American Recovery and Reinvestment Act (ARRA)

Impact of Requirements for Managed Care Organizations
On Indian Health Services and 638 Facilities

Background

The American Recovery and Reinvestment Act (ARRA) included Section 5006 entitled "Protections for Indians under Medicaid and CHIP." Paragraph (d) of Section 5006 applied certain rules to managed care organizations (MCOs) with respect to Indian enrollees and Indian health care providers. A copy of the legislation is attached.

In general, this provision in ARRA requires that AHCCCS contracted health plans (1) include Indian health care providers within their network sufficient to ensure timely access to covered Medicaid managed care services; and (2) make payments directly to those Indian health care providers for care furnished to American Indians (AIs) enrolled in a health plan "at a rate equal to the rate negotiated between such entity and the provider involved or, if a rate has not been negotiated, at a rate that is not less than" the amount the health plan would pay for the services if furnished by a non-Indian health care provider.

Current Practice

Currently, the AHCCCS program ensures access to care for American Indians enrolled in an AHCCCS contracted health plan by permitting American Indian Medicaid members enrolled in managed care to obtain services at an IHS or 638 facility. That IHS or 638 facility then submits their claims to the AHCCCS Division of Fee-for-Service Management directly and is reimbursed directly by AHCCCS. There are no limitations currently for an American Indian Medicaid managed care enrollee to obtain services from an IHS or 638 facility. Conversely, under the rules of their contracts with AHCCCS, managed care organizations cannot pay IHS and 638 facilities directly for services furnished to Medicaid managed care enrolled AI members.

Issues

This requirement represents a significant departure from the current practice and, consequently, poses a number of hurdles for participating in the AHCCCS program. Some of these challenges are outlined below.

- *Billing complexities/systems issues*. This requirement poses significant billing complexities and systems issues not only for the health plans but also for the I/T/Us who are not set up to bill various individual managed care entities for acute and long term care services. There would also be changes to the way in which Prior Authorization (PA) would be obtained as the health plans would require concurrent review and have different processes for obtaining PA.
- *Funding Source*. Because this would require MCOs to reimburse I/T/Us directly, a state match would be required for all AI MCO enrollees obtaining services through I/T/Us. This would impact the General Fund. This also means that I/T/Us would be paid at the FFS rate rather than the All Inclusive Rate (AIR).
- *Waiver limitations*. Currently, the AHCCCS Administration is preparing a request to CMS to waive AIs receiving care from IHS or 638s from the benefits limitations that will be applied to all other AHCCCS enrollees. The ARRA requirement discusses the

provision of "covered Medicaid managed care services" through the MCO for AIs receiving care from an I/T/U. "Covered Medicaid managed care services" is defined in ARRA as "items and services for which benefits are available with respect to the individual *under the contract* between the [MCO] and the State involved." The benefits limitations recently prescribed by the state legislature will be included in the contracts between AHCCCS and the health plans and, therefore, it would limit our ability to seek a waiver from these benefits reductions for services provided at I/T/Us.

- *Credentialing Requirements*. Typically, it is recommended that providers working with AHCCCS contracted health plans establish a contract with that health plan. If an I/T/U seeks to become a contracted provider, it will have to be credentialed with each individual health plan and be subject to all of the relevant credentialing requirements in the Balanced Budget Act (BBA) that establishes the requirements for Medicaid managed care.

Proposed Solution

The current practice that allows Medicaid MCO enrolled AIs to obtain health care services through any IHS and 638 facility ensures access to care at these facilities. The provision in ARRA did not contemplate a system similar to the AHCCCS model. Consequently, this provision does not expand access but rather creates barriers for AI Medicaid managed care enrollees to access care at IHS and 638 facilities where those barriers do not currently exist.

This problem is further exacerbated by a decrease in funds that will be received, particularly by smaller facilities, as a result of switching from the AIR to a FFS rate. Because of the decrease in reimbursement, some smaller facilities may not be equipped to expand services to meet their growing demands, and some may have to decrease the number or types of services offered.

To prevent a decrease in access to care because of these barriers and lowered reimbursement, the AHCCCS Administration is considering seeking a waiver of this ARRA requirement, but is first seeking advice through tribal consultation.