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Integrating Indian Health Programs Into Medicaid Managed Care Systems, Part 2

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FINAL ROUNDTABLE REPORT

"Integrating Indian Health Programs Into Medicaid Managed Care Systems"

IHS Roundtable Meeting of
March 13-14, 1996

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

OFFICE OF PLANNING, EVALUATION, AND LEGISLATION
Acting Associate Director: Leo J. Nolan
Division of Program Evaluation and Policy Analysis
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INTEGRATING INDIAN HEALTH PROGRAMS INTO MEDICAID MANAGED CARE SYSTEMS

A ROUNDTABLE SPONSORED BY THE INDIAN HEALTH SERVICE

MARCH 13-14, 1996

Facilitated and Reported by:

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Ann Zuvekas, DPA

Center for Health Policy Research of
The George Washington University Medical Center

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INTEGRATING INDIAN HEALTH PROGRAMS
INTO MEDICAID MANAGED CARE SYSTEMS

A ROUNDTABLE SPONSORED BY
THE INDIAN HEALTH SERVICE

March 13-14, 1996

EXECUTIVE SUMMARY

The Indian Health Service (IHS), recognizing that state Medicaid programs are rapidly purchasing managed care plans for their beneficiaries and that managed care enrollment has significant implications for both Indians and Indian health facilities, convened this Roundtable to discuss options for participation in such care.

The purpose of the Roundtable was to identify options to increase Medicaid managed care participation by Indian health programs. These include programs operated directly by IHS, programs operated by tribes under the Indian Self-Determination Act, and urban Indian programs under Title V of the Indian Health Care Improvement Act. The overall goal of the Roundtable was to determine how to increase participation in Medicaid managed care among Indian health programs while maintaining their mission and capacity to provide a comprehensive and culturally sensitive health care system for all American Indians and Alaska Natives.[1]

By design, Roundtable participants were a group with diverse backgrounds in Indian health programs, safety-net providers (e.g., federally qualified health centers, public hospital), state Medicaid and health departments, and the managed care industry. The Roundtable was facilitated by two senior members from the Center for Health Policy Research of The George Washington University Medical Center.

I.   THE IMPORTANT ISSUES FOR PARTICIPATION IN MEDICAID MANAGED CARE

Some of the issues raised during the Roundtable are applicable to any health care provider who desires to participate in Medicaid managed care, while others relate generally to safety-net providers. Other issues are important to Indian health programs, as well as to AI/ANs and tribes as consumers of health services. The group's consensus was that all issues must be addressed if Indian programs are to be successful participants. The 21 issues the Roundtable identified can be clustered into five areas, as shown in Exhibit 1.

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[1] *For brevity's sake, in this paper we will use the terms "AI/ANs" to refer to both American Indians and Alaska Natives as persons and "Indian" when used as part of a program title: "urban Indian program."*

EXHIBIT 1
ISSUES IDENTIFIED BY THE ROUNDTABLE

ISSUE AREA	SPECIFIC ISSUE
A. Indian Health Program Mission and Roles	A.1 Preserving the Indian health mission
	A.2 Non-medical services
	A.3 Opportunity costs
B. Indian Medicaid Managed Care Populations	B.1 Medicaid eligibility
	B.2 Managed care enrollment
	B.3 Geographic isolation
	B.4 Population mobility
	B.5 Case mix
C. Indian Health Program Participation	C.1 Small numbers and networks
	C.2 Data capacity
	C.3 Capital
	C.4 Payment
	C.5 Risk management
D. Legal Issues	D.1 Section 1115 waivers
	D.2 Anti-deficiency Act
	D.3 Licensing
	D.4 Federal Tort Claims Act
E. Other Areas Needing Assistance/Training	E.1 Learning to negotiate contracts
	E.2 Marketing
	E.3 Flexible policy to meet local conditions
	E.4 Federal/state/tribal collaboration

II. THE ROUNDTABLE'S RECOMMENDATIONS

Roundtable participants expressed their belief that IHS must facilitate increasing the participation of Indian health programs in Medicaid managed care in conjunction with the tribes and the urban Indian programs. The Roundtable's recommendations fell into four areas: A) discussion and resolution of the above five issue areas; B) inclusion of managed care in all IHS strategic planning; C) being proactive in discussions with the individual states; and D) further follow-up work on the development of Indian health programs as Health Maintenance Organizations or networks.

A. Discussion and Resolution of the Five Issue Areas

Roundtable participants recognized that the five issue areas are far too complex to resolve in a two-day conference but believed that they should be addressed without delay by the Indian Health Service, the tribes, and urban programs, as well as outside experts. This could be done through additional Roundtables, working groups, or meetings dedicated to specific issues.

In each case, the issue to be addressed during follow-up meetings should be discussed and resolved from four distinct perspectives: 1) tribes and the IHS as group purchasers of care; 2) tribal organizations and IHS as potential operators of/participants in plans or networks; 3) urban, tribal, and IHS programs as providers of services; and 4) AI/ANs as consumers of care. Although in many cases the resolutions can amicably accommodate all four perspectives, in other cases they may conflict. For example, an Indian managed care plan might want to limit its payments to Indian health programs to assure its own financial viability, but such limitations might threaten the survival of the individual Indian health programs. Such conflicts will require much thoughtful discussion to resolve. It is also important to retain local flexibility. For example, it would be unwise to formulate a policy that no Indian health program engage in risk-based activities or, alternatively, that all must do so.

B. Consideration of the Managed Care Environment in Strategic Planning

For most Indian organizations managed care represents a sea change in the delivery and financing of health care. Roundtable participants recommended that consideration of this managed care environment should be woven into every IHS and Indian health program strategic planning activity and not treated as a peripheral issue. For example, Medicaid managed care should have a prominent place in the deliberations of the Indian Health Design Team (IHDT). (This was not to say that additional special focus should not also be placed on managed care issues; see above.)

The data-MMIS initiative should be undertaken with the information needs of managed care in mind. The group recommended that there be a collaborative data-systems development effort that would involve interested parties from state agencies, private sector health plans, tribes,

effort that would involve interested parties from state agencies, private sector health plans, tribes, urban Indian programs, fiscal agents, system vendors, quality assurance and accrediting bodies such as the National Committee on Quality Assurance, those with health care evaluation expertise, and HCFA. The purpose of the group would be to design **specifications** for the requisite management information systems but not to design the systems themselves nor mandate their use. This would result in guidance to the programs but permit sufficient flexibility that systems could be tailored to individual program or local needs.

C.   Being Proactive in Discussions with the Individual States

Roundtable participants, including representatives from states, stressed the desirability of early, frequent, and frank discussions with state agencies around managed care issues and Indian health programs. These discussions must be proactive and thoughtfully demonstrate to the states that solutions can be found to sticky problems in ways that will benefit -- or at least minimize harm -- to all parties. State agencies requested that these discussions be initiated as early as possible, even before the Section 1115 process is begun, and that Indian health programs provide as specific information as possible.

Roundtable members suggested that IHS take the lead in this effort, building on its current communication efforts with the states, but that the tribes and urban programs also be involved.

D.   Further Work on the Development of Indian Health Programs as Health Maintenance Organizations or Networks

Because of the number and complexity of the issues involved in Indian health programs' participation in Medicaid managed care, the Roundtable focused much of its attention on the programs as providers of care. The group recommended that further effort be expended on the issues and options for developing Indian health programs or groups of programs as health maintenance organizations (HMOs) and/or delivery networks.

II. THE ROUNDTABLE'S RECOMMENDATIONS

Roundtable participants expressed their belief that IHS must take the lead in increasing the participation of Indian health programs in Medicaid managed care, but that it do so in conjunction with the tribes and the urban Indian programs. The Roundtable's recommendations fell into four areas: A) discussion and resolution of the above five issue areas; B) inclusion of managed care in all IHS strategic planning; C) being proactive in discussions with the individual states; and D) further follow-up work on the development of Indian health programs as Health Maintenance Organizations or networks.

A. Discussion and Resolution of the Five Issue Areas

Roundtable participants recognized that the five issue areas are far too complex to resolve in a two-day conference but believed that they should be addressed without delay under the leadership umbrella of the Indian Health Service, but with input and guidance from the tribes and urban programs as well as outside experts. This could be done through additional Roundtables or working groups dedicated to specific issues.

In each case, the issue to be addressed during follow-up meetings should be discussed and resolved from four distinct perspectives: 1) tribes and the IHS as group purchasers of care; 2) tribal organizations of IHS as potential operators of/participants in plans or networks; 3) IHS programs as providers of services; and 4) Indian consumers of care. Although in many cases the resolutions can amicably accommodate all four perspectives, in other cases they may conflict. For example, an Indian managed care plan might want to limit its payments to Indian health programs to assure its own financial viability, but such limitations might threaten the survival of the individual Indian health programs. Such conflicts will require much thoughtful discussion to resolve. It is also important to retain local flexibility. For example, it would be unwise to formulate a policy that no Indian health program engage in risk-based activities or, alternatively, that all must do so.

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INTEGRATING INDIAN HEALTH PROGRAMS
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The Indian Health Service (IHS), recognizing that state Medicaid programs are rapidly purchasing managed care plans for their beneficiaries and that managed care enrollment has significant implications for both Indians and Indian health facilities, convened this Roundtable to discuss options for participation in such care.

