



NATIONAL COUNCIL *of* URBAN INDIAN HEALTH

Recent Trends in Third-Party Billing at Urban Indian Organizations: A Focus on Medicaid Managed Care

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Executive Summary

This report serves as an update to NCUIH's previous reporting on recent trends in third-party billing. This report examines the history of managed care in Medicaid and the relationship between managed care organizations and Urban Indian Organizations (UIOs) in selected states. Specifically, this report includes:

- (1) **Background and history** of Medicaid managed care, pertinent legal authorities including Sections 1115, 1915(a), 1915(b), and 1932 of the Social Security Act, and unique provisions of law for American Indians and Alaska Natives in states with Medicaid managed care
- (2) **Data Analysis** examining the most recently available data from the Transformed Medicaid Statistical Information System (T-MSIS) related to Medicaid managed care at UIOs including enrollment numbers, average claims cost, and claims denial rates.
- (3) **Case studies** relating information concerning Medicaid managed care in selected states and interviews with certain UIOs from those states.
- (4) **A concluding discussion with key takeaways and potential best practices** based on the data analysis and case studies.

Key findings from this report's data analysis include estimated enrollment numbers, claims costs, and claim denial rates for UIOs serving patients enrolled in Medicaid managed care. NCUIH's analysis of Calendar Year 2019 T-MSIS data provides estimates that Medicaid managed care beneficiaries comprised 63 percent of the UIO patient population, submitted 68 percent of the claims, and produced 61 percent of the Medicaid payment revenue. The average amount paid for each managed care claim was \$132, compared to the average amount of \$176 paid for non-managed care claims. In 2019, 4 percent of managed care claim lines were denied, and 5 percent of non-managed care claim lines were denied.

This report also identified certain challenges and best practices through its case studies with UIOs. For example, UIOs who felt that they do not have a good working relationship with managed care organizations often cited the need for improved communication to strengthen that relationship. UIOs also noted that some managed care organizations lacked familiarity with the needs of AI/AN patients living in urban areas and made assumptions that AI/ANs living in urban areas would not want access to the same traditional healing and medicine that AI/AN beneficiaries living on reservations seek. Notably, clear consistent communication was a frequently cited factor in states where UIOs reported strong working relationship with managed care organizations. UIOs also emphasized the need for UIOs to work with other UIOs, Tribes, and other similarly situated health care providers to amplify their voice and strengthen their bargaining power to advance key Medicaid priorities.



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Part I: Managed Care Background and History

What is Managed Care?

Medicaid managed care is when a state contracts with a private organization to administer all or part of their Medicaid program. There are three main types of managed care arrangements: comprehensive risk-based managed care, primary case management (PCCM), and limited-benefit plans.ⁱ

In comprehensive risk-based managed care, a state contracts with a managed care organization (MCO) to cover all or most of the Medicaid-covered services for beneficiaries enrolled with that MCO.ⁱⁱ MCOs are compensated by the state on a per member, per month basis, also called a capitation rate.ⁱⁱⁱ MCOs take responsibility for overseeing patient care and managing reimbursement to providers.^{iv} MCOs provide medical services to Medicaid beneficiaries through their own networks of doctors and hospitals, and Medicaid beneficiaries must seek care through their MCO's network.^v

In PCCM, the state pays a designated primary care provider a monthly case management fee to “locate, coordinate, and monitor covered primary care,” for Medicaid beneficiaries.^{vi} The primary care provider may be a “[a] physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services,” or in some states a nurse practitioner, a nurse-midwife, or a physician’s assistant.^{vii} The state continues to pay providers on a fee-for-service basis for services outside the scope of primary care management.^{viii}

Some states work with limited benefit plans, which are unique to specific types of benefits. Included among limited benefit plans are those which manage “inpatient mental health or substance abuse benefits, non-emergency transportation, oral health, or disease management.”^{ix} Limited-benefit plans are usually paid on a capitated basis, like MCOs.^x

States can mandate enrollment in Medicaid managed care to varying extents by utilizing the following provisions of the Social Security Act, covered in more detail below: a Section 1115 demonstration, a Section 1915(b) waiver, or a Section 1932 State Plan Amendment (SPA).^{xi}

The Beginning of Medicaid Managed Care – The Creation of Medicaid, Section 1115 Demonstrations, and Section 1915 Waivers

The concept of managed care in the American healthcare system first emerged in the beginning of the 20th Century. In the late 1920s and early 1930s, healthcare providers joined together in area cooperatives to provide healthcare to locals for fixed monthly fees.^{xii} According to the National Council on Disability, “[t]he origins of managed care can be traced back to at least 1929, when



Michael Shadid, a physician in Elk City, Oklahoma, established a health cooperative for farmers in a small community without medical specialists or a nearby general hospital.”^{xiii} By 1934, Dr. Shadid’s program had grown to encompass 600 family memberships, the fees from which supported a staff of Dr. Shadid, four specialists, and a dentist.^{xiv} Other major prepaid group practice plans, now referred to as health maintenance organizations (HMOs) were created shortly after, including the Group Health Association in Washington, DC, in 1937, the Kaiser-Permanente Medical Program in 1942, and the Health Insurance Plan of Greater New York in New York City in 1947.^{xv}

Medicaid was enacted in 1965 with the passage of Public Law 89-97, which amended the Social Security Act. Pursuant to PL 89-97, states participating in Medicaid were required to create plans for the provision of medical assistance paid for by a cost-sharing arrangement between the state and the federal government.^{xvi} As enacted, Medicaid was an entirely fee for service program, as states were required to make “payment of part or all of the cost” of certain enumerated services including inpatient hospital services, outpatient hospital services, laboratory and x-ray services, and others.^{xvii}

However, states did make use of an amended pre-existing authority in the Social Security Act to enroll subsets of beneficiaries in managed care plans.^{xviii} Specifically, the Public Welfare Amendments of 1962 (P.L. 87-543), which added Section 1115 of the Social Security Act, granted the federal government the authority to waive compliance with numerous requirements of the Social Security Act.^{xix} PL 89-97 amended Section 1115 to broaden this authority to include the requirements for state plans for medical assistance.^{xx}

Section 1115 therefore permits states to make broad, structural changes to their Medicaid program, on a demonstration basis, if the Secretary of Health and Human Services determines that the demonstration project is likely to assist in promoting the objectives of the Medicaid program.^{xxi} The Centers for Medicare & Medicaid Services (CMS) have issued comprehensive regulations governing the submission and approval (or denial) of Section 1115 demonstrations.^{xxii} Among the required contents in a Section 1115 demonstration application are:

- (i) A comprehensive program description of the demonstration, including the goals and objectives to be implemented under the demonstration project.
- (ii) A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration to the extent such provisions would vary from the State's current program features and the requirements of the Act.
- (iii) An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable.
- (iv) Current enrollment data, if applicable, and enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration.
- (v) Other program features that the demonstration would modify in the State's Medicaid and CHIP programs.



