South Dakota Medicaid Report

South Dakota Department of Social Services (DSS)

Medicaid Overview Report:
Providing Cost-Effective Health Care to South Dakota’s Medicaid Recipients

October 2016

South Dakota's Medicaid program plays a vital role in the health care of many individuals. The program is much more than a vehicle for financing acute care in hospitals or care provided by physicians, dentists, optometrists and other medical providers.

- First and foremost, Medicaid or CHIP (Children's Health Insurance Program) covers South Dakota's children – 68% 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 life.

- More than 55% of our parents and grandparents in nursing homes are dependent upon Medicaid to pay for their care. 32% 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.

- Nearly 3,500 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.

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

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

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

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

- 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.

South Dakota will continue its efforts to respond to the health care needs of its citizens in a cost-effective manner, provide access and quality of care, and seek to improve health outcomes through innovative initiatives.

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Introduction

This report provides a summary of the Medicaid Program in South Dakota. It is designed to provide a high-level overview of the program, provide basic information on program operations, and highlight key program initiatives.

The report is broken into three sections.

Section 1 provides basic information on the Medicaid Program, including data and information on eligibility, coverage, and program expenditures.

Section 2 provides data relating to the operation and maintenance of program operations, including claims processing, utilization review activities, and the other important functions necessary to appropriately administer the program.

Section 3 highlights DSS's efforts to be good stewards of our tax dollars and to protect the Medicaid Program from fraud, abuse and waste.

Section 1: Program Overview

Organization

The Department of Social Services (DSS) is the designated State Medicaid Agency for South Dakota. The Division of Medical Services within the Department administers assistance to those who qualify for Medicaid or the Children's Health Insurance Program (CHIP). Other agencies also administer programs funded by Medicaid in South Dakota including the Departments of Human Services, Corrections, Education, Health, Military and Veterans Affairs.

What is Medicaid?

Medicaid is the nation's publicly financed health and long-term care coverage program for low-income people. Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program. As an entitlement program, all eligible individuals must receive services. An entitlement program differs from a block grant, which involves a cap in funding and can result in waiting lists. Over time, Congress has gradually expanded Medicaid eligibility criteria to reach more Americans living below or near poverty. Medicaid currently covers an expansive low-income population, including parents and children in both working and nonworking families, individuals with diverse physical and mental conditions and disabilities, and seniors.

Medicaid provides health coverage for millions of low-income children and families who lack access to the private health insurance system that covers most Americans. The program also provides coverage for millions of people with chronic illnesses or disabilities who are excluded from private insurance or for whom such insurance, which is designed for a generally healthy population, is inadequate or cost prohibitive.

What is CHIP? The South Dakota Children's Health Insurance Program, more commonly referred to as CHIP, provides quality health care (including regular check-ups, Well-Child Care exams, dental and vision care) for children and youth. To be eligible for CHIP, children must be under the age of 19 and reside in South Dakota. Children who are uninsured may be eligible for CHIP based on income and eligibility guidelines. Generally speaking, CHIP provides health care for children whose family income is too high to qualify for Medicaid.

What Services are Covered?

States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services based on the general federal guidelines. States are required to cover certain "mandatory services," and can choose to provide other "optional services" through the Medicaid program.[1] Mandatory Medicaid services, and optional services covered by South Dakota, are listed below. All optional services, when medically necessary, are mandatory for children under age 21.

Medicaid Mandatory Services (examples)	*South Dakota Optional Services (examples)*
• Inpatient hospital services • Outpatient hospital services • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services • Nursing facility services • Home health services • Physician services • Rural health clinic services • Federally qualified health center services • Laboratory and X-ray services • Nurse Midwife services • Certified Pediatric and Family Nurse Practitioner services • Transportation to medical care • Tobacco cessation counseling for pregnant women • All Medically Necessary care for eligibles under age 21	• Physician assistants • Psychologists and independent mental health practitioners • Intermediate Care Facilities for the Mentally Retarded (ICF/MR) • Podiatry • Prescription Drugs • Optometry • Chiropractic services • Durable medical equipment • Dental services • Physical, occupational, speech therapy, audiology • Prosthetic devices and eyeglasses • Hospice care, nursing services • Personal care services and home health aides

What is Medically Necessary?

