Community Based Providers Shared Savings Workgroup
Meeting Notes 1/18/2018

Attendees: Kim Malsam-Rysdon, Gloria Pearson, Brenda Tidball-Zeltinger, Deb Fischer Clemens, Tony Erickson, Sarah Aker, Darryl Millner, Brad Saathoff, Kim Gillan representing Scott Duke, Delores Pourier, Mark Deak, Melony Bertram, Dan Cross, Andrew Riggin, Conner Fiscarelli, Mark Limberg, TJ Stanfield, Sheila Weber, Marty Davis, Clint Graybill, Denice Houlette, Corey Brown representing Tim Rave, William Snyder, Rep Wayne Steinhauer, Virgena Wieseler, Yvette Thomas, Kelsey Smith, Jim Severson, Justin Smith, Laura Ellenbecker, Rhonda Webb (via phone).

Welcome and Introductions
Kim Malsam-Rysdon welcomed the group and thanked them for their participation. Each member has a binder of meeting materials that will be discussed throughout the meeting.

Purpose and Timeline of Work Group
Kim explained the recent change in federal Medicaid policy resulting in the opportunity 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. The work of this group will realistically take about a year to complete and members should expect to have the first few meetings in person as the group works through the more substantive issues. Meetings via conference call will occur when possible. Kim emphasized this is a consensus based group and everyone is asked to share ideas and ask questions as we figure the process out together. Kelsey Smith will be forwarding agendas and meeting invitations via email. Kelsey will also forward the web link where all meeting notes and documents will be posted in addition to the documents provided in the binders.

Background on 100% FMAP Policy (see presentation "Received-through" Policy, Maximizing Federal Funding)
Sarah Aker provided an overview of Federal Medicaid Assistance Percentage (FMAP). FMAP is based on the state's median income compared to the national average, consequently the FMAP changes on an

annual basis. Current FMAP rate for South Dakota is 55% federal and 45% state general funds.
Certain services have been eligible for enhanced FMAP; for example Native Americans who are Indian Health Services (IHS) eligible, receiving services through IHS or a tribal health program have their services paid at a 100% FMAP. Conversely, Native Americans who are IHS eligible, receiving services through a non-IHS facility have been paid at the state's regular FMAP.
In State Fiscal Year 17 almost $97 million in state general funds were utilized to provide care outside IHS facilities. Brenda Tidball-Zeltinger pointed out that in calculating opportunity, it is important to remember the changes in FMAP on an annual basis.

In February of 2016, federal policy interpretation was changed to cover more services for those Native American individuals who are IHS eligible with 100% Federal funds and to include coverage of services provided by a non-IHS provider as long as certain requirements are met. The new federal policy expands eligible services to:

- include those provided through 1915 (c) waivers
- include services referred by an IHS provider and delivered by others.

Waivers are a mechanism to allow a different model of service delivery; for instance, you may waive the requirement for the services to be delivered in either a nursing facility, or an ICF/MR. Currently there are 4 waivers operational in South Dakota all through the Department of Human Services with the Department of Social Services as the administrative authority: the CHOICES and Family Support 360 waivers operated by the Division of Developmental Disabilities, the ADLS waiver operated by the Division of Vocational Rehabilitation and the HOPE waiver operated by the Division of Long Term Services and Supports.

Brenda Tidball-Zeltinger pointed out that the service opportunities we will be discussing don't require the implementation of a waiver as they are part of the Medicaid State Plan.

With the change in federal policy, there are some requirements:

- Participation must be voluntary for the individual patient and provider
- There must be a written care coordination agreement between IHS and the non-IHS provider

- IHS must maintain responsibility for the patient's care
- Providers must share medical records with IHS.

Clint Graybill asked about the mechanism for shared medical records and if printed versions are allowed or if they must be electronic. Kim Malsam-Rysdon shared that the policy doesn't specify the mechanism. In general the federal policy provides the framework and the states implement the details.

Brenda Tidball-Zeltinger referred to the CMS letter dated February 26, 2016 which details the requirements of 100% FMAP and is the federal government's guideline to states and method of official communication. Sarah walked the group through each section of the letter's requirements and provided the opportunity to ask questions. Highlights from the letter include:

- American Indian patient must meet state Medicaid eligibility requirements;
- Participation must be voluntary;
- Both IHS and other providers have to be Medicaid enrolled and sign a care coordination agreement;
- Referral for services must come from an IHS practitioner;
- Minimum requirements of the care coordination agreement.

Clint Graybill asked whose definition of Medicaid eligible is used, and if it is the state's defined eligibility groups. Kim Malsam-Rysdon confirmed that it is the state defined groups, which in South Dakota is limited to children, and adults who are aged, blind, disabled or very low income parents.

Implementation to Date

The group then returned to reviewing the "Received-through" Policy, Maximizing Federal Funding slides with Bill Snyder and Sarah Aker leading the discussion. The Department of Social Services, Medical Services has started with implementation, selecting those groups that will have the highest opportunity for savings. Target groups are the three largest health systems, three dialysis providers and some administrative services including transportation and prescription drugs. $6.76 million in general funds savings to the FY20 budget is projected. The savings will be used to:

- Address services gaps in the Medicaid program, specifically substance abuse and mental health;
- Share savings with providers of services implementing the policy, including IHS;
- Commit the state's share of additional savings to increasing rates for Medicaid providers.

