420

7. APPEALS RECORDS

The Contract Health Manager will be administratively responsible for creating and maintaining a file on each denial of contract health service. The file will contain all correspondence and relevant information as outlined in the Indian Health manual. The file will be maintained for a period of six (6) years and three (3) months after the appeals process has been exhausted.

8. PAYMENTS AND RECONCILIATION OF COMMITMENT REGISTERS

Payment of the Contract Health Services purchase orders are required in a timely manner. Payment can not be made until the Provider returns the required forms. Once the forms are returned by the Provider and are complete, payment is made within five (5) to seven (7) days. The contract health service department will issue checks weekly.

9. DATA REPORTING

The Tribe is required under the terms of the contract to submit data to Indian Health Service for statistical purposes. This data is requested twice a month and is often referred to as UNICOR data. Each week a weekly status report is run and exported to the Portland Area Office. This report documents weekly obligations, register balance, pending obligations, and the last purchase order that was issued. This assist's the Indian Health Service Area Office by monitoring funding levels.

10. INDIVIDUAL STAFF RESPONSIBILITIES

- a) Contract Health Manager- Responsible for administration of the Contract Health Services, verify eligibility, be familiar with medical priorities, approves service if within medical priorities, assure program/budget control and effective utilization of contract health service funds. Works closely with the Health & Human Services Administrator in identifying needs for contract health service and in negotiating contracts with hospitals, clinical services, dentists, and other health care providers.

Advise patient of rights and responsibilities of the Contract Health Service program, process all requests for contract health services including issuance of purchase orders and processing payments, make weekly reports to the Portland Area Office on obligations and register balance. Assist eligible participants with problems associated with contract health and with utilizing alternate resources as required by the Indian Health Service.

- b) Billings Clerk - Responsible for registration of eligible Tribal members and advising them of how the program works. Develop, maintain, and review both patient and provider files. Issue purchase orders, distribute to providers, track and process them when returned. Transpose codes on purchase orders (requires familiarity with standard ICD-9 codes and IHS APC codes). Post medical data into the automated system, assists eligible participants in submitting third party billings. Send out registration updates annually. Assist eligible Tribal members in applying for alternate resources.

- c) CHS Case Manager - Responsible for identifying assessing and implementing individualized care plans for CHS eligible clients with high risk medical conditions. Develop and implement a system for assuring that CHS clients are accessing and receiving age and gender appropriate preventative health care screenings, procedures and assessments. Determine the quality and effectiveness of medical services provided and if necessary develop, implement and maintain systems for improvement. Assist CHS Manager in negotiating contracts with hospitals, clinical services, dentist and other health care providers.
- d) Resource Management Committee - Responsible to review, approve, or deny procedures that are in question, or do not fall within the levels of care. This panel consists of a Medical Director, Family Nurse Practitioner, Health & Human Services Administrator and Contract Health Manager.

11. MEDICAL TRANSPORTATION PROGRAM

The purpose of this program is to assist with travel and lodging expenses for medical procedures (procedures that would normally be covered by CHS that cannot be performed in their home area.

It is the policy of the Coquille Indian Tribe Community Health Center to provide transportation and lodging assistance for Contract Health eligible persons when they must travel outside of their home area to receive medical care. Subject to available Tribal appropriations, CHS will administer the program based upon need. ***This does not include those being transported by the Community Health Center staff.***

Any travel money received must be refunded to Contract Health Services if Tribal Member/Spouse fails to keep appointment. Payment for further services will be denied pending refund.

Procedure:

- a. Call CHS with request and supply any and all documentation requested at least one week before appointment unless it is an emergency.
- b. CHS will produce a check for up to seven days worth of assistance with proper documentation.
- c. The check can be made out to a Tribal member, Tribal member's spouse or Tribal member's parent or legal guardian.

- d. One hundred dollars (\$100.00) is available for the first night, with seventy-five dollars (\$75.00) for additional nights.
- e. One thousand dollars (\$1,000.00) is the maximum per CHS eligible person per year. However, the CHS Manager may raise cases involving extenuating circumstances to the Resource Management Committee for possible approval of additional dollars.
- f. If travel is less than twenty-four hours, then a flat rate of fifty dollars (\$50.00) per trip will apply.

