Shared Savings

Providers, including IHS, have to make changes and need incentive to implement the policy. The state has agreed to make an annual payment to providers based on general fund savings generated by providers. This is referred to as shared savings and is calculated each state fiscal year.

Shared Savings Distribution

State Savings Amount:	$0-500,000	$500,000-$1M	>$1M
Shared with Provider:	5%	10%	15%

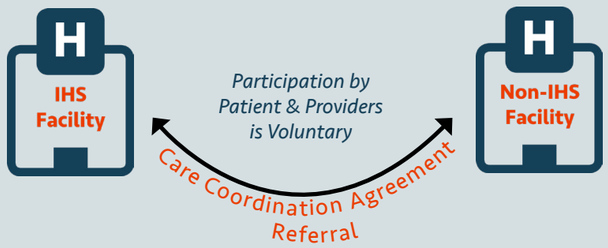
- Providers' proportionate share is distributed as follows:
  - If the state is able to realize general fund savings of $500,000 or less, the state will make a payment of 5% of the total state general fund savings and applicable federal matching funds to the provider.
  - If the state is able to demonstrate a general fund savings of $500,001 to $1,000,000 the state will make a payment of 10% of the total state general fund savings and applicable federal matching funds to the provider.
  - If the state is able to demonstrate a general fund savings of $1,000,000 or more, the state will make a payment of 15% of the total state general fund savings and applicable federal matching funds to the provider.
- Payments to IHS will utilize state general funds. Payments to providers may be matched with federal dollars.
- After sharing savings with participating providers, the state can use remaining savings to increase Medicaid provider rates.

Nursing Homes, Psychiatric Facilities & Community Support

Status: In Process of Implementation
Actual General Fund Expenditures
SFY 2018: $19M
SFY 2018 Residents: 450 Nursing Home, 264 Psychiatric Residential Patients, 406 Community Support Providers (CHOICES & Family Support)

Approximately 450 dual eligible American Indians are residents in long term care facilities, costing South Dakota approximately $16.3M every year.

The goal is to have Care Coordination Agreements in place with long term care facilities that care for American Indian residents.



100% FMAP
$19.3M savings to the state and no change in reimbursement to provider.

Medicaid in South Dakota

Continue to Leverage the Healthcare Solutions 100% FMAP

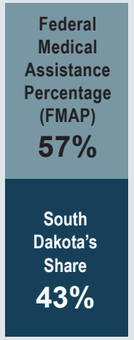
What is FMAP?

Medicaid is jointly funded by the federal government and each state.

The federal government's share of Medicaid is called the "**Federal Medical Assistance Percentage", or FMAP**. The FMAP is displayed as a percentage and is calculated each year based on the median income for each state.

Currently, the FMAP for South Dakota is 57%, meaning that for every $100 of Medicaid expense, the federal government pays $57 and the state's share is $43.
The higher the FMAP, the more money "saved" by the State of South Dakota.

Medicaid is Paid for by Federal & State Governments



Indian Health Service (IHS)

American Indians are eligible for free medical services at Indian Health Service (IHS) facilities. The FMAP for IHS services is 100%, meaning the federal government pays 100% of the cost and the state pays nothing.

Many American Indians are "dual eligible," meaning they qualify for IHS services and Medicaid services. Sometimes an IHS facility doesn't have the skills, providers or equipment to provide the necessary services and refers the patient to a non-IHS facility.

When an American Indian receives services at a non-IHS facility, the federal government pays 57% of the cost of care and the state is responsible for 43% of the cost. Fortunately for South Dakota, the Medicaid funding policy changed in 2016 for IHS patients who are referred to a non-IHS facility.

South Dakota Association of Healthcare Organizations

2016 Medicaid Funding Policy

In 2016, the federal government changed the policy regarding American Indians who are referred to a non-IHS facility.

- No longer limited to services provided in IHS facilities only.
- May apply to more than specialty care services, including transportation, pharmacy, hospital and long term care services.
- Maintains IHS responsibility to provide health care to American Indians.

The change makes it possible for states to receive 100% FMAP when an American Indian is referred to a non-IHS provider.

