DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD # 22-006

RE: Additional Guidance on Section 9815 of the American Rescue Plan Act of 2021

December 27, 2022

Dear State Medicaid Director:

This State Medicaid Director Letter (SMDL) provides additional guidance to states on section 9815 of the American Rescue Plan Act of 2021 (ARP) (P.L. 117-2). Section 9815 of the ARP amends the third sentence of section 1905(b) of the Social Security Act (Act) to make a 100 percent federal medical assistance percentage (FMAP) temporarily available for Medicaid services received through certain Urban Indian Organizations (UIOs) and certain Native Hawaiian health care providers. The Centers for Medicare & Medicaid Services (CMS) previously described this provision in State Health Official (SHO) Letter #21-004, "*Temporary increases to FMAP under sections 9811, 9814, 9815, and 9821 of the ARP and administrative claiming for vaccine incentives*" (August 30, 2021).[1]

This SMDL provides additional information about CMS's interpretation of section 9815 of the ARP by explaining: 1) which specific Native Hawaiian health care providers are referenced in section 9815 of the ARP; and 2) that the 100 percent FMAP available under section 9815 of the ARP for Medicaid services "received through" certain UIOs and certain Native Hawaiian health care providers is also available when these Medicaid services are provided by other health care providers pursuant to care coordination agreements with the qualifying providers, consistent with the guidance in SHO Letter #16-002, "*Federal Funding for Services 'Received Through' an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives*" (February 26, 2016).[2]

1. Native Hawaiian Health Care Providers Referenced in Section 9815 of the ARP

Under section 9815 of the ARP, a state may receive 100 percent FMAP for its medical assistance expenditures for services received through "a Native Hawaiian Health Center (as defined in section 12(4) of the Native Hawaiian Health Care Improvement Act) or a qualified entity (as defined in section 6(b) of such Act) that has a grant or contract with the Papa Ola Lokahi under section 8 of such Act." Under section 6(b) of the Native Hawaiian Health Care Improvement

[1] SHO Letter #21-004 is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-004.pdf.
[2] For specific details about what a qualifying care coordination agreement includes, please see SHO Letter #16-002 which is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf.

Act (NHHCIA), a "qualified entity" is "a Native Hawaiian health care system" (System). 42 U.S.C. § 11705(b).

Section 8 of the NHHCIA (42 U.S.C. § 11707), referenced at the end of section 9815 of the ARP, does not address grants or contracts between Papa Ola Lokahi and health care providers. Instead, section 8 of the NHHCIA sets forth certain provisions and requirements for the Secretary's grants or contracts made "under this Act," meaning the NHHCIA. Under the NHHCIA, the U.S. Department of Health & Human Services (HHS) makes grants or enters into contracts in two ways: (1) with Systems (to provide "comprehensive health promotion and disease prevention services as well as primary health services to Native Hawaiians" pursuant to the authority in section 6 of the NHHCIA (42 U.S.C. § 11705)),[3] and (2) with Papa Ola Lokahi (for activities such as coordinating, implementing and updating a Native Hawaiian comprehensive health care master plan; training; research; data collection; coordination of health care programs and services; and administration of special project funds, pursuant to the authority in sections 4 and 7 of the NHHCIA, 42 U.S.C. §§ 11703 and 11706).[4]

While Systems are recognized and certified by Papa Ola Lokahi for purposes of receiving HHS funding under the NHHCIA (section 12(6)(F) of the NHHCIA, 42 U.S.C. § 11711(6)(F)), the NHHCIA does not authorize HHS contracts or grant awards to Papa Ola Lokahi to provide health services or to provide health services through Systems. The NHHCIA also defines Native Hawaiian Health Centers (Centers) (section 12(4) of the NHHCIA, 42 U.S.C. § 11711(4)), and while Centers may be part of a System, the NHHCIA does not authorize HHS contracts or grant awards to Centers directly.

