Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

Submitted via e-mail: Victoria.Wachino1@cms.hhs.gov

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Victoria Wachino, Director
Center for Medicaid and CHIP Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Five-Year Grace Period for States and Indian Health Programs to Designate Tribal Clinics as Medicaid FQHCs, and Pay them under an Alternative Payment Methodology, to Mitigate the "Four-Walls" Interpretation of the Medicaid Clinic Benefit.

Dear Ms. Wachino:

As you know, on December 15, 2016, the Centers for Medicare and Medicaid Services (CMS) held an All Tribes' Call on the so-called "four walls limitation" of the Medicaid clinic services benefit. CMS staff explained that, although the limitation means Tribal clinics cannot be paid at the Tribal outpatient facility encounter rate for services that are provided outside the facility by the clinic's staff or by non-Tribal providers under a care coordination agreement, the impact can be minimized if clinics can be redesignated as FQHCs for Medicaid purposes, and States amend their Medicaid Plans to adopt an Alternative Payment Methodology (APM) that would allow Tribal clinics designated as Medicaid FQHCs to bill at the OMB encounter rate or an alternative payment method to be determined in consultation with Tribes. Announcing the call, CMS acknowledged that "states may not have been paying for services provided by Tribal clinics in accordance with the 'four walls' limitation;" suggested the transition would be easy because Tribal outpatient programs have statutory FQHC status; and assured that States would be "given a grace period to consult with Tribes and to modify the state plan." CMS invited Tribes to suggest an appropriate grace period.

The Tribal Technical Advisory Group[1] ("TTAG") does not agree with CMS's "four walls" interpretation of the clinic benefit, but we sincerely appreciate CMS's desire to mitigate any

[1] The TTAG advises the Centers for Medicare and Medicaid Services on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care programs funded (in whole or in part) by CMS. In particular, the TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives under these federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations.

resulting harm. For the reasons outlined below, we believe a grace period of at least five years is needed, along with technical assistance and clear assurances that, during the grace period, Tribal clinics may provide and be paid at the OMB Tribal outpatient facility rate for off-site services they deliver directly or through care coordination agreements with non-Tribal providers, and such services will qualify for 100% FMAP if all other applicable requirements of the February 26, 2016 State Health Official Letter are satisfied.

1. **The Federal Medicaid benefits for clinic and FQHC services are not identical. Differences may also exist at the State level. Tribal programs need time and assistance to identify, compare, and evaluate coverage differences, and to make programmatic, staffing, and other changes to respond to them.**

CMS has advised that federal law imposes a "four-walls" limitation on Medicaid clinic services but not on Medicaid FQHC services. But there are many other potentially important differences between the two service categories that CMS has not yet discussed with Tribal programs, and that they will need to fully understand and evaluate before deciding whether to make the change from clinic to FQHC Medicaid enrollment. CMS has also not yet formally advised whether a clinic that elects to convert to FQHC enrollment for Medicaid, must also convert to FQHC enrollment for Medicare. On the All Tribes' Call, CMS stated that a clinic that elects to be designated as an FQHC for Medicaid purposes would not also have to meet the requirements to bill as an FQHC for Medicare purposes. As discussed below, the TTAG supports this, as the governance and cost-reporting requirements for Medicare FQHCs impose burdens that many smaller Tribal clinics will not readily be able to meet in a cost-effective manner. We urge CMS to make this distinction clearly in any guidance it issues. We remain concerned, however, that even being redesignated as an FQHC for Medicaid purposes may involve requirements and limitations imposed by individual State plans that Tribes may not be aware of.

Comparing the two options is no easy task, and the sheer volume and complexity of the federal FQHC provisions are daunting. The Social Security Act and federal Medicaid regulations define "clinic" services both broadly and briefly, each in a single provision of 100 words or less.[2] By contrast, Medicaid FQHC services are defined as services of the type described in the Medicare FQHC provisions, and the Medicare provisions are found in a dizzying array of statutory and regulatory references and cross-references, at least twelve layers deep and thousands of words long, that describe covered services with great specificity.[3] It is not immediately clear whether the 49-page Medicare Benefit Policy Manual chapter on FQHC services applies to Medicaid FQHCs. (It might, since Medicaid defines the benefit by reference to the Medicare provisions.) But to further confuse matters, the Manual states that some of its provisions may not apply to

[2] 42 U.S.C. 1396d(a)(9); 42 CFR 440.90.

[3] 42 U.S.C. 1396d(*l*); cross-referencing 42 U.S.C. 1395x(aa)(1)(A)-(C) and 1395x(ddd)(3); which cross-reference, in turn and among other provisions, 42 U.S.C. 1395x(s)(2)(A), 42 U.S.C. 1395x(hh)(1), 42 U.S.C. 1395x(ddd), 42 U.S.C. 1395x(ww), 42 U.S.C. 1395x(s)(10), 42 U.S.C. 1395x(bb), and 42 U.S.C. 1395x(hhh); see also 42 CFR 405.2446, 42 CFR 405.2448, 42 CFR 405.2449, 42 CFR 405.2450, and 42 CFR 405.2452.

