Medicaid Solutions Work Group:

Recommendations to Contain Costs within South Dakota's Medicaid Program

South Dakota, Office of the Governor

Final Report

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Executive Summary

South Dakota, like other state Medicaid programs nationally, is facing unprecedented revenue challenges, escalating medical costs, and increased enrollment due to the ongoing economic downturn. As a result, South Dakota has taken steps to control costs, such as reducing reimbursement rates, and has identified one-time funding sources to minimize program funding cuts. In addition, South Dakota has implemented a number of other initiatives over the past decade to control the costs of the program.

To address these pressing issues, Governor Dennis Daugaard established the Medicaid Solutions Work Group during the 2011 Legislative session, with the goal to solicit key stakeholders to provide input and develop strategies to contain and control Medicaid costs. The Work Group and subcommittees (Pharmacy, Home and Community-Based Services, and Patient-Centered Care), met several times over a nine month period, evaluated data, heard presentations on numerous best practices in South Dakota and nationally, and developed recommendations to help contain costs. Although a consensus was not reached on all recommendations, the groups did achieve common ground on many significant issues.

Developing new approaches to contain the escalating state Medicaid costs presents a difficult challenge for a state like South Dakota that already employs a very conservative eligibility policy and spends less per enrollee than other contiguous states. Compounding these issues, federal law limits the ability of states to cut eligibility and benefits. South Dakota also faces unique challenges as a rural state. Although there is no "silver bullet" solution, many promising initiatives, taken collectively, can serve to address this pressing issue.

In developing its recommendations, the Work Group focused on programs to address the key cost drivers. These include high-need patients with chronic conditions, pregnant women and children, individuals that over-utilize the emergency department (ED), avoidable hospital re-admissions, over-reliance on institutional care, and managing pharmacy costs.

In general, the recommendations include strategies to:
- Re-design the primary care delivery system to change the way care is delivered and financed.
- Improve care management for high-cost individuals (including individuals with chronic conditions and pregnant women).
- Address the inappropriate utilization of ED services.
- Foster consumer accountability.
- Encourage the appropriate utilization of less costly home and community-based services.
- Reduce pharmacy costs while maintaining access and quality.
- Implement targeted benefit reductions.

The recommendations endorsed by the Work Group constitute a strong commitment to addressing the growing health care costs in the South Dakota Medicaid program. Although there is much work to be done, the task force is confident that, by working together, South Dakota can successfully "bend the cost curve" and continue to provide quality services to the State's Medicaid consumers.

The Faces of Medicaid

During discussions and deliberations the Medicaid Solutions Workgroup needed to remain mindful of who are the South Dakota citizens relying on Medicaid for their health care and other services. Medicaid pays for services beyond paying for acute care in hospitals or care provided by physicians, dentists, optometrists and other medical providers.

- o First and foremost Medicaid or CHIP covers South Dakota's children – 69% of those covered by Medicaid or CHIP are children. In fact, 50% of South Dakota's children will rely on Medicaid or CHIP during the first year of their life.

- o Over 50% of our parents and grandparents in nursing homesare dependent upon Medicaid to pay for their care. 25% need Medicaid in order to live in an assisted living facility. And, many of our parents and grandparents rely on Medicaid to pay for much needed services so they can remain living in their own homes and communities in their later years of life.

- o Over 3800 South Dakota citizens with developmental disabilities are living in our communities through the support of Community Support Providers, relying on Medicaid to pay for their services.

- o Approximately 10,000 South Dakotans with mental health and/or substance abuse challenges receive services in their community through their local mental health centers or substance abuse treatment centers paid for by Medicaid.

- o Children who have been abused and neglected are provided the services they need through Medicaid payments to psychiatric residential treatment programs.

- o Medicare premiums are paid for low-income South Dakota seniors through the Medicaid program.

- o Services provided at Children's Care Hospital and School are paid for by Medicaid.

- o Citizens with developmental disabilities served at the Developmental Center at Redfield are covered by Medicaid.

- o Pregnant women who have low-incomes receive pregnancy related services paid for by the Medicaid program to help ensure healthier birth outcomes.

These South Dakotans are our children, parents, grandparents, neighbors and friends.

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Medicaid Solutions Work Group: Introduction and Background

Almost one in seven South Dakotans are on Medicaid, and South Dakota, like other state Medicaid programs nationally, is facing unprecedented revenue challenges, escalating medical costs, and increased enrollment due to the ongoing economic downturn. As a result, South Dakota has taken steps to control costs, such as reducing reimbursement rates, and has identified one-time funding sources to minimize program funding cuts. In addition, South Dakota has implemented a number of other initiatives over the past decade to control the costs of the program, including the establishment of a primary care case management program (PRIME), recipient co-payments, Emergency Department diversion grant initiatives, enhanced utilization review activities, increased generic drug utilization, among many other initiatives.

In order to address the enormous cost pressures being faced by Medicaid programs nationally, and to begin to successfully "bend the cost curve," however, it is necessary to identify and implement additional program reforms in both the short and long-term.

The Medicaid Solutions Work Group was established by Governor Dennis Daugaard during the 2011 Legislative session, with the goal to solicit key stakeholders to provide input and develop strategies to contain and control Medicaid costs.[1] The group began meeting during the Legislative session and met several times to identify short term solutions, but none were identified.   The focus was subsequently shifted to identify longer-term, as well as short-term, strategies, and the Legislature became an official participant. Additional individuals were also invited to participate in the Work Group process.

The larger Work Group and subcommittees met several times throughout 2011 with meetings scheduled and held on February 16, March 8, April 20, May 24, June 23-24, July 28-29, August 22 and October 3. The Work Group used a consensus building process to develop the report's recommendations, strategies and actions. Prior to the final Work Group meeting, the group was provided with a draft of this report and asked to submit comments and suggestions relating to the draft. The final meeting was then used to discuss the findings and recommendations included in this report and reach consensus.

Below, this report will:
- Provide an overview of the Work Group structure and charge;
- Describe the challenge faced by South Dakota in controlling Medicaid spending;
- Provide an overview of the data analysis and fact-gathering process utilized by the Work Group to help identify possible solutions;
- Identify and describe the program cost drivers that must be addressed in order to help control Medicaid spending; and
- Outline the specific recommendations identified for implementation by the Work Group as a result of this process.

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[1] Note that the South Dakota Department of Social Services maintains a number of standing advisory committees to provide ongoing support and input relating to the effective operation of the state's Medicaid program. These committees include the Medicaid Advisory Committee, the Medicaid Task Force (which is a partnership with the SD Medical Association to discuss policy issues), the Medicaid Pharmacy and Therapeutics Committee, and the Drug Use Review (DUR) committee.

Work Group Structure and Charge

The Work Group was chaired by the Governor's Office and included a broad range of stakeholder representation, including Legislators, providers across the continuum of Medicaid funded services, and staff from both the Department of Social Services and the Department of Human Services.

