**South Dakota Health Care Solutions Coalition**
Meeting Notes 5/30/2018

Attendees: Sarah Aker, Kathy Bad Moccasin, Corey Brown, Jerilyn Church, Sara DeCoteau, Rep. Mike Diedrich, Terry Dosch, Scott Duke, Mark East, Steve Emery, Deb Fischer-Clemens, Rep. Taffy Howard, Rep. Jean Hunhoff, Michael Jost, Kim Malsam-Rysdon, Elliot Milhollin, Tim Rave, Kelsey Roth, Kelsey Smith, William Snyder, Sen. Deb Soholt, Jennifer Stalley, Brenda Tidball-Zeltinger, Lynne Valenti, Dr. Brian Shiozawa

Other Attendees: Jason Simmons

**Welcome and Introductions**

Kim welcomed the group and new members to the Coalition. All meeting materials and minutes are posted on the Board Portal at:
https://boardsandcommissions.sd.gov/Meetings.aspx?BoardID=145

**Review Last Meeting Minutes**

At the last meeting, the group discussed the 2018 legislative session agenda and the proposed budget impacts related to the Coalition's work, including substance use disorder (SUD) services, community health worker (CHW) services, additional mental health providers, and some primary care and prenatal care innovation grants. Kim noted the Coalition's work so far to facilitate the signature of care coordination agreements to fund these services. Kim clarified that none of the changes contemplated by the Coalition have changed the individuals eligible for Medicaid in South Dakota. Medicaid expansion typically refers to an expansion of groups eligible, usually associated with an increase in the qualifying income as a condition of eligibility.

At the last meeting, there was discussion about how the work of the Coalition benefits people eligible for Medicaid. The Shared Savings Agreements will help provide additional revenues to providers to allow them to invest in more service delivery options for the people they serve.

The group also discussed other changes in Medicaid including community participation and work requirements. The group also discussed next steps for moving forward with care coordination agreements in other areas of the Medicaid program. The group felt it was important to move forward with nursing facility care, community support providers (CSPs), and psychiatric residential treatment facility (PRTF) providers with the understanding that savings would be reinvested in Medicaid.

**Progress Update - Policy Implementation**

Kim thanked members of the Coalition who testified and the legislative members who helped support the recommendations of the Coalition.

Sara DeCoteau submitted some questions about care coordination agreements (CCAs) via email to the Coalition. Brenda Tidball-Zeltinger reviewed the purpose of the CCAs related to the requirements for claiming 100% FMAP. The policy applies to individuals who are American Indians who are eligible for both Medicaid and Indian Health Service (IHS). The policy also requires a CCA between IHS and the non-IHS provider. The care must be referred by IHS or a Tribal 638 provider. The policy requires sharing medical record information between IHS and the non-IHS provider. The CCA requires that medical records be shared within 30 days; emergent situations may require record sharing prior to 30 days. Sara also asked about the release of information from a patient perspective. Brenda noted that in healthcare delivery, whether under a CCA or not, a patient's approval or request for a referral will also allow the provider to share relevant medical information pertinent to that referral. Sara said that she appreciated the sharing of medical records. Sara noted that the CCAs have been put into place with the big facilities and that she assumes that the eventual plan is to have additional CCAs with other hospitals. Sara noted concern about situations where IHS does not have an emergency room and the patient presents at a private hospital. Sara asked about how the mechanism for a referral and continuity of care occurs between two different providers when the patient presents to the emergency room. Kim offered that the CCA describes the relationship between the IHS and non-IHS provider and helps solidify how information sharing will happen between providers. The CCA gives more opportunity for the appropriate record sharing to take place and ensure continuity of care.

Bill Snyder shared an update about the FMAP Savings Report data. The reports are located at: http://dss.sd.gov/keyresources/fmapreports.aspx. As of the end of April, current savings total $3.3 million, and $1 million in additional savings is projected before the end of the fiscal year. All three systems are ahead in savings based on the analysis. There was a small cluster of high dollar claims that were anomalies and contribute to the larger-than-expected savings. The data also shows an impact from the IHS Pine Ridge inpatient hospital closure and a subsequent increase in referrals for inpatient care. When the inpatient facility at Pine Ridge opens, DSS anticipates a reduction in referrals. Some increase is also attributed to more and better adherence to populating the IHS referral information on the claim. Kim noted that the Governor's FY 2019 budget recommendations were structured for savings accrued in FY18 to be carried over to SFY19 in order to fund the Coalition recommendations.

