CMS All Tribes Call
Consultation on Reimbursement Rates for Services Webinar
December 15, 2016

Ms. Marx: Good afternoon and welcome to today's All Tribes Call on Tribal Consultation on Reimbursement Rates for Services provided outside of an IHS or tribal facility. I'm Kitty Marx, Director of the Division of Tribal Affairs in the Centers for Medicaid and CHIP Services and joining me on today's call are my CMS colleagues and I'll just name a few. There are several on the call with us today—Mike Nardone, who is the Director of the Disabled and Elderly Health Programs Group; Kristin Fan, who is the Director of the Financial Management Group; and Andy Snyder, who is the Senior Advisor to the Director. As many of you know, on February 26, 2016, CMS issued a State Health Official Letter expanding the circumstances under which services were furnished to American Indian and Alaska Native Medicaid beneficiaries could be considered to be received through an Indian Health Service or a tribal facility. If you don't have a copy of the SHOL letter, it was linked in the "save the date" notice or can be found on Medicaid.gov under Indian Health and Medicaid and on the page to the right under tribal resources. In the development and implementation of the SHOL letter, we came across an issue of what reimbursement rates apply when services are provided outside of an IHS tribal facility, either under a care coordination agreement or by tribal employees. Understand with this regulation, there are limitations on reimbursements for services provided outside of the four walls of a clinic. And the purpose of today's call is to explain CMS's interpretation of the four walls policy and answer any questions and hear comments. On the call, CMS will explain an option under consideration for tribal clinics to possibly convert to Medicaid FQHC status. We will answer any questions that you might have and respond to comments regarding this issue to the best of our ability. At this time, I would like to turn the call over to Mike and my other CMS

colleagues. Mike will provide a more detailed explanation of the issues and we will be available to answer questions at the end of the presentation; Mike.

Mr. Nardone: Hello, this is Mike Nardone. Uh, thank you for the opportunity to talk to you today. We wanted to talk, as Kitty said, about an issue that has arisen and in follow up to the issuance of the SHOL earlier this year. As she stated, under the updated policy that SHOL basically made clear that IHS tribal facilities may enter into written care coordination agreements with non-IHS and tribal providers to furnish certain services for patients who are AI/AN Medicaid beneficiaries. Those services provided per the care coordination agreements and a request for the services could be seen as being received through the facilities and eligible for federal matching funds at the enhanced federal matching rate of 100%. Under the SHOL, either the tribal facility or the non-IHS tribal practitioner may bill Medicaid services and *** a tribal practitioner. One of the services that *** facility services... *(Unclear - 3:46.)*

Ms. Marx: Hey Mike.

Mr. Nardone: Yes.

Ms. Marx: I'm sorry. This is Kitty. You're breaking up a little bit on your end. I don't know if you are on your cell phone.

Mr. Nardone: I am. I am on my cell phone. Uh, is this better?

Ms. Marx: Yes, that's better. Thank you.

Mr. Nardone: I'm sorry. I'll try to stay close to the phone. I apologize. Um, services that can properly be claimed as services of an IHS tribal facility, and therefore authorized and reimbursed at the facility rate, um, are services that, you know, basically are within the ones that are tribal facility services or classified as tribal facility services and those services that do not qualify as IHS tribal facility services are reimbursed at the rate applicable under the medical state Medicaid

state plan to the provider type and service rendered. So, if a tribal facility is enrolled in the state Medicaid program as a provider of clinical services, um, our reading of the regulation is that the tribal facility may not bill for services furnished by a nontribal provider or tribal employee at the facility rate for services that are provided outside of its facility. Services provided outside the four walls of a facility are billed at the state plan rate for those services. So, this is what Kitty described as the four walls limitation and basically what it... Basically just to restate it, if the tribal facility is enrolled in a state Medicaid program as a provider of clinic services, the tribal facility may not bill for the services furnished outside the facility by a nontribal provider at the facility rate for clinic services, even if a written care coordination agreement is in place. The reason for this is the definition of "what are clinic services" and basically what the regulations state that, "clinic services do not include services furnished outside the four walls of the clinic except if the services are furnished by clinic personnel to a homeless individual." So, that's our reading of the regulation and that's one of the things that we understand since we've basically the SHOL and issued the SHOL is that there may be instances where tribal facilities are providing services outside the four walls of the clinic and basically...but billing at, um, at the facility rate, um, and so we... That's an issue and one of the things that we were trying to identify, and attempted to identify, as some potential solutions that might minimize the impact on tribal clinics that might be providing services outside the four walls and be... You know, tribal facilities that are clinics that are providing services outside the four walls to ensure that and who may be claiming the AIR rate for those services to ensure that they were not to minimize the negative impact of that...of this clarification. So, one of the solutions or potential solution that we have been exploring and it's the reason why we wanted to have this consultation today, is even though that limitation on four walls basically relates to the clinic services, it does not...

You know, there's more flexibility in terms of services provided if a facility is enrolled as an FQHC. Um, basically the FQHC benefit provides the most flexibility since there is no federal requirement that FQHC services be provided within the four walls of the facility and in addition, the Social Security Act, the provisions of the Social Security Act, recognize outpatient tribal health programs as being eligible to be designated as FQHC's. So, the way we've been thinking about this is if the tribal facility... So, if the tribal facility is enrolled in the state Medicaid program as a tribal FQHC, uh, services it provides, either directly or pursuant to a contract with a nontribal provider, is an FQHC service and potentially eligible for payment at the FQHC rate. And these contracts are distinct from the care coordination agreements that would be required for services to be considered received through a tribal facility. Now, also to the extent that tribal's FQHC may provide other medically necessary services, for example, contracted specialty services, they could also potentially be considered tribal FQHC services and potentially eligible for the 100% FFP available to the state. One of the provisions, because I know one of the concerns would be, you know, what is the impact that this change might have on rates that are paid, particularly based on what tribes may be currently receiving as a result of the AIR rate for facilities; however, one of the aspects with respect to FQHC's is that FQHC's under a federal legislation it permits states to establish a higher payment rate under an alternative payment methodology for FQHC's and one of the things that CMS has determined is that in light of the unique nature of the tribal health programs, CMS could support payment of the outpatient IHS AIR rate for FQHC services under an alternative payment methodology and the rate could potentially apply to all of the tribal facilities Medicaid visits, not just those by AI/AN Medicaid beneficiaries and the 100% FMAP would apply only to the cost of facility visits by... But the 100% FMAP would only apply to the cost of facility visits by the AI/AN beneficiaries. So,

