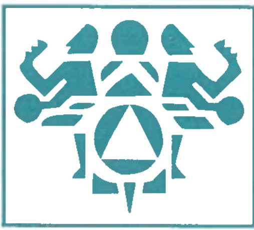

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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January 9, 2012

Oregon Health Policy Board
Eric Parsons, Chair
Lilian Shirley, Vice-Chair
500 Summer Street NE
Salem, OR 97301

Dear Mr. Parsons and Ms. Shirley:

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638[1] tribal organization that represents health care issues of forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. This includes all nine Tribes in the State of Oregon. We are writing to provide you with our comments and recommendations concerning the draft "CCO Implementation Proposal" to implement the requirements of HB 3650.

Our comments are intended for the second comment period that begins tomorrow, January 10, 2012, when the Oregon Health Fund Board convenes its meeting to begin consideration of an updated draft proposal to implement Coordinated Care Organizations (CCO). The recommendations included in the attached document represent the consensus views of all nine Oregon Tribes and the Native American Rehabilitation Association (NARA). These recommendations have been developed by Tribal leaders, health directors and NARA representatives in a series of meetings held over the past year.

We hope that you implement our recommendations as you finalize the CCO implementation plan and make recommendations to the Oregon Legislature. Our recommendations are included around five areas:

- Alternative Payment Methodologies and Global Budgets;
- Mandatory Enrollment;
- Indian Health Benefit Package;
- Options for providing specialty care, and;
- Tribal Consultation.

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[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

We believe that our recommendations will effectively integrate the Indian health system into the CCO process. Otherwise there will be complications that will need to be resolved, which will ultimately cost time and money and affect the quality of care that Indian people receive in the Medicaid program. We hope we can avoid these types of complications.

We welcome any questions you might have concerning our recommendations. We would also volunteer our organization to provide an overview to the OHFB on the Indian health system and its unique and complex set of federal laws that embody our recommendations. Please feel free to reach out to us if needed.

If you have any questions, feel free to contact Jim Roberts, Policy Analyst, at (503) 228-4185 or email at jroberts@npaihb.org. Thank you for your consideration!

Sincerely,

Joe Finkbonner, RPH, MHA
Executive Director

cc: Bruce Goldberg, OHA Director
Judy Mohr Peterson, Medicaid Director
Jeanne Phillips, Deputy Director, Medical Assistance Programs
Nine Oregon Tribal Leaders & Health Directors
Jackie Mercer, Executive Director, NARA

Tribal Recommendations to Integrate the Indian Health Care Delivery System Into Oregon's Coordinated Care Organizations (H.B. 3650)

January 9, 2012

Executive Summary

House Bill 3650 establishes the Oregon Integrated and Coordinated Health Care Delivery system to replace managed care systems for Medicaid beneficiaries. The new system of Coordinated Care Organizations (CCOs) would be accountable for management of integrated and coordinated health care within a set global budget. The law requires the state to develop qualification criteria for CCOs, alternative payment methodologies, and to develop standards for patient centered primary care homes. The law also requires the state to adopt consumer and provider protections and to monitor and enforce these requirements.

CCO's may seem new to most, but not in the Indian health system. Since 1954 the Indian Health Service (IHS) has operated an integrated health care delivery model (primary care, behavioral health, and public health) that operates on a fixed (global) budget from Congress. Tribal health budgets are fixed funding that come via annual funding agreements with IHS that use a prioritized list of services to manage services to a population via the CHS program. CCO's service geography is similar to CHSDA health delivery regions. CCO reporting of quality and outcomes are comparable to IHS quality measures and reporting processes that are in place for Government Performance Results Act and Performance Assessment Rating Tool, which Tribes have utilized for years. Annual audits and accreditation also enhance quality outcomes. Thus, the objectives of CCOs are not new to the Indian health system. CCOs are delivery systems that Tribes will embrace if they effectively integrate our health care system.

