Gmail

Jessie Barrington <jessie@culturalheritagepartners.com>

Response to your e-mail of 10.17.2024

Caroline Brown <Cbrown@brownandpeisch.com> Thu, Oct 24, 2024 at 10:24 AM
To: "jessie@culturalheritagepartners.com" <jessie@culturalheritagepartners.com>, "mcobb@williamsmullen.com" <mcobb@williamsmullen.com>
Cc: "Kim F. Piner (KPiner@oag.state.va.us)" <KPiner@oag.state.va.us>

Jessie,

Kim Piner at the Virginia Office of the Attorney General has asked me to respond to your questions and email of last week regarding the authority of the Division of Medical Assistance Services (DMAS) to request that Fishing Point Healthcare cease submitting Medicaid claims for personal care services and its authority to pend any claims that are submitted. I apologize that I am sending this so close to the meeting this afternoon.

DMAS's Authority to Transfer Care of Non-Indian managed care enrollees.

DMAS pays for covered services provided to Medicaid recipients under two interlocking and concurrent "waivers" approved by the Centers for Medicare & Medicaid Services ("CMS").

The Cardinal Care Managed Care (CCMC) 1915(b) waiver mandates enrollment in and receipt of covered services through managed care for most Medicaid recipients.

The Commonwealth Coordinated Care Plus (CCC+) 1915(c) waiver authorizes the provision of home and community-based services, including personal care services, to eligible waiver enrollees through the contracted managed care plans.

Your email to Kim Piner of October 17th suggested that Medicaid's freedom of choice provision at Section 1902(a)(23) of the Social Security Act, 42 U.S.C. § 1396a(a)(23), trumps the terms of a waiver. Although Title XIX generally provides that a Medicaid recipient may receive services from any provider "qualified to perform the service or services required . . . who undertakes to provide him such services," that provision can be waived under Section 1915(b), 42 U.S.C. § 1396n(b). That waiver authority has been exercised in the CCMC program.

Moreover, the concurrent Section 1915(c) waiver sets forth the limitations on that service, including that the services must be provided pursuant to a care coordination plan developed by the MCO's care

coordinator and limited to no more than 56 hours per week unless individual exceptions are authorized. *See* 12 VAC 30-120-924(D)(2)(e).

Under these two waivers, DMAS has the authority and obligation to ensure that Medicaid recipients enrolled in managed care are receiving services through an MCO (i.e., that the provider is enrolled with the MCO and the service is authorized by the MCO pursuant to the MCO's care coordination responsibilities), as set forth in its Section 1915(b) waiver agreement; and that the provision of service complies with the process and limitations set forth in DMAS's Section 1915(c) waiver agreement.

As was discussed last week, DMAS recognizes that there is an exception to these rules for American Indiana/Alaskan Native (AI/AN) enrollees. While DMAS has the authority to make enrollment in an MCO is mandatory for most populations (and has chosen to do so), AI/AN beneficiaries cannot be mandated to enroll in an MCO. 42 C.F.R. § 438.50(d)(2). Moreover, AI/AN beneficiaries who choose to enroll in an MCO have the option of going outside of the MCO network to access an Indian Health Care Provider. 42 C.F.R. § 438.14(b)(4). Because the ability to go outside the MCO network does not extend to non-AI/AN enrollees, DMAS has the authority and obligation to require that all Fishing Point patients enrolled in managed care who are not AI/AN have their care transferred to their managed care plans as set forth in its Section 1915(b) waiver.

In your email you suggest that the payment provisions of Section 438.14 require the MCO to make payment to tribal provider outside of their network even for non-AI/AN members. That is not an accurate reading of the regulation, as confirmed by the statutory provision that it is codifying. Section 1932(h) of the Act (42 U.S.C. 1396u-2(h)) requires MCOs to "agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered Medicaid managed care services **provided to those Indian enrollees who are eligible to receive services**," (h)(2)(A)(ii), and requires the States to supplement those payments only for services provided to Indian enrollees. *See* SSA 1932(h)(2)(C)(i)(I) (MCO must "agree to pay any Indian health care provider that is a federally-qualified health center under this title but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services **by such provider to an Indian enrollee of the entity**"); 1932(h)(2)(C)(ii) (State must supplement payment to a non-FQHC tribal provider up to the AIR for "services **provided by the provider to an Indian enrollee"**); *see also* State Medicaid Director Letter #10-001 (Jan. 22, 2001), at 3 (noting that statute requires that "I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees"); 81 Fed. Reg. 27498, 27744 (May 6, 2016) (noting that Section 438.14 is implementing requirements of Section 1932(h)).

