South Dakota Health Care Solutions Coalition
100% FMAP Subgroup
Meeting Notes 4/11/2017

Attendees: Kim Malsam-Rysdon, Jerilyn Church, Lynne Valenti, Brenda Tidball-Zeltinger, Shelly Ten Napel & Jennifer Stalley, Senator Troy Heinert, Deb Fischer-Clemens, Mike Diedrich, Nick Kotzea, Kathaleen (Kathy) Bad Moccasin, Elliot Milhollin, Sarah Aker

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.

Updates since previous meeting

Kim gave updates about the status of reform at the federal level. Governor Daugaard has been talking to congressional committee members, Secretary Price and key staff from the Department of Health and Human Services. The state had a follow-up call with CMS to talk about the IHS funding issue and the implications of the policy for South Dakota. There was an indication that CMS is willing to consider changes to the policy and the care coordination agreement.

At the last meeting, the group agreed that it would be helpful to know the status of tribes in relation to 638 status and barriers for tribes. Jerilyn gave an update on the survey to tribes. The survey went out to tribes on Friday, April 7. Great Plains Tribal Chairman's Health Board (GPTCHB) has had 5 responses so far. GPTCHB is working on compiling the survey and is planning to follow-up with tribes that have not responded by the due date of April 14. GPTCHB has also requested that IHS provide an updated roster of tribal 638 programs.

The state's original goal was to support Medicaid expansion through implementation of the 100% FMAP policy. When Medicaid expansion became an unviable option, the group refocused with a new goal of determining how to implement the policy without Medicaid expansion. Although the American Health Care Act (AHCA) has not yet passed, the state does not feel that Medicaid expansion is a viable option at this time. The governor has been clear that expansion will require the support of the state legislature; the state does not believe expansion to be a viable option given the make-up of the state legislature. The other federal reform efforts being discussed are not supportive of states relative to expansion. The enhanced FMAP will likely be reduced.

The subcommittee's goal is to discuss other incentives for 100% FMAP to still improve access to care and health outcomes of people in South Dakota. The Coalition originally proposed 7 recommendations. The 100% FMAP could be utilized to fund some of those recommendations. Other incentives might be expanding access in certain geographic

areas, increasing provider rates, expanding provider capacity. Implementing 100% FMAP still has the potential to increase health outcomes for South Dakota.

Elliot Milhollin asked about the method for implementation either through a waiver or a state plan amendment. The state would first like to figure out what the coalition would like to do and then figure out the method for implementation. The current administration has been supportive of working with states.

Senator Heinert asked the group to stay focused on increasing access to healthcare for tribal members and not move away from the primary purpose to discuss 100% FMAP. Senator Heinert asked if the state could just expand for tribal members. For any implementation of 100% FMAP, there has to be tribal buy-in. Senator Heinert does not feel that the coalition recommendations provide the necessary ability for IHS to recoup their costs with a non-IHS dollar and it does not increase access for tribes. Kim stated that discussing incentives for tribes and providers including IHS would be the focus of Thursday's Coalition meeting. Making the policy easier to implement would leverage more funding and therefore more opportunities. The subgroup needs to think about incentives and be prepared to bring those to the coalition meeting scheduled for April 13.

Review 100% FMAP Policy

CMS has stated they are open to suggestions regarding the language in the SHO letter. The subcommittee reviewed sections of the letter:

1) Wider Scope of Services:
   The group agreed that the policy should apply to all services authorized or covered under the Medicaid State Plan. Elliot referenced the limitations for clinic services in CFR that currently apply to IHS. The Social Security Act uses the term "tribal facility" in the 100% FMAP policy. CMS has previously defined a tribal facility for other purposes such as the American Indian Copay exemption to be more broad and inclusive of Urban Indian organizations. Elliot agreed that the language in the copay exemption was informed by and is consistent with congressional intent.
2) Voluntary Participation:
   The group discussed requiring participation in the policy. The group agreed that an approach utilizing incentives rather than mandating participation is preferable.

3) Established Relationship
   The group discussed the requirement for the patient to have an established relationship with IHS. This has been a key challenge to implementation. Deb Fischer-Clemens suggested striking the language regarding a self-request or a request from a non-IHS/tribal provider. Elliot suggested that the intent of the SHO is that services must be maintained in the IHS system. When the coalition and subgroups previously discussed this element, there was substantive discussion offering alternatives to what an established relationship could mean and that as adopted, the SHO did not maintain the degree of flexibility the coalition had

contemplated. Deb clarified that their intent is simplify the process for an individual to seek care without a formal referral from IHS. There could be a process by which the provider could send information back to IHS or Urban Indian Health at the request of the patient.

Senator Heinert asked the group to remember the patient who is likely living in poverty or with a disability and is seeking care for a health need. The process needs to include an incentive for tribal buy-in. Kim stated that the this is why we need to evaluate the policy- establishing a relationship in a traditional way is not always realistic, and the idea is evaluating expanding the concept of an established relationship to help people accomplish that.

Nick asked what the group's thoughts are relative to sharing medical information when there is no meaningful relationship with an IHS facility. Instead of sharing records at a patient level, is it better to share health outcomes or aggregate data for individuals that could health IHS assess the health needs of the population they cover?

4) Medicaid Billing and Payment
   The group agreed the SHO already contains enough flexibility here. Elliot pointed out the ability for tribes to bill at the OMB rate as a potential incentive. If the tribe billed for all services, the tribe could retain some portion of the OMB rate after paying the non-IHS/tribal provider.

5) Care Coordination Agreement
   GPTCHB offered Oklahoma's Care Coordination addendum as an example of more simplistic language. Jerilyn and Elliot were not sure of the date of implementation. OK's agreement is an addendum to existing referral contracts to specialist providers and hospitals. This language could be looked at as a replacement for language in the care coordination agreement, but couldn't replace a care coordination agreement in its entirety since IHS in South Dakota does not have formal contracts for purchased and referred care (PRC). Kathy Bad Moccasin explained that the individual purchase order is considered to be the contract for PRC and that the legal language is contained within the purchase order. Great Plains IHS contemplated addressing care coordination agreements on an area level in South Dakota.

Next Steps

Kim asked the group to review the draft agreement and provide comments about how to make the agreement easier to implement by Monday 4/17. Deb asked if the state had draft changes that the group could provide feedback on. Kim stated that the purpose is to compile thoughts and build consensus in the group. The state has distinct thoughts on changes to the agreement, but in order for the policy to be successful, there needs to be buy-in from stakeholders. Elliot appreciates the state's process for allowing stakeholders to provide substantive comments. The group agreed to come back together for a call at the end of next week to discuss the comments.

Next Meeting

April 21, 2017
3 PM CT
Governor's Small Conference Room
Phone: 1.866.410.8397
Passcode: 605 773 4836