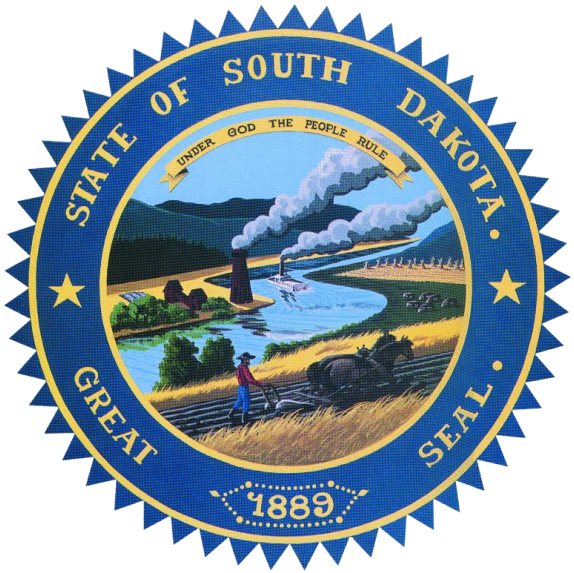


MEDICAID OVERVIEW

Jan. 10, 2018

What is Medicaid?

- Provides healthcare, long term care and other services through a federal-state partnership.
- Governed by the Medicaid State Plan which is a contract with the federal government outlining who is served and what services are covered.
  - Each State Plan is different. Comparisons between states can be difficult.
- Separate from Medicare.
  - Medicare is for individuals 65 years and older for all incomes, and for people with disabilities.
  - Medicare is 100% federally funded and administered at the federal level.

Who is covered by Medicaid?

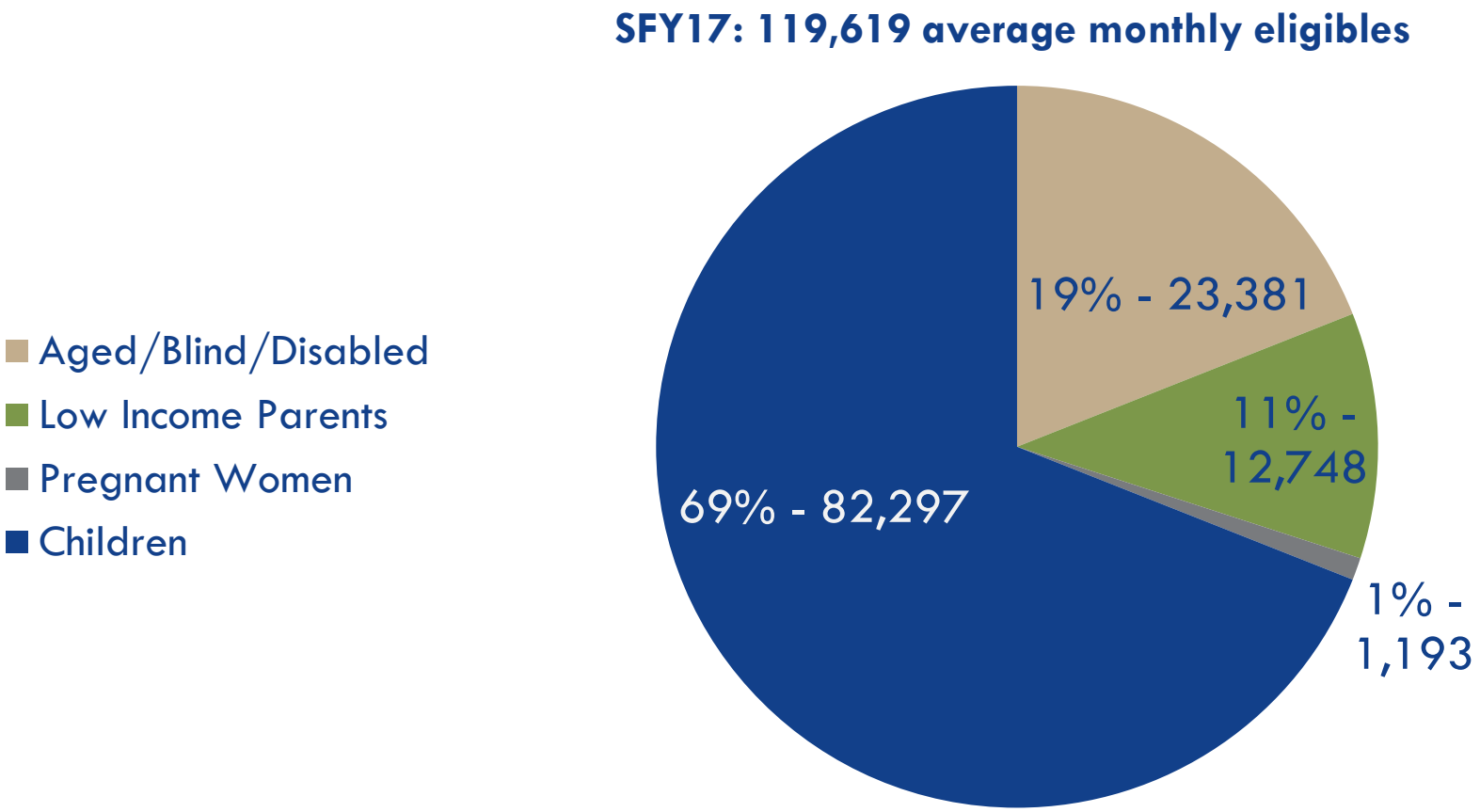
- States are required to cover certain "mandatory" groups.
  - Children under 138% Federal Poverty Level (FPL)
  - Pregnant women under 138% FPL
  - Elderly and disabled on SSI - also called Aged, Blind and Disabled
  - Low income parents
- South Dakota has a conservative program with income guidelines at federal minimums.

Who is covered by Medicaid?

2017 CALENDAR YEAR FEDERAL POVERTY GUIDELINES Annual Amount at Various Percentage Levels				
Family Size	Low Income Parents	138%	182%	209%
1	$7,356	$16,643	$21,949	$25,205
2	$9,252	$22,411	$29,557	$33,942
3	$10,572	$28,180	$37,164	$42,678
4	$11,856	$33,948	$44,772	$51,414
5	$13,164	$39,716	$52,380	$60,150

South Dakota:	**Low Income Parents**	**52% (family of 3)**
	Medicaid (Pregnant Women)	**138%**
	Medicaid Children	**182%**
	Children's Health Insurance Program (CHIP)	**209%**

Who is covered by Medicaid?



What services are covered by Medicaid?

