South Dakota Health Care Solutions Coalition
Alternative Services Delivery Subgroup
Meeting Notes 7/11/2017

Attendees: Tim Trihart and Chance Brown, Kim Malsam-Rysdon, Lynne Valenti, Sarah Aker, Kelsey Smith, Brenda Tidball-Zeltinger, Sara DeCoteau & Lori Sampson, Jerilyn Church, Jen Stalley, Shelly Ten Napel, Christina Konechne

Welcome and Introductions

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

Subgroup Goals and Purpose

This is a continuation of prior work of the Coalition when we were meeting on Medicaid Expansion. The goal is to use the concept developed by the prior Alternative Services Delivery Model subgroup to submit an 1115 Medicaid waiver to CMS. Hope to get the work done by the end of August with two planning meetings.

Review Prior Alternative Service Delivery Model

Brenda reviewed the prior proposal for an Alternative Service Delivery Model. The concept was proposed as an Indian Health Service (IHS) demonstration as opposed to a Medicaid demonstration. At the time, IHS gave the most flexibility. The concept was to embed a satellite IHS clinic within an FQHC. The challenges of that proposal were IHS's requirement for space use agreements and provider credentialing. The payment arrangement centered on the idea that IHS would be the billing facility and then reimburse the FQHC for services provided to eligible individuals in the demonstration. Medicaid would reimburse IHS at an encounter rate, and then IHS would make a payment arrangement with the FQHC. The initial proposal was fora five year demonstration and contained an approach to evaluate the effectiveness of the demonstration including impact on access, population health, emergency department utilization and cost avoidance. The state is excited to repurpose this concept to advance this model forward.

Sara DeCoteau asked if there was someone from IHS on the workgroup. Several individuals from IHS headquarters worked on this with the state and thought we could utilize a demonstration. Kathy Bad Moccasin participated and Terry Schmidt reviewed the work of the group as we started to put the proposal together. Jerilyn Church noted that this happened under Mary Smith's leadership at IHS.

Tim Trihart asked about the payment structure. The payment structure was organized around the IHS satellite clinic. IHS is currently paid an encounter rate for services. The proposal contemplated Medicaid would link an IHS provider number to the FQHC. The FQHC would submit the claims, and then IHS would reimburse the FQHC.
Kim noted there was discussion previously about the information system and the interaction of the billing between the FQHC and IHS.

Tim asked if there would be a separate rate negotiation for each FQHC. The state anticipated that one rate would be established for the model. There is some opportunity for some capacity expansion due to the differential between the FQHC rate and the IHS encounter rate.

Sara asked what the FQHC encounter rate is. Rates for FQHCs vary. The rate is federally prescribed based on the service configuration of the FQHC. Tim offered that his is around $140.

Kim added that the proposal anticipated starting in the four areas where we see a large number of individuals who are dually eligible for Medicaid and IHS.

Minnesota 1115 Waiver Application

Sarah reviewed Minnesota's application, noting that Minnesota is proposing to fund services at the Indian Health Board in Minneapolis which is an Urban Indian Clinic at the IHS encounter rate with 100% FMAP. The proposal contemplates that the additional funding will provide increased care coordination and reinforces Urban Indian Health as a source of primary care for American Indians. Brenda noted that Urban Indian Health providers are considered an FQHC.

Jerilyn noted the proposal was revised and asked if it was known what changes CMS requested. The changes were in Attachment D to the evaluation plan for the demonstration.

Shelly asked if there were any changes to the 1115 process in the Medicaid reform legislation. No changes are proposed to the 1115 process in the current legislation.

Sarah discussed about the ability to expand the proposal statewide; states can include an implementation plan that would allow for a state to take a pilot approach to implementation. Lynne suggested attaching outcomes or measures to trigger an expansion to additional sites.

Feedback/Discussion Regarding Waiver Application

Jerilyn asked what the difference was between care coordination and the cooperative agreements proposed in the model. The cooperative agreement language came from CMS to distinguish between care coordination agreements for 100% FMAP. Jerilyn noted that when the proposal only refers to IHS, there is a missed opportunity for agreements between tribes and non-IHS providers. Brenda suggested using the broader I/T/U language for the waiver proposal to ensure its broad enough to include tribal programs.

Kim asked if the group thought a cooperative agreement was needed. Sara asked if CMS would require a cooperative agreement. The agreements were specific to the IHS legal team's view of the IHS facility and the proposal. Shelly noted that individuals are going to go get health care from the location that makes the most sense for the individual and that while some communication and coordination is needed, it’s important not to make IHS a gatekeeper for services. Shelly noted that the group could better

evaluate if cooperative agreement is the right term or if that may look different as we go through the proposal.

