



Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Requirements for Payment and Other Protections to Indian Health Care Providers Under Marketplace Health Plans¹

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This brief provides information to Tribes on Federal requirements for payments to certain Indian health care providers (IHCPs) under qualified health plans (QHPs) offered by health insurance issuers through a Federally-Facilitated Health Insurance Marketplace (Marketplace).² Specifically, this brief examines requirements on QHP issuers with regard to (1) including IHCPs in plan provider networks, (2) making contract offers to IHCPs, and (3) meeting minimum payment standards for Tribal federally-qualified health centers (FQHCs), possibly including adoption of the OMB encounter rate.³ This brief also outlines the right of IHCPs to bill QHP issuers under the Indian Health Care Improvement Act (IHCA), pursuant to IHCA section 206, regardless of whether the IHCPs have contracted with the QHP issuers.

GENERAL NETWORK ADEQUACY REQUIREMENTS

The Marketplace, established by the Affordable Care Act (ACA), enables consumers to compare available health plans, determine eligibility for federal financial assistance (*i.e.*, premium subsidies and cost-sharing protections), and enroll in comprehensive health insurance coverage. Under federal regulations issued by the Centers for Medicare and Medicaid Services (CMS), and as stipulated by the ACA, QHP issuers must operate provider networks that:

- Include “sufficient numbers and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible without unreasonable delay”⁴; and
- Include a “*sufficient number and geographic distribution*” of essential community providers (ECPs), such as IHCPs and FQHCs, where available.⁵

For purposes of Marketplace protections:

- ECPs include IHCPs, and IHCPs include the Indian Health Service, Tribes and Tribal health organizations, and urban Indian organizations; and

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 These requirements generally apply in states with a Federally-Facilitated Marketplace (FFM) or State Partnership Marketplace (SPM). States with a State-Based Marketplace (SBM) or State-Based Marketplace on the Federal Platform (SBM-FP) in some cases have flexibility to impose different requirements. A listing of current state designations can be found at: <https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

³ A listing of these and other requirements for QHP issuers as they relate to IHCPs appears in Attachment A.

⁴ See 45 CFR 156.230.

⁵ See 45 CFR 156.235. ECPs include providers that serve predominantly low-income and medically underserved individuals. ECPs are providers described in Public Health Service Act section 340B and Social Security Act section 1927(c)(1)(D)(i)(IV).

- FQHCs include “an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services”⁶ (i.e., outpatient programs of T’s and U’s).

As stipulated by CMS, to meet these requirements, QHP issuers must contract with at least 20% of available ECPs located in a plan service area.^{7, 8}

“GOOD FAITH” CONTRACT OFFERS TO IHCPs: PAYMENT RATES AND QHP ADDENDUM

Federal regulations require QHP issuers to offer contracts in good faith to:

- At least one ECP in each ECP category⁹ in each county located in a plan service area, where an ECP in that category is available and provides medical or dental services covered by the plan¹⁰; and
- ***All available IHCPs*** located in a plan service area—including the Indian Health Service (IHS), Tribes and Tribal organizations, and urban Indian organizations (UIOs).¹¹

To qualify as a “good faith” offer, QHP issuers must “offer contract terms comparable to terms that it offers to a similarly-situated non-ECP provider, except for terms that would not be applicable to an ECP, such as by virtue of the type of services that an ECP provides”; CMS expects QHP issuers to have the ability to provide verification of good faith contract offers if the agency seeks to verify compliance with this policy.¹²

In addition, Federal regulations stipulate that ***QHP issuers must offer contracts to IHCPs that*** apply the special terms and conditions necessitated by federal law and regulations as referenced in the recommended model QHP Addendum for IHCPs.^{13,14}

MODEL QHP ADDENDUM FOR IHCPs

The Model QHP Addendum (Addendum) was created through a joint effort of CMS and Tribal representatives. The purpose of this Addendum for IHCPs is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement between the QHP issuer and

⁶ See Social Security Act (SSA) section 1905(l)(2)(B).