12. ESTABLISHMENT OF PRIMARY MEDICAL AND DENTAL CARE PROVIDERS FOR CONTRACT HEALTH ENROLLEES RESIDING IN COOS COUNTY.

This policy establishes the Coquille Indian Tribe Community Health Center as the primary medical care provider for all Contract Health enrollees who reside in Coos County, except Elders; and the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians (CLUS) Dental Clinic as their primary dental provider *if they have no other insurance coverage*. In addition, Coquille Indian Tribal members who reside in Douglas County, except Elders, must use Cow Creek Health and Wellness for primary medical care.

Contract Health Service enrollees who reside in Lane, Jackson and Curry County must use medical providers who are enrolled in a Preferred Provider Network, which is designated by the Coquille Indian Tribe Community Health Center.

All eligible Tribal Members/Spouses, except those eligible for the Elders Program, that reside in Coos County and request to be enrolled in Contract Health Services must utilize the Confederated Tribes of Coos, Lower Umpqua and Siuslaw (CLUS) Dental Clinic as their primary dental provider.

- 1. Tribal Members/Spouses covered by this policy must use the Coquille Indian Tribe Community Health Center and CLUS Dental Clinic for their health and dental care.
- 2. Members may see other medical and dental care providers when referred by the Community Health Department or CLUS Dental Clinic providers. Failure to obtain the referral will cause any request for payment of service to be denied by Contract Health Service. You will be responsible for this service.
- 3. You may use any emergency care provider when service is required after the Normal business hours of the Community Health Center or CLUS Dental Clinic, as long as it meets the “emergency requirements.” If an emergency situation prevents you from initially seeking care through the Community Health Center or the CLUS

Dental Clinic, where the slightest delay would jeopardize a member's life, you or a family member should seek care immediately and contact the appropriate provider within 72 hours of the emergency to receive a referral.

Note: When to use (or **not** to use) the emergency room. Making the right decision can save you time and money. It is natural to want immediate care when you are injured or suffering from symptoms that alarm you. But, if you go to the hospital emergency room and your condition is not considered a true medical or dental emergency (by your primary provider), you may have to pay the bill yourself. **A medical emergency is "a sudden and unexpected onset of a condition requiring medical or surgical care which the member receives immediately after the onset, or as soon after as the care can be made available, but in no case later than 24 hours after the onset of the condition."**

The following conditions should **not be treated in an emergency room**. Here are some examples of services that **do not** qualify for emergency benefits (not an all inclusive list):

- . Colds or slight fevers
- . Sore throats
- . Follow-up care for any condition
- . Routine treatment of chronic conditions
- . Routine physical exams
- . Medication refills

All emergency room and ambulance claims are subject to review to determine payment eligibility.

13. Orthodontia Treatment Policy

The Coquille Indian Tribe Community Health Center manages a program for funding of orthodontia that has been established by the Tribal Council. The Contract Health Services department has the responsibility to review each request for services and to authorize purchase orders for orthodontic services for Tribal members and spouses of Tribal members, where appropriate, and if funds for the program are adequate.

Attempts will be made to accommodate as many participants as possible, recognizing that the budget is limited. Some requests for funding may be denied or deferred. Funding of services will be prioritized as needed to conserve resources for those with the greatest need. If 50% of the funding is used by the midpoint of the fiscal year, lower priority cases may be deferred until the following year. Three general levels of priority have been established, Level I being the highest and Level III being considered last.

Priority Level I

Cases in this group are those which could have medical or dental consequences if early orthodontic intervention is not performed. Examples of this type of priority include, but are not limited to, skeletal jaw inequities (retrognathic and prognathic cases), abnormalities related to cleft palate, open bite (where upper and lower teeth do not contact), tongue thrusting, or severe crowding (generally due to inherited combinations of small jaws/large teeth).

Priority Level II

Youth under the age of 19.

Priority Level III

Any age.

