Tribal Protections in Medicaid and CHIP Managed Care Oversight Toolkit

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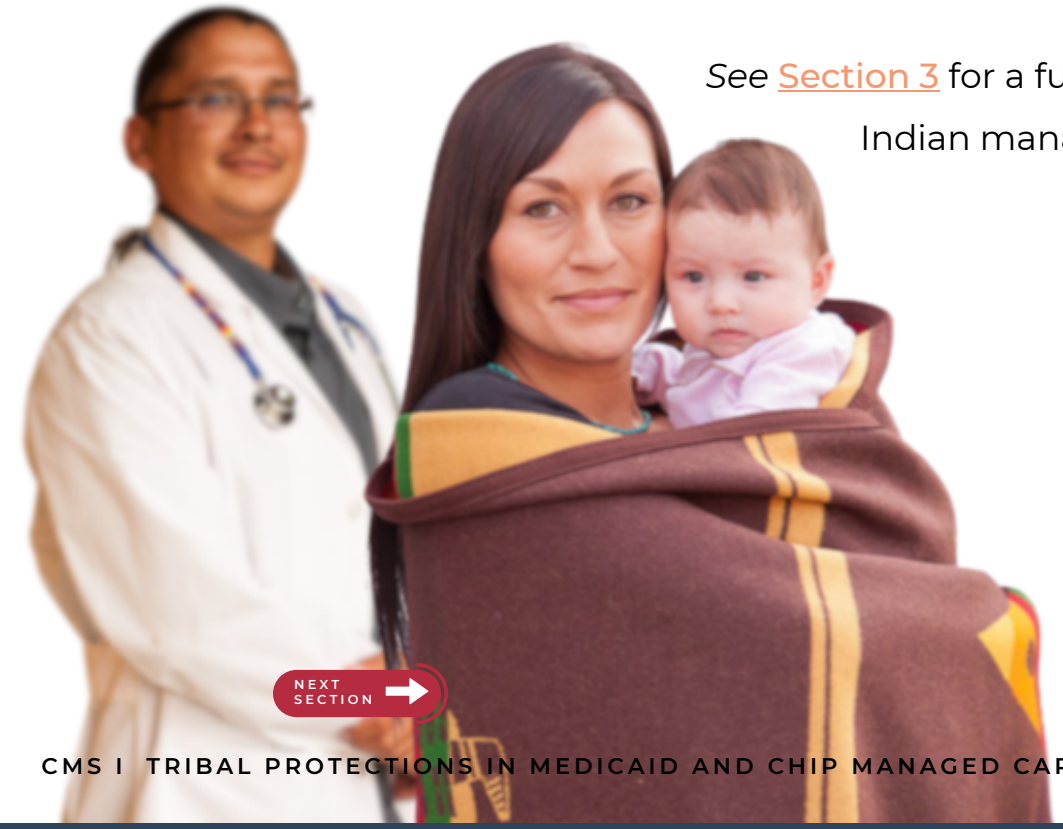
Background

In 2009, Congress amended Section 1932(h) of the Social Security Act (the Act) through the American Recovery and Reinvestment Act (ARRA) to provide certain protections for American Indian and Alaska Natives (AI/AN) enrolled in Medicaid managed care plans [1] and for Indian Health Care Providers (IHCP) who provide services to AI/AN enrollees. ARRA also extended these provisions to AI/AN enrollees and IHCPs in CHIP through Section 2107 (e)(1)(Q) of the Act. The Center for Medicare & Medicaid Services (CMS) codified these provisions in Medicaid regulations at 42 C.F.R. § 438.14 and made them applicable to CHIP by a cross reference at 42 C.F.R. § 457.1209.

In general, the Indian managed care protections allow AI/ANs enrolled in Medicaid and CHIP managed care plans to continue to receive services from an IHCP, even if the IHCP does not participate in the plan's network. The protections also ensure IHCPs are appropriately paid for covered services provided.



See Section 3 for a full discussion of these Indian managed care protections.

Background and Context for the Development of the Toolkit

National Indian Health Board (NIHB) and CMS Tribal Medicaid Managed Care Virtual Roundtable

To assist states in complying with the statutory and regulatory Indian managed care protections, CMS met with states, Tribes, IHCPs, and managed care plans on a state-by-state basis to address and resolve identified issues. To further these efforts to address implementation of the Indian managed care protections from a national perspective, NIHB and CMS convened a Tribal Medicaid Managed Care Virtual Roundtable in May 2021 (hereinafter referred to as Roundtable Report).[2]

The panelists included Tribal health directors, state Medicaid staff, and managed care plan staff who gathered to discuss strategies and identify recommended practices and resources that could be used to aid states and managed care plans in implementing the statutory and regulatory Indian Medicaid managed care protections. In July 2022, NIHB produced a Medicaid Managed Care Report (hereinafter referred to as Roundtable Report) that describes recommended practices and strategies for addressing Medicaid and CHIP managed care issues in Indian Country.

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Recommendations from the Roundtable Report

This Toolkit builds on the key recommendations from the Roundtable Report by providing more detail on what states can do to maximize the benefits of Medicaid and CHIP managed care for AI/AN enrollees and the IHCPs consistent with the statutory and regulatory Indian managed care protections.

The key recommendations from the Roundtable Report for improving implementation of Medicaid and CHIP Indian managed care protections for AI/AN enrollees and IHCPs and the corresponding section in the toolkit is outlined in the table below:

Key Recommendation	Toolkit Section
Engage in Tribal consultation	**Section: 4.1**
Ensure involvement of subject matter experts	**Section: 4.1**
Institutionalize knowledge of Indian health system	**Section: 4.2 and 4.4**
Designate a Tribal Liaison	**Section: 4.2**
Use the Managed Care Contract Addendum	**Section: 4.3**
Develop internal claims processing	**Section: 4.4**
Require managed care plans to pay the IHS all-inclusive rate	**Section: 4.4**

1 Medicaid managed care plan is a term that includes managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, primary care case management, or primary care case management entities, as defined in 42 C.F.R. 438.2, that contracts with a state Medicaid agency to deliver a portion or the entirety of the services provided through a Medicaid and CHIP program.
2 The Roundtable Report is available at, https://www.nihb.org/docs/phrc-uploads/08152022/medicaid-managed-care-report_final_08102022.pdf.

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Purpose: This section provides an overview of the Indian health care delivery system, which is comprised of health care facilities operated by the Indian Health Service (IHS), by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), and Urban Indian Organizations (UIO) under Title V of the Indian Health Care Improvement Act (IHCIA). This section also outlines the authority for IHS, Tribes, and UIOs to bill Medicaid and the Children's Health Insurance Program (CHIP).

Indian Health Care Delivery System

Indian Health Service

The Indian Health Service (IHS) [1] is an agency within the Department of Health and Human Services [2] that is responsible for providing health care to AI/ANs. 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 and is based on the Constitution, and articulated in numerous treaties, federal laws, federal court decisions, and Executive Orders.

IHS provides comprehensive primary health care and disease prevention services to approximately 2.6 million AI/ANs who are eligible for services per IHS eligibility regulations at 42 C.F.R. Part 136, which includes members and descendants of 574 federally recognized Tribes. [3] The IHS delivery system is comprised of 46 hospitals and over 600 clinics and health stations on or near Indian reservations. [4] The health services delivered are based on medical priorities and available funding. The IHS is administratively organized into twelve geographic regions referred to as IHS Areas. [5] The IHS delivery system includes programs and facilities operated by the IHS, Tribes and Tribal organizations under the ISDEAA, [6] and UIOs under Title V of the IHCIA, often collectively referred to as ITUs. These programs and facilities are located in 37 states, predominantly located in rural and remote locations. [7]

The IHCIA[8] is the statutory authority for IHS to provide health care to AI/ANs and was made permanent by the Affordable Care Act. Congress enacted the IHCIA to maintain and improve the health of AI/ANs with the goal of eliminating health care disparities. AI/ANs have long experienced lower health status compared to other Americans. These disparities continue today. AI/AN people are disproportionately affected by chronic conditions and die at higher rates than other Americans from chronic liver disease and cirrhosis, diabetes, chronic lower respiratory diseases, as well as nonchronic causes of death such as suicide and accidents. Drivers of health disparities include poor infrastructure, lack of adequate sanitation facilities, and lack of access to a safe water supply – problems more common in Tribal communities compared to the U.S. general population. Historical trauma – the long term, intergenerational impact of colonization, cultural suppression, and historical oppression of Indigenous peoples – is a key underlying factor contributing to negative outcomes in AI/AN communities.[9] AI/ANs also have risk factors and a high prevalence for experiencing mental health concerns and suicide, obesity, substance use, sudden infant death syndrome, teenage pregnancy, liver disease, and hepatitis.[10] Health disparities data for AI/AN children show they are more likely than white, African American, or Hispanic children to live in poverty, be victims of violent crime, die from accidents, die during infancy, suffer from fetal alcohol spectrum disorder and substance use disorder, and commit suicide.[11]

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Tribes and Tribal Organizations

Under the ISDEAA, Tribes and Tribal organizations have authority to operate Indian health care programs and assume responsibility for health care offered by the IHS. Tribes may contract with the IHS through self-determination contracts and annual funding agreements under Title I of the ISDEAA or may enter into self-governance compacts and funding agreements under Title V. Approximately half of the Tribes elect to operate their Indian health care programs and administer the IHS funding and resources through ISDEAA contracts and compacts, while the remaining Tribes have determined to receive health care directly from the IHS.

Urban Indian Organizations (UIO)

Pursuant to the authority under Title V of the IHCIA, the IHS provides contracts and grants to 41 urban-centered, non-profit Urban Indian Organizations (UIO) providing health care services at over 80 facilities in urban areas across 22 states. UIOs define their scope of services based upon the documented and unmet needs of the urban Indian communities they serve. The 41 UIOs provide services that range from the provision of outreach and referral services to the delivery of comprehensive ambulatory health care. UIOs 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 state plan reimbursement rates applicable to that provider type.

