From: Richardson, Hope (DMAS) <Hope.Richardson@dmas.virginia.gov>
Sent: Wednesday, July 31, 2024 10:28 AM
To: Lunardi, Jeff (DMAS) <Jeff.Lunardi@dmas.virginia.gov>
Subject: Re: Richardson, Hope (DMAS) replied to a comment in "Communication to Tribal providers on actions with citations 7-30-24"

Yeah, that's my read. I believe others as well, but I'll check. The talking points hint obliquely at this but we might want to wait for a later conversation to say it directly (after we've discussed with the MCOs and gotten their buy-in).

Get Outlook for iOS

From: Lunardi, Jeff (DMAS) <Jeff.Lunardi@dmas.virginia.gov>
Sent: Wednesday, July 31, 2024 10:19:15 AM
To: Richardson, Hope (DMAS) <Hope.Richardson@dmas.virginia.gov>
Subject: RE: Richardson, Hope (DMAS) replied to a comment in "Communication to Tribal providers on actions with citations 7-30-24"

Yes, totally understand they have to pay OON for tribal members, but they wouldn't for non-tribal right? So basically if the MCOs don't enroll them, and the non-tribal members can get services elsewhere, then they won't have anyone to serve outside of the tribal members.

From: Richardson, Hope (DMAS) <Hope.Richardson@dmas.virginia.gov>
Sent: Wednesday, July 31, 2024 9:09 AM
To: Lunardi, Jeff (DMAS) <Jeff.Lunardi@dmas.virginia.gov>
Subject: Richardson, Hope (DMAS) replied to a comment in "Communication to Tribal providers on actions with citations 7-30-24"

Communication to Tribal providers on actions with citations 7-30-24.docx

You left a comment

Are the MCOs required to include them in their networks, or can they just pay them as out of network for Tribal members?

Richardson, Hope (DMAS) replied

The MCOs aren't required to enroll them in their networks but they are required to pay them OON. Effectively, though, I think the network adequacy requirement may mean they'll have to (/we'll need to make them) enroll the tribal providers in their networks. The tribal providers will probably prefer this because otherwise there will be challenges with serving non-AI/AN members.

Message to tribes	What we know; Required action	Citation
AI/AN tribal list data exchange: We received confirmation from CMS that we must track and report to the federal government which services are provided to AI/AN tribal members and non-AI/AN tribal members. Given the large number of non-tribal members served, it has implications for the state budget, and we are required to track data to know when it should be 100% federal funds and when state is responsible for sharing the cost. Based on this, we will need to begin working with you immediately to get processes in place for a regular file transfer identifying which Medicaid enrollees you serve are tribal members.	FMAP is different for non-tribal members (not 100%). DMAS must identify services to AI/AN tribal members, include this information in our federal financial reporting, and claim appropriate FMAP. The blue highlighted language, "not otherwise eligible," refers to non-Tribal individuals who are otherwise eligible for govt. health program services (including Medicaid).	HYPERLINK "https://www.medi guidance/downloads/faq11817. Services "Received Through" an Medicaid Eligible American Indi QA #10: "The AIR rate would ap visits, not just those by AI/AN FMAP would apply only to the c HYPERLINK "https://www.feder 15087/medicare-and-medicaid- payment-and-ambulatory-surgi Outpatient Prospective Payme "Under CMS's longstanding inte 100 percent FMAP is available c received through an IHS/Tribal beneficiaries. State expenditur facility to other individuals are 100 percent, but rather at the S Confirmed on CMS call 7/25/24: resources. Regular state match

