

Behavioral Health Subcommittee Meeting

Meeting Minutes: 11/19/2015

Attendees: Kim Malsam-Rysdon, Lynne Valenti, Brenda Tidball-Zeltinger, Jerilyn Church, Amy Iversen-Pollreisz, Belinda Nelson, Dr. Dan Heinemann, Donna Keeler, Tom Stanage, Dan Foster, Betty Oldenkamp, Sandra Fortuna, Dr. Matt Stanley, Steve Lindquist, Alicia Collura

Welcome and Introductions

Dan Foster opened the meeting with a traditional Lakota prayer song.

The group introduced themselves.

Review November 5 Minutes

Amy Iversen-Pollreisz presented about the State's Medicaid behavioral health benefits and the structure of mental health and substance use disorder treatment services. There also were presentations about several IHS and Tribal behavioral health programs.

Don Novo asked the group to review the minutes from the last meeting [Behavioral Health Subcommittee Minutes 11-5-2015 Draft.pdf](#) and let Kelsey Smith (Kelsey.Smith@state.sd.us) know if there are any changes required.

Review of State Medicaid Health Home Provider Requirements

Behavioral Health and Medical Health Homes

Brenda Tidball-Zeltinger presented on the State Medicaid Health Home program (see the slides – posted at boardsandcommissions.sd.gov - for details).

Health Homes are specifically designed to support individuals with chronic conditions, including physical and behavioral health. South Dakota's Health Homes have been in operation for over two years. There are six core required Health Home services:

- Comprehensive care management – a plan of care for each individual
- Care coordination – helping to implement the plan of care and ensure access to needed services
- Health promotion
- Comprehensive transitional care/follow up – support through any type of transition
- Patient and family support
- Referral to community and social support services

There are two types of Health Homes in Medicaid – primary care health homes and behavioral health health homes. Behavioral health providers are limited to Community Mental Health Centers in the state. The core services are the same, but the primary focus may be different for individuals depending on their physical health and/or behavioral health needs. Providers must be enrolled as Medicaid providers. About 30% of those served today through South Dakota Medicaid Health Home are being cared for through IHS.

Application Process

Providers that want to be Health Homes need to submit applications to the Department of Social Services (DSS). The application can be found at: <http://dss.sd.gov/healthhome/application.aspx>. Behavioral Health Health Homes must be CMHCs. DSS provides technical assistance through the application process and will work with providers through the Health Home implementation process once an application is approved.

Health Homes must be able to track and report on multiple outcome measures. There currently are 60 outcome measures, such as percentage of individuals age 12 and older who were screened for depression, percentage of individuals age 12 and older with a new episode of alcohol or other drugs, percentage of individuals age 18-75 who had an encounter during the last 12 months with a diagnosis of diabetes, etc. Most of the measures are those that providers are already using for other federal and commercial programs. The measures are generally consistent across both Primary Care and Behavioral Health Health Homes. Providers really need to have a good electronic health record (EHR) to ensure the ability to capture and report all the required measures. The full list of measures can be found at: <http://dss.sd.gov/docs/healthhome/cmhcoutcomeindicatorsdocumentedfinalreviseddrafttwoastham.pdf>

Provider requirements

Providers must have the appropriate South Dakota licensure and be enrolled or eligible to enroll in Medicaid. They must be able to provide and document they have provided the six core services. This requires a robust EHR. They also must attend the Health Home Orientation training.

Health Home mental health professionals can be psychiatrists, psychologists, Licensed Professional Clinical Mental Health workers, Clinical Social Workers. Other staff of varying levels of licensure and training can be part of the care team.

Payment structure for Health Home Core Services

Health Homes receive a per member per month (PMPM) payment for the core services, made retrospectively each quarter. There are four Tiers of patients – 1 through 4, with 4 including individuals with the highest needs. The PMPM rates differ based on the Tier of the individual. The State looks at claims data and determines a risk score to identify individuals who would qualify for the Health Homes program. If an individual is in Tier 2 – 4, they are automatically enrolled in a Health Home, if one is available in their area. Those individuals in Tier 1 have the option to choose not to enroll in a Health Home. Individuals can move between Tiers over time; Health Home providers can request adjustments based on each individual's needs.