The purpose of the Roundtable was to identify options to increase Medicaid managed care participation by Indian health programs. These include programs operated directly by IHS, programs operated by tribes under the Indian Self-Determination Act, and urban Indian programs under Title V of the Indian Health Care Improvement Act. The overall goal of the Roundtable was to determine how to increase participation in Medicaid managed care among Indian health programs while maintaining their mission and capacity to provide a comprehensive and culturally sensitive health care system for all American Indians and Alaskan Natives.[1]

By design, Roundtable participants were a group with diverse backgrounds in Indian health programs, safety-net providers (e.g., federally qualified health centers, public hospital), state Medicaid and health departments, and the managed care industry. (See Appendix A for a list of participants.) The Roundtable was facilitated by two senior members from the Center for Health Policy Research of The George Washington University Medical Center.

To ensure that the participants shared a common understanding of key issues from which they could form their discussions and recommendations, the Roundtable convened by summarizing Indian health programs and Medicaid managed care (see Appendix B for agenda). The program then moved to presentations and discussions about Medicaid managed care in individual states, the formation of managed care networks, other strategies for addressing managed care, and other issues in Medicaid managed care. Finally, the participants formulated recommendations regarding actions that IHS could take to increase the participation of Indian health programs in Medicaid managed care. Throughout, the primary emphasis was placed on the Indian health programs as managed care providers and (potentially) as managed care plans; a secondary focus of the meeting was on the role of the IHS and tribes as purchasers of care and, more generally, as consumers.

This summary is presented in four parts: I) An overview of the Indian health programs;

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[1]*For brevity's sake, in this paper we will use the term "Indian" to refer to both American Indians and Alaskan natives.*

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II) State approaches to Indian and Indian health program participation in Medicaid managed care; III) The important issues for participation in Medicaid managed care; and IV) The Roundtable's recommendations. Appendix A contains a list of participants; Appendix B is the Roundtable's agenda; and Appendix C gives further relevant information about Indian health programs.

I.   AN OVERVIEW OF INDIAN HEALTH PROGRAMS

Indian health programs consist of three types: IHS-operated facilities, tribal health programs, and urban Indian health programs. The programs also contract for services (e.g., specialty physicians) that they do not directly provide. In FY 1995 they served a total of 1.4 million patients, from an estimated total eligible population of 1.8 million, costing an estimated $1.4 billion. In addition to personal health services, the IHS and tribal programs also provide sanitation and environmental services, such as assuring a clean water supply.

The health programs represent a major commitment to health care for Indians: 49 hospitals in 12 states, 180 health centers in 27 states, 8 school health centers, 273 health stations and satellite clinics in 18 states, and 400 substance abuse treatment programs. Clearly, the Indian health programs have wide experience in the management of health care under limited budgets.

In 1987 54.9 percent of the U.S. Indian population was uninsured, a rate that is likely to have increased since the survey was done, since there has been a significant decline in health insurance coverage in the U.S. population overall since 1987. About 28 percent of Indians had employer or other private insurance, 6 percent had Medicare coverage, and 11 percent were eligible for Medicaid. It is this last group (11 percent of the Indian population) that the Roundtable addressed. (See Appendix C for further information on Indian health programs.)

II.   STATE APPROACHES TO INDIANS AND INDIAN HEALTH PROGRAMS' PARTICIPATION IN MEDICAID MANAGED CARE

Since Medicaid has historically been a joint federal-state program administered largely by the states, there has been great variation in the program among states. This feature has been underscored recently with the eagerness of states, and willingness of the federal government, for states to experiment with modifications of the program, especially managed care arrangements for non-institutionalized beneficiaries. In doing so, states are seeking to restrain the costs of Medicaid, now consuming about a fifth of the state budgets, while assuring access to quality care. These modifications are usually conducted under waivers granted by the federal

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government to permit such demonstrations.[2]

The design of each state's Medicaid managed care arrangements for eligible Indian beneficiaries will affect both the issues and the strategies that Indian health programs must consider as they seek to increase their participation in Medicaid managed care. For example, in a state such as Oregon where Medicaid-eligible Indians must enroll in managed care plans and where the programs have no rights to payments for services to Medicaid beneficiaries enrolled in health plans that exclude Indian health programs, there are compelling reasons to participate aggressively in managed care.

Exhibit 1 shows the wide variation in critical aspects of state Medicaid managed care arrangements in selected states with concentrations of Indian populations. The major features of the arrangements are:

- **Whether eligible Indian beneficiaries must enroll in managed care**: With some exceptions, Medicaid-eligible Indians in Oregon, Oklahoma, and Minnesota (in Minnesota's case, for off-reservation Indians) must enroll, while in New Mexico they have the option to do so.

- **Whether managed care plans must include Indian health programs in their networks**: Only California currently has this requirement, and then only in selected areas.

- **Whether Indian health programs have the right to be fee-for-service primary care case management (PCCM) managed care providers:[3]** Oregon, Oklahoma, New Mexico, and California grants this right; Minnesota does not.

- **Whether IHS programs can receive payment for out-of-plan services:** Since Indians are accustomed to receiving services from IHS health programs and are likely to do so even after enrolling in managed care plans that exclude their traditional Indian health program, the programs naturally prefer to be paid for these "out-of-plan" services. In Oklahoma, New Mexico, and California the IHS programs have the right to these payments.

- **Whether IHS programs must receive 100 percent of their reasonable costs when serving as PCCM providers**: Of the five states, only in New Mexico and California do they have the right to recoup their costs.

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[2] *See discussion below on Medicaid waivers.*

[3] *PCCM primary care providers receive a separate case-management fee (typically $3 per month) for each enrollee whose care they are overseeing; they often must pre-authorize other types of care, such as visits to specialists or hospitalizations. However, their medical services and those of all other providers are paid on a fee-for-service basis, like traditional indemnity insurance.*

EXHIBIT 1

CHARACTERISTICS OF SELECTED MEDICAID MANAGED CARE PLANS WITH RESPECT TO
KEY ISSUES IN MANAGED CARE AND INDIAN HEALTH[4]

| ISSUE	Oregon	Oklahoma	Minnesota	New Mexico	California
Managed care enrollment is at beneficiary option for AI/ANs.	√	√	X[5]	X	√[6]
HMOs must include Indian health programs in networks.	X	X	X	X	√[7]
Indian health programs have right to be fee-for-service PCCM managed care providers.	√	√	X	√	√[8]
Indian health programs have right to payment for out-of-plan services.	X	√	X	√	√
Indian health programs have right to reimbursement for 100 percent of reasonable cost of care when acting as PCCM providers.	X	X	X	√	√

√ = yes   X = no

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[4]*Source: materials from states, augmented by comments from Roundtable participants.*

[5]*Reservation AI/ANs excluded from managed care demonstration.*

[6]*Except where there are county plans.*

[7]*Only in cases in which the model is other than the two-plan model or the county-organized system.*

[8]*In two-plan and county-organized areas only.*

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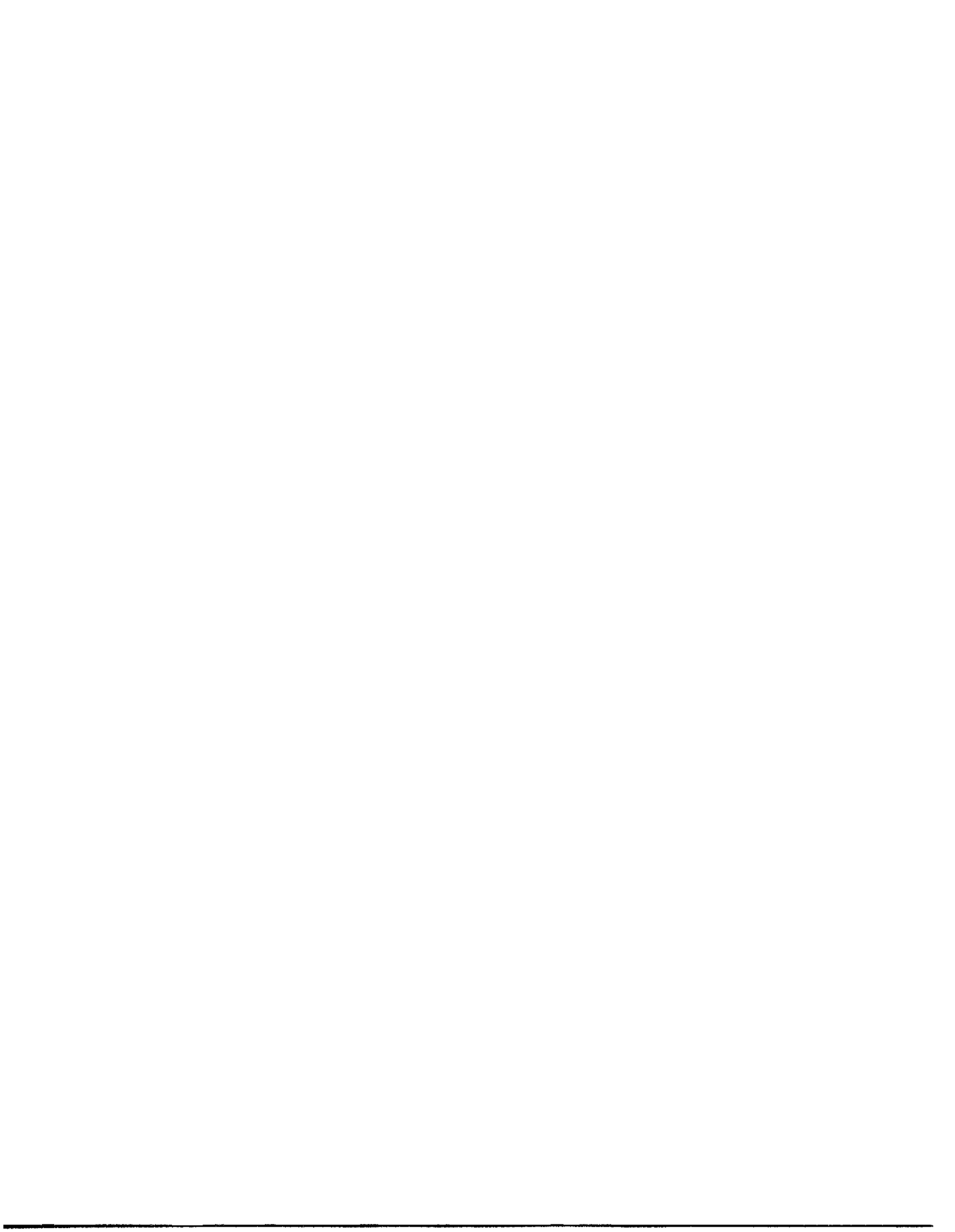
- Whether IHS programs must receive 100 percent of their reasonable costs or all-inclusive negotiated rates when serving as PCCM providers: Of the five states, only in New Mexico and California do they have the right to recoup their costs.[9]