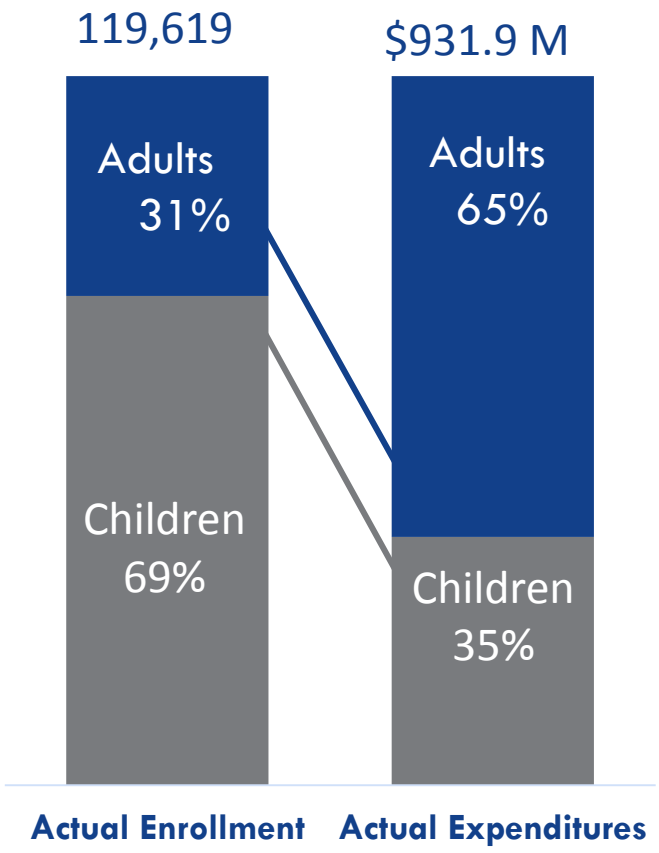
- States are required to cover certain mandatory services. For example:
  - Inpatient and outpatient hospital
  - Nursing homes
  - Physician
  - Home health
  - Federal Qualified Health Centers/Rural Health Centers
  - Medically necessary care for individuals under age 21
- South Dakota covers some "optional" services including:
  - Physician assistants, psychologists and independent mental health
  - Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
  - Podiatry, optometry, chiropractic, dental, durable medical equipment
  - Prescription drugs
  - Physical, occupational, speech therapy
  - Hospice, personal care and nursing services

How is Medicaid funded?

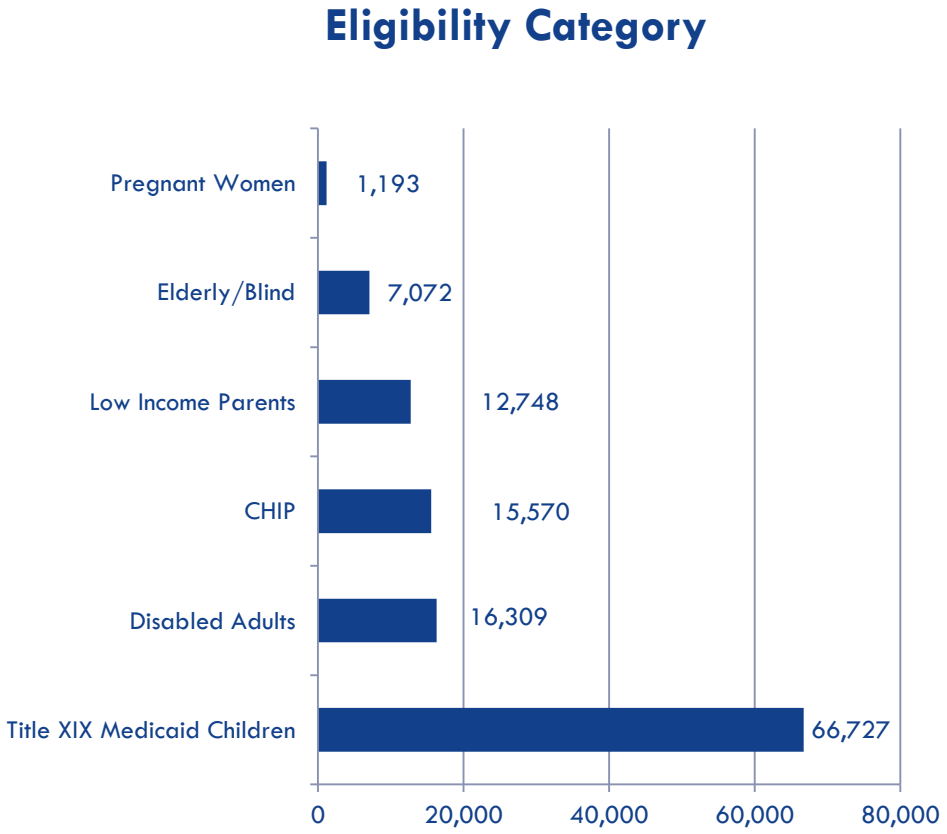
- FMAP- Federal Medical Assistance Percentage
  - Determines how much the federal government pays for Medicaid services.
  - Most administrative services are paid at 50% state match.
  - Services FMAP is based on the last three years of personal income, compared to other states.
  - When SD's income goes up compared to other states, the state pays more and the federal government pays less.
  - SFY18 FMAP: 55.34%. For every dollar of Medicaid expenditures the state will pay about 45 cents.
  - Every 1% change in FMAP equals about $7.5 - $8 million general funds.

Medicaid Expenditures & Enrollment

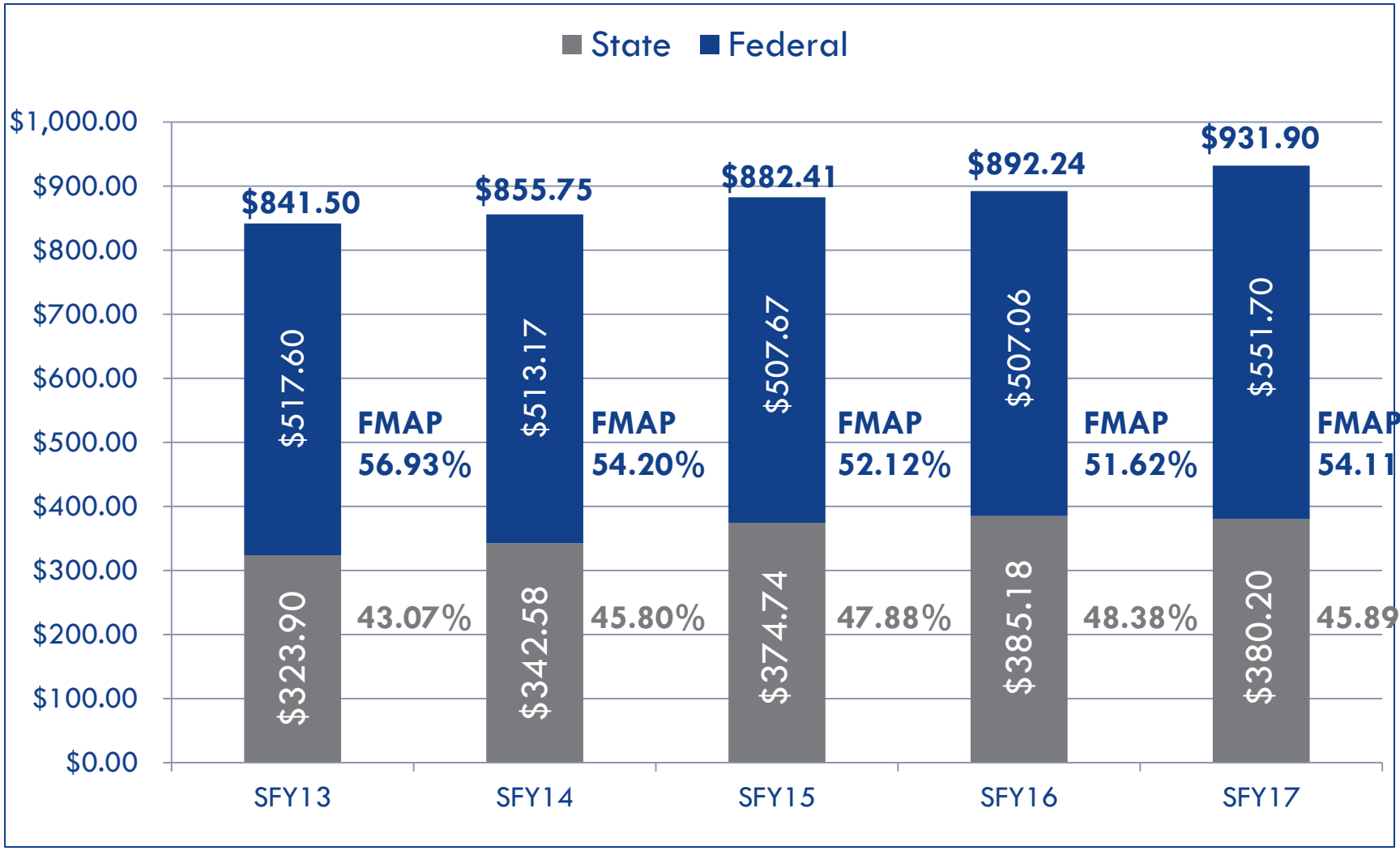
Medicaid Enrollment & Expenditures SFY17



