South Dakota Health Care Solutions Coalition
Meeting Notes 11/16/2017

Attendees: Sarah Aker, Kathaleen Bad Moccasin, Dr. Mary Carpenter, Sunny Colombe, Mike Diedrich, Scott Duke, Mark East, Deb Fischer-Clemens, Rep. Jean Hunhoff, Nick Kotzea, Tim Rave, Kim Malsam-Rysdon, Alissa Olson, Mark Quasney, Kelsey Smith, William Snyder, Sen. Deb Soholt, Jennifer Stalley, Rep. Wayne Steinhauer, Brenda Tidball-Zeltinger, Lynne Valenti

Other Attendees: Jason Simmons

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 June. The bulk of that meeting was devoted to reviewing the prior recommendations of the Coalition and coming to consensus about how to move forward with implementing the current 100% FMAP policy. With savings generated by implementing the policy, the group recommended to:

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. Provide innovation grants for primary and prenatal care.

The group also agreed that additional savings after funding the first recommendations 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.

Progress Update – Shared Savings Subgroup

Bill Snyder and Brenda Tidball-Zeltinger gave an overview of the work of the Shared Savings subgroup. The group reviewed Wyoming's model and agreed to recommend a tiered savings approach:

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

Brenda reviewed the plan to generate savings through the IHS policy change and explained how savings would be generated. The plan targets strategies that will be easiest to implement- starting with patients that go to IHS and are then referred to other providers, or "referred care". The financial analysis for funding the Coalition recommendation targets 95% of the opportunity for savings in order to account for potential expenditure or utilization differences that may change based on referral patterns. At full implementation which is slated to occur over the next two years, the total general fund savings opportunity for referred care is $6.76 million.

Kim noted that the state's approach is conservative and is consistent with the conservative analysis and estimates used by this group to look at other ways to utilize state savings. Brenda also noted that savings will be leveraged over time and that there is work to do in some areas. The state is using a phased approach to implementation for both saving strategies and recommendation implementation. The work will begin in the current fiscal year, but it's anticipated that more savings will be garnered in SFY 2019. The plan is to implement SUD services in July 2018, and then add behavioral health providers in January 2019 and Community Health Workers in in April 2019. Full implementation will be in SFY2020 with the innovation grants. As noted in the handout, the full cost of the coalition recommendations for a full year of implementation is $2.84 million. With the phased implementation dates for the various recommendations, the cost will incrementally increase to the full amount. The handout shows the impact of shared savings on providers as well as the assumptions and risks for the plan.

Relative to the shared savings targets, the handout outlined the recommended tiers developed by the subgroup and using actual 2017 claim data. After implementation of the coalition recommendations, the governor supports prioritizing rates for community-based providers to bring the rates to 90% of the providers' costs. Rep. Hunhoff asked what year providers would see the increases. The Governor supports using funds for this purpose in the FY2019 budget. Rep. Hunhoff noted that the plan does not include all providers and that the Governor has prioritized community-based providers; she asked if the plan would be expanded to include other providers. Kim noted that is a discussion point for this group about how to expand the implementation of the federal policy and generate more savings to reinvest into Medicaid.

It is important to be mindful of risks to implementation. One of the first risks was that the agreements would not be signed. We reached a key milestone with signage of the care coordination agreements by the three large health care systems and HIS in the last week. Sen. Soholt congratulated the group on accomplishing a three year trajectory of work that got the group to this point. She noted that this was a big lift and that

recognition is due for the work it took to get here by the state, systems, and IHS. Kim thanked Kathy Bad Moccasin for her work to get the agreements signed.

The state is working to get care coordination agreements signed with the three targeted dialysis providers that provide a significant amount of services to patients referred by IHS. The shared savings agreement is the next task for the subcommittee and the group is aiming to have those agreements vetted, signed and in place by July 1. The shared savings approach could apply to other provider groups as well.

Deb asked about the work that has been done on the referral process and IHS eligibility so non-IHS providers can identify patients that are eligible for 100% federal funding. Sarah described the eligibility inquiry in the Medicaid Online Portal that allows a provider to verify if someone is eligible for both IHS and Medicaid.

Sen. Soholt noted that it will take some legislative will to hold true to a shared savings model and focusing on the identified programs. As money is freed up in the budget, we will need to make sure it is invested back in health care. It is important to make sure legislators understand and have a clear picture of how the savings are generated and how the outcomes of enhanced services equate to lesser costs being expended, and how the state needs to invest in reimbursement to providers. It will be important to build in clear accountability reporting to ensure savings are reinvested in health care. Sen. Soholt noted that there is more work to do to clearly articulate this intent and to become part of institutional memory as the governor changes and the legislature changes.

Rep. Steinhauer agreed with Sen. Soholt's comments, noting that 1/3 of the legislature will be turning over. Many legislators have a sense of the less than adequate funding for Medicaid providers and there is a desire to improve funding for Community Support Providers (CSPs). He suggested an idea that the group should maybe set priorities for assuring that community-based Medicaid providers get to 100% of their costs.

