



NATIONAL COUNCIL *of*
URBAN INDIAN HEALTH

RECENT TRENDS IN THIRD-PARTY BILLING AT URBAN INDIAN ORGANIZATIONS:

A Focus on Primary Care Case Management
and Indian Managed Care Entities





EXECUTIVE SUMMARY

This report serves as an update to the National Council of Urban Indian Health's previous reporting on recent trends in third-party billing.¹ This report focuses on the experience of urban Indian organizations enrolled in Medicaid and the Children's Health Insurance Program as a primary care case manager or Indian Managed Care Entity. In particular, this report contains:

1. Background regarding primary care case management and its role in the Medicaid and the Children's Health Insurance Program,
2. Results of interviews conducted with urban Indian organizations leaders regarding their facilities experience with primary care case management within the Medicaid and Children's Health Insurance Program, and
3. A concluding discussion with key takeaways based on interviews.

This report identifies certain challenges and best practices regarding primary care case management and Indian Managed Care Entities. Urban Indian organizations almost universally felt that participating as a primary care case manager in Medicaid and the Children's Health Insurance Program improved the level of care that they were able to offer beneficiaries and represented a best practice for service delivery. Urban Indian organization-identified best practices included developing strong working relationships with their state Medicaid and Children's Health Insurance Program offices and Tribal Liaisons. Challenges include insufficient capitation rates for those participating as primary care case managers, a need for improved communication with state Medicaid and the Children's Health Insurance Program office, and a need for further education regarding the roles of urban Indian organizations in the Indian healthcare system and the unique populations they serve.

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¹ NCUIH's prior reports regarding third-party billing can be accessed at <https://ncuih.org/research/third-party-billing/>





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PART I: THE IMPORTANCE OF MEDICAID AND CHIP IN AMERICAN INDIAN AND ALASKA NATIVE HEALTHCARE

Developing a better understanding of how Medicaid and the Childrens Health Insurance Program (CHIP) serve American Indians and Alaska Natives as this report and the others in this series completed by NCUIH in 2020, 2021, and 2022 seek to do, is critically important given the role that Medicaid and CHIP plays in the fulfillment of the United States' trust responsibility to provide health services to maintain and improve the health of American Indians and Alaska Natives.² According to a 2021 report by the Medicaid and CHIP Payment Access Commission (MACPAC), in 2018 Medicaid covered 36 percent of American Indian and Alaska Native adults under 65, a significantly higher percentage than adults covered nationally, which was 22 percent.³ In some states, American Indians and Alaska Natives are among the largest group of Medicaid and CHIP beneficiaries, representing more than 30 percent of Medicaid and CHIP enrollees in states like Alaska and South Dakota.⁴

As an income-based program, Medicaid and CHIP is especially important for American Indians and Alaska Natives in urban areas, as they face high levels of poverty. According to a 2021 report by the Urban Indian Health Institute, approximately 20.3 percent of American Indian and Alaska Native families in all UIO service areas lived in households with income below the federal poverty level, compared to 5.3 percent of non-Hispanic white families.⁵

Additionally, Medicaid and CHIP is also an important source of funding for the Indian health system, which consists of the Indian Health Service (IHS), Tribal facilities, and Urban Indian Organizations (UIOs) (collectively the I/T/U system). For example, "in FY 2019, Medicaid and CHIP collections at IHS-run facilities amounted to \$808 million, nearly 70 percent of total collections from third parties."⁶ In some years, the amount of Medicaid reimbursements to UIOs is equal to the total amount of funding for urban Indian health in the IHS budget.⁷

*Congress has long recognized that "Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian."*⁸

² 25 USC § 1601(1).

³ Medicaid and CHIP Payment Access Commission, *Medicaid's Role in Health Care for American Indians and Alaska Natives 3* (Feb. 2021), available at <https://www.macpac.gov/wp-content/uploads/2021/02/Medicoids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf>.

⁴ *Id.*

⁵ Urban Indian Health Institute, *Community Health Profile: National Aggregate of Urban Indian Organization Service Areas*. Seattle, WA: Urban Indian Health Institute, *Community Health Profile* (2021), <https://www.uihi.org/download/community-health-profile-national-aggregate-of-urban-indian-organization-service-areas/>.

⁶ Medicaid and CHIP Payment and Access Commission, *supra* note 3, at 5.

⁷ Kalweit, Andrew, Chandos Culleen, and Isaiah O'Rear. Recent Trends in Third-Party Billing at Urban Indian Organizations: Impact of the American Rescue Plan Act and 100% FMAP Provisions 18 (2022), <https://ncuih.org/wp-content/uploads/ARPA-Draft-2022-09-28.pdf>.

⁸ H. Rpt. 94-1026 (May 12, 1976).





PART II: MANAGED CARE BACKGROUND

This year's report has a particular focus on primary care case management (PCCM), which is a form of Medicaid managed care. Medicaid managed care is when a state contracts with a private organization to administer all or part of their Medicaid and CHIP programs. State Medicaid and CHIP programs utilize three types of managed care delivery systems: comprehensive risk-based managed care, PCCM, and limited-benefit plans.⁹

Under a comprehensive risk-based managed care arrangement, states establish contracts with managed care organizations (MCOs) to provide coverage for most or all Medicaid and CHIP-covered services to their beneficiaries.¹⁰ MCOs are compensated by the state through a capitation rate, which is a fixed amount per member per month, and it covered a defined set of services.¹¹ MCOs take responsibility for overseeing patient care and managing reimbursement to providers.¹² MCOs provide medical services to Medicaid beneficiaries through their own networks of doctors and hospitals, and Medicaid and CHIP beneficiaries must seek care through their MCO's network.¹³

Through the PCCM managed care arrangement, the state pays a designated primary care provider a monthly case management fee to "locate, coordinate, and monitor covered primary care," for Medicaid and CHIP beneficiaries.¹⁴ The primary care provider may be a "[a] physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services," or in some states a nurse practitioner, a nurse-midwife, or a physician's assistant.¹⁵ The state continues to pay providers on a fee-for-service basis for services outside the scope of primary care management.¹⁶

Some states utilize limited benefit plans arrangements to manage specific areas of healthcare. Limited benefit plans focus on particular benefits such as "inpatient mental health or substance abuse benefits, non-emergency transportation, oral health, or disease management."¹⁷ Limited-benefit plans are usually paid on a capitated basis, like MCOs.¹⁸

9 Medicaid and CHIP Payment and Access Commission, *Managed Care Overview*, <https://www.macpac.gov/subtopic/managed-care-overview/> (last accessed May 30, 2023).

10 *Id.*; see 42 U.S.C. § 1396(b)(m); 42 CFR § 438.2 (statutory and regulatory definitions of Medicaid managed care organization).

11 Centers for Medicare & Medicaid Services, *Medicaid: Managed Care*, <https://www.medicare.gov/medicaid/managed-care/index.html> (last accessed May 30, 2023); Medicaid and CHIP Payment and Access Commission, *Managed Care Overview*, <https://www.macpac.gov/subtopic/managed-care-overview/> (last accessed May 30, 2023).

12 Christine Vestal, *Managed Care Explained: Why a Medicaid Innovation is Spreading*, May 31, 2011, <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2011/05/31/managed-care-explained-why-a-medicare-innovation-is-spreading> (last accessed June 9, 2023).

13 *Id.*

14 42 U.S.C. § 1396d(t)(3); 42 CFR § 438.2.

15 42 U.S.C. § 1396d(t)(2)(A)-(B); 42 CFR § 438.2.

16 Medicaid and CHIP Payment and Access Commission, *supra* note 9.

17 *Id.*

18 Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.





States can mandate Medicaid beneficiary enrollment in Medicaid managed care to varying extents by utilizing the following provisions of the Social Security Act, covered in more detail below: a Section 1115 demonstration, a Section 1915(b) waiver, or a Section 1932(a) State Plan Amendment (SPA).¹⁹

This report will examine the PCCM managed care model and its role in the Medicaid and CHIP programs in selected states where UIOs are located. For further explanation of Medicaid managed care, the various types of managed care within the Medicaid program, and case studies on how managed care organizations interact with UIOs, please refer to NCUIH's 2022 report entitled "Recent Trends in Third-Party Billing at Urban Indian Organizations: A Focus on Medicaid Managed Care."²⁰

PART III: PRIMARY CARE CASE MANAGEMENT AND ITS ROLE IN THE MEDICAID AND CHIP PROGRAMS

While case management is a concept found in the broader healthcare industry, within the Medicaid and CHIP programs, PCCM refers to a healthcare delivery model in which beneficiaries are assigned to a primary care case manager who is responsible for locating, coordinating, and monitoring primary health care services for those assigned beneficiaries.²¹

The PCCM Service Delivery Model

Through the PCCM managed care model, states assign Medicaid and CHIP beneficiaries a primary care case manager to locate, coordinate, and monitor their primary care services.²² Primary care services include "all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician."²³ The State pays each primary care case manager a monthly case management fee, referred to as a per member per month fee (PMPM), for each individual who's care they manage.²⁴ This fee is sometimes also referred to as a capitation rate or payment.²⁵ The state continues to pay primary case managers the standard Medicaid and CHIP reimbursement amount for any services delivered to the beneficiary outside the scope of primary care management.²⁶

19 Centers for Medicare & Medicaid Services, *Managed Care Authorities*, <https://www.medicare.gov/medicaid/managed-care/managed-care-authorities/index.html> (last visited Aug. 10, 2023).

20 NCUIH's report is available at: <https://ncuih.org/wp-content/uploads/Formatted-Managed-Care-Draft-07.28.2022.pdf>.

21 42 U.S.C. § 1396d(t)(3); 42 CFR § 438.2.

22 Medicaid and CHIP Payment and Access Commission, *Types of Managed Care Arrangements*, <https://www.macpac.gov/subtopic/types-of-managed-care-arrangements/>, (last accessed Jun. 6, 2023); see 42 U.S.C. § 1396d(t)(3); 42 CFR § 438.2.

23 42 U.S.C. § 1396d(t)(4).

24 North Carolina Healthcare Association, *Per Member Per Month*, <https://www.ncha.org/glossary/per-member-per-month-pmpm/#:~:text=The%20amount%20of%20money%20paid,often%20referred%20to%20as%20capitation> (last accessed Apr. 14, 2023).

25 See North Carolina Healthcare Association, *Per Member Per Month*, <https://www.ncha.org/glossary/per-member-per-month-pmpm/#:~:text=The%20amount%20of%20money%20paid,often%20referred%20to%20as%20capitation> (last accessed Apr. 14, 2023).

