South Dakota Health Care Solutions Coalition
Meeting Notes 5/03/2017

Attendees: Dr. Mary Carpenter, Sara DeCoteau, Mike Diedrich, Terry Dosch, James (Jim) Driving Hawk, Scott Duke, Debra Owen and Gil Johnson, Mark East, Steve Emery, Danielle Hamann on behalf of Deb Fischer-Clemens, Sen. Troy Heinert, Rep. Jean Hunhoff, Nick Kotzea, Kim Malsam-Rysdon, Sen. Jeff Partridge, Mark Quasney, Sen. Deb Soholt, Jennifer Stalley, Brenda Tidball-Zeltinger, Lynne Valenti, Sarah Aker, Kathaleen (Kathy) Bad Moccasin, Richard Greenwald

Other Attendees: Amy Guimond (Wyoming Medicaid), Jason Simmons, Bob Mercer

Welcome and Introductions

Kim Malsam-Rysdon welcomed the group and thanked them for their participation. Kim introduced Jim Driving Hawk, the new Great Plains IHS Area Acting Director.

Review Last Meeting Minutes
The group reviewed the minutes from the last meeting. The latest news regarding the American Health Care Act (AHCA) is that there may be a vote on the amended AHCA this week in the House of Representatives. The House has indicated that they will not vote until there is confidence that AHCA will pass. The amendments to AHCA center on adding flexibility for states relative to the individual health insurance market. The amendments are geared towards giving states lower cost options for health insurance and include options like changing the essential health benefits, and implementing different age banding and prices. There have not been any new amendments relative to the Medicaid provisions of the original bill. The state will continue to keep the group informed as things progress on the federal level.

Kim briefly overviewed the work of the two subcommittees and the discussion at the last coalition meeting. Discussion in the last meeting was prefaced on the fact that Medicaid expansion is not an option for South Dakota; the group brainstormed other incentives that could be utilized to promote tribal and provider buy-in and that also improve health outcomes and increase access to care. The group reviewed the prior coalition recommendations and discussed other ideas.

Subcommittee Report- Implementation of 100% FMAP Policy

The committee is engaged in the idea of assisting and supporting tribes interested in self-administration for 638 services. Jerilyn Church and Great Plains Tribal Chairman's Health Board (GPTCHB) are surveying all of the tribal health directors on the challenges and the assistance needed to move forward with more self-administration. The subcommittee is meeting tomorrow and hopes to have an update from Jerilyn on the results of the survey. The results from the survey may help to inform the Coalition recommendations for incentives.

CMS invited the state to suggest changes to the 100% policy and the care coordination agreement easier to implement.

Brenda Tidball-Zeltinger gave an overview of the changes to the 100% FMAP policy that have been discussed by the committee:

1. **Wider Scope of Services:** The group recommended that the policy should clarify that any service that is permitted to be provided by IHS that's also covered by the Medicaid State Plan should qualify for 100% FMAP. The intent of the clarification is ensure that the policy is broad and that the guidance is clear to ensure that the policy will not later be interpreted to be limited in scope.
2. **Referral Process:** The group also recommended increased flexibility for referrals by relying on standard practices in health care rather than prescriptively defining a referral. The current policy does not support a provider facilitated referral or self-referral. Nor does it clarify that a referral could be obtained retroactively consistent with current I.H.S. policy. The group recommended flexibility for a non-IHS provider to facilitate or initiate a referral or for an individual to give a self-referral for services. The group also discussed retro-active referrals consistent with other IHS policies for purchased and referred care.

The group plans to finalize the comments on the SHO letter and submit the comments to CMS following the next meeting. The group is still waiting for additional comments on the care coordination agreement.

Wyoming Approach to Implement 100% FMAP

Kim Malsam-Rysdon introduced Amy Guimond, who is the Tribal Waiver Manager in Wyoming. Amy gave an overview of Wyoming Medicaid and outlined key differences in American Indian care in Wyoming compared to South Dakota. American Indians comprise approximately 12.7% of Wyoming's Medicaid enrollees and about $40 million in total expenditures each year. Of the $40 million, $8 million is for direct care at Wyoming's IHS and 638 clinics; $32 million is attributed to care at non-IHS/tribal providers. Wyoming has two tribes that live on the same reservation. The reservation has 2 smaller 638 clinics, 1 large 638 clinic, 1 large clinic operated by IHS, a tribal-owned nursing facility, and two behavioral health recovery programs.