Tribal FQHCs, without identifying which provisions those might be.[4] We urge CMS to clarify that a Tribal clinic that enrolls as an FQHC for *Medicaid* does not have to meet the regulatory and policy requirements for entities enrolled as an FQHC for *Medicare*.

CMS correctly observes that Tribal outpatient clinics automatically qualify for FQHC status under section 1905(*l*)(2)(B) of the Social Security Act.[5] But while this means Tribal clinics do not have to satisfy the generally-applicable eligibility requirements in order to achieve FQHC status, it does not necessarily follow that they are also excused from the generally-applicable programmatic, service, reporting, and other requirements that apply to entities that operate and bill Medicaid or Medicare as FQHCs.

Federal Medicare FQHC programmatic and service requirements that may be problematic for some Tribal clinics include:

- The requirement to furnish all diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the healthcare delivery system;[6]
- The requirement to provide first-response medical procedures, drugs, and biologicals for common life-threatening injuries and acute illnesses during regular operating hours, and to provide telephone coverage and referrals for such services after-hours;[7] and
- The requirement to have agreements or arrangements with hospitals and other providers to furnish certain services that are not available at the FQHC, including inpatient hospital care, physician services, and certain diagnostic and laboratory services. [8]

Also of potential concern are federal supervision requirements and billing rules for FQHC services that are furnished by non-physician practitioners or by other staff members "incident to" the services of a physician or other practitioner. Under the clinic benefit, State Medicaid programs have been at liberty to develop standards that accommodate the unique circumstances of their State's Tribal clinics, and these may differ in important respects from the very detailed federal requirements for FQHCs.[9]

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[4] Medicare Benefit Policy Manual, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf. The following "Note" appears at p. 9: "NOTE: Information in this chapter applies to FQHCs that are Health Center Program Grantees and Health Center Program Look-Alikes. It does not necessarily apply to Tribal or urban Indian FQHCs or grandfathered Tribal (GFT) FQHCs."

[5] 42 USC _____.

[6] 42 C.F.R. 491.9(c)(1).

[7] 42 CFR 491.9(c)(3); Medicare Benefit Policy Manual Chapter 13, Sec. 50.3.

[8] 42 CFR 491.9(d); Medicare Benefit Policy Manual Chapter 13, Sec. ___

[9] 42 CFR 405.2413, 42 CFR 405.2414, 42 CFR 405.2415; Medicare Benefit Policy Manual Chapter 13, Sec. 110 – 180.

As a result, we strongly support clarification from CMS that enrolling as an FQHC for Medicaid purposes would not require a Tribal facility to meet the federal requirements for FQHCs for Medicare purposes. We remain concerned, however, that some States may as a matter of State law require entities that enroll as an FQHC for Medicaid purposes to meet the federal requirements for entities enrolled as Medicare FQHCs. The State of Alaska's FQHC regulations require an FQHC to be enrolled in Medicare and comply with the applicable federal regulations. See, e.g., 7 AAC 140.200 and 7 AAC 140.205. As a result, unless an exception is explicitly made, State requirements to comply with federal Medicare FQHC requirements could pose a significant barrier to Tribal facilities seeking redesignation as a Medicaid FQHC for purposes of the proposed workaround. Federal provisions aside, States may also cover different services under their "clinic" and "FQHC" benefits, or may impose limits on one but not the other. These will vary from state to state, and must also must be identified and assessed by any Tribal program considering a change from clinic to FQHC enrollment. For example, The Kaiser Family Foundation reported that, for 2012, 18 State Medicaid programs imposed limits on FQHC services, with at least 8 of these capping the number of visits per recipient per year. [10] Ironically, while Alaska's Medicaid program has consistently covered Tribal clinic services delivered outside the clinic facility in any appropriate community setting, it covers off-site FQHC services only if they are provided to homebound recipients.[11] Other State-coverage differences may include whether, to what extent, and under what conditions coverage is provided for behavioral health services, dental services, laboratory and radiology services, and services delivered by non-physician practitioners including Clinical Social Workers, Psychologists, other behavioral health clinicians, Nurse Practitioners, Physician Assistants, Physical Therapists, Occupational Therapists, Speech-Language Pathologists, Dietitians, Podiatrists, Chiropractors and Audiologists. In this regard, it is important to recognize the vital role played by non-physician practitioners in Tribal health programs, particularly those serving small, rural, or remote communities.

Tribal health programs will need substantial time and technical assistance to determine which of their current or planned Medicaid-covered clinic services would qualify as FQHC services, whether they would be covered as FQHC services to the same extent and under the same circumstances as they have been covered as clinic services, whether there are new services they could offer as an enrolled FQHC, whether the benefits of switching to FQHC status would outweigh the disadvantages and the cost and disruption such a switch would entail, and how to structure their programs and staffing to minimize the disadvantages and maximize the advantages of changing from clinic to FQHC status. For some Tribal programs, decisions of that magnitude

[10] The Report is available at http://kff.org/medicaid/state-indicator/federally-qualified-health-center-services/view/print/?currentTimeframe=0&print=true. Service caps per recipient ranged from 10 to 24 visits per year. The report does not address whether the same limits applied to clinic services.

