DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMCS Informational Bulletin

DATE: December 14, 2016

FROM: Vikki Wachino
Director
Center for Medicaid & CHIP Services

SUBJECT: Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations

The Center for Medicaid and CHIP Services (CMCS) is issuing this Informational Bulletin to summarize the relevant Indian provisions of the final Medicaid and the Children's Health Insurance Program (CHIP) managed care regulation into one document, clarify current statute and regulation regarding mandatory enrollment of Indians into managed care, and provide sample language for an Indian Addendum that can be offered to managed care plans on a voluntary basis when executing network provider agreements with Indian health care providers (IHCPs).

Introduction

On April 25, 2016, CMS published a final rule on managed care in Medicaid and CHIP. The final rule is available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

The final rule codifies a range of Indian managed care protections, including those in section 1932(h) of the Social Security Act (Act), as added by section 5006 of American Recovery and Reinvestment Act of 2009 (ARRA). These provisions allow Indians enrolled in Medicaid and CHIP managed care plans to continue to receive services from an IHCP 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, and referrals and prior authorization requirements. The Indian-specific provisions 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. They are titled: "Standards for Contracts Involving Indians, Indian Health Care Providers and Indian Managed Care Entities." These provisions must be implemented for Medicaid managed care plans by the start of the rating period for contracts starting on or after July 1, 2017, noting that the Indian managed care protections in 1932(h) were effective July 1, 2009. (The rating period is the 12 month contract period during which a particular rate is certified.) States with separate CHIP programs[1] that have plans that contract separately from their Medicaid managed care plans must

[1] If you have further questions concerning a CHIP program in a particular state, contact the state CHIP program.

come into compliance with these provisions no later than the state fiscal year beginning on or after July 1, 2018.

CMS engaged with Tribes throughout the rulemaking process and received several comments from Tribes and Tribal organizations which were incorporated into the final rule to the extent possible. CMS also engaged with Tribes in the development of this Informational Bulletin.

Specific Provisions in the Final Rule Applicable to Medicaid and CHIP that Impact American Indians and Alaska Natives and Indian Health Care Providers.

The final rule implements section 1932(h) of the Social Security Act (the Act) which added additional protections for the treatment of Indians, Indian health care providers and Indian managed care entities in Medicaid and CHIP managed care programs. Section 1932(h) was added to the Act by section 5006(d) of the American Reinvestment and Recovery Act of 2009 (ARRA). The rule applies the Indian protections in section 1932(a)(2)(C) and 1932(h) of the Act, to all types of managed care programs, including Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), Primary Care Case Management programs (PCCM), and Primary Care Case Management Entities (PCCM Entities), as applicable. In this bulletin, we collectively refer to these entities as, "managed care plans."

Definitions

The final rule defines the following terms consistent with statutory and existing regulatory 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.

"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

The final rule at §§438.14(b)(1) and 457.1209 requires every MCO, PIHP, PAHP, or PCCM entity, to the extent the PCCM entity has a provider network, to 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. 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 in accordance with §§438.56(c) and 457.1212.

The final rule at §§438.14(b)(3) and 457.1209 permits 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.

Payment and Contracting

When an IHCP is enrolled in Medicaid or CHIP as a federally qualified health center (FQHC) but is not a participating provider with a MCO, PIHP, PAHP, or PCCM entity, §§438.14(c)(1) and 457.1209 requires that the IHCP be paid the FQHC payment rate under the state plan, including any supplemental payment due from the state.

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, PIHP, PAHP and PCCM entity, §438.14(c)(2) and §457.1209 requires that the IHCP receive the applicable encounter rate published annually in the Federal Register by IHS, 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.

Per §§438.14(c)(3) and 457.1209, 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.

Indian Managed Care Entity (IMCE)

The rule at §§438.14(d) and 457.1209 codifies provisions of section 1932(h) that define IMCEs and set 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.

Avoiding Duplicate Visits for Referrals

The final rule at §§438.14(b)(6) and 457.1209 adds a new requirement to specify that 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.

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 as required in §§438.10(f)(2)(x), §438.10(f)(3), and 457.1207.

Mandatory Enrollment of Indians 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. States also have the option to exempt Indians from mandatory managed care. 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.

The final rule reiterates previous CMS guidance and transparency requirements for Medicaid demonstrations and Medicaid waivers that impact Indians and Tribes. 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.

Medicaid State Plan

Through a state plan amendment that meets standards set forth in section 1932 of the Act, states can implement a mandatory managed care delivery system for certain populations. However, section 1932(h) of the Act prohibits states from mandatory enrollment of an individual who is an Indian 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. However, states have the option to exempt Indians from a 1915(b) mandatory managed care waiver request in light of the special statutory treatment of Indians in federal statutes and other considerations listed above. In reviewing such waiver requests, CMS will consider any input the state received through its state-Tribal consultation process. Frequently, through Tribal consultation, a state and the Tribes could reach mutual consensus to exempt Indians from 1915(b) managed care waivers.

