Redacted - VFOIA Exempt

Crux of the issue:

- If the tribes opt to serve non-tribal members, they can. That is their choice, we don't have any choice in the matter.
- We have to pay them the same rate for non-tribal members that we pay for tribal members, which is currently the AIR rate.
- The state doesn't get the 100% FMAP for non-tribal members.

Our levers for getting a handle on the situation seem to be:

- Stop allowing the tribes to bill at the AIR rate for HCBS/**waiver services** "received through" non-tribal providers (we believe waiver services are not covered under our current tribal reimbursement SPA, and we think it is up to the state Medicaid agency what services to allow as received through).
- Implement the requirement that the tribal providers must bill MCOs for services to members in managed care. (We are required to do this anyway and are out of compliance.)

In communicating with the tribes, we have to provide them with options for whether to be in-network or out of network with the MCOs.

- We need to explain that if they are out of network, the MCOs are required to reimburse for managed care-enrolled AI/AN tribal members but that same protection **doesn't** apply for non-AI/AN members.
- Being in-network with the MCOs would be advantageous for the tribal providers because they could receive reimbursement for services provided to non-AI/AN members who are enrolled in managed care.

We no longer think it is a good idea to allow them to continue to provide waiver services because they could opt to go in network and under our current SPA/arrangement for received-through services, ultimately the state would be on the hook for half the cost of paying the clinic at the AIR rate for non-tribal members.

--

I'm going to start with managed care because I keep putting it last and as a result I think we haven't been able to have an in-depth discussion about it, but it is the most important piece.

Beyond the implications for double payment caused by paying the tribal providers entirely through FFS, there are requirements for states where tribal providers are serving members enrolled in managed care that we are not meeting.

We are federally required to have the MCOs reimbursing the tribes for services to tribal members who are in managed care, even if the tribal facility is not in-network with the plans.

A corollary to that is that the tribes must bill the MCOs for services to members in managed care.

It's important for us to proceed in this with the awareness of the managed care protections that the tribal providers and tribal members have and the requirements around tribal consultation in decision making.

The first step in the managed care transition is that we will need to explain the managed care options to the tribes.

The key choice is In-network or out of network

My understanding from the guidance is that we can't require the tribal providers to be in-network. However, it will likely be a better setup for them to be in-network.

We need to present the options to them and explain the implications of not participating in the networks on reimbursement for services to non-AI/AN individuals enrolled in managed care:

- MCOs must cover services provided to AN/AN tribal members by a tribal provider even if the tribal provider is out of network with the member's plan.
- However, *the same right does not exist* for non-tribal members.

For this reason, what will most likely make sense is to be in-network.

They could choose to provide waiver services at the AIR rate to only tribal members and remain out of network. But then if they change their mind down the road and want to be in-network and start providing services to non-AI/AN members, we would be back in a similar situation.

MCO networks – required to have enough tribal providers to serve tribal members or else AI/AN person has good cause to disenroll from managed care.

We need to assess the services they are currently providing and establish a process for reviewing new services they want to add in the future. There are services like dental, behavioral health, where these are services FQHCs can provide that they are providing, and they can bill at the AIR for both tribal and non-tribal members served.

Areas where DMAS decision-making control:

- What services the tribal providers can bill for at the AIR as "received through" services rendered by non-tribal providers (we could decide that they cannot do this for HCBS/waiver services and it is not covered under our current SPA)

- What rate is paid FFS
- In negotiation with the MCO, what rate the MCO pays the tribal providers (but we must still top off)
- For non-AI/AN Medicaid members served by the tribes, they do not have

Areas where we do NOT have control

Whether the tribal providers can serve non-AI/AN members (tribes choose)

Whether AI/AN tribal members participate in managed care

- in other words, in consultation with them, they could become an exempted population from our 1915(b).
- In addition, if it is found that the MCO networks don't have sufficient adequacy
- Whether tribal providers participate in the MCO networks (but they must still bill managed care even if OON for members who are enrolled in managed care).
- Whether to be reimbursed as a tribal FQHC

Areas