Sen. Soholt said that she appreciates the comment and that it is important to look at CSPs, but focusing on only one group can mean a deficit to other providers. Shared savings is a step in the right direction, and it's good to have intent to move community-based providers to 100% of their costs, but there also needs to be provisions for savings and innovation that affect all Medicaid providers.

Rep. Steinhauer noted that there is a strong desire to take care of CSPs due to the work they do, but that all Medicaid providers need their reimbursement evaluated. The next priority should address all Medicaid providers. This needs to happen before funding reverts to the general fund and disappears. The group noted that it will be important to make sure these funds are not seen as a way to supplant other funding for providers that would normally be available.

Rep. Steinhauer said that the Coalition needs to articulate a plan to implement the policy with other providers, for care that is not referred directly by IHS today, but could

be referred by IHS in the future. He advocated that CSPs are a logical choice to get contracts in place.

The group agreed. Other considerations that could drive the next phases of implementation include the amount of providers, the amount of claims, the opportunity for savings and the changes needed to meet the policy requirements. Care referred today by IHS is aligned most closely with the policy requirements. Other care like waiver or community support services, nursing homes, etc. aren't referred today by IHS and changes would be required and a bigger lift to meet the requirements and that will also take additional time. Kim suggested that the state analyze these factors and look for opportunities where the policy will be easiest to implement and then discuss prioritization with the group.

Rep. Steinhauer asked if a community support provider approached the state about shared savings, if the state is prepared to help them get contracts in place. Kim said yes, but the process is not as simple as just signing an agreement. Steinhauer agreed that it will take a team to make it happen. He said there has already been great work, but that we need to dedicate resources to make this happen. He asked the state what resources are needed to extend shared savings to more providers. Kim replied that is a great question, and that there needs to be a realistic picture of the effort needed. This work is not the only project that anyone around the table is working on. As we move towards care that will require fundamental changes to meet the intent of the policy, this work will take more time, but it does not mean there is a lack of commitment to the work. If there was ever a time when providers have been incented to do something different, this policy helps provide that incentive.

Tim Rave asked about the next low hanging fruit for implementation. Kim said that the Coalition's other current priority was exploring the alternative service delivery model. From there, it will be a matter of which providers are best poised to make the changes needed to implement the policy.

Rep. Steinhauer said he remembers the total potential savings of $90-100 million, and that as we talk about priorities, that any excess goes back to the general fund. Kim clarified that the Coalition has agreed that excess savings will be reinvested into Medicaid. Rep. Steinhauer said that the work has not resulted in the $90 – 100 million number that legislators are walking around with in their heads, and that if we get to that level of savings, then we need to talk about where those dollars will go. Kim said that we need to be realistic about the expectations for savings. Tim agreed, noting that the only way we will save the total amount is if there are changes on the federal level.

Progress Update – Alternative Services Delivery

Sarah Aker gave an overview of the alternative services delivery proposal. The proposal started as an IHS proposal, but was drafted as an 1115 proposal to CMS through the subcommittee's work this summer. Minnesota submitted a similar proposal to CMS earlier this year.

Kim summarized the concerns raised about the rate proposed in the waiver. Tribes expressed concern about extending the OMB rate to non-IHS providers because the rate IHS received is unique to IHS and should be reserved for IHS and tribal providers. The group is working through how the additional revenue for FQHCs would fund more resources to provide care and the impact at the local level as a result. Two of the FQHC pilot sites have provided information and the state is still working with the remaining site. The group is working on coming to consensus and hopes to move forward this spring with an 1115 waiver.

Deb Fischer-Clemens asked if the state has received information from 2 of the 3 pilot providers if the state would consider moving forward with other providers. Kim noted that the 1115 identifies specific pilot sites and contains a process to expand to other sites upon successful implementation at the pilot sites. The state could work with other providers, but the pilot sites were identified as locations where American Indians receive care today. Rep. Hunhoff asked about the timeline for pilot sites. Sarah said the pilot anticipates a 1 year pilot before expanding to other sites. Rep. Hunhoff said that it's important to focus on getting the process right in the pilot and reviewing outcomes around making progress on the goals of the demonstration before moving on to more providers. Kim said the state agrees with that approach.

Shelly Ten Napel said that she knows Community Health Center of the Black Hills and Horizon Health would be ready to move forward with the pilot tomorrow and are eager to move forward but remain committed to working through the concerns of Indian Health Services and the tribes.

Kim said that the next steps are to work on solutions to the concerns that have been brought forward and developing a win-win scenario for all stakeholders. The group is all working towards the same goal, but some work is needed on the details of the proposal.

Shelly clarified that the alternative service delivery work is separate from the plan for shared savings where the plan is to fund the Coalition recommendations, then sharing savings, with the remainder going towards provider rate increases.

Next Steps

Kim proposed a touch base call in January to provide a progress update and discuss further implementation of the federal policy.

Next Meeting

TBD