DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMCS Informational Bulletin

DATE: **January 15, 2021**

FROM: **Anne Marie Costello, Acting Deputy Administrator and Director, Center for Medicaid and CHIP Services**

SUBJECT: **Extension of Grace Period Related to the "Four Walls" Requirement under 42 C.F.R. § 440.90 for Indian Health Service and Tribal Facilities**

The Center for Medicaid and CHIP Services (CMCS) is issuing this Informational Bulletin (CIB) to announce that the Centers for Medicare & Medicaid Services (CMS) will extend a grace period previously granted to Indian Health Service (IHS) facilities, including those facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. No. 93-638.[1] This grace period permitted IHS and Tribal facilities to continue to claim Medicaid reimbursement under the clinic services benefit at 42 C.F.R. § 440.90 (including at the IHS All Inclusive Rate (AIR)) for services provided outside of the "four walls" of the facility through January 30, 2021. Due to the urgent need to ensure continued access to services provided by IHS and Tribal facilities during the COVID-19 pandemic, and the need for states, IHS, and Tribes to focus limited resources on addressing the COVID-19 public health emergency (PHE), CMS is exercising discretion to temporarily extend its policy to suspend enforcement of the "four walls" requirement under 42 C.F.R. § 440.90 for IHS and Tribal facilities – i.e., to extend the grace period previously granted to IHS and Tribal facilities – to October 31, 2021.[2] This CIB explains the steps Tribal facilities and states will need to take before the extended grace period expires in order for Tribal facilities to continue to receive Medicaid reimbursement for services provided outside the four walls of the facility after October 31, 2021.

Background

[1] In this document, we refer to facilities operated by Tribes and Tribal organizations under the ISDEAA as "Tribal facilities."

[2] We believe that this guidance is a statement of agency policy not subject to the notice and comment requirements of the Administrative Procedure Act (APA). 5 U.S.C. § 553(b)(A). Due to the urgent need to ensure continued access to services provided by IHS and Tribal facilities during the COVID-19 pandemic and the need for states, IHS, and Tribes to focus limited resources on addressing the COVID-19 PHE, CMS additionally finds that, even if this guidance were subject to the public participation provisions of the APA, prior notice and comment for this guidance is impracticable, and there is good cause to issue this guidance without prior public comment and without a delayed effective date. 5 U.S.C. § 553(b)(B) & (d)(3).

In February 2016, CMS issued a State Health Official (SHO) letter (#16-002) related to Federal funding for Medicaid services "received through" facilities of IHS, whether operated by IHS or by Tribes.[3] On January 18, 2017, CMS issued Frequently Asked Questions (FAQs),[4] to address various payment and billing questions triggered by SHO letter #16-002. Medicaid clinic services providers generally are not permitted to claim Medicaid reimbursement under 42 C.F.R. § 440.90 for services provided outside of the four walls of the facility.[5] The 2017 FAQs explained that IHS and Tribal facilities enrolled in Medicaid as clinic services providers are not permitted to claim Medicaid reimbursement under 42 C.F.R. § 440.90, including reimbursement at the IHS AIR,[6] for services provided outside of the four walls of the facility. Such claims are not permitted under the regulations at 42 C.F.R. § 440.90(a), which require that clinic services be provided "at the clinic" – that is, within the four walls of the clinic facility – with an exception at 42 C.F.R. § 440.90(b) for services furnished outside the clinic to people who are homeless. Services provided through outpatient departments of a hospital are generally billed as outpatient services under 42 C.F.R. § 440.20(a), not as clinic services under 42 C.F.R. § 440.90, and therefore are not affected by the four walls limitation. Such services may be reimbursed at the IHS AIR.

