Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Clarification on Federal Policy and Next Steps for Tribal Health Care Facilities Billing Medicaid for Clinic Services Provided Outside of Their "Four Walls"[1]

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This brief seeks to provide guidance to Indian health care providers (IHCPs), specifically those operated by a Tribe or Tribal organization, on a recent clarification of federal policy under which CMS will phase-in enforcement of a policy indicating that IHCPs enrolled in Medicaid as clinics cannot bill the program for "clinic services"[2] provided outside the "four walls" of their facilities, except for services provided to homeless individuals. In addition, this brief outlines steps that affected Tribal health care facilities enrolled as providers of clinic services can take in their state to continue to receive Medicaid payments at the facility rate (usually the "OMB encounter rate" or the "IHS All-Inclusive" outpatient rate) for services provided outside the four walls of their facilities.

Background

On February 26, 2016, the federal Centers for Medicare and Medicaid Services (CMS) issued a State Health Official (SHO) Letter[3] to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by American Indians and Alaska Natives (AI/ANs) through IHCPs. CMS, in the process of implementing the SHO Letter, realized that some IHCPs have billed Medicaid for clinic services provided outside the four walls of their facilities. On January 18, 2017, CMS issued a document[4] clarifying that "clinic services" include only services that are within the scope of the "clinic services" benefit and that are either furnished within the four walls of an enrolled Medicaid clinic or are furnished off-site to homeless individuals by clinic personnel. Consequently, after the grace period provided for in the CMS revised policy, IHCPs enrolled in Medicaid as clinics cannot bill for off-site services as "clinic services," and therefore cannot be paid for them at their facility rate (unless the patient is homeless). Instead, services that are provided off-site to persons who are not homeless may only be billed and paid for as an assigned claim from the off-site provider who furnished the service, for example, as a covered physician service paid for under the physician fee schedule.

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[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

[2] Defined at 42 CFR 440.90 as "preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients."

[3] See CMS, "SHO #16-002: Federal Funding for Services 'Received Through' an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives," at https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf.

[4] See CMS, "Frequently Asked Questions (FAQs): Federal Funding for Services 'Received Through' an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002)," at http://www.tribalselfgov.org/wp-content/uploads/2017/02/01-faq11817.pdf.

Impact of Policy

As mentioned above, the policy applies only to services provided outside of the four walls of IHCPs enrolled in Medicaid as clinics. Generally, the policy does not apply to the following:

- Clinic services provided within the four walls of a clinic;
- Clinic services provided by clinic personnel to homeless individuals outside the four walls of a clinic;
- On-site and off-site services of facilities that are enrolled and paid as outpatient hospital departments, including hospital-based clinics in States that offer that enrollment option;
- Services delivered by an outside provider, which is billed as an assigned claim at that provider's reimbursement rate; and
- Covered services of Federally Qualified Health Centers, whether provided on-site or off-site.

Possible Relief for Affected Tribal Health Care Facilities

Change in Designation to FQHC

For Tribal health care facilities affected by the policy, CMS has suggested re-designating as a Federally Qualified Health Center (FQHC) [5] as a means of continuing to bill Medicaid for services provided outside the four walls of their facilities, as FQHCs are not subject to the same "four wall" restrictions as clinics. Under section 1905(l)(2)(B) of the Social Security Act (Act), outpatient health care facilities operated by a Tribe or Tribal organization under the Indian Self-Determination Act are by definition FQHCs. Tribal health care facilities thus have the option to enroll in Medicaid programs as FQHCs. Tribal health care facilities currently enrolled in Medicaid as a clinic need only to inform the state of their desire to change their designation to an FQHC; they do not have to re-enroll in the program. It is important to note, however, that some states might have in place requirements on FQHCs negatively impacting the types of services billable under Medicaid. Prior to opting to elect to bill under Medicaid FQHC status, IHCPs might wish to reach agreement with the state to modify or eliminate the application of those provisions to Tribal FQHCs.

