SOUTH DAKOTA HEALTH CARE SOLUTIONS COALITION:

FINAL REPORT AND RECOMMENDATIONS

TABLE OF CONTENTS

EXECUTIVE SUMMARY 4
KEY ASPECTS OF MEDICAID TODAY 4
MEDICAID EXPANSION IMPACT 4
MEDICAID EXPANSION IN SOUTH DAKOTA 5
SOUTH DAKOTA MEDICAID EXPANSION CONCEPT PAPER 6
HEALTH CARE SOLUTIONS COALITION RECOMMENDATIONS 7
CMS POLICY CHANGE 7
CONCLUSION 8
NOVEMBER 2016 UPDATE 8
BACKGROUND AND HISTORY 9
KEY ASPECTS OF MEDICAID TODAY 9
MEDICAID EXPANSION DEMOGRAPHICS 12
AMERICAN INDIAN HEALTH DISPARITIES 15
INDIAN HEALTH SERVICE (IHS) AND MEDICAID 17
IHS-ELIGIBLES AND NON-IHS PROVIDERS 19
SOUTH DAKOTA MEDICAID EXPANSION CONCEPT PAPER 21
FUNDING CHANGES PROPOSED BY CMS 22
CMS POLICY CHANGE 27
COST OF MEDICAID EXPANSION 29
MEDICAID EXPANSION IN SOUTH DAKOTA 32
SOUTH DAKOTA HEALTH CARE COALITION 35
COALITION MEMBERSHIP 35
COALITION STRUCTURE AND CHARGE 36
COALITION DISCUSSION 38
IMPLEMENTATION TEAMS 39
RECOMMENDATIONS AND ACTION STEPS 41
RECOMMENDATION 1: 41
RECOMMENDATION 2: 42
RECOMMENDATION 3: 43

RECOMMENDATION 4: 43
RECOMMENDATION 5: 44
RECOMMENDATION 6: 46
CONCLUSION 47
NOVEMBER 2016 UPDATE 48
APPENDIX 1: Coalition Subcommittee Membership 49

EXECUTIVE SUMMARY

Governor Daugaard convened the Health Care Solutions Coalition (HCSC) to develop a strategy to improve healthcare access and outcomes for American Indians that, along with changes in federal policy for funding Medicaid services for people eligible for services through Indian Health Services, will simultaneously produce general fund savings that can be leveraged to finance Medicaid expansion. The HSCS is a partnership between South Dakota Tribes, IHS, Medicaid service providers, South Dakota Legislators, and State agencies.

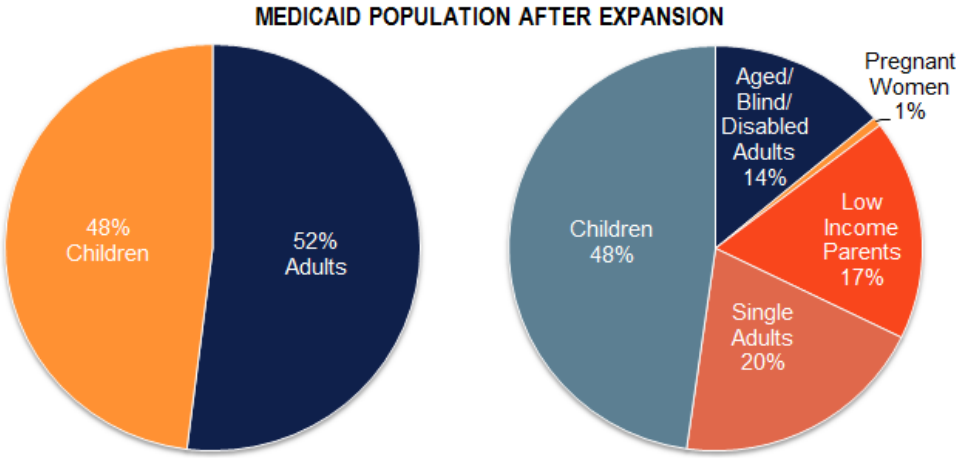
KEY ASPECTS OF MEDICAID TODAY

Medicaid is a State-Federal partnership with each entity sharing in financing. The amount of federal funding varies by state. When South Dakota Medicaid pays for health care, the federal government pays roughly half of every dollar and the State of South Dakota pays the other half. In South Dakota, the federal share is about 54% and the state share is the remaining 46%. [1]

About 118,700 individuals are currently covered by South Dakota Medicaid during an average month. South Dakota has a conservative program; coverage for adults is limited to those with disabilities, pregnant women, and low income parents. Children make up the largest group of individuals receiving coverage at 68%.

MEDICAID EXPANSION IMPACT

Based on a survey completed in 2015, the Medicaid expansion population in South Dakota is estimated at 49,721 individuals. Approximately 30% of the expansion population is American Indian. One third of the expansion group is comprised of adults in low income families with incomes between 53-138% of the FPL. Two thirds of the expansion group will be a new group of single adults.



[1] South Dakota FFY2017 Federal Medical Assistance Percentage as published in the Federal Register https://www.federalregister.gov/articles/2015/11/25/2015-30050/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for

INDIAN HEALTH SERVICE (IHS) AND MEDICAID

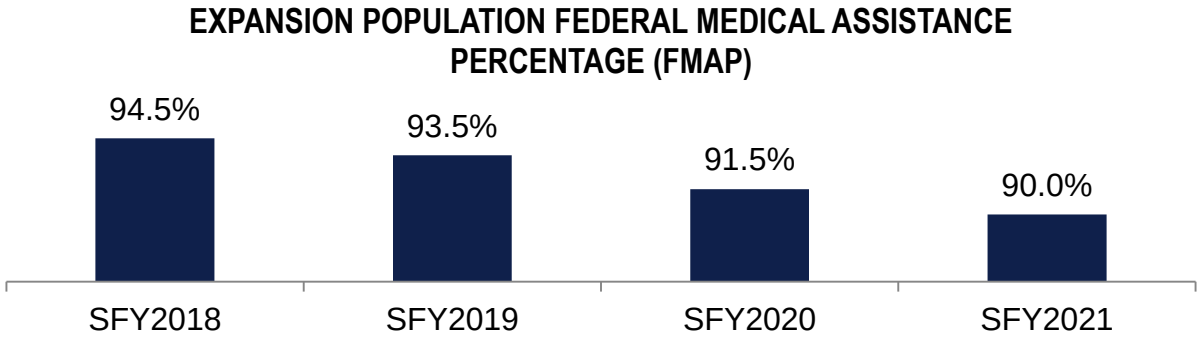
American Indians comprise approximately 35% of South Dakota's Medicaid population. This has significant financial implications for Medicaid as services provided directly by IHS are eligible for 100% Federal Financial Participation (FFP). However, services provided to Medicaid-eligible American Indians outside of IHS do not receive 100% federal funding. Instead, South Dakota Medicaid must pay for these services at the regular federal match rate.

During State Fiscal Year (SFY) 2015, South Dakota's Medicaid program expended $251 million for healthcare services for individuals eligible for both IHS and Medicaid. Of that total, $69.2 million was for services provided directly by IHS and paid with100% federal funds. The remaining $182 million was paid at the state's regular federal match rate, or $85 million general funds and $97 million federal funds.

South Dakota has long argued that services for individuals eligible for both Medicaid and IHS should be eligible for 100% federal funding whether provided directly through IHS or by non-IHS providers.

MEDICAID EXPANSION IN SOUTH DAKOTA

States have the option to expand Medicaid coverage to adults with incomes up to 138% of the Federal Poverty Level. One of the key features of Medicaid expansion is that the federal government pays most of the costs of expansion. States must pay 10% of total costs starting in State Fiscal Year 2021 and thereafter, per federal regulations in 42 CFR 433.10.



* Note: 90% is the FMAP for all fiscal years following SFY2021

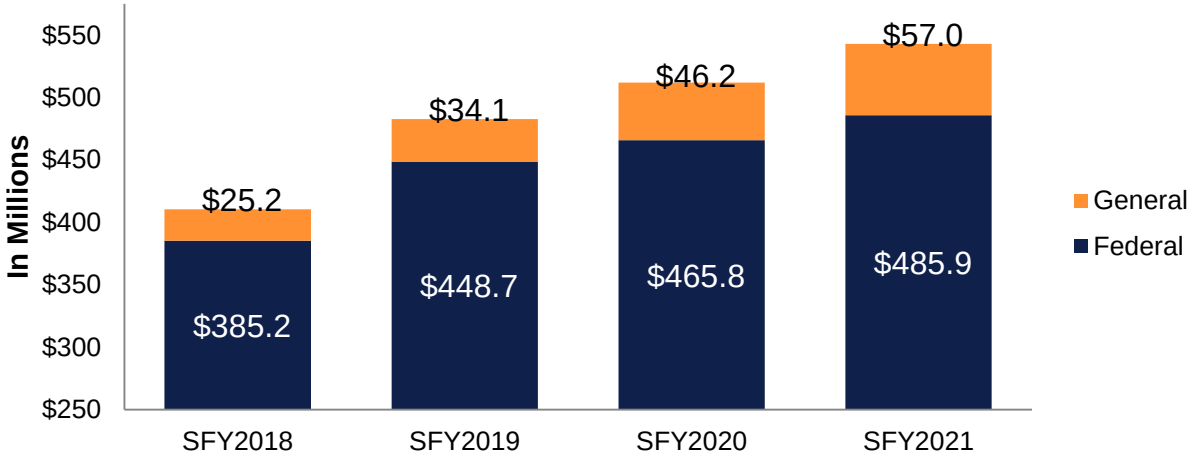
CONSERVATIVE BUDGET PROJECTIONS

The estimates used in Governor Daugaard's proposal include a number of conservative assumptions as a way to mitigate financial risk. South Dakota looked to the experience of other states to inform assumptions:

- Estimates assume 55,240 eligible individuals in 2018, a 10% increase over the 2015 survey of 49,721 and an annual growth rate of 1%
- Projects that 90% (49,721) would enroll day 1 of expansion and 100% by the end of year 1. ;
- Projects the average cost per Medicaid Eligible to be $8,131 in SFY 2018 with an annual increase of 5%. This rate is based on the actual cost for Low Income Family (LIF) members in SFY 2015 plus 20% and an annual growth rate of 5%;
- Projects administrative expenditures will increase by 5% and require DSS to hire an additional 55 employees;
- No consideration for 100% FFP for American Indians eligible for IHS; estimated to be up to $15 million per year.

Without taking into consideration economic impact to tax revenue, estimated at $8.6 million for 2021, South Dakota will need $57 million by 2021 in order to fully fund Medicaid expansion.

PROJECTED MEDICAID EXPANSION COSTS, SFY 2018- 2021



SOUTH DAKOTA MEDICAID EXPANSION CONCEPT PAPER

In early 2015, legislators, state officials, and health care providers saw an opportunity to leverage more federal funding for American Indian health care in South Dakota if the current CMS interpretation of services "received through" IHS could be expanded to include services provided by non-IHS providers. State savings from increased FFP could help defray the costs to expand Medicaid. After engaging in discussions with the Centers for Medicaid and Medicare Services (CMS), South Dakota submitted a Concept Paper to CMS with a proposal to provide better health care access to American Indians eligible for IHS, improve health outcomes for American Indians eligible for Medicaid, and increase access to health care for the entire expansion population in South Dakota.

In October 2015, CMS released a white paper proposing to update policy on funding services provided to Medicaid eligible American Indians and Alaskan Natives (AI/AN). Under CMS's proposed policy change, more services would be eligible for 100% federal funding, which would increase access to care for AI/AN Medicaid recipients, while generating savings to the state budget to fund Medicaid expansion.

HEALTH CARE SOLUTIONS COALITION RECOMMENDATIONS

Governor Daugaard tasked the HCSC with the development of a solution that supports increased access to healthcare for American Indians and improves health outcomes for American Indians in South Dakota, while leveraging state savings to finance Medicaid expansion. The Coalition began meeting in October 2015. Three subcommittees were formed to address specific issues outlined in South Dakota's concept paper:

After three months of meetings, the Coalition proposed the following recommendations:

RECOMMENDATION 1 Increase use of telehealth services to support emergency departments and support increased access to primary and specialty care consultation and treatment in through Indian Health Service and Tribal Programs.

RECOMMENDATION 2 Develop a formal Community Health Worker/Community Health Representative program under the Medicaid State Plan.

RECOMMENDATION 3 Expand support for prenatal and postpartum care to support healthy birth outcomes

RECOMMENDATION 4 Expand capacity for mental health and chemical dependency services through Indian Health Service and Tribal Programs.

RECOMMENDATION 5 Expand Medicaid eligible providers of behavioral health and substance use disorder (SUD) treatment services.

RECOMMENDATION 6 Add evidence-based behavioral health services and supports for children and families, including supporting the provision of functional family therapy as a Medicaid state plan service.

CMS POLICY CHANGE

The Centers for Medicare and Medicaid Services (CMS) issued final guidance on February 26, 2016 that allows states to claim 100% federal funds for care referred by IHS that is provided by non-IHS providers and meets certain care coordination criteria. Implementing the policy changes necessary to receive 100% federal funds for Medicaid services received through IHS requires action from IHS, health care providers, and the state. However, providers cannot be forced to implement the policy changes and the care coordination requirements in the final guidance will require additional work for

providers and IHS. Medicaid expansion is the incentive for providers and IHS to work together to realize the state savings and free up existing state funds.

CONCLUSION

In order to expand Medicaid coverage to adults with incomes up to 138% FPL, South Dakota must find a way to offset new costs. Governor Daugaard remains committed to ensuring that any expansion plan for South Dakota is fiscally responsible and has adopted a conservative estimate of cost. In SFY15 South Dakota Medicaid spent $182 million on health care for American Indians - $97 million was federal funds and $85 million in state funds. $85 million is more than enough to cover state costs for expansion. South Dakota only needs to save 2/3rds of the total to provide the $57 million needed to expand Medicaid. To move forward, the following considerations must be met:

- No general fund increase is required, expansion costs must be covered by current general fund budget;
- Tribes must support the expansion proposal; and
- South Dakota Legislature must support the expansion proposal through passage of the Governor's recommended budget.

NOVEMBER 2016 UPDATE

Following the November election, Governor Daugaard met with Vice-President Elect Mike Pence and discussed the Trump Administration's plans for repealing or reforming the Affordable Care Act (ACA). Based on the Trump Administration's plans for changes to the ACA, Governor Daugaard will not recommend Medicaid expansion in 2017. However, reform related to federal reimbursement for American Indians eligible for Indian Health Service is still an opportunity for South Dakota. Over the past two years, South Dakota's discussions with the federal government related to federal funding for American Indians led the federal government to change its policy relating to Medicaid reimbursements for Indian Health Service enrollees. Governor Daugaard intends to continue the discussion with federal officials and work with the Trump Administration, state Legislators, Tribes, providers, South Dakota's congressional delegation to find a way to leverage the IHS policy change to improve access to health care through Medicaid reform.