⁷ Under the Market Stabilization final rule issued on April 18, 2017, CMS relaxed this requirement from 30% to 20% percent for 2018. CMS has retained this policy in subsequent years.

⁸ A plan service area is a geographic area where a health insurance plan accepts members if it limits membership based on where people live.

⁹ The ECP categories are: FQHCs, Ryan White providers, family planning providers, IHCPs, hospitals, and other ECPs (defined as STD clinics, TB clinics, hemophilia treatment centers, black lung clinics, community mental health centers, rural health clinics, and other entities that serve predominantly low-income, medically underserved individuals).

¹⁰ See 45 CFR 156.235(a)(ii)(B).

¹¹ See 45 CFR 156.235(a)(2)(ii)(A).

¹² See the CMS guidance titled “Addendum to 2018 Letter to Issuers in the Federally-facilitated Marketplaces” and dated February 17, 2017, at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf>.

¹³ See 45 CFR 156.235(a)(ii)(A).

¹⁴ The Model QHP Addendum is available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Model_QHP_Addendum_Indian_Health_Care_Providers_PY2017.pdf. Note: QHP issuers do not have to use the actual Model QHP Addendum in contracts with IHCPs, but they must incorporate its elements.

an IHCP. Further, to the extent that any provision of the QHP issuer's network provider agreement or any other addendum thereto is inconsistent with any provision of the Addendum, the provisions of the Addendum supersede all such other provisions. In short, the Addendum is designed to assist QHP issuers in complying with applicable federal laws that pertain to IHCPs.

The Addendum provides a listing of definitions of applicable terms as well as a listing of applicable federal laws. The Addendum also identifies persons eligible for services from IHCPs. In addition, the Addendum provides explanations of common issues as they pertain to IHCPs, such as insurance and indemnification and licensure of health care professionals. Although the Addendum is not required to be incorporated into provider contracts in the same form as is the Addendum, the content of the Addendum is to be included in any contract between a QHP issuer and an IHCP.

MINIMUM PAYMENT RATES FOR FQHCs

Federal regulations also impose ***specific requirements on payment rates from QHP issuers to FQHCs.*** (Under the federal Medicaid statute, the definition of an FQHC includes Tribal and UIO clinics.)¹⁵ 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.”¹⁶ See Attachment B for the full text of SSA section 1902(bb).

FQHCs typically receive Medicaid payments based on a rate determined by a state using a prospective payment system (PPS) methodology. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act established a PPS methodology for Medicaid FQHCs in all states. The Medicaid FQHC payment rate is determined based on two components:

- **PPS base rate:** The law required states to set a per-visit payment rate for each Medicaid FQHC based on the average costs incurred by each FQHC during FY 1999 and FY 2000. The base rate was composed of the allowable capital cost per visit and the lesser of the allowable operating cost per visit or the peer group operating cost ceiling per visit. Payment rates for Medicaid FQHCs established after FY 2001 are (initially) based on either the average of other FQHCs in the same or adjacent areas or (subsequently) determined through facility-specific cost reporting.
- **Adjustments:** States use the Medicare Economic Index (MEI), a measure of medical practice cost inflation, to adjust the Medicaid FQHC payment rate annually. States also must adjust the payment rate for each FQHC to reflect changes in scope of services included in the (FQHC) encounter rate.

Apart from the PPS payment methodology discussed above, SSA section 1902(bb)(6) allows states and FQHCs to agree to ***use an alternative payment methodology*** (APM) in determining the Medicaid FQHC payment rate, meaning, for example, that states can use the OMB encounter rate, rather than the PPS rate, to set payments for Tribal clinics (as long as the APM rate is higher than the standard FQHC payment rate).¹⁷ As such, in cases in which a Tribal program bills Medicaid as an FQHC and receives the OMB encounter rate

¹⁵ These payments rates from QHPs apply to outpatient health programs or facilities operated by a Tribe or Tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by a UIO receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services. See SSA section 1905(l)(2)(B).

¹⁶ See 45 CFR 156.235(e).