Change in Medicaid Payment Rate

Tribal FQHCs typically receive Medicaid payments based on a rate determined by the state using the Prospective Payment System (PPS) methodology, rather than the encounter rate (aka the "OMB Rate" or "IHS All-Inclusive Rate"). However, under section 1902(bb)(6) of the Act, states and FQHCs have the ability to agree to use an Alternative Payment Methodology (APM) in determining Medicaid payment rates, meaning that states can use the encounter rate, rather than the PPS rate, to set payments for Tribal FQHCs, as long as the APM rate is higher than the FQHC payment rate. States must submit a State Plan amendment (SPA) to set Medicaid payments for Tribal FQHCs at the encounter rate, and must annually determine that the encounter rate is higher than the FQHC PPS rate that would otherwise

[5] Health care facilities enrolling as an FQHC under Medicaid generally do not have to meet the requirements for enrolling as an FQHC under Medicare.

apply. (This means States will have to calculate the FQHC PPS rate each year, but CMS says Tribal facilities will not be required to submit cost reports in connection with that process.)

Other Differences Between Medicaid FQHC Services and Medicaid Clinic Services.

There are other important differences between Medicaid "clinic services" and "FQHC services." The scope of coverage is not necessarily the same, and it may vary from state to state. States may impose different service caps or limitations on the two types of services. Supervision, staffing, documentation, and billing requirements may also be different. There may be both advantages and disadvantages to switching to FQHC enrollment. Affected facilities should work with their State Medicaid agencies to identify the differences, and evaluate them carefully, before deciding whether to make the change.

Grace Period

CMS has provided a grace period to allow affected Tribal health care facilities time to evaluate their options, re-designate as FQHCs under Medicaid, and negotiate with states to use the encounter rate rather than the PPS rate for payment. According to CMS, the agency will not review Medicaid claims for clinic services provided outside the four walls of Tribal health care facilities before January 30, 2021. CMS indicated, however, that Tribal health care facilities seeking to re-designate as an FQHC under Medicaid should notify the state of their intention to do so by January 18, 2018.[6]

<u>Minimum Payment Rates for FQHCs from Qualified Health Plans (QHPs)</u>

Apart from the implications for Medicaid payments, federal regulations impose specific requirements on payment rates from issuers of QHPs offered through a Health Insurance Marketplace (Marketplace) to FQHCs, including Tribal FQHCs. Specifically, for covered services provided by FQHCs, QHP issuers must pay an amount "not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act (SSA) for such item or service."[7]

It is worth noting that an FQHC and a QHP issuer can agree to payment rates other than those the FQHC would have received under SSA section 1902(bb), as long as the alternative rate at least equals the generally applicable payment rate of the issuer.[8] In addition, a Tribal FQHC that receives the OMB encounter rate for covered Medicaid services can negotiate a different payment rate when contracting with a QHP issuer, if desired, although as noted below, the amount is to be not less than the FQHC rate.

For Tribal clinics that do not operate as Medicaid FQHCs but nevertheless meet the definition of an FQHC at SSA section 1905(l)(2)(B), some uncertainty exists regarding the extent to which the QHP issuer requirements on payment rates apply. Federal regulations at 45 CFR 156.235(e) read:

> "If an item or service covered by a QHP is provided by a Federally qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally qualified health center for the item or service an amount that is not less than the amount of

[6] CMS subsequently communicated that the January 18, 2018, date is not absolute. Tribal programs are encouraged to reach out to their states as soon is feasible to do so.

[7] See 45 CFR 156.235(e).

[8] See the CMS guidance titled "Addendum to 2018 Letter to Issuers in the Federally-facilitated Marketplaces" and dated February 17, 2017.

payment that would have been paid to the center under section 1902(bb) of the Act for such item or service."