IHS and Tribal Facilities' Ability to Bill Medicaid and CHIP is Critical to Support the Indian Health Care Delivery System.

Section 1911 authority to bill Medicaid

Section 1911 of the Social Security Act (the Act), 42 U.S.C. §1396j, authorizes the IHS and Tribal facilities to bill Medicaid for services provided to enrolled individuals who are eligible for services through the IHS. Medicaid revenues are important to the operations of the IHS and Tribal facilities' operating budgets. For instance, in the FY 2022 IHS Congressional Budget Justification, Medicaid collections from IHS operated facilities exceed $750 million, a $28 million increase from FY 2020 collections. [12] These collections supplement IHS appropriations funding and are used to meet CMS accreditation and certification standards, hire additional staff, purchase medical equipment, and serve a critical source of revenue for patients who are uninsured.[13] Of the 2.6 million AI/ANs eligible for services from the IHS, approximately one million are enrolled in Medicaid and CHIP.[14]

Section 1905(b) authority for states to claim 100 percent Federal Medical Assistance Percentage (FMAP)

Under Section 1905(b) of the Act, the federal government is required to match state expenditures at the FMAP rate, which is 100 percent for state expenditures on behalf of AI/AN Medicaid enrollees for covered services received through an IHS facility whether operated by the IHS or by a Tribe or Tribal organization. In February 2016, CMS updated this policy to allow IHS and Tribal facilities to enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries. Amounts paid by the state for services provided by these non-IHS/Tribal providers in accordance with care coordination agreements would be eligible for the enhanced federal matching authorized under Section 1905(b) of the Social Security Act at a rate of 100 percent. [15]

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Medicaid reimbursement methodologies for IHS and Tribal facilities

On an annual basis, the IHS calculates and publishes in the Federal Register calendar year inpatient and outpatient Medicare and Medicaid reimbursement rates which are often referred to as the All-Inclusive Rate (AIR).[16] The AIR is applicable to reimbursement methodologies under the Medicare and Medicaid programs. The IHS and Tribal facilities bill at the Medicaid AIR for inpatient and/or outpatient Medicaid covered services provided to Medicaid enrolled beneficiaries.

1 More information on the Indian Health Service (his) can be found at, https://www.ihs.gov/.
2 More information about the department of Health and Human Services can be found at, https://www.hhs.gov/.
3 The list of federally recognized Tribes is published by the Bureau of Indian Affairs. The most current list can be found at, https://www.federalregister.gov/documents/2023/01/12/2023-00504/indian-entities-recognized-by-and-eligible-to-receive-services-from-the-united-states-bureau-of
4 See Endnote 8 for the Indian Health Service FY 2024 Budget Submission to Congress.
5 The twelve Indian Health Service Areas can be found at, https://www.ihs.gov/locations/.
6 Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638, ISDEAA), 25 U.S.C. §5301 et seq. is available at, https://uscode.house.gov/view.xhtml?path=/prelim@title25/chapter46&edition=prelim.
7 There are 37 states with IHCPs: Alabama, Alaska, Arizona, California, Colorado, Connecticut, Florida, Idaho, Illinois, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, Nevada, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, Wisconsin, and Wyoming.
8 Indian Health Care Improvement Act: https://www.ihs.gov/sites/ihcia/themes/responsive2017/display_objects/documents/home/USCode_Title25_Chapter%2018.pdf.
9 See 2021 HHS/ASPE Issue Brief, page 7, https://aspe.hhs.gov/sites/default/files/2021-07/aspe-aian-health-insurance-coverage-ib.pdf.
10 Indian Health Service FY 2024 Budget Submission to Congress page CJ 4, is available at, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2024-IHS-CJ32223.pdf.
11 Lauren Roygardner, Andy Schneider and Doug Steiger, Promoting Health Coverage of American Indian and Alaska Native Children https://ccf.georgetown.edu/wp-content/uploads/2019/09/AI-AN-health-coverage.pdf.
12 House Committee Report to IHCIA, (HR 94-1026, Part III) available at, https://www.govinfo.gov/content/pkg/STATUTE-90/pdf/STATUTE-90-Pg1400.pdf.
13 25 U.S.C. 1641, Treatment of payments under Social Security Act health benefits programs.
14 Medicaid's Role in Health Care for American Indians and Alaska Natives (MACPAC Issue Brief February 2021), is available at, https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf. See also National Indian Health Board Data and Analysis Research Project available at, https://www.nihb.org/tribalhealthreform/data/.
15 SHO #16-002, Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives is available at, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho022616.pdf.
16 The published 2023 All-Inclusive-Rate is available at, https://www.federalregister.gov/documents/2023/02/27/2023-03896/reimbursement-rates-for-calendar-year-2023.

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Purpose: This section provides an overview of the statutory and regulatory Medicaid and Children's Health Insurance Program (CHIP) Indian managed care protections.

Indian Medicaid and CHIP Managed Care Protections in Statute

Section 1932(a)(2)(C) [1] and Section 1932(h) [2] of the Social Security Act (the Act), as added by Section 5006 of the American Recovery and Reinvestment Act of 2009, [3] provide the statutory basis for Indian protections in Medicaid and CHIP managed care. Section 2107(e)(1)(Q) [4] of the Act extends the Medicaid provisions in Sections 1932(a)(2)(C) and 1932(h) to the CHIP Program.[5]

These provisions allow American Indians and Alaska Natives (AI/AN) enrolled in Medicaid and CHIP managed care plans to receive services from an Indian Health Care Provider (IHCP), and the IHCP is reimbursed for covered services provided to AI/AN enrollees even if the IHCP is not a network provider. An IHCP is a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization.

Mandatory Enrollment into Managed Care

States may require Medicaid or CHIP beneficiaries to enroll in a managed care plan to receive coverage using three different Medicaid authorities:

1. State plan authority under Section 1932(a).
2. Waiver authority under Section 1915(b) and (c).
3. Demonstration authority under Section 1115(a) of the Act.

States are prohibited from mandating AI/ANs into managed care through a state plan amendment (SPA) unless the state has an IMCE that is accessible to the state's AI/AN Medicaid population.

Background on the Indian Protections in the Medicaid Managed Care Rules

In 2016, the Centers for Medicaid & CHIP Services (CMS) published 42 C.F.R. Part 43 final rule[6] updating its Medicaid managed care regulations. The regulation at 42 C.F.R. § 438.14,[7] cross-referenced to CHIP in 42 C.F.R. § 457.1209[8] codifies the Indian managed care protections, provided under Section 1932(a)(2)(C) and Section 1932(h) of the Act. These regulations apply to managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, primary care case management programs, and primary care case management entities. In this toolkit, these are collectively referred to as "managed care plan(s)."

CMS issued a CMCS Informational Bulletin (CIB) in 2016 on the "Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations"[9] that summarizes all the Indian managed care provisions into a single CMS guidance for ease of reference. The 2016 CIB guidance addressed specific Tribal issues including network sufficiency, AI/AN access to out-of-network IHCPs, and payment and contracting requirements for managed care plans that serve AI/ANs. The CIB also addressed enrollment of AI/ANs into managed care and a state's option to exempt AI/ANs from mandatory enrollment into managed care established under a Section 1915(b) waiver or a Section 1115(a) demonstration. Mandatory enrollment into managed care using these authorities requires consultation with Tribes and IHCPs consistent with a state's consultation state plan process established under Section 1902(a)(73)[10] of the Act.

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Key Indian Managed Care Provisions in Regulation

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

Every managed care plan must demonstrate that there are sufficient IHCPs participating in its network to ensure that AI/ANs have timely access to covered services. If a state determines that timely access to covered services cannot be ensured due to few or no IHCPs operating in the state, there are two options. The first option is for AI/AN enrollees to be permitted by the plan to access out-of-state IHCPs, and for the plan to reimburse the out-of-network IHCP appropriately. The second option is for the state to deem the circumstance to be good cause for disenrollment and to allow AI/AN enrollees to disenroll from the state's managed care program and be enrolled into a fee-for-service (FFS) delivery system. (42 C.F.R. § 438.14(b)(1)).

AI/AN Enrollees May Access Out-Of-Network IHCPs

Any AI/AN who is enrolled in a managed care plan and who is eligible to receive services from a network IHCP must be able to choose that IHCP as his or her primary care provider (PCP) (42 C.F.R. § 438.14(b)(3)). In addition, states must allow AI/ANs enrolled in managed care to access care from out-of-network IHCPs and allow referrals from out-of-network IHCPs to network providers without a duplicative referral from a network PCP (42 C.F.R. §§ 438.14(b)(4) and 438.14(b)(6)). Many managed care plans erroneously deny claims from out-of-network IHCPs because they are not aware that AI/AN enrollees have the right to access out-of-network IHCPs. States are responsible for ensuring that all of their managed care plans that process claims are compliant with these provisions and that each managed care plan's claim system is correctly programmed to properly adjudicate IHCP claims. For more information *see* Section 4.4, "Develop Internal Processes to Improve Tribal Understanding of The Managed Care Delivery System."

Managed Care Payment and Contracting Requirements for IHCPs

IHCPs do not have to be a network provider in order to be paid by a managed care plan or the state Medicaid agency for covered services provided to AI/ANs enrolled in managed care. Payment requirement protections for IHCPs, which are codified at 42 C.F.R. §§ 438.14(c) and cross-referenced in CHIP at 42 C.F.R. § 457.1209, include:

1. **IHCPs that are Federally Qualified Health Centers (FQHC):** When an IHCP is enrolled in Medicaid or CHIP as an FQHC but is not a network provider, the IHCP must be paid the same payment rate that the plan would pay an FQHC that is a network provider including any supplemental payment due from the state to make up the difference between the amount the plan pays and what the IHCP FQHC would have received under a FFS payment methodology. (42 C.F.R. §§ 438.14(c)(1) and 457.1209).

