Health Care Reform in Indian Country
Self-Governance Communication & Education
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Clarification on Federal Policy and Next Steps for Tribal Health Care Facilities Billing Medicaid for Clinic Services Provided Outside of Their "Four Walls"[1]

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

Background

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

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

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

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

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

Impact of Policy

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

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

Possible Relief for Affected Tribal Health Care Facilities

Change in Designation to FQHC

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

Change in Medicaid Payment Rate

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

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

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

Other Differences Between Medicaid FQHC Services and Medicaid Clinic Services.

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

Grace Period

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

Next Steps

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

1. Begin working immediately with your state to identify all the differences between clinic and FQHC status, including scope of coverage, staffing, supervision, documentation, billing, and other requirements;

2. Evaluate the financial and programmatic pros and cons of making the change, beyond the ability to bill for off-site services at the encounter rate;

3. Reach an agreement with the state for Tribal FQHCs to use the encounter rate, rather than the PPS rate, in setting Medicaid payments for Tribal FQHCs;

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

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

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

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

Oklahoma example:

Oklahoma in March 2018 received approval from CMS for an SPA that sets Medicaid payments for IHS, Tribal, and urban Indian organization FQHCs (referred to in the SPA as "ITU-FQHCs") at the encounter rate.[7] The SPA, a simple one-page document, also specifies that the state Medicaid program will pay ITU-FQHCs more than one encounter rate per beneficiary per day when the beneficiary receives services for distinctly different diagnoses. Specifically, the SPA reads:

> "For qualified facilities operated by ITU providers that contract with the Medicaid agency as an FQHC, hereafter referred to as ITU-FQHC, an alternative payment method (APM) is allowed. The APM rate for services provided by an ITU-FQHC is set at the OMB rate. ... Reimbursement is made for an individual medical, dental, and outpatient behavioral health encounter per member per day. Reimbursement for more than one outpatient visit within a 24-hour period is made when services are provided for a distinctly different diagnosis."[8]

[7] See the Oklahoma SPA and the associated CMS approval letter at https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OK/OK-17-05.pdf.

[8] See the Oklahoma State Plan, Attachment 4.19-B, page 1g at http://www.okhca.org/about.aspx?id=19741.