South Dakota Health Care Solutions Coalition
Alternative Services Delivery Subgroup
Meeting Notes 10/27/2017

Attendees: Tim Trihart, Kim Malsam-Rysdon, Lynne Valenti, Sarah Aker, Kelsey Smith, Brenda Tidball-Zeltinger, Vince King, Myra Munson, Bill Snyder, Donna Keeler, Shelly Ten Napel, Nate Livermont, Sunny Colombe

Other Attendees: Bob Mercer

Welcome and Introductions

Kim Malsam-Rysdon welcomed the group and thanked them for their participation.

Review August 25 Meeting Minutes
This group last met on August 25 to review the draft 1115 Medicaid wavier regarding the Alternative Service Delivery Model the group previously worked on last year. The August 25 meeting was the first time the model had been reviewed in the 1115 Medicaid waiver format, but the mechanics of the model were the same as previously discussed. Donna Keeler, Myra Munson, and Jerilyn Church expressed concerns about the proposed payment methodology for FQHCs in the waiver. The concern centered on extending the OMB rate that is reserved for IHS and tribal 638 providers today to non-tribal providers and 100% FMAP for those services. The group talked through the need to understand how the OMB rate and 100% FMAP would affect providers and access to care.

Follow-Up from Last Meeting
Bill Snyder overviewed a handout summarizing the impact to each FQHC in the pilot group.

Donna noted that she sent her comments to Jerilyn to coordinate their response to the state. The information she sent to Jerilyn outlines the IHS Title V budget for South Dakota Urban Indian Health and shows how underfunded Urban Indian is in comparison to their costs. She felt the OMB rate is a special protection in the IHS system due to the underfunding of IHS.

Kim asked Tim Trithart to expand on what the additional revenue would mean for patients. Tim said he took the average cost per patient to calculate how many additional patients could be seen at Community Health Center of the Black Hills (CHCBH) with the additional funding. They are looking at expanding into more behavioral health services, and additional funding would help his FQHC expand more aggressively in this area. Donna asked why CHCBH could not expand now. Tim noted that like Urban Indian, the federal grant for CHCBH does not cover the cost of all patients now and they see a high number of uninsured patients without any compensation. Hiring an additional nurse practitioner focused on behavioral health is not a cost CHCBH can absorb within their current revenue stream. Donna asked about CHCBH's funding sources. Tim noted that they have a section 330 grant for operation of their FQHC and then bill Medicaid,

Medicare and other third party payers for services. Kim asked how new patients could be seen by CHCBH with the additional revenue. Tim said that about 950 patients would be able to be served.

Kim asked Donna to share how the additional revenue would be utilized by South Dakota Urban Indian Health (SDUIH). Donna said that when SDUIH compares the Title V contract with IHS and salaries and lease costs, SDUIH currently operates at a $1,000,000 deficit. Donna said that the additional revenue would be put into the core of the program to support the program in reaching parity between the current program cost and her operating budget. Donna said she would forward the documents she previously sent to Jerilyn.

Shelly Ten Napel clarified all non-profits have gaps and shortfalls and yet they all support the same mission of serving low income individuals. Shelly asked Donna to explain how FQHCs receiving a higher rate would impact SDUI H. Donna said that it would impact everyone since the higher rates would impact the federal budget. Shelly noted that the proposed waiver is relatively small and that CMS would ultimately have to approve the waiver and the costs associated with the waiver.

Brenda Tidball-Zeltinger asked if there is opposition to increasing the rate for the three FQHCs proposed in the pilot. The increased rate would not necessarily have to be the OMB rate. Donna noted that she is not opposed to FQHCs and RHCs getting a higher rate since they do a tremendous job of caring for people. Her question was if utilizing federal dollars to fund an increase will impact federal programs that rely on federal dollars like IHS.

Brenda agreed that the waiver must identify the federal dollar impact and the funding stream as part of the proposed methodology. However, the purpose of the waiver is to focus on increasing primary care to decrease overall healthcare costs by decreasing hospitalizations and emergency department use. Kim noted that the waiver does not contemplate reducing care by IHS or taking funds from IHS.

Donna asked what FMAP is utilized for the PMPM for the Health Home program in Medicaid. IHS is paid at 100% FMAP and the remaining providers are paid at South Dakota's regular FMAP. Donna asked how increasing the rates to FQHCs would impact the federal government spending for Medicaid. Shelly responded that CMS funding is mandatory funding and increases as individuals are determined eligible for the program. In terms of the impact of the proposed waiver on federal spending, it's a negligible amount when compared to overall federal health care costs. However, the impact to South Dakota of receiving more funding for FQHC services is that there are more federal resources coming into the state. The waiver is an opportunity to bring more resources to South Dakota, and the wavier can be structured to ensure it includes provisions for everyone to win and participate in the waiver.

Kim asked if the improved access and care noted by the pilot providers is not enough of an incentive to move forward, then what would be the right incentive or what changes

are necessary for the Great Plains Tribal Chairman's Health Board (GPTCHB) to support the waiver and asked for members to identify specific solutions that create a path forward.

Shelly noted that she spoke to Jerilyn and that the concern from tribes is that without Medicaid Expansion as an incentive there is not the same level of incentive to work on this model. Shelly said they talked about the opportunity to put more resources towards tribal programs like SUD and CHW services and that Jerilyn agreed this is a discussion that GPTCHB wants to continue. Kim clarified that this group is separate from the effort to implement care coordination agreements and this is a different mechanism to access federal funds. Shelly asked if the state was open to a discussion about reinvesting any state savings generated by this model. Kim said that the state is open to a discussion about reinvesting savings from this model, but that if the opposition is to increasing federal funding overall, then this effort cannot move forward.

Sunny Colombe said that the IHS provisions create an incentive for the state to work with tribes, but without the incentive there is not a reason for the state to tailor services to the American Indian population. Shelly noted that since FQHCs provide primary care then the services cannot be provided through care coordination agreements. If there is a concern about decreased collaboration, then collaboration could be written into the waiver as a requirement. Kim agreed, noting that the total spend for American Indians outside IHS was over $90 million and that there will continue to be incentives to work with tribal providers.

Next Steps

Kim asked Sunny to work with Jerilyn to provide feedback from GPTCHB. The state is looking for feedback to determine if this model continues to have merit moving forward and suggested changes from individuals who have concerns about the proposed model.

Shelly noted that from a health center perspective, they are aware of the challenges facing IHS and the challenges associated with underfunding. No one is interested in, nor does this proposal reduce IHS capacity, but the health centers are committed to looking for win-win solutions and finding more ways to work more closely with IHS and tribes to better serve American Indians and improve health care for everyone.

Lynne Valenti added that the proposed model centers on individuals already receiving services at FQHCs today and that the projected revenue increase is not taking away patients from IHS but will enhance capacity of providers to serve more individuals.

Kim thanked the group for their ideas. The state will send information for a call within the next 4-6 weeks.

Next Meeting

TBD