National Indian Health Board

MEDICAID MANAGED CARE LISTENING SESSION

MARCH 4, 2021

This meeting is being recorded

Agenda

I. Indian Protections in Medicaid Managed Care.
II. Overview of the Managed Care Protocol and Introduction of the Native American Contacts (NACs).
III. Discussion of Managed Care in Portland region
IV. Discussion of Managed Care in Oklahoma region
V. Facilitated Open Discussion.
VI. Wrap Up

National Indian Health Board

Indian Medicaid Managed Care Provisions

NIHB LISTENING SESSION

ELLIOTT MILHOLLIN

HOBBS, STRAUS, DEAN & WALKER LLP

ISSUE | Managed Care

- Many States have moved their Medicaid programs to managed care
- In a managed care environment, an outside entity operates the Medicaid program on behalf of the State
- Managed care entities set provider reimbursement rates based on arrangement with the State, and may be unwilling to pay IHS and tribal providers the full IHS encounter rate
- Managed care provider agreements may impose utilization restrictions, certification and insurance requirements and other restrictions that are inconsistent with tribal rights

ARRA| Indian Managed Care Provisions

- The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111–5)
- Section 5006 of ARRA includes important I/T/U Medicaid provisions:
  - 5006(a) Exemption from Premiums and Cost Sharing
  - 5006(b) Exemption of certain trust and other property from resources for Medicaid and CHIP eligibility determinations
  - 5006(c) Protection of Indian property from Medicaid Estate Recovery
  - ***5006(d) Special I/T/U managed care protections***
  - 5006(e) Codification of the CMS TTAG and tribal consultation requirements
- 42 C.F.R. § 438.14 – CMS Indian Managed Care Regulations (2016)

Access| Choice of I/T/U Primary Care Provider

- If an AI/AN elects to enroll in an MCO, they are allowed to designate an Indian health care provider as their primary care provider if in-network. SSA § 1932(h)(1); 42 U.S.C. § 1396u-2(h)(1).
- 42 U.S.C. § 1396u-2(h)(1): "Special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities:

  > Enrollee option to select an IHCP as primary care provider. In the case of a non-Indian Medicaid managed care entity that – (A) has an Indian enrolled with the entity; and (B) has an IHCP that is participating as a primary care provider within the network of the entity…"

- 42 C.F.R. § 438.14(b)(3): "Permit any Indian who is enrolled in a MCO … that is not an [Indian managed care entity] and eligible to receive services from an IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services."

Access | Out of network I/T/Us

- Managed Care Regulations allow AI/ANs enrolled in managed care to access care at out-of-network I/T/Us and allow referrals from I/T/U to in-network providers without prior authorization.
- 42 C.F.R. § 438.14(b)(4): MCOs must permit AI/AN enrollees to obtain MCO covered services from out-of-network IHCPs.
- 42 C.F.R. § 438.14(b)(6): MCO, to the extent it has a provider network, “must permit an out-of-network IHCP to refer an Indian enrollee to a network provider.”

Access|MCOs must ensure access to I/T/Us

- MCOs must ensure adequate access to I/T/U providers. SSA § 1932(h)(2)(A); 42 U.S.C. § 1396u-2(h)(2)(A).
- 42 C.F.R. § 438.14(b)(1): Requires the MCO to demonstrate that there are sufficient Indian Health Care providers participating in its network "to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services."
- 42 C.F.R. § 438.14(b)(5): In states where there are few or no IHCPs, MCOs will be deemed to meet the requirements of (b)(1) if they permit AI/AN enrollees to access out of state IHCPs or if circumstances demonstrate good cause for disenrollment in managed care plan.

Payment|MCOs and State must pay I/T/Us

- General rule: An IHCP must be promptly paid at a rate negotiated between the MCO and provider, or at a rate not less than the amount an MCO would pay to a non-Indian health care provider. SSA § 1932(h)(2)(A)-(C); 42 U.S.C. § 1396u-2(h)(2)(A)-(C).

- FQHC Payment: MCOs must pay IHCPs that are FQHCs but not participating providers at the rate they pay FQHCs that are participating providers. The State must make a wrap payment to make up any difference between what the MCO pays and what the FQHC would have received under FFS. 42 U.S.C. § 1396u-2(h)(2)(C)(i); 42 C.F.R. § 438.14(c)(1).

