Community Based Providers Shared Savings Workgroup
February 21, 2018

Attendees: Kim Malsam-Rysdon, Gloria Pearson, Brenda Tidball- Zeltinger, Anthony Erickson, Sarah Aker, Darryl Millner, Diane Flahaven-Neu and Janet Niehaus representing Brad Saathoff, Mark Deak, Melony Bertram, Dan Cross, Andrew Riggin, Mark Limberg, TJ Stanfield, Sheila Weber, Marty Davis, Clint Graybill, Denice Houlette, Tim Rave, William Snyder, Virgena Wieseler, Yvette Thomas, Jim Severson, Laura Ellenbecker, Kathaleen Bad Moccasin(via phone), Ed Chasing Hawk, Mark Deak, Mark Lyons, Danielle Hamann, Avera representing Deb Fischer Clemens.

Welcome and Introductions:
Kim Malsam-Rysdon welcomed the group and thanked them for their participation. Each member has a binder of meeting materials from the last meeting and a folder with information for today's meeting was handed out. Kim reviewed briefly the goal of the workgroup; to explore shared savings opportunities to save state general funds and reinvest those savings to address service gaps in current Medicaid services, share the potential savings with participating providers and increase the Medicaid reimbursement rates paid to providers. Kim asked if anyone from this workgroup was interested in joining the South Dakota Healthcare Solutions Coalition; please reach out if interested. Kim also shared that the state is already seeing accrued savings due to agreements established.

Review of January 18 Meeting Minutes:
No changes were suggested

Review of Care Coordination Agreement: (see copy of agreement in binder)
Sarah Aker provided an overview of the Care Coordination Agreement and went over some of the key elements. Sarah stated to keep in mind “care coordination” in this instance is not the care coordination or case management that we think of in other programs.

The Care Coordination Agreement and other agreements will be entered into at the highest Provider system level not with each individual provider location. In this document the term “Provider” is the non-IHS provider. Within this agreement the Provider agrees to be enrolled in SD Medicaid and agrees to annually certify their National Provider Identification (NPI).

Section IV contains definitions of terms used throughout the agreement. It defines an IHS beneficiary as an American Indian or Alaska Native (AI/AN) who is known to the IHS. A Request for Service means an order by an IHS practitioner for specified services and includes the time period during which the services are expected to be provided. Kathaleen Bad Moccasin clarified that this does not include 638 programs; if a tribe administers their own health program, additional agreements would be

necessary.

Section V details the care coordination agreement. It states that care coordination means that the IHS Practitioner will be responsible for determining the patient's needs and will manage the patient's care and that all such care will be recorded in the IHS facility records. The IHS practitioner must establish a relationship with the IHS Beneficiary. The IHS Practitioner may submit a Request for Services to a Provider that describes the services to be provided to the IHS Beneficiary. Services furnished by the Provider that are not on the request for services are not considered to have been provided pursuant to this agreement. This documentation may be electronic or in writing.

Currently, if an IHS Beneficiary is not enrolled in Medicaid the services provided must be requested by an IHS practitioner and paid for separately in accordance with Purchased/Referred Care (PRC) program laws and regulations. The PRC program is limited in funding and an unlikely funding source for the types of services we are discussing (long term care and community support providers); PRC program is typically for emergency type services.

Section V.g states that within 30 days of furnishing services the Provider will transmit, electronically or in writing, any medical information, test results and any findings and treatment recommendations. The information must be transmitted more promptly when medically warranted. This transmitted information will be incorporated into the patient's medical record at the IHS facility. Clint Graybill noted that these transmittals may not necessarily be a "result" but rather nursing notes for long term care services. This sounds similar to contracts with the Veteran's Administration (VA) where progress notes are transmitted to the VA. Kim affirmed that where existing processes would work, we should use them.

Kim Malsam-Rysdon asked how hospitals participating in the care coordination agreements get referrals today and any thoughts on how that is working. Several stated it seems to work fine now. Tim Rave commented that the language in these agreements and referrals were vetted at the Federal level and we are not able to make changes to the template. You have to sign the agreement as is, but providers can discontinue the agreements with 30 days notice.

Clint Graybill pointed out that long term care providers might not have much to update even at 30 days if patient is stable. Kathaleen from IHS stated they don't really want to reinvent something new for reporting and it could be up to the individual provider as to how often updates are necessary. Kim pointed out that all of this would be tied into the current sharing of medical records agreement and what information IHS needs and at what frequency are yet to be determined.

Section VI goes over the obligations of the non-IHS Provider including their responsibility to bill Medicaid. It also states that participation in this agreement is voluntary.

