National Indian Health Board

Memorandum on CMS Policy Change on 100% FMAP

I. Background on Medicaid & FMAP

Medicaid is a health insurance program that provides coverage to nearly seventy million Americans.[1] In terms of financing, Medicaid is jointly funded by the federal government and state governments. In order to facilitate this arrangement, the Federal Medical Assistance Percentage, or FMAP, was developed as a way to calculate what percentage of each state's Medicaid expenditures the federal government will reimburse**.** Each state's FMAP is calculated annually by the Secretary of Health and Human Services; while FMAP varies from state to state, law requires that each state have an FMAP of at least 50%, but no greater than 83%.[2]

FMAP applies to most medical services and populations. For the purposes of this memorandum, it is important to note that federal matching percentages for Medicaid services provided to Native populations in the United States are specified separately under federal law.[3] More specifically, through Section 1905(b) of the Social Security Act, Congress authorized the Centers for Medicare & Medicaid Services (CMS) to reimburse the Indian Health Service (IHS) at 100% FMAP for medical services provided, at either an IHS of Tribal facility, to Medicaid-enrolled American Indians and Alaska Natives; as a result, states were no longer financially responsible for these services.[4,5] In terms of the exact wording, Section 1905(b) states that "the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian Tribe or Tribal organization."[6]

However, it is important to note that many have criticized CMS for interpreting this provision in an extremely narrow manner, limiting applicability of 100% FMAP to "care provided inside the four walls of IHS facilities."[7] State and Tribal advocates have been working to broaden the 1905(b) provision, advocating for "full federal funding for all IHS-related care

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[1] "Distribution of Medicaid Enrollees by Enrollment Group: FY2011 Summary," The Henry J. Kaiser Family Foundation, http://kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/.
[2] Christine Scott, "Federal Medical Assistance Percentage (FMAP) for Medicaid," CRS Report for Congress (2005), http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2126203012005.pdf.
[3] Christie Provost Peters, "Medicaid Financing: How the FMAP Formula Works and Why It Falls Short," Issue Brief No.828 (2008), National Health Policy Forum, https://nhpf.org/library/issue-briefs/IB828_FMAP_12-11-08.pdf.
[4] Megan J. Renfrew, "The 100% Federal Medical Assistance Percentage: A Tool for Increasing Federal Funding for Health Care for American Indians and Alaska Natives," *Columbia Journal of Law & Social Problems*, 173 (2006), pages 186, http://www.columbia.edu/cu/jlsp/pdf/Winter2006/Renfrew.pdf.
[5] "Indian Health and Medicaid," http://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/indian-health-medicaid.html.
[6] Megan J. Renfrew, "The 100% Federal Medical Assistance Percentage: A Tool for Increasing Federal Funding for Health Care for American Indians and Alaska Natives," *Columbia Journal of Law & Social Problems*, 173 (2006), page 186, http://www.columbia.edu/cu/jlsp/pdf/Winter2006/Renfrew.pdf.
[7] Megan J. Renfrew, "The 100% Federal Medical Assistance Percentage: A Tool for Increasing Federal Funding for Health Care for American Indians and Alaska Natives," *Columbia Journal of Law & Social Problems*, 173 (2006), pages 174-180, http://www.columbia.edu/cu/jlsp/pdf/Winter2006/Renfrew.pdf.

provided to Medicaid-eligible American Indians and Alaska Natives (AI/ANs), including transportation services, medical services supplied by providers who treat AI/ANs under referral contracts with IHS, and services provided in Urban Indian Health Organizations."[8] CMS is now reconsidering its 100% FMAP policy and the goal of this memorandum is to review the changes it is proposing, as well as to review FMAP proposals developed by Alaska and South Dakota.