- (vi) The specific waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration.
- (vii) The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, a plan for testing the hypotheses in the context of an evaluation, and, if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators.
- (viii) Written documentation of the State's compliance with the public notice requirements^{xxxiii}

In addition to confirming compliance with the regulatory and statutory requirements for proposal design and submission, CMS reviews each Section 1115 demonstration proposal to determine whether the objectives of the demonstration are aligned with those of Medicaid, whether the proposed waiver authorities are appropriate, and whether the demonstration is budget neutral.^{xxiv} Because Section 1115 demonstrations can varied in scope and complexity, states often must engage in a lengthy negotiation process with CMS to receive approval.^{xxv}

CMS approves Section 1115 demonstrations for an initial five-year period.^{xxvi} Approval generally can be renewed for an additional three years, though it may sometimes be granted for an additional five years, depending on the impacted beneficiary population.^{xxvii} CMS has implemented a fast track review process for Section 1115 demonstrations which have had at least one full extension cycle without substantial program changes.^{xxviii} Section 1115 continues to be a popular vehicle among states for waiving certain Medicaid program requirements.^{xxix}

The number of Medicaid beneficiaries enrolled in managed care remained small for several decades following the addition of Section 1115 to the Social Security Act.^{xxx} In 1981 Congress enacted the Omnibus Reconciliation Act of 1981 (OBRA 1981), which expanded states' ability to implement Medicaid managed care. Specifically, OBRA 1981 added Section 1915(a) and (b) of the Social Security Act, which permit waivers for Medicaid managed care programs.^{xxxi} Pursuant to Section 1915(a) a state may enter into a contract with a managed care organization to provide care and services to Medicaid beneficiaries.^{xxxii} Beneficiary enrollment in a Section 1915(a) waiver program is voluntary.^{xxxiii} Currently only a small number of states use Section 1915(a)'s authority to operate managed care programs (both comprehensive and specialty).^{xxxiv}

Section 1915(b) permits the Secretary of Health and Human Services to waive certain requirements of the Medicaid program.^{xxxv} A state may use a Section 1915(b) waiver to limit Medicaid beneficiaries freedom of choice among certain providers, including requiring dual eligibles, American Indians, and children with special health care needs to enroll in a managed care delivery system.^{xxxvi} This limitation on beneficiaries' freedom of choice is referred to as mandatory managed care.^{xxxvii} Approval is only permitted if the program is "cost-effective and efficient and not inconsistent with the purposes of" Medicaid.^{xxxviii} As with Section 1115, CMS has



issued regulations governing the submission of state waivers pursuant to Section 1915(b).^{xxxix} Approval of a waiver is limited to two (2) years, but may be renewed.^{xi}

Throughout the 1980s, several states used Section 1915(b) waivers to enroll Medicaid beneficiaries in Medicaid managed care. However, enrollment in Medicaid managed care remained slow, with just 2.3 million Medicaid beneficiaries, less than 10 percent of total beneficiaries nationwide, enrolled in any form of managed care by the start of the 1990s.^{xii}

Expansion of Medicaid Managed Care – The Balanced Budget Act and State Plan Amendments

In the early 1990s, some states began to expand the use Section 1115 waivers to grow their Medicaid managed care programs state-wide (many prior waivers were limited in geographic scope).^{xlii} Although concerns were raised about “the adequacy of provider networks, education and marketing practices, payment, data systems, and oversight . . . by 1997 the federal government had approved 14 Medicaid statewide waivers, all of them mandatorily enrolling some individuals in managed care, with a total enrollment of 8 million enrollees.”^{xliii} Following the passage of the Balanced Budget Act (BBA) in 1997, enrollment in Medicaid managed care would grow rapidly.^{xliv}

The BBA made several significant changes to the Social Security Act. Of particular significance to this report was the addition of Section 1932, which permitted states to enroll most Medicaid beneficiaries in a managed care entity.^{xlv} Section 1932 differs from Section 1915 in that a state may pursue mandatory Medicaid managed care through an amendment to its state plan, as opposed to a waiver. In addition, mandatory managed care implemented through a SPA can be permanent, not requiring a renewal every 2 years like the 1915(b) waiver authority requires.^{xlvi}

Protections for AI/ANs in Mandatory Managed Care and Indian Managed Care Entities

If a state implements managed care pursuant to Section 1932, American Indian and Alaska Native (AI/AN) beneficiaries have unique protections which differ from those of the general beneficiary population. As originally enacted in 1997, and still provided for in the Social Security Act, Section 1932 plan amendments “may not require . . . the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) [1] of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) unless the entity is participating in the plan and is the Indian Health Service (IHS), an Indian health program operated by a Tribe or Tribal organization pursuant to an Indian Self-Determination Act contract, or an Urban Indian Organization operating pursuant to an Indian Health Care Improvement Act contract with IHS.”^{xlvii}



Similar protections do not exist for AI/AN beneficiaries when states implement managed care via Section 1915 waivers.^{xlvi} They also do not exist for managed care implemented pursuant to a Section 1115 demonstration.^{xlix}

The American Recovery and Reinvestment Act of 2009 (ARRA) added protections for AI/AN beneficiaries with respect to Medicaid managed care. ARRA amended Section 1932 to require non-AI/AN MCO contracts to permit AI/AN beneficiaries to choose in-network AI/AN health care providers as their primary care provider under the MCO.^l Other protections added to Section 1932 by ARRA include requirements that MCOs demonstrate access to AI/AN health care providers sufficient to ensure access to care for AI/AN enrollees and requirements that MCOs make prompt payment to AI/AN healthcare providers.^{li}

Notably, ARRA also delineated the creation of Indian Managed Care Entities (IMCEs).^{lii} An IMCE is “a managed care entity that is controlled . . . by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.”^{liii} IMCEs “may restrict enrollment under such program to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.”^{liv}

Nationwide Medicaid Enrollment and Spending

Following the passage of the BBA in 1997, enrollment in Medicaid managed care expanded enormously. In 2011, 40 percent of all Medicaid beneficiaries were enrolled in comprehensive MCOs.^{lv} Twenty-two percent (22%) of beneficiaries were enrolled in PCCM.^{lvi} By July 2019, 69.5 percent of Medicaid beneficiaries nation-wide were enrolled in comprehensive managed care plans.^{lvii} Hawaii (100%), Nebraska (99.6%), and Iowa (93.9%) enrolled the highest percentage of their beneficiaries in comprehensive managed care. A further 7.2% of beneficiaries nation-wide were enrolled in PCCM, with Idaho (84.9%), Colorado (82.8%) and Alabama (80.5%) having the highest percentage of beneficiaries enrolled in PCCM.^{lviii}

As of July 2021, 40 states and the District of Columbia used managed care to deliver comprehensive risk-based care to some or all of their Medicaid beneficiaries.^{lix} Thirty-four states and D.C. deliver comprehensive care services via MCOs only while six states utilize a combination of MCOs and PCCM.^{lx} Another six states use PCCM only.^{lxi} Only four states (Alaska, Connecticut, Vermont, and Wyoming) do not utilize managed care to deliver comprehensive care to Medicaid beneficiaries,^{lxii} although they may use managed care to deliver some forms of limited care.^{lxiii}

With the rise in managed care enrollment has come increased spending as well. In 2014, payments to MCOs made up 38 percent of total Medicaid spending.^{lxiv} By FY2020, payments to comprehensive MCOs accounted for 49 percent of total Medicaid spending.^{lxv}



For those states providing Medicaid benefits via MCOs in FY2020, most directed at least 40 percent of their total Medicaid funding to payments to MCOs.^{lxvi}

Managed care is often cited as a cost saving or cost managing option for the provision of care to Medicaid beneficiaries.^{lxvii} However, as of 2018, the Congressional Budget Office (CBO) had “not found consistent evidence to support those claims.”^{lxviii} According to the CBO, “[a]lthough average monthly spending is much lower for beneficiaries enrolled in managed care than it is for those who receive coverage only through fee-for-service Medicaid, that difference does not mean that managed care saves money.”^{lxix} The CBO posits that “beneficiaries in eligibility groups with higher average costs are more likely to be covered only by fee-for-service Medicaid,” which may account for the difference between average per-beneficiary Medicaid managed care and Medicaid fee-for-service spending.^{lxx}



