
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)

January 18, 2017

On February 26, 2016, the Center for Medicaid and CHIP Services (CMCS) issued a [State Health Official letter](#) (SHO) to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. Under the updated policy, IHS/Tribal facilities may enter into written care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries. Amounts paid by the state Medicaid program for services requested by facility practitioners in accordance with those agreements are eligible for federal matching funds at the enhanced federal matching rate (FMAP) of 100 percent.

This FAQ document addresses common questions related to the provisions at pages 5-6 of the SHO letter relating to Medicaid billing and payments to non-IHS/Tribal providers. Questions related to other provisions of the SHO letter will be addressed in subsequent FAQs.

Q1. When services are furnished to an AI/AN Medicaid beneficiary by a non-IHS/Tribal provider under the terms of a written care coordination agreement with an IHS/Tribal facility that meets the requirements of the SHO letter, what are the options for billing for the services?

A1. There are two options for billing the state Medicaid program. The first is for the non-IHS/Tribal provider to bill the state Medicaid program directly. In this case, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and the service rendered, not at the facility rate that the IHS/Tribal facility would receive. The second option is for the IHS/Tribal facility to enter into an arrangement with the non-IHS provider, under which the provider assigns its claim for payment to the facility in return for payment from the facility, and the facility bills the state Medicaid program for the service. In that case, the IHS/Tribal facility would have to identify services provided by non-IHS/Tribal providers under the care coordination agreement that are within the scope of covered services of the IHS/Tribal facility and separate them from those services that are not. The facility can claim and receive reimbursement from the state for services that can properly be claimed as services of the IHS/Tribal facility (“IHS/Tribal facility services”) at the facility rate authorized under the Medicaid state plan. The facility would be directly responsible to the extent of any overpayments resulting from such services that were not, in fact, covered under the state plan. The facility can claim and receive reimbursement from the state for those services that do not qualify as IHS/Tribal facility services at the rate under the Medicaid state plan applicable to the provider type and service rendered. The circumstances under which off-site services may be considered facility services are described in the response to question number four.

Q2. If the non-IHS/Tribal provider is willing to accept the Medicaid program payment rate for his or her service, is there any reason for the IHS/Tribal facility to bill the state Medicaid program for the service at the facility rate?

A2. No. In this circumstance, the first option above could apply. The non-IHS/Tribal provider could bill the state directly at his or her provider rate, the IHS/Tribal facility would not have to bill the state at the facility rate on the non-IHS/Tribal provider's behalf and the remaining FAQs would not be relevant.

Q3. Does the availability of 100 percent FMAP depend on whether the service furnished by the non-IHS/Tribal provider is billed directly by the non-IHS/Tribal provider or by the IHS/Tribal facility?

A3. No. If all of the requirements of the SHO letter are met, then federal matching funds are available to the state at the 100 percent rate for the amount paid by the state Medicaid program, regardless of whether the service is billed directly by the non-IHS/Tribal provider or by the IHS/Tribal facility. This is a separate issue than the amount paid by the state for the service, which will depend on the provider type and service rendered.

Q4. When may IHS/Tribal facilities claim services furnished by non-IHS/Tribal providers delivering services offsite under written care coordination agreements as IHS/Tribal facility services at the facility rate?

