South Dakota Health Care Solutions Coalition
Meeting Notes 6/13/2017

Attendees: Kim Malsam-Rysdon, Jerilyn Church, Lynne Valenti, Brenda Tidball-Zeltinger, Mike Diedrich, Mark Quasney, Jen Stalley, Terry Dosch, Scott Duke, Debra Owen, Steve Emery & Hannah Kagey, Danielle Hamaan on behalf of Deb Fischer-Clemens, Sara DeCoteau, Sen. Troy Heinert, Mark East, Sen. Billie Sutton, Nick Kotzea & Tim Rave, Sen. Deb Soholt, Rep. Jean Hunhoff, Rep. Wayne Steinhauer
Shelly Ten Napel, Sarah Aker, Kelsey Smith

Other Attendees: Jason Simmons, Bob Mercer

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. The group reviewed the work of the 100% FMAP committee and proposed comments to CMS to change to the policy to make it easier to implement. The state is still working with CMS to help them understand the state's comments on the policy.

Kim briefly overviewed Wyoming's approach to implementing the policy through shared savings arrangements with tribes and IHS in Wyoming. Discussion focused on the recommendations of the HCSC and cost associated with the recommendations and other potential incentives for implementing the policy.

Federal Update
The Senate intends to vote on AHCA by the end of June before the July recess. Key anticipated differences from the version that passed the House include a longer time period for states that have expanded Medicaid to get the enhanced match with a sunset provision for enhanced FMAP and changes to the premium structure and the subsidy structure to take more consideration for age and income. Relative to Medicaid, the bill is expected to contain more specific flexibilities for states such as the ability to institute work requirements and make changes to how Medicaid eligibility is currently handled. The bill is expected to utilize per capita caps as the primary vehicle for funding with a block grant at the state option.

Mike Diedrich asked if the base year or if the method of inflation is expected to change in the Senate version of the bill. Kim stated that the state has not heard that the base year will change from 2016 since Congress does not want states to influence Medicaid expenditures in the current year to increase their future allotments. The CPI factors are being discussed as a risk for states if the CPI does not keep up with expenditures.

Procedurally, there are a certain amount of changes that are allowed in a Senate bill relative to Medicaid. The Senate parliamentarian will determines if proposed

amendments are germane. It is expected there will be a review of the policy elements in a bill meant to fund Medicaid.

Scott Duke gave an update that the language of the bill is expected to be released in parts to CBO over the next two weeks. There is discussion of June 29 as the target date for the vote. There is speculation that Senate Majority Leader Mitch McConnell might put the bill forward for a vote even if the votes are not there.

Shelly Ten Napel asked if there was any flexibility in the new administration to partially expand Medicaid eligibility with the ACA match rates. Kim responded that it is anticipated states would have the ability to expand eligibility, but not at the enhanced rates. Any eligibility changes would be done at the traditional FMAP.

Review Current Medicaid/IHS Funding

At the last meeting, members requested an overview of the policy change and current IHS funding. Sarah Aker overviewed the policy change.

Rep. Steinhauer asked if 100% FMAP funding is related to the race of the individual or if individuals must be a member of an enrolled tribe. Brenda responded that when an individual applies for Medicaid the individual self attests race and that information is verified as Medicaid pays claims to IHS. Kim added that tribal enrollment is one path to IHS eligibility, but not the only pathway for IHS eligibility. There are very few individuals in South Dakota that are American Indian but not eligible for IHS. Jerilyn Church noted that there is often confusion associated with an individual who is eligible for direct care at an IHS service unit, but who may not be eligible for purchased and referred care through IHS depending on their location in an IHS catchment area.

Brenda Tidball-Zeltinger overviewed the expenditures for American Indians for services provided g outside of IHS. Terry Dosch asked which category contains expenditures for Community Behavioral Health Care. Brenda noted that those expenditures are in the “other” category.

Brenda noted that the slides from SFY15 to SFY16 contain the actual general fund expenditures; but that the opportunity for potential savings is projected using future SFY blended FMAPs. An increase in the federal share of the FMAP results in less state general funds which decreases the opportunity for savings. For example, there was $92 million in actual state spending in SFY16, but applying the SFY18 FMAP results in $86 million as an opportunity for state general fund savings.

