CMS Center for Medicaid and CHIP Services

Overview of the American Indian/Alaska Native Specific Provisions of the Medicaid Managed Care Rule

Background

- On May 6, 2016, CMS published Medicaid and Children's Health Insurance Program (CHIP) managed care regulations.

- These were the first extensive Medicaid managed care regulations published in over a decade.

- The effective date of the new rule was July 25, 2016 with a phased implementation of many provisions including the American Indian/Alaska Native (AI/AN) specific provisions on or after July 1, 2017.
- By now the Indian Protections should be in the managed care contracts between the states and the plans.

Overview of Indian Provisions

- The managed care regulations codify a number of AI/AN managed care protections, for the treatment of AI/AN beneficiaries and Indian Health Care Providers (IHCPs), as added by section 5006(d) of American Recovery and Reinvestment Act of 2009 (ARRA). The ARRA provisions were effective July 1, 2009.

- The managed care regulations apply the AI/AN protections to all types of managed care entities, including Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Management Entities (PCCM Entities).

Overview of Indian Provisions

- The Indian-specific provisions are located in the Medicaid regulations at 42 CFR §438.14, and made applicable to CHIP by a cross reference in the CHIP rules at §457.1209.
- These provisions allow AI/ANs enrolled in Medicaid and CHIP MCOs to continue to receive services from their Indian health care provider (IHCP) of choice and ensures that IHCPs are reimbursed timely and appropriately for services provided.
- The regulations address other issues impacting AI/AN beneficiaries and IHCPs, such as referrals, sufficient network and payment requirements for MCOs that serve Indians, network provider agreements with IHCPs, and state tribal consultation requirements.

Definitions

"**Indian"** means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. 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 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;
- 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.

Definitions

- **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).

- **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.

Network Sufficiency Standards and Provider Choice

- Any AI/AN who is enrolled in a ***non-Indian*** managed care plan and eligible to receive services from a network IHCP can choose that IHCP as his or her primary care provider, as long as that provider (§§438.14(b)(3) and 457.1209).

- A “in - network IHCP” is a IHS, tribal or urban Indian health program that has entered into contract with a managed care network.

- Every MCO, PIHP, PAHP, or PCCM entity, must demonstrate that there are sufficient IHCPs participating in the network to ensure timely access to services available under the contract from IHCPs for Indian enrollees (§§438.14(b)(1) and 457.1209).

Network Sufficiency Standards and Provider Choice

In the event that timely access to IHCPs in network cannot be guaranteed due to few or no network participating IHCPs, AI/AN enrollees, whether voluntarily or mandatorily enrolled, have the following options:

1. They can access services from out-of-State IHCPs; or

2. They may disenroll from the MCO plan for “good cause” and switch to the state’s fee-for-service program.

Payment and Contracting

- When an IHCP is enrolled in Medicaid or CHIP as a FQHC but is not in the managed care network, the IHCP must be paid the FQHC payment rate under the State plan, including any supplemental payment due from the state (§§438.14(c)(1) and 457.1209).

- When an IHCP is not enrolled as a FQHC, and regardless of whether the IHCP is a network provider or not, the IHCP must receive the IHS AIR encounter rate published annually in the Federal Register or the amount it would receive if the services were provided under the State plan's fee-for-service rate (§438.14(c)(2) and §457.1209).

Payment and Contracting

- When the amount an IHCP receives from a managed care entity is less than the IHS AIR rate or fee-for-service rate, whichever is applicable, the state must make a supplemental payment to the IHCP to make up the difference between the amount the managed care entity pays and the amount the IHCP would have received under fee-for-service or the IHS AIR rate (§§438.14(c)(3) and 457.1209).

- States may contract with the managed care entity to allow the managed care entity to pay the fee-for-service or IHS AIR rate directly to the IHCP.

- This payment arrangement allows the IHCP to be paid at the IHS AIR rate (or fee for service rate) and eliminates the need for the IHCP to bill the state for the supplement payment.

Indian Managed Care Addendum

- CMS encourages MCOs to contract with IHCPs, but the regulations do not require them to do so.
- The I/T/U Managed Care Addendum was developed to assist IHCPs contracting with managed care entities.
- The addendum outlines all the federal laws, regulations, and protections that are binding on managed care entities and identifies several specific provisions that have been established in federal law that apply when contracting with IHCPs.
- The use of this I/T/U Addendum benefits both managed care entities and IHCPs by lowering the perceived barriers to contracting with IHCPs, and minimizing potential disputes.
- The ITU Addendum helps to integrate IHCPs into managed care networks and ensures that AI/AN beneficiaries have access to a comprehensive and integrated benefits package and ensure that AI/AN can continue to be served by their IHCP of choice.

