

Dear Chairwoman Hunhoff, Vice Chairman Tidemann and Members of the Interim Committee,

Thank you for the opportunity to spend time with you on August 17 and August 18 to participate in your very important work of developing Medicaid payment methodologies that incentivize valued outcomes and that assure South Dakota's compliance with Title II of the ADA and the Olmstead Supreme Court decision as well as compliance with the CMS final rule for Home and Community Based Services (HCBS) "settings" to be fully integrated into the community, for all Medicaid beneficiaries. As the policy makers for the State, you have the responsibility and ability to focus the Medicaid purchasing power on what you want to buy for Medicaid beneficiaries. Providers play a key role as the intermediaries between the taxpayer and the beneficiary, but their role is tied to your policy directions and decisions.

As we discussed, individuals with disabilities, individuals experiencing mental health conditions and senior citizens represent disproportionately higher users of Medicaid services due to their higher incidence of acute health care conditions and their use of long term services and supports (LTSS), thus resulting in significant costs. Therefore, my recommendations will focus on these populations, which is consistent with the majority of testimony that was presented to you by witnesses on August 17th.

The items of "low hanging fruit" represent a diverse set of strategies for short to medium term action. I encourage you to explore the following items:

1. Review the South Dakota Nurse Practice Act and its rules to determine what is necessary to add the five tasks that are delegated to staff trained and supervised by nurses in many other states as depicted in the slides I presented to you. This change in policy and practice will allow more effective and efficient use of the limited number of nurses you have in the work force and reduce costs for those five services in order to make funds available for rate increases and/or additional services.
2. Explore the expansion of your Telehealth System to include more than Medicaid funded psychiatry services in order to expand access to specialty clinical services, reduce travel time on beneficiaries and improve efficiency in the use of your limited number of medical and allied health clinicians.
3. Review the array of services within your aging and disability Medicaid 1915 (c) HCBS waiver to be certain that the full range of HCBS necessary to assure individuals can continue to live at home in the community as long as possible are included with particular reference to payment for family members/neighbors, caregivers and expanded access to the full range of assistive technology and devices (in addition to the very good menu of durable medical equipment described by one of your witnesses) that promote independence for the beneficiary and reduce caregiver burden (fiscal and physical) and/or the use of paid assistance. South Dakota currently pays family caregivers in your HCBS waiver for individuals with developmental disabilities. These changes will enhance your HCBS utilization and thus have an impact over the next few years of reducing your nursing home and assisted living utilization and costs and improve the cost efficiency and cost effectiveness of your Medicaid LTSS funding. (Please review the website, WWW:Simply-Home.com to see some of the work being done with assistive technology to empower individuals to continue to live at "home" with a variety of off the shelf and customized technology and apps that can be paid for by Medicaid.)
4. Expand training for the service coordinators/case managers within the Aging and Disability Resource Centers (ADRCs) to raise their expectations about the possibilities for adults with disabilities and seniors to live good lives in the community with an enhanced menu of HCBS and supports. They have great difficulty today to offer individuals "real choice" given the data in the Abt report stating that over 6-7

years, the state has not made a significant increase in the availability of HCBS for these two populations and is one of the lowest users of these services in the country.

5. Review your payment methodologies and the use of cost reports to be certain that they are in compliance with the heightened scrutiny that CMS has been applying to rates and reimbursement methodologies during the past five years. I also encourage you to look at methodologies other than fee for service wherever and whenever possible to assure providers an episodic or milestone or performance outcome payment that requires less day to day documentation and does not encourage increasing billing for units of service in order to cover costs. The witness that described the difference in Medicaid payment methodology for her services (tied to Medicare standards as I recall) for the 44-year-old woman/mother with health issues and disability from Multiple Sclerosis compared with the hospital made the case for the critical work you have ahead of you to assure that HCBS can be the priority and real choice for everyone.

6. Decouple your Medicaid standards for home health services and related supports in the home from the Medicare standards. Medicare has no major stake in avoidance of long term facility based/institutional services since Medicare only pays for time limited post-acute rehabilitation services in a nursing home.

7. As you explore provider rate increases, which you indicated a willingness to do in order to increase wages for staff recruitment and retention, be sure to link the wage and rate increases to increased provider qualifications and performance based/certification of competency to do the work. As I mentioned in my testimony, the witness who testified from the substance use program on April 17th provided a superb example for "best practice" staff development by stating the procedures used when his organization hires a new employee. His agency provides training, coaching, mentoring, shadowing and documentation of competency and performance for which the employee is then held accountable for that level of performance by their supervisor. Nationally developed curricula are continuing to be made available in the marketplace in each of the population categories and they should be carefully explored for costs and return on investment by higher quality performance and reduced staff turnover, one of the largest hidden costs of human service organizations. (Please review the website WWW:NADSP.org to review the work done by the National Alliance of Direct Support Professionals with well-developed and validated curricula for individuals working at the hands on level with persons with developmental disabilities. I suspect that a contact to their office will produce information on comparable organizations developing similar performance based training curriculum for direct support staff and their supervisors for you to review.)

8. Explore the use of Medicaid funding to expand community mental/behavioral health services and supports with an initial focus on peer-to-peer services, an evidence-based practice recognized by the Substance Abuse and Mental Health Services Administration and allowable by CMS for Medicaid funding under several options, including the Rehabilitation State Plan Option currently in use in South Dakota for some community mental/behavioral health services.

9. All of the above cannot be done successfully without the availability of reliable, valid and real time data for the Executive and Legislative branches. I recommend that you explore the CMS 90/10 matching funds available for contemporary IT systems for Medicaid for which I provided you with the CMS letter to State Medicaid Directors.