BACKGROUND AND HISTORY

KEY ASPECTS OF MEDICAID TODAY

Medicaid is one of the largest healthcare insurers in South Dakota. It is a Federal-State partnership governed by federal requirements and the Medicaid State Plan, an agreement with the Centers for Medicare and Medicaid Services (CMS), regarding who is served and what services are covered. Each state's plan is different, which can make comparisons between states difficult. It is important to note that Medicaid is different from Medicare which is coverage for individuals age 65 years and older and some disabled adults that is 100% federally administered.

Funding for Medicaid is shared between the state and the federal government. The federal government's share is called the Federal Medical Assistance Percentage (FMAP). Most administrative services are paid at a 50% state match, while the FMAP rate for services varies by state. Every 1% change in FMAP results in about $7 million in state general funds impact. FMAP is based on the last three years of average personal income (compared to other states); for example, when South Dakota's average income increases compared to other states, the state pays more and the federal government pays less. When South Dakota Medicaid pays for health care, the federal government pays roughly half of every dollar and the State of South Dakota pays the other half. [2] In FY16, the federal government paid 51.61% and the state paid 48.39% of Medicaid service costs. In FY17, the blended FMAP is 54.11% federal and the state share is 45.89%.

MEDICAID ELIGIBILITY

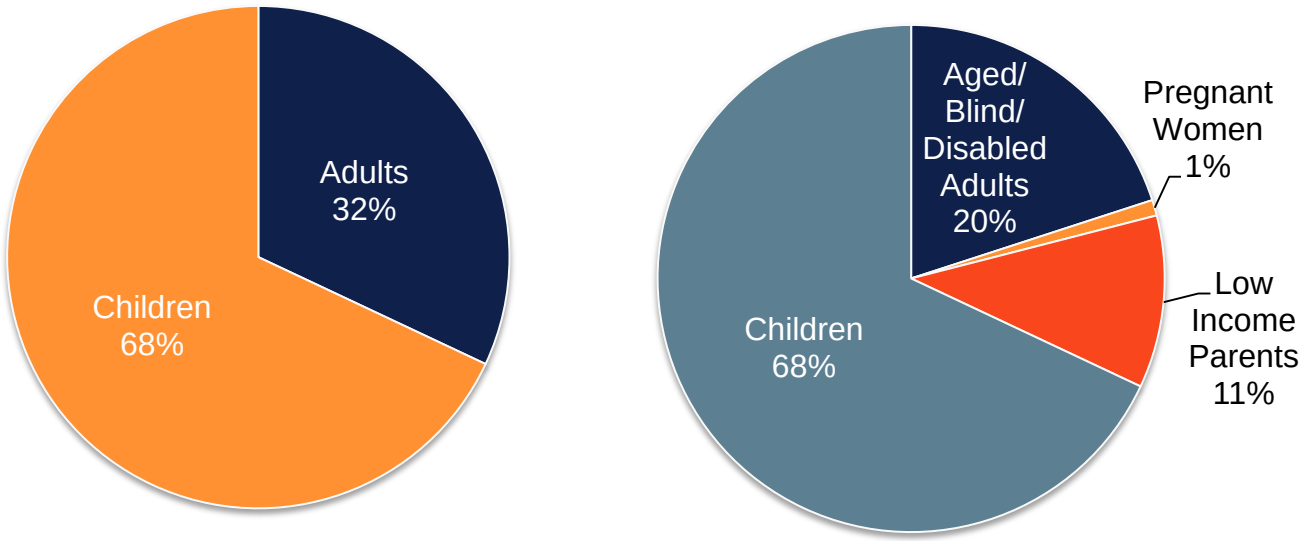
Eligibility depends on several factors including age, financial criteria, citizenship status and residency. Traditional Medicaid recipients may be low-income children, people with disabilities, low income older adults, and very low-income parents of children. Income and resource limits vary by coverage group: South Dakota covers:

- Children up to 209% of the FPL ($50,787 annually for a family of four);
- Pregnant women up to 138% FPL ($33,534 annually for a family of four);
- Parents of children up to 52% of the FPL ($12,656 annually for a family of four); and
- Elderly and disabled adults.

[2] South Dakota FFY2017 Federal Medical Assistance Percentage as published in the Federal Register https://www.federalregister.gov/articles/2015/11/25/2015-30050/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for

Currently, Medicaid provides health care coverage to about 14% of all South Dakotans. About 118,700 individuals are covered by South Dakota Medicaid during an average month. Children make up the largest group of individuals receiving coverage. Half of all children born in South Dakota will receive Medicaid or CHIP coverage in their first year of life. Across South Dakota, one third of children under age 19 receive coverage from South Dakota Medicaid annually. American Indians account for 35.5% of Medicaid eligibles.

CURRENT MEDICAID POPULATION



MEDICAID PROVIDERS

Currently, South Dakota has more than 15,000 Medicaid providers; on average there are 5,000 providers actively billing each month. In order to enroll, eligible providers complete an online application, submit required documentation, and sign agreements that outline terms and conditions of participation. Providers must meet federal requirements including screening and onsite visits for some providers.

Eligible providers render covered services under their scope of licensure/certification and Administrative Rule of South Dakota. Services must be medically necessary and physician directed; examples of individual practitioners eligible to enroll include physicians, dentists, psychologists, and optometrists. Similarly, the following examples of facilities may also be eligible: hospitals, nursing homes, assisted living facilities, community mental health centers, clinics, and federally qualified health centers (FQHCs). When individuals providing the covered services are not eligible to enroll, those services may be delivered under the supervision and direction of an enrolled provider. For example, nurses are not eligible to enroll directly; so Medicaid-covered nursing services are billed through an enrolled supervising physician.

COVERED SERVICES

States determine the type, amount duration, and scope of services based on general federal guidelines. States are required to cover certain mandatory services and may choose to cover other optional services through their Medicaid program, an example of services may be found in the South Dakota Medicaid Annual Report.

South Dakota currently employs several programs to deliver necessary health services to Medicaid recipients to maximize efficiency and minimize health care costs. One example is the Health Homes Program that provides enhanced health care services to individuals with high-cost chronic conditions or serious mental illness to improve health outcomes and reduce costs related to uncoordinated care. More information about the Health Homes Program may be found in the South Dakota Medicaid Annual Report.

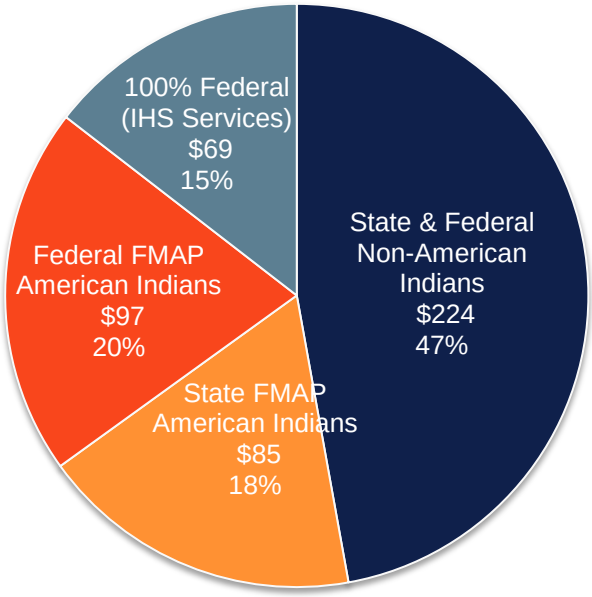
MEDICAID EXPENDITURES

The Medicaid budget is a large part of state government spending and is included in the budgets of several state agencies including:

- Department of Social Services
- Department of Human Services
- Department of Health
- Department of Corrections
- Department of Military and Veterans Affairs
- Department of Education

In FY15, expenditures reached $475.0 million total for typical health care services excluding long term care, Medicare Part A, B, and D premiums, and home and community based waiver services. In the same year, expenditures for American Indians were $251 million. Broken down, $182 million was funded at the State's FMAP rate ($85 million state funds and $97 million federal funds) and $69.2 million was entirely federally funded (100% FMAP).

DISTRIBUTION OF FEDERAL AND STATE FUNDS FOR MEDICAID, SFY 2015 (IN MILLIONS)

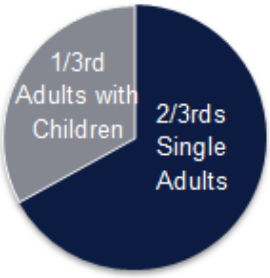


MEDICAID EXPANSION DEMOGRAPHICS

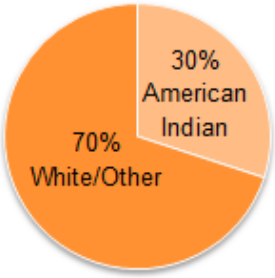
Medicaid expansion would add adults with incomes up to 138% of the Federal Poverty Level. This equates to incomes of $16,395 per year for one person or $33,534 for a family of four in 2016.[3] Based on a survey completed in 2015, the Medicaid expansion population in South Dakota is estimated at 49,721 individuals.

One third of the expansion group is comprised of low income families, adults with children with incomes between 53-138% of the FPL. Two thirds of the expansion group will be a new group of single adults with no children. Approximately 30% of the expansion population is American Indian; although an estimated 40% have received care through IHS. 58% of the expansion population is male; 42% is female.

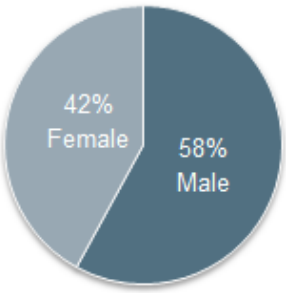
FAMILY TYPE



RACE/ETHNICITY



GENDER

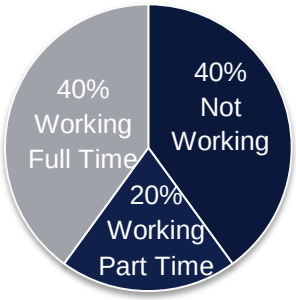


[3] 81 Federal Register 4036; https://www.federalregister.gov/documents/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines

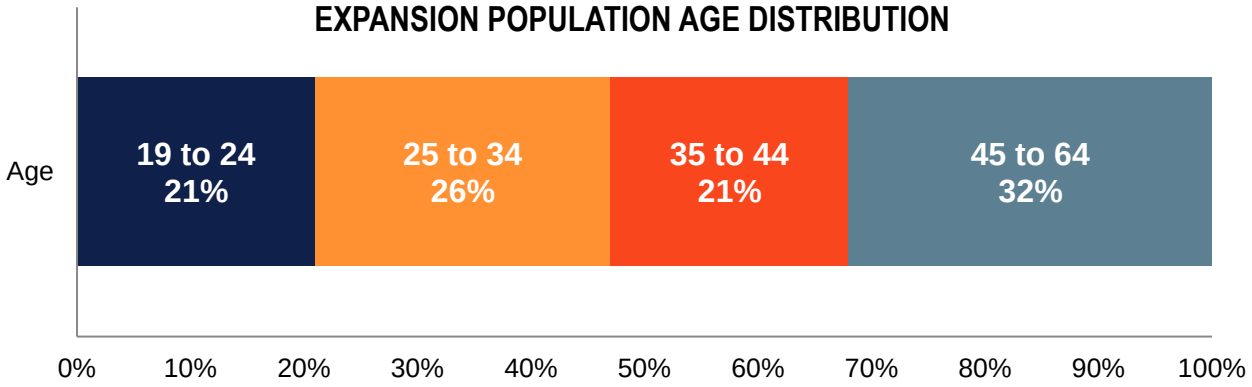
60% of the expansion population is working. Of those working, two thirds are working full time; one third is employed part time.

The expansion group ranges in age from 19 to 64. South Dakota's expansion population is young with 47% between the ages of 19-34. An age distribution of the expansion population is depicted below.

