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Abstract

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Keywords

Medicaid; Indian Health Service; Oregon; American Indian; Alaska Native



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ABSTRACT

The purpose of this case study is to examine the efforts made by the legislature and the Oregon Health Authority (OHA) to involve Oregon's nine federally recognized tribes in the implementation of the revised Oregon Health Plan. We identified eight key informants, consisting of four tribal representatives and four state representatives, for interviews. Additionally, we identified the contact person from each newly-established Medicaid delivery network to determine if they had included the tribe(s) or planned to include the tribe(s) in their network. The OHA made some steps to ensure the inclusion of tribes in the planning and implementation process, but were challenged with the rapid implementation timeframe. Formal linkages between the tribes and Medicaid delivery networks were not developed. The federally recognized tribes of Oregon and their respective members had legitimate concerns about the revised Oregon Health Plan and how they might affect access to health care services and provider reimbursements. As other states expand Medicaid based on changes resulting from the Patient Protection and Affordable Care Act, the needs of American Indians and Alaska Natives must be included in the planning process.

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INTRODUCTION

Oregon is home to nine federally recognized tribes and 69,693 American Indians and Alaska Natives (AI/ANs) (U.S. Census Bureau, 2013). Sixteen percent of Oregon's AI/AN residents are Medicaid beneficiaries, proportionately more than Whites (State of Oregon, 2012; U.S. Census Bureau, 2013). Health and health care disparities experienced by AI/ANs are well-documented. For instance, life expectancy at birth for AI/AN men and woman is 8 and 6 years shorter, respectively, than for men and women in the general U.S. population (Bramley et al., 2005). According to Oregon Behavioral Risk Factors and Surveillance Survey data, AI/ANs in

Oregon have significantly higher prevalence of arthritis, asthma, heart disease, stroke, and type 2 diabetes than their White counterparts (Oregon Department of Human Services, 2007). Preventive service use for AI/AN Medicaid beneficiaries aged 0 to 10 years are the lowest among any racial or ethnic group at 3.1 services per person per year compared to 4.2 for Whites (Oregon Department of Human Services and Oregon Health Authority, 2011). Perhaps most important from a cost perspective, AI/ANs have the highest rate of ambulatory care sensitive condition hospitalizations of Medicaid patients at 3,463 per 100,000 person years (Oregon Department of Human Services and Oregon Health Authority, 2011).

The U.S. federal government has a commitment to provide health care to members of federally recognized tribes through several trust agreements that were developed via treaties signed during the acquisition of tribal lands (U.S. Commission on Civil Rights, 2004). The Indian Health Service (IHS) is the agency within the Department of Health and Human Services with primary responsibility for health care for AI/ANs with a budget approved by Congress annually. IHS provides health services through tribally contracted and operated health programs as well as services purchased from private providers. The federal system currently consists of 28 hospitals, 62 health centers, and 25 health stations. In addition, 33 urban Indian health projects provide a variety of health and referral services. The IHS provides a health service delivery system for more than 2 million AI/ANs and its fiscal year 2013 appropriated budget totaled approximately \$4.1 billion (Indian Health Service, 2014). However, the IHS estimated that health care appropriations for eligible AI/ANs are 52% of the need, severely limiting access to health services (U.S. Commission on Civil Rights, 2004). The established government-to-government relationship between the tribes and federal government requires that states respect the sovereignty of tribes within their borders and that they do not impose any laws that interfere with the agreements made between the tribes and federal government (U.S. Commission on Civil Rights, 2004).

The Oregon Health Plan, a controversial approach to explicitly ration health care through a prioritized list of medical conditions and interventions, was implemented in 1996. Its purpose was to make Medicaid accessible to more people than a conventional non-rationed system (Bodenheimer, 1997; Oberlander, 2007). Oregon has recently moved forward to improve the sustainability of the Oregon Health Plan, once again transforming the way health care is delivered. Covered services are still prioritized, and as of August 2012, 13 newly-created Coordinated Care Organizations (CCO) are tasked with controlling costs and improving outcomes, primarily by increasing accountability of health care providers. CCOs are single corporate structures or networks of physical, mental, and dental providers, responsible for coordinating all aspects of patient care under fixed budget payments (Oregon Legislative Assembly, 2011). The CCO model provides most health care at Patient-Centered Primary Care Medical Homes, in which transdisciplinary teams work together to keep members healthy (Oregon Health Authority, 2011). Under the CCO system, providers must contract as an in-network provider with a CCO in order to receive payments for treating Medicaid patients (Oregon Health Plan, 2012).