It is the tribe's decision whether the tribal provider services non-tribal members (not up to the state Medicaid agency)	25 U.S. Code § 1680c - Health services for ineligible persons .... (c) Health facilities providing health services (1) In general The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside within the Service unit and who are not otherwise eligible for such health services if— .... (2) ISDEAA programs In the case of health facilities operated under a contract or compact entered into under the HYPERLINK "https://www.law.cornell.edu/topn/indian_self-determination_and_education_assistance_act"Indian Self-Determination and Education Assistance Act (HYPERLINK "https://www.law.cornell.edu/uscode/text/25/450"25 U.S.C. 450 et seq.), the governing body of the Indian tribe or tribal organization providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract or compact to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the consideration described in paragraph (1)(B). Any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph shall be deemed to be provided under the agreement entered into by the Indian tribe or tribal organization under the HYPERLINK "https://www.law.cornell.edu/topn/indian_self-determination_and_education_assistance_act"Indian Self-Determination and Education Assistance Act. The provisions of HYPERLINK "https://www.law.cornell.edu/rio/citation/Pub._L._101-512"section 314 of Public Law 101–512 (HYPERLINK "https://www.law.cornell.edu/rio/citation/104_Stat._1959"104 Stat. 1959), as amended by HYPERLINK "https://www.law.cornell.edu/rio/citation/Pub._L._103-138"section 308 of Public Law 103–138 (HYPERLINK "https://www.law.cornell.edu/rio/citation/107_Stat._1416"107 Stat. 1416), shall apply to any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph. Virginia's tribes have informed us that their tribal councils decided the providers would serve non-tribal members. For the Nansemond tribe, we have documentation of this in the agreement between the tribe and IHS/HHS (Attachment 2, p. 1-2): Section 4. Persons to whom services will be provided. The Contractor will provide health care services to its enrolled members, and other IHS eligible beneficiaries, in accordance with the Act, 25 U.S.C. § 1680c, 25 C.F.R. Part 900, 42 C.F.R. Part 136, and any other applicable law or regulation. The Tribe may also provide health care services to ineligible (i.e., non-Tribal members) persons in accordance with 25 U.S.C. §1680c(c)(2), and Resolution No: 2022-11-08-01. Confirmed on CMS call 7/25/24.	Single Medicaid facility rate for
HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf"CMS State Health Official (SHO) letter #16-002 Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives, dated 2-26-2016 "...a state agency cannot establish one rate for services furnished by the facility to AI/AN beneficiaries and another for the same services provided by that facility to non-AI/AN Medicaid beneficiaries." SHO #16-002, page 5 See also CMS 1-18-2017 FAQ cited above: "Q11. May a State pay a Tribal facility at the AIR rate for services furnished to AI/AN beneficiaries and at the FQHC PPS rate for non-AI/AN beneficiaries? A11. No. A Tribal facility may be	At this time, no known federally permissible means for tribe to put up state share.	On 7/25/24 CMS call, we asked approved examples of this in a happening but could not confir permissible.

only one type of provider (either a "clinic services" provider or an FQHC) and receive only one reimbursement rate that applies to all Medicaid beneficiaries. Whatever rate a Tribal FQHC facility and the state Medicaid agency agree upon, whether PPS or AIR, that same rate must be applied to all Medicaid beneficiaries who receive services through the facility."

Confirmed on 7/25/24 CMS call. One facility, one rate = long-standing Medicaid payment policy.

Managed care billing and potential network participation: Up until now, the tribal providers have been operating entirely through fee-for-service Medicaid, where you bill DMAS directly. We've received clarification from CMS that in a state with a setup like ours, where AI/AN Medicaid members are enrolled in managed care health plans, and the tribal providers are also serving a large number of non-AI/AN Medicaid members who are mostly enrolled in an MCO, it's important for the tribal provider to bill the member's managed care plan directly. We need to work with you and our MCOs to transition to that setup as quickly as possible. This is important because the health plan plays a role in coordination of services for the member and needs to know the full scope of services they're receiving. This is also important to prevent duplication of services and payment, since we know that a number of members are receiving services from providers through their MCO and also through the tribal provider.
We are aware as we move forward with this that there are protections for AI/AN tribal members as well as for tribal providers in a managed care setup, and you have options. For example, tribal providers aren't required to join the managed care networks. The MCO still has to pay you out of network even if you don't join the network. AI/AN tribal members can get services from the tribal provider regardless of whether the tribal provider is in-network with their MCO.
Because of the large number of non-AI/AN tribal members you serve, it may be beneficial to enroll with the MCOs. Either way, it is a top priority for us to start these discussions now with tribal providers and MCOs in order to ensure we're implementing all of the federal Medicaid managed care regulations as quickly as possible.