State-specific arrangements were important parts of the Roundtable's deliberations, as will be seen from the summaries of the issues in Section III.

III. THE IMPORTANT ISSUES FOR PARTICIPATION IN MEDICAID MANAGED CARE

Some of the issues raised during the Roundtable are applicable to any health care provider who desires to participate in Medicaid managed care, while others relate generally to safety-net providers. Other issues are important to Indian health programs, as well as to AI/ANs and tribes as consumers of health services. The group's consensus was that all issues must be addressed if Indian programs are to be successful participants. The 21 issues the Roundtable identified can be clustered into five areas, as shown in Exhibit 2.

A. Indian Health Program Mission and Roles

Roundtable participants made clear their commitment to the IHS programs' mission even as circumstances may present challenges to the traditional means of fulfilling that mission.

A.1 Preserving the Indian health mission

Indian health programs have as their legally defined mission the provision of high-quality care to AI/AN peoples within the resources available. While managed care plans sign state contracts that are valid for each enrollee only during the time that enrollee is eligible for Medicaid, Indian health programs continue to serve them during the periods that they are not · Medicaid eligible and, therefore, uninsured. Nationally, Medicaid eligibility lasts less than a year on average; in any given year 40 percent of resources available.[10] While managed care plans sign state contracts that are valid for each enrollee only during the time that Medicaid enrollees lose coverage. Because such a high proportion of AI/ANs are uninsured when not enrolled in Medicaid, the financial viability of IHS programs is crucial.

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[9]*It may seem paradoxical that states may pay less than 100% of the costs in IHS facilities when they can pass all such costs back to the federal Health Care Financing Administration for full reimbursement to the state. At the conference some states indicated that on principle they did not wish to pay IHS facilities at rates higher than for non-IHS facilities.*

[10]*Unlike Medicaid, the Indian health programs do not create a legal entitlement to all medically necessary health care; instead, the availability of care is limited to the amount that can be provided under annual appropriations. The financial limitations of the IHS should not be confused with the entitlement of Indians to obtain whatever care is available through IHS programs.*

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9. The Role of Medicaid in Funding IHS Operations

- $107 million in Medicaid collections represents 6.3% of the FY95 appropriations for the Indian Health services program[14].

1. Legal Authority of Indian Health Programs to Enter Into Risk Agreements Under Medicaid

- Under the Anti-Deficiency Act, 31 U.S.C. §1341, a Federal employee may not incur obligations in advance of or in excess of appropriations. As a result, contractual managed care obligations to furnish care to an enrolled population for a fixed premium that might not cover the cost of services under the contract would constitute a violation of the Act according to the Office of General Counsel, HHS.[15] However, if the contract conditions IHS obligations on the appropriation of federal funds by Congress, there would be no violation.[16] Moreover, contracttual specifications that permit the IHS to adjust service obligations to remain within the available budget would also allow the agency to avoid violation of the Act. Third, a managed care contract that provides reasonable cost reimbursement would not violate the Act.[17] Finally, stop-loss arrangements with the state, in combination with authority to limit benefits in light of budget constraints, might also avoid violation of the Act.[18]

- Because the Anti-Deficiency Act applies only to federal employees and not to tribal contractors, there is no bar to tribal participation in managed care under the Act.[19]

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[14]Telephone conversation with Harell Little, Special Assistant to the Director of the Office of Health Programs. Data source: Department of Health and Human Services, Indian Health Service, FY95 Justification of Estimate for Appropriations Committees, p. IHS-2.

[15]Memorandum from Barbara Hudson to Richard McClosky (February 13, 1995).

[16]Id.

[17]Id.

[18]Were the IHS facility permitted under a managed care contract with a state Medicaid program to reduce covered benefits rather than incur losses, other questions might arise under the Medicaid statute. The state's obligation to furnish mandatory benefits of sufficient amount duration and scope to individuals is not extinguished by their enrollment in a managed care plan; hence, the state might be liable for coverage of services that are reduced by the Indian health plan. Moreover, comparability issues might arise were services to be reduced for individuals enrolled in an IHS plan compared to individuals enrolled in other health plans that are not permitted to renegotiate the scope of their service agreements in the event that the premium is insufficient to cover their costs.

[19]Hudson, op. Cit.

However, the mission sometimes does not "fit" neatly with managed care:

- AI/ANs who have enrolled with a health plan that does not include an Indian health program in its network nonetheless will often seek care from the Indian health program, which cannot or will not turn them away. This "out-of-plan" use is not compensated by the plan or the state unless, as is the case in California and Oklahoma, arrangements to do so have been made.

- Managed care plans often have patient cost-sharing arrangements, such as co-payments or co-insurance.[11] These are designed both to be a hesitation fee (to discourage unnecessary utilization) and to keep the plans' costs down. Indian health programs, in contrast, offer services without such cost-sharing; the IHS is legally prohibited from charging patients.

- Indian health programs are designed to deliver or purchase care, not to purchase insurance and are legally prohibited from doing so. For health plans that have sliding-scale premiums based on income, there may be no way to subsidize AI/AN enrollees' premiums, even though doing so may be financially advantageous to all.

- Especially in areas where there are few other providers, plans may require Indian health programs to accept non-Indian patients, which can change the ambience of their programs.[12] This could also conflict with the right guaranteed by Congress to tribes to determine if they wish to allow non-Indians to be served in their facilities if certain conditions are met.[13]

- Indian health programs could possibly become too adept at the business side of health care, so that they drive away their traditional patient base. This could happen, for example, if patients feel rushed through the system by increased productivity requirements that result in shorter time with the clinicians.

Clearly, balancing the programs' mission with the new world of Medicaid managed care is a challenge.

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[11] *IHS rulings prohibit use of IHS funds for payment of insurance-related premiums and cost-sharing. See Memorandum from Ernest Isham to Dr. Clark Marquart (IHS, Regional Office, Portland, Oregon, 1995). As a result AI/ANs would have to hear the cost out of pocket.*

[12] *Opening IHS-owned and operated facilities to non-Indians would require following statutory procedures.*

[13] *These conditions include: 1) no decrease in services for Indian patients, and 2) no reasonable alternative facility available in the vicinity for the non-Indian patients.*

A.2 Non-medical services

Because of the complex of needs of their target populations, Indian health programs have long provided services that go far beyond the basic medical model of care. These services may be environmental or sanitary (e.g., development and maintenance of a safe water supply); public health in nature, such as health education campaigns or surveillance of diseases; enabling or access services such as cultural competence, translation, and transportation; psychosocial services to individuals, families, and groups; services of traditional healers; and others. Maintaining the funding streams to continue these services is critical.

Although most states' expectations of managed care are based on a medical model, which is also favored by the plans because they are already familiar with managing medical care from their commercial contracts, some states are showing some flexibility. For example, New Mexico is giving preferential treatment in its selection of contractors to locally based health plans offering more such services; perhaps more typically, Minnesota requires plans to show ties to psychosocial services even though the state will not pay the contractor for their provision. Where such requirements are in place and enforced, Indian health programs may have some leverage in helping the plans to meet the states' requirements and in insisting on payment for their assistance.

Nonetheless, managed care is unlikely to provide sufficient funding for the Indian health programs to provide these functions in the future, and alternative sources must be assured. Furthermore, services are often delivered in Indian health programs in ways that make it more difficult to determine the capitated COLA of care for a given benefit package.

