

MEDICAID 101

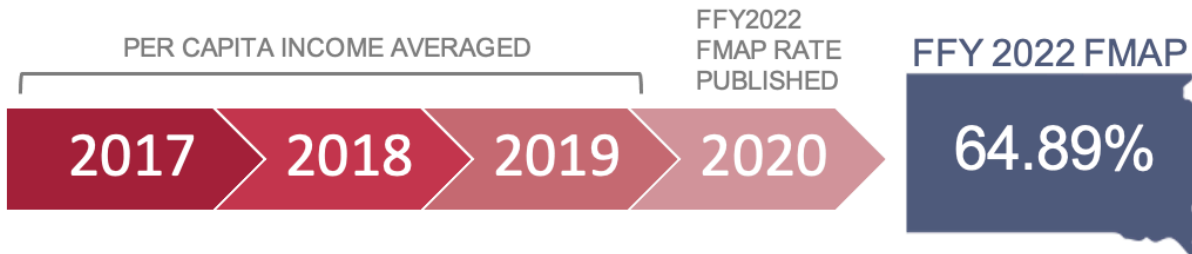
UPDATED OCTOBER 20, 2021

Medicaid is funded jointly by the state and federal government. The federal government’s share of a state’s Medicaid expenditures is called the Federal Medical Assistance Percentage (FMAP). States must contribute the remaining portion to qualify for the federal funds. The FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with per capita incomes lower than the national average.

$$FMAP = 1 - 0.45 \times \left[\frac{\text{State Per Capita Income}^2}{\text{U.S. Per Capita Income}^2} \right]$$

Section 1905(b) of the Social Security Act (SSA) sets a statutory minimum FMAP of 50% meaning that the federal government will always contribute at least 50% of the cost of Medicaid in each state. Similarly, the SSA also designates a cap of 83%, meaning states must always contribute at least 17% of the cost of Medicaid in their state. A state with average per capita income has an FMAP rate of 55%. The FMAP changes each federal fiscal year (October 1 – September 30); FMAP rates are generally released in the November/December of the year prior to allow states to budget for FMAP changes. To moderate large fluctuations in a state’s FMAP, per capita income used in the formula is averaged over three years.

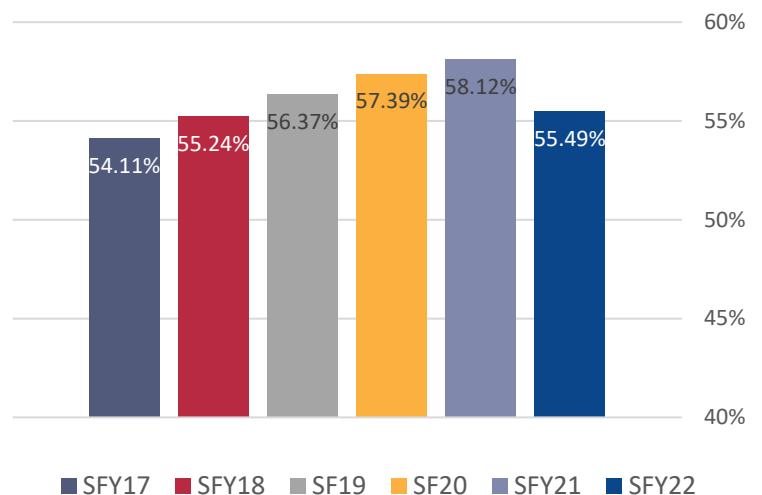
FEDERAL FISCAL YEAR 2022 FMAP CALCULATION OCTOBER 2021 – SEPTEMBER 2022



Blended FMAP

Because the state fiscal year runs from July 1 to June 30, South Dakota uses a blended FMAP to calculate the budget. The blended FMAP uses one quarter of the previous federal fiscal year and three quarters of the next federal fiscal year.

South Dakota Blended FMAP



Enhanced FMAP

Some services and coverage groups have statutorily higher FMAPs than the state’s regular FMAP.