Part II: Data Analysis of Medicaid Managed Care at Urban Indian Organizations

This section provides an overview of the Medicaid beneficiary population to provide context for the managed care case studies. The most recent available data on Medicaid claims is from the 2019 T-MSIS (Transformed Medicaid Statistical Information System), which was released on September 30th, 2019.^{lxxi} In CY2019, T-MSIS data indicated that UIOs provided services to 86,666 Medicaid beneficiaries. According to the IHS National Uniform Data System Summary Report, UIOs provides services to 97,413 Medicaid Beneficiaries.^{lxxii} The source of this discrepancy is unknown. Claims data could not be located for one Medicaid-participating UIO, indicating that the National Provider Index matching is incomplete, leading to a possible beneficiary undercount within T-MSIS data. Between 2018 and 2019, the UIO Medicaid beneficiary population remained stable, only increasing by a fraction of a percent. The number of Medicaid claims for UIO services also remained stable, only decreasing by 2 percent (Table 1). The most dramatic change between 2018 and 2019 is the 17.4 percent decrease in the total Medicaid payments. Because the beneficiary and claims counts were stable, this change was a mostly a result of a 15.9 percent decrease in the average amount paid for each claim. This decrease does not currently have an explanation and warrants further investigation. In contrast, the national Consumer Price Index for Medical Care increased by 2 percent between 2018 and 2019.^{lxxiii}

Table 1: 2018 and 2019 Medicaid Beneficiaries, Claims, and Payments

	2018	2019	Percentage Change
Number of Beneficiaries	86,335	86,666	0.4%
Number of Claims	621,511	610,498	-1.8%
Total Medicaid Payments to UIOs	108,360,910	89,504,467	-17.4%
Medicaid Paid Per Claim at UIOs	\$174	\$147	-15.9%

Following the national trends outline earlier, the majority of UIO Medicaid beneficiaries were in managed care programs. Medicaid managed care beneficiaries comprised 63 percent of the UIO patient population, submitted 68 percent of the claims, and produced 61 percent of the Medicaid payment revenue (Figure 1.) As might be expected from the cost-saving goals of managed care, the average amount paid for each managed care claim was only \$132, significantly less than the average amount of \$176 paid for non-managed care claims. The claims denial rate for managed care claims was lower than non-managed care claims. In CY2019, 4 percent of managed care claim lines were denied, and 5 percent of non-managed care claim lines were denied.



Figure 1: Medicaid Managed Care at UIOs, 2019

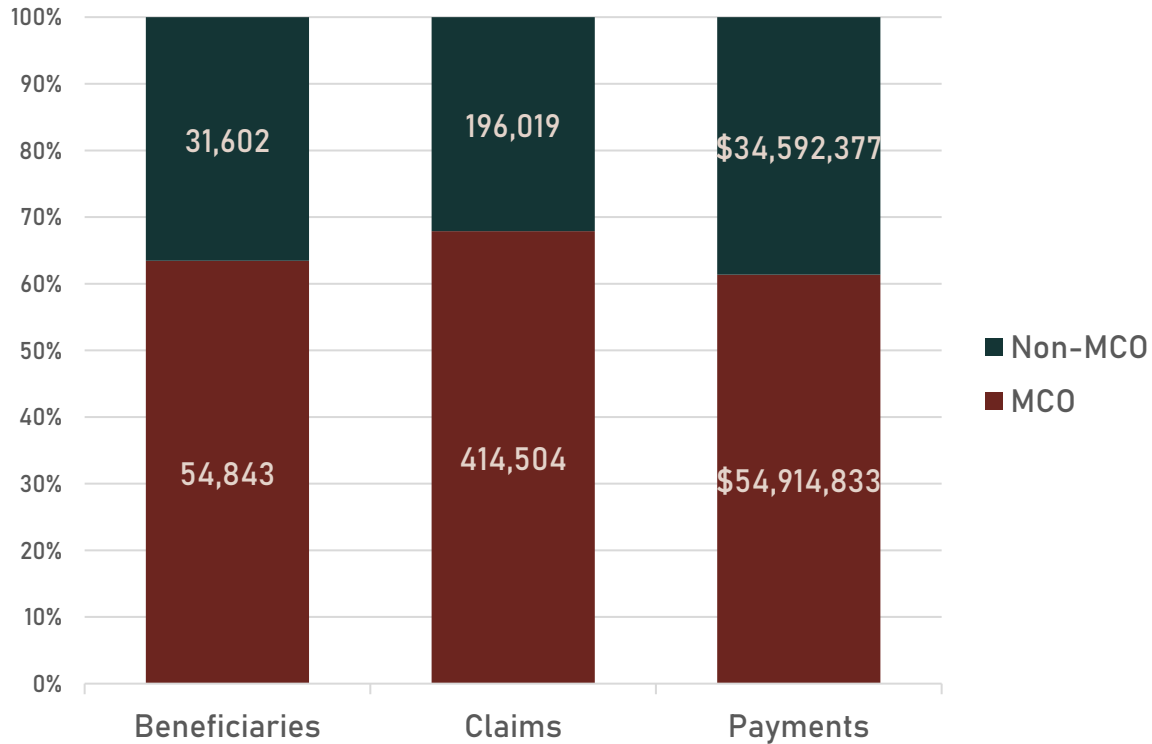


Table 2: Distribution of Managed Care Beneficiaries Across UIO Service Type

UIO Service Type	Number of Beneficiaries	Percentage of Total Beneficiaries	Number of Managed Care Beneficiaries	Percentage of Total Managed Care Beneficiaries
Full Ambulatory	70,948	81.86%	45,734	83.19%
Limited Ambulatory	600	0.69%	327	0.59%
Outreach and Referral	3,255	3.76%	1,495	2.72%
Residential or Outpatient Treatment Center	11,863	13.69%	7,418	13.49%
Total	86,666	100.00%	54,974	100.00%



Table 3: Distribution of Managed Care Claims Across UIO Service Type

UIO Service Type	Total Claims	Percentage of Total Claims	Total Managed Care Claims	Percentage of Total Managed Care Claims
Full Ambulatory	492,819	80.72%	351,879	84.90%
Limited Ambulatory	2,101	0.34%	1,308	0.32%
Outreach and Referral	61,120	10.01%	23,053	5.56%
Residential or Outpatient Treatment Center	54,458	8.92%	38,246	9.23%
Total	610,498	100.00%	414,486	100.00%

There were no large differences between the distribution of managed care beneficiaries across the four UIO Service Types (Table 2). Claims submitted at UIOs offering Outreach and Referral Services comprise 10 percent of all claims, but only comprised 6 percent of managed care claims (Table 3). Given that AI/AN beneficiaries have unique protections under Section 1932, it would be helpful to know how many UIO Medicaid beneficiaries are eligible for these protections. However, it is difficult to use T-MSIS data to determine how many Medicaid beneficiaries at UIOs are Urban Indians. See Appendix A for further discussion.



Part III: Medicaid Managed Care at Urban Indian Organizations Case Studies¹

State A

State A's Medicaid Program

State A's Medicaid program has over two million enrolled beneficiaries. Over 85 percent of Medicaid beneficiaries are enrolled in comprehensive MCOs. Between 7 and 10 percent of beneficiaries identify as AI/AN.

State A operates its Medicaid program under a Section 1115 waiver. While enrollment in managed care is generally mandatory in State A, AI/ANs can choose to participate in a fee-for-service plan instead. AI/AN beneficiaries may also choose to enroll in a managed care plan and in fact may switch freely between managed care plans and the AI/AN fee-for-service plan. A majority of AI/ANs in State A are enrolled in the fee-for-service plan.

