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RE: Legal Analysis in Response to DMAS's Interpretation of 42 C.F.R. § 438.14 and Response to DMAS's October 24 Argument

I. Introduction

The Virginia Department of Medical Assistance Services ("DMAS") has argued in an email sent on its behalf on October 24, 2024, that non-American Indian/Alaska Native ("non-AI/AN") Medicaid enrollees receiving personal care assistance ("PCA") services must transition into Managed Care Organizations ("MCOs") and that Indian Health Care Providers ("IHCPs") cannot be reimbursed for services provided to non-AI/AN beneficiaries outside MCO networks. DMAS bases this assertion on 42 C.F.R. § 438.14, as well as its 1915(b) and 1915(c) waiver programs.

II. Misapplication of 42 C.F.R. § 438.14

A. DMAS's Flawed Interpretation

DMAS contends that 42 C.F.R. § 438.14 restricts non-AI/AN Medicaid enrollees from receiving services from IHCPs outside the MCO network and mandates their transition into managed care. This interpretation is incorrect and is based on a narrow reading of the regulation, which was primarily designed to safeguard AI/AN enrollees' access to IHCP services, not to impose restrictions on non-AI/AN access. As discussed in more detail below, the Indian Canon of Construction, requires that laws and treaties concerning tribes must be interpreted liberally in favor of tribes and their sovereign rights

B. The True Scope of 42 C.F.R. § 438.14

42 C.F.R. § 438.14 was enacted to ensure that AI/AN Medicaid enrollees have unimpeded access to IHCPs, regardless of whether those providers participate in MCO networks. This regulation is intended to safeguard tribal sovereignty and protect the unique status of IHCPs under federal law by ensuring that AI/AN beneficiaries can continue to receive care from these providers, even in the context of state-managed Medicaid programs that use MCOs.

However, DMAS's interpretation of the regulation mischaracterizes its scope. The regulation was never designed to restrict access to IHCPs for non-AI/AN Medicaid beneficiaries. The text of 42 C.F.R. § 438.14 is explicitly focused on protecting AI/AN enrollees' access, but it does not contain any provisions that limit or prohibit non-AI/AN beneficiaries from utilizing IHCP services. This means that non-AI/AN

Medicaid beneficiaries can continue to receive care from IHCPs, just as they would from any other qualified Medicaid provider.

The regulation's lack of restrictive language with respect to non-AI/AN enrollees is deliberate. Federal law recognizes the unique trust relationship between the federal government and Indian tribes, as well as the importance of IHCPs in delivering healthcare services to both AI/AN and non-AI/AN populations. As such, 42 C.F.R. § 438.14 was written to strengthen, not restrict, access to IHCPs. The absence of any mention of non-AI/AN restrictions within the regulation indicates that it was not intended to create barriers to access for any group of Medicaid beneficiaries.

DMAS's attempt to use 42 C.F.R. § 438.14 to justify limiting IHCP services to only AI/AN beneficiaries misreads the regulation's intent and violates both the spirit and letter of the law. The regulation's intent is clear: to protect access to tribal healthcare services in a managed care environment. There is no statutory or regulatory basis for imposing limits on non-AI/AN access to IHCPs, and DMAS's restrictive interpretation is not only unsupported by the text but also contrary to the purpose of the regulation, which is to ensure broad access to critical healthcare services through IHCPs.

Furthermore, applying 42 C.F.R. § 438.14 in such a restrictive manner would violate the federal trust responsibility that obligates the federal government—and by extension, state Medicaid programs—to support tribal healthcare systems. IHCPs often serve non-AI/AN beneficiaries as part of their healthcare mandate, and federal law has long recognized that these services benefit both AI/AN populations and the broader community. Limiting non-AI/AN access to IHCPs would undermine the financial and operational stability of tribal healthcare facilities, which rely on serving a diverse patient base to continue offering comprehensive care.

In sum, DMAS's interpretation of 42 C.F.R. § 438.14 is legally flawed. The regulation's primary aim is to protect access to IHCP services for AI/AN enrollees, but it does not, in any way, restrict or limit access for non-AI/AN beneficiaries. By trying to impose restrictions on IHCP services for non-AI/AN beneficiaries, DMAS is overstepping its regulatory authority and contradicting the clear intent of federal law, which is to ensure the availability of tribal healthcare services to all Medicaid beneficiaries.