- Non-FQHC Payment: IHCPs that are not FQHCs are entitled to receive the IHS encounter rate regardless of whether they are enrolled as a network provider. If an MCO pays less than the encounter rate, the State Plan must pay the IHCP the difference. 42 U.S.C. § 1396u-2(h)(2)(C)(ii); 42 C.F.R. § 438.14(c)(2)-(3).

No Mandate into Managed Care and IMCEs

- Indians cannot be mandated into managed care through a State Plan Amendment. SSA § 1932(a)(2)(C).
- 42 C.F.R. § 438.50(d)(2): The State must provide assurances that, in implementing the State plan managed care option, it will not require the following groups to enroll in a MCO …
  - Indians, as defined in § 438.14(a), except as permitted under § 438.14(d) [regarding Indian MCO enrollment].
- 42 U.S.C. § 1396u-2(a)(2)(C): Indian enrollment – A State may not require an individual who is an Indian to enroll in a MCO, except in the case of an Indian Managed Care Entity.
- 42 C.F.R. § 438.14(a): Indian Managed Care Entity defined to include any MCO or other MCE that is controlled by a tribe, tribal organization, urban Indian organization, consortium or the IHS.

Contracting | Indian Managed Care Addendum

- MCO participating provider agreements often contain requirements that are inconsistent with the rights of IHCPs and difficult or impossible for IHCPs to agree to.
- CMS developed an Indian managed care addendum which MCOs can use in their participating provider agreements. CMS encourages, but does not require MCOs to use this agreement.
- The Indian managed care addendum sets out the rights of Indian health care providers, including the Indian managed care protections, the right not to purchase expensive malpractice insurance due to FTCA coverage, licensing rights, and preservation of sovereign immunity, among other provisions.
- https://www.medicaid.gov/sites/default/files/2019-12/addendum-ihcps.pdf

CMS Center for Medicaid and CHIP Services

Tribal Medicaid Managed Care Resolution Protocol

TTAG Managed Care Subcommittee

- In 2019, the CMS Tribal Technical Advisory Group (TTAG) formed a Managed Care Subcommittee to try to address a number of Medicaid managed care issues.
- The key issues identified by the Subcommittee include:
  - State Medicaid oversight of managed care entities (MCE);
  - American Indian/Alaska Natives (AI/AN), enrolled in a Medicaid MCE, the option to receive services from an Indian health care provider (IHCP) of their choice;
  - Timely and complete payment by MCEs to IHCPs;
  - Auto assignment of AI/AN beneficiaries;
  - Contracting with IHCPs and MCEs; and
  - Development of an Indian Managed Care Entity (IMCE).

Tribal Medicaid Managed Care Protocol

- The CMS Tribal Medicaid Managed Care Resolution Protocol establishes an internal working protocol to address Medicaid managed care issues identified by the CMS TTAG, Tribal leaders, IHCPs and AI/AN enrollees:
  - Report non-compliance by managed care entities;
  - Report non-compliance by state Medicaid and CHIP agencies;
  - Challenges with American Indian/Alaska Native (AI/AN) enrollment in Medicaid and CHIP Managed Care; and
  - Reimbursement to IHCPs from managed care entities and state and Medicaid and CHIP agencies.

Tribal Medicaid Managed Care Protocol

- The purpose of the CMS Medicaid Managed Care Resolution Protocol is to ensure Medicaid managed care issues are resolved in a timely and efficient manner. The protocol:
  - Formalizes an internal CMS process to track and work to resolve Tribal Medicaid managed care issues identified;
  - Establishes a process to review the issue and/or complaint (and supporting documentation) per the Medicaid managed care regulations;
  - Establishes a process to work with State Medicaid and CHIP agencies and IHCPs on resolving the issues within reasonable timeframes;
  - Ensures management and leadership are aware of significant issues; including any recommendations or next steps to resolve the issue.

CMS Native American Contacts (NACs)

- The Division of Tribal Affairs serves as the point of contact on Indian health issues at CMS and partners with Native American Contacts (NAC) to provide technical assistance on CMS programs.
- As a result of a CMS reorganization, four NACs are dedicated to work on Medicaid Tribal issues full-time and are assigned to states consistent with the IHS Area Office designations.
- These NACs serve as the point of contact for reporting Medicaid managed care issues.
- If you are experiencing managed care issues or problems with your State Medicaid or CHIP agency or with a Medicaid MCE, please contact your CMS NAC via email.
- Explain the issue and send supporting documentation, such as claim denials or letters from the MCE or State Medicaid or CHIP agency.
- The NAC will acknowledge receipt and contact you if additional information is needed.