Kim noted that some of the services provided to American Indians outside IHS more closely meet the provisions of the current 100%FMAP policy. For instance, the administrative category includes prescription drugs and transportation costs that are eligible through IHS and originate at IHS. The referred care category is also for patients originating at IHS with an IHS referral for care and that medical records are shared with IHS as a result of that care.

For services in the FQHC direct and referred care category, the previous strategy involved applying for a demonstration project from HHS to have certain FQHCs in SD become IHS satellite clinics and be paid with 100% federal funds. The Hospital care coordination category has some of the most challenges to meet the provisions of the 100%FMAP policy since the patient is often not connected with IHS as a primary care provider. Long Term Care services are not necessarily being referred by IHS right now, so some processes would have to be built to capture these savings. The other care category represents thousands of different providers and provider types that complicate the ability to implement the policy.

Rep. Steinhauer asked if South Dakota Urban Indian Health falls under the FQHC bucket. Brenda responded that Urban Indian is an FQHC and would be part of those expenditures. Care provided by Urban Indian Health is not funded at 100% FMAP currently.

Rep. Hunhoff asked if the expenditures included CHIP. Brenda responded that CHIP is included in the total and that the savings opportunity for CHIP is much less due to the enhanced FMAP rate for CHIP. Kim added that children on CHIP are usually low cost and tend to be healthier and do not make up a large share of the expenditures.

Sen. Soholt commented that she wanted to voice her support to start on projects that could easily result in cost savings and will not get derailed by what is happening federally. She commented that we should start thinking about what we can move forward with as a state.

Kim confirmed that the easiest categories to generate savings are the administrative and referred care by IHS categories; however the coalition can still work on the other categories. Tim Rave agreed that we should focus on the low hanging fruit and do that well, and then move on to the more complex categories. Rep. Steinhauer agreed to focus on the low hanging fruit first and that the other categories will take more heavy lifting. He noted that sharing a portion of the savings generated by American Indians will be an incentive to serve that population; he thinks it would be great for both facilities and the patient. Kim agreed that shared savings is something the coalition will talk through in detail in the context of incentives.

Finalize Recommendations for Incentives to Implement 100% FMAP Policy

The goal of the coalition's meeting is to get consensus and recommendations about how to get started using the 100% FMAP policy and what to provide as incentives for providers, IHS and tribes to implement the policy. Kim referenced the incentive handouts from the prior meeting. The first seven recommendations come through the prior work of the HCSC as ways to enhance the current Medicaid program. Several of the recommendations have already been implemented or do not have costs associated with them. Kim asked the group for their feedback regarding the first seven recommendations.

Rep. Hunhoff asked if there are services/programs on the reservations that provide Substance Use Disorder (SUD) services. Jerilyn responded that there is contract health dollars to provide those services, but it's extremely limited. The Great Plains Tribal Health Chairman's Health Board (GPTCHB) had received a $2 million in grant funding from SAMSHA to fund recovery support services and direct treatment. Sen. Soholt asked if the previous funding through GPTCHB improved health outcomes. Jerilyn noted that the program was successful and will gather outcomes data to share with the group. Sen. Soholt commented that it is important to know the trajectory of improvement in order to understand the most powerful way to invest in SUD treatment.

Sara DeCoteau provided information about Sisseton Wahpeton Oyate's Dakota Pride Center that offers inpatient and outpatient treatment. The tribe does not keep track of Medicaid clients, but if they were able to bill Medicaid, then they would have improved revenue to expand services. They are currently on the verge of having to lay off some workers due to lack of funds. Rep. Hunhoff asked if there were any dollars available through tribes to pick up the expenses of the program or an ability to support the program through IHS. Sara noted that the tribe has a 638 contract and receives IHS funding for services provided by Dakota Pride Center. They are also able to bill the state block grant and receive funds.