C. Federal Statutory Authority of IHCPs as Medicaid Providers

DMAS's restrictive interpretation of 42 C.F.R. § 438.14 directly conflicts with 42 U.S.C. § 1396j, also known as Section 1911 of the Social Security Act, which explicitly authorizes IHCPs to serve both AI/AN and non-AI/AN Medicaid beneficiaries. Section 1911, a crucial provision in the Social Security Act, recognizes IHCPs as Medicaid-qualified providers, establishing their right to receive reimbursement for services provided to all Medicaid beneficiaries, without distinction based on the beneficiaries' tribal status.

42 U.S.C. § 1396j is the foundational statute that affirms the legal status of IHCPs within the Medicaid program. It mandates that state Medicaid agencies, such as DMAS, reimburse IHCPs for covered services, regardless of whether the Medicaid enrollee is AI/AN or non-AI/AN. This statutory protection ensures that IHCPs can operate without unnecessary limitations imposed by state Medicaid programs, reinforcing their role as integral healthcare providers for both tribal and non-tribal populations. It recognizes the unique position of tribal healthcare providers within the broader Medicaid system, allowing them to operate as Medicaid-qualified entities while still adhering to the principles of tribal sovereignty and self-determination.

By authorizing IHCPs to serve both AI/AN and non-AI/AN beneficiaries, 42 U.S.C. § 1396j eliminates any potential ambiguity about the scope of services IHCPs can provide or the populations they can serve. The statute makes it clear that state Medicaid programs must treat IHCPs as qualified providers

for all Medicaid enrollees, thereby entitling them to reimbursement at the same rates available to other providers in the Medicaid system—specifically, the AIR that applies to services provided by tribal healthcare facilities under 638 contracts with the federal government. This guarantees full reimbursement for Medicaid-covered services, protecting the financial integrity of IHCPs and ensuring that tribal health systems can continue to serve a broad range of patients, including non-AI/AN individuals.

i. The Indian Canon of Construction: Preserving Tribal Sovereignty and Rights

The Indian Canon of Construction, a long-standing principle in federal law, dictates that laws and treaties concerning tribes must be interpreted liberally in favor of tribes and their sovereign rights. This doctrine has been repeatedly upheld by federal courts, including the U.S. Supreme Court. In *Montana v. Blackfeet Tribe*, 471 U.S. 759, 766 (1985), the Court reaffirmed that when statutes or treaties concerning tribes are subject to differing interpretations, they must be construed in favor of the tribes. This principle reflects the federal government's trust responsibility to protect tribal sovereignty and ensures that tribes are not subjected to restrictive or ambiguous interpretations of federal law that would undermine their rights.

Applying this canon of construction to 42 U.S.C. § 1396j and 42 C.F.R. § 438.14, it is evident that IHCPs must be allowed to serve both AI/AN and non-AI/AN Medicaid enrollees without arbitrary restrictions imposed by state agencies. Any attempt by DMAS to limit the scope of IHCP services or deny reimbursement for non-AI/AN patients contradicts both the statutory intent of Section 1911 and the overarching federal policy to protect tribal healthcare sovereignty. The Indian Canon of Construction reinforces the position that tribal healthcare providers have the right to deliver Medicaid services to all eligible beneficiaries and receive full reimbursement, free from state-imposed constraints.

ii. Judicial Precedent: Consistent Protection of Tribal Rights

The U.S. Supreme Court and lower federal courts have consistently applied the Indian Canon of Construction in cases involving tribal rights, particularly when state actions threaten to encroach on those rights. For instance, in *Bryan v. Itasca County*, 426 U.S. 373 (1976), the Supreme Court held that ambiguities in statutes relating to tribal authority must be resolved in favor of preserving tribal self-governance. Similarly, in *Montana v. Blackfeet Tribe*, the Court underscored that federal statutes concerning tribes must be interpreted to benefit the tribes, not limit their sovereign authority.

By attempting to restrict IHCPs' ability to serve non-AI/AN beneficiaries and limit their reimbursement rights, DMAS is violating both the letter and spirit of 42 U.S.C. § 1396j, 42 C.F.R. § 438.14, and the Indian Canon of Construction. Courts have shown an unwavering commitment to protecting tribal sovereignty in the face of state interference, and any legal challenge to DMAS's interpretation of Medicaid regulations would likely result in a ruling favoring the tribal providers.

