Key takeaways – Look at 4 walls and received through

1. Tribal Nations decide what populations they will serve; this can be AI/AN and non-AI/AN members.
2. Tribal Nations can decide to be an FQHC or non-FQHC tribal clinic provider and can also enroll as other provider types with the state (home health, personal care, etc.) and be reimbursed for any Medicaid covered benefits (state plan and non-state plan.) Virginia tribal clinics have declared as FQHC clinics.
3. Received through services - the provider rendering the service should be enrolled with the state.(* mentioned 2016 SHO letter) in order to receive FMAP/receive reimbursement.
4. Regardless of the populations served, the state should pay ***tribal clinic providers for tribal clinic services*** the same all-inclusive rate (AIR) for AI and Non-AI members. FMAP is only available for AI/AN members.
5. The State decides and the State Plan reflects what services are included in the AIR Rate.
    a. CMS needs to consult internally on what is part of an all-inclusive encounter and what constitutes a separate encounter. Example physician visit, dental visit, and specialist visit on same day. Also example - Doc, radiologist, and pharmacy for broken arm. CMS will let us know.
6. For FQHCs the scope of services is generally *clinic services*. However, the scope of FQHC services vary by state. "Beyond the 4 walls" is also generally within the scope of *clinic services* but can be performed by external providers, such as lab services, which are then recorded in the patient's medical record.
7. Non-State Plan services are permitted but not required to be included in the scope of services paid at the AIR rate. States can also negotiate and pay using an alternative payment model (APM.).
8. States are permitted to apply or to waive utilization management rules, i.e., service authorization and benefit coverage limits.
9. Federal match is only available for AI members.
10. It is acceptable for the state to receive the list of AI members from the tribe. (Nashville IHS may have the list, but it is not complete; only includes individuals who have received services in the past 3 years.)
11. Consultation should be meaningful and give fair consideration to tribal concerns. States should be consulting with tribes on correct billing practices, if they are not billing correctly.
12. Managed care protections - for AI/AN members, tribal provider can bill/be paid whether in or out of MCO Network. For non-AI/AN providers, MCO can require that the member receive services in-network; MCOs can contract with the tribal provider as a network provider.

    a. For FQHCs, MCO pays the tribal FQHC at the contracted rate for both AI/AN and non AI/AN members; DMAS makes the wrap around payment; same as FQHC payment rules today.
    b. For OON tribal FQHCs or tribal clinics, where no payment agreement has been negotiated, MCO payment should not be less than the rate it pays to other FQHCs/clinic providers.

- We did not get into the licensure, certification, and oversight questions.
- We did not confirm if the Tribal Clinics must meet 1) licensure /certification for certain provider types (BH, SUD, LTSS). Did not confirm other rules, i.e., LTSS home and community-based settings, EVV, patient pay towards LTSS.
- From the CFR, AI members can go out of state to receive services. Can opt to be in FFS if networks are not sufficient. NonAI members can be required to receive services from network providers.
- AI and non-AI members cannot be required to use tribal providers (voluntary.)

References mentioned -
2016 SHO letter
State Plan
ARA
Managed Care protections (42 CFR 438.

Emily's notes - Call with CMS, 9:30-10:30 on Thursday, July 25, 2024

CMS Attendees: Nancy Grano, Kitty Marx, Peggi Kosherzenko, Susan Karol, Rachel Ryan Pederson, Cynthia Lemesh, Alice Robinson Ross, Nicole McKnight

DMAS Attendees: Jeff Lunardi, Tammy Driscoll, Brian Campbell, Cat Pelletier, Hope Richardson, Jarek Muchowski, Sevda Nixon, Brian McCormick, Nichole Martin, Emily McClellan

OAG Attendees: Kim Piner, Jennifer Gobble

Jeff: Broad group of DMAS staff, will skip introductions

Nancy G: Introduced Kitty Marx and Susan Karol from the Division of Tribal Affairs. Some individuals in that Division have over 30 years of experience in Indian Health Policy and work closely with Indian Health Services.