2. **IHCPs that are *not* FQHCs:** When an IHCP is not enrolled in Medicaid or CHIP as an FQHC, and regardless of whether the IHCP is a network provider, the IHCP has a right to receive the applicable All Inclusive Rate (AIR) published annually in the Federal Register by the IHS, or, in the absence of a published AIR, the amount it would receive if the services were provided under the state plan's FFS payment methodology (42 C.F.R. §§ 438.14(c)(2) and 457.1209).

3. **Supplemental Payment Requirement:** When the amount an IHCP receives from a managed care entity is less than the applicable AIR or FFS rate, the state must make a supplemental payment (wrap payment) to make up the difference between the amount the plan pays and the amount the IHCP would have received under the applicable AIR of the FFS rate (42 C.F.R. §§ 438.14(c)(3) and 457.1209).

4. **Timely Payment:** Managed care plans must pay IHCPs in a timely manner (42 C.F.R. § 438.14(b)(2)(iii).

1 Section 1932(a)(c), available at https://www.ssa.gov/OP_Home/ssact/title19/1932.htm#act-1932-h.
2 Section 1932(h). Available at https://www.ssa.gov/OP_Home/ssact/title19/1932.htm#act-1932-h.
3 Section 1902(a)(73) as added by Section 5006 American Reinvestment and Recovery Act is available at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Section-5006-Protections-for-Indians-under-Medicaid-and-CHIP.pdf.
4 Section 2107(e)(1)(Q). Available at https://www.ssa.gov/OP_Home/ssact/title21/2107.htm#act-2107-e-1-q.
5 42 C.F.R. § 438.14(a) Indian Health Care Provider defined.
6 The final 2016 Medicaid and CHIP rule is available at, https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.
7 42 C.F.R. § 438.14. Available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.14.
8 42 C.F.R. § 457.1209. Available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-L/subject-group-ECFR851d8cc8acda3ca/section-457.1209.
9 The December 14, 2016 CMCS Informational Bulletin titled, "Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulation" is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf.
10 *See* page 4 of the December 14, 2016 CMCS Informational Bulletin. Available at, https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf.

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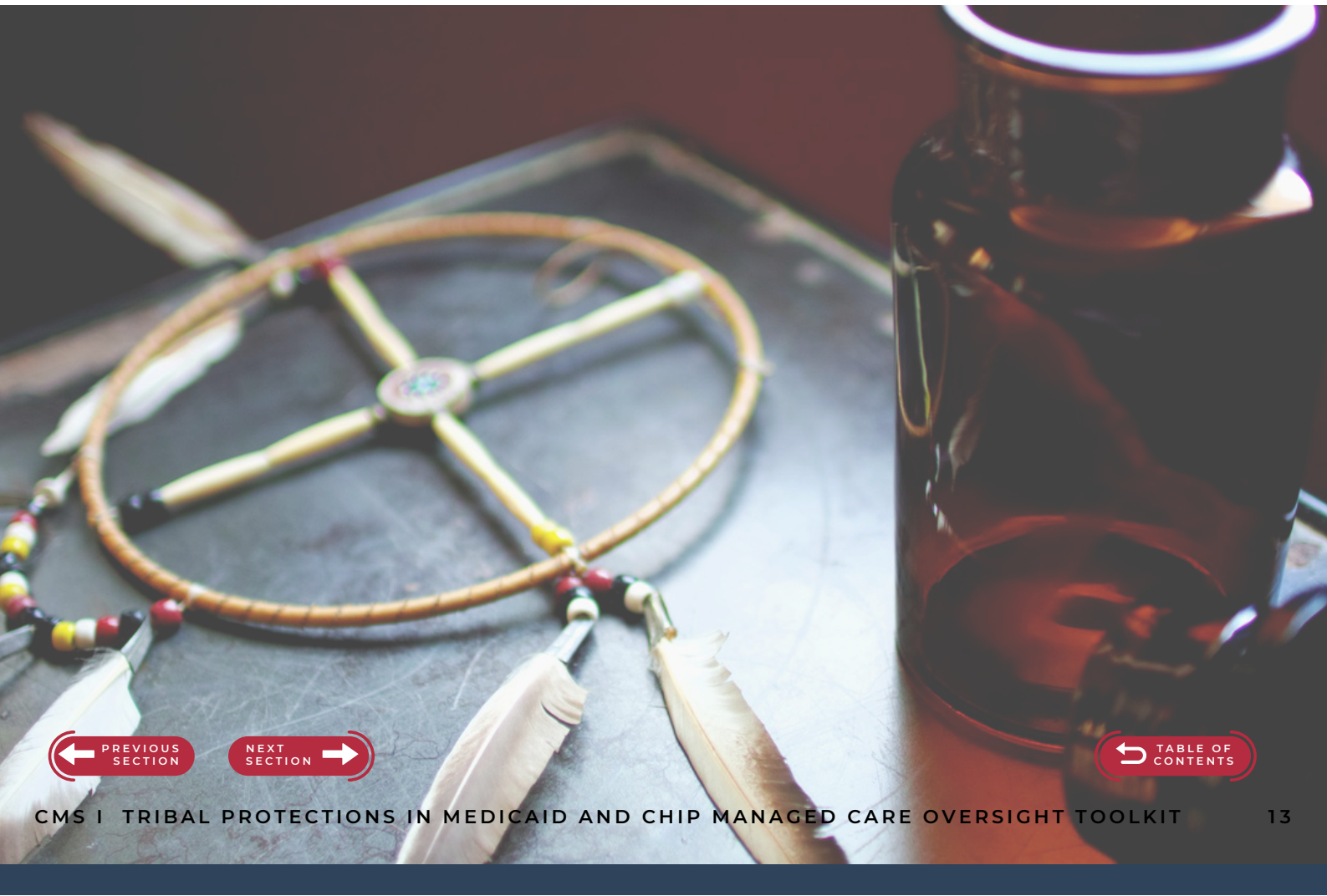
Purpose: This section has five separate subsections that provide resources and strategies that states can use to:

1. Improve state-Tribal relationships in the implementation of the Indian protections in Medicaid and CHIP managed care including Tribal consultation.
2. Require managed care plans to maintain a Tribal Liaison position.
3. Improve contracting between managed care plans and Indian Health Care Providers (IHCP) by using the model Medicaid and CHIP managed care contract addendum.
4. Develop internal processes to improve understanding of the managed care delivery system for American Indians and Alaska Natives (AI/AN) and IHCPs.
5. Partner with Tribes to develop an Indian Managed Care Entity (IMCE).



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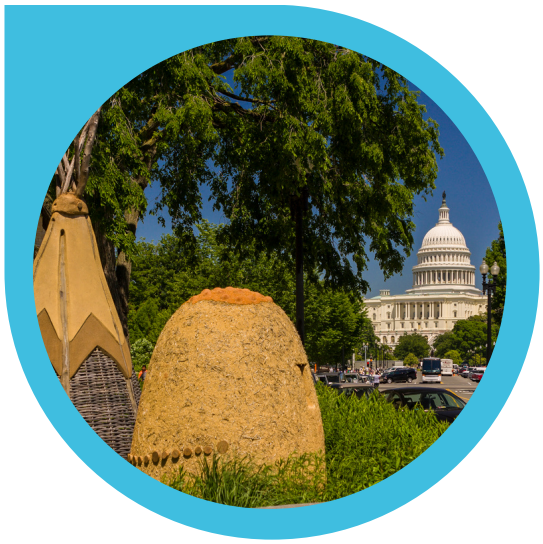
Purpose: This section will provide an overview and history of the federal and state-Tribal consultation requirements and Tribal consultation recommended practices to improve state-Tribal relationships in the successful implementation of the Medicaid and Children's Health Insurance Program (CHIP) Indian managed care protections.

Federal Government Tribal Consultation Requirements



Tribes are sovereign nations with a unique government-to-government relationship with the United States federal government. This relationship is grounded in the U.S. Constitution, numerous treaties, federal statutes, federal court decisions, regulations, and executive orders.

The federal government recognizes and honors this relationship by requiring federal agencies to engage in meaningful Tribal consultation, per Executive Order 13175.[1] This Executive Order was reaffirmed by President Biden on January 26, 2021, in the Presidential Memorandum on Tribal Consultation.[2]

The Department of Health and Human Services requires all executive departments and agencies, including the Centers for Medicare & Medicaid Services (CMS), to engage in regular, meaningful, and robust consultation with Tribal officials in the development of federal policies that have Tribal implications.

CMS Tribal Consultation Policy

In 2011, through Tribal consultation and input from the CMS Tribal Technical Advisory Group,[3] CMS issued a Tribal Consultation Policy, which was revised in 2015.[4] The CMS Tribal Consultation Policy requires CMS to conduct consultation on policies, guidance, and regulations having Tribal implications. The policy defines consultation as, "an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues."[5]

Tribal Consultation Requirements for State Medicaid and CHIP Agencies

Section 1902(a)(73)[6] of the Social Security Act, as added by Section 5006 of ARRA of 2009,[7] sets forth the requirements for states to seek advice from Indian Health Care Providers (IHCP) and Urban Indian Organizations (UIO) on Medicaid and CHIP matters that may impact Indian Health Programs and UIOs.

This includes requiring states to submit a State Plan Amendment (SPA) to document the consultation process. CMS has an interactive map[8] that links to all state-Tribal consultation SPAs for the 37 states that have at least one IHCP in their state.

Tribal Consultation Requirements for Medicaid and CHIP Managed Care

The same Tribal consultation requirements that apply to state Medicaid and CHIP agencies also apply to all Medicaid and CHIP managed care authorities including Section 1932(a) SPAs, Section 1915(b) and (c) waivers, and Section 1115(a) demonstration proposals. Section 1902a(73) requires States to solicit advice from IHCPs prior to submission of any SPAs, waivers, and demonstration proposals likely to have a direct effect on Indians, Indian Health Programs, or UIOs.

