

Medicaid Managed Care Report



National Indian
Health Board



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Mission Statement

Established by the Tribes to advocate as the united voice of federally recognized American Indian/Alaska Native Tribes, the National Indian Health Board seeks to reinforce Tribal sovereignty, strengthen Tribal health systems, secure resources, and build capacity to achieve the highest level of health and well-being for our people.





About the National Indian Health Board

The National Indian Health Board (NIHB) represents Tribal governments — both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from the Indian Health Service (IHS). Located in Washington, DC, NIHB, a non-profit organization, provides a variety of services to Tribes, Area Indian Health Boards, Tribal organizations, federal and state agencies, and private entities, including:

- Advocacy
- Public health policy formation and analysis
- Legislative and regulatory tracking
- Direct and timely communication and information dissemination
- Research on Indian public health issues
- Public health program development and assessment
- Public health training and technical assistance programs
- Project management

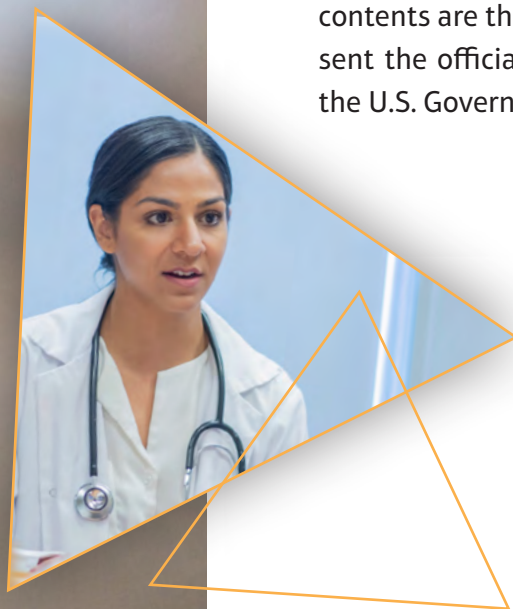
NIHB is committed to advocating on behalf of all Tribal governments and American Indian/Alaska Native (AI/AN) peoples to promote healthy practices; prevent diseases and injuries; provide basic health resources and infrastructure to Tribes; and research and develop Tribal, local, state, and national health policy that is inclusive of Tribes and Tribal health systems. The only organization of its kind, NIHB is dedicated to strengthening health and well-being for all AI/ANs.





About the Medicaid Managed Care Report

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Executive Summary

Background

In 2019, the [Centers for Medicare & Medicaid Services](#) and the Tribal Technical Advisory Group recommended holding a Medicaid managed care Roundtable as a forum to better understand. The goal of the Roundtable was to showcase recommended practices in implementing the regulatory and statutory Medicaid managed care protections for Indians. Another goal of the Roundtable was to address access and payment issues that American Indian/Alaska Natives and Indian Health Care Providers experience when interacting with managed care delivery systems. The Roundtable was originally planned for 2020, but due to the COVID-19 pandemic, it was not held until May 2021. In

preparation for the Roundtable, the [National Indian Health Board](#) and Centers for Medicare & Medicaid Services held a Listening Session on March 4, 2021, where Tribal leaders and health directors were invited to share their experiences with Medicaid managed care delivery systems in their states. Throughout the planning process, National Indian Health Board and the Centers for Medicare & Medicaid Services remained engaged with the Tribal Technical Advisory Group Managed Care Subcommittee, which assisted in the planning of both the Listening Session and the Roundtable.

Medicaid Managed Care Listening Session


On March 4, 2021, National Indian Health Board and Centers for Medicare & Medicaid Services held a Listening Session in preparation for the Roundtable. The Listening Session was designed to solicit feedback from Tribal leaders and health directors on how managed care was working in their states, including challenges and recommended practices to be included as agenda items at Roundtable discussion.

The Listening Session opened with a presentation by Elliott Milhollin, Technical Advisor to the Indian Health Service Nashville Area, who provided an overview of the Indian Managed Care protections. Those protections include access for American Indian/Alaska Natives to an Indian Health Care Provider of choice and proper payments by states and managed care plans managed care plans to Indian Health Care Providers

when services are provided to American Indian/Alaska Native beneficiaries. Following the presentation, Tribal speakers from the Portland and Oklahoma Areas discussed their unique experiences in working with Medicaid managed care plans and state Medicaid agencies. Dr. Sharon Stanphill, Health and Wellness Director for the Cow Creek Band of Umpqua Tribe, and Michael Collins, Director of Managed Care for the Confederated Tribes of Warm Springs, discussed their experience working with the Oregon Health Authority to establish a Primary Care Case Management Indian Managed Care Entity¹.

Melanie Fourkiller, Director of Self-Governance for the [Choctaw Nation](#), and Melissa Gower, Senior Advisor and Policy Analyst for the Chickasaw Nation, from the Oklahoma Area, discussed claim denials and

1 An Indian Managed Care Entity (ICME) is a Medicaid managed care plan that is controlled by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service. 42 C.F.R. § 438.14 (a).



payment issues from Medicaid managed care plans for services provided by the Oklahoma Indian Health Care Providers to Tribal citizens who reside in Texas and who are enrolled in Texas Managed Care. The Oklahoma representatives cited concerns that the state and the managed care plans² were not familiar with the Indian managed care plans in [42 C.F.R. 438.14](#), even when those protections are included in managed care contracts between the state and managed care plans.

The presentations were followed by an open discussion, which provided an opportunity for participants to ask questions of the panelists. Attendees provided feedback and shared their challenges and recommended practices of navigating managed care delivery systems. The Listening Session was attended by 213 Tribal leaders and health directors. The information obtained at the Listening Session helped to inform the discussion topics for the Roundtable.

Indian Health Service Delivery System

Indian Health Service

The [Indian Health Service](#), an agency within the [Department of Health and Human Services](#), is responsible for providing health services to American Indian/Alaska Natives. The provision of health services to members of federally recognized Tribes grew out of the special government-to-government relationship between the federal government and Indian Tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The [Indian Health Care Improvement Act](#), the cornerstone legal authority for the provision of health care to American Indian/Alaska Natives, was made permanent by the Affordable Care Act.³

Indian Health Service provides comprehensive primary health care and disease prevention services to approximately 2.6 million American Indian/Alaska Natives

through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations. Indian Health Service is administratively organized into 12 geographic regions referred to as Indian Health Service Areas and provides services in 37 states.⁴ Indian Health Service is comprised of programs and facilities operated by Indian Health Service, operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, and operated by Urban Indian Organizations under Title V of the [Indian Health Care Improvement Act](#). The programs and facilities are predominantly located in rural primary care settings and are managed by the Service, Tribal, and urban Indian organizations, collectively referred to as the ITU system.

Tribes and Tribal Organizations

Tribes and Tribal organizations operate Indian health care programs under the Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638,

² Managed care plan” includes managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, primary care case management, and primary care case management entity as defined at 42 C.F.R. § 438.2.

³ Indian Health Care Improvement Act: https://www.ihs.gov/sites/ihcia/themes/responsive2017/display_objects/documents/home/USCode_Title25_Chapter%2018.pdf.

⁴ See Appendix D: IHS Area Map.

ISDEAA), 25 U.S.C. §5301 *et seq.* and the Indian Health Care Improvement Act, 25 U.S.C. §1601 *et seq.* Under this authority, Tribes and Tribal organizations may enter Title I contracts or Title V compacts to take over operation of one or more Indian Health Service programs, functions, services and activities. Under the Indian Self-Determination and Education Assistance Act, many Tribes have assumed the administrative and programmatic roles previously carried out by the federal government. Tribes currently administer over half of the Service resources through contracts and compacts. The Service directly administers the remaining resources and manages programs where Tribes have chosen not to contract or compact health program.⁵

Urban Indian Organizations

Pursuant to the authority of Title V of the Indian Health Care Improvement Act, Indian Health Service provides contracts and grants to 41 urban-centered, nonprofit urban Indian organizations providing health care services at 59 locations throughout the United States. The programs define their scope of services based upon the documented and unmet needs of the urban Indian communities they serve. The 41 programs engage in a variety of culturally appropriate activities to increase access to health services for urban Indians. These services range from the provision of outreach and referral services to the delivery of comprehensive ambulatory health care.

Importance of Medicaid and Children's Health Insurance Program to Indian Health Service

Medicaid and the Children's Health Insurance Program serves as a critical resource for care for American Indian/Alaska Native individuals. More than one million individuals are enrolled in coverage through Medicaid and Children's Health Insurance Program. Under Section



1911 of the Social Security Act, 42 U.S.C. §1396j, Indian Health Service and Tribal facilities are authorized to bill the Medicaid program for services provided to Medicaid enrolled individuals who are eligible for services from the Indian Health Service at 42 C.F.R. Part 136. On an annual basis, Indian Health Service calculates and publishes in the Federal Register calendar year inpatient and outpatient Medicare and Medicaid reimbursement rates which are often referred to as the “Encounter – All-Inclusive Rates.” The Encounter rate is applicable to reimbursement methodologies under the Medicare and Medicaid programs.⁶ Indian Health Service and Tribal facilities bill at the Medicaid Encounter rate for Medicaid covered services provided to Medicaid eligible individuals who receive inpatient or outpatient services at an Indian Health Service and Tribal facilities. Urban Indian organizations are ineligible for the Encounter rate, but can bill Medicaid as an enrolled Medicaid provider under the state plan, such as a clinic or Federally Qualified Health Center, and are paid at the same state plan reimbursement rates applicable to that provider type.

Under section 1905(b) of the Social Security Act, the federal government is required to match state expenditures at the Federal Medical Assistance Percentage rate, which is 100 percent for state expenditures on behalf of American Indian/Alaska Native Medicaid beneficiaries for covered services “received through” an Indian Health Service facility whether operated by Indian Health Service or by a Tribe or Tribal

⁵ See page 13, IHS budget FY 22 Justification: https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2022.pdf

⁶ See 2022 IHS reimbursement rates: <https://www.federalregister.gov/documents/2022/04/08/2022-07468/reimbursement-rates-for-calendar-year-2022>

organization (as defined in section 4 of the Indian Health Care Improvement Act).”

Section 9815 of the American Rescue Plan provides a temporary increase of 100 percent Federal Medical Assistance Percentage for Medicaid services received through Urban Indian Organizations that have a contract or grant with the Service. The 100 percent Federal Medical Assistance Percentage rate is available only for the eight fiscal quarters beginning April 1, 2021 and ending March 31, 2023.⁷

Summary of Medicaid Managed Care Roundtable

On Wednesday, May 19, 2021, National Indian Health Board, in conjunction with the Centers for Medicare & Medicaid Services held a Medicaid Managed Care Roundtable to better understand protections for Indian Health Care Providers operating with Medicaid managed care plans and to collaborate on strategies and solutions to benefit all parties. The Roundtable brought together panelists from state Medicaid agencies and Tribes from Washington, Oklahoma, Texas, California, North Carolina, and Oregon. The Roundtable began with an overview of the Indian Medicaid managed care protections which set the stage for all the participants and continued with different parts of the meeting focused on different managed care arrangements in different regions of the U.S. Part II, was a discussion of State-Tribal Relations in Washington State, followed by a discussion concerning overcoming challenges of implementing managed care in California and Texas. Part III was dedicated to the development of Indian Managed Care Entities using a primary care case management model in Oregon and North Carolina. The Roundtable wrapped up with a discussion of recommended practices and next steps. The Roundtable was attended by 264 participants, including 40 state officials, 43 managed care plan representatives, and 87 Tribal representatives.

Summary of Key Takeaways from the Roundtable

The contents of this report are drawn from the Roundtable event held on May 19, 2021, and subsequent interviews with Roundtable panelists and Oregon’s Urban Indian Organization, Native American Rehabilitation Association Northwest. The following is a list of key takeaways for improving implementation of Medicaid managed care for American Indian/Alaska Native beneficiaries enrolled in managed care and Indian Health Care Providers who provide services to these beneficiaries, whether in-network or as out-of-network providers:

- **Tribal Consultation.** Ensure that the Tribal consultation process that state Medicaid programs must engage in under federal law is timely, collaborative, and meaningful. States need to establish a process that provides for mutual, clear communication between the Tribes and the state. For states engaging in managed care reforms, effective Tribal consultation can be a key element in the states’ successful implementation of a managed care delivery system for American Indian/Alaska Native populations.
- **Early Involvement of Subject Matter Experts.** When encountering claims issues from Indian Health Care Providers, it is important for the state to have subject matter experts available early in the process. This ensures appropriate analysis of the claims to avoid rejection of claims and timely resolution of claim submissions. The same is true when a state is transitioning Medicaid beneficiaries from a fee-for-service delivery system to a managed care delivery system. Transitions between delivery systems should be handled by state staff with knowledge of the Indian health care system and the Indian managed care protections.