Medicaid is a critically important program for AI/ANs, serving as 1) an insurance program covering physician, hospital, and other basic health care for eligible individuals; 2) a source of revenue for IHS and tribally-operated clinics and hospitals, 3) a purchaser of managed care products, 4) a source of financial assistance for low-income older and disabled AI/ANs to

meet Medicare premium and cost-sharing obligations, and 5) a source of coverage for nursing home care and other long-term care services for frail and disabled AI/ANs (Schneider, Martinez, 1997). Roughly 13% of the IHS clinical services budget is from Medicaid, while less than 0.5% of total U.S. Medicaid expenditures go to Indian health (Indian Health Service, 2013). Given the important role that Medicaid plays in financing health services for AI/ANs but yields such poor outcomes for the AI/ANs it serves, there is the potential for tribes to benefit from CCOs. However, the IHS is exempt from altering their system under CCOs and AI/ANs do not have to participate. Thus, the purpose of this case study is to examine the efforts made by the legislature and the Oregon Health Authority (OHA) to involve the tribes in the initiation and formulation of CCOs and to determine how CCOs were designed to meet the needs of the AI/AN population.

METHODS

This case study of the revised Oregon Health Plan was conducted during spring 2012. We identified eight key informants, consisting of four tribal representatives and four state representatives for interviews that were selected based on their level of involvement during the initiation and formulation of the legislative process, confirmed by legislative and citizen members of the Health Care Transformation Committee. For the interviews, we designed an interview guide to identify the key tribal issues raised during the initiation and formulation of the legislation and to help identify the potential challenges and opportunities of integrating the Indian health system into CCOs. Our first attempt at reaching the key informants was by email and subsequently by telephone if they did not respond within two weeks of the initial email message. Of the eight people we contacted, we interviewed five of them, including two tribal representatives and three representatives from the state. One person declined participation because they were uncomfortable answering the questions and we did not receive an explanation from the other two key informants. The five interviews were conducted over the telephone were audio-recorded and transcribed.

Additionally, we identified the contact person from each CCO from the publically available letters of intent and sent an email to each contact person that had a tribe within their geographical service unit to see if they had included the tribe(s) or planned to include the tribe(s) in their network. Each contact person was asked 1) what efforts they had made to include tribal members in the development of the CCO and 2) If they had initiated or planned to initiate a contract or memorandum of understanding with local tribe(s). Of the seven CCOs we identified, contact information was available for six of them. We first attempted to reach the contact person via email. For those who did not respond within one week, we followed up with a telephone call. Of the contact persons at the six CCOs that we were able to contact, we obtained responses from four.

RESULTS

Although AI/ANs were not at the forefront of initiating the CCO legislation, the two tribal leaders were members of the Health Care Transformation Committee This Committee met weekly during the 2011 legislative session and led to the first draft of HB 3650.

Given the low-level of funding the tribes receive from IHS, the cost-containment goals of CCOs were troubling to the tribes. According to Mike Bonetto, PhD, MPH, former Senior Health Care

Policy Advisor to Governor Kitzhaber “great concern from the tribes about being forced into this structure” led to the decision to exempt the tribes from participating in CCOs. Richard Acevedo, Tribal Relations Liaison with the State of Oregon argued, “You can’t save money unless you aren’t paying for something. Where are those services going to be reduced? Where will the cuts be?” Representatives from the state acknowledged the potential savings by managing the care of AI/ANs through CCOs, but they ultimately respected the decisions of tribal leaders to allow their members to remain in the fee-for-service system. The OHA continues to meet with tribal health care appointed to a tribal technical workgroup six times per year through December, 2014.

