South Dakota Health Care Solutions Coalition
Shared Savings Subgroup
Meeting Notes 8/24/2017

Attendees: Mark Quasney, Mike Diedrich, William Snyder, Brenda Tidball-Zeltinger, Kim Malsam-Rysdon, Lynne Valenti, Rep. Jean Hunhoff, Kelsey Smith, Sarah Aker, Scott Duke, Kathy Bad Moccasin, Deb Fischer-Clemens, Jerilyn Church & Myra Munson, Nick Kotzea

Welcome and Introductions
Kim Malsam-Rysdon welcomed the group and thanked them for their participation. Kim introduced Bill Snyder, South Dakota new Medicaid Director.

Review July 11 Meeting Minutes
Kim reviewed the July 11 meeting. That meeting set out the goals and purpose of the subgroup to finalize the care coordination agreement and develop consensus on an approach to shared savings and the shared savings agreement. At the July 11 meeting, the group finalized the care coordination agreements, reviewed Wyoming's approach to Shared Savings contracts and came to consensus that the amount of savings shared should be tied to the level of savings achieved. The group agreed to focus on services directly referred by IHS or a tribal health program, and that shared savings should leverage federal funds where possible.

Medicaid Supplemental Payments Overview
Brenda overviewed supplemental payments. Supplemental payments are made above and beyond the approved methodology in the State Plan. States may not exceed the defined upper payment limit calculation either through the approved methodology in the State Plan or a supplemental payment. States may use the supplemental payment authority in the state plan to make payments to providers. The state may leverage federal funds for non-IHS providers; however, states do not have the ability to leverage federal funds for IHS. This means IHS can only realize the general fund savings portion of shared savings. South Dakota has room in the upper payment limit for hospitals and clinics to support supplemental payments.

Nick Kotzea asked what rationale or justification is needed in the State Plan in order to pursue the supplemental payment match. States have used a variety of rationales for supplemental payments. Payments could be made under a rationale to reduce uncompensated care, or could be looked at more generally to enhance reimbursement. Some states enhance reimbursement for certain services for high acuity patients. The state's understanding is that should we move forward with this approach to supplemental payments, we can align the outcome and justification in the state plan. .

There are some additional reporting requirements and administrative processes for the State Medicaid Agency. South Dakota will be required to submit a State Plan Amendment in order to access the FMAP. Supplemental payments are reimbursed at the services FMAP. The current FMAP is about 54% Federal.

Review Tiering Scenarios
Brenda reviewed the shared savings models based on the data provided in the July minutes. The models are based on SFY17 numbers and assume all savings are realized and shared. Option 1 is based on the sharing percentages that Wyoming is using. Wyoming is also using a floor in order to access shared savings. The models do not include a floor amount. The savings noted in the models represent the amount of general fund savings using historical 2017 data. There is the potential to leverage the FMAP to essentially double the amount for non-IHS providers. In option 1, IHS would receive about $300,000. Leveraging the FMAP, there would be about $672,000, leaving a balance of $3.4 million to the state. The scenarios assume 100% of all savings are leveraged.

Nick Kotzea asked if CMS will have to approve the State Plan Amendment, to what extent CMS will have an opinion on the shared savings agreements themselves. Would South Dakota be required to get CMS approval? CMS does not have a role and does not want to be part of the approval process for care coordination or shared savings agreements. Mechanically, CMS would have approval over the State Plan Amendment and the process associated with the SPA. Wyoming gave CMS a courtesy copy of their shared savings agreement, but there was not a formal approval process.

Option 2 uses 5%, 10%, and 15% in place of the percentages used by Wyoming. Myra asked if providers will receive 10% on all of the savings or 5% up to $500,000 and then 10%, etc. The models assume that providers would receive the highest qualifying percentage on the entire amount. The model assumes making payment once a year using a retrospective process to identify all payments and using the total to assign the percentage. Kim noted that for this purpose, it’s in the best interest of providers to have one look back time period in order to capture all payments to support a higher tier. This method would also be less administratively burdensome to the state. Deb Fischer-Clemens agreed that it is advantageous.

Mike Dietrich asked about the timing of the payment and if it will use a calendar year or a different twelve month period. The state will need to coordinate the shared savings process with the upper payment limit demonstration and the budget cycle and claims data. The state will develop a timeline with more specifics about the payment cycle.

Deb voiced support for option 2. Nick agreed that Sanford is open to these approaches. Deb noted the models seem workable and to align with the group’s discussion.

Jerilyn Church asked if the state went with option 1 with the higher state savings, if the difference in savings would be invested back in Medicaid. The state does not have a definitive plan for the state share of savings, apart from the funding of the Coalition incentives. Either option results in significant general fund savings. The Governor has prioritized addressing provider rates within the resources available to the state in the past.

Deb asked if there is a way to create a restricted account that could be appropriated by the Secretary of DSS to fund specific items such as telehealth sustainability and investment in housing, new technology, and home care services. Kim deferred to Mark Quasney.

Mark said that the budget office typically tires to avoid creating restricted accounts with state funds. He noted that it is a priority of the budget office and the governor to address provider rates and determine how to reinvest savings into Medicaid.