All benefits must be "medically necessary" in order to be covered by the program. To be "medically necessary" in South Dakota, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

[1] *Medicaid Benefits*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html.

What is EPSDT? EPSDT stands for Early and Periodic Screening, Diagnosis & Treatment. Federal Law requires the State to provide screening, diagnosis and all "medically necessary" treatment services, including mental health services, to all Medicaid recipients under 21.

Seniors & Medicare and Medicaid Enrollees

In South Dakota, Medicaid provides health coverage to more than 7,000 low-income seniors, nearly all of whom are also enrolled in Medicare. Medicaid also provides coverage to over 19,000 people with disabilities, of whom about half are enrolled in Medicare. On average each month, about 12,000 people are "dually eligible" and enrolled in both Medicaid and Medicare, which is about 10% of all Medicaid enrollees in South Dakota. For these "dual eligible" individuals, Medicaid assists with Medicare premiums and cost-sharing obligations and covers key services, such as long-term care, that Medicare limits or excludes. Medicaid is South Dakota's largest source of coverage for long-term care, covering 55% of all nursing home residents.

Who is Covered?

Medicaid is one of the largest healthcare insurers in South Dakota with 147,671 individuals participating in the program during State Fiscal Year 2016. The average monthly enrollment in State Fiscal Year 2016 was 118,674

South Dakota's Medicaid Program covers primarily children of low-income families and plays a very important role in the health care of this age cohort. More than 68% of individuals covered by Medicaid or CHIP are children, and 50% of the children born in South Dakota will be on Medicaid or CHIP during the first year of their life.

The Affordable Care Act included changes to standardize eligibility determination nationally. January 1, 2014, all states, including South Dakota, began using gross vs net income as the basis for determining Medicaid eligibility. These changes also impacted the Federal Poverty Levels used to determine eligibility. The Affordable Care Act has also included changes to the way people can apply for Medicaid and find other insurance if not eligible for Medicaid. Applicants must be able to apply directly to the State Medicaid agency or to the Federally Facilitated Marketplace or a State established exchange. South Dakota is using the Federally Facilitated Marketplace. The ACA also requires that states, as a condition of Medicaid funding, maintain Medicaid income eligibility standards as of March 2010 to calculate eligibility.

In order to receive federal funding, states must cover certain "mandatory" groups. The mandatory groups are pregnant women with income below 138 percent of the Federal Poverty Level (FPL), children under age 6 with family income below 182 percent of the FPL; children age 6 to 18 below 116 percent of the FPL; parents below cash-assistance eligibility levels; and elderly and persons with disabilities who receive Supplemental Security Income (SSI). South Dakota Eligibility Categories, and their relationship to the FPL, are outlined in Table 1. In South Dakota, childless non-disabled adults are not currently eligible for Medicaid regardless of their income.

Table 1. Sample of 2016 Federal Poverty Level Guidelines

Family Size	Annual Income				
	100% FPL	116% FPL	138% FPL	182% FPL	209% FPL
1	11,880	13,781	16,395	21,622	24,830
2	16,020	18,584	22,108	29,157	33,482
3	20,160	23,386	27,821	36,692	42,135
4	24,300	28,188	33,534	44,226	50,787

