

# South Dakota Health Care Solutions Coalition

Meeting Notes 10/7/2015 (revised on 11/2/15)

Attendees: Sen. Bernie Hunhoff, Sen. Troy Heinert, Sen. Deb Soholt, Terry Dosch, Council of Community Mental Health Centers and Substance Abuse Providers; Deb Fischer-Clemens, Avera Health; Brenda Tidball-Zeltinger, Department of Social Services; Lynne Valenti, Department of Social Services; Charlene Red Thunder, Cheyenne River Sioux Tribe; Kathaleen Bad Moccasin, Indian Health Services (IHS); Jerilyn Church, Great Plains Tribal Chairman's Health Board; Kim Malsam-Rysdon, Governor's Senior Advisor/ Secretary of Health; Don Novo, Health Management Associates; Sunny Columbe, Great Plains Tribal Chairman's Health Board; Barb Smith, South Dakota State Medical Association; Sonia Weston, Oglala Sioux Tribal Council; Monica Huber, Sanford Health; Rep. Don Haggar, Steve Emery, Governor's Secretary of Tribal Relations; Janet Jessup, Department of Tribal Relations; Jason Dilges, Governor's Budget Director; Mike Diedrich, Regional Health; Jennifer Stalley, Community Health Centers of South Dakota.

## Welcome and Introductions

JR LaPlante opened with a prayer. Kim Malsam-Rysdon and Jerilyn Church welcomed coalition members and thanked everyone for their participation.

## Workgroup Overview

Don Novo provided an overview of the Health Care Solutions (HCS) Coalition purpose and scope. The group will focus on development of a solution that supports increased access to healthcare for Native Americans while leveraging general fund savings to fund expansion in the long term, and to improve health outcomes for Native Americans in South Dakota.

Kim Malsam-Rysdon outlined that Gov. Daugaard is cautiously approaching the expansion discussion given the expected costs. The State cannot support expansion unless revenue to support projected expenditures is available in both the short and long term. In order to move forward with any Medicaid expansion discussions, the group needs to identify strategies that align with these goals and specifically identify ways to free up the State dollars needed to cover the state cost of expansion.

Jason Dilges added that the challenge has been identifying the long-term coverage and ensuring that the State can cover any obligations that it may incur for expansion. He reiterated that the \$30-\$32 million in expected costs are the net costs for the long-term effort and consider job creation and other state economic benefits.

Don Novo explained that there will be three subgroups supporting the larger HCS Workgroup efforts. Kim Malsam-Rysdon noted that these subcommittees will include a mix of people from the larger HCS Workgroup, as well as others from the community with specific subject matter expertise or knowledge about particular issues. Kim outlined that the workgroup is organized to align with the goals and strategies outlined in the concept paper submitted to CMS in March 2015.

- Access subgroup – looking at better ways to deliver services currently covered by Medicaid through IHS and Tribal programs.
- New Services subgroup - charged with identifying innovative ways to provide new services not covered today to reduce more costly future care.
- Behavioral Health Services subgroup – charged with identifying solutions to address behavioral health service gaps.

Deb Fischer-Clemens noted the technical discussions with CMS regarding flexibility for the 100% FMAP. Kim noted that there are ongoing discussions with CMS regarding the flexibility CMS is considering and any updates from CMS on this issue will come back to the workgroup through updates.

**Increasing Access to Services Provided through Indian Health Services/Tribal organizations:**

This workgroup held its first meeting 9/18/15. The group is targeting its efforts to identify specific strategies that could be put forward to CMS as examples of increasing access. The group has identified some examples including use of telehealth to increase access to care at IHS facilities and expansion of specialty services through partnerships with non-IHS providers. This workgroup is also scheduled to meet following the HCS Workgroup meeting. Kim Malsam-Ryson referred the Access subgroup minutes from the first meeting of this group held via conference call. Part of the process has been getting information from Medicaid and information from IHS and providers about patterns of care and utilization. The Access group has information it will review and discuss at its next meeting. The group is working to refine a template that will be used to expand on some of the concepts outlined to CMS around improving care at IHS/Tribal facilities.