Jeff: We are reaching out because the Virginia tribes are growing and evolving and we need to set up policies and processes to allow that to occur and to meet our responsibilities. We are concerned about possible long-run budget impacts, and want to know more about what states can/cannot do in relationships with the Tribes. Virginia is a heavily managed-care state. With regard to individuals who are not American Indian/Alaskan Native (AI/AN), does the state have options.

Kitty: Tribes can contract with IHS. The Indian Health Determination Act is 93-638, and tribes that fall under this law are called 638 tribes. States must follow IHS regulations.

Tribal members and descendants are covered, but they can open coverage up to non-AI/AN individuals including children, spouses, and other non-Indians. There is no additional money available from IHS. Non-Indians should have third-party resources.

Jeff: For non-Indians who are Medicaid members, is the rate paid for services the same?

Kitty: Yes. One facility, one rate. This is long-standing policy. There is the regular state match for non-Indian members.

Jeff: Is there a difference in how clinics and "beyond the four walls" services are treated?

Kitty: The non-IHS provider that is providing services via a care coordination agreement would bill at the rate the provider negotiates with the state. Virginia tribes are enrolled as FQHCs – the 7/10/24 proposed rule eliminates the four walls limitation for clinics. FQHCs are not limited – they can claim the item as a service of the FQHC and bill up to the state.

Jeff: Do providers choose how they are enrolled?

Kitty: Yes, they can enroll as a clinic or an FQHC.

Jeff: What about a non-tribal provider and non AI/AN members – can they provide personal care?

Kitty: Is it covered under the state plan?

Jeff: We have another question on that. We have heard from another state that they negotiated with tribes and that for non AI/AN members, the tribes put up the state-funded portion of the cost of the service.

Kitty: The CMS Financial Management Group is looking into that in one state. Which state?

Hope: Wyoming

Kitty: That is not the state we are looking at.

Jeff: We aren't sure that Wyoming is doing that. How do we identify tribal members?

Kitty: The IHS office sometimes sends an "active user file" to states – it contains individuals who are eligible and who have received services in the past three years. Tribes also have a list.

Jeff: We have been using the tribal list but wanted to see whether there were other sources.

Kitty: We would need to check with IHS and see if it is possible to get the list for Virginia. They are a small office with limited staff.

Hope: Is there a contact we should reach out to or with CMS reach out?

Kitty: CMS will reach out to see if it is feasible for IHS to provide this. CMS is exploring other best practices related to tribal verification.

Jeff: What levers/authorities do states have vs. tribes … do states have discretion to tell tribes what can/cannot be reimbursed?

Kitty: If it is a Medicaid-covered service it is covered. Some states define what is paid at the IHS rate or the FFS rate. NEMT and pharmacy are examples. The state plan reimbursement pages say how tribal providers will be paid, and changes have to go through tribal consultation.

Tammy D: What about 1915(c) waivers?

Kitty: Alice Robinson Ross will need to follow up on this question.

Kitty: Personal care – is that covered under 1915(c)?

Tammy: Yes.

Nancy: Is personal care covered under the state plan?

Emily: Only for EPSDT.

Kitty: How are the tribes billing?

Jeff: At the AI/AN rate. Are there differences in whether services are received directly by the tribal provider or from a non-tribal provider?

Kitty: FQHC services have a scope of services. If the tribal provider is enrolled as a clinic, they would provide the clinic scope of services.

Tammy D: What about services like PT/OT/Speech – those are not typically provided through FQHCs.

Nancy: Home health is another example. Tribal providers may enroll to provide that service – they are not limited to enrolling as a clinic or FQHC. CMS doesn't look at 1915(c) waiver services and the state plan differently.

Tammy D: It sounds like the tribal provider could enroll as an FQHC and as a home health provider and a waiver provider.

Nancy: The FQHC scope of service varies by state. The IHS contract can also include LTC services.

Kitty: I'm not sure to what extent the state meets with tribes through consultation. The tribes are new – if they are not billing correctly, they need to be advised on how to enroll, what the scope of services is, and what the rate is. It would be helpful to have the state reach out and have a discussion. Her office can help with that type of meeting/discussion.