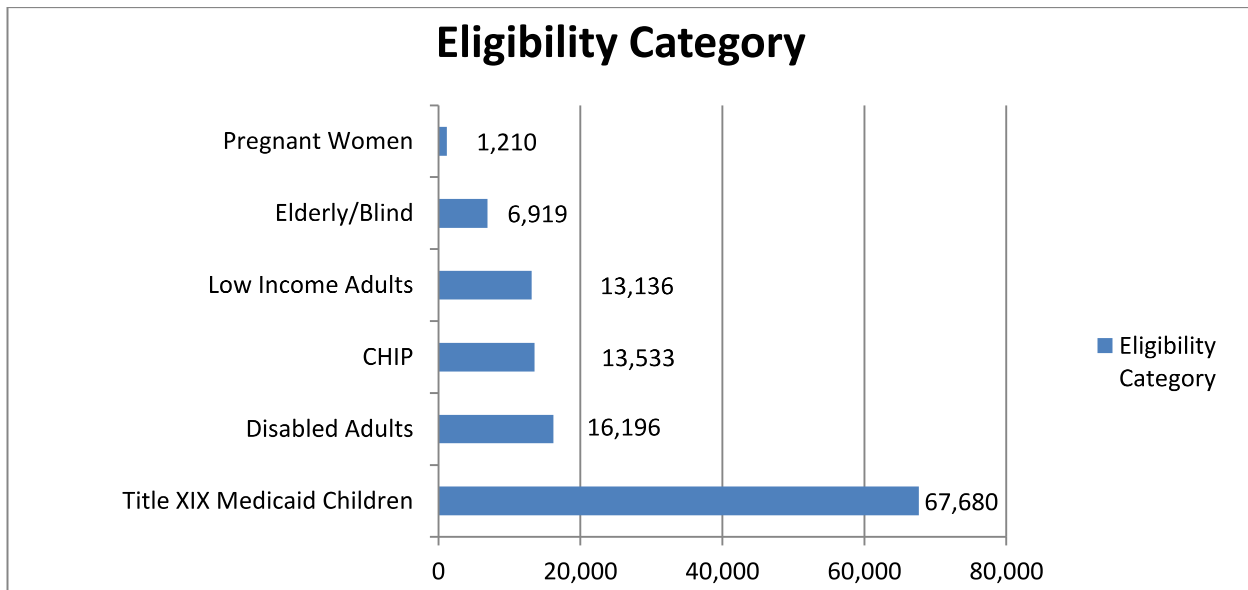
Table 2. South Dakota Eligibility by Percent of Federal Poverty Level

Eligibility Group	% FPL
Pregnant Women	138%*
Children Under Age 6	182%*
Children Age 6 – 19	116%*
Parent/Caregiver/Relatives of Low Income Children	52%*
Aged, Blind and Disabled (Single)	74%
Aged, Blind and Disabled (Couple)	83%
CHIP (Children's Health Insurance Program)	209%*

*These figures include the 5% mandatory disregard for MAGI groups

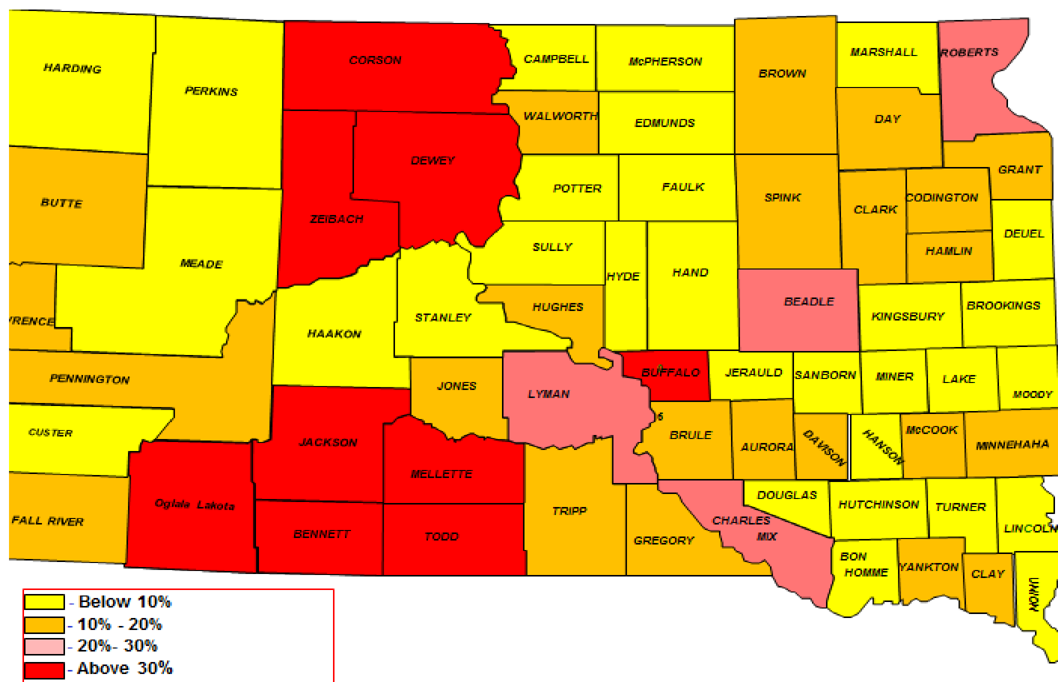
For the Medicaid Program as a whole, two-thirds of enrollees are children and one-third of enrollees are adults. The latter category is comprised of pregnant women (pregnancy-related services only), individuals who are elderly or disabled, and parents in very low income families (e.g., a family of three has an annual income of $10,560 which is 52% of the federal poverty level). The number of individuals participating in the program, by eligibility category, is outlined in Graph 1.