Background: Managed Care and UIOs in State A

Although a late participant in Medicaid, State A was one of the first states to implement mandatory Medicaid managed care state-wide. Prior to its decision to participate in Medicaid, medical care for those living with incomes below a certain level of the national poverty line was provided by individual counties. However, increasing costs became unsustainable for the counties, leading to the State's participation in Medicaid.

State A contracts with between 10 and 20 MCOs to provide managed care to Medicaid beneficiaries. This includes several state-wide comprehensive MCOs, regional MCOs which provide plans covering integrated physical health and behavioral health services for members with serious mental illnesses, and MCOs which provide coverage for individuals who are age 65 or older, or who have a disability, and who require nursing facility level of care.

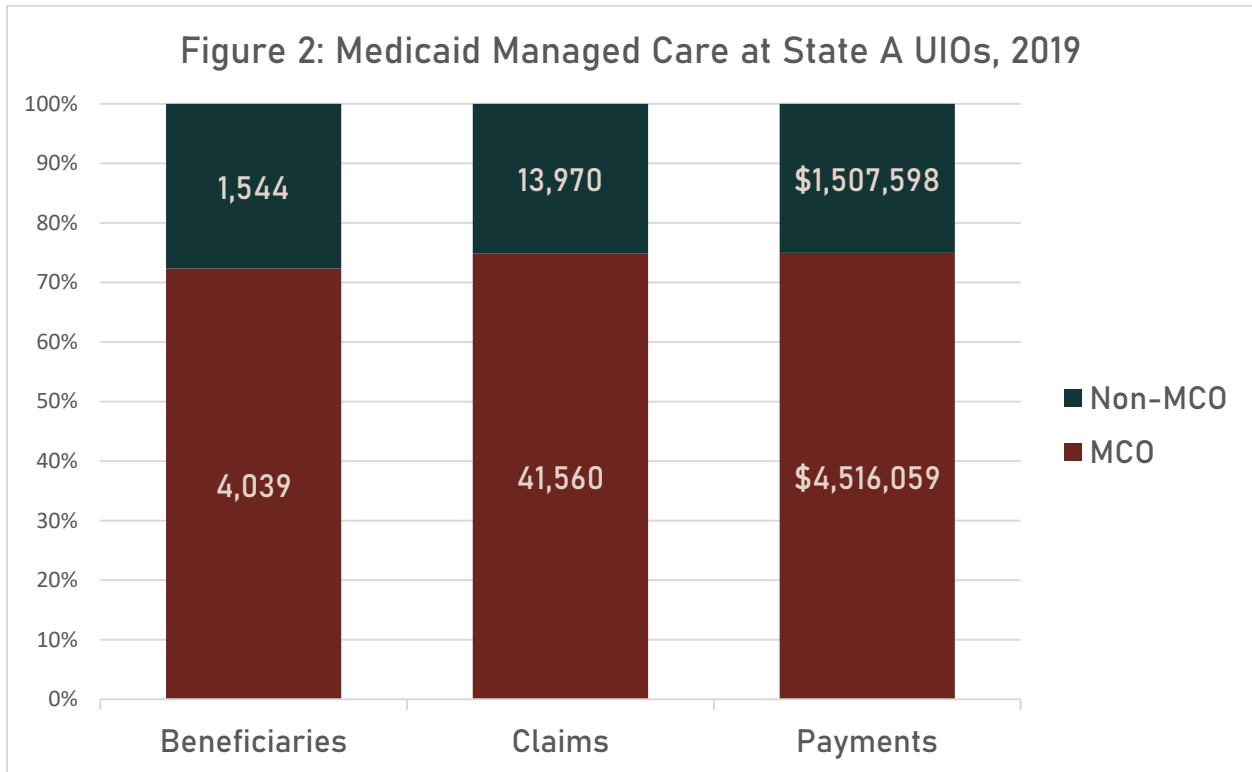
There is more than one UIO within State A which provides medical services to AI/AN patients. At least one UIO in State A is also a Federally Qualified Health Center (FQHC) look-alike, a community-based health care provider funded in part by the Health Resources & Services Administration (HRSA). FQHCs receive Medicaid payments under the prospective payment system (PPS).^{lxiv}

¹ All background data and information provided in this section is based on publicly available government sources (state and federal). Citations are generally not provided to preserve the anonymity of UIOs. In addition, some information has been generalized, again to protect the anonymity of UIOs.



The PPS base rate was set in 2001 and states should use the Medicare Economic Index to adjust the PPS rate on an annual basis.^{lxxv} An FQHC receives the PPS rate for any visit by a Medicaid beneficiary.^{lxxvi} If an MCO pays an FQHC less than the PPS rate, the state must make up the difference.^{lxxvii}

Medicaid Managed Care at UIOs in State A



In general, UIOs in this state reported an excellent working relationship with their state Medicaid office. The state employs a Tribal Relations Liaison, who is also responsible for working with UIOs. In addition, for over a decade, the State has implemented a Tribal Consultation Policy. The Consultation Policy requires the state to seek advice from IHS, Tribes, Tribal Organizations, and UIOs on a regular basis concerning matters which will have a direct impact on those organizations. State A has regular meetings with UIOs, which include discussion of relevant policy changes. UIOs have also been able to routinely meet separately with the state Medicaid director, as needed. UIOs which receive the FQHC PPS rate in this state report that they believe they receive a reasonable rate in part due to their strong relations with the state Medicaid office.

UIOs in State A generally reported a good working relationship with MCOs. Each comprehensive care MCO in State A is required to have a Tribal Coordinator.^{lxxviii} The Tribal Coordinator must be located in State A and their role of the Tribal Coordinator is to facilitate



promotion of services and programs to improve the health of eligible AI/AN beneficiaries. UIOs have generally found it easy to communicate with MCOs through their Tribal Coordinators and have developed productive partnerships with MCOs. UIOs have been able to access special intern opportunities, literacy programs, nutrition programs, and other opportunities via special initiative dollars put out by the MCOs in State A.

One of the few challenges UIOs experience in State A is the auto-enrollment of AI/AN beneficiaries into MCOs, as opposed to the separate fee-for-service program for AI/ANs. The fee-for-service program may offer better reimbursement rates for providers than the rates set by MCOs. Therefore, being in a fee-for-service plan might be more beneficial for AI/AN beneficiaries as they would have greater access to providers. Higher reimbursement rates are also vital for UIOs, given Congress' chronic underfunding of the AI/AN healthcare system generally and UIOs specifically.^{lxxxix}

Different procedures between MCOs sometimes made processes, like provider registration or patient referral, more onerous for UIOs. In addition, because each MCO has separate networks of providers, it sometimes makes it more difficult for UIO providers to refer patients out for care, as each patient will only be able to see certain providers based on their MCO.

UIOs in this state recommended relationship building with state Medicaid offices and MCOs as a key best practice for ensuring proper provision of medical care to AI/AN Medicaid beneficiaries. UIOs appreciated the consistent communication they received from the state Medicaid office and the availability of the Director and staff.

The state Primary Care Association (PCA) is also a key partner for UIOs. PCAs “are state or regional nonprofit organizations that provide training and technical assistance (T/TA) to safety-net providers.”^{lxxx} PCAs also “facilitate collaboration between health centers and Governors, Medicaid Directors and state health departments to educate them on the health center program and its value to patients, and to work with health centers on the best approaches to meet the needs of their constituents.”^{lxxxi} The state PCA assists UIOs in making its voice heard to the state Medicaid office.



