In initially setting up our tribal reimbursement, DMAS expected that services billed would be mostly traditional FQHC/clinic services in the tribal 638 facility, serving mainly tribal members.

Rapid expansion of services, particularly services outside four walls; high percentage non-AI/AN.

Redacted - VFOIA Exempt

We as the state Medicaid agency need to work with the tribal providers **as well as our state legislature** and other decision-makers to come up with a solution that meets approval for the state funds spent.

In the near term, we are requesting CMS assistance reviewing DMAS' decisions and options provided to the tribes regarding what is covered and not covered currently under our tribal reimbursement SPA and in accordance with CMS regulation and guidance. These questions center on:

- "Outside the four walls" guidance and Virginia's tribal reimbursement SPA
- Managed care regulations pertaining to tribal entities and individuals, and Virginia's 1915b waiver

Our short-term goal is to clarify what instructions DMAS can give to the tribal providers that may represent a change from current practices, prior to submission and approval of a new SPA and/or waiver amendments. **Redacted - VFOIA Exempt**

Redacted - VFOIA Exempt

In the long term, we are asking for ongoing CMS technical support – and potentially facilitation of conversations with the tribal providers – as we work together to revise the state plan tribal reimbursement language and develop a path forward that is sustainable for Virginia and our tribal providers.

Reimbursement and Provider Enrollment Questions:

1. 1915c waiver services are not covered as a facility service in Virginia's current tribal reimbursement SPA. Tribal 638 clinics (whether FQHC or clinic services provider) are not listed as a provider type for provision of personal care services under our 1915(c) waiver.

   Based on this information, we are planning to stop reimbursing the tribal facilities for 1915c waiver services (i.e., personal care) at the facility rate (AIR) as an outside the four walls service. We have informed the tribal providers that they can enroll with DMAS as a normal personal care provider type with reimbursement at the regular rate/payment methodology for this service.

   Because this is based on our read of the current SPA language, our stance is that we do not require additional federal authority to do this. **We are requesting confirmation from CMS that Virginia can take this action under our current State Plan.**

2. The tribes have told us that they are authorized by IHS to provide certain services, including personal care, under their tribal 638 agreement with the federal government. **We would like your help us understand the tribe's agreement with IHS as distinct from the Medicaid state plan, and how these two documents interact?**

   With respect to personal care, does the fact that IHS has authorized the tribe to provide personal care dictate a specific Medicaid payment methodology or reimbursement rate?

   Does the IHS agreement obligate DMAS to reimburse the tribal providers for personal care as a facility service, or is it allowable for us to reimburse the tribal provider at our normal rates for this service (in the absence of tribal reimbursement SPA language covering 1915c waiver services)?

3. One issue that has caused confusion between DMAS and the tribal providers is whether they wish to be a tribal FQHC or a tribal clinic. We are planning to inform the tribal providers that they must choose to be either a tribal FQHC or a tribal clinic, as we have seen other states, such as California do. **Can you confirm that we are able to require this?**

4. **Are we correct in informing the tribes that in accordance with current federal guidance** (SHO letter #16-002 and related FAQ, setting aside the proposed rule)**, if they choose not to enroll as a tribal FQHC, at this time we will not pay the facility rate (AIR) for clinic services outside the four walls?**

Or must we offer a state grace period reflecting the federal grace period in place?

5. **Is it correct that scope of services for the tribal facility is based on the usual scope of services for the chosen provider type, whether FQHC or clinic?** This would impact some of the home health services that we have been reimbursing at the tribal facility rate that a Virginia FQHC ordinarily would not provide outside the four walls, such as PT, OT, home health and skilled nursing.

6. **Can we align the rules for what is included in a single encounter for a tribal FQHC with that of other FQHCs in our state Medicaid program? (i.e., can we do this without additional federal authority?)** We understand that there are some definitions in our state plan tribal reimbursement language, including the upper limit of 5 encounters per member, per day for tribal facilities, that would require a SPA to change. We'd like to know if there are unique federal rules pertaining to how an encounter is defined for tribal FQHCs or tribal clinics.

Managed Care Integration Questions:

7. As described in our last call, Virginia has been reimbursing the tribal providers exclusively through FFS, even though AI/AN individuals are a managed care population in our state (not an excepted population under our 1915b managed care waiver) and over 90% of the members served by the tribal providers are enrolled in managed care. **Under federal regulations, should we have provisions in our managed care contracts requiring the MCOs to pay the tribal providers for services to members in managed care (out of network if the tribal providers choose not to participate in MCO networks)?**

   Does the answer to this question change if the individual is not an AI/AN member?

   We understand that we cannot require the tribal providers to participate in-network with the MCOs. **However, is it correct that we can require the tribal providers to bill the MCOs rather than FFS** for members enrolled in managed care?

   We understand that the Medicaid managed care regulations include protections enabling AI/AN individuals to see tribal providers even when not in-network with their plan, and to choose a tribal provider as PCP. **However, it is our understanding that these rules do not apply to non-AI/AN individuals.** Is this correct?

   We are developing a transition plan to move the services provided by Virginia's tribal providers into managed care, as appropriate. **Do we first need to amend our 1915(b) waiver to explicitly include tribal providers before implementing a requirement that they bill managed care?**

8. Can you confirm that our interpretation of how managed care reimbursement would work under our current state plan correct:

   - For tribal FQHCs, our FFS facility rate is the AIR. The rate of payment to the Tribal FQHC by the managed care plan would be the amount the plan pays an

FQHC that is a network provider (including for allowable outside four walls services); DMAS would make supplemental payment up to the AIR. However, DMAS would have the option of arranging for the MCOs to pay the AIR directly to the tribal providers and DMAS settles up with the MCOs afterwards (California model).

- For non-FQHC tribal "clinic services" providers, MCOs would pay the tribal clinics at the same facility rate as for FFS directly (AIR). At this time, no services outside four walls are allowable through the clinic at the facility rate. If the proposed rule is finalized, it would be mandatory to pay at facility rate for outside the four walls services through tribal clinics. **Would Virginia have option of SPA to amend reimbursement methodology/rate for clinic services, or is AIR essentially the only option?**

Tribal Consultation and CMS TA Questions:

9. **In the long term, we are asking for ongoing CMS technical support – and potentially facilitation of conversations with the tribal providers – as we work together to develop a path forward that is sustainable for Virginia and our tribal providers.**
    - The solution needs to account for growth of existing facilities, new facilities, new tribes choosing to participate in Medicaid tribal reimbursement, potential new provider types and services.
    - Needs to involve managed care, because most of the members served are in MCOs.
    - We need to understand the impact of the proposed rule, should it become finalized, regarding clinic services provider type.

10. Can you help us with contacts in other states with mature tribal reimbursement programs? It would be particularly helpful if they reimburse any HCBS services through the tribal providers.

    Contacts in Oklahoma (tribal PACE, other longstanding tribal LTSS programs)?

    Contacts in other states with tribal HCBS?

    - Minnesota
    - Oklahoma
    - North Dakota
    - Washington
    - Wisconsin