Graph 1. Medicaid Participation by Eligibility Category, SFY 2016



Medicaid enrollment varies considerably by county. For the entire state of South Dakota, 14% of the population was eligible for Medicaid in SFY 2016 (see Map 1 – refer to Appendix A for complete details).

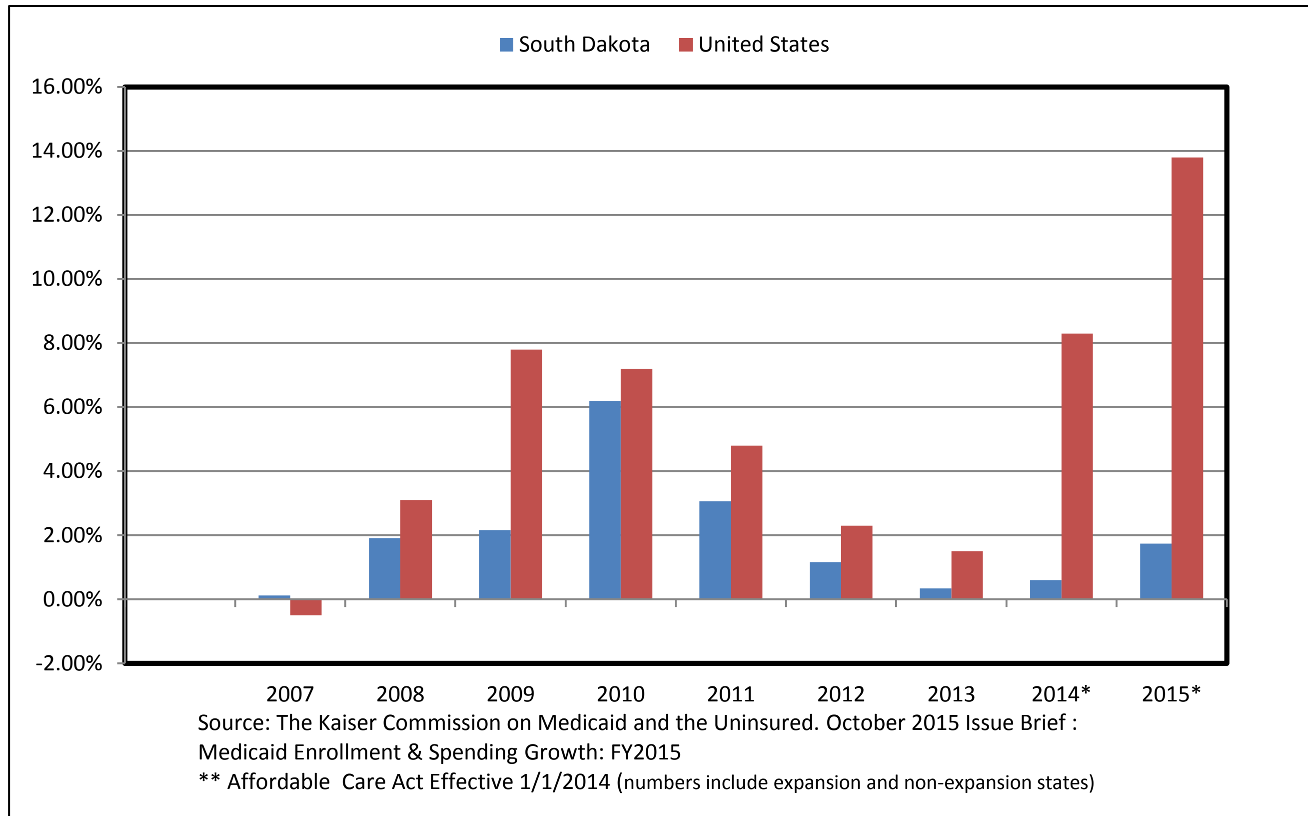
Map 1. Percent of County Population Enrolled in Medical Services 2016