CMS Native American Contacts (NACs)

Name	NAC Responsibilities
Nancy Grano Nancy.Grano@cms.hhs.gov 617-565-1695	Medicaid Tribal Issues in **IHS Bemidji Area** (MI, MN, WI), **IHS Nashville Area** (AL, CT, FL, IL, IN, LA, MA, MD, ME, MS, NC, NY, RI, SC, VA)
Stacey Shuman Stacey.Shuman@cms.hhs.gov 214-767-6479	Medicaid Tribal Issues in **IHS Oklahoma City Area** (OK, KS, TX), **IHS Great Plains Area** (IA, NE, SD, ND) **IHS Albuquerque Area** (CO, NM). AI/AN Issues in other States: AR, MO, OH
Cindy Lemesh Cynthia.Lemesh@cms.hhs.gov 415-744-3571	Medicaid Tribal Issues in **IHS California Area** (CA), **IHS Phoenix Area** (AZ, NV, UT) and **IHS Navajo Area.** AI/AN Issues in other States: DC, DE, GA, HI, KY, NH, NJ, PA, TN, VT, WV
Rhonda Martinez-McFarland Rhonda.Martinez-McFarland@cms.hhs.gov 206-615-2267	Medicaid Tribal Issues in **IHS Portland Area** (ID, OR, WA), **IHS Billings Area** (MT, WY), **IHS Alaska Area** (AK)
Cyndi Gillaspie Cynthia.Gillaspie@cms.hhs.gov 720-347-8661	Tribal Issues Technical Director, Medicaid and CHIP Operations Group, CMCS

V. Questions Comments??

Link to the CMS Native American Contact list:

www.cms.gov/files/document/cms-native-american-contact.pdf

Please send any questions or comments to:

Tribalaffairs@cms.hhs.gov

The Oregon Experiment: The Tribes and Care Coordination Organizations

March 04, 2021

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Presenters

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Agenda

- Oregon Tribes and Urban Indian Organizations
- Overview of Oregon Managed Care
  - Coordinated Care Organizations (CCOs)
- CCO 2.0 – Implementing Lessons Learned
- 100% Federal Medical Assistance Percentages (FMAP)
- Indian Managed Care Entity (IMCE)
- Next Steps on IMCE

Oregon Tribes and Urban Indian Organizations

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Source: Oregon Health Authority (2018), *100% FMAP Savings and Reinvestment Program: Partnership with Oregon Tribes and Oregon Health Authority* [PowerPoint Slides].

Overview of Oregon Managed Care: Coordinated Care Organizations

- Overview of the Oregon Managed Care Coordinated Care Organizations (CCOs)
  - First formed in 2012 through an 1115 Medicaid Waiver extension
  - Primary goals include limiting increases in per capita spending, and improving health care access and quality
  - 16 provider networks within a geographic area, providing physical, dental, and behavioral health services
  - Each CCO operates with a global budget and is responsible for all services covered by the global budget

- Initial Tribal Challenges with CCO Implementation
  - No contact with tribes
  - No tribal liaisons
  - No tribal participation in CCO leadership
  - Problems with access to care

Evaluation of Oregon's 2012 – 2017 Medicaid Waiver. OHSU Center for Health Systems Effectiveness, Final Report. Dec 29, 2017.

CCO 2.0 – Implementing Lessons Learned

- Contract review and redline by the tribes
- Hiring Tribal Liaisons
  - Job description design
- Implementing Tribal Advisory Committees
- Adding Tribal leadership to CCO Boards

100% Federal Medical Assistance Payment

- **SHO#16-022 issued Feb 2016**
  - 100% FMAP expands to include services "received through" an IHS/Tribal facility
  - Tribes coordinate access to services with non-Tribal/IHS providers
    - If a care coordination agreement is in place, state claims 100% FMAP on these services
    - Care coordination agreements create savings to the State General Fund
- **Oregon FMAP Reinvestment**

"I am committed to reinvesting the savings to the state from this change in Medicaid policy into tribal programs and services that improve the health of American Indian and Alaska Native communities." - Governor Kate Brown