A4. As stated in the SHO letter, the circumstances under which IHS/Tribal facilities may claim services as their own are the same as those that apply for other similar facilities in the state (e.g., inpatient or outpatient hospitals, nursing facilities, clinics, Federally Qualified Health Centers, etc.). For IHS facilities, services furnished by non-IHS providers outside of an IHS facility generally cannot be claimed as IHS facility services. For Tribal facilities, whether services furnished by non-Tribal providers can be billed as facility services depends on whether the Tribal facility is enrolled in the state Medicaid program as a provider of "clinic services" or as a Federally Qualified Health Center (FQHC). If the Tribal facility is enrolled in the state Medicaid program as a provider of "clinic services", the Tribal facility may not bill for the services furnished outside the facility by a non-Tribal provider at the facility rate for clinic services even if a written care coordination agreement is in place. The reason is that, as CMS has interpreted section 1905(a)(9) of the Social Security Act in its regulation at 42 CFR 440.90, "clinic services" do not include services furnished outside of the "four walls" of the clinic, except if the services are furnished by clinic personnel to a homeless individual. If, on the other hand, the Tribal facility is enrolled in the state Medicaid program as an FQHC, and if the Tribal facility has a contract in effect with the non-Tribal provider, the Tribal facility may properly claim payment for services furnished outside of the facility by the non-Tribal provider at the facility rate. For example, if a Tribal FQHC contracts with a cardiologist whose practice is offsite, and if the cardiologist treats an AI/AN Medicaid beneficiary as a patient of the FQHC, the Tribal facility may bill the Medicaid program for the cardiologist's service at the facility rate, not at the Medicaid rate for that cardiologist's service, and 100 percent FMAP would apply to the state's payment for the service. A Tribal facility that is enrolled as a "clinic services" provider may enter into a written care coordination agreement with an off-site non-Tribal provider and bill the state Medicaid program for the services furnished as an assigned claim by that provider, but the payment rate for the service would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan Tribal facility rate.

Q5. Does the contract between a Tribal FQHC and an offsite non-Tribal provider need to meet the requirements of the written care coordination agreement under the SHO letter in order for the Tribal FQHC to bill the state for the services furnished to Medicaid beneficiaries at its facility rate?

A5. No. The contract between the Tribal FQHC and the offsite non-Tribal provider for this kind of arrangement is different than a written care coordination agreement; it must establish that the non-Tribal provider is a Tribal facility contractor furnishing services of the facility offsite. Since the services would be services of the Tribal facility for purposes of this Medicaid billing policy, we would expect that the Tribal facility would coordinate and monitor such services in the same manner as it does any other facility services. The amount paid by the state for these Tribal FQHC services to an AI/AN Medicaid beneficiary would qualify for 100 percent FMAP.

Q 6. For what services may a Tribal FQHC contract? If the contracting offsite non-Tribal provider is a specialist, may the services qualify as FQHC services?

A6. Yes. FQHC services are defined in section 1905(l)(2)(A) of the Social Security Act as “services of the type described in subparagraphs (A) through (C) of section 1861(aa)(1) when furnished to an individual as a patient of a Federally-qualified health center...” Section 1861(aa)(1)(A) describes “physicians services”, which include services furnished by specialists as well as those furnished by primary care physicians. As discussed in FAQ #4, above, the Tribal FQHC may bill for the services furnished by the contracting non-Tribal specialist at the Tribal FQHC’s facility rate, and the amount paid by the state for the FQHC service would qualify for 100 percent FMAP. For example, a Tribal FQHC could contract with a neurologist or orthopedist or dentist and bill for the services provided by those specialists at their offsite practice locations at the Tribal FQHC’s facility rate.

Q7. Most Tribal facilities are now enrolled in state Medicaid programs as “clinic services” providers. As explained in A4, if these Tribal facilities seek to bill for services furnished by off-site non-Tribal providers at the facility rate, they will have to bill for those services as FQHCs, not as “clinic services” providers. How does a Tribal facility change its provider enrollment designation to FQHC?

A7. Under section 1905(l)(2)(B) of the Social Security Act, outpatient health programs or facilities operated by a Tribe or Tribal organization under the Indian Self-Determination Act (Public Law 93-638) are by definition FQHCs. Tribal facilities may enroll in state Medicaid programs as FQHCs, but they are not required to do so. A Tribal facility that elects to enroll in a state Medicaid program as an FQHC bills Medicaid for covered services on a per-visit basis at a rate determined by the state Medicaid program using the Prospective Payment System (PPS) methodology, whether those services are furnished at the facility or by off-site providers under contract to the FQHC. The decision as to whether to enroll in the Medicaid program as a “clinic services” provider (to the extent that the state plan covers the optional clinic services benefit) or as an FQHC is solely that of the Tribal facility. Tribal facilities that wish to bill for services furnished to their AI/AN patients outside of their “four walls” will need to change their provider enrollment designation from “clinic” to FQHC by notifying their state Medicaid agency. The state will then need to determine the applicable FQHC payment rate under its state plan. The treatment of tribal clinics as FQHCs without any change in actual provider enrollment for purposes of the eligibility of physicians for Electronic Health Record (EHR) Incentive Payments, as indicated in a June 17, 2011 CMCS Information Bulletin, is not applicable for purposes of determining facility payment under the state plan.