State B

State B's Medicaid Program

State B provides medical coverage to over 13 million beneficiaries through its Medicaid program. Over 80 percent are enrolled in managed care plans. Less than 1 percent of beneficiaries identify as AI/AN. However, note that the state does not report individuals who identify with more than one ethnicity and has a significant portion of its beneficiary population who do not report any ethnicity. Until recently, State B primarily implemented managed care through a Section 1115 demonstration. It also operated a Section 1915(b) waiver permitting mandatory enrollment of certain beneficiaries. However, at the start of 2022, State B transferred most of its managed care programs to its renewed and expanded Section 1915(b) waiver.

Background: Managed Care and UIOs in State B

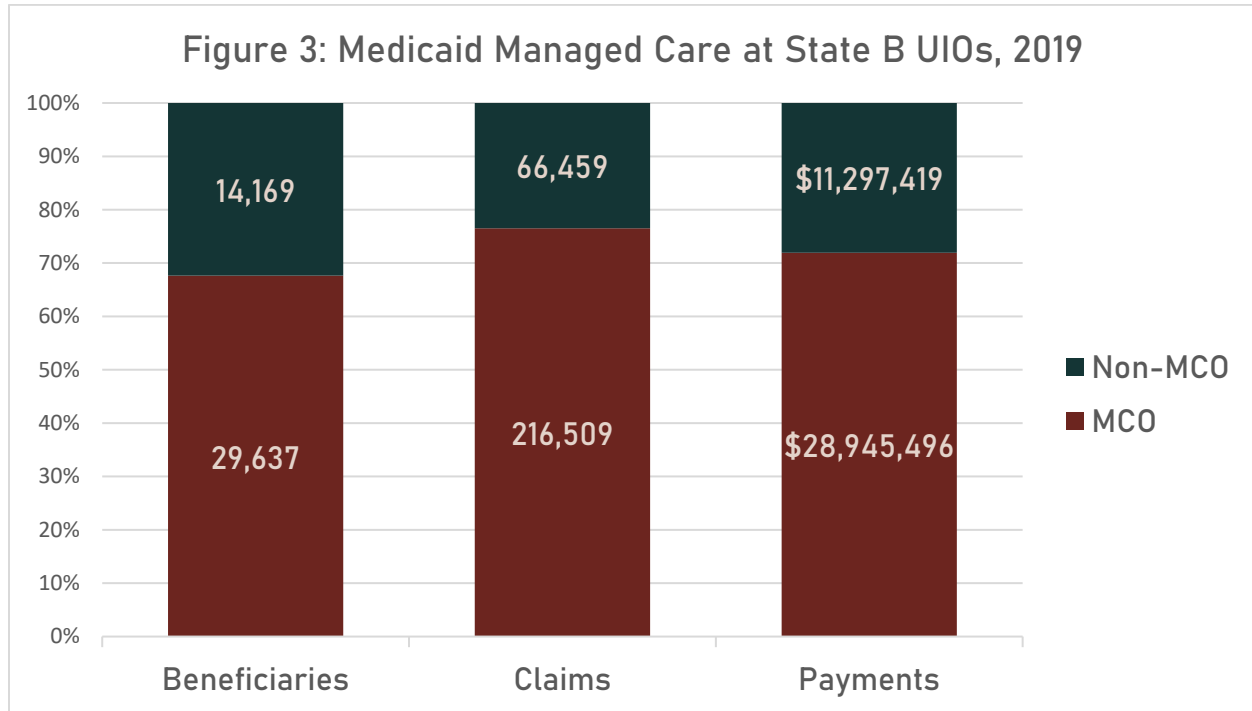
There are six managed care models in State B. These include models in which a county runs a managed care plan, which is the only plan permitted in that county; a geographic model, in which multiple MCOs operate within a county; and a two-plan model, in which a county-run plan and a commercial MCO operate within a county. In State B, AI/ANs are only required to enroll in managed care if they live in a county which operates a county-run model.

As of 2020, roughly 55 percent of beneficiaries were served by the two-plan model. The county-run model and the geographic model served around 25 percent of the population, with the other three managed care models covering under 5 percent of beneficiaries. Almost 70 percent of beneficiaries were enrolled in public plans.

There is more than one UIO within State B which provides medical services to AI/AN patients. At least one UIO in State B is also a Federally Qualified Health Center (FQHC) look-alike.



Medicaid Managed Care at UIOs in State B



UIOs in this state reported difficulties in communicating with the State B Medicaid office. There are several Tribes in this state, though the state may lack familiarity with UIOs and the particular needs of urban AI/AN patient populations. For example, one UIO explained that they felt as if the state Medicaid office did not understand that AI/ANs in urban areas would also be interested in the same Traditional Medicine and Traditional Healing that AI/ANs living on reservations pursued. Another UIO reported that while UIOs have a seat at the table through a workgroup run by State B, the UIO usually was notified of important issues at the last minute.

Several authorities in State B require it to seek the advice of Tribes and UIOs with respect to Medicaid. This includes a State Plan Amendment and the state’s Tribal Engagement Plan. State B is unique in that it not only has a stand-alone Tribal Engagement Plan but it also established an advisory group by law, with members nominated by rural and urban advocacy groups. Unfortunately, this statutorily required advisory group ceased meeting for a period of time, although the state has committed itself to reviving the group.

UIOs reported that the MCOs they participated in were generally unfamiliar with UIOs and the needs of AI/ANs living in urban areas. However, it is important to note that given the managed care models of State B, some UIOs may only interact with one MCO and so this may not be representative of MCOs statewide. The COVID-19 pandemic was cited as a particular factor in straining the



relationship between MCOs and UIOs, with one UIO reporting very limited communication with remote workers at the county MCO. Turnover among staff at some MCOs was also reported to be high, making it difficult to build institutional memory regarding UIOs.

UIOs in State B stressed the importance of coalitions to promote an understanding of and consideration for UIOs in state Medicaid policy decisions. UIOs specifically mentioned their state PCA as an essential connector on their behalf in addition to a statewide AI/AN coalition and NCUIH. In addition, UIOs mentioned the significance of a state-wide AI/AN policy organization and the national policy work of NCUIH.



State C

State C's Medicaid Program

State C was an early adopter of Medicaid. It serves over a million beneficiaries through the state Medicaid program with almost eighty percent enrolled in comprehensive MCOs. More than 2 percent of Medicaid beneficiaries identify as AI/ANs, but note that almost 20 percent of beneficiaries in State C did not report their ethnicity and a further 3 percent identified as multi-racial.

State C originally implemented managed care via a Section 1115 demonstration. Included in this the demonstration was authority to mandatorily enroll AI/AN beneficiaries living off reservation in managed care. Within the last 10 years, the Centers for Medicare & Medicaid Services informed State C that it would need to transfer this authority to a Section 1915(b) waiver. It did so, and now AI/ANs who live in the areas served by UIOs in this state are required to enroll in managed care pursuant to an approved Section 1915(b) waiver.

Background: Managed Care and UIOs in State C

State C currently has nine health plans which offer comprehensive managed care to Medicaid beneficiaries. These plans include plans provided by non-profit MCOs and plans operated either by a single county or consortium of counties. The availability of plans varies by county of residence, with beneficiaries in some counties only have one choice of MCO and beneficiaries in other counties having up to six choices.

As of 2016, around 75 percent of Medicaid beneficiaries in State C were enrolled in managed care. The other 25 percent were enrolled in State C's fee-for-service system.

There is more than one UIO within State C which provides medical services to AI/AN patients. At least one UIO in State C is also a Federally Qualified Health Center (FQHC) look-alike.

