Commentary: Medicaid Reform Issues Affecting the Indian Health Care System

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Medicaid reform was among the most prominent of state health care reform efforts in 1995, as states attempted to control expenditures by enrolling recipients in managed care programs. Because of its unique structure and history, Medicaid reform is likely to affect the Indian health care system differently than other parts of state health care systems. The Indian health care system is composed of providers and services developed for the exclusive use of Indian people and owned and operated by either the Indian Health Service (IHS) or tribal entities. The purposes of this commentary are to identify issues relative to the Indian health care system that emerge from Medicaid reform initiatives and to suggest strategies for overcoming recognized problems.

The IHS provides comprehensive health care services free of charge to eligible Indian people regardless of their ability to pay. IHS, however, is a “residual” payer; other payment sources for which an Indian patient is eligible (e.g., Medicare, Medicaid, commercial insurance) must be exhausted before IHS will pay for services. Across IHS service units, the percentage of patients eligible for Medicaid ranges from 12% to 35% (written communication, Cynthia A. Smith, IHS, March 28, 1996). The national average is approximately 9% of the US population. Because substantial numbers of Indian people rely on Medicaid for their primary health insurance coverage, it is essential that Medicaid reforms address the unique circumstances of the Indian health care system.

The Indian Health Care System Perspective

Like other Americans, tribal leaders hope that Medicaid managed care will lower state expenditures, enhance access to health care services for the poor, and improve the quality of services delivered to this population. These objectives, however, are largely of secondary importance to most tribal leaders. From their perspective, Medicaid reform—regardless of other measures of success—will be successful only if it (1) ensures the delivery of culturally appropriate services to Indian people, (2) maintains or improves Indian health care system funding, and (3) respects and preserves tribal sovereignty.

Delivery of Culturally Appropriate Services

Many tribal leaders are apprehensive that Medicaid reforms relying on managed care will channel Indian people away from Indian health care system providers and toward providers who are not as sensitive to the cultural needs of Indian patients. Some Indian people are uncomfortable seeking care outside of the Indian health care system, because providers may not be familiar with native languages, customs, and lifestyles. For example, traditional healers, working side by side with physicians, play an important role in the delivery of services to some Indians. Indian health policymakers believe that providers outside of the Indian health care system may be less tolerant of these practices.

The reluctance of Indian people to use providers outside of the Indian health care

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system becomes an issue when a Medicaid managed care plan requires Indian patients to select a primary care provider from a panel of participating providers and to obtain all health services through that provider. Typically, Indian health care system providers are unable to comply with the specifications of managed care contracts and do not participate in managed care organizations. For example, managed care providers are often required to have hospital privileges. Indian health care system providers in service units without hospitals may not have hospital privileges because they live too far from a hospital to allow them to admit and treat patients conveniently. Another provision may require providers to offer services 24 hours per day. As a result of the limited resources of the Indian health care system and the sparse populations it serves, some system clinics are open fewer than 24 hours per day. Finally, contracting providers may be asked to make services available on a nondiscriminatory basis. Most Indian health care system clinics are excluded by federal law from treating people who are not Indians (except in emergency situations) and therefore would not be able to participate in the managed care system.

Indian people who do not select managed care providers may be assigned automatically to nonsystem primary care providers under Medicaid managed care programs. The automatic assignment of Indian people to such providers may have two unintended consequences. First, they may receive services that are not culturally appropriate. Second, they may continue to obtain care from Indian health care system providers rather than the provider to whom they were assigned. Although cultural sensitivity may be achieved by this action, Indian health care system providers will not be reimbursed by managed care plans for delivering these services.

These problems may be solved by a variety of solutions, such as exempting Indians from Medicaid managed care plans, making it easier for Indian health care system providers to contract with managed care plans, and establishing Indian health care system managed care plans. Implicit in each of these solutions is recognition by states of the distinctive social and legal status of American Indians; they are unlike any other recipient group.