Subcommittees relating to patient-centered care, pharmacy, physician services and home and community-based services were also established. During the process, the Physician Services and Patient-Centered Care subgroups were combined into one group (termed Patient-Centered Care) to avoid overlap and duplication of efforts. Each subcommittee was tasked with evaluating various approaches to reduce costs within their respective area of focus. The composition of each Subcommittee, and a description of the subject matter addressed by each Subcommittee, is outlined below.

Patient-Centered Care/Physician Services Subcommittee

Subcommittee members:

Name	Organization
Deb Bowman*	Governor's Office
Carna Atherton-Pray	Avera St. Luke's Hospital
Rob Bates	Avera
Diana Berkland	Sanford
Susy Blake*	Representative
Andrew Burchett	Avera McGreevy Clinic
Mary Carpenter	Department of Social Services
Dave Christensen	Avera Health
Michael Crandell	Sanford
Justin Cronin*	Representative
Julie Fieldsend	Avera McKennan Hosp/University Health
Deb Fischer-Clemens*	Avera Health
Laurie Gill*	Human Services
Sandy Gehl	Avera Sacred Heart Hospital
Charlie Hart	Regional Health
John Healy	Avera
Dan Heinemann	Sanford
Travis Henderson	Mobridge Regional Hospital & Clinics
Tom Huber*	Sanford Clinic
Sharon Hunt	Sanford
Rick Kafka	Avera Gregory Healthcare Center
Mike Keegan	Rapid City Regional Hospital
Don Kosiak	Avera Health

Name	Organization
Kim Malsam-Rysdon*	Department of Social Services
Eric Matt*	Governor's Office
Doreen Miller	Sanford
Cindy Morrison*	Sanford Health
Scott Munsterman*	Representative
Shawn Nills*	Community Counseling Services
Doug Nowak	Sanford
Deb Peters*	Senator
Patricia Peters	Avera McGreevy Clinic
Beth Plahn	Avera McKennan Hosp/University Health
Bruce Rampelberg*	Senator
Stacy Reitmeier	Avera McKennan Hosp/University Health
David Rollason	Prairie Community Health
Joe Sluka*	Regional Health
Angelia Svihovec	Mobridge Regional Hospital & Clinics
Jim Szana*	Dentistry at the St Charles
Tony Tiefenthaler	Sanford
Tim Trihart*	Community Health Center of the Black Hills
Gale Walker*	Avera St. Benedict Health Center

* Denotes members of the Medicaid Solutions Work Group.

Objectives: The objective of this Subcommittee was to explore opportunities for cost savings within the health delivery systems, such as care management approaches, primary care medical homes, evidence based care guidelines, reimbursement models, patient accountability, and other possible reform opportunities.

Home and Community-Based Services Subcommittee

Subcommittee members:

Name	Organization
Jennifer Barnes	Avera St Luke's Hospital
Mark Bratt	Southwest Behavioral Health
Marty Davis	Golden Living
Anthony Erickson	Avera Sacred Heart Hospital
Dan Fosness*	Good Samaritan Society
Amy Richardson	Falls Community Health
Jason Frerichs*	Senator
Clint Graybill	Southridge Health Care
Curt Hohman	Avera McKennan Hosp/University Health

Name	Organization
Jean Hunhoff	Avera Sacred Heart Hospital
Amy Iversen-Pollreisz*	Department of Social Services
Kris Killeas	Volunteers of America Dakota
Daryl Kilstrom	Lifequest
Dan Lusk	Dept. of Human Services
Betty Oldenkamp*	Lutheran Social Services
Amy Olson	Avera McKennan Hosp/University Health
Gloria Pearson	Ability Building Services
Shelly Pfaff	SD Coalition of Citizens with Disabilities
Daryl Reinicke	West Hills Village Therapy
Amy Richardson	Falls Community Health
Ann Rieck-McFarland*	SD Assoc. of Community Based Services
Brad Saathoff	Black Hills Workshop
Cindi Slack	Sanford
Alan Solano	Behavior Management System
Marcia Taylor	Rapid City Regional Hospital
Amy Thiesse	Sanford
Gerry Tracy	SESDAC
Sam Wilson*	AARP

* Denotes members of the Medicaid Solutions Work Group.

Objectives: The objectives of this Subcommittee were to develop recommendations on different models of service to meet the needs of individuals who require supports and services in the least restrictive and most appropriate environment, analyze future funding opportunities available through the federal government, and explore patient accountability and reimbursement models.

Pharmacy Subcommittee

Subcommittee members:

Name	Organization
Jared Boyer	Department of Social Services
Jim Bregel	Casey Drug
Dana Darger	Rapid City Regional Hospital
Cole Davidson*	SD Pharmacist - Hy-Vee
Mike Duncan	Sanford
Deb Farver	South Dakota State University
Mike Jockheck	Department of Social Services
Eric Kutscher	Avera McKennan Hosp/University Health
Robert Kwasniewski	Community Pharmacist

Name	Organization
Rob Loe	Dakotamart
Scott Peterson	Rapid City Regional Hospital
Steve Petersen	Avera McKennan Hosp/University Health
Lenny Petrik	Kmart
Curt Rising	Medicine Shoppe
Tim Soundy	South Dakota Childrens Spec. Clinic
Brenda Tidball-Zeltinger*	Department of Social Services

* Denotes members of the Medicaid Solutions Work Group.

Objectives: The objectives of this Subcommittee were to evaluate the feasibility of developing a prescription drug formulary for Medicaid, reviewing prior authorization practices, studying the possible expansion of 340B program as a reimbursement model, and evaluating patient accountability enhancements.

The Challenge of Controlling Medicaid Spending

At the conclusion of the Work Group process, the group reached one over-riding conclusion – that the challenge of controlling Medicaid spending in South Dakota (and in other states) is an incredibly difficult one. It will require an array of short and long-term program reforms and the cooperation of all stakeholders to successfully "bend the cost curve" and continue to provide quality services to South Dakota's Medicaid enrollees.   This conclusion is based, in part, on the following factors:

➢ South Dakota has a very conservative Medicaid eligibility policy. Approximately 69% of Medicaid consumers in South Dakota are children, and 31% are adults. Eligible adults include pregnant women, individuals who are elderly or disabled, or parents in very low income families (i.e. 52% of the federal poverty level, or annual income of $9,552 for a family of three). In other words, unless you are an adult who is pregnant, elderly, disabled or a parent that is extremely low income, you are not eligible for Medicaid in South Dakota.[2]

➢ South Dakota spends less for each Medicaid enrollee (per capita) than Iowa (4% less), Wyoming (14%), Nebraska (22% less), Montana (28% less), North Dakota (47% less), and Minnesota (55% less).

➢ South Dakota's Medicaid Program, like other Medicaid Programs across the country, is a "countercyclical" program. This means that as the economy worsens and more people lose their jobs and health benefits, many people turn to government safety-net programs such as Medicaid, thus requiring an increase in funding for the program. State governments, however, are ill-equipped to meet the funding needs, as more than 45 states and the District of Columbia have projected budget shortfalls for FY 2012. Note that South Dakota's Medicaid Program will likely grow by an additional 54,000 enrollees by 2019, as a result of the Medicaid Expansion mandated by recent health care reform legislation.[3]

➢ Even as additional individuals qualify for Medicaid, overall medical costs continue to rise. A recent report from the federal Centers for Medicare & Medicaid Services (CMS) indicates that national State Medicaid expenditures are projected to reach $327.6 billion by FY 2019, increasing at a compounded annual growth rate of 9.8 percent, or more than twice the historical rate.

