Behavioral Health Subcommittee Meeting

Meeting Minutes: 11/05/2015
8:30 a.m. to 11:30 a.m. (Central time)

Attendees: Lynne Valenti, Amy Iversen-Pollreisz, Kim Malsam-Rysdon, Jerilyn Church, Brenda Tidball-Zeltinger, Belinda Nelson, Alicia Collura, Matt Stanley, MD, Thomas Stanage, Dan Foster, Sandra Fortuna, Richard Bird, Dan Heinemann, MD, Marlies Whitehat, Evelyn Espinosa, Donna Keeler, Steve Lindquist, Betty Oldenkamp

Welcome and Introductions

Jerilyn Church opened the meeting with a prayer. The group introduced themselves and Don Novo gave everyone the background on the larger coalition meeting and other subcommittees. As a reminder, all the agendas and minutes for the various subcommittees are on the website: http://boardsandcommissions.sd.gov/Template.aspx?id=145

Review Purpose of BH Subcommittee

Lynne Valenti provided an overview of the Behavioral Health (BH) Subcommittee and the group's focus specifically in the context of the larger Health Care Solutions Coalition and other subcommittees (Access to IHS Services, New Services). This group will work on opportunities to increase BH services for current Medicaid enrollees and in particular among Native Americans, as well as think about what services would be needed to support the expansion population, which is largely low income adults without dependent children.

The overall goal of these workgroups is to identify ways to make more services that are delivered to Native Americans enrolled in Medicaid eligible for the 100% FMAP (federal match rate), instead of the regular State match rate of approximately 50%. When Native Americans who are enrolled in Medicaid receive services outside of an IHS/Tribal Health Organization, the State Medicaid program can only get the 50% federal match for those services; whereas if they receive the Medicaid services in an IHS/Tribal Health Organization, the State can get a 100% federal match. Expanding the services for which the State can get 100% FMAP could help offset the State general fund dollars currently spent on Medicaid, which potentially could then be used for expanding Medicaid to more individuals, both Native American and non-natives.

Overview of Behavioral Health Services/Programs

Amy Iversen-Pollreisz gave a presentation on current BH services, which include both mental health (MH) and substance abuse (SA) treatment services.

Substance Abuse Treatment Program Structure and Services

Currently only pregnant women and children are eligible for substance abuse (SA) services under Medicaid. State-funded services are provided by accredited providers through state accreditation or deemed status. There are 39 accredited SA providers throughout the state and they provide a variety of services from outpatient to inpatient treatment. Currently Oglala Sioux Tribe is accredited through deemed status, via IHS accreditation. DSS has staff who can offer technical assistance to providers to help with the deemed status process. The Sisseton Wahpeton tribal program indicated they have a

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been State accredited for many years; but they also get reviewed by IHS, which is basically double accreditation.

Most of the Tribes have 638 agreements for SA services; some also have 638 agreements for BH services. But the accreditation and deeming process seems to be a barrier for several of the Tribal providers. In the past, there were some contractual issues between the Tribes and DSS. Amy Iversen-Pollreisz noted that those issues were resolved some time ago and should not be a barrier anymore, at least for Medicaid. SA providers do still have to be enrolled as Medicaid providers, but that is a relatively easy process and there are staff at DSS who can help facilitate enrollment.

Mental Health Services and Programs

Community Mental Health Centers (CMHCs) provide outpatient services to adults with serious mental illness and children with serious emotional disorders. Each of the 11 CMHCs is assigned a catchment area of various counties Services include psychiatry, medication therapy management (MTM), care management, individual and group therapy. CMHCs are required to provide services to all individuals across the lifespan (meaning children to seniors), as well as offer crisis services on a 24/7 basis.

CMHCs serve primarily individuals with serious emotional disturbances (children - SED) or Serious Mental Illness (adults – SMI). They do not have a lot of capacity for enrollees with less intense diagnoses. This system was never really intended to meet the larger Medicaid population's MH needs; it was designed specifically for those with SED/SMI.