¹⁷ A Tribal clinic is permitted to bill as an FQHC under Medicaid (Medicaid FQHC) and at the same time is permitted not to bill as an FQHC under Medicare (Medicare FQHC).

under the APM option for covered Medicaid services, and the Tribal program contracts with a QHP issuer, the QHP issuer generally would have to pay this facility at the OMB encounter rate.

It is worth noting that a Medicaid 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.¹⁸ 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 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.¹⁹

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.

¹⁸ See CMS guidance titled “Addendum to 2018 Letter to Issuers in the Federally-facilitated Marketplaces” and dated February 17, 2017.

¹⁹ 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 Tribal clinics at the FQHC rate if the Tribal clinic is actually/currently paid under Medicaid as a Tribal FQHC for covered services provided to Medicaid enrollees.

TRIBAL CLINICS OPTING TO BILL MEDICAID AS TRIBAL FQHC

The standard FQHC PPS rate is facility-specific (based on the costs at the facility) and can be somewhat burdensome for many smaller clinics to calculate. Many Tribal clinics elect not to bill as an FQHC due to the burden of generating cost reports, and due to the fact that the OMB encounter rate is higher than the rate they would receive if electing to bill as an FQHC. With regard to securing the FQHC minimum payment protections for services provided to Marketplace plan enrollees, Tribal clinics might be hesitant to bear the transaction costs of generating cost reports to bill as an FQHC solely for the purpose of generating a rate that a QHP must pay—particularly if not many of their Tribal clinic patients are enrolled in coverage through the Marketplace. But, in contrast to payment of the standard FQHC PPS rate, if the Tribal provider and the state agree to the use of the OMB encounter rate under the APM option when billing as a Tribal FQHC (and the Medicaid State Plan is changed to reflect this), the Tribal FQHC would not be required to generate an annual cost report in order to bill as a Tribal FQHC.

As such, if an APM is in place—permitting a Tribal facility to choose to bill as a Tribal FQHC under Medicaid and to receive the OMB encounter rate for Marketplace enrollees—there might be a substantial financial benefit for a Tribal clinic to elect to bill Medicaid as a Tribal FQHC under an OMB encounter rate APM. This option to bill as a Medicaid Tribal FQHC could be particularly beneficial for Tribes and Tribal health organizations that are “sponsoring” Active Users in Marketplace coverage and as a result serve a significant number of Marketplace enrollees. In addition to Marketplace revenues, for Medicaid billing purposes, billing as a Tribal FQHC can enable the Tribal clinic to receive payment for services provided outside the physical four walls of the Tribal clinic, which otherwise might not be reimbursable.²⁰ Conversely, though, if electing the Tribal FQHC status for Medicaid billing purposes, it is important to ensure there that other program restrictions are not imposed by a state that are detrimental to the Tribal clinic providing, and being paid for, services to Medicaid enrollees.

RIGHT OF RECOVERY FOR IHCPs

In addition to the protections for IHCPs discussed above, IHCIA section 206, as amended by the ACA, stipulates that an IHCP can bill a QHP issuer for covered services provided to plan enrollees, regardless of whether the IHCP participates in the provider network of the plan.²¹ Specifically, IHCIA section 206 provides for a right of recovery from insurance companies and other third-party entities, including QHP issuers, for (a) reasonable charges billed by an IHCP when providing services, or, if higher, (b) the highest amount the third party would pay for services furnished by other providers.²² Additional details on the IHCIA are available on the IHS Web site at <http://www.ihs.gov/ihcia>.

²⁰ See TSGAC briefing paper on the topic of the “Four Walls Limitations” at <https://www.tribalseg.gov/wp-content/uploads/2019/11/TSGAC-Brief-CMS-Restrictions-on-Billing-Medicaid-for-Services-Outside-Four-Walls-2019-11-21b.pdf>.

²¹ This protection applies in all Marketplaces, including SBMs and SBM-FPs.

²² IHCIA section 206 (25 U.S.C. 1621e) specifies that “an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such by a nongovernmental provider; and (2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.”

