# Improving American Indian Health in South Dakota

## 1115 Waiver Proposal

## Table of Contents

## Program Description

**1. Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).**

Access to Indian Health Service (IHS) is limited in South Dakota. Although IHS provides an array of healthcare services, not all services are available in every community and specialized physician and hospital services are especially limited. Staffing challenges within IHS strain the ability of IHS to provide a consistent source of primary care. Additionally, IHS providers are geographically distant from the state's large population centers, creating barriers to healthcare access for American Indians living in those communities.

South Dakota proposes to develop an alternative service delivery model to target access to primary care services for American Indians. This model would test alternative means of delivering healthcare through existing facilities in population centers that serve high percentages of American Indians and provide culturally competent services to American Indians to improve primary care health outcomes. South Dakota proposes to use FQHCs, RHCs, and Urban Indian Health Clinics to provide services to dual Medicaid and IHS eligibles. Through this alternative delivery model South Dakota seeks to increase access to culturally competent primary care, enhance the ability of Indian Health Service in South Dakota to serve American Indians statewide by encouraging linkages between the Indian Health Service and non-IHS health care delivery systems in South Dakota, reduce unmet healthcare needs for American Indians in South Dakota, and decrease non-emergent emergency department usage and inpatient hospitalizations.

The specific goals of this proposal are to:

1. Improve access to primary care sources for American Indians enrolled in SD Medicaid.
2. Improve health outcomes for American Indians enrolled in SD Medicaid.
3. Decrease non-emergent emergency department utilization and inpatient hospitalizations.

South Dakota proposes that successful implementation of an alternative service delivery model will result in improved access, capacity, and appropriate utilization.

**2. Include the rationale for the Demonstration.**

American Indians living in South Dakota experience high rates of poverty and significant health disparities when compared to other South Dakotans as well as other American Indians in the United States.

- American Indians in South Dakota are more likely to be in poverty, have lower household incomes, and be without health insurance when compared to other South Dakotans.
- American Indians in South Dakota have lower household incomes, a higher percentage of families and children in poverty than American Indians nationally.

TABLE 1: SELECTED POPULATION CHARACTERISTICS[1]

| | Year Measured | South Dakota | | National | |
|---|---|---|---|---|---|
| | | AI/AN | All Races | AI/AN | All Races |
| Median Household Income | 2015 | $28,726 | $53,017 | $38,530 | $55,775 |
| % of families in poverty | 2015 | 37.4% | 8.3% | 21.6% | 11.3% |
| % of children under 18 in poverty | 2015 | 50.8% | 18.1% | 33.8% | 20.7% |
| % without health insurance coverage | 2015 | 34.2% | 10.2% | 20.7% | 9.4% |
| % who owned their own homes | 2015 | 38.9% | 68.2% | 53.1% | 63.0% |
| % with no vehicle available | 2015 | 18.1% | 5.3% | 13.7% | 8.9% |

- American Indians in South Dakota have higher birth rates than other South Dakotans and other American Indians; data shows that infant mortality is significantly higher than it is for other American Indians as well as the total population.
- American Indians also have a much lower median age at death compared to other South Dakotans. The median age at death for American Indians in South Dakota is much lower than the national life expectancy for American Indians and the total population.

TABLE 2: SELECTED HEALTH STATISTICS

| | Year Measured | South Dakota | | National | |
|---|---|---|---|---|---|
| | | AI/AN | All Races | AI/AN | All Races |
| Total Live Births[2] (per 1,000 population) | 2014 | 24.9 | 14.4 | 9.9 | 12.5 |
| Infant Mortality[3][4] (per 1,000 live births) | 2013 | 11.25 | 6.53 | 7.61 | 5.96 |
| Median Age at Death[5] | 2015 | 56 | 80 | -- | -- |
| Life Expectancy[6] | 2014 | -- | -- | 73.7 | 78.9 |

The Helmsley Charitable Trust found that American Indians experience more adverse childhood experiences (ACE) than their non-American Indian counterparts.[7] Adverse childhood experiences (ACEs) are potentially traumatic events that can have negative, lasting effects on health and well-being.[8] 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.