A.3 Opportunity costs

Participation in Medicaid managed care requires expenditures of resources. Sometimes the costs are obvious, such as spending for new facilities or information systems. Sometimes they are more hidden, such as the devotion of management time to the conversion. Managed care contracts may require 24-hour coverage, longer hours, malpractice insurance, and shorter times to obtaining an appointment, all of which have cost implications. It should be noted that these costs rise for all patients, not just Medicaid patients, yet resources for the uninsured may be limited.

Covering these expenditures may divert funds from other opportunities, causing them to be called "opportunity costs"; in other words, resources may be spent on preparing for Medicaid managed care that otherwise might have gone for addition or maintenance of programs to meet special needs, expansions in geographic accessibility, or other vital needs. The trade-offs are real and must be carefully weighed in a program's decisions whether or not to participate in Medicaid managed care, how much to do so, and under what terms.

These determinations can be made only in the local context. For example, in a state with mandatory enrollment in managed care and with no payments for out-of-plan use of services, a

tribal or IHS-operated program may well decide that it cannot afford to lose the Medicaid revenues that would inevitably be gone if the entity does not participate in managed care. On the other hand, in a state where AI/AN beneficiary enrollment in managed care is voluntary and out-of-plan payments are reasonable, the entity may decide to forego aggressive participation in managed care.

B. Indian Medicaid Managed Care Populations

For Indian health programs to receive Medicaid funding under a Medicaid managed care environment, AI/AN individuals must first be determined to be eligible for Medicaid and then enroll in a Indian health or enroll in a managed care plan which will pay for services provided in an Indian health program. In addition, Roundtable participants raised the issues of geographic isolation, population mobility, and case mix, all of which have implications for managed-care participation by both AI/ANs and the IHS programs.

B.1 Medicaid eligibility

For Indian health programs to participate in Medicaid managed care, their patients must be enrolled in Medicaid. Unfortunately, several enrollment barriers exist. First, AI/ANs must apply for Medicaid, which they may be reluctant to do, because they perceive that they have a right to IHS benefits under treaty obligations and federal law. Those who believe that health care is a right have little incentive to apply for Medicaid, except for those who require IHS contract health services (CHS) which are specialty services that cannot be provided by an Indian health program. CHS funds cannot be authorized prior to the utilization of alternate third party resources including Medicaid. AI/ANs' reluctance to apply may be reinforced by federal legislation enacted in 1993 that requires states to recover assets from deceased Medicaid beneficiaries.[14] This threat could become even more real as states move into managed long-term care. AI/ANs may also view Medicaid as unwelcome charity, particularly if the health plan includes the term "Medicaid" in its name.

The philosophical barriers created by the Medicaid process are compounded by practical problems. Applications may require extensive documentation. Application centers may be located at sites that are quite distant from the applicants' homes. These barriers are somewhat lowered in the case of the urban Indian programs' classification as "Federally Qualified Health Centers (FQHCs)," since federal law requires that the state outstation eligibility workers at FQHCs to serve pregnant women. In addition, some states such as Arizona outstation eligibility workers at tribal and/or IHS health facilities.

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[14]*Although the conditions under which the federal statute can be applied are limited (usually to long-term or other institutional care), some state and local governments may also have legislation requiring liens, causing great confusion and apprehension. In addition, many states have limited understanding of AI/AN laws regarding inheritance and abrogation of tribal property.*

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Like many of their Medicaid-eligible non-Indian counterparts, the categorical and financial restrictions on eligibility by Medicaid mean that AI/ANs may move on and off the eligibility lists as they gain or lose employment, finish a pregnancy, or experience changes in financial and family circumstances. Despite the fact that AI/ANs can enroll in Medicaid managed care only during the periods that they are Medicaid-eligible, Indian health programs, unlike other providers, have both the moral and the legal obligation to provide available services during their non-eligible periods without receiving Medicaid payments during those periods.

B.2 Managed care enrollment

Although state Medicaid programs can offer Medicaid beneficiaries voluntary enrollment in managed care plans, mandating that they do so can only be implemented under a Section 1915(b) or 1115 federal waiver. Almost all states are moving toward mandatory enrollment in managed care, at least for the non-institutionalized Medicaid populations, because they believe that managed care can control costs while assuring access to quality care. In light of studies showing that voluntary enrollment achieves relatively low Medicaid managed care penetration, mandatory enrollment arrangements are increasingly widespread, as data presented during the Roundtable indicate. Where managed-care enrollment is mandatory, providers, including the Indian health programs, either must participate in some way or else risk loss of their patients to providers who do participate unless states make provision for direct payment to IHS programs regardless of their participation; such a loss of patients could threaten the scope of services to uninsured AI/ANs (who represent the majority of Indian health patients) because of the loss of Medicaid revenues.

Even when they have federal approval to mandate enrollment in managed care plans, some states are approaching AI/ANs living on reservations differently from those who live off-reservation. For example, Minnesota will be phasing in mandatory enrollment for on-reservation AI/ANs over three years; New Mexico mandates that AI/ANs enroll in a primary care case management plan (PCCM), but not in a capitated at-risk plan. In Arizona, on the other hand, AI/ANs have 16 days from the time of eligibility determination to sign up with either a health plan or an Indian health facility; if they live on a reservation, then they are assigned to an Indian health facility.

In Oklahoma Medicaid-eligible AI/ANs must enroll in a managed care plan, although they can continue receiving care at Indian health facilities; those facilities are then paid directly by the Medicaid agency on a fee-for-service basis. In effect, AI/ANs who have enrolled in managed care but who retain the freedom to seek Medicaid-covered care directly from Indian health facilities have "dual insurance coverage" much like elderly and disabled individuals enrolled in both Medicare and Medicaid. In Oregon AI/ANs may either sign up with a managed care plan or with an Indian program; however, once they have selected a plan, an Indian health program that serves them on an out-of-plan basis (i.e., the program is not a contracted provider for their managed care plan) cannot receive Medicaid payments for their care.

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In states where enrollment in managed care plans is mandatory for Medicaid-eligible AI/ANs, beneficiaries must select their health plans. Those who do not make a selection may be "auto-enrolled" in a plan, i.e., the state Medicaid agency chooses a plan for them. States' rules for auto-enrollment can include assignment to the health plan with the patient's existing provider panel, by geography, or even by Indian/non-Indian status. In most states, however, there is no guarantee that the health plan chosen by the state for auto-enrollees will include Indian health facilities in its provider network, even when AI/AN auto-enrollees have been receiving their care from IHS program facilities.

B.3 Geographic isolation

Many IHS and tribal facilities provide services in remote, sparsely populated, rural areas with few other health care providers. On the one hand, this may make the Indian programs attractive to managed care plans because they offer both service capacity and enrollment of the population. On the other hand, clinics located in sparsely settled areas will likely be unable to accept risk themselves, at least without substantial stop-loss or reinsurance provisions.[15] In addition, the clinics might not be able to meet the requirements to become a managed care provider.

Because they may be among the only providers in an area, Indian health programs may be under pressure to accept non-Indians into their patient panels; indeed, they may choose to do so to raise their patient load and thus decrease unit costs and risk (See below). However, adding significant numbers of non-Indians as patients may decrease the Indian health programs' attractiveness to AI/ANs and/or be seen as abandoning their AI/AN culture and mission.

B.4 Population mobility

Many AI/AN people do not fit the traditional managed care enrollee-profile, particularly in stability of residence. AI/ANs migrate to large cities for a variety of reasons including jobs, education, job training programs, cultural ties, family needs better health care, moving frequently between reservation and urban areas. Those who do so are likely to be young and lower risk, leaving older, more costly persons behind.

Most managed care plans prefer -- and even contractually require -- that enrollees receive

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[15]*Reinsurance and stop-loss are variations on the theme of limiting the financial risk to which a health plan or provider may be exposed. In some cases, the state self-insures for losses above a contracted limit; in other cases, the plan or provider may purchase reinsurance for that exposure. Alternatively, the provider or plan may be able to select the risk-sharing mechanism, or the state, plan, and provider share the risk.*

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their care from a geographically limited network of providers and will pay only for emergency care when the patient is out of the area. In the case of migrating AI/ANs, need for such health services as prenatal care may not fit the plan's definition of "emergency," making the patient uninsured for such services.

B.5 Case mix

AI/AN enrollees in Medicaid managed care plans may have more complex medical and social needs then their non-Indian counterparts, necessitating more expensive interventions. The phenomenon of costly case mix can occur either because a particular AI/AN community has more complex health needs (e.g., for diabetes care) or else because the Indian health programs have traditionally reached out and made their services accessible to those most in need.[16] Case mix matters potentially have significant financial implications. This is particularly true if the Indian health program is paid on a capitated basis but is still present even if payment is on a fee-for-service (usually discounted) schedule.

C.   Indian Health Program Participation

Roundtable participants identified issues that arise as Indian health programs seek to participate in managed care as either providers or health care plans.

