



NATIONAL COUNCIL *of* URBAN INDIAN HEALTH

Recent Trends in Third Party Billing at Urban Indian Organizations: Impact of the American Rescue Plan Act and 100% FMAP Provisions

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Executive Summary

This report serves as an update to NCUIH's previous reporting on recent trends in third-party billing. This report focuses on the role of Medicaid trends against the background of pandemic-era changes in Urban Indian Healthcare legislation. In particular, this report contains:

- (1) **A background** covering the Federal Medical Assistance Percentage (FMAP) and recent changes as a result of Section 9815 of the American Rescue Plan Act (ARPA) in 2021.
- (2) **Data Analysis** estimating the potential financial impacts of these changes, and
- (3) **A concluding discussion with key takeaways** based on this analysis and interviews with a sample of UIOs.

Key findings include projected costs of Medicaid services for patients at Urban Indian Organizations (UIOs), and changes due to Section 9815 of the American Rescue Plan act. NCUIH estimates that \$70,407,559 of Medicaid costs will shift from State governments to the Federal government during the two-year period in which Section 9815 of the American Rescue Plan Act (ARPA) was enacted. If 100% FMAP provision is extended beyond eight quarters, NCUIH predicts that over 10 years, \$547 million will be spent by the federal government instead of states. This estimate is less than half the increase predicted by previous projections, by virtue of factoring in existing state FMAP and Medicaid spending rates. Strengths and limitations of this approach are discussed, along with policy recommendations. NCUIH concludes that extending the 100% FMAP provision on a permanent bases would support health equity and the Indian healthcare system, at a lower federal expense than has previously been estimated.

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Part I: Background

What is the Federal Medical Assistance Percentage, and why does it matter in Urban Indian Healthcare?

In general, the cost of services provided to Medicaid beneficiaries is shared between the federal government and the state Medicaid program in which the individual is enrolled.¹ The share of covered services provided to Medicaid beneficiaries which is covered by the federal government is referred to as the Federal Medical Assistance Percentage (FMAP).² The Social Security Act sets forth a formula by which the FMAP and state share are determined; as a baseline a FMAP cannot be less than 50 percent of the cost.³ The FMAP formula is based on a state's average personal income – states which have lower average personal incomes receive a higher FMAP.⁴

In 1976, Congress passed the Indian Healthcare Improvement Act (IHCA) which made significant changes to the manner in which healthcare is provided to American Indians and Alaska Native (AI/AN) people in the United States. Among the changes, Congress added Section 1911 of the Social Security Act (SSA) to authorize reimbursement by Medicaid for services provided to AI/AN Medicaid beneficiaries in Indian Health Service (IHS) and Tribal health care facilities.⁵ Notably, in addition to providing for reimbursement, the IHCA also amended section 1905(b) of the SSA setting FMAP at 100% for Medicaid “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 In ensuring that IHS and Tribal health care facilities are eligible for 100% FMAP, it was Congress’ intent “to implement the Federal responsibility for the care . . . of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs.”⁷

In passing the IHCA, Congress found that “[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.”⁸ Recognizing that the Federal Government's trust responsibility to AI/AN people extended to AI/ANs living in urban areas, the IHCA also formalized the Federal government's relationship with Urban Indian Organizations (UIOs), directing the Secretary of Health and Human Services to enter into contracts with UIOs for the provision of health services to AI/ANs living in urban areas.⁹ Urban Indian Organizations (UIO) were not included in the IHCA's amendments to the SSA and therefore services provided at a UIO were not eligible for 100% FMAP.¹⁰



In interpreting the 100% FMAP provision with respect to IHS and Tribal facilities, the Centers for Medicare & Medicaid Services (CMS) found that 100% FMAP was “limited to expenditures for services received by American Indian and Alaska Native (AI/AN) Medicaid beneficiaries through” IHS and Tribal health care facilities.¹¹ Therefore, if IHS or Tribal facilities provided services to non-AI/AN beneficiaries 100% FMAP was not available for those services, even if the patient was a Medicaid beneficiary. In addition, for many years, CMS interpreted services “received through” an IHS or Tribal facility and therefore eligible for 100% FMAP to be those services meeting the following standards:

- (1) The service must be furnished to a Medicaid-eligible AI/AN;
- (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 [FQHC]/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation;
- (3) The service must be furnished by an IHS/Tribal facility or by its contractual agent as part of the facility’s services; and
- (4) The IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service¹²

However, in 2016, CMS announced in State Health Official (SHO) Letter #16-002, that it was expanding the services it considered to be “received through” an IHS or Tribal Facility and therefore eligible for 100% FMAP.¹³ Among the services CMS announced it now considered to be “received through” an IHS or Tribal Facility were “any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS).”¹⁴ Additionally, CMS announced that services would be considered to be “received through” an IHS or Tribal facility:

not only when the service is furnished directly by the facility to a Medicaid-eligible AI/AN patient, but also when the service is furnished by a non-IHS/Tribal provider at the request of an IHS/Tribal facility practitioner on behalf of his or her patient and the patient remains in the Tribal facility practitioner’s care in accordance with a written care coordination agreement¹⁵

Accordingly, states may now claim 100% FMAP for care provided pursuant to a written care coordination agreement between an IHS or Tribal provider and a non-IHS or non-Tribal provider.¹⁶