In addition, the Transparency regulations at 42 C.F.R. 431.408(b) [9] apply to Medicaid Section 1115(a) demonstration proposals, including proposals that seek to implement managed care. The Transparency regulations require states to consult with federally recognized Tribes in addition to IHCPs.

Tribal Consultation Recommended Practices

One of the key takeaways from the Medicaid Managed Care Report (hereinafter referred to as Roundtable Report) [10] is that effective Tribal consultation can be a key element in the states' successful implementation of the Indian managed care protections. The recommendation includes state Medicaid and CHIP agencies having Tribal consultation processes that allow for mutual and clear communication between the Tribes and the state that is timely, collaborative, and meaningful.

State-Tribal consultation processes can vary between states. CMS assessed the success and efficacy of state consultation processes for Minnesota,[11] Oregon, [12] and Washington [13] in 2013 using case studies [14] in an effort to understand strategies that could be used to improve Tribal consultation processes nationwide.

Below is a summary of key recommended Tribal consultation practices from the Roundtable Report:

Key leadership should engage with Tribes and IHCPs:

State Medicaid and CHIP Directors are encouraged to participate in Tribal consultation and include department heads and staff with relevant expertise. They should engage in open communication and establish a working relationship with Tribes and IHCPs. An effective state-Tribal consultation process requires leadership support with someone in a decision-making authority to be at the table during the consultation meeting.

Adequate Tribal Consultation Notice

The first step of engaging in Tribal consultation is notification. States should make sure the Tribal consultation notice explains:

1. Details of the change the state is proposing.
2. Why the state is proposing the change.
3. The potential Tribal implications.
4. The timeline for Tribal response.
5. The state's plan for submission to CMS or implementation of the proposed change.

The notification should include background material, including draft SPAs and waivers, if possible. The notice should be provided sufficiently in advance so that Tribes and IHCPs can prepare for the consultation. States should use multiple methods of communication to notify Tribes and IHCPs, including mail and electronic notices. The consultation materials should be posted on the state's Medicaid and CHIP website. States should also maintain an up-to-date list of contact information of Tribal leaders and IHCPs, including names, mailing addresses, phone numbers, fax numbers, and e-mail addresses.

Offer Alternative Means for Consultation Attendance

The state might consider conducting consultation in various parts of the state to reduce travel time for Tribes and IHCPs located in remote areas. States should offer alternative means to attend the Tribal consultation such as webinars and conference calls for Tribal representatives that are unable to attend in person. States should make sure that the on-line meeting platform enables timely opportunity to comment or raise questions so that the consultation is interactive.

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Assume there are Tribal Implications for Changes to Medicaid and CHIP Programs

The state should be as transparent as possible regarding anticipated policy and operational changes. States should engage with Tribes at the earliest opportunity when the state has identified the need for a proposed change to the Medicaid or CHIP program. The Indian health care delivery system is complicated and changes that may appear minor to a state agency could have unintended or significant operational impacts on Tribes.

Consultation Workgroups

States could consider establishing workgroups with representatives from Tribes and IHCPs to address a particular proposed policy change. Workgroups may be tasked with policy analysis, data compilation, and recommendations which can be presented at a future consultation meeting for consideration by other Tribes, IHCPs and Medicaid and CHIP program staff.

Documentation and Follow-up on Items Discussed During Consultation

It is important to document the Tribal consultation process, including items requiring follow-up. This may include questions that could not be answered during the initial discussion, fulfilling data requests, and other action items. The state may consider having internal follow-up meetings to ensure all documented follow-up items are addressed in a timely manner. Documentation should be publicly available on the state's website.

1 Executive Order 13175 is available at, https://www.federalregister.gov/documents/2000/11/09/00-29003/consultation-and-coordination-with-indian-tribal-governments.
2 The Presidential Memorandum on Tribal Consultation is available at, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/26/memorandum-on-tribal-consultation-and-strengthening-nation-to-nation-relationships/.
3 More information on the CMS Tribal Technical Advisory Group can be found at, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Tribal-Technical-Advisory-Group.
4 The CMS Tribal Consultation Policy is available at, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf.
5 *See* page 3, section 5.1 of the CMS Tribal Consultation Policy. The policy is available at, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf.
6 Medicaid Tribal consultation requirements in Section1902(a)(73) are available at, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm#act-1902-a-73.
7 Section 1902(a)(73) as added by Section 5006 American Reinvestment and Recovery Act is available at, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Section-5006-Protections-for-Indians-under-Medicaid-and-CHIP.pdf.
8 The State-Tribal Relations page with the ARRA 5006 SPA Interactive Map is available at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/State-Tribal-Relations-on-Health-Care#bookmark3.
9 42 C.F.R. 431.408(b) governing Section 1115 demonstration Transparency requirements are available at, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-G/section-431.408#p-431.408(b).
10 The Roundtable Report is available at, https://www.nihb.org/docs/phrc-uploads/08152022/medicaid-managed-care-report_final_08102022.pdf.
11 The Minnesota Tribal consultation case study is available at, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/State-Consultation-Additional-Resources/CMS-Task-E-Report_MN.pdf.
12 The Oregon Tribal consultation case study is available at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/State-Consultation-Additional-Resources/CMS-Task-E-Report_OR.pdf.
13 The Washington Tribal consultation case study is available at, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/State-Consultation-Additional-Resources/CMS-Task-E-Report_WA.pdf.
14 State -Tribal Relations- A Summary of Best Practices is available at, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/State-Consultation-Additional-Resources/CMS-Task-E-Report_Annual.pdf.

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Purpose: This section explains the advantages of requiring managed care plans to establish a Tribal Liaison position to facilitate improved communications between managed care plans and Indian Health Care Providers (IHCP) to resolve Medicaid and Children's Health Insurance Program (CHIP) managed care issues.

Background

The Medicaid Managed Care Report (hereinafter referred to as Roundtable Report) [1] recommends that states require Medicaid and CHIP managed care plans to establish staff positions to improve and facilitate communications with IHCPs. States that require their managed care plans to maintain a Tribal Liaison position have reported better Tribal and managed care plan relationships, better access, and care coordination for American Indian and Alaska Natives (AI/AN), and fewer IHCP claim denials. Some states contract with their managed care plans to establish and maintain a Tribal Liaison position.

Tribal Liaison Responsibilities

A Tribal Liaison is the point of contact responsible for responding to operational questions or technical requests from IHCPs, including utilization management requirements or understanding claim denials. The Tribal Liaison should be someone with sufficient familiarity with the Indian health care delivery system and managed care protections and sufficient health plan expertise to respond to IHCP requests. The responsibilities of the Tribal Liaison could encompass a number of activities that improve the relationship and understanding between IHCPs and the plan, including:

Periodic Meetings and Trainings: To improve mutual understanding of the Indian health care delivery system and the plan's operations, a Tribal Liaison could meet frequently with IHCPs in the plan's geographic service area and develop trainings for IHCPs.

Developing and Disseminating Educational Materials: A Tribal Liaison could also be responsible for developing Tribe-specific educational materials for plans to distribute to AI/AN enrollees and IHCPs to assist in understanding the plan's policies and processes.

Providing a Single Point of Contact on Eligibility or Payment Disputes: A Tribal Liaison could serve as the plan's representative for AI/AN beneficiary enrollment issues and answer questions regarding claims payment processes.

Drawing on promising practices from states, the Centers for Medicare & Medicaid Services (CMS) encourages states to require plans to establish a Tribal Liaison position within the plan designated to assist IHCPs. IHCPs may contact the CMS Division of Tribal Affairs for assistance in identifying a Tribal Liaison for a particular plan.[2] CMS has found that establishment of these types of positions improves relationships between the IHCPs and managed care plans, resulting in improved enrollee access to care and timely resolution of claims. The examples in Washington and Oregon highlighted below demonstrate how two states have successfully established Tribal Liaison positions.

Spotlight on Oregon and Washington's Establishment of a Tribal Liaison Position to Improve Relationships Between Medicaid and CHIP Managed Care Plans and IHCPs

In Oregon, each plan in the managed care program has a Tribal Liaison who serves as a single point of contact for Oregon's nine federally recognized Tribes, their UIO, Native American Rehabilitation Association Northwest, and the state's Office of Tribal Affairs.[3] The managed care plan Tribal Liaison position description indicates that the Tribal Liaison is responsible for a large range of functions aimed at improving the physical, behavioral, and oral health of AI/AN managed care plan enrollees. The Tribal Liaison communicates with managed care plan network providers, members, and other stakeholders in the managed care service area to coordinate this work. AI/ANs are not mandated into Oregon's Coordinated Care Organization (CCO),[4] which is the state's Medicaid and CHIP managed care program. Most AI/ANs are enrolled in Oregon's Medicaid and CHIP fee for service (FFS) program. However, AI/ANs can choose to enroll in either FFS, the CCO, or an Indian Managed Care Entity (IMCE). The Tribal Liaison understands the Indian health care delivery system and how it interacts with the managed care delivery system. The Tribal Liaison also assists with issues related to the delivery of health care services to AI/AN enrollees; reimbursement to IHCPs IHCP participation in the managed care plan network; and AI/AN's navigation between Oregon's FFS, managed care plan, and IMCE delivery systems.[5]

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In 2022, Washington developed an Integrated Managed Care Contract [6] that requires, among other things, that each managed care plan appoint a Tribal liaison and then notify the Washington Medicaid and CHIP program [7] of the appointment. The managed care plan's Tribal Liaison is responsible for a multitude of functions, including coordinating with non-Tribal providers on treatment and discharge planning of AI/AN enrollees. The Tribal Liaison also serves as "the Indian Health Care Compliance Manager" who reports on the plan's compliance with contract provisions relating to IHCPs to executive leadership. In addition, each plan's Tribal Liaison must undergo extensive training on the government-to-government relationship between the state of Washington and the federally recognized Tribes. The Tribal Liaison is also trained on all federal and state laws and regulations applicable to IHCPs and AI/AN enrollees, applicable provisions in the Integrated Managed Care Contract, and matters specific to IHCPs.