[11] 7 AAC 140.200 – 7 AAC 140.220. Comparing Medicaid Clinic and FQHC coverage in Alaska, where many affected Tribal clinics are located, is further complicated by the fact that the 180-page FQHC "Provider Billing Manual," last revised in 2003, is currently "under revision" and providers are instructed not to rely on it.

may require training, consideration, and formal action by the Tribal council or other governmental body, adding more complexity and exponentially to the time required to make the decision.

Once a Tribal program decides to convert to FQHC Medicaid enrollment, it will then need even more time to implement that choice. Among other things, this may entail significant changes to programs, policies, staffing, medical record and billing systems, and arrangements with other health service providers.

2. **States that restrict FQHC services will need time to consider whether to modify or lift those restrictions, the financial consequences of doing so, and whether they may impose different restrictions on Tribal and non-Tribal FQHCs.**

CMS has proposed the FQHC work-around as a way to minimize the impact of the four-walls clinic services limitation. As CMS recognizes, this will require all States to amend their Medicaid Plans to adopt the Tribal outpatient facility encounter rate as an alternative payment methodology for Tribal FQHC services. But, to minimize the impact for affected Tribal clinics, some States would also have to amend their Plan's FQHC coverage provisions to remove or modify service limits that do not apply to Tribal clinic services. As noted above, at least 18 States imposed annual visit caps or other restrictions on FQHC services in 2012, the last year on which that information was reported by The Kaiser Family Foundation.

We do not know whether States may lawfully lift service restrictions only for Tribal FQHCs, and if so, whether they would need to obtain a waiver to do so. But if they may not, or if for other reasons a State prefers to apply the same limitations to Tribal and non-Tribal FQHCs, the State will need time to consider its options, confer with other stakeholders, and determine the fiscal impact of removing or modifying its FQHC service limitations.

3. **In addition to amending their State Plans, some States will need to amend State statutes, regulations, and sub-regulatory advice; adequate time must be allowed for those processes.**

To implement the FQHC work-around, States will need to amend more than just their Medicaid State Plans. All States will likely have to amend their regulations, after giving the required public notice and giving due consideration to public comment. Billing manuals and other sub-regulatory materials will also have to be revised. In some States, statutory changes will be required, and Tribal programs and Medicaid agencies will need time to educate and work with their State legislatures to accomplish the changes – a process that can require several years, especially in States whose legislatures meet only every other year. And at least one State requires legislative approval of all Medicaid State Plan amendments.

Given the work involved, States should not be expected to make these changes until affected Tribal programs have had time to evaluate their options and at least one has decided to

convert to FQHC enrollment. Yet all the changes must be in place before the conversion can occur.

4. **States will need time to design, test, and implement changes to their Medicaid information and reimbursement systems.**

In addition to amending their State Plans, statutes, regulations, and sub-regulatory materials, States agreeing to implement the FQHC solution will need to change their Medicaid information and reimbursement systems. We understand that the required changes can be extensive, costly, and time-consuming to design and implement. For example, Alaska's Medicaid agency has informed us that, in order for its system to pay Tribal FQHCs at the Tribal outpatient facility rate, it will have to create up to three different FQHC provider types – one each for general, behavioral health, and dental services -- that will have to be designed, aligned with appropriate billing and procedure codes, and thoroughly tested before it goes live. States must be granted ample time to make the necessary system changes, to ensure a smooth transition for Tribal clinics converting to FQHC enrollment. This will need to be balanced against other competing State priorities and system changes; historically, some State Medicaid programs have not classified as a high priority, changes that are relevant to only a few or small Indian health providers.

5. **State Medicaid agencies and Tribal health programs have competing demands on their limited time and resources. These must be prioritized and deadlines set accordingly. Given other ongoing and anticipated priorities, a five-year grace period is reasonable.**

Even if State Medicaid agencies and Tribal programs had no other demands on their time, they would need several years to fully understand, evaluate, and implement the proposed FQHC work-around, for the reasons we outlined above. But in fact they have a tremendous amount of other important work to do and are likely to face unprecedented challenges in the near term. They are striving to implement Medicaid managed care and to comply with the new managed care regulations. They are working to design and adopt important Medicaid waivers and reforms. And they must be prepared to quickly evaluate and respond to more extensive changes and initiatives that seem likely to emerge under the Trump administration. Under the circumstances, we think a five-year grace period is both reasonable and necessary, and we respectfully ask it be granted.

Thank you for considering this request and for your efforts to mitigate the impact on Tribal programs of the clinic "four walls" limitation.

Sincerely,

W. Ron Allen,

Tribal Chairman and CEO, Jamestown S'Klallam Tribe
Chairman, Tribal Technical Advisory Group

cc: Tim Hill, Deputy Director, Center for Medicaid and CHIP Services
Deidre Gifford, M.D., Deputy Director, Center for Medicaid and CHIP Services
Kitty Marx, Director, Division of Tribal Affairs, IEAG, CMCS, CMS