Avoiding Duplicate Visits for Referrals

- Managed care entities must permit an out-of-network IHCP to refer an AI/AN enrollee to an in-network provider for covered services.
- So instead of the IHCP referring the AI/AN enrollee back to his/her assigned “in-network” primary care provider for the purpose of receiving an in-network referral, the IHCP may make the referral directly to the in-network provider.
- This provision is intended to avoid duplicate visits to an in-network provider to obtain a referral which may delay treatment (§§438.14(b)(6) and 457.1209).

Auto Assignment

- Auto assignment is the process that managed entities use to assign enrollees to a particular ***in-network*** primary care medical provider.

- So when auto-assigning AI/ANs to in network primary care physicians, managed care plans should review their auto-assignment algorithm to ensure that an appropriate logic is used to accomplish the most appropriate primary care provider assignment.

- Such criteria could include an enrollee's historical relationship with a primary care provider including the client's in network IHCP.

- Managed care entities should have information on the process for changing primary care providers at a minimum, described in the enrollee handbook and on the managed care plan's website (§§438.10(f)(2)(x), §438.10(f)(3), and 457.1207).

Mandatory Enrollment into Medicaid Managed Care

- To require Medicaid or CHIP beneficiaries to enroll in managed care to receive coverage, a state must obtain approval from CMS either through a Medicaid state plan amendment (SPA), a 1915(b) waiver, or through the section 1115 demonstration authority.

- States implementing Medicaid managed care are required to engage in a meaningful consultation with federally recognized Tribes and/or IHCPs located in their state prior to the submission of a SPA, waiver, or demonstration because managed care has tribal implications. For example, IHCP enrollment and reimbursement issues, payment and contracting, and option for states to exclude AI/ANs from mandatory enrollment.

Medicaid State Plan Authority and IMCE

- States can implement a mandatory managed care delivery system for certain populations through a Medicaid state plan amendment that meets standards set forth in section 1932 of the Act.
- However, section 1932(h) of the Act prohibits states from mandatory enrollment of an individual who is an Indian into managed care unless the MCO, PIHP, PAHP, PCCM or PCCM entity contracted with the state is an "***Indian Managed Care Entity" (IMCE).***
- An IMCE must be at least 51 percent owned by a the Indian Health Service, a Tribe, a Tribal Organization, Urban Indian Organization, or a consortium.
- The special enrollment rule permits an IMCE to restrict its enrollment to Indians in the same manner as IHCPs may restrict the delivery of services to Indians (§§438.14(d) and 457.1209).
- To date there are not any IMCEs in existence.

1915(b) Waiver

- CMS may grant a waiver under section 1915(b) of the Act that permits a state to require all Medicaid beneficiaries in a state to enroll in a managed care delivery system, including Indians.

- In reviewing such waiver requests, CMS will consider any input the state received in the tribal consultation process.

- A state and its tribes could reach mutual consensus to exempt Indians from 1915(b) managed care waivers for reasons such as network sufficiency, contracting and payment difficulties, or access to culturally appropriate providers.

1115(a) Demonstration

- States have the option to exempt Indian populations from mandatory enrollment in a managed care delivery system permitting Indian populations to obtain access to health care through a fee for service delivery system.

- Historically, CMS has not approved section 1115(a) demonstrations that have mandated Indians into managed care. Those approvals were the result of state/Tribal consultation and CMS/Tribal consultation with participation from the state. We strongly encourage states and Tribes to engage in meaningful consultation when considering mandating Indians into managed care. States are required to consult consistent with the process outlined in its approved ARRA Tribal consultation state plan amendment.

TTAG Managed Care Subcommittee

- Recently the CMS Tribal Technical Advisory Group (TTAG) formed a Managed Care Subcommittee to try to address a number of issues that are impacting Indian Country.
- The key issues identified by the Subcommittee include but are not limited to:
- State oversight of MCOs;
- Right of AI/AN to use a IHCP of choice;
- Timely and complete payment;
- Auto assignment:
- Contracting; and
- Indian Managed Care Entity (IMCE).

V. Questions Comments??

Please send any questions or comments to:

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