1 For more information regarding the Virtual Roundtable event see Section1 of this Tribal Toolkit "Background and Context for the Tribal Toolkit." The Roundtable Report is available at https://www.nihb.org/docs/phrc-uploads/08152022/medicaid-managed-care-report_final_08102022.pdf.
2 IHCPs may contact the CMS Division of Tribal Affairs to assist in locating a managed care plan's Tribal Liaison by sending an email to TribalAffairs@cms.hhs.gov.
3 For more information about the Oregon Health Authority-Office of Tribal Affairs see https://www.oregon.gov/DHS/ABOUTDHS/TRIBES/pages/index.aspx.
4 For more information about Oregon's Coordinated Care Organization managed care program managed care delivery system, see https://www.oregon.gov/oha/hsd/ohp/pages/coordinated-care-organizations.aspx.
5 For more information about the Oregon Coordinated Care Tribal Liaison Position see https://www.oregon.gov/oha/HSD/OHP/Contractor%20Workgroups%20CCO%20Operations%20Collaborative/CCO%202.0%20Tribal%20Liaison%20Sample%20Job%20Description.pdf.
6 Washington Medicaid and CHIP Integrated Contract integrates; (1) all Washington's Medicaid and CHIP managed care contractual provisions; (2) the Indian managed care protections for Medicaid and CHIP; (3) all federal and state statutory and regulatory requirements applicable to IHCPs and AI/AN Medicaid and CHIP enrollees; (4) the Model Medicaid and CHIP ITU Contract Addendum; and (5) several requirements not federally mandated that ease IHCP network participation, reimbursement, and care coordination for AI/ANs between non-IHCPs and IHCPs. The contract is available at https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf.
7 For more information regarding the Washington State Health Care Authority (Washington's Medicaid and CHIP e program) see, https://www.hca.wa.gov/.

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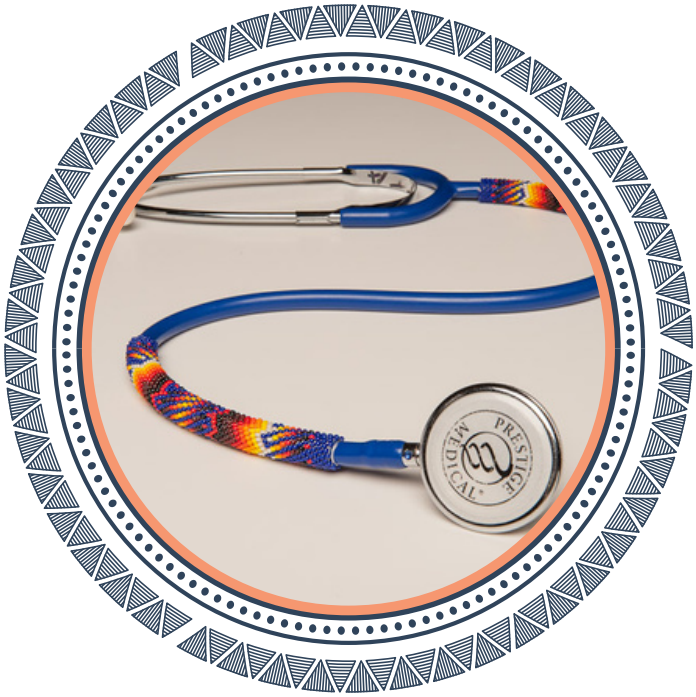
Purpose: This section explains the advantages of using the Model Medicaid and CHIP Managed Care Indian Addendum for contracting and negotiating participating provider agreements with IHCPs.

Background



There are many federal statutory requirements from the Indian Health Care Improvement Act (IHCIA) and Indian Self Determination and Education Assistance Act that apply to IHCPs with which managed care plans may not be familiar. This can lead to managed care plan network provider agreements that are inconsistent with federal statutory requirements for IHCPs and these provisions may make entering into agreements between IHCPs and managed care plans challenging.

The Centers for Medicare & Medicaid Services (CMS), in consultation with Tribes, developed a Model Medicaid and CHIP Managed Care Indian Addendum for contracting with IHCPs (ITU Addendum) that can be used by IHCPs in negotiating network provider agreements.

The ITU Addendum[1] is a CMS-drafted contract supplement for inclusion in Medicaid and CHIP managed care contracts that outlines all the federal laws and regulations that apply when contracting with IHCPs[2] and provides contract language specific to these provisions. The ITU Addendum identifies key federal laws to make contract negotiation easier for both parties and ensures compliance with applicable federal laws and regulations unique to IHCPs.

Key Provisions of the ITU Addendum

Below are some of the key ITU Addendum provisions for improving contracting with managed care plans and IHCPs.

Cost-Sharing Exemption for Indians/No Reduction in Payments

The managed care plan cannot impose enrollment fees, premiums, copayments, cost sharing, or similar charges on American Indians and Alaska Natives (AI/AN) for a covered item or service provided directly by an IHCP or through a referral under contract health services, consistent with Medicaid regulations at 42 C.F.R. § 447.56(a)(vii)(x). In addition, payments due to an IHCP may not be reduced by the amount of any enrollment fee, premium, copayment, cost sharing, or similar charge, consistent with Medicaid regulations at 42 C.F.R. § 447.56 (c)(2)(42 U.S.C. §1396o-(j)).[3]

Enrollee Option to Select the IHCP as Primary Health Care Provider and IHCP Right to Make Referrals

The managed care plan shall allow any AI/AN otherwise eligible to receive services from an IHCP to choose the IHCP as their primary care provider. Any referral from an IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement from the managed care plan. (42 U.S.C. § 1396u-2(h)).[4]

Payment of Claims

The managed care plan shall pay claims from the IHCP in accordance Section 1932(h) [5] of the Act, 42 C.F.R. § 438.14[6] and 42 C.F.R. § 457.1209,[7] and shall pay at either the rate provided under the state plan in a fee-for-service (FFS) payment methodology, or the applicable All Inclusive Rate (AIR) published annually in the Federal Register by the Indian Health Service (IHS). (42 USC 1396u-2(h)).[8]

Persons Eligible for Items and Services from an IHCP

The managed care plan cannot require IHCPs to serve individuals who are not eligible for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.[9]

Insurance and Indemnification

The managed care plan cannot require IHCPs to obtain malpractice insurance because IHS, Tribes and Tribal organization providers are generally covered by the Federal Tort Claims Act (FTCA).[10] Some Urban Indian Organizations UIO are also covered under FTCA. Since a claim under the FTCA is the exclusive remedy for actions against FTCA covered IHCPs, IHCPs are not required to obtain professional liability insurance (28 U.S.C. §§ 2671-2680).

Licensure of Health Care Professionals

The managed care plan cannot require IHS and Tribal programs to employ only health care professionals with a state license in the state where they are located. Section 221 of the IHCIA (25 U.S.C. § 1621t)[11] permits an Indian Tribe or Tribal organization to employ a health care professional who is subject to licensure if that individual is licensed in any state. Employees of the IHS obtain their "licensed in any state" status through other federal laws. (25 U.S.C. § 1621t).[12]

Claims Format

The managed care plan shall process Medicaid and CHIP claims from IHCPs in accordance with Section 206(h) of the IHCIA. Section 206(h) does not permit an issuer to deny a Medicaid or CHIP claim submitted by an IHCP because the format does not comply with Medicare claims submissions requirements. (25 U.S.C. § 1621e(h)).[13]

1 The Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Indian Addendum for contracting with Indian Health Care Providers is available at, https://www.medicaid.gov/sites/default/files/2019-12/addendum-ihcps.pdf.
2 The Division of Tribal Affairs conducted an "All Tribes Call" in November 2016 explaining how to best use the ITU Addendum. The All-Tribes Call YouTube video can be found at https://www.youtube.com/watch?app=desktop&v=uk-YXvuxaP8.
3 42 U.S.C. §1396o-(j)) can be found at, https://www.law.cornell.edu/uscode/text/42/1396o#:~:text=No%20enrollment%20fee%2C%20premium%2C%20or%20similar%20charge%2C%20and%20no,or%20through%20referral%20under%20contract.
4 42 U.S.C. § 1396u-2(h) can be found at, https://www.law.cornell.edu/uscode/text/42/1396u-2#:~:text=may%20restrict%20the%20number%20of,substantially%20impair%20access%20to%20services.
5 Section 1932(h) is available at, https://www.ssa.gov/OP_Home/ssact/title19/1932.htm#act-1932-h.
6 42 C.F.R. § 438.14 is available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.14.
7 42 C.F.R. § 457.1209 is available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-L/subject-group-ECFR851d8cc8acda3ca/section-457.1209.
8 42 USC 1396u-2(h)) can be found at, https://www.law.cornell.edu/uscode/text/42/1396u-2#:~:text=may%20restrict%20the%20number%20of,substantially%20impair%20access%20to%20services.
9 42 C.F.R. Part 136 is available at, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B.
10 Federal Tort Claims Act (28 U.S.C. § 1346), is available at, https://www.law.cornell.edu/uscode/text/28/1346.
11 More information on licensure requirements applicable to Tribal health care professionals can be found at https://www.ihs.gov/sites/ihcia/themes/responsive2017/display_objects/documents/home/USCode_Title25_Chapter%2018.pdf#page=34.
12 More information on licensure requirements applicable to Tribal health care professionals can be found at https://www.ihs.gov/sites/ihcia/themes/responsive2017/display_objects/documents/home/USCode_Title25_Chapter%2018.pdf#page=34.
13 More information on the Claims Format requirements for Indian Health Care Providers in 25 U.S.C. § 1621e(h) can be found at, https://www.ihs.gov/sites/ihcia/themes/responsive2017/display_objects/documents/home/USCode_Title25_Chapter%2018.pdf#page=34.

