DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: Emergent Care Section I-6-17

DESCRIPTION: Effective for dates of service on or after May 1, 2018, four primary care visits per state fiscal year to a hospital based walk-in clinic or hospital based emergent care center will no longer require a referral from a primary care physician if the beneficiary has not yet been assigned a primary care physician. These visits still count toward existing benefit limits.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on February 8, 2018. The Department received no comments.

The proposed effective date is May 1, 2018.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Department of Human Services is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated §20-76-201 (12). Arkansas Code §20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

Act 546 of 2017, sponsored by Representative Aaron Pilkington, mandates that the Arkansas Medicaid Program provide for reimbursement for up to four (4) healthcare visits per year at an emergent care clinic or a walk-in clinic when the Medicaid beneficiary does not have a primary care provider assigned if the walk-in clinic or emergent care is associated with a hospital. *See* Ark. Code Ann. §20-77-132 (Supp. 2017). Under Arkansas law, an "emergent care clinic" is a walk-in clinic focused on the delivery of ambulatory care in a facility outside of traditional emergency care, and a "walk-in clinic" is a medical clinic that accepts patients on a walk-in basis without an appointment. *See* Ark. Code Ann. §20-77-132 (Supp. 2017).

Ownership Models
- Hospitals
- Multi-Specialty Physician Practice Groups
- Private Equity/Joint Ventures

EMTALA Requirements
Medical Screening Exam (MSE); and
Treatment or necessary stabilization before transfer or discharge
An MSE and treatment or stabilization must be provided regardless of the patient's ability to pay
Regulations contain specific EMTALA requirements

Application of EMTALA

Treatment obligations of EMTALA do not apply unless the urgent care center is owned by a hospital or in a joint venture with a hospital and services provided are billed as a department of the hospital ♦ No obligation to treat patients who arrive at the center ♦ Triage policy – stabilize and transport

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

Medical Liability Mutual Insurance Company (MLMIC) points out that the decision focused on whether the **urgent care clinic** fell within the definition of a "dedicated emergency department" of the hospital, per definitions established by the Centers for Medicare and Medicaid Services.

EMTALA

Because urgent care centers often provide what some consider emergency care, whether an urgent care center must comply with the requirements of EMTALA (the Emergency Medical Treatment and Labor Act) is a frequently asked question. Generally speaking, the answer is no. Under EMTALA, hospitals with dedicated emergency departments must provide certain services to patients who present at the emergency room, regardless of the patient's ability to pay. The hospital must provide a medical screening examination to determine whether an emergency medical condition exists and then must treat the patient or stabilize the patient so he or she may be transferred.

If an urgent care center is not owned in whole or in part by a hospital, it is not subject to EMTALA and, as a general rule, there is no obligation to treat patients who arrive at the center. It is a good idea for the center to have a policy on how to handle patients who are not able to pay for services, but the center is not required to treat such patients under EMTALA. If a facility is a department of a hospital on the hospital campus, then the center must comply with EMTALA obligations. For urgent care centers owned by hospitals or in joint ventures with hospitals, EMTALA requirements must be carefully researched to ensure compliance with the regulations

Confusion sometimes arises from urgent care facilities over which Place of Service (POS) code to use in billing.

Back in 2003 the Centers for Medicare and Medicaid Services created the "Urgent Care Facility" designation as POS-20, defined as "a location distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention."

The claims adjudication system is built around these identifiers (NPI, TIN, POS, etc), and they all affect reimbursement for urgent care centers, explains Kelly Mattingly, Director of Contracting and Credentialing at Practice Velocity.

There are several benefits for an urgent care to use POS -20. It establishes a track record of urgent care utilization in a particular market that justifies a higher payment scale for all urgent care centers. And, being recognized as an urgent care facility in contracting is useful when negotiating higher rates based on the extra costs of operating a walk-in facility.

Here are some points to consider when sorting through the issue of coding with POS-20 or POS-22, an outpatient hospital, or POS-11, a physician's office.

CMS Guidelines

Most insurance plans follow CMS guidelines, so unless an insurance contract specifies that the urgent care facility should bill as POS-11 the center should use POS-20.