The definition of clinic services at 42 C.F.R. § 440.90 does not apply to Medicaid Federally qualified health center (FQHC) services provided by FQHCs, and therefore FQHCs can claim Medicaid reimbursement for FQHC services provided outside of the four walls of the FQHC. State Medicaid reimbursement to FQHCs for Medicaid-covered FQHC services must be consistent with the requirements specified in section 1902(bb) of the Social Security Act (Act). States have two Medicaid reimbursement options for FQHC services. States can opt to reimburse FQHC services at the prospective payment system (PPS) rate established under section 1902(bb)(3) of the Act. The 2017 FAQs explained that Tribal facilities could enroll in Medicaid as FQHCs and receive the PPS rate paid to FQHCs in the state. Alternatively, states can adopt an alternative payment methodology (APM) under section 1902(bb)(6) of the Act, in lieu of the PPS rate. If consistent with section 1902(bb)(6) of the Act, states can adopt the IHS AIR as an APM rate for any Tribal facilities that are FQHCs. Below, we refer to this option to convert from a Medicaid clinic to an FQHC as the "Tribal FQHC option."

In the 2017 FAQs, CMS explained that it did not intend to review claims by Tribal providers of clinic services under 42 C.F.R. § 440.90 for services furnished outside of the "four walls" of the facility before January 30, 2021 unless there was clear evidence of bad faith efforts to engage in improper claiming procedures in violation of the guidance provided in the 2017 FAQs.

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[3] https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf

[4] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/faq11817.pdf

[5] During the COVID-19 PHE, states can request that CMS provide a time-limited waiver, pursuant to section 1135(b)(1)(B) of the Social Security Act (Act), to modify the requirement in 42 C.F.R. § 440.90 that clinic services be provided "by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients," to permit services under 42 C.F.R. § 440.90 to be provided via telehealth when patients and clinic practitioners are in their respective homes or in another location. For more information, see the question and answer on page 91 of the COVID-19 FAQs, at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf .

[6] As relevant here, the IHS AIR is an all-inclusive encounter rate reimbursed to IHS and Tribal facilties for Medicaid-covered services and is published in the Federal Register on an annual basis.

Accordingly, IHS and Tribal facilities have a grace period through January 30, 2021, during which they could continue to claim Medicaid reimbursement under 42 C.F.R. § 440.90 for services furnished outside the four walls of the facility, including at the IHS AIR, without converting to FQHC status. During this time, Tribal facilities were expected to work with the state Medicaid agency in states where they bill Medicaid for services to decide whether to pursue the Tribal FQHC option. The grace period also gave IHS-operated facilities additional time to pursue options for working toward compliance with the "four walls" requirement. CMS also recognized that states needed time to implement the Tribal FQHC option; for example, states might need time to make legislative or regulatory policy changes, provide public notice of these changes, define FQHC services, make changes to their claims and/or provider enrollment systems, and potentially make programmatic and staffing changes.

Note that whether a Tribal facility is enrolled in Medicaid as an FQHC or a clinic, the 100% Federal medical assistance percentage (FMAP) under section 1905(b) of the Act for state expenditures for Medicaid services provided to American Indian and Alaska Native Medicaid beneficiaries and received through an IHS or Tribal facility remains available to the state.

Grace Period Extension

Some state Medicaid agencies and Tribal facilities have already adopted the Tribal FQHC option, but CMS is aware that other states and Tribal facilities had not done so prior to the COVID-19 PHE. Because the COVID-19 PHE has placed additional strain on state and Tribal resources, impeding their ability to complete the work needed to make an informed decision and take the necessary steps to effectuate the Tribal FQHC option, we are extending the grace period for states and Tribal facilities to October 31, 2021. This will allow states to work with Tribal facilities and, as applicable, submit a state plan amendment (SPA) to establish the IHS AIR as an APM for a Tribal FQHC. To ensure that such a SPA would take effect November 1, 2021, a state will need to submit it no later than December 31, 2021. CMS is also extending the grace period for IHS-operated facilities to October 31, 2021, to give IHS and states additional time to work toward a solution addressing compliance with the "four walls" requirement for IHS-operated facilities.