Bill stated that Substance Use Disorder treatment for adults will be available July 1, 2018 as anticipated and that expanded capacity for Behavioral Health providers will be effective by January 1, 2019 and Community Health Workers for rural and tribal areas to provide low cost and high value services is expected to be in place by April 1, 2019. DSS will outreach mental health providers to facilitate enrollment as Medicaid providers.

Brenda noted that the CHW model has a bigger lift for implementation. A larger workgroup met previously in summer 2016 to discuss CHW services. DSS will form a workgroup in the fall to finalize details for reimbursement of the service. Sara DeCoteau asked about necessary documentation for reimbursement for CHW services and which services will be reimbursed under the CHW benefit. Sara asked if a CHW agency that is not connected or within the same system be reimbursed. The intent is that the entity that is providing the service is the entity that will be enrolled and bill for the service. An overarching tenant of the Medicaid program is physician direction and medical necessity which will also be a component of CHW services. Kim asked Sara to serve on the group. Sara agreed. Elliot Milhollin asked how people who want to participate should get involved. Interested individuals should contact Bill Snyder. Rep. Hunhoff asked for more information about how CHWs provide high value services at low cost. Bill described the CHW service.

Savings generated from the policy will also fund provider rate increases, specifically for providers with Medicaid rates at less than 90% of cost including ambulance providers, in home service delivery providers, group care providers, assisted living centers, and some outpatient care providers. Rates are typically effective on July 1 with the new State Fiscal Year. This year, rate changes were effective April 1 along with a 2% inflationary increase for those groups.

Shared savings agreements have been executed by the state and have been sent to the providers generating savings today. Tim Rave noted that Sanford expects to sign the agreements soon. Avera and Regional are in the process of routing for signature. Kathy Bad Moccasin noted that there has not been movement on the shared savings agreements from IHS headquarters. Kim asked if the state could provide additional information that might help IHS headquarters. Kathy indicated that she would look into it and let the state know if there is additional information that could be helpful.

**Subcommittee Updates**

Kim thanked members of the subcommittees for their work. The Community Based Providers Shared Savings group has met monthly since January. Bill gave an update about the work of the subgroup.

The Community Based Providers subgroup has focused on care provided to American Indians by nursing facilities, community support providers, and psychiatric residential treatment facilities. There was an exploratory meeting with IHS on the PRTF referral process to determine next steps and develop an understanding of the opportunities available for obtaining a referral. IHS clinical staff will attend the State Review Team meeting next week. There was also an onsite meeting last week in Chamberlain with IHS and Sanford to better understand nursing facility care that happens today. The group discussed how to formalize referrals and collaboration that is happening today. The group came away with some concrete next steps. Kim added that IHS recommended starting in Chamberlain due to the successful relationships and processes for care coordination in Chamberlain today. The group will look to also focus

on Gregory and Winner to bring in Avera facilities and the Community Support Provider in Winner. The biggest lift is to coordinate the referral process.

The group also discussed how Sanford Chamberlain is able to grant IHS staff access to the Electronic Medical Record (EMR) for IHS patients. This process allows efficient sharing of records between IHS and Sanford. Avera is taking steps to also allow IHS access to the Avera EMR. This allows there to be continuity of care between providers. Tim Rave added that one of his key takeaways is that the group is close to buttoning up the process and being able to replicate it across the state. He noted that case managers at each facility are key to this process and facilitating the referrals. Terry Dosch asked if the work of the subgroup includes assisted living care; at this point assisted living care is not part of the group's focus.

Kim noted that IHS expressed concern about maintaining responsibility for that care which is a key tenant of the policy. Defining IHS's responsibility for the patient's care is something that we are fine-tuning. Dr. Lawrence has been involved in these conversations and the subgroup will be focusing on this area in the next few months. The subgroup hopes to leverage the VA process replicate that process where applicable. Tim Rave noted that this process could scale up on a fairly rapid basis to other facilities once in place. The Community Based Providers subgroup plans to continue to meet monthly.

Scott Duke said there is strong interest in this work from other providers. In particular, Mobridge is looking to jump into this process. The state will focus on these pilots and will help facilitate the readiness of IHS and non-IHS providers to expand the process to other facilities. There needs to be some work in the next month to finish mapping the process of expanding use of the policy.