**Average monthly Enrolled – DSS
**County Population FY 2015 Estimates - Census Bureau

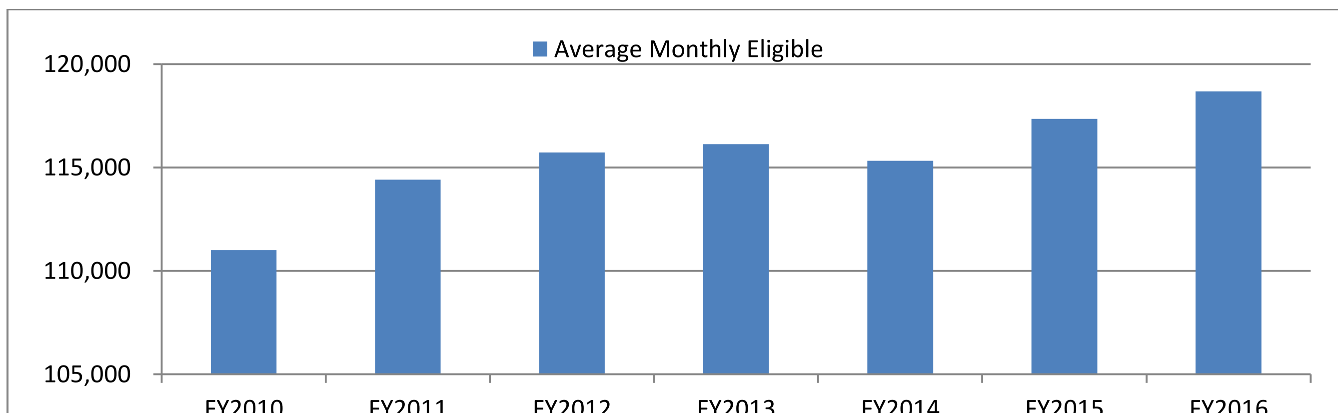
Enrollment in the South Dakota's Medicaid program has also generally experienced less annual growth than the United States as a whole (see Graph 2).

Graph 2. Annual Change in Medicaid Enrollment in 50 States and DC, 2007 to 2015



Medicaid is naturally counter-cyclical, when the economy weakens, revenues decline, and the number of Medicaid Eligible increases. National experts indicate that every 1% increase in unemployment results in an increase of 1 million Medicaid and CHIP Eligible nationwide.