To be successful, IHS, Tribes, providers, and other key stakeholders will need to develop strategies that look differently at delivery of healthcare through IHS. Examples include tele-medicine, and expanding specialty care through partnerships with non-IHS providers. Telemedicine is an example can be used by either Tribal or IHS providers; at least some Tribes are working on doing this through Avera Health, although the contracting process with IHS is very slow. There is a similar contract with the Billings HIS region. IHS has challenges with the reimbursement rates for telemedicine and space availability.

**Development of New Services:**

This subgroup will focus on increasing access through development of new services through IHS and Tribal organizations not currently covered by Medicaid (e.g., Tribal Community Health Representatives, etc.). While identifying ways to increase access considerations such as the impact to benefits for all Medicaid recipients will need to be considered. Membership suggestions for this group should be sent to Kelsey Smith in the Governor’s Office as soon as possible.

**Development of Behavioral Health Services:**

This subgroup will focus on increasing additional capacity for behavioral health services. If the state were to expand, there are certain behavioral health services outlined through the ACA as essential health benefits that are not currently funded through Medicaid. The group will identify strategies to increase capacity for behavioral health services provided through IHS and Tribal Organizations.

Sen. Deb Soholt asked a question about looking at new services and who would be looking at efficiencies and how to ensure that clients are accessing and able to access services in the most efficient way. Sen.

Deb Soholt also noted gaps in behavioral health services. Sonia Weston noted the issues with substance abuse and other behavioral health services and limited access for high demand, and the need for Tribes to better manage things like pharmacy and access to medications. Terry Dosch noted that behavioral health challenges relate somewhat to what Medicaid covers and the 11 Community Mental Health Centers have relationships with the Tribes, but there is a lot of need. Kim Malsam-Rysdon added that the medical model of care funded by Medicaid does not always meet the behavioral health needs of the community. Jerilyn Church added that the social determinants of health also have a big impact on behavioral health issues among Tribal members. There certainly is a place for Medicaid, but the conversation must be broader to truly resolve. These concepts will be addressed by the subgroup.

### **Decision-Making Process**

Don Novo explained that there will be a consensus approach to decision-making, inclusive of all HCS Workgroup members. Realizing individuals and organizations won't all always get everything they wanted, the goal is still to find things to which the group collectively can agree. Don Novo will work with Kim Malsam-Rysdon and Jerilyn Church to provide research and support for any issues the HCS Workgroup identifies for additional information needed to make decisions.

Don Novo noted that the HCS Workgroup will continue to refine things as it progresses and as the State communicates with CMS. Kim Malsam-Rysdon added that it will be an iterative process with the State and CMS so we can get quick feedback and not have to wait until the end to present it all as a package to CMS for their response. The State wants CMS to offer feedback and ideas as the HCS Workgroup progresses.

### **Timeline of Events – Concept Paper Discussion with HHS**

Kim Malsam-Rysdon provided an overview of high level key events leading to the formulation of the HCS Workgroup. The discussions with CMS began during the 2015 Legislative Session. Kim Gillen, with the federal Department of Health and Human Services was in South Dakota for a legislative discussion and Senator Corey Brown asked if CMS was willing to reconsider its policy regarding funding for services provided outside Indian Health Services. A key construct of this discussion is how funding for services provided by IHS works. When an individual eligible for Indian Health Services and also eligible for Medicaid receives services through IHS, the Medicaid program pays IHS for those services with 100% federal funds. When an individual eligible for IHS and also eligible for Medicaid receives services through non-IHS provider, those services are funded at the state's regular Federal Medical Assistance Percentage or FMAP (approximately 50/50 state/federal match). The request to CMS was to consider broader interpretation of services provided "through" IHS and therefore to claim the 100% federal participation for services funded today at the regular state FMAP.

Expenditures through the Medicaid program for FY14 for services provided by IHS totaled \$71.2 million. Services provided outside IHS totaled \$133.3 million for that same period. To free up existing funds in the state's Medicaid budget to fund Medicaid expansion, there would need to be a shift of \$60-\$65 million in expenditures previously funded at the state's regular FMAP to 100% federal funds. That would free up \$30 - \$33 million in state funds necessary to fund expansion.

The last call with CMS suggested CMS is willing to make changes but specific policy guidance is still forthcoming. The discussions are very promising but the details will determine the specific impact to the expansion funding discussion.