Jeff: The relationship with the tribes has been very positive. DMAS meets with them every other week. DMAS wants to gather information on what our authority is before we communicate changes to them.

Kitty: Is it the Nansemond?

Hope: The Nansemond and the Upper Mataponi.

Nancy: It is helpful to communicate with all tribes. The Mid-Atlantic Service Unit would be a good place to start. Communicate about the state plan. There is a consultation process in Wisconsin that has a good back and forth.

Jeff: Questions on scope of services. Regardless of the scope of services, does the service still have to be in the benefit plan? If we require service authorization for high-intensity behavioral health services, would SA still be required?

Kitty: Generally yes, but states can waive that if they want.

Jeff: Under a care coordination agreement with a non-IHS provider, would that provider need to be enrolled as a primary care provider?

Kitty: Yes.

Jeff: Do the same TPL rules apply?

Kitty: Yes.

Hope: Does the AIR rate apply for both 638 and non-638 providers?

Kitty: Will take that back and look. Home Health is a little bit different.

Hope: For "received through" services does the tribal provider need to choose to be a clinic or FQHC?

Kitty: Yes, but some states allow both. Services would need to be consistent with the scope of practice for an FQHC or clinic.

Nancy: If the facility is enrolled as an FQHC, no care coordination agreement is needed.

Kitty: The FQHC scope of services is defined in the state plan.

Jeff: For managed care, how do the rules differ?

Kitty: The American Recovery and Reinvestment Act contains protections for Indians under managed care. An individual can continue services under an Indian health care provider and can bill the managed care plan. The state makes a supplemental payment to match the all-inclusive rate. Protections under managed care only apply to Indians. For non-Indians, the tribe would need to have a contract with the MCO – or they would be considered out of network.

Jeff: Are there differences if it is an FQHC or a clinic?

Kitty: Yes. FQHCs in managed care are paid a supplemental payment. Does Virginia do that now?

Cat: Yes.

Jeff: Does being in managed care affect the ability to serve non-AI/AN?

Kitty: Under FQHC rules, managed care plans pay a supplemental payment.

Jeff: Would an MCO have to include them in their network if they were enrolled as an FQHC?

Kitty: I think so. Why wouldn't an MCO not include an FQHC?

Tammy D: Only if they didn't want to enroll with the MCO. What would be paid as network provider whether they are in managed care or not?

Kitty: If the provider is a clinic, there is a supplemental payment for AI/AN.

Jeff: With regard to encounters, do you have any guidance or other state models related to what is included in an encounter?

Kitty: States vary. Some only pay the all-inclusive rate for listed services.

Jeff: If the tribal provider is an FQHC, does that change things due to the FQHC bundled rate?

Kitty: Covered services are within the FQHC scope of services. The OPPS rate only applies to certain services that are within scope.

Jeff: Do we have discretion to define an encounter for all-inclusive rate billing?

Nancy: There is an alternative billing methodology in the Virginia state plan.

Peggi: [She read the state plan text.]

Kitty: Changes would require consultation.

Tammy D: If a member sees a physician and then has lab work and then gets a prescription, is that three encounters even though there is an all-inclusive rate?

Kitty: In the example of a broken arm, the individual might see a nurse, a doctor, get an x-ray, and get a prescription for pain pills. This would be considered one encounter.

Susan Karol: Different providers would mean different encounters.

Kitty: No, that's not the case. CMS will take this back.

Brian C: What types of claim detail is needed to differentiate between encounters?

Susan: CMS will take this back.

Kitty: CMS will take back: verifying tribal status, how 1915(c) waiver services are reimbursed now under the state plan (asked Virginia to review as well), whether services are within the FQHC scope of services.

Jeff: Does consultation mean that we consult or that the tribes agree?

Kitty: There must be a meaningful discussion and fair consideration of tribal views and concerns.

Jeff: Who is the best direct point of contact on these issues at CMS?

Kitty: Nancy Grano and copy Peggi.