EMPLOYMENT STATUS

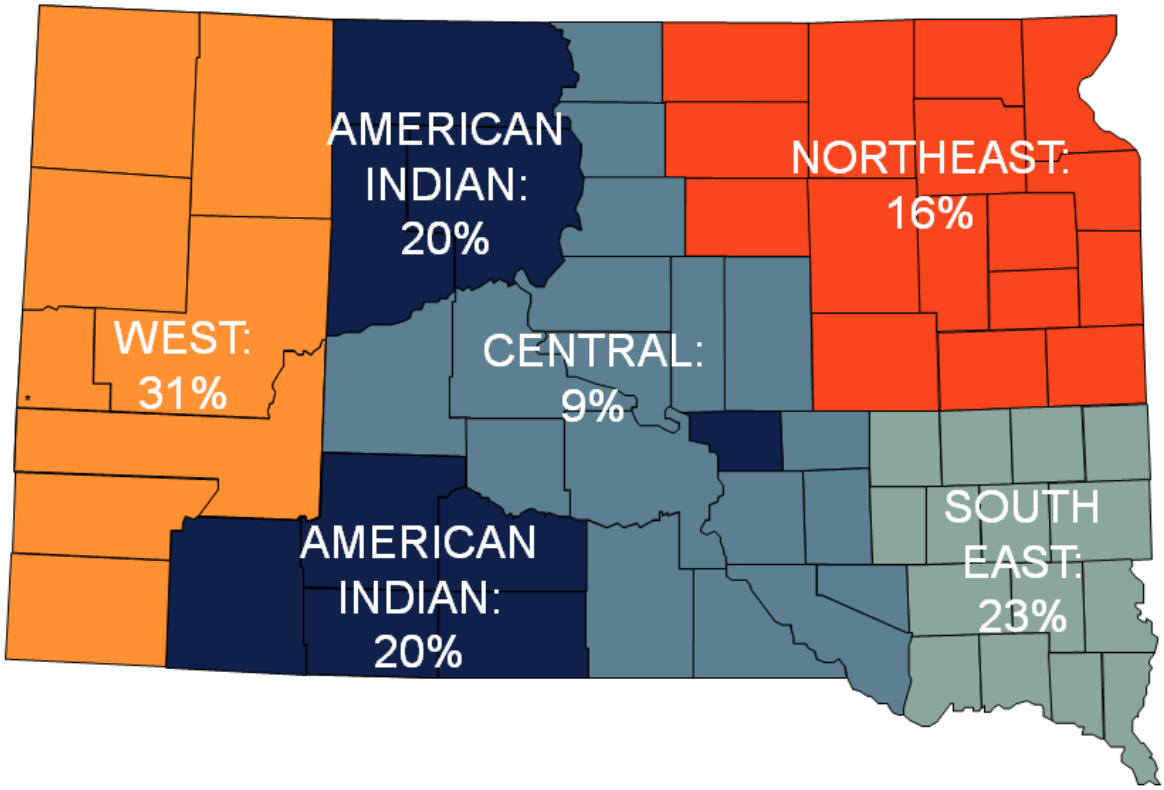


EXPANSION POPULATION AGE DISTRIBUTION



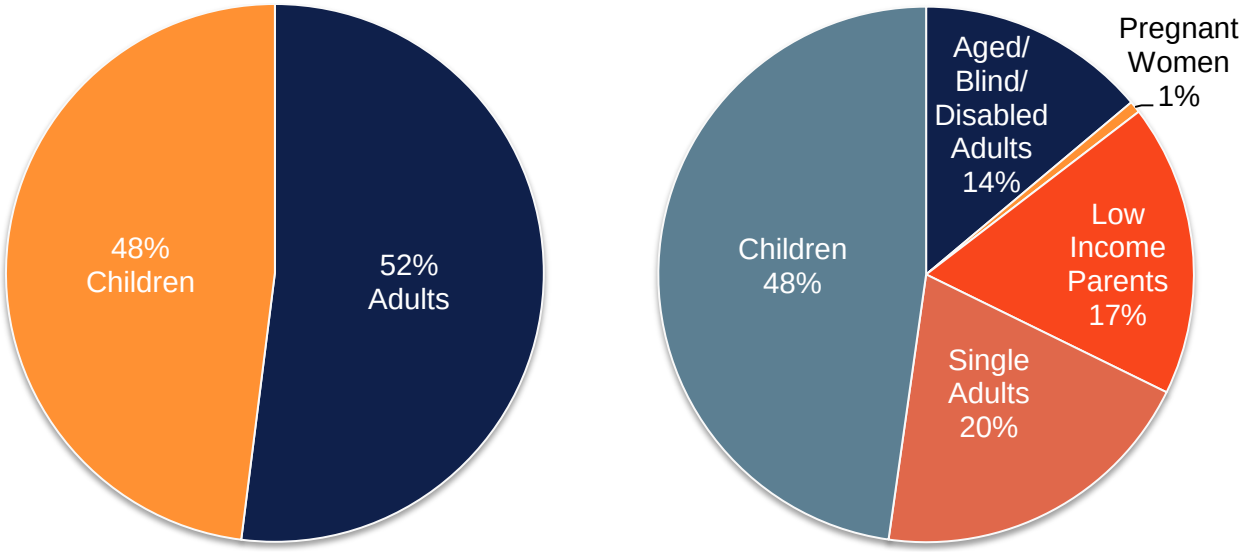
on is below.

EXPANSION POPULATION GEOGRAPHIC DISTRIBUTION



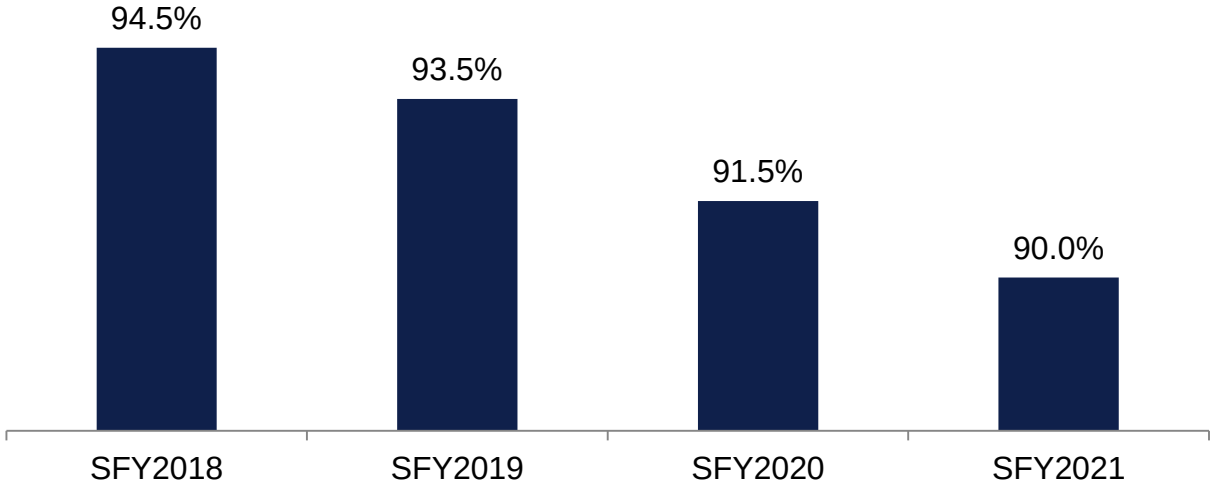
The addition of the Medicaid Expansion population would increase enrollment of adults in both the low-income families' category and in a new single adults group. Overall, adults would become a larger share of the Medicaid Population after expansion.

MEDICAID POPULATION AFTER EXPANSION



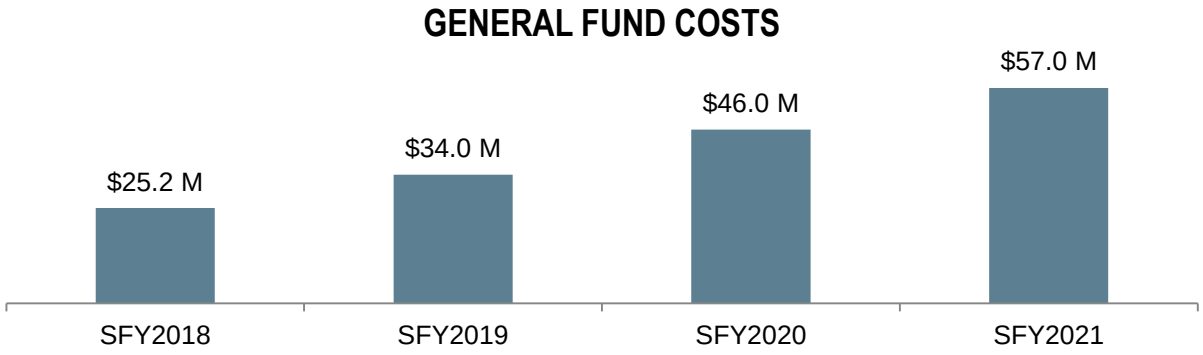
Although the federal government pays 100% of the cost of expansion in the early years of expansion, states are responsible for 10% of costs by calendar year 2021. The FMAP for the expansion population decreases each year as shown in the following table.

EXPANSION POPULATION FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)



* Note: 90% is the FMAP for all fiscal years following SFY2021, per federal regulations in 42 CFR 433.10. For budgeting purposes a blended enhanced FMAP is calculated using 6 months of the calendar year.

In SFY 2018, the cost of expansion to the state would be roughly $25 million, but would increase to $57 million by 2021.



AMERICAN INDIAN HEALTH DISPARITIES

There are significant disparities relating to health care in South Dakota. Research shows that American Indians are disproportionately affected by a multitude of adverse health-related issues and outcomes. This section will examine race disparities among infants, children and adults, and will conclude by looking at similar trends in certain health-related behaviors and factors.

The birth rate is significantly higher for American Indians (24.9 per 1,000) compared to the total birth rate (14.4 per 1,000).[4] However, data from 2014 shows that infant mortality rates are considerably higher among American Indians (12.18 per 1,000 live births) than the total population (5.94 per 1,000 live births).[5] The Helmsley Charitable Trust found that American Indians experience more adverse childhood experiences (ACE) than their non-American Indian counterparts.[6] Adverse childhood experiences (ACEs) are potentially traumatic events that can have negative, lasting effects on health and well-being.[7] In fact, when focusing on an ACE score of 5 or greater, the prevalence for American Indians (23.5%) is more than triple that of non-American Indians (7%). Similarly, the absence of ACEs is important to consider; while one half of non-American Indian participants had never had an ACE, less than 17% of American Indians reported the same answer.

[4] South Dakota Department of Health (2014). At a Glance. Accessed on December 9, 2015 from: https://doh.sd.gov/statistics/2014Vital/DataCard.pdf

[5] South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators (2014). Infant mortality. Accessed on December 9, 2015 from: https://doh.sd.gov/statistics/2014Vital/InfantMortality.pdf.

[6] The Helmsley Charitable Trust. Focus on South Dakota: A Picture of Health. Accessed on December 10, 2015 from: http://helmsleytrust.org/publication/focus-south-dakota-picture-health.

[7] Sacks, V. et al. Adverse Childhood Experiences: National and State Prevalence. Child Trends. Accessed on December 10, 2015 from: http://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

Stark racial disparities continue into adulthood in terms of morbidity, mortality and access to care. American Indian population exhibits higher rates of diabetes, asthma, high blood pressure, heart disease, and high cholesterol, when compared to the general population rates in South Dakota.[8] For example, the rate of obesity (BMI ≥30.0) for American Indians is 38% compared to 28% for white South Dakotans.[9] Furthermore, many behavioral health issues are also more prevalent among American Indians including depression, anxiety, and PTSD. The prevalence of both depression and PTSD is double among American Indians. Notably, regarding mortality rates, the median age of death is 58 years of age for American Indians and 80 years for the total population; the disparity between median ages is true among many common conditions.[10] The total population experiences higher median ages of death than American Indians for the following conditions: heart disease, malignant neoplasms, accidents, chronic lower respiratory diseases, cerebrovascular diseases, Diabetes Mellitus, and suicide. While the vast majority (96.1%) of American Indians can access care, only 43.4% have a personal doctor, which is considerably lower than the general South Dakota population (77.4%).[11] Similarly, American Indians tend to have greater unmet medical, prescription and mental health needs than their counterparts.

American Indians are also often disproportionately affected by health related factors. For example, the majority of the homeless and housing insecure study participants in South Dakota self-identify as American Indian.[12] Tobacco and marijuana use are significantly higher among American Indians when compared to the rest of South Dakota. From 2011-2013, the Behavioral Risk Factor Surveillance System (BRFSS) showed that while fewer American Indians had consumed alcohol in the past month (60% of whites compared to 41% of American Indians), more American Indians reported binge drinking (26%) than whites (20%).[13] In addition, 48% of American Indian South Dakotans currently smoke cigarettes compared to only 19% of the white population.[14] Opportunities to reduce these significant health disparities through a Medicaid expansion solution will have a positive impact for the citizens of South Dakota.

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[8] The Helmsley Charitable Trust. Focus on South Dakota: A Picture of Health. Accessed on December 10, 2015 from: http://helmsleytrust.org/publication/focus-south-dakota-picture-health.

[9] The Health Behaviors of South Dakotans, 2013. A report of the South Dakota Behavioral Risk Factor Surveillance System, South Dakota Department of Health; http://doh.sd.gov/statistics/2013BRFSS/default.aspx

[10] South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators (2014). Mortality. Accessed on December 9, 2015 from: https://doh.sd.gov/statistics/2014Vital/Mortality.pdf.

[11] The Helmsley Charitable Trust. Focus on South Dakota: A Picture of Health. Accessed on December 10, 2015 from: http://helmsleytrust.org/publication/focus-south-dakota-picture-health.

[12] *Ibid.*

[13] The Health Behaviors of South Dakotans (Behavioral Risk Factor Surveillance System) (2013). Alcohol Use. Accessed on December 9, 2015 from: https://doh.sd.gov/statistics/2013BRFSS/default.aspx; https://doh.sd.gov/statistics/2013BRFSS/AlcoholUse.pdf.

[14] *Ibid.*

INDIAN HEALTH SERVICE (IHS) AND MEDICAID

The federal government has a responsibility to provide health care services for American Indians that are members of a federally recognized tribe. This obligation is a direct result of treaties between Indian Nations and the United States, executive orders, and federal law. The Indian Health Service (IHS) is the agency responsible for fulfilling the federal government's obligation to American Indians.

American Indian eligibles comprise approximately 35% of South Dakota's Medicaid population. This has significant financial implications for Medicaid as services provided directly by IHS are eligible for 100% Federal Financial Participation (FFP).

The rules governing reimbursement for healthcare services delivered to American Indians are complex. Eligibility for IHS is determined by membership in a federally recognized tribe or by being a descendent of an American Indian in a federally recognized tribe; effectively making the vast majority of American Indians in South Dakota eligible for IHS (IHS-eligibles). Indian Health Service, like other healthcare providers, bills third party payers including Medicaid, Medicare, and private health insurance. If there is no third party to bill, IHS uses funding received directly from the federal government. When referring or paying for services from non-IHS providers, IHS uses a medical priority system to determine which services it can pay for through its limited Purchased and Referred Care (IHS PRC) budget.

In addition to IHS services, tribes may choose to operate a Tribal Health 638 Facility. Under the authority of the Indian Self-Determination and Educational Assistance Act (P.L. 93-638), Tribes may assume operation of any program, function, service or activity operated by the Secretary of the Department of Health & Human Services for Indians, including the Indian Health Service. Tribes can assume total operation of a facility or individual programs or component services or activities of a program. When an IHS-eligible is also Medicaid eligible and receives care directly from IHS or a Tribal 638 facility, the services are billed to Medicaid and paid at 100% FFP.

When an IHS eligible is also Medicaid eligible and receives care from a non-IHS provider, the services are billed to Medicaid by the non-IHS provider and paid at the state's regular Federal Medical Assistance Percentage (FMAP) rate. South Dakota's FY17 blended FMAP is 54.11% state/45.89% federal. The following examples illustrate this unique funding stream:

- A 10-year-old Tribal member is examined at an IHS facility. Her condition requires treatment which is available at the IHS facility. The child is eligible for Medicaid so IHS bills Medicaid. The federal government pays the entire bill (100% FFP).
- A 10-year-old Tribal member is examined at an IHS facility. Her condition requires treatment which is <u>not</u> available at the IHS facility, and she is referred to

Rapid City Regional Hospital. The child is eligible for Medicaid, so Rapid City Regional bills Medicaid. The federal government pays at the State's FMAP rate, or roughly half the bill for services provided by Rapid City Regional Hospital. The State of South Dakota pays the other half (State's FMAP).

- A low-income adult tribal member is examined at IHS. His condition requires treatment which is available at the IHS facility. The federal government pays the entire bill (100% FFP).
- A low-income adult tribal member is examined at IHS. His condition requires treatment which is not available at the facility, and he is referred to the Rapid City Regional Hospital. The IHS Purchased / Referred Care (PRC) funding has been exhausted in the current federal fiscal year, and no additional funding will be available until October. The adult is not eligible for Medicaid. The tribal member must receive charity care, pay for the treatment himself or wait until the next federal fiscal year (IHS PRC).
- A low-income adult tribal member has an emergency while in Rapid City. He is treated in the emergency room at Rapid City Regional Hospital, does not have private insurance and is not eligible for Medicaid. The tribal member may submit a request for purchased/referred care to IHS within 72 hours of the service; but coverage by IHS is not guaranteed and the tribal member may receive a denial from IHS. The tribal member then must receive charity care, pay the bills himself or risk having the bills turned over to a collection agency.