Medicaid participation by eligibility category, SFY17

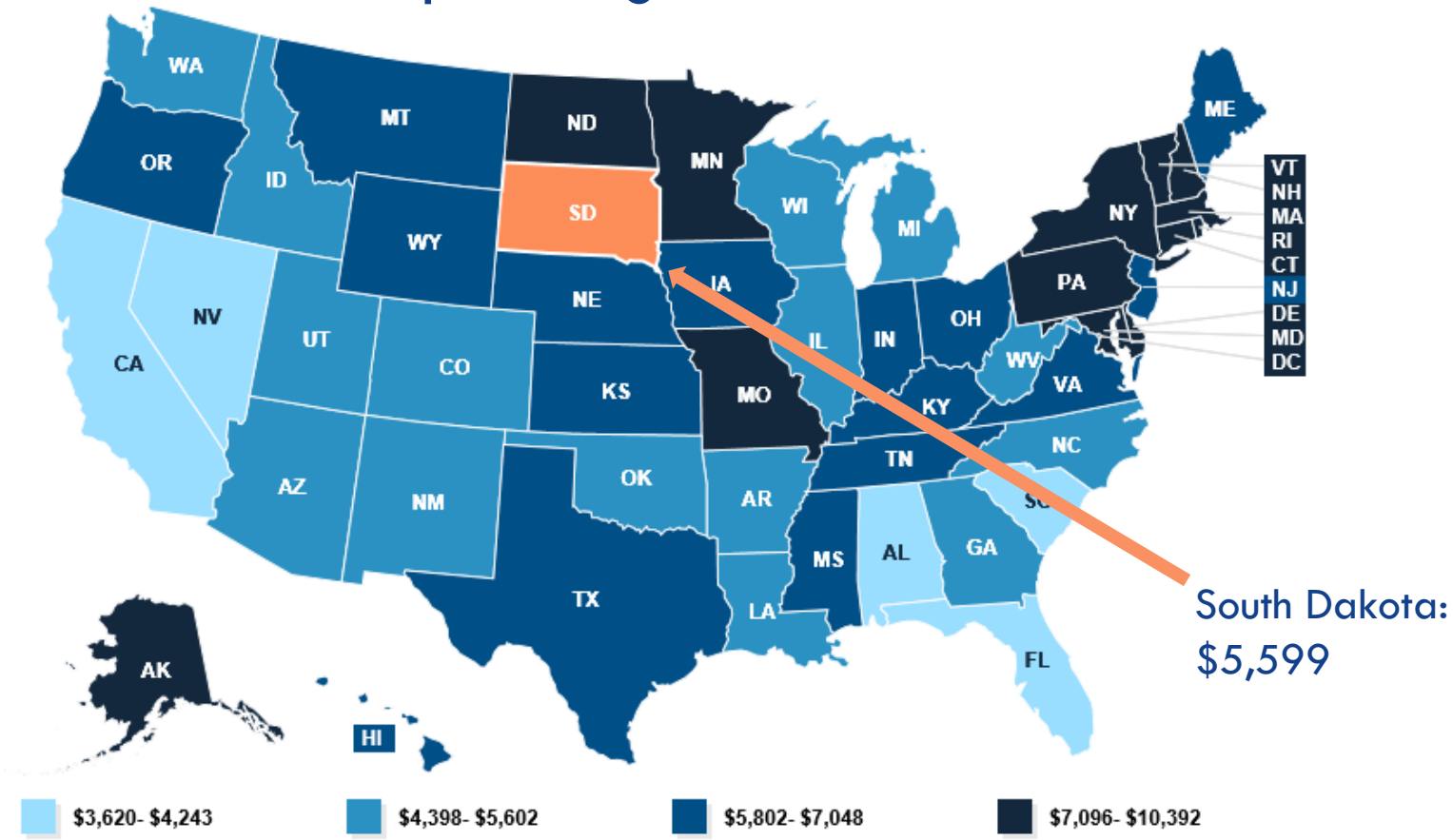


Medicaid Expenditures



Medicaid Expenditures

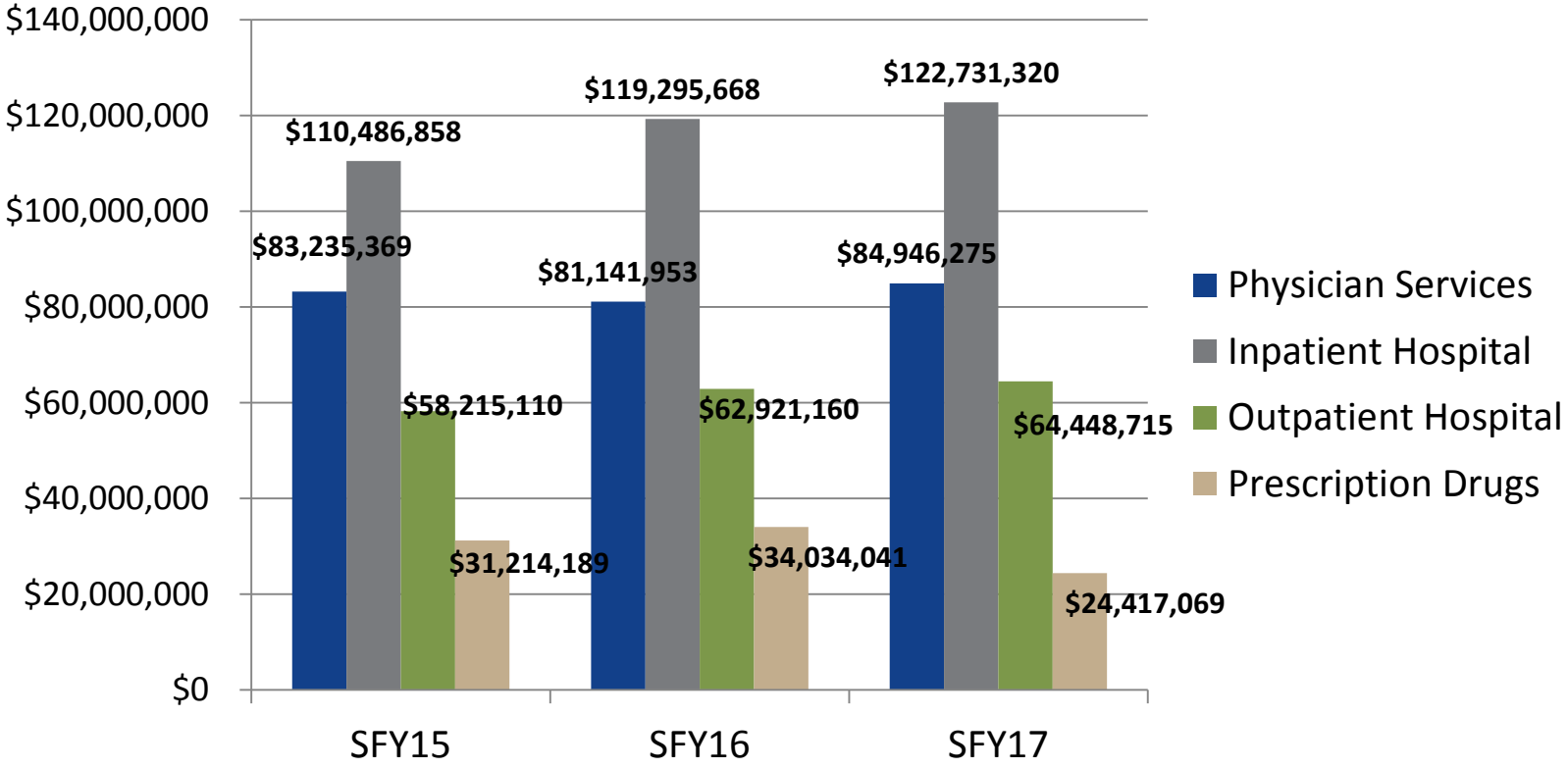
- Medicaid Spending Per Enrollee



Henry J. Kaiser Family Foundation (2014 report)

Medicaid Expenditures

- Certain health care services represent the largest share of the Medical Services budget. These are sometimes referred to as "The Big 4."



Majority of Expenses by Provider

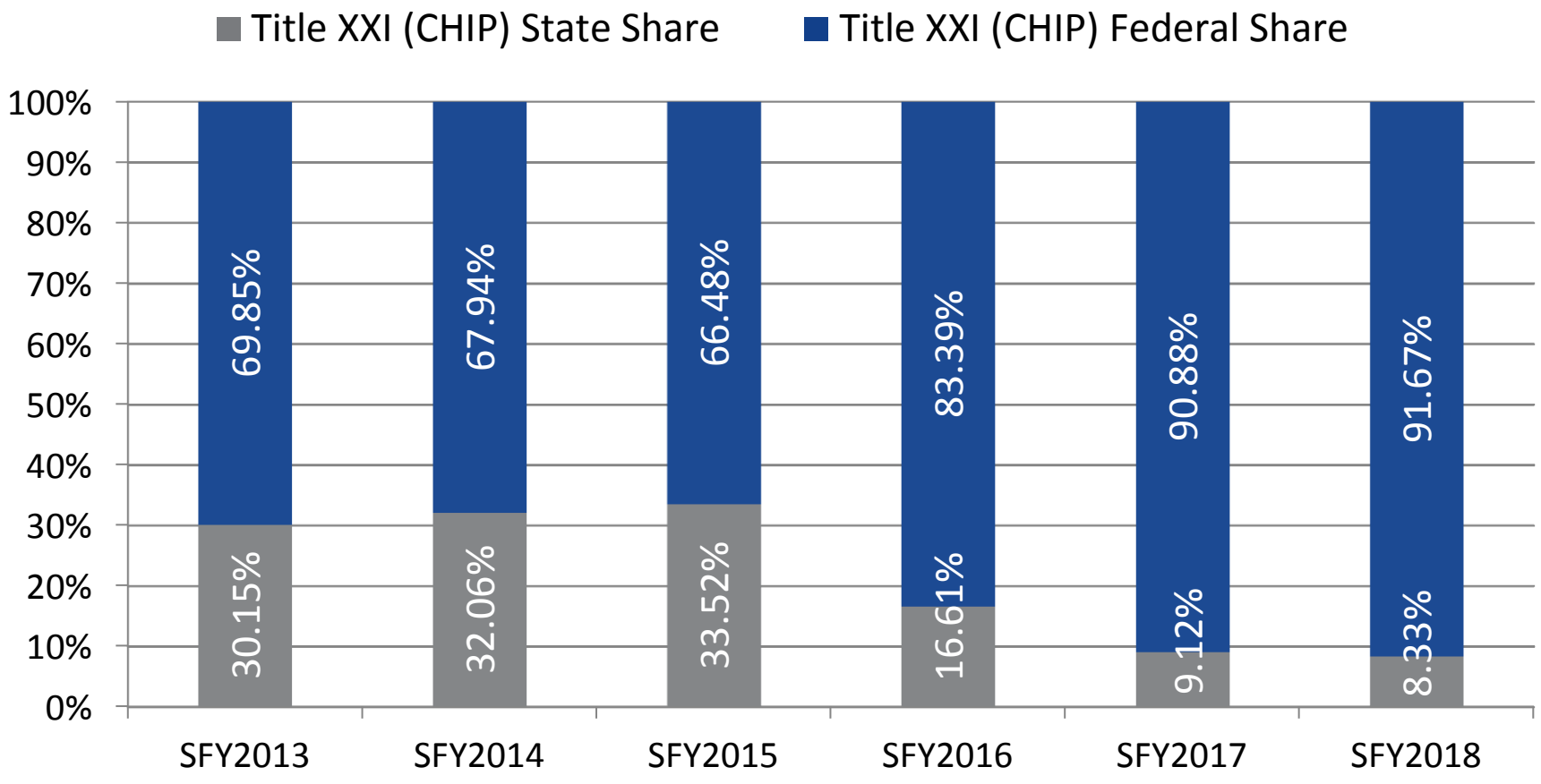
Provider	SFY17 (Millions)	% of Total
Hospital	$217.10	23.3%
Nursing Homes/Assisted Living Providers/Hospice	$158.80	17.0%
DHS Community Support Providers	$131.00	14.1%
Physicians, Independent Practitioners and Clinics	$107.40	11.5%
Indian Health Services	$69.40	7.4%
South Dakota Developmental Center and Human Services Center	$36.10	3.9%
Pharmacies	$27.60	3.0%
Substance Abuse, Mental Health, Other Community Based Providers	$20.20	2.2%
Psychiatric Residential Youth Care Providers	$30.80	3.3%
Dentists	$23.20	2.5%
Durable Medical Equipment Providers	$11.20	1.2%
In-Home Service Providers for the Elderly and Skilled Home Health	$12.80	1.4%
Emergency Transportation	$9.90	1.1%
Other (Part A, B, D Premium Payments, Administration, etc)	$76.40	8.1%
	$931.90	100%

Children's Health Insurance Program (CHIP)

- Unlike Medicaid, CHIP (Title XXI) is a block grant with a fixed amount of annual federal funds provided to each state.
  - Annual Federal Grant: $27.5 million
  - SFY17: 15,570 children (monthly average)
- South Dakota CHIP and Medicaid programs mirror each other (i.e., same services and programs).
- Federal share averages 13% - 15% higher than Medicaid FMAP.
  - Affordable Care Act provided a temporary additional 23% increase (for a total of 36%) to the CHIP match rate - ends Sept. 30, 2019.
    - Annual general fund impact of additional 23% is $7 - $7.5 million.