On December 20th, Oregon Tribes and the NPAIHB met with State representatives to discuss the implementation of CCOs and how the changes might impact Tribal health programs. This dialogue allowed the opportunity to develop tribal recommendations for how CCOs can effectively integrate Indian health programs into the new CCO delivery system. The recommendations developed are around the following items:

- Alternative Payment Methodologies
- Mandatory Enrollment
- Indian Health Benefit Package
- Options for providing specialty care
- Global Budgets
- Tribal Consultation

The recommendations we provide are consistent with the Federal protections and requirements of IHS, Tribal and urban Indian operated health programs in Medicaid managed care organizations (MCOs). Medicaid MCOs refer to programs that coordinate, rationalize, and channel the delivery of care without being risk-based, and; also refers to care managed by organizations that assume full financial risk for the care managed. Medicaid MCOs in general are efforts to coordinate, rationalize, and channel the use of services to achieve desired access, service, and outcomes while controlling costs. These applications also

apply to Oregon's new CCOs and meet the CMS definitions of being managed care organizations. Thus, CCOs are used interchangeably with MCOs in our recommendations.

Background

The provision of health services to AI/AN people stems from a unique trust relationship between the United States and Indian Tribes. The Federal government's trust responsibility provides the legal justification and moral foundation for Indian specific health policymaking – with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this segment of the American population. It's important to underscore that when Congress passed the Affordable Care Act[1], there were a number of Indian specific protections included to promote the health reform goals for AI/AN people. Similar protections were included in the Recovery Act[2] that exempted AI/ANs from cost sharing in Medicaid and CHIP, Medicaid estate recovery and provided rights of reimbursement for Indian health providers from Medicaid managed care entities. This serves as an example of the policy precedence for Indian specific health policy making. The existence of this truly unique obligation supplies the legal justification and moral foundation for health policy making specific to AI/ANs—with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of Indian people.

The Indian health system in Oregon is a unique and complex system comprised of ten ambulatory care clinics and one urban program that is governed by unique laws, regulations and policies. The Indian health system consists of services provided by the Indian Health Service (an agency in the U.S. Department of Health and Human Services); programs operated by Indian tribes and tribal organizations through Indian Self-Determination and Education Assistance (ISDEAA) agreements, and; by urban Indian organizations that receive grant funding from IHS under Title V of the Indian Health Care Improvement Act.

These programs serve some of the poorest and most isolated populations in the state. Due to the severe and chronic underfunding of Indian health system, AI/ANs have limited access to health care services and suffer some of the highest rates of health disparities when compared to other population groups. Many beneficiaries served by the Indian health system live in remote or sparsely-populated reservation areas. The Indian health system was designed to reach these beneficiaries in their communities which have little, if any, other health infrastructure presence. Even in more populated areas, the Indian health system provides the most meaningful access to health care due to challenges of low income and cultural differences that make other health services essentially inaccessible.

These characteristics are what make the Indian health system unique and requires it to have a comprehensive focus. The IHS delivery system strives to be an integrated, a community-based system that emphasizes prevention and public health, delivers and purchases health care services, and provides the infrastructure for health improvements by building health facilities and sanitation systems. It also provides work force improvement through training, recruitment and retention of health personnel. This system is the health care home for the AI/AN people that it serves. The tribal leaders who direct it, and, increasingly, its workforce, are its users, as are their grandparents and their grandchildren, and it

[1] Patient Protection and Affordable Care Act, (P.L. 111-148), commonly referred to as the "Affordable Care Act".

[2] American Recovery and Reinvestment Act of 2009 (P.L. 111-5), commonly referred to as the "Recovery Act".

will be the health care home for their grandchildren's grandchildren. The incentives in the Indian health system are not financial; its mission is the improvement of the health status of Indian people.

This is why it is important that the implementation of CCOs effectively integrate Indian health programs into their service model. The following recommendations can achieve this objective.

