South Dakota Health Care Solutions Coalition
Meeting Notes 1/8/2018

Attendees: Sarah Aker, Dr. Mary Carpenter, Jerilyn Church, Sara DeCoteau, Rep. Mike Diedrich, Scott Duke, Mark East, Deb Fischer Clemens, Steve Emery, Sen. Deb Peters, Kim Malsam-Rysdon, Mark Quasney, Tim Rave, Kelsey Roth, Dr. Brian Shiozawa, Kelsey Smith, Bill Snyder, Jennifer Stalley, Rep. Wayne Steinhauer, Brenda Tidball-Zeltinger, Lynne Valenti, Scott Duke, Sen. Deb Soholt, Myra Munson, Rep. Jean Hunhoff, Sen. Troy Heinert, Shelley Ten Napel

Welcome and Introductions

Kim Malsam-Rysdon welcomed the group and thanked them for their participation and noted that handouts for the meetings are posted on the Boards and Commissions Portal.

Review Last Meeting Minutes

This group last met in November right after the care coordination agreements were signed between IHS and the three systems. The bulk of the November meeting was devoted to reviewing the prior recommendations of the Coalition and coming to consensus or validating those recommendations moving forward. The coalition continues to support recommending added services to Medicaid to address service gaps. The four recommendations include:

1. Cover substance abuse treatment for adults currently eligible for Medicaid. Note: current coverage limited to adolescents and pregnant women.
2. Develop a Community Health Worker program in Medicaid.
3. Add Medicaid eligible behavioral health and substance use disorder providers including:
    - Licensed marriage and family therapists;
    - CSW working toward PIP; and
    - LPC working toward MH providers.
4. Innovation grants for primary and prenatal care.

Once the coalition recommendations are funded, the group also agreed that additional savings should be shared with providers through a shared savings agreement and reinvested into the Medicaid program with an emphasis on provider rates. Since the Coalition last met, there have been additional subcommittee meetings on Shared Savings and the Alternative Service Delivery Model.

Kim thanked everyone that has been a part of those meeting and devoted time to working on these subcommittees.

Policy Implementation

Brenda Tidball-Zeltinger shared progress since the last meeting. In addition to the care coordination agreements signed and in place with the 3 health systems, care coordination agreements have been signed by two dialysis providers and DSS is working to secure IHS signatures. DSS has also made the necessary changes within the Medicaid billing and payment system to leverage the savings as of the signature date of the agreement. Bill Snyder reviewed the received through policy savings report that reflects the savings garnered in November and December through the policy. The state will claim 100% FMAP for the claims under the care coordination agreements. Brenda added that the report will be published monthly with the monthly total and the year to date total. The list will expand to include other providers as additional care coordination agreements are signed. The report is available at: http://dss.sd.gov/keyresources/fmapreports.aspx

Representative Steinhauer asked if the totals represented claims that have been submitted. Bill confirmed that the totals represent paid claims. Representative Hunhoff asked if the claims represent only the main campus of the provider or if they represent the system. Bill confirmed that the claims represent the system level and would include all provider locations including Yankton.

Kim asked DSS how the savings for November and December compare with estimates for shared savings using prior expenditure data. The target amount for savings on an annual basis was $6.7 million in state general fund savings. A straight-line projection puts the state on target to meet the projection based on SFY17 claim volume.

Representative Hunhoff asked which line item of the budget will show savings. Brenda noted that the savings will flow through reductions and adjustments out of the Division of Medical Services budget primarily in hospital based services but there will be corresponding adjustments to add funding to support the coalition recommendations to add services to the Medical program. There will also be a positive adjustment to the DSS and DHS budgets to reflect funding to increase community based provider rates that are less than 90% of cost to 90% pursuant to Governor Daugaard's three year rate plan. The budget centers that will see reductions from the savings will be prescription drugs, inpatient and outpatient hospital and physician services.

Kim asked if there were additional questions about the report. Senator Heinert responded that the savings we are creating is good, but that he does not see any benefit going to the average IHS eligible- not a dual Medicaid/IHS eligible, but a benefit to the average IHS eligible. He noted that as an Indian, it looks like we are saving money for the state at the expense of American Indians.

Kim thanked Senator Heinert for raising his concerns. The first priority for the savings is to invest in Medicaid- specifically substance use disorder (SUD) services and mental health services. Kim noted that the services will be available to all Medicaid enrollees and will help create additional capacity across our state. The other piece of this work is

the shared savings agreement between the state and the provider including Indian Health Service through the shared savings agreement, the provider will have more resources to provide care. IHS has the ability to enter into those agreements and benefit from shared savings as well and this will add revenue to Indian Health Services to fund healthcare for all individuals that IHS serves. Kim noted that the timeline for the shared agreements is to be signed and implemented no later than July 2018.

Brenda added that by adding additional services in SUD and behavioral health, tribal providers who are unable to bill today will also be able to access Medicaid and get Medicaid dollars for services they are providing today. Senator Heinert said he has heard about the possibility of increasing bed limits which is needed in reservation communities. But there is concern that IHS relies on Medicaid funding in order to provide care to non-Medicaid eligibles and there is a fear that as health clinics and hospitals outside of IHS are allowed to receive 100% FMAP, that while it may increase access for dual eligibles, it has not addressed problems at IHS for non-Medicaid eligibles. Kim noted that the care coordination agreements in no way reduce or take away from any care happening today at Indian Health Service as these projections are based on care that starts at IHS today and is then already referred out. Nothing that the Coalition has recommended will take away from IHS or the tribal health system but should enhance resources for both.