Kim asked Terry Dosch to speak to effect of investment in SUD on providers. Terry noted that SUD providers work with tribes, counties, schools and other partners to provide services where possible. Community behavioral health providers can help to grow tribal health capacity. Terry noted that his group is willing to collaborate to help tribes and IHS adopt the Community Mental Health Center model. Brenda added a few points of clarification regarding recommendation seven:

- The recommendation does not add or expand new Medicaid coverage; the recommendation proposes funding SUD services for people who are already Medicaid eligible.
- The recommendation is the net amount of state costs to add the service. There are some nuances to federal funding rules for SUD services provided outside of Medicaid through the block grant.
- The recommendation would apply equally to any individual who receives Medicaid across the state and would provide a funding source for more individuals. The availability of a fund source for services will help build more services.

Jerilyn asked if the calculation for recommendation seven includes 100% FMAP for American Indians served by a 638. Brenda noted that the calculated fiscal impact does not take into account the opportunity for 100% FMAP and is calculated at the regular match rate. Jerilyn noted that the rate of Medicaid eligibles that would utilize SUD services is likely higher in the American Indian population and could be reimbursed at 100% FMAP through 638 providers.

Using the administrative and referred care categories, the potential state general fund savings totals $9 million dollars. Kim noted that the seven HCSC recommendations total

about $1.8 million in general funds. Kim asked if the group was supportive of funding the recommendations. Jerilyn agreed. Nick Kotzea stated that Sanford is comfortable with funding the recommendations since these recommendations address many of the needs of American Indians and others that have been expressed through the coalition. The group agreed to recommend that incentives #1-8 be funded if applicable with savings from implementing the 100%FMAP policy.

Kim reviewed incentive 8 on the table. This incentive was proposed to address individuals who are not eligible for Medicaid but who do not quality for subsidies on the exchange. The smallest eligibility expansion would require at least $18 million in state dollars. Sen. Soholt said this incentive is a non-starter for the legislature. She noted that without demonstrated savings she does not see the political climate for changes to eligibility right now. Rep. Hunhoff agreed that the state dollars would have to be saved prior to proposing this idea and that there is not the support for moving forward with this as an incentive. Rep. Hunhoff commented that it would be better to focus on other incentives for what we can do realistically. The group agreed that changing Medicaid eligibility is not feasible.

Incentive 9 is focused on assisting tribes that have 638 contracts and want to have more 638 programs. There is not an estimated fiscal impact because we are still working through what those strategies would be and any expanded capacity by tribal programs operating as 638 contracts is already eligible for 100% FMAP. Jerilyn Church noted that both she and other tribal leaders were struck by the percentage of services being provided off the reservations by non-IHS providers. She noted that primary care is referred out due to the lack of providers at times. She stated that the work of coalition has helped to energize tribes to work on providing more services on the reservation. One way to address this is for tribes to assume more responsibility for primary care. Kim agreed that there is strong support for this area, but further work is needed to know how the state can assist in this area and to determine potential costs. The group agreed to consider this incentive in the future when further information is available.

Incentive 10 is innovation grant opportunities to inspire new models of care in prenatal care and primary care. For the conversation with the coalition, the table included$1 million of state general funds to fund the grant. There's the possibility to match state funds with federal dollars if the services provided through the grant follow Medicaid rules.

Sen. Soholt stated that when we keep babies out of the NICU three good things happen: 1) Better health outcomes for the child; 2) Better outcomes for the family; 3) Outcomes are realized quickly. Strategies aimed at other chronic conditions can take a long time to realize the outcomes; with pregnancy, outcomes are seen within the year. Sara DeCoteau said that funding more treatment beds for pregnant women could reduce neonatal abstinence syndrome.

Kim noted that if implemented, the state would look to use a process similar to an RFP to request ideas and models for the innovation grants. The state would share basic data

for use by potential bidders and would allow individual communities to submit ideas that may make a difference for care within their communities. The process would be an open process in order to solicit ideas.

Shelly Ten Napel agreed with the ideas around prenatal care and noted that for primary care there is a lot of discussion in Value Based Payment and Shared Savings. Community Health Centers are starting to discuss ideas to control total costs of care and becoming true patient centered medical homes. She asked if the innovation grants could fund a value based payment model of care.

