

## New Services Subcommittee

Meeting Minutes: 11/18/2015

**Attendees:** Kim Malsam-Rysdon, Lynne Valenti, Brenda Tidball-Zeltinger, Deb Fischer-Clemens, Monica Huber, Sonia Weston, Edmund Johnson Jr., Evelyn Espinoza, Donna Keeler, Michael Coyle, Pam Locken, Capt. John Schuchardt, Mike Jockheck (guest presenting on Medicaid pharmacy benefit)

### Welcome and Introductions

Kim Malsam-Rysdon started the meeting and noted that Jerilyn Church has experienced travel delays, so would miss this meeting, but does plan to be at the meetings later in the afternoon. Don Novo from HMA welcomed the subcommittee members and reminded everyone to initial the attendance list. Don also asked the subcommittee members to review the minutes from the November 4<sup>th</sup> meeting [New Services Subcommittee Minutes 11-4-2015 Draft.pdf](#), and to email Kelsey Smith ([Kelsey.Smith@state.sd.us](mailto:Kelsey.Smith@state.sd.us)) with necessary edits.

### Review of November 4 Meeting

At the last meeting, the group discussed Community Health Worker (CHW) and Community Health Representative (CHR) programs provided under IHS at Ft. Thompson, and Tribal programs of the Rosebud Sioux Tribe and Oglala Sioux Tribe. Capt. John Schuchardt also presented an overview of the medication therapy management (MTM) program through IHS.

### Tribal CHR Program Survey

The information related to the survey of Tribal CHR programs will be presented by Jerilyn Church at the next New Services Subcommittee meeting on December 3, as she was not able to attend today's meeting.

### *Other State Medicaid CHR/CHW Service Definitions*

Stephanie Denning presented information about other states' CHW program (see slide deck, posted at - [boardsandcommissions.sd.gov](http://boardsandcommissions.sd.gov) – for details).

The most common definition of a CHW was developed by the American Public Health Association (APHA): *"...frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."*

There are many different titles used to refer to individuals in these types of positions, such as: *community health advisors, lay health advocates, promotoras, outreach educators, community health representatives, peer health promoters, and peer health educators.* Generally CHWs provide non-clinical services, but program models differ across states and across groups that use CHWs. Alaska Health Aides can provide limited clinical care as specially trained physical, behavioral or dental aides. CHW programs

still are largely funded through grants; however, more states are looking at expanding reimbursement for CHWs through State Innovation Model (SIM) grants and through Medicaid.

Almost all states have some type of specifically defined and structured CHW program – South Dakota does not. Although there are certainly CHWs and CHRs working in South Dakota, there is not a specific State-sponsored or statewide CHW program. A number of states currently include CHW services and funding mechanisms in their Medicaid programs. In particular, Alaska, New Mexico, Oregon, South Carolina, Texas and Washington are the states included in this review that have built CHW programs in Medicaid.

Alaska: Uses Community Health Aides to support physical, behavioral and oral health care. Required training and certification through the Community Health Aide Program, which is funded and overseen by the Alaska Tribal Health Consortium. Alaska's CHAs do provide some lower level clinical services, but must be trained and certified.

New Mexico: New Mexico's Centennial Care Medicaid program requires all the managed care organizations to use CHWs or CHRs (for Native American enrollees). The state has spelled out in the managed care contracts what services CHWs/CHRs should provide, and allows the health plans to count a percentage of the costs for their CHWs/CHRs as medical expense vs. admin expense. One health plan in New Mexico, Presbyterian Health Plan, contracts with a number of Tribes for CHR services, including: providing translation services, coordinating transportation, conducting health assessments, assisting with e-doctor visits, providing health education and other supports for care coordinators and members.

Oregon: Oregon requires its Coordinated Care Organizations (CCOs) to include "non-traditional healthcare workers" like CHWs on their care teams in Health Homes. Only certified CHWs may participate in Health Homes and a health professional must supervise a CHW in order for Oregon Medicaid to reimburse for services they provide.

South Carolina: Uses CHWs in both its full-risk managed care and Primary Care Case Management programs. The state recognizes CHWs as an authorized service for reimbursement under its Medicaid State Plan and allows providers to bill Medicaid using unique CPT codes for individual or group CHW education sessions. The State is the only body certifying CHWs for Medicaid, after they go through 120 hours of classroom training and 120 hours of internship/mentorship.