During State Fiscal Year (SFY) 2015, South Dakota's Medicaid program expended $251 million for healthcare services for individuals eligible for both IHS and Medicaid. Of that total, $69.2 million was for services provided directly by IHS and paid by Medicaid at 100% federal funds. The remaining $182 million was paid at the state's regular FMAP rate or $85 million general funds and $97 million federal funds.

South Dakota has long argued that services for individuals eligible for both Medicaid and IHS should be eligible for 100% federal funding whether provided directly through IHS or by non-IHS providers. In 2001, CMS disallowed federal financial participation for Medicaid services for American Indians who were treated at non-IHS facilities that had contracts to provide care on referral for IHS clients at reduced rates. South Dakota understood from a 1997 CMS memorandum issued to the State of Arizona that these services qualified as "received through" an IHS facility. The CMS Departmental Appeals Board (DAB) [15] upheld the disallowance of FFP. That ruling was overturned by a district court in 2003, and later upheld by similar cases in North Dakota[16] and Arizona. CMS appealed the decisions in North and South Dakota to the United States Court of

[15] South Dakota Department of Social Services, DAB No. 1847, (2002).
[16] North Dakota, ex. rel. Olson v. Centers for Medicare and Medicaid Services. 286 F. Supp. 2d 1080 (D.N.D. 2003)

Appeals.[17] In 2005, the United States Court of Appeals reversed the decisions by the District Courts and ordered North and South Dakota to return the FFP to CMS for referred services provided by non-IHS facilities.

CMS's policy for 100% FFP required services to meet the following conditions:

(1) The service must be furnished to a Medicaid-Eligible AI/AN Individual

(2) The service must be a "facility service" – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center, nursing facility) can offer under Medicaid law and regulation;

(3) The service must be furnished in an IHS or Tribal facility or by its employees or contractual agents as part of the facility's services; and

(4) The IHS or Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.

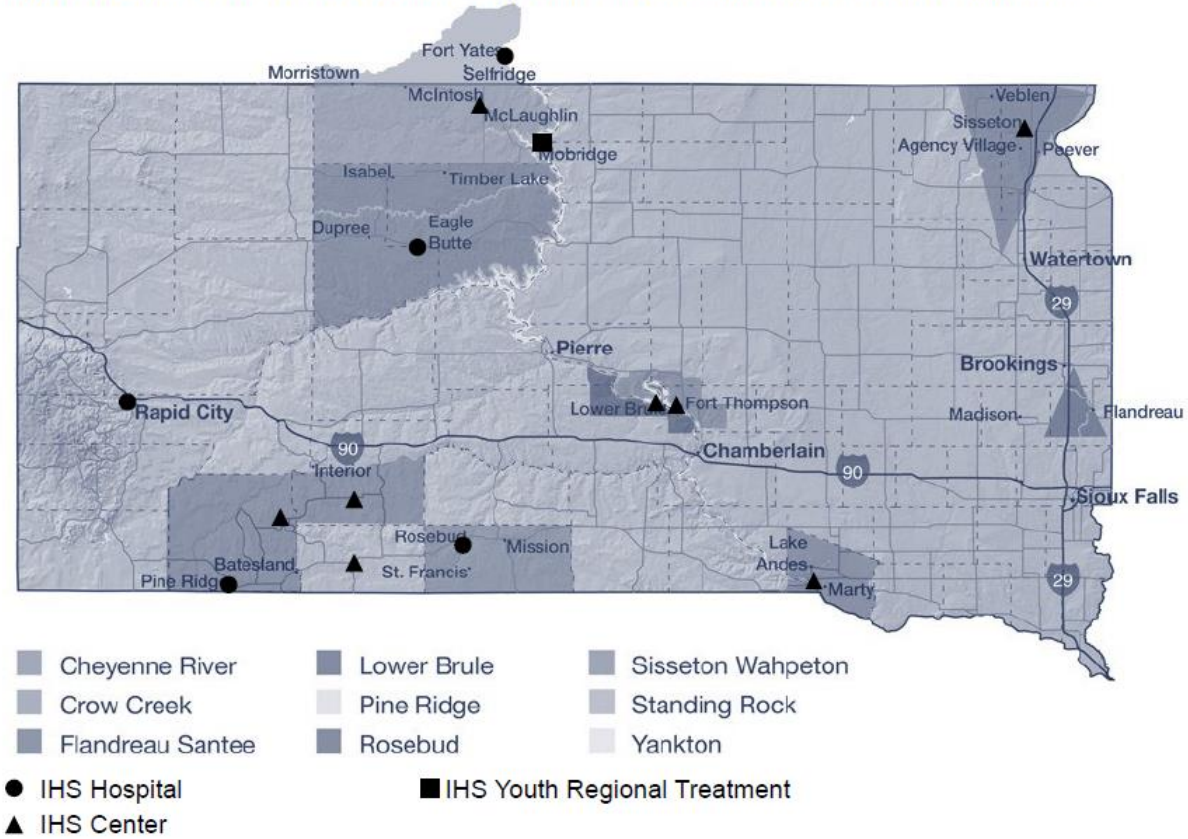
IHS-ELIGIBLES AND NON-IHS PROVIDERS

IHS-eligibles in South Dakota are served by the Great Plains Indian Health Service and Tribal 638 Facilities. South Dakota is served by 9 IHS Service Units: Cheyenne River Service Unit, Standing Rock Service Unit, Fort Thompson Service Unit, Lower Brule Service Unit, Pine Ridge Service Unit, Rosebud Service Unit, Woodrow Wilson Keeble Memorial Health Care Center at Sisseton, Yankton Service Unit, and the Rapid City Service Unit.

Although IHS provides an array of healthcare services, not all healthcare services are available directly from an IHS or Tribal 638 facility. IHS Hospitals offer the widest array of services, but are only located in four communities in South Dakota: Eagle Butte, Pine Ridge, Rosebud, and Rapid City. IHS Health Centers offer a range of ambulatory services that include primary care, nursing, pharmacy, laboratory and x-ray, but lack specialized care, emergency room services, round the clock urgent care, and hospital services. IHS Health Stations offer limited primary care services. Across South Dakota, specialized physician and hospital services such as neonatology are limited and not provided by IHS. Consequently, IHS-eligibles have to seek non-IHS providers for those services.

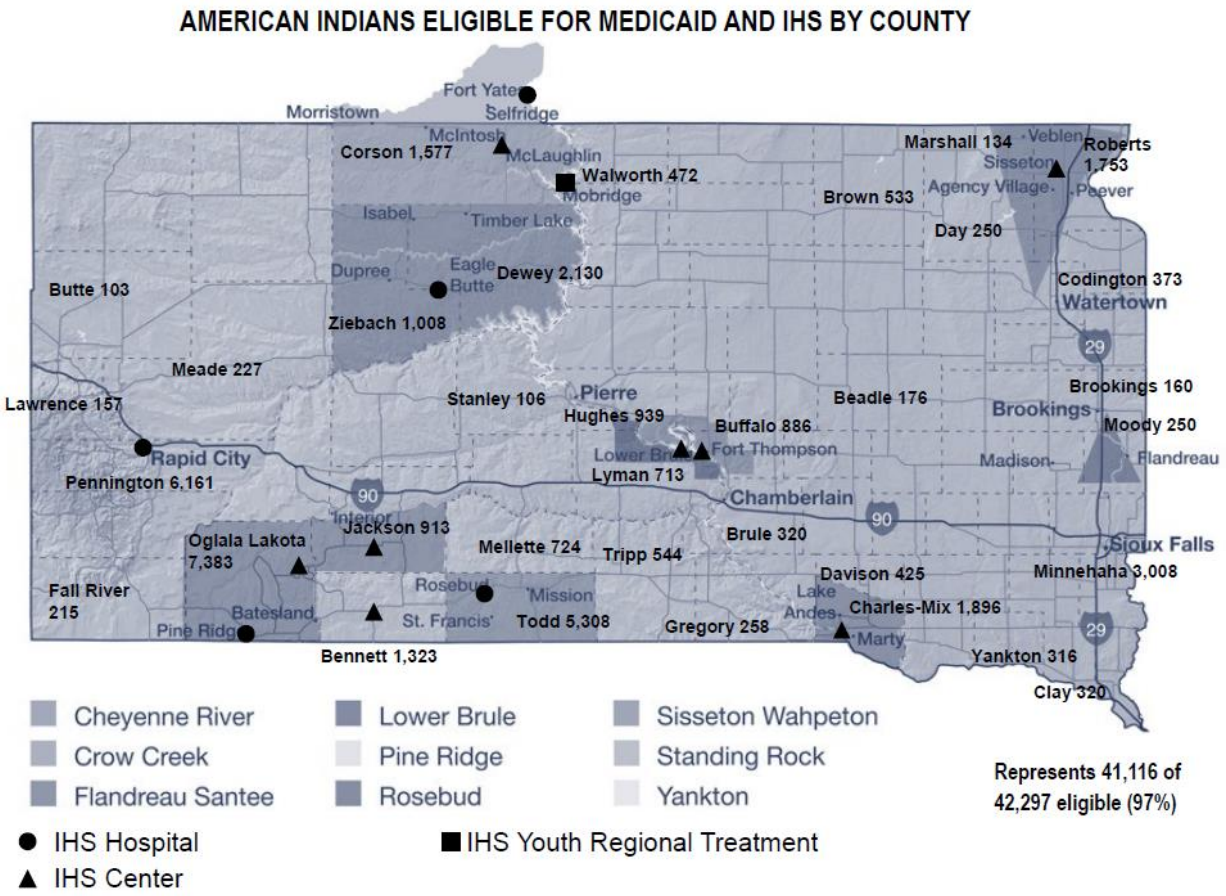
[17] North Dakota, ex rel. Olson, Appellee, v. Centers for Medicare and Medicaid Services, Appellants; Ellenbecker, Appellee, v. Centers for Medicare and Medicaid Services, Appellants. 403 F.3d 537 (8th Cir. 2005)

SOUTH DAKOTA FEDERALLY RECOGNIZED TRIBES AND INDIAN HEALTH SERVICE FACILITIES



IHS-eligibles also experience geographic barriers when accessing IHS healthcare. Some IHS-eligibles do not live in an IHS Health Service Delivery Area or close to an IHS or Tribal 638 facility. Large concentrations of IHS eligibles live in South Dakota population centers that do not have an IHS facility or Tribal 638 facility. South Dakota's most populous city does not have an IHS facility, but Sioux Falls is home to 22%[18] of Medicaid-eligibles. IHS-eligibles may access South Dakota Urban Indian Health in Pierre, and Sioux Falls for primary care services, but must seek non-IHS providers for specialized physician, emergency room, urgent care, and hospital services. Services provided by South Dakota Urban Indian Health are not eligible for 100% FFP.

[18] Medicaid Eligibles Residing in Minnehaha and Lincoln Counties; November 2015



Finally, Medicaid IHS-eligibles are not required to seek IHS as a source of care. Federal requirements indicate individuals eligible for Medicaid have freedom of choice when determining a health care provider and may choose to see any participating Medicaid provider. Some IHS-eligibles may choose a non-IHS provider as their primary source of care.

SOUTH DAKOTA MEDICAID EXPANSION CONCEPT PAPER

Early in 2015, key stakeholders including legislators, health care providers, and staff from the Department of Social Services and Governor Daugaard's office engaged in discussions about opportunities within the existing Medicaid Program to fund Medicaid Expansion in South Dakota. Stakeholders saw an opportunity to leverage more federal funding for American Indian health care in South Dakota if the current CMS interpretation of services "received through" IHS could be expanded to include additional IHS services and contract care services provided by non-IHS providers. The state savings from increased FFP for services "received through" IHS could be directed towards the state costs of Medicaid expansion.

Senator Corey Brown (District 23) posed the question to the federal Department of Health and Human Services (HHS) during a meeting with regional representatives from

HHS regarding state flexibility for Medicaid Expansion. In March 2015, South Dakota submitted a Concept Paper to CMS explaining three goals: provide better health care access to American Indians for services provided through IHS, improve health outcomes for American Indians eligible for Medicaid, and increase access to health care for the entire expansion population in South Dakota. At CMS' request, South Dakota identified examples of strategies to improving health care access for American Indians and other rural populations in South Dakota. The concept paper outlined use of telehealth services which already have a strong presence in South Dakota to be expanded within IHS to promote access to high quality health care for American Indians. Development of a Community Health Representative (CHR) model was suggested as an effective strategy to help individuals access necessary medical services and supports. Partnerships with IHS to develop joint venture clinics or expand IHS clinic services to increase access to primary and other specialty care. These were examples of the type of strategies that could be used to promote better health outcomes and, if provided through IHS, could leverage cost savings through increased federal financial participation.

In August 2015, CMS indicated interest in the concept paper and intent to conduct tribal consultation on the proposals described in South Dakota's concept paper. Governor Daugaard directed Department of Tribal Relations Secretary Steve Emery to hand deliver letters explaining the concept paper to each Tribal Chairman. During the October 8, 2015 South Dakota Medicaid Tribal Consultation the concept paper was reviewed and feedback for the concept was positive.

During the month of September, CMS conducted tribal consultation and held calls with State Medicaid Directors. Tribal Consultation for South Dakota Tribes was conducted during a meeting of the Great Plains Tribal Chairman's Health Board in North Dakota. In late September, Governor Daugaard met with HHS Secretary Burwell in Washington DC. Secretary Burwell indicated interest at the federal level to pursue federal action to expand the availability of FFP for health care in American Indian communities.

Governor Daugaard formed the Health Care Solutions Coalition to explore options to improve access to care for American Indians in collaboration with the Tribes, Indian Health Service (IHS) and health care providers in South Dakota.

FUNDING CHANGES PROPOSED BY CMS

CMS WHITE PAPER

In October 2015, the Centers for Medicare & Medicaid Services (CMS) released a white paper proposing to update policy on funding for services provided to Medicaid eligible American Indian/Alaskan Native (AI/AN) enrollees. Currently, CMS policy allows AI/AN Medicaid beneficiaries to choose any provider participating in a State's Medicaid program, including hospitals, clinics and qualified I/T/U facilities, which include:

1) Indian Health Services (IHS); and
2) Tribal Health Providers (Tribal 638).

If an individual seeks a service at one of these facilities, the federal government pays 100% of the costs. However, if the service is provided outside of an IHS or Tribal facility (I/T), the state is required to pay up to half of the service. Under CMS's proposed policy change, more services would be eligible for 100% federal funding, which would increase access to care for AI/AN Medicaid beneficiaries while generating savings to the state budget that could be used to help fund Medicaid Expansion.