II. Summary of the Various Players in Regards to FMAP Coverage

In order to fully grasp FMAP and how it relates to the medical care landscape facing AI/ANs, it is important to understand the various players, defined as: IHS & Medicaid beneficiaries; IHS & non-Medicaid beneficiaries; and uninsured AI/ANs (non-IHS beneficiaries—or those lacking access to IHS services—and non-Medicaid beneficiaries).[9]

- When an IHS & Medicaid beneficiary receives treatment at an IHS or Tribal facility, CMS pays IHS 100% of the cost of the care.
- When an IHS & Medicaid beneficiary receives treatment at a non-IHS, non-Tribal facility, 100% FMAP does not apply. Rather, the state and the federal government share the cost of the care, as determined by the state's regular FMAP (in accordance with Medicaid).
- When an IHS & non-Medicaid, uninsured beneficiary receives treatment at an IHS or Tribal facility, federal funding appropriated to the IHS by Congress (in the IHS's annual operating budget) is used to pay for the care.
- A significant percentage of American Indians and Alaska Natives "live in urban areas… and cannot access IHS services, forcing them to rely on other sources of coverage or become uninsured."[10] Urban Indian Health Organizations provide care to this population, and the care is usually on an income-based, sliding scale fee schedule (so patients pay only what they can afford); Urban Indian hospitals and clinics receive minor funding from the Indian Healthcare Improvement Act (IHCIA).[11]

III. Alaska FMAP Proposal

Governor Bill Walker of Alaska expanded Medicaid for his state, effective September 1, 2015. In a letter to Secretary Burwell, Governor Walker requests continued support from HHS as his state expands Medicaid, specifically in the form of demonstration waivers available under the Social Security Act. Commissioner Valerie Davidson outlines Alaska's waiver opportunities via the following four provisions:

1. When a Medicaid beneficiary receives services at an IHS of Tribal facility, the state of Alaska is reimbursed at 100% FMAP. However, transportation and accommodation services for referrals to IHS facilities are only reimbursed at the state's FMAP. Given Alaska's size, dispersed communities and difficult terrain, access to transportation and accommodation services is a critical part of healthcare service in Alaska. Thus, Alaska requests 100% FMAP for transportation and accommodation services when they are part of the care an IHS beneficiary receives at a Tribal health facility. More specifically,

[8] Ibid.
[9] Ibid.
[10] Zuckerman et al., "Health Service Access, Use, and Insurance Coverage Among American Indians/Alaska Natives and Whites," (2004): 53.
[11] Mim Dixon and Yvette Roubideaux, *Promises to Keep: Public Health Policy for American Indians & Alaska Natives in the 21st Century* (2001), 64, 130.

transportation and accommodation services include: pre-maternal homes, patient housing facilities, hotels, meals, air travel, ground transportation, and medevacs.

   a. *Outcome:* Based on the $40 million to $60 million currently spent on travel costs for Alaska Natives and American Indians from rural areas, Alaska expects approximately $20 million to $30 million in state general fund savings annually.

2. Currently, when IHS facilities refer Medicaid beneficiaries to non-IHS facilities, the state of Alaska receives only 50% FMAP. Alaska requests, through HHS policy or a waiver, that referrals from an IHS facility to a non-IHS facility receive 100% FMAP for IHS beneficiaries. This change is necessary for all referred services given that the Alaska Tribal Health System depends heavily on referrals to other specialty care facilities. Moreover, this request is consistent with recent changes in federal regulations that aim to exclude IHS beneficiaries from cost sharing for referred services.
   a. *Outcome:* Approximately $158 million annual state general fund savings. This is half of the total expenditures ($316 million) paid to non-Tribal providers for healthcare services provided to Alaska Natives and American Indians.
3. Federal policy is unclear about when Tribal air ambulance and emergency transportation services can be claimed at 100% FMAP. Alaska requests that CMS clarify its policy to permit 100% FMAP when these services are provided by entities with 51% or more Tribal ownership. Additionally, these entities should be added to the IHS facility list. If point 1 is approved, this amendment will be included; if point 1 is not approved, then the approval of this amendment is essential.
   a. *Outcome:* Approximately $10 million annual state general fund savings.
4. Currently, Medicaid will not reimburse any services for adult patients who receive treatment at an Institution for Mental Diseases (IMD), defined as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases." Rather, these services are funded entirely through state general funds. Thus, Alaska is requesting the approval of an 1115 Waiver permitting Medicaid payment of services received in IMDs. Approval of this Waiver would allow federal match for adults with serious mental illness to be treated in facilities such as Alaska Psychiatric Institute (API) and North Star Hospital. Moreover, approval of this Waiver would encourage other private facilities to develop programs for adults with serious mental illnesses, given that it would generate a new source of revenue.
   a. *Outcome:* Approximately $10 million annual state general fund savings.