therefore to the extent that, you know, some clinics are currently receiving the AIR or perhaps being paid another rate or receiving some other rate, the existing arrangements could potentially continue under APM's. So, and as I said, the FQHC's under the Social Security Act outpatient programs or facilities operated by a tribe or tribal organizations under the Indian Self-Determination Act borrowed by definition can be classified as FQHC's. Now, if we were to go this route, um, a state Medicaid agency would need to modify its payment designation of the tribal clinic. The tribal organization or tribal facility would have to be enrolled in Medicaid as an FQHC, um, but...and we recognize that this might take some time in terms of actually being able to make this change and so one of the things we're also contemplating would be a transition period of some duration to allow both the tribes and the states to do what is necessary in order to come...to basically become an FQHC, get enrolled in Medicaid, and also have the state submit its State Plan Amendment to make this change. So, this is our thinking around a potential option to try to address this payment issue that, you know, we've identified as it appears that some states and some may not be...have not been paying for services by tribal clinics in accordance with the four walls limitation. We... You know, ideally we would and one of the reasons for kind of having it on the call today to provide consultation is that, you know, one of the things that would be... Ideally we would be able to, if this is a good solution to this issue, you know, we would like to move quickly to try to put out some guidance prior to, you know, the end of our administration which, you know, basically will be wrapping up in about a little over a month and so, you know, that's one of the reasons for wanting to have this opportunity to speak to you today. I'm sure there are questions. I am not the expert—I apologize—on payment policy, but I do have, in addition to myself, a team of other people here who can assist with other questions. So with that, Kitty, I think I would like to turn it over to you if there are others of the speakers

who want to amplify or, you know, if I didn't state something totally correctly, that you want to correct, please feel free. But I think we want to open it up for questions.

Ms. Marx: Okay and are there any other comments by CMS colleagues at this time? *(Pause.)* Okay, we'll go ahead and open the phone lines up for questions. Dave, can you help us facilitate those questions?

Operator: All right. Thank you. Okay. I would just kind of would like to remind everyone, in order to ask a question, press star and the number one on your telephone keypad. We will pause for a moment to compile the Q&A roster. So once again, in order to ask a question, press star and the number one on your telephone keypad. Thank you.

(Pause.)

Operator: Well, the first question comes from the line of Walt Terrell from Native Health. Please ask your question.

Mr. Terrell: Uh, good afternoon Kitty. This is Walt Terrell in the urban program in Phoenix, Arizona. Uh, we're facing an issue like dealing with FQHC and the total range of coverage services as an FQHC. Is there... With the range of coverage services provided by an FQHC be limited to the state plan or would it be some other range of FQHC services given the scope of an Indian health facility?

Ms. Marx: Okay, well thank you, Walter for your question. You operate an urban Indian program in Phoenix and so technically you would not be covered under the 100% FMAP SHOL; so your question I think is more broad. I don't know if there's anybody on the call that can answer that or perhaps we could have a separate conversation about that.

Mr. Terrell: Yes, perhaps. I figured mostly of this because of the recent Ninth Circuit opinion issued two years ago that mandates states to pay Indian FQHC's for their scope of work. So I

was interested in if there was a predefined scope of services that FQHC's can provide that CMS will cover.

Ms. Gadson: Hi, this is Sharee Gadson *(sp?)* and that is an issue we are going to explore that we've been thinking about. So more to come on the range of services based on that Ninth Circuit decision.

Mr. Terrell: Thank you.

Ms. Marx: Thank you, Walter.

Operator: Your next question comes from the line of Jessica Windy Boy from Rocky Boy. Please ask your question.

Ms. Windy Boy: Yes, so I'm the CEO for the Rocky Boy Health Board over here in Montana and I am wondering if we are having to choose as a tribal facility—so we're not an IHS facility. We are a fully contracted Title V facility—if we're now having to choose either the all-inclusive rate in order to be reimbursed or the FQHC rate for CMS services. If we decide to go down this path in order for our state to receive 100% FMAP or if we'll be able to... Because we're already considered an FQHC, um, if we'll be able to bill...receive our all-inclusive rate.

Ms. Tavener: Okay, this is Linda Tavener and there are two things. In order for the state to get a 100% FFP pursuant to the "received through" policy, there has to be a care coordination agreement in place. That's different from the rate that gets paid for the services.

Ms. Windy Boy: Right.

Ms. Tavener: Under the statute there's a special provision that says that, "All Indian health programs are by definition recognized as FQHC's." That's distinct from the FQHC's that HRSA recognizes, but the other requirements concerning how FQHC's can get paid by a state apply; which means that FQHC's can get paid under an alternative payment methodology that's agreed

to by the FQHC and the state. A state can have as many alternative payment methodologies as it wants. It can actually have facility specific alternative payment methodology. So if you, for example, are currently receiving the AIR, you could continue to receive the AIR under an alternative payment methodology as an FQHC. If you're being paid reconciled cost by the state, you can continue to receive that under an alternative payment methodology. So, there should really be no change in what you are paid as long as the state agrees. You yourself don't need to do anything to change your designation to FQHC. What needs to happen is that the states will change the designation in its MMIS system and they have to submit a State Plan Amendment to us that says that they are now going to pay you under an APM as an FQHC. And that's a rather simple state plan for us to approve. So, we don't anticipate that it would take a great deal of time.

Ms. Windy Boy: Right. Okay. Thank you.

Ms. Gillespie: And Jessica, this is Cindy Gillespie and I just wanted to clarify that this change is only necessary if you want to get the AIR rate for services provided outside the four walls of your facility.

Ms. Marx: Whether provided by...

Ms. Windy Boy: Right.

Ms. Marx: ...full employees or through a care coordination agreement.

Ms. Windy Boy: Right. Which is what we're wanting to do. So exactly.

Ms. Marx: Okay, to the extent that your tribal clinic provides services outside of the four walls and you want to receive the facility rate, the FQHC option might be something that the tribe might want to look into so that you can reserve and preserve the facility rate or those services provided outside of the facility.

Ms. Tavener: Yeah, this is Linda Tavener and I think that's a very important point to make clear because it's come to our attention that a lot of tribal programs don't really understand or know how they are recognized under the Medicaid state plan. Here in central office, we've actually seen a lot of those plans and as far as we know, except for a couple of exceptions, all states are recognizing tribal health programs under the clinic benefit which means that anything that is provided outside of the four walls of the clinic itself, you cannot be receiving payment for at the AIR.

Ms. Windy Boy: Okay.

Ms. Tavener: So, even if you think this doesn't apply to you, if you are getting the AIR for any services that are provided outside of your four walls, it does apply to you.