There was discussion of the fact that only CMHCs are able to get paid for case management and home based services. Independent practitioners who bill Medicaid directly are not able to provide case management and home based services. This means the current scope of Medicaid billable services for these practitioners is incompatible with the evidence of best practice for treating the real needs and doesn't allow for all the services needed as part of the larger continuum of care. Similarly, the program in Rosebud is not eligible for Medicaid reimbursement for some of their services since it is not through a CMHC. The scope of what private providers can do is different from what the CMHCs can do, and as noted above, CMHCs are required to provide services to all patients – children to seniors – and cannot carve out any specific populations.

The education standard for independent practiioners to be able to bill for Medicaid are a challenge for the IHS/Tribal programs. It is very hard to recruit and retain providers licensed at the highest licensure for private independent practitioners. Digital and telehealth can help, but is still not the same as being there in person. It takes at least four years to get the licensure as a LPC-MH. CMHCs can bill with lower level staff if they are supervised by someone at a higher level because they also are accredited by the State, so have a lot more oversight than independent practitioners. The Health Home model does allow some flexibility to address that, but does not reimburse for therapeutic services. Independent providers cannot do the same. Betty Oldenkamp indicated that there are many people in independent practices who work in programs that are accredited by other organizations with very high standards and there should be a way to make it easier for more providers to participate in the Medicaid program and get paid for it.

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Health Homes and How They Intersect with BH Care

Based on new opportunities under the Patient Protection and Affordable Care Act (ACA), South Dakota launched its Health Homes project in August 2013 with two types of Health Homes – chronic disease Health Homes and BH Health Homes. CMS requires Health Home providers to deliver a set of Core Services around care coordination, health promotion, transitions of care, patient and family supports, and referrals to community services. Medicaid pays Health Home providers a per member per month (PMPM) fee for these core services and reimburses all other services at the regular Medicaid provider rates. The model does lend itself to treating adults more than for children because of the focus on chronic diseases.

South Dakota's Health Homes program identifies individuals who meet certain disease criteria that make them eligible for Health Home enrollment (two or more chronic conditions or one chronic condition and at risk for another, and/or an SED/SMI diagnosis). Each recipient is placed on one of four tiers based on a risk assessment of their conditions (1 lowest risk, 4 highest risk). Tier 1 recipients, which comprise about half of the enrollees eligible for Health Homes, can opt in to the Health Home program. Tiers 2 – 4 enrollees are automatically put into a Health Home but may opt out if they chose. Medicaid reimburses the Health Homes a PMPM for the required Core Services based on each recipient's risk tier. Payments are calculated retrospectively and are made if the recipient received at least one of the Core Services during the previous quarter.

Tom Stanage from Lewis & Clark BHS noted that as a BH Health Home, they already know they have diverted at least a dozen emergency room (ER) visits and hospitalizations because they were able to get patients' chronic disease conditions under control. They conduct follow up with patients after every ER visit and hospitalization, to help them get their medications under control, ensure appropriate housing and home support. With the SED/SMI population, it really is going well to have the ability to do care coordination, and is one of the most important aspects of the model on the BH side because they now can better serve the chronic health needs of their adult patients. Even for children there are families who need the care coordination support, although those tend to be much more family based issues that chronic care needs.

Another chronic disease Health Home provider noted that for them, one of the most effective components of the Health Home is the relationships they develop with their patients. They focus more on trying to restore balance in the patient's life, rather than just on their medical conditions. Example of a patient who was literally using at least one health system service every day – ER, acute care, BH. He had very strong SA and BH issues, and was a really difficult patients who was highly resistant to the system approach to care. The Health Home provider developed trust with him and worked with him on what his goals in life were and as they worked with him, he dropped from daily health system encounters to three in an entire year. This shows the model also includes a component of accountability for the patients and helping them develop goals they can achieve. Once the team focused on these other things, medication often becomes the least important component of their care. For example, after putting BH triage therapists (who function like Community Health Workers) into the primary care practice, they saw the total number of prescriptions required for patients go down.