1115(a) Demonstration

Section 1115(a) of the Act authorizes the Secretary to waive provisions of section 1902 of the Act and grant expenditure authority to treat demonstration costs as federally matchable expenditures under section 1903 of the Act. As part of a section 1115(a) demonstration project, CMS may authorize mandatory enrollment in managed care programs for Medicaid beneficiaries, including for dually eligible

beneficiaries, Indians, and children with special health care needs. Demonstration approval is discretionary, and must be based on a finding that the demonstration is likely to promote objectives of the Medicaid program. Similar to the 1915(b) authority, CMS will consider any input the state received in the Tribal consultation process. In addition, there are opportunities for Tribal consultation through the CMS consultation process and the public comment process at the federal level under the Medicaid procedural rules at §431.416. 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) in light of the special statutory treatment of Indians in federal statutes concerning Medicaid managed care.

Historically, as a result of state-Tribal consultation and CMS-Tribal consultation with participation from the state, CMS has not approved section 1115(a) demonstrations that have mandated Indians into managed care; instead managed care enrollment has been voluntary. 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.

CHIP State Plan

Section 1932(h) of the Act (made applicable to CHIP through section 2107(e)(1)(M) of the Act) prohibits states from mandatory enrollment of an individual who is an Indian unless the MCO, PIHP, PAHP, PCCM or PCCM entity contracted with the state is an IMCE. 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.

Indian Managed Care Addendum

Consistent with the rule, this guidance provides sample language for a Medicaid and CHIP Indian Managed Care Addendum (“ITU Addendum”). Indian Tribes are entitled to special protections and provisions under federal law, which are described further in Section II of the ITU 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 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.

We anticipate that offering contracts that include an ITU Addendum will provide managed care plans with an efficient way to establish network provider agreements with IHCPs, and that such agreements include the federal protections for IHCPs. Furthermore, the ITU Addendum helps to integrate IHCPs into managed care networks and ensures that Indian beneficiaries have access to a comprehensive and integrated benefits package and ensure that Indians can continue to be served by their IHCP of choice. Indians enrolled in managed care plans will be better served when IHCPs can coordinate their care through the managed care provider network.

ATTACHMENTS:

Model Medicaid and CHIP Managed Care Addendum for Indian Health Care Providers

Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)

1. Purpose of Addendum; Supersession.
The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between ________________________________(herein "Managed Care Plan") and ____________________________________ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.[2]

2. Definitions.
For purposes of this Addendum, the following terms and definitions shall apply:

(a) "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.

The term "Indian" also includes an individual who 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.

(b) "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).

(c) "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Manager (PCCM) or Primary Care Case Managed Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.

(d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.

[2] Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

(e) "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).

(f) "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).

(g) "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).

(h) "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of IHCP.
The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

/_/ IHS.

/_/ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

/_/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§450 et seq.

/_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Cost-Sharing Exemption for Indians; No Reduction in Payments.
The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services. Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 U.S.C. §1396o-(j)), 42 C.F.R. 447.56 and §457.535.

5. Enrollee Option to Select the IHCP as Primary Health Care IHCP.
The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, (42 U.S.C. § 1396u-2(h)), 42 CFR 438.14((b)(3), and 457.1209.

6. Agreement to Pay IHCP.
The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act, (42 USC 1396u-2(h)), 42 CFR 438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP.
(a) Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

(b) No term or condition of the Managed Care Plan's network provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers.
Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in Appendix A.

9. Non-Taxable Entity.
To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. Insurance and Indemnification.
(a) Indian Health Service. The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the managed care plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

(b) Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

(c) Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any

addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.
Pursuant to 25 USC 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

12. Dispute Resolution.
In the event of any dispute arising under the Managed Care Plan's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. Governing Law.
The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements.
To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA (25 U.S.C. § 1675).

15. Claims Format.
The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA (25 U.S.C. § 1621e(h)), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. Payment of Claims.
The Managed Care Plan shall pay claims from the IHCP in accordance section 1932(h)(2) of the Act, (42 U.S.C. §1396u-2(h)), 42 C.F.R. 438.14(c)(2), and 457.1209, and shall pay at either the rate provided under the State plan in a Fee For Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. Hours and Days of Service.
The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. Coordination of Care/Referral Requirements.
The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.

19. Sovereign Immunity.
Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. Endorsement.
IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS

For the Managed Care Plan: **For the IHCP:**

Date: __________________________ Date: ______________________________

_______________________________ ___________________________________

APPENDIX A

(a) The IHS that is an IHCP:
(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.;
(3) Federal Tort Claims Act (“FTCA”), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 (“Privacy Act”), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:
(1) ISDEAA, 25 U.S.C. § 450 et seq.;
(2) IHCIA, 25 U.S.C. § 1601 et seq.;
(3) FTCA, 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an IHCP:
(1) IHCIA, 25 U.S.C. § 1601 et seq.
(2)Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(3) HIPAA, 45 C.F.R. Parts 160 and 164.