Children's Health Insurance Program (CHIP)

- SFY18 CHIP State Blended Match Rate: 91.67% federal – 8.33% state



*SFY16 - SFY18 include temporary additional 23% federal share.

Program Management

Program Administration

Processing Over 5M Medical Claims	Medicaid State Plan	Program Integrity	Provider Enrollment & Screening

Medical Cost Management

Primary Care Case Management	Health Homes for the High Cost Patients with Chronic Conditions	Prior Authorization	Case Tracking For Inpatient Stays	Premium Assistance for High Risk Pregnant Women	Money Follows the Person (MFP)

Pharmacy Management

Prior Authorization and Drug Utilization Review	High Rate of Generic Drug Utilization (85% Compared to National Average of 80%)	Maximize Drug Rebates from Pharmaceutical Companies

Program and Cost Management

- Primary Care Case Management (PCCM) program:
  - 80% of SD Medicaid's population is required to participate including children, low income families, pregnant women and certain disabled recipients.
- Health Home program:
  - Comprised of about 6,000 people on average, with high cost chronic conditions and risk factors.
- Patient Responsibility (copayments):
  - Subject to specific federal guidelines.

Third Party Liability and Fraud Prevention

- Collected $8.4 million in SFY17.
  - < 1% of collections are fraud related.
  - General fund share of collections deposited to the state general fund.
  - Federal share returned to the federal government.
- Medicaid Fraud Control Unit:
  - SFY17 recoveries: $295,252
- Exempt from recovery audit contractor requirement due to low payment error rates. South Dakota is the only state in the nation to receive continuous exemption since 2010.

Medicaid Waivers

Medicaid Waivers

- Using a waiver, states can change some basic rules of Medicaid related to things like access to services, level of care requirements, services provided or populations served.
- Waivers are often directed at groups of people who might need extra services, like people with disabilities or older adults to keep them out of institutions.
- Waivers also must be "budget neutral" (i.e., not projected to cost more than status quo). This requirement significantly limits waiver awards.

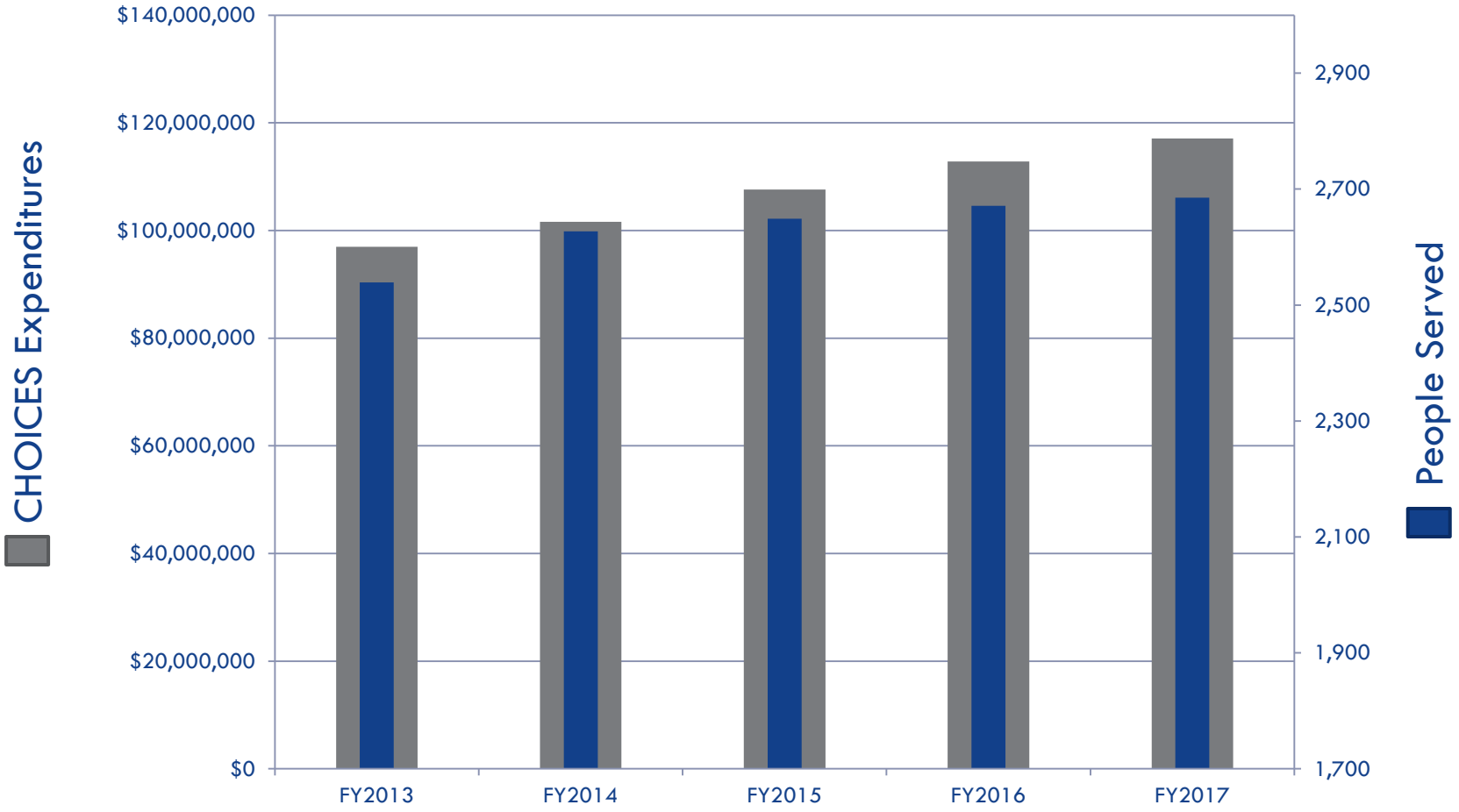
Medicaid Waivers

- **Section 1115** Medicaid waivers provide states an opportunity to test new and existing ways to deliver and pay for health care services in Medicaid.
- **Section 1332** Waivers allow states to waive certain provisions of the Affordable Care Act such as requirements related to the essential health benefit, metal tiers of coverage (bronze, silver, gold).
- **Section 1915(c)** Waivers offer flexibility to provide home and community-based services to enrollees who would otherwise need institutional care.
- The Department of Human Services administers four Home and Community-based Services (HCBS) waivers.