Major Changes due to the American Rescue Plan Act

As mentioned above, UIOs were not included in the 1976 amendments to the Social Security Act extending 100% FMAP for services received through IHS and Tribal health care facilities. Omission of UIOs had several unfortunate



consequences, including exclusion of some UIOs from state Medicaid provider networks.¹⁷ For many years, UIOs engaged in extensive advocacy to extend 100% FMAP for services provided at UIOs. This effort was also endorsed by Indian Country more broadly, including by organizations like the National Congress of American Indians.¹⁸

In response to the COVID-19 pandemic, President Biden signed into law the American Rescue Plan Act of 2021 (ARPA) on March 11, 2021, which provides relief to address the continued impact of COVID-19 on the economy, public health, state and local governments, individuals, and businesses. Section 9815 extends 100% FMAP for services provided to Medicaid beneficiaries by UIOs and Native Hawaiian Health Care entities.¹⁹ In extending 100% FMAP for these services, the intent was to “provide[] increased financial support to health care providers serving Native American Medicaid beneficiaries” in urban areas.²⁰ The Biden Administration supported section 9815 and thus, acknowledges the role that UIOs have played in meeting federal obligations to AI/AN people living in urban areas, including care during the COVID-19 pandemic.²¹

Specifically, ARPA Section 9815 amended Section 1905(b) of the Social Security Act by inserting the following:

for the 8 fiscal year quarters beginning with the first fiscal year quarter beginning after the date of the enactment of the American Rescue Plan Act of 2021, the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Urban Indian organization (as defined in paragraph (29) of section 4 of the Indian Health Care Improvement Act) that has a grant or contract with the Indian Health Service under title V of such Act;²²

There was no distinction made in the legislative text with respect to the identity of the Medicaid beneficiary. In other words, ARPA Section 9815 extended 100% FMAP for all services received through a UIO for AI/AN and non-AI/AN beneficiaries alike.²³ On August 30, 2021, CMS issued SHO Letter #21-004 which confirmed that “CMS is interpreting the amendments made by section 9815 of the ARP [sic] to authorize 100% FMAP for expenditures for services received by *all* Medicaid beneficiaries through UIOs, NHHCs, and NHHCSs.”²⁴ CMS found this interpretation to be consistent with the statutory language and the legislative history of ARPA Section 9815.²⁵

This legislative fix was not permanent, and 100% FMAP was extended for only eight fiscal year quarters starting with the first fiscal year quarter beginning after the date of the enactment of ARPA. ARPA was enacted on March 11, 2021, in Quarter 2 of Fiscal Year 2021. Therefore:

- The 100% FMAP went into effect on April 1, 2021 (the beginning of Quarter 3 of Fiscal Year [FY] 2021).²⁶



- The 100% FMAP will expire at the end of Quarter 3 of Fiscal Year 2023.

Congress is currently considering legislation to permanently extend 100% FMAP for services provided by UIOs beyond the eight fiscal year quarters currently authorized by ARPA.²⁷

How do Medicaid reimbursement rates relate to fiscal impact of 100% FMAP provisions?

In general, services provided to Medicaid beneficiaries at IHS and Tribal facilities are billed by the provider at the IHS all-inclusive rate (AIR) – generally a higher rate than otherwise available to FQHCs within a State.²⁸ The AIR allows services at IHS and Tribal facilities to be billed on a per encounter basis, they are usually not billed based on the specific service provided.²⁹ IHS publishes the AIR in the Federal Register (FR) annually.³⁰ Each year, IHS’ AIR FR notice sets the rates for Medicaid outpatient visits and an inpatient hospital per diem rate. The FR notice also includes Medicare rates, not relevant to this discussion.³¹ In 2022, the all-inclusive rate was \$640 for Medicaid outpatient visits in the lower 48 states (the most relevant rate for healthcare in UIO service areas).³² In contrast, most UIOs do not currently receive the AIR for encounters with Medicaid beneficiaries. Rather, UIOs bill encounters at a variety of rates, including the Prospective Payment System (PPS) for UIOs enrolled as FQHCs and rates set by Managed Care Organizations. In some instances, some AI/AN Medicaid beneficiary visits may be billed on a fee for service basis.

It is important to note the distinction between the AIR and FMAP. FMAP refers to the Federal share for Medicaid expenditures for services provided to a Medicaid beneficiary. The AIR refers to a reimbursement rate set by IHS and billed by IHS and Tribal facilities for services provided to Medicaid beneficiaries. There is no “100% FMAP Rate” to providers. For more historical information on the process and options for reimbursement rate setting at UIOs, please review previous NCUIH reports on the topic.³³ Although changes related to (a) FMAP and (b) the AIR are made separately, both are critical to discuss when projecting the financial impact of ARPA.