Medicaid Managed Care at UIOs in State C

UIOs have a strong relationship with the chief executive's office, but there are opportunities to strengthen the relationships with the state Medicaid office. In particular, UIOs noted that high-level officials within the chief executive's office were intimately familiar with AI/AN communities and consistently offered support for initiatives which would support UIOs. It should also be noted that State C is required by statute to maintain an advisory board which provides guidance to a state-wide Indian Affairs Council on the unique concerns of AI/ANs living in urban areas.



In contrast, State C's Medicaid office does not require the inclusion of urban AI/AN representatives in its Tribal Health Directors Work Group. Attendees of that work group include Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, and a state representative, but no member representing the UIOs in State C. In addition, while all states are required by law to meet with UIOs on matters relating to the implementation of Medicaid that will impact UIOs,^{lxviii} State C's Tribal Consultation policy only specifically requires it to send notice of waiver requests, waiver renewals, or waiver amendments to some, but not all, UIOs in State C.

In State C, MCOs did not address SDOH that are unique to AI/AN communities and cultures. In particular, UIOs noted the importance of providing cultural services to AI/AN patients, including traditional medicines like sage, cedar, and tobacco, as well as cultural practices like hand drumming, but reported that these services were not covered by MCOs. An increased awareness of SDOH and traditional practices for Urban AI/AN communities has the potential to benefit population health equity goals in the state, and ultimately reduce costs in time.

Some UIOs in this state participate in an Accountable Care Organization (ACO). ACOs are groups of care providers who voluntarily work together to deliver coordinated care to patients. In State C, ACOs may participate in a program which allows participating providers to enter into an arrangement with the state Medicaid agency to care for Medicaid beneficiaries using a payment model that holds the ACO accountable for the costs and quality of care their Medicaid beneficiaries receive. Participating providers who are able to deliver care for less than a targeted cost get to share in the State's savings and conversely, providers may also share in the risk of loss if costs are higher than targeted.

UIOs participating in ACOs stated that the ACO had increased the quality of their patient care and improved their negotiating leverage with the State and MCOs. UIOs noted that their ACO had always produced savings for State C and had reduced emergency visits. Publicly available information confirms that ACOs in State C generally reduce emergency room visits and reduce inpatient admissions, while also ranking highly on State C's statewide quality benchmarks.

UIOs in State C are continuing to investigate ways to increase collaboration and integration with other healthcare providers. For example, one UIO reported that they were considering organizing an independent physician association (IPA) with other providers in State C. IPAs are networks of independent physician practices who create a business entity for several purposes, including pursuing contracts with MCOs. UIOs hope that an IPA might give them improved leverage in negotiating rates for services with MCOs.



State D

State D's Medicaid Program

State D serves over a million Medicaid beneficiaries through its state Medicaid program. Over 90 percent of beneficiaries are enrolled in managed care. Between 1 and 3 percent of beneficiaries identify as AI/AN. Note that over 40 percent of beneficiaries in State D reported their ethnicity as other or unknown.

State D implements managed care through a Section 1115 demonstration. Enrollment in managed care is mandatory for most beneficiaries. However, tribal member are not required to enroll in managed care. They may do so through an affirmative voluntary choice.

Background: Managed Care and UIOs in State D

State D contracts with MCOs, referred to in State D as coordinated care organizations, which are paid a fixed monthly budget for providing physical, behavioral, and oral health services. State D's plan gives MCOs with financial flexibility to address members' needs outside traditional medical services, including flexibility to pay for non-medical services that improve health outcomes. State D aims for these MCOs to focus on prevention and management of chronic conditions to help reduce unnecessary emergency room visits and improve overall health.

There are currently sixteen (16) MCOs operating in State D. The MCOs receive a budget that grows at a fixed rate for behavioral, physical and dental care. The MCOs are governed by partnerships consisting of health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.

There is one UIO within State D which provides medical services to AI/AN patients. The UIO in State D is also a Federally Qualified Health Center (FQHC) look-alike.

Medicaid Managed Care at UIOs in State D

State health officials in State D report that it has a strong working relationship with the UIO on Medicaid issues. State D has both a Tribal Consultation and an Urban Confer policy. The Urban Confer policy essentially places the UIO on equal footing with Tribes, and requires State D to notify the UIO when all Tribes in State D are provided notice of Tribal Consultation.

State D health officials state that Tribes and the UIO meet weekly to connect and discuss healthcare issues. It is the impression of officials from State D that the Tribes and the UIO work very well together and collaborate for the benefit of AI/AN patients in State D.



State D health officials spoke highly of UIO leadership and the longstanding commitment of State D to working collaboratively with AI/AN health care providers.

State D is currently working with Tribes and the UIO to create IMCEs. As mentioned above, IMCEs are a recent innovation in Medicaid created by ARRA.^{lxxxiii} An IMCE is “a managed care entity that is controlled . . . by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.”^{lxxxiv}

In 2018 during Tribal Consultation on State D’s managed care program, Tribal and UIO representatives requested State D’s assistance in implementing IMCEs. The Tribes and the UIO requested that the IMCEs not be risk-bearing, that the Tribes and UIO direct enrollment, the PPS or IHS All-Inclusive rate continue for reimbursement purposes, that the IMCEs operate as PCCM entities, and that each tribe or UIO be permitted to create their own IMCE.

The IMCEs will not operate in the same manner as other MCOs in State D. Rather, the IMCEs will operate as PCCM entities offering telephonic or face-to-face case management, development of care plans, enrollee outreach and education activities, call centers, quality improvement activities including administering satisfaction surveys, outcome measurement and reporting to State D, and a nurse triage and advice line.

For enrollment purposes, the UIO will be sent a list of all eligible AI/AN beneficiaries in a multi-county service area. The UIO will validate the list and will have enrollment of any AI/AN members in the service area unless they are assigned to a tribal IMCE.



State E²

State E's Medicaid Program

State E provides medical coverage to approximately two million enrolled beneficiaries through its Medicaid program. Over 80 percent are enrolled in managed care plans. State E reports that Medicaid eligibility for AI/ANs is between 4 and 5 percent and between 1 and 2 percent of enrollees in MCOs are AI/ANs.

Background: Managed Care and UIOs in State E

State E's Medicaid program operates under Section 1932(a) through five health plans, or managed care programs (MPCs) which offer comprehensive managed care to Medicaid beneficiaries. Since 2012, the state has enrolled blind and disabled populations into the State Medicaid Program through a Section 1915(b) waiver and since 1993, the state has operated a mandatory managed care behavioral health program under the same waiver. Four of the MPCs are national, for-profit plans and one MPC is a local, non-profit plan. State E also contracts with eleven county-based Regional Support Networks to manage behavioral health care.

Three of the five contracted MPCs currently hold a NCQA Multicultural Healthcare Distinction in an effort to improve health equity in the State's Medicaid program. Tribal members eligible for State E Medicaid can choose to be enrolled in a managed care plan, and can use an Indian health, tribal or urban Indian clinic for services in addition to their State E Medicaid health coverage. AI/ANs are exempt from mandatory managed care enrollment. There are two UIOs within state E which provide medical services to AI/AN patients. Both UIOs in State E are Federally Qualified Health Centers (FQHCs).

² Due to complications arising from the COVID-19 pandemic the authors were not able to complete a site visit with UIOs in State E. As with other states, the background information presented here is drawn from publicly available government sources but citations are generally not provided to preserve the anonymity of UIOs.



Overarching Challenges and Best Practices

Certain challenges and best practices have consistently emerged throughout this study. In states where UIOs feel that they do not have a good working relationship with either the state Medicaid office or MCOs, UIOs consistently reported that communication with those entities was minimal. In those states, UIOs also noted state Medicaid offices and/or MCOs lacked familiarity with the needs of AI/AN patients living in urban areas. Of particular importance, UIOs related that it was often assumed that AI/ANs living in urban areas would not want access to the same traditional healing and medicine that AI/AN beneficiaries living on reservations seek.