C.1 Small numbers and networks

In managed care, serving larger numbers of enrollees has three advantages:

■   Assuming that sufficient service capacity exists, fixed costs (e.g., information system hardware) and quasi-fixed costs (e.g., need for a receptionist) can be spread over larger numbers, thus lowering unit costs. This phenomenon is called "economies of scale."[17]

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[16]*Readers should be aware that Indian health program data on utilization and costs are for patients only, while managed-care plan "enrollment" includes some people who will never use the services. In fact, the actuarial projections for managed care plans always assume that some proportion of the enrolled population will not require services. Since Indian health programs may be converting their patients -- who by definition are using services -- to enrollees, they likely will have higher costs resulting from this "adverse selection."*

[17]*Programs will, however, want to do financial projections to determine if this is true for their particular circumstances, since bigger is not always more efficient.*

- Where it exists, financial risk can be spread over more patients, making it less likely that one seriously ill (and therefore expensive) patient will break the program's bank.

- The ability to serve large numbers enhances the market power of the Indian health programs as they negotiate with the state or managed care plans.

One way of building larger numbers, even for a small program, is by networking with other AI/AN and/or non-Indian providers. These networks can be horizontally integrated, i.e., all at one service level such as primary care, they also can be vertically integrated, i.e., at different levels of service such as primary care, home health care, and inpatient hospital care. These networks may develop into full-blown HMOs (e.g., horizontally integrated Neighborhood Health Plan in Massachusetts and vertically integrated CareOregon in Portland); alternatively, they may accept little or no risk. Even for-profit managed care plans such as United Health Care have created networks in some states.

As Indian health programs have long known, patients tend to receive better care when they are part of integrated health care systems. First, integrated systems may promote greater continuity of care. Second, funds that are freed by sharing such expenses as information systems can be used to provide for an AI/AN community's special health-related needs such as for elder care or outreach. Third, a network may be able to afford more sophisticated quality improvement programs than could a single program. Finally, a network can be very attractive to a purchaser of services (e.g., a state Medicaid agency) or a plan because one contract can be negotiated on behalf of all participants, thereby lowering administrative costs.

Roundtable participants noted several impediments to formation of Indian health care networks, even in areas in which the base for a network of directly operated and contracted providers may exist. The first impediment is money. Network formation is costly, with start-up costs often in the several million-dollar range. A second problem is acquiring the extensive legal and business expertise in management information systems, contract negotiations, actuaries, etc.

Beyond provider-network formation lies the issue of health plan development by a tribe or group of tribes. While this matter received only limited attention at the Roundtable, it was clear that some tribes might be interested in developing fully integrated health plans capable of meeting the health care needs of AI/ANs. Possible approaches might be partnering with an established plan or creating a new plan.

C.2 Data capacity

Managed care, whether capitated or not, requires information systems that can link data related to patient demographics and care, utilization of services, financial and billing data.

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Systems also might be asked to deal with applicable claims-processing requirements. Information systems with the level of sophistication to measure costs for various types of services and patients do not yet exist in Indian health programs. This lack of information limits the programs' abilities to market themselves as reasonable-cost providers, to negotiate contracts with good rates, and to manage the contracts once received. This gap will become even more critical as states such as New Mexico demand both that claims be submitted electronically and that encounter-level data be made available.

C.3 Capital

Participation in managed care requires up-front capital to compete effectively and satisfy state licensure/federal qualification requirements. Large commercial health plans have ready access to such capital, while safety-net providers including Indian health programs generally do not. The capital is needed for sophisticated information systems capable of handling managed care; facilities and equipment that will attract both patients and clinicians; start-up costs, such as planning and legal fees; hiring of administrators with managed-care experience; and often the state-required reserve funds. Although the need for such capital is directly related to the degree of risk that the program plans to accept, these capital needs are real and are present in any managed care enterprise.

C.4 Payment

Reimbursements: As noted above, participation in "managed care" may or may not involve accepting payment on a capitated basis. Depending on a state's managed care arrangements, Indian health programs can contract directly with the state on a capitated or non-capitated basis. Even where states use only risk-bearing managed care arrangements, IHS programs could contract with health plans on a capitated or non-capitated basis. In New Mexico, for example, the state pays health plans on a fee-for-service basis for care given by any Indian health program and the plan passes on the payments to the Indian health program providers; the state makes no direct payments to Indian health program providers. In contrast, in Oklahoma, Indian health programs can bill the state directly for out-of-plan use by AI/ANs. Some states regulate how plans pay their sub-contractors; others do not. Urban Indian programs that are FQHCs remain entitled to cost-based reimbursement unless that provision has been waived under a Section 1115 waiver. (See below.)

Scope of care: Clearly, payment must be proportionate to the scope of services related to that payment, and these scopes must be crystal clear. For example, although "primary care" is too vague a term on which to base a contract, too many for-profit and not-for-profit providers have agreed to provide it for a fixed price without further definition. Arizona permits tribes to determine the scope of services that they will provide, with cross-referral among the health plan, the IHS, and the tribe.

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IHS as a cross-subsidy to Medicaid: The Health Care Financing Administration (HCF), the federal agency that administers Medicaid, requires that managed care plans cost the government no more than 95 percent of Medicaid expenditures under fee-for-service for a comparable population. To date HCF has the authority to define budget-neutrality only in terms of Medicaid expenditures, excluding IHS expenditures on covered populations. Thus it is possible that, if Medicaid payments to IHS facilities were to decline under contracts with plans, IHS funds flowing to these facilities for the non-covered populations would cross-subsidize Medicaid-insured care. Similar trends have been identified in other publicly supported health programs following the advent of managed care. As this happens, then the Indian health programs' ability to serve uninsured AI/ANs would be diminished.

C.5 Management of Financial Risk

As noted above, the case mix of AI/AN Medicaid enrollees may be more complex medically -- and thus financially -- than a comparable group of non-Indian enrollees. As is true for most financial transactions, the greater the absorbed risks, the greater the potential for both payoffs and losses. Unfortunately, Indian health programs lack the deep pockets available to large insurance companies and managed care plans, so that they are wise to take on only the risks they can manage (e.g., services) or lay off through other arrangements such as stop-loss or reinsurance.

D.   Legal Issues

Roundtable participants identified four legal issues that must be addressed: Section 1115 waivers, the Anti-Deficiency Act, licensing, and the Federal Tort Claims Act.

D.1 Section 1115 waivers

As discussed above, states must receive a waiver of federal Medicaid freedom-of-choice rules before they can mandate that Medicaid beneficiaries enroll in managed care plans. These waivers generally take one of two forms: the more restrictive Section 1915(b) waiver and the broader Section 1115 waiver. With HCF's permission, states may use the Section 1115 waivers to avoid federal Medicaid regulations not waivable under Section 1915.[18] Because of this increased flexibility, many states that have previously had 1915(b) waivers are now seeking 1115 waivers.

States receiving Section 1115 waivers are designing managed care systems that could be expected to have a major impact on Indian health programs:

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[18]For example, Section 1115 allows changes in eligibility, benefits, and federal standards governing contracts with Health Maintenance Organizations. Section 1915, on the other hand, only permits states to waive federal freedom-of-choice rules (and a few selected other provisions).
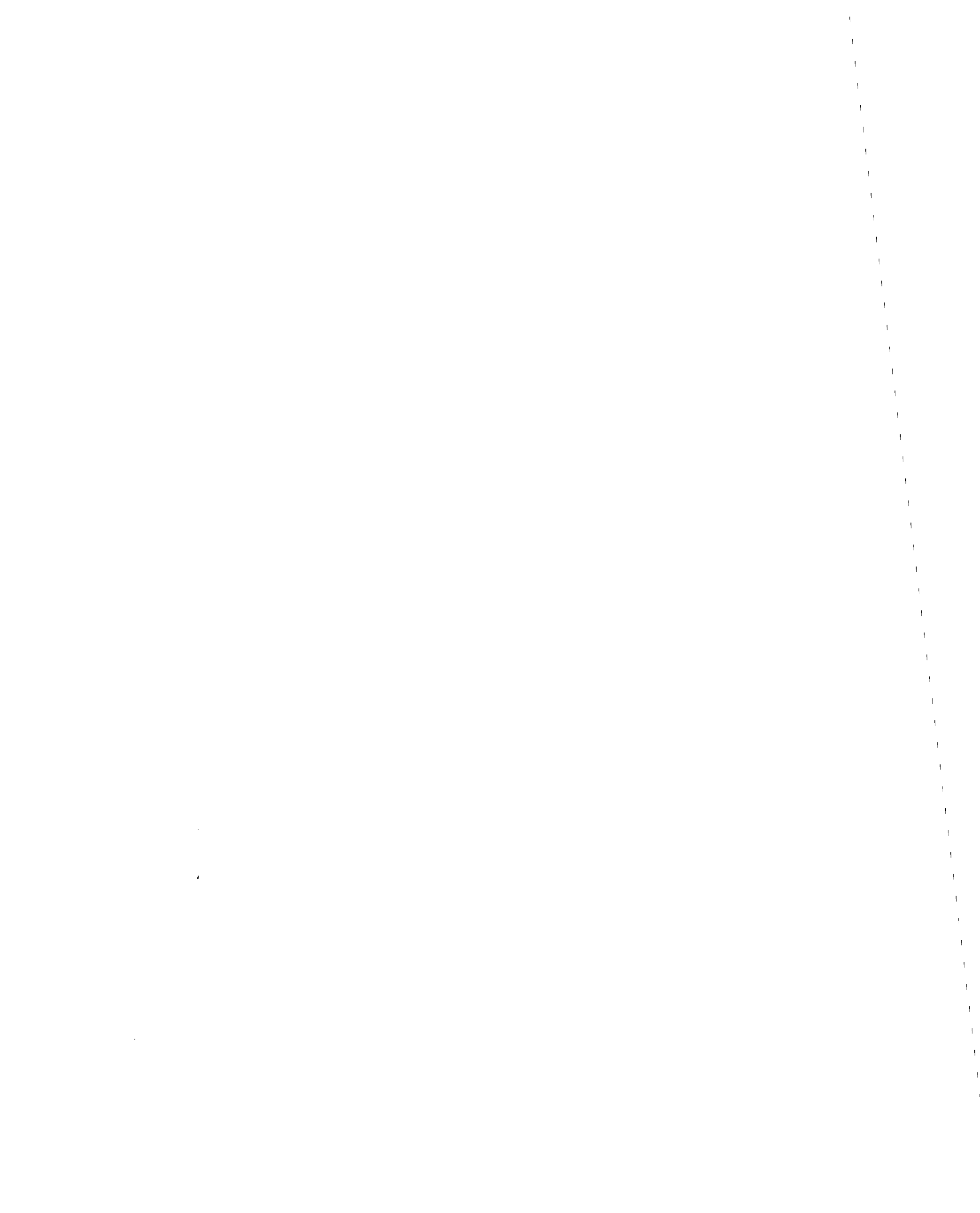
- Mandating enrollment in types of managed care plans defined as acceptable by the state. Unless Indian health programs participate in managed care, they may find that they no longer qualify for Medicaid revenues[19]. (This change would also be present in a Section 1915 waiver).

