

# CMS Center for Medicaid and CHIP Services



Medicaid and  
Children's Health  
Insurance Program  
(CHIP) Managed Care  
Final Rule

Overview of the  
Indian Specific  
Provisions



# Background

This final rule is the first update to Medicaid and CHIP managed care regulations in over a decade. The health care delivery landscape has changed and grown substantially since 2002.

- Publication of Final Rule in the **Federal Register** May 6<sup>th</sup> (81 FR 27498).
- Effective date, is July 25, 2016 with a phased implementation of new provisions primarily over 3 years, starting with contracts on or after July 1, 2017 ***including Indian specific managed care provisions***
  - Compliance with CHIP provisions beginning with the state fiscal year starting on or after July 1, 2018



# Overview of Indian Provisions

- The final rule codifies a range of Indian managed care protections, for the treatment of Indians, Indian Health Care Providers (IHCPs), and Indian Managed Care programs (IMCPs), including those in section 1932(h) of the Social Security Act (Act), as added by section 5006(d) of American Recovery and Reinvestment Act of 2009 (ARRA). These provisions were effective July 1, 2009.
- The final rule applies the Indian protections in 1932(a)(2)(C) and 1932(h) to all types of managed care programs, including Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Management Entities (PCCM Entities).



# Overview of Indian Provisions

- The Indian-specific provisions, “Standards for Contracts Involving Indians, Indian Health Care Providers and Indian Managed Care Entities” are located in the Medicaid rules at §438.14, and made applicable in CHIP by a cross reference in the CHIP rules at §457.1209.
- These provisions allow Indians enrolled in Medicaid and CHIP managed care plans to continue to receive services from an Indian health care provider and ensures IHCPs are reimbursed appropriately for services provided.
- The final rule addresses other tribal issues, such as sufficient network and payment requirements for managed care plans that serve Indians, network provider agreements with IHCPs, state tribal consultation requirements, referrals and prior authorization requirements.



# Definitions

**“Indian”** means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

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



# Definitions

- **Indian Health Care Provider (IHCP)** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
- **Indian Managed Care Entity (IMCE)**,” means a MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.





# Network Sufficiency Standards and Provider Choice

- Any Indian who is enrolled in a non-Indian managed care plan and eligible to receive services from a network IHCP to choose that IHCP as his or her primary care provider, as long as that provider has the capacity to provide the services (§§438.14(b)(3) and 457.1209).
- Every MCO, PIHP, PAHP, or PCCM entity, must demonstrate that there are sufficient IHCPs participating in the network to ensure timely access to services available under the contract from IHCPs for Indian enrollees who are eligible to receive services (§§438.14(b)(1) and 457.1209).



# Network Sufficiency Standards and Provider Choice

In the event that timely access to IHCPs in network cannot be guaranteed due to few or no network participating IHCPs, §§438.14(b)(5) and 457.1209 provides that the sufficiency standard in §§438.14(b)(1) and 457.1209 is satisfied if:

1. Indian enrollees are permitted by the MCO, PIHP, PAHP, or PCCM entity (if applicable) to access out-of-State IHCPs; or
2. This circumstance is deemed a good cause reason under the managed care plan contract for Indian enrollees to disenroll from the State's managed care program into fee-for-service (§438.56(c) and 457.1212).





# Payment and Contracting

- When an IHCP is enrolled in Medicaid or CHIP as a FQHC but is not in the network with a MCO, PIHP, PAHP, or PCCM entity, the IHCP must be paid the FQHC payment rate under the State plan, including any supplemental payment due from the state (§§438.14(c)(1) and 457.1209).
- When an IHCP is not enrolled in Medicaid or CHIP as a FQHC, and regardless of whether the IHCP participates in the network, the IHCP must receive the applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology (§438.14(c)(2) and §457.1209).



# Payment and Contracting

- When the amount an IHCP receives from a MCO, PIHP, PAHP, or PCCM entity is less than the applicable encounter or fee-for-service rate, whichever is applicable, the state must make a supplemental payment to the IHCP to make up the difference between the amount the MCO, PIHP, PAHP, or PCCM entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate (§§438.14(c)(3) and 457.1209).
- States may allow the managed care entity to pay the FFS or applicable encounter rate directly to the IHCP.



