



# Health Care Reform in Indian Country

Self-Governance Communication & Education

*Self-Governance Tribes Striving Towards Excellence in Health Care*

## Guidance on Permanent Exception for Tribal Health Care Facilities Billing Medicaid for Clinic Services Provided Outside of Their “Four Walls”<sup>1</sup>

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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 final rule<sup>2</sup> under which the federal Centers for Medicare and Medicaid Services (CMS) established new regulations that allow Tribal health care facilities enrolled in Medicaid as a clinic (Tribal clinics) to bill the program for “clinic services”<sup>3</sup> provided outside the “four walls” of their facilities (four walls requirement). Under the four walls requirement, Tribal clinics previously could not bill Medicaid for these services, except when provided to homeless individuals.

### Background

CMS issued the new rule in response to requests from Tribes and Tribal organizations to eliminate the four walls requirement for Tribal clinics. Tribes and Tribal organizations had raised concerns about the impact of this requirement on access to care for Medicaid enrollees who receive services from Tribal clinics, after CMS indicated that Tribal clinics could no longer bill Medicaid for services provided outside the four walls of their facilities in most cases.

On February 26, 2016, CMS issued a State Health Official (SHO) Letter<sup>4</sup> 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. After implementing the SHO Letter, CMS reassessed whether IHCPs could bill Medicaid for clinic services provided outside the four walls of their facilities as they had been doing.

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<sup>1</sup> 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](mailto:DonegMcD@Outlook.com).

<sup>2</sup> See CMS-1809-FC, “Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, et al.” (89 FR 93912), at <https://www.govinfo.gov/content/pkg/FR-2024-11-27/pdf/2024-25521.pdf>.

<sup>3</sup> 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.”

<sup>4</sup> 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>.

On January 18, 2017, CMS issued a document<sup>5</sup> taking a new position that “clinic services” provided by tribal health providers include only services that are either furnished within the four walls of an enrolled Medicaid clinic or are furnished off-site to homeless individuals by clinic personnel. CMS provided a grace period to January 30, 2021, to allow states and Tribal clinics to come into compliance with the four walls requirement. In response to overwhelming objection by tribes on this new position, CMS subsequently extended the grace period several times, most recently to February 11, 2025.

### New Rule

Under the new rule, issued on November 27, 2024, CMS revised the definition of “clinic services” in federal regulations at 42 CFR 440.90(c) to allow an exception to the four walls requirement for services provided by Tribal clinics.<sup>6</sup> As a result, the regulations now clarify that **Tribal clinics can bill Medicaid for services provided outside the four walls of their facilities** by clinic personnel under the direction of a physician as they always have. **All states must implement this exception, and CMS indicated that the exception applies to services provided to any Medicaid enrollee who receives services from a Tribal clinic.**<sup>7</sup>

CMS has approved State Plan amendments (SPAs) for several states to implement the new four walls regulation, including Alaska, California, Connecticut, Kansas, Louisiana, Minnesota, Nevada, New Mexico, Oregon, Rhode Island, South Dakota, Utah, Washington, and Wyoming.

### Change in Designation from Tribal Clinic to FQHC

Prior to issuing the new rule, CMS had announced that Tribal clinics could re-designate as a Federally Qualified Health Center (FQHC)<sup>8,9</sup> 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 walls requirement as clinics. The new rule makes this re-designation as an FQHC unnecessary for the purposes of avoiding the restrictions of the four walls requirement, but Tribal clinics still might consider this option for the

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<sup>5</sup> 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.tribalself.gov/wp-content/uploads/2017/02/01-faq11817.pdf>.

<sup>6</sup> Specifically, the exception applies clinics owned and operated by the Indian Health Service (IHS), clinics owned by IHS and operated by Tribes as authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), or clinics owned and operated by Tribes and Tribal organizations as authorized by the ISDEAA. The exception does not apply to urban Indian organizations (UIOs).

<sup>7</sup> See CMS, “All Tribes Consultation Webinar, August 8, 2024,” at <https://www.cms.gov/files/document/all-tribes-consultation-webinar.pdf>.