DMAS's attempt to restrict the services IHCPs provide to non-AI/AN Medicaid beneficiaries directly conflicts with 42 U.S.C. § 1396j, 42 C.F.R. § 438.14, and the Indian Canon of Construction. The statute affirms that IHCPs are Medicaid-qualified providers for all beneficiaries, and the courts have consistently interpreted federal law in ways that favor tribal sovereignty and self-determination. Therefore, Tribal healthcare providers, including those serving non-AI/AN patients, are fully entitled to reimbursement for all Medicaid-covered services, in line with federal statutory protections.

D. Freedom of Choice Provision under 42 U.S.C. § 1396a(a)(23) and Protection of IHCP Services

The freedom of choice provision under 42 U.S.C. § 1396a(a)(23) is a cornerstone of Medicaid law, designed to ensure that all Medicaid beneficiaries retain the right to receive healthcare services from any qualified provider that participates in the Medicaid program. This statutory right is clear: Medicaid

beneficiaries, whether AI/AN or non-AI/AN, must be allowed to access services from any provider who is authorized to deliver Medicaid-covered services, without arbitrary restrictions imposed by the state. The statute ensures that beneficiaries are not forced to rely solely on managed care networks or specific healthcare providers dictated by the state's MCO system.

IHCPs, as recognized under 42 U.S.C. § 1396j, are explicitly identified as Medicaid-qualified providers. This means that IHCPs are authorized to provide Medicaid-covered services to all eligible beneficiaries, both AI/AN and non-AI/AN. IHCPs, by their very nature and status under federal law, are not just qualified providers for tribal members but for any Medicaid beneficiary seeking care from them. Section 1911 also makes clear that states, like Virginia, must reimburse IHCPs for services provided to Medicaid enrollees, irrespective of their AI/AN status.

i. DMAS's Restrictions on Non-AI/AN Access to IHCPs Violates Federal Law

By attempting to limit non-AI/AN Medicaid beneficiaries' access to IHCP services and forcing these beneficiaries to transition to MCOs, DMAS is infringing upon the explicit freedom of choice protections afforded to Medicaid recipients under 42 U.S.C. § 1396a(a)(23). This provision guarantees that Medicaid beneficiaries are entitled to choose any qualified Medicaid provider, including IHCPs, without being restricted by state policies that might mandate MCO participation. The freedom of choice provision is a vital safeguard in ensuring that beneficiaries are not denied access to quality healthcare services from providers who are qualified to deliver them under federal law.

DMAS's efforts to restrict non-AI/AN access to IHCPs not only undermines the rights of Medicaid beneficiaries but also conflicts with the statutory framework that supports IHCPs as federally recognized providers. By doing so, DMAS is essentially overriding federal law with state-imposed limitations, a move that cannot withstand legal scrutiny under the Supremacy Clause of the U.S. Constitution, which establishes that federal law preempts conflicting state laws.

ii. Indian Self-Determination and Education Assistance Act and Tribal Autonomy

The Indian Self-Determination and Education Assistance Act ("ISDEAA") further strengthens the argument that IHCPs should operate without state interference when providing services to both AI/AN and non-AI/AN Medicaid beneficiaries. ISDEAA is a landmark piece of legislation that recognizes the inherent right of tribes to manage their own affairs, including healthcare services, in accordance with tribal sovereignty. ISDEAA allows tribes to assume responsibility for programs and services previously managed by federal agencies, particularly those related to healthcare, under 638 contracts.

Under ISDEAA, tribes have the authority to control and administer their own healthcare programs through IHCPs, free from unnecessary state oversight. This means that DMAS cannot impose restrictions on how IHCPs provide care to Medicaid beneficiaries, nor can it limit the scope of services that IHCPs offer. Federal law, particularly ISDEAA, protects the autonomy of tribal healthcare providers to make decisions that are in the best interest of their communities and the Medicaid populations they serve.