IV. South Dakota FMAP Proposal

South Dakota has not expanded Medicaid under the Affordable Care Act. It is estimated that expansion would provide an additional 48,500 people with access to Medicaid, including 13,000 Native Americans, and would cost an additional $30 million in state funds each year (beginning in 2020). Due to this, Governor Dennis Daugaard of South Dakota has not supported expansion, but he is willing to do so if there is a way to fund the expansion.

When an AI/AN Medicaid beneficiary receives services at an IHS of Tribal facility, the state of South Dakota is reimbursed at 100% FMAP. However, when these individuals receive care through Medicaid from a non-IHS facility, South Dakota receives its state's regular FMAP. When AI/AN individuals cannot receive services from the IHS, it is extremely costly for the state; in 2014, the Medicaid program paid $133 million for care provided to AI/ANs by non-IHS providers in the state of South Dakota. Under South Dakota's regular FMAP, this means that

South Dakota paid for nearly half this amount with state funds. Thus, Governor Daugaard is requesting that the federal government apply 100% FMAP to medical services provided to IHS beneficiaries in South Dakota, *no matter where these individuals receive such services.* In order to achieve this, Governor Daugaard is interested in exploring "innovative partnerships between IHS and other providers." Moreover, Governor Daugaard proposes using the funds saved in the state budget to expand Medicaid "if enough healthcare services currently funded by the state's Medicaid program can be paid using 100 percent federal funds."

While the Great Plains IHS Unit serves South Dakota AI/ANs, access to IHS-provided services is limited in all areas of the state. Thus, IHS-beneficiaries in South Dakota rely heavily on non-IHS services. For this reason, approval of 100% FMAP for the provision of non-IHS services to IHS beneficiaries is critical for the state of South Dakota, and the state is interested in pursuing innovative ways for IHS-beneficiaries to receive care that qualifies for 100% federal funding. Examples of these innovative strategies include employing health care specialists available through non-IHS providers to serve patients at IHS sites via telehealth or specialty clinic arrangements. For these innovative strategies to be successful, flexibility is required in how IHS services are defined, specifically in terms of providers and locations of services.

Outcome: With 100% federal funding for services provided to IHS beneficiaries at non-IHS facilities, a significant amount of state general funds would be available to offset the costs of expanding Medicaid in South Dakota. This would result in coverage for 48,500 additional individuals, including 13,000 AI/ANs.

V. CMS FMAP Proposal & Response

CMS is updating its policy concerning the circumstances under which 100% FMAP can be applied to services provided to Medicaid-eligible American Indian and Alaska Native individuals. The goal of this policy change, which would apply to all states, is to improve access to care for AI/AN Medicaid beneficiaries. CMS begins its proposal by discussing its current policy. As CMS notes, "If the provider is not an IHS/Tribal facility, the FMAP is the state-specific FMAP." In contrast, when the service is "received through" an IHS/Tribal facility, 100% FMAP applies. For Medicaid managed care plans, different rules apply.

CMS interprets section 1905(b) of the Social Security Act as allowing 100% FMAP to be applied under the following circumstances (using the exact language of CMS):

1. The service must be furnished to a Medicaid-eligible AI/AN individual;
2. The service must be a "facility service"—i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center, nursing facility) can offer under Medicaid law and regulation;
3. The service must be furnished in an IHS or Tribal facility or by its employees or contractual agents as part of the facility's services; AND
4. The IHS or Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service

Policy Changes under Consideration

State Medicaid programs, Tribes and others have expressed concern that the way CMS interprets Section 1905(b) of the Social Security Act is extremely narrow. Related is the additional concern of Tribes that the current CMS 100% FMAP policy is not in full compliance with the federal legal responsibility for health care for AI/AN individuals. Also, states have expressed concern that the federal government is not covering a large enough share of the cost of services provided to Medicaid AI/AN beneficiaries. In response, CMS has proposed a number of changes to its current 100% FMAP policy, specifically focusing on the second, third and fourth conditions of its current policy (as listed above).

A. Modifying the second condition

- *Current CMS policy:* To qualify for 100% FMAP, the service "received through" an IHS/Tribal facility must be a "facility service."
- *Proposed change:* To expand the definition of a service "received through" an IHS/Tribal facility to any service encompassed within a Medicaid state plan benefit category that the IHS/Tribal facility is authorized to provide. (Alaska includes such a provision in its own proposal, calling for the need to expand 100% FMAP to accommodation and transportation services).
    1. Services that could be considered "received through" an IHS/Tribal facility now include transportation services, including emergency transportation (EMT) services and non-emergency transportation (NEMT) services, as well as related travel expenses (CMS provides the following examples: meals, lodgings, and the cost of an attendant pursuant to federal and state requirements).