➢ Despite the increase in Medicaid enrollment and the escalating costs of care, federal law generally limits the ability of states, including South Dakota, to cut Medicaid eligibility.[4]

➢ As a result of the inability to make significant cuts to eligibility or benefits, states, including South Dakota, have cut provider reimbursement rates. While enhanced matching funds were

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[2] In general, Medicaid is available only to people with limited income, and stringent requirements must be met. Persons must fall into one of several categories: individuals who are aged, blind and disabled; low income families with children under 21, and singe and married individuals with a temporary disability.

[3] John Holahan and Irene Headen. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL." Kaiser Commission on Medicaid and the Uninsured, May 2010.

[4] The federal Affordable Care Act (ACA) requires that states, as a condition of Medicaid funding, maintain existing Medicaid eligibility, including income and resource standards used to calculate eligibility.

used to avoid or lessen the extent of Medicaid provider rate cuts, rate cuts or freezes were still prevalent nationally. A recent survey revealed that a total of 39 states restricted provider rates in FY 2010 and 37 states have restricted or planned to restrict provider rates in FY 2011. Rate cuts are not, however, a long-term solution, as Medicaid provider payment rates are generally much less than Medicare or commercial rates.

➢ The rural nature of South Dakota also poses challenges for state policy makers, as rural populations experience higher rates of poverty than their urban counterparts, are less likely to have health insurance, have a greater proportion of elderly residents, and are more likely to have children in the household.

➢ South Dakota also faces challenges coordinating medical care for American Indians with the Indian Health Services (IHS). While IHS is responsible for providing health care to American Indians, the South Dakota Medicaid Program serves as the safety net for this population, and will cover services that cannot be provided or accessed through the IHS system. This has significant financial implications, as Medicaid (unlike the federal IHS) is jointly funded by the State and federal government. During SFY11, an average of 40,109 American Indians were on Medicaid every month, which represents 35.1% of all the individuals eligible for Medicaid. This percentage has remained fairly consistent over the course of the last 7 years, despite the fact that American Indians comprised only 10.1% of the state's population. During SFY10, total expenditures for services provided to American Indians, including services at the Indian Health Services, totaled $236.8 million. This represents 31.5% of all expenditures during this timeframe.

➢ Finally, over the past decade, South Dakota's Medicaid Program has been under immense pressure to contain the growth of the program and cut costs. As a result of this pressure, the program has implemented a wide array of initiatives, both large and small, to contain costs and/or reduce expenditures. Many of the remaining cost-savings opportunities involve complicated and controversial initiatives that will require a significant amount of effort, commitment and expertise in order to effectively implement. These challenges also come at a time when the Medicaid agency has been asked to "do more with less."

Despite these many challenges and the absence of any "silver bullet" solutions, Medicaid programs across the country have identified promising practices, service delivery reforms, and other initiatives that have served to "bend the cost curve." These promising practices were carefully evaluated and discussed by the Work Group during the course of this process, and many of these reforms and best practices have been included as recommendations within this report.

The group cautions, however, that implementing these reforms will not be easy, and that many of the recommendations will require program investments to re-design the care delivery system to achieve long-term cost containment. The problem of dealing with the escalating costs of the Medicaid program is enormously complicated, and there are no easy solutions.

Data Analysis and Evaluation of National "Best Practices"

As part of the process to identify and formulate recommendations, the Work Group engaged in an information gathering process that involved presentations from Work Group members, a review of program data, and an analysis of program reforms adopted by other state Medicaid Programs. All participants were encouraged to share information that would be helpful to the Work Group in formulating its program recommendations. A summary of the information and presentations reviewed by the Work Group is outlined below.

Background Presentations

A number of general background presentations were given to the Work Group to provide context and to help inform the discussion. For example, staff from the South Dakota Medicaid Program provided a Medicaid Program Overview Presentation, and presented the findings from physician focus group meetings, which were designed to solicit ideas for program improvements from physicians across the state.

In addition, consultants engaged on this project gave a number of presentations, including an overview of Medicaid Managed Care Programs in Pennsylvania, North Carolina, and Wisconsin, as well as an overview of a range of cost containment programs adopted by other state Medicaid programs. Separate presentations and findings were presented to each subcommittee. Presentations relating to allowable Emergency Department co-payments, and co-payments generally, were also provided. An informational overview of federal "Health Home" Funding opportunities was also part of this process.

The Home and Community-Based Services subcommittee had several presentations on various waiver options, including: the Elderly Waiver, which serves individuals 65 years and older, as well as individuals 18 years and over who are physically disabled; the Assisted Daily Living Services Waiver, which allows individuals with significant disabilities to manage and self-direct their services and live as independently as they choose in their home, community, and workplace; the Family Support Waiver, which is based on a severe chronic disability attributable to mental retardation, cerebral palsy, epilepsy, head injury, brain disease, or autism or any other condition (other than mental illness) closely related to mental retardation that impairs general intellectual functioning or adaptive behavior; and the Comprehensive Waiver, also known as CHOICES, which has the same eligibility requirements as the Family Support Waiver but offers a different array of services such as residential supports, day habilitation, prevocational services, supported employment, nursing services, medical equipment and drugs, and other medically related services. Additional presentations were given on Programs of All-inclusive Care for the Elderly (PACE), including details from a review done in 2008 on the feasibility of utilizing PACE in South Dakota, and "Managing High Risk, High Cost Frail Elderly & Individuals with Developmental Disabilities," a Domiciliary Care (DOM CARE) program.

Finally, all of the Work Group members shared their experience and expertise relating to other cost trends that have been identified nationally, or through the varied professional experiences of Work Group members. For example, the Work Group discussed the current national bias towards institutional care for Medicaid consumers with the need for long-term care supports and services (in lieu of more cost-effective and desirable community-based services), the high costs generated by avoidable hospital inpatient admissions and re-admissions, and the increased expenditures generated by Medicaid consumers with both a mental illness and chronic physical conditions.

Data Analysis – Inpatient Utilization and Cost

The South Dakota Medicaid program staff provided a significant amount of data relating to Medicaid utilization and cost. [5] This information included detailed information on inpatient Medicaid patients with $50,000 or more in expenditures, information on the top 25 diagnosis by expenditure, and data relating to Medicaid recipients who had more than $50,000 in hospital inpatient claims.

This analysis revealed that 2.8% of South Dakota Medicaid hospital inpatient stays are responsible for 49% of inpatient payments. [6] In addition, the diagnosis information demonstrated that a very high percentage of South Dakota Medicaid inpatient hospital users are pregnant women and newborns. This utilization pattern reflects Medicaid's role as a primary payer for childbirth in South Dakota, and Medicaid generally. This information also provides further evidence of the ongoing need of Medicaid Programs to focus on improving pre-natal care. [7]

Other leading South Dakota Medicaid inpatient diagnoses include episodic mood disorder, acute illness and injuries, mental/behavioral health conditions, and chronic physical conditions. These diagnoses are consistent with the needs of the Medicaid population, which include low-income families and children, seniors and persons with disabilities, and individuals with alcohol and/or substance abuse issues.