Ms. Windy Boy: Okay.

Ms. Marx: And Linda, when you mean a facility rate—at least for these particular tribal clinics—we're probably talking about the OMB rate, because...

Ms. Tavener: Correct, the AIR. Right.

Ms. Marx: ...it is a fee-for-service rate, but that's...

Ms. Tavener: Right. If you are receiving and I don't think anyone is, but if you are a clinic and you are... Well, I can't think of a case where a tribal facility would be billing the state plan rate for those services. We just haven't seen those kinds of arrangements because normally if you're referring to a community provider, they're getting paid directly by the Medicaid agency at the community rate, which is significantly lower than the AIR.

Ms. Windy Boy: Right.

Ms. Gillespie: But there are some tribal staff that provide by services outside the four walls that may be billing at a state plan rate now.

Ms. Windy Boy: Right and I think that was something that we were investigating doing at least in the interim. We lost our main...our big clinic about a couple of years ago in a flood and we're in kind of temporary... We were looking at the possibility of contracting with other providers to be able to provide pediatric dental services in their facility until our new facility is ready and then we'll be able to provide the services in our facility. But we wanted to be able to bill through the billing for that...for those services.

Ms. Tavener: Okay, and that's another point that I think needs a little bit more clarification because setting aside the care coordination agreement which gets you to the 100% FFP.

Ms. Windy Boy: Right.

Ms. Tavener: If you are an FQHC, FQHC's routinely contract with outside providers for services. Under that contract; again, it's different from the care coordination piece, but under that contract, whatever those outside providers render become an FQHC service eligible for payment at the FQHC rate. So, if you contract with a dental provider or you contract with Doctor X down the road to help you out, um, although those services become FQHC services that you can bill for at the AIR or whatever your FQHC rate ends up being.

Ms. Windy Boy: Okay.

Mr. Nardone: But, just to be clear. I want to make sure that we're clear on this, is if you're a clinic... So, if you are not an FQHC, um, and you are a clinic and you have providers that are providing services under a care coordination agreement, those clinics...those providers outside of the four walls can bill for state plan services at the state plan rate and that would be reimbursed at 100% FMAP. The place where we've identified some issues is where the clinic is billing its facility rate for those services that are provided outside the four walls.

Operator: Your next question comes from the line of Jim Lamb of Southcentral Foundation. Please ask your question.

Mr. Lamb: Good afternoon. My name is Jim Lamb and I am the Director of Revenue Cycle for the Southcentral Foundation in Anchorage, Alaska. I'm also the alternate to the TTAG for Alaska and I'm interested in learning more about the exception for providing services to a homeless person. What's that legal citation to make sure that we're all looking at the same, the same statute? And maybe we could elaborate because it sounds like there is an exception for providing services to a homeless person outside of the four walls of the clinic.

Mr. Nardone: Uh, yes. If you would just give me a second; I have the...

Ms. Marx: Mike, I think we have it...

Mr. Nardone: You have the site?

Ms. Gadson: Yeah, so in Title XVIIII is found at 1905A9. A9 is the clinic benefit and if you want, I can go ahead and just read it straight from the language here. "Clinic services..." I'm sorry.

Mr. Lamb: Please do.

Ms. Gadson: Okay, sure. Item XVIIII says, "Clinic services furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician including such services furnished outside the clinic by clinic personnel who is an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address." That last piece of what I read is how we get to the homeless exception. That is also further explained in our Code of Federal Regulations at 44090.

Ms. Tavener: And I think we should also say that we recognize that this is a major shift for some tribal programs. The Office of the Center Director has been very involved in trying to find

a way around this in terms of that interpretation. And after many, many discussions with our counsel, the bottom line is that this is really the interpretation and its supported by I guess the language that was in the preamble that went along with that particular statutory provision. So, it is only for the homeless and there is no exception for tribal providers even though we tried very hard to find one. So, I don't want you to think that this was something that we went into lightly, because it is not by a longshot. But I really do think, we all really do think that the FQHC benefit will allow you to do pretty much anything that you have been doing and will permit you to continue to receive the same rates that you have been doing with very little disruption for the tribal program. Because the burden of making this happen really falls on the state and it's not a heavy lift.

Ms. Marx: Jim, does that answer your question?

Mr. Lamb: Yes, it does. Thank you very much.

Operator: The next question comes from the line of Jim Roberts from ANTHC. Please ask your question.

Mr. Roberts: Yes, Jim Roberts. I'm also a Technical Advisor on the Tribal Technical Advisory Committee, but I just want to come back to the point that the issue that you were talking about, the regulation and the definition of clinic services, but before I kind of get into the issue I brought up, I want to piggyback on what Jim just brought up too. So, if a tribal program is enrolled as a provider of clinic services and provides homeless...or services to homeless people they would... I think what I heard is they would be eligible to receive the IHS OMB encounter rate? Is that what I heard?

Ms. Gadson: Yes, that's correct. For services to the homeless individual, they can pull down the clinic's facility rate, which in this case would be the OMB rate.

Mr. Roberts: Okay. And I think that was Sharee, but Sharee you had explained that, you know, the regulation, but I want to follow it a little further upstream where the definition describes, "the term includes the following services furnished to outpatients." So, I think the regulation defines clinic services very broadly to me and kind of an array of different services. It describes preventive, diagnostic, therapeutic, rehabilitative, and palliative services that are furnished by a facility that is not part of a hospital, but it's organized and operated to provide medical care to outpatients and I want to come back to the term "includes services furnished by...the term furnished or include services." So, I think... I'm just trying to understand that either OGC's interpretation or your interpretation of the term "includes" because I think as a general matter "includes" almost invariably... I mean "includes and is not limited to" and in my reading of the definition, I think CMS has, you know, interpreted this definition of clinic services very narrowly and you know, I think it's interesting on one hand that when a tribe will provide services to a homeless person, they're eligible to receive the encounter rate, but if they provide the service to say to a child vaccination in a school, they wouldn't be able to receive the encounter rate. Can you elaborate a little bit on what it includes?

Ms. Tavener: This is Linda, and you know, we do understand where you're coming from. We have similar kinds of discussion with our General Counsel. There really isn't any point in taking a lot of time on this call to debate this because we've already gone down all of those roads and I mean, it is what it is. We are where we are. This is the opinion of the HHS General Counsel and we're bound by it. You can certainly feel free to submit comments and we will send them to General Counsel, but at this point we are where we are and we have to figure out a way to deal with it, especially given the change in the administration that is coming up.

Operator: Next question comes from the line of Angie Wilson of Washoe Tribe. Please ask your question.