Section VII details the obligations of the IHS Practitioner and Section VIII outlines the general obligations of this agreement.

Review of Shared Savings Agreement:
Bill Snyder from DSS went over the Shared Savings Agreement with the group. This document is an agreement between the State and non-IHS Providers. It is important to get this agreement finalized soon so we can move on with this effort.
The Provider must meet Medicaid requirements and agree to submit a copy of the care coordination agreements and annually certify the provider NPI numbers.
The Agreement lays out the concept that the first $3 million in general fund savings will be reserved to strengthen services within the Medicaid program. After $3 million of general funds savings is realized then a share of the savings will go to the providers. There will be a 3-tier savings approach for providers based on the amount of general fund savings credited to the Provider. Marty Davis asked if the Shared Savings would also be calculated at the highest Provider system level, and the answer is yes. This approach will give the provider and IHS the maximum tiering level possible. Annual payments to the Providers will be made within 60 days of the completion of the State fiscal year. Provider participation is voluntary and there is no pay-in from provider funds. Section 10 of the agreement states that the agreement can be terminated by either party with 30 days' notice. The rest of the agreement is standard State contract template.

Janet Niehaus from Black Hills Works asked how long do you anticipate it would take to reach $3 million threshold and how is that information reported back to the Providers? Brenda Tidball-Zeltinger stated this is framed around hospital care agreements already in effect and that we are on target to achieve this level of savings in the upcoming fiscal year. DSS is reporting out this information on its website. The South Dakota Healthcare Solutions Coalition has had a lot of discussion about the tiers, annual payments to allow providers to get to the highest tier level possible and leveraging federal funds through a State Plan Amendment. The State Plan Amendment is intended to be in place by the end of the fiscal year in anticipation of making the first payment.

Financial Modeling Considerations
Kim Malsam-Rysdon noted that it is important to acknowledge that we are never likely to maximize 100% of the opportunity because some facilities will not participate and some eligible participants will not participate.

Sarah Aker went over tables in handouts to describe what is represented:
Community Support Provider table shows the last time CSP recipients had an IHS visit based on Medicaid claims data in DSS MMIS. The map shows the primary location of IHS facility in relation to the CSP's in the state. Individuals served by CSP's generally have fewer visits to IHS than those served by other providers. There is also a table showing CSP expenditures for AI/AN at all CSPs. The other map shows where the last IHS visit was for 18 Black Hills Works participants.

Gloria Pearson stated the $7.5 million in general funds actual expenditures on chart would be the total opportunity in general fund savings – assuming 100% is leveraged. However, until we finalize the referral process and better understand how to link the referral from IHS, we won't be able to calculate exact general fund savings that can be leveraged. The approach to repurpose available savings would be consistent with the coalition recommendations and any savings garnered would be paid to the participating provider via the tiered shared savings plan; the rest could potentially be used to increase provider rates. Small providers might not have much for shared savings but could potentially benefit from increased rates in the future.
It was asked if Provider can actively seek out the referral from IHS, answer was yes. Clint Graybill asked if the referral can be done via telehealth. That is an issue for this group to work out along with other issues to make it as easy as possible to get a referral.

Janet Niehaus asked about increased rates and the procedure for that.
Kim Malsam-Rysdon stated we will continue to talk about that with the subcommittee, right now we are focusing on the process change to be able to get a better understanding of how much can be saved. Any rate increase would have to go through the regular budget process by providing a plan to the legislature with funding allocated through the regular or interim appropriations process.

Psychiatric Residential Treatment Facility (PRTF)
A table showing actual expenditures for AI and the number of recipients for PRTF was presented next. The data also indicates that over 50% of these patients have had a claim through or relationship with IHS in the last 5 years. Taking Aurora Plains Academy as an example they draw participants from all over the state relative to the services received from IHS by facility and the PRTF facility location.

Nursing Facility
The same data for Nursing Facilities indicates that 40% of the AI recipients have received services through IHS in the last 2 years and 58% in the last 5 years. The top 20 facilities by expenditure are on the map. All facilities with American Indians that had claims are listed on the table. (FY17 data)

Clint Graybill pointed out that the Wilmot facility is not associated with Sanford, this will be corrected. Marty Davis asked if the Red Wing, MN facility could qualify for this opportunity -yes if they have SD patients paid by SD Medicaid.

Community Support Providers
The data for CSP's indicates that 28% of recipients received a service through IHS in the last 5 years and less than 8% the last 2 years. This group has the lowest % of IHS services. In FY2017 there were just over $16 million in total expenditures for American Indians received community support services.