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Purpose: This section provides examples of internal processes states have implemented to improve American Indian and Alaska Native (AI/AN) enrollees' understanding of Medicaid and Children's Health Insurance Program (CHIP) managed care and to address claims processing and reimbursement issues encountered by out-of-network Indian Health Care Providers (IHCP).

Background

The Indian managed care protections at 42 C.F.R. § 438.14 [1] require that IHCPs, whether participating in the network or not, be paid for covered services provided to Indian enrollees who are eligible to receive services and must permit an out-of-network IHCP to refer an Indian enrollee to a network provider. Although the Indian managed care protections are included in all Medicaid and Children's Health Insurance Program (CHIP) managed care contracts, IHCPs continue to encounter difficulties with managed care plans denying claims because the IHCP is out-of-network.

The Centers for Medicare & Medicaid Services (CMS) explored network adequacy and service availability standards for Medicaid and CHIP enrollees in the April 2017 Promoting Access in Medicaid and CHIP Managed Care Toolkit (Access Toolkit). [2]

The Access Toolkit was designed as a resource guide intended to:

1. Assist state Medicaid and CHIP agencies with implementing the requirements of the 2016 final rule [3] related to network adequacy and service availability standard.
2. Provide an overall framework and suggest metrics for monitoring provider network adequacy and service availability.
3. Highlight effective or promising practices that states currently use to develop and monitor provider network and access standards, and promote access to care.

The Access Toolkit explored difficulties AI/AN enrollees have experienced in accessing specialty care from network providers through a referral from an out-of-network IHCP. Even though the regulations require managed care plans to permit an out-of-network IHCP to refer an Indian enrollee to a network provider (42 C.F.R. § 438.14(b)(6)), in some instances, some plans still erroneously require the AI/AN enrollee to obtain a duplicate referral from a network primary care provider (PCP) before receiving specialty care. The toolkit also highlighted issues where IHCPs should be but have not been reimbursed by the plan because they are out-of-network. These issues create barriers to health care access for AI/AN enrollees and reimbursement delays for IHCPs. [4]

In addition to the recommendations in the Access Toolkit, similar recommendations to improved internal processes were identified in the Medicaid Managed Care Report (hereinafter referred to as Roundtable Report).

Develop Internal Processes to Improve the AI/AN Enrollee's Understanding of Medicaid and CHIP Managed Care

Managed Care Plans Should Develop Internal Processes to Improve the Assignment of AI/AN Enrollees to Primary Care Providers (PCP)

States could require plans to have processes in place to ensure that when an AI/AN enrolls in the plan, the enrollee is given the opportunity to designate their IHCP as their PCP immediately upon enrollment. This will avoid passive or default assignment of AI/AN enrollees to a PCP that is not the enrollee's IHCP.

In states where Medicaid and CHIP enrollees are mandatorily enrolled into a managed care program, plans often passively or by default assign enrollees to PCPs within the plan's network based upon algorithms like an enrollee's zip code. This process does not consider the AI/AN enrollee's existing use and relationship with an IHCP. Plans should review their passive or default-assignment algorithm to ensure that an appropriate logic is used to accomplish the most appropriate PCP assignment for AI/AN enrollees. Such criteria could include a review of utilization data or medical records to determine an enrollee's historical relationship with an IHCP. States should work with IHCPs to ensure AI/AN enrollees are assigned to a designated IHCP PCP and avoid passive or default assignments to a non-IHCP PCP. This could avoid disruption of care to the AI/AN enrollee and administrative burdens to the IHCP in helping the AI/AN enrollee reassign from their PCP to an IHCP PCP.

Managed Care Plans Should Develop Tribal Specific Educational Materials

States could require managed care plans to develop educational materials for AI/AN enrollees that are easily accessible and described in a culturally appropriate manner in the enrollee handbook and on the plan's website. Some states have developed Tribal specific educational materials to guide AI/AN enrollees and IHCPs through Medicaid and CHIP eligibility process; managed care enrollment and disenrollment process; and billing processes and requirements, including referrals to in-network providers. For example, the Washington Medicaid and CHIP program developed a Tribal Billing Guide [5] to assist enrollee's navigation of the state's Medicaid fee-for-service (FFS) and managed care delivery systems by providing an overview of the state's Medicaid and CHIP programs. [6] This guide also explains provider eligibility requirements for Indian Health Service (IHS) operated facilities, Tribally operated facilities and IHCPs that are designated as Federally Qualified Health Centers and specific billing instructions for IHCPs. In addition, beginning on page 40, the guide provides instructions for enrolling and disenrolling AI/ANs from managed care and the state's Primary Care Case Management programs program into the state's FFS program.

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Develop internal processes to address reimbursement and claims processing for IHCPs.

Managed Care Plans Should Avoid Automatic Claim Denials for Claims from Out-of-Network IHCPs

Most managed care plans have internal processes that automatically generate claim denials based on a health care provider's out-of-network status. However, because the managed care protections for Indians at 42 C.F.R. § 438.14(b)(4) allow AI/AN enrollees to access services from out-of-network IHCPS, states should include a contractual provision that requires plans to develop internal processes that identify claims from IHCPs and accurately process them regardless of network status. For example, some managed care plans that operate in states with large AI/AN populations keep a current list of IHCPs located in the state so the plan can confirm if the IHCP is on that list before a claim from an IHCP is denied based on out-of-network status.

States could also develop similar internal processes to identify out-of-network IHCPs located in neighboring states and ensure that those claims are also accurately processed regardless of network status. This helps states that have few network IHCPs meet regulatory network sufficiency standards by allowing AI/ANs to access out-of-state IHCPs (42 C.F.R. § 438.14(b)(5)).

Managed Care Plans Should Contract with as Many IHCPs as Possible

States have the flexibility to require that managed care plans reach out and offer a provider agreement to all IHCPs in the plan's service area. While IHCPs do not have to be a network provider to be reimbursed, making them network providers will ensure timelier reimbursement and avoid resource intensive claim denial resolutions for the IHCP and the managed care plan. A network IHCP will also be able to quickly refer AI/ANs to in-network specialists promoting better access to care. To assist managed care plans with contracting with IHCPs, CMS developed an ITU Addendum [7] for contracting with Medicaid and CHIP managed care plans. Use of this contract addendum is voluntary and fully discussed in section 4.3 of this Toolkit. In addition, the IHS publishes comprehensive lists of its facilities by Area and facility type (hospital, health center, dental clinic, or behavioral health facility). States can use this information to locate facilities and encourage managed care plans to contract with as many facilities as possible. [8]

Some states reimburse IHCPs for community health representative and translation services if the IHCP is in the network. [9] Other states have offered enhanced reimbursement to IHCPs as an incentive to implement electronic claims and payment processing. States could also monitor the number of IHCPs in plan networks. If an IHCP is not contracted with a managed care plan, the state could contact the managed care plan to encourage the plan to offer a contract to the IHCP. California is an example of a state that requires all plans to attempt to contract with IHCPs. [10]

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Managed Care Plans Should Pay IHCPs the Total IHS All Inclusive Rate (AIR) Directly

IHCPs typically bill the managed care plan for the negotiated contract rate and then bill the state for the difference between the negotiated rate and the AIR, often referred to as the "wrap" payment. Requiring IHCPs to bill the plan and the state places a significant administrative burden on the IHCPs and often delays complete payment for services rendered. To alleviate this administrative burden, states can submit a state plan amendment to CMS to utilize an alternative payment methodology as specified in section 1902(bb)(6) of the Act. Once approved, the state would need to amend their managed care contracts to require plans to pay the entire IHS AIR directly to IHCPs.

Medicaid Managed Care Roundtable Report highlights this practice in California. When California first approached its managed care plans about paying the AIR to IHCPs, the plans were concerned because paying the AIR might subject the plans to financial risk. To address this concern, California established separate non-risk contract arrangements with their plans so when the plans pay the AIR for services provided to AI/ANs, the plans are not at risk for the higher payment. Payment of the AIR directly to IHCPs has been a requirement for California managed care plans since January 1, 2018. As explained in an "All Plan Letter," the state requires all plans to make the necessary payments to IHCPs so that they receive the applicable AIR for eligible services provided after January 1, 2018. [11]

1 42 C.F.R. § 438.14 is available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.14.
2 Many of the AI/AN and IHCP issues identified in the 2017 Promoting Access in Medicaid and CHIP Managed Care Toolkit are similar to the issues raised during the Roundtable. The Access Toolkit can be found here: https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf.
3 The final Medicaid and CHIP rule is available at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.
4 To explore more barriers AI/ANs have to accessing care, *see* pages 101-102, 2017 Promoting Access in Medicaid and CHIP Managed Care Toolkit Access Toolkit.Available at: https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf.
5 The Washington Tribal Billing Guide, (last updated October 1, 2022) can be found here, https://www.hca.wa.gov/assets/billers-and-providers/Tribal-health-bg-20221001.pdf.
6 See endnote 5 above, Washington Tribal Billing Guide at page 40.
7 The Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Indian Addendum for contracting with Indian Health Care Providers is available at, https://www.medicaid.gov/sites/default/files/2019-12/addendum-ihcps.pdf.
8 IHS facilities are available through the IHS website at https://www.ihs.gov/locations/.
9 For examples of managed care plan provider incentives in California and New Mexico, *see* page 103, 2017 Promoting Access in Medicaid and CHIP Managed Care Toolkit Access Toolkit. Available at: https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf.
10 *See* January 19, 2018 California "All Plan Letter" reminding the state's managed care plans of their obligation to attempt to contract with IHCPs. The letter is available at, https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-020.pdf.
11 The January 19, 2018 California "All Plan Letter" announcing the reimbursement change that requires the state's managed care plans to directly reimburse IHCPs for the entire AIR rate is available at, https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-020.pdf.