⁷ See page 9 of SHO# 21-004 Temporary Increases to FMAP: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-004.pdf>

This will avoid unintended consequences for Indian Health Care Providers and American Indian/Alaska Native Medicaid beneficiaries.

- **Institutionalize Knowledge of the Indian Health Care Delivery System.** States and managed care plans should institutionalize knowledge of the Indian managed care protections and the unique structure of the Indian health care delivery system by providing routine training to staff, so the expertise in this area survives staff turnover.
- **Single Point of Contact/Tribal Liaison.** States should assign a single point of contact and/or a Tribal Liaison whom the Tribes can contact when they have difficulties resolving issues with a managed care plan. Panelists recommended that states include a provision in their contracts with managed care plans requiring the managed care plans to do the same. Having a single point of contact like a Tribal Liaison can ensure more efficient communication and effective engagement for Tribes and Indian Health Care Providers. Because the single point of contact is responsible to coordinate internally and report back to the Tribes on the status of claims, having a single Liaison also provides improved accountability and visibility on the status of ongoing payment issues for both Tribal providers and the states.
- **Use of the Indian Specific Managed Care Addendum.** The Indian Managed Care Addendum is a Centers for Medicare & Medicaid Services-drafted contract supplement for inclusion in Medicaid managed care contracts that outlines all the federal laws, regulations, and specific provisions that apply when contracting with Indian Health Care Providers. The Addendum was developed by Centers for Medicare & Medicaid Services, in consultation with the Tribes, to identify key federal laws that might conflict with standard contract

provisions with the purpose to make negotiation of contracts easier for both parties and ensure compliance with applicable federal laws and regulations unique to Indian Health Care Providers. Use of the Addendum benefits both managed care plans and Indian Health Care Providers by lowering the perceived barriers to contracting and assuring that key federal laws are applied minimizing potential disputes.

- **Develop Internal Claims Processing Practices.** Managed care plans should develop internal claim processing practices that recognize and treat Indian Health Care Providers as “in-network” providers to avoid automatic claim denials for providing services “out-of-network” when Indian Health Care Providers serve American Indian/Alaska Native beneficiaries enrolled in managed care plans.
- **Require Managed Care Plans to Pay the Entire Indian Health Service Encounter Rate to the Indian Health Care Provider.** Have states amend their contracts to require managed care plans to pay the entire Indian Health Service Encounter Rate directly to Indian Health Care Providers. This practice avoids additional billing by the Indian Health Care Provider to the state for the difference between the negotiated contract rate and the Encounter Rate for a particular claim (often referred to as the “wrap” payment).
- **Successful Development of an Indian Managed Care Entity Requires a Strong Partnership between Tribes and States.** To establish a successful Indian Managed Care Entity, Tribes and states need to be fully committed to its development. Working together from the beginning ensures that the state and the Tribes develop a delivery system that complies with the Centers for Medicare & Medicaid Services statutory and regulatory requirements. This will avoid unnecessary delays in the state plan approval process, contract approval process, and the delivery system readiness reviews.



Medicaid Roundtable Report

Roundtable Welcome & Introduction

Nickolaus Lewis

National Indian Health Board (NIHB) Vice Chairperson and Councilman for the Lummi Nation.⁸

Christopher Chavis, former NIHB Policy Center Deputy Director,⁹ introduced Councilman Nickolaus Lewis¹⁰ of the [Lummi Nation](#) in Washington State, who opened the Roundtable and welcomed guests. Councilman Lewis

introduced the focus of the Roundtable and gave an overview of the format of the discussion. Councilman Lewis noted the panelists in each session, would share their experiences, lessons learned, recommended practices, and strategies around implementing the Indian protections in managed care. Councilman Lewis then provided an invocation and then turned the event over to Elliott Milhollin, the moderator.

Part I: Overview of Indian Managed Care Protections

Moderator

Elliott Milhollin

Partner, Hobbs Straus Dean and Walker

Elliott Milhollin moderated the Roundtable on behalf of NIHB. Milhollin began by providing an overview of Medicaid managed care and the Indian Medicaid managed care protections.

Medicaid is increasingly being provided through managed care plans (MCPs). As of July 2018, 69 percent of Medicaid recipients were receiving care through a comprehensive risk-based MCP.¹¹ In a managed care delivery system, a state contracts with MCPs to perform certain functions on behalf of the state,

including furnishing Medicaid-covered services to Medicaid beneficiaries. Although many of these contracts include requirements for MCPs to comply with the Indian managed care protections at 42 C.F.R. § 438.14, many MCPs are not familiar with these Indian protections or the Indian health care delivery system.


Milhollin explained from a Tribal perspective, the Indian Health Care Provider (IHCP) experience has been frustrating because of difficulties with IHCPs receiving reimbursement for services provided to American Indians/Alaska Natives (AI/ANs) enrolled in Medicaid managed care and the impact to the AI/AN beneficiary in timely accessing health care. The purpose of the Roundtable was to bring together interested parties – Tribes, states, and MCPs – to better understand the

⁸ The Lummi Nation has over 5,000 citizens and is based in western Washington State.

⁹ As of July 2021, Mr. Chavis is the Director of NIHB's Policy Center.

¹⁰ Councilman Lewis also serves as the NIHB representative to the CMS Tribal Technical Advisory Group (TTAG), and Vice Chairman of the NIHB Board of Directors.

¹¹ Medicaid managed care statistics: [10 Things to Know about Medicaid Managed Care | KFF](#).



Indian protections and to collaborate on strategies and solutions to benefit all parties. Milhollin presented an overview of the Indian managed care protections in 42 C.F.R. § 438.14 to provide a better understanding of the rules for all participants and attendees. He stressed the importance of the Indian managed care protections in ensuring continued access to care for AI/ANs and that IHCPs are promptly and correctly reimbursed for the services they provide.

On December 14, 2016, the Center for Medicare & Medicaid Services (CMS) issued a CMCS Informational Bulletin (CIB) on the “Indian Provisions in the Final Medicaid and Children’s Health Insurance Program Managed Care Regulations.” The following information is a summary of the Indian protections, as outlined at 42 CFR § 438.14 and the CIB.¹²

Background on the Indian Protections in the Medicaid Managed Care Rules

On May 6, 2016, CMS published a final rule updating its Medicaid managed care regulations.¹³ The final rule codifies a range of Indian managed care protections, including those in Section 1932(a)(2)(C) and Section 1932(h) of the Social Security Act (Act) as added by Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA). These provisions allow Indians enrolled in Medicaid and the Children’s Health Insurance Program (CHIP) MCPs plans to continue to receive services from an IHCP and ensures IHCPs are reimbursed appropriately for services provided.

The regulation applies the Indian protections in Section 1932(a)(2)(C) and 1932(h) of the Act, to all types of managed care programs, including managed care organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), Primary Care Case Management programs (PCCM), and Primary Care Case Managed Entity (PCCM Entity) as applicable. The regulation address other Tribal issues, such as network sufficiency and payment requirements for MCPs that serve AI/ANs; network provider agreements with IHCPs; and referrals to in-network providers by IHCPs. The Indian-specific provisions are located in the Medicaid rules at 42 C.F.R. § 438.14 and made applicable in CHIP by a cross reference in the CHIP rules at § 457.1209, titled: “Standards for Contracts Involving Indians, Indian Health Care Providers and Indian Managed Care Plan.” States were required to ensure compliance with these regulations for Medicaid MCPs with contract rating periods starting on or after July 1, 2017.

Managed Care Plans Must Demonstrate IHCP Network Sufficiency to Ensure Timely Access to Care for AI/ANs

The regulations require every MCP to demonstrate that there are sufficient IHCPs participating in the network to ensure AI/ANs have timely access to services. If a state determines that timely access to covered services cannot be ensured due to few or no IHCPs, the network sufficiency standard is only satisfied if AI/AN enrollees are permitted by the MCP to access out-of-state IHCPs or AI/AN enrollees have the option to disenroll from the state’s managed care program into

¹² Link to the CIB: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf>.

¹³ The final rule is available at <https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicicaid-managedcare-chip-delivered>.

a fee-for-service delivery system.¹⁴ For example, if the state mandatorily enrolls all Medicaid individuals into managed care including AI/ANs, and the plan cannot demonstrate that there are sufficient IHCPs in-network, the individual AI/AN can disenroll from the plan and/or use out-of-state IHCPs.

Option to Access Health Care from Out-Of-Network IHCPs

The regulations permit any AI/AN individual who is enrolled in a non-Indian managed care plan and eligible to receive services from a network IHCP to choose that IHCP as his or her primary care provider, as long as that provider has the capacity to provide the services.¹⁵ In addition, the regulation allows AI/AN individuals enrolled in managed care to access care at out-of-network IHCPs and allow referrals from IHCP to in-network providers without a duplicative referral to an in-network primary care provider.¹⁶

Payment and Contracting

IHCPs do not have to be an in-network provider to be paid by the MCP or the state Medicaid agency for services provided to AI/AN individuals enrolled in managed care. The regulations explain how payment is made to IHCPs as follows:

- When an IHCP is enrolled in Medicaid or CHIP as a federally qualified health center (FQHC) but is not a participating provider with an MCP, the regulation requires that the MCP pay the IHCP the same payment rate that the plan would pay an FQHC that is a network provider (but is not an IHCP), including

¹⁴ 42 C.F.R. § 438.14(b)(1).

¹⁵ 42 C.F.R. § 438.14(b)(3).

¹⁶ 42 C.F.R. §§ 438.14(b)(4) and 438.14(b)(6).

¹⁷ 42 C.F.R. §§ 438.14(c)(1) and 457.1209.

¹⁸ 42 C.F.R. §§ 438.14(c)(2) and 457.1209.

¹⁹ The [Calendar Year 2022 IHS Reimbursement Rates](https://www.federalregister.gov/documents/2022/04/08/2022-07468/reimbursement-rates-for-calendar-year-2022): <https://www.federalregister.gov/documents/2022/04/08/2022-07468/reimbursement-rates-for-calendar-year-2022>



any supplemental payment from the state to make up the difference between the amount the MCP pays and what the IHCP FQHC would have received under a fee-for-service (FFS) payment methodology. This supplemental payment is often referred to as a “wrap” payment.¹⁷

- When an IHCP is not enrolled in Medicaid or CHIP as a FQHC, and regardless of whether the IHCP participates in the network of an MCP, the regulation requires that the IHCP receive the applicable encounter rate published annually in the Federal Register by IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan’s FFS payment methodology.¹⁸ The term IHS Encounter Rate is used throughout this report to refer to the IHS rate published in the Federal Register.¹⁹
- When the amount an IHCP receives from an MCP is less than the applicable encounter or fee-for-service rate, whichever is applicable, the state must make a wrap payment to the IHCP to make up the difference between the amount the MCP pays and the amount the IHCP would have received under FFS or the

applicable encounter rate.²⁰ States have the option to contract with MCPs to pay the Indian Health Service (IHS) Encounter Rate directly to the IHCPs, so IHCPs don't have to balance bill the state. MCPs must pay IHCPs promptly.²¹

Indian Managed Care Entity

An Indian Managed Care Entity (IMCE)“ means an MCO, MCP, PIHP, PAHP, PCCM, or PCCM entity that is controlled by the Indian Health Service (IHS), a Tribe, Tribal organization, or Urban Indian Organization (UIO), or a consortium, which may be composed of one or more Tribes, Tribal organizations, or UIOs, and which also may include IHS. An IMCE is permitted to restrict its enrollment to AI/AN individuals in the same manner as IHCPs may restrict the delivery of services to AI/AN individuals.²² As discussed later in this report, Tribes in Oregon and North Carolina have worked closely with their respective states to establish IMCEs. The Section 1932 Medicaid State Plan Amendments (SPAs) for Oregon and North Carolina to implement this option were approved on July 16, 2021 and September 13, respectively.²³

Primary Care Provider Assignment

In states where Medicaid beneficiaries are mandated into managed care, MCPs auto assign enrollees to primary care providers (PCPs) within the MCP network. In their comments to the proposed rule, Tribes requested that CMS prohibit MCPs from auto-assigning

AI/ANs to PCPs. In response to those comments, CMS suggested in the preamble to the final rule that when auto-assigning AI/ANs to PCPs, MCPs should review their auto-assignment algorithm to ensure that an appropriate logic is used to accomplish the most appropriate PCP assignment. Such criteria could include an enrollee's historical relationship with an IHCP. Additionally, MCPs should ensure that information on the process for changing PCPs is easily accessible and, at a minimum, described in the enrollee handbook and on the managed care plan's website.²⁴

Mandatory Enrollment into Managed Care

States may require Medicaid or CHIP beneficiaries to enroll in managed care to receive coverage under certain circumstances. States are prohibited from mandating AI/ANs into managed care through a SPA unless the state has an IMCE that is accessible to the state's AI/AN Medicaid population. States may not mandate AI/ANs into managed care using other Medicaid managed care authorities, specifically a Section 1915(b) waiver or through a Section 1115 demonstration, without first obtaining approval from CMS. Consistent with the CMS Tribal Consultation Policy,²⁵ states are required to engage in meaningful consultation with federally recognized Tribes and/or IHCPs located in their state prior to the submission of any SPA, waiver, or demonstration having Tribal implications, which would include mandating AI/ANs into managed care.²⁶

20 42 C.F.R. §§ 438.14(c)(3) and 457.1209.