While ARPA Section 9815 extended 100% FMAP for services received by Medicaid beneficiaries at a UIO, it was silent as to the rate at which services would be paid. In other words, while it required the federal government to reimburse state Medicaid agencies at 100% for Medicaid services received by Medicaid beneficiaries at a UIO, it did not establish a reimbursement methodology or rate at which those services were to be paid to the UIO.³⁴ In SHO Letter # 21-004 CMS informed State Health Officials that because ARPA Section 9815 is silent with regard to payment rates, “[s]tates have the discretion to set and adjust Medicaid provider payment rates, consistent with section 1902(a)(30)(A) of the [Social



Security Act].”³⁵ CMS offered to provide technical assistance to states interested in adjusting their reimbursement rates for UIOs.³⁶

A state interested in making changes to Medicaid payment rates must submit a state plan amendment (SPA) to CMS.³⁷ Submitting a reimbursement SPA requires a state to engage in rigorous analysis and calculations,³⁸ as well as go through a public notice and comment period,³⁹ and states cannot claim federal financial participation for a SPA pending approval from CMS.⁴⁰ A SPA must be reviewed and approved by CMS within 90 days after receipt.⁴¹ However, “[i]f CMS requests additional information, the 90-day period for CMS action on the plan or plan amendment begins on the day it receives that information.”⁴² In the first quarter of 2018, 84% of Medicaid SPAs were approved within the first 90 day review period.⁴³



Part II: Data Analysis

In this section, NCUIH estimates the impact of ARPA Section 9815 on federal payments to states for services provided by UIOs to Medicaid beneficiaries. In addition, the analysis explores the potential impact the 100% FMAP provision, were it implemented permanently. Throughout, NCUIH compares its methods and results to other work. To our knowledge, this is the only analysis of federal legislation on this topic that uses a systematic, national review of billing data.

Data Source and Methods

The Transformed Medicaid Statistical Information System (T-MSIS) is a data set maintained by CMS. States are required to submit Medicaid claims data to CMS in a standardized format, but state T-MSIS submissions differ in data quality. Information on Medicaid claims made by UIOs was available from T-MSIS for claims in Calendar Year 2019.

NCUIH searched for Medicaid claims data using UIO facilities' National Provider Indexes (NPIs), which are publicly available in an online registry.⁴⁴ Out of 41 UIOs, 39 have associated National Provider Identifiers (NPIs) listed in the CMS National Plan and Provider Enumeration System NPI Registry. The use of NPIs is not a perfect identifier and the claims and payments linked to NPI may be an undercount at some UIOs as a result. However, the use of publicly available IDs allowed for analysis of a greater number of UIOs without any additional survey or administrative burden. Two UIOs could not be matched with any NPI numbers, but likely do not participate in Medicaid or Medicare Billing based on a review of other internal information available on these sites.

Out of the 39 UIOs with NPIs, 2019 Medicaid claims information was located for 30 UIOs in the T-MSIS Other Services File.⁴⁵ Among the nine UIOs with an NPI identifier but without T-MSIS claims data, NCUIH confirmed that eight UIOs were likely not participating in Medicaid during 2019. For unknown reasons, claims data is missing for one Medicaid-participating UIO using NPI as an identifier, so this UIO was excluded from analysis.ⁱ Medicaid payment estimates for UIOs were generated using the variable "MDCD_PD_AMT," defined as: "The total amount paid by Medicaid or the managed care plan on this claim or adjustment at the header claim level."

Among the 30 UIOs included in the analysis, 24 UIOS were in states participating in Medicaid expansion, and six were in states that were not participating in Medicaid expansion during 2019. During the 2018 Calendar Year, 84.2% of Medicaid beneficiaries served by UIOs were residents of Medicaid expansion States.⁴⁶

ⁱ For privacy reasons, this UIO and its state are not identified.



Table 1: UIOs by State Expansion Status

2019 Status	UIOs	% of UIOs	Medicaid beneficiaries	% of Medicaid beneficiaries
Expansion	24	80.0%	72,979	84.2%
Non-Expansion	6	20.0%	13,687	15.8%
Total	30	100.00%	86,666	100.00%

Using this T-MSIS data, NCUIH was able to:

- 1) compile an aggregate estimate for all Medicaid payments made to UIOs in 2019,
- 2) forecast future payments through 2022 based on national medical expenditure growth, and
- 3) estimate the amount of state-federal cost-shifting due to Section 9815 of ARPA under different scenarios.

It is worth specifying the inherent timeline constraints in this method. T-MSIS data is available on a delay (with 2019 the most recently available calendar year), yet the 100% FMAP provision began on April 1, 2021 and will continue through March 31, 2023. As a counterfactual, Medicaid beneficiaries who are not covered by the 100% FMAP provision are reimbursed at the FMAP rate determined for each individual state. The U.S. Department of Health and Human Services published FMAP rates for 2021 and 2022 in the Federal Register on November 30, 2020.⁴⁷ NCUIH used current state FMAP rates to determine what the projected federal and state cost share would have been for the projected Medicaid payments to each UIOs without the 100% FMAP provision. Because FMAP rates are not available for Calendar Year 2023, we used the time period of January 1, 2021 to December 31, 2022 to approximate costs, even though the 100% FMAP provision extends from April 1, 2021 through March 31, 2023.

How Much Medicaid Costs are Shifted from States due to ARPA Implementation?

In 2019, UIOs received at least **\$89,504,467** in Medicaid payments, based on estimates from T-MSIS. CMS publishes estimated Medicaid expenditure growth rates using National Health Expenditure (NHE) Data.⁴⁸ Assuming that UIO Medicaid expenditures follow national trends, NCUIH estimates that Medicaid payments at UIOs will grow to **\$98,676,437** in 2021 and **\$104,498,348** in 2022.