[1] United States Census Bureau, Selected Population Profile in the United States, American Indian and Alaskan Native and Total Population, 2015
[2] South Dakota Department of Health (2015). At a Glance. http://doh.sd.gov/statistics/2015Vital/default.aspx
[3] South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators (2013). Infant mortality. https://doh.sd.gov/statistics/2013Vital/InfantMortality.pdf
[4] National Vital Statistics Report Volume 64, Number 9: Infant Mortality Statistics from the 2013 Period Linked Birth/Infant Data Set: https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf
[5] South Dakota Department of Health (2015). At a Glance. http://doh.sd.gov/statistics/2015Vital/default.aspx
[6] Indian Health Services (2016). Disparities: https://www.ihs.gov/newsroom/factsheets/disparities/
[7] 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.
[8] 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.[9] For example, the rate of obesity (BMI ≥30.0) for American Indians is 39% compared to 29% for white South Dakotans.[10] 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 56 years of age for American Indians and 80 years for the total population; the disparity between median ages is true among many common conditions.[11] 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%).[12] 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.[13] Tobacco and marijuana use are significantly higher among American Indians when compared to the rest of South Dakota. From 2011-2015, the Behavioral Risk Factor Surveillance System (BRFSS) showed that while fewer American Indians had consumed alcohol in the past month (59% of whites compared to 39% of American Indians), more American Indians reported binge drinking (23%) than whites (19%).[14] In addition, 45% of American Indian South Dakotans currently smoke cigarettes compared to only 18% of the white population.[15]

American Indian health disparities are intensified by limited access to IHS in South Dakota. Staffing challenges within IHS strain the ability of IHS to provide a consistent source of primary care. IHS has experienced quality of care challenges that have caused hospital and emergency room closures in South Dakota. The closures followed federal inspections by the Centers for Medicare and Medicaid Services identifying issues related to patient safety. The Rosebud emergency room closure in December 2015 required patients seeking care to travel more than 50 miles to the next closest emergency room for the seven months of the closure. Between December 2015 and July 2016, five individuals died while being transferred to hospitals and two women gave birth in ambulances on the road. Additionally, the CMS reviews at Pine Ridge Hospital, Rosebud Hospital, and Sioux San Hospital put the hospitals at risk of losing CMS certification. The closures and federal audit findings have weakened tribal trust in

[9] The Helmsley Charitable Trust. Focus on South Dakota: A Picture of Health. Accessed on August 16, 2017 from: http://helmsleytrust.org/publication/focus-south-dakota-picture-health.
[10] The Health Behaviors of South Dakotans, 2015. A report of the South Dakota Behavioral Risk Factor Surveillance System, South Dakota Department of Health; http://doh.sd.gov/statistics/2015BRFSS/default.aspx
[11] South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators (2015). Mortality. Accessed on August 16, 2017 from: http://doh.sd.gov/statistics/2015Vital/Mortality.pdf
[12] The Helmsley Charitable Trust. Focus on South Dakota: A Picture of Health. Accessed on August 16, 2017 from: http://helmsleytrust.org/publication/focus-south-dakota-picture-health.
[13] *Ibid.*
[14] The Health Behaviors of South Dakotans 2015. Alcohol Use. Accessed on August 16, 2017 from: http://doh.sd.gov/statistics/2015BRFSS/Alcohol.pdf
[15] The Health Behaviors of South Dakotans 2015. Tobacco Use. Accessed on August 16, 2017 from: http://doh.sd.gov/statistics/2015BRFSS/Tobacco.pdf