Kim asked noted that the proposal will need to be planful about eligibility for the demonstration and that all individuals must be eligible for Medicaid since this is a Medicaid demonstration. Sara asked if the sites would register patients for IHS. Kim noted that the state is working on some ways to help providers know when a patient is eligible for Medicaid and IHS. Jerilyn said there needs to be a mechanism in place to ensure that whoever is getting the services is IHS eligible. DSS has been working on a portal to perform eligibility verification that we plan to make available to servicing providers that would also communicate information like IHS eligibility and the copayment exemption for American Indians.

Kim would like to see culturally competent care stay in the proposal. The group agreed. Kim asked if the language around medical record sharing adds value. IHS currently gets records back from referred providers and this process is expected to continue.

Shelly asked about the HIE and if IHS is enrolled. IHS is not fully participating in the HIE currently. Tim noted that Community Health Center of the Black Hills is enrolled and is close to being fully connected.
Kim said that the proposal is to prove that we can improve health outcomes. The idea of sharing records came out of that conversation so there may be room for discussion about how to incorporate this into the evaluation plan to have data sharing for health outcomes in place of medical record sharing.

Sara DeCoteau gave an example of record sharing between Sisseton and Coteau de Prairie. The emergency department has remote access to the EHR to access the patient medication list and the problem list. She noted that the mobile nature of the population will make it important for providers to access all information on an individual's medical record. Sara said she could see a lot of benefit to sharing records. Jerilyn agreed, the target population is very transient and tribal health programs and IHS are required to report outcomes and some measures. If that information does not get entered into the medical record at IHS, the reports do not capture the services happening outside IHS.

The evaluation plan and the HIE could be an opportunity to share outcomes and data. Sharing data will strengthen outcomes and may be an incentive for tribes and IHS to participate. Jerilyn suggested Donna Keeler as a resource to find out what information is measured by both FQHCs and IHS. Jerilyn will outreach Donna Keeler.

The group agreed that facility use agreements should not be part of the demonstration. The group also agreed to include pilot sites as the first phase of implementation. The state will work on suggestions for statewide implementation throughout the length of the demonstration. Shelly Ten Napel commented that it makes sense to focus on pilot locations to start but to allow for expansion across the state.

Sara DeCoteau asked if there was any analysis on the impact to IHS in Mission and Rapid City. The analysis is based on the volume of patients currently going to those locations. The model's purpose is to increase access to care and make more services available in these locations. Jerilyn is interested in exploring this more. She hopes that the pilot will result in better coordination and shared best practices. If the FQHC and IHS/tribal health facilities establish a relationship, then there is an opportunity for better integration and coordination of care that could strengthen the tribal program or IHS. Brenda noted there is another opportunity is for tribal programs to be designated an FQHC as a way to strengthen tribal programs. That work does not require a demonstration waiver, but could be explored through a separate track. Jerilyn agreed.

Kim summarized that the goal of the demonstration is strengthening and building a network of primary care that works for people and leveraging strengths for tribal programs and IHS. Tim suggested that could be built into the evaluation plan.

Jerilyn noted that this would be part of tribal consultation throughout, and that structuring the demonstration to be mutually beneficial will be key to tribal support.

The group discussed payment rates and specifying the OMB encounter rate in the demonstration. The pilot sites would be able to enter into care coordination agreements on the same basis as IHS for referred services. Jerilyn asked if CMS and IHS agreed with that approach. Kim thought CMS and IHS were in agreement with that approach. Jerilyn noted that can get tricky dependent on where the person resides dependent on where they are enrolled in the tribe. The group noted this would only be an issue for PRC, but not Medicaid referrals that take place outside PRC.

Sara asked if pharmacy costs would be covered and if an individual could fill a script at IHS. Yes, the demonstration would cover pharmacy.

Tim summarized the proposed payment methodology for FQHCS: If the individual is IHS and Medicaid eligible, then the FQHC will get paid the OMB encounter rate for that patient. If the patient is just Medicaid eligible, the FQHC will get Medicaid FQHC rate. If the individual is only IHS eligible, the FQHC would bill that service as a normal service.

Sara asked if someone selects the satellite clinic as a PCP would they have to sign a consent form to be part of the demonstration. No a consent form would not be required to be part of the demonstration. Sara asked if consent would be needed for sharing information with IHS. The term satellite clinic came of the initial discussions with IHS as a care mechanism specific to Medicaid. If the state uses a concept similar to Minnesota and target the increased payment as a resource for expanded capacity for services, the model may look a little different.

Brenda noted that next steps should establish consensus around what data and data collection methods for the demonstration. The group agreed that the measures should align with GIPRA and UDS where possible and Medicaid Health Homes. Christina will re-send the FQHC performance measures. Jerilyn will send the GIPRA measures.

Jerilyn will be talking about this to tribal leaders. Jerilyn will bring questions back to this group. Kim asked Jerilyn to share the questions she received with the group.

Next Steps
The state will work on revising the alternative service delivery model into the 1115 format and get a draft to the group in advance of the next meeting.

Next Meeting

August 25, 2017
1:00 PM, CT
Governor's Large Conference Room
Phone: 1.866.410.8397
Passcode: 605 773 4836#