Ms. Wilson: Hi Kitty and staff on the phone. This is Angie Wilson here now over in Washoe. Washoe is a border tribe. So it's a tribe of both California and Nevada, and of course, you know we have Pit River tribal members. So, I'm going to ask you a couple of questions in regards to California and Nevada. I certainly understand that, you know, the "two and throughs" *(sp?)* is great for the states. You know, really truly they're a great... Uh, they're winning here for sure, and you know, it makes us be able to look at the ways that we can bill for these services. Recently in California, we had the tribal consultation with the Department of Healthcare Services in Nevada...I mean in November and Jennifer Kent, the Director, uh, we had asked her about, you know, the perspective of the leverage of the "two and through" for increased FMAP for the state in regards to trying to push for parity for the state of California to be in mind with the number of encounters and what we can bill for to be in purity with the other CMS Region Nine states. She replied that the state already gives 100% FMAP for American Indians outside of our tribal health programs and I didn't think that that was true, but I don't know if there's any thought to that that you might have. So that's one. The other issue is in regards to billing, so you know, really if we looked at billing for our Medi-Cal patients, that is such a difficult process in itself, but if we were to, you know, switchover or we were to do the billing internally for our clinics at the all-inclusive rate, are we able... Because we then pick up all of the administrative functions of billing; if we're billing at the all-inclusive rate, are we able to keep a portion of that reimbursement and then reimburse the outside nontribal provider a discounted rate, but one that would be higher than their state rate as a benefit for them to

continue to see our patients so that we address the access to care issue? So, that is one question and then I'll come back for another one after we hear the answer on that.

Ms. Tavener: Okay, so I'll start with the second one and hopefully remember the first one. If you are an FQHC and you have a contract with that outside provider, making it an FQHC service, you can have a contract that says that you will pay him $50 for a visit. You will bill the AIR, which is what, 240 or something like that now and yes, the rest of the money is yours. But that's only if you are an FQHC and there is a contract as opposed to the care coordination agreement. Keep in mind that the care coordination agreement has absolutely nothing to do with payment. It only has to do with making the service eligible for the 100% match.

Ms. Wilson: So, the benefit...

Ms. Tavener: But becoming a...

Ms. Wilson: So, if I'm a tribal health program...

Ms. Tavener: Yes, you're an FQHC by definition under the statute, whether the program or not.

Ms. Wilson: Right, and I guess that's the thing is I think here in the state of Nevada that would be no problem. We have a great relationship with the state. But over in California, it's almost like, "No, if you say you're going to be a FQHC, you're going to have to go through and actually become a FQHC." So, there's some concern with that.

Ms. Tavener: No. No, no, no. No, they have no right to say that, because under the law, which they are bound by, you are by definition an FQHC right now, whether you decided to participate as one or not. They have no say in that whatsoever.

Ms. Wilson: Yes, we understand that, but it would be great that they give a reminder on that in California because it's very difficult for us on the California side with our tribes getting anything through the division of healthcare services over there.

Ms. Tavener: We will...

Mr. Nardone: One of the things that we will be doing... You know this is Mike. One of the things we will also be doing is talking to NAMD, the National Association of Medicaid Directors, and but we wanted to have this call first before we did that. I have, you know, kind of made the association aware that, you know, that this tribal consultation is happening and what the issue is. But, we haven't given them the full briefing that we've given you today and I think the first part of this was to kind of... I know that this is a big change for many of you, and so, one of the things we wanted to do was give you the opp...make sure that we give you the opportunity first to kind of comment on it and put it before you.

Ms. Wilson: So, here what we would then do as a benefit from what I'm hearing is, to continue as a tribal program with the FQHC look-alike. We would want to push the states for a State Plan Amendment for the APM rate then, right? I mean for the APM, for our federal encounter rate.

Ms. Tavener: That's exactly right.

Ms. Wilson: Okay.

Ms. Marx: And this is Kitty Marx. Are you an FQHC look-alike or are you a tribal FQHC based on your status as a 648 tribal provider?

Ms. Tavener: There is no look-alike involved in this. The tribal facilities are their own entity. They're not 330 grantees and they are not look-alikes. They are their own type of FQHC which has nothing to do with HRSA or the look-alike process; which is why I'm saying that the F... You folks in tribal programs will not have to lift a finger to become FQHC's. You are already recognized under the law as FQHC's. So, the only thing that has to happen is that the state... They have an MMIS system which gives you a code which says you're a clinic or an FQHC or a cardiologist or whatever, they change that code and they can continue to pay whatever they are

paying you. Now, getting to what I heard as your first question, I think there were two parts to it. With respect to the encounters, that's something that unfortunately we have no control over. You will have to work with the state Medicaid agency on that.

Ms. Wilson: Sure. The question was...there was just clarification that the states are not already receiving 100% FMAP for American Indians outside of the tribal health programs or you know Indian health programs.

Ms. Tavener: Right, and therein lies the problem because we know for a fact, in particular in California, that they have been paying the encounter rate for services provided outside of the clinic and they have been charging those at 100% FMAP. And, if there were to be an audit, that would be a huge problem which is why we're trying to fix this.

Ms. Wilson: And it's a huge... And just so that you guys know, just because we're on this and then I promise I will get off the phone, but... *(Chuckle.)*

Mr. Nardone: That's okay.

Ms. Wilson: Just that, so you know, because that has happened, because California is doing that, it really hurts the California tribes when we try to use the two and through as leverage to at least get somewhere near parity for the other states that are in Region Nine. I think it's absolutely such a detriment to the state of California for our tribes or tribal programs through Medi-Cal that we're not able to run that because the state is already claiming a 100% FMAP for those visits.

Ms. Tavener: Right. They are already claiming it, but now that we know and this new policy is out, they will not be able to claim it any longer.

Ms. Wilson: One other issue is that in the state of Nevada, because our tribes are on both sides, is that in the state of Nevada, Nevada also has clinics that see non-Indian patients the same as tribal health clinics that see non-Indians, same as some of our California tribes. So, in the state

of Nevada, they give us two different provider type numbers; one that is obviously our American Indian Medicaid patients so that the state understands it's getting 100% FMAP and one that's a separate provider type where we still get the AIR but the state is claiming the appropriate FMAP for non-Indians. What I'm concerned is in the state of California, there are no separate provider type numbers and I'm concerned that they're, you know, claiming 100% FMAP on non-Indians as well.

Ms. Tavener: Yeah, as I said, we do recognize that there are quite a few problems out there which is why we tried very hard to find a fix for this situation and we will be dealing... Not only will we be giving the message to all the Medicaid agencies pretty quickly, but we will be dealing with these individual cases.