10. Explore joining the states that now are enrolled in the new version of the National Core Indicators (NCI) for the Aging and Disability populations (NCI-AD) that has been funded by and endorsed by the Administration on Community Living within the U.S. Department of Health and Human Services, as I referenced in my testimony and slides. South Dakota is a participant in the NCI program for state agencies serving individuals with developmental disabilities (NCI-I/DD). These data will provide you with in state provider comparison data as well as aggregate state to state comparison data.

11. One additional strategy that you may wish to explore is in the area of health prevention for individuals with disabilities and individuals who are aging. We know that early detection and intervention is another win-win for the person and the Medicaid program. A web-based tool that is internationally validated for multiple populations from its original development for individuals with developmental disabilities is the Health Risk Screening Tool developed by Karen Green-McGowan, R.N., a very well respected nurse who has been used by the Department of Justice as an "expert witness" on individuals labeled as "medically fragile". The HSRT can be administered by family members and personal care staff. You can learn more about it at [HTTP://HRSTONLINE.com](http://hrstonline.com)

In the next phase, I suggest that you consider the following strategies:

1. Explore the use of the Medicaid 1915 (k) Community First Choice personal assistance state plan amendment, which provides a permanent 6% increase in the federal matching ratio. This service could replace a number of services currently paid for in home health care, personal care, the Rehabilitation Option for mental health services and similar support services in your HCBS waivers, reducing costs in those service categories and refinancing them with an 6% higher matching rate. The eligibility standards will have to be carefully drawn since the 1915 (k) is an "entitlement" to all eligible individuals. A number of states are well along in its implementation including Oregon and California. One of the most recent states to adopt this State Plan Service amendment is Connecticut.

2. Affordable, accessible, safe and decent housing is a critical component of life in the community and Medicaid does not pay for housing. I recommend major conversations between the State Housing Finance Authority and the Medicaid agency as well as with the branches of the Department of Social Services to pursue federal funds and investor tax credits to assure that housing is in place with particular emphasis on Supportive Housing for individuals with mental illness. CMS now has agreed to pay for many of the supportive services in supportive housing situations and I have provided you with a new publication from the Technical Assistance Center and the National Association of Behavioral Health that provides many examples for the legal use of Medicaid funding.

3. Employment and career development are key social determinants of health as is housing. As we discussed and as presented in my slides and the Iowa Policy Brief that has been sent to you, the compelling data from Iowa clearly indicate that claims for Medicaid acute care and outpatient mental health claims decrease significantly when a person receiving Supplemental Security Income (SSI) engages in competitive integrated employment. The responsibility for employment services does not belong to Medicaid; however, Medicaid has a role to play and has a huge stake in the outcomes over the course of the individual's adult life. As a result of the Workforce Investment and Opportunity Act (WIOA) enacted in July 2014, the state Rehabilitation agency must enter into formal MOUs with the state Workforce Agency, Medicaid agency, DD agency, Mental Health agency and the Department of Education to define how the agencies will divide the responsibilities for employment services leading to competitive integrated employment (including self-employment) for individuals with disabilities, including those individuals with the most significant disabilities. The target population for a portion of

the Rehabilitation Act funding is youth ages 14-24 given the huge impact their employment will have on their lives and reducing their LTSS costs from Medicaid funding over their lifetimes. I recommend that the Interim Committee review the MOUs to be confident that a strong plan with meaningful interagency collaboration is in place to maximize the use of all public funds (Rehabilitation Act funding is about 80% federal) that result in increasing the number of South Dakotans who are competitively employed and developing careers, having greater self-esteem and valued roles in the community and reducing dependency on the public dollar.

As part of this Employment First initiative in South Dakota, encourage the use of the Individual Placement and Support (IPS) approach to Supported Employment for individuals with persistent mental/behavioral health issues as this is an evidence-based approach from Dartmouth-Hitchcock Medical Center that has been endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is a covered Medicaid service along with vocational rehabilitation. A comparable service for individuals with developmental disabilities is Customized Employment and it has been added as a covered service in WIOA and is covered both by VR and Medicaid in HCBS waivers.

4. Develop a plan with all stakeholders for the downsizing and eventual closure of the South Dakota Developmental Center by building upon the experiences of the 15 states that no longer have any individuals with developmental disabilities residing in state facilities as well as those states that also have no or very few individuals living in public or private "small institutions" (intermediate care facilities for individuals with developmental disabilities - ICF/DD) that I provided in the slide presentation. This plan will need to include mobile crisis teams and other infrastructure components at the local/regional level as well as a plan to meet the needs of individuals at the Developmental Center with court commitments for legal offenses, etc.

If Money Follow the Person (MFP) funds are still available within the state, they can be used for the relocation process and they will provide the state with an enhanced match for the first 365 days that the person is residing in the community and can cover startup costs for housing for the individual. The long term savings from the recommended closure will be very helpful in freeing up resources for rate increases for community providers and meeting the needs of youth transitioning from school and the aging population of individuals with developmental disabilities that will be continuing as part of the changing demographics.

5. Explore the development of a Medicaid section 1115 Research and Demonstration Waiver for individuals with substance use and addiction, following the lead of New Jersey, which is currently in negotiations with CMS over this initiative as a means to expand the use of federal Medicaid matching funds for this underserved constituency.

Thank you again for the opportunity to be of service to you on behalf of the National Conference of State Legislatures (NCSL) and the Health Resources Services Administration (HRSA). I wish you well in the work plan you have ahead of you. I am confident, given your commitment to and engagement in addressing both the challenges and opportunities, that you will begin to solve the problem. I look forward to hearing good news and hope to have the opportunity to work with you and your colleagues again in the future.

Best regards.

Allan