26 See Medicaid and CHIP Payment and Access Commission, *supra* note 9.





A Brief History of PCCM in the Medicaid and CHIP Programs

PCCM is one of the oldest types of Medicaid managed care programs. Medicaid was enacted in 1965 with the passage of Public Law 89-97, which amended the Social Security Act to include Title XIX. Pursuant to PL 89-97, states participating in Medicaid were required to create plans for the provision of medical assistance paid for by a cost-sharing arrangement between the state and the federal government.²⁷ As originally enacted, Medicaid was an entirely fee-for-service (FFS) program.²⁸ States were required to pay "part or all of the cost" of certain enumerated services including inpatient hospital services, outpatient hospital services, laboratory and x-ray services, and others.²⁹

While states could use a pre-existing authority in the Social Security Act to enroll subsets of beneficiaries in managed care plans when the Medicaid program was first established,³⁰ the use of PCCM programs began in earnest following amendments made to Title XIX of the Social Security Act in the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981).³¹ OBRA 1981 added Sections 1915(a) and 1915(b) to the Social Security Act, which grant the Secretary of Health and Human Services the authority to waive certain statutory requirements of the Medicaid program to allow a state to implement a case-management system.³² Of particular note, while enrollment in a managed care plan under Section 1915(a) must be voluntary, Section 1915(b) permits a State to limit Medicaid beneficiaries' freedom of choice among providers.³³

By 1986, PCCM programs were implemented in seven (7) states.³⁴ Growth continued quickly, with the number of states utilizing PCCM programs increasing to nineteen (19) by 1990.³⁵ By 1994, thirty-three (33) states had enrolled 2.4 million beneficiaries in PCCM programs.³⁶ According to the National Academy for State Health Policy, early implementors of PCCM programs had several motivations for doing so, including: improving access to healthcare; saving money by reducing high-cost care such as inappropriate emergency room visits; and improving managed care in rural areas.³⁷ Early PCCM programs resembled traditional fee-for-service (FFS) Medicaid in several ways including minimal provider requirements and non-competitive primary care provider (PCP) selection.³⁸

27 Public Law 89-97, Sec. 1905(a)(Jul. 30, 1965).

28 See Public Law 89-97, Sec. 1905(a)(Jul. 30, 1965); Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid* 19 (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.

29 See Public Law 89-97, Sec. 1905(a)(Jul. 30, 1965); Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid* 19 (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.

30 The Public Welfare Amendments of 1962 (P.L. 87-543), which added Section 1115 of the Social Security Act, granted the federal government the authority to waive compliance with numerous requirements of the Social Security Act. PL 89-97 amended Section 1115 to broaden this authority to include the requirements for state plans for medical assistance. See Public Law 89-97, Sec. 1109 (Jul. 30, 1965); Public Law 87-543, Sec. 122 (Jul. 25, 1962); 42 U.S.C. § 1315 (current authority for Section 1115 demonstration projects, including changes to the law following its enactment in 1962); 42 U.S.C. § 1396(a); see also National Council on Disability, *An Overview of Medicaid Managed Care*, <https://www.ncd.gov/policy/chapter-1-overview-medicaid-managed-care> (last accessed May 6, 2022); Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid* 19 (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.

31 See Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35; Neva Kaye, *Primary Care Case Management in Medicaid A Strategy for Supporting Primary Care in Rural Areas* 2 (2021)(stating that "State Medicaid agencies have operated primary care case management (PCCM) programs for 40 years); Saul Spigel, *Primary Care Case Management* (Apr. 9, 2003), <https://www.cga.ct.gov/2003/rpt/2003-R-0339.htm> (stating that "PCCM emerged in the 1980s.").

32 Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35 §1915(a) and (b).

33 *Id.*

34 Joanne Rawlings-Sekunda, Deborah Curtis, and Neva Kaye, *Emerging Practices in Medicaid Primary Care Case Management Programs* 6 (2001)(citations omitted), available at https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/40046/report.pdf.

35 *Id.*

36 *Id.* at 9.

37 *Id.* at 6-7.

38 *Id.* at 7.





In 1997, the Balanced Budget Act of 1997 (BBA) gave state Medicaid and CHIP programs the authority to pursue mandatory Medicaid and CHIP managed care enrollment through an amendment to its state plan, as opposed to a waiver.³⁹ Following the passage of the BBA, Medicaid and CHIP managed care enrollment grew rapidly.⁴⁰ Interestingly, by 1998, the number of states utilizing PCCM had dropped to twenty-nine (29) states, but those programs served 4.1 million beneficiaries, more than 1.7 million more than were served by PCCM just four years before.⁴¹ Additionally, in 1998 the number of Medicaid and CHIP beneficiaries enrolled in PCCM represented 13 percent of all Medicaid and CHIP beneficiaries.⁴²

The Current State of PCCM Use

Use of PCCM in Medicaid programs has steadily declined over time. Usage dropped from thirty-three (33) states in 1994⁴³ to only twelve (12) states as of July 1, 2022.⁴⁴ Of these twelve states, only five (5) use PCCM as the primary form of Medicaid and CHIP programs in the state.⁴⁵ Seven (7) use PCCM in combination with comprehensive MCOs.⁴⁶

As the number of states utilizing PCCM has declined, so has the percentage of beneficiaries enrolled in a PCCM program. The number of Medicaid beneficiaries served by PCCM nation-wide dropped from 22% of beneficiaries in 2011,⁴⁷ to 7.2% of beneficiaries in 2019.⁴⁸ PCCM lags significantly behind comprehensive risk-based managed care in terms of beneficiaries served, as 69.5% of Medicaid beneficiaries nationwide were served by comprehensive managed care in 2019.⁴⁹ As of 2022, Alabama (98%), Idaho (89%), and Colorado (89%) have the highest percentages of their Medicaid beneficiaries served by PCCM, while North Carolina (28%), Arizona (1.8%), and Washington (<1%) have the lowest percentage of their populations served by PCCM (excluding those states which do not use PCCM).⁵⁰

39 The Balanced Budget Act of 1997 §4702 (P.L. 105-33).

40 Medicaid and CHIP Payment and Access Commission, *supra* note 18, at 20; Vestal, *supra* note 12 ("State Medicaid programs began making the switch in 1990. Then in 1997, Congress passed a law making it easier for states to get federal permission to put Medicaid recipients under managed care. The momentum has continued since."); see Congressional Budget Office, *Exploring the Growth of Medicaid Managed Care* (Aug. 2018), available at https://www.cbo.gov/system/files/2018-08/54235-MMC_chartbook.pdf (exploring the increase in Medicaid managed care enrollment beginning in 1999).

41 41 Rawlings-Sekunda, Curtis, and Kaye, *supra* note 34, at 9.

42 *Id.*

43 *Id.*

44 Elizabeth Hinton and Jada Raphael, *10 Things to Know About Medicaid Managed Care* (Mar. 1, 2023), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>.

45 Those five states are: Alabama, Idaho, Montana, Oklahoma, and South Dakota. Kaiser Family Foundation, *Share of Medicaid Populations Covered Under Different Delivery Systems*, [https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Type\(s\)%20of%20Managed%20Care%20in%20Place%22,%22sort%22:%22desc%22%7D#note-4](https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Type(s)%20of%20Managed%20Care%20in%20Place%22,%22sort%22:%22desc%22%7D#note-4) (last accessed Apr. 9, 2023).

46 Those seven states are: Arizona, Arkansas, Colorado, Massachusetts, North Carolina, North Dakota, and Washington. Kaiser Family Foundation, *Share of Medicaid Populations Covered Under Different Delivery Systems*, *supra* note 45.

47 Vestal, *supra* note 12.

48 Medicaid and Chip Payment and Access Commission, *Percentage of Medicaid Enrollees in Managed Care by State, July 1, 2019* <https://www.macpac.gov/wp-content/uploads/2018/05/EXHIBIT-29.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-July-1-2019.pdf> (last accessed Mar. 29, 2022).

49 *Id.*

50 Kaiser Family Foundation, *supra* note 45.





The Legal Framework of PCCM

Title XIX of the Social Security Act and Part 438 of Chapter 42 of the Code of Federal Regulations set forth the basic framework and requirements of a PCCM program. For example, pursuant to 42 U.S.C § 1396d(t)(3), a PCCM contract must:

- (A) provide[] for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;
- (B) restrict[] enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;
- (C) provide[] for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;
- (D) prohibit[] discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this subchapter;
- (E) provide[] for a right for an enrollee to terminate enrollment in accordance with section 1396u-2(a)(4) of this title; and
- (F) complies with the other applicable provisions of this title.⁵¹

Additionally, § 438.100 sets forth enrollee rights which a state must ensure the PCCM respects and honors, and Part 438 Subpart J details the conditions for Federal Financial Participation in a managed care program, including a PCCM program. As long as the State complies with the basic requirements in federal law and regulation, it has significant discretion in designing and implementing PCCM programs.

There are three statutory vehicles provided in the Social Security Act by which most states design and implement their managed care programs: Section 1115, 1915(b) and Section 1932(a).⁵² Section 1115 permits states to make broad, structural changes to their Medicaid and CHIP programs, on a demonstration basis, if the Secretary of Health and Human Services determines that the demonstration project is likely to assist in promoting the objectives of the Medicaid and CHIP program.⁵³ In addition to confirming compliance with the regulatory and statutory requirements for proposal design and submission, CMS reviews each Section 1115 demonstration proposal to determine whether the objectives of the demonstration are aligned with those of Medicaid, whether the proposed waiver authorities are appropriate, and whether the demonstration is budget neutral.⁵⁴ Because Section 1115 demonstrations can vary in scope and complexity, states often must engage in a lengthy negotiation process with CMS to receive approval.⁵⁵ CMS approves Section 1115 demonstrations for an initial five-year period.⁵⁶ Approval generally can be renewed for an additional three years, though it may sometimes be granted for an additional five years, depending on the impacted beneficiary population.⁵⁷

⁵¹ 42 U.S.C § 1396d(t)(3)(A)-(F).

⁵² See Medicaid and CHIP Payment and Access Commission, *Features of Federal Medicaid Managed Care Authorities*, <https://www.macpac.gov/features-of-federal-medicaid-managed-care-authorities/> (last accessed Jun 5, 2023)(reviewing the authorities for comprehensive Medicaid managed care programs).

⁵³ See 42 U.S.C. § 1315; Centers for Medicare & Medicaid Services, *About Section 1115 Demonstrations*, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html> (last accessed Jun. 2, 2023).

