What we know:

MCOs required to reimburse tribal providers for services to AI/AN members enrolled in their plan, even if out of network.

Can't require tribal provider to be in-network with one or more MCOs. (But you can require tribal provider to bill MCO for services provided to MCO-enrolled AI/AN individuals.)

Must allow AI/AN to choose tribal provider as PCP regardless of whether in-network with their MCO

Every MCO is required to demonstrate that there are sufficient tribal providers participating in network to ensure timely access to services for Indian enrollees.

If this cannot be guaranteed due to few or no network participating tribal providers, there exists good cause for Indian member to disenroll from managed care into FFS

States have the option to exempt Indians from mandatory managed care. (In our case, to make them no longer a 1915(b) population and serve AI/AN members entirely through FFS.)

> Considerations:
> States must consult with Tribes in accordance with the state's Tribal consultation policy if the state is proposing to mandate Indians into managed care (MCOs, PIHP, or PIHP) to receive coverage. Because states have authority to exclude Indians from mandatory enrollment into managed care, states should, through Tribal consultation, consider such factors as access to specialty providers, contracting and payment difficulties with MCEs, and ensuring continued access to culturally appropriate providers before a decision is made to mandatorily enroll Indians into managed care.

When a tribal provider is enrolled in Medicaid as a FQHC but is not a participating provider with a MCO, they must be paid the FQHC payment rate under the state plan, including any supplemental payment due from the state. [[Guidance indicates this means the REGULAR FQHC rate, and then DMAS is required to top it off to the AIR rate~~. However, if the MCOs consent, CMS has recommended that state Medicaid agencies work out arrangements for MCOs to pay the AIR rate directly. (may require no-risk arrangement)~~]]

When an IHCP is not enrolled in Medicaid or CHIP as a FQHC, *and regardless of whether the IHCP participates in the network of an MCO*, the IHCP receives the AIR rate or the amount it would receive if the services were provided under the state plan's FFS payment methodology (which is the AIR rate). TRIBES COULD POTENTIALLY FAVOR THIS ARRANGEMENT IF NOT BILLING FOR "RECEIVED THROUGH" SERVICES AND ONLY SERVING AI/AN MEMBERS AND FFS NON-AI/AN MEMBERS. SO IF WE TAKE THOSE TWO OPTIONS OFF THE TABLE, THERE WOULD BE MINIMAL INCENTIVE FOR THEM TO ENROLL WITH MCOs AS A NETWORK PROVIDER.

Require MCOs to include all tribal providers in their network?

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 IHCPs located in their state prior to the submission of a SPA, waiver, or demonstration having Tribal implications.

CMS expects that states will continue to submit any planned managed care program changes through the state plan amendment process and comply with their Tribal consultation process.

What we don't know:

Can managed care plans reimburse the tribal FQHC (/can the tribal FQHC bill for) 1915(c) waiver services outside the 4 walls?

Must we allow this?

MCOs reimburse the tribal provider at the rate for FQHCs. DMAS then required to supplement payment to the tribal providers up to the AIR rate.

- Even with the wrap, this will be much less than currently receiving, because of the way we've been implementing the "all-inclusive rate" to be billed for individual services rather than per F2F/telehealth visit.
- Even with the wrap, this will be less than currently receiving if they cannot serve (i.e., MCO can't be required to pay for)/ provide outside the four walls services to non-tribal members.

Special considerations if requiring the MCOs to contract with Tribal providers:

> The use of this ITU Addendum benefits both MCOs, PIHPs, PAHPs, PCCM entities and IHCPs by lowering the perceived barriers to contracting, assuring that key federal laws are applied when contracting with IHCPs, and minimizing potential disputes. For example, MCOs, PIHPs, and PAHPs typically require participating providers to have private malpractice insurance. However, the ITU Addendum explains that IHCPs, when operating under a contract or compact with IHS to carry out programs, services, functions, and activities, (or programs thereof) of the IHS, are covered by federal tort immunity and private malpractice insurance is not required.