ZANIYA PROJECT TASK FORCE

Create Access To Affordable, Comprehensive Health Insurance For All South Dakotans

Final Report

September 2007

ZANIYA TASK FORCE MEMBERS

Lt. Governor Dennis Daugaard, Chair
Senator Thomas Dempster
Senator Tom Hansen
Senator Tom Katus
Representative Joel Dykstra
Representative Clayton Halverson
Representative Tim Rave
Dr. Kevin Bjordahl, Health Care Provider
Deborah Bowman, South Dakota Department of Social Services
Judy Buseman, Falls Community Health Center
Roger Campbell, Tribal Government Relations
Robert Clark, Bob Clark Insurance
Vern Donnell, Tribal Health Professional
Terry Dosch, South Dakota Council of Mental Health Centers
Dan Dryden, Consumer
Dr. James Engelbrecht, Health Care Provider
Kevin Forsch, South Dakota Governor's Office
Janet Griffin, Wellmark Blue Cross Blue Shield
Hugh Grogan, Minnehaha County Department of Human Services
Dr. Jeffery Henderson, Black Hills Center for American Indian Health
Dave Hewett, South Dakota Association of Health Care Organizations
Jerry Hofer, South Dakota Department of Human Services
Doneen Hollingsworth, South Dakota Department of Health
Larry Iversen, South Dakota Department of Social Services
Kay Johnson, South Dakota Retailers Association
Scott Jones, Delta Dental of South Dakota
Donna Keeler, South Dakota Urban Indian Health
Larry Kucker, Health Care Management Technology, Inc.
Dr. Doug Larson, Health Care Provider
Dr. Steve Lee, Medical Associates Clinic
Thomas Livermont, Personal Group, Inc.
Greg Miner, Siouxland Surgery Center
Ron Moquist, Raven Industries
Randy Moses, South Dakota Division of Insurance
Becky Nelson, Sanford USD Medical Center
Bob O'Connell, Sioux Falls Area Chamber of Commerce
Kim Olson, South Dakota Governor's Office
David Owen, South Dakota Chamber of Commerce & Industry
Ted PettyJohn, Phase Technologies, LLC
Darla Pollman-Rogers, Trade Association
Jean Reed, Avera Health
Tom Roberts, State Publishing
Merle Scheiber, South Dakota Division of Insurance
Michael Shaw, May, Adam, Gerdes & Thompson
Clark Sinclair, Montgomery's Furniture
Joe Sluka, Regional Health, Inc.
Barbara Smith, South Dakota State Medical Association
Dennis Studer, South Dakota Bureau of Personnel
Rob Wheeler, Wheeler Manufacturing
Sam Wilson, AARP
Kirk Zimmer, Dakota Care
Sandra Zinter, South Dakota Bureau of Personnel

Note to Readers

State statute directs the Zaniya Project Task Force to develop cost estimates and funding sources for each new recommended proposal. Early on, the Task Force was faced with the issue of producing either a narrowly focused report in which costs and funding sources would be identified or a more comprehensive, action-oriented document. As the process unfolded, it became clear that a comprehensive approach – one in which many strategies were employed to help stem rising health care costs for the people and businesses of South Dakota while ensuring access for the uninsured – would be most appropriate given the short time frame.

The Task Force believes all proposals contained in this report are advisory. As such, they are conditioned upon a later determination of cost estimates and funding sources by those entities proposing specific implementation strategies. The practicality of any proposal will depend in large part upon its actual cost and benefit.

The Task Force used a consensus building process to develop the report's recommendations, strategies and actions. As part of the final meeting, work group members were asked to submit comments or concerns in an unattributed format. These unattributed comments were collected and can be viewed on the Zaniya website (http://www.zaniya.sd.gov). The final meeting was then used to achieve consensus, which was accomplished in nearly all instances.

Despite widespread agreement on the final document, not every recommendation, strategy or action enjoys the same degree of support from every member of the taskforce. Task Force members were allowed to submit attributed viewpoints to clarify their concerns. These attributed comments can also be found on the Zaniya website.

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Zaniya Project Task Force

Legislation, Goals, Process & Timeline

"Zaniya" (pronounced zah-nee-yah), the Lakota term for "health and well-being" characterizes the holistic approach supported by the wide range of perspectives represented on the Task Force. While state-based health care reform initiatives are occurring throughout the country, it is important to note that the health care system in South Dakota is working relatively well. Currently, surveys show that 91% of adults and over 97% of children in South Dakota have health care coverage. Thus, it is critical that changes "do no harm."

The goal of the Zaniya Project Task Force is to develop a plan to provide access to affordable, comprehensive health insurance to all South Dakota residents. The Task Force was born out of the passage of House Bill 1169 during the 2007 Legislative Session, which stated in part:

> *"The task force shall develop a plan, complete with action steps and timelines, to provide health insurance to South Dakota residents who lack health insurance coverage. The task force shall seek to create efficiencies in the purchase of health insurance products. For any new proposal it recommends, the task force shall prepare cost estimates and designate funding sources. As part of its charge, the task force shall explore and pursue opportunities available from the federal government."*

Governor M. Michael Rounds charged the Task Force to approach Zaniya as a commitment, not an exercise in theory, to create a report with specific recommendations, strategies and action steps to reduce the number of uninsured in South Dakota. During its deliberations, Task Force members sought input from stakeholders and national experts to define problems and propose solutions for the estimated 9% adult South Dakotans without health insurance. The Zaniya Project Task Force focused its efforts on understanding who is uninsured and why individuals are uninsured in order to craft solutions targeting access to health insurance and health care.

