

Behavioral Health Subcommittee Meeting

Meeting Minutes: 12/04/2015

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

Welcome and Introductions

Don Novo from HMA opened the meeting and subcommittee members introduced themselves. Marlise White Hat provided an opening prayer. Don reminded subcommittee members to review the November 19th meeting minutes at <http://boardsandcommissions.sd.gov/Template.aspx?id=145> and to send any comments or revisions to Kelsey Smith at Kelsey.Smith@state.sd.us. He also reminded subcommittee members of the day and location change for the next Behavioral Health Subcommittee meeting on **Wednesday, December 16th, 8:30 AM – 11:30 AM** at the **Ramkota Conference Center** in Pierre.

Review November 19th Minutes

There was a presentation and review of the State's Medicaid Health Home provider requirements. There are two types of Health Homes, primary care and behavioral health. The core services are the same, but the focus is on chronic health conditions or behavioral health conditions, depending on the individual patient's needs. About 30 percent of those served today through the Medicaid Health Homes program receive their care from IHS.

There also was a presentation of the requirements for being a community mental health center (CMHC). CMHCs serve designated counties, and must serve individuals of all ages. They care primarily for individuals with Serious Emotional Disorders (SED-children) and Serious Mental Illness (SMI- adults). A clinical supervisor must supervise all staff.

There was a discussion of the Community Health Representative (CHR) model that is under review by the New Services Subcommittee and how CHRs can support behavioral health services. There was also a brief presentation of the behavioral health services provided through IHS and Tribal health organizations.

Review of Substance Abuse Services

Amy Iversen-Pollreisz presented information about the state's substance use disorder (SUD) services, including those SUD services that are Medicaid reimbursable today and those that are funded through federal or state dollars (see slide deck, posted at boardsandcommissions.sd.gov).

Today, there are SUD services available through Medicaid, but only for adolescents and pregnant women. Federal block grants and State general funds currently fund these services for adults. Services include outpatient services, day treatment, inpatient treatment, low intensity (halfway house) and detox services.

There is a variety of outpatient SUD programs across the state and new efforts to expand services especially in rural areas through telehealth, including some pilots where individuals participate in group SUD services through the use of telehealth. Day treatment services are more intensive and may include

a residential component. Inpatient treatment requires prior authorization and includes programs in Kyle, Sturgis, Sisseton, Mitchell and Canton. There also are specialized programs for pregnant women in Rapid City and Sioux Falls. Adolescent programs located in Rapid City, Huron, Canton and Sioux Falls.

There are non-Medicaid eligible SUD services, including low-intensity (e.g., Halfway House) services, detoxification, and prevention services. Prevention services also include public awareness programs and activities in schools and other community locations. These services are funded by a combination of federal and state general funds.

If the state expands Medicaid, SUD services is an essential health benefit and will be a covered service for adults in the Medicaid program. Under Medicaid expansion, the State expects that of the current population of adults estimated as eligible (54,693), approximately 10,202 of them would need SUD services (based on South Dakota's prevalence rate for substance use disorder – 11.2%). Of these individuals, approximately 7,274 are already receiving SUD services today but would be eligible for funding under Medicaid expansion, and approximately 2,928 would be new individuals eligible to access services that are not getting services today.

Of those 2,928 individuals, the Department has begun looking at estimates of these individuals who would access SUD services and what services they would use. Among the “new” individuals who would be eligible, 72 percent are *estimated* to use outpatient services, 2 percent would access day treatment, 3 percent would access inpatient services, 9 percent would access low-intensity (halfway house) services, and 11 percent would access detoxification services. This represents the capacity-need expectations. In order to fully analyze capacity and estimated need, the State needs to obtain additional data, particularly for individuals accessing services through IHS and non-accredited Tribal programs, not included in these current numbers. This information should be available from IHS.

The general fund dollars the State uses today to support SUD services include a federal maintenance of effort (MOE) requirement. The MOE means that the State must maintain the level of State funding for SUD services; however, the ability to shift some dollars to Medicaid would allow the State to fund additional SUD services that are not covered by Medicaid such as halfway house services and prevention services.

