Indian Health Care in a Managed Care Environment

September 14, 2020

Overview of Indian Health and Medicaid

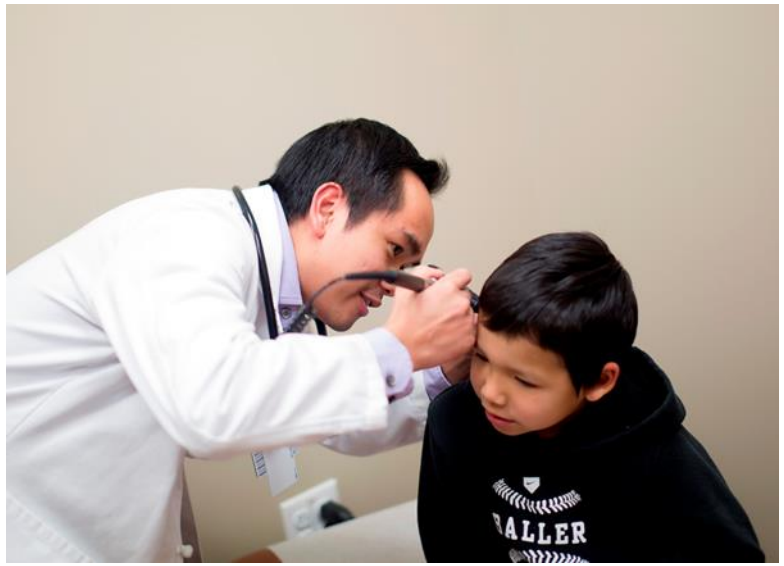
- 2017 - Oklahoma population = 3.75m
  - AI/AN population = 533,000 (or 14.2% of the population)
- June 2020 - AI/AN enrollment in SoonerCare = 93,702
  - (10.6% of the total enrollment). Total enrollment is 877,496.
- 2018 Census- Oklahoma has the second highest proportion of AI/AN population (17.4%)
- 2019 IHS User Population - Oklahoma Area = 382,695
  - Patients seen in an Indian health/Tribal facility in the last three years
- 2016 Manatt Report projected that 272,000 individuals would gain coverage in the new adult group, with about 44,000 of those being AI/AN.
- Indian Healthcare facilities purchase $120,900,118 in outside care annually.
- 2019 - average Medicaid spending per enrollee in Oklahoma was $6,377

100% Federal Match for Indian Health

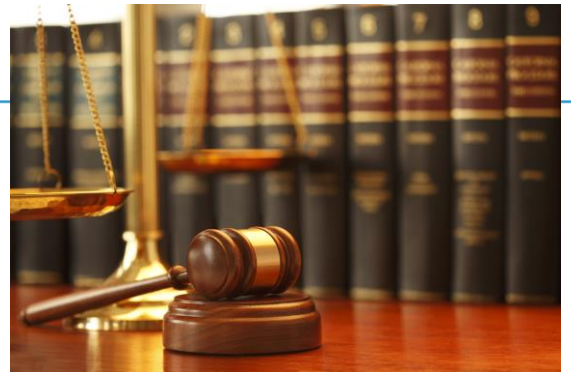
- Recognizes the federal trust responsibility to Tribal Nations
- Authorized in 1976 in the SSA
- Services ***provided through*** Indian Health Care Providers are included for the full match
- Congress authorized 100% matching to supplement inadequate federal appropriations to meet the trust responsibility
- Not shift the responsibility onto the states
- States must accurately claim the 100% match for authorized health services provided through Indian health facilities

State/Tribal Managed Care Workgroup

- July 7, 2020 - Tribal Consultation presentation on Third Party Managed Care Organizations.
- OHCA formed a state/tribal workgroup to have further discussions on this topic.
- Workgroup has held two meetings, July 21, July 30, 2021.