⁵⁴ See Centers for Medicare and Medicaid Services, *supra* note 53.

⁵⁵ Medicaid and CHIP Payment and Access Commission, *Section 1115 Research and Demonstration Waivers*, <https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/> (last accessed Jun. 2, 2023).

⁵⁶ Centers for Medicare & Medicaid Services, *supra* note 53; Medicaid and CHIP Payment and Access Commission, *supra* note 55.

⁵⁷ Centers for Medicare & Medicaid Services, *supra* note 53; Medicaid and CHIP Payment and Access Commission, *supra* note 55.





CMS has implemented a fast track review process for Section 1115 demonstrations which have had at least one full extension cycle without substantial program changes.⁵⁸ States may use Section 1115 demonstrations to mandate enrollment in managed care programs for Medicaid beneficiaries, including “Indian” beneficiaries, subject to CMS approval.⁵⁹ Section 1115 waivers must meet statutorily mandated Tribal consultation and urban confer requirements, and CMS will consider all information provided from the consultation and confer prior to approving or denying the demonstration.⁶⁰

A state may also use a Section 1915(b) waiver to implement a PCCM program. CMS has the authority to grant waivers under Section 1915(b) of the Social Security Act, allowing states to implement mandatory enrollment in a managed care delivery system for all Medicaid and CHIP beneficiaries.⁶¹ Approval of 1915(b) waivers is only permitted if the program is “cost-effective and efficient and not inconsistent with the purposes of” Medicaid.⁶² Notably, a state may use a Section 1915(b) waiver to limit Medicaid beneficiaries’ freedom of choice among certain providers, including requiring American Indian and Alaska Native individuals to enroll in a PCCM program.⁶³ When considering waiver requests, CMS takes into consideration any input received by the state through its statutorily-required state-Tribal consultation and urban confer processes.⁶⁴ Through these consultation processes, it is possible for states, Tribes, and UIOs to reach an agreement to exempt American Indians and Alaska Native individuals from mandatory managed care as part of a Section 1915(b) waiver. Generally, Section 1915(b) waivers are approved, and subsequently renewed, for two years at a time.⁶⁵

Finally, a state may implement PCCM program by amending its state plan through a Section 1932(a) state plan amendment (SPA). Unlike PCCM programs implemented under Section 1115 or Section 1915(b), which must be periodically renewed, a program implemented through a Section 1932(a) SPA can be made permanent.⁶⁶ Unlike a 1915(b) waivers and 1115 demonstrations, Section 1932(a) SPAs may not require an individual who is “Indian,” as defined by Section 4(c) (1) of the Indian Health Care Improvement Act (IHCIA), to enroll in a managed care entity, unless the required entity is: (1) participating in the state plan and (2) is one of the following: Indian Health Service; a Tribal health program operating pursuant to a cooperative agreement, grant or contract with the Indian Health Service (IHS) under the Indian Self Determination Act; or an Urban Indian Organization operating pursuant to a grant or contract with the IHS pursuant to Title V of the IHCIA.⁶⁷

58 Centers for Medicare & Medicaid Services, *supra* note 53.

59 Centers for Medicare & Medicaid Services, CMCS Informational Bulletin, *Indian Provisions in the Final Medicaid and Children’s Health Insurance Program Managed Care Regulations* 4, Dec. 14, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf>. (note: “Indian” in this guidance means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12).

60 *Id.*; 42 U.S.C. 1902(a)(73).

61 42 U.S.C. § 1396n(b)(1)(note that there are four sub-varieties of waiver available).

62 42 U.S.C. § 1396n(b).

63 42 U.S.C. § 1396n(b)(1); see Medicaid and CHIP Payment and Access Commission, *1915(b) waivers*, <https://www.macpac.gov/subtopic/1915b-waivers/> (last accessed Apr. 9, 2023).

64 42 U.S.C. 1902(a)(73).

65 42 U.S.C. § 1396n(h)(1).

66 Centers for Medicare & Medicaid Services, *Managed Care Authorities*, <https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html> (last accessed Apr. 9, 2023).

67 42 U.S.C. § 1396u-2(a)(2)(C); Centers for Medicare & Medicaid Services, *supra* note 66.





Notably, the Social Security Act and CMS' regulations set forth several broadly applicable protections for American Indians and Alaska Natives served by managed care, regardless of the statutory vehicle used to implement the program.⁶⁸

For example,

[a]ll contracts between a State and a . . . PCCM entity, to the extent that the PCCM entity has a provider network, which enroll Indians must . . . [r]equire the . . . PCCM entity to demonstrate that there are sufficient IHCPs [Indian Health Care Providers] participating in the provider network . . . to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.⁶⁹

In addition, that contract must

[p]ermit any Indian who is enrolled in a . . . PCCM or PCCM entity that is not an IMCE [Indian Managed Care Entity] and eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services.⁷⁰

American Indians and Alaska Natives also are permitted "to obtain services covered under the contract between the State and the . . . PCCM entity from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services."⁷¹ Other protections concern further network and coverage requirements as well as payment requirements.⁷²

Indian Managed Care Entities: A New Innovation in Managed Care

Many of the protections for American Indians and Alaska Natives in Medicaid managed care were added to the Social Security Act by the American Recovery and Reinvestment Act of 2009 (ARRA).⁷³ ARRA also created a new type of managed care entity – "Indian Managed Care Entity (IMCE)." An Indian Managed Care Entity is a managed care entity (Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), or PCCM entity) "that is controlled...by the IHS, Tribe, Tribal organization, or UIO, or a consortium, which may be composed of 1 or more Tribes, Tribal organizations, or UIOs, and which also may include the Service."⁷⁴ IMCEs "...may restrict enrollment under such program to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians."⁷⁵

68 42 U.S.C. § 1396u-2(h); 42 C.F.R. § 438.14.

69 42 C.F.R. § 438.14(b)(1).

70 42 C.F.R. § 438.14(b)(3).

71 42 C.F.R. § 438.14(b)(4).

72 42 C.F.R. § 438.14.

73 Public Law 111-5, Sec. 5006(d).

74 42 U.S.C. § 1396u-2(h)(4)(B); 42 C.F.R. § 438.14(a).

75 42 U.S.C. § 1396u-2(h)(3).





NCUIH is only aware of two states, North Carolina and Oregon, in which Tribal Organizations and UIOs have created IMCEs since ARRA's passage. In 2020, the North Carolina Department of Health and Human Services and the Cherokee Indian Hospital Authority (CIHA) entered into a contract to support the Eastern Band of Cherokee Indians (EBCI) in addressing the health needs of American Indian and Alaska Native Medicaid beneficiaries by creating an IMCE.⁷⁶ The IMCE, "EBCI Tribal Option" was created as part of North Carolina's transition to statewide Medicaid Managed Care, which launched on July 1, 2021.⁷⁷ Tribes and the state worked together to develop the EBCI Tribal option, and the state submitted a ICME Section 1932(a) SPA, which was approved by CMS on September 13, 2021.⁷⁸ The EBCI Tribal Option is a PCCM entity⁷⁹ for federally recognized Tribal members and other individuals eligible to receive health services from the IHS.⁸⁰ Of the state's 2,953,505 Medicaid enrollees, approximately 4,528 are enrolled in the EBCI Tribal Option.⁸¹ This program focuses on primary care, preventive health, chronic disease management, and care management for high-need members.⁸²

The Oregon Health Plan (OHP) also contracts with IMCEs to manage the care of American Indian and Alaska Native beneficiaries. In 2018, the Oregon Health Authority (OHA) received a request from the state's nine federally recognized Tribes and one UIO (Native American Rehabilitation Association of the Northwest – NARA NW) to assist in implementing IMCEs.⁸³ Over the course of three years, the state, Tribes, and UIOs met over 30 times to develop the IMCEs and a 1932(a) SPA.⁸⁴ CMS approved the IMCE Section 1932(a) SPA on July 16, 2021. Pursuant to the approved SPA, Oregon contracts with individual IMCEs operated by the Tribes and NARA NW to provide six (6) PCCM services: intensive telephonic case management; face-to-face case management; operation of a nurse triage line; development of enrollee care plans; provision of enrollee outreach and education activities; and operation of a customer service all center.⁸⁵ Each IMCE receives a PMPM payment to manage their members' care.⁸⁶

76 North Carolina Department of Health and Human Services, *NCDHHS and Cherokee Indian Hospital Authority to Create First-in-Nation Indian Managed Care Entity* (Oct. 30, 2020), <https://www.ncdhhs.gov/news/press-releases/2020/10/30/ncdhhs-and-chokeee-indian-hospital-authority-create-first-nation-indian-managed-care-entity>.

77 *Id.*

78 North Carolina, State Plan Amendment #NC 21-0011(September 13, 2021), [NC-21-0011.pdf](https://www.ncdhhs.gov/news/press-releases/2020/10/30/ncdhhs-and-chokeee-indian-hospital-authority-create-first-nation-indian-managed-care-entity) (medicaid.gov).

79 National Indian Health Board, *Medicaid Managed Care Report 25* (2022), https://www.nihb.org/docs/phrc-uploads/08152022/medicaid-managed-care-report_final_08102022.pdf; North Carolina Department of Health and Human Services, *Fact Sheet Eastern Band of Cherokee Indians (EBCI) Tribal Option Overview*, <https://medicaid.ncdhhs.gov/ebci-tribal-option-overview/download?attachment>

80 North Carolina Department of Health and Human Services, *supra* note 76.

81 North Carolina Department of Health and Human Services, *Dashboards*, <https://medicaid.ncdhhs.gov/reports/dashboards> (last accessed Apr. 9, 2023).

82 Cherokee Indian Hospital Authority, *EBCI Tribal Option*, <https://ebcitrionaloption.com/> (last accessed Apr. 9, 2023).

83 National Indian Health Board, *Medicaid Managed Care Report 26* (2022), https://www.nihb.org/docs/phrc-uploads/08152022/medicaid-managed-care-report_final_08102022.pdf.

84 Oregon, State Plan Amendment #:21-0008 (July 16, 2021), <https://www.medicaid.gov/medicaid/spa/downloads/OR-21-0008.pdf>.