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Purpose: This section describes the statutory framework that allows states and Tribes to establish an Indian Managed Care Entity (IMCE) and highlights the work that Oregon and North Carolina undertook to develop the first IMCEs.

Statutory Framework Establishing the IMCE

Section 1932(h) 4)(B) [1] of the Social Security Act provides authority for states to establish an IMCE as a type of Medicaid managed care plan that predominantly serves AI/AN individuals. [2] IMCE is defined as a managed care entity that is controlled by the Indian Health Service (IHS), a Tribe or Tribal organization, or Urban Indian Organization (UIO), or a consortium of any of these entities. IMCEs can include managed care organizations (MCO), Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plans (PAHP), Primary Care Case Management programs (PCCM), or PCCM entities (PCCMe). Per the regulations at 42 C.F.R. 438.14, an IMCE can take the form of any of these types of managed care plans. IMCEs may restrict enrollment to American Indians and Alaska Natives (AI/AN) in the same manner that Indian Health Care Providers (IHCP) may restrict the delivery of services to AI/ANs (42 C.F.R. § 438.14(d)). [3] An IMCE may limit enrollment geographically to Tribal members living on the Tribe's reservation land or the Contract Health Service Delivery Area, known as the Purchased/Referred Care Delivery Area.

States seeking to address historic inequities and improve health outcomes for AI/AN populations living in their state may want to consider contracting with an IMCE as one way to pursue this goal. Development of an IMCE could provide an option for AI/AN enrollees to select a Tribal managed care plan that coordinates care of Medicaid services in a culturally competent manner and improves access to health services and health outcomes for AI/AN Medicaid beneficiaries. An IMCE could also be advantageous for Tribes to promote Tribal sovereignty and self-governance and provide additional financial resources to fund Tribal health programs. Tribes interested in developing an IMCE in their state, should contact their state Medicaid agency.

Spotlight on Oregon and North Carolina Approved IMCEs

CMS Approves SPAs Establishing a PCCM IMCE:

In 2021, CMS approved two Section 1932(a) SPAs from Oregon and North Carolina establishing PCCM IMCEs. The Oregon PCCM IMCE SPA[4] was approved on July 16, 2021 and the North Carolina PCCM IMCE SPA[5] was approved on September 13, 2021.

The nine Tribes and one UIO in Oregon and the one Tribe in North Carolina worked closely with their respective states through robust Tribal consultation in the development of the PCCM IMCE SPAs. Both SPAs cover similar care coordination services. However, the Oregon PCCM IMCE SPA authorizes individual PCCM IMCE entities that will be operated by each of the Tribes in Oregon and a UIO. The North Carolina SPA authorizes a single PCCM IMCE entity. The process the Tribes, UIO, and each state undertook to develop the IMCEs and obtain CMS approval of both the SPAs and the managed care contracts is highlighted below. Programmatic features of both IMCEs are also described, highlighting the IMCE service delivery area(s), eligibility, enrollment, and care coordination benefits.

Oregon has over 1.5 million[6] individuals enrolled in the Oregon Health Plan (OHP), Oregon's Medicaid and CHIP program. Approximately 58,000 of those individuals enrolled in the OHP are AI/AN. Oregon has nine federally recognized Tribes[7] and one UIO. The Oregon Tribes and the Native American Rehabilitation Association Northwest (NARA NW, Oregon's UIO)[8] developed separate PCCM IMCE entities.

Development of the Oregon IMCEs:

The state-Tribal-UIO collaboration to develop the Oregon IMCEs took place over a two-year period. The Tribes first approached the state about the concept of creating an IMCE at a regularly scheduled Tribal consultation meeting. The state held discussions with the Tribes, IHCPs, and state Medicaid managed care subject matter experts. Following those discussions, the state, Tribes, and UIO formed workgroups to address the various components of an IMCE that would meet the requirements at 42 C.F.R. Part 438.[9] The state, Tribes, and UIO identified dedicated staff to work on the development of the IMCE. Systems needed to be developed to allow for sharing of enrollment data between the IMCE and the state Medicaid program. In addition, Tribal specific enrollee materials had to be developed by each Tribe and the UIO. The state drafted a Section 1932(a) managed care SPA and submitted the SPA for approval by CMS.

While the SPA was under review, each IMCE went through state managed care readiness reviews. CMS requires that every managed care plan pass a comprehensive joint CMS/state readiness review to ensure that every plan is ready to fulfill its contractual obligations. For a Primary Care Case Management Entity (PCCMe,) the review includes the entity's readiness to: accept enrollments; provide the necessary primary care case management and continuity of care; and facilitate access to Medicaid providers services, including pharmacy providers.[10] Following successful completion of the readiness reviews, each IMCE had to negotiate a contract with the state to provide PCCM services. Oregon submitted the IMCE contract to CMS for approval. Following CMS approval of the 1932(a) SPA and the IMCE contracts, the state began enrolling members into the IMCE.

Service Delivery Area:

The Tribal PCCM IMCEs operates in the individual Tribe's Contract Health Service Delivery Areas. The UIO, NARA NW, operates in a tri-county service area, which includes the three metropolitan counties surrounding Portland.

IMCE Eligibility:

AI/ANs, as defined under 42 C.F.R. 438.14(a)), are eligible to enroll in a PCCM IMCE, as long as they are Medicaid eligible and enrolled in fee-for-service (FFS). If the AI/AN is enrolled in another managed care program, they must disenroll from that plan and request to enroll in the IMCE. AI/ANs that reside in a nursing facility or intermediate care facility for individuals with intellectual disabilities are not eligible to enroll in the IMCE.

IMCE Enrollment:

AI/AN Medicaid beneficiaries are not mandated into Medicaid managed care and have the option to enroll in the state's FFS program or managed care program, known as a Coordinated Care Organization.[1] Once the Tribal PCCM IMCEs become operational, AI/AN Medicaid beneficiaries enrolled in the state's FFS program can request to be enrolled in their respective Tribe's PCCM IMCE. If an AI/AN enrollee is currently enrolled in a state's managed care program, they can voluntarily disenroll from their managed care plan and request enrollment in their Tribe's IMCE or the UIO IMCE. The PCCM IMCEs submit monthly rosters of individuals enrolled in their respective IMCEs to the state's Medicaid program so they can pay the IMCE for the primary care case management services provided to these individuals.

IMCE PCCM Services:

The PCCM IMCEs provide primary care case management services to AI/ANs enrolled in their IMCE and assist these individuals by coordinating health care provided by the Tribal or UIO health care providers and health care provided by non-Tribal Medicaid or CHIP providers as needed. In addition to primary care case management, the PCCM IMCEs provide the following services:

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

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North Carolina has over 2.8 [12] million Medicaid and CHIP beneficiaries. Approximately 64,000 of these beneficiaries are AI/ANs, representing 34 percent of North Carolina's AI/AN population. Because the state was in the process of moving all Medicaid beneficiaries into managed care, the state began exploring managed care options with the Eastern Band of Cherokee Indians (EBCI) in 2015. With the expansion of managed care across the state, EBCI wanted to develop a Tribal managed care option to improve health outcomes of AI/AN enrollees by coordinating health care needs, such as primary care, preventive health, chronic disease management, and care management for individuals with functional limitations. The EBCI operates the Cherokee Indian Health Authority (CIHA), [13] which is a hospital-based delivery system that operates under the Indian Self-Determination and Education Assistance Act [14] and includes the hospital, three outpatient clinics, a recovery center, and a residential treatment center.

On July 1, 2021, "EBCI Tribal Option" [15] was established as a PCCMe IMCE managed by the CIHA. The EBCI Tribal Option manages the primary care coordination needs of AI/AN Medicaid enrollees. The EBCI Tribal Option also includes care coordination for mental health disorders, substance use disorders, intellectual/developmental disability, or traumatic brain injury. The EBCI offers added services, such as wellness programs and education vouchers. EBCI Tribal Option members can get services from any North Carolina Medicaid or North Carolina Health Choice provider. More information about the EBCI Tribal Option can be found in the North Carolina Department of Health and Human Services fact sheet on the EBCI Tribal Option. [16]

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Development of the North Carolina IMCEs:

In 2015, the EBCI, through the CIHA, began working with the state to create an PCCMe IMCE. The CIHA was responsible for managing patient care but did not have the infrastructure to support creating an IMCE. CIHA became a Patient-Centered Medical Home under the state's Medicaid program and subsequently, a primary care provider in a statewide PCCM network. Under this arrangement, the CIHA and state negotiated an enhanced care case management payment for services provided to AI/AN enrollees. The Tribe used the income from the enhanced care case management payments to support the development of the EBCI Tribal Option including eligibility and enrollment processes, care coordination services, and the service delivery area for the IMCE.

Service Area:

The EBCI Tribal Option is offered in five counties that includes the EBCI reservation and the counties contiguous to the reservation consistent with the EBCI's service delivery system under its ISDEAA compact with IHS.[17]

IMCE Eligibility:

Enrollees are eligible for the EBCI Tribal Option if they are AI/ANs eligible to receive health services from the CIHA, the Tribe's health delivery system, and enrolled in Medicaid or CHIP.

IMCE Enrollment:

An AI/AN Medicaid beneficiary who does not select one of the state's "North Carolina Medicaid Direct" managed care plans and whose current primary care provider (PCP) is the CIHA, is automatically enrolled into the EBCI Tribal Option. If the AI/AN enrollee does not have CIHA as their PCP, they may request to enroll in the EBCI Tribal Option. The state sends monthly updates to CIHA of those AI/AN Medicaid beneficiaries that select the EBCI Tribal Option.