Jerilyn Church noted that there is a Tribal Consultation behavioral health meeting next week, a part of a set of meetings to discuss the issues related to suicides among Tribal members. This could be a good opportunity to present to that group some of the work of this Behavioral Health Subcommittee and ways to collaborate or leverage programs.

GPTCHB Access to Recovery Program

Jerilyn Church provided some documents about the Great Plains Tribal Chairmen's Health Board (GPTCHB) Access to Recovery program, including a PowerPoint presentation, a list of the program locations, and the service rates and definitions (documents found at boardsandcommissions.sd.gov).

Access to Recovery (ATR) is an SAMHSA-funded community-based recovery program that includes faith-based counseling and support and other services that support clients during the recovery process. The GPTCHB program is one of only two Tribal grantees for the program, and SAMHSA has allowed some flexibility for the program to support treatment because of the unique needs of the Tribal members and their families.

The ATR program started in 2010 and had enrolled 6,599 clients; most are men (52%), and 72.9 percent are between the ages of 18 – 44. The top services are individual counseling, group counseling, transitional drug free housing, intensive outpatient treatment and transportation. Clinical assessments account for the majority of spending in the most current fiscal year, residential treatment is the second highest line item. Support services covered by ATR include:

- Transitional drug-free housing
- Care coordination
- Physical fitness and well-being activities
- Bus passes
- Alternative therapies
- Spiritual support (traditional healing, sweat lodges, talking circles, spiritual/cultural supplies, spiritual/cultural retreats, Tribal arts, and crafts)
- Substance abuse education
- Employment services
- Transportation
- Family services
- Alcohol/drug testing
- Education services
- Peer recovery coaching/mentoring
- Sober living activities
- Medical care
- Nutrition management

Providers must complete the GPTATR application, give proof of professional license or accreditation for themselves and employees, have professional liability insurance, undergo a background check, have an IRS Form W9, give a letter of good standing for Traditional Healer/Faith-Based Provider, and have documentation of Cultural Competence training.

The ATR program uses the Orion Healthcare Technology AccuCare System as its EHR and practice management system. AccuCare also allows the GPTCHB to conduct audits and do required SAMHSA reporting. There is a third party vendor that manages the billing.

SAMHSA substantially downsized the ATR program, and the GPTCHB did not receive a renewal on their grant, even though they partnered with other Tribes in neighboring states.

Capacity for IHS Participation in Behavioral Health Health Homes Program

Jerilyn Church was able to have some additional discussions with Indian Health & Tribal representatives about opportunities for expanding capacity to serve as Behavioral Health Health Homes. The most effective option appears to be for the Tribes to fully take on the mental health and substance abuse treatment services through 638 contracts. The concern is that the present issues are so pressing and the time it will take to develop Tribal programs cannot meet the current need. Additionally, in order for the Community Mental Health Center model to feasibly work with in tribal communities, regulatory rules would need to be reviewed and amended to accommodate Indian Health/Tribal Health System participation.

Especially with the ATR program ending, the needs are critical, and it will be important to find ways to continue services and supports for people who need them.

All of the IHS service units are already Primary Care Health Homes. Working with IHS to develop Behavioral Health Health Homes is a way to help expand services and capacity for Tribal members who need mental health and SUD services. The same authority for IHS would transfer to a Tribal 638 program. This requires strong coordination between the Tribal program and IHS, as well as other primary care providers and providers of other needed services. All tribes have a 638 program for substance abuse services except Crow Creek. Several of the Tribes also have 638 programs for mental health services. The Tribal SUD programs could receive deemed State accreditation.

There was discussion regarding the eligibility criteria of SED or SMI for individual eligibility for a Behavioral Health Health Home. Individuals with long-term chronic conditions or short-term intensive conditions can meet the SED or SMI diagnoses. Additional screening also can help to identify needs that may not have been apparent otherwise. Tom Stange reported that in his experience with his agency in participating in a Behavioral Health Health Home, he has not seen these criteria as a barrier to individuals being eligible for a health home.