85 *Id.*

86 OAR 410-146-5000(3).





PART III: PRIMARY CARE CASE MANAGEMENT AT URBAN INDIAN ORGANIZATIONS CASE STUDIES

This section presents the results of case studies completed with UIOs in five different states. NCUIH interviewed UIO leaders concerning their facility's experience with Medicaid managed care PCCM delivery systems and the creation of IMCEs, and the respective impacts on the provision of healthcare to American Indians and Alaska Native Medicaid and CHIP beneficiaries who receive their care at UIOs.⁸⁷

State O

Background: Medicaid, PCCM, and UIOs in State O

State O's Medicaid and CHIP programs have over 1,300,000 enrolled beneficiaries. Around 64% of those enrolled Medicaid and CHIP beneficiaries receive care through the State's PCCM program. About 35% of beneficiaries are enrolled in a FFS plan and the remainder are enrolled in a specialty program for family planning services. Approximately 17% of Medicaid and CHIP beneficiaries in State O identify as American Indian or Alaska Native. Of those beneficiaries, around 66% receive care through the state's PCCM program, and around 33% are enrolled in the FFS plan.

How State O's Medicaid and CHIP Program Operates

State O operates its PCCM program pursuant to a Section 1115(a) demonstration. The demonstration was first approved in 1995 and implemented in 1996 to address concerns regarding access and quality of care in a fiscally prudent manner. The State initially introduced fully capitated services in urban areas, followed by a partially capitated PCCM program in rural areas, and later expanded PCCM statewide in 2004.

In State O's PCCM model, the State Health Authority contracts directly with primary care providers to serve as patient centered medical homes⁸⁸ for Medicaid and CHIP beneficiaries. State O Medicaid and CHIP beneficiaries have the freedom to choose their own primary care provider or clinic from providers enrolled with the State O Health Authority. If a beneficiary does not select a primary care provider, one may be assigned to them. Beneficiaries have the flexibility to change their primary care providers at any time. Providers at the medical homes declare their panel size upon enrollment as a Medicaid provider. There are limits on panel capacity: no more than 2,500 members per provider and 1,250 for mid-level providers.

Providers receive monthly care coordination payments (PMPM) for each beneficiary who is a member of their panel. The monthly care coordination payment varies depending on the provider's tier level and the mix of children and adults on the provider's panel. There are three tiers: entry level, advanced, and optimal. Each tier level requires increasingly complex levels of care coordination and extra services to be provided to beneficiaries. PMPM rates increase roughly \$3 from the entry level to the optimal level. As of 2019, the rates were as follows: Tier 1: \$3.63 (Children only), \$4.39 (children and adults), \$5.08 (adults only); Tier 2: \$4.73 (Children only), \$5.73 (children and adults), \$6.63 (adults only); and Tier 3: \$6.28 (Children only), \$7.61 (children and adults), \$8.82 (adults only). Aside from care coordination, all services furnished in the medical home and by other providers are reimbursed using a FFS methodology.

⁸⁷ All background data and information provided in this section is based on publicly available government sources (state and federal). Citations are generally not provided to preserve the anonymity of UIOs. In addition, some information has been generalized, again to protect the anonymity of UIOs.

⁸⁸ Many states refer to their primary care case managers as patient centered medical homes. Accordingly, that term is used in this report interchangeably with primary care case manager.





This monthly care coordination payment is intended to ensure the provision or coordination of necessary preventive and primary care medical services. Through this arrangement, primary care providers are responsible for arranging referrals for specialty services and obtaining prior authorizations, except for services that do not require authorization. Certain services that do not require a referral from a primary care provider include preventive or primary care services provided by another contracted PCCM provider such as outpatient behavioral health services, vision services for children, dental services, child abuse/sexual abuse examinations, prenatal and obstetrical services, family planning services, emergency physician and hospital services, chronic disease prevention and management programs, other care coordination programs, and services delivered to American Indians and Alaska Natives at I/T/U facilities.

State O's PCCM and UIO Providers

Most of the I/T/U providers in State O are Medicaid and CHIP providers and may serve as a medical home. State O recognizes that I/T/U providers can provide culturally sensitive case management to American Indian and Alaska Native Medicaid and CHIP beneficiaries. American Indian and Alaska Native Medicaid and CHIP beneficiaries can select a contracted I/T/U facility as their Medicaid and CHIP primary care provider. Additionally, the beneficiary can self-refer to any I/T/U facility for the services which can be provided within the facility.

There are two UIOs in State O. Both are considered full-ambulatory clinics, meaning they provide direct medical care to the population served for 40 or more hours per week.

Lessons Learned: Feedback from State O UIOs

The UIO interviewed for this project participates in the state's Medicaid program as a patient centered medical home. Overall, staff reported that PCCM participation has been a good experience and operating as a medical home has been beneficial for their patients. In particular, staff highlighted that as a medical home they are able to improve continuity of care for their patients and better coordinate care outside of the clinic. The UIO has developed a robust set of direct services for its patients. Further, staff noted improved efficiency due to the UIOs' ability to refer patients for specialty care, as opposed to having to get additional prior authorizations.

UIO staff also reported challenges with the PCCM program. One identified challenge is providing medical care in the UIO facility to beneficiaries whose care is managed by another medical home. The UIO interviewed for this project treats all American Indian and Alaska Native patients who visit its facility regardless of residency or assigned medical home. However, the UIO reported that occasionally reimbursement for services rendered to patients not assigned to its medical home panel will be denied. UIO staff also felt that there were added layers of bureaucracy for I/T/U facilities in the Medicaid program, including duplicative referral processing.

Moreover, UIOs in State O reported that they face challenges in terms of the current capitation rate. The general sentiment was that the current capitation rate does not accurately reflect the work and time the case managers provide to coordinate care. In particular, staff asserted that the rate has not kept up with healthcare inflation and the personnel cost for the providers that are coordinating the care. The staff noted that they did not recall the rate increasing for roughly a decade. While the UIOs noted that they have participated in Tribal Consultation related to increasing the capitation rate in the past, nothing had changed. However, UIO staff did state that operating as a medical home was ultimately a good business decision.





In general, the relationship with the state Medicaid office was reported to be excellent. The UIOs always have a seat at the table regarding the Medicaid and CHIP programs as it impacts American Indians and Alaska Natives. The state employs a Tribal Relations Liaison, who also works with UIOs, and the UIO reported a good working relationship with the Liaison. They stated that the Liaison is very responsive and seeks ways to help the UIO resolve any Medicaid or CHIP related issues, such as beneficiary re-enrollment. Moreover, UIOs in State O are able to access state Medicaid and CHIP data repositories, which is beneficial to their patient population in order to modify or update enrollment, addresses, and the Medicaid Unwinding process. Furthermore, State O hosts a bi-monthly Tribal Consultation and the UIOs in the state are always represented.

State O is currently in the process of transitioning from a PCCM model to a comprehensive risk-based MCO model. There has been extensive Tribal Consultation regarding this change, which has included UIOs. It is the understanding of UIO staff that the UIOs will still be able to operate as a medical home, but they will also have the ability to contract with MCOs. The UIO is hopeful that MCOs may cover additional services not currently reimbursed by the State Health Authority and therefore the UIO will be able to bill for a more extensive set of services provided to Medicaid and CHIP beneficiaries.

State C

Background: Medicaid, PCCM, and UIOs in State C

State C's Medicaid and CHIP program has over 1,500,000 enrolled beneficiaries. State C operates both MCO and PCCM programs. Over 89% of Medicaid beneficiaries are enrolled in State C's PCCM program, while 11% are enrolled in the MCO program. Approximately 20% of Medicaid and CHIP beneficiaries in State C identify as American Indian or Alaska Native.

State C is in the midst of significant Medicaid reform pursuant to an approved Section 1915(b) waiver. State C has instituted an Accountable Care Collaborative (ACC), which is a managed care hybrid model that adds characteristics of an Accountable Care Organization (ACO)⁸⁹ to a PCCM Entity model. The goal of the ACC is to have every member linked with a primary care medical provider (PCMP)⁹⁰ as their central point of care, and the PCMPs are directly responsible for ensuring timely access to primary care for ACC members. PCMPs are also responsible for assessing members' nonmedical needs and helping them access wraparound services including childcare, housing assistance, transportation, and other services. The success of the ACC program relies on several key characteristics that are crucial for ACOs, including managing and integrating the continuum of care across different settings; having enough members to support comprehensive performance measurement; being capable of prospectively planning budget and resource needs; and having the ability to develop and organize provider networks. State C's ACC program is designed to be iterative, with Phase I having started in 2011 and Phase II starting in 2018. The State is currently in Phase II of its reform, with Phase III scheduled to begin in Summer 2025.

⁸⁹ An ACO is a group of "healthcare providers that coordinate treatment for a defined population of patients and voluntarily accept financial accountability for the cost and quality of their care. (The Commonwealth Fund, *Realizing Potential of Accountable Care in Medicaid* (April 12, 2023), available at <https://www.commonwealthfund.org/publications/issue-briefs/2023/apr/realizing-potential-accountable-care-medicaid>).

⁹⁰ State C uses the term "primary care medical provider," which is commonly referred to as a primary care provider, or PCP.





How State C's Medicaid and CHIP Program Operates

In Phase II, State C has contracted with seven regional accountable entities (RAEs), which implement and oversee all aspects of the ACC program. Each RAE covers a region of State C and the state assigns almost all Medicaid beneficiaries to a RAE. RAEs are responsible for coordinating the care of Medicaid beneficiaries in their assigned region, building networks of providers, administering the states' behavioral health program, monitoring data and metrics, and improving the health of Medicaid beneficiaries.

In this model, primary care providers continue to serve as medical homes to Medicaid beneficiaries. Providers are required to contract with a RAE in order to serve Medicaid beneficiaries. Primary care providers serving as medical homes now receive their PMPM payment to manage patients' care from an RAE, but they are paid for medical services directly by the state Medicaid agency. Many of the RAEs have established tiered PMPM payment structures based on their evaluation of the capacity and performance of the provider.

State C's PCCM and UIO Providers

State C has one UIO, which participates in the State's Medicaid program as a medical home. The UIO in State C contracts with a RAE that has an American Indian and Alaska Native population of approximately 1%.⁹¹ RAEs are paid \$15.50 per-member per-month to cover the cost of coordinating care for its members. Of this \$15.50, \$4 is withheld and deposited into a pool, which is later awarded to the RAEs based on their success in meeting certain performance metrics. The RAE is required to pass along at least 33 percent of the \$11.50 administrative per-member per-month payment to the member's patient-centered medical home, or in this case, the UIO. The RAE also pays the UIO an administrative fee of at least \$2 per-member per-month for each RAE member the provider is responsible for or negotiates a value-based payment option to provide incentives for higher-performing practices.

Lessons Learned: Feedback from State C UIOs

In general, UIO staff described a challenging operational environment. The UIO highlighted that the transition to RAEs was initially very confusing, burdensome, and challenging. One of the primary challenges is the administrative burden that falls on the UIO, despite the fact that much of the responsibility for ensuring access to primary care and behavioral health services, coordinating member care, and monitoring data should fall on the RAE.

