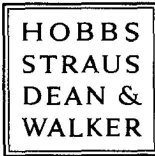

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MEMORANDUM

February 1, 2017

To: TRIBAL HEALTH CLIENTS

From: HOBBS, STRAUS, DEAN & WALKER, LLP

Re: ***CMS Releases FAQs Addressing Medicaid Reimbursement for Services Furnished Outside an IHS/Tribal Facility***

On January 18, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a Frequently Asked Questions (FAQ) document that clarifies CMS policies regarding Medicaid reimbursement for services furnished outside of an Indian Health Service (IHS) or tribal facility. The FAQ also addresses questions regarding Medicaid billing and payments to non-IHS/tribal providers that have arisen in response to CMS's February 2016 State Health Official (SHO) letter on 100% Federal Medical Assistance Percentage (FMAP).. A copy of the FAQ is enclosed.

In the FAQ, CMS clarifies that, based on its interpretation of the Social Security Act, services provided outside of the "four walls" of IHS/tribal facilities, which are enrolled in Medicaid as a provider of "clinic services," may not be billed as "clinic services" or reimbursed at the facility rate (*e.g.*, the OMB rate). This means that tribal facilities enrolled in Medicaid as clinics may not bill Medicaid for services provided by their personnel outside the four walls of the facility. However, this does not prevent a tribal facility enrolled as a clinic from entering into a written care coordination agreement with an off-site non-Tribal provider, having that provider assign his or her Medicaid claims to the tribal program, and billing the state Medicaid program for the services furnished (for which the state Medicaid program would then receive 100% FMAP). However, the applicable billing rate would not be the tribal facility rate, but the rate that applies under the Medicaid state plan to the provider type and services rendered.

This rule only applies to clinic services provided outside the four walls of a facility. As a result, it does not apply to services provided outside a facility that are billed as provider-based services, nor does it apply to tribal hospital-based services including hospital clinics.

To overcome the four walls limitation for clinic services, CMS suggests in the FAQ that tribal clinics may elect to enroll in Medicaid as Federally Qualified Health Centers (FQHCs), rather than as providers of clinic services. If the tribal facility is enrolled in the State Medicaid program as an FQHC, the FAQ explains that the tribal

facility can claim payment for services furnished outside of the facility at the facility rate, because FQHCs are not subject to the four walls limitation. While the facility rate for FQHCs is generally based on the Prospective Payment System, CMS suggests that states can amend their state plans to allow such tribal facilities to bill for services at the OMB rate. In order to give tribes and states time to make this change, and in response to tribal input, the FAQ provides that CMS will not review claims by tribal facilities for clinic services provided outside their four walls before January 30, 2021, unless there is evidence of bad faith.

Background: CMS's SHO Letter on 100% FMAP

On February 26, 2016, CMS issued a SHO letter that announced that 100% FMAP would be extended to services rendered by non-IHS/tribal providers to American Indians or Alaska Natives (AI/ANs) enrolled in Medicaid if the service was provided based on a referral from the IHS/tribal facility pursuant to a written care coordination agreement. One of the elements addressed in the SHO letter is how billing for services may be handled, providing two options to tribal health programs. One option is for the outside provider to directly bill Medicaid at the rate applicable to that furnishing provider and the service.

The other option is for the tribal program to handle all of the billing, through an agreement under which the provider assigns its claims to the facility and the facility then bills the state Medicaid program for the service. For any services provided *within* the "four walls" of the tribal facility enrolled as a clinic, the tribal program could bill Medicaid at the facility rate, but for anything provided *outside* of the "four walls" of the tribal facility (with the exception of services provided to a homeless person), the SHO explains that the tribal program would have to bill Medicaid at the state plan rate applicable to the furnishing provider and the service.

On December 15, 2016, CMS held an All Tribes Call in which it proposed a way in which tribal facilities currently enrolled as providers of clinic services *could* bill at a facility rate for both onsite and offsite services—they would need to enroll in the state Medicaid program as an FQHC rather than as a provider of "clinic services." This is because there is no federal requirement that FQHC services be provided within the four walls of the facility.

CMS's "Four Walls" Limitation on Clinic Services

The four walls limitation is a product of CMS's interpretation of statutes and regulations defining clinical services for Medicaid purposes. Section 1905(a)(9) of the Social Security Act (SSA) provides Medicaid coverage for:

> clinical services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including

> such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

42 U.S.C. § 1396d(a)(9). The applicable regulations provide:

> *Clinic services* means 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. The term includes the following services furnished to outpatients:
>
> (a) Services furnished at the clinic by or under the direction of a physician or dentist.
>
> (b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

42 C.F.R. § 440.90.

CMS has interpreted these provisions to mean that clinical services are only those services provided within the four walls of a clinic facility, save for the limited exception of services provided to homeless persons. Although we do not agree that CMS is required to interpret the law in this way, the agency has settled on this interpretation as its final legal determination. CMS insists that tribal facilities enrolled in Medicaid as providers of clinical services cannot bill for services provided outside of the clinic—whether provided by facility employees or by non-Tribal providers under contract—as "clinic services" to be reimbursed at the facility rate (unless the patient receiving the service is homeless).

