

CMS has posted links to the December 15, 2016 Tribal Consultation conference call: Reimbursement Rate for Services Provided Outside of an I H S/Tribal Facility. If you missed the original conference call, the links will take you to a recording.

<https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/All-Tribes-Calls.html>

Description of call copied below:

## **Tribal Consultation: Reimbursement Rate for Services Provided Outside of an IHS/Tribal Facility**

**December 15, 2016**

[Watch on YouTube](#)

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On February 26, 2016, CMS issued a State Health Official letter (SHO) expanding the circumstances under which services furnished to American Indian and Alaska Native (AI/AN) Medicaid beneficiaries could be considered to be “received through” an Indian Health Service (IHS) or Tribal facility. 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. Those services provided per the care coordination agreements are eligible for federal matching funds at the enhanced federal matching rate (FMAP) of 100 percent.

Under the SHO, either the Tribal facility or the non-IHS/Tribal practitioner may bill Medicaid for services furnished by the non-IHS/Tribal practitioner. If the non-IHS/Tribal provider were to bill the state Medicaid program directly, 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. If the Tribal facility were to bill for the service, the Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under the care coordination agreement that can be claimed as services of the Tribal facility from those that cannot. Services that can properly be claimed as services of the

IHS/Tribal facility (“IHS/Tribal facility services”) are reimbursed at the facility rate authorized under the Medicaid state plan. Those services that do not qualify as “IHS/Tribal facility services” are reimbursed at the rate applicable under the Medicaid state plan to the provider type and service rendered.

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” under 42 CFR 440.90, the Tribal facility may not bill for the services furnished by a non-Tribal provider or Tribal employee at the facility rate for services that are provided outside of the facility. This is referred to as the ‘four walls’ limitation. Instead, the Tribal provider would bill for the services at the rate applicable to the non-Tribal provider and the service. (As noted above, the Tribal provider has the option to allow the non-Tribal provider bill to bill directly for the service rather than bill on the provider’s behalf). If the Tribal facility is enrolled in the state Medicaid program as an FQHC, the Tribal facility may properly claim payment for services furnished by the non-Tribal provider at the facility rate.

We understand that states may not have been paying for services provided by Tribal clinics in accordance with the ‘four walls’ limitation. In reviewing possible solutions that will minimize the impact on Tribal clinics, we have determined that the FQHC benefit provides the most flexibility since there is no Federal requirement that FQHC services be provided within the ‘four walls’ of the facility. In addition, section 1905(l)(2)(B)(iv) of the Social Security Act recognizes outpatient Tribal health programs as FQHCs. Pursuant to the Benefits Improvement and Protection Act (BIPA) of 2000, FQHCs must be paid no less than a rate developed based on 1999/2000 cost trended forward by the MEI. However, BIPA also permits states to establish higher payment rates under an alternative payment methodology (APM). In light of the unique nature of Tribal Health programs, CMS could support payment of the outpatient IHS/AIR for FQHC services under an APM.

To effectuate this change, Tribal Health programs should work with their Medicaid agencies to have their provider designation changed from clinic to FQHC. No other steps need be taken by the Tribal Health program. The state Medicaid agency will be required to submit a state plan amendment to designate payment for Tribal FQHC services at the IHS AIR as an APM. States will be given a grace period to consult with Tribes and to modify the state plan.