21 42 U.S.C. § 1396u-2(h)(2)(B).

22 42 C.F.R. §§ 438.14(d) and 457.1209.

23 Link to Oregon SPA approval documents: <https://www.medicaid.gov/medicaid/spa/downloads/OR-21-0008.pdf>
Link to North Carolina SPA approval documents: <https://www.medicaid.gov/Medicaid/spa/downloads/NC-21-0011.pdf>.

24 See preamble to final rule, CMS Medicaid Managed Care, 81, Fed. Reg. 27497, at pg. 27747 (May 6, 2016).

25 Link to CMS Tribal Consultation policy: <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf>.

26 Section 1902(a)(73) of the Act, added by ARRA § 5006(e).

As explained above, State Medicaid agencies can adopt a managed care delivery system under several different authorities:

- State plan authority under Section 1932(a);
- Waiver authority Section 1915(a) and (b); and
- Waiver demonstration authority under Section 1115.

A brief discussion of these different Medicaid managed care authorities that can be used to enroll AI/ANs and the limitations on those authorities follows.

Medicaid State Plan Authority

Through a SPA, states can implement a mandatory managed care delivery system for certain populations. However, Section 1932(a)(2)(C) of the Act prohibits states exercising this state plan option from mandatory enrollment of an AI/AN individual unless the MCP contracting with the state is an IMCE.²⁷ As discussed in more detail below and in the panelist discussion in Section III of this report, there are only two states, North Carolina and Oregon, that have approved Section 1932 IMCE SPAs. Both are PCCM Entities.

1915(b) Waiver Authority

CMS may grant a waiver under Section 1915(b) of the Act that permits a state to require all Medicaid beneficiaries to enroll in a managed care delivery system. As part of a Section 1915(b) demonstration project, CMS has authorized mandatory enrollment in managed care programs for Medicaid beneficiaries, including for dually eligible beneficiaries, AI/ANs, and children with special health care needs. States have the option to exempt AI/ANs from mandatory managed care under this authority in light of the special statutory treatment of AI/ANs and other considerations listed above. In reviewing such waiver requests, CMS will consider any input the state received through its state-Tribal consultation process. It is possible for states and Tribes

to agree to exempt AI/ANs from mandatory enrollment into managed care in a Section 1915(b) waiver.

1115(a) Demonstration Authority

Section 1115(a) of the Act authorizes the Secretary to waive provisions of Section 1902 of the Act and grant expenditure authority to treat demonstration costs as federally matchable expenditures under Section 1903 of the Act. Demonstration approval is discretionary and must be based on a finding that the demonstration is likely to promote objectives of the Medicaid program.

States have the option to exempt AI/AN populations from mandatory enrollment in a managed care delivery system, permitting AI/AN populations to obtain access to health care through a FFS delivery system in light of the special statutory treatment of AI/AN individuals in federal statutes concerning Medicaid managed care.

Historically, as a result of state-Tribal consultation and CMS-Tribal consultation with participation from a state, CMS has rarely approved Section 1115(a) demonstrations that have mandated AI/AN individuals into managed care; instead, managed care enrollment has been voluntary.

Contracting: Indian Managed Care Addendum

MCP network provider agreements often contain requirements that are inconsistent with the statutory rights of IHCPs not explicitly specified in 42 C.F.R. part 438 and make compliance or entering into agreements difficult or impossible for IHCPs. CMS, in consultation with Tribes, developed an Indian Managed Care Addendum (“ITU Addendum”) that can be used by IHCPs in negotiating participating provider agreements. CMS encourages but does not require MCPs to use the ITU addendum in their contracts with IHCPs.²⁸

²⁷ 42 U.S.C. § 1396u-2(a)(2)(C).

²⁸ See Appendix C or link to the addendum:

<https://www.medicaid.gov/sites/default/files/2019-12/addendum-ihcps.pdf>.

The ITU Addendum outlines all the federal laws, regulations, and protections for IHCPs that are binding on MCPs, PIHPs, PAHPs, and PCCM Entities and identifies several specific provisions that have been established in federal law that apply when contracting with IHCP. The use of this ITU Addendum benefits both MCPs and IHCPs by lowering the perceived barriers to contracting, assuring compliance with key federal laws when contracting with IHCPs, and minimizing potential

disputes. For example, MCPs typically require participating providers to have private malpractice insurance. However, the ITU Addendum explains that IHCPs, when operating under a contract or compact with IHS to carry out programs, services, functions, and activities, of the IHS, are covered by the Federal Tort Claims Act and private malpractice insurance is not required.²⁹

Part II: State-Tribal Relations

Session I: Washington State: Lessons Learned in Working Together

This session of the Roundtable explored the state-Tribal relations in Washington State. Panelists outlined recommended practices for establishing a productive state-Tribal relationship that respects Tribal sovereignty and resulted in the development of many novel processes to overcome Medicaid managed care barriers for IHCPs and AI/AN beneficiaries.

Panelists

Vicki Lowe

Executive Director, [American Indian Health Commission](#) (AIHC)

Jessie Dean

Tribal Affairs Administrator, [Washington Health Care Authority](#) (HCA)



Tribal Sovereignty: The Authority for Tribes to Govern

Vicki Lowe, Executive Director for the American Indian Health Commission in Washington State,³⁰ highlighted Tribal sovereignty and the role it plays in encouraging the preservation of Tribal culture, religion, and traditional practices. Tribes have the authority, among other things, to govern their people and their land; define their Tribal membership criteria; create Tribal legislation, law enforcement, and court systems; and impose taxes in certain situations. The lack of understanding of federal law, Tribal codes, and Tribal processes by states can have detrimental impacts on Tribal governments and AI/AN individuals. The following subsections highlight the federal and state authorities that establish the government-to-government relationship.

²⁹ For an explanation of Federal Tort Claims Act coverage and application to IHCP, see <https://www.ihs.gov/riskmanagement/ftca/>.

³⁰ Link to the American Indian Health Commission website: <https://aihc-wa.com/>.

Federal Authorities That Establish the Government-to-Government Relationship

Executive Order [13175](#), “Consultation and Coordination with Indian Tribal Governments,” signed on November 6, 2000, by President Clinton.³¹ This order requires federal departments and agencies to consult with Tribal governments when considering policies that would impact Tribal communities. This executive order was reaffirmed by President Biden on January 26, 2021, in the Presidential Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships (Memorandum). In the 2021 Presidential Memorandum, President Biden reiterated the federal government’s previously acknowledged commitment to Tribal self-government and sovereignty. The Memorandum further directed federal departments and agencies to submit plans and reports to hold them accountable for implementing Executive Order 13175.³²

Mr. Dean, Tribal Affairs Administrator, Washington Health Care Authority, discussed the Social Security Act, [Section 1902\(a\)\(73\)](#), which requires states to provide for a process in the Medicaid state plan, under which the state seeks advice on a regular, ongoing basis from designees of Indian Health Care Programs (IHCPs) on Medicaid matters that are likely to have a direct effect on IHCPs.³³ The Washington Tribal Consultation State Plan includes consultation with elected Tribal leaders of federally recognized Tribes.³⁴

Authorities That Govern State-Tribal Relations in Washington State

In 1989, the Tribal leaders in Washington State came together to create a treaty-like document with the state.³⁵ At the time, the state and Tribes were in constant conflict over many issues, and it began to affect the quality of services provided to Tribal citizens. Tribal leaders negotiated with the governor to set the stage for successive agreements that created a framework for state-Tribal relations. The first document was the Centennial Accord of 1989,³⁶ followed by the Millennium Agreement of 1999.³⁷ In these agreements between the State of Washington and the Tribes, each party agreed to: respect the sovereignty of the other; improve the services delivered to people by the parties; establish goals for improved services and identify obstacles to the achievement of those goals; institutionalize government-to-government processes to promote timely and effective resolution



31 Exec. Order No. 13175 65 FR 67249 (Nov. 6, 2000). This Executive Order can be found at: <https://www.federalregister.gov/documents/2000/11/09/00-29003/consultation-and-coordination-with-indian-tribal-governments>.

32 The Presidential Memorandum can be found at: <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/26/memorandum-on-tribal-consultation-and-strengthening-nation-to-nation-relationships/>.

33 42 U.S.C § 1396a(a)(73).

34 Link to Washington ARRA Consultation Process: https://www.hca.wa.gov/assets/program/tribal_consult_policy_state_plan_031315.pdfhttps://www.hca.wa.gov/assets/program/tribal_consult_policy_state_plan_031315.pdf.

35 There are 29 federally recognized Tribes in Washington State, 32 IHCPs, and 1 Urban Indian Organization.

36 Link to Centennial Accord: <https://goia.wa.gov/relations/centennial-accord>.

37 Link to Millennium Agreement: <https://goia.wa.gov/relations/millennium-agreement/agreement>.

of issues of mutual concern; work in collaboration to engender mutual understanding and respect, and to fight discrimination and racial prejudice; and strive to coordinate and cooperate. These efforts laid the foundation for modern day collaboration between Washington State and the Tribes.

In 2012, [Chapter 43.376](#) of the Revised Code of Washington was enacted which laid the groundwork for a minimum expectation for state agencies to work with Tribes.³⁸ This law requires all state agencies to make reasonable efforts to collaborate with Tribes in the development of policies, agreements, and program implementation that directly affect Tribes. It also requires agencies to:

1. Develop a consultation process;
2. Designate a Tribal Liaison who reports directly to the head of the state agency;
3. Coordinate training of state agency employees in government-to-government relations; and
4. Submit an annual report to the governor on activities to implement the law.

Recommended Practices for State-Tribal Relations

Collaboration is Critical to Consultation

Lowe explained that collaboration is a critical step to facilitate meaningful consultation: “[i]f you haven’t had collaboration, you can’t have a consultation.” “Tribal consultation does not require agreement, but it is a process by which to try to agree.” Washington State requires every state agency to have a consultation policy. In addition to a formal consultation policy, a recommended practice would be to have state staff trained on consultation and have a process to ensure Tribal consultation requirements are met.

Consultation Must Have Prior Notice

The second consideration, or recommended practice, noted by the panelists was that *consultation should have sufficient prior notice* beyond the minimum federal requirement to consult prior to submitting a SPA or waiver to CMS. Dean noted that there must be enough advance notice to allow the Tribes to understand and process the impact of the proposed change. In Washington State, most agencies require thirty days advance notice; however, Tribal leaders strongly prefer sixty days advance written notice of any Tribal Consultation. Lowe advised that the notice provided to Tribes must include the agency’s analysis of Tribal implications. State agencies also must be transparent – which means providing a copy of the SPA, waiver, or demonstration proposal, and an explanation of the change it is proposing. States must make sure that there is enough information in the notice so that Tribal leaders can understand what change the agency is proposing to make.

Use Multiple Methods to Alert Tribal Leaders of Tribal Consultations

The panelists also noted the importance of using multiple communication methods to transmit information regarding the consultation. In Washington State, the Health Care Authority physically mails the notices to Tribal leaders *and* sends them electronically. The Health Care Authority continued to use physical mail during the COVID-19 pandemic and set up a system for the notices to be signed electronically by the Medicaid Director.

Consultations Must be Respectful

Respectful consultation requires that state agency leadership be involved and present for Tribal consultations. Common recommended practices for successful consultations noted by Lowe, include making sure that someone attends that has decision-making authority. Tribal leaders find it disrespectful when state staff

38 Link to Wash. Rev. Code § 43.376: <https://app.leg.wa.gov/rcw/default.aspx?cite=43.376.020>.

attend the consultation and no one with decision making authority is in attendance. If there is no decision-maker present, then it is a “listening session,” not a consultation. Also, state leadership must avoid being late and must stay for the duration of the consultation session. It is also important that Tribal leaders be allowed to speak about any issue that they want to address, regardless of whether it is within the “scope” of the reason the state agency called the consultation.