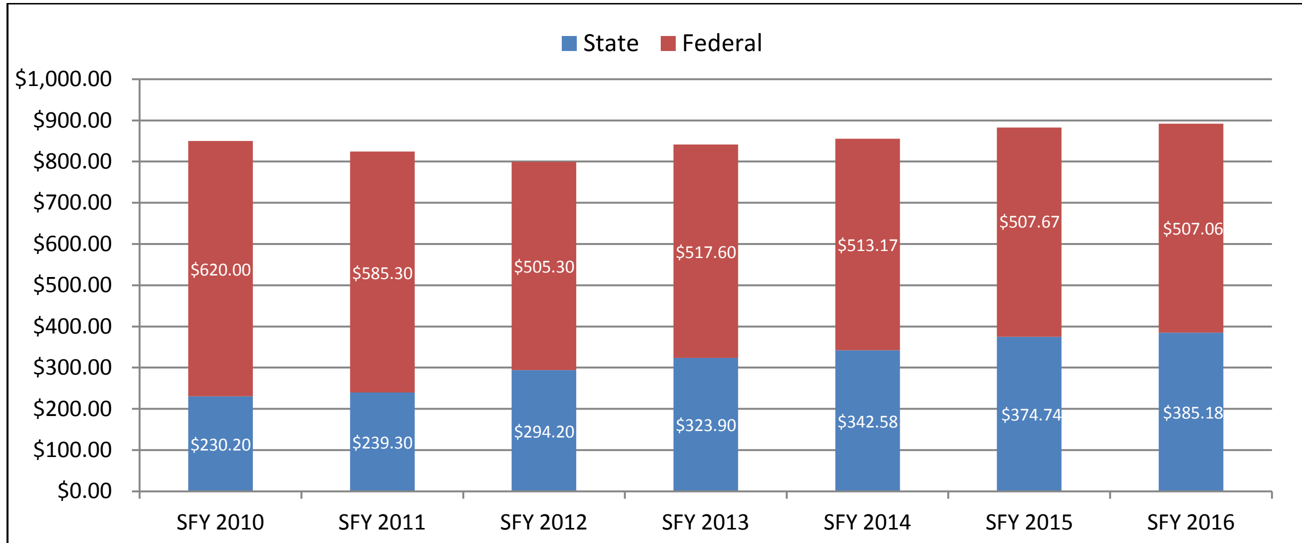
Graph 3. South Dakota Medicaid Average Monthly Eligible, SFY 2010 – 2016



How Much Does the Program Cost?

In SFY 2016, South Dakota's Medicaid expenditures were $892.3 million. Rates of growth in recent years have been fairly level. (See Graph 3-A).

Graph 3-A. South Dakota Medicaid Expenditures, SFY 2010-2016



Notes: From SFY09-SFY11, state general fund matches were impacted by enhanced federal funding through the American Reinvestment and Recovery Act (ARRA). SFY10 also includes certain one-time expenditures.

The providers with the largest percentage of total Medicaid expenditures in South Dakota in SFY 2016 were hospitals, nursing homes/assisted living providers and Department of Human Services/Developmental Disability community support providers. A list of providers and their respective expenses include the following:

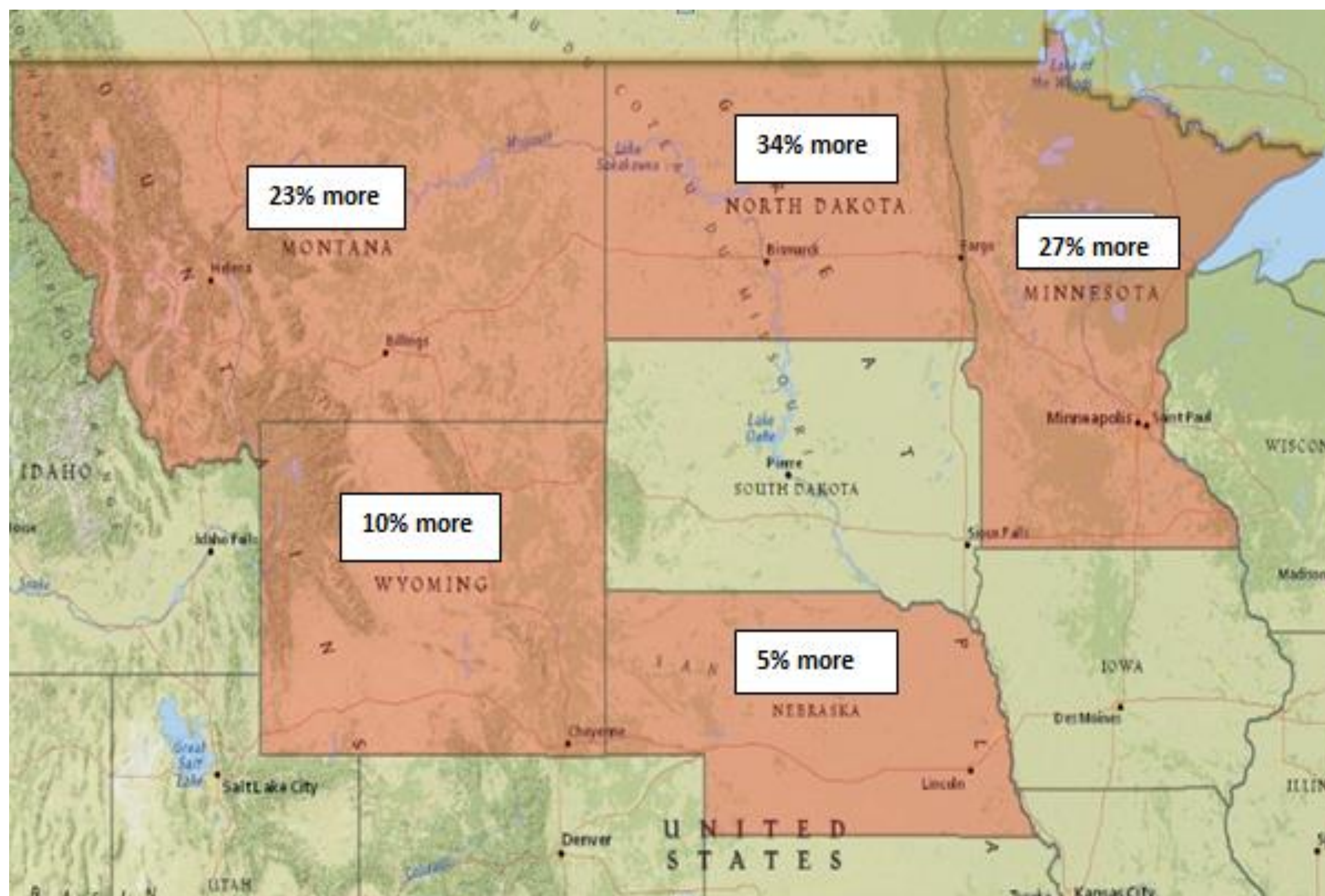
Table 3-B. Majority of Expenses by Provider Type, SFY 2016