DMAS's attempt to restrict non-AI/AN beneficiaries from accessing IHCP services, therefore, not only violates the freedom of choice provision under 42 U.S.C. § 1396a(a)(23), but also infringes upon the sovereignty and autonomy of tribal healthcare providers as protected by ISDEAA. IHCPs, operating under ISDEAA and 42 U.S.C. § 1396j, are entitled to provide Medicaid services to any Medicaid beneficiary, and any interference by DMAS in this regard would constitute a violation of federal law.

iii. DMAS's Position Contradicts Federal Medicaid Law and Tribal Autonomy

In trying to mandate that non-AI/AN Medicaid beneficiaries can only access IHCP services if the providers are part of an MCO network, DMAS is disregarding federal law's clear protections for

beneficiary choice and tribal sovereignty. Under 42 U.S.C. § 1396a(a)(23), beneficiaries have the right to access IHCP services without regard to the state's MCO requirements. 42 U.S.C. § 1396j reinforces that IHCPs must be reimbursed for services provided to both AI/AN and non-AI/AN beneficiaries. DMAS's position is, therefore, legally unsupportable, as it conflicts with well-established federal law that places IHCPs on equal footing with other Medicaid providers.

Furthermore, DMAS's restrictions infringe upon the rights and autonomy granted to tribes under ISDEAA, which protects the ability of tribal entities to manage and operate healthcare programs independently. The Indian Canon of Construction, a legal principle that resolves ambiguities in favor of tribes, further supports the view that IHCPs must retain the full scope of their services to all Medicaid beneficiaries, without restrictive state interference.

iv. Conclusion

The freedom of choice provision under 42 U.S.C. § 1396a(a)(23) guarantees Medicaid beneficiaries the right to access services from any qualified provider, including IHCPs. DMAS's attempts to restrict non-AI/AN Medicaid beneficiaries from accessing IHCP services not only violate this statutory right but also infringe on the autonomy of IHCPs and tribal sovereignty as protected under the ISDEAA. Federal law, through both the Social Security Act and ISDEAA, mandates that IHCPs have the authority to provide Medicaid services to any eligible beneficiary and that states must reimburse them for those services without imposing unnecessary restrictions. DMAS's position is inconsistent with these legal principles and is legally indefensible.

III. Response to DMAS's Waiver-Based Arguments and Tribal Consultation Deficiencies

A. DMAS's Waiver-Based Arguments Are Legally Deficient

DMAS attempts to justify its restrictions on IHCP services by relying on Section 1915(b) and 1915(c) waivers, asserting that these waivers allow the state to transition non-AI/AN Medicaid beneficiaries into MCOs and limit reimbursement for services provided outside MCO networks. However, this reliance on waivers is legally deficient and conflicts with established federal protections for IHCPs.

While 1915(b) waivers may allow states to implement managed care programs and waive certain Medicaid provisions, they do not grant states the authority to override key federal protections for IHCPs. Specifically, the freedom of choice provision under 42 U.S.C. § 1396a(a)(23) guarantees that Medicaid beneficiaries, including non-AI/AN individuals, can access services from any qualified provider, including IHCPs, irrespective of MCO network participation. Furthermore, 42 U.S.C. § 1396j explicitly recognizes IHCPs as qualified Medicaid providers for all Medicaid beneficiaries, not just AI/AN enrollees.

Similarly, 1915(c) waivers, which authorize home and community-based services (HCBS), do not give states the authority to limit the rights of Medicaid beneficiaries to access IHCP services. The authority granted under Section 1915(c) for HCBS does not permit the state to bypass mandatory federal requirements concerning tribal healthcare providers. Federal law mandates that IHCPs be reimbursed for services provided to all Medicaid beneficiaries, and nothing in the 1915(c) waiver framework allows a state to force a shift to managed care in violation of these requirements. While 1915(b) and (c) waivers can be utilized to restrict freedom of choice by requiring Medicaid recipients who do not receive services from an IHCP to participate in managed care, such waivers cannot override the statutory framework established in 42 U.S.C. § 1396j, which recognizes the broad scope of tribal healthcare authority. It also cannot prevent Medicaid recipients from seeking services from an IHCP regardless of whether the ICHP is participating with an MCO.

Had DMAS conducted appropriate and meaningful tribal consultation, it is likely that the legal and practical issues surrounding these waiver-based arguments would have been raised early

and could have been addressed before implementing the proposed changes. By engaging in proper consultation, DMAS could have avoided its current reliance on flawed legal interpretations that conflict with established federal protections for IHCPs.

Thus, DMAS's reliance on these waivers does not alter the federal requirement that IHCPs be reimbursed at the federally established rate for services provided to both AI/AN and non-AI/AN beneficiaries. Federal law guarantees that IHCPs must be fully reimbursed for all Medicaid-eligible services, regardless of whether the beneficiary is part of an MCO network.