Consultation Must Take Place Before Decisions are Made

Consultation must be conducted before a final decision is made. State agencies must clearly understand the potential Tribal implications of a proposed policy change as it makes its way through the decision-making process within the state agency. Conducting the Tribal implication analysis is essential to ensuring that adequate consultation is conducted before deciding. Lowe advised that it should be assumed that there are Tribal implications for all proposed changes until it is proven that there are no implications. The panelists acknowledged the difficulties of trying to train state staff on how to identify potential Tribal implications, especially concerning a system as complicated as managed care. Another idea proposed by Dean was to have a Tribal Liaison within each office and division within the Health Care Authority.

Ensure That There is a “Meeting of the Minds”

The Health Care Authority will typically host two roundtables before holding a consultation to help

identify any potential issues the proposed change may implicate so that the state has sufficient time to work with the Tribes on possible solutions. Agency leadership does not typically attend roundtables. Rather, subject matter experts attend. Subject matter expert participation helps ensure that a “meeting of the minds” takes place and that both sides understand in detail what change is being proposed, why the change is being proposed, and the Tribal implications of the change. These activities can save time and costs and help agencies solve problems before implementing changes.

Building Relationships

The panelists also discussed the importance of strengthening the relationship between the state and Tribes and engaging in relationship building. While political leadership may change, state agency staff may remain the same. It can be very productive to try to forge relationships with the career state agency staff because they can serve as allies and points of contact.

The Importance of an Indian Specific Addendum

The State of Washington requires that MCPs use the ITU Addendum with all managed care contracts with IHCPs. This helps to educate MCPs on the Indian managed care protections and creates a mechanism for incorporating and implementing the protections internally within the operations of the MCPs.

Session II: Overcoming Challenges with Positive Results: Implementing Managed Care in California & Texas

Panelists from California and Texas discussed challenges and recommended practices in implementing the Medicaid managed care Indian protection provisions in their states. Below are two case studies that

show how Tribes and their state partners worked to overcome hurdles to decrease claim denials and to increase timely payment of Indian Health Care Programs (IHCPs) claims. The California case study

explores how the Tribes worked with the state to ensure that IHCPs are paid at the IHS Encounter Rate directly by the managed care plans (MCPs) which avoids requiring the Tribes having to balance bill the state for the wrap payment. The Texas case study explores the longstanding issues associated with out-of-state IHCPs billing Texas MCPs for Oklahoma Tribal citizens enrolled in Texas MCPs, who receive services from out-of-state IHCPs, located in Oklahoma.

PART I: CALIFORNIA CASE STUDY

Panelists

California Tribal Representative:

Rosario Arreola Pro, Health Systems Development Director, [California Rural Indian Health Board](#) (CRIHB)

[California Department of Health Care Services](#) (DHCS):

Michele Retke, Chief, Medi-Cal Managed Care Operations Division, DHCS

Lindy Harrington, Deputy Director Health Care Financing, DHCS

Background

The California Managed Care case study examined how IHCPs and the California Department of Health Care Services (DHCS) worked together to address problems with DHCS not making timely wrap payments to IHCPs. There are 109 Tribes in California, 59 of which are represented by the CRIHB. There are 19 Tribal health programs that are members of CRIHB, with representation focused in the North and Central regions and some members in the South.³⁹ However, many of these health programs are consortiums run by multiple Tribes. There are also 95 Indian health clinics enrolled in Medi-Cal. Although AI/AN beneficiaries are defaulted into a MCP, they can opt out of managed care into FFS Medicaid.



In 2016, California expanded managed care, which changed how Medicaid beneficiaries received health care and impacted how IHCPs interacted with MCPs and the state. Prior to the managed care expansion, IHCPs billed the state directly FFS at the IHS Encounter Rate. After the managed care expansion, IHCPs had to enter contracts with MCPs, bill the MCPs at a negotiated contract rate, and balance bill the state to receive full reimbursement of the IHS Encounter Rate. Significant obstacles kept the IHCPs from receiving timely payment because the wrap payments were chronically late and the IHCPs were subject to a complicated reconciliation process.

Working Together to Overcome the Challenges

California is a large and diverse state with a complex Medicaid delivery system, which created many challenges during the expansion of managed care. The state has 25 different MCPs and provides healthcare services to about

39 Link to California Rural Indian Health Board website: <https://crihb.org/>.

13 million beneficiaries, with 10.6 million enrolled in managed care. Each of the state's 58 counties has different MCP plans for beneficiaries to choose from. The expansion required the California IHCPs to engage with the state and develop relationships where none had previously existed. Moreover, IHCPs were pressed into becoming in-network MCP providers causing many problems early on. CRIHB and other IHCPs began meeting with various California MCPs and state partners to help identify the reasons for the delays in reimbursement. The California DHCS Tribal Liaison began including a standing agenda item at the Tribal health meetings to specifically address managed care issues, including timely reimbursement issues.

After a lot of consultation with the Tribes, and with technical assistance from CMS, the state determined that the solution to the payment issues was for the state to contract with the MCPs to pay the IHS Encounter Rate directly to IHCPs. California Medicaid managed care contracts are "at-risk" contracts; therefore, many MCPs were concerned that the IHS Encounter Rate was higher than the MCP contract rates. To address this issue, the state was able to exempt Tribal health programs from the risk portions of the MCP contracts. Starting January 1, 2018, MCPs were no longer at risk for all eligible AI/AN services. The MCPs are paid via a separate payment arrangement that is not part of the plan's capitation rates. The MCPs manage these services under a non-risk arrangement with DHCS. Because plans are paid for these services outside of capitation payment and are made whole for all their costs associated with the service, the cost of the service does not present any risk to the plan's finances.

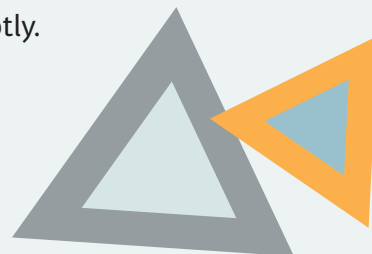
Exempting Tribal health programs from the risk portions of the MCP contracts was put into effect with the new contracts in January 2018. California sent out an "All Plan" letter detailing which Tribal health programs, services, and reimbursement structures were eligible for the new process.⁴⁰

Communication

As a result of the work in creating a payment process for IHCPs, the IHCPs and California developed an enhanced working relationship. For instance, California designated a contract manager to handle managed care issues raised by IHCPs and work with the MCPs and IHCPs to resolve claim denials and payment issues. The state also set up processes to improve communication between IHCPs and the DHCS Primary Rural Health Division on managed care and other Medicaid issues, including regular standing meetings dedicated to resolving managed care claims issues. These regular standing meetings created an established forum where the claims and other issues would be discussed and resolved, instead of handling claims or issues on an ad hoc basis. Meeting regularly also deepened relationships and trust as both parties were better able to identify and timely resolve issues.

Engaging All Involved Parties

Panelists agreed that engaging all involved parties was a critical element in California's successes in improving IHCPs and MCPs working relationship. The Tribal panelist recommended involving all parties, including Tribal and state leadership, and for the non-Tribal parties that participate to have representatives with decision-making authority at the table, not just the Tribal Liaison. The state panelist indicated that it is important to hear directly from Tribal leaders because this helps the state understand the importance of various issues. State officials emphasized that a recommended practice was to have state and Tribal subject matter experts at the table, which can help resolve issues promptly.



⁴⁰ Link to All Tribes Letter announcing the reimbursement change:

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-020.pdf>.

PART II: TEXAS CASE STUDY

Panelists

Oklahoma Tribal Representatives:

Melanie Fourkiller

Senior Policy Analyst, [Choctaw Nation](#)

Melissa Gower

Senior Advisor, Policy Analyst, [Chickasaw Nation](#)
[Division of Health](#)

[Texas Department of Health Services:](#)

Dana Williamson

Director, Policy Development Support

Agnes Henry

Program Specialist, Research and Resolution,
Managed Care Compliance & Operations

Barbara Benavidez

Manager, Research and Resolution, Managed Care
Compliance & Operations

Frank Mendez

Manager, Research and Resolution, Managed Care
Compliance & Operations

Background

The Texas Managed Care case study highlighted long-standing automatic claims denial issues resulting from out-of-state Texas AI/AN MCP beneficiaries seeking care from Oklahoma IHCPs.

Oklahoma has 39 federally recognized Tribes. Oklahoma expanded Medicaid to the childless adult



population, ages 19 to 64, under the Affordable Care Act option on July 1, 2021. With the expansion, Oklahoma is expected to serve an additional 190,000 individuals.⁴¹ The state has a total AI/AN population of around 525,000, with just under one-third (31 percent) covered by the Medicaid program. Oklahoma has no managed care delivery system due to an Oklahoma Supreme Court decision.⁴²

The IHS Oklahoma City Area includes Oklahoma, Texas, and Arkansas. The Chickasaw Nation encompasses nine counties in Southern Oklahoma.⁴³ The Choctaw Nation encompasses 13 counties in Southeast Oklahoma, bordering Texas and Arkansas.⁴⁴

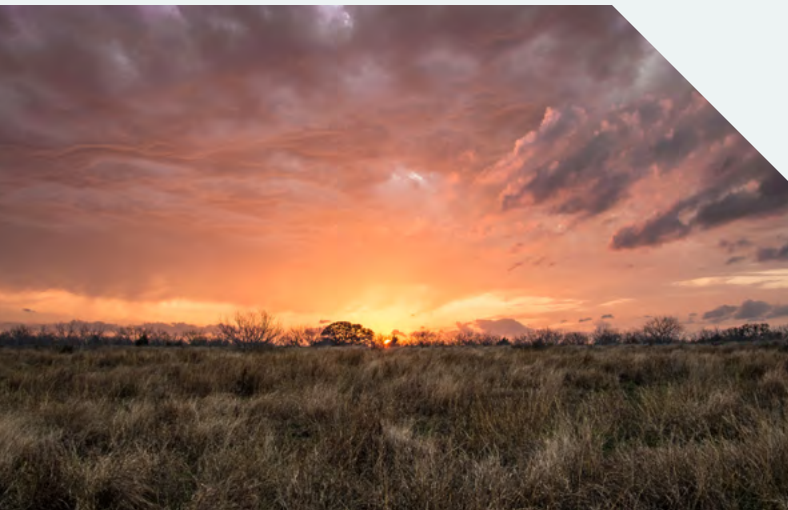
Texas has a smaller Tribal population having only three federally recognized and two state-recognized Tribes. There are 4.6 million Medicaid beneficiaries in Texas, including around 171,000 AI/AN beneficiaries (about

41 Before the state's recent Medicaid expansion, Oklahoma Medicaid served 983,000 Medicaid beneficiaries, including 162,000 AI/AN beneficiaries.

42 Link to the June 29, 2021 Oklahoma Supreme Court Ruling on Medicaid managed care: <https://www.oscn.net/dockets/GetCaseInformation.aspx?db=appellate&number=119357>.

43 The Chickasaw Nation is based in south-central Oklahoma, along the border with Texas, and has more than 70,000 citizens.

44 The Choctaw Nation is based in southeastern Oklahoma, along the border with Texas, and has approximately 224,000 citizens. They are the third largest federally recognized Tribe.



4 percent of beneficiaries). Texas has not expanded Medicaid. The Texas Medicaid program has approximately 3.6 million beneficiaries enrolled in Medicaid managed care through a section 1115 Medicaid demonstration.⁴⁵ The STAR program is the primary managed care program serving low-income families and children. STAR+PLUS provides acute care and long-term service and supports (including home and community-based care) to the aged, disabled, and chronically ill. STAR Kids provides services through managed care to disabled children.⁴⁶

IHS and Tribes operate eight hospitals and 60 health centers in Oklahoma. In addition, IHS provides funding to two Urban Indian Organizations (UIOs). The Choctaw and Chickasaw Tribes have the largest health care systems that border Texas. Their proximity to the border means that they have Tribal citizens that reside in Texas. As these Tribal health care systems expand, there has been an increase of Tribal citizens crossing the border into Oklahoma to obtain services from their respective Tribal programs. The increase in patient workload has resulted in the Choctaw and Chickasaw Tribes having to work with Texas MCPs to secure reimbursement for services provided to AI/AN Texas Medicaid beneficiaries enrolled in Texas MCPs.