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IMCE PCCM Services:

Under the EBCI Tribal Option, the IMCE offers primary care case management of medical, behavioral health, pharmacy, and support services to address the health needs of AI/AN Medicaid enrollees. It is a relationship-based patient-centered model that connects patients to doctors, appointments, medication, and therapy ensuring that enrollees get the most out of their Medicaid benefits. In addition to primary care case management, the PCCM IMCEs provide the following services:

1. Provision of intensive telephonic case management.
2. Provision of face-to-face case management.
3. Development of enrollee care plans.
4. Provision of enrollee outreach and education activities.
5. Operation of a customer service call center.
6. Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
7. Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
8. Coordination with behavioral health systems/providers.
9. Coordination with long-term services and supports systems/providers.

1 Section 1932(h)(3)(4)(B). Available at https://www.ssa.gov/OP_Home/ssact/title19/1932.htm#act-1932-h-4-b.
2 The development of a Children's Health Insurance Program IMCE is not addressed in this section of the toolkit because there is no corresponding cross-reference in title XXI.
3 42 C.F.R. § 438.14(d).Available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.14.
4 To review the approved Oregon PCCMe SPA, see https://www.medicaid.gov/medicaid/spa/downloads/OR-21-0008.pdf.
5 To review the approved North Carolina PCCMe SPA, see https://www.medicaid.gov/Medicaid/spa/downloads/NC-21-0011.pdf.
6 Oregon 2023 Medicaid enrolment report is available at, https://app.powerbigov.us/view?r=eyJrIjoiMTRhMmNhZDktYzY4OS00MzIxLTg4NTAtNjc4NmVlNjA1NzI4IiwidCI6IjY1OGU2M2U4LThkMzktNDk5Yy04ZjQ4LTEzYWRjOTQ1MmY0YyJ9.
7 For more information about federally recognized Tribes, see https://www.bia.gov/service/tribal-leaders-directory/federally-recognized-tribes.
8 For more information about the Native American Rehabilitation Northwest Urban Indian Organization, see https://www.naranorthwest.org/.
9 Tribal consultation, roundtable discussions, and forming workgroups are regular components of the Oregon Health Plan (OHP) Section 1902(a)(73) ARRA Tribal consultation process. More information on OHPs Tribal consultation process can be found at, https://www.oregon.gov/oha/documents/Tribal_Consultation_and_UIHP_Confer_Policy.pdf.
10 Sample readiness tool can be found at, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ReadinessReviews.
11 More information about the Oregon Care Coordination Organizations can be found at, https://www.oregon.gov/oha/hsd/ohp/pages/coordinated-care-organizations.aspx.
12 North Carolina 2023 Medicaid enrollment report is available at, https://medicaid.ncdhhs.gov/reports/nc-medicaid-enrollment-reports.
13 Cherokee Indian Health Authority https://cherokeehospital.org/.
14 Indian Self-Determination and Education Assistance Act of 1975. Available at https://uscode.house.gov/view.xhtml?path=/prelim@title25/chapter46&edition=prelim.
15 The Cherokee Indian Hospital Authority fact sheet on the EBCI Tribal Option is available at, https://ebcitribaloption.com/ or the EBCI Tribal Option Fact Sheet at https://medicaid.ncdhhs.gov/media/9524/download?attachment.
16 The North Carolina Medicaid factsheet on the EBCI Tribal Option is available at, https://medicaid.ncdhhs.gov/documents/county/ncmt-fact-sheet-ebci-tribal-option-overview-dec-22-2021/download?attachment.
17 Operating under a 638 contract/compact with IHS pursuant to the Indian Self-Determination and Education Assistance Act of 1975. Available at, https://www.bia.gov/sites/default/files/dup/assets/bia/ots/ots/pdf/Public_Law93-638.pdf?source=post_page----------#:~:text=The%201975%20Indian%20Self%2DDetermination,Act%20and%20other%20Acts%2C%20Pub.

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AI/AN	American Indians and Alaska Natives
AIR	All Inclusive Rate
ARRA	American Reinvestment and Recovery Act
CCO	Coordinated Care Organization
CHIP	Children's Health Insurance Program
CIHA	Cherokee Indian Hospital Authority
CMS	Centers for Medicare & Medicaid Services
EBCI	Eastern Band Cherokee Indians
FFP	Federal Financial Participation
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FTCA	Federal Tort Claims Act
IMCE	Indian Managed Care Entity
IHCP	Indian Health Care Provider
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
ISDEAA	Indian Self-Determination and Education Assistance Act of 1975
ITU	IHS, Tribal and Urban health care delivery system
MCO	Managed Care Organization
MLTSS	Managed Long Term Supports and Services
NARA NW	Native American Rehabilitative Association Northwest
OHP	Oregon Health Plan
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCCMe	Primary Care Case Management Entity
PHIP	Prepaid Health Insurance Plan
PRC	Purchased and Referred Care
SPA	State Plan Amendment
SSA	Social Security Act
TTAG	Tribal Technical Advisory Group
UIO	Urban Indian Organization

All-Inclusive Rate (AIR)

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). The AIR is published in the Federal Register annually and is applicable to reimbursement methodologies primarily under the Medicare and Medicaid programs. The current rate can be found at https://www.ihs.gov/BusinessOffice/reimbursement-rates/.

American Indians and Alaska Natives (AI/AN)

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

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." The ARRA package included a series of federal government expenditures aimed at countering the job losses associated with the 2008 recession. ARRA Section 5006 included Medicaid protections for AI/ANs and IHCPs, including managed care protections and cost sharing protections.

American Indian Health Commission (AIHC)

The American Indian Health Commission (AIHC) is a local state Indian health board that focuses on American Indian and Alaska Native health in Washington state. AIHC membership includes 29 federally recognized Indian Tribes whose traditional lands and territories included parts of Washington, and two Urban Indian Health Organizations (UIHOs).

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Care Coordination Organization (CCO)

An organization that deliberately organizes patient care activities and shares information among all of the participants concerned with a patient's care to achieve safer and more effective care.

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 and partners with states to administer the Medicaid and Children's Health Insurance Program (CHIP) programs.

Eastern Band of Cherokee Indians Tribal Option (EBCI Tribal Option)

The EBCI Tribal Option is an Indian Managed Care Entity (IMCE) that participates in North Carolina Medicaid to provide managed care for federally recognized Tribal members and other individuals eligible to receive Indian Health Services.

Executive Order 13175

An Executive Order signed by President Clinton on November 6, 2000, requiring federal agencies to engage in meaningful Tribal consultation. President Biden reaffirmed this Executive Order on January 26, 2021. The Department of Health and Human Services requires all executive departments and agencies, including CMS, to engage in regular, meaningful, and robust consultation with Tribal officials in the development of federal policies that have Tribal implications.

Fee-for-Service (FFS)

States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both. Under the FFS model, the state pays providers directly for each covered service received by a Medicaid beneficiary.

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 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.

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Federal Tort Claims Act (FTCA)

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 and 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. Also known as the ITU system. (25 U.S.C. § 1603).

Indian Health Service (IHS)

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 Managed Care Entity (IMCE)

An IMCE is a managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, primary care case management (PCCM), or PCCM entity (PCCMe) 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.

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Indian Self-Determination and Education Assistance Act of 1975 (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.

ITU System (ITU)

Three types of Indian health care programs make up the core of the Indian health system:1) IHS, an operating division of the U.S. Department of Health and Human Services, 2) Tribes/Tribal organizations, and 3) Urban Indian Organizations, collectively abbreviated as ITU.

Managed care organization (MCO)

An MCO means an entity that has, or is seeking to qualify for, a comprehensive risk contract with a state Medicaid or CHIP agency to deliver a portion or the entirety of the services provided through a Medicaid program. (42 C.F.R. 438.2).

Medicaid Managed Care Plan (MCP)

A managed care plan is a managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, primary care case management, or primary care case management entity, as defined in 42 C.F.R. 438.2, that contracts with a state Medicaid or CHIP agency to deliver a portion or the entirety of the services provided through a Medicaid program.

Managed Long Term Supports and Services (MLTSS)

Managed Long Term Services and Supports (MLTSS) refers to the delivery of long-term services and supports through capitated Medicaid managed care programs.

Model Medicaid and Children's Health Insurance Program Managed Care Indian 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, identifies several specific provisions that have been established in federal law that apply when contracting with IHCPs, and provides contract language to support those provisions.

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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 and Alaska Natives.

Oregon Health Plan

The Oregon Health Plan (OHP) is Oregon's Medicaid and Children's Health Insurance Program.

Prepaid Inpatient Health Plans (PIHPs)

A pre-paid health plan that provides certain inpatient services to enrollees and can include mental and behavioral health. (42 C.F.R. § 438.2).

Prepaid Ambulatory Health Plans (PAHPs)

A pre-paid health plan that provides certain out-patient health services to enrollees. (42 C.F.R. § 438.2).

Primary Care Case Management Programs (PCCM)

A managed care 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. (42 C.F.R. § 438.2).

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.

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.

Social Security 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.

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State Quality Strategy

Federal regulations at 42 C.F.R. § 438.340(b) lay the groundwork for the development and maintenance of a quality strategy to assess and improve the quality of managed care services offered within a state. This quality strategy is intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care that enrollees receive, as well as for setting forth measurable goals, objectives, and targets for improvement.

Transparency Requirements

The Affordable Care Act requires opportunity for public comment and greater transparency of the Section 1115 demonstration projects. The final rule, effective on April 27, 2012, established a process for ensuring public input into the development and approval of new section 1115 demonstrations as well as extensions of existing demonstrations. Transparency requirements ensures that the public will have an opportunity to provide comments on a demonstration while it is under review at CMS.

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).

Urban Indian Organization (UIO)

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.

Washington Health Care Authority (HCA)

The Washington Health Care Authority (HCA) is Washington's Medicaid and Children's Health Insurance Program.

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