Attachment A: CCIIO Marketplace Matrix

CMS Policies on Select Health Insurance Marketplace Issues, 2014-2020

Except where noted, qualified health plan (QHP) issuer requirements apply to Federally-Facilitated Marketplaces (FFMs), including the newly created State-Based Marketplaces on the Federal Platform (SBM-FPs),²³ but not State-Based Marketplaces (SBMs).

Issue	2014	2015	2016	2017	2018	2019	2020
Essential community providers (ECPs)							
Contract offers to Indian health care providers (IHCPs)	QHP issuers must make contract offers to all available IHCPs to meet the ECP standard. If not meeting this standard, a QHP issuer must provide an explanation of the reasons why and the	QHP issuers must make <u>good faith</u> contract offers to all available IHCPs to meet the ECP standard. <u>When required to submit a narrative justification because did not meet the 30%</u>	QHP issuers must make good faith contract offers to all available IHCPs to meet the ECP standard. When required to submit a narrative justification because did not meet the 30%	Language same as previous year.	Language same as previous year.	Policy same as previous year.	Policy same as previous year.

²³ This Marketplace model, newly established in the HHS Notice of Benefit and Payment Parameters for 2017, will enable SBMs to execute certain processes using the federal eligibility enrollment infrastructure (namely, HealthCare.gov). SBM-FPs and HHS will have to enter into a federal platform agreement that will define a set of mutual obligations, including the set of federal services upon which the SBM-FP agrees to rely. Under this model, certain requirements previously only applicable to QHPs offered on FFMs will apply to QHPs offered on SBM-FPs, such as the requirement for QHP issuers to offer contracts to all IHCPs. SBM-FPs must agree to enforce certain QHP and QHP issuer requirements no less strict than those HHS applies to QHPs and QHP issuers in FFMs, as follows:

- 45 CFR 156.122(d)(2): the standards for QHPs to make available published up-to-date, accurate, and complete formulary drug lists on its website in a format and at times determined by HHS;
- 45 CFR 156.230: network adequacy standards;
- 45 CFR 156.235: ECP standards;
- 45 CFR 156.298: meaningful difference standards;
- 45 CFR 156.330: issuer change of ownership standards;
- 45 CFR 156.340(a)(4): issuer compliance and compliance of delegated and downstream entity standards; and
- 45 CFR 156.1010: casework standards.

CMS Policies on Select Health Insurance Marketplace Issues, 2014-2020

Except where noted, qualified health plan (QHP) issuer requirements apply to Federally-Facilitated Marketplaces (FFMs), including the newly created State-Based Marketplaces on the Federal Platform (SBM-FPs),²³ but not State-Based Marketplaces (SBMs).

Issue	2014	2015	2016	2017	2018	2019	2020
	corrective actions (to be) taken. CMS may verify the offering of contracts after certification.	<u>ECP contracting requirement, must attest to making good faith contract offers to all available IHCPs.</u> <u>In application, issuer to list the contract offers that it has extended to all available Indian health providers.</u>	ECP contracting requirement, <u>do not have to attest to making good faith contract offers to all available IHCPs.</u> <u>CMS will expect issuers to be able to provide verification of such offers if CMS requests to verify compliance with the policy.</u>				
Definition of good faith contract offers to ECPs	Not discussed.	QHP issuers must offer contract terms that a “willing, similarly-situated, non-ECP provider would accept or has accepted.”	Language same as previous year.	QHP issuers must “offer contract terms <u>comparable to terms that it offers to a similarly-situated non-ECP provider.</u> ” ²⁴	Language same as previous year.	Policy same as previous year.	Policy same as previous year.

²⁴ For Stand Alone Dental Plans (SADPs), the CCIIO Issuer Letter uses the same terminology for what is a “good faith offer” as used in the 2015 and 2016 Issuer Letters, namely “QHP issuers must offer contract terms that a willing, similarly-situated, non-ECP provider would accept or has accepted.”