Over the last several years, the Choctaw and Chickasaw Tribes have billed the Texas MCPs for services provided to Texas AI/AN beneficiaries and received claim denials because the Oklahoma IHCPs were not in-network providers.

In working with the state of Texas to resolve claims denial issues, it was determined that some of the Choctaw and Chickasaw health facilities were not properly enrolled in Texas Medicaid. In response to this concern, the Choctaw and Chickasaw Tribes, working with the state, enrolled their facilities in Texas Medicaid. After this issue was resolved, Texas Medicaid officials and the Tribes worked on processing back claims, system issues, and processing future claims. As a result of this experience, the state and Tribal panelists made several recommendations to help IHCPs and the state to manage claims going forward. The Tribal panelists recommended that Texas develop tools to help Tribal organizations understand and complete the Medicaid provider enrollment process.

Train and Educate Managed Care Staff

The Tribal panelists recommended that Texas should train and educate managed care staff, both at the state and MCP level, on the Indian protections in the managed care regulations and on MCP contract requirements. It was recommended that these trainings be done regularly and that refreshers be offered annually.

Single Point of Contact – States Should Require that MCPs Have Designated Tribal Liaisons in Their MCP Contracts

Tribal panelists also recommended each MCP have a designated person that is a dedicated point of

45 KFF (2019): <https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

46 Link to Texas demonstration approval documents: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-ca.pdf>.

contact for all Tribal issues. This allows Tribal staff to build relationships with the MCP staff who could work directly with Tribes to resolve managed care issues. If this requirement is included in MCP contracts, it could help ensure timely resolution of claim denials and payment issues.

In-Network Provider

The Tribal panelists recommended that Texas and MCPs develop internal processes that allows MCPs to recognize all IHCPs as in-network providers. This would

ensure that all IHCPs are put into an MCP system as an in-network provider regardless of whether they have a contract with the MCP or not. Pursuant to the Medicaid managed care regulations at 42 C.F.R. § 438.14, IHCPs are *not* required to contract with MCPs to be reimbursed for services provided to AI/ANs. If this requirement were included in MCP contracts, it could help with timely processing of claims without the IHCPs having to go through the claim denial and resolution process.

Session III: State-Tribal Relations – Collaborating with States to Develop an Indian Managed Care Entity Using a Primary Care Case Management Model

By contracting with an Indian Managed Care Entity (IMCE), states and Tribes can ensure that Tribal citizens can enroll in a managed care program (MCP) that will comply with the federal managed care protections for American Indian/Alaska Native (AI/AN) beneficiaries and IHCPs. By virtue of focusing on AI/AN enrollment, IMCEs also have the added potential of improving care coordination and health outcomes for Tribal beneficiaries. Tribes in Oregon and North Carolina collaborated with their respective states to develop IMCEs using a Primary Care Case Management (PCCM) entity model. Authority to create an IMCE was enacted as part of Section 5006(e) of the American Recovery and Reinvestment Act of 2009 (ARRA) (42 U.S.C. § 1396o). An IMCE is an MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled by the Indian Health Service (IHS), a

Tribe, Tribal organization, or Urban Indian Organization (UIO), or a consortium, which may be composed of one or more Tribes, Tribal organizations, or UIO, and which also may include the IHS.

During this session, the panelists discussed challenges and recommended practices associated with working with their respective states to develop IMCE delivery systems. Both Oregon and North Carolina submitted IMCE State Plan Amendments (SPAs). At the time of the Roundtable, some of the IMCE delivery systems were undergoing managed care “readiness reviews” and other IMCEs were at different points of development.⁴⁷ The Oregon SPA was approved July 16, 2021.⁴⁸ The North Carolina SPA was approved September 13, 2021.⁴⁹

47 A readiness review allows CMS and the state to ensure that the MCP has the appropriate tools and processes necessary to begin working with beneficiaries. This involves making sure that they have procedures in place to handle care coordination and adequate staffing to carry out the functions of an MCP.

48 Link to the Oregon PCCM IMCP Approval Documents: <https://www.medicaid.gov/medicaid/spa/downloads/OR-21-0008.pdf>.

49 Link to the North Carolina PCCM IMCP Approval Documents: <https://www.medicaid.gov/Medicaid/spa/downloads/NC-21-0011.pdf>.



PART I: OREGON INDIAN MANAGED CARE ENTITIES

Panelists

Oregon Tribal Representatives:

Sharon Stanphill, DrPH, RD

[Cow Creek Band of Umpqua Tribe](#)⁵⁰

Michael Collins

[Confederated Tribes of Warm Springs](#), Director of
Managed Care⁵¹

Oregon Health Authority:

Jason Stiener, MS, JD

Tribal Policy & Program Analyst, [Oregon Health
Authority](#) (OHA)

Background

Approximately 1,255,750 individuals are enrolled in the Oregon Health Plan, Oregon's Medicaid program. This number includes approximately 58,000 AI/AN beneficiaries that are either enrolled in managed care or the states FFS program.⁵² There are nine federally recognized Tribes in Oregon and one UIO.

In 2018, during Tribal consultation on the development of Oregon's Medicaid managed care program, known as Coordinated Care Organizations (CCO 2.0), the Tribes and the [Native American Rehabilitation Association of the Northwest](#) (NARA NW),⁵³ representatives requested the state's assistance in creating and implementing an IMCE delivery system.



A couple of important features of the Oregon IMCE delivery system are highlighted. First, the participating Tribes developed their own respective IMCEs. Second, the IMCEs are *not* risk-bearing MCPs. The Tribes will direct their Tribal citizens to enroll into their respective Tribal IMCEs. The IMCEs assist their Tribal citizens by coordinating health care received through the Tribes' respective health programs, who operate as FQHCs and are reimbursed at the IHS Encounter Rate for health care services provided. In Oregon, each IMCE will receive a per member per month (PMPM) payment for care coordination services in the amount of \$39.65. If a patient is currently enrolled in a CCO (Oregon's MCP), they can voluntarily change over to an IMCE. The care coordination services are listed below with six areas of PCCM activities. Currently four of the nine Oregon Tribes and NARA NW are in the process of developing individual IMCEs. They are all at various stages of development.⁵⁴

50 The Cow Creek Band of Umpqua Tribe has over 1,800 citizens and is located in Southwestern Oregon (<https://www.cowcreek-nsn.gov/tribal-story/>).

51 The Confederated Tribes of Warm Springs, which consists of the Warm Springs, Wasco, and Paiute Tribes, has over 5,000 citizens and is located in north-central Oregon (<https://critfc.org/member-tribes-overview/the-confederated-tribes-of-the-warm-springs-reservation-of-oregon/>).

52 December 2021. Medicaid enrollment is reported to CMS on a monthly basis.

53 Link to NARA: <https://www.naranorthwest.org/>

54 Tribes that are in developing IMCEs include: Confederated Tribes of Warm Springs; The Cow Creek Band of Umpqua Tribe; Coquille Indian Tribe; Confederated Tribes of Grand Ronde; and the UIO NARA NW.

There are four Oregon Tribes that intend to establish IMCEs: the [Cow Creek Band of Umpqua Tribe](#); the [Confederated Tribes of Warm Springs](#); the [Coquille Indian Tribe](#); and the [Confederated Tribes of Grand Ronde](#). In addition, the UIO, NARA NW, located in downtown Portland, will be an IMCE for a three-county area in the Portland metropolitan area. The collaboration to develop the IMCEs took place over a three-year period. The state, Tribes and NARA NW attended over thirty meetings. At the time of this report, three of Oregon's IMCEs were undergoing managed care readiness reviews. Two IMCEs are still under development. Following successful readiness review results, each IMCE will negotiate a contract with the state. Oregon will then submit the contracts to CMS for review and approval. After CMS approval of the contracts the IMCEs will begin enrolling individuals into the IMCEs.

This report provides a status update on proposed care coordination activities of the IMCEs and the three IMCEs under active development in Oregon.

IMCE Care Coordination Activities

Oregon's IMCE SPA approves the provision of the following six intensive case management services, either in person or telephonically:

1. The development of enrollee care plans;
2. Conducting enrollee outreach and education activities;
3. Providing a 24-hour call center to take calls and route client calls after hours;
4. Implementation of quality improvement activities including administering satisfaction surveys;
5. Outcome measurement and outcome reporting to the Oregon Health Authority; and
6. A nurse triage and advice line staffed with licensed registered nurses who have access to a client's medical record and will provide non-diagnostic assessments and triage treatment options.

IMCE Development and Approach in Oregon

As noted, at the time of this report, there were three IMCEs that were actively preparing to begin operations in Oregon: (1) Cow Creek Band of Umpqua; (2) Confederated Tribes of Warm Springs; and (3) NARA NW. The following provides a brief overview of the intended approach for each of the IMCEs and their current status.

Cow Creek Band of Umpqua Tribe IMCE

Care coordination services will be provided through the Cow Creek Health & Wellness Center (CCH&WC). To safeguard the health of their Tribal citizens, the Cow Creek Band of Umpqua Tribe of Indians maintains two health clinics that Tribal citizens can go to for medical aid in Roseburg and Canyonville, Oregon. CCH&WC has a comprehensive medical staff. Tribal health programs include a Nesika Health Insurance Group, (a self-funded Tribal health insurance program) and a breast and cervical cancer prevention program. The Center provides medical services including general medical care; minor medical emergencies; health physicals; women's and men's health screenings; well child care; diabetes screening and preventative care; family planning and counseling; nutrition services; weight management; and tobacco cessation. The Center also holds a diabetes clinic once a month.⁵⁵

Three years ago, the health administrators at Cow Creek were made aware that the CCO providing care coordination services could only see a limited number of patients per year. Alarmed by this,

55 <https://www.cowcreek-nsn.gov/>

the Cow Creek Tribal Council along with other Tribal leaders in Oregon started exploring options to provide care coordination services to their members. The Tribes approached the state about forming an IMCE. The Tribes were impressed by the state's receptiveness to help them develop an IMCE delivery system. Tribal leaders began the process of designing their respective IMCEs. It has been approximately three years since the Tribes and state embarked on this project. In year three, the IMCEs are completing state readiness surveys, reviews, and contract negotiation with the state. A future goal for the Cow Creek IMCE is to expand beyond Medicaid to provide care coordination services to all members of the Tribe who receive services at their facilities.

Confederated Tribes of Warm Springs IMCE

Care coordination services will be provided through the Warm Springs Health and Wellness Center (the Center), which is an IHS Service Unit. The Center is a primary care clinic that provides a comprehensive system of healthcare services including treatment of a wide range of medical and dental conditions. The Center offers medical, dental, optometry, pharmacy, laboratory, radiology, and podiatry services to all AI/ANs in the Warm Spring Service Unit area. The goal of the Wellness Center is to assist its patients in promoting and improving the health of the Warm Springs community to the highest possible level.⁵⁶

The Center developed an IMCE with the goal of providing services to improve the health of their members, not just treat illnesses as they arise. This model similar to Cow Creek, provides the same six care coordination services which allow Warm Springs to see

to the overall care of a patient. The Center also expects to expand eligibility for the IMCE beyond Medicaid beneficiaries to all Tribal citizens.

Native American Rehabilitation Association of the Northwest, Inc (NARA NW) IMCE

NARA NW did not participate in the Roundtable but agreed to be interviewed about the development of its IMCE.⁵⁷ Founded in 1970 in Portland, Oregon, NARA NW is an Indian- owned, Indian-operated, nonprofit entity. Originally an outpatient substance abuse treatment center, NARA NW now operates a residential family treatment center, an outpatient treatment center, a dental clinic, a child and family services center, a primary health care clinic, several adult mental health locations, a wellness center, and transitional housing for Native women and children. All services are centered on the family as it is NARA NW's philosophy that, without the family circle there will be no future. The mission of NARA NW is to provide education, physical and mental health services and substance abuse treatment that is culturally appropriate to AI/ANs and anyone in need.

NARA NW provides the same six care coordination services reflected in the state plan. It is reimbursed at the Prospective Payment System (PPS) rate⁵⁸ for health care services provided and at the PMPM of \$39.65 for care coordination services.⁵⁹ NARA NW serves a tri-county service area which includes three metropolitan counties surrounding Portland, Oregon. Those counties include Multnomah, Clackamas, and Washington. If an individual is already enrolled in a Tribal IMCE, they will not be counted in NARA's IMCE enrollment list.⁶⁰ NARA NW will contract out the

⁵⁶ <https://warmsprings-nsn.gov/program/warm-springs-health-wellness-center/>

⁵⁷ Shannon Bremer, IMCE Program Director for NARA and Bruce Goldberg, MD Former Director, Oregon Health Authority were interviewed for this report.

