South Dakota Health Care Solutions Coalition
100% FMAP Subgroup
Meeting Notes 4/21/2017

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

Welcome and Introductions

Kim Malsam-Rysdon welcomed the group and overviewed the purpose of the meeting to discuss the comments received on the 100% FMAP policy and build consensus for revisions to the policy to submit to CMS.

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 theme of comments in this area was to ensure that the policy is not interpreted to limit IHS or other stakeholders to only services available in a particular service unit location or geographic area. The group agreed that the language should be broad in scope to address all services available for Medicaid funding. Deb Fischer-Clemens requested that long term care and home care clearly be included and addressed throughout the SHO letter.

2) Voluntary Participation:
   The group agreed that participation in the care coordination agreement should be voluntary.

3) Request for Services
   Comments expressed a desire for the policy to allow a non-IHS provider to facilitate a referral on behalf of a recipient or for a recipient to make a self-referral. The comments reflected a need to be more flexible in this area, especially when a non-IHS provider refers a recipient for additional care.

   Jerilyn Church asked Kathy Bad Moccasin to explain the current referral process. Kathy overviewed the system used by Purchased and Referred Care (PRC) currently. The referral will note if a recipient is allowed to see additional providers. If the referral is for a consultation only, then no other services by additional providers are allowed without a return visit to IHS. When a referral is for consultation and treatment, the referral would support secondary care by additional providers.

The group agreed that the state should request flexibility to help a patient facilitate coordination of a referral or a secondary referral in these circumstances. Nick Kotzea also advocated for retro-active referrals and maximum flexibility for those services.

Kim asked Kathy about referrals of emergency care. When an IHS-eligible goes to the ER, the patient must notify IHS within 72 hours, or if the patient is elderly or disabled within 30 days, to be eligible for PRC. The patient still has to meet all of the requirements for coverage under PRC.

The group suggested a time period of up to 30 days after a health care service is provided as a time frame to obtain a retro-active referral.

4) Medicaid Billing and Payment
   The group agreed the SHO already contains enough flexibility here.

5) Care Coordination Agreement
   The group agreed that states should retain flexibility to design how care coordination agreements are implemented and to organize agreements at the highest level to be inclusive of all providers within an organization, all IHS sites within the Area, and for all tribal programs operated by a tribe. The group needed clarity around language describing the care coordination activities that IHS will provide. Jerilyn indicated that GPTCHB is developing feedback on the care coordination agreement to share with the group.

   The group discussed the Oklahoma's Care Coordination addendum shared by GPTCHB. Nick asked who is evaluating how care coordination occurs and the process for the review. The review would be within the purview of CMS, but the state is responsible for ensuring services are rendered within the federal rules.

Tribal Survey Responses
Jerilyn shared an update about the survey. GPTCHB received about half of the surveys back from tribes, and has begun outreach by phone for the remaining tribes. Kim asked Jerilyn to share the survey questions with the group. Deb Fischer-Clemens asked Jerilyn to share preliminary results. 83% of sites currently bill for 638 programs. The biggest barriers to increased billing were that the serviced were not billable to Medicaid, a lack of trained business office staff, and staff vacancies. Challenges to billing are denials and incorrect coding. All respondents stated that coding training would be helpful for staff; 33% asked for additional billing training. 33% asked for technical assistance for the 638 application process. Shelly Ten Napel stated that they are working on offering a billing/coding training for Community Health Centers and would offer to partner with tribes on the training.

Kim asked how long follow-up would take. Jerilyn expects to have full results in two weeks. Deb asked if the information currently gathered is enough to share with CMS. The information gathered from the tribes isn't necessary to respond to CMS regarding

the changes to the SHO. However, this data is valuable for identifying opportunities to assist tribal health programs, such as assisting tribes with building health program infrastructure.

Next Steps

The state will mark-up the SHO letter with the changes discussed and send to the group for a quick review before sending the SHO on to CMS. Jerilyn and Elliot will mark-up the care coordination agreement and will share a draft within two weeks. The next meeting will share the tribal survey results.

Next Meeting

May 4, 2017
1:30 PM CT
Governor's Small Conference Room
Phone: 1.866.410.8397
Passcode: 605 773 4836