Emergency room utilization data was also reviewed. This analysis revealed high Emergency Department (ED) utilization among South Dakota Medicaid consumers, with over 1,400 individuals using the ED seven (7) or more times during the period measured (1/1/2010 – 3/31/2011). This utilization pattern is consistent with national trends, and reflects the difficulty faced by State Medicaid programs to provide timely access to primary care, educate consumers on the appropriate use of the ED, and reduce preventable ED utilization.

To provide context to South Dakota's Medicaid program, publically-available information was also evaluated that compared South Dakota to other states on a number of key measures. Several national trends were identified that provided context to South Dakota's situation.

Data Analysis – Institutional and Community Based Services

Data specific to the Home and Community-Based Services subcommittee were discussed to understand the landscape and potential cost saving opportunities. Nursing Home Facilities caring for 3,591

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[5] The data analysis produced by the Department of Social Services was designed to provide high level information to the Work Group in order to identify Medicaid program cost drivers, and help inform the development of innovative care management program recommendations to control costs. More micro-level utilization data relating to specific subtopics within the Medicaid program was not carefully evaluated because it was deemed tangential to the goals and objectives of the Work Group.

[6] Nationally, and more broadly, according from data from the Centers for Medicare and Medicaid Services, approximately 4% of Medicaid enrollees account for half of all Medicaid spending.

[7] The data also reflect the significant utilization of cesarean sections. Cesarean sections have been increasing in every state, and many Medicaid programs are taking steps to address inappropriate utilization.

individuals and Assisted Living Centers caring for 743 individuals represented expenditures of $147.2 million and $9.4 million, respectively, in SFY10. The remaining Community Based Services (e.g., In-Home, Senior Meals, Transportation) accounted for $16.0 million in health care costs in SFY10.

Data Analysis – Pharmacy Utilization

The Work Group spent considerable time reviewing the current prior authorization process, Pharmacy and Therapeutics (P&T) Committee, Drug Utilization and Review Committee (DUR) and other cost containment strategies that exist today.

Data evaluated by the sub-group included data sets such as monthly prior authorization reports that identified the number of prior authorizations by month, as well as the prior authorization method (i.e. electronic vs. paper). The group also evaluated information regarding the Top 25 drugs by both cost and numbers of prescriptions. Numerous other reports were reviewed and analyzed by the group, including the utilization of generic drugs and per member, per month cost information compared to known performance data from commercial plans.   Generic utilization was found to be comparable to commercial plans at 72%.

Current South Dakota "Best Practices"

A number of Work Group members and participants provided presentations on "best practices" that have been implemented in South Dakota or in other states served by their organizations, and that could potentially be replicated or expanded in South Dakota to obtain savings, contain costs, and improve quality of care.

For example, an expert physician from a large health system provided a presentation titled the "Patient-Centered Medical Home," which described the potential cost savings and quality gains that could potentially be achieved by adopting this emerging care delivery model. Experts from local health systems also provided information on best practices, such as a Maternity Care Centering Program (known as "Centering Pregnancy"), diabetes management programs for pregnant women, efforts to reduce Neonatal Intensive Care Unit admits, and practices to reduce inappropriate Emergency Room Utilization.

Finally, an expert from a local health system shared research and data on national best practices relating to Care Transitions and Care Coordination, which are practices designed to ensure appropriate medical care and reduce costly hospital re-admissions.

Observations & Conclusions: Program Cost Drivers

As a result of the data analysis and fact-gathering process described above, the Work Group identified several program cost-drivers, which are consistent with cost drivers faced by Medicaid and other health care programs across the nation.

Program Cost Drivers	
High-Need Patients	An analysis of South Dakota's inpatient data demonstrated that in South Dakota, as in other states, a small percentage of users are responsible for a disproportionate percentage of the costs. As a result, the group recognized that the recommendations should focus on managing the care of this population, as reducing even a small fraction of the spending for this group could potentially provide meaningful savings.
Pregnant Women and Children	The diagnosis information demonstrated that a very high percentage of South Dakota Medicaid inpatient hospital users are pregnant women and newborns, and the data revealed the high costs of care relating to adverse birth outcomes. As a result, the group recognized the ongoing need to focus on improving pre-natal care in particular, and other educational and preventive strategies that will improve maternal care and health outcomes.
Individuals with Chronic Conditions	Data revealed that significant inpatient costs were generated by individuals with episodic mood disorder, mental/behavioral health conditions, acute illness and injuries, and chronic physical conditions. This is consistent with the experience in many states that costs are driven, in large part, by individuals with chronic conditions such as diabetes, congestive heart failure, and chronic obstructive pulmonary disease, among others. As a result, the Work Group recognized that it is important to take steps to improve the delivery of care to these individuals.
Overutilization of Emergency Department Services	The data revealed high Emergency Department (ED) utilization among South Dakota Medicaid consumers, consistent with the experience nationally. As a result, the Work Group recognized it is important to implement programs to better address this issue in South Dakota.
Over-reliance on Institutional Care	The Work Group concluded that South Dakota (and Medicaid programs more generally) spend a disproportionate percentage of Medicaid resources on institutional care, and that it is important to take steps to encourage the appropriate utilization of less-costly community-based long-term care services and supports.
Avoidable Hospital Readmissions	During the Work Group proceedings, the issue of avoidable hospital readmissions was discussed. It was recognized by the Work Group that all health care payers, including Medicaid programs, can take steps to control costs by implementing programs and efforts to reduce avoidable hospital readmissions.

Program Cost Drivers	
Pharmaceutical Expenditures	It was recognized by the Work Group that Pharmacy costs represent a significant proportion of Medicaid expenditures, and that South Dakota must continue to take steps to ensure that it appropriately manages its Medicaid drug spend (e.g. through the ongoing utilization review activities, promotion of generic utilization, and prescriber education).

The identification of these cost drivers served to inform and shape the recommendations outlined in the following section of the report.

Recommendations Overview

As a result of the review of South Dakota-specific data, national trends, an analysis of best practices, and lengthy discussions, the Work Group and the three subcommittees identified several recommendations that can potentially be implemented to control costs in both the short and long-term.

In general, the recommendations include strategies to:
- Re-design the primary care delivery system to change the way care is delivered and financed;
- Improve care management for high-cost individuals (including individuals with chronic conditions and pregnant women);
- Address the inappropriate utilization of ED services;
- Foster consumer accountability;
- Encourage the appropriate utilization of less costly home and community-based services;
- Reduce pharmacy costs while maintaining access and quality; and
- Implement targeted benefit reductions.

The specific recommendations relating to these general strategies are set forth in detail below. For each recommendation, the Work Group will provide a brief overview, describe the strategy for implementation, and identify specific next steps. Estimated savings will also be provided, when possible.