⁵⁸ UIOs do not receive the encounter rate for Medical Assistance services.

⁵⁹ Urban Indian Organizations do not receive the IHS Encounter Rate. They receive the prospective payment system rate if they operate as an FQHC.

⁶⁰ AI/ANs in Oregon are not subject to mandatory enrollment into managed care. They may opt out of managed care.

24-hour call center and select other functions, demonstrating an alternative type of IMCE model. NARA NW will directly provide the other five case management services approved in the Oregon IMCE PCCM SPA. NARA NW has completed its readiness reviews and is awaiting CMS review of its MCP contract with Oregon.

PART II: NORTH CAROLINA INDIAN MANAGED CARE ENTITY

Panelists

North Carolina Tribal Representatives:

Casey Cooper, CEO

[Cherokee Indian Hospital Authority](#)

[North Carolina Department of Health and Human Services:](#)

Jay Ludlam

*Assistant Secretary for Medicaid, North Carolina
Department of Health and Human Services*

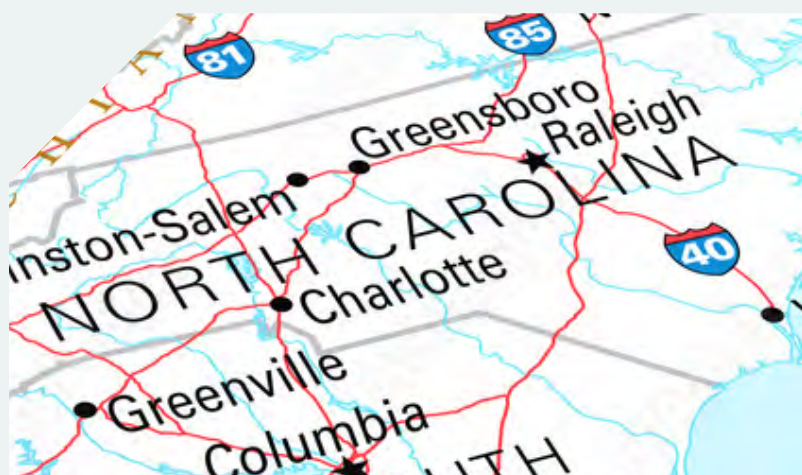
Tribal Partner:

Tara Larson

*Tribal Partner, and former North Carolina
Medicaid Director*

Background

North Carolina has approximately 2.5 million Medicaid members and beneficiaries.⁶¹ Approximately 64,000 of these beneficiaries are AI/AN individuals making up 33.63 percent of North Carolina's AI/AN population.⁶² The state began exploring Medicaid managed care



and began meeting and consulting with the Tribes in 2015. As of July 1, 2021, all North Carolina Medicaid beneficiaries were enrolled in statewide managed care. The [Eastern Band of Cherokee Indians](#) (EBCI)⁶³ and the [Cherokee Indian Hospital Authority](#) (CIHA)⁶⁴ began working with the state very early on to create a Tribal PCCM IMCE, called the “EBCI Tribal Option.”⁶⁵ The EBCI is a hospital-based delivery system that operates under Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975. EBCI has three clinics, a recovery center, and a residential treatment center.

The EBCI Tribal Option provides care coordination to approximately 4,000 Medicaid-eligible Tribal citizens to improve their health care outcomes. The EBCI Tribal Option is a relationship-based, patient-centered delivery system that transforms care by connecting eligible members to doctors, appointments, medication, and therapy seamlessly, ensuring that members get the most out of their benefits. The EBCI Tribal Option focuses on primary care, preventive health,

61 North Carolina enrollment reports are available through the North Carolina Department of Health and Human Services: <https://medicaid.ncdhhs.gov/medicaid-and-health-choice-enrollment-reports>.

62 This data is from the 2018 American Community Survey. <https://www.nihb.org/tribalhealthreform/wp-content/uploads/2021/04/NIHB-State-Health-Report-approved-by-TTAG-March-2021.pdf>.

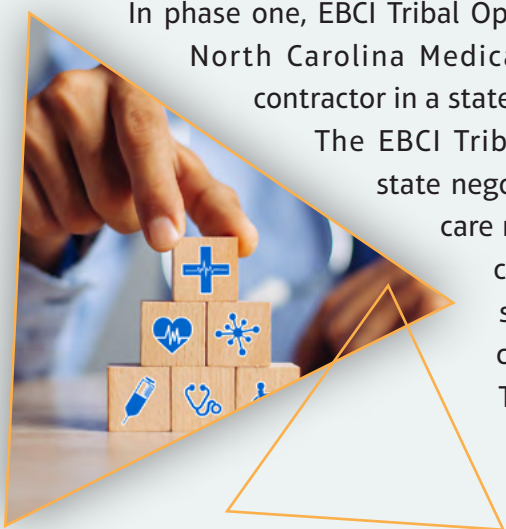
63 The Eastern Band of Cherokee Indians has approximately 14,000 citizens and is located in western North Carolina (<https://visitcherokeenc.com/eastern-band-of-the-chokeee/>).

64 Link to Cherokee Indian Hospital Authority: <https://cherokeehospital.org/>.

65 Link to EBCI Tribal Option: <https://ebcitribaloption.com/>.

chronic disease management, and providing care management for high-need members.⁶⁶

Over the last two decades, the EBCI was responsible for managing patient care but did not have the infrastructure to support creating a managed care delivery system. CIHA started as an IHS-operated service unit, and as such, had the responsibility for the Purchased and Referred Care (PRC) program.⁶⁷ As CIHA continued to evolve its primary care program, it became a Patient-Centered Medical Home (PCMH). Then, the next iteration of the primary care delivery system was to partner with the Southcentral Foundation in Anchorage, Alaska to implement the Nuka System of Care (Nuka)⁶⁸. The implementation of Nuka brought about the process and administrative changes that better positioned CIHA to become an IMCE.



In phase one, EBCI Tribal Option partnered with North Carolina Medicaid and became a contractor in a statewide PCCM network.

The EBCI Tribal Option and the state negotiated an enhanced care management fee for care management services for its Tribal citizens. The EBCI Tribal Option used

the income from the enhanced care management payments to develop the PCCM infrastructure. The EBCI Tribal Option infrastructure includes the IMCE as a division within the EBCI health system.

Working closely with the state in a partnership allowed EBCI Tribal Option many flexibilities. For example, the state recognized EBCI's commitment to quality and allowed it to continue to use all of their existing quality metrics. EBCI's existing quality metrics are primarily Government Performance and Results Act (GPRA) indicators. Because EBCI is a Resource and Patient Management System (RPMS) site, the numerators and denominators of the metrics are consistent with GPRA. EBCI uses those same metrics to crosswalk and benchmark to Healthcare Effectiveness Data and Information Set (HEDIS) and Medicaid and Medicare. Also working closely with the state, EBCI built new enrollment processes from scratch, including training modules, policies, and procedures.

In the second phase, EBCI auto-enrolled Tribal citizens into the EBCI Tribal Option. The state provided the auto-enrollment files to EBCI and EBCI transferred those files into the EBCI IMCE system. Enrollment began in July 2021. The next phase of implementation will involve operationalizing and automating their processes now that the IMCE PCCM SPA is approved.

⁶⁶ North Carolina's IMCE SPA approves the provision the following case management services: intensive telephonic case management; face-to-face case management; development of enrollee care plans; enrollee outreach and education activities; operation of a customer service call center; review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement; implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; coordination with behavioral health systems/providers; and coordination with long-term services and supports systems/providers.

⁶⁷ Medical/dental care provided at an IHS or Tribal health care facility is called Direct Care. The Purchased and Referred Care (PRC) Program is for medical/dental care provided away from an IHS or Tribal health care facility. PRC is not an entitlement program and an IHS referral does not imply the care will be paid. If IHS is requested to pay, then a patient must meet the residency requirements, notification requirements, medical priority, and use of alternate resources. Link to IHS: <https://www.ihs.gov/prc/>.

⁶⁸ Southcentral Foundation's Nuka System of Care (Nuka) is a relationship-based, customer-owned approach to transforming health care, improving outcomes and reducing costs. Link to Nuka: <https://www.southcentralfoundation.com/nuka-system-of-care/>.

PART III: OREGON AND NORTH CAROLINA PANELIST DISCUSSION

During the panelist discussion, Elliott Milhollin presented various questions and topics to the panelists to discuss.

What Motivated you to Develop an Indian Managed Care Entity?

The Tribal representatives sought to:

- More effectively coordinate care for their members;
- Create a more patient-centered delivery system;
- Improve the overall health care and health outcomes for their Tribal communities;
- Care for the “whole-person” and address health disparities of their Tribal communities; and
- Have control over their own health care delivery system.

What Obstacles and Challenges did you Encounter in Developing Your Respective Indian Managed Care Entities?

The panelists discussed obstacles that they encountered during the process of developing their respective IMCE projects. The following is a summary of those challenges:

- Working with the state to ensure that that Medicaid managed care statutory and regulatory requirements are met. For example, every regulatory requirement necessitated the completion of multiple tasks to comply with Medicaid regulations. Each task usually had a corresponding IT component that needed to be addressed to make the task operational. This entire process was very complex and time consuming.
- Defining Eligibility for the respective IMCEs. This included determining:
 - » The geographic area for each delivery system. For example, in Oregon the Tribes had their own



individual IMCEs. However, one of the IMCEs was an UIO that potentially could serve members of a Tribe that will operate as an IMCE. A process had to be in place to ensure that the IMCEs were not sending enrollee lists to Oregon Medicaid that were duplicative of individuals on the NARA NW list.

- » Whether to limit enrollment to only IHS-eligibles. The statute allows limiting the IMCE to IHS eligibles. However, if the Tribe serves non-Indian Medicaid beneficiaries, a decision had to be made on whether or not to allow those individuals to enroll in the IMCE or limit enrollment to IHS-eligibles.

- Determining how to use existing information technology (IT) systems that are used to determine IHS eligibility for services (the entire patient user data) to identify individuals eligible to enroll in the IMCE. Tribes wanted to avoid duplicating IT systems and not create another IT system. Medicaid managed care IT security system requirements required of all MCPs, are complex and resource intensive for the IMCEs.
- Finding funding for the administrative costs and dedicated resources to support the development of the IMCE.

Recommended Practices and Next Steps

In this section, we consolidated recommended practices from all the sessions: Recommended Practices in implementing Tribal Medicaid Managed Care in Washington; Overcoming Challenges with Positive Results – Case Studies in California, Oklahoma, and Texas; State Tribal Relations – Developing an Indian Managed Care Entity Using a Primary Care Case Management Model, in Oregon and North Carolina. The recommended practices are divided into the practices identified as Key Takeaways in the Executive Summary:

Recommended Practices


1. Tribal Consultation. Beyond the minimum federal requirements to notify IHCPs and Tribes prior to submitting SPAs and waivers to CMS, states should develop a process in collaboration with the Tribes in their states to ensure that Tribal consultation is timely, collaborative, and meaningful. States should establish a process that provides for mutual clear communication between the Tribes and the state.

- **Notice:** The Tribal consultation notice needs to adequately explain the change the state is proposing and the state's timeline for submission to CMS or implementation of a change. Notice of the change should be provided sufficiently in advance (perhaps sixty days) so that the Tribes can prepare for the consultation. Consultation also must take place before a decision is made. If the change is a proposed SPA or waiver, include drafts of those documents with the consultation notice. Have the Tribes participate in developing the agenda for the consultation. They may have other matters they wish to discuss with the state besides the change the state is proposing. Offer alternative means to attend the consultation

(1) Tribal consultation; (2) early involvement of subject matter experts; (3) institutionalize knowledge of the Indian health care delivery system and managed care protections; (4) single point of contact/Tribal Liaison; (5) use of Indian specific contract addendum (ITU Addendum); (5) develop internal claims processing practices; (6) require MCPs to pay the entire IHS Encounter Rate to IHCPs; and (7) the successful development of an Indian Managed Care Entity (IMCE) requires a strong Tribe-state partnership.

such as webinars and conference calls for Tribal representatives that are unable to attend in person. Tribes are often located in very rural areas and this situation has been exacerbated by the complications of the COVID-19 Public Health Emergency (PHE).