Measuring Health Quality and Reporting in the Indian Health System

The Indian health system strives to provide the best health care possible and is required by federal law to report annually on quality measures on its patients under the Government Performance and Results Act (GPRA). Other government health programs operated by the the Department of Veterans Affairs and the Department of Defense have to do the same. This means that all government health care programs are expected to improve the health of their patients with the money they get from Congress. Each year IHS includes its GPRA report card to Congress as part of the IHS budget submission. The GPRA report card tells Congress about the quality of care IHS is providing to its patients. The report card includes certain performance measures developed by IHS for the AI/AN patient population. For example, quality of care is measured by how well we are treating diabetes and heart disease. It also measures how well we are doing in preventing diseases like cancer, obesity, and HIV. Last year, IHS reported on 21 GPRA and three other clinical performance measures. The GPRA report is provided to the Office of Management and Budget (OMB) and Congress.

IHS programs also required to meet quality and accreditation standards for the purposes of participating in the Medicare, Medicaid and CHIP programs. To comply with this requirement IHS, Tribal and urban Indian programs are routinely accredited through such organizations as the Accreditation Association for Ambulatory Care or the Joint Commission Joint Commission on Accreditation of Health Care Organizations. This process requires Indian health programs to submit to a process in which their quality of care services and performance are measured against nationally-recognized standards. The accreditation process demonstrates that the Indian health system is committed to providing high-quality health care and that it has demonstrated that commitment by measuring up to the nationally-recognized standards.

IHS programs are required to comply with federal requirements for financial accountability. IHS programs must submit data for the purposes of the federal Program Assessment Rating Tool (PART), which measures budget and program performance so that the Federal government can achieve better results. A PART review helps identify a program's strengths and weaknesses to inform funding and management decisions aimed at making the program more effective. The PART therefore looks at all factors that affect and reflect program performance including program purpose and design; performance measurement, evaluations, and strategic planning; program management; and program results. This process includes a consistent series of analytical questions to measure programs over time it allows weakness to be identified so that improvements can be made to improve outcomes.

Tribes enter into legal binding contracts or compacts with the federal government under the Indian Self-Determination and Education Assistance Act (P.L. 93-638, "ISDEAA"), and; urban Indian programs enter into legal binding grant arrangements under Title V of the IHCIA. In the course of carrying out these legally binding agreements with the Federal government, Tribes and urban programs must comply with the requirements of the Single Audit Act. Each IHS programs must complete the requirements of an OMB A-133 audit; which is a rigorous, organization-wide audit examination of funds that are received by

private, state and federal sources. Completion of this requirement demonstrates to the Federal government that the use of funds to provide health care is appropriately utilized. The audit is typically performed by an independent certified public accountant (CPA) and encompasses both financial and compliance components. Incomplete or irregular audits can jeopardize the funding that is received by IHS programs if corrective action is not taken and completed.

Recommendations:

1. Alternative payment methodologies and Global Budgets

   H.B. 3650, Section 5, requires OHA to encourage CCOs to establish alternative payment methodologies that reward value and good health outcomes rather than volume and that limit increases in medical cost. CCOs shall also be encouraged to use payment structures other than fee-for-service that promote prevention, provide person-centered care and reward comprehensive care coordination. Providers and facilities may not charge, and CCOs may not reimburse for, services not covered by Medicare because they are related to health care acquired conditions.

   This section also requires CCOs to reimburse Type A, Type B and rural critical access hospitals at cost until July 1, 2014. After July 1, 2014, OHA shall require CCOs to continue to reimburse specific hospitals at cost if the OHA determines that hospitals face sufficient financial risk. However, this section does not prohibit a CCO and a hospital from mutually agreeing to another method of reimbursement. The basis of this payment principle should be the same for the treatment of Indian health providers who serve similar populations and experience higher cost to provide care.

   Tribal Recommendation:

   HB 3650, Section 5 includes a requirement that CCOs must comply with federal requirements for payments to providers of the Indian health services, including but not limited to the payment protections of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C). Tribes recommend that the established Federal reimbursement process that uses the OMB encounter rate for IHS and Tribal programs and FQHC fee for service for urban health programs be maintained. IHS, Tribal and urban Indian health programs should not be subjected to any unnecessary certification or licensure requirements to participate in the CCO networks or as a condition of reimbursement.