NCUIH’s estimate for 2019 UIO Medicaid payments is likely an undercount, with an estimated minimum undercount up to 3 percent (or \$2.5 million –\$3 million). This estimate is based on the potential contributions from the single UIO whose claims were not identifiable in T-MSIS (yet known to be billing state Medicaid). NCUIH reached this limit by



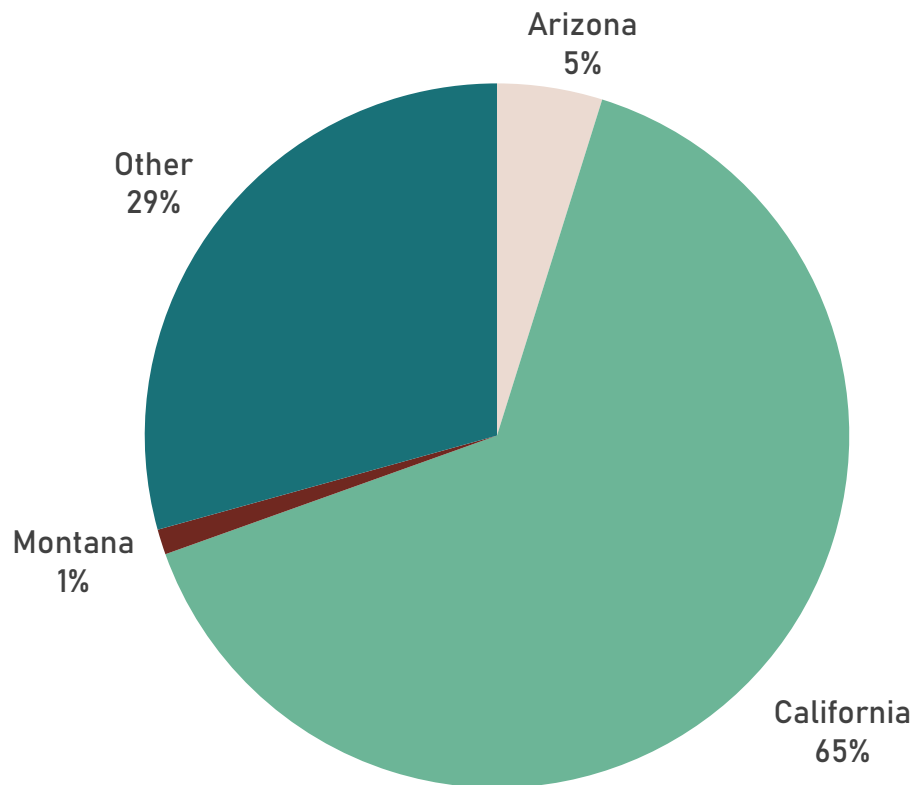
multiplying the facility's public 990 tax Form information on "program services revenue" by its publicly-reported proportion of Medicaid patients served. When predicting future year federal costs, NCUIH did not factor in this potential undercount in order to simplify methods and due to its marginal impact on our final calculations when factoring in the shift of less than fifty percent from the state's current FMAP to 100% matching.

If all twenty-two states in which UIOs are located participate in 100% FMAP, NCUIH projects that **\$70,407,559 of UIO Medicaid costs will shift from State governments to the Federal government during the two-year period of the temporary 100% FMAP provision.**

NCUIH also disaggregated the cost-shifting by state. To protect UIO privacy, we are providing cost-shifting estimates only for the three states which have three or more UIOs: California, Montana, and Arizona. The disaggregation reveals that two-thirds of the cost-sharing is concentrated in California. Only 37% of UIO beneficiaries are in California, but California has the lowest state FMAP rate in the country (50% in 2021 and 56% in 2022).



Figure 1: Distribution of cost-shifting across California, Montana, and Arizona.



What if the 100% FMAP provision was permanent?

If 100% FMAP provision is extended beyond eight quarters, NCUIH predicts that over ten years around \$547 million of costs would be shifted from states to the federal government during this period. There is more potential variation in this forecast than our two-year prediction however, given that (1) FMAP rates themselves may change substantially over the next ten years and (2) UIO encounter rates may also change over this period.

These estimates of the cost-shifting of FMAP are substantially smaller than estimates generated by the Congressional Budget Office (CBO).⁴⁹ CBO estimates are created to inform congressional decision-making and provide evidence on the potential budgetary impacts of legislative actions. In this section, NCUIH compares our methods to those of the CBO.



The CBO estimated a two-year cost of \$155 million in their report to the House Committee on Energy and Commerce. If projected out using the same medical expenditure growth rate applied to NCUIH's estimates, CBO's methods provide a ten-year estimate of nearly \$1 billion. The CBO used four assumptions to generate their estimates.

- 1) CBO assumed \$2,000 of annual per-patient costs. NCUIH's analysis of 2019 T-MSIS data generates an annual per-patient billing estimate of \$1,033. Using the National Health Expenditure Accounts (NHEA) growth rates, we estimate that per-patient billing will rise to only \$1,306 in 2022.
- 2) CBO assumed 90,000 Medicaid patients per year. This assumption is consistent with the 2019 T-MSIS patient count of 86,666 Medicaid beneficiaries.
- 3) CBO assumed a 57% average FMAP rate for 2021 and 2022. This assumption does not account for the distribution of UIOs across states. UIOs are disproportionately located in high FMAP states. The average FMAP for UIOs in 2021 was 60%. In 2022, the average FMAP rate for UIOs in 2022 is 67%. Because these FMAP rates are higher than the national average, cost-shifting will be smaller than CBOs estimates.

