Provider Type:

It is our understanding that Virginia's two Tribal providers, Aylett Family Wellness (Upper Mattaponi Indian Tribe) and Fishing Point Healthcare (Nansemond Indian Nation) are both health care facilities owned and operated by the tribe under a tribal 638 agreement. It is our understanding that they are tribal FQHCs, but we are confirming this with them.

1. Can you verify that it is the tribal provider's choice what provider type to enroll as with Medicaid, whether FQHC, "clinic services provider," or another type, and the only requirement is that they choose a single provider type and notify the state Medicaid agency of that provider type so that we can reimburse them accordingly?

AI/AN Tribal Members and FMAP:

Virginia's Tribal providers are no serving both AI/AN and non-AI/AN Medicaid members. As they expand in this way we want to make sure our understanding of the appropriate reimbursement and FFP depending on the different scenarios.

2. Can you verify that this choice is the tribe's and is not up to the state Medicaid agency?

3. We understand that the state Medicaid agency must reimburse for the facility's services to both AI/AN and non-AI/AN Medicaid members at the same facility rate (the AIR if that is the reimbursement arrangement); is this correct?

4. Does this also apply to "outside the four walls" received through services?

5. Our understanding is that 100% FMAP is not available for services to non-AI/AN Medicaid members served by and through the tribal clinics; instead, DMAS/Virginia should claim the usual FMAP applicable to that member's aid category. Is this correct?

6. We understand that some states have negotiated with tribes for the tribe to pay the state share for non-AI/AN members served. Is this federally permissible (if agreed between the state and tribes)? If so, can you identify examples of states with this setup or point us to any resources that explain how this would work?

7. Can you provide guidance on the best data source to use to identify AI/AN tribal members for purposes of our federal reporting and ensuring that we are claiming appropriate FMAP?
    a. Is there a preferred source for accuracy or completeness—directly from tribe, file/list from IHS, Medicaid application data?

Services Provided by/through and Billed by Tribal Clinics:

Both tribes are billing for services outside the four walls, including home health, skilled nursing, and personal care (which in Virginia is a HCBS 1915(c) waiver service) at the AIR. Our understanding is that they are billing for services outside the four walls as a "received through" service. It appears that in some cases the services are provided by non-tribal providers who are contracted with the facility and in other cases by clinic personnel.

8. Can these types of services (including HCBS and waiver) be provided outside the facility as "received through" services and billed by the facility at the AIR:
    a. by a tribal FQHC?
    b. by a clinic services provider?
    (The AIR is the rate paid to tribal 638s and FQHCs under Virginia's tribal reimbursement SPA.)

9. Does the state Medicaid agency decide what services can be provided/reimbursed as received through services?
    a. Is it the state's decision whether to allow the tribal facilities to bill this way for HCBS? Waiver services?

10. We are operating under the assumption that for the Tribal facility to properly bill for a service, it must be in the member's approved benefit plan and subject to the same coverage limitations and utilization management criteria, such as service authorizations, that would apply through their managed care plan. This would include special requirements pertaining to waiver services, which can only be provided to individuals who are enrolled in the waiver. Is this correct?

11. Can you confirm that the contracted "non-tribal" provider in a "received through" arrangement, such as a home health agency, must be a Medicaid-enrolled provider?

Managed Care Integration:

Currently, tribal providers are carved out of our managed care contract and are reimbursed solely through FFS. In Virginia, AI/AN tribal members are *not* excluded from Medicaid managed care (they are not an excluded population under our 1915(b) waiver). In addition, the tribal providers can serve non-AI/AN tribal members, including members enrolled in managed care. We are considering amending our managed care contract and SPA and waivers as necessary so that tribal providers bill the MCO for their patients who are enrolled in a Medicaid managed care plan.

12. Would this potentially affect the tribal providers' ability to serve non-AI/AN members, particularly for "outside the four walls" / "received through" services?

13. How would it affect what reimbursement methodology is allowable for outside the four walls services (for either FQHC or clinic services provider type)?

Billing at the AIR and Definition of a Visit/Encounter:

14. Under our tribal reimbursement SPA, the tribal facility can bill at the AIR for up to 5 face-to-face encounters/visits per recipient, per day. Can you point us to any guidance or state models for best practices on what is properly included in a single visit/encounter at the AIR?
    a. For example, if a patient comes in for an outpatient visit and gets labs and x-rays, would those three things all be part of the same encounter?

15. To what extent can the state Medicaid agency define what constitutes an enounter and set parameters? We understand there may be different guidelines for tribal FQHCs than for other (non-tribal) FQHCs.

16. In consultation with the tribes, can we set the number of times that the tribal facility can bill at the AIR per day?
    b. Currently 5 times per member per day in our SPA – could we reduce the number?

State's Role in Oversight/Audit/Compliance:

We would also appreciate guidance and technical assistance on the role of oversight between state Medicaid agencies and the federal government. Below are examples of the questions we have, and we would very much appreciate any best practices you have seen in other states.

17. What oversight is the responsibility of the state (versus the federal government)?

18. What pre- or post-payment documentation are DMAS and the MCOs allowed or expected to request?
    c. For example, is it the state's role to monitor whether the tribal facility is meeting the requirements that enable a "received through" service to qualify for 100% FMAP; e.g., that there is an established relationship between the patient and a qualified practitioner at the Tribal facility, that there is a care coordination agreement between the Tribal facility and the non-Tribal provider, and that the Tribal facility practitioner remains responsible for the patient's care?

19. Can you explain the requirements or exemptions around licensure for tribal providers?
    d. Is it correct that tribal providers do not have to be licensed in the state? Can tribes contract with non-licensed providers to provide services?

Patient Pay and LTC:

20. We understand that AI/AN members are exempt from cost-sharing such as co-pays and coinsurance. With respect to long term care services, are they exempt from having to meet the LTSS financial criteria? Specifically, are they exempt from post-eligibility treatment of income, i.e., patient pay towards the cost of 1915(c) HCBS long-term-care services received through the tribal provider?