To obtain accurate data, the state provided the necessary resources to conduct:

- A **phone survey** to estimate the count, the demographic characteristics, and the factors critical to the lack of coverage for the uninsured in South Dakota;
- **Focus groups** for the general population and for the American Indian population to determine the reasons South Dakotans do not have health insurance; and
- An **employer survey** on access to health insurance and coverage in South Dakota.

The Zaniya Project Task Force met monthly from April to September and is required to provide its final report to the Health Care Commission, the Governor and the Legislature by September 30, 2007. With a diverse membership of employers, health care providers, the insurance industry, tribal health representatives, consumers, trade association representatives, and state government officials, the Task Force is well positioned to provide both the experience and the imagination to identify effective and responsible solutions. The recommendations of the Zaniya Project Task Force are detailed in this report.

Work Group Structure and Charge

The Zaniya Project Task Force was split into four work groups to explore specific data and potential solutions in four areas. The mission and charge of each work group and the membership, including Task Force appointees and other participants, follow (Non-task force members are denoted by *).

Long Term Cost Containment Work Group

The work group was charged with developing recommendations and strategies to help control health care costs. The work group identified five areas for discussion, including:

- Health Information Technology
- Informed Consumer Choice
- Chronic Disease Management
- Lifelong Wellness and Disease Prevention
- Emphasis on Treatment in Primary Care Setting

Work Group Members

- Doneen Hollingsworth, Co-chair
- Sandy Zinter, Co-chair
- Dr. Kevin Bjordahl
- Sen. Tom Dempster
- Sen. Tom Hansen
- Dave Hewett
- Ron Moquist
- Laurie Gill*
- Becky Nelson
- Ryan Nelson*
- Bob O'Connell
- Kim Olson
- Merle Scheiber
- Sam Wilson
- Kirk Zimmer
- Bernie Osberg*

Insurance Work Group

The work group was charged with developing recommendations and strategies to provide access to health insurance for the uninsured population.

Work Group Members

- Randy Moses, Co-chair
- Dennis Studer, Co-chair
- Rep. Joel Dykstra
- Dr. James Engelbrecht
- Janet Griffin
- Larry Kucker
- Bob Clark
- Ted PettyJohn
- Darla Pollman-Rogers
- Joe Sluka
- Barb Smith
- Dan Dryden
- Rob Wheeler
- David Christensen*
- Tom Martinec*
- Melissa Kusser*

Government Work Group

The work group first determined if government needed to play a role in increasing access to health care coverage for the uninsured. Upon making that determination, the group was charged with developing a list of recommendations and strategies for the role government entities would play, priority populations, the types of benefits to would be offered, and how the benefits would be provided.

Work Group Members

- Deb Bowman, Chair
- Clark Sinclair
- Clayton Halverson
- Dave Owen
- Dr. Steve Lee
- Hugh Grogan
- Larry Iversen
- Jean Reed
- Kay Johnson
- Ken Senger*
- Paula Hallberg*
- Scot Graff*
- Scott Jones
- Sharon Boysen*
- Tim Rave
- Tom Livermont
- Deb Fischer-Clemens*
- Tom Roberts

Indian Health Service (IHS) Work Group

The work group was charged with providing recommendations to improve access and healthcare services provided by Indian Health Service in South Dakota.

Work Group Members

- Jerry Hofer, Chair
- Judy Buseman
- Roger Campbell
- Terry Dosch
- Dr. Jeff Henderson
- Larry Iversen
- Maureen Cadwell*
- Ed Chasing Hawk*
- Dixie Gaikowski*
- Gail Gray*
- Karla Hall*
- Sen. Tom Katus
- Donna Keeler
- Maeve King*
- Dr. Doug Larson
- Greg Miner
- Mike Shaw
- Joe Kippley*
- Tom Livermont
- Robert Moore*
- Wanda Seiler*
- Dr. Gerald Yurtrzenka*

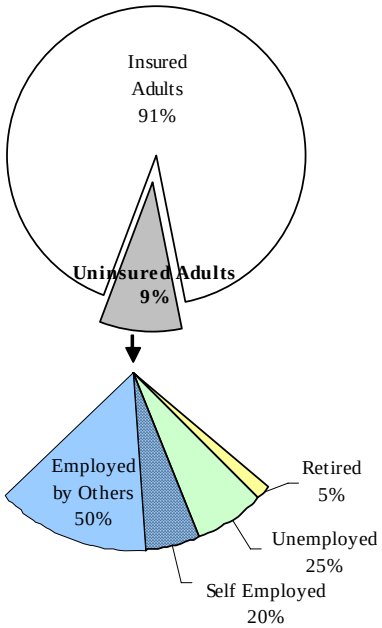
Key Data and Findings

In the course of exploring issues and options for South Dakota's uninsured population, the Zaniya Project Task Force identified key data and findings. These included data on the adult uninsured; findings from focus groups of uninsured persons; employers; and testimony from stakeholders and national experts. An overview of key data and findings follows.

- ***Uninsured Survey***. A statewide telephone survey was conducted in May, 2007 to update the percent and number of uninsured *adults* in South Dakota. According to the results, 91% of adult South Dakota residents are insured and 9% of adults in South Dakota are uninsured. Compared to prior surveys, the percent of uninsured adults is slightly higher than 8.1% in 2001 and 8.5% in 2004.

- ***Uninsured Adults.*** Survey results also indicated that:

  - Of uninsured adults, nearly 70% are employed (20% self-employed; 50% employed by others).



  - Of the uninsured adults who are employed, 25% work at more than one job.

  - Most uninsured adults work 30 or more hours a week.

  - Many uninsured adults tend to be younger or nearing retirement age and have nearly as much education as the overall population.

  - The cost of insurance was cited as the major reason for being uninsured (67%), followed by no offer of employer insurance (20%), no job (9%) and pre-existing medical conditions (7%).