Lastly, CBO applied their national average FMAP calculation for each of its estimated 90,000 UIO Medicaid patients, regardless of where they lived. However, the UIO patient population is not equally distributed across each state, and not every UIO bills Medicaid for the same volume of its patients. Because NCUIHs estimate is based on actual payments made to each UIO within their state, we were able to factor in the contribution of each beneficiary within their state, instead of broadly applying national averages.

Table 2 (below) shows a comparison between CBO and NCUIH methods, and the resulting differences between the forecasted costs over a two year and ten-year period. NCUIH projects that the federal cost of 100% FMAP at less than half of the amount that is estimated by the CBO, both during the time of ARPA implementation as well as over the next 10 years (were 100% FMAP extended indefinitely). Even if imperfect, NCUIH's analysis of UIO billing data is more well-tailored to current Medicaid spending trends, and suggests that states and UIOs may actually benefit a great deal at less than half the budgetary impact than was initially suggested by the CBO.



Table 2: NCUIH and CBO Estimates for the Federal Cost of 100% FMAP

	Annual Cost Per-Patient	Average FMAP in 2021	Average FMAP Rate in 2022	2-Year Cost Shift (2021-2022)	10-Year Cost Shift* (2021- 2030)
CBO Estimates	\$2,000	57%	57%	\$155,000,000	\$941,000,000
NCUIH Estimates (based on T- MSIS)	\$1,306	65.1%	65.6%	\$70,407,559	\$547,432,000

**Rounded to the nearest hundred thousand*

Strengths, Limitations, and Unknowns

NCUIH is not aware of any other efforts to estimate the impact of ARPA Section 9815 based on data estimates for actual billing volume at UIOs (or any other federal legislation). This remains a key strength to NCUIH’s approach, and an innovative approach to urban Indian health policy analysis more broadly. Too often, national estimates overemphasize cost by applying national averages for what is (in actuality) a very particular portion of the Medicaid population within the country. NCUIH’s estimates are based on the realities of current UIO billing capacity, in the specific geographies where services are provided to patients. However, some inherent limitations to NCUIH’s approach remain, particularly when projecting impact beyond two years.

First, NCUIH assumed that the growth in Medicaid payment amounts to UIOs will follow general national trends. While UIOs will likely experience the same growth in costs as other healthcare facilities due to medical inflation and population growth, they may also experience additional UIO-specific policy changes. In particular, encounter rates may expand more quickly for UIOs than for other urban FQHCs if state or federal changes allow UIOs access to an expanded Medicaid reimbursement rate (with a maximum expansion to the IHS AIR). Such a change is unlikely to strongly impact NCUIH’s two--year estimate, given that no such change had yet occurred over halfway through the analysis period. However, if UIOs were to gain access to an enhanced reimbursement rate, NCUIH’s ten-year estimate would likely undercount UIO Medicaid billing since it is based on 2019 reimbursement data. However, it is important to note that CBO’s ten-year estimate still seems like a high or maximum estimate given that NCUIH’s estimate is based on current billing volume and is less than half of the CBO’s estimate. To reach the billing levels projected by the CBO, UIOs would need to double the acceleration of their Medicaid growth rate beyond the national average in a little over eight years, which would involve overcoming major capacity challenges (and increasing the number of patients served beyond current growth). Apart from issues of organizational capacity, there remain structural limitations on serving an

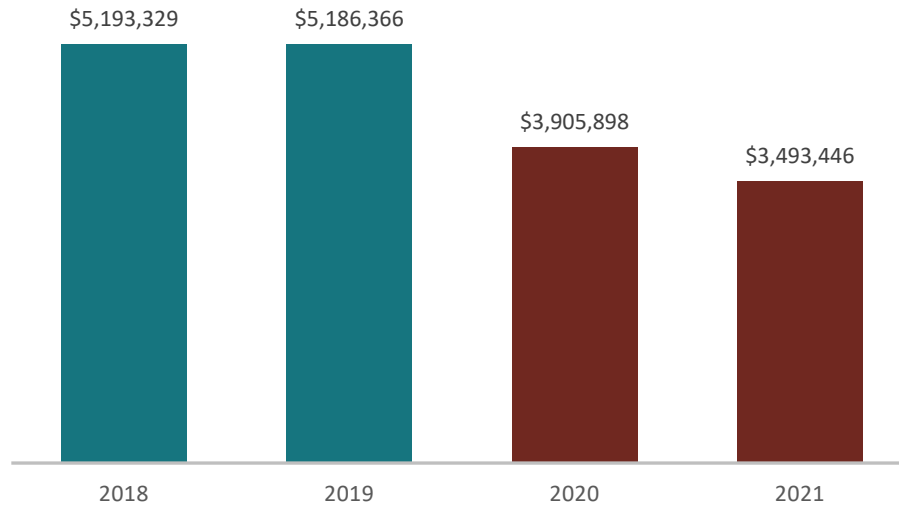


expanded patient population given that UIOs have historically not had access to federal facilities funds (apart from minor renovations to meet or maintain accreditation standards).⁵⁰