B. Inadequate Tribal Consultation by DMAS

DMAS's handling of its 1915(c) waiver renewal application highlights a critical deficiency in its tribal consultation process. Although DMAS notes that it notified tribes about the proposed waiver on June 1, 2023, the absence of feedback from tribal entities likely reflects a lack of meaningful engagement. This failure is significant because federal law, specifically 42 C.F.R. § 431.408, requires states to engage in active and meaningful tribal consultation when proposing changes to Medicaid programs that affect AI/AN communities or services provided by IHCPs.

42 C.F.R. § 431.408 mandates more than a simple notification—it requires states to actively solicit input from tribal entities and engage in substantive discussions regarding any changes to Medicaid programs that affect them. The regulation ensures that tribal voices are not only heard but also considered in the policymaking process. In this instance, DMAS's passive approach to tribal consultation—merely notifying tribes without creating pathways for genuine dialogue or actively seeking input—falls short of the legal requirements for meaningful consultation.

The absence of tribal feedback does not excuse DMAS from its responsibilities. Instead, it highlights the state's failure to comply with 42 C.F.R. § 431.408, as meaningful consultation requires efforts to involve tribes in the decision-making process. In this case, DMAS's failure to engage in this process undermines the legitimacy and legality of any policy changes resulting from the waiver, particularly those affecting the provision of IHCP services.

Without adequate tribal consultation, DMAS's waiver proposal lacks the necessary legal foundation to enforce the proposed changes. Failure to meet federal consultation requirements can invalidate state actions, and DMAS's passive approach makes its waiver policies vulnerable to legal challenges. Proper consultation would have preemptively addressed these concerns, likely preventing the current conflict over the legality of restrictions on IHCP services.

IV. Virginia Budget Appropriation, Capitation Payments, and Legal Justification for IHCP Reimbursement Outside MCO Networks

The Virginia budget appropriates a designated amount each fiscal year for "Long-Term Care Services." While the budget includes specific language regarding managed care services for Medicaid recipients it also recognizes a role for continued fee-for-service arrangements. For Example, Paragraph M of the budget directs DMAS to "merge the [CCC+] and Medallion 4.0 managed care programs…into a single, streamlined managed care program that links seamlessly with the fee-for-service program." The budget clearly contemplates a role for fee-for-services, which should include IHCPs. While PCA services generally fall under the managed care program, DMAS explicitly recognizes that tribal health services are exempt from its MCO program in the latest version of the Cardinal Care contract. Additionally, making capitation payments to MCOs alongside AIR payments to IHCPs is legally permissible under federal Medicaid law and does not constitute "double payment" but instead fulfills distinct regulatory, financial, and public health objectives for all Medicaid beneficiaries, regardless of tribal affiliation.

A. Virginia's Contractual Carve-Outs for IHCP Services

Virginia's Medicaid program further differentiates the roles of MCO and AIR payments through its Cardinal Care contract, which specifically exempts IHCP services from MCO network requirements. Paragraph 7.2.13 states that "Services provided through Indian Health Care Providers, including tribal clinic providers, are carved out of this Contract and reimbursed through fee-for-service, per the provider's agreement with the Department." Additionally, Paragraph 12.2.2 clarifies, "Services provided through Indian Health Care Providers as defined in this contract, including tribal clinical providers, are carved out of this Contract and reimbursed through the Department's fee-for-service program, per the provider's agreement with the Department." These provisions ensure that IHCP services are excluded from MCO requirements and affirm that IHCPs are reimbursed at the AIR according to their agreement with the state per the State Plan Amendment. These contractual provisions align with federal statutes and CMS guidance by recognizing that IHCP services must remain accessible and independently funded, regardless of MCO capitation payments. Virginia's approach under the Cardinal Care contract exemplifies a compliant structure for simultaneously making capitation payments and reimbursing IHCPs through AIR for all Medicaid beneficiaries.