  - Forty-two percent of adults who have been uninsured at some point during the past two years were without insurance for more than five years, while 34% were without health care coverage for one to five years.

  - Approximately 60% of the uninsured have incomes below 200% of the federal poverty.

- ***Uninsured Focus Groups*** cited the value of health insurance as important, but the cost of insurance and job-dependent coverage as significant barriers to becoming insured.

  Although American Indians are able to access care through the Indian Health Service, focus group participants were most critical of the extended wait times to access care and the substandard quality of care.

- ***Employer survey*** results found that:
  - Approximately three-fourths of all South Dakota firms offer health insurance to their full-time employees.
  - Smaller employers are less likely to offer their employees health insurance. For example, 60% of South Dakota firms having 1-9 employees offer some type of insurance, whereas 100% of South Dakota firms having more than 100 employees offer insurance.
  - The "take up rate" (participation rate) among employees is about the same regardless of employer size. If an employer offers health insurance, about 60% of employees typically enroll in coverage.
  - Employers contribute approximately 70% of the premium cost for full time employees.
  - Section 125 plans for pre-tax contributions were used by less than 50% of employers.
  - Few firms offer health insurance to their retirees.
  - The main reason for offering health insurance was to attract and retain good employees; the primary reason for not offering health insurance was expense.

- ***American Indian Health Status*** in South Dakota indicates that:
  - In South Dakota, the average age at death in 2006 was 56 for American Indians versus 81 for whites.
  - South Dakota American Indians had the highest years of potential life lost before the age of 75 of any race/ethnic group in the U.S. The leading causes of death are heart disease, cancer, accidents and diabetes.
  - According to a recent behavioral risk factor survey, 20% of American Indians rate their health as fair or poor versus 13% of whites.

Overview of Recommendations and Strategies

The Zaniya Task Force formed work groups to develop recommendations, strategies and actions in four areas:

- Insurance;
- Government;
- Long Term Cost Containment; and
- Indian Health Service

Each work group held face-to-face meetings and prepared reports for discussion and incorporation into the Zaniya Task Force Report.

Each recommendation, strategy and action step grew out of a process that included:

1) the collection and analysis of background data;
2) identification of problem areas and potential target populations;
3) discussion of alternative solutions; and
4) potential time frames.

Overlapping recommendations were consolidated over time so that duplication was kept to a minimum.

The report presents recommendations to:

- Expand the opportunities for purchasing more affordable, quality commercial health insurance for more of South Dakota's citizens;
- Extend health care coverage to more of South Dakota's low-income uninsured through premium subsidies for commercial insurance;
- Improve private and public health care purchasing in South Dakota by reducing costs and purchasing for value; and
- Improve health care coverage and health status of American Indians living in South Dakota through targeted national, state and tribal initiatives.

Photo by South Dakota Tourism

The report's recommendations are designed to be comprehensive but not necessarily interdependent. Some recommendations can be pursued immediately; some will require a longer time frame; and some may need to be approved by the state and/or federal government and the appropriate tribal authority.

In total, the recommendations present a pathway for all South Dakotans to be "well in health."

Recommendation 1

Create a High Risk Pool to Extend Coverage to "Uninsurables"

Those with pre-existing medical conditions face a particular challenge finding access to affordable health insurance coverage.

The South Dakota Risk Pool was enacted on June 27, 2003 to provide coverage to people who have lost health insurance through no fault of their own and have previous creditable coverage. However, the program does not serve uninsured individuals who have a pre-existing condition or illness that causes them to be declined by private insurers unless the person recently lost creditable coverage. In 2006, the Risk Pool was made available to "closed block insureds" whose premiums exceeded two times the premiums for the Risk Pool.

The South Dakota Risk Pool is roughly similar to other states. It has a premium cap of 150% of the average market premium for comparable coverage and funding is provided from member premiums, insurer assessments, limited state and federal funding, and discounted payments to providers.

Strategy 1-1

Promote legislation to establish eligibility criteria for an uninsurable risk pool to allow an estimated 5,211 individuals, or roughly 1% of the population, who cannot purchase health insurance due to pre-existing health conditions to enroll.

Actions

- Create a work group to:
  - ✓ Develop the eligibility criteria;
  - ✓ Define funding mechanisms; and
  - ✓ Design the risk pool for "uninsurables".
- Encourage passage of legislation for a risk pool, including provisions for a funding mechanism.
- Access any available federal funding to assist with the costs associated with an uninsurable risk pool.

Recommendation 2

Develop an Employer Assistance Program

Of insured, non-elderly South Dakotans, roughly 60% access coverage through employer-sponsored plans. Firms are more likely to offer coverage for full time workers if the size of the business exceeds 50 employees. Certain industries with seasonal and low-wage employees are somewhat less likely to offer health insurance, including agriculture, leisure and hospitality, retail trade, construction and natural resources and mining.

While not a primary reason for most employers not offering health insurance, administrative burdens and lack of information contribute to employer's decisions not to offer health insurance.

Strategy 2-1

Create a work group to study what types of assistance can be provided to employers to better enable employers to purchase health insurance and to administer their health benefit plans.

Actions

- Explore options for an employer assistance program by 2009.

Recommendation 3

Offer Additional, More Affordable Insurance Continuation Options

Under Federal COBRA law and state continuation law for smaller employers, employees and dependents have a right to continue their group plan upon the employee leaving employment and certain other qualifying events. However, cost has been a significant barrier to many who wish to continue their coverage.

