

South Dakota Health Care Solutions Coalition

Meeting Notes 12/03/2015

Attendees: Kim Malsam-Rysdon, Lynne Valenti, Brenda Tidball-Zeltinger, Jerilyn Church, Sonia Weston, Charlene Red Thunder, Monica Huber, Jennifer Stalley, Terry Dosch, Rep. Don Hagggar, Janet Jessup, Gil Johnson, Mike Diedrich, Dr. Tad Jacobs, Mark Quasney, Rep. Spencer Hawley, Kathaleen Bad Moccasin, Richard Huff, Sunny Colombe

Welcome and Introductions

The opening prayer was offered by Sonia Weston. Don Novo from HMA opened the meeting, and Coalition members introduced themselves.

Review of November 18 Meeting Minutes

Don reminded Coalition members to review the November 18th meeting minutes at <http://boardsandcommissions.sd.gov/Template.aspx?id=145> and to send any comments or revisions to Kelsey Smith at Kelsey.Smith@state.sd.us. That meeting focused on understanding the IHS contracting processes and discussed opportunities for how to contract in a streamlined fashion going forward. The group also received updated Medicaid expansion projections.

Subcommittee Reports and Draft Recommendations

Access to Care Subcommittee

This group is very focused on implementing strategies to partner non-IHS and Tribal providers with IHS and Tribal providers. There were several presentations at the last meeting about some Tribal and IHS prenatal care programs that are making a difference in helping to prevent low-birth weight babies and supporting new mothers.

The key recommendations of this subcommittee are:

- Support for prenatal care and new mothers through leveraging programs like the centering approach.
- The use of telehealth to support emergency departments in IHS facilities. Eagle Butte and Rosebud will be the priority locations for starting this program.
- The use of telehealth to support specialty care, in particular for behavioral health care and high-risk OB/GYN care. The group is continuing to work with IHS and the Great Plains Tribal Chairmen's Health Board on the specific specialty needs.

New Services Subcommittee

There was a discussion of Community Health Workers/Community Health Representative (CHW/CHR) programs in several other states. Several Tribal representatives talked about their specific CHR programs. The group reviewed options for creating a formal CHW/CHR program within Medicaid.

The group heard an overview of the Medicaid prescription drug benefits and how Medicaid pays for medications.

This group also met this morning (12/3) and finalized recommendations for the Coalition. The first recommendation from the New Services Subcommittee is to develop a formal a CHW/CHR program within Medicaid. The group determined some key components of a CHR program, including:

- CHW/CHR services
 - Health promotion and health education
 - Arranging for transportation (as opposed to providing transportation)
 - Disease-specific education
 - Specific direct client services, e.g., wound care, medication support, vital signs
 - Assist individuals in navigating the health care system
 - Connecting individuals to other community services and supports
- CHW/CHR qualifications
 - Tiered model of education and certification to allow CHW/CHRs to serve specific community needs
 - Leverage current training programs and certification programs that exist today (e.g., CNA and CHR curriculum through IHS); work through AHEC system and with Department of Health
- CHW/CHRs under Provider Supervision
 - Physician, Physician Assistant, Nurse Practitioner would make a referral for CHW/CHR services to tie back to payment for Medicaid
 - CHW/CHRs would be part of the care coordination team
- Populations Served
 - CHWs/CHRs would be a key part of Health Homes teams (and payment for their services would be covered under the payments to Health Homes)
 - For individuals not eligible for Health Homes or where no Health Home is available, CHW/CHRs would target those with ED visits or inpatient hospitalizations, including chemical dependency treatment

Next Steps for the CHW/CHR program is to establish a smaller group to develop program details. Also, this group would look at the reimbursement and funding for a CHW/CHR program and assess the fiscal impact of the program in Medicaid.

The second recommendation is for ensuring that Medicaid works to ensure that Health Homes are maximizing their Medication Therapy Management capabilities.

Behavioral Health Subcommittee

This group has met fewer times than the others, so is not quite as far along as the others. Discussions have been primarily about current Medicaid behavioral health structures and services, what Medicaid covers and does not cover, and what services are available through Tribal provider programs. There was a presentation on Health Homes and the Community Mental Health Centers model. Behavioral health is a significant need in Indian Country, and the group has been discussing how to reduce barriers that might be impacting the ability of IHS and tribes to provide expanded behavioral health services, such as how to help IHS and Tribal facilities to be Behavioral Health Homes or expand the Community Mental Health Center model. There is a need for additional assessments and increased technical assistance to IHS and Tribal providers.

Final Recommendations

The next Coalition meeting will focus on finalizing these recommendations. The staff will be working on ways to present the information from each of the subcommittees graphically in the final report, to visually show the areas of the state where these supports and services would be targeted.

Discussion of Other Recommendations

There was a note that it will be important for the Coalition to consider which recommendations can be most cost-effective or how to implement the recommendations in the most cost-effective manner. Keeping services local as much as possible is key, as is ensuring that we do not disrupt the existing referral patterns and individuals' relationships with current providers.

Telehealth opportunities, in general, should be a key service that Medicaid supports in a way that allows providers to maximize care and access for patients. Access to primary care still needs to be a critical focus, because it is a "jumping off" point for everything else. Addressing the primary care need is part of what prompted the relationship with CareSpan and the Great Plains Tribal Chairman's Health Board. IHS can use providers from other states and technology and models such as this can open more opportunities.