Texas: Requires CHWs to complete 160 hours of training on eight standardized core competencies, but offers the training through multiple avenues such as community colleges, other academic institutions, AHECs, FQHCs, a CHW network, and community-based organizations. The State certifies CHWs for two years, after which they must recertify. Texas State statute defines CHWs as individuals who "provide a liaison between health care providers and patients through activities that may include ... assisting in case conferences, providing patient education, making referrals to health and social services, conducting needs assessments, distributing surveys to identify barriers to health care delivery, making home visits, and providing bilingual language services."

Washington: Includes all "allied health care staff" (CHWs, peer counselors and other non-clinical personnel) as key partners in the Health Homes program. There is an eight-week training (in-person or online) through the Department of Health on core competencies and CHWs receive a certification of completion, but there is no certification required. Allied health care staff provide Health Home

administrative support such as arranging for beneficiary transportation to appointments, mailing health promotion material, and calling beneficiaries to facilitate face-to-face meetings with care coordinators.

Some additional CHW resources that may be of interest to the Subcommittee includes:

**APHA CHW information**

<http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities>

**HRSA CHW Toolkit**

<http://www.hrsa.gov/ruralhealth/pdf/chwtoolkit.pdf>

**NASHP State Community Health Worker Models, May 2015**

<http://www.nashp.org/state-community-health-worker-models/>

**Costs and Cost Effectiveness of CHWs: Evidence from a Literature Review, Sept. 2015**

<http://www.human-resources-health.com/content/13/1/71/>

**Group Discussion about CHWs and CHRs**

The group agreed that it would be good to help the current CHR programs in South Dakota find a way to move from providing mostly transportation services, to being able to provide more of the health education and system navigation services that CHWs in most of the other states seem to do.

Ft. Thompson found that even though their CHRs do a lot of patient transportation, they were not billing Medicaid for very much of it. Urban Indian Health Clinic stopped billing Medicaid because of issues with about not transporting patients to the closest facility. Brenda Tidball-Zeltinger clarified that Medicaid can only reimburse for transportation to a primary care provider who is outside of the patient's city of residence, or for specialty referred care outside of patient's city of residence. If the care is provided in the same city where the Medicaid enrollee lives, Medicaid will not pay for the transportation. Some Tribes do have transit programs that could support some of the transportation needs, but not all of them because of the limitations in number of vehicles and routes, etc. DSS can do some follow up on how to help IHS and Tribal programs understand how to bill Medicaid for transportation services today. Over a longer period, the new opportunity with the 100% FMAP will require changes in the Medicaid transportation billing processes to leverage this most effectively.

The group recommended IHS and Tribal programs bill Medicaid for the transportation services that CHRs are currently providing to Native American Medicaid enrollees. The state agreed to provide assistance to IHS or tribes as needed.

There are not common training requirements for CHRs across the Tribes and/or IHS today in South Dakota. Each Tribe has its own program and does its own training. For example, Rosebud requires CHRs to be Certified Nurse Assistants through the local community college. They have a 638 contract with IHS

for CHR services. Legal issues have impacted some of the home visits CHRs used to do, and the staffing requirements (things like background checks) also have impacted programs.

The group expressed concern that there needs to be funding to hire and train CHW/CHR staff before they can begin to bill for services that would be covered under Medicaid. Kim Malsam-Rysdon noted that among the high-level recommendations, this group could recommend developing CHW services and key aspects for implementation. That would include fleshing out time frames for training and certification, payment models, etc. The Subcommittee can use the information and models from other states as a starting point. The HRSA toolkit could be very helpful, as well. The group should connect with Ron Galloway, the Regional IHS CHR coordinator (in Aberdeen) to better understand the CHR curriculum that exists today through IHS.

Key next steps for the Subcommittee regarding a CHW/CHR program in Medicaid are:

1. Ensure existing programs are able to bill for transportation services. Non-Emergency Transportation is about \$3M out of the total Medicaid budget. South Dakota counts transportation as an admin cost today because it is an easier process.
2. Define what we think the CHW services should look like in South Dakota. Transportation is a piece, but this shouldn't be the full focus of what they do. Core to CHW/CHR duties are patient education, help with follow up from doctor visits or hospitalizations, and health coaching.
3. Define individuals eligible for CHW services. If a person is eligible and in a Health Home, the CHR is part of the Health Home team. If someone is not eligible for Health Home services, CHRs available to support their access to primary care, for example through the IHS and Tribal clinics, FQHCs and CHCs.

Staff will flesh out these recommendations for the group to react to at the next meeting, so the Subcommittee can make a more formal recommendation to the larger Coalition on December 3.