Senator Soholt noted that the collaboration for implementing care coordination agreements, utilizing a shared EMR, and expanding services available to our current Medicaid population is a credit to the group and the work of the Coalition. Sen. Soholt thanked the group for their work.

Kim then reviewed the work of the Alternative Services Delivery Model subgroup. Initial work of this group focused on individuals eligible for IHS and Medicaid utilizing a Federally Qualified Health Center (FQHCs) for their primary care needs. The group drafted an 1115 application and is working on revisions due to concerns raised about the proposal related to reimbursement of services at the IHS rate for non-IHS/tribal providers. FQHCs are reimbursed at an encounter rate, similar to IHS. The group is currently gathering information from pilot FQHCs to work through cost information to recommend a rate for the services described in the waiver. The increased rate will allow FQHCs to provide more primary care and reduce the need for more expensive healthcare services. This work will not take away capacity from IHS, but will allow FQHCs to better serve primary care needs for areas not served by IHS. Deb Fischer-Clemens asked for clarification about the data collection process. Brenda noted that the last phase of work is focused on rate development. The application has been reviewed

and there is agreement about the goals of the 1115 application and the measurements in the application. Elliot noted that he has not heard anything on this proposal from tribes recently, but will bring information back to the subgroup.

**Other Medicaid Updates**

Bill gave an update about progress on the community engagement and work requirements discussed at the January coalition meeting. DSS and DLR partnered to form a stakeholder workgroup to discuss the details of an 1115 waiver proposal. The program targets low-income parents eligible for Medicaid living in Pennington and Minnehaha Counties. The intent of the program is to promote work and to help individuals be success to meet their individual goals for employment. The approach includes transitional services. In other federally required programs, there are not requirements for providing transitional services. South Dakota's proposal stands out for offering transition benefits. The waiver is built to be flexible with an individualized plan for each individual.

The public comment period began on Monday of last week. DSS held a public comment meeting in Sioux Falls last week and will hold one in Rapid City tomorrow. Bill indicated that the estimate of people eligible is 1,300 for the two counties. Jerilyn asked about the demographic breakdown for American Indians. A demographic handout is available on the DSS website here: http://dss.sd.gov/medicaidworkgroup.aspx. The population mirrors the Medicaid population; approximately 31% of individuals are American Indians.

Jen Stalley asked about childcare and about how medically frail individuals excluded from the requirements will be determined. From a process perspective, medically frail exemptions will require documentation from a physician. Brenda noted that the transitional benefit will connect individuals with a child care subsidy and assistance with co-payments as wages increase and out of pocket costs for child care increase. Parents of low-income children are at 53% of FPL or below which allows them to also qualify for childcare subsidy. Another important transition piece is the opportunity for individuals to remain eligible for Medicaid for a bridge period under Transitional Medical Benefits and a premium assistance option for employer or marketplace health insurance.

Lynne Valenti added that the waiver contemplates flexibility and includes treatment for chronic and behavioral health conditions as a component of meeting the requirements of the program. Terry Dosch said that his group supports the waiver. He said that the individual focus of the plan helps support health and wellness. He said that success of the plan will be dependent on forming individual resource teams and engaging individuals at the local level. Deb Fischer-Clemens asked about integrated resource teams. Terry Dosch and Sarah Aker described how the Department of Labor utilizes teams for individuals at the local level.

Jerilyn suggested including IHS eligibles as an exempt group in the waiver. The stakeholder group discussed that idea at length and the application does not include an exemption for American Indians. The pilot locations of Minnehaha and Pennington

counties were selected for their job opportunities and availability of employment and training resources. CMS indicated that they would not approve an application that includes an exemption based on race. Jerilyn believes that there may be an ability to request an exemption on a facility basis for individuals able to use IHS. Jerilyn asked what the process was for comments and Brenda noted that the state will incorporate Jerilyn's comments along with any other comments received as part of the public comment process.  DSS welcomes public comment through June 19 for the waiver. Bill invited Jerilyn to attend the public comment hearing in Rapid City and submit a formal letter as a comment on the waiver.

**Next Steps/Next Meeting Date**

Kim suggested August 29 as the next meeting date. Kim asked for individuals interested to join the CHW or other subgroups to contact her or Bill Snyder.

Dr. Shiozawa congratulated the state on their work and asked the state to let CMS know if there are topics that CMS can assist the state with, specifically if the state needs assistance with coordinating shared savings agreements with IHS.