Another significant challenge for UIOs is the low reimbursement rates they receive for their services. While the UIO does provide care to patients who are enrolled with other providers as their patient-centered medical homes, it is often not reimbursed for this care, which UIO staff attributed to the patient's assignment to another medical home. Additionally, the PMPM rate is very low, approximately \$3 per person per month. UIOs are working to streamline the billing process and improve reimbursement rates, but these efforts are ongoing.

The UIO in State C manages care for approximately 1,200 Medicaid beneficiaries and estimates that over 450 of those beneficiaries identify as American Indian or Alaska Native. Even if a Medicaid beneficiary in State C identifies as American Indian or Alaska Native and is located within the UIO's RAE, they will not automatically be assigned to the UIO as their medical home. There is no rule requiring enrollment of American Indian or Alaska Native beneficiaries with the UIO and the UIO is located in a large urban area with a number of large competing healthcare organizations. UIO staff noted that the failure to enroll American Indian and Alaska Native beneficiaries with the UIO is a significant challenge and

⁹¹ Note that this RAE is responsible for two regions. Data was only available for the total population for the entire RAE, including both regions it is responsible for. It was not possible to disaggregate the data for the region in which the UIO is located.





burden given that they provide primary care to many of the American Indian and Alaska Native beneficiaries who are enrolled with other PCCMs. This makes it difficult to realize the intended care coordination benefits the PCCM program is designed to provide.

Generally, the UIO reported that there is a need to strengthen its relationship with the State Medicaid Office, particularly noting the lack of communication and unfamiliarity with the UIO. While the UIO noted that the Tribal Liaison is knowledgeable about the unique needs of UIOs, the overall State Medicaid Office lacks training and understanding of the role UIOs play in providing care to American Indians and Alaska Natives. This may be the result of the relatively low number of federally recognized Tribes and UIOs in the State, as compared to other states in which UIOs reported strong working relationships with their State Medicaid Office. The UIO did report that they receive support from the Board of the state's Commission of Indian Affairs.

State S

Background: Medicaid, PCCM, and UIOs in State S

State S' Medicaid and CHIP program has over 140,000 enrolled beneficiaries. State S operates its managed care program as a PCCM model with approximately 66% of beneficiaries enrolled in PCCM and 34% of beneficiaries enrolled in a FFS or other non-MCO programs. Over 51,000 American Indians and Alaska Natives are enrolled in Medicaid and CHIP in State S, which represents around 35% of all individuals eligible for Medicaid and CHIP in the state.

How State S' Medicaid and CHIP Program Operates

State S has operated its statewide PCCM program through a Section 1932(a) SPA since 2002. Enrolled PCPs provide primary care and manage enrollee care by preauthorizing, locating, coordinating and referring visits to other Medicaid and CHIP providers. PCPs receive a monthly case management fee of \$3 per month as well as FFS reimbursement for medical care services. The program is designed to improve access, availability, and continuation of care while reducing inappropriate utilization, over-utilization, and duplication of Medicaid and CHIP covered services while operating a cost-effective program. In May 2023 CMS approved a Section 1932(a) SPA to update the State S's program to new CMS templates and include the Medicaid Expansion population as participants in the program. The SPA also updated the program to require State S to pay IHS facilities, Tribal 638 (self-governance) facilities, UIOs, and others the \$3 PMPM case management fee.

State S' PCCM and UIO Providers

There is at least one UIO in State S participating in the state's PCCM program. The UIO reported 60-70% of the Medicaid and CHIP beneficiaries whose care it manages identify as American Indian or Alaska Native. Despite utilizing a Section 1932(a) SPA, which traditionally exempts American Indians and Alaska Natives from mandatory enrollment, State S mandatorily enrolls American Indians and Alaska Natives in its PCCM program. It justifies this action by stating that it contracts with every IHS, Tribal clinic, and UIO within the state that meet the definition of Indian Managed Care Entity in 42 CFR 438.16 as an enrolled PCP. This information is current as of the May 2023 Section 1932(a) SPA referenced above.

As a PCCM, the UIO is the primary care home for coordinating all care services for enrolled patients. According to the UIO interviewed in State S, most of the patients whose care it manages through the PCCM program generally have multiple complex health conditions that require care to be managed with multiple specialty providers. As a PCCM, the UIOs are





additionally required to do quarterly visits with these patients, follow up on any ER reports, and update patient care plans twice a year.

The UIO first became certified as a patient centered medical home in 2013⁹² as a result of five years of on-going efforts to improve patient care. Beginning in 2008, the UIO participated in training sessions and completed an Improved Patient Care initiative led by the Institute for Healthcare Improvement (IHI). Over three years, the UIO assessed different models of healthcare delivery, analyzing the advantages and disadvantages of each, and in 2011, the UIO decided to pursue patient centered medical home accreditation. After achieving accreditation, the UIO realized that many of the services they offered overlapped with those required of Medicaid health homes.⁹³ Around the same time, the State S Medicaid office approached the UIO and began discussing enrollment as a patient centered medical home in the state Medicaid program. Mutual interest led to the UIO joining the Medicaid program as a patient centered medical home.

Lessons Learned: Feedback from State S UIOs

The UIO in State S reported that participating as a patient centered medical home has generally enhanced the UIO's ability to improve the health of the American Indian and Alaska Native community. Since becoming a PCCM, the UIO reported that they have seen the benefits in working with their patients, understanding their unique needs, and ensuring the patient has a voice in the process of receiving quality, culturally competent care that they desire.

The UIO further reported that a particular benefit of managed beneficiaries' care is an enhanced ability to offer whole-person care. Too often, the UIO was finding that when they did not manage a beneficiary's care, it became fragmented, especially when the patient needed to see multiple specialists. The UIO further noted unique aspects of whole-person care in the Native community, including cultural components of healing, and emphasized that as a patient centered medical home for American Indians and Alaska Natives, they were able to help patients access a broader range of these important services. For example, this UIO offers traditional healing practices like sweat lodge ceremonies and talking circles, as well as culturally based classes like beading, sewing, and language.⁹⁴ Currently the ability to bill Medicaid or CHIP for traditional healing practices does not exist. Despite this, as the beneficiaries' medical home, the UIO is able to ensure that beneficiaries have access to traditional healing services and is working to incorporate them more fully into the clinical patient record.

The UIO interviewed for this project also stated that patient engagement has increased as a result of the patient-centered nature of the state's PCCM model. According to staff, over the years, beneficiaries served by the PCCM program have developed a stronger voice and have become more involved in the coordination of their own care. UIO staff directly attributed this to the patient-centered and patient-focused nature of the care coordination model they implement as a patient centered medical home. Overall, this approach prioritizes the patient's needs, preferences, and involvement in their own care.

There were also several challenges reported about participating as a PCP in the PCCM program. One of the most challenging aspects of participation is the low PMPM rates. State S has a four-tier reimbursement rate system, which assigns patients with more complex needs to higher tiers. UIO staff in particular felt that the rates for tiers 1-3 did not

⁹² Note that this refers to an outside accreditation, not enrollment as a medical home in the state's Medicaid program.

⁹³ Note that this term is synonymous with patient centered medical home, primary care case manager, or medical home, as used in other states.

⁹⁴ For a full study of the importance of traditional healing and its role in the Medicaid program, please see NCUIH's 2023 report on this topic entitled "Recent Trends in Third-Party Billing at Urban Indian Organizations: Thematic Analysis of Traditional Healing Programs at Urban Indian Organizations and Meta-Analysis of Health Outcomes."





accurately reflect the level of work required for those patients. UIO staff provide every beneficiary with the same amount of time and care. They felt that the tier payments should better reflect this effort. In State Fiscal Year 24, there is around a \$55 difference between the PMPM rate for Tier 1 and Tier 3. Between Tier 3 and Tier 4, that difference jumps around \$195. In State Fiscal Year 23, the difference was even more dramatic. There was a around a \$52 difference between Tiers 1 and 3; and a \$244 difference between Tiers 3 and 4.

Another challenge that UIOs in State S face is the penalty for not seeing enrollees on a quarterly basis. While the rationale behind this is to encourage primary care providers to maintain contact with their patients and ensure continuity of care; UIO staff noted that despite reaching out to patients' numerous times, some patients simply do not connect with the UIO for follow ups. However, the UIO did report that the state Medicaid Office has been responsive in helping the UIO to inactivate a patient from their lists if a patient is unresponsive, thus helping to ensure that the UIO is not penalized. Further, in the event that a patient is disenrolled because they did not respond, the UIO can subsequently reenroll them, which is critical to ensuring they can continue to receive the care they need at their health home.

Additionally, the UIO staff interviewed for this report stated that they have a positive working relationship with their State Medicaid Office. For example, the Medicaid Office has previously approached the UIOs about being an initial participant in a pilot program for the health home program, which was largely in part because of the UIO's reputation for excellent service in their community. While the UIO did note that the State Medicaid Office could develop a better understanding about the needs of American Indians and Alaska Natives Medicaid and CHIP beneficiaries and particularly those beneficiaries who live in urban areas, they felt that overall, they have a positive and collaborative relationship with the Medicaid Office. This relationship has been integral in ensuring the UIOs receive consistent and timely communication with the office and also ensures that the UIO is aware of any potential programmatic changes that may affect their patients' care. Moreover, the UIO reported that they have felt like Tribes located in State S have been very accepting of the UIO's role in the care of American Indians and Alaska Natives beneficiaries. The UIO noted that during the state's quarterly Medicaid meetings, they always feel welcome and have a voice to share the needs and concerns of their service populations.

State A

Background: Medicaid, PCCM, and UIOs in State A

State A's Medicaid and CHIP programs have over two million enrolled beneficiaries. Over 85% of Medicaid and CHIP beneficiaries in State A are enrolled in comprehensive MCOs and 1.8% are enrolled in PCCM. Approximately 10.9% of Medicaid and CHIP beneficiaries are enrolled in a FFS or another non-MCO/PCCM program. Approximately 8% of Medicaid and CHIP beneficiaries in State A identify as American Indian or Alaska Native.

