

Increasing Access to Services Provided through Indian Health Services Subcommittee

Meeting Notes 10/7/2015

Attendees: Kim Malsam-Rysdon, Governor's Office; Stephanie Denning, HMA; Lynne Valenti, DSS; Jason Dilges, Governor's Budget Office; Jerilyn Church, Great Plains Tribal Chairman's Health Board; Kathleen Bad Moccasin, IHS; Brenda Tidball-Zeltinger, Department of Social Services (DSS); Senator Troy Heinert, Mission; Tim Trihart, Community Health Center of Black Hills; Justin Taylor, Flandreau Tribal Administrator; Bryan Slaba, Wagner Community Hospital; Rachael Sherard, Avera; Monica Huber, Sanford; Angelia Svihovec, Mobridge Hospital; Sonia Weston, Ogala Sioux Tribal Council

Opening

Kim Malsam-Rysdon opened the meeting and introduced Stephanie Denning from Health Management Associates (HMA) who will be supporting the activities of the subcommittee. The goal of this subcommittee is to increase access to services provided by Indian Health Service (IHS) and Tribal Health programs. Two of the areas for particular consideration are increasing access through 1) the use of telehealth, and 2) making more specialty services available.

Review of Information from the State Medicaid Program

The group discussed a report with South Dakota SFY 14 Medicaid Expenditures for Native Americans enrolled in Medicaid. This information includes services provided through the Division of Medical Services only and these services are funded at the regular FMAP rate of about 50%.

Brenda Tidball-Zeltinger further explained the data is presented by categories commensurate with the DSS budget (Physician; Inpatient; Outpatient, Prescription Drugs, etc.). The data shows South Dakota spent \$133.3 million in total funds (about \$64.1 million general funds) for Native Americans in SFY14. Because the services were not provided at or through an IHS/Tribal health facility, the State received the regular services FMAP rate of roughly 50% match. Only care provided to Native Americans by IHS or a Tribal Health Organization directly in their facility is eligible for 100% FMAP.

Brenda Tidball-Zeltinger also outlined another view of this same data set that outlines these expenditures among the three largest health systems in the State (Avera, Rapid City Regional and Sanford). The data is also presented by the city of residence (where the Medicaid enrollee lives) and Provider City which is the location where services were delivered (where they actually got care).

The group discussed Inpatient Hospital services, which is the largest category of Medicaid spending in this data set. Specialized Inpatient Hospital services, including neo-natal ICU, and psychiatric services are not provided by IHS/Tribal Health Organizations. There should be opportunity to request from CMS that they be matched at 100% because they are not available through IHS and given the specialized nature of the services probably won't be.

Sonia Weston asked what was included in outpatient costs. Brenda Tidball-Zeltinger clarified that the outpatient costs include emergency room utilization, specialized outpatient surgery, etc. There was a group discussion on the prescription drugs expenditure information. Medicaid and IHS/Tribal Health Organization formularies vary and result in Medicaid covering costs that could potentially receive 100%

Federal match by aligning the IHS/Tribal Health Organization and Medicaid formularies. This might be an area where the State could achieve significant savings somewhat easily. However, Kathleen Bad Moccasin noted that each IHS/Tribal service site can establish its own formulary, so it might be hard to understand exactly what is covered by each site.

Stephanie Denning asked if services delivered through hospitals out-of-state require a prior authorization. Brenda Tidball-Zeltinger explained that Medicaid does require a prior authorization, but only for hospitals more than 50 miles past the State border.

Sunny Colombe noted that emergency transportation is a big expense, and air ambulance transport is a large portion of that. Kim Malsam-Rysdon noted that the State of Alaska sent CMS a letter requesting to include EMT/NEMT in claiming protocol changes.

Jason Dilges noted that the majority of expenditures are tied to the three big systems for hospital based services but appear low for physician services. Brenda clarified that physician services are difficult to align with a specific health system depending on the contractual relationship between the physician and health system so these are likely somewhat understated.