Establishing a "Health Home" is an alternative approach to the delivery of primary care services that promises better patient experience and better results than traditional care. The Health Home has many characteristics of the Patient-Centered Medical Home (PCMH), but is customized to meet the specific needs of low-income patients with chronic medical conditions. Pursuant to this model, a team of healthcare professionals partners with the patient to create an individualized plan of care. Patients are provided with all the support needed to follow their treatment plans and to adopt healthy habits. The medical home model is expected to lower healthcare costs by preventing costly complications and hospitalizations. Payment policies generally provide fee-for-service payments with add-ons for coordination and shared savings or bonuses for quality outcomes and reductions in ED and hospital utilization.

Since 2006, more than 30 state Medicaid programs have adopted medical home initiatives with some level of enhanced payments, shared savings, and/or bonus payments. Recent changes to federal law provide states with a new Medicaid option to provide "health home" services for enrollees with chronic conditions. To encourage states to take up the new option, federal legislation authorized a temporary 90% federal match rate (FMAP) for health home services specified in the law. The health home option became available to states on January 1, 2011. In order to obtain federal assistance to plan a Medicaid health home initiative and State Plan Amendment (SPA), states must submit a *Letter of Request* to CMS describing the anticipated planning activities. If approved, a state is authorized to spend up to $500,000 for planning activities.

Strategy

Promote the utilization of Health Homes in South Dakota by seeking enhanced federal funding available for this model, and establishing pilot delivery sites in appropriate areas within the State.

Actions
- Create a Health Home Work Group to begin planning activities, develop a proposal for submission to the federal government, and identify an appropriate implementation time-frame.
- Establish appropriate program standards, payment structures, and an application process utilizing best practices adopted by other states.
- Submit a State Plan Amendment and obtain federal approval.
- Implement pilot sites.
- Evaluate program outcomes and take steps to encourage private payors to develop similar models. Many states have taken the lead to adopt "multi-payor" initiatives, where commercial and government payors agree to implement a patient-centered medical home program.

Estimated Savings

Evidence suggests that medical homes help coordinate care, improve health outcomes, reduce avoidable services such as ED visits and inpatient admissions, and provide financial supports to primary care practices. A recent study demonstrated that patient-centered care is associated with decreased

utilization of health care services and lower total annual charges.[8] Due, in part, to the strength of this research, a recent 50 state survey of State Medicaid agencies revealed that 39 states reported having a medical home initiative in place (27 states) or under development (12) states. Of these states, 22 plan to elect the new "health home" option to obtain enhanced federal funding.[9]

Return on investment (ROI) calculators are available, but final estimates are dependent on the scope and design of the specific health home model chosen as a result of the planning process.

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[8] *Patient-Centered Care is Associated with Decreased Health Care Utilization,* Journal of the American Board of Family Medicine, 24(3), 229-39 (May 24, 2011).

[9] *A Profile of Medicaid Managed Care Programs in 201: Findings from a 50 State Survey,* Kaiser Commission on Medicaid and the Uninsured, 41-42 (September 2011).

Recommendation II: Implement Care Management Programs for High Need and High Cost Medicaid Enrollees

State Medicaid programs have been operating primary care case management (PCCM) programs since the 1980s. These programs typically link beneficiaries to primary care providers (PCPs) and pay providers about $3 per beneficiary per month for basic care management activities. South Dakota operates a PCCM model known as "PRIME." Beginning in the 1990s and increasingly today, states have sought to enhance and supplement these PCCM programs with additional features and programs, including more intensive care management and care coordination for high-need beneficiaries, disease management, improved Primary Care Physician (PCP) incentives, increased use of performance and quality measures, and utilizing targeted staff to manage the critical transition of individuals who are transitioning from an inpatient stay to the community.

These programs can be designed to focus on specific chronic conditions (e.g. diabetes, asthma, congestive heart failure), individuals with co-occurring behavioral and physical health diagnosis, and pregnant women. The programs can also incorporate consumer incentive programs to reward consumers who adopt healthy behaviors. These programs can be implemented statewide, or in specific geographic areas within a state to target specific populations or instances of over-utilization.

During the Work Group process, numerous stakeholders gave presentations on promising care management approaches and programs that have implemented with success to better manage high-needs individuals, and there was much discussion relating to the possibility of expanding and replicating these programs within South Dakota. The Work Group also recognized that it was critically important to carefully evaluate possible programs to ensure that the resources and investments devoted to these efforts result in meaningful cost savings. As a result, the group concluded that it would be prudent to engage in an information-gathering process to further investigate and evaluate possible programs.

It is worth noting that consumers who receive services through a Medical Home may not require the services provided through these enhanced program, as the care management function is "embedded" in Medical Home models.

Strategy

While the Work Group did not reach a consensus on the specific approach to implement an enhanced case management model, the group agreed that it was important to implement a care management program in some form. Providing care management to high-cost, high-needs populations was seen as a critical opportunity, and as one of the most promising areas for program cost containment. As a result, the South Dakota Department of Social Services intends to issue what is known as a "Request for Information" to solicit concrete thoughts and suggestions relating to a possible program model.

Actions
- Prepare and issue a Request for Information to solicit proposals for care management programs.
- Develop program model and issue Requests for Proposals to solicit program bids.
- Obtain necessary federal approvals.
- Implement care management program(s).

Estimated Savings --- TBD

Recommendation III: Implement an Emergency Department Diversion Program

Emergency Department (ED) utilization in state Medicaid programs has been growing significantly. To address this issue, many states, including Utah, have implemented utilization management programs to help address inappropriate ED utilization through targeted educational efforts and recipient restriction measures.

Utah, for example, implemented a "Safe-to-Wait" project that includes three components. First, Utah Medicaid patients who made unnecessary trips to emergency rooms are sent a letter from the state stressing ED costs and urging them to find a primary care doctor. Second, if they visited an ER for routine care again, they received a second letter. Finally, after a third visit, Medicaid officials placed patients on a restricted access, which required them to see a family doctor to get prescriptions filled.

In addition to these programs, state Medicaid programs or contracted managed care entities often establish hotlines that permit consumers who require medical care or advice to contact the hotline as possible alternative to an ED visit. Campaigns to educate consumers and discourage the inappropriate use of EDs are also commonplace. These activities could be performed by State staff, or incorporated into care management contracts with vendors or providers.

The success of ED diversion programs is contingent on the availability of alternative options for individuals to receive primary care in lieu of visiting an ED (e.g. urgent care centers, physician practices with extended office hours, etc.). Access to care and provider availability issues in South Dakota may serve to limit the effectiveness of these programs.

Strategy

Reduce inappropriate utilization of EDs for non-emergent conditions by implementing an ED Utilization Management Program, modeled on the successful Utah "Safe-to-Wait" Program.

Actions
- Prepare program design description and identify funding needs.
- Evaluate need for federal approval to restrict the ability of frequent ED users to obtain prescriptions from ED physicians.
- Explore federal grant funding opportunities.
- Implement program.