Group Discussion on Health Homes

Indian Health Service/Tribal health programs are eligible to apply to be Primary Care Health Homes; however, only community mental health centers are eligible today to be Behavioral Health Health Homes. As an FQHC, Urban Indian Health Clinic serves as a Primary Care Health Home, but was already an integrated practice. The Health Home allows them to more seamlessly provide care and bill them under the Health Home program.

The level of effort to become a Health Home depends on how a practice or clinic is set up today. If there are not many of the support services today, that piece can take a lot of effort to implement. There is a lot of registry management and ensuring care plans are followed. Alicia Collura shared the Health Home

model has really helped Falls Community Health by providing a mechanism to bill for more services that support patients.

On the behavioral health side, community mental health centers had the expertise to do the case management, but had to build up the physical health coordination. This is one reason some of the CMHCs use nurses as a key part of the care team. One example of a positive outcome of the Behavioral Health Health Home is that they can help individuals get stable with their behavioral health so they can access the care they need for their physical health. The integration of physical and behavioral health in one place has had very positive effects for both groups.

One issue that has been a challenge for Health Homes is the lack of interoperability across EHRs for different providers that are part of the care team. People move around a lot and so the Health Homes have had to learn how to share information on care received by patients. Hospital follow-up is one of the biggest challenges, to ensure that the Health Homes get the information about hospital admissions and discharges on a timely basis to meet the reporting requirements.

The group discussed whether to recommend the provider base for Behavioral Health Health Homes include providers in addition to community mental health centers. It does seem possible for IHS to be a Behavioral Health Health Home, as well as the Tribal behavioral health programs. IHS is a Primary Care Health Home today. The mental health professional provider base to support access to behavioral health care needs would likely be the biggest challenge. The reimbursement rates may be somewhat of a barrier to some Tribal health providers – although it is important to remember that the PMPM is specifically for the six core Health Home services; all other services are reimbursed at the regular Medicaid rates. The majority of individuals seen in IHS probably would qualify for Health Home enrollment, so there may be a higher level of burden represented in the IHS population. IHS could also contract with Tribal behavioral health home programs to provide certain core services through the 638 contracting process.

Jerilyn Church noted IHS needs to be part of the conversation. IHS has the professional providers; the Tribal health providers have more of the support staff. There needs to be a system of care developed for IHS and Tribal providers that would fit into the Health Home model. What is working in Indian Country is known, but we need to identify ways to help sustain it. If we can better leverage today what is Medicaid reimbursable, that can help free up IHS and Tribal funds to support the programs Medicaid cannot cover.

No matter what model is used, there are not ever going to be enough physicians and psychiatrists and other such staff to meet the needs. We must find a way to build out the types of providers and support staffs that can be reimbursed for their services. The Health Homes offers a mechanism for payment that allows a great deal of flexibility for providers to provide services to integrate mental health and primary care.

Community Mental Health Center (CMHC) Provider Requirements

Amy Iversen-Pollreisz presented information on the State requirements for becoming a CMHC (see slide deck – posted at boardsandcommissions.sd.gov - for details).

There are specific administrative, clinical and personnel accreditation requirements for CMHCs, which come with a significant number of reporting requirements. CMHCs are primarily providing services to

individuals with Serious Emotional Disorders (SED – children) and Serious Mental Illness (SMI – adults), so they have some flexibility in staff who can provide services. All staff must be supervised by a clinical supervisor.

CMHCs serve designated counties and must provide the full array of services across the entire life cycle (children to seniors). Some CMHCs also provide optional room and board services. All CMHCs must provide case management services that include direct assistance, psychosocial rehabilitation, liaison services, collateral contacts (family, other community organizations, etc.). CMHCs must follow a specific clinical process that includes initial and ongoing assessments and reviews, development of treatment plans, crisis intervention plans, and documentation of progress. CMHCs are required to serve eligible individuals seeking services and must notify the Division of Behavioral Health if they refuse to serve an individual; they still must provide emergency services and arrange for other appropriate services during transition to another provider.