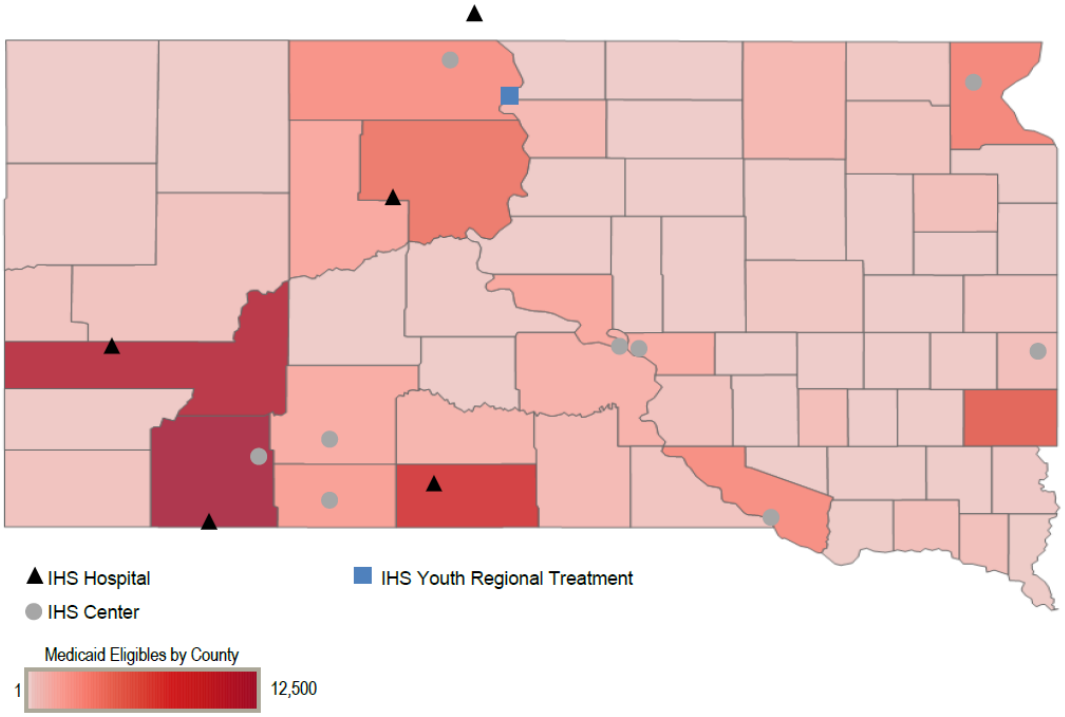
the IHS system to provide quality care for American Indians in South Dakota. Rosebud Sioux Tribe filed a lawsuit against Indian Health Service over the emergency room closure, citing that IHS has not met the federal government's obligations to provide adequate health care to American Indians and has violated the Treaty of Fort Laramie as well as the 1921 Snyder Act and the 1976 Indian Health Care Improvement Act. South Dakota's utilization statistics indicate that care at IHS is decreasing while overall American Indian Medicaid eligibles continue to grow. This trend supports the need for a model that addresses the challenges associated with care delivered at IHS in South Dakota.

TABLE 3: IHS EXPENDITURES AND AMERICAN INDIAN MEDICAID RECIPIENTS IN SOUTH DAKOTA

| | SFY13 | SFY14 | SFY15 | SFY16 | SFY18 |
|---|---|---|---|---|---|
| IHS Expenditures | $72,080,678 | $72,758,205 | $70,265,060 | $69,798,392 | $69,397,643 |
| Total Unduplicated American Indian Medicaid Recipients | 32,904 | 39,942 | 45,922 | 51,135 | 52,658 |

IHS is geographically distant from the state's large population centers and even some communities within South Dakota's nine American Indian reservations. The gaps in IHS coverage in South Dakota create barriers to healthcare access for American Indians living in those communities. The map below shows the locations of American Indian eligibles by county in relation to the location of IHS health centers and hospitals.

SOUTH DAKOTA MEDICAID AMERICAN INDIAN ELIGIBLES AND IHS LOCATIONS BY COUNTY, SF2017



The state intends to add to the IHS care network through the proposed demonstration, which would utilize FQHCs and RHCs to broaden the network of culturally competent primary care providers for American Indians. The demonstration also proposes to give demonstration providers the same status as IHS allowing them to refer and coordinate care for a recipient in the IHS network.

**3. Describe the hypotheses that will be evaluated during the Demonstration's approval period and the plan by which the state will use to test them.**

**Hypothesis:** If South Dakota utilizes an alternative delivery model to broaden the IHS network through the use of FQHCs and RHCs to provide culturally competent care to American Indians then access to primary care will increase, non-emergent ED use and inpatient hospitalization will decrease, and health outcomes will improve.

