*Updated 11/29/2018

Clinic Payment Methodology

This guidance applies to states that cover and pay for clinic services under the state plan authority utilizing a fee-for-service (FFS) payment methodology.

Overview of Clinic Services

Clinic services at Section 1905(a)(9) of the Social Security Act (Act) are defined at 42 Code of Federal Regulations (CFR) 440.90 to include 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. These services are provided in the following the types of clinics (not limited to): dental, mental health, end-stage renal disease (ESRD), ambulatory surgical center (ASC), family planning, primary care, and Tribal/638 clinics. While Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) provide similar, clinic-like services these services are rendered under the separate Medicaid benefit category defined at 1905(a)(2) of the Act.

In addition, the regulation specifies that clinic services must be provided under the direction of a physician (including dentists) and that their services must be provided within the facility (four walls of the clinic) unless being provided to eligible individuals who do not have a permanent dwelling, fixed home, or mailing address. Mobile clinics are covered under the clinic benefit at 42 CFR 440.90 when they meet the four requirements below to provide clinic services as a satellite clinic facility:

1. The mobile unit is owned/leased by the clinic;
2. The state recognizes, licenses, or authorizes the mobile unit clinics to operate in the state;
3. The services are provided within the mobile unit; and,
4. The physician direction requirements are met per 42 CFR 440.90.

Payment for Clinic Services

Clinics services provided to Medicaid beneficiaries that meet the guidelines at 42 CFR 440.90 can be reimbursed in the following ways:

1. Payment using an all-inclusive encounter or visit rate, OR
2. The practitioner or physician fee schedule rates, OR
3. Reconciled Cost (Requires approved cost report).

Clinic Services Upper Payment Limit (UPL)

Clinic services are subject to the clinic UPL specified at 42 CFR 447.321, which requires that states pay no more than a reasonable estimate of Medicare's payment for these services.
In accordance with State Medicaid Director Letter (SMDL) 13-003 states are required to submit their demonstrations annually and to show compliance with the UPL when modifying payment. Similar to other UPL calculations, CMS requires states to demonstrate that any change in clinic payment methodology is in compliance with UPL regulations in the aggregate for state

government-owned or operated facilities, non-state government owned or operated facilities, and privately owned or operated facilities. Tribal/638 clinics are exempt from the clinic UPL.[1]

Further guidance on the clinic services UPL may be found in Medicaid.gov at the Payment Limit Demonstrations landing page: https://www.medicaid.gov/medicaid/finance/payment-limit-demonstrations/index.html.

[1]Per State Health Official (SHO) Letter 16-002, "IHS operates its own hospitals and clinics and partners with Tribes as authorized by the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended. The IHS also provides funding for Urban Indian Health Organizations to operate Urban Indian Health Programs (UIHP) under Title V of the Indian Health Care Improvement Act, P.L.94-97, as amended. The IHS, Tribes, and UIHPs operate health programs in 36 states."