These examples show that there are opportunities for exploring how IHS and Tribal providers could build programs where they could do more care coordination services with other providers and get Tribal members the BH services they need before they hit the crisis level. This would include incorporating

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some more traditional cultural approaches to care into the programs to support helping them change some of their lifestyle choices and be healthier overall. For example, allowing programs to use sweat lodges or other healing ceremonies that are important to Tribal members. The Navajo Nation has done a great job incorporating their own traditions and culture into their programs and it is very effective in helping their people.

The integration of physical and behavioral health through a Health Home model is something that could be very beneficial to IHS and Tribal providers, as well. Many of the IHS primary care providers are already doing BH/SA diagnoses and management. Having collaborative partners to work with towards better supporting patients' whole care needs would be very powerful, especially with the designer drugs that are hitting many Tribal communities. So many people end up in jail because there are not good programs in place for their needs.

Kim Malsam-Rysdon reiterated that there are ways to be flexible enough to cover many supports as part of the core services that Health Homes are required to provide. The question is would IHS or Tribal providers be able to be BH Health Homes (could they meet the specific Health Home requirements) and if so, there is good promise for this option. Additionally, there are strategies to look at what are the opportunities for changing payments today that can free up IHS and Tribal provider dollars for other things for which Medicaid does not pay.

Other Potential Models of Care Similar to Health Homes

Several other models of care similar to Health Homes were mentioned and the group decided it would be worth exploring them more. One was the "Baltimore model" noted by Dan Foster especially because it has a significant health promotion and wellness component, which is very important for individuals with BH issue. Another was the South Central Foundation in Alaska (a Tribal provider), which integrates BH and primary care at the hospital and clinics and works with the entire family of the patient. Additionally, Dr. Heinemann said Sanford conducted an integration project over the summer that included working with some Tribal providers in Minnesota. That project showed that in order for things to work optimally, there needs to be more coordination between primary care and BH. Also, Donna Keeler explained that the Urban Indian Health Clinic is an integrated model now, with share-care visits, not just co-located providers. Introduction to a BH counselor is basically part of every visit. Marlies Whitehat said that at Rosebud they have a system of care that also includes care coordination, which frees their therapists to do therapy. The wrap-around services allow the families and children to focus on getting help for their BH needs.

There was acknowledgment that the majority of BH does happen in primary care, and because the work done by the CMHCs is more focused on SED/SMI patients (which is good work and greatly needed) it will be important to also look at other models that can serve more people more effectively.

Tribal Behavioral Health Programs

There are several types of programs that serve Native Americans and they are all different.

Richard Bird described the Sisseton BH program, which is currently accredited with the State and just received accreditation for another two years. All of their addiction counselors are certified and they do have a few counselor trainees. They have 12 beds available. They have not billed the Medicaid program, but do participate in the State-funded program (this is because the population they currently serve –

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non-pregnant adults – is not eligible for Medicaid today). They occasionally do serve non-Indians, but very few, and they do not have capacity to serve adolescents at this time. About 10% of their funding comes from the State, and they can bill certain private jealth insurance, as well, although they have few patients with private insurance. Most of their funding comes through the IHS 638 contract. Medicaid expansion would support more services for the population that Sisseton serves today because IHS and 638 funds only cover about half of the actual need.