Ms. Wilson: Okay. Thanks guys.

Ms. Marx: And we have *** *(unclear - 43:19)* to raising these issues on the call and we are here, you know, and available to provide any technical assistance or follow up on any specific issues.

Ms. Wilson: Thanks, Kitty.

Ms. Marx: Okay.

Ms. Tavener: Thank you.

Operator: The next question comes from the line of Melanie Fourkiller from Choctaw Nation. Please ask your question.

Ms. Fourkiller: Hello, this is Melanie Fourkiller. Thanks for having this call. It's been very helpful so far, and I apologize in advance if I missed this point, but when I read the definition of clinic services it states that it is... Those are services furnished by a facility that's not part of a

hospital. So, are we only addressing non-hospital-based services? How does that affect or not affect tribes that have hospitals that they're billing under? That's question number one.

Ms. Tavener: Can I answer the questions one at a time, because otherwise I forget them.

Ms. Fourkiller: Okay, great.

Ms. Tavener: The answer to that question is yes, you are correct. For Medicaid purposes, clinics that are associated with hospitals are actually viewed as outpatient hospital services and they have always been eligible for the AIR.

Ms. Fourkiller: Okay, thank you for that verification. I just wanted to make that clear. And then the second part of my question, because I am the TTAG and alternate for Self-Governance Tribe is the second part of my question is, as for FQHC whether they've already been a grandfathered FQHC or whether they are deemed an FQHC under this new initiative - I would say, I don't know what it is, but the new track that we're on—in order to overcome this issue, what trappings of FQHC's come along with that, including cost reporting?

Ms. Tavener: None. None. You are your own type of FQHC and there would be no requirement for cost reporting or anything like that.

Ms. Fourkiller: Okay.

Ms. Marx: Melanie, this is Kitty. You know the Medicaid tribal or the Medicaid FQHC's go under different rules than the Medicare FQHC's that you were just referencing regarding, you know, the provider based and the grandfathered status. So, as a Medicaid tribal FQHC under Medicaid, you do not have to do an annual cost report.

Ms. Fourkiller: Okay, so there won't be additional requirements imposed on these clinics that are deemed to be FQHC's?

Ms. Tavener: No. As far as we know, you will continue operating just as you have been.

Ms. Fourkiller: Okay. Thank you.

Ms. Tavener: Uh huh.

Operator: The next question...

Ms. Marx: Could...

Operator: Yes, I'm sorry. The next question comes from the line of Renée Hogue from Chickasaw Nation. Please ask your question.

Ms. Hogue: Good afternoon and I apologize for being a green and newbie with some of this. I'm trying to learn as I hear. We provide outpatient behavioral health services outside of our clinic or medical facility. And so, I heard a 638 status and the FQHC, I'm a little bit confused on that. The thing is, we're losing the ability to collect Medicaid because we... First of all, we are not inside our medical facility inside the clinic. So, we're not able to capture the Medicaid rate. Am I hearing that the only thing we could do is capture maybe a state...through the state rate?

Ms. Tavener: I mean I guess I'm... You're recognized as a clinic right now, but you're sending folks out to do behavioral health services, is that what's happening?

Ms. Hogue: Well, our programs and services are not imbedded in the medical facility which I understand... They're a 638 clinic or status and they do capture the Medicaid rate but our programs and services are outside of the clinic—it's within the tribe. Ours is always a little confusing to explain to others. We... Actually, we are part of the tribe. It's a tribal employee behavioral health license provider that provide outpatient behavioral health services, but we lose the Medicaid rate. We're not able to capture that because, you know, we don't have the 638 status within these programs and then I'm a little confused when I hear the 638 and the FQHC and what does that do or... Basically we're trying to learn, "How can we capture a Medicaid rate because we're losing that for these services?"

Ms. Marx: If you're not a... If you're outpatient behavioral health program is not operated under a 630 contract with...

Ms. Hogue: No, it is not.

Ms. Marx: You're not a subcontractor to a 638 tribe?

Ms. Hogue: Well, we are the tribe. I mean, we're actually in the tribe. These programs just do not operate under the 638 status—the way our structure or the way we're structured.

Ms. Marx: Okay, just to be clear; the 100% FMAP in the Social Security Act applies to, you know 638 facilities and programs.

Ms. Hogue: Okay.

Ms. Tavener: And I think that's true of the OMB rate, too Kitty.

Ms. Marx: Right and the OMB rate applies to the IHS and 638 tribal facilities and programs.

Ms. Hogue: Okay.

Ms. Marx: So, I think you would fall outside of this discussion unless you were able to qualify, you know, as an FQHC under a HRSA authority and I'm not sure... And, you know, you would have to check with HRSA on that. But, that would be outside of this discussion, today's discussion.

Ms. Hogue: Okay, is it something that someone can provide me a little more information outside of this discussion that I can contact?

Ms. Marx: Yeah, I think I would just start by going to the HRSA.gov website. They have a lot of information on how programs can qualify to be FQHC's and you know...

Ms. Jensen: Kitty, this is Kirsten Jensen in Baltimore. Uh, why don't you contact... You can contact me directly and I work in the Division of Benefits and Coverage and we can walk through your particular situation. It sounds like that we might need to understand your situation.

Ms. Hogue: Exactly. Right.

Ms. Johnson: So, actually why don't we go ahead and use the Tribal Affairs mailbox. If you send a note to the Tribal Affairs mailbox, they'll make sure it gets to me and we can set up a separate call to talk through your...

Ms. Hogue: I'm sorry. Tell me what that is, again, the...

Ms. Marx: Yeah, so this is Kitty. I'm sorry. Thank you, Kirsten for that offer. So, the Tribal Affairs mailbox is tribalaffairs—all one word—@CMS.HHS.gov. And so, you can use that mailbox. Go ahead and send that question and then we'll forward it to Kirsten. And that's true for other participants on the call. If you have questions that you're not able to ask or think about after the call, you can send those questions to that mailbox.

Ms. Hogue: Okay. Thank you.

Operator: The next question comes from the line of Melissa Gower from Chickasaw Nation. Please ask your question.

Ms. Gower: So, good afternoon. This is Melissa Gower. I'm Senior Advisor Policy Analyst for Chickasaw Nation in Oklahoma. Thanks for having the call. One of my questions, um, Melanie Fourkiller asked. So, that one's been cleared up. The other question I had was, when you talk about the all-inclusive rate under the FQHC, um, designation, that's a different designation that we have talked about but haven't previously used. Are we talking about the IHS OMB encounter rate and not the FQHC encounter rate?