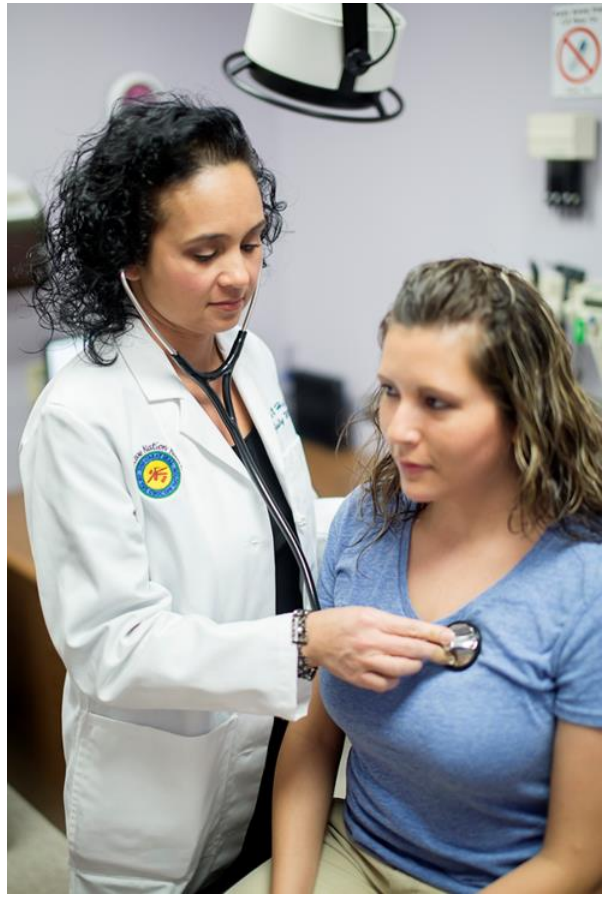
Indian Managed Care Protections



- There are Specific Protections in Law and Regulations
- Congress enacted special Indian Medicaid managed care protections
  - No Indians may be mandatorily enrolled in managed care through a State Plan Amendment
  - Exemption from Medicaid cost sharing (including co-pays) for Indian patients served by IHS, tribal and urban Indian organization (I/T/U) providers, including referrals under Contract Health Services (CHS) program
  - Exemption of certain Indian-owned property from being considered as “resources” for purposes of eligibility of individual Indian for Medicaid and CHIP
  - Other protections

Indian Managed Care Protections

- State must either require the MCOs to pay IHCPs at the full encounter rate, or make a wrap payment to IHCPs to make them whole.
- States must require that MCOs offer to contract with IHCPs in their area, and CMS encourages an Indian managed care addendum for contracts with IHCPs.
- Although both Congress and CMS have recognized that Indian managed care protections are important, they do not solve all of the issues with managed care in Indian country.



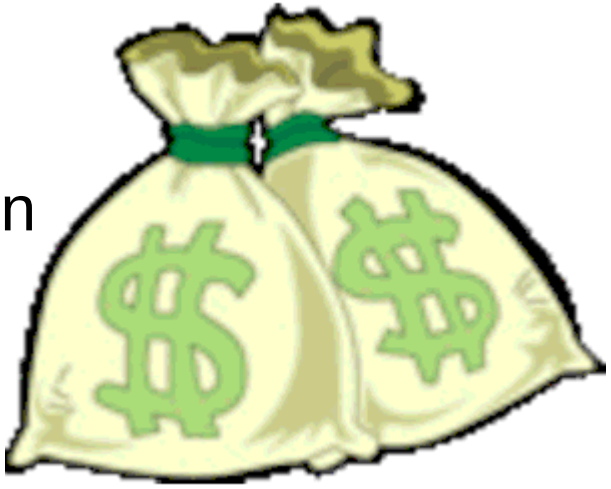
Why Isn't Outside Managed Care Successful in Indian Health?

- IHCPs already provide care coordination and comprehensive services
- Directs AI/AN Members Outside of the I/T/U system
- Patient engagement and trust in IHCPs
- Continuity of care

- Compliance with Indian Health protections & administrative burden
  - Payment to IHCPs in/out of MCO network
  - Credentialing requirements being inappropriately applied
  - Indian addendum to contracts
  - Operating hours
  - FTCA
  - Duplicative approvals for higher levels of care
  - Manual opt out process

Capturing the Full 100% FMAP in Managed Care

- Services “provided through” an IHCP matched at 100%
- Managed Care can be ‘opt in’, or ‘opt out’ – current direction is that there will be auto enrollment and members may later ‘opt out’
- AI/AN should not be auto enrolled
  - 137,702 current AI/AN Medicaid members with expansion population
  - The state will pay capitated payments for a certain number of AI/AN who will later opt out (ave. spend $6,377)
  - No 100% match for capitated payments, because it is not limited to services “provided through” an IHCP



Capturing the Full 100% FMAP in Managed Care

- Care Coordination Agreements
  - IHCP provider networks and MCO networks may not be the same
  - Unless there are CCAs with external provider, cannot claim 100% FMAP
  - If the member is in MC, then the MCO is paying the provider
  - Places the MCO as another administrative level for tracking 100% FMAP claiming, when there is no incentive

Current: IHCP…….Outside Medicaid Provider…….OHCA

Managed Care: IHCP…..MCO…..Outside Provider….OHCA

Capturing the Full 100% FMAP in Managed Care

- If the state does not directly pay any care coordination fees to IHCP, but rather contracting to MCO for AI/AN, fees would not be at 100% FMAP
- New services, dental, behavioral health, if paying MCO in the capitated rate, and AI/AN are auto enrolled, question 100% match

Conclusion

- Managed Care creates another bureaucratic layer that duplicates care coordination by IHCPs
- Duplication is wasteful and confusing for patients
- AI/AN should not be auto enrolled
- State will have added burden and will likely lose some existing 100% Federal matching for AI/AN patients, with MCOs as middlemen
- Oklahoma has an opportunity to design a system that complements the Indian health system and leverages all resources, rather than one that creates barriers for AI/AN patients.

Yakoke!

(Thank You)