Estimated Savings

TBD

While access to dental services for children under 21 is required under federal law, the federal government does not mandate states to provide adult dental services in their programs. Some benefits, such as hospital and physician services, are required to be provided by State Medicaid programs, but many services, such as dental services, are "optional." As a result, under federal law, states can generally change optional benefits or limit their amount, duration or scope through an amendment to their State plan, provided that each service remains sufficient to reasonably achieve its purpose. For adult dental services, a large number of states impose yearly "caps" on expenditures relating to dental services.

Medicaid adult dental expenditures in South Dakota in FY2011 were $4,117,063, with 9,896 different adults accessing dental care. It was discussed in the Work Group that individuals with private dental insurance have a yearly maximum for dental services, while Medicaid patients can access unlimited services. The group reached a consensus that the maximum yearly benefit for adult dental services should be $1,000, consistent with the limitations included in other state Medicaid programs that currently have annual benefit limits for dental care. State Medicaid Programs that implement annual dental benefit limits for adults include Alaska, California, Hawaii, Indiana, Mississippi, Nebraska, and Vermont.

Strategy

Implement a maximum yearly benefit limit on dental services, consistent with limitations in commercial plans and other state Medicaid Programs.

Actions
- Submit State Plan Amendment.
- Prepare and communicate appropriate policy changes and procedures to stakeholders.
- Make appropriate system changes.
- Implement cap.

Estimated Savings

Approximately 1,106 individuals had more than $1,000 in total dental expenses in FY11, and limiting their non-emergency expenditures to $1,000 would save a total of $550,000 - $600,000. General fund savings (the state share of the total savings) would total approximately $220,000 – $240,000.

Recommendation V: Evaluate the Cost/Benefit of Implementing a Preferred Drug List

The purpose of the preferred drug list (PDL) is to promote clinically appropriate utilization of pharmaceuticals in a cost-effective manner. Based on safety, efficacy, and cost effectiveness, drugs are designated as preferred or non-preferred, and the program seeks to negotiate rebates from drug manufacturers for inclusion of their drugs as preferred drugs. These programs are also designed to limit spending growth by increasing the use of these preferred drugs, including generics. Non-preferred drugs are still covered by Medicaid, but require prior authorization. Currently, forty-five states have instituted a PDL in their Medicaid programs.

The Work Group spent considerable time reviewing the current prior authorization process, Pharmacy and Therapeutics (P&T) Committee, Drug Utilization and Review Committee (DUR) and other cost containment strategies that exist today. South Dakota currently utilizes an eight member P&T Committee and seven member DUR Committee comprised of pharmacists and physicians appointed by the Governor, and utilizes less than 2.0 full-time equivalents (FTEs) to manage the Medicaid pharmacy program. Members of both the P&T and DUR Committees have served for many years, participate on a volunteer basis, and have significant knowledge of the South Dakota marketplace.   In addition, based on the evaluation of available metrics, South Dakota's management of the pharmacy benefit was determined to be very strong. For example, generic utilization was found to be comparable to commercial plans at 72%. The group also considered the relatively low volume market share in South Dakota that pharmaceutical companies will rely on to achieve savings and also discussed leveraging a larger purchasing pool or consortium to obtain greater volume to attract rebates.

Despite the strong performance of program and the fact that the relatively small size of the program may potentially limit the effectiveness of a PDL operated by a private vendor, the group concluded that it would be prudent to investigate and evaluate the benefits of implementing a PDL.

Strategy

Publish a Request for Information (RFI) to obtain additional information in order to make a determination if a PDL would be cost effective, and evaluate the consumer and provider impacts of such a proposal. In the event that the outcome of the RFI process results in the decision to not implement a PDL, the group recommends that the P&T Committee revisit high cost areas and pursue additional therapeutic initiatives.

Actions
- Develop benchmarks to examine cost savings from PDL and supplemental rebates.
- Develop and issue RFI.
- Analyze vendor proposals.
- Analyze pricing data from CMS.
- Identify consumer and provider impacts along with any potential cost savings.
- Taking into account consumer and provider impacts as well as cost benefit, choose a vendor and implement PDL program.

Estimated Savings

TBD

The Veterans Health Care Act of 1992 established the 340B Program in section 340B of the Public Health Service Act (PHS Act). The 340B Program requires drug manufacturers participating in Medicaid to provide discounted covered outpatient drugs to certain eligible health care entities, known as covered entities.

Effective CY 2010, changes in federal law extended participation in the 340B Program to children's hospitals, free standing cancer hospitals, critical access hospitals, rural referral centers, and sole community hospitals. Further, changes to federal law altered the Medicaid rebate amounts that determine the value of the 340B discount. The legislation increases the minimum manufacturer rebate on innovator products from 15.1% to 23.1% of average manufacturer price (AMP) and increased the manufacturer rebate on non-innovator products from 11% to 13% of AMP.

The Work Group spent considerable time evaluating the benefits and challenges of implementing or expanding 340B programs. The subcommittee noted early in the discussion that 340B programs in and of themselves are not typically included in the top 5-10 cost saving strategies for Medicaid programs. One important note about the composition of the subcommittee is that it included representation from two providers (Regional Health Systems and Avera Health Systems) that currently operate 340B programs. Given the complexities and federal requirements necessary to manage these programs, the Work Group members agreed there would have to be substantial savings opportunity in order for most small providers to implement these programs.

In South Dakota, the current 340B providers carve out Medicaid for retail pharmacy due to challenges in the data exchange between the pharmacy and the pharmacy billing system. Current 340B providers do bill Medicaid for outpatient services and have expressed interest in including Medicaid and expanding 340B utilization. The thought is that the low cost of the 340B drugs would be passed on to the state Medicaid program.

The Department of Social Services has implemented a stakeholder work group to provide input into planned changes to the current outpatient reimbursement methodology. The current outpatient reimbursement methodology creates challenges in the current 340B billing and payment processes that will be addressed in conjunction with the transition to a new reimbursement methodology for outpatient hospital services. In addition to finance and administrative representation on this financial workgroup, a pharmacist and current 340B providers are participating in the workgroup.

Strategy

In order to determine potential savings, specific pricing information is needed. Changes to the minimum drug rebate amounts were recently implemented, and states are waiting for pricing data from CMS. The Work Group recommends that when pricing data is available, a study be done to attempt to determine cost savings. In addition, as the outpatient hospital reimbursement changes are implemented, they need to afford the ability to bill 340B drugs separately so that they can be removed from Medicaid Drug Rebate and ensure acquisition price is billed.

Actions

- Analyze potential cost savings to the Medicaid program – or Medicaid providers – from the expansion of use of the 340B program.
- Develop amendments and waivers necessary to implement increased use of 340B pricing.
- Review use of 340B in terms of Medicaid pharmacy expenditure/cost containment.
- Conduct baseline/benchmark metrics (e.g. comparison to 340B price lists).
- Outreach to newly eligible 340B entities with significant Medicaid patient volume.
- Analyze access to services: Provider and Medicaid population location analysis.
- Review South Dakota statutory provisions, Medicaid payment and billing policies relating to pharmacy billing requirements for 340B dispensed drugs.