Should Fishing Point elect to become a network provider with one or more MCOs, DMAS agrees that Fishing Point can provide services to any enrollee (AI/AN or non-AI/AN). However, reimbursement is limited to the negotiated MCO rate. Pursuant to § 438.14(c), DMAS may have an obligation to supplement that payment up to the applicable FQHC or AIR rate, but only for clinic services.

Fee-for-service.

Some individuals are exempt from enrollment in an MCO but can still qualify for personal care services on a fee-for-service basis under the Section 1915(c) CCC+ waiver. These services must still be provided in accordance with the Section 1915(c) waiver, to individuals who are enrolled in the waiver, pursuant to a care coordination plan developed under the waiver and limited to no more than 56 hours per week unless individual exceptions are authorized. In addition, the Section 1915(c) CCC+ waiver identifies eligible providers of personal care services as "personal care agencies" who are "licensed by the Virginia Department of Health or have accreditation from any organization recognized by CMS for the purposes of

Medicare certification." DMAS does not interpret this provision as including tribal providers but acknowledges that a tribal provider may choose to provide services through a personal care agency. However, in that case the reimbursement rate is not the A.I.R., as explained below. Members who are not enrolled in a 1915(c) waiver can receive personal care under the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program. This program is for children under the age of 21 who are enrolled in Medicaid. EPSDT is available to those in managed care or FFS.

Reimbursement rate.

Section 1905(b) of the Social Security Act, 42 U.S.C. § 1396d, authorizes 100% federal matching funds for covered services "received through" an Indian Health Service (IHS) facility whether operated by the Indian Health Service or by a Tribe or Tribal organization. Prior to 2016, CMS's long-standing interpretation of this statutory provision was that the 100 percent matching was available only for a "facility service" that was within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation. In 2016, CMS loosened its interpretation such that "the scope of services that can be considered to be 'received through' an IHS/Tribal facility for purposes of 100 percent FMAP includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the Medicaid state plan, including long-term services and supports (LTSS). Medicaid coverable benefit categories include all 1905(a), 1915(i) 1915(j), 1915(k), 1945, and 1915(c) services set forth in the state plan, as well as any other authority established in the future as a state plan benefit." *See* CMS, State Health Official (SHO) Letter #16-002 (Feb. 26, 2016); Frequently Asked Questions (FAQs) (Jan. 18, 2017).

The CMS guidance from its February 2016 SHO letter authorizes tribal providers to contract with non-tribal providers to provide personal care and other non-clinic services through a care coordination agreement and to bill for those services. However, only "services that can properly be claimed as IHS/Tribal facility services may be billed directly by the IHS/Tribal facility and . . . paid at the applicable Medicaid state plan IHS/Tribal facility rate." SHO 16-002, at 5. "For all other services provided by non-IHS/Tribal providers, IHS or the Tribe could bill for these services as an assigned claim by that provider" but "the payment rate would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan IHS/Tribal facility rate." *Id.* at 5-6.

I read this guidance to mean that if personal care services (or any other non-facility services) are provided through Fishing Point by non-tribal providers, they can be billed only at the rate otherwise applicable for personal care services, not at the AIR. DMAS is seeking confirmation of this understanding from CMS. There is also the possibility that the tribe and DMAS could negotiate a separate rate, which CMS and the General Assembly would have to approve.

Pended Claims.

There is no provision in Title XIX requiring that specific claims be paid within specific periods of time. Rather, there is a general requirement at 42 C.F.R. § 447.45(d) that the agency must pay 90 percent of all clean claim from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt, and 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt. Otherwise, the agency is required to pay all other claims within 12 months of the date of receipt, subject to various exceptions. A "clean claim" is one that "can be processed without obtaining additional information from the provider of the service or from a third party." As DMAS has indicated to your client, it believes additional information is required both from Fishing Point (as to which of its patients are AI/AN) and from a third party (CMS) and it therefore does not consider Fishing Point's claims for personal care services to be "clean" and therefore subject to the 30/90 day timeframes. DMAS recognizes that the claims must be paid within one year, unless one of the exceptions applies. This is not a suspension of payment governed by 42 C.F.R. § 455.23.

I would be happy to answer any questions you may have regarding any of the above.

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