South Dakota Health Care Solutions Coalition
Shared Savings Subgroup
Meeting Notes 7/11/2017

Attendees: Sarah Aker, Kathaleen Bad Moccasin, Jerilyn Church, Mike Diedrich, Terry Dosch, Scott Duke, Deb Fischer Clemens, Rep. Jean Hunhoff, Nick Kotzea, Kim Malsam-Rysdon, Elliott A. Milhollin, Mark Quasney, Brenda Tidball-Zeltinger, Lynne Valenti

Welcome and Introductions
Kim Malsam-Rysdon welcomed the group and thanked them for their participation.

Subgroup Goals and Purpose
Kim reviewed the purpose of the group to finalize the care coordination agreement and develop consensus on an approach to shared savings.

Review Draft Care Coordination Agreement
Lynne Valenti reviewed the care coordination agreement. This is the vehicle that providers will use to enter into agreements with IHS to leverage the 100% FMAP, based on the policy revised through the SHO letter. There have been many discussions to develop the agreement including the former Policy Operations subgroup which included members from this group and with IHS and CMS. The agreement is final other than populating the timeframe to submit medical records. CMS is using this as the example and giving it to other states to use. The agreement can be signed by the IHS Area Office on behalf of all IHS facilities in the state, and can also be signed at the provider system level as opposed to the individual provider level. The agreements define the roles and responsibilities for the parties. The group reviewed specific terms in the agreement:

- IHS Beneficiary – This term includes American Indians that are registered users of IHS. Kathy Bad Moccasin helped with this language since it has a broader meaning than the previous language. The arrangement for care coordination dictates that the IHS practitioner is responsible for coordinating and managing the patient and that their information will be included in the IHS medical record. Rep. Hunhoff asked if non-Medicaid eligibles can participate. The agreement is specific to Medicaid enrolled IHS beneficiaries.

- Medical Records Transmission- Nick Kotzea suggested 30 days for the transmission of medical records. Kathy indicated that records are required within 30 days from the date of discharge under Purchased and Referred Care (PRC) contracts and the group concurred 30 days should be used.

Develop Shared Savings Approach/Agreement
Sarah Aker reviewed the Wyoming shared savings agreement. Elliot Milhollin asked if Wyoming's contracts had been approved by CMS. Brenda Tidball-Zeltinger stated that because Wyoming's agreement is sharing state funds only and is not planning to

leverage any federal funds there is no requirement for federal approval as part of the process. Wyoming has given CMS a courtesy copy, but CMS has indicated that they would not be involved unless the agreement would leverage federal funds.

Mike Diedrich asked if the contract should include any activities related to education for tribal members to enroll in Medicaid and utilize IHS. The group agreed that these activities are inherent in the success is signing people up for Medicaid. No statement to that effect is needed in the agreement. Providers already have an incentive to help eligible individuals apply for Medicaid benefits. Deb Fischer-Clemens noted that once a patient has left the facility or program it becomes challenging to sign the patient up for Medicaid and thinks eligibility is an important part of the process and that if a person becomes Medicaid eligible, then that an individual should get a referral.

Jerilyn asked Kathy what percentage of IHS users are already on Medicaid. About 35% of all individuals on Medicaid in South Dakota are American Indian. According to the IHS system for Great Plains IHS Service Units, about 45% of IHS patients have active Medicaid. Jerilyn Church thinks it would be helpful to know who might meet the criteria for Medicaid eligibility but may not be enrolled in Medicaid.

Kim noted that it will be important to think about where we are starting from and care that happens now relative to referred care today. The state already has data about individuals who are directly referred by IHS today that will be relatively easy to transform into 100% FMAP savings. It is more challenging when an individual does not start at IHS. The care coordination agreement applies to all situations that can qualify under the agreement. The shared savings agreements need to be able to apply to where we're starting and where we want to go to.

Nick noted that using Wyoming's shared savings agreement as an example, that there are a lot of different ways to structure the agreement. Nick asked if the state starts talking about leveraging federal dollars for supplemental payments how the shared savings contract would have to change. Brenda responded that the mechanism would involve a state Plan Amendment and that both the SPA and the shared savings agreement would have to be approved by CMS.

Rep. Hunhoff asked where the savings would be generated from. Kim noted that the total amount of care currently referred by IHS to non-IHS providers is $7 - $9 million in state general funds. The claim already has referral information and medical record already shared back so it makes sense to start with this care. Rep. Hunhoff asked what is leading to the savings. When the claim meets the requirements in the SHO letter for services "received through" IHS, the state can claim 100% Federal funds instead of the regular FMAP, thus the state "saves" about half the cost for this care compared to what it pays today.

Rep. Hunhoff asked what is not working that is going to change. Kim walked through from a patient perspective: a patient lives in Pine Ridge, goes to IHS, the IHS provider thinks the child needs a specialty ENT consult, and the child goes to Rapid City, the IHS

provider writes a referral to see the non-IHS provider in Rapid City. The ENT bills Medicaid and the state pays about half the cost of the care in this scenario. With a care coordination agreement between the ENT and IHS, the federal government will pay 100% of the cost. Rep. Hunhoff asked if the changes will improve care, and promote efficiency or better utilization. While leveraging the policy change doesn't impact service delivery and therefore, the cost of health care, the state expects to see increased provider capacity and access for individuals who are not eligible for Medicaid.

Mark Quasney clarified that because the provider participates in the savings and is specific to the provider's activities that the shared savings approach incentivizes providers to take the necessary steps to implement the agreement.