- Children’s Health Insurance Program

(CHIP) Recipients

- Medicaid Expansion Recipients
- Money Follows the Person (MFP) Services
- Family Planning Services
- Services Received through Indian Health Service or a Tribal 638 Provider

CARES Act Enhanced FMAP

The Coronavirus Aid, Relief, and Economic Security (CARES) Act authorized a 6.2 percentage point increase in federal Medicaid matching funds from January 1, 2020 through the quarter in which the public health emergency (PHE) ends if states meet certain conditions. States must meet five conditions to receive the enhanced CARES Act FMAP:

1. States must apply Medicaid eligibility standards that are no more restrictive than those in place on January 1, 2020.
2. States must not increase any Medicaid premium above those in effect on January 1, 2020.
3. States must cover coronavirus testing and COVID-19 treatment, including vaccines, specialized equipment and therapies without cost sharing during the PHE.
4. States cannot increase political subdivisions' contributions to the non-federal share of Medicaid costs beyond what was required on March 1, 2020.
5. States must provide continuous eligibility through the end of the month in which the PHE ends for individuals enrolled as of March 18, 2020 or any time thereafter during the PHE unless the person moves out of state, dies, or requests a voluntary coverage termination.

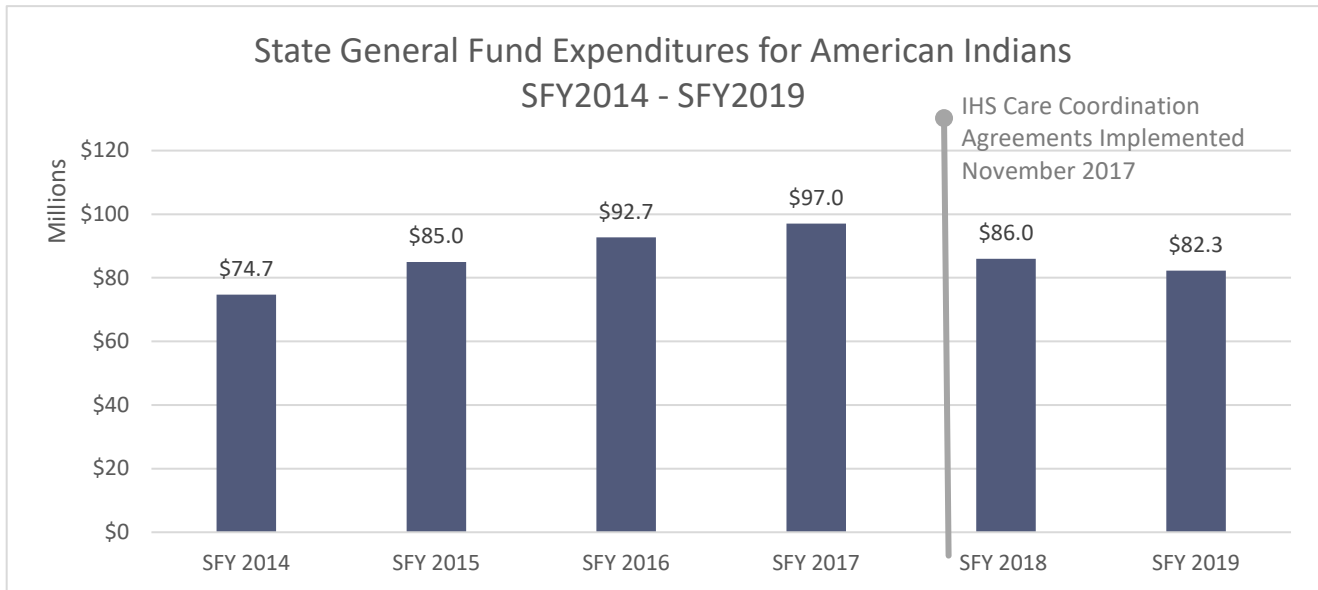
By drawing down the enhanced funding, states automatically attest to these conditions. CMS may require a state to return funds if CMS later determines that the state did not meet all five conditions.

American Indians, Indian Health Service (IHS) and 100% FMAP

American Indians eligible for Medicaid can elect to receive medical services from IHS or a tribal 638 provider as they are “dual eligible” for both programs.

- When an American Indian receives services through Indian Health Services or a tribal 638 provider, the service is eligible for 100% federal financial participation. The FMAP for these services is 100%, meaning there is no cost to the state.
- When an American Indian receives services at a non-IHS provider, the service is paid at the state's regular FMAP, meaning that the federal government pays roughly 58% of the cost and the state pays the remaining 42% of the cost.

State general fund expenditures for American Indians eligible for Medicaid has been growing steadily.