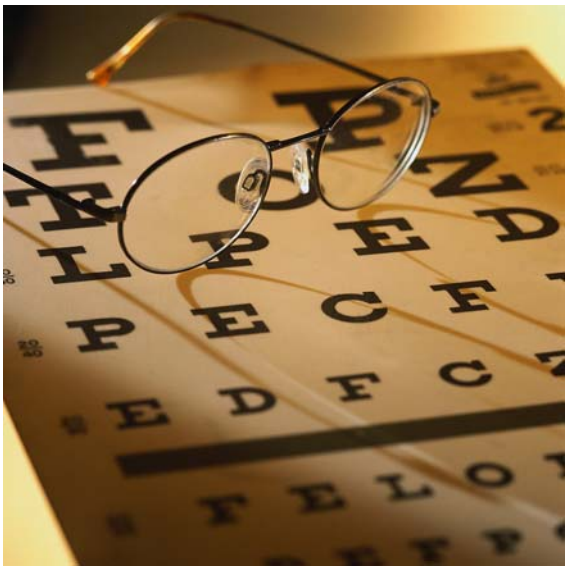
More qualifying individuals might choose continuation rather than going without health insurance if lower cost coverage was available.

Strategy 3-1

Promote legislation that requires health insurance carriers to offer drop down options to enrollees that have continued coverage.

- To provide more affordable options for those who have exercised continuation rights, additional plan options would be made available to enrollees. These options would allow the employee or dependents to reduce coverage to save premiums.

- To minimize the administrative impact on employers and health carriers, the offer would be in a format that limited the coverage options and did not require the formulation of a benefit structure outside what is being currently offered to such employees.



Actions

- Design legislation requiring health insurance carriers to offer drop down options to enrollees who have continued coverage by 2008.

- Encourage passage of legislation by 2009.

Recommendation 4

Promote Personal Responsibility for Health Care

In some instances, individuals choose to not have health insurance even though they can afford it.

One consequence of choosing to not have health insurance is that unpaid health care expenses increase the cost of health insurance for others. The Task Force labored over the issue of mandating health insurance financial responsibility versus advocating and educating for personal responsibility. The consensus of the Task Force was to encourage and promote personal responsibility as the most appropriate measure.

Strategy 4-1

Create a work group to promote personal responsibility for health care.

Actions

- No specific actions proposed.

Recommendation 5

Increase Enrollment of Eligible Persons in Existing Public Programs

Some uninsured children, parents and childless adults are eligible for, but not enrolled in, publicly funded health care programs, including Medicaid, the State Children's' Health Insurance Program (SCHIP), and Medicare. While some uninsured may not be enrolled, others may drop out of these programs due to fluctuating income, assets and household characteristics. Strategies to improve "take-up" or participation rates through enrollment and retention can leverage existing programs to decrease the number of uninsured.

Strategy 5-1

To enroll all citizens currently eligible for Medicaid and SCHIP through a more comprehensive outreach and marketing campaign**,** the Department of Social Services will form a work group consisting of representatives of state agencies, schools, health care providers, tribes, the Indian Health Service, and other interested organizations to develop a multi-pronged approach to increasing the enrollment of children and parents eligible for SCHIP and Medicaid.

Actions

- Identify the number of children and adults currently eligible, but not yet enrolled, in Medicaid and SCHIP.
- Identify organizations and other entities that need to be represented on the work group.
- Invite individuals to participate in the work group.
- Hold regular meetings.
- Develop and implement an outreach and marketing campaign.

- Monitor success of outreach campaign through regular analysis of enrollment numbers.

- Work with the federal Centers for Medicare & Medicaid Services (CMS) officials to ensure enrollment of eligible seniors and individuals with disabilities in Medicare as well as eligible American Indians to IHS-funded services.

Recommendation 6

Expand Medicaid Eligibility and Prenatal Care Coordination for Pregnant Women

South Dakota currently extends Medicaid eligibility to pregnant women for pregnancy-related services up to 133% of the federal poverty level, the level required under federal law. Expanding the current Department of Health (DOH) High Risk Pregnancy Case Management Program to include a prenatal care coordination program and extending eligibility to additional low-income pregnant women are initiatives designed to promote healthy birth outcomes for all low-income children.

Strategy 6-1

Submit a Medicaid State Plan Amendment to the federal Centers for Medicare and Medicaid Services (CMS) to expand Medicaid eligibility for pregnant women to 200% of the federal poverty level.

Actions

- Determine the number of eligible women and associated cost for expansion.

- Seek approval of the Governor and the Legislature for the expansion, including a DSS budget increase through the appropriations process.

- Submit a Medicaid State Plan amendment to CMS.

Strategy 6-2

Expand the DOH High Risk Pregnancy Case Management program to improve access and utilization of pregnancy-related services.

Actions

- Determine feasibility and resources required to expand the DOH's High Risk Pregnancy Case Management Program to include a prenatal care coordination program.

- Develop an education campaign to make certain providers and citizens are made aware of the new eligibility standards and program benefits.

Recommendation 7

Extend Coverage to Low Income Children, Parents and Childless Adults Through Private Health Insurance Using Medicaid-Funded Premium Subsidies or Medicaid/SCHIP Expansion.

South Dakota currently extends coverage through Medicaid and SCHIP to children up to 200% of the federal poverty level and to parents of eligible children up to 58% of the federal poverty level.

- Of the total number of uninsured adults in South Dakota, over 32,000, or 60%, have incomes below 200% of the federal poverty level.
- An additional 2,000 uninsured children live in households with incomes between 201% and 250% of the federal poverty level.

A multi-pronged approach to providing health insurance coverage may need to be taken to best position the State of South Dakota in meeting the needs of its low-income uninsured citizens. Recent changes in federal law and policy and innovative Medicaid-funded state health care initiatives across the country may provide guidance in the use of private health insurance coverage for South Dakota's low-income residents. By building on the strengths of the insurance market, employer-sponsored insurance and government operated insurance programs, South Dakota can make health insurance more affordable for low-income uninsured by leveraging Medicaid funds.