Kim added that whether or not a dedicated account is available, the state anticipates a transparent process about any shared savings arrangements, including periodic reports about the status of the agreements and the expenditures associated with the general fund savings.

Mike also voiced his support for option 2. Jerilyn noted that if there is not a firm commitment to reinvest back into Medicaid, then option 2 would be the better option 1 from the tribal perspective. Mike noted that while either option is good, Regional prefers option 2 because it allows them to broaden their scope to improve access. He noted that while the state may not have a firm commitment regarding the state savings, that the dollars reinvested into the health systems will promote access. Providers including IHS need to be transparent about what they do with the savings as well.

The state expects to have to report on the activities related to shared savings, including contract status, saving levels, payments to providers, state savings and expenditures, and provider activities related to savings by both IHS and non-IHS providers. Kathy Bad Moccasin agreed.

The group agreed to move forward with option 2 in terms of the tiering and payments.

Kim noted that the Coalition recommendations will be funded before savings are shared. After applying the savings from applying the policy to administrative services, $750,000 is needed to offset costs for the Coalition recommendations. Brenda explained that the referred care opportunity for each provider will be proportional to the amount contributed to funding the recommendations. This will be expressed in the shared savings agreement. The group agreed with this approach.

Review Draft Shared Savings Agreement
Sarah Aker reviewed the draft agreement. The agreement is based on the Wyoming agreement with South Dakota's contract language inserted.

Myra Munson asked about the state's methodology for using administrative funds to the meet the $3 million needed to fund the coalition recommendations and how that process would tie into the shared savings agreements. Kim clarified that that the $3 million would just need to be leveraged based on the policy and that the agreements are intended to wrap around ensuring funding for the coalition recommendations. Nick

suggested revising the language relating to the provider contributions, noting that the current language creates a concern that there is a liability to pay into the savings.

The document was intended to be universal, but a separate agreement for IHS and non-IHS providers may be needed. The state will re-draft to create drop downs specific for IHS and non-IHS providers. Kim asked Nick to send suggested language for the agreement.

Brenda reviewed other questions received about the agreement:

- What is the Vendor Number? It's a state number associated with the provider. Deb asked if there would be many vendor numbers for each hospital. DSS would use one vendor number for Avera Health System.
- Will each IHS facility have a separate shared savings agreement? The state contemplates one shared savings agreement with IHS for South Dakota IHS providers. IHS could then distribute funding internally. Myra agreed that makes sense.
- Will NPI numbers be needed for all IHS providers? The state will need a mechanism to appropriately identify providers under the agreement and calculate savings.

Myra asked if tribal programs could enter into an agreement. Yes, tribal providers would be able to enter into the agreement.

Myra asked about how payments are calculated for the CMS-64 and to determine the 100% FMAP. South Dakota Medicaid will add an indicator to provider records to indicate that a care coordination agreement is in place and check the information on the claim to determine if IHS referred the service. The system will calculate that the claim is eligible for 100% FMAP if all of the requirements are met. Lynne Valenti commented that there will be a lot of work behind the scenes to implement the process. Providers already identify when a claim is referred by Indian Health Service so the data is part of the claim submission.

Kim asked the group to share specific thoughts about language for the shared savings agreement so the state can make changes and distribute the next draft to the group.

Next Steps

Kim noted that since the group has finalized the care coordination agreements, from a DSS standpoint, the agreements are able to be routed between the IHS and non-IHS providers. Kim asked Kathy to overview what's required for IHS to complete the agreements. Kathy is hoping to have a call with headquarters and get an update by next week. Jerilyn noted that she had a call into Jim Driving Hawk and Kevin Meeks and that the Oklahoma Area has entered into care coordination agreements with all of the hospitals in that region. Jerilyn noted that Great Plains Tribal Chairman's Health Board (GPTCHB) will advocate for IHS to sign the agreements as soon as possible. Bill Snyder offered Medicaid's assistance with routing the agreements to the systems after

they have been signed by IHS. Mike noted that he looks forward to hearing from Kathy about how to start the process with IHS.

Kathy said that she has been updating Mr. Driving Hawk on the process. Kim asked if it would be feasible to have the agreements signed by IHS by October 1. Kathy said she hopes to have them approved by then, but noted that Jim Driving Hawk would have to approve the timeline. She suggested that Kim and Jerilyn outreach Jim on that process. Jerilyn noted that tribes will also advocate for a quick turnaround. Jerilyn is going to outreach Oklahoma to determine how long the signature process took in Oklahoma and agreed to facilitate discussions with Jim Driving Hawk to get the agreements signed by the Aberdeen Area IHS.

The state will continue to work on revisions to the Shared Savings agreements and outreaching the dialysis providers.

Nick asked for a copy of the finalized care coordination agreement and the workflow diagram that was previously put together. Myra also requested a copy. Kelsey Smith will send a copy to the group.

Kim asked the group to reach out with any concerns or thoughts for the shared savings agreements.

Next Meeting
October 6, 2017
10:00 AM, CT
Governor's Large Conference Room
Phone: 1.866.410.8397
Passcode: 605 773 4836#