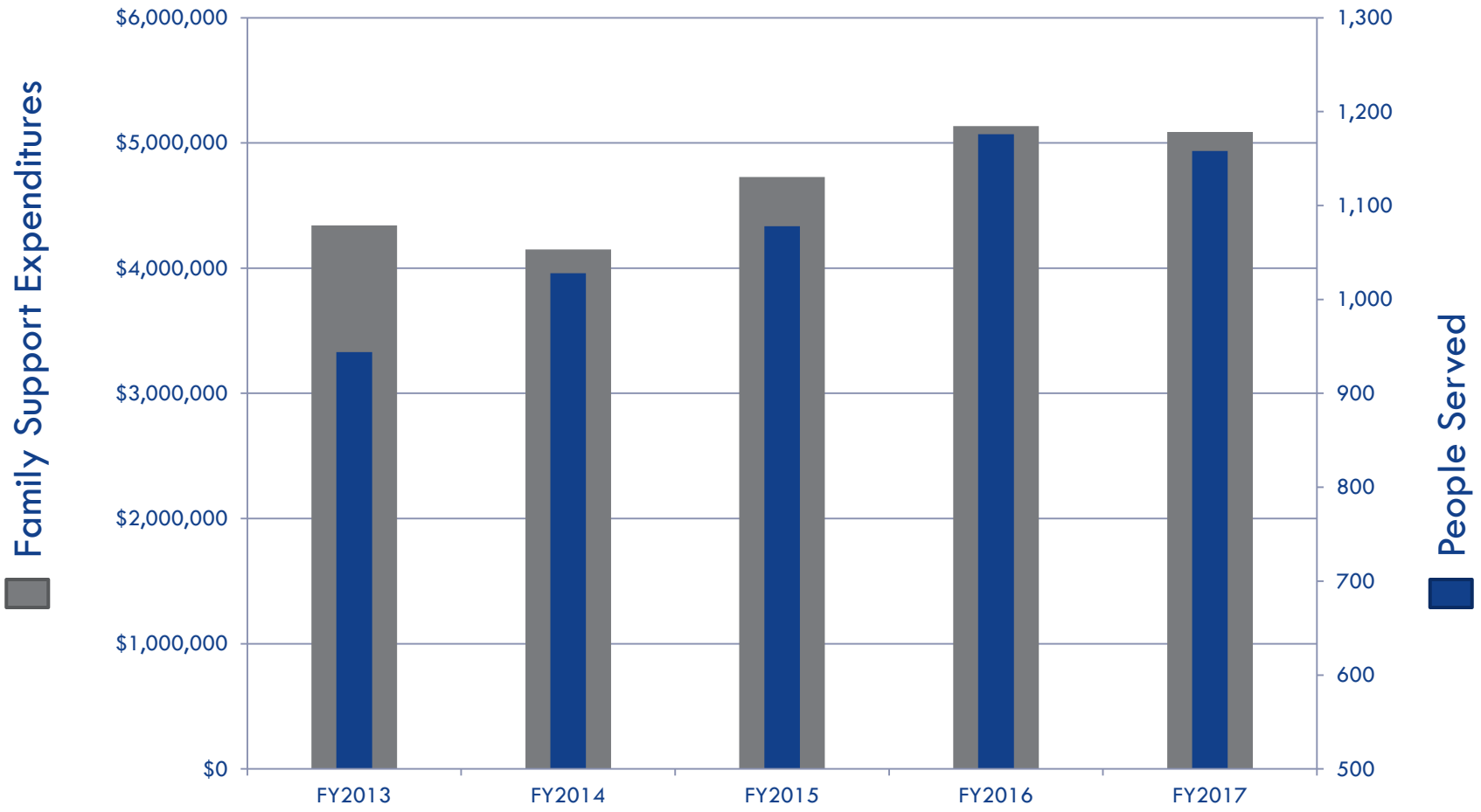
Developmental Disabilities

- The Division of Developmental Disabilities administers two 1915(c) HCBS Medicaid Waiver Programs - CHOICES and Family Support 360 waivers.
- The CHOICES and Family Support 360 waivers authorize the state to use Medicaid funding to support people to live in the community rather than in an intermediate care facility (i.e., South Dakota Developmental Center)
- Eligibility:
  - An individual must have an intellectual or developmental disability defined in law.
  - Ability to function independently is substantially limited and disability occurs before age 22.

CHOICES Expenditures & People Served



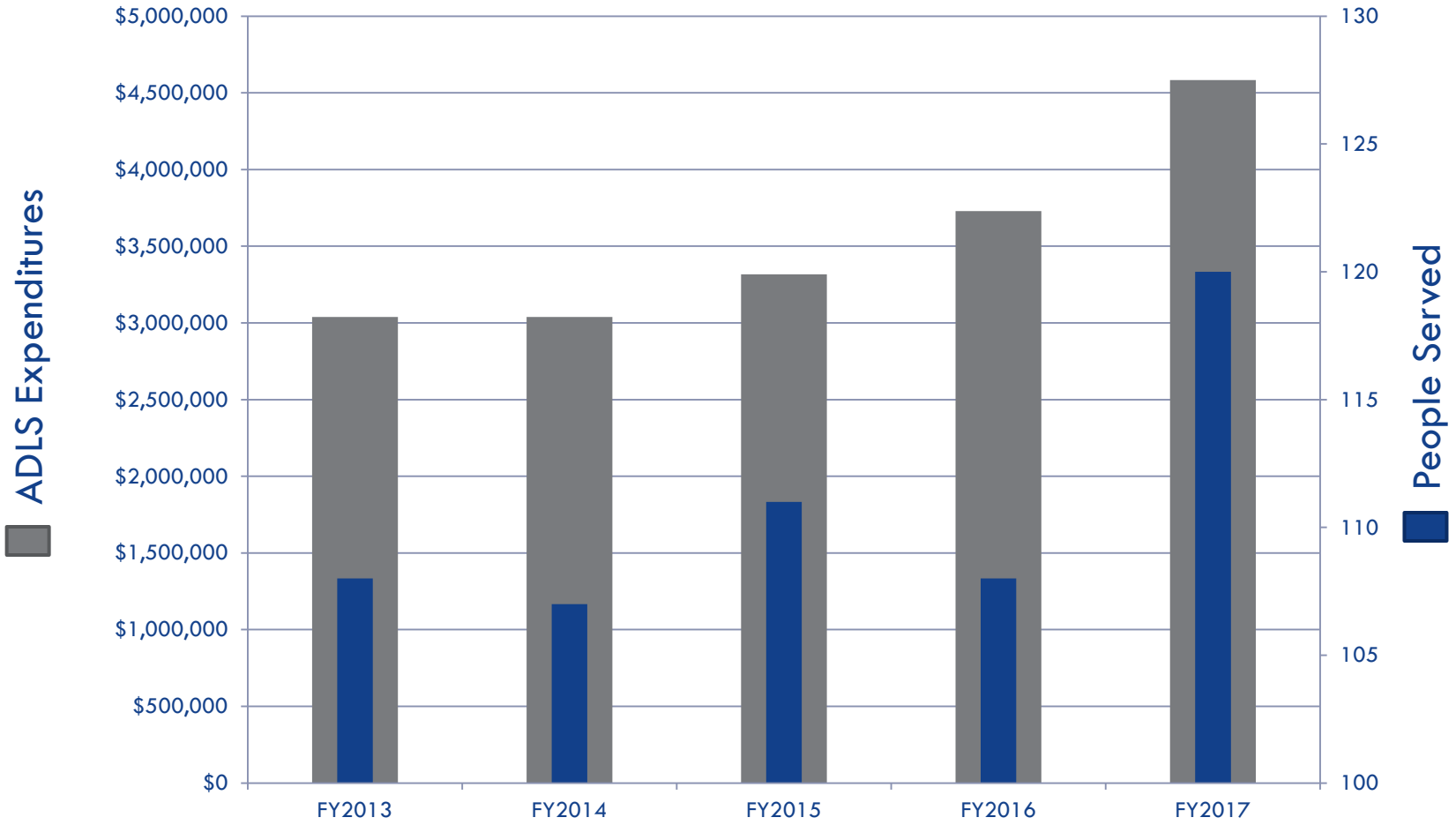
Family Support Expenditures & People Served