B. Reimbursement for Tribal Health Clinics as Outlined in the Virginia State Plan

The Tribal Health Clinic Amendment to the Virginia State Plan clarifies the reimbursement approach for services provided by IHCPs. According to the State Plan:

1. **IHS OMB Rate Payment**: Services provided by facilities of the Indian Health Service ("IHS"), as well as Tribal 638 facilities operated by tribes or tribal organizations under Title I or V of the ISDEAA, are reimbursed at the applicable IHS Office of Management and Budget ("OMB") rate, as published in the Federal Register. This rate represents the AIR rate applicable to these facilities.
2. **Outpatient AIR**: The most current published IHS OMB outpatient per-visit rate, also known as the outpatient all-inclusive rate, is applied for up to five outpatient visits per beneficiary per calendar day for professional services. An outpatient visit is defined as a face-to-face or telemedicine contact between any authorized health care professional at or through the IHS facility, and a Medicaid beneficiary. These visits encompass all Title XIX-defined services, as documented in the beneficiary's medical record, ensuring that services provided by IHCPs are comprehensively reimbursed.
3. **Scope of Services Included in the AIR:** The all-inclusive outpatient per-visit rate encompasses a wide range of services, including pharmaceuticals/drugs, dental services, rehabilitative services, behavioral health services, any and all ancillary services, emergency room services provided on-site, and medical supplies incidental to the services rendered. This comprehensive rate structure supports the financial stability of IHCPs by ensuring that all necessary services provided to Medicaid beneficiaries are reimbursed under the AIR, independent of MCO capitation rates.

These provisions under the Virginia State Plan establish a clear and separate funding structure for IHCPs, ensuring that they are reimbursed at the AIR for services rendered to Medicaid beneficiaries, whether the services are provided in person or via telemedicine. The distinct all-inclusive rate, which encompasses a broad spectrum of services provided by IHCPs, is designed to support the unique healthcare role of tribal providers within Medicaid without conflicting with the capitation payments made to MCOs.

C. Capitation Payments and IHCP Reimbursement as Distinct Financial Obligations

Capitation payments to MCOs are authorized under Medicaid regulations to compensate MCOs for assuming financial risk and managing a defined scope of care for Medicaid enrollees. Specifically, 42 U.S.C. § 1396u-2 allows states to pay MCOs a fixed per-member, per-month rate, regardless of the actual

services utilized by enrollees. This payment model incentivizes MCOs to efficiently manage costs and optimize care, allowing the state to delegate financial risk to the MCO. Importantly, federal law does not require capitation payments to MCOs to exclude additional Medicaid payments to providers outside the MCO network, such as IHCPs, when federally authorized exemptions apply.

Capitation rates are further subject to actuarial soundness requirements under 42 C.F.R. § 438.4, ensuring that states do not overpay MCOs based on expected utilization patterns and costs. This actuarial process accounts for typical in-network managed care costs without considering out-of-network services provided by IHCPs, as these are reimbursed separately through AIR payments.

D. Budget Appropriations and Medicaid Forecasting for Sustainable IHCP Funding

Virginia's budget structure includes annual appropriations for Medicaid services, with mechanisms for adjusting funding levels through the Medicaid forecasting process. This forecast, conducted by the state each year, determines the projected costs of Virginia's Medicaid program. Budget amendments can be introduced to address any shortfall in the forecast permitting the General Assembly to appropriate funds to address any shortfalls the forecast including, for example, IHCP funding. The forecasting process ensures the General Assembly can appropriate sufficient resources to meet both capitation and AIR payment requirements, thus preventing potential budgetary conflicts between MCO and IHCP payments. By incorporating IHCP services into budget forecasts and amendments, Virginia effectively supports Medicaid's objectives without limiting beneficiaries' access to IHCP care or jeopardizing the financial stability of tribal health providers.

E. Conclusion

In sum, capitation payments to MCOs and AIR payments to IHCPs are fully compatible under federal law and align with Medicaid's regulatory framework, which prioritizes both the efficiency of managed care and unrestricted access to IHCP services for all beneficiaries. Virginia's Medicaid budget, the Cardinal Care contract, and the Virginia State Plan jointly affirm that these dual payments do not constitute "double payments" but rather represent distinct obligations, each serving essential and complementary roles. Federal statutes, CMS guidance, and provisions in the Virginia State Plan guarantee that IHCPs remain accessible outside MCO networks, underscoring the legality of dual payments as a means of fulfilling Medicaid's commitment to comprehensive healthcare access for all beneficiaries.

V. DMAS Has No Legal Authority to Pend Payments

DMAS's assertion that Fishing Point Healthcare's claims are not "clean" under 42 C.F.R. § 447.45(d) due to a purported need for additional information is legally unfounded. Federal regulations define a clean claim as one that can be processed without further information from the provider or a third party. Fishing Point Healthcare has already supplied complete documentation, including all required patient data, service details, and billing information, fully satisfying DMAS's requirements for processing. Any further demand for information contravenes federal regulations and constitutes an unwarranted delay in payment.