Q8. Does a Tribal facility that wishes to change its provider enrollment designation to FQHC need to enroll in Medicare as an FQHC?

A8. No. An outpatient health program or facility operated by a Tribe or Tribal organization under P.L. 93-638 is qualified under the Medicaid statute to participate as an FQHC. There is no requirement that the facility enroll as an FQHC under the Medicare program. For purposes of being recognized as an FQHC by Medicaid, Tribal facilities need not meet any requirement other than being operated by a Tribe or Tribal organization under P.L. 93-638.

Q9. Does a Tribal facility that wishes to change its provider enrollment designation to FQHC need to meet the requirements for receipt of grant funds under section 330 of the Public Health Service Act or for designation as a “look alike” by the Health Resources and Services Administration (HRSA)?

A9. No. The Medicaid FQHC status of an outpatient health program or facility operated by a Tribe or Tribal organization under P.L. 93-638 is specified in the Medicaid statute. HRSA rules for receipt of section 330 grant funding or “look alike” status do not apply. A Tribal facility may in addition choose to apply for section 330 grant funding or for designation as a “look alike;” in this case, it must meet the relevant HRSA requirements. For purposes of being recognized as an FQHC by Medicaid, however, Tribal facilities need not meet any requirement other than being operated by a Tribe or Tribal organization under P.L. 93-638.

Q10. If a Tribal facility elects to enroll in the Medicaid program as an FQHC, what is its facility rate?

A10. In general, FQHCs are paid at rates that are based on the Prospective Payment System (PPS) methodology. However, under the authority of section 1902(bb)(6) of the Social Security Act, state Medicaid agencies and FQHCs have the ability to agree to use an Alternative Payment Methodology to determine rates. Under this authority, Tribal facilities and the state Medicaid agency may agree that the Tribal provider’s facility rate is the IHS All-Inclusive Rate (AIR) rather than the Tribal provider’s PPS rate. The AIR rate would apply to all of the Tribal facility’s Medicaid visits, not just those by AI/AN Medicaid beneficiaries; the 100 percent FMAP would apply only to the costs of facility visits by AI/AN beneficiaries.

Q11. May a State pay a Tribal facility at the AIR rate for services furnished to AI/AN beneficiaries and at the FQHC PPS rate for non-AI/AN beneficiaries?

A11. No. A Tribal facility may be only one type of provider (either a “clinic services” provider or an FQHC) and receive only one reimbursement rate that applies to all Medicaid beneficiaries. Whatever rate a Tribal FQHC facility and the state Medicaid agency agree upon, whether PPS or AIR, that same rate must be applied to all Medicaid beneficiaries who receive services through the facility.

Q12. What must the state Medicaid agency do to operationalize this change in provider enrollment designation?

A12. If a Tribal facility is enrolled in the state Medicaid program as a “clinic services” provider, and notifies the state agency that it wishes to change its designation to an FQHC, the state Medicaid agency must simply change the designation of the facility in its Medicaid Management Information System (MMIS) from clinic services provider to FQHC. The Tribal facility is not required to re-enroll in the program, and the state Medicaid agency is not required to process a new enrollment or re-screen the

facility. If the state Medicaid agency and one or more Tribal FQHCs agree to use the IHS AIR rate as the facility rate, the state agency will have to submit a state plan amendment (SPA) to designate payment for Tribal FQHC services at the IHS AIR as an Alternative Payment Methodology. The Medicaid agency will also be required to assign a PPS rate to the Tribal facility so that the agency can demonstrate on an annual basis that the APM is higher than the PPS rate. The Tribal facility would not be required to report its costs for purposes of establishing a PPS rate. Under 42 CFR 430.20(b)(2) and 42 CFR 447.256(c), an approved SPA will be effective not earlier than the first day of the calendar quarter in which an approvable amendment is submitted.