Assistive Daily Living Services Waiver

- The Division of Rehabilitation Services administers one HCBS waiver, the Assistive Daily Living Services (ADLS) waiver. The ADLS waiver provides personal attendant care and other services to 108 adults with quadriplegia to live independently in their own home. Budget: $4,647,525
- Eligibility:
  - Quadriplegia
  - Over 18 years of age and able to manage and direct own care
  - Requires assistance with activities of daily living

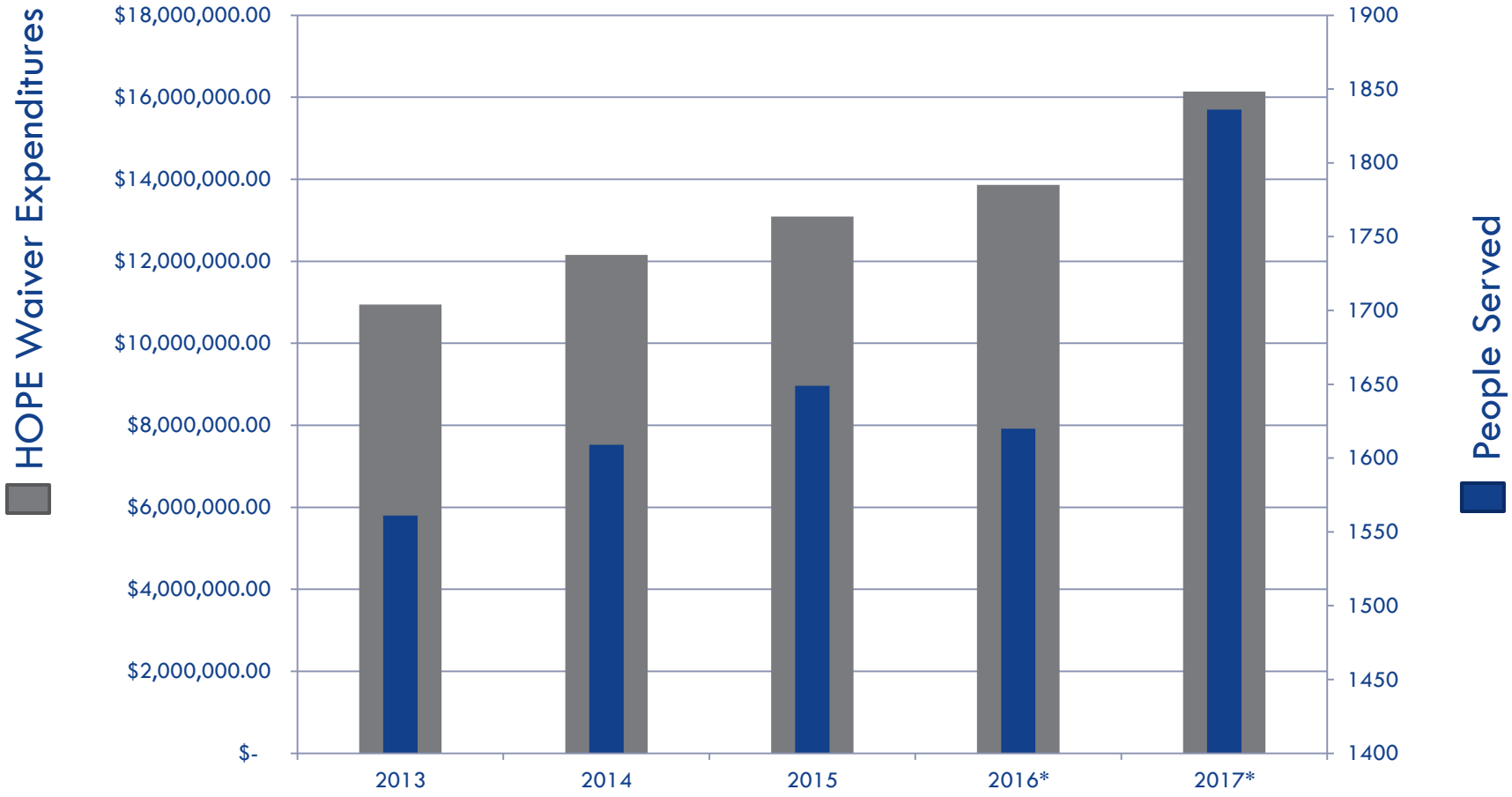
ADLS Expenditures and People Served



HOPE Waiver

- The Division of Long Term Services and Supports administers one HCBS waiver which is the HOPE (Home and Community-based Options and Person Centered Excellence) Waiver. The HOPE waiver is estimated to serve around 1,600 adults in SFY18. Implementation of the waiver allows these individuals to be supported in a less restrictive environment. Budget: $15,838,558
- Eligibility:
  - Adults aged 65 and older, or aged 18 and older with a qualifying disability who meet a nursing facility level of care.
  - Individuals must demonstrate a need for services and supports through a standard assessment and meet financial eligibility.

HOPE Waiver Expenditures & People Served



*2016 and 2017 information is 372 data not yet submitted to CMS

Medicaid Waivers

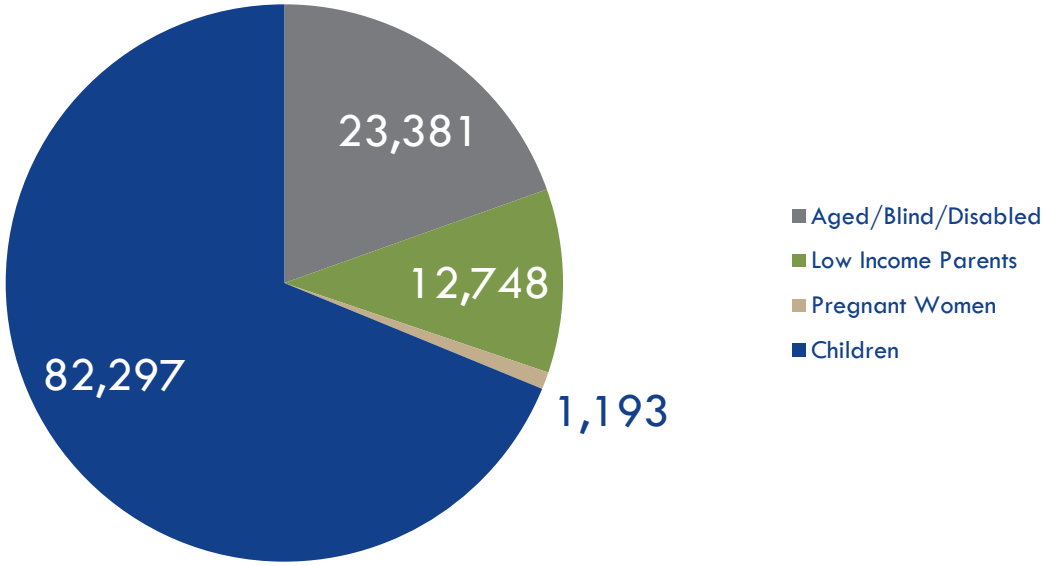
- Section 1115 Research and Demonstration Waivers:
  - Provide flexibility for states to test new or existing approaches to financing and delivering Medicaid and CHIP.
  - South Dakota has one pending 1115 waiver application to Centers for Medicare and Medicaid Services (CMS). This was recently submitted at the request of CMS to align regulatory authority from the Medicaid State Plan to waiver authority.
  - Exploring other opportunities including alternative service delivery models with Federally Qualified Health Centers.
  - Exploring opportunities to apply for an 1115 waiver to use Medicaid funding for inpatient substance use disorder treatment. Absent a waiver, Institute for Mental Disease (IMD) exclusion prohibits use of Medicaid in facilities greater than 16 beds.