The CIT CHS orthodontia program will cover orthodontic treatments, records fees, and aftercare equipment (primarily retainers). Extractions for preparation to receive orthodontic care are not covered by the orthodontia program. Creation of a false tooth is a general dentistry procedure and, although an orthodontist may recommend this, the orthodontic funding will not generally be used to cover this-even if it is recommended to maintain alignment and spacing. Exceptions will be considered if, by judgment of the orthodontist, failure of alignment could occur if creation of a false tooth is deferred until the patient receives the next calendar year of dental benefits.

Orthodontic therapy requires a high level of cooperation from patients to successfully complete treatment. This includes possibly wearing head gear, wearing elastics (rubber bands), brushing extra thoroughly, keeping monthly appointments over a two and one-half year period, altering one's diet so as not to fracture off braces, etc. In addition patient must maintain regular dental check-ups (ever 6-12 months) while they have their braces on. Patient motivation is critical to reach a successful result. For this reason, the following "cooperation factors" must be present before beginning this program.

1. Patients must strongly desire orthodontic treatment.
2. Patients must have a history of seeking annual routine dental care.
3. Parent(s) or guardians must be interested and supportive.
4. Patients must have a history of keeping their appointments for regular dental care. Those with a history of broken or cancelled appointments are not eligible for orthodontic treatment.
5. Patients must have good oral hygiene with no active gum disease or cavities.

14. HEARING AID POLICY EFFECTIVE APRIL 13, 2006

Contract Health Services will purchase hearing aids for those Tribal Members/Spouses with acute hearing problems based on hearing tests performed by a certified audiologist.

Tribal Member/Spouse will be eligible for hearing aids every 5 years. Broken hearing aids will be covered by Contract Health Services if the warranty does not cover. Cleaning will be covered as needed.

Lost hearing aids will not be replaced before the 5 years.

15. VISION POLICY Adopted 01/01/2008

Each Tribal Member/Spouse has \$450.00 in vision coverage annually.

Prescriptions for eyeglasses and/or sunglasses must be to correct vision and must be for corrections of .50 or greater.

Vision coverage includes: Vision exams
Corrective prescription lenses
Corrective prescription contacts
Eyeglass frames for corrective prescription lenses

90 DAY PRESCRIPTION POLICY

CIT CHS enrollees who have Contract Health Service for prescription medication coverage (Walgreens Health Initiative WHI) **exclusively** will utilize the WHI 90 day Advantage Prescription plan if available and applicable. Support for compliance to this policy will be provided by CHS staff.

Comment [MSOffice1]: What about those who do not use exclusively or is that an option

Procedure:

After the third monthly refill of a prescription medication, **WHI** will automatically transfer the prescription to a 90 day refill (WHI 90 day Advantage Prescription Plan) unless otherwise directed by patient's physician. If patient lives in an area where there is no participating pharmacy the patient may use the 90 day mail order pharmacy through WHI.

Comment [K2]: Please clarify that WHI must obtain a physicians prescription before transferring the script from 30 to 90 days,

Generic Prescription Policy

Purpose:

Those CIT CHS enrollees who have only Contract Health for their prescription medication must use the preferred pharmacy provider, Walgreen's Health Initiative (WHI). To ensure access to quality prescription drug coverage and contain pharmaceutical costs it is policy of the CIT CHS that members must utilize cost effective medications when medically appropriate.

Policy

WHI uses a three tier drug formulary, in which the medications are classified by costs, to three levels. Contract Health Service eligible individuals must use the lowest tier prescription available to treat their medical condition.

1st Tier: **Generics.** Generics contain the same active ingredient as their brand-name equivalents and offer the same effectiveness and safety. Some generics use a brand name instead of a chemical name.

2nd Tier: **Preferred.** Medications in this tier have been selected by your pharmacy benefit plan as preferred-brand medications. They are a higher cost than generics but are less costly than non-preferred medications on the third tier.

3rd Tier: **Non-preferred.** Because a generic version or a second-tier alternative is available, non preferred medications have a higher cost and are not listed on the Prescription Medication List (available upon request)

CHS enrollees will be required to utilize generic prescriptions when medically appropriate. If available, WHI will automatically fill all prescriptions using generic medications, unless otherwise directed by the licensed medical provider.