- Expanding eligibility to certain classes of low-income people (e.g., adult single non-disabled males) previously not covered by Medicaid, often with premiums and cost-sharing for services on a sliding schedule tied to beneficiary income. Potentially expanded eligibility could mean additional payments to Indian health programs for care to the previously uninsured, but the change also could result in confusion for potential enrollees who cannot or choose not to pay the required cost-sharing, especially since they have come to regard the Indian health programs as a right without cost-sharing.

- Deletion or phase-out of FQHC services as a covered benefit and elimination of their cost-based reimbursement policy for FQHC services. Urban Indian programs and programs operated by tribes under the Self-Determination Act or the Indian Health Care Improvement Act have come to rely on this cost-based reimbursement; payment under managed care may well be at lower levels.

D.2 Anti-Deficiency Act

The federal Anti-Deficiency Act (ADA) prohibits federal employees from engaging in activities that would result in a financial risk to the federal government beyond levels permitted under federal appropriations. Thus far, IHS has interpreted the Act to prevent IHS-operated programs from entering into risk contracts with either states or health plans,[20] thus limiting the managed-care options for IHS-operated programs to non-risk arrangements.

The questions is what constitutes a "risk arrangement." According to the IHS, open-ended commitments to provide health services to certain beneficiary populations constitute risk arrangements. In managed care, a provider is obligated by contract to furnish one or more services to enrolled members. Therefore, any agreement that reimburses the provider less than its cost would constitute a "risk agreement", since the provider must furnish the service regardless of the level of the compensation received. Clearly a capitation agreement under which a health care provider agrees to furnish a range of care for a fixed, all-inclusive, per-person rate constitute

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[19]The fact that federal payments to an IHS facility are reimbursed at 100% Federal Medical Assistance Percentage (FMAP) has no bearing on whether the facility's services are covered when furnished to an enrollee. Unless the facility is part of a managed care network, its services would be considered out-of-plan and therefore nonreimbursable unless a demonstration were to mandate continued out-of-plan coverage. Presumably, states would not object to this requirement given the 100% FMAP rate.

[20]The Anti-Deficiency Act does not apply to tribal or urban health programs.

a risk arrangement, since the provider is at risk for the cost of the services regardless of whether the capitation payment covers the cost. Similarly, a fee-for-service agreement that requires a provider to furnish any particular service for a fee that covers less than the cost of the service places the provider at financial risk for the uncompensated cost of the care which the contract obligates the provider to furnish. For Anti-Deficiency Act purposes, both capitation and non-capitation managed care service agreements raise serious risk issues, an in both cases steps would be needed (through supplemental payments, cost-settlement, stop-loss, or otherwise) to avoid the risk of loss.

D.3 Licensing

Virtually all states license managed care plans, many types of facilities, and individual providers. Where a facility is not exempt from licensure, it is the policy of insurers (including Medicaid) to make payments only to those facilities who are duly licensed and not to those without licenses. As a result, states licensure requirements can become critical to participating in managed care:

- Managed care plans: States typically license risk-based[21] Health Maintenance Organizations (HMOs) that meet certain standards in order to participate in Medicaid and lawfully sell managed care products to other group purchasers. Some states also choose to license other classes of prepaid health plans such as "integrated service networks." State licensure is important to Indian health programs because, in the absence of an exemption, licensure affects the capitalization and risk-reserve requirements, which can be substantial.[22]

- Facilities: Some states, license primary care facilities apart from their individual providers who are employed at these facilities. Tribal clinics report that, although they satisfy all FQHC requirements, they cannot receive Medicaid funds because they do not meet state licenses and certification requirements.

- Individual providers: Providers who are direct-hire employees of tribal and Indian programs such as physicians may be licensed by the state in which they practice. This is not an issue for IHS physicians who are federal employees.

In cases of state licensure, issues of tribal sovereignty may arise, requiring substantial education and negotiation with state officials.

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[21] *Receiving fixed payments per member per month regardless of the amount or cost of services provided. This payment or "capitation" places them at financial risk if costs exceed the payment.*

[22] *States are becoming more conservative by requiring larger reserve funds from plans than they have in the past, reflecting their negative experiences with plans becoming insolvent and forcing the state to scramble to enroll beneficiaries in other plans. However, alternatives to large up-front reserves do exist, such as reinsurance and treatment of physical plant as assets.*

D.4 Federal Tort Claims Act

Under current law, IHS and tribal facilities (both directly operated and contracted and compacted tribal programs) need not purchase malpractice insurance. Under the Federal Tort Claims Act (FTCA) the federal government self-insures against liability claims for covered torts (including liability arising from acts of malpractice), and tribal programs are covered under the same Act.[23] However, under managed care arrangements, difficulties can arise: 1) the standard contracts offered by many plans require proof of sufficient malpractice liability coverage and plans may be unwilling to accept FTCA in lieu of insurance coverage; and 2) FTCA may not cover all of additional malpractice-related risks inherent in Indian health program participation in managed care plans. Examples of added liability might be allegations of malpractice involving health plan coverage-determination matters, coverage during on-call periods for non-IHS physicians, and coverage while treating non-AI/ANs.

E.   Other Areas Needing Assistance and Training

Indian health programs have decades of experience in managing health care with limited resources, which should serve them well in the new managed care world. However, comprehension of the intricacies of the insurance component of managed care is far less widespread; indeed, many AI/AN providers have only recently been exposed to traditional fee-for-service insurance. Recognizing that the tribes will not have the required expertise in the beginning, Arizona provides six to twelve months of training and technical assistance for the tribes.

Roundtable participants identified the following areas in which IHS programs will need additional assistance and training: learning to negotiate contracts, marketing, developing policy flexible enough to meet local conditions, and federal/state/tribal collaboration.

E.1 Learning to negotiate managed care contracts

For most safety-net providers, including Indian health programs, negotiating a contract with either the state or a health plan can be a minefield. The final contents of the contract are critical, since the written document is binding on both parties. As may be expected when contracts are typically drafted by either the state or the plan, initial terms are likely to be more favorable to the state or plan than to the Indian program.

Among the contracting issues that may arise are: 1) consistency with federal requirements; 2) compliance with antitrust and anti-kickback federal and state laws; 3) "evergreen" clauses that allow the contract to be extended with no opportunity to renegotiate terms; 4) the relationships

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[23]*Although urban Indian programs are Federally Qualified Health Centers (FQHCs), unlike other FQHCs they are not covered by FTCA but must purchase their own malpractice insurance.*

between risk and payments; 5) the plan's duties to provide timely information such items as patient enrollment status, provider network, and drug formularies; 6) termination provisions and post-termination requirements; and 7) who makes necessary medical decisions and pre-authorizes services -- the plan or Indian health providers. Clearly, although this list is far from exhaustive, it illustrates the need for Indian health programs to have access to the training and technical assistance required to do well in the managed care contracting process.

E.2 Marketing

Indian health programs have very real strengths in marketing themselves to states, plans, and patients: large numbers of loyal past patients ("covered lives" in managed care terms); favorable cost structures; unique services for high-need populations; centers of excellence; and, in many cases, location in areas shunned by other providers. On the other hand, they lack the large marketing budgets that commercial plans can muster and are frequently little known outside their core constituency.

Because of marketing abuses on the part of some managed care plans, states are generally tightening allowable marketing processes. For example, some states restrict marketing to state employees or to third-party contractors and prohibit plans from marketing directly to Medicaid beneficiaries. The education of patients in general and AI/AN peoples in particular as to how to use the system becomes a critical factor to successful managed care. Otherwise, for example, patients may not realize that they are being enrolled with a plan that excludes Indian health providers.