MODIFICATION TO INTERPRETATION OF SECTION 1905(B) OF THE SOCIAL SECURITY ACT

The CMS white paper proposes three substantive changes that would have significant impact for South Dakota. Changes would affect payment for services for AI/AN Medicaid eligibles and the state would claim the 100% federal match.

The most far reaching is the ability for IHS and Tribal facilities to contract with providers outside of the physical "four walls" of the facility that, to date, has limited services that can be provided with 100% FFP. This provision has the potential to greatly expand access for American Indians. Secondly, expansion of the services that qualify for 100% federal match to include any service covered through the Medicaid State Plan. One potential opportunity for South Dakota is the provision of NEMT services which are now provided under administrative services rather than as a state plan service. Third, the ability for IHS-contracted providers to be able to bill Medicaid directly for services will eliminate some of the variability in payment methodologies that currently exist. The white paper also contemplates changes to the reimbursement rates paid to IHS suggesting that some services be reimbursed at the IHS encounter rate and others at the state's Medicaid state plan rates.

Section 1905(b) of the Social Security Act requires the federal government to pay 100% of all services received through an IHS and tribally operated facility. CMS is considering modifications to the interpretation of these conditions as follows:

CURRENT INTERPRETATION	PROPOSED CHANGE
1) The service is furnished to a Medicaid eligible AI/AN;	No change

CURRENT INTERPRETATION	PROPOSED CHANGE
2) The service is a "facility service" within the scope of services at various facilities that meet Medicaid law and regulations, such as: a) Inpatient and outpatient hospitals b) Clinics c) Federally Qualified Health Centers, and d) Nursing facilities;	Expands the definition of "facility service" to include **any service provided within the Medicaid State Plan**, including transportation services.
3) The service is rendered in an IHS or Tribal facility or by its employees or contractual agents and included as part of the facility's services; and	Expand the meaning of a contractual agent to include a qualified individual or entity that is enrolled as a Medicaid provider and who provides items or services not within the scope of a Medicaid "facility services" benefit but within the IHS/Tribal facility authority
4) The IHS or Tribal facility maintains responsibility for provision of service and bills the state Medicaid program directly for the service.	Enable IHS and Tribal facilities to include provisions in their contracts with providers that would allow them to bill the State Medicaid program directly

APPLICATION TO MEDICAID

Under a Fee-For-Service (FFS) delivery system, like South Dakota's, the state Medicaid agency reimburses IHS and Tribal facilities under an all-inclusive rate (AIR). These rates are set federally for inpatient and outpatient settings. CMS' proposal to expand would impact fee-for-service payments in two major areas:

1. For services that are part of the applicable facility benefit, the IHS/Tribal facility would be reimbursed at the IHS facility rate under the Medicaid state plan regardless of whether they are provided by IHS facility employees or their contracted providers.
2. If an IHS/Tribal facility opts to provide Medicaid services that are of a type that could be funded through the IHS/Tribal authority but are not within the scope of the applicable facility benefit, such as personal care, waiver services, or non-emergency medical transportation (NEMT), those services will be paid at the applicable Medicaid state plan rates.

STAKEHOLDER INPUT

Nationwide, many tribal organizations, state and federal agencies, health plan organizations and universities have commented on the proposed CMS regulatory changes. Comments are available to the public online. There is overwhelming support for this initiative from stakeholders. The proposed changes have implications for all

American Indians to help address health care disparities, access to care, and the burden of disease that adversely affect American Indians residing in South Dakota. In addition to the SD HCSC, support in South Dakota came from the Great Plains Tribal Chairmen's Health Board (GPTCHB), Cheyenne River Sioux Tribe, Oglala Sioux Tribe, Rosebud Sioux Tribe, Sisseton Wahpeton Oyate, and Urban Indian Health.

The Great Plains Tribal Health Board (GPTCHB) and Tribal leadership submitted comments strongly supporting the broader interpretation of Section 1905(b) but stressed the importance of flexibility as states and tribes collaborate on this initiative. In their comments, the GPTCHB recommended that CMS retain and highlight language it used in the proposal that "states retain flexibility in establishing economic and efficient payment rates to sufficiently reimburse for the provision of services." The GPTCHB did not support changes to current IHS reimbursement that would impact IHS and Tribal facilities by implementing variable rates depending on the service provision and the "applicable facility benefit" determination. Further, the Board indicated they would like to explore reimbursement for services rendered by Traditional Practitioners that are widely used in Tribal Mental Health Services today.

South Dakota Urban Indian Health also provided support, noting that as a Title V contractor with IHS, Urban Indian Health should be recognized for their shared obligation, and along with IHS and Tribes should be entitled to receive the 100% FMAP "consistent with their standing within the Indian Health system."

The Oglala Sioux Tribe noted their support for these policy changes also highlighting that "CMS proposal to make 100% FMAP available to the State for services received through the Indian Health System is consistent with the United States treaty obligation and trust responsibility."

The Cheyenne River Sioux Tribe offered their support indicating that the policy changes will improve coordination of care for Medicaid-eligible American Indians, but noted the importance of contracted providers remaining accountable to the originating IHS or Tribal facility. The Tribe strongly supported CMS's broader interpretation of the definition of facility services.

The Sisseton-Wahpeton Oyate agreed that health care for American Indians is a federal responsibility and supports the ability to provide services beyond the "bricks and mortar" of the IHS/Tribal facility. They stressed that I/T facilities must retain the ability to oversee and control services eligible for 100% FMAP.

HEALTH CARE COALITION COMMENTS

The South Dakota Health Care Solutions Coalition submitted written comments to CMS stating appreciation of the proposed changes. These changes can increase programmatic flexibility, minimize unneeded bureaucracy, and maximize health care options for all South Dakotans. While supporting expanded access to 100% FFP to be

applicable to providers outside of the IHS and Tribal facility systems, the HCSC requested that CMS provide clarification on two key provisions:

1. How services being "arranged and overseen" by IHS will be defined, particularly in areas where the nearest provider is geographically removed from IHS or Tribal service programs.
2. Reimbursement for facility-based services –100% FMAP should be available for all services that meet the requirements of being coordinated by IHS and provided by a contractual agreement between the IHS or Tribal provider and the non-Indian provider.

Relative to care being arranged and overseen by IHS or Tribal programs the Coalition noted that many South Dakotans are located in urban areas geographically distant from IHS or Tribal programs and these individuals receive primary care outside IHS today. The comments provided Sioux Falls as an example. Sioux Falls is the largest population center of the State but the nearest IHS or Tribal 638 Facilities are located in Wagner and Flandreau respectively. The closest IHS-operated facility in Wagner is over 110 miles away. Without public transportation between these two cities, it would not make sense to disrupt current care coordination and have care directed by the IHS-operated facility. The coalition suggested that the "arranged and overseen" provision could be met through the contractual agent arrangement where non-IHS providers could contract for care coordination and any services provided through the non-IHS provider or referrals by the non-IHS provider would be eligible for 100% federal reimbursement. Another suggestion was to leverage use of the state's Health Information Exchange or other integrated electronic health record tool as a way to meet this requirement.

The Coalition requested flexibility to determine the most appropriate contracting mechanism between the IHS or Tribal provider and non-IHS providers and suggested that this be incorporated into the Medicaid State Plan. The Coalition requested the ability to develop a master area wide contract between IHS and non-IHS providers and also specifically requested flexibility and alternatives to the current IHS procurement process citing challenges with the current process.

The Coalition also sought clarification on the definition of "facility based services," noting that all services that meet the requirements of being coordinated and overseen by IHS or Tribal programs should qualify for the 100% federal match. The Coalition provided an illustrative example of an individual who received prenatal care through the Pine Ridge IHS facility and due to complications was referred to a non-IHS provider for perinatology services in Rapid City. The baby developed complications and was in the neonatal intensive care unit. Assuming a contract is in place between IHS and the perinatology provider, the Coalition requested that all services provided outside IHS be eligible for 100% federal match.

Furthermore, the Coalition strongly recommended that non-IHS providers be reimbursed at the state plan rate rather than IHS encounter rates. Generally, providers view Medicaid reimbursements to align with actual service provision. There can be great variation between the South Dakota Medicaid reimbursement rate and the IHS encounter rate as is illustrated in the following examples.

SERVICE	SD MEDICAID RATE	IHS ENCOUNTER RATE
Magnetic Resonance Imaging (MRI)	$950	$350
Inpatient Stay for 3 Days	$1,053	$7,329

Although the Coalition agreed with many of the changes in the white paper, they indicated that extending the encounter rate to non-IHS providers would infringe upon the intent of federal policy. The encounter rate is a unique provision to all Indian Health providers as an extension of the federal trust responsibility to I/T/U's and should remain exclusive to Indian Health programs.

Overall, the Coalition supported the CMS proposal but stressed the importance of maintaining flexibility in how the State and IHS and Tribal facilities would implement the provisions in a way that best meets the needs of South Dakota.

CMS POLICY CHANGE

The Centers for Medicare and Medicaid Services released final guidance on February 26, 2016 in State Health Official (SHO) Letter #16-002. The SHO Letter slightly revised the proposed policy outlined in the White Paper. The changes to the final policy are outlined below:

CURRENT INTERPRETATION	PROPOSED CHANGE	FINAL POLICY
1) The service is furnished to a Medicaid eligible AI/AN;	No change	No change
2) The service is a "facility service" within the scope of services at various facilities that meet Medicaid law and regulations, such as: a) Inpatient and outpatient hospitals b) Clinics c) Federally Qualified Health Centers, and d) Nursing facilities	Expands the definition of "facility service" to include **any service provided within the Medicaid State Plan**, including transportation services	Expands definition to any services that IHS is authorized to provide under IHS rules and is also covered the by the Medicaid State Plan, including long-term services and supports (LTSS)

CURRENT INTERPRETATION	PROPOSED CHANGE	FINAL POLICY
3) The service is rendered in an IHS or Tribal facility or by its employees or contractual agents and included as part of the facility's services; and	Expands the meaning of a contractual agent to include a qualified individual or entity that is enrolled as a Medicaid provider and who provides items or services not within the scope of a Medicaid "facility services" benefit but within the IHS/Tribal facility authority	Expands the meaning of services "received through" to include services requested by an IHS/tribal practitioner for an established IHS patient from a non-IHS/tribal provider who is a Medicaid provider **in accordance with a care coordination agreement**
4) The IHS or Tribal facility maintains responsibility for provision of service and bills the state Medicaid program directly for the service.	Enable IHS and Tribal facilities to include provisions in their contracts with providers that would allow them to bill the State Medicaid program directly	IHS/Tribal providers must voluntarily enter into care coordination agreements with non-IHS providers. Non-IHS providers may bill the state directly or IHS/Tribal providers may handle all the billing.

The most significant change between the White Paper and the final policy is the requirement for care coordination agreements. Under the final policy, care coordination must involve:

1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;
2) The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;
3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
4) The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

CMS left states and IHS the flexibility to determine how care coordination agreements may be structured. Care coordination agreements may take various forms including formal contracts, provider agreements, memorandum of understanding, etc. CMS also clarified that care coordination agreements will not be subject to federal procurement rules.

CMS stressed that participation by beneficiaries, IHS, tribes, and non-IHS providers must be voluntary. The policy change does not affect the federal requirements for freedom of choice of provider for Medicaid beneficiaries under the Social Security Act. States may not require American Indian beneficiaries to seek care from IHS/Tribal providers or establish care with IHS/Tribal providers. States may not require either IHS. Tribal providers, or non-IHS providers to enter into care coordination agreements.

In essence, the federal policy change for 100% federal financial participation for services "received through" IHS comes down to four key points:

1. Participation by individuals and providers must be voluntary;
2. Services outside IHS provided via written care coordination agreement;
3. IHS must maintain responsibility for the patient's care; and
4. Providers must share medical records with IHS.

COST OF MEDICAID EXPANSION

Implementation of Medicaid expansion will provide health care coverage to South Dakotans up to 138% federal poverty level (FPL). The State's goal is to seek flexibility in federal regulations to better meet health care needs of all South Dakotans, including those who are currently eligible for services at Great Plains Area Indian Health Service. In 2013, South Dakota commissioned studies to estimate the impacts of a Medicaid expansion in the State. Leif and Associates conducted an actuarial study estimating future enrollment and per capita expenditures under an expansion scenario. Their work was complemented by a survey conducted by Market Decisions to estimate the insurance status of South Dakotans, including those without insurance and the number of adults potentially eligible for coverage under Medicaid expansion. The State recently updated these estimates to reflect the results of a new Market Decisions survey, as well as increased actual per capita expenditures.

In other states, actual expenditures and uptake rates exceeded initial cost estimates and enrollment for the expansion population. Therefore, the cost estimates used for Medicaid expansion in South Dakota are based on conservative assumptions that take the experiences of other states into account. The cost estimates assume 54,693 eligibles, providing a 10% buffer over the 49,721 estimated by a survey of the expansion population. The estimate also assumes rapid enrollment of the expansion population, with 100% uptake by SFY2019. Furthermore, the cost estimates assume an average Medicaid cost per person of $8,131 in 2018, a 20% increase over state fiscal year 2015 actual costs in order to account for inflation and provide a cost buffer. None of the cost estimates assume the expansion population will be eligible for 100% FFP for services received through IHS, even though 30% of the expansion population is American Indian. The cost estimates also ignore economic impact to tax revenue, which

is estimated at $8.6 million for SFY 2021. Using these assumptions, $57 million will be needed by 2021 to fully fund the costs of Medicaid Expansion.

The estimates used in Governor Daugaard's proposal include a number of conservative assumptions as a way to mitigate financial risk, ensure the cost estimates for expansion consider experience of other expansion states. Key estimates and assumptions include:

- Estimated 55,240 eligible individuals. This number is based on the 2015 survey of 49,721 plus 10% and 1% annual growth;
- Accelerated enrollment projected to be 90% in Year 1 (49,716) and 100% in Year 2Estimated 30% of expansion population are American Indian, however no consideration for 100% FFP for this population was considered;
- The average cost per Medicaid Eligible is projected to be $8,131 in SFY 2018 with an annual increase of 5%. This rate is based on the actual cost for Low Income Family (LIF) members in SFY 2015 with a 20% adjustment; and
- Administrative expenditures will increase by 5% and require DSS to hire an additional 55 employees.

In calendar years 2014 through 2016, the federal government assumed 100% of the benefit costs for Medicaid expansion members. However, the amount of federal funding reduces beginning in 2017, declining to 90% by 2020. Because the State Fiscal Year begins in July of each year, the blended funding percentages for each state fiscal year are different than those used in the calendar year.

