South Dakota Health Care Solutions Coalition
Meeting Notes 2/8/2017

Coalition Attendees: Kim Malsam-Rysdon, Jerilyn Church, Lynne Valenti, Brenda Tidball-Zeltinger, Kelsey Smith, Steve Emery, Charlene Red Thunder, Sarah Aker, Senator Jeffrey Partridge, Mike Diedrich, Scott Duke, Terry Dosch, Mark East, Debra Owen, Deb Fischer-Clemens, Senator Troy Heinert, Senator Deb Peters, Senator Deb Soholt, Shelly Ten Napel, Dr. Mary Carpenter, Nick Kotzea

Other Attendees: Mark Quasney, Elliot Milhollin

Welcome and Introductions

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

Review Last Meeting Minutes
The group reviewed the minutes from the last meeting and the goals of the Coalition.

Update on Federal Developments Regarding Medicaid
Several themes have emerged surrounding federal repeal and replace efforts:
1. Expanding the use of Health Savings Accounts
2. Enacting High Risk Insurance Safety Pools
3. Reforming Medicaid Financing
4. Authorizing Tax Credits for Insurance Purchasing

Anticipate that there will be congressional action in March on the repeal and replacement; there are technical questions on the federal level about what replacement provisions can be combined into repeal legislation. Anticipate more details from the administration about plan for ACA repeal and replacement and Medicaid reform after Tom Price is appointed. His confirmation is expected within the week.

Scott Duke referenced an update regarding federal developments available on his website: https://sdaho.org/2017/02/08/pace-of-change-out-of-washington-increases-level-of-uncertainty/ The House Energy and Commerce committee has discussed four bills dealing with critical provisions of the ACA. The bills would require patients to pre-verify their eligibility for special enrollment periods, allow states to reduce the grace period for subsidized coverage, revise the age-rating ratio and prohibit individual and group health plans from limiting or excluding benefits related to pre-existing conditions if the ACA is repealed.

Scott added that President Trump has stated that replacement may take up to a year. The terms “repair” and “rebuild” are also being used more which may signal a more cautious approach to the ACA repeal and replacement effort.

Review Ideas on Using 100% FMAP in Future

The Great Plains Tribal Chairman's Health Board (GPTCHB) has a call scheduled with tribes for February 20 to bring tribes up to speed with the recent work of the coalition, and ensure tribes understand why supporting 100% FMAP is still important. GPTCHB needs tribal buy-in to help move forward with key concepts. Tribes are opposed to changes to federal "received through" language in the SSA and seeing 100% FMAP used for non-tribal providers; however tribes support working with what exists now and leveraging opportunities to make changes within the existing policy. Elliot Milhollin gave an overview of a CMS FAQ that was released in January that has opportunities to leverage 100% FMAP through tribal facilities. The FAQ is available electronically at: https://www.medicaid.gov/federal-policy-guidance/downloads/faq11817.pdf

The FAQ describes how tribal clinics may be enrolled as tribal FQHCs in Medicaid and then contract for FQHC services with an external provider. The services by the external provider would be eligible for 100% FMAP and the IHS encounter rate when billed by the tribal FQHC. CMS has not clarified how this policy will apply to IHS. This may be an opportunity for tribes to utilize increased claiming for Medicaid services.

Shelly Ten Napel asked what the incentive is for IHS under the new FAQ. Jerilyn stated that this could ensure better access to health care. The Indian Self Determination and Education Assistance Act (ISDEAA), also known as P.L. 93-638, authorizes Indian Tribes and Tribal Organizations to contract for the administration and operation of certain Federal programs which provide services to Indian Tribes and their members. Under the ISDEAA, Tribes and Tribal Organizations have the option to either (1) administer programs and services the IHS would otherwise provide (Title I) or (2) assume control over health care programs and services that the IHS would otherwise provide (Title V). Flandreau is the only tribe with a Title I contract for all services, although every tribe contracts for some health services under 638. No tribes in South Dakota operate a Title V contract currently.

Jerilyn indicated that tribes have an ability to enter into contracts much easier than IHS, and that tribes also have an incentive to enter into contracts because they are directly affected by the lack of adequate care from IHS. Jerilyn stated that Sisseton and Rosebud are exploring Title V self-governance; other tribes may need to build capacity for Title V self-governance. Ultimately, tribes want to leverage better access by assuming control of their programs and entering into other agreements with providers. Kim Malsam-Rysdon indicated that the coalition supports tribes in increasing access to care and 100% FMAP.

Senator Peters asked if this opportunity is only available to 638 facilities. The FAQ focused on tribal facilities that could be designated as FQHCs and was relatively silent on the ability for IHS to replicate this model. Tribes that operate a 638 facility must elect to become an FQHC and enter into contracts. There are many nuances to the policy and questions that need clarification from CMS. The current encounter rate is $391 which is roughly double the encounter rate for FQHC services. There would be a financial incentive to route services through a contract with a tribal FQHC to access increased funding for providers. Tribes and the state support the idea of extending

100% FMAP to Urban Indian Health. Shelly Ten Napel offered that CHAD could help support a model for Urban Indian Health and other FQHCs to contract with tribes.

Senator Heinert asked if tribes could contract with others for non-Medicaid patients. The payment process would only affect Medicaid recipients. Senator Heinert asked if there are models where clinics serve everyone and not just Medicaid patients. There does not seem to be a benefit to the regular IHS patient that doesn't qualify for Medicaid; tribes do not have an incentive to push this model forward if it does not help all of their members.

Jerilyn Church stated that there is a potential for savings to the tribal health budget with this model, which could then be used by the tribe to purchase insurance. The challenge is ensuring that tribal health facilities have the capacity to bill third party insurance. Not many tribal programs currently bill third party insurance. GPTCHB is committed to helping tribes bill third party payers and working through any barriers to third party billing.