How State A's Medicaid and CHIP Program Operates

State A operates its managed care programs under a Section 1115 demonstration project. State A was one of the first states to implement mandatory Medicaid and CHIP managed care statewide. Today, State A contracts with several state-wide comprehensive MCOs, regional MCOs which provide plans covering integrated physical health and behavioral health services for members with serious mental illnesses, and MCOs which provide coverage for individuals who are age 65 or older, or who have a disability, and who require nursing facility level of care. State A's State Medicaid program contracts with managed care entities that do not provide for payment for Indian health care providers as specified in section 1932(h) of the Social Security Act, when such services are not included within the scope of the managed care contract. In





addition, this authority permits State A to make direct payments to IHS or Tribal 638 providers, which are offset from the managed care capitation rate.

State A maintains a FFS program for American Indians and Alaska Natives. American Indians and Alaska Natives beneficiaries may choose to enroll in a managed care plan and may switch freely between managed care plans and the FFS delivery system. A majority of American Indian and Alaska Native beneficiaries in State A are enrolled in the FFS delivery system.

State A also uses a Patient Centered Medical Home PCCM program for American Indians and Alaska Natives enrolled in the FFS program. The PCCM program covers primary care case management, diabetes education, care coordination, and encourages participation in the state Health Information Exchange (HIE). Beginning in 2017, State A began registering eligible IHS and Tribal health facilities as Patient Centered Medical Homes, making them eligible for PMPM payments. State A's Patient Centered Medical Home PCCM program has four tiers, with a corresponding PMPM payment based on the level of services offered. Beneficiary participation in the PCCM program is voluntary.

State A's PCCM and I/T/U Providers

There are more than two UIOs within State A which provides medical services to American Indian and Alaska Native Medicaid and CHIP beneficiaries. UIOs are not eligible to participate in State A's Medical Home PCCM program. However, UIOs do contract with several of the comprehensive MCOs within State A.

Lessons Learned: Feedback from State A UIOs

The most significant barrier to an effective PCCM program identified by UIO staff is the lack of 100% Federal Medical Assistance Percentage (FMAP) for services to Medicaid beneficiaries at UIOs. It is the understanding of UIO staff that the state has limited provider enrollment in the PCCM program to IHS and Tribal facilities because the state receives 100% FMAP for services provided at those facilities.

In general, the cost of services provided to Medicaid beneficiaries is shared between the federal government and the state Medicaid program in which the individual is enrolled.⁹⁵ The share of covered services provided to Medicaid beneficiaries which is covered by the federal government is referred to as FMAP.⁹⁶ The Social Security Act sets forth a formula by which the FMAP and state share are determined; as a baseline a FMAP cannot be less than 50 percent of the cost.⁹⁷ The FMAP formula is based on a state's average personal income – states which have lower average personal incomes receive a higher FMAP.⁹⁸ Beginning in 1976, Congress authorized setting FMAP at 100% for Medicaid "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."⁹⁹ Since then, 100% FMAP has also been expanded to cover "Medicaid services furnished to Medicaid eligible American Indians and Alaska Natives by any Tribal facility operating under a 638 agreement," including those facilities owned and operated by a Tribe.¹⁰⁰ Unfortunately, with the exception of an eight quarter period beginning

95 42 U.S.C. § 1301(a)(8)(A); 42 U.S.C. § 1396d(b); Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)* (Sep. 2012), <https://www.kff.org/wp-content/uploads/2013/01/8352.pdf>.

96 42 U.S.C. § 1396d(b); Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)* (Sep. 2012), <https://www.kff.org/wp-content/uploads/2013/01/8352.pdf>.

97 42 U.S.C. § 1301(a)(8)(A); 42 U.S.C. § 1396d(b).

98 42 U.S.C. § 1301(a)(8)(A); 42 U.S.C. § 1396d(b); Kaiser Commission, *supra* note 95.

99 42 U.S.C. § 1396d(b); P.L. 94-437 (Sep. 30, 1976); CMS, *Indian Health Care Improvement Act*.

100 Memorandum of Agreement between the Indian Health Service and the Health Care Financing Administration (Dec. 19, 1996), available at <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/pdf/memorandum-of-agreement.pdf>.



April 1, 2021 and ending March 31, 2023 authorized by the American Rescue Plan Act, services provided at UIOs are not eligible for 100% FMAP.¹⁰¹

This means that, in the context of State A's PCCM program, the state does not incur any additional financial responsibility by including IHS and Tribal facilities in the program. However, because services provided by UIOs are reimbursed at the standard FMAP percentage the state would be required to expend its own resources to include UIOs in the PCCM program. UIO staff noted that the temporary 100% FMAP provision in the American Rescue Plan Act did not help them convince State A to allow them to enroll as a medical home. Staff believed that the state would not wish to assume a portion of the cost of the PMPM payments once the temporary period of 100% FMAP authorized in ARPA expired.

According to UIO staff interviewed for this project, the UIO is already providing robust case management services to its patients. UIO staff believed that they would qualify to provide Tier 4 services which is the most robust level of care coordination. The UIO already employs clinical care coordinator, carries out case management services, and offers 24-hour telephonic access to the care team, among other services. As a result, they estimate that they are losing over \$1 million in PMPM fees that could be used to support these services. If the UIO had access to the PCCM program, it could then reallocate funding to expand services throughout the UIO. In particular, UIO staff identified diabetes care and other public health indicators it would like to address by reallocating funding currently being used to provide case management services.

Despite State A's unwillingness to allow UIOs to participate in the Medical Home PCCM program, UIO staff reported an excellent working relationship with the state Medicaid office. The state employs a Tribal Relations Liaison, who is also responsible for working with UIOs. State A has regular meetings with UIOs, which include discussion of relevant policy changes. UIOs have also been able to routinely meet with senior staff and the Medicaid Director. UIO staff described the relationship as a "working relationship and a policy relationship."

UIO staff felt that they were treated in an equitable manner when compared to Tribal health programs. UIOs and Tribes are on the same listserv and the State conducts a combined quarterly consultation with Tribes and UIOs together. In the event an issue impacts UIOs and Tribes differently, the State is always willing to hold separate meetings.

State N

Background: Medicaid, PCCM, and UIOs in State N

State N's Medicaid and CHIP program has almost 1,500,000 enrolled beneficiaries. Over 90% of beneficiaries in State N are enrolled in managed care and approximately 8% of beneficiaries are enrolled in FFS or another program.¹⁰² Over 30,000 American Indians and Alaska Natives are enrolled in Medicaid and CHIP, which represents approximately 2% of all beneficiaries in the state.

¹⁰¹ For analysis of the impact of 100% FMAP on UIOs, please see NCUIH's report entitled "Recent Trends in Third Party Billing at Urban Indian Organizations: Impact of the American Rescue Plan Act and 100% FMAP Provisions", available at <https://ncuih.org/wp-content/uploads/ARPA-Draft-2022-09-28.pdf>.

¹⁰² FFS or another program refers to Medicaid beneficiaries who are not in MCOs or PCCM programs. See KFF, *Share of Medicaid Population Covered under Different Delivery Systems*, Jul. 1, 2022, <https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Percent%20of%20Medicaid%20Population%20in%20FFS%20Other%22,%22sort%22:%22asc%22%7D>.





How State N's Medicaid and CHIP Program Operates

State N initially began implementing Medicaid managed care for certain subsets of beneficiaries in the 1980s to address serious budget shortfalls. In 1994, State N utilized its Section 1115 demonstration to significantly expand eligibility for Medicaid. This demonstration also expanded the use of managed care to cover most of the Medicaid beneficiaries in State N.

In 2012, State N initiated a transformation of its Medicaid program through a new Section 1115 demonstration project which transitioned the state away from working with fully capitated MCOs. Under the new demonstration project, the state contracted with a network of regional health plans called Coordinated Care Organizations (CCOs) to manage the care of Medicaid beneficiaries. Each CCO received a single global Medicaid budget that grew at a fixed rate but allowed some budget flexibility for CCOs that provided different services. The CCOs are responsible for coordinating all aspects of care, including primary care, specialty care, behavioral health services, dental care, and prescription drugs. American Indians and Alaska Natives were specifically exempted from mandatory enrollment in managed care.

In 2017, the state extended its Section 1115 demonstration project, expanding on the previous CCO model and including several new initiatives aimed at improving health outcomes and controlling costs. Some of the key new features of the demonstration project included:

- ▶ A focus on social determinants of health, such as housing, food insecurity, and transportation, to address the root causes of poor health outcomes.
- ▶ An emphasis on addressing the opioid epidemic through expanded access to addiction treatment and other services.
- ▶ A new payment model that rewards CCOs for achieving specific health outcomes, such as reducing emergency department visits and hospital readmissions.
- ▶ A new program called the Community Health Workers Program, which will provide funding for community-based organizations to hire and train individuals to provide outreach, education, and support to Medicaid and CHIP beneficiaries.
- ▶ State N's Section 1115 demonstration project was recently extended in September 2022. The demonstration project makes several changes to address health inequities, expand coverage for health-related social needs, and provides for longer periods of enrollment to avoid loss of enrollment in Medicaid and CHIP for administrative reasons.

State N IMCE and UIO Providers

State N is unique in that it is the only state which has submitted a Section 1932(a) SPA to contract with a UIO as an IMCE.¹⁰³ In 2016, Tribes, the UIO, and the state began serious discussions regarding improvements that could be made to the Medicaid and CHIP program so that it better served American Indian and Alaska Native beneficiaries in the state. These discussions were prompted by CMS releasing a State Health Official (SHO) letter regarding the availability of 100% FMAP for services provided by a non-IHS or Tribal provider when an IHS or Tribal facility practitioner requests the service for a patient from a non-IHS or Tribal Medicaid provider in accordance with a care coordination agreement. The relationships developed between State N, the Tribes, and the UIO during discussions regarding this SHO letter carried forward into Tribal consultation in 2018 regarding State N's CCO program. During Tribal Consultation, the Tribes and UIO requested assistance in implementing IMCEs to enhance the health of American Indians and Alaska Natives in the state.

¹⁰³ As explained above, State S and State O both treat UIOs within the state as primary care case management entities (State S even refers to this as an IMCE). However, this is a function of the UIO's participation in the state's primary care case management program. In State N, the UIO functions as an IMCE outside of the state's usual Medicaid managed care system.





Over the course of two years, the Tribes, UIO, and State N met over 30 times regarding formation of an IMCE and the state's eventual Section 1932(a) SPA. Tribal Consultation and Urban Confer on the Section 1932(a) SPA itself was formally initiated through a Dear Tribal Leader Letter issued on December 28, 2020 and subsequent face-to-face meeting on January 29, 2021. The Section 1932(a) SPA was submitted in March 2021. While the Section 1932(a) SPA was under review by CMS, the IMCEs were undergoing readiness reviews to ensure that the plans were ready to accept enrollment, provide continuous care, ensure access to healthcare and pharmacy services, and meet the diverse needs of their enrollee populations. The Section 1932 SPA was officially approved in July 2021 and the State N UIO was the first IMCE to begin operations and has been providing case management services for beneficiaries since September 2022. The UIO serves a tri-county service area including three metropolitan counties.