Outpatient services include screenings/assessments/evaluations, individual and group therapy, psychiatric services, and coordination with family and other community supports. Children/Youth and Family services are comprehensive and cover those under age 18 who meet the SED criteria. They are provided in the location preferred by the family and through an integrated system of care. All services are based on an individualized needs and plan of care.

CARE is for adult clients who meet criteria that include undergoing psychiatric treatment, episode of psychiatric hospitalization, been on a psychiatric medication in the last year, has frequent crisis contact with the CMHC. Individuals must also have difficulty in functional areas such as unemployment, social behavior, lack of social support, etc. CARE services are provided in the individual's preferred location and through an integrated care team based on the needs of the individual and individual care plan.

The IMPACT program is for those needing the highest level of outpatient treatment for adults with SMI who cannot be served in a less restrictive environment. It is based on the Assertive Community Treatment model and uses a mobile group of mental health professionals. It is similar to the CARE program, but more intensive. It is an optional program for CMHCs. Eligibility is the same as for CARE along with no other appropriate community-based services available, but must be approved by the Division of Behavioral Health. It is available today in Yankton, Sioux Falls, Huron, Rapid City, Pierre, and Aberdeen.

The Room and Board program provides housing support for individuals age 18 and older with SMI, including those with co-occurring substance use issues. These individuals also are receiving services through CARE or IMPACT. Services are available through Rapid City, Pierre and Huron. For residential treatment, the State pays with State general fund dollars. One of the biggest issues for this group of people is supportive housing.

Group Discussion on CMHCs

The CMHCs have flexibility for using various types of staff to support the care teams for individuals and typically include people with Bachelor's degrees as well as staff with higher levels of educations. Community Health Workers could be a part of the care team.

There are a lot of co-occurring mental health and substance use issues among individuals with behavioral health issues, so it is important to connect the mental health with the substance use treatment. Many of the CMHCs have become accredited substance use treatment providers as well, for

exactly these same reasons. For some CHMCs, the teams meet daily and include a variety of levels of professionals. The IMPACT teams work only with IMPACT clients and are available to support IMPACT clients so those individuals can build relationships with the care team.

The reality is that some areas in the State have better access than others. To the degree that there is unmet need and the CHMC model can support better access, the State definitely supports that. Years ago, the administrative rules actually spelled out the counties included in each CMHC catchment area—but that was removed so is no longer a barrier. It would be ideal for different providers to work together to maximize resources, for example the clinical supervision aspects of the requirements. Lewis and Clark Behavioral Health Services has a drug and alcohol counselors embedded with an IHS clinic two days a week, but is not able to keep up with the need.

Betty Oldenkamp shared that Lutheran Social Services has studied the process to become a CMHC, and the requirements to provide the full scope of services for all ages makes it a significant barrier for many providers. There needs to be a way to expand the ability of providers to meet all the service requirements. This is a promising opportunity for IHS and Tribal health organizations, but they may need help from other providers. For example, the model that Marlies White Hat discussed at the last meeting should be able to fit under the CMHS model for children and family services, but it would need to be part of a program that also serves adults as part of the CMHC model.

Jerilyn Church asked if there are governance requirements that Tribes should consider. CMHCs have to have boards of directors but there can be flexibility in how that requirement is met and could potentially be modified to meet Tribal governance structures. Any administrative rules such as this are much easier to change; as long as something is not set in federal regulations, we have options to change things.

There was general support to encourage IHS/tribal program development of the CMHC model of services. This model works and we have good outcomes to prove it. It is important to look at new kinds of partnerships to expand this model and to leverage the 100% FMAP. Being able to shift people out of residential situations that are paid with State general funds, would be a big win.

CHR Model Discussion

Kim Malsam-Rysdon noted that the other Subcommittees have been talking about development of services provided by Community Health Workers (CHWs). The American Public Health Association definition of CHWs offers a good start for helping to determine the roles and responsibilities of CHWs. There are 41 states that have formalized CHW programs; South Dakota does not. There are a number of states that have built CHWs specifically into their Medicaid programs and provide some level of reimbursement for CHW services.