Ms. Tavener: Correct.

Ms. Gower: I was a little confused on the rate you're talking about.

Ms. Tavener: Yes. Yes, the FQHC rate would probably be in most cases—because most of the tribal clinics are rather small—it would probably be a lower rate than the all-inclusive rate,

which is why we're saying that if you enroll as... And again, it's not... You're not doing anything. The Medicaid agency will recognize you as an FQHC and will determine that it's appropriate to pay you the all-inclusive rate, the OMB all-inclusive rate as an alternative payment methodology. So, you would be getting the OMB AIR.

Ms. Gower: All right. Thank you.

Ms. Tavener: Uh huh.

Operator: The next question comes from the line of Roberta Barro *(sp?)* from Navajo. Please ask your question.

Ms. Barro: Good afternoon. This is Roberta Barro. I'm calling from Tuba City Regional Healthcare. I just have a question here. Um, we... Currently we are enrolled as a hospital in our state Medicaid program. We provide outpatient services and patient ambulatory surgery and, you know, emergency room services, but we also have contracts with specialty services such as cardiology and oncology services that we don't provide here and that could even be sometimes radiology services. And in some of these contracts, you know, we do the billing and then we pay them at a contracted rate and then there are some contracts where they are responsible for their billing. Um, so does this apply to us as a hospital if we're enrolled as a hospital to our state Medicaid program?

Ms. Gadson: No. You're enrolled in the Medicaid program as a hospital. So, this policy that we're discussing today does not affect you. Again, this is only for those tribal facilities operating as Medicaid clinics—freestanding clinics.

Ms. Barro: Okay.

Ms. Marx: But that is the limitation on the facility rate for services provided outside of the clinic, but you might want to look at the SHOL letter, especially on page 5 to see if there's some

flexibility that Tuba City might want to consider in negotiating care coordination agreements under the SHOL letter with non-IHS tribal provider specialists.

Ms. Barro: Okay. I just needed to make sure. Thank you very much.

Ms. Marx: Thank you.

Operator: The next question comes from the line of Jim Roberts from ANTHC. Please ask your question.

Mr. Roberts: Yeah, Jim Roberts again from ANTHC. Yeah, so Linda, I just want to come back to your explanation. I appreciate you providing that and I didn't mean to be contrarian about the interpretation. I think that these All Tribes Calls are a matter of tribal consultation. I think it's an important point, as you stated, to get that on record. So, I do appreciate your response and your willingness to take that back to whomever, OGC or whoever interpreted that definition of clinic services. But, the point I wanted to raise was I think already started to be addressed by Mike and some of the folks here is moving forward, what are you doing with the states to kind of get them in the loop to how to address this issue and then I think the question... I had another question about some of the FQHC requirements related to governance and some of the reporting and cost report requirements and I think that's already been kind of clarified that that wouldn't necessarily apply. But my question is, it sounds like you all are going to issue a set of Frequently Asked Questions or some other sub-regulatory guidance in the form of a State Medicaid Director Letter in some form that will explain this all to the states in terms of how they operationalize, uh, kind of developing an alternative payment methodology into the state plan. I think what would also be helpful if there was some model state plan language that could be developed either whether a SPA is going to be required for the authorization of the service and then also the payment methodology that would adopt the OMB encounter rate as the APM. So,

can you elaborate a little bit about what's the status of getting that out to the states? And then I think one final question, I don't think we'll have this problem in Alaska, but just putting on my national hat, I do expect that, you know, there are some states that don't do anything without going to their legislature. So, how are you all going to work with those states would be interested to do this, but there may not be the political will to submit a State Plan Amendment to implement the process? So, I'll just sign off and listen to the responses from there. Thank you.

Mr. Nardone: So, I think I would just say that, you know, this was our first step here. Um, we are looking at what form of sub-regulatory guidance we might want to provide. You know, this is something where from the perspective of the Center Director, we would like to try to get this resolved as quickly as possible and we certainly, you know, kind of handle this program operation issue, you know, by the end of the administration if we can, so that this doesn't then kind of lead into the next administration. We have a call tomorrow with the representatives from the Medicaid Association and again, I think our goal is to do sub-regulatory guidance of some kind, you know. Hopefully we would be able to do that prior to this administration, before Inauguration Day. Um, in terms of the transition, you know, I think that the... You know, one of the things we are looking at is what type of...in that guidance, which is one of the issues we're going to resolve and something that's helpful to hear your comments around, you know, that this may take some time, uh, is we are looking at what are... You know, what is an appropriate transition period to basically make the switch and basically allow, you know, those facilities some time to transition to this new approach recognizing that there might be some issues encountered as we enroll in the OSB kind of, uh, roll this out. And so, that would also be part of the guidance would be some sort of transition period to provide some time for that. And I don't know if there's *** *(unclear - 59:57)* want to add any additional...

Mr. Roberts: Yeah, Mike thanks for that explanation. It might be helpful to kind of understand what you all are thinking of a transition period. As I explained, I think that on some parts of the country, it's going to take a little bit of an education and awareness process for those programs to kind of understand the policy issue and then to engage with their state in a dialogue about how to kind of best move forward. You know, and then you've got to do the mechanics of putting together the State Plan Amendment, and then, doing whatever needs to be done to fulfill tribal consultation requirements in each of the states, and you know, that's going to take some more time and then through the internal process at CMS and to the final point of approval. So, what are you all thinking in terms of a transition period? I can think that in some states we can do that very expeditiously, but you know, my experience working nationally in other states and I worked in an area formally that's part of one of those states that's very difficult to work in. It could take them possibly 2 to 3 years and that might seem like a long time, but I think a transition period of at least 4 to 5 years might be helpful. So, what are you all thinking about the transition process?

Operator: The next question comes from the line of...

Ms. Marx: I think...

Operator: Yes.

Ms. Marx: Um, I think Jim Roberts asked a question.

Ms. Fan: This is Kristin Fan.

Ms. Marx: Okay. Thank you.

Ms. Fan: I think that information is all very useful. I think that those are a lot of the factors that we're trying to take into consideration in developing the policy and also hopefully with the fix and be cognizant so that we can, you know, work with the states and the tribes to have something that is workable within a reasonable amount of time. I don't really have one in particular that I

can give you at this point, since again, we are in the consultation process and this is still under development. But those are important points for us to take into consideration.

Ms. Marx: Okay. Thank you. Okay, next question, please

Operator: Yes, next question comes from the line of Steve Klipstid *(sp?)* from Gallop *(?unclear - 1:02:15)* Indians. Please after question.