Contracts

If a provider uses the incorrect code based on what's in their contract, claims may be denied, processed at an incorrect rate, or processed with an incorrect copay, said Monica Klosa, Director of PV Billing. If an urgent care center is set up in a payer's system as a physician's office, then claims using POS-20 may be rejected. It's important to verify with each payer which POS code to use.

Reimbursement

If an urgent care center is affiliated with a physician's office or multi-specialty group, it should consider whether reimbursement will be higher using POS-20 or POS-11. That depends on several factors:

1. Does the urgent care bill with its own Tax ID# or that of the physician practice that owns the facility?
2. Are insurance contracts negotiated separately for the urgent care or as a package for the entire practice?
3. Do providers who are seeing urgent care patients also practice in the physician office or multi-specialty group that owns the facility?
4. Is a different co-pay charged because patients are being seen as a specialist or urgent care facility (as opposed to a regular office visit)?

Conclusion

While there are benefits to using the POS-20 code instead of POS-11, there are important steps to consider before simply changing the billing number. The most important consideration is to verify that the code you use aligns with the type of service provided by your clinic and what is designated in the contracts. "Otherwise claims will not pay appropriately," Mattingly said. Work closely with your payers and verify contracts to make sure you don't pay the price down the road.

How do states reimburse Rural Health Clinics for Medicaid?

All state Medicaid programs are required to recognize RHC services. The states may reimburse RHCs under one of two different methodologies.

The first is a prospective payment system. Under this methodology, the state calculates a per visit rate based on the reasonable costs for an RHCs first two years of operation. For each succeeding year, this per visit baseline rate is increased by the Medicare Economic Index factor.

The second methodology is an Alternative Payment Methodology. Under this methodology, there are only two requirements: 1) the clinic must agree to the methodology, and 2) the payment must at least equal the payment it would have received under the prospective payment system.

Medicaid agencies also may cover additional services that are not normally considered RHC services, such as dental services.

For more information about state Medicaid benefits for RHC services, see this state-by-state guide to Medicaid benefits from the Kaiser Family.

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Medical Services

DIVISION DIRECTOR Rose Naff

CONTACT PERSON Cathy Coffman

ADDRESS PO Box 1437, Slot S295 Little Rock AR.72203

PHONE NO. 501-537-1670 **FAX NO.** 501-404-4619 **E-MAIL** cathy.coffman@arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Tami Harlan

PRESENTER E-MAIL tami.harlan@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

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1. What is the short title of this rule? Emergent Care/Section I-6-17

2. What is the subject of the proposed rule? Effective April 1, 2018, a beneficiary may receive up to four (4) primary care visits per state fiscal year when performed by a hospital based walk-in or emergent care clinic without a PCP referral if the beneficiary has not been assigned to a primary care physician.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐

If yes, please provide the federal rule, regulation, and/or statute citation. Act 546 of the 91st General Assembly

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒

If yes, what is the effective date of the emergency rule?

When does the emergency rule expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. AR Statute 20-76-201

7. What is the purpose of this proposed rule? The purpose of this rule is to allow a beneficiary to receive up to four (4) primary care visits per state fiscal year when performed by a hospital based walk-in or emergent care clinic without a PCP referral if the beneficiary has not been assigned to a primary care physician.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b). www.medicaid.state.ar.us/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☐ No ☒
If yes, please complete the following:

Date: _____
Time: _____
Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
February 8, 2018

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
April 1, 2018

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. (see attached)

13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library required pursuant to Ark. Code Ann. § 25-15-204(e). (see attached)

required pursuant to Ark. Code Ann. § 25-15-204(e). (see attached)

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. All Medicaid providers will be for this change.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE 501-537-2064 **FAX** 501-404-4619 **EMAIL:** Brian Jones @dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Emergent Care/Section I-6-17

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	0	Total	0

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year

Next Fiscal Year

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year

$ 0

Next Fiscal Year

$ 0

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
   (a) justifies the agency's need for the proposed rule; and
   (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

SUMMARY FOR FOUR VISIT-NO REFERRALS

Effective for dates of service on or after April 1, 2018 four primary care visits per state fiscal year to a hospital based walk-in clinic or hospital based emergent care center will no longer require a referral from a primary care physician; if the beneficiary has not yet been assigned a primary care physician. These visits still count toward existing benefit limits.