Because there are no health care providers with grants or contracts with Papa Ola Lokahi to provide health services under section 8 (or any section) of the NHHCIA, CMS interprets section 9815 of the ARP's phrase "a qualified entity … that has a grant or contract with the Papa Ola Lokahi under section 8" of the NHHCIA to refer to Systems that: (1) otherwise meet the definition of a System at section 12(6) of the NHHCIA (42 U.S.C. § 11711(6)) (including that they are recognized and certified by Papa Ola Lokahi under this NHHCIA provision), and (2) have a grant or contract with HHS under section 6 of the NHHCIA (42 U.S.C. § 11705) that meets the requirements in section 8 of the NHHCIA (42 U.S.C. § 11707). Thus, state expenditures on Medicaid services received through the five Systems that have grants from or

[3]Under 42 U.S.C. §11705, HHS may make grants to or enter into contracts with qualified entities for the purpose of providing comprehensive health promotion and disease prevention services as well as primary health services to Native Hawaiians. Systems are defined in 42 U.S.C. § 11711(6) to mean an entity in which Native Hawaiian health practitioners provide or arrange for health care services, significantly participate in the planning, management, monitoring, and evaluation of health care services and that, among meeting other requirements, is organized under the laws of Hawaii and certified by the Papa Ola Lokahi. Additionally, per 42 U.S.C. § 11705(d), the Secretary may make a grant to, or hold a contract with, not more than 5 Systems per fiscal year. The Health Resources and Services Administration (HRSA) administers the HHS programs that provide funding to Native Hawaiian providers under the NHHCIA.

[4] Under 42 U.S.C. § 11706, HHS may make grants to or enter into contracts with Papa Ola Lokahi for specified administrative purposes. The NHHCIA also provides for grants or cooperative agreements with Papa Ola Lokahi for the provision of scholarship assistance (42 U.S.C. § 11709) which is unrelated to the provision of health care services at issue in section 9815 of the ARP.

contracts with HHS under section 6 of the NHHCIA (42 U.S.C. § 11705) will be matched at 100 percent FMAP under section 9815 of the ARP.

Separately, because HHS does not enter directly into contracts with, or provide grants to, Centers under the NHHCIA, CMS does not interpret section 9815 of the ARP's phrase "has a grant or contract with the Papa Ola Lokahi under section 8" of the NHHCIA to apply to Centers. Rather, CMS interprets section 9815 of the ARP to authorize 100 percent FMAP for state expenditures on Medicaid services received through all Centers, as defined in section 12(4) of the NHHCIA (42 U.S.C. § 11711(4)), regardless of whether the Center is part of a System that has a grant from or contract with HHS under section 6 of the NHHCIA (42 U.S.C. § 11705). When claiming 100 percent FMAP for Medicaid services received through a Center, the state would need to attest that the provider meets the definition of a Center in section 12(4) of the NHHCIA (42 U.S.C. § 11711(4)).[5]

In sum, CMS interprets section 9815 of the ARP to authorize 100 percent FMAP for state expenditures on Medicaid services received through the following Native Hawaiian health care providers: (1) all Systems that meet the definition at 42 U.S.C. § 11711(6) and have a grant or contract with HHS under 42 U.S.C. § 11705; and (2) all Centers as defined in 42 U.S.C. § 11711(4), regardless of whether the Center is part of a System that has a grant from or contract with HHS under section 6 of the NHHCIA (42 U.S.C. § 11705).

States may claim FFP under section 9815 of the ARP retroactively back to April 1, 2021, provided that their claims are filed within the two-year claims filing limit described in section 1132 of the Act.

2. Medicaid Services Received through Providers Referenced in Section 9815 of the ARP Pursuant to a Care Coordination Agreement

As discussed in SHO Letter #21-004, CMS interprets the amendments to section 1905(b) of the Act made by section 9815 of the ARP to apply to Medicaid services received by *all* Medicaid beneficiaries through UIOs with a grant or contract with the Indian Health Service (IHS) under title V of the Indian Health Care Improvement Act, and through certain Native Hawaiian health care providers.[6]

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[5] The term Native Hawaiian Health Center (Center) is defined in 42 U.S.C. 11711(4) to mean a public or private nonprofit entity organized under Hawaii state law in which Native Hawaiian health practitioners provide or arrange for health services and significantly participate in the planning, management, monitoring, and evaluation of health care services.