Q13. Some Tribal facilities enrolled in state Medicaid programs as “clinic services” providers have been billing at facility rates for services that are furnished by facility employees or non-Tribal providers outside the “four walls” of the facility (for example, behavioral health services provided to children in schools). Will CMS seek to recover overpayments from state Medicaid programs that pay for such “clinic services” at facility rates or from the Tribal facilities that bill for such “clinic services” at facility rates?

A13. As noted in Q4 above, the Medicaid statute and regulations require that “clinic services” be provided at the clinic – i.e., within the “four walls” of the facility – unless the beneficiary is homeless. Services furnished outside of the “four walls,” even services furnished by an off-site non-Tribal practitioner under a written care coordination agreement that meets the requirements of the SHO letter, may not be billed as “clinic services” or reimbursed at the facility rate (unless the beneficiary receiving the service is homeless). CMS recognizes that it has not given tribal-specific guidance on this issue or outreach, and that as a result policies and practices vary. CMS further recognizes that some states and tribes will need to make legislative or regulatory policy changes, provide public notice, define services, make systems changes, and potentially make programmatic and staffing changes. For this reason, CMS has no present intention to review claims by Tribal “clinic services” providers for services furnished outside of the “four walls” before January 30, 2021 unless there is clear evidence of bad faith efforts to engage in improper claiming procedures in violation of this guidance. Tribal facilities that are enrolled in Medicaid as “clinic services” providers and bill for services furnished outside the “four walls,” whether by facility employees or by non-Tribal providers under contract, will either need to discontinue billing for those services or change their enrollment status to FQHC before that date. If a Tribal facility wishes to change its enrollment status to FQHC, it should notify the state Medicaid agency of its intent to change its status no later than one year from the date of this letter. Tribal facilities that are enrolled in Medicaid as “clinic services” providers that do not bill for services furnished outside the “four walls” will not need to change their provider enrollment status.

Q14. In many IHS areas, the IHS or Tribes operate a hospital that has remote health centers or health stations on the reservation affiliated with it that bill for their services to AI/AN Medicaid beneficiaries through the hospital. Do the rules described above relating to “clinic services” apply to these health centers or clinics?

A14. In most cases, these health centers or health stations participate and are enrolled in Medicaid as outpatient departments of the hospital, not “clinic services” providers. The hospital, and not the health center or health station, would bill for the services furnished at the remote site as a hospital outpatient service. Hospital services are not affected by the “four walls” limitation on the “clinic services” benefit.

Q15. What billing and payment rules apply if the AI/AN Medicaid beneficiary is enrolled in a Medicaid managed care plan?

A15. The previous FAQs assume that the AI/AN Medicaid beneficiary is receiving services on a fee-for-service basis. In the case of beneficiaries that are enrolled in a Medicaid managed care organization (MCO), a prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), the following rules apply. As set forth in the SHO letter on page 6, the non-IHS Tribal provider with a care coordination agreement would have to participate in the MCO's or PIHP's or PAHP's provider network and would have to be paid at a rate consistent with the provider's contractual agreement with the managed care plan. However, if the Tribal facility elects to enroll in the state Medicaid program as an FQHC, the Tribal FQHC may properly bill the MCO for services furnished by a non-Tribal provider with which it contracts as a facility service. The rate of payment to the Tribal FQHC by the managed care plan would be the amount the plan pays an FQHC that is a network provider. The FQHC may also be entitled to a supplemental payment from the State Medicaid agency as required under sections 1902(bb) and 1932(h)(2)(C)(i) of the Social Security Act. This payment rule applies whether or not the Tribal facility participates in the provider network of the MCO, PIHP, or PAHP.