B. Modifying the third condition

- *Current CMS policy:* For services to qualify for 100% FMAP, they must be provided in an IHS/Tribal facility, or be provided by the facility's employees or contractual agents as part of the facility's services.
- *Proposed change:* To expand the meaning of a contractual agent to include: "a qualified individual or entity that is enrolled as a Medicaid provider and who provides items or services not within the scope of a Medicaid 'facility services' benefit but within the IHS/Tribal facility authority, pursuant to a written contract under which the services for the Medicaid beneficiary are arranged and overseen by the IHS/Tribal facility and the individuals served by the contractual agent are considered patients of the facility." (Alaska and South Dakota each include a similar provision in their own proposals, calling for flexibility in defining IHS services and for the application of 100% FMAP to medical services received by AI/AN Medicaid beneficiaries at non-IHS facilities; however, no explicit mention is made in either proposal about a written contract).
    1. Under this proposed change, the IHS/Tribal facility would still be responsible for the provision of services.
        a. This responsibility includes the following duties: retaining control of the medical records, updating the records with health information received from contractual agents, and providing care coordination for each AI/AN patient.

b. This is consistent with the proposed changes for the second condition (as described on pp.8), specifically in regards to the new interpretation of the phrase "received through."

2. Urban Indian Health Programs could participate as contractual agents.

C. Modifying the fourth condition

- *Current CMS policy:* The IHS/Tribal facility must bill the state Medicaid program directly for the services provided.
- *Proposed change:* To provide each IHS/Tribal facility with the ability to choose whether it would bill the state Medicaid program or whether the contractual agent would assume the responsibility of billing directly. Either way, the decision would need to be specified in the written contracts with contractual agents.

D. Application to fee-for-service

- IHS/Tribal facilities are typically reimbursed for facility services using one of the following, as stipulated by each state's Medicaid plan:
    1. An all-inclusive rate (AIR), the Federally Qualified Health Center (FQHC) prospective payment system (PPS) rate, or the FQHC alternate payment methodology (APM) rate.
- Fee-for-service payments would be impacted by the proposed changes (detailed under points A through C) as follows:
    1. For services included in the applicable facility benefit, an IHS/Tribal facility would receive payment at the applicable IHS facility rate under the state plan.
        a. This would be the case whether the service was provided by facility employees or by contracted providers as a facility service.
    2. If an IHS/Tribal facility chooses to provide Medicaid services that are of a type that could be funded through the IHS/Tribal authority, but are not within the scope of the applicable facility benefit, those services will be paid at the state plan rates applicable to those services.
        a. This includes personal care, home health, 1915(c) waivers, non-emergency medical transportation, etc.

E. Application to managed care

- *Clarification of current CMS policy:* For AI/AN individuals enrolled in a managed care plan, if the services they receive are furnished by an IHS/Tribal facility or its employees, the state would be able to claim 100% FMAP for the portion of the capitation rate representing those services expended by the managed care plan.
    1. To determine the portion of the capitation rate that would be eligible for 100% FMAP, the services provided must be taken into account. Only services that meet all of the following conditions would be applicable:
        a. The service is furnished to a Medicaid-eligible, enrolled, AI/AN individual.
        b. The IHS/Tribal facility provides the service, either directly or through a contractual agent, and maintains oversight responsibility.
        c. The service is payable under the managed care plan and is, in fact, paid by the managed care plan.

2. CMS would like to obtain more information about the methods states use to determine the number of managed care claims reported on the CMS-64 at 100% FMAP; this will be helpful in order to inform future guidance.

Request for Stakeholder Feedback and Comments

CMS requests feedback from states, Tribes and other stakeholder regarding the parameters of the reinterpretation of Section 1905(b) of the Social Security Act. CMS is particularly interested in how the policy revisions it is proposing will improve the health status of AI/AN Medicaid beneficiaries, in addition to the perceived feasibility of these changes. CMS requests that written comments be sent to TribalAffairs@cms.hhs.gov.