Mr. Klipstid: Yeah, hi this is Steve Klipstid, Director for the Gallop's Tribes of the Health and Human Services programs. Um, I want to make sure... We keep talking about clinic services and I want to make sure that the discussion here includes dental, mental health, and substance abuse services as part of this and then we also have been paying the state match for our non-Natives in our CD programs and so when we...if we go to this FQHC route, it sounds like our non-Natives that we're serving we could bill, under the FQHC, we can bill the encounter rate also. So those are my questions. Thank you.

Ms. Tavener: Um, yes. I mean if you go... Well, if you go to the FQHC rate then you become an FQHC and you bill whatever the APM is, which might be the all-inclusive rate. But as an FQHC you would also be billing that same rate for your Medicaid eligible non-AIAN's and if in your state you're responsible to come up with the state share for that, it would probably be a higher amount. Was that your question?

Mr. Klipstid: Well, my question is if we became an F... Right now we're not an FQHC. If we became an FQHC would we be able to bill without paying the match? And that may be a question...

Ms. Tavener: Oh, that's a state question. No. As far as I know, somebody other than the Feds is always responsible for the state share of the service provided to a non-AIAN and that's really between you and the state. *** *(unclear - 1:04:16)* change that.

Ms. Marx: Right. That's been consistent policy and the interpretation under 1905B where the 100% FMAP flows to eligible Indians. So, this change of policy that we're talking about won't impact that. That's long-standing policy. Does that clarify...

Mr. Klipstid: So, if we became an FQHC, we would be working under a little bit set of different rules though, right?

Ms. Fan: Not for the financing of the payment for those non-Natives. That's again, I think as Linda mentioned, would be something that you would have to discuss with the state; even if you become an FQHC would not be eligible at 100% FMAP.

Female: For any non-Native?

Ms. Fan: Correct.

Female: And what would be the definition of that?

Ms. Tavener: We'll defer to Kitty on that.

Ms. Marx: Well, under the statute is eligible Indians, it's my understanding is Indians that are eligible for services from the Indian Health Service. So, however the state has been claiming for Indians and non-Indians, that would remain the same regardless if the tribe converted to FQHC status or remained a clinic.

Mr. Klipstid: Okay. Thank you.

Ms. Tavener: Thank you.

Operator: The next question comes from the line of Elliott Mulholland from *** *(unclear - 1:06:00.)* Please ask your question.

Mr. Mulholland: Hi, this is Elliott Mulholland from ***. I just wanted to clarify, um, and thank you all very much for taking the time. This has been very informative. With regard to the...what a tribe would need to do in order to elect to be treated as an FQHC for Medicaid purposes and

the purposes of qualifying to provide services to bill at the clinic, uh, bill the clinic provided services outside of the four walls. Um, as I think I heard, uh, or as was clarified earlier, because tribal 638 deemed to be FQHC's, they would not also have to meet through the governance and cost reporting requirements that they are eligible to participate as an FQHC under the Medicare program. What affirmative steps, if any, would a tribe need to take then in order to implement this other than working with their states to come up with an amendment to their state plan that would provide an alternate payment methodology that would ensure that they would be paid at the OMB rate?

Ms. Tavener: At first, we know, you would not have to do anything. You are already a FQHC under the law. All you need to do is work with the state Medicaid agency to have your designation changed and they're probably going to continue to pay you the same rate. So, they would just submit the state plan to us recognizing it is an alternative payment methodology.

Mr. Mulholland: So, you would have to have your designation changed for Medicaid purposes with the state?

Mr. Nardone: Yes. So you would have to enroll as an FQHC I believe.

Ms. Tavener: Right. And when we say enroll; this is not a big deal as far as we understand it. The Medicaid agency is basically changing a code in their system to say, "You were a clinic, now you're an FQHC." So, there are no standards you have to meet. I don't think there's any paperwork you have to fill out. There really is not much you have to do, other than work with them to set your APM.

Ms. Fan: The states might want to update the provider agreement.

Ms. Tavener: That's true. Yes.

Ms. Fan: But that would be administrative paperwork.

Ms. Tavener: Right.

Mr. Mulholland: Okay. Well, that's very helpful. In clarifying that in any sub- regulatory guidance would be very helpful in terms of the actual steps *(sound of loud alarm - 1:08:44)* we probably would need to take. Um, and I would also like to second some of the suggestions made by Jim Roberts and others that providing a roadmap for the states as well would be very helpful in terms of providing either a model State Plan Amendment language and/or some of the *** *(unclear - 1:09:10)* what might need to be included in a State Plan Amendment to qualify tribes that elect to be designated as FQHC's to continue to receive the OMB rate and then finally, I would just like to second the recommendations made that due consideration be given to the need for a more lengthy transition period; particularly given as Jim pointed out some of the difficulties in certain states in terms of working with legislatures otherwise to obtain State Plan Amendments. Thank you very much.

Operator: The next question comes from the line of Walter *** *(?unclear - 1:10:07)* from the service program ***. Please ask your question.

Male: Hi, this is Walter *** with the *** *(unclear - 1:10:13)* service program. Just a comment on recognition as an FQHC. So, I know, the FMAP and all those, it sounds like it won't apply to us. We do have, under that same authority, have the ability to be recognized as an FQHC and I wanted to comment that Medicare/Medicaid guidance says that a form 855A has to be provided along with a copy of our contract and that is a process we as urbans have been doing. For example, Flagstaff completed that, but it took up to two years to convince CMS that we were qualified as an FQHC. Are you expediting the process with this or are you sending out a notice to somebody? Because we...

Ms. Tavener: Okay, again...

Male: ...got an approval letter...

Ms. Tavener: Again, this is not anything that has to do with the HRSA process or the look-alike process. We can't...

Ms. Marx: Right. Linda, this is Kitty. The 855 is a Medicare enrollment process. So this is... What we're... We're not talking about tribes or urban Indian programs qualifying as Medicare FQHC's. That's a completely different process, Walter.

Male: Okay, thank you. Thanks for the clarification. I think...

Ms. Marx: I was just going to explain, you know, we anticipate the process under Medicaid to be a lot simpler than the Medicare profit.

Male: Yeah, it's just that you're talking to a lot of different regulatory bodies, so if the state Medicaid programs knew that, you know that would save us a lot of time.

Ms. Marx: Okay, Walter. That's helpful. I think that's what we've heard as well. Perhaps a model SPA, and as we've indicated, we'll be reaching out to the Medicaid directors on that. So, I think, if this policy does go through, there will be opportunity to clarify any operational issues, so that it's not as difficult I know as some urban programs have experienced in qualifying for a Medicare FQHC status.