The group also agreed there are opportunities to improve or expand the Health Home model, particularly in Indian Country. All the IHS facilities today are Health Homes; however, it will be important to look at how to help the Tribes that are operating their own programs or looking to operate their own programs leverage IHS partnerships or other community resources to meet the requirements to be successful. It will be critical to look at if/how there are ways to leverage other programs and their requirements (e.g., the IPC program at IHS) to remove barriers for Tribal providers. For example assessing and cross-walking requirements between Medicaid and IHS would be helpful to understand how to limit duplicative and burdensome administrative requirements.

As the Medicaid program covers more people, it should free up funds for IHS to be able to cover more services than what are covered today. In North Dakota, the Purchased/Referred Care program was able to expand coverage to many lower-level priority services than it did before because of Medicaid expansion. That helps all IHS eligibles get access to needed care.

When Tribes take over services through a 638 process, they have more flexibility to use the funds in ways that best support their Tribal members' needs. South Dakota Tribes should look at what some Tribes in other states are doing, such as purchasing private health insurance and paying the premiums or other cost-sharing for members.

Updated Expansion Cost Estimates and Expansion Approaches

Before discussing updated costs, the group discussed updates on discussions with CMS on the federal guidance being finalized on the 100% FMAP option. CMS is reviewing the comments they received on the White Paper, but South Dakota is continuing the dialogue with CMS to keep things moving. Jerilyn Church noted that the unified consensus among all Tribes has been to standardize as much as needed, but leave options for each IHS area and tribes to work with the individual states in which they operate in the most effective way possible to meet their local area, state, and community needs. There is no

estimate on when CMS will release the final official guidance, which will be needed to finalize the recommendation for South Dakota to expand Medicaid.

Updated Costs

Brenda Tidball-Zeltinger presented information about updates to the estimates for expansion costs and approach. There were no changes in the benefits costs; however, there were changes in the administrative costs.

The original estimates were that the State would need about 39 staff to support expansion, primarily to support eligibility determinations and claims processing. Based on the revised assumptions, additional staff for quality control, care management, administrative reporting, and additional eligibility and claims processing support have been included. Additional administrative costs related to administering the dental benefit. The administrative update has not resulted in any substantive changes and the estimated new 2020 state cost bottom line number is \$34.6M, as opposed to \$33.5M previously.

Expansion Approaches

Brenda Tidball-Zeltinger presented information gathered from other states that have already expanded Medicaid. Each state has created a program tailored to its unique goals and political culture. Some common approaches in other states include:

Promoting Personal Responsibility through:

- Health behavior incentives
 - Sometimes tied to reduced premiums or cost-sharing
 - Also tied to Health Savings “like” accounts (AR, IN)
 - 16 states use some kind of healthy behavior incentives (looked at IA, IN, NY, WV in particular)
 - The Medicaid environment in which the state operates makes a difference (e.g., full-risk managed care vs. fee-for-service)
 - Federal rules limit cost-sharing based on individual’s income – cannot exceed more than 5% of family income.
- Premiums and other cost-sharing tied to health behaviors
- Health Savings “like” accounts

Of these strategies, the most widely used and easiest to administer is reducing/eliminating copayments or premiums tied to some form of healthy behavior such as participation in chronic disease management programs or completion of health assessment or health screening. Health savings “like” accounts have been used on a very limited basis and states have found them to be administratively burdensome to implement. States have better success in managed care environments since the state’s managed care organizations are typically tasked with implementing.

- Premium assistance through the Federally Facilitated Marketplace
 - States can buy qualified health plans for individuals through the FFM using Medicaid funds however individuals cannot be eligible for both Medicaid and subsidy through the exchange so any buy-in of premiums would be at the full cost of the marketplace plan.

- Cost-sharing still cannot exceed the 5% total
- States still must provide all essential health benefits that are required Medicaid benefits

Given the historical interest in this approach, some preliminary financial modeling was conducted. When the full cost of the marketplace plans, out of pocket deductible, coinsurance, and wrap around benefits are considered, the cost of coverage through the FFM is higher than the traditional Medicaid cost from the latest cost estimates provided. While Arkansas and Iowa used this approach, Iowa has since dropped this due to lack of cost effectiveness and Arkansas is evaluating.

- Premium Assistance to maintain Employer-sponsored coverage
 - A large number of states have some form of premium assistance. Overall cost sharing limits of 5% still apply and all Medicaid benefits must still be provided.
 - South Dakota has a small program targeted for high-risk pregnant women. More analysis is necessary to determine types of employer sponsored plans and to identify specific populations that may be viable to consider should South Dakota move forward with expansion.
- Work referral and training
 - CMS has been clear that states cannot tie work requirement to Medicaid eligibility. Several states do have work referral and training programs (UT model). States interested in this approach are leveraging work programs they already have in place for other programs such as Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP). This is an area the state would be interested in pursuing if South Dakota moves forward with expansion.

In South Dakota's continued discussion about expansion, it is important to learn about the experiences in other states and what is working and what is not working. As the discussion continues, premium assistance through the exchange, and overly complicated healthy incentives appear to be ruled out based on the cost (direct and administrative costs) and what has been shown to be ineffective in other states.

Kathy Bad Moccasin noted that since Tribal members already have exemptions to cost-sharing so that approach isn't as directly beneficial to the Native American population but premium assistance for Native American members to maintain employer sponsored could be a very good option. Often times, individuals need a small amount of support for deductibles or other out of pocket to maintain their coverage. Not disrupting coverage available through private options is a good strategy to consider.

Next Steps:

- Final discussion of recommendations from the subcommittees
- Draft summary report of the Coalition's work

Next Meeting

Wednesday, December 16, 1 – 2:30 p.m., Central Time, conference call

1.866.410.8397 / 6057734836

REMINDER - All the materials from the Coalition and Subcommittees can be found on the State website at: boardsandcommissions.sd.gov