DMAS's suggestion that additional verification of AI/AN status for individual patients is required also lacks a legal basis and is directly contradicted by the Tribal Health Clinic Amendment in the Virginia State Plan. The State Plan explicitly provides that the IHS OMB AIR applies to all "beneficiaries for the provision of Title XIX defined services" without making any distinction between AI/AN and non-AI/AN individuals. This language establishes that reimbursement under the AIR applies universally to all Medicaid beneficiaries receiving services through IHS or Tribal 638 facilities like Fishing Point. The amendment's broad language supports an inclusive reimbursement model, entitling Fishing Point to AIR

reimbursement for all Medicaid-eligible services provided to any Medicaid beneficiary, irrespective of AI/AN status.

The Virginia State Plan further reinforces this position by specifying that services provided at or through IHS and Tribal 638 facilities—covering a comprehensive range of care—are uniformly reimbursed at the AIR. DMAS's attempt to impose additional requirements based on patient demographics not only misinterprets the State Plan but also undermines federal Medicaid law, which mandates equal access to reimbursement for tribal providers. Fishing Point, as a tribal provider under Medicaid, is entitled under 42 U.S.C. § 1396j and § 1396a(b)(10) to receive reimbursement on par with non-tribal providers, ensuring unrestricted access to Medicaid funds.

Additionally, DMAS's reliance on 42 C.F.R. § 447.45(d) to justify its delay lacks merit. Although this regulation allows up to twelve months for the payment of non-clean claims, it does not authorize unnecessary delays for claims where no legitimate issue exists. DMAS's ongoing withholding of payment is an overreach that fails to recognize Fishing Point's right to timely reimbursement. Fishing Point has satisfied all applicable requirements under federal and state law, and DMAS's attempt to classify these claims as unclean due to unsupported verification requirements constitutes a legally baseless delay tactic.

Fishing Point Healthcare's claims meet all federal and state law requirements for prompt payment. The State Plan, through the Tribal Health Clinic Amendment, makes clear that AIR reimbursement applies to all Medicaid beneficiaries under Title XIX services provided through tribal facilities, with no demographic limitations. DMAS's refusal to process these payments not only breaches its legal obligations but also unlawfully restricts access to Medicaid reimbursement guaranteed by federal law. **Fishing Point is legally entitled to immediate and complete reimbursement, and DMAS must discontinue its unlawful delay and release all amounts owed without further obstruction.**

VI. Conclusion

DMAS's interpretation of 42 C.F.R. § 438.14 and its proposed restrictions on IHCP services for non-AI/AN Medicaid beneficiaries are legally indefensible. Federal law, including 42 U.S.C. § 1396j and 42 U.S.C. § 1396a(a)(23), clearly supports the right of all Medicaid beneficiaries—whether AI/AN or non-AI/AN—to access services from IHCPs. CMS guidance further affirms that IHCPs must be reimbursed for these services, regardless of MCO participation, under the AIR structure.

Additionally, the Virginia State Plan and Cardinal Care contract establish a state-specific framework that allows IHCPs to operate outside of MCO network requirements. Virginia's budget appropriations, supported by the contractual language in the Cardinal Care contract, explicitly carve out IHCP services from MCO obligations, ensuring that these services are reimbursed at the AIR. This contractual and budgetary approach is fully compliant with federal guidance, which permits DMAS to make capitation payments to MCOs alongside AIR payments to IHCPs without these payments constituting "double payment." This dual-payment structure fulfills distinct regulatory, financial, and healthcare objectives for all Medicaid beneficiaries, as mandated by the state plan and supported by federal law.

Moreover, DMAS's failure to engage in meaningful tribal consultation before proposing its waiver changes violates federal regulations, further weakening its position. Federal law, supported by the Supremacy Clause and ISDEAA, protects tribal healthcare sovereignty, reinforcing that IHCPs must remain accessible to all Medicaid beneficiaries, and that AIR payments are legally compatible with capitation payments made to MCOs.

Accordingly, DMAS's restrictive interpretation is unsupported by both federal and state policy frameworks, rendering its position legally untenable. DMAS must therefore remit the full amounts owed and reverse its stance on withholding payments in recognition of these obligations.

Sincerely,

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