E.3 Flexible policy to meet local conditions

Since nowhere is the old saw that "all health care is local" more true than in managed care, IHS faces a challenge of providing sufficient training, technical assistance, and other resources to individual and networked Indian health programs without becoming so centralized that local programs cannot adapt to state and local conditions.

E.4 Federal/state/tribal collaboration

Federal, state, and tribal entities all have a stake in assuring that Indian health programs survive and thrive as states move into Medicaid managed care in order to retain the availability of high quality and culturally competent services for Indian people, who are among the most vulnerable in our society. It is especially critical that Medicaid not weaken the safety net for persons who have no insurance. However, each party may not recognize the legal and other requirements of the other parties. For example, states may be unaware of the implications of tribal sovereignty and law as they relate to Medicaid.

A successful example of federal/state/tribal collaboration is Arizona's Advisory Council on Indian Health Care with representatives from IHS, the tribes, the state, the Bureau of Indian Affairs, the Department of Veterans Affairs, HCF and the Office of Management and Budget

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which meets six times a year to iron out problems. Other states such as Washington and Oklahoma have similar mechanisms.

These communications channels can become central in two instances: 1) in cases like New Mexico where health plans are now a layer between the state and the Indian health providers, which means the development of whole new relationships, and 2) where states such as Oregon are seeking modifications of their Section 1115 waivers that may have impact on Indian health providers, such as the inclusion of behavioral health services that were heretofore excluded from the waiver.

IV.   THE ROUNDTABLE'S RECOMMENDATIONS

Roundtable participants expressed their belief that IHS must facilitate increasing the participation of Indian health programs in Medicaid managed care in conjunction with the tribes and the urban Indian programs. The Roundtable's recommendations fell into four areas: A) discussion and resolution of the above five issue areas; B) inclusion of managed care in all IHS strategic planning; C) being proactive in discussions with the individual states; and D) further follow-up work on the development of Indian health programs as Health Maintenance Organizations or networks.

A.   Discussion and Resolution of the Five Issue Areas

Roundtable participants recognized that the five issue areas are far too complex to resolve in a two-day conference but believed that they should be addressed without delay by the Indian Health Service, the tribes, and urban programs, as well as outside experts. This could be done through working groups or meetings dedicated to specific issues.

In each case, the issue to be addressed during follow-up meetings should be discussed and resolved from four distinct perspectives: 1) tribes and the IHS as group purchasers of care; 2) tribal organizations and IHS as potential operators of/participants in plans or networks; 3) all types of IHS programs as providers of services; and 4) AI/AN consumers of care. Although in many cases the resolutions can amicably accommodate all four perspectives, in other cases they may conflict. For example, an Indian managed care plan might want to limit its payments to Indian health programs to assure its own financial viability, but such limitations might threaten the survival of the individual Indian health programs. Such conflicts will require much thoughtful discussion to resolve. It is also important to retain local flexibility. For example, it would be unwise to formulate a policy that no tribal health program engage in risk-based activities or, alternatively, that all must do so.

One area that cuts across many of these potential roles is that of risk management. Roundtable participants recommended that the IHS consider the following risk-management strategies:

- **Risk adjustments:** The program or network can negotiate payment rates that reflect the additional costs of the population. The methodologies for these "risk-adjusted rates," whether capitated or fee-for-service are, unfortunately, not well developed; states generally adjust by age and sometimes sex of the enrollee, as well as class of Medicaid eligibility, such as Aid to Families with Dependent Children vs. the elderly or disabled. The ultimate "risk adjustment" is cost-based reimbursement such as that available to Federally Qualified Health Centers, including urban Indian programs.

- **Contracting only for those services that the Indian health program directly provides:** Both utilization and costs are easier to control for those services that the program directly provides. Thus, financial risk can be limited to such services.

- **Taking risk only for the amount the program can afford to lose:** This may mean limiting the number of enrollees,[24] the service mix, the payment mechanism, or off-loading risk.

- **Off-loading risk:** Programs can limit their financial exposure by purchasing reinsurance (which might require new legislative authority), negotiating stop-losses with their purchasers or plans, and capitating any subcontractors that they may have. Theoretically, the IHS Catastrophic Emergency Fund could be used for this purpose,; however, it is already under funded to meet present needs.

- **Managing care:** Indian health programs have a head start on other providers in the managed care environment, since they have been managing care on limited budgets for years.

Another specific issue that the Roundtable stressed in its discussions was the Anti-Deficiency Act. The group recommended that the IHS consider three options to address this problem: 1) reinterpretation of the ADA to include risk-based contracts where adequate provision has been made for managing risk (e.g., sufficient stop-loss insurance); 2) participating in other types of managed care that do not require assumption of risk by the IHS; and 3) devolving directly operated programs to tribes, which are not bound by the ADA.[25] In the last case, the IHS could either help form a network that accepts some or all of the risk as a whole but not go at risk for the IHS facility's services. Alternatively, an Indian health non-risk-bearing network could be developed.

For those issues that the follow-up meetings determine that training and technical assistance would be desirable, expertise could be obtained through attendance at appropriate conferences, although the costs of such conferences are a concern; distribution of materials, such as what to

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[24]*Small numbers, however, do not per se equal lowered risk. In fact, they can mean higher risk if one or more patients has extraordinary expenses that cannot be spread over a large base.*

[25]*This of course could create tribal financial problems unless the tribes acquired stop-loss or reinsurance.*

look for in a contract, by the IHS, perhaps under contract to outside resources; training sessions; opportunities for cross-fertilization of ideas and experiences across tribes and states; development of an Indian health program clearinghouse and resource center; and other mechanisms. To be avoided is each program's reinvention of the managed care wheel.

B.   Consideration of the Managed Care Environment in Strategic Planning

For most Indian organizations managed care represents a sea change in the delivery and financing of health care. Roundtable participants recommended that consideration of this managed care environment should be woven into every IHS and Indian health program strategic planning activity and not treated as a peripheral issue. For example, Medicaid managed care should have a prominent place in the deliberations of the Indian Health Design Team (IHDT). (This was not to say that additional special focus should not also be placed on managed care issues; see above.)

The **data-MMIS initiative** should be undertaken with the information needs of managed care in mind. The group recommended that there be a collaborative data-systems development effort that would involve interested parties from state agencies, private sector health plans, tribes, urban Indian programs, fiscal agents, system vendors, quality assurance and accrediting bodies such as the National Committee on Quality Assurance, those with health care evaluation expertise, and HCF. The purpose of the group would be to design specifications for the requisite management information systems but not to design the systems themselves nor mandate their use. This would result in guidance to the programs but permit sufficient flexibility that systems could be tailored to individual program or local needs.

The Indian health programs should give special thought to the dual-coverage status of Medicaid-eligible Indians. Although traditionally the Indian health programs have thought of themselves as service-delivery programs, their role as service financing programs also merits exploration. Such consideration will open new perspectives on coping with the insurance components of managed care, as well as on communicating with private managed care plans.

C.   Being Proactive in Discussions with the Individual States

Roundtable participants, including representatives from states, stressed the desirability of early, frequent, and frank discussions with state agencies around managed care issues and Indian health programs. These discussions must be proactive and thoughtfully demonstrate to the states that solutions can be found to sticky problems in ways that will benefit -- or at least minimize harm -- to all parties. State agencies requested that Indian health programs provide as specific information as possible. A further examination of State Medicaid managed care program provisions that affect Indian health programs would be helpful with an evaluation of what works and what does not. IHS should consider developing a "model" set of provisions which States could use to help preserve and support Indian health program as they move into Medicaid managed care.

Roundtable members suggested that IHS facilitate this effort, building on its current communication efforts with the states, but that the tribes and urban programs also be involved.

D.   Further Work on the Development of Indian Health Programs as Health Maintenance Organizations or Networks

Because of the number and complexity of the issues involved in Indian health programs' participation in Medicaid managed care, the Roundtable focused much of its attention on the programs as providers of care. The group recommended that further effort be expended on the issues and options for developing Indian health programs or groups of programs as health maintenance organizations (HMOs) and/or delivery networks. The major issues in doing so are summarized in Section III above.

APPENDIX C

ADDITIONAL INFORMATION ON IHS PROGRAMS

KEY FACTS ON INDIAN HEALTH PROGRAMS

Prepared for the Indian Health Service Roundtable on Medicaid Managed Care

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The George Washington University Medical Center
Center for Health Policy Research

March, 1996

ROUNDTABLE

INTEGRATING INDIAN HEALTH PROGRAMS
(INDIAN/TRIBAL/URBAN)
INTO MEDICAID MANAGED CARE SYSTEMS

Sponsored by the Indian Health Service,
United States Department of Health and Human Services

March 13-14, 1996

Sponsored by the Indian Health Service
6th Floor Conference Room, Suite 600
Twinbrook Metro Plaza Building
12300 Twinbrook Parkway
Rockville, MD 20852

Wednesday, March 13

8:00-8:30   Registration and coffee

8:30-9:00   Introductions

9:00-9:30   Statement of purpose and overview of meeting

To identify options to increase Medicaid managed care participation by Indian health programs while preserving their mission and capacity to serve American Indians and Alaskan Natives.