Integrating the tribal providers into managed care will address many of the issues we are having.

In addition, we must make changes to come into compliance with federal Medicaid managed care requirements, while upholding mandatory protections for tribal providers and AI/AN Medicaid members. These include the following:

Contracts between a State and a MCO that enrolls AI/AN individuals must require that Indian health care providers be paid for covered services provided to AI/AN enrollees, regardless of whether the tribal provider participates in the MCO network.

MCO contracts must allow AI/AN enrollees to obtain covered services from tribal providers, even if they are out-of-network.

MCOs required to demonstrate sufficient network of tribal providers to ensure timely access for AI/AN enrollees. Sufficiency standard is satisfied if AI/AN enrollees may access out-of-state tribal providers for MCOs enrolling AI/AN members or have good cause to disenroll from the MCO and into FFS.

Indian Managed Care Addendum = best practice. MCO contracts currently do not have this and all services provided by tribal providers are carved out of MCO contracts

FYI, applicability of payment through managed care to reimbursement rate for tribal FQHCs:

HYPERLINK "https://www.ecfr.
C/part-438/subpart-A/section-4
apply to MCO, PIHP, PAHP, PCC
Indians, Indian health care prov
entities (IMCEs).
Cited below:

"All contracts between a State
Require that [Indian Health Car
not, be paid for covered service
eligible to receive services fro

"All contracts between a State
Permit Indian enrollees to obta
between the State and the MC
network IHCPs from whom the
such services."

HYPERLINK "https://www.medi
guidance/downloads/cib12141
Indian Provisions in the Final M
Program Managed Care Regulat
CIB 12-14-16, Page 3: "The final
that there are sufficient [Indian
in the network to ensure timel
contract from IHCPs for Indian e
services. In the event that time
guaranteed due to few or no ne
standard … is satisfied if (1) Indi
access out-of-state IHCPs or (2)
reason under the managed care
disenroll from the state's mana

CIB 12-14-16, p. 5: "We anticipat
Addendum will provide manag
establish network provider agr
agreements include the federal
Addendum helps to integrate I
ensures that Indian beneficiari
integrated benefits package an
served by their IHCP of choice. I
be better served when IHCPs ca
managed care provider networ

CMS 1-18-2017 FAQ cited above
#15): "In the case of beneficiari
care organization (MCO)… the f
letter on page 6, the non-IHS Tr
agreement would have to parti
have to be paid at a rate consist
agreement with the managed c
elects to enroll in the state Me
may properly bill the MCO for s
with which it contracts as a facil
Tribal FQHC by the managed ca
an FQHC that is a network provi
supplemental payment from th
sections 1902(bb) and 1932(h)(2
payment rule applies whether
provider network of the MCO…

Coverage limitations and utilization management criteria apply: We understand that you have expanded since the founding of the clinic to provide additional services. Our current FFS billing setup was designed to pay for basic outpatient clinic visits and services included in that encounter, and we don't have the system set up to gather the needed information about services provided or include the necessary checks/edits to be reimbursable by Medicaid. For example, the service must be in the member's plan of benefits and meet waiver participation rules and service authorization criteria (home health, behavioral health). CMS has confirmed that these requirements apply to services billed by tribal providers. Also: when a service is rendered by a contracted provider and billed through the tribal facility, we must have checks in place to ensure that the contracted provider is a Medicaid-enrolled provider.	There are certain operational and systems changes that we can initiate without delay to improve billing, utilization management, and other processes. -Service must be in member's plan of benefits -Must meet service authorization criteria -Tribal provider must follow Medicaid payor of last resort rules. (This may impact home health and other services Medicare covers.) Need rendering provider on claim; must ensure that contracted provider is a Medicaid-enrolled provider.	Confirmed on 7-25-24 CMS call, authorizations can be waived at Confirmed on 7-25-24 CMS call. member. "Under this policy, both the IHS provider must be enrolled in th providers." CMS SHO #16-002, p

...

•Need to define clinic services or possibly remove clinic services as a provider type (it is an optional Medicaid provider type and we may not have any providers currently enr implications of the proposed rule.

Go to comment

Why am I receiving this notification from Office?