   In addition to the Section 5 exemption, there are federal requirements that protect the Indian health system for reimbursement and participation in the Medicaid program. The Indian Health Care Improvement Act (IHCIA or P.L. 94-437; amended as P.L. 111-148) contains such protections. The IHCIA at Section 206 stipulates that Indian health providers have a Federal right to receive reimbursement for the services they provide. Under Section 206, Indian health providers have the right to recover the "reasonable charges billed … or, if higher, the highest amount any third party would pay for care and services furnished by providers other than governmental entities… "

   The HHS Secretary has the responsibility under the Act to enforce this provision. If Indian health providers are not included in CCO plan networks, there may be more expensive transaction costs incurred by both the Indian providers and the CCO. Alternatively, if the requirement for Indian providers to be reimbursed by health plans is not effectively enforced, then the CCO may realize a potential windfall by collecting premiums or alternate resources for AI/AN enrollees – most likely

paid for with Federal dollars – and not making full payment for the health services their Indian enrollees receive from IHS and Tribal providers.

Additionally, the IHCIA at Section 408(a)(2), provides that Indian health programs are not required to obtain a license from the State as a condition of reimbursement by any Federal health care program so long as the Indian program meets "generally applicable State or other requirements for participation as a provider of health care services under the program." A "Federal health care program" means "any plan or that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or in part, by the United States Government," including health insurance programs under chapter 89 of title 5; and any State health care program, which includes Medicaid, and CHIP, as well as any program receiving funds under certain other provisions of Federal law. Thus, the State or CCOs cannot require licensing in the State as a condition for network provider status nor as a condition for payment for services. Section 408 is as follows:

> [a]ny requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the [Indian Health] Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law.

IHCIA Section 408 further states that "IHS, tribal and urban Indian organization programs shall be eligible for participation in any Federal health care program to the same extent as any other provider." Consequently, federal law requires that tribal and urban health programs be offered participation in CCOs. Although tribal and urban programs are not required to participate, Section 408 mandates that states and CCO must offer to include all tribal and urban health programs within their provider networks.

In order address issues that might arise concerning reimbursement or participation of Tribal and urban programs in the networks of CCOs, the State should require CCOs to contract with IHS, Tribal or urban Indian providers using a contract addendum that sets forth federal rights and responsibilities similar to that used in the Medicare Part D program. This is also important to ensure that CCOs meet network adequacy and cultural competency requirements that are essential to providing and managing the care of AI/AN people. Use of a standard contract addendum will reduce legal and administrative uncertainty as CCOs seek to maintain compliance with all applicable federal laws.

2. Mandatory Enrollment

H.B. 3650, Section 27 and 28, requires that persons eligible for health services, which do not include Medicaid-funded long-term care for the purposes of this section, must enroll in a CCO, with several exceptions including: non-citizens; American Indian or Alaska Native beneficiaries; and other groups that OHA may exempt by rule (e.g. pregnant women in the third trimester). Mandatory enrollment does not apply to a person living in an area not served by a CCO or where the CCO's provider network is inadequate, or PACE enrollees. In any area not served by a CCO but covered by a prepaid

managed care organization, a person must enroll with the managed care organization to receive any of the health services it offers.

There are a variety of reasons why and AI/AN may choose to exercise their option to opt out of being enrolled in a CCO. AI/ANs may prefer to continue to see providers they have an established relationship and that understand their needs and concerns and provides culturally appropriate care. There may be transportation or other economic constraints that prohibit them from receiving care other than through Indian programs. Or they may have job or educational related circumstances that result in relocation between cities and the reservation. Whatever the reason, there must be options for AI/AN who opt in and out of CCOs and requirements for CCOs to coordinate with Indian health programs to manage AI/AN clients access to care and to ensure that Indian health programs are reimbursed in a timely manner. Unless this happens it limit access to specialty care for AIAN patients that will result in negative health outcomes and an unintended consequence that discriminates against AI/ANs from being able to access specialty care.