CALENDAR YEAR	FMAP
2018	94%
2019	93%
2020 & beyond	90%

STATE FISCAL YEAR	BLENDED FMAP
SFY2018: 7/1/17-6/30/18	94.5%
SFY2019: 7/1/18-6/30/19	93.5%
SFY2020: 7/1/19-6/30/20	91.5%
SFY2021 & beyond	90.0%

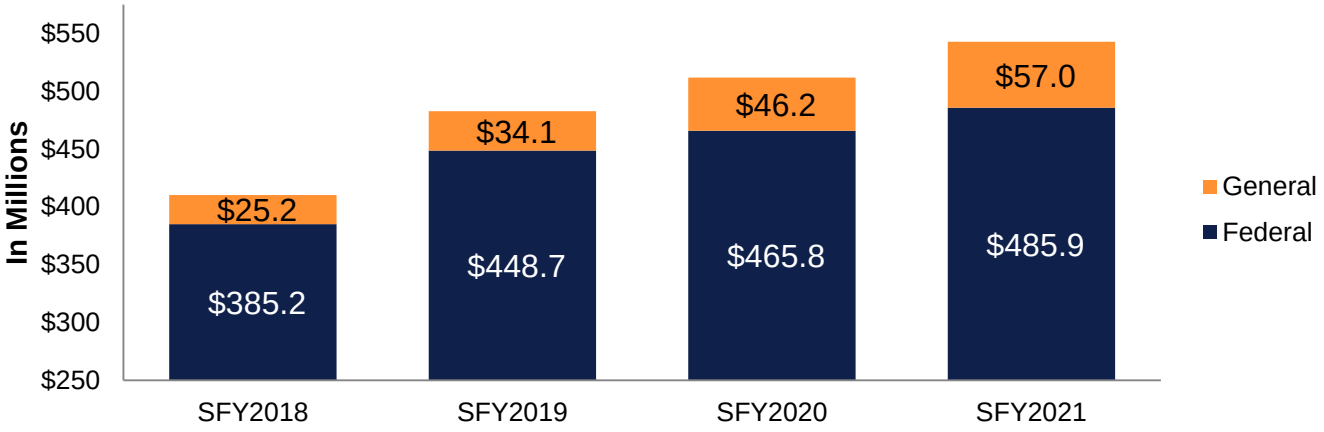
As a result, the cost to South Dakota in state funds will increase over time for the new population. The projected expenditures and necessary savings are detailed below.

PROJECTED EXPENDITURES AND NECESSARY SAVINGS

Cost projections are based upon assumptions like projected eligibles, rate of enrollment, cost of benefits, healthcare system capacity and administrative impact and costs. South Dakota has assumed a conservative approach to the budget to ensure that the costs of Medicaid expansion can be managed without jeopardizing other general fund responsibilities. The ability to receive additional federal funding for services provided to

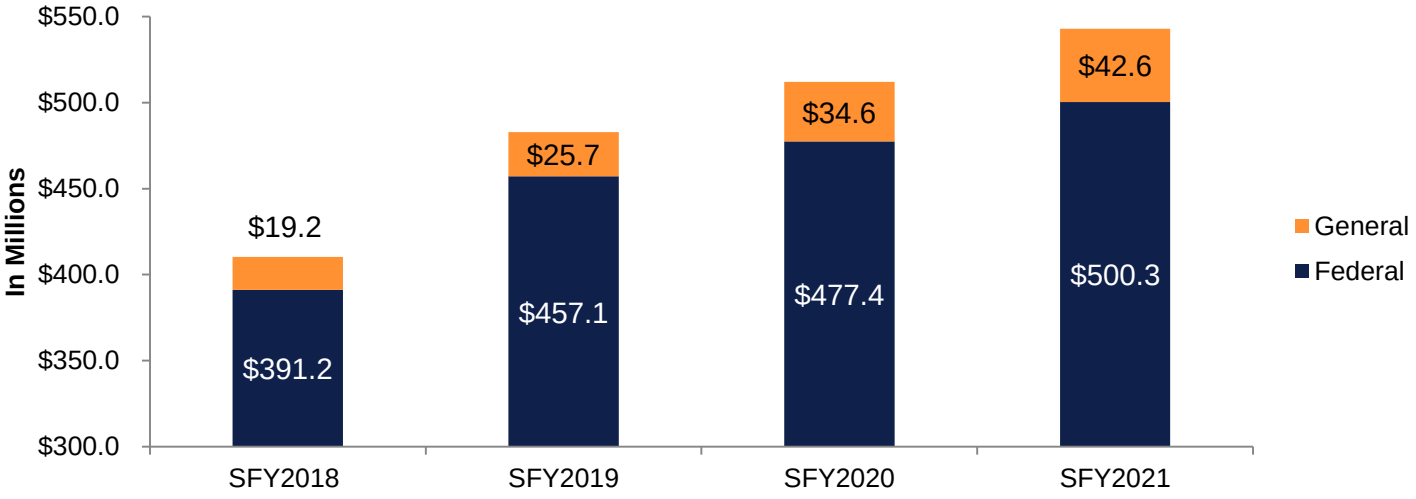
American Indians is critical to the State's Medicaid expansion. Total projected costs over the next seven years, without any new federal IHS dollars, are projected to be over $3.5 billion with South Dakota having responsibility for just over $300 million. The details by year are detailed below. By SFY 2021, South Dakota will need to generate $57 million dollars in general fund revenue.

PROJECTED MEDICAID EXPANSION COSTS, SFY 2018- 2021

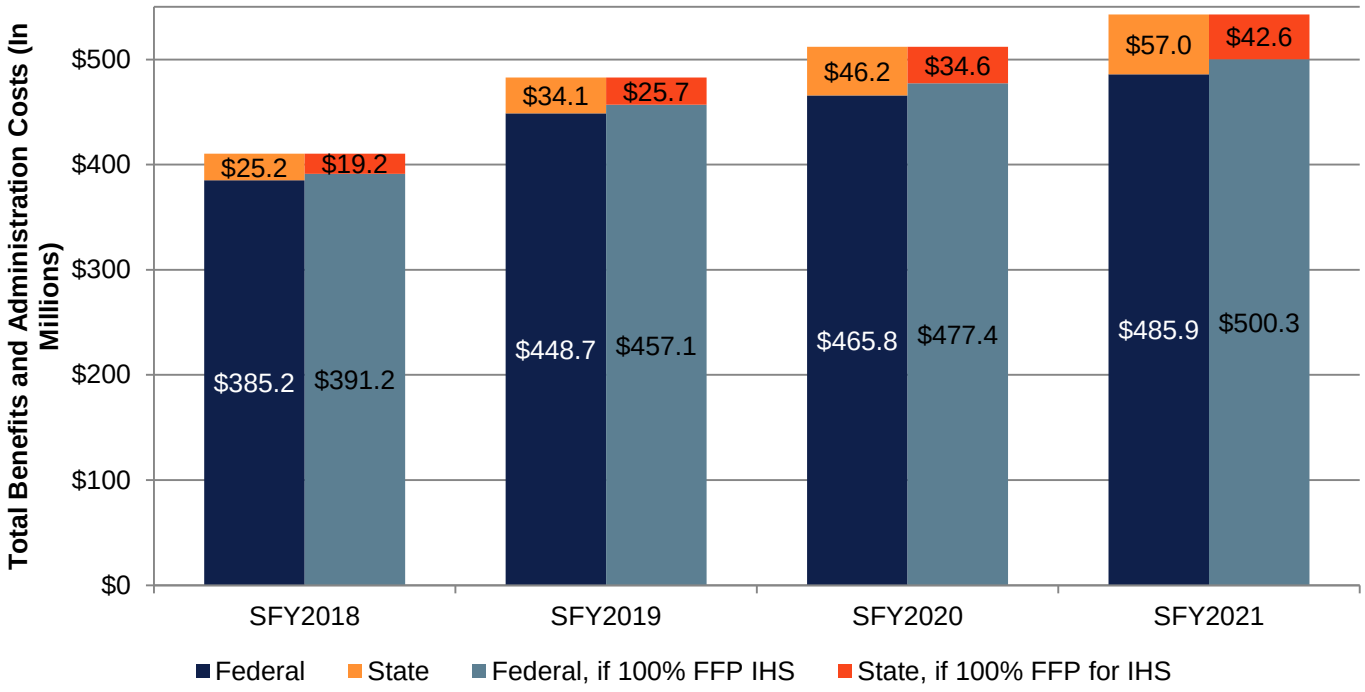


However, the changes to how the federal government funds services to American Indians offers the opportunity to refinance some services currently funded with state funds. If South Dakota is able to claim 100% FFP for services provided to American Indians eligible for IHS, the state cost of expansion will be greatly offset. As depicted in the figure below, the projected state share could be reduced to $42.6 million through SFY 2021.

PROJECTED MEDICAID EXPANSION COSTS WITH 100% FFP FOR AMERICAN INDIANS IN EXPANSION POPULATION, SFY 2018 – 2021



PROJECTED MEDICAID EXPANSION COSTS WITH AND WITHOUT 100% FFP FOR AMERICAN INDIANS IN EXPANSION POPULATION, SFY 2018 – 2021



The State can leverage sufficient savings across the Medicaid program to free up general funds to apply to Medicaid expansion. The CMS policy change contains potential savings to fully fund Medicaid expansion within existing general funds.

MEDICAID EXPANSION IN SOUTH DAKOTA

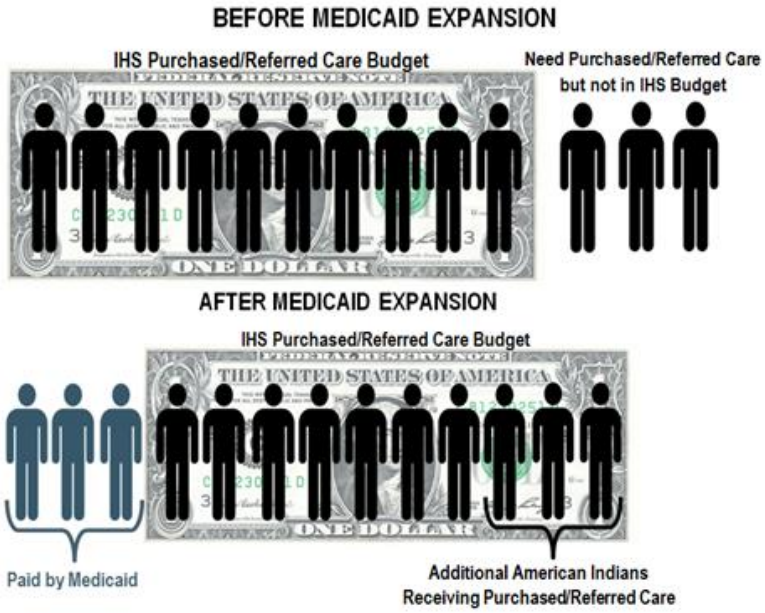
Governor Daugaard supports expansion with a solution that ensures costs to the state now and in the future are covered within existing general funds. The South Dakota Medicaid Expansion Concept Paper requested the ability to leverage additional federal funds through services received through Indian Health Service (IHS). Discussions with the federal government have been promising; CMS released a White Paper describing proposed IHS funding changes, and then finalized the policy in the State Health Official (SHO) letter allowing states to generate additional federal funding for services "received through" IHS. In SFY15, South Dakota Medicaid spent $182 million on health care for American Indians - $97 million was federal funds and $85 million in state funds. $85 million is more than enough to cover state costs for expansion. South Dakota only needs to save 2/3rds of the total to provide the $57 million needed to cover a very conservative estimate of state costs to expand Medicaid.

Implementing the policy changes from the SHO letter requires action from IHS, health care providers, and the state. However, providers cannot be forced to implement the policy changes. Medicaid expansion is the incentive to work together so the state can

free up existing state funds and quit using state tax dollars to fund federal responsibilities.

INDIAN HEALTH SERVICE

Medicaid expansion will stretch the IHS budget further and allow more American Indians to get needed health care. IHS is responsible for providing health care to American Indians, including payment for care provided outside of IHS. IHS's budget for purchased/referred care is limited. Some who need health care outside IHS do not receive it because IHS must prioritize which care is paid by their limited budget. Medicaid expansion will make the IHS budget go farther because more IHS enrollees will be covered by federal Medicaid funds.



HEALTH CARE PROVIDERS

Medicaid expansion will reduce uncompensated care. Federal rules require hospitals to provide emergency care to uninsured individuals, even if they cannot afford it. Uncompensated care costs are either absorbed by the provider or shifted to other payers. South Dakota hospitals had $123 million in uncompensated care in 2014.19

Medicaid expansion is an opportunity for rate enhancements. The State currently pays about 50% for individuals who should be paid for entirely by IHS. Implementing the policy changes under the Governor's plan will allow the State to save that 50%, totaling an amount that not only pays for Medicaid expansion, but would allow extra savings to be used to enhance rates for Medicaid providers.

STATE OF SOUTH DAKOTA

The governor's plan for Medicaid expansion would cover approximately 50,000 people and does not require an increase in state general funds. Medicaid expansion makes sense for South Dakota as an opportunity to improve healthcare for American Indians, save money for providers, and potentially save millions in state dollars. Without

19 "SD Uncompensated Care Costs - $123M," South Dakota Association of Healthcare Organizations: https://www.sdaho.org/index.php?option=com_content&task=view&id=5039&Itemid=638, Retrieved on August 19, 2016.

Medicaid expansion, South Dakota will not realize the full value of IHS rule changes and SD taxpayers will be forced to fund what should be federal obligations.

Governor Daugaard remains committed to ensuring that an expansion plan for South Dakota includes input and buy-in from South Dakota's nine tribes and support from the legislature. To move forward, the following considerations must be met:

- No general fund increase is required, expansion costs must be covered by current general fund budget;
- Tribes must support the expansion proposal; and
- South Dakota Legislature must support the expansion proposal through passage of the Governor's recommended budget.

SOUTH DAKOTA HEALTH CARE COALITION

Governor Daugaard formed the Health Care Solutions Coalition as a partnership between South Dakota Tribes, Legislators, health care providers, relevant State agencies, and other stakeholders. The Coalition was tasked with the development of a solution that supports increased access to healthcare for American Indians and improves health outcomes for American Indians in South Dakota, while leveraging general fund savings to finance expansion in the long term.

This broad stakeholder group appointed by the Governor was co-led by Kim Malsam-Rysdon from the Governor's Office and Jerilyn Church from the Great Plains Tribal Chairman's Health Board.

A consensus approach to decision-making, inclusive of all Coalition members, was employed to identify agreed-upon strategies. The Coalition held its first meeting on October 7, 2015 and met six times to work toward final recommendations. All presentations, documents, and meeting minutes of the Coalition are archived online.