CMS's FAQ and Proposed Solution of Billing Medicaid as FQHCs

CMS's FAQ notes that there are two options for billing a state Medicaid program 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 that meets the requirements set forth in the SHO letter. First, the non-IHS/tribal provider can bill Medicaid directly. Second, the non-IHS/tribal provider may enter an agreement with the IHS/tribal facility under which the provider assigns its claims to the facility and the facility then bills the state Medicaid program for the service. Under this second option, the facility can receive reimbursement for clinic services—services that can properly be claimed as services of the tribal facility (e.g., services within the scope of covered services of the tribal facility that are provided within the four walls of the facility) at the

facility rate.[1]

For services furnished outside of the four walls of the facility, the question of whether the tribal facility can claim reimbursement at the facility rate depends on whether it is enrolled in the state Medicaid program as a provider of clinic services or as a FQHC:

- The FAQ provides that if a tribal facility is enrolled as a provider of clinic services, it may not bill for services at the facility rate when those services were delivered outside of the facility's four walls, even if a written care coordination agreement is in place (though the facility could enter into a written care coordination agreement with the offsite non-tribal provider and then bill the state Medicaid program for the offsite services furnished as an assigned claim by the provider, but the payment rate for such services would be the state plan rate applicable to the furnishing provider and the services—rather than the tribal facility rate).
- However, if the tribal facility is enrolled as an FQHC and it has a contract with the non-tribal provider, then the tribal facility may claim payment for services furnished outside of the facility by the non-tribal provider at the facility rate.

The FAQ notes that 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 and Education Assistance Act (ISDEAA), P.L. 93-638, are by definition FQHCs. Therefore, such tribal facilities may enroll in their state Medicaid programs as FQHCs if they wish to do so. The FAQ notes that this is different from becoming an FQHC for the purposes of the Medicare program, receipt of grants under section 330 of the Public Health Service Act, or designation as a "look alike" by the Health Resources and Services Administration. The FAQ explains that to be an FQHC for purposes of the Medicaid state plan, none of the heightened requirements applicable to these other programs apply. Rather, the only requirement is that the facility be operated by a tribe or tribal organization under the ISDEAA.

In order to make the transition from being enrolled as a provider of clinic services to an FQHC, the FAQ provides that tribal facilities must notify their state Medicaid agency. The state will then need to change the designation of the facility in its Medicaid Management Information System and determine the applicable FQHC payment rate.

The FAQ states that in general FQHCs are paid based on the Prospective Payment System, but it notes that under section 1902(bb)(6) of the Social Security Act, states and FQHCs may use an Alternative Payment Methodology. The FAQ says that based on this authority, tribal facilities and states may agree that the tribal provider's facility rate is the

[1] The FAQ notes that the facility itself would be responsible for overpayment that results from receiving reimbursement for services that did not meet the requirements of a facility service.

OMB rate. The state Medicaid agency will have to submit state plan amendments (SPAs) to CMS in order to make the OMB rate the Alternative Payment Methodology applicable to tribal providers billing as FQHCs.

CMS's Four-year Grace Period

Although CMS has provided the FQHC work-around for the issue of billing at the facility rate for services provided outside the four walls of a tribal facility, tribes expressed concern about the time needed to implement CMS's proposed solution of billing as FQHCs. Tribes noted, for instance, that such a transition may not be difficult in a state that has good relationships with tribes but that tribes may have difficulty in other states. For instance, in some states legislative approval is required to submit a SPA to CMS.

In its FAQ, CMS states that it recognizes that practices vary as a result of its not having given guidance on this issue and that some states and tribes will need to make legislative or regulatory policy changes, provide public notice, define services, make system changes, and possibly make programmatic and staffing changes. CMS announced, therefore, that it does not intend to review claims by tribal "clinic services" providers for services furnished outside the four walls of a facility before January 30, 2021, unless there is evidence of bad faith. The FAQ states, however, that tribal facilities that wish to transition to being enrolled in their Medicaid state plan as FQHCs should notify the state of this intention within one year from the date of the FAQ—before January 18, 2018.

Conclusion

If you would like additional information or assistance regarding this matter, please contact Elliott Milhollin (emilhollin@hobbsstraus.com or 202-822-8282); Geoff Strommer (gstrommer@hobbsstraus.com or 503-242-1745); Starla Roels (sroels@hobbsstraus.com or 503-242-1745); or Akilah Kinnison (akinnison@hobbsstraus.com or 202-822-8282).