9:30-10:15   Overview of Indian Health Programs

In this part of the meeting participants will receive a short briefing on the various programs of the IHS, including programs administered directly by the IHS, programs operated by tribes, and urban Indian programs. Participants will be introduced to the concepts of direct and contract care services and will also review those activities of the IHS that are public health and population-based in nature and that are carried out as part of the agency's overall health care activities. Participants also will review key facts about the Indian user population.

10:15-10:30   Break

10:30-12:00   Overview of Medicaid managed care

In this session participants will review key aspects of Medicaid managed care programs as they exist today. Included will be a review of the basic structure of Medicaid managed care systems, with an emphasis on systems operating on a financial risk basis, given the increase in risk-based contracting. Also discussed will be the role of Section 1915(b) and Section 1115 waivers in structuring Medicaid managed care systems operating on a mandatory enrollment basis. After a summary overview, participants will discuss the managed care programs in their states.

12:00-1:00   Lunch

1:00-2:30   Managed care participation barriers experienced by Indian health programs

This session will consider the types of limitations and barriers that have arisen in efforts by Indian health programs to participate in Medicaid managed care. Issues to be discussed include limitations on certain types of contract practices under federal law, the impact of managed care design on continuity of care and providers' relationships with patients, the impact of managed care participation on revenues, the effect of managed care on the capacity of Indian health programs to furnish public health and patient support services not covered by managed care contract agreements, problems associated with service and data collection and reporting, and issues relating to conflicts between IHS operational policies and typical managed care practices and system requirements.

The experiences of Roundtable participants in addressing or overcoming these barriers will be discussed as well.

2:30-2:45   Break

2:45-4:45   Gaining membership and ongoing participation in managed care networks: issues for essential providers.

In this session participants will review conditions of participation and credentialling and ongoing profiling programs for providers in managed care networks. Participants will consider how these conditions affect providers treating large numbers of low income patients with higher than average health risks. Participants will specifically consider the implications of provider credentialling and profiling for IHS operational policies with respect to both directly administered and contract health services. Strategies for gaining and maintaining membership in health plans will be described by participants and the group will consider ways in which opportunities to participate in managed care programs can be enhanced.

4:45   Adjourn

Thursday, March 14

8:30-10:00   Addressing the needs of essential providers and patients in negotiating contracts with managed care plans.

The key to managed care for providers is their contract with health plans. This session will consider specific issues that arise for essential providers in developing participation contracts with health plans. Issues to be considered include the scope of services covered under the contract, payment for contract services, stop-loss and reinsurance, cost based provider contracting, and other elements commonly found in provider contracts. Also considered will be potential cost settlement relationships between state Medicaid agencies and providers that are part of managed care plans as well as issues related to continued coverage of and payment for services furnished outside of managed care contracts.

10:00-10:15   Break

10:15-12:00   Negotiating provider contracts: the role of networks

As networks become increasingly vital to the successful integration of providers into managed care, the need for the formation of specialized networks for providers serving vulnerable populations grows. In this session participants will consider specific issues that arise for essential providers generally and the IHS specifically in developing networks that can negotiate participation contracts with managed care plans as well as with other providers. Issues to be considered include network formation, capitalization, risk and non-risk network models,

12:00-1:00.   Lunch

1: 00-3:00   Discussion and recommendations; next steps (joined by Dr. Trujillo and senior staff)

3: 00   Adjourn

- *IHS Patient Registration System* (contains demographic data on persons that access the IHS and tribal system.)

- *Community Services* (e.g., Public Health Nursing, Nutrition, CHR's)

7. Relationship of Indian and Tribal Facilities and Services to the Medicaid Program

a. Federal financial contribution for covered services furnished by facilities operated by the Indian Health Service or a tribe or tribal organization

- Section 1905(b) provides that federal financial participation (FFP) is 100 percent "with respect to amounts expended as medical assistance for services which are received through an Indian Health Service Facility, whether operated by the Indian Health Service or by an Indian tribe or tribal organization."

- Medical assistance furnished by IHS or tribal contract providers are reimbursed at normal FFP rates and does not qualify for 100 percent FFP.

b. Relationship between Indian health service providers and the federally qualified health centers program

- Section 1905(l), which defines federally qualified health centers, provides that FQHCs include "an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self Determination Act or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act". As FQHCs tribal organization clinics and urban Indian clinics are entitled to reimbursement for the reasonable cost of care furnished to Medicaid beneficiaries. FQHC services are a mandatory service to which eligible individuals are entitled.

- A tribal contract clinic would not be considered an FQHC unless it otherwise met the requirements of the FQHC statute.

- An IHS direct operation or contract outpatient clinic would not be considered an FQHC (although all services furnished by IHS direct operation clinics would be eligible for 100 percent FFP). IHS clinic services are not a mandatory covered service as are FQHC services, and the special managed care rules under Section 1915 and Section 1115 demonstrations that apply to FQHCs (see below) would not apply to IHS clinics.

Regardless of insurance status, American Indians tend to rely heavily on IHS services

Percent of SAIAN Population with a Regular Source
of Care Other Than an IHS Facility

All persons	All areas
Health care coverage	32.9
IHS only	
all year	12.2
part year	32.1
Other coverage all year	
any private	60.4
public only	44.7
Family Income	
poor	17.6
low	31.6
middle	47.8
high	63.9
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Source: Peter Cunningham. Health Care Access, Utilization and Expenditures for American Indians and Alaskan Natives Eligible for the Indian Health Service, April, 1995 (Unpublished, Center for Studying Health System Change. Washington , D. C.

6. Major Patient Care Data Systems

- *The Inpatient Care System and the Contract Care System*. Prepared by IHS and tribal and CHS hospitals. Contains hospital inpatient data by various patient characteristics (age, sex, principal and other diagnoses, community of residence)

- *Ambulatory Patient Care System and the Contract Care System*. Reports on ambulatory visits to IHS and tribal and CHS facilities by patient characteristics (age, sex, clinical impression, community of residence). Data compiled based on one record per visit.

- *Clinical Laboratory Workload Reporting System*

- *Pharmacy System*

- *Urban Projects Reporting System*

- *Dental Data System*

8. Treatment of Indian Health Programs that are Federally Qualified Health Centers under Section 1115 and Section 1915 Mandatory Managed Care Demonstrations

a. Section 1915 demonstrations

- The FQHC service requirement may not be waived in a Section 1915 mandatory Medicaid managed care freedom-of-choice waiver. Therefore, Indian Health clinics that are FQHCs remain covered on a mandatory basis and are eligible for the reasonable cost of care they furnish. Note, however, that HCFA guidelines implementing Section 1915 provide states with discretion to limit access to FQHC services in the case of enrollees who select a plan that includes no FQHCs so long as they could have selected a plan with participating FQHCs.

b. *Section 1115 demonstrations*

- The Secretary may waive FQHC mandatory service coverage and reasonable cost payment rules in a Section 1115 waiver and has frequently done so (see accompanying materials on Section 1115). However, conditions of approval under certain demonstrations include supplemental payments to FQHCs to compensate for the loss of revenues as a result of participation in risk-based managed care systems that do not pay on a reasonable cost basis. Indian tribal organization and urban Indian clinics that are FQHCs would be covered by all conditions applicable to FQHCs in Section 1115 demonstration states.

- The Secretary can elect to apply waiver conditions applicable to other IHS programs (IHS direct or contract providers and tribal contract providers).

9. The Role of Medicaid in Funding IHS Operations

- In Fiscal 199_ Medicaid accounted for ___ percent of all operating revenues received by facilities operated by the Indian Health Service, tribal organizations and Urban Indian Health Clinics.

10. Legal Authority of Indian Health Programs to Enter Into Risk Agreements Under Medicaid

- Under the Anti-Deficiency Act, 31 U.S.C. §1341, a Federal employee may not incur obligations in advance of or in excess of appropriations. As a result, contractual managed care obligations to furnish care to an enrolled population for a fixed premium that might not cover the cost of services under the contract would constitute a violation of the Act according to the Office of General Counsel, HHS.[15] However, if the contract conditions

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[15]Memorandum from Barbara Hudson to Richard McClosky (February 13, 1995).

IHS obligations on the appropriation of federal funds by Congress, there would be no violation.[16] Moreover, contractual specifications that permit the IHS to adjust service obligations to remain within the available budget would also allow the agency to avoid violation of the Act. Third, a managed care contract that provides reasonable cost reimbursement would not violate the Act.[17] Finally, stop-loss arrangements with the state, in combination with authority to limit benefits in light of budget constraints, might also avoid violation of the Act.[18]

• Because the Anti-Deficiency Act applies only to federal employees and not to tribal contractors, there is no bar to tribal participation in managed care under the Act.[19]

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[16] Id.

[17] Id.

[18] Were the IHS facility permitted under a managed care contract with a state Medicaid program to reduce covered benefits rather than incur losses, other questions might arise under the Medicaid statute. The state's obligation to furnish mandatory benefits of sufficient amount duration and scope to individuals is not extinguished by their enrollment in a managed care plan; hence, the state might be liable for coverage of services that are reduced by the Indian health plan. Moreover, comparability issues might arise were services to be reduced for individuals enrolled in an IHS plan compared to individuals enrolled in other health plans that are not permitted to renegotiate the scope of their service agreements in the event that the premium is insufficient to cover their costs.

[19] Hudson. op. Cit.