  - 2016 – State/Tribal workgroup convened
  - 2017 – Care Coordination Agreements negotiated and signed with hospitals
  - 2018 – Tribes negotiated agreements with the state
  - Jun 2018 – First reinvestment payment made to a Tribe

Source: Oregon Health Authority (2018), *100% FMAP Savings and Reinvestment Program: Partnership with Oregon Tribes and Oregon Health Authority* [PowerPoint Slides];

Indian Managed Care Entity

- An **Indian Managed Care Entity (IMCE)** means a MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) 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. (CMCS Informational Bulletin, 12/14/16).
- **Oregon IMCEs**
  - Tribally governed Primary Care Case Management (PCCM) Entities (not risk based)
  - Care management and care coordination services, including
    - Case management (telephonic and/or face-to-face)
    - Development of care plans for enrollees
    - Enrollee outreach and education
    - Quality improvement activities, outcome measures, provide outcome reports to the state
  - Per member/per month fee paid by the state to the tribe
  - Tribes still paid per-visit fees at the IHS rate for outpatient primary care services
  - Tribes and NARA individually decide on engagement, enrollment, and services provided

Source: Moving Forward with an Indian Managed Care Entity (IMCE). Bruce Goldberg, MD. Jan 26, 2021 (PowerPoint presentation).

Next Steps on IMCE

- Oregon Health Authority is contracting with CAREOregon to provide technical assistance to the Tribes and NARA regarding the cost to provide care coordination services
- **Anticipated Challenges**
  - Does the tribe have resources and capacity to implement?
  - Is the payment sufficient to support the work?
  - What additional care coordination resources and capacity do our tribes need?
- **Progress to Date**
  - Four tribes and NARA are moving forward to form IMCEs
  - Oregon is seeking federal approval, preparing draft contracts, establishing administrative structures
  - Go live – this summer?

Source: Moving Forward with an Indian Managed Care Entity (IMCE). Bruce Goldberg, MD. Jan 26, 2021 (PowerPoint presentation).

Questions or Comments

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Discussion of Managed Care in Oklahoma Region

Melissa Gower, Senior Advisor, Policy Analyst, Chickasaw Nation
Melanie Fourkiller, Director of Self-Governance, Choctaw Nation
March 4, 2021

Oklahoma Region: OK, TX, AR

- Number of Tribes within the States:
  - TX: 3 Federally-recognized; 2 State-recognized
  - AR: none
  - OK: 38