Defining the Referral Process
Kim Malsam-Rysdon stated we need to figure out process changes and the process has

to work for IHS as well as non-IHS providers. IHS has been a great partner so far and we appreciate the work that has already been done. There is a document in the packet titled “Great Plains Area IHS/PRC-Approved Referral Process” that shows how the process works today to request payment from IHS referral. This applies to PRC funded services, but may have some aspects that could apply to the referrals made under the care coordination agreements for 100% Medicaid funding.

Yvette Thomas went through process to access Medicaid funding for Nursing Facility Services. A person might be eligible right away or after spending down funds. An annual Level of Care review is done, and can be done more frequently if needed. Kim Malsam-Rysdon stated it’s important to go through each of these scenarios and see if changes need to be made to make this process easier.
Lynne Valenti pointed out that we are now coding the American Indian (AI) designation on all Economic Assistance applications. She noted that DSS exchanges data with IHS regarding paid claims from IHS and individual eligibility for IHS.

Clint Graybill pointed out that many AI have never seen an IHS provider.
Kim Malsam-Rysdon asked IHS representatives if they had any thoughts about how we get information on whether they have received IHS services from people in nursing facilities now.

Ed Chasing Hawk stated that in order to establish a relationship with IHS, historical practice has been that the initial visit is always in person. Many Native Americans may have been born and raised off the reservation, for example in Sioux Falls, and have lived their entire life there. They may never have had an IHS encounter, or established that affiliation. It was questioned if an initial visit could be conducted via telehealth. Historically it has been in person but telehealth as an option is allowable in the policy. IHS has recently implemented expanded telehealth services and these services could be leveraged in the future.

Kathaleen stated we want to think outside the box and do this the best way possible. IHS will have to do more research and get medical consultation to see if they would be comfortable doing referrals without an in-person visit. They will need to get together with clinical administrators and IHS headquarters to discuss.

Kim Malsam-Rysdon stated there are 2 likely scenarios:

1. Person has been seen at IHS in the past-what timeframe would be acceptable? If seen within a recent time period could IHS do a chart review or would they need to have been seen in person or via telehealth?
2. Person has never been seen, maybe lives in Sioux Falls, how do they become a patient of IHS?

Eddie stated he would think the IHS provider would need to see the patient, but they will review to see if telehealth is feasible Eddie recalled that the maximum time limitation from an in-person type visit was probably 3 years; they will confirm the

timeframe and process.

Clint Graybill stated they would be open to helping with a remote visit to make it more efficient; it could it be like a VA referral using a local Primary Care Provider (PCP) with a video visit. We would also want to make it easy and comfortable for the patient, some would not be able to travel.

Virgena Wieseler went over the PRTF referral sheet, flow chart and referral form in the packet. The State Review Team meets every Monday; this could be the place to involve IHS in the initial referral. Usually 6 months is the initial length of stay. If coming from Child Protection, DOC, BIA or parent referral DSS would know tribal affiliation. The referral form could be revised to include IHS information.

Darryl Millner went through the process to access CHOICES waiver services. A new applicant goes to the case management agency and works with a case manager who completes a funding request and submits to the State. The State doesn't make an eligibility determination at this point, rather uses the request to be aware of the applicant and allocate resources. The case manager then works with the client to complete a Level of Care (LOC) to determine eligibility using various assessments. The LOC documentation is then sent to DHS who reviews and makes recommendation to DSS Economic Assistance. Within the LOC documents, the ICAP is the first piece that identifies ethnicity. We could possibly change funding request to identify ethnicity instead of waiting for later in the process. Darryl Millner pointed out that a CHOICES referral would include not just medical information but would need to include the plan for residential services, employment services, etc. Kim offered that the State could outline these existing referral processes and available documentation to help IHS with discussions with clinical administrators and IHS headquarters to see if the current referral documentation would be adequate to get an IHS referral

Next Steps:

- State will provide a summary of informational documents that are available from existing processes to help IHS determine what if any additional information is needed to get a referral from IHS.
- Kathaleen Bad Moccasin will schedule a meeting with the IHS Chief Medical Officer, Dr. Lawrence to discuss outstanding questions about the referral process and to determine if referrals can be made via chart review, in-person visit or telehealth visit.

Next Meeting Date

Conference call on March 29, 2018 from 1-2 pm Central time. An email from Kelsey Smith with information for call-in will be forthcoming

Kim thanked members for sending an RSVP; it really helps with meeting logistics. Meeting adjourned.