A reasonable interpretation of these regulations is that a QHP issuer must pay a Tribal clinic that does not operate as a Medicaid FQHC at the same rate as a Tribal clinic that does operate as a Medicaid FQHC in a given state (either the Medicaid FQHC PPS rate or an alternative payment rate, if established, such as the OMB encounter rate), as the Tribal clinic meets the definition of an FQHC under the Medicaid statute. Nonetheless, it appears to be the current policy of CMS that, only in instances in which a Tribal clinic has chosen to bill under Medicaid as a Tribal FQHC would the Tribal FQHC rate (either the standard FQHC PPS rate or an APM (such as the OMB encounter rate, if specified in the state Medicaid State Plan) be the applicable rate.[9]

Applying this interpretation of the applicability of the FQHC rates still provides substantial benefit to Tribal providers, although it requires the Tribal provider (*e.g.*, clinic) to choose to bill Medicaid as an FQHC. (For background on a Tribal clinic billing as an FQHC, see the TSGAC issue brief titled "CMS Restrictions on Billing Medicaid for Services Outside Four Walls.") For example—

- A Tribal clinic not billing as an FQHC under Medicaid might not be subject to the "FQHC minimum payment protections";
- A Tribal clinic that has chosen to bill Medicaid as an FQHC, under the standard Medicaid FQHC PPS rate, would receive no less than the standard Medicaid FQHC PPS rate under Marketplace plans; and
- A Tribal clinic that has chosen to bill Medicaid as a Tribal FQHC, under an APM established by a state that provides for payment of the OMB encounter rate for clinic services, would receive no less than the OMB encounter rate.

Next Steps

Affected Tribal health care facilities should consider taking the following steps:

1. Begin working immediately with your state to identify all the differences between clinic and FQHC status, including scope of coverage, staffing, supervision, documentation, billing, and other requirements;
2. Evaluate the financial and programmatic pros and cons of making the change, beyond the ability to bill for off-site services at the encounter rate;
3. Reach an agreement with the state for Tribal FQHCs to use the encounter rate, rather than the PPS rate, in setting Medicaid payments for Tribal FQHCs;

[9] Tribes and Tribal health organizations are seeking an opinion from CMS on this matter.. Until such time as it is clarified, though, this policy brief is adopting the position that the QHP issuer is obligated to compensate FQHCs at the rate the FQHC (Tribal or otherwise) is actually/currently paid under Medicaid for covered services provided to Medicaid enrollees.

4. Consider engaging with the state to determine if elements of billing as an FQHC under the current Medicaid State Plan that are not advantageous can be modified, just for Tribal FQHCs or all FQHCs;

5. Work with the state in drafting and submitting to CMS an SPA to set Medicaid payments for Tribal FQHCs at the encounter rate and to make another other changes agreed to between the state and Tribal representatives; the SPA should be submitted by the state to CMS no later than March 31, 2021, in order to be able to be in effect on January 1, 2021; and

6. If you decide the change in billing status would be advantageous, notify the state as soon as is feasible that you intend to change your Medicaid enrollment status from a clinic to an FQHC.

Examples of SPAs from several states:

Several states recently have received approval from CMS for an SPA that sets Medicaid payments for IHS, Tribal, and urban Indian organization FQHCs (referred to in the SPA as "ITU-FQHCs") at the encounter rate. Examples of these Tribal FQHC payment policies appear below.

- **Arizona**: "If a 638 FQHC elects an Alternative Payment Methodology [for Tribal facilities recognized as 638 FQHCs] then the 638 FQHC will be reimbursed an outpatient all-inclusive rate for all FQHC services. The published rate is paid for up to five encounters/visits per recipient per day. ... AHCCCS will establish a Prospective Payment System (PPS) methodology for the 638 FQHCs so that the agency can determine on an annual basis that the published, all inclusive rate is higher than the PPS rate. The PPS rate will be established by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads. The 638 FQHCs would not be required to report its costs for the purposes of establishing a PPS rate."[10]

- **Connecticut**: "**Alternative Payment Methodology for Tribal Facilities Recognized as 638 FQHCs**. For dates of service July 1, 2017 and forward, these FQHCs may elect to be reimbursed under the Alternate Payment Methodology. Reimbursement to an Indian Health Services (IHS) clinic enrolled as an FQHC shall be as follows:

    1. IHS/Tribal 638 facilities are reimbursed in accordance with the most recently published Federal Register notice addressing the IHS encounter rate.

    2. Encounters with more than one health professional for the same type of service and multiple interactions with the same health professional that take place on the same day constitute a single encounter eligible for one payment, except when the patient after the first interaction, suffers illness or injury requiring additional diagnosis and treatment. Payment is allowed for one medical encounter, one behavioral health encounter, and one dental encounter per day.