Another source of concern from the tribes is related to provider reimbursements. Tribal health programs were concerned they would not be reimbursed for treating Medicaid patients if they were not a contracted in-network provider under the CCO. These fears stemmed from a problem of this nature in the 1980s and 1990s with the onset of managed care.¹⁵ Jim Roberts, Policy Analyst with the Northwest Indian Area Health Board said “It’s a more rigorous way of managed care. I call it managed care on steroids.” At that time, the IHS lost Medicaid reimbursements because tribes were not contracted members of managed care networks (Marquez, 2001). Jim Roberts, expressed his concern about CCOs, saying, “To providers, it means less reimbursement and more administrative barriers to participating.” Medicaid fee for service payments, the current reimbursement structure for tribal health services, will be decreasing over time. This applies pressure to IHS and tribal health programs to consider joining CCOs in order to receive better reimbursement rates. Given the reimbursement changes, Mike Bonetto reported, “Over time, the tribes have been more open to joining [CCOs] because they have seen the potential.”

The lack of guidance in HB 3650 has mostly left it up to CCOs to decide how to involve the tribes and at what capacity. Richard Acevedo said, “You can’t exempt tribal members unless you have tribal hospitals and tribal expertise. There will always be integration into the outside system.” The OHA provided a tribal contact list after the first waive of CCO applicants had been approved, encouraging them to establish linkages with the clinics or facilities in their geographical service area. Kelle Little, Health Administrator for the Coquille tribe said “At the end of the day, it will be up to the tribes to ensure adequate integration with the CCOs.” The legislation forbids a CCO from unreasonably refusing to contract with a partner; however, it does not include any specifications for contracting with Indian health systems or tribal providers. Regarding continuity of care for Medicaid eligible tribal members who seek care within the CCO and Indian health system, she said, “Can we be assured about the continuity, no?” Bruce Goldberg, Director of the Oregon Health Authority, noted in his address to the Oregon Public Health Association on October 9, 2012 that they wanted these relationships to happen organically. Of the 42 letters of intent filed by potential CCO entities, excluding the one filed by the Northwest Portland Area Indian Health Board and the Confederated Tribes of the Warm Springs Reservation, only one listed a tribe as an affiliate member (Oregon Health Authority, 2011).

Among the CCOs we contacted, there was a general willingness to do what is necessary to partner with tribes. However, none of them had initiated a contract or memorandum of understanding with a tribe or tribal provider. Representatives from CCOs commonly cited uncertainty as a reason for why they had not initiated a contract. In general, representatives from CCOs did not express urgency to contract or partner with tribes. Another reason cited for not

initiating a contract or memorandum of understanding, was that they did not believe they served tribal members in their network.

DISCUSSION

The OHA made some steps to ensure the inclusion of tribes in the implementation process, but they were challenged with the rapid implementation timeframe. Formal linkages between the tribes and CCO networks were not developed. The only mention of tribes in HB 3650 was the language related to their exemption, which was necessary to comply with tribal sovereignty. The nine federally recognized tribes of Oregon and their respective members had legitimate concerns about CCOs and how they might affect access to health care services and provider reimbursements. Tribal representatives perceived CCOs to potentially decrease the amount of services available to tribal members. This is particularly troublesome given the poor health indicators of AI/AN Medicaid beneficiaries in conjunction with their poorly funded health service programs. These concerns may have been laid to rest if the legislation included language that required CCOs to meet network adequacy by contracting with the tribes prior to going live on August 1st, 2012. Not only would this have ensured the CCO met network and cultural competency requirements, required by the legislation, but also would ensure that the infrastructure was in place for tribal providers to establish in-network status, thus, eliminating access barriers to tribal members. It would benefit the state to modify the legislation to legally mandate that CCOs take the steps necessary for contracting with the tribes. Such mandate would reduce the probability that there is not a repeat of the reimbursement issues during the first wave of managed care, including the right of tribes to receive timely reimbursement for covered health care services.

CONCLUSION

As states implement new reimbursement and delivery models in accordance Medicaid expansion under the ACA, it is likely that many AI/AN will qualify for Medicaid benefits. It behooves states to recognize and take action to address the needs of AI/ANs at the earliest point possible in the planning process (Centers for Medicare and Medicaid Services, 2009). System wide changes present an opportunity to explore new ways to collaborate with Indian health providers and improve the health care and health status of AI/ANs. However, states must be careful to consider the effect new systems have on the financial viability of tribal health services. Oregon serves as a good example of how the health care needs of AI/AN require legislative protections from reducing services and provider reimbursements.

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