Strategy 7-1

Expand the South Dakota SCHIP program for children in families with incomes between 201% and 250% of the federal poverty level.

Actions

- Determine the most cost-effective approach to serving children in families within this income level either through premium subsidies or SCHIP expansion.
- Refine estimates of the count of eligible children.
- If privatized, determine benefit levels and costs; recipient premium contributions and cost sharing; options to leverage Employer Sponsored Insurance (ESI); and phase-in and take-up rates.
- Seek approval from the Governor and Legislature and promote legislation, including a Department of Social Services budget increase through the appropriations process.
- Seek approval of SCHIP expansion or waiver from CMS.

Strategy 7-2

Extend access to Medicaid-funded premium subsidies for ESI and the purchase of private insurance for parents of Medicaid/SCHIP children in families with incomes between 58% and 200% of the federal poverty level. Establish premium subsidies based on a minimum core benefit package with a focus on primary and preventive care, including incentives for wellness, healthy behaviors and disease management.

Actions

- Estimate the number of eligible parents, benefit levels and costs, premium contributions and cost sharing, options to leverage ESI and phase-in and take-up rates.
- Seek approval from the Governor and the Legislature for a DSS budget increase through the appropriations process.
- Develop a Medicaid Section 1115 waiver and seek federal approval to extend premium subsidies to low-income, uninsured parents.

- Develop an education campaign to ensure providers and citizens are made aware of the new eligibility standards and program benefits.

Strategy 7-3

Extend access to Medicaid-funded premium subsidies to purchase private insurance for childless adults with incomes up to 200% of the federal poverty level.

Actions

- Estimate the number of eligible childless adults, benefit levels and costs, premium contributions and cost sharing, options to leverage ESI and phase-in and take-up rates.
- Seek approval from the Governor and the Legislature and promote legislation, including a DSS budget increase through the appropriations process.
- Develop a Medicaid Section 1115 waiver and seek federal approval to extend premium subsidies to low-income, uninsured childless adults.
- Develop an education campaign to ensure providers and citizens are made aware of the new eligibility standards and program benefits.

Recommendation 8

Leverage Existing Funds and Public-Private Partnerships to Support Health Care for the Uninsured

South Dakota currently requires counties to pay for emergency hospital care for the very poor who do not qualify for Medicaid. While most counties pay hospital bills only, more populous counties tend to pay for most medical services covered under the South Dakota Medicaid program. In addition, the state's federal allotment for disproportionate share hospital (DSH) payments is currently not fully utilized. Currently, South Dakota's DSH allocation is $13 million in federal and state funds, but the state is only utilizing approximately $3 million. The remaining $10 million may be available to fund care for those who are currently uninsured.

Strategy 8-1

Work with our partners, both public and private sector, to identify funds supporting health care currently not recognized by the federal Department of Health and Human Services that would enable the State of South Dakota to access additional Medicaid funds to pay for services for uninsured, low-income Medicaid subsidy expansion groups.

Actions

- Analyze available data to determine current unmatched funds now utilized to support indigent health care services.
- Develop a plan to utilize existing and new funding options, leveraging public-private partnerships to the extent possible, to support the extension of coverage for the uninsured.
- Advance the plan to CMS as part of the Medicaid Section 1115 waiver, with approval of the Governor and the Legislature.

Strategy 8-2

Pursue with the federal Department of Health and Human Services the possibility of negotiating rates for certain IHS services at an enhanced rate to increase funds into IHS facilities.

Actions

- Compare South Dakota's rates for IHS services to other states and explore options to implement reimbursement strategies now used with other public providers.
- Meet with IHS officials to outline potential reimbursement initiatives.
- Develop and submit a proposal, as part of a Medicaid Section 1115 waiver, to maximize federal matching payments on state funding for indigent health care services.

Recommendation 9

Use Health Information Technology to Promote Quality and Efficiency

Health information technology holds promise as one means to reduce health care costs in the long term. This is accomplished in a number of ways, such as reducing medication errors through electronic medication management systems or improving continuity of care through the use of electronic medical records. A collective partnership between the private sector and state government can provide the leadership necessary to promote quality and efficiency by fostering e-Health initiatives to improve care, quality and outcomes and to introduce new technologies into the marketplace.

Strategy 9-1

Develop a vision and plan for the use and expansion of health care technology, addressing issues such as interoperability, employment of portable personal health records, health information exchanges and data sharing.

Actions

- Recommend the South Dakota Health Care Commission appoint a group of experts to develop a long range plan to facilitate the implementation of interoperable electronic health/medical records, data exchange and the use of personal health records.
- Establish an annual Health Information Technology Summit to share information and promote coordination of health information technology efforts across the state.

Strategy 9-2

Promote the dissemination and use of electronic prescribing capabilities throughout the state.

Actions

- Work with the National ePrescribing Patient Safety Initiative (a coalition of companies, health insurers and provider organizations dedicated to enabling free ePrescribing for every physician in the country at www.nationaleRx.com) to provide a point of contact to furnish information and technical assistance to South Dakota physicians.
- Explore ways in which the state employee health insurance plan and/or the State's Medicaid and SCHIP programs can support ePrescribing.

Strategy 9-3

Use electronic medication management systems to reduce medical errors.

Actions

- Determine the extent to which community hospitals in South Dakota employ electronic medication management systems and what barriers exist to wider use.
- Provide incentives for hospitals and nursing homes to implement

electronic medication management systems within their facilities.

Strategy 9-4

Require all providers and insurers to use electronic forms and communicate electronically in standardized formats.