When services are not "received through" IHS, the state must pay for services that are supposed to be provided by the federal government. In state fiscal year (SFY) 2018, $64M was funded at 100% FMAP at IHS; $205M was funded at the regular FMAP (45% state, 55% federal).

- $74.7 million in state funds in SFY 2014
- $85M in state funds in SFY 2015
- $92.7M in state funds in SFY 2016
- $97M in state funds in SFY 2017
- $86M in state funds in SFY 2018

In order for the federal government to pay 100% of the cost of care when an American Indian is referred to a non-IHS facility, a Care Coordination Agreement must exist between the IHS facility and the non-IHS facility.

There are four conditions of a Care Coordination Agreement:

1. Participation by providers and patient must be voluntary and IHS must refer the patient to a non-IHS facility;
2. The non-IHS provider must send patient's records back to IHS;
3. IHS must maintain responsibility for the patient's care; and
4. IHS must incorporate the non-IHS medical record into the IHS record.

When all four conditions are met, the FMAP is 100%, saving the state millions of general fund dollars.

The change in FMAP does not change or impact the rate paid to providers.

Leveraging the 100% FMAP policy change saves the state millions of dollars.

[2016]

A policy change in 2016 now allows the State to be reimbursed at 100% FMAP if a Care Coordination Agreement is in place between the IHS facility and the receiving non-IHS facility.

Care Coordination Agreement Conditions:

1. IHS must refer patient to non-IHS facility;
2. Non-IHS provider must send records back to IHS;
3. IHS must maintain responsibility for patient's care; and
4. IHS must incorporate non-IHS medical record into IHS record.

Funding is prioritized to address service gaps in Medicaid, increase provider rates and share savings with providers.

Referred Care by IHS

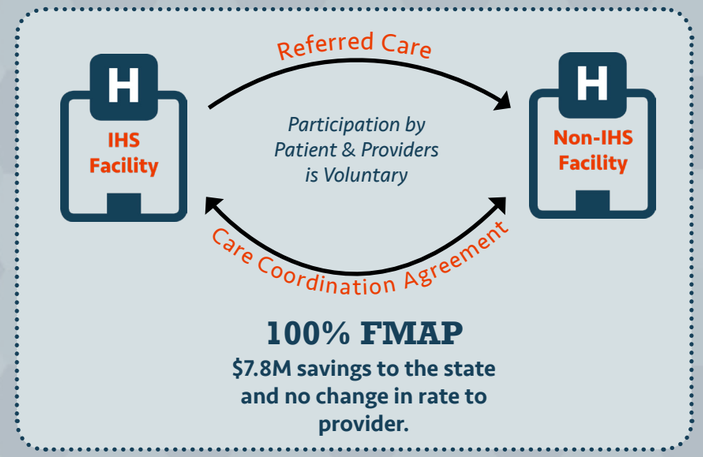
Status: Implemented
Savings SFY 2018: $4.6M
SFY 2017 Patients: 6,500
SFY 2017 Providers: 18 (3 health systems, 3 dialysis providers and administrative care such as prescription drugs, ambulance and non-emergency medical travel)

Implementation of the 100% FMAP policy for services that start at IHS and are referred to another provider is called "referred care."

Providers must:
- Sign care coordination agreements with IHS.
- Share medical records with IHS.

IHS must:
- Sign care coordination agreements with providers.
- Maintain responsibility for patient care.
- Accept medical records.

State tracks:
- Care coordination agreement status and ensures appropriate billing.



100% FMAP
$7.8M savings to the state and no change in rate to provider.

Address Service Gaps in Medicaid

Providers participating in Care Coordination Agreements are not entitled to any portion of general fund savings until the state, within each state fiscal year, realizes from participating providers a total of $3M in general fund savings. The state will use the first $3M of general fund savings for service gaps for substance abuse services, mental health services, community health services, prenatal and primary care for American Indians.

First **$3M Savings** Used To Fund

Service Gaps For American Indians:

- **Substance Abuse Services**
- **Mental Health Services**
- **Community Health Services**
- **Prenatal and primary care**

Once enough general fund savings in the existing Medicaid budget are available to fund the service recommendations listed above, the savings in excess of $3M will be shared on a tiered basis with participating IHS and non-IHS providers (see back page for details.)