Mike Diedrich asked if the agreements would apply to other IHS eligibles outside the Great Plains IHS. South Dakota will only share savings for South Dakota Medicaid patients.

Kathy asked if IHS would share savings as a whole or as an individual service unit. Kathy would want every service unit to have the ability to share up to the $1.5 million outlined in Wyoming's agreement. Tribes would have to make their own agreements instead of through IHS. The amounts and tiers could be subject to more discussion. The Wyoming contract is an example as a starting point for discussion.

Tiering Concept

Kim asked if the group was supportive of the tiering model where increased savings results in more sharing. Mike said that this benefits the state, the provider, and the patient. Nick is supportive of the tiering concept as well. He noted that to the degree that the Medicaid eligible population is a subset of the larger IHS population, if you're seeing a high percentage of Medicaid IHS patients, then you're likely seeing a high percentage of IHS patients without resources.

Terry Dosch asked how shared savings would work with a non-IHS provider. Brenda Tidball-Zeltinger gave an example of sharing savings of $100 at 5%. If the state was sharing 5% with IHS and the non-IHS provider, each provider would get $5.00 (5%) from the $100. The rest of the savings would go to the state.

The state thinks it is appropriate for IHS and tribes to participate in the shared savings and sees the opportunity to participate in savings as a benefit to IHS and tribes. The group also concurred that the state should look to leverage federal funds to maximize the impact of any savings leveraged. This will add complexities to the approval process, but the group could come back to just state funds if the process gets too drawn out. Nick said he is supportive of finding ways to leverage federal dollars

Review Referred Care Expenditure Data

Brenda reviewed the referred care data, including how an IHS referral shows up on the claim form to Medicaid. Approximately $16.2 million in care originated at IHS and was referred from IHS in SFY17. The potential for state savings is based on the FMAP at the

time the savings takes place. The three health systems account for about $3.5 million in potential state savings, with another $1.2 million from independent dialysis providers. The rest of the referred care is spread across multiple providers and services. There is an additional $5 million in "administration" services such as transportation and prescription drugs that originate at I.H.S. that could be converted.

SFY17 MTD - May Projected through June 30 (2018 FMAP)			
Care Referred from an IHS Facility to:			
In State Hospitals & Clinics			
	State	Federal	Total
Big 3 Health Systems	**3,533,188**	4,318,340	7,851,528
Other In State	**2,075,942**	2,537,263	4,613,205
Total In State Hospitals & Clinics	**5,609,130**	6,855,603	12,464,733
In State Dialysis (non hospital)	**1,243,738**	1,520,124	2,763,862
Out of State	**452,962**	553,620	1,006,581
Total ALL Referred	**7,305,829**	8,929,347	16,235,176
Admin (NEMT, Rx Drugs, Ambulance)	**2,250,000**	2,750,000	5,000,000
Total Referred and Admin	**9,555,829**	11,679,347	21,235,176

Deb Fischer-Clemens asked if another contract would have to be created between the state and the system that would mirror Wyoming's contract for shared savings. The state would have a contract in place with providers (including IHS or Tribal programs) that would be the same contract with all providers; there will be no individual negotiations for shared savings.

Terry Dosch asked about participation by community mental health centers. The provider could enter into a care coordination agreement and shared savings agreement. There may be some providers who do not enter into a care coordination agreement because the shared savings may not be enough incentive for the provider to enter into the agreement. Every care coordination agreement is better for the state since it saves the state dollars.

Rep. Steinhauer provided an email with some thoughts about shared savings for small providers. Within some provider groups, there may be interest and a mechanism for providers to want to enter into care coordination agreements.

Rep. Hunhoff asked if the shared savings will hurt small providers since larger systems can share savings and potentially utilize savings to expand into other service areas. The state does not see shared savings negatively affecting access, but will want to be mindful of that in the future.

Rep. Hunhoff asked if there is an incentive to partner with more community based organizations in order to get more coverage and access. Kim directed the question to the health systems. Mike said that he's not certain, but that it appears to be a logical progression. Deb agreed that she does not know, but that it seems like a logical progression. Rep. Hunhoff asked if asked about if the tiered system creates a potential for partnering and delivering services that are having challenge. Yes, there is a potential for partnering to promote new service delivery.

Next Steps

Kim outlined next steps:

- The state will continue modeling different scenarios that include funding the recommendations for the group to review and build to consensus going forward.
- Kim asked the group to give ideas of levels of tiering that would be meaningful.
- Kim asked the group to share ideas and feedback about the agreement using the Wyoming shared savings agreement as a starting point.
    - Nick asked about what the audit function of the state. Wyoming is planning to review 5 records. As discussed in prior work of the coalition, the state requires providers to include information about the referring provider today so that is a key piece of any audit trail. Additional information is housed within the MMIS including capturing the care coordination agreement on the provider enrollment record and the individual's eligibility for I.H.S. The state anticipates using a similar process.
    - The state will start working with CMS and what impacts there may be to the state plan to leverage supplemental payments as part of the shared savings arrangement.

The state will send meeting materials prior to the next meeting and include the numbers Brenda references in the minutes. As the work progresses, the state expects to have evaluation points for potential changes. Kim encouraged members to contact state staff with questions about the mechanics of shared savings.

Jerilyn asked if someone could resend the final list of Coalition priorities. Sarah Aker will forward that to Jerilyn. All materials are also on the website.

Next Meeting

August 24, 2017
10:00 AM, CT
Governor's Large Conference Room
Phone: 1.866.410.8397
Passcode: 605 773 4836#