Introduction to South Dakota Medicaid Expansion Concept Paper

March, 2015

Access to health care in South Dakota is limited by factors including geography and provider availability. South Dakota comprises almost 76,000 square miles with a very low population density of 10.7 persons per square mile. 57 of 66 counties are defined as primary care Health Care Professional Shortage Areas or sites, and 59 counties have Medically Underserved Areas. These **access issues are even worse for Native Americans living in South Dakota**. South Dakota Native Americans live in some of the poorest counties in the country, and access to local health care is limited. Health care disparities among South Dakota Native Americans are pronounced.

Eligible South Dakota Native Americans are served by the Great Plains Indian Health Service Unit. However, actual access to Indian Health Services is limited in all areas of the state, and IHS contract care budgets do not meet the demand for healthcare beyond even limited emergency services. As a result, **Native Americans eligible for IHS services use non-IHS services at high rates**, and often at higher cost than if they were able to access care earlier and closer to home.

The state Medicaid program pays almost twice as much for health care for Native Americans by non-IHS providers as IHS providers. For Native Americans eligible for IHS services and also Medicaid eligible, health care expenditures provided through IHS are reimbursed at 100% federal funds through Medicaid. Health care expenditures for Medicaid eligible Native Americans by a non-IHS provider are reimbursed at the state's regular FMAP (51.62% federal/48.38% state in state fiscal year 2016). For this reason it is fiscally beneficial to the state to help eligible Native Americans get care from IHS instead of non-IHS providers. Given the capacity issues with IHS, the state is looking for **innovative ways for eligible Native Americans to get care that qualifies for 100% federal funding** as it would if IHS were able to provide it.

The state, in collaboration with IHS and non-IHS health care provider, is specifically seeking to implement different strategies to significantly augment services that can be provided to Medicaid eligibles through 100% federal funding authority through a **variety of strategies**. Examples include using health care specialists available through non-IHS providers to serve patients at IHS sites via telehealth or specialty clinic arrangements. Other examples include use of telehealth emergency room services to reduce non-emergency transfers of patients from IHS to non-IHS providers in the state and the provision of clinic services in non-reservation population centers to better serve IHS eligible Native Americans. For these strategies to work there would need to be flexibility in how IHS services are defined in terms of providers and locations of services for the purposes of Medicaid reimbursement. That means CMS would pay the same match rate (100% federal) as they would today for IHS services to Medicaid eligibles, but for more services than the current IHS system can accommodate. These strategies would benefit both the current Medicaid population and the Medicaid expansion population eligible for services from IHS.

To be clear, we are not asking for fundamental changes of funding for IHS, but for CMS to work with the state to provide needed Medicaid services that can be billed at the IHS federal rate for IHS eligible individuals.

The result of increasing access to services to individuals eligible for IHS would include better health outcomes for South Dakota Native Americans. With an increase in IHS funded services through Medicaid at 100% federal funds, state general funds used now to pay for services to this population would be **redirected to offset the costs of expanding Medicaid** in South Dakota. That would result in coverage for 48,000 additional people in South Dakota, more than a quarter of whom are Native American.