<sup>8</sup> 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 ISDEAA are by definition FQHCs and, as such, have the option to enroll in Medicaid 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 bill under Medicaid FQHC status, Tribal clinics might wish to reach agreement with the state to modify or eliminate the application of those provisions to Tribal FQHCs.

<sup>9</sup> Health care facilities enrolling as an FQHC under Medicaid generally do not have to meet the requirements for enrolling as an FQHC under Medicare.

purposes of securing payment at the encounter rate (aka the “OMB Rate” or “IHS All-Inclusive Rate”) for covered services provided to patients enrolled in Marketplace plans.

#### *Change in Medicaid Payment Rate*

Tribal clinics enrolled in Medicaid as an FQHC typically receive payments based on a rate determined by the state using the Prospective Payment System (PPS) methodology, rather than the encounter rate. However, federal law allows states and FQHCs 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 clinics participating in the program as FQHCs, as long as the APM rate is higher than the standard FQHC payment rate (Tribal FQHC option).<sup>10</sup> States must submit a 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 apply.<sup>11</sup>

Federal regulations impose specific requirements on payment rates from Marketplace plan issuers to FQHCs. Specifically, for covered services provided by FQHCs to Marketplace plan enrollees, issuers must pay an amount “not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act (SSA) for such item or service.”<sup>12</sup> As such, in cases in which a Tribal FQHC receives the encounter rate for covered services under Medicaid and contracts with a Marketplace plan issuer, the issuer generally would have to pay this facility at the encounter rate.<sup>13</sup>

#### *Other Differences Between Medicaid Clinic Services and FQHC Services*

Other important differences exist between Medicaid “clinic services” and “FQHC services.” The scope of coverage is not necessarily the same and might vary from state to state. States might impose different service caps or limitations on the two types of services. Supervision, staffing, documentation, and billing requirements also might differ. Re-designation to an FQHC might have advantages and disadvantages for Tribal clinics. Tribal clinics should work with their state Medicaid agencies to identify the differences, and evaluate them carefully, before deciding whether to make a change in designation.

#### *Next Steps for Tribal Clinics Seeking to Re-Designate as FQHCs*

#### **Tribal clinics seeking to enroll in Medicaid as FQHCs 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;

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<sup>10</sup> See section 1902(bb)(6) of the Act.

<sup>11</sup> States must calculate the FQHC PPS rate each year, but Tribal health care facilities are not required to submit cost reports in connection with that process.

<sup>12</sup> See 45 CFR 156.235(e).

<sup>13</sup> It is important to note that a Medicaid FQHC and a Marketplace plan issuer can agree to payment rates other than those the FQHC would have received under section 1902(bb), as long as the alternative rate at least equals the generally applicable payment rate of the issuer. Instances might occur in which a Tribal FQHC finds it advantageous to agree to a rate less than the Medicaid FQHC rate, and it is possible that Tribal FQHCs will have to negotiate a rate less than the Medicaid FQHC rate.

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

**Examples of SPAs from several states:**

Several states recently have received approval from CMS for an SPA that sets Medicaid payments for Tribal FQHCs at the encounter rate. Examples of these Tribal FQHC payment policies appear below.

- **Arizona:** “If a 638 FQHC elects an Alternative Payment Methodology [for Tribal facilities recognized as 638 FQHCs] then the 638 FQHC will be reimbursed an outpatient all-inclusive rate for all FQHC services. The published rate is paid for up to five encounters/visits per recipient per day. ... AHCCCS will establish a Prospective Payment System (PPS) methodology for the 638 FQHCs so that the agency can determine on an annual basis that the published, all inclusive rate is higher than the PPS rate. The PPS rate will be established by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads. The 638 FQHCs would not be required to report its costs for the purposes of establishing a PPS rate.”<sup>14</sup>
- **Connecticut: “Alternative Payment Methodology for Tribal Facilities Recognized as 638 FQHCs.** For dates of service July 1, 2017 and forward, these FQHCs may elect to be reimbursed under the Alternate Payment Methodology. Reimbursement to an Indian Health Services (IHS) clinic enrolled as an FQHC shall be as follows:
  1. IHS/Tribal 638 facilities are reimbursed in accordance with the most recently published Federal Register notice addressing the IHS encounter rate.
  2. Encounters with more than one health professional for the same type of service and multiple interactions with the same health professional that take place on the same day constitute a single encounter eligible for one payment, except when the patient after the first interaction, suffers illness or injury requiring additional diagnosis and treatment.