Marlies Whitehat explained that the Rosebud Systems of Care program is funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) and is a system of care focused only on children ages 3 – 22; they serve about 70 children a week with equine therapy and transportation to/from multiple communities. They have a collaborative with 19-20 partners that share training, activities, and other resources, and they have a common MOA that includes the cultural Lakota values and all providers operate under that understanding. There is a common referral form that everyone uses so the families only have to do it once no matter what aspect of the program they are in or what providers they see. The original program started 5 years ago with one horse and one Tribal elder; today they have a large group equine therapy program that has four age-based groups. A large part of what they do includes transportation of children to/from sessions. Recently they have started working on school grounds, which helps to reduce the need for transportation. They focus a lot on cultural needs of the children and their families. They recently began using a new EMR (Accumedic). The biggest challenge is how to sustain the program with only one year left on the SAMHSA grant. They have tried to hire people who are "reimbursable" so they can keep their funding going after the grant as much as possible, but today cannot get any reimbursement other than through the grant. They would like to work with the schools to be able to provide services and bill under Individual Education Plans.

They have money they can use for "flex dollars," but they use it sparingly and expect families who receive it to contribute something back so do not create a culture of dependency (i.e., the Lakota philosophy of giving back – cleaning, doing dishes, sewing, family dinner gatherings, laid a sidewalk, etc.). Their focus has been on reducing suicides in Rosebud, which is critically important, given the epidemic of suicides and attempted suicides they have experienced there.

Further Discussion about IHS/Tribal Program Opportunities and Challenges

The Health Home model has a lot of merit, but it is limited in many respects and the PPPM rate for a tier 4 recipient for the core services is about $3800/year. Plus, services are essentially "clinic-bound." Some of the IHS/Tribal programs today are definitely at risk if we cannot find ways to pay for them outside of grants. Under the IHS budget, MH and SA are separate. Most Tribes have a 638 for SA, but not for MH. The Tribes have to request to do MH under 638, which they can do under their own Tribal facility or through other means. They also have to go through a resolution process with their Tribal Councils. For a program like the Rosebud Systems of Care, it would likely be easier to get Tribal approval. The challenge is that these programs get grant funded, then end because the Tribes and IHS cannot provide sustained funding sources. If they could be incorporated into the State structure and have sustainable funding it would be a huge benefit to the Tribes, their people and the State.

The question was raised that SA programs have been able to get 638 status, so why hasn't the same thing happened more with MH. A lot of it is access to providers, and meeting the accreditation requirements can be difficult. It also has to be a Tribal decision. It is also hard to show what is

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"effective" or "evidence-based" even though it works with Tribal members. We have to recognize that for this to work in Indian Country, we may need a different provider type.

Donna Keeler reiterated that when we talk about Indian Health Services, we have to talk about all three pieces – IHS, Tribal and Urban Indian Health programs (Title 5) or I/T/Us. Otherwise, Urban Indian Health gets excluded. They experience all the same issues as the IHS and Tribal facilities. Urban Indians are defined as Tribal members who live off the reservation and new data shows that 78% of Tribal members live off reservation. There are 38 Urban Indian Health clinics in the country, from full service to basic services. Most of those that are full service are Federally Qualified Health Care Centers(FQHCs). Today, Urban Indian Health providers are NOT included in the 100% FMAP. New language in the CMS white paper would change this, but only under contractual agent status. It is important to make sure the new language allows Urban Indian providers to continue to "own" their patients and not create yet another disruption of care for Tribal members. CMS does appear to be looking at this issue, although some things would require an act of Congress to change. However, there are opportunities for other changes that could be made more quickly to better support and incorporate Urban Indian Health providers into the system.

Next Steps/Agenda Items for Nov 19 Meeting:

- Baltimore Model – Dan Foster
- South Central AK Model – Jerilyn Church
- Thief River Falls project – Dr. Dan Heinemann
- Information on the IHS requirements for 638 MH contracts and impacts of moving out of IHS – Jerilyn Church
- Data on inpatient BH costs for Medicaid – Brenda Tidball-Zeltinger
- Learn more about the HH model and potential opportunities to expand to more providers being HHs (links to other subcommittees) - Lynne Valenti

Next Meeting:

Thursday, November 19th, 8:30 – 11:30am Central Time, Ramkota Gallery B

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