[6] As explained in SHO Letter #21-004, based on the legislative history of section 9815 of the ARP, CMS has interpreted that provision to apply to expenditures for Medicaid services received by all Medicaid beneficiaries through the providers listed in section 9815 of the ARP. CMS's longstanding interpretation of the pre-ARP language in section 1905(b)'s third sentence, under which 100 percent FMAP for services received through IHS facilities (whether operated by IHS or by Tribes or Tribal organizations) is limited to Medicaid services received by American Indian and Alaska Native (AI/AN) beneficiaries, remains unchanged.

In SHO Letter #16-002[7] and subsequent Frequently Asked Questions (FAQ)[8] that CMS issued in 2017, CMS explained that the 100 percent FMAP under section 1905(b) of the Act is available for Medicaid services that are "received through" IHS/Tribal facilities because they are furnished by non-IHS/Tribal providers pursuant to a "care coordination agreement" with an IHS/Tribal facility, if that care coordination agreement meets certain criteria outlined by CMS in the 2016 and 2017 guidance.

As explained in SHO Letter #16-002, amounts paid by the state for Medicaid services provided in accordance with a qualifying care coordination agreement are eligible for the 100 percent FMAP authorized under section 1905(b) of the Act. Section 9815 of the ARP amends section 1905(b) of the Act to authorize 100 percent FMAP for Medicaid services received through certain UIOs and certain Native Hawaiian health care providers, and does so by using language that is nearly identical to the language of the existing authority providing for 100 percent FMAP for Medicaid services received through IHS/Tribal facilities. Thus, the guidance in SHO Letter #16-002 explaining that 100 percent FMAP is available for state expenditures on Medicaid services furnished by non-IHS/Tribal providers under a qualifying care coordination agreement with an IHS/Tribal facility also applies with respect to state expenditures on Medicaid services furnished under a qualifying care coordination agreement with the providers listed in section 9815 of the ARP.

Consistent with SHO Letter #16-002, states can claim the 100 percent FMAP under section 9815 of the ARP for their expenditures on Medicaid services furnished under a qualifying care coordination agreement only beginning with the date of execution of such an agreement. In addition, states should keep in mind that the 100 percent FMAP authorized under section 9815 of the ARP is limited to the eight fiscal quarters beginning April 1, 2021 and ending March 31, 2023.

Technical Assistance

As explained in SHO letter #21-004, section 9815 of the ARP temporarily changes the federal matching percentage that CMS pays to states for certain Medicaid expenditures, but that section is silent about the payment rates states opt to pay to the health care providers listed in it. States have the discretion to set and adjust Medicaid provider payment rates, consistent with section 1902(a)(30)(A) of the Act, as long as the state payment rates are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the state plan at least to the extent that such care and services are available to the general population in the geographic area. States must comply with the provisions of section 1902(bb) of the Act when setting Medicaid payment rates for Federally Qualified Health Center (FQHC) services and Rural Health Clinic (RHC) services (as described in section 1905(a)(2) of the Act) that are furnished by FQHCs and RHCs. CMS is available to provide technical assistance to states that believe adjusting their reimbursement rates to UIOs, Centers, or Systems is appropriate.

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[7] SHO Letter #16-002 is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf.
[8] The 2017 FAQs are available at: https://www medicaid.gov/federal-policy-guidance/downloads/faq11817.pdf.

We encourage states needing technical assistance to contact their CMS state lead, and UIOs, Centers, and Systems needing technical assistance to contact their CMS Native American Contact.[9] For more information or questions regarding this SMDL, please contact Kitty Marx, Director, Division of Tribal Affairs, kitty.marx@cms.hhs.gov.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

[9] Native American Contacts: https://www.cms.gov/files/document/cms-native-american-contact.pdf.