Pursuant to State N's Section 1932(a) SPA, the Tribal and UIO IMCEs operate as a PCCM entity. Each IMCE receives a PMPM payment of around \$39.00 for care coordination services. Each IMCE is responsible for providing the following functions, in addition to locating, coordinating and monitoring primary health care services:

1. Provision of intensive telephonic case management;
2. Provision of face-to-face case management;
3. Operation of a nurse triage advice line;
4. Development of enrollee care plans.;
5. Provision of enrollee outreach and education activities;
6. Operation of a customer service call center;
7. Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; and
8. Conduct outcome measurement and provide outcome reports to the state.

Each IMCE is also expected to conduct outcome measurement and provide outcome reports to the state. According to UIO staff, they had discussions with State N regarding adding additional services to their IMCE contract in the future, with a corresponding increase to the PMPM payment.

Enrollment in an IMCE is voluntary. Tribal citizens will be eligible for enrollment with an IMCE operated by the Tribe or Tribal organization. However, Tribal members may participate in State N's FFS or COO Medicaid and CHIP managed care delivery system and American Indians and Alaska Natives may move freely between the FFS, COO, and the IMCEs. American Indians and Alaska Natives living in a three-county area around the state's largest city will be eligible for membership in the IMCE operated by the UIO. The UIO IMCE will enroll a state N Medicaid and CHIP Tribal member in this tri-county area if they are not already enrolled in a COO or Tribal IMCE. After IMCE eligibility and enrollment is validated, State N notifies the American Indian or Alaska Native beneficiary of their IMCE enrollment. Pursuant to the state's SPA, the standard welcome notice must provide the name, location, and contact information of their IMCE, along with other information required by CMS regulations. The notice must explain that IMCE enrollment is voluntary, and that members can choose to disenroll at any time.

UIO staff interviewed for this report stated that the UIO IMCE currently has over 4,500 members and enrollment has been growing steadily since the UIO's IMCE officially began operations in September 2022. They estimate that the IMCE is adding approximately 150-200 members each month. They also estimate that around 75% of the UIO IMCE members receive primary care from the UIO. The remaining 25% who do not use the UIO for primary care do so primarily because





of existing relationships with their primary care providers who do not work at the UIO. UIO staff were clear that their only concern is that beneficiaries are being seen by a provider with whom they have a good working relationship. According to one UIO leader interviewed for this project, "people may have a long-term doctor that they love so we don't want them to switch. We just want them to be healthier and happier."

Lessons Learned: Feedback from State N UIO

According to UIO staff, operating an IMCE has brought significant improvements to the level of care that they are able to provide to their American Indian and Alaska Native patients.

In the words of one interviewee, forming an IMCE "changes the whole paradigm of care . . . it's a total game changer."

While the UIO provided a level of care coordination for its primary care patients prior to forming the IMCE, staff were heavily reliant on patients' self-advocacy to identify care gaps like travel to medical appointments, food insecurity, and housing. To address these issues, the UIO would rely on Tribal Patient Navigators or other programs to gather the appropriate resources to assist their patients. This approach was not optimal and resulted in a fragmented system of care. Patients and providers would have to navigate through multiple programs and providers to receive the help they needed.

Now, as an IMCE, the UIO is able to proactively provide comprehensive case management services to Medicaid and CHIP beneficiaries. For example, on a daily basis, UIO case managers read reports through State N's Emergency Department Information Exchange (EDIE) to track members who have been to a hospital or emergency department. UIO nurses then contact the member to ensure that they have transportation home from the hospital, that they understand their discharge instructions, and that they have durable medical equipment like walkers or wheelchairs. Case managers also help schedule follow up appointments and connect beneficiaries to housing providers if needed. Case managers will even go to the hospital or emergency department to see beneficiaries in person and to help them build stronger relationships with their providers and ensure a warm handoff when the beneficiary is discharged. By providing these wrap-around services, the UIO has been able to improve health outcomes and reduce emergency department visits.

UIO staff also reported that expanded case management has resulted in higher medical compliance. UIO staff attribute this to the relationships which have developed between beneficiaries and their case managers. For example, case managers call beneficiaries to talk to them about their medications, the purpose of those medicines, and how to take them. UIO staff stated that they had gotten good feedback about those services and believed that it led to beneficiaries having better success in taking their medication as directed.

UIO staff believe that the case management services they offer will significantly reduce the rate at which illnesses develop in their beneficiary population and lead to successful management of chronic diseases, although more time is needed to develop data in this area. UIO staff pointed out that prior to being an IMCE, there was little funding for managing a beneficiary's health because providers only got paid for when patients came in to receive a healthcare service. Now the UIO is able to work on keeping people from needing to come in for care at all. In particular, UIO staff highlighted an expanded ability to focus on the social determinants of health.¹⁰⁴ For example, they are able to connect

¹⁰⁴ "Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." U.S. Department of Health and Human Services, *Social Determinants of Health*, <https://health.gov/healthypeople/priority-areas/social-determinants-health> (last accessed Apr. 28, 2023).





beneficiaries with an on-site food bank if they are experiencing food insecurity and connect beneficiaries with housing services when they begin to be at risk of homelessness, instead of following an eviction.

A senior medical provider observed the significant negative health impacts of stress and stated that “I feel like the steps that we’re making today will go a long way. 20 years down the road . . . maybe we will help to prevent the severity of heart disease because we’re able to intervene . . . early.”

The State N UIO reported that their current capitation rate is fair. As mentioned above, the UIO's IMCE currently provides six of the ten PCCM services outlined in 42 CFR 438.2.¹⁰⁵ If the UIO were to add more case management services than it currently provides, then it would be likely that they would have a higher capitation rate.

The UIO reported that they have a positive working relationship with the State N Medicaid Office and that this positive relationship existed prior to becoming an IMCE. While State N does not receive 100% FMAP for services provided to Medicaid and CHIP beneficiaries at the UIO like it does for services rendered at IHS or Tribal facilities, this did not hinder the UIO from being involved in the IMCE formation process. UIO staff stated that the State Medicaid Office recognizes that the UIO provides critical care that is culturally appropriate and that the UIO has long met the needs of the American Indian and Alaska Native population living in the state's urban area. According to one interviewee, State N “understands the needs of Native American people writ large and isn't going to count pennies over we're going to pay for this group but not for another group.” Interviewees were clear that State N is committed to improving the health of American Indians and Alaska Natives no matter where they live and that the lack of 100% FMAP for services at UIOs was never a part of the conversation surrounding forming an IMCE.

The UIO has found that collaboration between Tribes and healthcare providers has also been crucial to the success of operating as an IMCE. All nine Tribes and the UIO agreed to pursue the IMCE model in State N and worked together up until the implementation phase. Although some Tribes decided not to pursue the IMCE due to various reasons, including workload or competing priorities, there was no policy disagreement about going in this direction.

UIO staff identified bureaucratic barriers as the biggest difficulty they experienced in creating an IMCE. At the state level, there was initially a lack of understanding regarding what an IMCE is and what it can be. Fortunately, the UIO reported that the strong working relationship between the UIO, Tribes, and the state allowed all parties to work together to address misunderstandings or a lack of knowledge. At the federal level, interviewees reported that there was also misunderstanding of what an IMCE is and how the SPA should be processed. For instance, according to interviewees, CMS was not sure if the SPA should be reviewed by the managed care unit or the FFS unit. These levels of misunderstanding at the state and federal level lead to delays in the development of the SPA and the development of the IMCEs. Five years after the idea was first discussed by Tribes, the UIO, and the state, only the UIO IMCE is operational, although four Tribal IMCEs are in the process to become approved.

There is still more room for improvement in the scope of services that the UIO IMCE can offer. In particular, UIO staff observed that many UIO patients fall into a lower socioeconomic background and may not have the finances to afford a cellphone and internet. The UIO expressed that it would be incredibly beneficial if these resources were covered by Medicaid to better ensure patient communication. The UIO reported that through the IMCE program, they are continuously looking for areas that need more improvement to improve population health.

¹⁰⁵ <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.2>





An additional challenge the UIO IMCE faces is obtaining more patient data. Because the UIO IMCE is a PCCM entity, State N pays for the UIO beneficiaries' claims. Consequently, the UIO does not receive data reported back to the claim payor. On the other hand, a traditional MCO does receive this claim data because the MCO is both responsible for processing and paying claims. According to UIO staff this can limit their insight into patients' care and needs. While most of the necessary data does eventually make its way to the IMCE, staff believe receiving it in a more timely and efficient way will help improve care coordination.

Overall, the UIO reported that operating as an IMCE has been a positive experience and has provided the UIO and the American Indians and Alaska Natives patients they serve with significant improvements in continuity of care, medical compliance, and reduced emergency room visits. Operating as an IMCE has been a learning experience for UIO, but it has also allowed them to provide better care coordination and eliminate disparities in care for American Indian and Alaska Native beneficiaries. The lessons learned from the UIO's experience can be applied to other organizations that may be considering pursuing creation of an IMCE.

PART IV: LESSONS LEARNED

Throughout this study, the interviewed UIOs consistently highlighted several benefits for beneficiaries, challenges for the UIOs, and best practices. The most significant benefit for both UIOs and patient beneficiaries has been the improved continuity of care. UIOs also identified best practices including strong working relationships with their state Medicaid offices and Tribal Relations Liaisons and benefits of participating as PCCMs for improved continuity of care. Challenges included insufficient capitation rates, a need to strengthen working relationships with their respective state Medicaid office, and insufficient knowledge in state Medicaid offices of the roles of UIOs and the unique populations they serve. Below are the identified challenges and best practices with more thorough analysis.

Benefits for UIOs and Patients

Improved Care for Beneficiaries

Overall, most UIOs agreed that providing primary care case management was a best practice for improved care for their American Indian and Alaska Native Medicaid and CHIP beneficiaries. By serving as a main point of contact for all of their patients' care needs, UIOs can ensure their patients receive timely and appropriate care, which ultimately helps prevent more serious health issues from developing. Additionally, because most PCCM programs emphasize the importance of preventive care, UIOs providing primary care case management services can utilize their Medicaid reimbursement on preventative measures such as regular check-ups, screenings, and vaccinations. For example, most UIOs interviewed mentioned the requirement for consistent follow-up appointments and required appointments after a patient has an ER visit. By promoting preventive care, participating UIOs can also help reduce the need for more costly and invasive future treatments. Lastly, UIOs noted that providing primary care case management services allows the patient to have a voice in the care they receive and also creates a more personable relationship between the provider and the beneficiary.