Review of Information from IHS

The group reviewed information provided by IHS related to Purchased/Referred Care (PRC – formerly known as Contract Health Services-CHS). The group also reviewed the utilization data broken down by the service sites. The PRC services are identified by 12 categories of referred services.

Kathleen Bad Moccasin noted that IHS screens all patients for any other potential payer source and requires them to enroll if they are eligible. Kim Malsam-Rysdon also noted that providers are incentivized to help enroll anyone eligible into Medicaid and that if an individual is accessing or needs to access care, they are highly likely to be enrolled.

Kathleen Bad Moccasin explained that the information presented covered only care that was referred and paid for by PRC; it did not include any services that were denied for referral or payment. Denials are included in a different report.

Bryan Slaba noted that it would be helpful to look at both the number of patients and average inpatient length of stay (LOS) for IHS care to understand which services to target for cost savings. He pointed out that infectious diseases had a high number of patients, but also a very high average hospital LOS, so it might be a good place to explore savings opportunities through something like telemedicine. A suggestion was made to look at the Medicaid data for the same categories as the PRC categories to help understand the crossover (infectious disease, diabetes, substance abuse, heart disease, lung disease, etc.).

Sen. Troy Heinert said that the real problem is that Native Americans cannot access primary and other basic care at the IHS/Tribal clinics, especially for things like infectious diseases. They put off care until it results in higher cost care needs that often require hospitalization. Monica Huber agreed the real issue is primary care as that is the mechanism for individuals to be referred appropriately to specialists. She asked about the delta or gap based on primary care and if at least some of the gaps could be filled via tele-health. Primary care is a need across the state and so any strategies or information providers have that can support increased access in this area are welcome.

Kathleen Bad Moccasin said part of the problem is the very high rates of vacancies within IHS. They need new ways to provide the care and recruit. Housing is one of the biggest issues for recruitment for IHS in a lot of places.

Brenda Tidball-Zeltinger said additional PRC information would be helpful including denied care and care that was referred, but that IHS could not pay for. She also asked how IHS bills Medicare. Kathleen Bad Moccasin said she could send the additional PRC information out, and noted that for Medicare, IHS has all-inclusive rates for inpatient care and for outpatient care. The inpatient rate is based on DRGs, and ER is a flat rate.

Sen. Troy Heinert said there also are issues with Native Americans going for hospital care to Sioux Falls or Rapid City, when there might actually be an IHS hospital closer. Senator Heinert suggested we look at care within the closest proximity to people's place of residence and why they are going farther away for care. Maybe there are ways we could encourage or incentivize enrollees to use local facilities first. This would increase access and reduce travel and keep medical dollars local.

Kim Malsam-Rysdon noted that using more Tele-health in certain areas could help and could change some aspects of spending. She reminded the subgroup that its focus should be on the current \$133M spending for care to Native Americans to determine how we can leverage more federal dollars for that care and reduce expenditures of state funds.

Sonia Weston noted that just because IHS makes a referral for care does not mean they pay for it. If the care does not meet a high enough priority level, then PRC won't pay for it and members have to cover the costs themselves. That means some people just don't get the care they need. She asked if IHS could report back on this information and also noted that to support expansion, tribal members will be looking for real changes in these areas so that tribal members receive the healthcare they need in their communities.

Sen. Troy Heinert asked if IHS has procedures in place to mandate all sites meet their reporting obligations so there is good data about the services provided and services needed, regardless of the priority level.

Bryan Slaba asked if there is a way to look at reducing inpatient spend in the regular Medicaid program by addressing hospital re-admissions. He suggested that the health systems look at their Medicaid readmissions to see if there are Native Americans among those patients and what the costs associated with them were.

Kim Malsam-Rysdon said those are the kinds of ideas from providers across the State on provision of services through IHS/Tribal Health Organizations that the subgroup needs to see from providers. South Dakota Medicaid wants help to identify services that IHS/Tribal Health Organizations cannot provide that Medicaid is paying for due to lack of access through that system. For example, specialty clinics could help to bring Tribal members back into IHS/Tribal facilities. For this subgroup, there is a draft template to help providers' present ideas about what services they could offer with/to IHS/Tribal Health Organizations. There will be a separate subgroup that will consider if there are new services that could be covered in the future that would reduce the need for more expensive care.