Conversely, in states where UIOs reported strong working relationship with the state and MCOs, clear consistent communication was a frequently cited factor. Notably, in State A, not only did the state have a Tribal liaison who was responsible for working with UIOs, but each MCO was also required to staff a similar position. This is a specific best practice which may be beneficial to state Medicaid programs which contract with a variety of MCOs to ensure that relevant knowledge regarding AI/AN Medicaid beneficiaries is not restrained just to the state Medicaid office, but is available throughout the Medicaid system. As a general matter, state Medicaid offices should continuously work to ensure all levels of the Medicaid system which serve AI/AN beneficiaries have open and continuous lines of communication.

Another best practice identified through this report is the need for UIOs to work with other UIOs, Tribes, and other similarly situated health care providers to amplify their voice and strengthen their ability to advocate for the best possible outcomes for their patients. UIOs in several states praised collaborative organizations like PCAs or NCUIH as having helped to advance key Medicaid priorities with states and nationally. Given the limited population size most UIOs serve, effective partnership building is a best practice which may be beneficial to UIOs across the country.



Appendix A: AI/AN Status and Race/Ethnicity Reporting

The T-MSIS Data Set^{lxv} includes a variable called “Certified AI/AN,” which has three response code options:

- **Code 0: Individual does not meet the definition of an American Indian/Alaskan Native**
- **Code 1: Individual meets the definition of an American Indian/Alaskan Native.** This definition cites three legally defined subcategories:
 - 25 USC 1603(13): Any person who is a member of an “Indian tribe.”
 - 25 USC 1603(28): Urban Indian. The term “Urban Indian” means any individual who resides in an urban center define as any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under subchapter IV, as determined by the Secretary.
 - 25 USC 1679(a): California Indian.
- **Code 2: Yes, individual does have Certificate of Degree of Indian or Alaska Native Blood (CDIB).** This definition cites seven legally defined subcategories:
 - Is a member of a Federally-recognized Indian tribe.
 - 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 promulgated by the Secretary of Health and Human Services.
 - Is considered by the Secretary of the Interior to be an Indian for any purpose.
 - 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.

Unfortunately, serious data quality issues were discovered with the “Certified AI/AN” variable. The variable has a large rate of missingness, and it is inconsistently reported from state to state. There are also consistency issues when the variable is compared to the T-MSIS Race/Ethnicity variable (Table 3). Among the 12,883 beneficiaries coded as meeting “the definition of AI/AN,” only 9146 were reported in the AI/AN Race/Ethnicity category. Among beneficiaries coded as the AI/AN Race/Ethnicity Category, 2,883 were coded as non-AIAN in the Certified AI/AN variable.



Table 3: Certified AI/AN Status and Race/Ethnicity of UIO Medicaid Beneficiaries, 2019

Race/Ethnicity	1 = Individual meets the definition of an American Indian/Alaskan Native	2 = Yes, Individual does have Certificate of Degree of Indian or Alaska Native Blood (CDIB)	0 = Individual does not meet the definition of an American Indian/Alaskan Native	Null/missing = source value is missing or unknown
American Indian and Alaska Native (AIAN), non-Hispanic	9,146	1,106	2,883	3,212
White, non-Hispanic	1,240	82	14,338	1,740
Black, non-Hispanic	445	0	6,717	849
Asian, non-Hispanic	43	0	55,45	119
Hawaiian/Pacific Islander	24	0	347	0
Multiracial, non-Hispanic	31	0	71	0
Hispanic, all races	1,515	176	19,919	3,691
Null/missing	439	264	6,708	5,786
Total	12,883	1,628	56,528	15,397



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ⁱⁱ Medicaid and CHIP Payment and Access Commission, *Managed Care Overview*, <https://www.macpac.gov/subtopic/managed-care-overview/> (last accessed May 6, 2022); see 42 U.S.C. § 1396(b)(m); 42 CFR § 438.2 (statutory and regulatory definitions of Medicaid managed care organization).

ⁱⁱⁱ Centers for Medicare & Medicaid Services, *Medicaid: Managed Care*, <https://www.medicaid.gov/medicaid/managed-care/index.html> (last accessed May 6, 2022); Medicaid and CHIP Payment and Access Commission, *Managed Care Overview*, <https://www.macpac.gov/subtopic/managed-care-overview/> (last accessed May 6, 2022).

^{iv} Christine Vestal, *Managed Care Explained: Why a Medicaid Innovation is Spreading*, May 31, 2011. Available at: <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2011/05/31/managed-care-explained-why-a-medicaid-innovation-is-spreading>.

^v *Id.*

^{vi} 42 U.S.C. § 1396d(t)(3); 42 CFR § 438.2.

^{vii} 42 U.S.C. § 1396d(t)(2)(A)-(B); 42 CFR § 438.2.

^{viii} Medicaid and CHIP Payment and Access Commission, *Managed Care Overview*, <https://www.macpac.gov/subtopic/managed-care-overview/> (last accessed May 6, 2022)

^{ix} Medicaid and CHIP Payment and Access Commission, *Managed Care Overview*, <https://www.macpac.gov/subtopic/managed-care-overview/> (last accessed May 6, 2022)

^x Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.

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^{xii} National Council on Disability, *An Overview of Medicaid Managed Care*, <https://www.ncd.gov/policy/chapter-1-overview-medicaid-managed-care> (last accessed May 6, 2022).

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^{xv} National Council on Disability, *A Brief History of Managed Care*, <https://www.ncd.gov/policy/chapter-1-overview-medicaid-managed-care> (last accessed May 6, 2022).

^{xvi} For an explanation of the federal medical assistance percentage (FMAP) and Medicaid cost sharing, please see [Will insert NCUH FMAP report title when finalized].

^{xvii} See Public Law 89-97, Sec. 1905(a) (Jul. 30, 1965); Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid 19* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.

^{xviii} See National Council on Disability, *An Overview of Medicaid Managed Care*, <https://www.ncd.gov/policy/chapter-1-overview-medicaid-managed-care> (last accessed May 6, 2022); Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid 19* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.

^{xix} Public Law 87-543, Sec. 122 (Jul. 25, 1962); Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid 19* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.

^{xx} Public Law 89-97, Sec. 1109 (Jul. 30, 1965); Public Law 87-543, Sec. 122 (Jul. 25, 1962); see 42 U.S.C. § 1315 (current authority for Section 1115 demonstration projects, including changes to the law following its enactment in 1962); 42 U.S.C. § 1396(a).

^{xxi} See 42 U.S.C. § 1315; Centers for Medicaid and Medicare Services, *About Section 1115 Demonstrations*, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html> (last accessed Jul. 22, 2022).

^{xxii} 42 CFR § 431.400-428.

^{xxiii} CFR § 431.412(a)(1)(i)-(viii).

^{xxiv} See Centers for Medicare and Medicaid Services, *About Section 1115 Demonstrations*, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html> (last accessed Jul. 22, 2022).

^{xxv} Medicaid and CHIP Payment and Access Commission, *Section 1115 Research and Demonstration Waivers*, <https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/> (last accessed Jul. 22, 2022).

^{xxvi} Centers for Medicare and Medicaid Services, *About Section 1115 Demonstrations*, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html> (last accessed Jul. 22, 2022); Medicaid and CHIP Payment and Access Commission, *Section 1115 Research and Demonstration Waivers*, <https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/> (last accessed Jul. 22, 2022).