[10] See the Arizona SPA and the associated CMS approval letter at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AZ/AZ-18-004.pdf. Additional details on this policy are available in the Arizona IHS/Tribal Provider Billing Manual, Chapter 20 at https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chapter20_638_FQHC.pdf.

3. The State will establish a Prospective Payment System (PPS) methodology for the 638 FQHCs so that the agency can determine on an annual basis that the published encounter rate is higher than the PPS rate. The PPS rate will be established by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads. The 638 FQHCs would not be required to report its costs for the purposes of establishing a PPS rate."[11]

- **Montana**: Tribal facilities ... that enroll in Montana Medicaid as a Tribal FQHC have agreed through tribal consultation to be paid using an alternative payment methodology (APM) that is the all-inclusive rate (AIR) for services published annually in the Federal Register. Reimbursement will be allowed for the same categories of service as included within this State Plan that tribal facilities provide. Tribal FQHCs may bill the appropriate number of payable daily encounters based on the services that members receive. ... Montana Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal FQHC so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate will be established by comparing the PPS rate that is currently paid to non-tribal FQHCs to determine if the all-inclusive rate is higher."[12]

- **Nevada**: "Outpatient health programs or facilities operated by a Tribe or Tribal organization that choose to be recognized as FQHCs ... will be paid using an alternative payment methodology (APM) for services ... that is the published, all-inclusive rate (AIR). The APM/AIR rate is paid for up to five face-to-face encounters/visits per recipient per day. ... Nevada Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal facility so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate will be established by reference to payments to one or more other FQHCs in the same or adjacent areas with similar caseloads. ... The Tribal facility would not be required to report its costs for the purposes of establishing a PPS rate. The APM is effective for services provided on and after April 1, 2019."[13]

- **Oklahoma**: "For qualified facilities operated by ITU providers that contract with the Medicaid agency as an FQHC, hereafter referred to as ITU-FQHC, an alternative payment method (APM) is allowed. The APM rate for services provided by an ITU-FQHC is set at the OMB rate. ... Reimbursement is made for an individual medical, dental, and outpatient behavioral health encounter per member per day. Reimbursement for more than one outpatient visit within a 24-hour period is made when services are provided for a distinctly different diagnosis."[14]

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[11] See the Connecticut SPA and the associated CMS approval letter at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CT/CT-17-0017.pdf.

[12] See the Montana SPA and the associated CMS approval letter at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-18-0003.pdf.

[13] See the Nevada SPA and the associated CMS approval letter at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NV/NV-19-002.pdf.

[14] See the Oklahoma SPA and the associated CMS approval letter at https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OK/OK-17-05.pdf. In addition, Oklahoma Health Care Authority (OHCA) Policies and Rules, part 110 stipulates, "I/T/U covered services provided off-site or outside of

- **Washington**: "Tribal facilities ... that enroll in Washington Medicaid as a Tribal Federally Qualified Health Center (Tribal FQHC) have agreed through tribal consultation to be paid using an alternative payment methodology (APM) that is the published outpatient all-inclusive rate. The agency allows reimbursement for the same outpatient services and the same number of encounters per day that Tribal 638 facilities provide under this State Plan. ... The agency establishes a Prospective Payment System (PPS) methodology for the Tribal FQHCs so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate is established by reference to the PPS rate that is currently paid to non-Tribal FQHCs. Tribal FQHCs are not required to report their costs for the purposes of establishing a PPS rate."[15]

the I/T/U setting, including mobile clinics or places of residence, are compensable at the OMB rate when billed by an I/T/U that has been designated as a Federally Qualified Health Center." See http://www.okhca.org/xPolicyPart.aspx?id=612&chapter=30&subchapter=5&part=110&title=INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/US).

[15] See the Washington SPA and the associated CMS approval letter at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-19-0009.pdf. Additional details on this policy are available in the Washington Apple Health (Medicaid) Tribal Health Billing Guide at https://www.hca.wa.gov/assets/billers-and-providers/Tribal-health-bi-20200101.pdf.