CMS Policies on Select Health Insurance Marketplace Issues, 2014-2020

Except where noted, qualified health plan (QHP) issuer requirements apply to Federally-Facilitated Marketplaces (FFMs), including the newly created State-Based Marketplaces on the Federal Platform (SBM-FPs),²⁵ but not State-Based Marketplaces (SBMs).

Issue	2014	2015	2016	2017	2018	2019	2020
Payment rates to FQHCs, including Tribal and urban Indian clinics ²⁵	Not discussed.	For covered services provided by an FQHC, 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 for such item or service.”	Language same as previous year.	Language same as previous year.	Language same as previous year.	Policy same as previous year.	Policy same as previous year.
Inclusion of Model QHP Addendum (Addendum) in contracts offered to IHCPs	QHP issuer contract offers to IHCPs must use the Addendum to meet the ECP standard (CMS also notes that use of the Addendum is voluntary).	QHP issuers are to offer contracts “using the recommended model QHP Addendum for Indian health providers developed by CMS.” CMS “is continuing to recommend the	QHP issuer contract offers to IHCPs must “ <u>apply</u> ” the <u>special terms and conditions necessitated by federal law and regulations as referenced in the Model QHP Addendum.</u>	Language same as previous year.	Language same as previous year.	Policy same as previous year.	Policy same as previous year.

²⁵ These payment rates apply to outpatient health programs or facilities operated by a Tribe or Tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.

CMS Policies on Select Health Insurance Marketplace Issues, 2014-2020

Except where noted, qualified health plan (QHP) issuer requirements apply to Federally-Facilitated Marketplaces (FFMs), including the newly created State-Based Marketplaces on the Federal Platform (SBM-FPs),²³ but not State-Based Marketplaces (SBMs).

Issue	2014	2015	2016	2017	2018	2019	2020
		use of the Model QHP Addendum (Addendum) as described in the 2014 Letter to Issuers.” (CMS also notes that <u>use of the Addendum is expected</u>)	(Actual use of the Addendum is not required.)				
Inclusion of ECPs on HHS ECP List	HHS compiled a “non-exhaustive list of available ECPs” (HHS ECP List), based on data it and other federal agencies maintained, and allowed QHP issuers to include qualified providers not on the list when calculating whether they	Same as previous year.	Same as previous year.	To remain on the HHS ECP List, IHCPs and other ECPs must submit a revised entry to provide missing required data (IHCPs and other ECPs seeking placement on the list for the first time also must submit the petition). ²⁶ QHP	CMS will include on the HHS ECP List eligible providers that submitted an ECP petition during the ECP petition window. QHP issuers will be permitted to “write-in” providers not on HHS ECP List in order to satisfy requirement. ²⁸	Language same as previous year.	Language same as previous year.

²⁶ This requirement will apply in 2018; CCIIO relaxed this requirement for 2017. The 2017 HHS ECP List included available ECPs based on data maintained by CMS and other federal agencies, as well as provider data that CMS received directly from providers through the ECP petition process for the 2017 plan year.

²⁸ The 2018 Issuer Letter called for the elimination of the “write-in” process; however, the Market Stabilization final rule issued on April 18, 2017, allowed issuers to continue to identify ECPs through this process, provided that the issuers arranged for these providers to submit an ECP petition to HHS by no later than the deadline for issuer submission of changes to their QHP application.

CMS Policies on Select Health Insurance Marketplace Issues, 2014-2020

Except where noted, qualified health plan (QHP) issuer requirements apply to Federally-Facilitated Marketplaces (FFMs), including the newly created State-Based Marketplaces on the Federal Platform (SBM-FPs),²³ but not State-Based Marketplaces (SBMs).

Issue	2014	2015	2016	2017	2018	2019	2020
	met the ECP standard.			issuers will no longer be permitted to “write-in” providers not on HHS ECP List in order to satisfy requirement. ²⁷			
Hardship exemption (from shared responsibility payment): Eligibility determination and claiming exemption (i.e., exemption from individual mandate penalty)	Tribal members and IHS-eligible individuals can apply for an exemption through the Marketplace. In addition to Tribal members who can establish eligibility for an exemption through the federal tax-filing process, IHS eligible persons are provided that option as well (applicable for 2014 and	Policy same as previous year.	Policy same as previous year.	The Marketplace will no longer make eligibility determinations for exemptions based on Tribal membership or IHS eligibility. (New) eligibility determinations are made only through tax-filing process. AI/ANs who already have received an exemption certificate number (ECN) from the Marketplace can	Policy same as previous year. (Shared responsibility payment/ individual mandate penalty reduced to \$0 in enacted 2017 tax bill.)	Policy same as previous year.	Policy same as previous year.