COALITION MEMBERSHIP

MEMBER	ORGANIZATION
Kim Malsam-Rysdon	Governor's Senior Advisor/Secretary of Health
Jerilyn Church	Great Plains Tribal Chairman's Health Board
Willie Bear Shield *Evelyn Espinoza*	Rosebud Sioux Tribal Council *Rosebud Sioux Tribal Health Program, Alternate*
Sen. Corey Brown	South Dakota Legislator District 23
Dr. Mary Carpenter	South Dakota Medicaid Medical Director
Sunny Colombe	Great Plains Tribal Chairman's Health Board
Ron Cornelius *Kathaleen Bad Moccasin*	Indian Health Service *Alternate*
Rep. Justin Cronin	South Dakota Legislator District 23
Mike Diedrich	Regional Health
Jason Dilges	Governor's Budget Director
Terry Dosch	Council of Community Mental Health Centers and Community Substance Abuse Providers
Scott Duke *Gil Johnson*	South Dakota Association of Health Care Organizations *Alternate*
Steve Emery	Secretary of Tribal Relations
Deb Fischer-Clemens *Dr. Tad Jacobs*	Avera Health *Alternate*
Rep. Don Haggar	South Dakota Legislator District 10
Rep. Spencer Hawley	South Dakota Legislator District 7
Sen. Troy Heinert	South Dakota Legislator District 26

MEMBER	ORGANIZATION
Monica Huber *Nick Kotzea*	Sanford Health *Alternate*
Richard Huff	Indian Health Service
Sen. Bernie Hunhoff	South Dakota Legislator District 18
Janet Jessup	Department of Tribal Relations
Sen. Deb Peters	South Dakota Legislator District 9
Charlene Red Thunder	Cheyenne River Sioux Tribe Tribal Health Consultant
Bruce Renville *Sara DeCoteau*	Chairman of Sisseton Wahpeton Oyate *Sisseton Wahpeton Tribal Health Coordinator, Alternate*
Barb Smith *Mark East*	South Dakota State Medical Association *Alternate*
Sen. Deb Soholt	South Dakota Legislator District 14
Jennifer Stalley	Community HealthCare Association of the Dakotas
Sen. Billie Sutton	South Dakota Legislator District 21
Justin Taylor	Flandreau Santee Sioux Health Clinic
Brenda Tidball-Zeltinger	Deputy Secretary of Social Services
Lynne Valenti	Secretary of Social Services
Tony Venhuizen	Governor's Chief of Staff
Sonia Weston	Oglala Sioux Tribal Council

COALITION STRUCTURE AND CHARGE

The Coalition was organized to align with the goals and strategies outlined in the concept paper submitted to CMS in March 2015. Three subcommittees were formed to address specific issues outlined in the concept paper:

- **INCREASING ACCESS TO SERVICES FOR AMERICAN INDIANS THROUGH IHS-TRIBAL PROGRAMS SUBCOMMITTEE:** Charged with analyzing more efficient ways to deliver services currently covered by Medicaid through IHS and Tribal programs.
- **NEW SERVICES SUBCOMMITTEE:** Charged with identifying innovative ways to provide new services not covered by Medicaid today to reduce more costly care.
- **BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE**: Charged with identifying solutions to address behavioral health service gaps.

Each subcommittee included a mix of people from the larger Coalition, as well as others from the community with specific subject matter expertise or knowledge about particular issues. The membership of each subcommittee is contained in Appendix 1. All presentations, documents, and meeting minutes of the subcommittees are archived online.

INCREASING ACCESS TO SERVICES FOR AMERICAN INDIANS THROUGH IHS-TRIBAL PROGRAMS SUBCOMMITTEE

The Access subcommittee was charged with identifying specific strategies that increase access to services provided through Indian Health Service and tribal health programs. The group targeted its efforts to identify specific strategies that could be put forward to CMS as examples of increasing access. Two major considerations included the use of telehealth to increase access to care at IHS facilities and expansion of specialty services through partnerships with non-IHS providers, particularly prenatal care and behavioral health.

Telehealth is one of South Dakota's strengths; a strong telehealth presence already exists as a way for individuals in rural areas to access high quality health care. The subcommittee evaluated a variety of telehealth options that could be utilized by IHS including Avera eCare, Sanford OneConnect, and CareSpan's Primary Care E-Health System. Each telehealth platform offers a unique way to connect individuals in remote locations to high quality health care. The subcommittee encouraged IHS to pursue a multi-award contracting process to ensure that American Indians maintained access to existing sources of care and to ensure that new telehealth services would not interrupt existing referral patterns and partnerships.

The subcommittee also discussed ways to increase access to primary care, especially obstetric and gynecological care. Regional Health presented their work to embed certain family practice and other physicians within IHS facilities and Regional's current partnership with IHS. The subcommittee evaluated several existing programs focused on promoting healthy birth outcomes and recommended utilizing telehealth and community health workers to increase access to prenatal care.

NEW SERVICES SUBCOMMITTEE

This subcommittee was charged with increasing access through development of new services through IHS and Tribal Organizations not currently covered by Medicaid. While identifying ways to increase access, the subcommittee was mindful of the impact of new services to all Medicaid recipients. This group focused on two key ideas for new Medicaid services: leveraging the Community Health Worker model (CHW) and discussing Medication Therapy Management (MTM) services. Both of these services have the potential for a positive impact on costs and quality of care.

The coalition discussed the importance of integrating CHWs into a collaborative delivery team. The coalition recommended that services be recommended by a physician and provided face-to-face in the individual's home or community. A physician could mean any primary care provider like a physician, physician assistant, certified nurse practitioners, behavioral health provider, etc. The coalition further recommended that

CHWs work under the supervision of licensed helath care professionals inlcuding physicians, physician assistants, and nurse practitioners.

The coalition discussed targeting CHWs to care for specific individuals who need assistance to implement a care plan after discharge from a hospital or inpatient behavioral health or substance abuse treatment. The coalition also recommended using CHWs to support pregnant women who need access to prenatal or postpartum care. Since care coordination is already available through the Medicaid Health Home program and Medicaid Home and Community Based Services Waivers, the coalition recommended targeted CHW services to individuals not eligible for other care coordination services.

The committee discussed mechanisms to access MTM services. South Dakota Medicaid has expanded the role of pharmacy services in Health Homes. The subcommittee agreed that Health Homes should provide MTM services to their patients, and that IHS should maximize their Health Homes to provide necessary MTM services.

BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE

This subcommittee focused on increasing additional capacity for behavioral health services for current Medicaid recipients, especially American Indians. The group took the behavioral health services likely to be needed by the Medicaid expansion group under consideration. If South Dakota expands Medicaid, there are certain behavioral health services the Affordable Care Act (ACA) defines as essential health benefits (EHBs) that are not currently funded through Medicaid. South Dakota will need to ensure that recipients can access all required services. The group started by focusing on understanding the behavioral health system in place for Medicaid today, including the services available from Community Mental Health Centers and Behavioral Health Health Homes. The group identified strategies to increase capacity for behavioral health services provided through IHS and Tribal Organizations.

COALITION DISCUSSION

In addition to the work of the subcommittees, several key themes emerged from coalition discussions, including:

- Ensure access to primary care services across South Dakota while maintaining individuals' relationships with current providers and existing referral patterns;
- Maximize the use of telehealth in Medicaid across South Dakota for both primary and specialty care;
- Leverage existing Medicaid service delivery models like Health Homes, Community Mental Health Centers, and Tribal 638 programs to maximize health promotion and management services in the state;

- Encourage partnerships between IHS and other health care providers through sharing of electronic health records, provider credentialing, and interaction through the state Health Information Exchange; and
- Direct increased revenue to IHS from Medicaid Expansion and other cost savings to IHS's Purchased/Referred Care program.

The coalition discussed other benefits of expansion, including savings to counties for poor relief expenditures, reduced charity care for hospitals, and the benefits of health coverage for South Dakota's uninsured.

The coalition also discussed Medicaid Expansion and the experiences of other states relative to options for Medicaid Expansion in South Dakota. The coalition discussed the ability of states to purchase qualified health plans through the Marketplace as a method for expansion. Since Medicaid-eligible individuals are not eligible for premium tax credits, the state must pay the full cost of commercial premium rates as well as other costs associated with out-of-pocket expenses in excess of those allowed under Medicaid and other Medicaid services not covered by the Marketplace, like dental benefits and non-emergency medical transportation. The total estimated cost of providing QHP services exceeds the average cost of providing care via Medicaid. The coalition determined QHPs to be cost prohibitive as an expansion mechanism. However, there was broad consensus for expanding the Medicaid's program to cover premium assistance associated with Employer Sponsored Insurance to the extent that it is cost effective.

The coalition also discussed health savings accounts (HSAs) and other similar programs employed by other states. Only three states have pursued this option, and all have seen significant administrative costs associated with HSAs with limited outcomes. Other states have already scaled back HSAs in their states due to concerns regarding cost effectiveness. The coalition agreed that the high costs of this option exceed the limited benefits available under Medicaid. Instead, the coalition agreed to further evaluate incentives tied to healthy behaviors. For example, there may be opportunities to incentivize healthy behaviors like chronic disease management by tying wellness activities to reduced co-payments or cost sharing. States are not allowed to tie Medicaid eligibility to work requirements; however the coalition agreed that work referral or training opportunities for the expansion population should be explored.

IMPLEMENTATION TEAMS

Since publication of the interim report in January 2016, South Dakota formed behavioral health and telehealth implementation teams to begin work on the recommendations of the coalition. Other teams were formed to operationalize the CMS policy. The teams met periodically throughout summer and fall 2016.

Policy Operations Team was tasked with identifying common processes that impact all other implementation areas. This team worked with CMS to finalize a draft Care Coordination Provider Agreement and worked with IHS to identify a central email location for medical record updates and sharing until IHS can connect to the Health Information Exchange (HIE) to send and receive information electronically. This group also identified information needed for the patient identification process. DSS is developing an online portal for providers that will allow providers to verify Medicaid eligibility and dual IHS/Medicaid eligibility. The eligibility function is slated to go-live in early 2017.

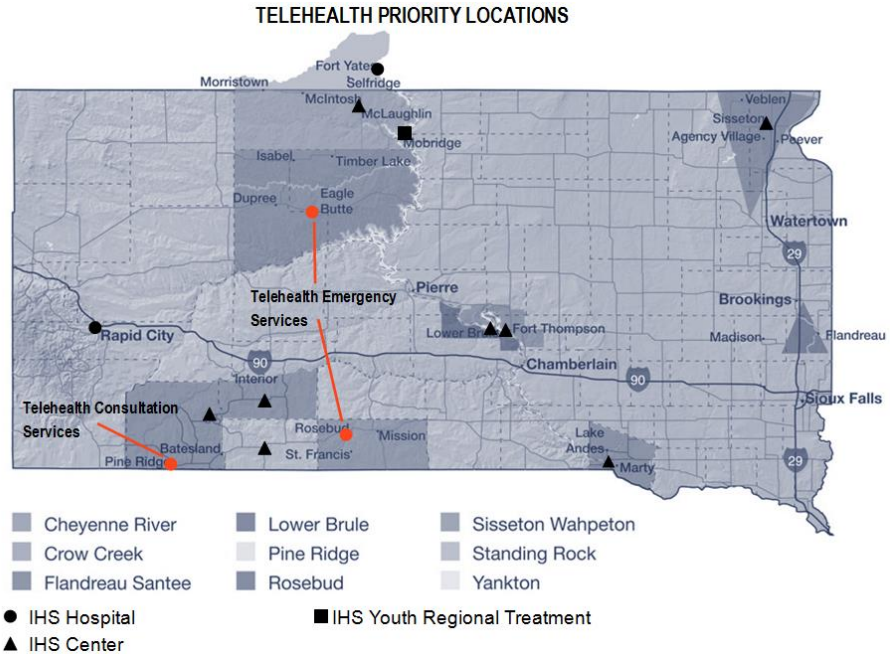
Alternative Service Delivery Team is working on a proposal to target IHS beneficiaries not currently served by an IHS or Tribal program and is focused on utilizing FQHCs, including SD Urban Indian Health, to form Satellite IHS Clinics to serve individuals geographically distant from IHS. The team has identified pilot sites for implementation: Horizon Healthcare – Mission; Urban Indian Health – Pierre and Sioux Falls; and Community Health Center of the Black Hills. The team continues to work closely with CMS and IHS to finalize details regarding dedicated space and use agreement, dedicated personnel, and billing/payment arrangements.

Care Transitions Team is focused on care coordination for inpatient and outpatient services, including targeted service delivery for transition services post-hospital and transitions back to the community. The group is working to identify opportunities for hospital based services and mapping patient flows to identify opportunities to increase referrals through IHS.

RECOMMENDATIONS AND ACTION STEPS

RECOMMENDATION 1: INCREASE USE OF TELEHEALTH SERVICES TO SUPPORT EMERGENCY DEPARTMENTS AND INCREASED ACCESS TO PRIMARY AND SPECIALTY CARE CONSULTATION AND TREATMENT THROUGH INDIAN HEALTH SERVICE and TRIBAL PROGRAMS.

Telehealth quickly emerged as a key strategy to increase access to care for American Indians in South Dakota. The flexibility of telehealth to meet diverse healthcare needs and the innovation already at work in South Dakota were key to developing recommendations in this area. A survey of IHS CEOs indicated access needs in behavioral health, cardiology, internal medicine, psychiatry, and emergency medicine.



The coalition identified Eagle Butte and Rosebud as priority locations to pilot telehealth emergency services, and Pine Ridge as a priority site for specialty care consultations. The coalition also spent time evaluating the ability to support support prenatal care for high risk pregnant women through telehealth. Across South Dakota, access to Behavioral Health services is limited; the coalition also recommended leveraging telehealth for existing behavioral health services and providers.

ACTION STEPS:

1. Great Plains Area Indian Health Service will implement an area wide standardized approach for the provision of telehealth services.
   - IHS will develop a menu of services all IHS locations may pick from to support access to primary and specialty care consults and treatment within IHS facilities.
   - IHS will publish a request for proposals and multiple providers may be selected to support this service.

- IHS will gather the necesssary information to formulate area wide service contracts. Individual IHS service areas will be able to choose the specialty care services most suited to their populations and communities.

2. Explore the ability to expand the use of telehealth in behavioral health and substance abuse services through existing providers and services eligible for Medicaid reimbursement.

FALL 2016 UPDATE

Indian Health Services published an area-wide request for proposals (RFP) in May 2016. HHS released an award notification in September 2016 naming Avera as the awardee. The award prioritizes telehealth for behavioral health services and support for IHS emergency departments. DSS is working closely with IHS and Avera as telehealth is implemented in IHS.

DSS also evaluated expanding the use of telehealth in behavioral health and substance abuse for current providers. DSS implemented additional telehealth services to support behavioral health offered through existing providers.

RECOMMENDATION 2: DEVELOP A COMMUNITY HEALTH WORKER/COMMUNITY HEALTH REPRESENTATIVE PROGRAM UNDER THE MEDICAID STATE PLAN.