The New Services Subcommittee is looking specifically at how to create a CHW program for South Dakota that would incorporate some of the work already being done, particularly through Community Health Representative (CHR) programs among the Tribes. Much of the work Tribal CHRs are doing today is actual transportation of patients; the Subcommittee discussed how to expand the services to have CHRs do more of the patient education and community support services, and arranging for transportation needs, rather than spending all their time actually transporting patients. The Subcommittee discussed briefly how CHWs/CHR could also be used to support behavioral health teams. For example, CHWs/CHR can help do assessments and help get individuals connected with the right services to start, and then provide the support system when they come back from treatment. For

individuals who are recovering from addictions it is very powerful to have someone who “speaks their language” and understands the challenges of recovery – a kind of “sponsor on steroids.” Native Americans who have an intact cultural connection had higher rates of recovery over the longer term. Dr. Heinemann said that for the project in Minnesota with one of the Tribes there, the CHWs are part of the care team and are included in the care planning.

To the degree that there are people in these types of roles, it is important to have standards and evidence-based training and even certification programs. There is a very strong CHW movement nationally and there are continuing education opportunities that allow CHWs to specialize in certain areas, such as geriatrics or behavioral health. Many Tribal substance use treatment programs use these types of support staff, such as mental health technicians, very effectively. There is an important, trusted role that CHWs play that cannot be underestimated. They can support compliance and find individuals when other providers cannot.

This Behavioral Health Subcommittee agreed that a CHW program should be pursued and be able to support behavioral health care. In particular there needs to be a way for people that are not eligible for Health Homes or who do not have access to a Health Home to receive this service if needed.

IHS and Tribal 638 Behavioral Health

Core Behavioral Health services authorized under IHS

With the passage of the Patient Protection and Affordable Care Act (ACA), it included the Indian Health Care Improvement Act (IHCIA) making it permanent, which gives IHS with greater authority to provide services. IHS at a national level looked at behavioral health services and how to improve them, particularly in the Great Plains area, which has one of the highest suicide rates in Indian Country. The issue of having multiple CHSDAs creates a problem for behavioral health services. Section 704 mandates comprehensive behavioral health, but does not fund it. The Great Plains Tribal Chairman’s Health Board integrated information from the IHCIA into their comments to CMS about the 100% FMAP opportunities.

Tribal Behavioral Health Services

Ed Parsells shared information about the Rosebud Sioux Tribe substance use treatment program. The funding level from IHS covers about 40% of what the actual needs are. Rosebud has inpatient, outpatient and after care programs. Rosebud has a strong working relationship with Dan Foster and IHS. Some Tribes don’t have that level of relationship between their substance use programs and IHS behavioral health. Each Tribal contract specifies what services will be provided. If a Tribe contracts for substance use services they must provide all the required services. The Medicaid requirement to serve all individuals, even non-Native Americans, so that could present a barrier for some Tribal providers to participate in Medicaid.

IHS Behavioral Health Model of Care

Dan Foster presented about the IHS behavioral health program. The IHS.gov website includes the Indian Health Manual. Chapter 8 is Social Work, Chapter 14 is Mental Health, and Chapter 18 is Alcohol and Substance Abuse.

Next Steps:

- Jerilyn Church will explore the options for Tribal health providers.
- State staff will connect with IHS to dialogue about options for IHS to participate in Health Homes more fully.
- Lynne Valenti will provide additional information about telepsychiatry use in Medicaid.
- Jerilyn Church will provide a summary of new authorities related to behavioral health outlined in the Indian Health Care Improvement Act of the ACA, most of which was referenced in the comments provided to CMS by the GPTCHB.
- Staff will review the issues related to contracting between Medicaid and Tribes and the requirements for non-discrimination and sovereignty issues. Jerilyn Church will look at what Tribes in other states have done.
- DSS will present about substance use services at the next meeting, as well as the types of providers that can be reimbursed through the State Medicaid program today.

Next Meeting

Friday, December 4, 8:30 a.m.– 11:30 a.m., Central Time, AmericInn, Fort Pierre, SD

REMINDER - All the materials from the Coalition and Subcommittees can be found on the State website at:

boardsandcommissions.sd.gov