Initially encountering problems with automatic assignment of Indians, Washington and Oregon selected different methods for addressing the issue. Washington State adopted a policy that required American Indians to state their desire to participate in the managed care system; those who did not were excluded from it. This policy may be described as a presumptive exclusion with an opt-in provision. Presumptive exclusion from the Medicaid managed care system means that Indians are free to obtain service wherever they choose and that providers are reimbursed on a fee-for-service basis. Allowing Indian Medicaid participants to choose primary care providers outside of the managed care system permits them to select Indian health care system providers who might have been excluded from contracting with Medicaid managed care plans. An opt-in provision ensures that Indian Medicaid recipients (1) understand their right to choose whether or not to participate in the managed care system and (2) select a participating managed care provider. Opt-in provisions, however, may also have the consequence of minimizing the enrollment of Indian people in Medicaid managed care plans.

In contrast, Oregon adopted an “opt-out” provision. It also requires Indian Medicaid recipients to choose whether or not to participate in the managed care system, but instead of presumptively excluding Indians, it includes them. If Indian Medicaid recipients do not opt out of the system within a prescribed time, they are assigned to participating managed care providers. Although allowing Indians to opt out of the system addresses the issue of cultural sensitivity, it is only a partial solution.

States that do not enroll Indian Medicaid recipients in managed care plans may obtain some of the anticipated benefits of managed care by assigning them to participating Indian clinics that agree to function as primary care case managers. In Oregon, primary care case managers receive a small per-client-per-month fee to serve as “gatekeepers” for the Medicaid system, providing, coordinating, controlling, and monitoring all services for the patients assigned to them.

Almost half of all American Indians live in rural areas on or close to reservations. Indian patients who are assigned to primary care providers in distant locations may continue to obtain services from the local Indian health care system providers from whom they typically received services. They may continue to use local providers because the cost of travel to the assigned provider is too high, because they desire services that are more culturally appropriate, or for other reasons. If an out-of-plan Indian health care system provider delivers services to an Indian person covered by a managed care plan, that provider probably will not be reimbursed by the plan for the care given. This new source of uncompensated care will add to the funding problems of the Indian health care system.

Another possible solution is to hold Indian health care system providers harmless for the provision of services to Indian Medicaid beneficiaries. Under a hold-harmless provision, these providers would be reimbursed for all of the services delivered to Indian Medicaid patients on a fee-for-service basis, whether or not the patients are enrolled in a managed care plan. In exchange for being held harmless, providers might be required to counsel Indian Medicaid recipients on the design of the Medicaid system and the responsibilities of recipients.

Most section 1115 applications for statewide Medicaid demonstrations have proposed eliminating cost-based reimbursement for federally qualified health centers and the list of mandatory covered services. Tribal clinics that apply for certification are automatically designated federally qualified health centers. Eliminating cost-based reimbursement for these health centers and the list of covered services would mean that tribal centers might receive less reimbursement for some services and no reimbursement at all for other services typically provided to Indian Medicaid patients. One method of ensuring access and continuity of care under Medicaid reform is to designate federally qualified health centers as “essential community providers” (i.e., providers who have traditionally been available to treat underserved populations). Health plans serving Medicaid recipients would be required to contract with essential community providers and to reimburse them at rates based on Medicare payment principles. Requiring cost-based payments would
ensure that payments for services provided to managed care patients are not lower than those that would have been paid had the state not received a Medicaid waiver. Similarly, requiring managed care plans to contract with essential community providers to provide mandated federally qualified health center services would ensure access to the same set of services available to Indian patients before a waiver was granted.

Respecting and Preserving Tribal Sovereignty

Some tribal governments that own or operate clinics may be reluctant to contract with larger provider networks because they believe that management of the network by people who are not members of the tribe provides a challenge to tribal sovereignty. Typically, tribal governments are reluctant to surrender autonomy to another organization, and they may view network management as an intrusion into the internal affairs of the tribe.