Kim responded that the innovation grant would invest in new models of care that we do not fund currently, determine if the model is effective, and find a way to fund effective models through Medicaid, or through savings. Tim Rave stated that $1 million in funding is a good place to start and the state could change the funding amount for innovation grants up or down as the coalition continues to discuss ideas. The group agreed to recommend that incentive #10 be funded from savings from implementing the 100%FMAP policy.

Kim reviewed incentive 11 and the relationship between uncompensated care and shared savings that was discussed in prior meetings of the coalition. Wyoming is using an approach that shares savings share between IHS and tribes and the state. Wyoming is using a tiered savings percentage based on actual savings accrued; more savings are shared as more savings are saved.

Rep. Steinhauer stated that smaller providers do not have the same opportunity to save dollars as larger providers. He added that smaller providers are not incentivized to participate if they do not have a high amount of care to leverage. He added that a small nursing home is never going to reach the necessary dollar amount of savings for participation; Rep. Steinhauer suggested tying shared savings to the opportunity for that facility to participate in savings.

Nick Kotzea noted that from Sanford's perspective, Wyoming's model is a fairly straightforward approach to address uncompensated care. Sanford is in agreement that a shared savings model is something that they can get behind.

Terry Dosch indicated that the incentive for a CHMC to do extra work could be a dedicated reinvestment to fund more services or increase rates as a result of the shared savings. Shelly Ten Napel agreed, noting that rate increases or funding new Medicaid services allows the state to generate a federal match on the state dollars. The state agreed that we would want to leverage federal dollars where appropriate. Mike Dietrich said that from Regional Health's perspective they support the shared savings approach and recommendations and there is a difference between general providers and more specialized services. In their health system, they would appreciate the flexibility to direct dollars to where they are most needed and not just allocate dollars to a specific specialty or program.

The group supported shared savings as an approach to provider incentives and that funding recommendations 1-7 and the innovation grants would be the first priority. The mechanism for calculating shared savings may look different depending on the type of care and the nuances of that care. Kim also noted that the coalition has discussed uncompensated care and Medicaid rates. She asked the group for ideas about how shared savings may go back to the provider.

Rep. Hunhoff asked about the incentive for providers to design and deliver services in fee for service payment arrangements and how to demonstrate that the care is costing less and having good quality outcomes for the patient. The group noted that if IHS can accept savings, the hope would be for savings to fund care for individuals that is not being funded today. Sen. Heinert agreed, noting that the amount of uncompensated care will likely grow if there are cuts to Medicaid, CHIP, and IHS.

Jerilyn Church commented that in the Billings region of IHS, the acceptance for shared savings is being seen as doable by both IHS and CMS. Dorothy Dupree is the Billings Area Director and has been instrumental in the discussion. Jerilyn asked her to work with South Dakota and Jim Driving Hawk to replicate the work done in Wyoming.

Sen. Soholt said that in order to incentivize the provider community to adopt case management for services they are already paid for today is to provide an assurance of reimbursement for those services.

Kim noted that the shared savings model needs more work before implementation. She proposed putting together a smaller group to work through the details, such as the care coordination agreements and the shared savings agreements. She asked interested coalition members to submit their name to Kelsey Smith by June 16.

Kim reviewed coalition's previous work on FQHC direct and referred care and the previous proposal to develop IHS satellites to get access to primary care for American Indians. The previous proposal had some challenges, but the state thinks there are some opportunities to move forward with this proposal again through partnerships with FQHCs. Kim proposed re-forming this group to see if the proposal can be simplified for implementation through an 1115 waiver. Kim asked for Jerilyn's assistance in outreaching tribes about the proposal.

Mark East thanked the group for the presentation and bringing the conversation together.

Next Steps
The Shared Savings and Alternative Services subgroups will plan to meet over the summer. The larger coalition will plan to meet in the fall in September or October to review the work of the Shared Savings and Alternative Services subgroups. The state will send information about federal updates as they happen.

Next Meeting TBD