Promoting Work

- Federal regulations currently prohibit work requirements as a condition of eligibility for Medicaid.
- CMS has recently indicated they would consider flexibility in this area using 1115 waiver authority.
- A work component could be implemented as voluntary or mandatory using an 1115 waiver.
  - Five states have a voluntary program
  - Seven states have submitted 1115 waivers – mandatory
    - To date – no states have been approved
- The states referenced above have expanded Medicaid coverage to childless, non-disabled adults or already cover adults up to 100% FPL.

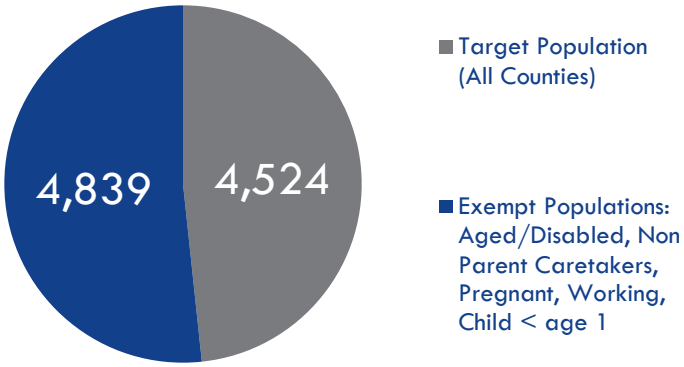
Promoting Work

- South Dakota does not cover able bodied, childless adults; therefore, the number of individuals is relatively small.
- SFY17 Average Monthly: 119,619



Promoting Work

- South Dakota is proposing to apply for an 1115 waiver demonstration that would mandate certain parents in the low income parent coverage group to participate in an intensive employment and training program as a condition of eligibility.
- Targeting to start the program in July 2018 as voluntary while awaiting approval of 1115 waiver.
- Target population:
  - Able bodied parents with children age 1 or older. Using data for a monthly period:



Promoting Work

- Proposing a two year pilot in Minnehaha and Pennington counties where there is the greatest availability of jobs and employment and training resources; estimated to impact 1,300 recipients.
- Participants would be automatically enrolled in intensive employment and training services with the Department of Labor and Regulation (DLR).
- DLR would provide individualized and supportive services to assist in addressing barriers and connecting participants to employment and training services.

Promoting Work

- Waiver would include transitional services so as family income increases, families can transition successfully from the program.
  - Transitional child care assistance.
  - Transitional Medicaid coverage including potential for premium assistance for employer sponsored coverage.
- Targeting July 2018 to submit 1115 waiver application.

"Received-through Policy:" Maximizing Federal Funding

IHS and 100% FMAP

- People can be eligible for IHS **and** also Medicaid eligible.
  - When an American Indian is Medicaid eligible and gets services through an IHS Facility, IHS bills Medicaid, and the federal government pays 100%.
  - When an American Indian is Medicaid eligible and gets services outside IHS, the non-IHS provider bills Medicaid and the federal government pays about 55%, and the state pays the balance.

100% Federal

55% Federal 45% State

Care for American Indians

- When services are not "received through" IHS, the state must pay for services that are supposed to be provided by the federal government.
- This trend is growing:
  - $74.7 million in state funds in SFY2014
  - $85.0 million in state funds in SFY2015
  - $92.7 million in state funds in SFY2016
  - $96.9 million in state funds in SFY2017

Care Outside IHS by Service Type, SFY17

	Actual SFY17 General Funds (in millions)	Projected SFY18 General Funds (in millions)
Administrative	$2.3	$2.2
Referred Care by I.H.S.	$7.8	$7.6
FQHC Direct and Referred	$8.4	$8.1
Nursing Home, CSP, PRTF	$19.3	$18.8
Hospital Care Coordination	$33.2	$32.4
Physician	$9.9	$9.7
Other (dental,vision, Medicare premiums, etc)	$16.0	$15.7
Total	**$96.9**	**$94.5**

Federal Policy Change

- February 2016: Health and Human Services changed national **Medicaid funding policy** to cover more services for IHS eligibles with 100% federal funds.
  - More services now considered eligible through IHS.
  - Participation by individuals and providers must be voluntary.
  - Services outside IHS must be provided via written care coordination agreement.
  - IHS must maintain responsibility for the patient's care.
  - Provider must share medical records with IHS.

Federal Policy Implementation

- Start with Administrative and Referred Care
  - Target six largest providers: three Systems, three Dialysis providers.
  - Total $6.76 million savings to current general funds budget.
  - Use savings to support provider participation and reinvest in health care.

Federal Policy Implementation

- With savings, will accomplish the following in SFY19:
  - Address service gaps in Medicaid program
  - Share savings with participating providers
  - Increase rates for Medicaid providers

Federal Policy Implementation

1. Address service gaps in Medicaid program - $1.2m in SFY19

- Substance Abuse: add services for 1,900 adults
  - Cost: $872k
- Mental Health providers: add Licensed Mental Health and Family Therapists to serve 465 people - two quarters of SFY19
  - Cost: $265k
- Community Health Workers: add services to serve 1,500 people - one quarter of SFY19
  - Cost: $100k

Federal Policy Implementation

2. Share savings with participating providers - $630k in SFY19

- Amount of payments tiered to level of savings
  - $0-$500k 5%
  - $501k-$1m 10%
  - $1m+ 15%
- Will leverage federal Medicaid funds if possible
- Total incentive for providers = $874,000

Federal Policy Implementation

3. Increase rates for Medicaid providers - $2.7m general in SFY19

- Community-based providers to 90% of costs
- Complete three year plan
- Increases for assisted living, in-home services, emergency transportation, group care, outpatient psychiatric services

Federal Policy Implementation

Strategy	SFY19 Partial Implementation	SFY20 Full Implementation
Add Substance Abuse Services	$872k	$872k
Add Mental Health Providers	$265k	$540k
Add Community Health Workers	$100k	$400k
Innovation Grants-Prenatal and Primary Care		$1m
Shared Savings with Providers	$630k	$800k
Provider Rates	$2.7m	$3.1m
Total	$4.6m	$6.7m

Federal Policy Implementation

- Next Steps

1. Expand policy implementation
   - Develop IHS referral mechanism for other services
   - Expand to other provider groups in SFY19/SFY20
     - Community support providers, nursing homes, psychiatric residential treatment facilities
     - Expand to other services for hospital based services
2. Continue to share savings with participating providers
3. Continue to enhance provider Medicaid rates

Questions?