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<sup>14</sup> See the Arizona SPA and the associated CMS approval letter at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AZ/AZ-18-004.pdf>. Additional details on this policy are available in the Arizona IHS/Tribal Provider Billing Manual, Chapter 20 at [https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chapter20\\_638\\_FQHC.pdf](https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chapter20_638_FQHC.pdf).

Payment is allowed for one medical encounter, one behavioral health encounter, and one dental encounter per day.

3. The State will establish a Prospective Payment System (PPS) methodology for the 638 FQHCs so that the agency can determine on an annual basis that the published encounter rate is higher than the PPS rate. The PPS rate will be established by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads. The 638 FQHCs would not be required to report its costs for the purposes of establishing a PPS rate.”<sup>15</sup>
- **Montana:** Tribal facilities ... that enroll in Montana Medicaid as a Tribal FQHC have agreed through tribal consultation to be paid using an alternative payment methodology (APM) that is the all-inclusive rate (AIR) for services published annually in the Federal Register. Reimbursement will be allowed for the same categories of service as included within this State Plan that tribal facilities provide. Tribal FQHCs may bill the appropriate number of payable daily encounters based on the services that members receive. ... Montana Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal FQHC so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate will be established by comparing the PPS rate that is currently paid to non-tribal FQHCs to determine if the all-inclusive rate is higher.”<sup>16</sup>
  - **Nevada:** “Outpatient health programs or facilities operated by a Tribe or Tribal organization that choose to be recognized as FQHCs ... will be paid using an alternative payment methodology (APM) for services ... that is the published, all-inclusive rate (AIR). The APM/AIR rate is paid for up to five face-to-face encounters/visits per recipient per day. ... Nevada Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal facility so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate will be established by reference to payments to one or more other FQHCs in the same or adjacent areas with similar caseloads. ... The Tribal facility would not be required to report its costs for the purposes of establishing a PPS rate. The APM is effective for services provided on and after April 1, 2019.”<sup>17</sup>
  - **Oklahoma:** “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

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<sup>15</sup> See the Connecticut SPA and the associated CMS approval letter at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CT/CT-17-0017.pdf>.

<sup>16</sup> See the Montana SPA and the associated CMS approval letter at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-18-0003.pdf>.

<sup>17</sup> See the Nevada SPA and the associated CMS approval letter at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NV/NV-19-002.pdf>.

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.”<sup>18</sup>

- **Washington:** “Tribal facilities ... that enroll in Washington Medicaid as a Tribal Federally Qualified Health Center (Tribal FQHC) have agreed through tribal consultation to be paid using an alternative payment methodology (APM) that is the published outpatient all-inclusive rate. The agency allows reimbursement for the same outpatient services and the same number of encounters per day that Tribal 638 facilities provide under this State Plan. ... The agency establishes a Prospective Payment System (PPS) methodology for the Tribal FQHCs so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate is established by reference to the PPS rate that is currently paid to non-Tribal FQHCs. Tribal FQHCs are not required to report their costs for the purposes of establishing a PPS rate.”<sup>19</sup>

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<sup>18</sup> 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>. In addition, Oklahoma Health Care Authority (OHCA) Policies and Rules, part 110 stipulates, “I/T/U covered services provided off-site or outside of the I/T/U setting, including mobile clinics or places of residence, are compensable at the OMB rate when billed by an I/T/U that has been designated as a Federally Qualified Health Center.”

<sup>19</sup> See the Washington SPA and the associated CMS approval letter at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-19-0009.pdf>. Additional details on this policy are available in the Washington Apple Health (Medicaid) Tribal Health Billing Guide at <https://www.hca.wa.gov/assets/billers-and-providers/Tribal-health-bi-20200101.pdf>.