Kim suggested a small group meet to work through some of the nuances on the 100% FMAP options. Jerilyn Church, Elliot Milhollin, Mike Diedrich, Shelly Ten Napel, Senator Heinert, Deb Fischer-Clemens, Nick Kotzea, and Charlene Red Thunder volunteered to be part of the group.

Mike Diedrich gave an update on a pilot that Rapid City Regional is exploring with the Oglala Sioux Tribe with assistance from GPTCHB and how to implement a contract with the tribe for services.

Review Ideas for Work Requirements

The governor supports work participation requirements as a way to help individuals become employed and realize the benefits of employment. Any changes in this area will need to be common sense and ensure they aren't merely a barrier to people getting Medicaid in the future.

Lynne Valenti gave an overview of the work requirements currently associated with SNAP and TANF. SNAP recipients must work or participate in work activities unless they meet an exemption. Exemptions include:

- Individuals under 16 or over 60;
- Parents of children under age 6;
- Disabled individuals;
- Individuals already employed at least 30 hours per week or participating in TANF work or Native Employment Work (NEW) Programs.

In Minnehaha and Pennington counties, individuals must work or participate in work activities that include job search, GED classes, job classes, and community training. DLR monitors and verifies that work requirements are being met. In other counties, the individual attests that they are looking for or maintaining employment and will not

reduce work hours. Noncompliance can result in penalties including sanctions from the program.

The majority of TANF cases in South Dakota are non-parent cases and are exempt from work requirements. 19% of cases are required to work unless exempt. Examples of exemptions include:

- Parent of a child under 12 weeks;
- Incapacity as determined by the disability team;
- Individuals on SSI, SSDI, or with 100% VA disability.

Parents with children under age 6 are required to work 20 hours a week. Parents with children over age 6 are required to work 30 hours a week. Child care assistance is available for these populations when required to support work or school.

Kim said that we want to leverage programs already in place and our current partnership with the Department of Labor.

In SFY2016, on average 118,674 individuals were eligible for Medicaid. 68% of the population is children and 32% are adults; 21% are aged, blind, disabled or pregnant women. The remaining 11% (roughly 13,000) are low income parent or caretaker relatives that would be the likely target population. Within that group, some individuals would likely be exempt and the numbers would need to be refined. Individuals would be identified at the time of application and then referred to DOL for a targeted engagement strategy.

Steve Emery asked about places where there is no unemployment. Individuals may participate in community service activities to meet work requirements.

This is an issue today in some areas of the state and DSS works with DLR on a variety of strategies for job training activities or alternatives where employment opportunities are limited.

Terry Dosch commented that he agrees with what we're trying to do, but that we need to be cognizant of individuals with severe mental illness diagnosis and have considerations built into work requirements for ability and nature of work. Terry stated that he does not think a full exemption is needed, but that those individuals may not be able to succeed with a 30 hour work requirement.

Senator Partridge asked if there has been a conversation with DOL about adding Medicaid work requirements. Lynne Valenti stated that the state has outreached DOL Secretary Marcia Hultman and her staff and DOL is excited about the opportunity work with this population. Kim added that DOL has had success by providing supportive services to individuals where they need help, and is interested in expanding the model of help that individuals receive to be similar to the model used for individuals seeking unemployment.

Senator Heinert commented that he's disappointed about this path and putting up barriers to basic needs like health care when his community does not have jobs or training centers. Senator Heinert would like to look at jobs and economic development separate from basic needs like health care, child care, and food.

Jerilyn Church stated that she thinks work requirements may be a challenge for tribal communities and is a requirement that may discourage individuals from enrolling in Medicaid. The federal trust responsibility for tribes has never had a work requirement attached to it. If the 100% FMAP in Medicaid is a vehicle to expand the federal trust responsibility, then there's an issue that may need to be reconciled. Jerilyn asked what percentage of the 13,000 already has an exemption or are American Indian.

Senator Soholt asked if a system for tracking work requirements makes financial sense to the state. Kim stated that administrative costs are a legitimate concern that needs to be factored into the discussion and about the perspective of work and work as a value of our state. We need to be realistic to the fact that Medicaid reform will mean cuts of 20-30% in federal Medicaid dollars. There's not room to support those types of cuts in rates or services, which leaves cuts to individuals being served. If we're going to see the kind of cuts being discussed at a federal level and still preserve benefits, then we need to promote ties between Medicaid and what's valuable to our state. Adults are the most vulnerable population for cuts. Work and work opportunities that support employer sponsored health insurance are a key strategy to make Medicaid dollars go further.

Senator Soholt said we need to think through innovation for Medicaid to see less dollars do more and increase care. We also need to push for federal dollars in the allotment process. Senator Peters agreed that innovation is one of South Dakota's strengths and that our state has always been able to move fast and facilitate changes faster than other states.

Senator Heinert commented that we need to lay all possible ideas on the table and start with a high ask to the federal government for American Indians in South Dakota. Steve Emery stated that despite the funding formula, we are going to have to work to make sure American Indians are counted appropriately. Kim Malsam-Rysdon clarified that all current allocations being discussed are based on a state's prior expenditures.

Terry Dosch, Steve Emery, and Senator Partridge volunteered to be part of a smaller group to discuss work requirements.

Next Steps

Kim Malsam-Rysdon proposed an email update to the coalition in two weeks on federal developments for Medicaid reform. The sub-group on 100% FMAP will plan to meet before the next meeting.

Next Meeting

March 9, 2017, 2:00 – 4:00 PM CT
Governor’s Large Conference Room
Conference Call: 1.866.410.8397
Passcode: 6057734836