Second, NCUIH assumed that trends in pre-pandemic Medicaid billing (from 2019) will carry over into pandemic-era billing (2020 and beyond), because claims data is not yet available to examine probable changes in the population's actual usage of services during the pandemic. However, there is considerable evidence that Medicaid patients have sought and received fewer health care services during the pandemic (particularly during the earliest days of stay-at-home orders, during periods of high community spread, and prior to widespread vaccination). NCUIH was able to perform a small test of whether there was any systemic reduction in claims and payments to UIOs during the pandemic using Medicare data. Although T-MSIS reporting is only available through 2019, Medicare data was available for analysis through calendar year 2021 via the same methods used in previous reports.⁵¹ Unfortunately, UIOs observed around 38% reduction in Medicare claims in the first two years of the pandemic, compared to the two years prior to the pandemic (see Figure 2). Medicare billing at UIOs provides a substantially smaller proportion of overall reimbursement than Medicaid,⁵² for a specific population that may be more likely to avoid in-person healthcare (namely elders and disabled individuals at a higher risk of serious COVID-19). Although crude, this analysis suggests there was some national reduction in services at UIOs in the first two years of the pandemic, compared to the pre-pandemic year of baseline Medicaid data used for NCUIH's analysis (2019). This provides initial evidence for the prediction of a loss of billing revenue made in last year's report.⁵³ Yet in the absence of any pandemic-era Medicaid data, NCUIH was unable to adjust our two-year estimate for any possible reduction in patient services. We are aware that the pandemic has introduced an element of instability in third-party revenue. On a Fall 2020 NCUIH survey of UIOs, 50% of UIOs had reduced services in response to the pandemic, yet 59% offered some form of telemedicine in their stead (a percentage that has since increased). Therefore, it is possible that our two-year estimate of cost-shifting overestimates the extent of UIO billing by using pre-pandemic data. The effect on NCUIH's ten-year estimate is unknown – there is no clear indication for how long the pandemic will depress healthcare-seeking behaviors, or whether costs will be even higher once postponed care resumes.



Figure 2: Total Medicare Payments to all UIOs (2018-2021)



Lastly, NCUIH estimates have had to assume that FMAP rates in future years will reflect those currently set, given that state FMAP percentages are only set a year in advance. Our two-year estimate used the published FMAP rates, but our ten-year estimates depended on an assumption that 2023 FMAP rates will remain constant through 2030, making the estimates less reliable if there are large FMAP rate changes in that time period. Critically, the directionality of this effect is itself unknown – although state FMAP rates could decrease as states recover from the pandemic, they could also increase again to account for prolonged or future states of emergency. While changes in the future of state FMAPs are unpredictable, NCUIH’s effort to factor in the actual effect of each UIO’s individual state FMAPs remains a strength.



Part III: Discussion and Recommendations

In addition to performing an analysis of Medicaid claims, NCUIH spoke directly with six UIOs on this topic to inform our conclusions and discussion. NCUIH interviewed UIOs between December 2021 and April 2022, on topics including their experience after implementation of Section 9815 of ARPA, their payor mix, rate setting and negotiation, and communication with their state Medicaid office. UIO sites were selected based on their state in collaboration with CMS, and states were chosen based on a combination of factors such as UIO service population size, unique state policy environments, and innovative practices or partnerships. Full methods can be found in NCUIH's companion report "*Recent Trends in Third-Party Billing at Urban Indian Organizations: A Focus on Medicaid Managed Care.*"⁵⁴

A large opportunity to improve urban AI/AN healthcare disparities has opened, yet UIOs are not currently benefitting from Section 9815

As of publication of this report, none of the six UIOs interviewed for this project had seen a financial benefit from the passing of Section 9815 of ARPA, despite its inclusion in the bill as a means of supporting pandemic response and parity for the urban Indian healthcare system. **Based on this, NCUIH estimates that if all twenty-two states in which UIOs are located received 100% FMAP as authorized, the states will have saved \$38,912,984 without any financial benefit to UIOs as of August 2022.** If no state increases its reimbursement rates to UIOs by the time ARPA Section 9815 expires, UIOs will not have seen any financial benefits from the nearly \$76 million in state savings, despite performing critical healthcare services for a high-vulnerability group during the COVID-19 pandemic. Critically, CBO estimates have generally overestimated the federal cost compared to NCUIH's projections based on actual UIO billing data, inflation, and usage trends. There remains a great untapped potential benefit to UIOs, likely at a lower federal cost than initially anticipated.

NCUIH is aware of only two states which have elected to directly share financial savings from the 100% FMAP provision of ARPA with UIOs. In Minnesota, Governor Tim Walz has proposed a new grant program entitled "Supporting Urban American Indians in Minnesota Health Care Programs" in Minnesota's FY 2022 supplemental budget.⁵⁵ These funds (\$2.5 million in FY22-23 and \$5 million in FY24-25) are to be used to by the Indian Health Board of Minneapolis to "provide medical assistance, application assistance, increased care coordination, and outreach/navigation by community health workers to address health care needs and other social drivers of health."⁵⁶ It is NCUIH's understanding that this grant is funded at least in part by Minnesota's savings as a result of ARPA Section 9815. Similarly, in Colorado the state legislature recently authorized "a supplemental state payment to Urban Indian Organizations to address health-care disparities among the urban Indian community."⁵⁷ This two-year supplemental payment will total \$70,825 in state fiscal



year 2021-22 and \$48,025 in state fiscal year 2022-23.⁵⁸ As with Minnesota, it is NCUIH's understanding that this grant is funded at least in part by Colorado's savings as a result of ARPA Section 9815. However, in other states in which UIOs were interviewed, states have realized the benefits of 100% FMAP by a reduction of their Medicaid expenditures, but UIOs have not experienced any trickle down of those savings.