Some individuals need assistance to navigate the health care system and address barriers to accessing health care. Community Health Workers (CHWs) are trusted members of the community and help individuals access health care services. Services typically provided by CHWs include health promotion and health education, arranging for transportation, disease-specific education, specific direct services, assisting individuals in navigating the health care system, and connecting individuals to other community services and supports. The target population would be individuals discharging from hospital or inpatient behavioral health and services for pregnant women. The coaltion also discussed the different roles and areas of overlap between CHWs and providers of similar services like Home Health Aides, Certified Nurse Assistants (CNAs), and Certified Medical Assistants (CMAs). The coalition recommended a tiered service delivery model that integrates the roles of various health professionals to ensure services are not duplicated.

ACTION STEPS:

1. If funding is available, the Department of Social Services will implement a Community Health Worker benefit under Medicaid.
   - DSS will collaborate with a small group of members of the coalition to develop a Medicaid State Plan Amendment proposing the service.

- DSS will solicit feedback from tribes and other stakeholders during the drafting process.

2. Implementation will be dependent on the availability of funds generated by increased 100% FFP for services for American Indians. The amount of funds necessary is dependent on expected utilization of the service, and if CHW services provided by tribal organizations or IHS will be eligible for 100% FFP.

FALL 2016 UPDATE

The Department of Social Services and the Department of Health collaborated to form a small workgroup made up of tribes and health care providers to develop the framework for a CHW benefit under the Medicaid State Plan. The group worked collaboratively to identify a scope of work, core competencies, and available education programs for CHWs. DSS and DOH will continue to work together to develop a CHW benefit if the funding is available.

RECOMMENDATION 3: EXPAND SUPPORT FOR PRENATAL AND POSTPARTUM CARE TO SUPPORT HEALTHY BIRTH OUTCOMES FOR AMERICAN INDIANS.

The coalition discussed the need for more prenatal and postpartum care to support healthy birth outcomes for American Indians. The coalition analyzed several on-going programs and initiatives and recommended that Community Health Worker services incorporate prenatal and postpartum services for pregnant women, as part of Recommendation 2. The coalition also recommended utilizing telehealth to support specialty prenatal care for high risk pregnant women as part of Recommendation 1.

RECOMMENDATION 4: EXPAND CAPACITY FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES THROUGH INDIAN HEALTH SERVICE AND TRIBAL PROGRAMS.

Access to behavioral health, psychiatric care, and substance use disorder (SUD) services, is a priority of tribes and IHS CEOs. The coalition discussed strategies to leverage existing programs and infrastructure to meet the needs of American Indians in South Dakota.

Almost 1/3 of the individuals in the Medicaid Health Home program are served through IHS primary care health homes. The coalition discussed leveraging this existing infrastructure and developing partnerships with tribal and community behavioral health programs to develop behavioral health homes for American Indians.

The coalition also recommended exploring the ability for IHS and Tribes to develop a Community Mental Health Center (CMHC) model. Collaboration between Tribes and IHS will be necessary to meet all of the federal service requirements for CMHCs.

Services provided by IHS or Tribal programs are currently eligible for 100% FFP, but few Tribal programs are enrolled as Medicaid SUD providers. The coalition recommended providing assistance to IHS and Tribal programs to expand SUD services through Medicaid.

ACTION STEPS:

1. The Department of Social Services will provide technical assistance to develop IHS Behavioral Health Health Homes.
   - IHS and Tribal programs will partner to leverage existing infrastructure to support Behavioral Health Health Home model.
2. The Department of Social Services will provide technical assistance for IHS and Tribal programs to better understand CMHC model and requirements.
3. The Department of Social Services will assist IHS and Tribal programs to expand substance use disorder services through Medicaid.
4. IHS Health Homes are already able to access 100% FFP. The CMHC partnership between IHS and Tribal programs needs further development before a cost estimate may be developed, but it is anticipated that services provided by IHS or a Tribal Program will be able to access 100% FFP. IHS and Tribal programs providing SUD services are already able to access 100% FFP.

FALL 2016 UPDATE

DSS formed a behavioral health implementation team to expand the capacity for IHS to provide additional behavioral services, such as the community mental health center model or behavioral health Health Homes.

- Lewis & Clark Behavioral Health hosted a site visit with the Great Plains Tribal Chairmen's Health Board consultant in June 2016. Information on the development of a community mental health center and the related requirements were shared. A second site visit occurred in October 2016 with three IHS staff.
- The Great Plains Tribal Chairmen's Health Board continues to compile the technical assistance related to establishing a community mental health center and meeting all requirements of the community mental health center model. This information continues to be shared with tribes and IHS. In addition, the GPTCHB hosted a Tribal Action Planning Summit through SAMHSA's Tribal Training and Technical Assistance Center and invited all Tribes to participate. Information on the CMHC model was shared.
- IHS and the GPTCHB are exploring potential providers to serve as pilot sites to become accredited community mental health centers.

RECOMMENDATION 5: EXPAND MEDICAID ELIGIBLE PROVIDERS OF BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER (SUD) TREATMENT SERVICES.

The coalition analyzed the ability to increase access to behavioral health services by leveraging providers not currently eligible to enroll in Medicaid but who possess similar qualifications to other Medicaid providers. The coalition identified Licensed Marriage and Family Therapists and Licensed Professional Counselors under a formal supervision plan from the Board of Counselor Examiners as new providers of behavioral health services. Expanding providers of behavioral health services is not a requirement of expansion, but will be necessary to ensure access to care due to the increased number of Medicaid recipients.

Substance use disorder (SUD) services are a required benefit for the expansion population but are limited to children and pregnant women in South Dakota's current Medicaid program. Medicaid-eligible adults who require SUD services not funded by Medicaid typically access care through South Dakota's Federal Substance Abuse Prevention and Treatment Block Grant today. The coalition discussed that services should be consistent across funding sources, and recommended SUD services for the current Medicaid population alongside the expansion population. Expanding capacity for chemical dependency services in IHS and Tribal Programs in Recommendation 4 will be necessary to ensure access to care for American Indians.

ACTION STEPS:

1. If funding is available, the Department of Social Services will add Licensed Marriage and Family Therapists and Licensed Professional Counselors (LPC) under a formal supervision plan from the Board of Counselor Examiners to eligible providers under the Medicaid State Plan.
    - As a new benefit, Licensed Marriage and Family Therapist and LPCs under formal supervision services will be associated with an increase in Medicaid costs and implementation will be dependent on the availability of funds generated by increased 100% FFP for services for American Indians.

Services currently provided through South Dakota's Substance Abuse Prevention and Treatment Block Grant are subject to a federal maintenance of effort (MOE) requirement. The MOE requires South Dakota to maintain the same amount of general fund expenditures for SUD services. To the extent that individuals would receive services from Medicaid instead of the block grant, the priority would be to repurpose existing general funds made available through Medicaid expansion to provide the same non-Medicaid eligible services available today.

RECOMMENDATION 6: ADD EVIDENCED BASED SERVICES AND SUPPORTS FOR CHILDREN AND FAMILIES, INCLUDING FUNCTIONAL FAMILY THERAPY AS A MEDICAID STATE PLAN SERVICE.

Functional family therapy (FFT) is an evidence-based, short-term, behavior oriented family therapy program that targets youth with severe behavior programs. Trained FFT therapists provide intensive family therapy to change patterns of family interaction that are contributing to problem behavior. The coalition discussed the expansion of the current pilot programs as a Medicaid-eligible service in order to access federal funds to replace state general funds currently dedicated to the program.

The coalition also discussed other opportunities to provide less intensive behavioral health and SUD services in settings other than inpatient facilities. The coalition recommended evaluating school-based services and day treatment (partial hospitalization) services as part of the full continuum of services for children and youth. Day hospital services could also be targeted as a service for adults.

ACTION STEPS:

1. If funding is available, the Department of Social Services will add Functional Family Therapy as a Medicaid State Plan service.
   - FFT is currently funded entirely with state general funds as part of the Juvenile Justice Reinvestment Initiative. Implementing FFT as a Medicaid State Plan service will allow South Dakota to access federal funds through the state's regular FMAP to provide the service to eligible youth.
2. If funding is available, consider feasibility of behavioral health school-based services for children and day treatment services as part of the full continuum of services for children, youth, and adults.

FALL 2016 UPDATE

DSS implemented FFT as a Medicaid State Plan service to draw down federal funds to support the service. 11 agencies provide FFT statewide in South Dakota. Agency teams were trained in FFT in early 2016 and services began as soon as the teams were trained.

CONCLUSION

In order to expand Medicaid coverage to adults with incomes up to 138% FPL, South Dakota must find a way to offset new costs. Governor Daugaard has adopted a conservative estimate of costs, taking into account the experiences of states that have already expanded Medicaid, to ensure that South Dakota will have sufficient resources to fund the expansion in State Fiscal Year 2021 when South Dakota becomes responsible for 10% of costs. In SFY 2018, the cost of expansion to the state would be $12 million but would increase to $57 million by SFY 2021.

The Coalition, through its recommendations, has paved a path for moving forward to increase access to services and strengthen capacity in IHS and Tribal programs. While in the long run these initiatives have the potential to produce long-term cost savings, some recommendations will incur costs for implementation. The HCSC will consider which recommendations are most cost-effective and will work to implement them in an efficient manner, as funding is available.

South Dakota's Medicaid expansion funding strategy hinges on expanded access to federal dollars for services for American Indians. Discussions with the federal government have been promising; CMS finalized a policy in the State Health Official (SHO) letter allowing states to generate additional federal funding for services "received through" IHS. In SFY15, South Dakota Medicaid spent $182 million on health care for American Indians - $97 million was federal funds and $85 million in state funds. $85 million is enough to cover state costs for expansion. South Dakota only needs to save 2/3rds to provide the $57 million needed to cover state costs to expand Medicaid.

Implementing the policy changes from the SHO letter requires action from IHS, health care providers, and the state. However, providers cannot be forced to implement the policy changes. Medicaid expansion is the incentive to work together so the state can free up existing state funds.

The governor's plan for Medicaid expansion would cover approximately 50,000 people and does not require an increase in state general funds. Medicaid expansion makes sense for South Dakota as an opportunity to improve healthcare for American Indians, save money for providers, and potentially save millions in state dollars. Without Medicaid expansion, South Dakota will not realize the full value of IHS rule changes and SD taxpayers will be forced to fund what should be federal obligations. However, Governor Daugaard will only move forward with Medicaid expansion with the support of South Dakota's tribes and the state legislature.

NOVEMBER 2016 UPDATE

Following the November election, Governor Daugaard met with Vice-President Elect Mike Pence and discussed the Trump Administration's plans for repealing or reforming the Affordable Care Act (ACA). Based on the Trump Administration's plans for changes to the ACA, Governor Daugaard will not recommend Medicaid expansion in 2017. However, reform related to federal reimbursement for American Indians eligible for Indian Health Service is still an opportunity for South Dakota.

While expansion was the incentive for providers, IHS, and tribes to make necessary changes and leverage state savings through implementation of the new federal policy, Governor Daugaard intends to continue the discussion with federal officials and work with the Trump Administration and South Dakota's congressional delegation to find a way to leverage the IHS policy change to improve access to health care and to advocate for increased state flexibility and other reforms in the Medicaid program.

APPENDIX 1: Coalition Subcommittee Membership

INCREASING ACCESS SUBCOMMITTEE MEMBERS

MEMBER	ORGANIZATION
Jerilyn Church	Great Plains Tribal Chairman's Health Board
Sunny Colombe	Great Plains Tribal Chairman's Health Board
Ron Cornelius	Indian Health Service
Sara DeCoteau	Sisseton Wahpeton Tribal Health Coordinator
Mike Diedrich	Regional Health
Scott Duke	South Dakota Association of Healthcare Organizations
Senator Troy Heinert	South Dakota Legislator District 26
Monica Huber	Sanford Health
Richard Huff	Indian Health Service
JoEllen Koerner	CareSpan, Inc.
Kim Malsam-Rysdon	Governor's Office
Charlene Red Thunder	Cheyenne River Sioux Tribe Tribal Health Consultant
Rachael Sherard	Avera Health
Bryan Slaba	Wagner Community Hospital
Angelia Svihovec	Mobridge Hospital
Justin Taylor	Flandreau Tribal Heath Administrator
Brenda Tidball-Zeltinger	Department of Social Services
Tim Trithart	Community Health Center of the Black Hills
Lynne Valenti	Department of Social Services

NEW SERVICES SUBCOMMITTEE MEMBERSHIP

MEMBER	ORGANIZATION
Willie Bear Shield	Rosebud Sioux Tribal Council
Jerilyn Church	Great Plains Tribal Chairman's Health Board
Michael Coyle	Coteau Des Prairies Health Care System
Evelyn Espinosa	Rosebud Sioux Tribal Health Program
Deb Fischer-Clemens *Dr. Tad Jacobs*	Avera Health *Alternate*
Monica Huber *Nick Kotzea*	Sanford Health *Alternate*
Edmund Johnson, Jr.	Sisseton Wahpeton Oyate Tribal Council
Donna Keeler	Urban Indian Health
Bernie Long	Indian Health Service, Ft. Thompson
Kim Malsam-Rysdon	Governor's Office

MEMBER	ORGANIZATION
John Mengenhausen *Pam Locken*	Horizon Health Care *Alternate*
Brenda Tidball-Zeltinger	Department of Social Services
Lynne Valenti	Department of Social Services
Sonia Weston	Oglala Sioux Tribal Council

BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE MEMBERSHIP

MEMBER	ORGANIZATION
Richard Bird	Sisseton Wahpeton Oyate Chemical Dependency Treatment Center
Jerilyn Church	Great Plains Tribal Chairman's Health Board
Evelyn Espinosa	Rosebud Sioux Tribal Health Program
Sandra Fortuna	Southern Plains Behavioral Health Services
Dan Foster	Rosebud Sioux Tribe Behavioral Health
Jill Franken *Alicia Collura*	Falls Community Health *Alternate*
Dr. Dan Heinemann	Sanford Health
Amy Iversen-Pollreisz	Department of Social Services
Donna Keeler	Urban Indian Health
Steve Lindquist *Deanna Larson*	Avera Health *Alternate*
Kim Malsam-Rysdon	Governor's Office
Richard Moves Camp	Oglala Sioux Tribe
Belinda Nelson	Community Counseling Services
Betty Oldenkamp	Lutheran Social Services
Delores Pourier	Oglala Sioux Tribe
Charles Sitting Bull	Oglala Sioux Tribe Behavioral Health
Tom Stanage	Lewis & Clark Behavioral Health Services
Dr. Matt Stanley	Avera Behavioral Health Services
Brenda Tidball-Zeltinger	Department of Social Services
Lynne Valenti	Department of Social Services
Marlies White Hat	Rosebud Systems of Care Program