- **Assume Tribal Implications:** Always assume there are Tribal implications for any change proposed until it is determined through discussions with the Tribes that there are not implications. The Indian health care delivery system is complicated and changes that may appear inconsequential often have major operational impacts on Tribes.
- **Subject Matter Experts:** Make sure to have subject matter experts at the table, which can help resolve issues promptly.
- **Methods of Communication.** Use multiple methods to alert Tribal leaders of Tribal meetings and consultations including mail and electronic notices. It is respectful to provide written notice to Tribal leaders along with electronic submissions to Tribal health



directors, other Tribal designated individuals, and local Indian health boards. If a matter needs an expedited discussion, make sure that phone communication is used as well.

- **Consultation Decorum.** Consultations must be respectful. Let the Tribes control the consultation. Invite the Tribes to open the consultation with an opening prayer or invocation.
- **Have Decision Makers at the Table.** Make sure that state decision makers are at the table. If they are not, the consultation turns into a listening session. Let Tribes discuss any topic they want even if the topic is not on the agenda.
- **Regular Communications.** States should engage all involved parties on a regular basis to review and discuss managed care issues. This could include setting up regular dedicated meetings outside the Tribal consultation process.

2. Early Involvement of Subject Matter Experts.

When encountering claims issues from IHCPs, it is important for the state to have subject matter experts available early in the process. This ensures timely analysis of the claims resulting in more timely resolution of claim denials. The same is true when a state is transitioning from a fee-for-service delivery system to a managed care delivery system. Transitions between delivery systems should be handled by state staff with knowledge of the Indian health care system and the Indian managed care protections. This will avoid unintended consequences for IHCPs and AI/AN Medicaid beneficiaries.

- States should engage all involved parties on a regular basis to review and discuss managed care issues. This

could include setting up regular dedicated meetings outside the Tribal consultation process dedicated to discussing managed care issues.

- Educate and develop tools to help Tribal organizations through the Medicaid provider enrollment process.

3. Institutionalize Knowledge of the Indian Health Care Delivery System.

States and MCPs should institutionalize knowledge of the Indian managed care protections and the unique structure of the Indian health care delivery system by providing routine training, so the expertise survives staff turnover. States should use the Indian Specific Contract Addendum to institutionalize understanding of requirements with Medicaid managed care staff and MCP staff should be trained on the provisions of the Addendum, including federal laws, regulations, and several specific provisions applicable when contracting with IHCPs.

4. Single Point of Contact/Tribal Liaison.

States should assign a single point of contact and/or a Tribal Liaison to whom the Tribes can contact when they have difficulties resolving issues with an MCP and include a contract provision requiring MCPs to do the same. Having a single point of contact/Tribal Liaison can ensure more efficient communication and effective engagement for Tribes and IHCPs. Because the single point of contact is responsible to coordinate internally and report back to the Tribes on the status of claims, having a single Liaison also provides improved accountability and visibility on the status of ongoing payment issues for both Tribal providers and the states.



5. Use of the Indian Specific Contract Addendum (ITU Addendum). The ITU Addendum outlines the federal laws, regulations, and several specific provisions that have been established in federal law that apply when contracting with IHCPs. The use of the ITU Addendum benefits both MCPs and IHCPs by lowering the perceived barriers to contracting and assuring compliance with key federal laws to minimize potential disputes.

- Another recommended option is to integrate the addendum provisions into the body of the managed care contract instead of at the end of the contract as an appendix. This will assist MCPs in understanding where the addendum's provisions impact various contract requirements. It also educates MCP staff on the special statutory and regulatory protections for IHCPs which will help avoid disputes, set expectations, and make contracting with IHCPs easier.

6. Develop Internal Claims Processing Practices. MCPs should develop internal claims processing practices that recognize and/or treat IHCPs as “in-network” providers to avoid claim denial for providing services “out-of-network” when IHCPs serve AI/AN clients that are enrolled in their plans. This practice avoids automatically generated denials based on out-of-network status.

- States can include a provision in the MCP contracts to require MCPs to develop internal processes to indicate IHCPs are “in-network” providers to avoid claims denials based on out-of-network provider status.
- MCPs in states in which AI/ANs enrolled in an MCP utilize out-of-state IHCPs, should include the other state's IHCPs as if they were also in-network.

7. Require Managed Care Plans to Pay the IHS Encounter Rate Directly to the Indian Health Care Provider. States can amend their contracts to have the MCP pay the entire IHS Encounter Rate directly to IHCPs. This practice avoids additional billing by the IHCP to the state for the difference between the negotiated contract rate and the IHS Encounter Rate for a particular claim (often referred to as the wrap payment). States can exempt IHCPs claims from the risk portions of a managed care contract so if the IHS Encounter rate is higher than the negotiated contract rate, the plan will not be at risk for the higher payment. Services provided by IHCPs are paid for outside of a capitation payment and MCPs are made whole for all their costs associated with the service. The cost of the service does not present any risk to the plan's finances.

A good example is California, where they exempted Tribal health programs from the risk portions of the MCP contracts. Starting January 1, 2018, MCPs were no longer at risk for all eligible AI/AN services. The state pays the MCPs via a separate payment arrangement that is not part of the plan's capitation rates.

8. MCPs should avoid auto-assignment of AI/ANs to a Primary Care Provider. In states where Medicaid beneficiaries are mandated into managed care, MCPs often auto-assign enrollees to primary care providers (PCPs) within the MCP network. Auto assignment of AI/AN beneficiaries to non-IHCP PCPs can cause confusion and disrupt care a client is receiving from their IHCP. It can also interfere with the right of an AI/AN beneficiary to elect to receive primary care services from their

IHCP under the regulations.⁶⁹ As a result, MCPs should avoid assigning AI/AN beneficiaries – passively or by default – to PCPs to the maximum extent possible.

- States can work with Tribes to develop processes to identify AI/AN Medicaid enrollees before assignment to a PCP within an MCP network.
- MCPs should review their auto-assignment algorithm to ensure that an appropriate logic is used to

accomplish the most appropriate PCP assignment. Such criteria could include a review of claims or medical record to determine an enrollee’s historical relationship with an IHCP.

- MCPs should ensure that information on the process for changing PCPs is easily accessible and, at a minimum, described in the enrollee handbook and on the MCPs website.⁷⁰

Next Steps to Implement Recommended Practices

The Panelists, CMS, and the TTAG Managed Care Subcommittee recommended four steps that could be taken to implement the recommended practices outlined.

1. Develop a Tribal Managed Care Oversight Toolkit that will assist states and MCPs in complying with the Indian protections in managed care and make the managed care delivery system for AI/ANs and IHCPs a positive experience that promotes greater access to care with less operational barriers for IHCPs to provide that care.⁷¹

2. Provide training to state Medicaid managed care staff and MCPs. This could include CMS/Tribal webinars, workshops at national conferences such as the National Association of Medicaid Directors and Managed Care conferences. Also, develop a standard managed care training for the annual CMS ITU trainings that focuses on educating IHCP business office staff on how to manage MCP claims denials.

3. Develop Tribal-specific contract language for states to use when amending MCP contracts. Integrate the Indian managed care protections into

applicable sections of a contract instead of limiting inclusion of the Indian protections to the addendum part of the contract. This will call more attention to the Medicaid managed care Indian protections. For example, in the section of a contract that addresses network sufficiency and using out-of-state providers, add the protection at 42 C.F.R. § 438.14(b) that requires MCPs to demonstrate that there are sufficient IHCPs in the network – and, if not – allow the AI/AN to either use out-of-state IHCPs or disenroll from the MCP.

4. Establish a workgroup of TTAG members, CMS staff, state Medicaid staff, and MCP staff to engage and collaborate on Indian managed care protections implementation and enforcement. Currently only the TTAG Managed Care Subcommittee works on these issues with the Division of Tribal Affairs and Medicaid Operations Group. Involving CMS managed care leadership and staff, state partners, and MCP staff could result in a more unified approach to identifying, prioritizing, and resolving Medicaid managed care issues.

⁶⁹ 42 C.F.R. §§ 438.14(b)(4).

⁷⁰ See preamble to final rule, CMS Medicaid Managed Care, 81 Fed. Reg. 27497, at pg. 27747 (May 6, 2016).

⁷¹ Link to “Medicaid and CHIP Managed Care Monitoring and Oversight Tools” <https://www.medicaid.gov/federal-policy-guidance/downloads/cib06282021.pdf>.

Conclusion

The National Indian Health Board (NIHB) and CMS thank the participating panelists and NARA NW, who agreed to be interviewed about its creation of an UIO IMCE, for their participation, insights into solutions, and recommended practices that will help address implementation of the managed care Indian protections. Both the Listening Session and the Roundtable were well attended by Tribes and IHCPs, MCPs, and state Medicaid managed care staff and leadership who will be better informed because of those events and the report. With both events and the report itself, we set out to provide a better understanding of the statutory and regulatory managed care Indian protections, the Tribal health care delivery system, and the journey a Tribe or UIO can take when developing an IMCE. The events and the report have accomplished that. A significant key take-away from all this work is the importance of developing a strong Tribal-state relationship. None of the things that the panelists and NARA NW achieved could have been accomplished without a strong Tribal-state relationship.



Appendix A: Roundtable Agenda

TRIBAL MANAGED CARE ROUND TABLE

AGENDA

May 19, 2021

12:30 – 5:00 pm EST

Round Table Discussion Format:

The Round Table will be moderated by Elliott Milhollin, Technical Advisor to Nashville Area on the CMS Tribal Technical Advisory Group. He will introduce the panel members who will share their experiences/lessons learned/strategies utilized for each focus area. The moderator will open the discussion to the other Round Table members who are encouraged to share challenges and best practices with the focus area or topic. At the end of the allotted time (or when discussion has ended), the moderator will transition to the next topic. At the end of the three outlined issues/areas/topics, an open dialogue will be held to allow topics not addressed previously and to take QAs via Question box from the participants in listening mode.

I. INTRODUCTORY SESSION

12:30 – 12:45Welcome and Introductions

12:45 – 1:00Overview of Indian Medicaid Managed Care Protections
(Elliott Milhollin, Partner, Hobbs Straus Dean and Walker)

1:00 – 1:30Best Practices in implementing Tribal Medicaid Managed Care in Washington
Vicki Lowe, Executive Director, American Indian Health Commission (AIHC)
Jessie Dean, Washington Health Care Authority

1:30 – 2:45Overcoming Challenges with Positive Results

California:

- California Tribal representative (Rosario Arreola Pro, Health Systems Development Director, California Rural Indian Board)
- California Department of Health Care Services (Michele Retke, Chief, Medi-Cal Managed Care Operations Division and Lindy Harrington, Deputy Director Health Care Financing)

Texas:

- Oklahoma Tribal representatives (Melanie Fourkiller, Choctaw Nation and Melissa Gower, Chickasaw Nation)
- Texas, Department of Health Services (Dana Williamson, Director, Policy Development Support, Agnes Henry, Program Specialist, Research and Resolution, Managed Care Compliance)

& Operations; Barbara Benavidez, Manager, Research and Resolution, Managed Care Compliance & Operations; and Frank. Mendez, Manager, Research and Resolution, Managed Care Compliance & Operations)

Description:

In this session, panelists will discuss challenges and best practices in implementing the Medicaid managed care provisions in their states. Some of the issues that will be discussed include reimbursements to IHCPs, by both in-state and out-of-state providers, building relationships with MCPs, and effective outreach and education to AI/AN beneficiaries and IHCPs. By having panelists share their experiences, other Medicaid managed care programs might benefit and adopt similar strategies in their respective states.

2:45 – 2:55Break

II. LATE AFTERNOON SESSION

2:55 – 4:00.....State-Tribal Relations – Developing an Indian Managed Care Entity Using a Primary Care Case Management Model

Oregon:

- Oregon Tribal representative (Sharon Stanphill, DrPH, RD, Cow Creek Band of Umpqua Tribe and Michael Collins, Confederate Tribes of Warm Springs, Director of Managed Care)
- Oregon Health Authority (Jason Stiener MS, JD, Tribal Policy & Program Analyst)

North Carolina:

- North Carolina Tribal representative (*Casey Cooper, CEO, Cherokee Indian Hospital Authority*)
- North Carolina, Department of Health and Human Services (*Jay Ludlam, Assistant Secretary for Medicaid and Tara Larson, Tribal partner and former NC Medicaid Director*)

Description:

Panelists will discuss challenges and best practices associated with setting up a Tribal Indian Managed Care Entity using a Primary Care Management Model. Participants will learn about this Tribal managed care option and consider whether this model could be adopted in their respective states.