Gov. Daugaard also met last week with HHS Secretary Sylvia Burwell about these issues and about expansion of Medicaid in South Dakota. HHS reiterated their desire to work on this. Secretary Burwell seemed very interested in helping expand access to services and care for populations that are underserved, as well as appreciating the Governor's concerns about the budget implications for the State.

### **Tribal Consultation**

Jerilyn Church explained that Great Plains Tribal Chairmen's Health Board (GPTCHB) was notified in August of the request to consult, although with very short notice. The three larger Tribes were able to join and had a good discussion about the concept and issues. There was a meeting of the GPTCHB in North Dakota that was attended by both State and CMS representatives to further discuss these issues. Additionally, Governor Daugaard asked Secretary Emery to hand deliver a letter to each tribal chairman. Secretary Emery visited all 9 tribes and hand delivered these letters over a three day period. Governor Daugaard has also discussed this with several Tribes.

Some of the GPTCHB concerns are that healthcare related services available through IHS often are very different than what is available through other providers. For example, IHS relies much more heavily on Community Health Representatives (CHRs), peer recovery, mentorship and other lower-level providers. So the HCS Workgroup needs to take into consideration those differences. Access to behavioral health and substance use disorder services (SUD) also is a big problem. There are not a lot of opportunities to take advantage of Medicaid for these services. Some of the Tribes are waiting to see what happens with the behavioral health subgroup, but there is general support for these efforts.

Kim Malsam-Rysdon shared feedback from the tribal consultation that some people eligible for IHS are able to get care in their home community through a non-IHS provider and didn't want that to change. She pointed out that it is important for the HCS Workgroup to ensure individuals have provider choice, to the degree possible and practical, and being aware of issues related to having to change providers or go to another community just to see an IHS provider.

Steve Emery said a number of Tribes have already sent letters of support to Governor Daugaard regarding this work and are working on passing resolutions to that effect. Some Tribes are taking a "wait and see" approach, but are generally in agreement. Several Tribes are in support of the concept, but it must go through the process of the Councils before they can formally offer support.

Sonia Weston and Jerilyn Church explained that will be the process for all the Tribes. The Chairmen may support the concept, but it must be processed through the Tribal Councils before formal Tribal support can be given.

### **Funding and Service Delivery**

Kim Malsam-Rysdon noted that it will be helpful for the group to understand some of the ways both IHS and Medicaid work. She asked Jerilyn Church to give an overview of the difference between IHS and Tribal organizations.

Jerilyn Church explained that IHS is separate and distinct from Tribal health organizations. Both are funded through IHS overall, but are different. The GPTHC is comprised of the 18 Tribal Chairmen in ND, SD, NE, IA. The group advocates for and represents the Tribes, but works hand-in-hand with IHS. The GPTHC serves as a liaison between IHS and the Tribes, and between the Tribes as a whole and with other organizations such as CMS and the State. One of the national conversations the GPTHC is having right now is about the definition of who an “Indian” is. IHS, CMS and the IRS each have different definitions that vary slightly. Tribes in this region and the Billings region have been reluctant to make changes to the definition, so have chosen to use the term “IHS eligible” for discussions such as the ones the HCS Workgroup is having, which allows the broadest inclusion of Native Americans.

Kathleen Bad Moccasin explained the difference between purchased/referred care (PRC - formerly Contract Health Services) through non-IHS providers and direct care services through IHS. (Go to this link for a more detailed explanation of direct care and PRC <http://www.ihs.gov/chs/>).

Individuals must prove Tribal membership or prove they are a Tribal descendant through a federally recognized Tribe (CMS definition). The Bureau of Indian Affairs (BIA) determines whether a tribe is federally recognized. The Tribes determine who is a member of their Tribe. IHS then takes the information provided by individuals from the BIA/their Tribe.

IHS sites provide PRC programs based upon the Contract Health Service Delivery Area published in the Federal Register, medical priority and if funding is available. PRC is not an entitlement program – it must be requested every year in the budget process. IHS is the payer of last resort for any kind of care. The PRC requirements include funds available and medical priorities (1– 5, 1 highest; 5 lowest). Each site can have its own priority list, although most follow the path of paying only for the highest priority (1).

Kim Malsam-Rysdon noted that when a person is eligible for both IHS and Medicaid, Medicaid is the payer – IHS is the provider.