Actions

- Promote legislation or administrative rules which require the mandatory use of electronic claims in a standard format, with a 2 to 3-year phase in period.

Recommendation 10

Encourage Informed Consumer Choice

Informed choice or transparency of quality and price allows purchasers to make comparisons among products and services. For health care consumers, this enables them to take more responsibility for their health and to seek services which are the most cost-effective. In the long-term, the provision of information to all parties can help to slow the growth of health care costs through price competition, higher quality and improved outcomes.

Strategy 10-1

Establish a "neutral, credible" source which consumers can use to access national, state and/or other sources of comparative data relative to health provider performance (e.g. pricing, quality indicators, etc.).

Actions

- Undertake the assessment and development of the Wisconsin *PricePoint* program in South Dakota to replace and expand the current hospital price reporting web site.
- Initiate a program that will allow consumers to more easily view the CMS "hospital compare" program.
- Promote state legislation that would require the Department of Health, in collaboration with provider organizations to develop a list of outpatient procedures by which every provider offering that service would be required to report their charge for providing that service to the Department of Health. Comparative charges would be posted on the Department's website.
- Require the reporting by hospitals of selected information to improve quality and delivery systems, including health care facility-acquired infection rates and "never events".

Strategy 10-2

Design a broad-based education program that focuses on health literacy, personal responsibility, wellness, lifestyle management and health care fiscal responsibility.

Actions

- Health care providers should expand their websites to provide consumers with information, contacts and sources for appropriate treatment and providers in the area.
- Collaborate with health provider groups and experts to develop, distribute and implement practice guidelines and toolkits, building on initiatives such as the recent joint collaboration of the South Dakota Department of Health, the South Dakota State Medical Association, and other partners to create a toolkit for South Dakota primary care providers to address the obesity epidemic with their patients.
- Develop a "call to action" comprehensive, positive media campaign which focuses on taking care of personal health by targeting two or three practices that consumers could do to save on health care costs (themed campaign with cycles of specific messages targeting behaviors responsible for exorbitant health care costs).

Strategy 10-3

Develop a county-based listing of drug prices available to consumers.

Actions

- Leveraging the successful experience of other states and private vendors, create a work group to explore opportunities to create a web site to allow individuals to compare retail prices of the 100 most common prescription drugs in the state.
  - ✓ Allow an individual to identify a prescription drug and compare the retail price that each pharmacy in a selected county charges for that medication.
  - ✓ Specify the “retail price” is the price an uninsured consumer, with no discount or supplemental plan, would normally pay.
  - ✓ Update retail pharmacy prices on a regular basis.
  - ✓ Caution individuals to account for both cost and individual services needed when selecting a pharmacy.

Recommendation 11

Improve and Expand Chronic Disease Management

Chronic disease management seeks to improve patient care and outcomes and reduce health care costs by concentrating services on people with chronic diseases. Care for these people tends to cost more because they use a greater share of medical services, typically from multiple medical providers and often without care coordination. Disease management programs often work directly with these patients and their physicians on treatment plans, diet, keeping to medicine schedules, and other self-management techniques.

Many private insurance companies and public programs use disease management techniques. A number of private companies known as disease management organizations sell their specialized services to insurance companies, employers, managed care organizations, and more recently, state Medicaid programs. Pharmaceutical companies may also engage in disease management services. Pharmacy Benefit Management Organizations (PBMs) use disease management activities to reduce their clients' drug costs.

Strategy 11-1

Establish a pilot project using a personal "coach" to help educate individual patients through treatment options and regimens.

Actions

- Create more opportunities for clinic-based coaches/navigators/care coordinators with third party reimbursement for these services.
- Expand the 'Bright Start' Nurse Home Visiting Program to include more communities with a high percentage of at-risk families.
- Leverage the expertise of active or retired health professionals by using them as "coaches" in a volunteer capacity.
- Explore opportunities to use a "coach" in home health care settings.

Strategy 11-2

Establish programs for K-12 students addressing chronic childhood illnesses or conditions, including asthma, diabetes, heart disease, and obesity.

Actions

- Expand support for community-based programs as a venue for prevention and education, since a majority of current initiatives focus on school time activities.
- Advocate for access to health care within the school setting using School Based Health Centers, school nurses, wellness coaches, etc.

Strategy 11-3

Use the purchasing capacity of state government to test approaches which leverage value-based purchasing and appropriate chronic disease management in publicly funded programs.

Actions

- Review other state health plans and Medicaid programs for best practices.
- Expand opportunities to link payments more directly to the quality of care provided.
- Review federal approaches and other state health programs for best practices concerning value-based purchasing and chronic disease management.

Recommendation 12

Promote Lifelong Wellness

Physical activity and healthy eating significantly decrease the risk of heart disease, cancer and stroke – the three leading causes of death in South Dakota accounting for nearly 60% of all deaths. The prevalence of overweight and obese individuals has steadily increased both nationally and in South Dakota. In South Dakota, the percentage of adults who are overweight or obese increased from 53% in 1993 to over 64% in 2006. Almost 48%

of adults reported moderate physical activity in 2005 while only 20% of adults reported eating five fruits and vegetables a day.

Tobacco use is the single most preventable cause of death and disease, responsible for the death of more than 1,000 South Dakotans each year. It kills more people each year than alcohol, HIV, car crashes, illegal drugs and suicide – combined.

Research shows for companies with means of measuring productivity, increases can begin to show up in the 6 to 12-month time frame. Reductions in health plan premium increases may not occur until 2 or 3 years after initiation when health care claims have shown a significant decline.

Strategy 12-1

Develop or expand physical activity programs for children, adults and the elderly.