The Minnesota and Colorado grant programs represent an interesting and innovative best practice that may work well for some states during or shortly after the current period of 100% FMAP for services at UIOs. If UIOs work collaboratively with state Medicaid offices, calculating the amount of a state's savings may be relatively straightforward by using patient visit trends and billing amounts (similar to the methods employed to create the projections used in this report). Complications may arise in states where multiple UIOs bill Medicaid and/or where billing is done using a fee-for-service model, which might require greater coordination and effort to calculate the amount of money the state will save during two years of 100% FMAP reimbursement (compared to those solely utilizing PPS billing). However, reasonable estimates are still possible to create based on prior usage trends. In addition, it is important to note that, in the event of an indefinite extension of 100% FMAP for services at UIOs, any similar grant programs would be most effective if accompanied by a reimbursement rate increase. A rate increase will help to alleviate the underfunding of UIOs, further the federal government's efforts to meet its trust responsibility for AI/AN healthcare, and allow UIOs to reinvest increased financial resources in the provision of culturally focused and high-quality medical care to AI/ANs living in urban areas. As noted throughout this report, any rate increase during a period of 100% FMAP is at no cost to the state.

Since ARPA was enacted on March 11, 2021, NCUIH is not aware of any SPAs that have been approved to adjust the reimbursement rate paid to UIOs for the duration of 100% FMAP.ⁱⁱ While it is difficult to determine if this is because no SPAs for this purpose have been submitted (or if a limited amount have been submitted and are awaiting approval), every UIO which NCUIH interviewed for this project reported that their state was not planning to submit a SPA for the purposes of revising the rate paid for Medicaid services at UIOs. As a general matter, beyond the information gleaned

ⁱⁱ Note that Oregon SPA #20-0010 and Oregon SPA #20-0019 permit a UIO using the prospective payment system (PPS) rate to chose to receive "an enhanced PPS rate during the duration of the public health emergency." For 2020, Oregon calculated the enhanced PPS rate "by dividing total Medicaid FFS billing for services rendered during the analogous calendar month in 2019 by the total number of Medicaid patient encounters during the same month in 2020." In 2021, Oregon calculated the enhanced PPS rate "by dividing total Medicaid FFS billing for services rendered during the analogous calendar month in 2019 by the total number of Medicaid patient encounters during the current billing month" analogous with the 2019 reimbursement month. Oregon SPA # 20-0019 notes that "All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extensions." While the public health emergency currently overlaps with the period of 100% FMAP, the Oregon SPAs predate the passage of ARPA and the 100% FMAP provision.



from UIOs interviewed for this project, NCUIH is not aware of any SPAs drafted and submitted for the purpose of adjusting the rate paid for Medicaid services received at UIOs related to 100% FMAP.ⁱⁱⁱ

A potential increase in Medicaid reimbursements to UIOs (as a result of 100% FMAP for services provided at UIOs) is important given the United States' chronic underfunding of UIOs and the American Indian/Alaska Native (AI/AN) healthcare system generally.⁵⁹ The United States has a trust responsibility to maintain and improve the health of all AI/ANs, no matter where they live.⁶⁰ To fulfill the trust responsibility, Congress has declared it to be the national policy of the United States "to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."⁶¹ Despite this obligation, the Indian Health Service, the federal agency charged with fulfilling the trust responsibility for health services, is funded at roughly 14 percent of need.⁶² According to the United States Commission on Civil Rights, "[t]he efforts of the federal government have been insufficient to meet the promises of providing for the health and wellbeing" of AI/ANs, and as a result "a vast health disparity exists today between Native Americans and other population groups."⁶³ In fact, "when adjusted for inflation and population growth, the IHS budget has remained static in recent decades."⁶⁴

UIOs typically receive only one percent of IHS' limited budget.⁶⁵ Historically, "the budget for urban Indian health care has failed to keep pace with inflation and the growing urban Indian population."⁶⁶ In 2018, while average health care spending was \$11,172 per person⁶⁷, Congress appropriated just \$672 per AI/AN patient at UIOs.⁶⁸ Even after historic increases to the Urban Indian Health line item in the IHS budget, Congress appropriated only \$73,424,000 for urban AI/AN health in Fiscal Year 22, less than forty percent of the National Tribal Budget Formulation Workgroup's recommendation for the Urban Indian Health line item.⁶⁹ Congress' failure to appropriate sufficient funding for urban AI/AN health "likely fails to meet the obligations of the federal government under the trust relationship."⁷⁰

As a result of Congress' failure to fully fund UIOs, UIOs "must continue to leverage additional health care funds from other federal agencies, states, and foundations," although this funding also remains limited.⁷¹ Notably, Congress' annual appropriation for the Urban Indian health line item is less than the amount UIOs receive from Medicaid reimbursement in a similar one-year time frame, as detailed above. In addition, in each of the last two Fiscal Years,

ⁱⁱⁱ Like Oregon, Montana has proposed an increase to the PPS rate for UIOs beginning on July 1, 2021 and lasting for the duration of the public health emergency. Montana's Disaster Relief SPA proposes to increase the UIO PPS rate by 61.1%. While the effective date of this rate increase occurs during the period of 100% FMAP, it is unclear whether 100% FMAP is the motivating factor for this SPA.



