South Dakota Health Care Solutions Coalition
100% FMAP Subgroup
Meeting Notes 2/22/2017

Coalition Attendees: Kim Malsam-Rysdon, Jerilyn Church, Lynne Valenti, Brenda Tidball-Zeltinger, Kelsey Smith, Charlene Red Thunder, Sarah Aker, Mike Diedrich, Danielle Hamann (for Deb Fischer-Clemens), Shelly Ten Napel, Nick Kotzea

Welcome and Introductions

Kim Malsam-Rysdon welcomed the group and overviewed the purpose of the subgroup to develop recommendations for moving forward with 100% FMAP.

Review Current 100% FMAP Options in Medicaid

Brenda Tidball-Zeltinger reviewed how American Indians use IHS and Tribal 638 facilities and how those expenditures qualify for 100% FMAP. SD Medicaid's expenditures for IHS services were approximately $72.8 million in SFY14 and $69.8 million in SFY16. During that same time period, the IHS outpatient encounter increased from $350 per encounter in CY2015 to $391 in CY2017, equivalent to a 11.71% increase. Expenditures for American Indians for care outside IHS increased from $182 million ($85 m general funds) in SFY15 to $191 million ($92.7 m general funds) in SFY16. The trend is that the utilization of care received directly from IHS and eligible for 100% FMAP is declining while care outside IHS is increasing. Nebraska and Wyoming recently submitted State Plan Amendments clarifying IHS and 638 services eligible for 100% FMAP. Nick Kotzea asked why utilizing the 100% FMAP would require a Medicaid State Plan Amendment. The state does not think implementing or accessing the new guidance from CMS should require a State Plan Amendment. Jerilyn commented that a SPA would provide assurances to CMS that tribal consultation took place and that there is tribal buy-in and engagement.

Kim asked Nick to give an update about North Dakota's progress on using the 100% FMAP policy. The ND Legislature passed bills that essentially mandated exploration of the 100% FMAP policy.

Nick asked about the care coordinator agreements that the state was working on last year with the federal government and if there is an opportunity to loosen the language in those agreement to make them more flexible and practical for stakeholders. We do not know yet how flexible the new administration will be on this point. Seema Verma has not been confirmed at CMS yet. Our experience with the last administration is that they felt they were going as far as they could in this regard. The ask for the new administration is for HHS to rethink its role in funding services to these individuals.

Jerilyn Church noted that she recently had a call with Captain Francis Fraiser, Acting Area Director of IHS, to identify appropriate individuals at the area office or at IHS headquarters to engage with the state on this issue. Great Plains Tribal Chairman's

Health Board (GPTCHB) met with two senior staff and encouraged them to reach out to the state to re-explore how to make care coordination work.

Kim asked Jerilyn to give an update about what's happening at the federal level with IHS. Tribes are preparing to outline their priorities. GPTCHB met with Senator Thune and Senator Rounds about addressing IHS issues. Fixing IHS is a priority for Senator Thune and Senator Rounds.

Charlene Red Thunder presented a PowerPoint overviewing tribal self-governance and 638 authority. Title I contacts are approved locally by the area office. Title V contracts are reviewed by IHS Headquarters since the Great Plains area does not have an Area Lead Negotiator.

Kim asked what happens if a Title I contract is denied. IHS would tell the tribe what is missing or what the tribe needs to improve in order for the Title I contract to be approved. Title I contracts are almost always accepted. Crow Creek is the only tribe in South Dakota where IHS runs everything. There's no recent history of a tribe being denied for Title I or Title V. Jerilyn noted that tribes work through any issues that would potentially cause a denial during the planning phase. Additionally, there has never been a tribe that has taken over their program through Title V and then rescinded control back to IHS. Programs tend to thrive and do better under tribal authority than under IHS direct service.

Shelly asked if the tribal 638 FQHC status allows for tribes to also receive 330 FQHC funding. There are tribes that have the IHS 638 contract as well as 330 funding; however, this is not common nationwide. Some tribes pool funding to form a consortium to provide more services for their members such as nursing facility services.

GPTCHB is encouraging tribes to move towards Title V by starting with services already under Title I; this would give them an opportunity to pursue greater funding and move towards assuming full responsibility of their health programs. There are some barriers in place in the Great Plains region. The Fort Laramie treaty is unique in that it has explicit language regarding access to health care in exchange for land. Generationally, American Indians in our region have fought to protect and pursue the obligations that came with those treaties. There is also a lack of encouragement from the Great Plains Area IHS office for tribes to move towards Title V. Additionally, while the tribal leadership may see a benefit to pursuing Title V, support is sometimes not present in the community since IHS is a major employer in tribal communities. Title V contracts contain provisions for keeping current employees and allowing current employees to maintain federal status. Tribes need to ensure community buy-in before moving forward with Title V contracts.

Some tribes also lack capacity in some areas such as business office practices and they are not always billing for services. GPTCHB is working with tribes to develop business office practices and ensure that tribes are leveraging third party billing opportunities. The IHS RPMS billing software is also a barrier. IHS has tried to revamp

that system to make it easier for tribes to bill, but the system is antiquated and not designed as a third party billing system.

Shelly noted that standalone primary care clinics are becoming less predominant as the billing requirements become more complicated. There's an opportunity to share infrastructure and knowledge of billing/finance when operating as part of a system.

Kim asked if there are readiness assessments that could be used to gauge where tribes are at in the Great Plains region. Jerilyn indicated there is a team in Oklahoma that will assist tribes that apply for planning grants. Tribes often work with a consultant and an attorney during the planning phase. The IHS Office of Self Governance also can assist tribes. Jerilyn provided a list of each tribe and their contract status. Next steps would be to further determine the degree of services provided as identified in this document.

Kim asked what level of interest is there from tribes in the Great Plains to pursue Title V. Jerilyn indicated that there is always a willingness to expand access for tribal members and that the concept has been shared with multiple tribal leaders.

The group discussed next steps for helping tribes gain capacity in the short term. Ideas included exploring grant opportunities to build tribal infrastructure; exploring administrative assistance opportunities in Medicaid to support billing; and bringing Tribal Health Directors together for training on business office practices. Jerilyn indicated that GPTCHB would put together a survey for tribal health directors to identify needs. GPTCHB will target having the survey distributed by March 9, 2017.

Next Steps

Kim Malsam-Rysdon proposed meeting after the Coalition meeting scheduled for March 9 and after GPTCHB has had a chance to draft and distribute the survey to tribal health directors. Further explore the list of Title I and Title V contracts to determine services provided.

Next Meeting

The subcommittee will meet again via phone or in person on Tuesday, April 11 at 3:00 p.m. CT.

1.866.410.8397
passcode: 6057734836#
For those in Pierre, we will meet in the Governor's Small Conference Room.