Actions

- Build on existing physical activity and nutrition programs for young children, including "*Fit from the Start*" to promote opportunities for regular physical activity and healthy eating habits.

- Expand and assure physical activity opportunities for children in grades K-12.

- Expand state efforts as well as community-based recreation programs to support physical activity and nutrition education across the lifespan.

Strategy 12-2

Expand the '*Healthy South Dakota*' program to encourage South Dakotans to be more physically active and eat healthier, with the ultimate goal to reduce obesity and other chronic diseases.

Actions

- Develop a newsletter that communicates useful information to employers, consumers and health care providers.

- Conduct South Dakota-specific studies on the cost savings related to prevention programs vs. treatment.

- Provide incentive programs for employees to take advantage of their health plan's prevention benefits.

Strategy 12-3

Provide incentives for employers to participate in wellness, healthy behaviors, and prevention programs.

Actions

- Develop a guide or tool kit which shows how interested employers can develop and integrate employee wellness programs into their health plans.

- Promote worksite wellness programs, particularly for small businesses facing a much greater challenge in implementing practical, affordable efforts to improve employee health.

- Explore opportunities to provide financial incentives to employers to incorporate evidence-based outcome measures and monitoring into employer-sponsored wellness, healthy behavior and prevention plans.

Recommendation 13

Support Access to Primary and Preventive Care

Health costs are lower when consumers seek care from primary care providers in the context of a 'Medical Home'. Such providers can work with their patients to treat and manage conditions on an ongoing basis and can access specialists in an appropriate manner. In order to do this, South Dakotans need a qualified primary care workforce.

By the year 2012, nearly 10,000 additional health care workers will be needed in South Dakota. At the same time the state's baby boomers are retiring and leaving the health care workforce. As this group ages, additional health care services will be required.

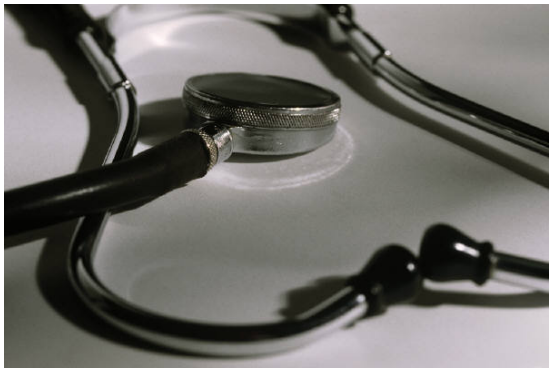
To address the critical need for health care workers in the state, initiatives should build on existing efforts to encourage middle and secondary students to pursue

health care career pathways such as medicine, nursing and allied health.

In addition, initiatives can be structured to influence how care is delivered to result in higher-quality, more cost-effective care for South Dakota's citizens.

Strategy 13-1

Support workforce planning and initiatives like Health Occupations for Today and Tomorrow (HOTT) and IN-MED for American Indians to ensure an adequate primary health care workforce in rural areas and on reservations.



Actions

- Enhance the South Dakota Department of Labor exchange program as a point of contact regarding health care job postings and candidate information.
- Create the South Dakota Health Care Workforce Center which will serve as a clearinghouse for workforce-related issues. This entity will oversee the implementation of all healthcare workforce initiatives.
- Implement programs that will increase students' awareness of healthcare careers and strengthen the state's medical and health professional education and training programs.

Strategy 13-2

Support the 'Medical Home' concept for the uninsured to foster appropriate health care utilization.

Actions

- Explore ways to increase technical assistance to Medical Homes, including primary care physicians, Rural Health Clinics, Community Health Centers and Indian Health Service facilities in order to promote continuity and quality of care in the most cost-effective setting.
- Provide information about access and incentives to emergency room alternatives for patients who inappropriately access hospital emergency rooms.

Recommendation 14

Promote Federal Policies to Improve the Health Status of American Indians

There exists a pervading and persuasive perspective that American Indian health care is (or should be) an entitlement and is the responsibility of the federal government under trust and treaty obligations, as justified by the early confinement of American Indians to reservations, and subsequent loss of Native lands and resources. Two major pieces of legislation are at the core of the federal government's responsibility for meeting the health needs of American Indians.

The Snyder Act of 1921 authorized regular appropriations for the relief of distress and conservation of health of American Indians. "The act's broad language, however, may be read as authorizing – though not requiring – nearly any Indian program, including health care, for which Congress enacts appropriations."

The Indian Health Care Improvement Act (IHCIA; P.L. 94-437) of 1976 was enacted to implement the federal responsibility for the care and education of the Indian people by improving the services and facilities of federal Indian health programs and encouraging maximum participation of Indians in such programs. "IHCIA authorizes many specific Indian Health Service activities, sets out the national policy for health services administered to American Indians, and sets health condition goals for the IHS service population in order to raise the health status of American Indians and Alaska Natives (AI/AN) to the highest possible level."

Although perspectives vary on the extent of the government's obligation, per capita health care expenditures and outcomes both indicate that funding and other resources are greatly inadequate.

Strategy 14-1

Partner with the nine tribes located in South Dakota and other organizations such as the National Indian Health Board, National Congress of American Indians, American Medical Association, American Public Health Association, the American Hospital Association, and Western Governors' Association, etc. to advocate for positive change in federal policy toward AI/AN health.

Actions

- Urge South Dakota's congressional delegation to immediately advocate for expeditious reauthorization of the Indian Health Care Improvement Act.
- Ensure continued funding for maintenance of existing IHS hospitals and clinic facilities and services in South Dakota.
- Encourage congressional prioritization of new facilities construction funding for aging IHS hospital and clinic facilities in South Dakota.
- Identify a needs-based budget for IHS and strongly advocate that Congress fully fund appropriations necessary to meet these obligations.
- Advocate changing the Centers for Medicare and Medicaid Services (CMS) policy interpretation to ensure reimbursement of Contract Health Services at a federal medical assistance percentage (FMAP) of 100%.