Male: Thank you.

Ms. Marx: Thanks.

Operator: The next question comes from the line of Beverly Lewis from the *** *(unclear - 1:12:26.)* Please ask your question.

Ms. Lewis: Hello, this is Beverly and we are a tribal 638 clinic and I'm kind of a newbie on this. This is the first call I've been on, so I'm just kind of trying to hear everything—a lot of good information. But, we're structured as an IHS with the state and CMS. We didn't qualify for the

grandfather; so, that's the reason why we're structured as an IHS and as I'm going through what I'm hearing is that the tribal and 638 facilities are already considered FQHC through the state and CMS under the law?

Ms. Gadson: No. In terms of what we've been referencing, there's a provision in Title XVIIII that allows tribal health programs operating under a 638 agreement to also to be FQHC. It's long-standing. It's been in Title XVIIII for a long time.

Ms. Gillespie: This is Cindy Gillespie. Tribes are identified as FQHC's in the statute and that's why you are able to switch over.

Ms. Lewis: So, we would be able to switch over to the FQHC?

Ms. Marx: As a Medicaid FQHC, you referenced grandfathering which means... To me, it sounds like you might be talking about a Medicare grandfathering tribal FQHC status which is completely different. So, just under Medicaid based on the definition in the Social Security Act, 638 tribal programs and urban Indian programs are defined as FQHC's for both Medicaid and Medicare, but the process for Medicaid is simpler for the tribal facility to convert to FQHC status under the Medicaid state plan.

Ms. Lewis: Oh, okay. So, there is a difference between the two, Medicare and Medicaid. Okay, I was kind of... I think I was getting them confused.

Ms. Marx: Yeah. This is not... We know that Medicare can be a little bit more cumbersome and more complicated. But that's not true in the Medicaid FQHC rules.

Ms. Lewis: Okay. Thanks for clarifying that.

Ms. Marx: Okay. Dave, next question.

Operator: Yes, our next question comes from the line of Rosario Arreolapro from California Rural. Please ask your question.

Ms. Arreolapro: Hi, this is Rosario with the California Rural Indian Health Board Health Assistance Development Director. My question is, will tribal health programs have the option to opt in or opt out of being part of the APM or will they be automatically designated provider by CMS?

Ms. Tavener: No, you... If you choose to be an FQHC... Well, first of all, you don't have to choose to be an FQHC. You can keep your clinic status if that's what you want to do; keeping in mind though that anything that is provided outside the four walls you will no longer be able to bill at the all-inclusive rate, the OMB all-inclusive rate. Um, if you do choose to be an FQHC, then you can negotiate with the state Medicaid agency to decide whether you would get an FQHC PPF payment or the AIR or something else.

Ms. Arreolapro: Okay. Thank you.

Ms. Tavener: Uh huh.

Operator: The next question comes from the line of Aletta Montiel *(sp?)* from Pascua Yaqui Tribe. Please ask your question.

Ms. Montiel: Hi. Good afternoon. This is Alida Montiel with the Inter Tribal Council of Arizona. I understand that this remedy is so that we remedy the four walls limitation because tribal clinics do many times provide or tribal providers are out in the communities providing services, or whether it be at the school or at some other way shape or form, in order to really provide good services in their communities outside of the four walls. So, I understand that this will help with that. What if a state... Would a state be inclined to provide maybe their preferences to tribes or will they not be able to...or will the option be open to the tribes?

Ms. Tavener: The alternative payment has to be agreed to by the provider, the FQHC, and the state. So, I'm not sure that I would see a state refusing to continue paying you what they have

been paying you. If you've been paid less than the all-inclusive rate right along and I'm not sure whether that's the situation you're in, is it? Have you been receiving the all-inclusive rate for services?

Ms. Montiel: Uh, yes. That happens in the state of Arizona.

Ms. Tavener: Okay, then I don't see any reason at all why the state wouldn't want to continue to pay you the same way. All they would have to do is change the state plan designation to an FQHC alternate payment.

Ms. Montiel: Okay and my second question has to do with the care coordination agreements. The bulk of the American Indians in Arizona enroll in the American Indian Health Program Plan, but there are several managed-care plans and there are American Indians, a sizable number, that enroll in managed-care plans, but still receive services at IHS and tribal facilities. So, will the rate depend on which plan they are enrolled in? Will the rate of reimbursement per the care coordination agreements depend on which plan they're enrolled in?

Ms. Gadson: I managed to have that question... I think that's an Arizona specific for the situation and I think we should have that question sent to the mailbox that Kitty provided earlier, because I think it's a little bit more nuances there.

Ms. Tavener: And, we're also coming up to the end of the hour. So I think we want to make sure we have...you know, don't rush it and answer that question incorrectly.

Ms. Marx: Yeah, Aletta, this is Kitty. Can you go ahead and send your question to our mailbox, tribalaffairs—all one word—@CMS.HHS.gov? And we can follow up with.

Ms. Montiel: All right.

Ms. Marx: Thank you.

Ms. Montiel: Very good.

Ms. Marx: And let's just take... It is almost 4:00. So Dave, let's just take one more question and just for those who are on the call, again, if you weren't able to ask a question, please send your question to tribalaffairs@CMS.HHS.gov. We'll take one more quick call, Dave.

Operator: Yeah. The last question comes from Jessica Windy Boy from Rocky Point Creek. Please ask your question.

Ms. Windy Boy: Oh, I'll go ahead and pass. You guys have already answered a lot of it and I'll just email my other part of my question. So, please take another question from another tribal person.

Ms. Marx: Okay, well, thank you very much for... Um, just please go ahead and forward your question. Um, I guess we'll just go ahead and conclude today's call because I have... We're at the top of the hour. I do want to thank Mike and Linda and Sharee and Kristin and Christian and everybody who has been available to answer all of these great questions and to respond to comments. I think all of the questions and issues that you all raised are very, very helpful. The call is being recorded and will be available by close of business Monday, December 19th. Um, but I took notes on the call as well. So Mike, I don't know if you wanted to say a few closing words about...

Mr. Nardone: No, I just wanted to thank everybody for participating in the call and just reiterate Kitty's comments about the great questions as we think through this and I appreciate any other questions that we get through the mailbox and I look forward to continuing to work with you on this as we work through this. So, thank you very much for staying with it and I appreciate your time on the phone call today.

Ms. Marx: Okay. Thank you, Mike and thank you all, to all the participants. It was a very good call and have a good rest of your day. Thank you. Bye-bye. *(End of webinar - 1:22:16.)*