Estimated Savings

TBD

Recommendation VII: Increase Pharmacy Copays

Federal law provides flexibility to states to implement co-payments on drugs, in order to encourage appropriate utilization and contain costs. Currently, South Dakota imposes co-payments of $3.00 on brand drugs, but does not impose co-payments for generic drugs. After considerable discussion, the Pharmacy Subcommittee recommended increasing the co-payment on brand drugs from the current $3.00 to the federal maximum allowed ($3.30), as well as implementing a $1.00 co-payment on generic drugs (currently $0). The Work Group discussed at length the possible impacts of increasing co-payments. While the estimated initial savings generated by the co-payments is not significant from a budgetary perspective, the group recommended continued efforts that incorporate patient responsibility for the cost of care. In addition, it is possible that the co-payments may encourage more appropriate drug utilization, leading to longer term (and potentially more substantial) cost savings.

Concerns were raised about the possible reduction in the use of generics as a result of implementing co-payments. As a result, the Pharmacy Subcommittee recommended that monitoring efforts are needed if this option is implemented so that co-payments can be removed if generic utilization trends downward.

Strategy

Raise the co-payment for brand drugs and implement a minor co-payment for generic drugs to promote patient accountability.

Actions
- Increase the co-payment on brand drugs from $3.00 to $3.30
- Implement a $1.00 co-payment on generic drugs

Estimated Savings

Savings of approximately $241,700.00 on a yearly basis will result from the collection of the co-pays. Additional savings resulting from improved utilization may also be generated on a longer-term basis.

There is a well-known bias in Medicaid policy that extends an entitlement to institutional care to Medicaid beneficiaries when medically necessary, but does not entitle needy individuals to comparable community-based services. While all states provide some community services and have been expanding their offerings over time, progress has been slow. Even though community services are often cost-effective compared to institutional care on a per person basis, and many needy individuals across the country are isolated in institutions when they would prefer to live in the community, community services can be limited and waiting lists for Medicaid home and community-based services waiver programs can be large.

The Money Follows the Person (MFP) Rebalancing Demonstration Program was authorized by Congress in section 6071 of the Deficit Reduction Act (DRA) of 2005 and was designed to help states balance their long-term care systems and help Medicaid consumers transition from institutions to the community. The MFP Demonstration Program reflects a growing consensus that long-term supports must be transformed from being institutionally based and provider-driven to person-centered, consumer-directed, and community-based.   As an incentive to participate, the program gives states an enhanced federal matching rate (the federal Medicaid assistance percentage) for state Medicaid spending on home and community-based services provided to MFP program enrollees.

As of 2011, forty-three (43) states plus the District of Columbia have been awarded grant money under this program. Newly awarded states must submit an operational protocol within one year of the grant award.

Strategy

Conduct detailed evaluation of the MFP option to determine if it could assist in moving individuals from institutional care to less costly and desirable community-based settings. The Work Group recognized the opportunity this option has in covering initial costs; however, questions remain regarding whether current community-based services could provide the services needed to support individuals who are residing within institutions. It may be that additional community-based services would need to be developed, which may not be cost neutral.

Actions
- Identify target populations for MFP.
- Conduct feasibility determination.
- If initiative deemed feasible, move forward to obtain grant funds and implement program.

Estimated Savings

TBD

Recommendation IX: Evaluate Agency Model Domiciliary Care Initiative

Domiciliary Care (or Dom Care) is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental or visual disabilities. This type of program is appropriate for individuals age 18 and older, who are unable to live independently and who need assistance with the activities of daily living.

Pursuant to this model, states that adopt this model allow an organization to recruit Adult Foster Homes/Domiciliary Homes. The organization, through its home network, provides a lower-cost community alternative to nursing home care. Caregivers and clients are supported by an interdisciplinary team. The Organization manages home compliance with regulations, provides reports to the state, provides case management, pays care givers and provides care giver support.

It is important to note that states that implement these programs often have robust adult foster care programs, as well as a licensure and regulatory framework to ensure that services are provided in an effective and safe manner. An initiative to implement this model in South Dakota would require significant preparatory activities.

Strategy

Perform a detailed analysis of the Domiciliary Care model, particularly for long-term care services for the elderly and possibly for individuals with developmental disabilities. Based on the information shared with the subcommittee, it appears this model may offer benefits for some individuals who could reside with family members versus needing nursing home care.

Actions
- Conduct detailed return on investment analysis and feasibility study. Quality of care issues must also be examined.
- If determined cost effective, feasible and safe, identify finance vehicle and issue Request for Proposal for program vendor.
- Move forward with program implementation.

Estimated Savings

TBD

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Recommendation X: Implement a Durable Medical Equipment Recycling Program

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Durable Medical Equipment (DME) is defined as medical equipment like wheelchairs, walkers, crutches, hospital beds and other items (such as assistive communications equipment) that can be used repeatedly by one or more individuals. Such equipment is often costly, and constitutes a significant expense for Medicaid programs and other insurers. A DME recycling program involves repurposing certain DME when the aggregate cost of recycling an item of DME, including costs for pickup and delivery, repairs, maintenance, tracking of DME and other directly related costs, are less than the Medicaid maximum fee allowance for the purchase of new DME. Medicaid Programs in other states, such as Kansas and Georgia, have implemented DME recycling programs.   These programs can provide cost savings for a state Medicaid program, but are fairly labor intensive and may require substantial warehousing capacity and logistical support. Specific subsets of DME, such as assistive technology devices, can be targeted.

Strategy

Evaluate the feasibility of implementing a recycling program in South Dakota to reduce Medicaid expenditures relating to expensive DME.

Actions
- Explore DME recycling program opportunities.
- Engage consumers, providers and other stakeholders to provide input and advice on the program design.
- Develop program cost savings and design models.
- Prepare procurement document.
- Implement program.

Estimated Savings

TBD

Recommendation XI: Evaluate Implementation of a Community First Choice Option (1915(k))

The Community First Choice Option (CFCO) establishes a new statewide Medicaid 1915(k) state plan option for states to leverage a 6% increased FMAP rate to provide home and community based attendant services for individuals whose income does not exceed 150% FPL, or higher for those needing an institutional level of care. States are able to elect CFCO as a Medicaid state plan option, beginning on October 1, 2011.

During the full fiscal year CFCO is implemented, States are required to maintain the same level of Medicaid expenditures (state plan, 1915 and 1115 waivers) for the elderly and persons with disabilities as in the year prior to implementation. States must also make services available statewide, with no caps or targeting by age, severity of disability, or any other criteria.

CFCO covers home and community based attendant services in a community setting, including "Mandatory"[10] and "Optional"[11] services.   These services may be provided under an agency or other model including care by family members. In addition, these services must be available statewide, with no caps or targeting by age, severity of disability or other criteria, and must be provided in the most integrated setting appropriate, given individual needs, and controlled by the person, if possible.

States must establish a Development and Implementation Council to collaborate on program design and implementation, and must develop quality and data systems that incorporate consumer feedback and that monitor health measures.

Strategy

Evaluate the feasibility of implementing the Community First Choice Option (1915(k)) in order to leverage enhanced federal matching funds.