Recommendation 15

Maximize Existing Resources for Access to Health Care for American Indians

The IHS plays a critical role in the provision of health care services to American Indians in South Dakota. Nine IHS service units located in South Dakota serve 72,067 people annually. IHS services include primary care (medical, dental and vision); ancillary services, such as laboratory and pharmacy; and specialty care, including services provided by physician specialties.

IHS provides some services through direct care at hospitals, health centers and health stations, which may be federally or tribally operated. When services are not available – that is, both offered and accessible – on site, IHS offers them, as funds permit, through contract care furnished by outside providers. At the request of the United States Senate, the Government Accountability Office (GAO) examined health care services available to American Indians through IHS. In August 2005, the GAO reported health care services are not always available to American Indians.

South Dakota Medicaid has worked diligently to promote healthy families. As of August 2007, South Dakota Medicaid had 101,867 enrollees including 68,927 children. One of every three children in South Dakota has health coverage through Medicaid. Although Medicaid has successfully penetrated a wide population of eligible participants across South Dakota, the Indian Health Service continues to deny claims for contract health services due to failure to access alternative resources such as Medicaid, Medicare, etc.

Strategy 15-1

Establish a formal collaboration of vested parties, comprised of representation from tribal, state, private sector and federal authorities responsible for the provision of Indian health care, to study and formulate a plan to maximize to the greatest extent possible the resources necessary to afford improved access by American Indian citizens of South Dakota to comprehensive primary and preventive health care.

Actions

- In conjunction with Strategy 5-1 under Recommendation 5, conduct a study that estimates the Medicaid and SCHIP penetration rate of eligible American Indians in South Dakota.
- Create and implement a plan that maximizes Medicaid, SCHIP, Medicare and other third-party participation and reduces/eliminates the number of contract health claims denied by IHS due to failure to access alternative resources.
- Identify and address primary and preventative health care service gaps by IHS service units in order to improve access to comprehensive primary

and preventive health care and, possibly, enhance revenues available to IHS service units from alternative resources.

- Collaborate among the vested parties to enhance efforts that provide training and education to and support the recruitment and retention of IHS and tribal health care practitioners.

Recommendation 16

Seek Creative Solutions to Improve American Indian Health Care Outcomes

There are key differences in health status indicators for American Indians and the general population. American Indians in South Dakota have the highest death rate (Years of Potential Life Lost) of any race/ethnic group in the United States. The infant mortality of South Dakotan American Indians is 2.4 times the infant mortality rate of whites in South Dakota. American Indian adults are 2.2 times as likely as white adults in South Dakota to be diagnosed with diabetes and 5 times as likely to die from diabetes.

Photo by South Dakota Tourism

Strategy 16-1

Collaboratively study the issues related to disparate health outcomes for American Indians and formulate in partnership a strategic plan to comprehensively address these disparities.

Actions

- Explore opportunities for health care coverage that supplement existing health care resources.
- Identify and address issues within the public health care delivery system to simplify access and use, enhance capacity, support systematic data collection and analysis, and promote health, wellness, and disease management.
- Consider best practices which improve access to, and efficiency of, care.

- Work to address the individual health care crises created by the funding shortfall of IHS contract health care, focusing on acute and preventive health care.

- Advocate for all nine of the tribes in South Dakota to be full-fledged, equal partners in all efforts intended to address the health status of American Indians in the state.

- Explore opportunities to better integrate the IHS and non-IHS health care systems specifically in terms of providers and physicians, facilities, interactions, quality of review, and coordination of services.

Fiscal Overview

As stated in the Note to Readers section, given the short time available, Task Force members chose to focus their energies on developing a comprehensive as opposed to narrowly-focused report. This approach created a large number of recommendations, strategies and actions, but effectively prevented the identification of cost estimates and funding sources for each new proposal, as directed by statute.

The number of proposals contained within this document (16 Recommendations, 30 Strategies, and 89 Actions) attests to the comprehensiveness of the Task Force's approach. It is the expectation of the Task Force 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 Task Force 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. In any case, this is an appropriate time to identify cost estimates and funding sources.

There are many potential funding sources, including taxpayer/government (local, state, federal), the private sector (employers, providers, insurers) and individuals (users of service). To achieve success, policymakers and those proposing implementation strategies will need to determine the right mix of funding sources available at the time of implementation.

Journey to "Zaniya"

The recommendations outlined in this report should be viewed as a multi-year pathway to controlling health care costs and ensuring access for all residents of South Dakota to affordable, quality health insurance and health care. The proposals in this report are "stepping-stones" down this pathway and will need to be developed and pursued as an incremental package. The initial steps to start down this pathway are well defined by the Task Force. Stepping stones further down the path are less refined and will need modification.

Beginning this journey will require a multi-year commitment. South Dakotans cannot merely address the short-term issues affecting access to health insurance or health care services. We must also recognize individual responsibility for one's own health coupled with the need to restrain the growth in health care costs over the long term. There must also be greater recognition of the special circumstances of the American Indian population within the state's borders. Based on the strong insurance market of South Dakota, a receptive and effective health care industry and the culture of responsibility that permeates South Dakota, the Task Force believes the goal of providing access to affordable, quality health insurance and health care services for all citizens is achievable.

The path set forth by these recommendations builds on the work that has been done to bring South Dakota to this point by its elected leaders, the health care and insurance industries, employers and other stakeholders. We urge the journey to "Zaniya" begin for all people in South Dakota.