III. CLOSING SESSION

4:00 – 4:45.....Open Discussion for panelists and opportunity for participants to submit QAs through the Question Box

4:45 – 5:00.....Wrap Up and Next Steps

Appendix B:

Glossary of Common Terms and Acronyms

American Indians/Alaska Natives. Means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a federally recognized Indian Tribe or resides in an urban center and meets one or more of the following criteria:

1. Is a member of a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
2. Is an Eskimo or Aleut or other Alaska Native;
3. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
4. Is determined to be an Indian under regulations issued by the Secretary;
5. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
6. Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

American Recovery and Reinvestment Act of 2009 (ARRA). The American Recovery and Reinvestment Act

of 2009 (ARRA) was a piece of fiscal stimulus legislation passed by the U.S. Congress in response to the Great Recession of 2008. It is more commonly known as the “stimulus package of 2009” or simply the “Obama stimulus.” The ARRA package included a series of federal government expenditures aimed at countering the job losses associated with the 2008 recession.⁷² ARRA Section 5006 included Medicaid protections for AI/ANs and IHCPs, including managed care protections and cost sharing protections.⁷³

Centers for Medicare & Medicaid Services (CMS). The federal agency within the United States Department of Health and Human Services that directly administers the Medicare program. CMS partners with states to administer the Medicaid and Children’s Health Insurance Program (CHIP) programs.

Coronavirus Disease 2019 (COVID-19). COVID-19 is a respiratory disease caused by SARS-CoV-2, a coronavirus discovered in 2019.⁷⁴

Federally Qualified Health Center (FQHC). Federally Qualified Health Centers are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under

⁷² <https://www.investopedia.com/terms/a/american-recovery-and-reinvestment-act.asp>.

⁷³ <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Section-5006-Protections-for-Indians-under-Medicaid-and-CHIP.pdf>.

⁷⁴ <https://www.cdc.gov/dotw/covid-19/index.html>.

a governing board that includes patients. Federally Qualified Health Centers may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Health Centers for Residents of Public Housing, and an outpatient health program operated by a Tribe or Tribal organization facility under the Indian Self-Determination Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act.⁷⁵

Federal Tort Claims Act. The Federal Tort Claims Act is the federal legislation that allows parties claiming to have been injured by negligent actions of employees of the United States to file claims against the federal government. The Act also provides authority for the federal government to defend against such claims. In 1988 and again in 1990, Congress extended the Federal Tort Claims Act to negligent acts of Tribal contractors carrying out contracts, grants, or cooperative agreements pursuant to Public Law 93–638, the Indian Self-Determination and Education Assistance Act [25 U.S.C. § 450f (d) and 25 U.S.C. § 458aaa–15].

Indian Health Care Improvement Act (IHCIA). The Indian Health Care Improvement Act (IHCIA), the cornerstone legal authority for the provision of health care to American Indians/Alaska Natives, was made permanent when President Obama signed the bill on March 23, 2010 as part of the Patient Protection and Affordable Care Act. The Indian Health Care Improvement Act of 1976 (25 U.S.C. § 1601, et seq.) and the Snyder Act of 1921 (25 U.S.C. § 13) comprise the basic legislative authority for the Indian Health Service.

Indian Health Care Provider (IHCP). A health care program that is operated by the Indian Health Service (IHS) or an Indian Tribe, Tribal organization, or an Urban Indian Organization as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603). Also known as the ITU system.

Indian Health Service. The Indian Health Service is an operating division within the U.S. Department of Health and Human Services. IHS is responsible for providing direct medical and public health services to members of federally recognized Native American Tribes and Alaska Native people.

Indian Health Service Encounter Rate. On an annual basis the Indian Health Service calculates and publishes calendar year reimbursement rates for Medical Assistance services which are often referred to as the All-Inclusive Rates (AIR or the “OMB rate”). The AIR is published in the Federal Register annually, and is applicable to reimbursement methodologies primarily under the Medicare and Medicaid programs. For current rates, go to IHS.gov.

Indian Medicaid Managed Care Addendum. Indian Tribes are entitled to special protections and provisions under federal law. The Addendum outlines all the federal laws, regulations, and protections that are binding on MCPs and identifies several specific provisions that have been established in federal law that apply when contracting with IHCPs.

Indian Managed Care Entity (IMCE). An IMCE that is controlled by the Indian Health Service, a Tribe, Tribal organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal organizations, or Urban Indian Organizations, and which also may include the Indian Health Service.

Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638, ISDEAA). The Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638) authorized the Secretary of the Interior, the Secretary of Health, Education, and Welfare, and some other government agencies to enter into contracts with, and make grants directly to, federally recognized Indian Tribes.

75 <https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html>.

ITU System. Three types of Indian health care programs make up the core of the Indian health system, IHS, an operating division of the U.S. Department of Health and Human Services, Tribes/Tribal organizations, and Urban Indian Organizations.

Medicaid Managed Care Plan (MCP). A private plan that contracts with a state Medicaid agency to deliver a portion or the entirety of the services provided through Medicaid program. MCPs usually cover a geographic area of a state.

Medicaid Managed Care Organization. The term “Medicaid managed care organization” means a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) and — (i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and — (ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization’s insolvency.⁷⁶

National Indian Health Board (NIHB). An inter-Tribal organization that advocates on behalf of Tribal governments to provide quality health care to all American Indians/Alaska Natives (AI/ANs).



Nuka System of Care (Nuka). Developed by the Southcentral Foundation in Anchorage, Alaska, it refers to a relationship-based, customer-owned approach to transforming health care, improving outcomes and reducing costs.⁷⁷

Patient Centered Medical Home (PCMH). A health care model where the patient is engaged in a direct relationship with a provider, who coordinates with the patient’s care with a team, which may include non-medical providers, to ensure that the patient’s needs are provided for through a wraparound service model.⁷⁸

Prepaid Inpatient Health Plans (PIHPs). A pre-paid health plan that provides certain in-patient services to enrollees and can include mental and behavioral health.

Prepaid Ambulatory Health Plans (PAHPs). A pre-paid health plan that provides certain out-patient health services to enrollees.

⁷⁶ 1903 (m)(1)(A) of the Social Security Act.

⁷⁷ <https://www.southcentralfoundation.com/nuka-system-of-care/>.

⁷⁸ 42 CFR § 438.2.

Primary Care Case Management Programs (PCCM).

A health plan in which enrollees are assigned to a primary care case manager who is responsible for providing case management to help manage the care that they receive.

Primary Care Case Managed Plan (PCCM Entity).

An organization that provides primary care case management services for the state, as well as other services defined in 42 C.F.R. § 438.2 and that may be negotiated.

Purchased and Referred Care Program (PRC).

A program that assists with the payment of services, not available at an Indian health care facility, provided to IHS-eligible patients.

Resource and Patient Management System (RPMS).

Resource and Patient Management System – or RPMS – is a decentralized integrated solution for management of both clinical and administrative information in these healthcare facilities.⁷⁹

Tribal Technical Advisory Group (TTAG).

CMS established its Tribal Technical Advisory Group (TTAG) in 2004 to provide advice and input to CMS on policy and program issues impacting AI/ANs served by CMS programs. Although not a substitute for formal consultation with Tribal leaders, TTAG enhances the government-to-government relationship and improves increased understanding between CMS and Tribes. The TTAG is comprised of 17 representatives: an elected Tribal leader, or an appointed representative from each of the twelve geographic Areas of the Indian Health Service (IHS) delivery system, and a representative from each of the national Indian organizations headquartered in Washington DC: the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), and the Tribal Self-Governance Advisory Group (TSGAC).

Social Security Act (SSA, the “Act”).

The Social Security Act of 1935 is a law enacted by the 74th United States Congress and signed into law by US President Franklin D. Roosevelt. The law created the Social Security program as well as insurance against unemployment. The law was part of Roosevelt’s New Deal domestic program. The law is the governing Act for both Medicaid and Medicare. The provisions that govern the structure and allowable services for both programs are found in this Act. The Act has been amended many times by subsequent legislation since its initial passage in 1935. Medicaid and Medicare were added to the Act in 1965.

Urban Indian Organizations (UIOs).

Urban Indian Organizations are private, non-profit, corporations that provide AI/ANs people in their service areas with a range of health and social services, from outreach and referral to full ambulatory care. UIOs are funded in part under Subtitle IV of the Indian Health Care Improvement Act and receive limited grants and contracts from the federal Indian Health Service (IHS). UIHPs provide traditional health care services.

Youth Regional Treatment Centers (YRTC).

The IHS has 12 Youth Regional Treatment Centers to address the ongoing issues of substance abuse and co-occurring disorders among AI/AN youth. The YRTCs provide a range of clinical services rooted in a culturally relevant, holistic model of care. These services include: clinical evaluation; substance abuse education; group, individual, and family psychotherapy; art therapy; adventure-based counseling; life skills; medication management or monitoring; evidence-based/practice-based treatment; aftercare relapse prevention; and post-treatment follow-up services.

⁷⁹ <https://www.ihs.gov/rpms/>.

Appendix C: ITU Addendum

Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)

1. Purpose of Addendum; Supersession

The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____ (herein "Managed Care Plan") and _____ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.⁸⁰

2. Definitions

For purposes of this Addendum, the following terms and definitions shall apply:

(a) "Indian" means any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. 136.12. This means the individual is a member of a federally recognized Indian Tribe or resides in an urban center and meets one or more of the following criteria:

- Is a member of a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is considered by the Secretary of the Interior to be an Indian for any purpose;
- Is determined to be an Indian under regulations issued by the Secretary.

The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(b) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

⁸⁰ Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

(c) “Managed Care Plan” includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Manager (PCCM) or Primary Care Case Managed Plan (PCCM plan) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such plan that is engaged in the operation of a Medicaid managed care contract.

(d) “Indian Health Service or IHS” means the agency of that name within the U.S. Department of Health and Human Services established by the IHCA Section 601, 25 U.S.C. § 1661.

(e) “Indian Tribe” has the meaning given in the IHCA Section 4(14), 25 U.S.C. § 1603(14).

(f) “Tribal health program” has the meaning given in the IHCA Section 4(25), 25 U.S.C. § 1603(25).

(g) “Tribal organization” has the meaning given in the IHCA Section 4(26), 25 U.S.C. § 1603(26).

(h) “Urban Indian organization” has the meaning given in the IHCA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of IHCP

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

☐ IHS.

☐ An Indian Tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

☐ A Tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

☐ A Tribe or Tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

☐ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCA.

4. Cost-Sharing Exemption for Indians; No Reduction in Payments

The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal organization or Urban Indian Organization or through referral under contract health services. Payments due to the Indian Health Service, an Indian Tribe, Tribal organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance



under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 U.S.C. §1396o– (j)), 42 C.F.R. 447.56 and §457.535.

5. Enrollee Option to Select the IHCP as Primary Health Care IHCP

The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, (42 U.S.C. § 1396u–2(h)), 42 C.F.R. 438.14((b)(3), and 457.1209.

6. Agreement to Pay IHCP

The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act, (42 U.S.C. 1396u–2(h)), 42 C.F.R. 438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP

(a) Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

(b) No term or condition of the Managed Care Plan's network provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. 80.3(d),

an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in Appendix A.

9. Non-Taxable Plan

To the extent the IHCP is a non-taxable plan, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. Insurance and Indemnification

(a) Indian Health Service. The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the managed care plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

(b) Indian Tribes and Tribal Organizations. A provider which is an Indian Tribe or a Tribal organization operating under a contract or compact to

carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a Tribe or Tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because Indian Tribes and Tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a Tribe or Tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

(c) Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation

Pursuant to 25 U.S.C. 1621t and 1647a, the managed care organization shall not apply any requirement

that any plan operated by the IHS, an Indian Tribe, Tribal organization or urban Indian organization be licensed or recognized under the state or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the state or local law where the entity is located, if the professional is licensed in another state.

12. Dispute Resolution

In the event of any dispute arising under the Managed Care Plan's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. Governing Law

The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian Tribe, Tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements

To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCA (25 U.S.C. § 1675).

15. Claims Format

The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCA (25 U.S.C. § 1621e(h)), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. Payment of Claims

The Managed Care Plan shall pay claims from the IHCP in accordance Section 1932(h)(2) of the Act, (42 U.S.C. §1396u-2(h)), and 42 C.F.R. §§ 438.14(c) (2) and 457.1209, and shall pay at either the rate provided under the state plan in a Fee-For-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. Hours and Days of Service

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. Coordination of Care/Referral Requirements

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.

19. Sovereign Immunity

Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or Tribal sovereign immunity.

20. Endorsement

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS

For the Managed Care Plan:

Date: _____

For the IHCP:

Date: _____

Appendix D: Indian Health Services Area Map



Credit: Indian Health Service (<https://www.ihs.gov/careeropps/where-we-work/>)





National Indian
Health Board



www.nihb.org