Steps Required to Implement the Tribal FQHC Option

Whether the Tribal FQHC option is preferable for a given Tribal facility depends on the services that the Tribal facility provides, the extent to which it furnishes services outside the four walls of its facility, and the facility and state's willingness to adopt the IHS AIR as an APM for Tribal FQHCs. Below, we explain the steps that Tribal facilities and states should take in order for a Tribal facility to be reimbursed as an FQHC at the IHS AIR for provision of services outside the four walls of the facility.

<u>Transitioning Tribal Facilities to Tribal FQHC Status</u>
Because section 1905(*l*)(2)(B) of the Act defines outpatient health programs or facilities operated by a Tribe or Tribal organization under the ISDEAA as FQHCs, converting to FQHC status could be relatively simple for Tribal facilities. Under Federal law, the Tribal facility need only

notify the state Medicaid agency of its desire to change from a clinic services provider to an FQHC and the state Medicaid agency will then change the designation of the facility in its Medicaid Management Information System (MMIS) from clinic services provider to FQHC. Under Federal law, Tribal facilities need not meet any requirement other than being operated by a Tribe or Tribal organization under ISDEAA and are not required to re-enroll in the Medicaid program as an FQHC. The state Medicaid agency is not required to process a new enrollment or re-screen the facility.[7]

The decision about whether a Tribal facility should convert from a provider of clinic services under 42 C.F.R. § 440.90 to an FQHC should involve a discussion between the Tribal facility and the state Medicaid agency. If the Tribal facility does not provide any services outside of its four walls, no further action is needed because the facility can continue to claim Medicaid reimbursement under 42 C.F.R. § 440.90 consistent with the Federal regulation. If the Tribal facility is considering converting to FQHC status, it should work with the applicable state Medicaid agency (or agencies, if services are provided in multiple states) to determine which services provided by the facility are covered as FQHC services under the state plan. If the Tribal facility determines it would be advantageous to convert to FQHC status only if it is reimbursed at the IHS AIR, the Tribal facility should work with the state to determine if the state would be willing to submit a SPA to establish the IHS AIR as an APM for Tribal FQHCs.

State Adoption of the IHS AIR as an APM for Tribal FQHCs

If the state Medicaid agency and one or more Tribal FQHCs agree to establish the IHS AIR as an APM to reimburse a Tribal facility that elects to convert to FQHC status, the state Medicaid agency will need to submit a SPA to designate payment for the Tribal FQHC at the IHS AIR as an APM consistent with section 1902(bb)(6) of the Act. States will be required to consult with Indian health care providers and Tribes consistent with the state Tribal consultation plan prior to submission of the SPA (which may have been accomplished through the discussions between the Tribal facilities and state agency described above). In addition, the Medicaid agency will need to assign a PPS rate to the Tribal facility, consistent with section 1902(bb)(4) of the Act, so that the agency can demonstrate on an annual basis that the APM is at least equal to the PPS rate the facility would otherwise receive, consistent with section 1902(bb)(6)(B) of the Act. The Tribal facility might not be required to report its costs for purposes of establishing a PPS rate in this circumstance.

To date, CMCS has approved nine (9) SPAs that pay the IHS AIR as an APM to Tribally operated FQHCs. These SPAs are available on Medicaid.gov; CMS also can provide copies upon request.

Technical Assistance

We encourage states needing technical assistance to contact their CMCS state lead and Tribes needing technical assistance to contact their CMCS Native American Contact. These CMS

[7] It is possible that some states may impose additional screening requirements for Tribal facilities to convert to FQHC status, in which case the facility also would need to comply with such requirements.

contacts are available to provide any additional technical assistance needed in determining whether to adopt the Tribal FQHC option. For more information about the four walls limitation and the grace period discussed in this CIB, please contact Kitty Marx, Director, Division of Tribal Affairs, kitty.marx@cms.hhs.gov.