^{xxvii} Centers for Medicare and Medicaid Services, *About Section 1115 Demonstrations*, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html> (last accessed Jul. 22, 2022); Medicaid and CHIP Payment and Access Commission, *Section 1115 Research and Demonstration Waivers*, <https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/> (last accessed Jul. 22, 2022).

^{xxviii} Centers for Medicare and Medicaid Services, *About Section 1115 Demonstrations*, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html> (last accessed Jul. 22, 2022).

^{xxix} See Centers for Medicare and Medicaid Services, *State Waivers List*, <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html> (last accessed Jul. 22, 2022).

^{xxx} See e.g., Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid 19* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>; Christine Vestal, *Managed Care Explained: Why a Medicaid Innovation is Spreading* (May 31, 2011)(citing 1990 as the year state Medicaid programs began to switch to managed care).

^{xxxi} Public Law 97-35, Sec. 2175 (Aug. 13, 1981).

^{xxxii} 42 U.S.C. § 1396n(a).

^{xxxiii} 42 U.S.C. § 1396n(a); Centers for Medicare and Medicaid Services, *Managed Care Authorities*, <https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html> (last accessed May 7, 2022).

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^{xxxv} 42 U.S.C. § 1396n(b)(note that there are four sub-varieties of waiver available).

^{xxxvi} 42 U.S.C. § 1396n(b); see Medicaid and CHIP Payment and Access Commission, *Features of Federal Medicaid Managed Care Authorities*, <https://www.macpac.gov/features-of-federal-medicaid-managed-care-authorities/> (last accessed Jul. 25, 2022).

^{xxxvii} Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid 19* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.

^{xxxviii} 42 U.S.C. § 1396n(b).

^{xxxix} 42 CFR § 430.25; 431.55.

^{xl} 42 U.S.C. § 1396n(h)(1).

^{xli} Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid 19* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.



^{xlii} Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid 19* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.

^{xliii} Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid 19* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>.

^{xliv} Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid 20* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>; Christine Vesta, *Managed Care Explained: Why a Medicaid Innovation is Spreading*, May 31, 2011. Available at: <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2011/05/31/managed-care-explained-why-a-medicaid-innovation-is-spreading> (“State Medicaid programs began making the switch in 1990. Then in 1997, Congress passed a law making it easier for states to get federal permission to put Medicaid recipients under managed care. The momentum has continued since.”); see Congressional Budget Office, *Exploring the Growth of Medicaid Managed Care* (Aug. 2018), available at https://www.cbo.gov/system/files/2018-08/54235-MMC_chartbook.pdf (exploring the increase in Medicaid managed care enrollment beginning in 1999).

^{xlv} Public Law 105-33, Sec. 4701 (Aug. 5, 1997).

^{xlvi} Centers for Medicare and Medicaid Services, *Managed Care Authorities*, <https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html> (last accessed May 8, 2022).

^{xlvii} 42 U.S.C. § 1396u-2(a)(2)(C).

^{xlviii} See 42 U.S.C. § 1396n(a)-(b); Centers for Medicare and Medicaid Services, *Managed Care Authorities*, <https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html> (last accessed May 8, 2022).

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^{li} See 42 U.S.C. § 1396u-2(h)(2).

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^{liii} 42 U.S.C. § 1396u-2(h)(4)(B).

^{liv} 42 U.S.C. § 1396u-2(h)(3).

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^{lvi} Christine Vestal, *Managed Care Explained: Why a Medicaid Innovation is Spreading* (May 31, 2011).



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^{lxi} Elizabeth Hinton and Lina Stolyar, *10 Things to Know About Medicaid Managed Care* (Feb. 23, 2022), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>. The six states are: Alabama, Idaho, Oklahoma, Maine, Montana, and South Dakota.

^{lxii} Elizabeth Hinton and Lina Stolyar, *10 Things to Know About Medicaid Managed Care* (Feb. 23, 2022), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>.

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^{lxvii} *E.g.* Congressional Budget Office, *Exploring the Growth of Medicaid Managed Care 1* (Aug. 2018), available at https://www.cbo.gov/system/files/2018-08/54235-MMC_chartbook.pdf; Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid 20* (June 2011), available at <https://www.govinfo.gov/content/pkg/GPO-MACPAC-2011-06/pdf/GPO-MACPAC-2011-06.pdf>; Centers for Medicare and Medicaid Services, *Managed Care*, <https://www.medicare.gov/medicaid/managed-care/index.html> (last accessed May 8, 2022).

^{lxviii} Congressional Budget Office, *Exploring the Growth of Medicaid Managed Care 1* (Aug. 2018), available at https://www.cbo.gov/system/files/2018-08/54235-MMC_chartbook.pdf.



^{lxxix} Congressional Budget Office, *Exploring the Growth of Medicaid Managed Care 13* (Aug. 2018), available at https://www.cbo.gov/system/files/2018-08/54235-MMC_chartbook.pdf.

^{lxxx} Congressional Budget Office, *Exploring the Growth of Medicaid Managed Care 13* (Aug. 2018), available at https://www.cbo.gov/system/files/2018-08/54235-MMC_chartbook.pdf.

^{lxxxi} “2019 Medicaid and CHIP Data Now Available | ResDAC.” Accessed May 12, 2022. <https://resdac.org/cms-news/2019-medicaid-and-chip-data-now-available>.

^{lxxxii} OUIHP Resource and Patient Management System Uniform Data System (UDS) Summary Report Final – Calendar Year 2019,” Indian Health Service, May 10, 2022.

^{lxxxiii} “Consumer Price Index: 2019 in Review : The Economics Daily: U.S. Bureau of Labor Statistics.” Accessed May 10, 2022. <https://www.bls.gov/opub/ted/2020/consumer-price-index-2019-in-review.htm>.

^{lxxxiv} Medicaid and CHIP Payment and Access Commission, *Medicaid Payment Policy for Federally Qualified Health Centers 2* (Dec. 2017), available at <https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf>.

^{lxxxv} Medicaid and CHIP Payment and Access Commission, *Medicaid Payment Policy for Federally Qualified Health Centers 2* (Dec. 2017), available at <https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf>.

^{lxxxvi} Medicaid and CHIP Payment and Access Commission, *Medicaid Payment Policy for Federally Qualified Health Centers 2* (Dec. 2017), available at <https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf>.

^{lxxxvii} Medicaid and CHIP Payment and Access Commission, *Medicaid Payment Policy for Federally Qualified Health Centers 4* (Dec. 2017), available at <https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf>.

^{lxxxviii} Note that each plan may have a specific title for this role, but the required function is the same.

^{lxxxix} For a more thorough discussion of issues regarding underfunding of UIOs and the importance of Medicaid as a source of financial resources for the AI/AN health system, see [Will insert NCUIH FMAP report title when finalized]; Medicaid and CHIP Payment and Access Commission, *Medicaid’s Role in Health Care for American Indians and Alaska Natives* (Feb. 2021), <https://www.macpac.gov/wp-content/uploads/2021/02/Medicoids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf>.

^{lxxx} Health Resources & Services Administration, *Primary Care Associations*, <https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/associations.html> (last accessed May 9, 2022).

^{lxxx} Health Resources & Services Administration, *Primary Care Associations*, <https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/associations.html> (last accessed May 9, 2022).



^{lxxxii} 42 U.S.C. § 1396a(a)(73).

^{lxxxiii} Public Law 111-5, Sec. 5006(d).

^{lxxxiv} 42 U.S.C. § 1396u-2(h)(4)(B).

^{lxxxv} “Certified American Indian or Alaska Native Code - Latest in Year | ResDAC Data Dictionary,” accessed May 24, 2021, <https://resdac.org/cms-data/variables/certified-american-indian-or-alaska-native-code-latest-year>.