### **Medicaid Pharmacy Benefit and Covered Services**

#### *Overlap between Medicaid prescription drug benefit with MTM*

Mike Jockheck and Brenda Tidball-Zeltinger presented information about the State Medicaid prescription drug benefit (see slide deck – posted at [boardsandcommissions.sd.gov](http://boardsandcommissions.sd.gov) - for details).

South Dakota Medicaid drug spending in SFY 15 was \$35.1M (net of rebates), for nearly a million prescriptions annually. The State has a very high rate of generic use – 83.3%

Federal guidelines dictate much of what Medicaid can/will cover (e.g., cannot cover cosmetic, fertility or experimental drugs). Medicaid generally reimburses based on the Average Wholesale Price (AWP) for most drugs. There also is a dispensing fee paid to pharmacies. There are medication co-pays for beneficiaries except those who are exempt from cost-sharing, including children, pregnant women and Native Americans.

Federal regulations don't allow Medicaid to implement a true "closed" formulary, as many private payers have, because of some of the federal requirements that limit states' ability to restrict certain medications. However, states including South Dakota utilize controls such as prior authorizations. There is a state Pharmacy & Therapeutics (P&T) committee that meets quarterly and is comprised of both pharmacists and physicians. Rather than review specific drugs, the P&T committee often reviews

the class of drugs to better understand appropriate use. Drug utilization review (DUR) is done prospectively (pharmacists often do this at time of fill) and retrospectively. Medicaid has a review committee of clinical pharmacists and a physician that reviews information from all claims of all Medicaid beneficiaries, based on a system-generated review that identifies outliers or issues for alert. Staff will contact providers to let them know when issues have been found – it is not punitive. There is about a 50% response from providers.

Pharmacists also work directly with beneficiaries to make sure they understand their medications and know how to take them appropriately. They are the front line for identifying any issues with contraindications, or with drug-seeking behaviors for controlled substances (this includes all providers – public and private).

Medicaid has expanded the role for pharmacy in Health Homes. They are part of the care team to support individuals in Health Homes who have chronic conditions through most of the core components of Health Home required services (care management, care coordination, health promotion, transitional follow-up, patient and family support). It is important for the State to leverage the Health Home model to support MTM-kinds of services. CHWs also could be another level of support to help with the health education about medications.

#### **Group Discussion about Medicaid Pharmacy Benefits and MTM**

Avera has a coordinated care model (its version of Health Homes), which includes medication reconciliation at several points in the process: upon admission (compare what a patient is taking when they arrive to what was in the last in clinic record); upon discharge (make sure the patient knows what has changed), and through a follow up call or home visit post-discharge. They also do medication reconciliation in long-term care facilities, through variety of transition points, etc. They try to look at the specific pharmacies a patient is using make sure there is coordination across pharmacists.

Non-adherence and inappropriate medication use are huge cost drivers in health care. Over the counter (OTC) medications also drive a lot of complications and costs, so they have to be factored in.

There was a question about whether there are there people outside of Health Homes who need this service and how would they get it. The State wants to ensure that the Health Home model is flexible to support beneficiary needs. Billing for this kind of service should fall into the Health Home payment, which could be modified in the future if needed. Tele-pharmacy is an option that could be very effective if it is covered by Medicaid, especially in a rural state like South Dakota.

The group noted that there still is the issue of people who choose to opt out of Health Home services or who do not have a Health Home provider in their area. . Public Health Nurses (PHNs) are key staff at the Ft. Thompson IHS service site for supporting medication management. But Ft. Thompson is having trouble billing for PHN services. There further are serious difficulties with staffing at many IHS/Tribal Health Homes, and the turnover among providers definitely impacts the ability to manage medications, as well as other things.

The group agreed Health Homes should provide MTM services to their patients. Capt. John Schuchardt provided a handout on what MN has done to implement MTM. He will identify within IHS who potentially doesn't get served by Health Homes today (other than those who choose to opt out) that would benefit from MTM.

**Next Steps:**

- Staff to flesh out recommendations related to CHWs/CHRs for subcommittee to review and approve at next meeting.
- Capt. John Schuchardt will identify who would need MTM that is NOT eligible for Health Home services.
- Jerilyn Church will provide the update on the Tribal CHR program at the next meeting.

**Next Meeting**

**Thursday, December 3, 10 AM – Noon, Central Time, Americlnn, Fort Pierre, SD**

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

[boardsandcommissions.sd.gov](http://boardsandcommissions.sd.gov)