Angelia Svihovec said it might be helpful for each provider to look at the primary diagnoses of Native Americans that would tell more about what the care needs are. Given the vast majority of Medicaid

enrollees are children, pregnant women, and aged, blind, and disabled adults we should be looking at inpatient hospital expenditures, and what we can do to address obstetrics or what the higher volume higher cost services are and identify strategies to address those needs.

Brenda Tidball-Zeltinger said that provider ideas need to focus on what problems we are trying to resolve, procedural and clinically and what makes the most sense from the patient experience. Partnerships with non-IHS providers as an example, use of telehealth or e-emergency, e-care, models that can increase capacity at the local level and divert individuals from having to leave their communities for care.

Bryan Slaba said that Medicaid payment should follow the individual. IHS closed some of its ERs in 2008, so now the only place to get ER care in those areas is outside of the IHS/Tribal settings. Providers should get 100% FMAP for services not available through/at IHS/Tribal Health Organizations.

Kim Malsam-Rysdon thanked Deb Fischer Clemens and her team with Avera for drafting the template. The group reviewed the draft and discussed feedback/updates. Rachael Sherard said she liked the service line note in the template, because it is helpful to define it that way. Providers can complete a questionnaire for each service line idea. Then we could give CMS multiple ideas and let them react and determine what they can and cannot cover at 100% FMAP (e.g., infrastructure questions, tele-medicine, etc.).

Senator Troy Heinert asked if there are there things that would require any statute changes. Kim Malsam-Rysdon said that is undetermined at this point. Brenda tidball-Zeltinger noted that from an implementation perspective statutory changes are more challenging, administrative rules and policy guidance changes are easier to facilitate so as the group outlines strategies and we consider the important points Senator Heinert made regarding needed changes, we consider those types of impacts so we can plan to address those in the best way possible.

Sonia Weston asked if the group will be looking at Medicaid covering traditional healers and incorporate them into traditional Medicaid health services. That issue will be addressed in the workgroup looking at new services. Medicaid is traditionally a more medical model but there may be opportunities in behavioral health. Sonia also outlined that the OST tribe is interested in continuing to expand their ability to provide services.

Jason Dilges asked if it would be helpful to take a particular focused service idea and walk it all the way through from start to finish at the next meeting. The group suggested that providers choose a tele-health/specialty care idea, since there are a lot of cost-avoidance opportunities there and a lot of need.

Brian noted that it would be helpful for providers to understand what the needs are at the local IHS level and Stephanie Denning suggested two templates, one for IHS/Tribal Health Organizations, and one for non-IHS providers. Jerilyn Church said there should be an IHS/Tribal Health Organization questionnaire that identifies the more difficult services to provide. Sonia Weston noted that Tribal leadership did request a report identifying service types - what needs are being met where. The group agreed there needs to be two separate templates, so both will be drafted and sent to everyone for review.

Senator Troy Heinert added that the State will need Tribal buy-in for any care delivery ideas and the expansion plan to work.

Next Steps

- Follow-up on Rx formularies for Medicaid and IHS (Brenda Tidball-Zeltinger & Kathleen Bad Moccasin, due 10/21)
- Send report of Direct Care information from IHS (Kim Malsam-Rysdon, due 10/21)
- Move re-admits to the new services committee (Kim Malsam-Rysdon)
- Update IHS/Tribal Access to Care strategy Questionnaire templates (Stephanie Denning, due 10/12)
- Providers develop ideas for specialty care/telemedicine services to review at Oct. 21 meeting (all providers - due 10/16 for distribution to group)

Next Meeting

Wednesday, October 21, 2015, 3-5 PM CST

Best Western - Ramkota in Gallery B, 920 W Sioux Ave, Pierre, SD 57501