South Dakota proposes the following goals for measurement in the demonstration:

**Goal 1:** Improve access to primary care sources for American Indians enrolled in SD Medicaid.

| Hypothesis | Proposed Measures | Data Sources |
|---|---|---|
| The demonstration will maintain or improve patient satisfaction with care. | CAHPs | |
| The demonstration will maintain or increase access to behavioral health services. | Alcohol Screening<br>Screening, Brief Intervention and Referral to Treatment (SBIRT)<br>Depression Screening | UDS, GPRA<br>UDS, GPRA<br><br>UDS, GPRA |

**Goal 2:** Improve health outcomes for American Indians enrolled in SD Medicaid.

| Hypothesis | Proposed Measures | Data Sources |
|---|---|---|
| The demonstration will maintain or improve health outcomes and chronic disease management for at-risk populations. | Controlling High Blood Pressure<br>Diabetes Glycemic Control | UDS, GPRA<br>UDS, GPRA |
| The demonstration will maintain or increase the use of preventive services. | Childhood Immunization Status<br>Dental Sealants<br>Cancer Screening<br>Tobacco Screening & Cessation | UDS, GPRA<br>UDS, GPRA<br>UDS, GPRA<br>UDS, GPRA |

**Goal 3:** Decrease non-emergent emergency department utilization and inpatient hospitalizations.

| Hypothesis | Proposed Measures | Data Sources |
|---|---|---|
| The demonstration will maintain or improve rates of non-emergent ED usage. | Rate of Non-Emergent ED Use | Medicaid Claims Data |

| | | |
|---|---|---|
| The demonstration will maintain or decrease inpatient hospitalizations. | Rate of Inpatient Hospitalization | Medicaid Claims Data |

**4. Describe where the Demonstration will operate, i.e., statewide, or in specific regions; within the state.**

The demonstration will operate statewide.

**5. Include the proposed timeframe for the Demonstration.**

South Dakota seeks to implement this demonstration for a five-year period.

**6. Describe whether the Demonstration will affect and/or modify other components of the state's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.**

The demonstration will not affect or modify other components of the state's current Medicaid and CHIP programs.

## Demonstration Eligibility

1. **Include a chart identifying any populations whose eligibility will be affected by the Demonstration.**

   South Dakota intends to make the demonstration applicable to all American Indians enrolled in South Dakota Medicaid who elect to receive services from a participating provider.

2. **Describe the standards and methodologies that state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the state plan.**

   South Dakota will not utilize different standards or methodologies for determining eligibility.

3. **Specify any enrollment limits that apply for expansion populations under the Demonstration.**

   South Dakota will not apply enrollment limits for eligible population under this demonstration.

4. **Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid state plan, or populations covered using other waiver authority such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.**

   South Dakota expects that all groups affected under the demonstration would otherwise be eligible for South Dakota Medicaid.

5. **To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924 or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).**

   This is not applicable to the demonstration.

6. **Describe any changes in eligibility procedures that state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).**

   This is not applicable to the demonstration.

7. **If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.**

   This is not applicable to the demonstration.

## Demonstration Benefits and Cost Sharing Requirements

1. **Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP state plan:**

   ____ Yes  __X__ No (if no, please skip questions 3-7)

2. **Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP state plan:**

   ____ Yes  __X__ No (if no, please skip questions 8-11)

## Delivery System and Payment Rates for Services

1. **Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP state plan:**

____ Yes
__X__ No (if no, please skip questions 2-7 and the applicable payment rate questions)

8. **If fee-for-service payment will be made for any services, specify any deviation from state plan provider payment rates. If the services are not otherwise covered under the state plan, please specify the rate methodology.**

Providers participating in the demonstration will be required to report outcomes to South Dakota Medicaid and share population health data with Great Plains Indian Health Service. Providers participating in the demonstration will be required to integrate culturally competent care into their clinics. South Dakota will develop a core curriculum with assistance from Great Plains Tribal Chairman's Health Board. Culturally competent care will include:

- Care Delivery
- Targeted Health Education Materials
- Staffing and Hiring Decisions
- Employee Onboarding and Ongoing Training
- Patient Satisfaction

South Dakota intends to reimburse services provided to American Indians eligible under the demonstration by FQHCs and RHCs participating in the demonstration at the rates listed in South Dakota's Medicaid State Plan for Indian Health Service clinics and tribal 638 providers. FQHCs and RHCs will continue to receive the designated FQHC or RHC payment for individuals not eligible for the demonstration. South Dakota proposes that payments made to FQHCs and RHCs for individuals eligible for the demonstration be eligible for 100 percent federal financial participation under Section 1905(b) of the Social Security Act due to the status of these providers as an extension of the IHS network. FQHCs and RHCs under the demonstration will have the same status as IHS to enter into care coordination agreements and refer individuals to care not able to be provided by the demonstration providers.