Wyoming worked with their tribal advisory group to move forward with the 100% FMAP policy. Wyoming does not see the policy as adding any new requirements for providers and is following the standard process for referrals with the addition of a care coordination agreement. Wyoming is using the HHS care coordination agreement which is the same template South Dakota is considering.

Wyoming is using a shared savings approach to incentivize implementation of the policy for tribes. For savings up to $5 million, Wyoming will share 5% of the savings with the tribes, 7.5% for care up to 10 million, and 10% for any savings in excess of 10 million. Wyoming gave tribes the top 20 providers of non-IHS/tribal services and asked their tribes to focus care coordination agreements with those providers. Wyoming has one

contract in place with one of their tribes. The tribe is working on implementing a care coordination agreement with the hospitals. Wyoming has not outreached non-tribal facilities in this process since Wyoming believes the basic rules of Medicaid would already require the activities under the care coordination agreement.

Wyoming is scheduled to meet with the administration of the Wind River IHS Clinic to discuss if savings can be shared with IHS. The previous administration of the Wind River Clinic told Wyoming they were not eligible to receive shared savings, but Wyoming is following up with the new administration to determine if there is any potential for IHS to take part in the savings.

Brenda asked what amount the state has focused on for realizing shared savings. Amy stated that Wyoming conservatively targeted $2 million in care that originates with a direct referral from IHS/tribal clinics. Wyoming is working with tribes to see if they can increase the amount Senator Soholt asked if Wyoming was only focusing on physician referrals. Amy stated that there is a potential for up to $17 million in potential savings, but that Wyoming is estimating $2 million to start, with the intent to expand to capture more savings.

Sara DeCoteau asked about the Wind River IHS clinic savings; if the savings are not able to be shared with IHS, could they be directed to the tribe? Sara went on to explain that Sisseton Wahpeton often provides supports or a portion of the services rendered, but does not see reimbursement for those services from IHS. The tribe also refers certain services that may be eligible for 100% FMAP and asked if there is a way for the tribe to take part in savings from the referred care. Amy clarified that the intent is for the savings to be shared with the tribes and Kim clarified that the work of the coalition is meant to capture savings for services referred by tribes too. The state will resend the care coordination agreement to the Coalition members.

Brenda asked how the agreement between the state and the tribe for shared savings is structured. The agreement is between the tribe and state, and includes all 638 sites operated by the tribe. The contract indicates the requirements for the tribe, the process for sending care coordination agreements to the state, the quality assurance requirements to ensure the requirements of the policy are met. Wyoming is also working with the tribes to utilize the EHR program. The tribe is responsible for obtaining the care coordination agreements. The amount of dollars is directly linked to the number of referrals generated by the tribe. There are essentially two agreement types – one with the state and the tribe or IHS outlining the shared savings approach and then separate care coordination agreements between the tribal program or IHS and the non-IHS providers.

Kim asked Amy to talk about the plan for the state's share of savings. Amy explained that Wyoming faced a $56 million cut to Wyoming Medicaid last year that resulted in cuts to services like dentures and dental. Wyoming has not designated the state savings for any particular purpose, but anticipates that any state savings could be used to supplement their budget and potentially add services back to Wyoming's benefits.

Kim noted that shared savings is a direct incentive for tribes directly related to implementation of the policy, but that South Dakota would need to determine if IHS can participate in shared savings. Senator Heinert agreed that shared savings is a possibility to gain tribal buy-in and should be explored further.

Senator Partridge asked Amy to explain the potential for savings and how Wyoming estimated $2 million as the potential. Amy explained that Wyoming currently spends $40 million on American Indian care in Medicaid. $32 million is paid to non-tribal providers at the regular FMAP. $2 million is a conservative estimate based on what Wyoming thought would be realistic for implementation of the policy. Brenda added that South Dakota's spend on care outside IHS is $190 million, with about $93 million in state costs.

Senator Heinert asked if the state new the dollar amount associated with care in South Dakota that originates at IHS and goes to a non-IHS provider with a referral. The state is working by FY2015 numbers, but is working to update to FY16. In FY15, there was roughly $16 - $18 million in care originating at IHS, with a state share of about $8- $9 million.

Follow Up: Cost Estimates of Incentives to Implement 100% FMAP Policy

Brenda reviewed the incentive table the as the estimated costs with the group:

- Telehealth: Individuals receiving care at IHS will benefit from telehealth, but will need experience to know the number of patients who benefited from the implementation.
- CHR Pilot Program: The state provided a rough estimate of Medicaid recipients who may benefit from this service. This type of service is currently more common at IHS and tribal facilities statewide.
- Increase Capacity for IHS Behavioral Health Services: The state does not have a good estimate at this time of the number of individuals impacted at IHS by increased capacity. New services would be eligible for 100% FMAP.
- Add Mental Health Providers: In addition to the information on the table, Brenda added that conversations at tribal consultation have indicated this would have a substantial impact for 638 providers and Urban Indian Health. This would also impact other providers across the state.