Regardless, whether an IHS, Tribal or urban Indian health program is a participating provider in a CCO, it should be a requirement that any covered service rendered to a Medicaid patient should be reimbursed at the FFS rate or comply with the established federal requirements for payments to providers of Indian health services under the OMB encounter rate. The State should also establish procedures to make prompt and timely payment consistent with the rule for prompt payment of providers under Section 1932(a) of the Social Security Act. These payment requirements should also apply to any wrap-around payments from the State in accordance with ARRA, Section 5006 (42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C)).

Tribal Recommendations:

Since H.B. 3650 includes an exemption for AI/AN from mandatory enrollment the CCO system should be able to identify AI/AN beneficiaries and provide them with the an open card option similar to what is used in the OHP and IHS, Tribal and urban health programs should be eligible to be reimbursed on a FFS basis. The patient population that is eligible for this option would be any individual that is eligible to receive services through the Indian health system. HB 3650 defines AI/AN beneficiary consistent with the definition adopted by the Centers for Medicare and Medicaid Services (CMS) definition of “Indian” in its implementation of the Medicaid cost sharing protections enacted in Sec. 5006 of the Recovery Act (codified at 42 U.S.C. § 1396o(j)). This regulation, 42 C.F.R. § 447.1 - 447.50, broadly defines the term “Indian” consistent with the Indian Health Service’s (“IHS”) regulations on eligibility for IHS services.

We recommend that the state develop requirements to address the issues related to the relationship of shared patients between the Indian health system and CCOs. These requirements should address coordination and access to care for AI/AN patients, and; compliance with Medicaid prompt payment requirements to Indian health providers. The development such requirements should not be placed on IHS programs or CCOs, but should be the responsibility of the Oregon as the single state Medicaid agency. At a minimum these requirements should address AI/ANs enrolled in CCOs, who receive services from IHS, Tribal and urban Indian health programs and specialty care access for those for AI/ANs not enrolled in MCOs.

The State should require CCOs that enroll AI/ANs to treat any referral made by an IHS, Tribal or urban Indian health program to be treated as a participating primary care provider for the purposes

of receiving services from the CCOs network and for reimbursement of services provided by the Indian health system. Without such a requirement Indian health referrals will likely be refused service by the CCO network providers.

3. Indian health benefit package

H.B. 3650, Section 39, makes a conforming amendment to ORS 414.428, which is the regulation that provides an individual who is eligible for or receiving medical assistance and who is an AI/AN beneficiary shall receive the benefit package of health services described in ORS 414.707 if: (a) The Oregon Health Authority receives 100 percent federal medical assistance percentage for payments made by the authority for the health services provided as part of the benefit package described in ORS 414.707, or; "(b) The authority receives funding from the Indian tribes for which federal financial participation is available.

Tribal Recommendation:

Tribes have requested that the state explore options to exempt AI/AN from benefit reductions or explore alternatives to be able to provide optional services that have already been reduced in the Oregon Health Plan. We recommend that the State continue to work with Tribes and CMS in the development of waiver or state plan amendment (whichever is necessary) to allow implementation of Section 29. The requirements of Section 39 would make such services completely budget neutral to the State and provided needed services to address the health disparities that persist in Oregon's tribal population.

4. Global Budgets

HB 3650, Section 13 requires the OHA develop—and the legislature to approve—a meaningful public process for CCO qualification criteria and a global budgeting process. It is noted that the draft report "CCO Implementation Proposal" for HB 3650 mentions that "all Medicaid dollars are in the global budgets" with the exception of long-term and mental health drugs. It is important to recognize that Oregon provides Tribes funding under its Medicaid plan for targeted case management (TCM) and out-stationed eligibility workers. Oregon operates a Tribal TCM program that provides Medicaid case management services to AI/ANs to assist eligible beneficiaries in obtaining medical and other services necessary for their treatment.[3] The target group consists of individuals served by tribal programs, or receiving services from a federally-recognized Indian tribal government located in the State, and not receiving services from other Title XIX programs. The OHA also provides IHS, Tribal and urban programs reasonable compensation for activities directly related to the receipt and initial processing of applications for individuals, including low-income pregnant women and children, to apply for Medicaid at outstation locations other than state offices. [4] Both of these programs are very important in providing outreach, enrollment and linkage activities for Indian people.