Jerilyn Church explained that there are issues of residency for many Tribal members, which causes a lot of denials for PRC. The GPTCHB is working with IHS to try to get authorization for creating a Contract Health Service Delivery Area (CHSDA) that would include all of North and South Dakota. Today there are CHSDAs for every Tribe, which includes the counties that border a reservation. There has not before been a strong political will to do this, but perhaps that could change with this project. This relates to someone who is eligible for IHS, but does not live within the CHSDA area (reservation). PRC is driven by which county Native Americans live in. Both Kathleen Bad Moccasin and Jerilyn Church noted there would be an up-front cost to making this CHSDA change, but it would open a lot of opportunities for better access to care and paying more appropriately for care in the long-term.

Deb Fischer-Clemens asked what the process was to change a CHSDA. Jerilyn Church explained that it essentially is a matter of implementation costs. Tribal support (resolutions) is required, but the big issue is funding for the Tribes and IHS to do it. Oklahoma is a single CHSDA. It will be included again in the Tribal budget request to IHS and now with the opportunity for expansion there may be a way for IHS to recoup the front-end costs.

Jason Dilges asked about the funding available for both direct and PRC services and Kathleen Bad Moccasin explained that there are finite dollars in IHS for both types of services, which is why CMS funding for Medicaid is so important to IHS.

Rep. Don Haggar asked about the allocation of funding throughout a fiscal year, how IHS manages the priority of care. Kathleen Bad Moccasin said the priority levels are only applied to PRC, which runs out of money because the demand is greater than the dollars. And there also are IHS sites that have run out of all funding (including for direct services) prior to the end of their fiscal year.

Kim Malsam-Rysdon noted that many referred services work exactly the same way in IHS as they do in non-IHS facilities (a facility does not provide a specific service, so makes a referral to another provider); South Dakota is just asking CMS to pay for those services provided to Native Americans.

Jason Dilges asked a question about what the IHS budget for direct care is vs. the budget for PRC. Kathleen Bad Moccasin will get this information.

Deb Fischer-Clemens asked about the term “IHS provider site” and if that term is used only for an IHS facility on the reservation or if there are there other designations for IHS facilities not on a reservation. Jerilyn Church noted that IHS facilities and provider sites are located both on and off the tribal reservations. For example, there is an IHS facility in Rapid City. There are also Urban Indian Health Centers, which do not have any budget for PRC. Deb Fischer-Clemens asked if it is possible to create a new Tribal provider site, through the 638 authority.

Charlene Red Thunder described that is possible through Title V of the 638 authority. All the South Dakota Tribes provide some services through a 638 contract; some through Title 1 and some through Title V (less restrictive). The 638 authority allows Tribes to use IHS money to fund their own Tribally-administered health systems and services. All “638s” are very different and depend on the individual Tribe.

Jerilyn Church said that for the most part, there has been better outcomes and management of health services through the Tribes vs. IHS. There are definitely opportunities for Tribes to do more through 638 in the future.

Kim Malsam-Rysdon said one thing to remember is that the HCS Workgroup also should be looking at these issues from a place of how to improve the patient experience. Anything that the State asks CMS for needs to include flexibility for both IHS and Tribal providers.

Sen. Troy Heinert noted that not all Tribal members are Medicaid eligible. However, if we improve the outcomes and experience for Medicaid eligibles, it should also result in better access and care for non-Medicaid eligible Tribal members.

Rep. Don Haggar asked about financial disincentives to refer to care, even though a facility may be closer, but out of state or not in the designated service area. Kathleen Bad Moccasin noted that because the IHS Great Plains region includes ND, SD, NE, and IA it doesn’t matter for Medicaid as long as the out-of-state provider is enrolled with South Dakota Medicaid.

### **Action Items – Information for October 21 Meeting**

- Medicaid eligibility 101 to ensure common understanding of Medicaid and Medicaid eligibility
- Provider eligibility for Medicaid - overview or provider qualifications
- IHS provider sites and Tribal use of 638

- Kathleen Bad Moccasin will provide a breakdown of the IHS budget between direct care services and PRC.
- Any suggestions for members for the New Services or Behavioral Health subgroups please send those to Kelsey Smith as soon as possible.

**Next Steps -**

Please watch your e-mails; Kelsey Smith from the Governor's Office will be helping with communications for all of the workgroups including agendas and meeting minutes.