

South Dakota Health Care Solutions Coalition Conference Call

Meeting Notes 4/28/2016

Attendees: Kim Malsam-Rysdon, Jerilyn Church, Lynne Valenti, Brenda Tidball-Zeltinger, Senator Bernie Hunhoff, Senator Deb Soholt, Representative Spencer Hawley, Terry Dosch, Jason Dilges, Steve Emery, Janet Jessup, Scott Duke, Nick Kotzea, Sara DeCoteau, Mike Diedrich, Kathy Bad Moccasin, Danielle Hamann on behalf of Deb Fischer-Clemens, Mark East, and Jennifer Stalley.

Welcome and Updates

Kim Malsam-Rysdon updated the members on the State Health Official letter issued by CMS on Friday, Feb. 26. The letter was distributed to the Coalition and is available online. Conversations are ongoing with CMS and IHS. CMS did clarify services which would be eligible for 100% FMAP under the new policy include long-term care, disability services in home and community-based settings, psychiatric and residential care. This was an outstanding question previously that CMS has not addressed. This expands the opportunity relative to the pool of expenditures that happen outside of IHS and increases the opportunity for state savings. In Fiscal Year 15, \$182 million were spent, of which \$85 million was state general fund dollars. Based on the projected Medicaid expansion costs, the plan must shift about two-thirds of the current \$182 million spending in the future.

In order to claim 100% FMAP, people have to be eligible for funding through IHS. The care has to be referred and coordinated through IHS. Medical records have to be shared with IHS. Whenever possible, officials are trying to leverage existing processes (medical records sharing are an example of this). Billing requirements must be compliant with existing Medicaid policies.

When the policy change was released nationally, South Dakota also received a draft provider agreement for care coordination services. There is a group working through the details of this agreement, which will be a key part of accessing funds the policy allows. It's very important for IHS and non-IHS providers to engage on this issue to work out the details and move forward. The federal policy change is now in effect, but very little, if anything can be leveraged without expansion since providers are not incented to do additional processes/steps if not coupled with expansion. Providers and patients cannot be forced to make changes for the sake of 100% federal funding.

There are three areas of strategy we are continuing to work in:

- **Administrative:** Providers and Medicaid have to complete changes at the administrative level. The patient will probably not notice any difference. This includes things like ambulance services that originate at IHS and telehealth.
- **Low Impact Service Delivery:** This is the lower impact area on how care happens today, which includes nursing facility services, psychiatric residential treatment services, and Home and Community Based waiver services. Care coordination will be modified but the beneficiary will not see significant change. Currently focusing on FQHCs for alternative service delivery.
- **Higher Impact Service Delivery:** This includes approaches that support individuals receiving care closer to home and high cost inpatient and outpatient transition services. In order to be able to implement the policy change for this group of services, care delivery will need to be modified.

There have been five implementation teams formed, meeting and working in the following areas:

The Policy Operations Team has identified common processes to impact all other implementation areas, such as patient identification so that providers have Medicaid and IHS eligibility information, standardized draft provider care coordination agreement and billing and payment processes.

The telehealth implementation team is expecting a RFP for telehealth services from the Great Plains Area very soon. Once IHS selects the providers and the services, the group can complete its work.

The alternative services delivery model group is working on a proposal to target IHS beneficiaries not currently served by an IHS or Tribal program. The effort is focused on FQHCs (includes Urban Indian Health). The group will continue working through its proposal and feedback from HHS.

The behavioral health implementation group is working to expand the capacity for IHS to provide additional behavioral services, such as the community mental health center model or behavioral health health homes. The group is focusing efforts for technical assistance to IHS and Tribes to improve capacity. This area is very important for tribes and tribal members to continue to expand behavioral health access and capacity but isn't directly related to the federal policy change since services provided by IHS or Tribal 638 programs already qualify for 100% FFP today.

The final group is focused on care coordination for inpatient and outpatient services, which includes targeted service delivery that needs to be developed such as transition services post hospital and transitions back to the community. The group will determine what the opportunity is and focus efforts in particular high cost/high volume area.

To move forward, IHS must be able to implement the changes, and they remain committed to working with state officials and the implementation teams. Providers must continue to be willing to make changes to implement the provider agreement and IHS satellite clinic. DSS has to make administrative and programmatic changes. The implementation teams are helping to guide realistic timelines, including pilots and phased-in implementation. Estimations on services and cost projections that will transition to the 100% remain conservative. In order to implement the policy change, there is little incentive for providers to do anything unless it is tied to Medicaid expansion. Providers have been very helpful in the planning work to date and are willing to make changes needed to implement the new federal policy.

The Governor remains committed to considering a special legislative session for the purpose of expanding Medicaid or considering expansion in a future regular legislative session depending on the progress of implementation planning. The Coalition will meet again in mid-June for an update.