Addressing service gaps includes the implementation of substance abuse services for 1,900 adults in State Fiscal Year 2019 (SFY19), addition of licensed Mental Health and Family Therapists to serve 465 people in two quarters of SFY19, and addition of Community Health Workers to serve 1,500 people in one quarter of SFY19. Gloria Pearson asked for an explanation of the role of Community Health Workers. Kim Malsam-Rysdon explained that Community Health Workers (sometimes referred to as Community Health Representatives, or CHRs) help people get to appointments, help with medication administration and other tasks. They are trusted members of the community that work for an entity to help people comply with their recommended health care plan. Individuals in this role aren't necessarily professionally licensed. Currently they are only associated with tribal entities in South Dakota, although Sanford uses this model in Minnesota.

The group then walked through an example of the shared savings and how it will work to include a savings opportunity for the state, the provider and IHS. The process includes looking at the prior 12 months of claim history and calculating the percentage of savings to be paid to the IHS and the provider. The full calculated percentage goes to both IHS and the non-IHS provider; they don't each get half of the percentage payment. The payment will be an annual payment. One care agreement will be signed between each entity (Avera, Sanford, and Regional Health) and IHS; not with individual physicians. This allows the claims to be rolled up and accumulated at the organizational level which maximizes the savings opportunity. There were several questions regarding the shared savings calculation and the payments to each entity. In the example, the payment to Regional includes $168,304 in general fund savings, which is matched with federal dollars of $205,704 via a Medicaid supplemental payment, resulting in a total payment of $374,008 to Regional Health. IHS is not eligible to receive supplemental payments; therefore they will only receive a payment of the $168,304 of general fund savings.

Brenda Tidball-Zeltinger explained the process for identifying IHS eligible American Indians within the Medicaid Management Information System (MMIS) payment system that is already in place. Brenda explained that certain Native Americans are eligible for a zero co-payment for services, so the MMIS already captures Native American ethnicity and IHS eligibility due to the existing processes.

Deb Fischer Clemens asked if an IHS physician referred a patient to an Avera gerontologist, who then referred them to nursing facility services, would this quality as a referred service. Kim Malsam-Rysdon replied this would not qualify; the referral for nursing facility services would need to come from an IHS provider. Clint Graybill asked when the referrals need to be done and can they be done retroactively. Referrals are part of the process that needs to be talked through. Telehealth should be a resource for people to get the necessary referrals.

The group next reviewed the feasibility matrix which indicates nursing homes, Community Support Providers and Psychiatric Residential Treatment Facilities have been identified as the most logical next group for implementation due to the existing process for State staff reviewing each case prior to the person entering the facility.

Implementation Steps

Referral Process Flow Charts

The group next walked through the flow charts. Brenda Tidball-Zeltinger reviewed the Medicaid Billing and payment flow chart for care originating from IHS today. There were no questions. Darryl Millner provided a review of the access to care flow chart for the CHOICES waiver. There were no questions. Yvette Thomas provided an overview of the access to care flow chart for nursing facility care. There were no questions. Virgena Wieseler provided a review of the access to care flow chart for Psychiatric Residential Treatment Facilities (PRTF). At each step providers were asked to validate that the process described was consistent with their knowledge of the process.

Financial Modeling Considerations

Kim Malsam-Rysdon led a discussion of considerations. The group needs to consider what would be a reasonable projection for shared savings.

Brenda Tidball-Zeltinger suggested starting with looking at the current Medicaid populations, performing a data match to determine how many people have recently, or ever, had an encounter with IHS. This will provide a better picture of potential savings opportunity. Other considerations for the group to discuss include

- How will we go about obtaining IHS referrals for individuals in the current population receiving services from a non-IHS provider.
- Develop a process for referrals for persons entering into services.
- What IHS facility is used by the person served by the NH, CSP or PRTF?
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The goal is to pilot some facilities to try out the developed process and make sure it is sound before rolling out to the larger group.

Melony Bertram asked about current processes since they have some staff of their agency that are Native American and seek care alternatively through either IHS Rosebud of Sanford in Winner. Individuals indicate that there is an agreement in place so it doesn't cost them more at either place and they can go where it is most convenient. This will be another important consideration to ensure any future changes make sense for individuals. .

Clint Graybill commented on the need to create an incentive for the individual to participate. Since it must be voluntary, it will be important that it not be burdensome to the individual. It may be a positive opportunity for the person to remain connected to their home community and tribal affiliation.

It was questioned how IHS will reinvest the savings they realize, and if they will use the savings to enhance community services. A question was asked that since the interaction with IHS is at the Area Agency level, would the savings remain in South Dakota. Kim Malsam-Rysdon replied that we certainly hope so. Rhonda Webber will take the IHS related questions back for comment at the next meeting.

Next Meeting Date

The next meeting date has been established for an in-person meeting in Pierre on February 21, 2018. Information on the meeting location will be determined and provided to members. Prior to the next meeting members should take time to review the Care Coordination Agreement located in

their binder. Kim Malsam-Rysdon shared that the Care Coordination Agreement is in final form; it has been reviewed to assure compliance with federal requirements and will be used in the existing form; however it is important for members to become familiar with the document. Members should also review the Shared Savings Agreement, which is in draft form and will be targeted for finalization soon.

Mark Deak commented that although State staff had not emphasized the amount of effort expended to accomplish the federal change in policy, he wanted to recognize the state's leadership for their efforts in achieving this important change.

Kim thanked members for their participation and the meeting was adjourned.