9. **If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.**

No payments will be made through managed care entities on a capitated basis as part of this demonstration.

10. **If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.**

Quality-based supplemental payments are not being made to any providers or class of providers as part of this demonstration.

## Implementation of Demonstration

1. **Describe the implementation schedule. If implementation is a phase-in-approach, please specify the phases, including starting and completion dates by major component/milestone.**

   South Dakota intends to implement using a phased implementation, targeting implementation at FQHC and RHC sites with large American Indian populations in phase 1 before statewide implementation in phase 2. Phase 1 will target South Dakota Urban Indian Health in Sioux Falls and Pierre, Horizon Health in Mission, and Black Hills Community Health Center in Rapid City and will last for 2 years. Phase 2 will begin in year 3 and allow statewide participation for all eligibles and willing providers.

2. **Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.**

   Eligible individuals who elect to receive services at a provider participating in the demonstration will automatically be enrolled in the demonstration and notified at the clinic level.

3. **If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct procurement action.**

   This is not applicable to the demonstration.

## Demonstration Financing and Budget Neutrality

The federal government's responsibility to finance the health care of American Indians and the associated Medicaid expenditures for the demonstration population would be the same if the demonstration did not exist. Under section 1905(b) of the Social Security Act (SSA), the federal government is required to match state expenditures at 100 percent for covered services received by American Indians and Alaskan Natives through an IHS facility whether operated by the IHS or by a Tribe or Tribal organization, as defined in section 4 of the Indian Health Care Improvement Act.

Furthermore, under the federal trust responsibility, the federal government has a special obligation or duty when interacting with tribes and American Indians and Alaskan Natives. In the originating language of section 1905(b) of the SSA, Congress reaffirmed this duty by declaring that "it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." 25 U.S.C. Sec. 1602.

South Dakota applies these authorities support the budget neutrality of this 1115 waiver demonstration. American Indians who make up the demonstration population are not limited to receiving Medicaid-eligible services from a specific provider. These individuals may receive care and services, at any time, from an IHS or Tribal provider. The federal government would be responsible under the federal trust doctrine and requirements of section 1905(b) to pay all of the costs for Medicaid-eligible services at the approved rates.

South Dakota's cost projections for the demonstration assumes the same reimbursement and percentage rate that would be available to IHS facilities or tribal organizations for this population. Under this premise, the proposed demonstration will not result in increased federal expenditures than what would have otherwise been spent providing care at IHS and Tribal 639 facilities absent the demonstration.

Through the demonstration, South Dakota seeks to demonstrate an alternative delivery system that recognizes the role of FQHCs in providing culturally competent primary care to American Indians in areas where IHS is unable to meet the needs of American Indians. Budget neutrality is achieved through the application of the federal trust responsibility to this population and a reduction in non-emergent ED use and inpatient hospitalizations.

# Proposed Waivers and Expenditure Authorities

1. **Provide a list of proposed waivers and expenditure authorities.**

   South Dakota is requesting section 1115(a)(2) expenditure authority.

2. **Describe why the state is requesting the waiver or expenditure, and how it will be used.**

   South Dakota is requesting expenditures, which are not otherwise included as expenditures under Section 1903, for services to American Indian people at federally qualified health centers (FQHCs) receiving grants under Section 330 of the Public Health Service (PHS) Act and Urban Indian Programs funded through grants and contracts under Title V of the Indian Health Care Improvement Act, PL 94-437at the same FMAP percentage and reimbursement rate available to Indian Health Service facilities or tribal organizations under section 1905(b) of the Social Security Act.

## Public Notice

1. **Start and end dates of the state's public comment period.**

   This section will be added following the Public Notice Period.

2. **Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.**

   This section will be added following the Public Notice Period.

3. **Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.**

   This section will be added following the Public Notice Period.

4. **Certification that the state used an electronic mailing list or similar mechanism to notify the public.**

   This section will be added following the Public Notice Period.

5. **Comments received by the state during the 30 –day public notice period.**

   This section will be added following the Public Notice Period.

6. **Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.**

   This section will be added following the Public Notice Period.

7. **Certification that the state conducted tribal consultation in accordance with the state's approved Medicaid state plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect of Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.**

   This section will be added following the Public Notice Period.

## Demonstration Administration

The state's point of contact for the demonstration application is the following:

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South Dakota Department of Social Services
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