# Avoiding Duplicate Visits for Referrals

- MCOs, PIHPs, PAHPs, and PCCM entities (if applicable)s must permit an out-of-network IHCP to refer an Indian to a network provider for covered services.
- This provision is intended to avoid duplicate visits to a network provider to obtain a referral and any delay in treatment when referrals are made under these circumstances (§§438.14(b)(6) and 457.1209).



# Auto Assignment

- When auto-assigning Indians to primary care physicians (PCP), managed care plans should review their auto-assignment algorithm to ensure that an appropriate logic is used to accomplish the most appropriate PCP assignment.
- Such criteria could include an enrollee's historical relationship with a PCP.
- Additionally, managed care plans should ensure that information on the process for changing PCPs is easily accessible and, at a minimum, described in the enrollee handbook and on the managed care plan's website (§§438.10(f)(2)(x), §438.10(f)(3), and 457.1207).



# Mandatory Enrollment into Medicaid Managed Care

- To require Medicaid or CHIP beneficiaries to enroll in managed care to receive coverage, a state must obtain approval from CMS either through a Medicaid state plan amendment, a 1915(b) waiver, or through the section 1115 demonstration authority.
- Consistent with the CMS Tribal Consultation Policy, and the requirements of section 1902(a)(73) of the Act, added by ARRA §5006(e), states are required to engage in a meaningful consultation process with federally recognized Tribes and/or Indian health care providers located in their state prior to the submission of a SPA, waiver, or demonstration having tribal implications.



# Mandatory Enrollment into Medicaid Managed Care

- States must consult with tribes in accordance with the state's ARRA tribal consultation policy if the state requires Indians to enroll in managed care to receive coverage.
- States have authority to exclude Indians from mandatory enrollment into managed care.
- CMS strongly encourages states to engage in meaningful consultation with Tribes and Tribal health programs before mandatorily enrolling Indian beneficiaries into managed care.



# Medicaid State Plan

- States can implement a mandatory managed care delivery system for certain populations through Medicaid state plan amendment that meets standards set forth in section 1932 of the Act.
- However, section 1932(h) of the Act prohibits states from mandatory enrollment of an individual who is an Indian into managed care unless the MCO, PIHP, PAHP, PCCM or PCCM entity contracted with the state is an IMCE.





# 1915(b) Waiver

- CMS may grant a waiver under section 1915(b) of the Act that permits a state to require all Medicaid beneficiaries to enroll in a managed care delivery system, including Indians.
- In reviewing such waiver requests, CMS will consider any input the state received in the tribal consultation process.
- state and its tribes could reach mutual consensus to exempt Indians from 1915(b) managed care waivers for reasons such as network sufficiency, contracting and payment difficulties, and access to culturally appropriate providers.



# 1115(a) Demonstration

- States have the option to exempt Indian populations from mandatory enrollment in a managed care delivery system permitting Indian populations to obtain access to health care through a fee for service delivery system.
- Historically, CMS has not approved section 1115(a) demonstrations that have mandated Indians into managed care. Those approvals were the result of state/Tribal consultation and CMS/Tribal consultation with participation from the state. We strongly encourage states and Tribes to engage in meaningful consultation when considering mandating Indians into managed care. States are required to consult consistent with the process outlined in its approved ARRA Tribal consultation state plan amendment.



# Indian Managed Care Addendum

- The ITU Addendum outlines all the federal laws, regulations, and protections that are binding on MCOs, PIHPs, PAHPs, and PCCM entities (if applicable) and identifies several specific provisions that have been established in federal law that apply when contracting with IHCP.
- The use of this ITU Addendum benefits both managed care entities and IHCPs by lowering the perceived barriers to contracting with IHCPs, and minimizing potential disputes.
- The ITU Addendum helps to integrate IHCPs into managed care networks and ensures that Indian beneficiaries have access to comprehensive and integrated benefits package and ensure that Indian can continue to be served by their IHCP of choice.



# Indian Managed Care Entity (IMCE)

- The rule at codifies provisions of section 1932(h) that define IMCEs and sets out a special rule for enrollment in an IMCE.
- The special enrollment rule permits an IMCE to restrict its enrollment to Indians in the same manner as IHCPs may restrict the delivery of services to Indians (§§438.14(d) and 457.1209).



# V. Questions Comments??

Please send any questions or comments to:

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