²⁷ As a transition to this new policy, CMS allowed issuers to count their qualified ECP write-ins toward satisfaction of the 30 percent ECP standard for plan year 2017 as long as the issuer arranged that the written-in provider had submitted an ECP petition to CMS by no later than August 22, 2016.

CMS Policies on Select Health Insurance Marketplace Issues, 2014-2020

Except where noted, qualified health plan (QHP) issuer requirements apply to Federally-Facilitated Marketplaces (FFMs), including the newly created State-Based Marketplaces on the Federal Platform (SBM-FPs),²³ but not State-Based Marketplaces (SBMs).

Issue	2014	2015	2016	2017	2018	2019	2020
	subsequent years). Persons in either category each claim exemption through tax-filing process. (In regulations, not Issuer Letter.)			continue to use their ECN on their federal income tax return to claim this exemption until such time that they no longer qualify for the exemption. (In regulations, not Issuer Letter.)			
Network adequacy							
Inclusion of certain percentage of available ECPs ²⁹	QHP issuers must <u>contract</u> with at least 20% of available ECPs in the service area of their plan(s).	QHP issuers must <u>contract</u> with <u>at least 30%</u> of available ECPs in the service area of their plan(s).	Language same as previous year.	Language same as previous year.	QHP issuers must <u>contract</u> with <u>at least 20%</u> of available ECPs in the service area of their plan(s). ³⁰	Language same as previous year.	Policy same as previous year.
Inclusion of at least one ECP from each category in each county	QHP issuers must <u>offer contracts</u> in good faith to at least one ECP in each ECP category in each county in the	Language same as previous year.	Language same as previous year.	Language same as previous year.	Language same as previous year.	Policy same as previous year.	Policy same as previous year.

²⁹ Also, see discussion under “Inclusion of ECPs on HHS ECP List” under “ECPs” above.

³⁰ Under the Market Stabilization final rule issued on April 18, 2017, CMS relaxed this requirement from 30 percent to 20 percent for 2018.

CMS Policies on Select Health Insurance Marketplace Issues, 2014-2020

Except where noted, qualified health plan (QHP) issuer requirements apply to Federally-Facilitated Marketplaces (FFMs), including the newly created State-Based Marketplaces on the Federal Platform (SBM-FPs),²³ but not State-Based Marketplaces (SBMs).

Issue	2014	2015	2016	2017	2018	2019	2020
	service area of their plan(s), where available.						
Provider directory information on IHCPs	QHP provider directories should include information about whether the provider is an IHCP.	QHP provider directories should include information about whether the provider is an IHCP, <u>and directory information for IHCPs should describe the population they serve, as some IHCPs might limit services to AI/ANs.</u>	Not discussed.	Not discussed.	Not discussed.	Not discussed.	Not discussed.
Summary of Benefits and Coverage (SBC) ^{31,32,33}	QHP issuers must prepare an SBC for their plans.	QHP issuers must prepare an SBC for their plans <u>but do not have</u>	QHP issuers must prepare an SBC for their plans and <u>must</u>	Language same as previous year.	Language same as previous year. ³⁴	Policy same as previous year.	Policy same as previous year.

³¹ This requirement generally applies to both FFMs and SBMs, as well as outside the Marketplace.

³² In April 2016, CMS finalized a new sample SBC template, which issuers had to begin using on the first day of the first open enrollment period that started on or after April 1, 2017 (effectively the 2018 plan year).