2016 Received Through Policy Change

Historically, the Centers for Medicare and Medicaid Services interpreted the “received through” language in Section 1905(b) of the SSA to mean that 100% FMAP was only available when a service took place inside the four walls of an IHS facility. In 2015, South Dakota asked the federal government to review this interpretation. In 2016, CMS issued a State Health Official Letter revising federal interpretation of the policy. The new policy:

- Changes the interpretation of “received through” to apply to services referred by IHS or a tribal 638 provider under a Care Coordination Agreement.
- Expands the definition of services eligible for 100% FMAP to include specialty services including transportation, pharmacy, hospital, and long-term care services.
- Maintains IHS responsibility to provide healthcare to American Indians.

This change makes it possible for the states to receive 100% FMAP when an American Indian is referred to a non-IHS provider under a care coordination agreement between IHS and the non-IHS provider. The federal policy has four main conditions:

1. Participation by providers and patient must be voluntary;
2. Services outside IHS must be provided via a written care coordination agreement with referral from IHS;
3. IHS must maintain responsibility for patient care; and
4. Medical records must be shared with IHS.

When the requirements are met, this converts the FMAP from the regular FMAP to 100% FMAP, saving state general fund dollars. The FMAP change does not change or impact the rate paid to providers.

Indian Health Service Care Coordination Agreements in South Dakota

A model Care Coordination Agreement (CCA) for use by Great Plains Area IHS was drafted through collaboration by South Dakota and IHS Headquarters and approved by IHS’s legal team. The CCA is an agreement between IHS and the non-IHS provider; agreements are signed at the entity level, meaning that one agreement encompasses all Great Plains Area IHS providers and locations. Similarly, one agreement encompasses the non-IHS provider entity including all that entity’s providers and locations.

Initial Care Coordination Agreements were signed in November 2017 between Great Plains Area IHS and Avera Health, Monument Health, and Sanford Health. Additional care coordination agreements have been added since 2017. Agreements are signed by the non-IHS provider and IHS and routed through the state to track the care coordination status. State general fund savings over three years totals \$21.5 million. The Department of Social Service tracks state savings in a [monthly report](#).

The first \$3 million of savings each year is used to address service gaps for American Indians in Medicaid. The first \$3 million of general fund savings is used to fund substance use disorder (SUD) services for all Medicaid adults, fund additional mental health practitioners, and community health worker services. After the first \$3 million is shared, providers participating in Care Coordination Agreements are eligible for shared savings payments. Shared Savings payments are calculated by the amount of state general fund savings generated each calendar year. Payments are distributed using a tiered formula:

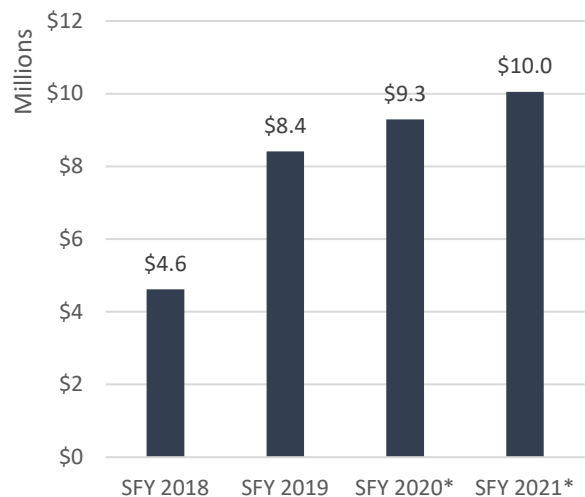
Care Coordination Shared Savings Distribution			
State General Fund Savings	\$0 - \$500,000	\$500,000 - \$1M	> \$1M
Shared Savings Tier	5%	10%	15%

The savings are distributed as a Medicaid Supplemental Payment, requiring a State Plan Amendment to be submitted to the Centers for Medicare and Medicaid Services (CMS) in order to match state general fund shared savings payments with federal funds at the state’s FMAP.

Indian Health Services (IHS) has indicated to the state that they are unable to participate in shared savings due to federal anti-kickback statutes. Savings designated for IHS are used to fund Intergovernmental Personnel Act (IPA) staff to assist IHS with implementation of the care coordination agreements. South Dakota has three IPA nurse case manager positions and one IPA midlevel provider position. IPA staff are state employees who are assigned to work at IHS service units. Nurse case managers are currently located in Pine Ridge, Rosebud, and Eagle Butte.

Additional general fund savings each year are reinvested into the Medicaid program to enhance rates for community providers.

State Savings Generated by IHS Care Coordination Agreements



* Note: CARES Act increased FMAP by 6.2% from January 1, 2020 through June 30, 2020 during the COVID-19 Public Health Emergency, reducing state savings generated through care