South Dakota Health Care Solutions Coalition
100% FMAP Subgroup
Meeting Notes 5/4/2017

Attendees: Kim Malsam-Rysdon, Lynne Valenti, Brenda Tidball-Zeltinger, Shelly Ten Napel, Nick Kotzea, Kathaleen (Kathy) Bad Moccasin, Sarah Aker, Kelsey Smith, Mike Diedrich, Deb Fischer-Clemens

Welcome and Introductions
Kim Malsam-Rysdon welcomed the group and reviewed the purpose of the meeting to finalize the comments on the 100% FMAP to submit to CMS. Jerilyn Church is at a National Direct Service Tribes Meeting with Indian Health Service (IHS) in Washington, DC and will not be on the call. Jerilyn plans to talk to IHS about how to simplify the care coordination agreement.

Follow Up: 100% FMAP Policy Recommendations
Brenda reviewed the comments received on the SHO letter. The original SHO letter is available online: https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf

The subcommittee reviewed sections of the letter:

1) Wider Scope of Services:
   The group recommended defining an IHS/tribal facility to include Urban Indian Health and tribal organizations to ensure consistency with the definition of tribal facility in other areas of federal law and to clarify the intent for Urban Indian to receive 100% FMAP.

   The group also recommended language should be broad in scope to address all services that an IHS facility may provide or authorize. Kathy Bad Moccasin commented that authorization has a specific meaning related to Purchased and Referred Care (PRC) within IHS that may cause challenges with the policy being interpreted with flexibility. An authorization from IHS typically means a PRC order, which means the care would need to meet PRC guidelines. Medicaid recipients are exempt from the PRC guidelines since they have Medicaid as a payer source. Lynne Valenti suggested ‘permitted’ as a replacement for authorized. The group agreed to the change.

2) Voluntary Participation:
   The group agreed that participation in the care coordination agreement should be voluntary. There were no changes to this section of the SHO letter.

3) Request for Services
   Language was added to support situations where a provider may coordinate with IHS to obtain a referral. There was also discussion about adding language to

support a timeframe to obtain a retro-active referral, similar to existing policy within IHS. The group agreed that the policy should support a retro-active referral.

Kim reviewed the previous discussion regarding self-requests and the impact to IHS and tribal facilities of supporting self-requests. The state wants to be responsive to concerns from Jerilyn and tribes that this could have a negative impact to IHS; however, the state also wants the policy to reflect care that his happening today. Kathy Bad Moccasin commented that she understands the importance of this provision for IHS and tribes, but individuals with Medicaid already use self-referrals to see other providers today. IHS runs into some challenges when a patient does not have a record with IHS, but that challenge exists any time there is coordinated care and would exist with or without changes to the policy. Kathy stated that the policy is well worded to direct care and work back to IHS and supports current practice.

Mike Diedrich asked if a patient was referred for cardiac care that wasn't able to be offered by IHS and while being treated needed other care that was able to be provided by IHS if the other care would be denied. Sarah Aker responded that as long as the referral was inclusive of secondary referrals or services, then that care would be covered. The medical records from those services would also need to be shared with IHS.

Kim summarized that the goal of the coalition is for the policy to reinforce flexibility and to not be prescriptive of the definition of a referral and instead have a referral reflect health care standards and practice.

4) Care Coordination Agreement
The group agreed that comments in this area should ask CMS to confirm that care coordination agreements can take various forms and are not limited. The group discussed that agreements should be permitted to take place at the service unit level and at the provider system level. Nick Kotzea stated that it would make sense to confirm our interpretation that is allowable with CMS. Nick asked if CMS has offered guidance about who would need to sign a care coordination agreement; his reading seems to indicate that CMS is offering flexibility. The state's understanding is that CMS would not need to approve a care coordination agreement as long as all of the required elements in the SHO letter are addressed in the agreement. Kathy offered that IHS's understanding is that the agreement could be signed at the Area Office and would not need to go to Headquarters for review unless substantial changes are made to the current care coordination agreement. Mike Diedrich stated that he thinks the policy anticipates that as long as the four tenets outlined in the SHO letter are met than a certain degree of flexibility is allowed. The group agreed to add a comment and language for CMS to confirm the state's interpretation of the flexibility allowed under the agreement.

Next Steps
The state plans to send the final mark-up on the SHO letter to CMS. The state is still waiting for comments on the care coordination from Jerilyn, and will schedule the next subgroup meeting after CMS returns comments or feedback on the suggested edits.

In closing, Kim relayed the passage of the AHCA by the House of Representatives earlier in the day. The state will continue to monitor the bill as it transitions to the Senate. The version passed by the House is unlikely to pass the Senate. The state will keep the Coalition updated as we learn more about developments on the federal level.

Next Meeting
To be determined