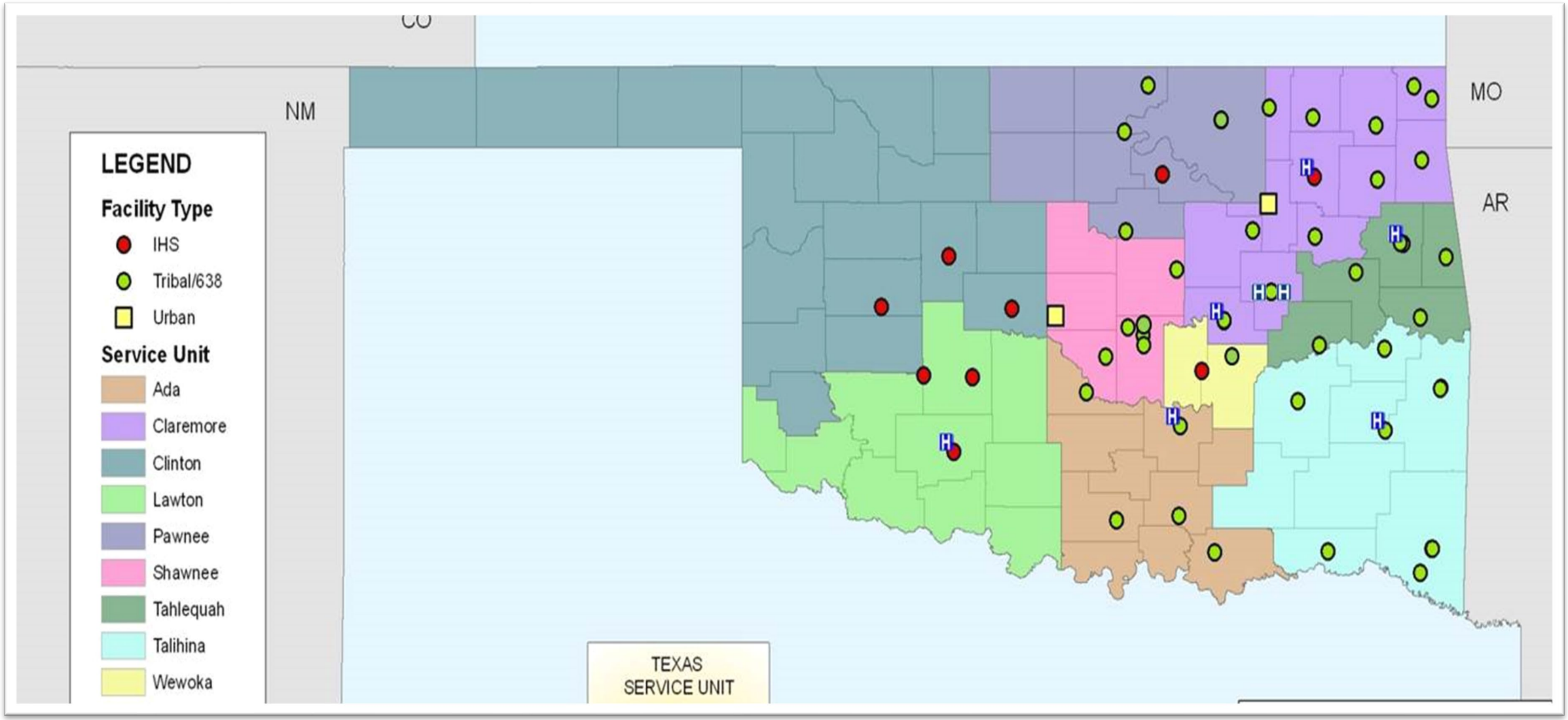
Medicaid Population in the Region

- TX: has not expanded Medicaid;
  - Total Medicaid population = 4,626,433
  - Total AI/AN population 170,972
- AR: expanded with private insurance option
  - Total Medicaid population = 2,600,000
  - Total AI/AN population = 22,248
- OK: not expanded; expansion to become effective 7/1/2021
  - Total Medicaid population = 982,465
  - Total AI/AN population 523,360 (13.23% of total population)
  - Total AI/AN Medicaid Enrollees = 162,054 (16%)

Status of Medicaid Managed Care

- TX: Began Managed Care in 1994
- AR: Upon expansion, utilized a commercial premium assistance model beginning in 2013
- OK: No Managed Care currently. State has announced Managed Care for all except ABD population beginning 10/1/2021

The Indian Healthcare System in Oklahoma



Systemic Problems Encountered in Managed Care

- Not meaningful Tribal input before managed care implementation
- Even with Indian protections in managed care and the 2016 rules:
  - State Medicaid Agency nor the MCOs even knew about the Indian Protections or CIB
  - State did not include provisions in MC contracts initially
  - State did not know to enroll us as Indian health care providers
- CMS approved SPA or waiver for Managed Care without any mention of Indian Health Care Providers

Efforts to Resolve Managed Care Issues

- Correcting provider contracts between Medicaid agency and THP's
- CMS required including IHCP provisions in the MCO contracts, after the fact
- Education and outreach to MCOs – Tribes had to provide the information (CIB, Federal Register Notice on the OMB rate) directly one-on-one with each MCO, rather than Medicaid to MCO's
- Working each rejected claim separately with the State and MCO

Discussion – How can we effect more permanent solutions?

- CMS develops toolkit with Tribal Consultation – conducts training with State Medicaid agencies
- Assume all IHCPs as in-network, enrolled as an IHCP
- CMS Provides updated list of all I/T/U facilities in their state and surrounding states – Division of Tribal Affairs
- Ensure that Tribal Consultation occurs with these Tribes at minimum
- States responsible for MCO training and compliance
- CMS responsible for State compliance
- Each level of compliance include correction of claims, develop of policy/processes, evaluation and measurement tools

Yakoke (Thank You)

Open Discussion

Moderated by: *Kristen Bitsuie and Edward Fox, National Indian Health Board*

National Indian Health Board

Comments?

Contact Me!

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202-750-3402

Prefer to Remain Anonymous?

https://www.surveymonkey.com/r/X226BTR

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