Actions
- Conduct feasibility determination
- If initiative deemed feasible, move forward to obtain grant funds and implement program.
- Implement plan

Estimated Savings

TBD

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[10] Mandatory services include: assisting with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health related tasks, including hands-on assistance, cuing, and supervision; acquisition, maintenance and enhancement of skills to complete those tasks; voluntary training to select/manage/fire direct care workers; and backup services, such as beepers, to ensure continuity of services.

[11] Optional services involve: transition costs (rent & utility deposits, 1st month's rent/utilities, bedding, basic kitchen supplies, other necessities for transition from an institutional to a community setting); and supports to increase independence or substitute for human assistance.

Notable Considerations

In addition to the formal recommendations included in this report, the Work Group and Subcommittees also discussed a number of other initiatives that did not rise to the level of a formal recommendation, but warranted mention in this report. Many of these initiatives may result in cost savings to South Dakota.   Other initiatives were discussed, and not deemed feasible for implementation in South Dakota. A summary of these initiatives are included below.

Pharmacy Subcommittee

The pharmacy subcommittee discussed the fact that some retail pharmacies have a "club" (e.g., Wal-Mart, Walgreens) where members can pay a fee to join and then benefit with $4 prescriptions, for example. As a result of this policy, steps are being taken to ensure that policies are implemented to ensure that if Medicaid recipients enroll in purchasing clubs, the Medicaid program will only be billed the amount charged the enrollee. This is consistent with Medicaid provisions that require Medicaid to pay the "best price".

In addition, the Pharmacy subcommittee identified several areas where the prior authorization process can be improved to ensure that the Medicaid program pays for, and authorizes, the most cost-effective drug therapy.

The group also discussed the anticipated benefits of a new statewide electronic database being implemented by the South Dakota Department of Health's Board of Pharmacy. The database collects designated data on controlled substances dispensed in the State. This database will be accessible by physicians and pharmacists and will help reduce inappropriate and duplicative prescribing of controlled substances, as well as enrollee drug-seeking behavior.

Finally, the Pharmacy Subcommittee discussed the fact that inappropriate prescribing of prescription medications leads to unnecessary and avoidable costs.   In order to improve inappropriate prescribing by physicians, the Subcommittee recommended implementing a peer-based prescriber education approach using the current DUR committee. A similar project was successful in sending information to prescribers about how they compare to other prescribers in the State. The South Dakota Medicaid Program intends to follow-up on this recommendation, and develop targeted reports to help improve physician prescribing practices.

Home and Community-Based Services Subcommittee

This subcommittee discussed the possibility of implementing what is known as a "PACE" program, which provides long-term care services and supports to dual eligible (individuals eligible for both Medicare and Medicaid). Questions remained regarding whether current providers would be interested in pursuing the PACE program for the elderly.   Additional follow-up will be pursued.

In addition, the group recommended that further work be done to identify opportunities to expand the use of technology to improve services to the elderly, while controlling costs. The group suggested that the Veteran's Administration and Minnesota Medicaid programs may offer options that should be considered.

Finally, the group recommended that additional work be done to ensure that individuals with Traumatic Brain Injuries who are currently served out-of-state cannot be supported in State at a lesser cost.

Additional options that were considered and determined not viable for South Dakota included: State Plan Home and Community Based Services 1915 (i), which allows targeted expansion of options without creating a new entitlement; Self-Directed Personal Assistance Services State Plan Option Section 1915 (j), which essentially allows a state to convert the personal care state plan option to a self-directed personal assistance services (PAS); Managed HCBS 1915 (a) PHIP Combination, which provides Long Term Services and Support in a managed care delivery system; and Balancing Incentive Payments, which is a temporary program that provides qualifying states with either a 2 or a 5 percentage point increase in their federal match for Medicaid Home and Community-Based Services (HCBS) costs.

Patient-Centered Care/Physician Services Subcommittee

The Work Group had a robust debate relating to a proposal by the Department of Social Services to implement co-payments for selected populations for the non-emergency use of the ED, but a consensus was not reached on this topic, as a result of objections by numerous providers.

Pursuant to federal law, states may apply cost sharing, in the form of "nominal" co-payments, to certain Medicaid populations. States cannot require cost sharing for persons eligible under mandatory groups. Moreover, generally providers may not refuse services to Medicaid enrollees based on inability to pay. As a result, co-payments are often seen as a "hidden" payment reduction, as it is difficult for providers to obtain co-payments from consumers, but they still must provide services.   Research on the effectiveness of co-payments as a cost containment tool is also mixed.   That said, many Work Group members argued that targeted co-payments could potentially be a useful tool to control the inappropriate utilization of ED services.   Non-emergency services constitute a significant component of increased ED utilization, and inappropriate, non-emergency use of the emergency department not only increases health care costs, but it also fragments coordination and continuity of health care for patients.

In addition to discussions relating to co-payments, several Medicaid providers shared information on successful program models implemented within their care delivery systems that can serve to improve enrollee outcomes and control spending. These programs include a Maternity Care approach (known as "Centering Pregnancy"), which is an obstetrics clinic program where expectant mothers meet on a regular basis to learn about pregnancy and how to relieve some of the common symptoms. These programs have demonstrated improved clinical outcomes and cost savings.   Other programs discussed during the Work Group process included a diabetes management program for pregnant women.

During the Work Group meetings, Medicaid Providers offered suggestions on possible approaches that would encourage the expanded adoption of these best practices throughout South Dakota. These approaches could involve the sharing of best practices, targeted grant funding, and possible fee schedule revisions. As a result of these discussions, the South Dakota Medicaid Program intends to evaluate reimbursement changes that will encourage Medicaid providers to expand the utilization of promising programs to improve patient outcomes and reduce long-term costs.

Finally, it is also important to note that the Work Group discussed the possibility of implementing what is known as "full-risk, comprehensive Medicaid managed care." Pursuant to this approach, states typically pay health maintenance organizations (HMOs) on a capitated basis – a set amount per member per month – to provide all Medicaid benefits and services pursuant to a contract between the state and

the managed care entity. Several potential barriers to this model were discussed, including the difficulty of implementing this model in rural areas, identifying entities that would be willing to assume risk under a contract, and the up-front costs that would have to be assumed by the state to pay prospective capitated rates. As a result of these issues, including a number of other barriers, implementing a full-risk Medicaid managed care program was not a consensus recommendation of the Work Group.

Fiscal Overview

As stated in the Note to Readers section, given the short time available, Work Group members focused their energies on developing a feasible approach to controlling Medicaid costs in both the short and long-term. It is the expectation of the Work Group that additional work will be needed in order to fully develop and implement each proposal and to determine the fiscal interactions of multiple proposals.

Recognizing this, the Work Group provided recommendations on the next steps needed to develop each proposal. In many cases, a proposal will suggest action from policymakers. This will necessitate refinement of the proposal, with cost estimates and identification of an appropriate funding source. In other cases, the next step calls for a smaller group to reach consensus and refine the proposal, providing a final recommendation for which a cost estimate can be developed.