Myra Munson asked about the status of a waiver with CMS and if the shared savings agreements are contingent on a waiver with CMS. Implementing the federal policy change does not require a waiver. CMS is not a party to the shared savings agreement so has indicated they will not approve these as the agreements are between the state and the provider. To the degree that there are no federal funds involved, CMS does not need to be involved in the agreements. In order to capture matching federal funds, the state will need to submit a State Plan Amendment. There are other waiver ideas being discussed, but those do not affect the shared savings of the care coordination agreements.

Shared Savings Agreements

At the last Shared Savings Subgroup meeting, the subgroup reviewed a draft shared savings agreement. Kim asked for anyone with written comments to send them to Sarah Aker so that the next iteration of the agreements can be sent to the group for review. The target is to finalize the agreement template in the Spring and route the agreement for signature and have in place by July 2018

Brenda reviewed the modeling of the shared savings for IHS and participating providers in the target group. She noted that IHS has an opportunity to garner shared savings payments and utilize those dollars to add resources or as an opportunity to supplement coverage and this is the incentive for IHS and the health systems to participate in the care coordination agreements.

Myra said that she is pleased to hear about the ability for shared savings. She asked how much would be allocated to individual programs. Brenda clarified that the handout

shows year to date savings for the last few months. The first $3 million in savings will be used to fund the Coalition recommendations and then the shared savings workgroup recommended sharing in the following percentages:

State Savings Amount	$0 - $500,000	$500,001 - $1,000,000	>$1,000,000
% Shared	5%	10%	15%

Myra asked hypothetically if $600,000 was available for shared savings how much would go to IHS and how much would flow to other providers? Brenda noted that the tiering is an equal percentage share between IHS and the non-IHS provider. For example, if Avera generated state savings of $140,000 then that would put Avera into the 5% tier, yielding $7,000 of shared savings or 5% each to Avera and IHS, plus we would pursue federal matching of the $7,000 for Avera as a non-IHS provider, whereas federal regulations preclude federal matching of the shared savings for IHS.

Other Updates

Lynne Valenti shared that the Trump administration has signaled increased flexibility in Medicaid policy. Under prior administrations, work requirements could not be tied to Medicaid eligibility. The Trump administration has signaled they are flexible in this area and wants to provide opportunities for states to help individuals find meaningful work. The Governor has directed DSS to look into this. The Department would use an 1115 waiver as the regulatory vehicle to submit to CMS. The waiver would target a small portion of the Medicaid population, low income adults with children. The waiver would pilot work requirements in areas of the state where more resources and employment opportunities exist today, specifically in Minnehaha and Pennington counties. The state plans to submit the wavier in July 2018 and anticipates implementing a voluntary program in those counties at that time. DSS will work with a group of stakeholders to ensure the waiver makes sense for South Dakota and focuses on helping individuals to be successful. The waiver contemplates providing transitional benefits to aid in individuals transitioning to employment.

Next Steps

Kim noted that work continues on the Alternative Services Delivery Model, but that additional work is needed for the rate of payment for that model.

The group also discussed next steps in terms of leveraging the policy in other service areas outside of referred care today. Sarah Aker reviewed a feasibility chart that outlines key decision points about the areas for potential savings through the policy today. The chart assesses the level of change needed to implement the federal policy and includes several data points including the number of providers and patients for different services. Based on feasibility, the next area to focus on is care provided in Community Support, Nursing Facilities, and PRTFs. Kim added that this care also has an advantage to implement the policy because state staff reviews the eligibility for these services which offers a chance to help with getting an IHS referral.

Senator Heinert noted that he thought care had to start at an IHS facility. He asked if the rest of the services noted would be eligible for the policy. Kim clarified that this care happens without a direct IHS referral today and that we need to build in the referral process from IHS in order for these services and individuals to qualify for 100% FMAP. Brenda added that there is added value for the individual to help connect this care to IHS and support services when individuals return to their communities following this care. Kim agreed, noting that better coordination will be part of the process, but that the process needs to make sense to the provider and the individual.

Representative Hunhoff asked how the referral will come from IHS. Kim said that is the next step to work with provider representatives, as well as members of the Coalition to work through the process and the changes needed to implement the policy. A subgroup of providers and stakeholders from those provider groups will meet on January 18. Representative Steinhauer has agreed to serve on the subgroup and Kim extended an invitation to other legislators wanting to serve on the subgroup. The subgroup will plan to build on the infrastructure currently in place for referred care and shared savings. The state savings generated can be used to reinvest in Medicaid through provider rates.

Senator Heinert asked if there are IHS and tribal health representatives on the subgroup. Brenda noted that the state has outreached Kathy Bad Moccasin to serve on the committee and outreached IHS to request any other additional providers who do admission or referrals that might also help the work group. The group will review how many of the recipients using that care today have been to IHS or a tribe in the last few years. Myra noted that engaging individuals and creating an incentive for them to be meaningfully engaged in the IHS system creates an opportunity to bring those individuals back into the system.

Senator Soholt and Representative Hunhoff volunteered to be on the referral group. Senator Heinert noted that if he cannot find another tribal member, then he will be on the committee. Kim noted that Steve Emery will also outreach tribes for a representative. Kim and Kelsey will send a note to the group regarding details for the meeting.

Next Meeting

Kim noted that the Coalition will plan to alternate between in-person meetings and calls and will plan to schedule the next meeting in a few months after the community based provider subgroup has had an opportunity to meet.

Representative Steinhauer thanked the state for reaching out to these new providers and setting up the January meeting.