Congress' appropriations for the Urban Indian Health line item has been less than the two-year cost saved by state governments by the federal government's assumption of cost through the 100% FMAP provision of ARPA. Sharing even just a portion of the savings each state has received as a result of 100% FMAP for services provided by UIOs could have an outsize impact on UIOs budgets and their provision of care.

Best practices for the remaining period of 100% FMAP under ARPA, and beyond

ARPA Section 9815 presents a unique opportunity for states and UIOs to collaborate to strengthen the provision of high quality and culturally focused care to AI/AN patients. As detailed above, during the two-year period of 100% FMAP, a total of \$70,407,559 of UIO Medicaid costs will shift from State governments to the Federal government. States and UIOs would both benefit if state savings were extended to UIOs.

Perhaps the most straightforward way for both states and UIOs to benefit during the two-year period of 100% FMAP is for states to submit SPAs that increase the reimbursement rate for Medicaid services provided at a UIO, potentially to the AIR or an AIR developed by IHS that is specific to UIOs. This would result in increased revenues to UIOs, who could then invest the revenue to in ensure the quality of existing services, broaden service offerings, and improve their offerings to urban AI/AN communities in general. During the period of 100% FMAP, this rate increase would be at no cost to states.

All UIOs who spoke to NCUIH for this project reported that they had communicated with a state government concerning a rate change concordant with implementation of 100% FMAP. However, the level of engagement and support for a rate change differed greatly across the country. In some states, UIOs reported that they had in-depth conversations with the state regarding a rate change, in other states UIOs reported that conversations were perfunctory at best. Interestingly, one UIO reported that while they had inconsistent engagement with their state Medicaid office about a rate change, they had extensive engagement through other offices in the state executive branch.

Among those UIOs who did have extensive engagement with a state concerning a rate change, they reported two obstacles that the state raised to changing the rate paid to UIOs. First, states were unwilling to invest the resources necessary to change the rate given the relatively short two-year time frame in which 100% FMAP is available. UIOs reported that states described bureaucratic blocks, political challenges, and logistical challenges which the states did not feel could be overcome quickly enough. A second related obstacle that states raised to UIOs was their worry that once the two-year provision of 100% FMAP expires, any state which increased the rate paid to UIOs for services to



Medicaid beneficiaries would now be responsible for that higher rate without federal support. It is important to note that UIOs who experienced a high degree of interaction and collaboration with their state on potential rate changes reported an appreciation for the state's position, regardless of any disappointment. This emphasizes the critical importance of state agencies meaningfully engaging and conferring with UIOs.

Further federal support for increased reimbursement rates to UIOs may be effective in supporting states wishing to realize the shared benefit of 100% FMAP for UIOs and the state. As detailed above, in SHO Letter # 21-004 CMS offered to provide technical assistance to states interested in adjusting their reimbursement rates for UIOs following passage of 100% FMAP.⁷² However, it is unknown if any states have contacted CMS for technical assistance in adjusting their reimbursement rate.

Given that 100% FMAP expires in less than a year (at time of writing), it appears unlikely that any states will submit a SPA to change the rate for Medicaid services provided at UIOs for the duration of the 100% FMAP period. Unfortunately, this will result in an unrealized financial benefit to states and UIOs. However, given that most of the barriers to rate change raised by states concerned a short time frame in which to overcome logistical hurdles and financial loss with the end of 100% FMAP, it is possible that an indefinite extension might result in states supporting a rate change, submitting SPAs, and a shared benefit to states and UIOs from the financial savings. Just as in 1976, extending 100% FMAP indefinitely will help “to implement the Federal responsibility for the care . . . of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs.”⁷³ This is a long-term strategy endorsed by leading AI/AN organizations and legislation is under consideration in Congress to extend parity to each part of the Indian Health system.⁷⁴

It is critical that UIOs, states, and the federal government to begin to develop plans for future implementation, given that legislation is currently pending in Congress to extend 100% FMAP for services provided to Medicaid beneficiaries at UIOs indefinitely.⁷⁵ For example, CMS and IHS might consider drafting an MOA clarifying UIO eligibility for an AIR, so that it is ready for signature upon passage of indefinite 100% FMAP.

At the state level, UIOs and states can work together to explore options for adjustments of reimbursement rates if 100% FMAP for UIOs is extended indefinitely. For example, a state could pass legislation directing the state Medicaid agency to submit a SPA increasing the UIO reimbursement rate in the event of federal re-authorization for 100% FMAP



following its expiration in 2023. The state Medicaid agency could even draft such a SPA in advance, so that it could be submitted as soon as possible after re-authorization.

While most UIOs have not seen a financial benefit from ARPA Section 9815 to date, there remains time for states to submit SPAs increasing the reimbursement rate to UIOs, at no cost to the state. As Congress continues to consider indefinite expansion of 100% FMAP for services provided at UIOs, it is important for all stakeholders to plan how to best implement the Federal responsibility for the care of AI/AN people by utilizing expanded federal resources to improve the services and facilities of UIOs.⁷⁶



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