[3] ORS 410-138-0610, Targeted Group - Federally Recognized Tribal Governments in Oregon.
[4] ORS 410-146-0460, Compensation for Out-stationed Outreach Workers.

Tribal Recommendation: TCM and out-stationed eligibility workers are services that in most instances could not be performed on reservations by CCOs. Thus the funds provided to Tribes for these programs should be exempt from CCO global budget and continue to be received by Tribes under the State Medicaid plan. CCOs will likely lack the presence in Tribal communities to perform these services. IHS, Tribal and urban programs also carry these services out within their existing health programs that give them a distinct advantage in conducting these services. They are in the clinics and conducted with members of the community who understand the needs of the patients they serve.

5. Tribal Consultation

In recognition of the special relationship with tribal governments, the United States government has recognized the importance of Tribal consultation by reaffirming Executive Order 13175 to ensure regular and meaningful consultation and collaboration with tribal officials in Federal policy decisions that have tribal implications. In 1975, Oregon established the Legislative Commission on Indian Services (CIS) to improve services to Indian people by improving communication and coordination with Tribes. Following establishment of the Commission, the legislature overwhelmingly supported passage of SB 770, a bill that acknowledges and promotes government-to-government relations with Oregon Tribes. This establishes a foundation that the State and the legislature consult with Oregon Tribes in developing policies and implementing programs that will affect their interests.

Section 5006(e) of the Recovery Act codifies in statute, at section 1902(a)(73), the requirement that States utilize a process to seek advice on a regular, ongoing basis from designees of the Indian Health Programs and Urban Indian Organizations concerning Medicaid and CHIP matters having a direct effect on Indians, Indian Health Programs or Urban Indian Organizations. The statute requires the solicitation of advice on an "on-going, regular basis". In order to assure the spirit of this obligation is fulfilled; CMS will require States to demonstrate that they have sought advice from designees of Indian Health Programs and Urban Indian Health Organizations throughout the process of developing state plan amendments, waiver requests, and demonstration projects. The "on-going, regular basis" requirement is intended to assure that the State has the benefit of substantive input and evaluation of impact from Indian Health Programs and Urban Indian Health Organizations during the proposal development process so that the State can meaningfully take this information into account.

Tribal Recommendation:

Tribes recommend that the State consult with Tribes over the final operational plan to implement CCOs where there are tribal implications that will affect the above recommendations and prior to the State's submission of the Medicaid State plan amendment or waiver request to implement CCOs. Tribes acknowledge that some of the State's Medicaid responsibilities could be subrogated to CCOs and that in these instances that State and CCOs must ensure that the tribal consultation process is adhered to when issues are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations.

6. Criteria for Coordinated Care Organizations

   HB 3650, Section 5 sets forth the qualification criteria for CCOs including the governance structure, financial requirements, and components of health care delivery systems. Options to organize CCOs include community-based organizations, statewide organizations with community-based participation, a single corporate structure, or a network of providers organized through contractual relationships. In almost every instance the Oregon's Indian health care delivery system can meet all the requirements of these structures. Tribal and urban communities by their very nature are community based and their health clinics are their organizations that provide health care. Collectively they can coordinate to be statewide or become a single corporate structure and already include community participation. The Indian health system can also be formalized into a networked structure of providers through contractual relationships amongst itself or with other health system providers. While the benefits and challenges of becoming a CCO are not known by the Indian health system at this time, we would like to preserve the ability to become CCOs if it would be beneficial to our providers and patients.

   Tribal Recommendations: We recommend that the qualification criteria to establish a CCO should not preclude the ability of IHS, Tribal and urban Indian health programs to become a CCO. We also recommend that the criteria for CCOs must require that they meet network adequacy requirements for providing care to AI/ANs located on Indian reservations and that there also be requirements for meeting cultural competency for providing care to all Oregonian populations.

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