The State can provide technical assistance to both IHS and Tribal programs around accreditation, organizational structure, billing, and reporting, etc. Several of the existing Behavioral Health Health Homes also are available for technical assistance. All of the components of the ATR program align very well with the Health Home program requirements. There should not be any issues regarding Tribal providers applying for other federal funding if they move forward with Health Home implementation, and the Department can support technical assistance for Tribes to work through those questions.

The GPTCHB is working on some initiatives to support the Tribes in moving toward 638 status for more services – including both under Title I and Title V structures of the Indian Self Determination Education and Assistance Act (ISDEA).

Overview of Tele-Psychiatry and Billing in Medicaid

Lynne Valenti presented information about Medicaid's use of telemedicine today (see slide deck at boardsandcommissions.sd.gov).

The definition of telemedicine includes the distant site (where the provider delivering the service is located), the originating site (where the patient is located), and the equipment used (at minimum real time audio and visual equipment for two-way communication). Services provided via telemedicine are reimbursed at the same rate as in-person services; services must be billed using a "GT" modifier. Personal technology such as laptops, smart phones and tablets can be used, but only with Zoom technology that allows the transmission to be secure and HIPAA compliant.

Services billed today are billed by physicians and psychiatrists, physician assistants, advance practice nurses, specialists, IHS, FQHCs and RHCs. Originating sites are eligible to receive a facility fee for technology, equipment and personnel performing telemedicine services. The facility fee may not be reimbursed as an encounter.

There are opportunities to expand telemedicine coverage and services that can be billed to Medicaid, such as those provided by Licensed Professional Counselors with Mental Health designations.

The group discussed some of the challenges of using telemedicine. The rates may not cover the full costs to the facility, although they may cover the cost of the actual transmission and equipment use. Today, there are limitations around what types of facilities can bill for telemedicine services. An idea to explore is how to make telemedicine services available to clients in their homes. Credentialing for providers is a challenge because it's required for each originating site. There are also issues with HIPAA compliance for some of the new technologies.

Subcommittee Recommendations

The group discussed the recommendations it would like to put forward to the Health Care Services Coalition. They include expanding behavioral health capacity through IHS and Tribal Programs by:

1. Expanding capacity through development of Behavioral Health Health Homes and Tribal Community Mental Health Centers within IHS and Tribal programs. This would require reviewing and recommending appropriate amendments to regulatory rules for participation Indian Health participation as a Community Mental Health Center and to ensure feasible and successful implementation.

This would include funding technical assistance for IHS and Tribal programs to understand how to work through the specific requirements and infrastructure development required to implement these programs. This recommendation also includes incorporating Community Health Workers and Community Health Representatives (CHW/CHRs) as part of the Health Home model (per recommendation from the New Services Subcommittee), as peer support specialists for behavioral health, and building a formal CHW/CHR program under Medicaid as a strategy to increase access. The Rhineland Model is one model that would be useful to explore specifically for behavioral health, and having CHW/CHRs certified as Medication Assistants (as in some behavioral health Health Homes).

2. Review who can be an eligible provider of behavioral health and substance use treatment services under Medicaid to determine if there are options to expand to additional provider types. For example, with private providers who may not be associated or providing the service through a specific clinic. This encompasses who can bill, what they can bill for, and where they can bill (location) and will need to be explored further to understand the cost implications.
3. Adding evidence-based services and supports for children and families, including supporting the provision of functional family therapy as a Medicaid state plan service. This could include looking at options for less intensive settings than inpatient such as day hospital stays and school-based services, as part of the full continuum of services for children and youth (as well as adults).
4. Explore the ability to utilize and expand the use of telehealth though consideration of additional providers and additional services eligible for Medicaid reimbursement.

Next Steps:

- Get information about the number of individuals served through IHS and non-accredited SUD Tribal programs.
- Assess costs and continuum of care options to provide less restrictive/intensive and less costly treatment settings such as school-based and outpatient treatment programs.

- Look at the restrictions in Medicaid regarding the use of telemedicine for individuals in the same community as the originating site, as well as the requirement for visual connectivity (versus audio only).

Next Meeting

Wednesday, December 16, 8:30 – 11:30 a.m., Central Time, Ramkota

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