READ THE FOLLOWING: IF YOU DO NOT COMPLY, YOU WILL BE RESPONSIBLE FOR MEDICAL, DENTAL AND/OR VISION EXPENSES.

Contract Health Program Update

Contract Health Services has a limited amount of money available to provide medical care. To make the best use of these funds, Indian Health Service regulations require CHS enrollees to apply for “alternate resources” such as the Oregon Health Plan, if they are eligible. Please see the Indian Health Service regulation described below and call (541) 888-4405 or 1-866-862-7506.

Alternate Resource Regulations

Indian Health Service regulations require an individual to apply for an alternate resource if there is a reasonable indication that the individual may be eligible. The use of alternate resources is mandated in 42 CFR 36.23 (a).

Pursuant to Indian Health Service regulation 42 CFR 36.23(a), Contract Health Services will notify a Tribal member/spouse one time only of the need to apply for alternate resources and the failure to apply will cause denial of payment by Contract Health Services for medical, dental and vision services/charges. These charges will then be the personal responsibility of the Tribal member/spouse.

Exhibit A.

CIT CONTRACT HEALTH SERVICES

6/08/06

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Recovery of Contract Health Payments form Certain Speculative Alternate Resources.

From time to time the Contract Health Program will identify an alternate resource that can only be accessed through litigation or settlement negotiations that is beyond the Tribe's control. This type of alternate resource is speculative. Federal law authorizes the Tribe to sue contract health clients who ultimately collect on the speculative alternate resources described above. However, it is not the Tribe's policy to sue in every instance. Instead, it is the Tribe's policy to assess these situations on a case-by-case basis, and only after considering the totality of the circumstances. The Tribe will assess such factors as the patient's pain and suffering, the amount of the debt to the Contract Health Services program, socio-economic status of the patient, consequences of asserting the Tribe's claim, and any other relevant factors.

15. **Tribal Contract Health Service department telephone numbers**, local (541) 888-4405 or toll free (866) 862-7506. Individuals eligible for Contract Health Services are encouraged to contact the Contract Health Service department should they have any questions.

Consent to Use and Disclosure of Protected Health Information

45 C.F.R. 164.506.

I consent for CITCHC to use and disclose Protected Health Information (PHI), as necessary, to carry out treatment, payment, or health care operations.

The CITCHC has referred me to the *Coquille Indian Tribe Notice of Privacy Practices* (the “Notice of Privacy Practices”) for a more complete description of its treatment, payment, or health care operations covered by this consent and the uses of PHI included in my consent. I have been given an opportunity to review the Notice of Privacy Practices prior to signing this consent. The CITCHC reserves the right to amend the Notice of Privacy Practices. If CITCHC makes material changes to the Notice of Privacy Practices, it will post and distribute a copy of the revised Notice of its Privacy Practices to me at my most current address. The Notice of Privacy Practices will be posted in the CITCHC offices in a visible location. I understand that I may request a copy of our most current Notice at any time. Material changes to the Notice of Privacy Practices include, but are not limited to, changes to permissible uses or disclosures, changes to my rights or CITCHC’s duties under the Notice of Privacy Practices, or changes to other privacy practices contained in the Notice of Privacy Practices.

I have the right to request that the CITCHC restrict how PHI is used or disclosed to carry out treatment, payment or health care operations. The CITCHC need not agree to my requested restrictions. However, if the CITCHC agrees to my requested restrictions, the restrictions will be binding on the CITCHC.

I have the right to revoke this consent in writing, except to the extent that the CITCHC has taken action in reliance on this consent at the time it is revoked.

I acknowledge that I have received the Notice of Privacy Practices and understand that this document details how my PHI will be managed.

_____	_____	_____	_____
Patient Signature	Date	Authorizing Official	Date
_____	_____		
Parent/Custodian	Date		

I have read and understand the Contract Health Service Delivery Plan

Signed: _____ **Date:** / /

Printed Name: _____