³³ CMS on July 13, 2016, released sample SBC templates for a limited cost-sharing variation (L-CSV) plan and a zero cost-sharing variation (Z-CSV) plan. CMS posted these documents on the CCIIO Web site and shared them with QHP issuers as a reference tool, but issuers do not have to use these templates. The sample L-CSV SBC is available at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SBC-2017-Template-AI-AN-limited-6-7-16-clean-508-MM.PDF>. The sample Z-CSV SBC is available at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SBC-2017-Template-AI-AN-zero-6-7-16-clean-508-MM.PDF>.

CMS Policies on Select Health Insurance Marketplace Issues, 2014-2020

Except where noted, qualified health plan (QHP) issuer requirements apply to Federally-Facilitated Marketplaces (FFMs), including the newly created State-Based Marketplaces on the Federal Platform (SBM-FPs),²³ but not State-Based Marketplaces (SBMs).

Issue	2014	2015	2016	2017	2018	2019	2020
		<u>to prepare an SBC for each plan variation, such as the zero cost-sharing variation and the limited cost-sharing variation.</u>	prepare an SBC for each plan variation, such as the zero cost-sharing variation and the limited cost-sharing variation.				
Tribal sponsorship of premiums (third-party payment of premiums and cost-sharing)	In § 156.1250, CMS “requires issuers of QHPs... to accept premium and cost-sharing payments made on behalf of enrollees by... Indian tribes, tribal organizations, and urban Indian organizations.” (In regulations, not Issuer Letter.)	Language same as previous year (in regulations, not Issuer Letter).	Added reference to regulations (45 CFR § 156.1250) in Issuer Letter.	Policy same as previous year. (Regulations at 45 CFR § 156.1250 remain in place.) ³⁵	Issuers “offering individual market QHPs, including SADPs, and their downstream entities, must accept premium and cost-sharing payments on behalf of QHP enrollees from ... [a]n Indian tribe, tribal organization, or urban Indian organization.”	Policy same as previous year.	Policy same as previous year.

³⁴ The Issuer Letter reads (on page 82), “With advice and input received through tribal consultation, CMS released sample completed SBCs for an AI/AN limited cost-sharing plan and an AI/AN zero cost-sharing plan. As with the other SBC documents, these documents are posted to the CMS website and can be used as a resource for issuers to develop SBCs for AI/AN consumers in zero cost-sharing or limited cost-sharing plans.”

³⁵ In the HHS Notice of Benefit and Payment Parameters for 2017, CMS proposed, but ultimately did not adopt, a policy that would have required Tribes (and other entities) that engage in sponsorship to notify HHS, indicating their intent to sponsor individuals and the number of individuals they intend to sponsor.

CMS Policies on Select Health Insurance Marketplace Issues, 2014-2020

Except where noted, qualified health plan (QHP) issuer requirements apply to Federally-Facilitated Marketplaces (FFMs), including the newly created State-Based Marketplaces on the Federal Platform (SBM-FPs),²³ but not State-Based Marketplaces (SBMs).

Issue	2014	2015	2016	2017	2018	2019	2020
	<p>In Issuer Letter, CMS noted that it assessed its various systems to determine how FFMs could establish a process to facilitate sponsorship and concluded FFMs do not have the ability to establish such a process.</p> <p>CMS encourages T/TO/Us to work with SBMs and QHPs to facilitate aggregate premium payments.</p>						

Sources: CCIIO Letter to Issuers in the Federally Facilitated Marketplaces, 2014-2020, and other CMS/CCIIO regulations and guidance.

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf>

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf>

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf>

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2020-Letter-to-Issuers-in-the-Federally-facilitated-Exchanges.pdf>

Attachment B: Text of SSA Section 1902(bb)

(bb) Payment for Services Provided by Federally-Qualified Health Centers and Rural Health Clinics.—

(1) In general.—Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

(2) Fiscal year 2001.—Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3) Fiscal year 2002 and succeeding fiscal years.—Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) Establishment of initial year payment amount for new centers or clinics.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) Administration in the case of managed care.—

(A) In general.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic by

the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

(B) Payment schedule.—The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6) Alternative payment methodologies.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.