Best Practices for UIOs

Strong Working Relationships with State Medicaid Offices, Tribes, and Other Partners

In states where UIOs reported strong working relationship with their state Medicaid program, clear consistent communication was a frequently cited factor. Notably, in State A, not only did the state have a Tribal liaison who was responsible for working with UIOs, but each MCO was also required to staff a similar position. This is a specific best





practice which may be beneficial to state Medicaid and CHIP programs which contract with a variety of managed care programs to ensure that relevant knowledge regarding American Indians and Alaska Natives Medicaid and CHIP beneficiaries is not restrained just to the State Medicaid office but is available throughout the Medicaid system. One of the key benefits of strong working relationships between UIOs and state Medicaid offices is that they can lead to greater access to healthcare services. In State S, for example, the positive working relationship between the State Medicaid office and the UIO led to the UIO being invited to participate in the state's pilot program as a medical home. By participating in this program, the UIO was able to provide a broader range of healthcare services to American Indians and Alaska Natives beneficiaries, which in turn helped to improve continuity of care and patient outcomes. As a general matter, State Medicaid offices should continuously work to ensure all levels of the Medicaid and CHIP systems which serve American Indian and Alaska Native beneficiaries have open and continuous lines of communication. State Medicaid offices should also consider working with UIOs as participants in pilot programs and other unique funding opportunities to ensure that urban American Indian and Alaska Native beneficiaries have access to the highest standards of care.

State N also highlights the importance of a strong working relationship between UIOs, State Medicaid offices, and Tribes and the benefits of including UIOs in the state's Tribal Consultations. Over the course of five years, the UIO in State N and the State Medicaid Office have worked hand-in-hand to create the first UIO IMCE specifically designed to operate outside of a state's primary Medicaid and CHIP delivery system. UIO staff were clear that this would not have been possible without the commitment of the state and the State N Medicaid Office's willingness to commit to a long-term project, and associated costs, to achieve a shared goal of improving care for American Indian and Alaska Native beneficiaries. The UIO and Tribes were also able to work together on a shared journey towards creating IMCEs. This ensures that American Indian and Alaska Native beneficiaries throughout the state will have the opportunity to experience enhanced case management and access to expanded care services.

Challenges for UIOs

Insufficient Capitation Rates

One of the most significant challenges observed by UIOs in several states is insufficient or low capitation rates. Several UIOs felt that their current rates are low and not sufficient to cover the costs of care management. This was particularly the case for UIOs serving populations with high levels of chronic conditions or multiple complex health conditions that require care to be managed with multiple specialty providers.

*Given that American Indians and Alaska Natives “**have higher rates of chronic diseases than other ethnic groups in the United States,**”¹⁰⁶ failure to provide sufficient capitation rates will have an outsize impact on the UIOs who manage the care for members of this community in urban areas. In some states studied in this project, PMPM rates for some tiers of patients were under \$4.*

¹⁰⁶ Centers for Disease Control, *Chronic Diseases*, [https://www.cdc.gov/tribal/data-resources/information/chronic-diseases.html#:~:text=American%20Indian%2FAlaska%20Native%20\(AI,more%20likely%20to%20be%20smokers](https://www.cdc.gov/tribal/data-resources/information/chronic-diseases.html#:~:text=American%20Indian%2FAlaska%20Native%20(AI,more%20likely%20to%20be%20smokers) (last visited Apr. 4, 2023).





The costs associated with care management and coordination typically include provider time, administrative staff time, data systems (including health information technology like electronic health records systems), and other resources required to deliver and coordinate care for patients. UIO providers need to spend time identifying patients' care needs, communicating with multiple providers and specialists, and ensuring that patients receive the necessary treatments and services. This work can be time-consuming and requires a significant amount of coordination and collaboration among providers.

Insufficient capitation rates are particularly difficult for UIOs because it compounds problems caused by chronic underfunding of the Indian health system. The Urban Health line item historically is just one percent (1%) of IHS' annual appropriation. In FY 2018, U.S. healthcare spending was \$11,172 per person, but UIOs received only \$672 per American Indian or Alaska Native patient from the IHS budget.¹⁰⁷ As discussed above, Medicaid and CHIP has become a critical source of supplemental funding for the entire Indian health system, including UIOs.

Lack of 100% FMAP for Medicaid Services Provided by UIOs

As noted above, the lack of 100% FMAP for Medicaid and CHIP services provided by UIOs is a significant impediment to UIO participation in PCCM in at least one state. This requires UIOs in that state to find alternative sources of funding to be able to provide the same level of care coordination as IHS and Tribal healthcare facilities, despite providing care to the same patient population. This in turn creates an unintended inequity in the I/T/U and Medicaid and CHIP programs.

Interestingly, the lack of 100% FMAP for Medicaid and CHIP services provided by UIOs was not a barrier to the UIO in State N creating an IMCE and entering into a contract with the State to provide PCCM services to American Indian and Alaska Native beneficiaries. Interviewees attributed this to a commitment by State N to improving the health of American Indians and Alaska Natives. It is also worth observing that State N has fewer enrolled Medicaid and CHIP beneficiaries and a state budget surplus that is twice that of State A, so fiscal concerns may be less significant for State N. However, this should not take away from State N's willingness to absorb the cost of the UIO's IMCE contract and its deep commitment to its American Indian and Alaska Native beneficiaries.

Fortunately, in states where PCCM has been implemented for the Medicaid and CHIP programs broadly, regardless of patient population, the lack of 100% FMAP does not appear to be a barrier to UIO participation. However, it is concerning that the lack of 100% FMAP has been a barrier to UIO participation in an innovation designed to improve care coordination for a vulnerable patient population and reduce health care costs. As other states look to contain rising Medicaid and CHIP costs and improve the health of Medicaid and CHIP beneficiaries, lack of 100% FMAP may continue to be a roadblock to UIO participation in new case management programs.

Poor Communication with State Medicaid Offices

While most UIOs interviewed for this project felt that they had a strong working relationship with their State Medicaid offices, several UIOs did note that communication with their State Medicaid office could be improved, especially concerning the calculation of capitation rates. The need for improved communication was especially apparent in states undertaking Medicaid and CHIP reform. For example, in State C, UIO staff reported that recent changes to the state's managed care system were confusing and poorly communicated, resulting in the UIO feeling that it did not have access to the administrative and management support which is supposed to be provided by its RAE. In contrast, in State O, UIO staff

¹⁰⁷ See National Council of Urban Indian Health, *U.S. Healthcare Spending: America's Disproportionate Investment in Healthcare for American Indians and Alaska Natives*, https://ncuih.org/wp-content/uploads/Health-Care-Spending-Flyer_NCUIH_D101_V7.pdf (last accessed Apr. 5, 2023).





felt that they had a good understanding of the future of the state Medicaid and CHIP programs and the UIOs role as the state begins transition to a comprehensive managed care system.

Failure to Auto-Enroll American Indians and Alaska Natives with UIOs

Several UIOs observed that when American Indian and Alaska Native beneficiaries in urban areas enrolled in their state's PCCM program, they frequently became enrolled with a non-ITU primary care case manager. UIOs felt that these patients often chose to come to their facility for culturally competent care and that failure to enroll the beneficiary with the UIO as their primary care case manager meant that the UIO was providing services to these beneficiaries but not receiving the necessary compensation. UIOs suggested auto-enrolling American Indian and Alaska Native beneficiaries with the UIO, to the extent allowable by law, or providing more information to beneficiaries regarding UIOs as a primary care case manager option as a way of addressing this issue.

American Indians and Alaska Natives Population in the State

UIOs located in states with smaller American Indian and Alaska Native populations, or few federally recognized Tribes, noted that this has also proved to be a barrier to their participation in their state's PCCM program. For example, in State C, the UIO noted that they are the only UIO in the state and the state has a small American Indian/Alaska Native population, creating challenges in building a stronger relationship with their State Medicaid office because the population is often overlooked. This lapse can limit the ability of American Indian and Alaska Native patients to access the care they need and can result in increased healthcare disparities. States should recognize the importance of providing access to care for all American Indians and Alaska Natives patients, regardless of their location or the size of their community. This can be achieved through focused outreach efforts and collaboration with UIOs and other community-based organizations. In addition states should consider collaborating with UIOs to provide training to Medicaid and CHIP staff on the unique needs of urban American Indian and Alaska Native populations and the role of UIOs in the I/T/U system. Overall, it is important for State Medicaid offices to prioritize the healthcare needs of American Indian/Alaska Native populations, regardless of the size of the community.

Lack of Familiarity with IMCEs

While not necessarily a challenge for UIOs to participate in PCCM programs, most UIOs interviewed noted that they were unfamiliar with IMCEs, with only one UIO mentioning they knew a little about IMCEs (excepting the UIO in State N currently operating as an IMCE). This lack of familiarity could indicate a lack of communication from the State Medicaid office or the lack of interest in understanding the needs of the state's American Indian and Alaska Native-serving facilities. Given that IMCE programs are relatively new in the managed care realm, and the fact that only two states have worked with I/T/U facilities to create managed care entities specifically delineated as IMCEs, it may also be likely that a majority of State Medicaid offices are also unfamiliar with the programs and how they operate. This may be particularly true for states with smaller American Indian and Alaska Native populations. However, all UIOs were interested in learning more about IMCEs.





PART V: CONCLUSION

Medicaid and CHIP remain critically important to fulfilling the United States' trust responsibility to provide health services to maintain and improve the health of American Indians and Alaska Natives.¹⁰⁸ The information gathered from UIOs in this report indicate that UIO participation as a primary care case manager in Medicaid and CHIP provides resources which may enhance the level of care available for American Indian and Alaska Native beneficiaries. In particular, improvement in care coordination, increased access to preventative care, and reduced reliance on patient self-advocacy are all reported benefits which may be of interest to other providers in the ITU system. Further work is needed to address barriers identified in this report, including insufficient capitation rates, a need for improved communication with state Medicaid offices, and a need for further education regarding the roles of UIOs in the Indian healthcare system. NCUIH looks forward to continued collaboration between UIOs, state Medicaid offices, and the Centers for Medicare & Medicaid Services as all parties seek ways to improve outcomes for American Indian and Alaska Native beneficiaries.

¹⁰⁸ 25 USC § 1601(1).





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