Mark East asked how the estimates for the number of individuals impacted by Recommendation 5 were developed. Brenda explained that the estimates were developed using information from the state licensing boards as well as prevalence and utilization information from current providers.

Kim reviewed estimate 7 to add substance use disorder services as a benefit for adults currently eligible for Medicaid. Today, Medicaid coverage of these services is limited to pregnant women and adolescents. Substance use disorder services are an essential health benefit under the ACA and the feeling of the coalition was that those services

should be extended to all Medicaid eligible individuals. Although Medicaid Expansion is not an option, there is still a need for individuals around the state.

Sara DeCoteau stated that Sisseton-Wahpeton Oyate feels strongly that SUD benefits should be on the list of recommendations and incentives. Brenda pointed out a correlation between recommendations 4 and 5 from the Coalition and recommendation 7. Mike Diedrich added that he thinks this recommendation is important given the alcohol-related mortality rate. Senator Soholt added that in order to fully address problems related to substance abuse and mental health, we need to move forward with this recommendation.

The Coalition's previous discussion included a desire to see more individuals have access to Medicaid. Brenda reviewed the next items on the incentives table related to changing Medicaid eligibility. The estimates were derived using the same methodology that was used to calculate estimates for Medicaid expansion; however the core assumption is that costs for any changes would be at the regular FMAP. Because of this, the state costs of changing current Medicaid eligibility standards are very high. The potential savings from implementing the policy change would not cover most of the scenarios that would increase income levels for Medicaid eligibility. The state is working on additional stratifications of the data to determine if eligibility changes can be scaled into finer increments.

Senator Heinert commented that his preference is that the state implement some type of waiver to provide eligibility for American Indians up to 138% of the FPL. He added that after seeing the cost and hearing the information Amy shared, there may be other incentives that could be used.

Jean Hunhoff asked if the costs reflect Medicaid as it is structure today. She asked if the estimates considered the impact of moving to a per capita cap or block grant. Brenda explained that the estimates for expanding eligibility are based on historical expenditures for the population most like the group that would be impacted. The state has worked to understand the potential impact of the AHCA and that these estimates are in essence a per capita estimate for a set number of individuals. However, the estimates for the impact of AHCA contain assumptions around items not specifically addressed in the federal bill. Kim noted that if the coalition were to recommend anything in this area, the recommendations will have to take into account any federal changes relative to eligibility.

Kim reviewed the previously discussed idea of innovation grants, where there would be a set sum of dollars to invest in a pilot program to test a new service delivery model geared at addressing population health issues in the Medicaid program. This recommendation would have the ability to scale the pilot to match the available funds. Sara DeCoteau asked if high risk pregnancies could include pregnant women with substance use disorders. Yes, those individuals would qualify.

Kim reviewed the uncompensated care recommendation. Uncompensated care is broader than just that occurring through the IHS system. The idea of shared savings may be an approach to get at uncompensated care both within the IHS/tribal system and the non-IHS/tribal system. Senator Soholt stated that it's important to talk about solutions that can address uncompensated care coming into the system and help support continuity of care and case management in the tribal/IHS system. Nick Kotzea thinks shared savings geared towards mitigating uncompensated care could help address the incentive for non-IHS/tribal providers.

Senator Heinert commented that there are two different avenues for addressing uncompensated care: 1) Shared savings could be written into contracts as a direct payment for uncompensated care. 2) Shared savings could be reinvested into purchasing insurance coverage for other IHS eligibles to generate a payer for the remaining IHS population. Kim noted that it will be important to determine any expectations for shared savings and how stakeholders will meet those expectations in order to ensure a robust program that has full consensus of the coalition. The state will work on bringing back more information relative to shared savings and uncompensated care. Senator Heinert and Mike Diedrich were supportive. Mark East requested diving into shared savings in greater detail at a future meeting.

Next Steps

The 100% FMAP subcommittee will meet on May 4 to finalize changes to the SHO guidance to return to CMS. The next coalition meeting will focus on understanding the incentive ideas and prioritizing recommendations. The state hopes to have the Coalition meet in person for the next meeting in Pierre.

Next Meeting

June 13, 2017, 1:30 – 4:00 PM CT
Pierre (location: TBD)
Conference Call: 1.866.410.8397
Passcode: 6057734836