Some local Indian health care systems may wish to seek designation as managed care entities themselves. These local systems would contract with Medicaid agencies to provide services to Indians (and possibly others) at a fixed amount per enrolled recipient. To protect consumers, some state governments require all risk-bearing entities to comply with the reserve requirements of health maintenance organizations. The reserves (i.e., net worth) of a managed care organization are intended to finance services should the entity incur greater losses than expected. Depending on the state, reserve requirements range from several hundred thousand dollars to more than $1 million. Many Indian health care systems cannot afford to fund reserves at the required level.

Some state managed care laws provide that the state may assume the operation of a managed care organization for reasons such as insololvency or poor quality. Again, tribes are likely to interpret such provisions as an abrogation of tribal sovereignty and refuse to participate in managed care arrangements, even if they are large enough and offer enough services to accept risk for a covered population on their own.

One strategy for reconciling the interests of states and tribes is to insert a neutral third party, such as the Joint Commission on Accreditation of Healthcare Organizations or the National Committee on Quality Assurance, between the state and tribal governments. Since January 1994, all IHS and tribally operated hospitals and all eligible IHS-operated health centers have been accredited by the Joint Commission on Accreditation of Healthcare Organizations. Accreditation by this commission provides a precedent for external accreditation that apparently does not challenge tribal sovereignty. Rather than the state or managed care plan determining specific performance criteria for Indian health care system providers, the providers would be deemed to be in compliance with all state and managed care plan regulations if they are accredited by an independent, nongovernmental third party.

The IHS is the payer of last resort for all eligible Indians. In the unlikely event of default by a managed care plan sponsored by the Indian health care system, IHS would assume the liability of financing services to eligible Indian people covered by the plan. People covered by a managed care plan sponsored by the Indian health care system who are not eligible for IHS-financed services would still be at risk of losing coverage and services should the plan default. For these people, states might allow Indian health care system providers to pledge to provide services without payment to enrolled Medicaid recipients for up to 120 days (or until the end of the contract year) following the insololvency of a systemsponsored plan in lieu of meeting net worth requirements. This strategy rests on the willingness of IHS or tribal health programs to subsidize the marginal cost of providing services, in the case of plan default, to system-sponsored managed care enrollees who are not eligible for IHS services.

The State Perspective

Medicaid is one of the largest and fastest growing components of any state budget. Fueled by enrollment growth and medical care inflation, Medicaid spending between 1990 and 1992 grew at an average rate of 28% per year. Managed care is viewed by many states as one strategy to help control the cost of providing Medicaid services.

Even in states with sizable Indian populations, the number of Indian Medicaid recipients is relatively small. There are, for example, 26 Indian tribes in Washington state, but these tribes account for only 3.4% of Medicaid recipients. Overall, Indians constitute approximately 0.8% of the US population. According to the Health Care Financing Administration, Indians account for 0.9% of all Medicaid recipients, and services provided to Indians account for 0.6% of all Medicaid provider payments. Because the proportion of Indian Medicaid recipients is small in most states, a presumptive exclusion/opt-in or hold-harmless provision in the Medicaid managed care program for Indian Medicaid recipients would probably have a small impact on state Medicaid budgets. However small the negative impact on state budgets might be, it could be reduced by including Indian health care system providers in the provider networks of managed care organizations (i.e., increasing the probability that Indian Medicaid recipients would opt in to the managed care system), establishing fee schedules for patients treated outside the managed care system (i.e., controlling the cost per unit of service), and developing primary care case management systems with Indian health care system providers to help coordinate services for Indian Medicare patients not served by managed care organizations.

It seems clear that Indians may be treated differently under Medicaid managed care systems without significantly endangering program savings. However, implementing Medicaid managed care programs without consideration of the unique problems of the Indian health care system might weaken the financial position of system providers. The weakening of the Indian health care system may have perverse consequences for Medicaid: to the extent that the system is unable to finance and deliver services, Indian citizens of the state might be required to rely more heavily on Medicaid to obtain needed health care services.

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