Provider	SFY 2016 Expense (Millions)	% of Total
Hospital	$206.1	24.8%
Nursing Homes/Assisted Living Providers/Hospice	$156.4	18.8%
DHS Community Support Providers	$126.8	15.3%
Physicians, Independent Practitioners and Clinics	$102.1	12.3%
Indian Health Services	$69.8	8.4%
Pharmacies	$37.6	4.5%
South Dakota Developmental Center and Human Services Center	$29.8	3.6%
Substance Abuse and Mental Health Community Support Providers	$19.2	2.3%
Psychiatric Residential Youth Care Providers	$29.8	3.6%
Dentists	$22.7	2.7%
Durable Medical Equipment Providers	$11.7	1.4%
In-Home Service Providers for the Elderly and Skilled Home Health	$ 10.1	1.2%
Emergency Transportation	$ 8.2	1.0%
Total for Majority of Expenses	**$830.3**	

Although children make up the majority of Medicaid enrollees, most Medicaid spending is attributable to the elderly and people with disabilities. In South Dakota, similar to the rest of the United States, the elderly and disabled represent 20% of the Medicaid population but account for roughly 60% of spending. In addition, a recent analysis of South Dakota Medicaid inpatient hospital statistics revealed that 3% of South Dakota Medicaid inpatient hospital recipients are responsible for 51% of inpatient hospital payments. This is consistent with findings that nationwide, the top 5 percent of the population accounted for nearly 50 percent of health care expenditures.[2]

It is also worth noting that South Dakota has a very conservative Medicaid reimbursement policy and focuses on managing program costs. As a result, the state spends less for each Medicaid enrollee (per capita) than surrounding states. Wyoming pays 10.2% more per Medicaid enrollee; Nebraska pays 5% more; Montana pays 23% more; North Dakota pays 34% more; and Minnesota pays 27% more.[3]

Map 2. South Dakota's Variance in Medicaid Spending per Enrollee, FY2011



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[2] Steven B. Cohen, PhD Statistical Brief #392: The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2009-2010 (November 2012)
http://meps.ahrq.gov/data_files/publications/st392/stat392.pdf

[3] Kaiser Family Foundation, Statehealthfacts.org

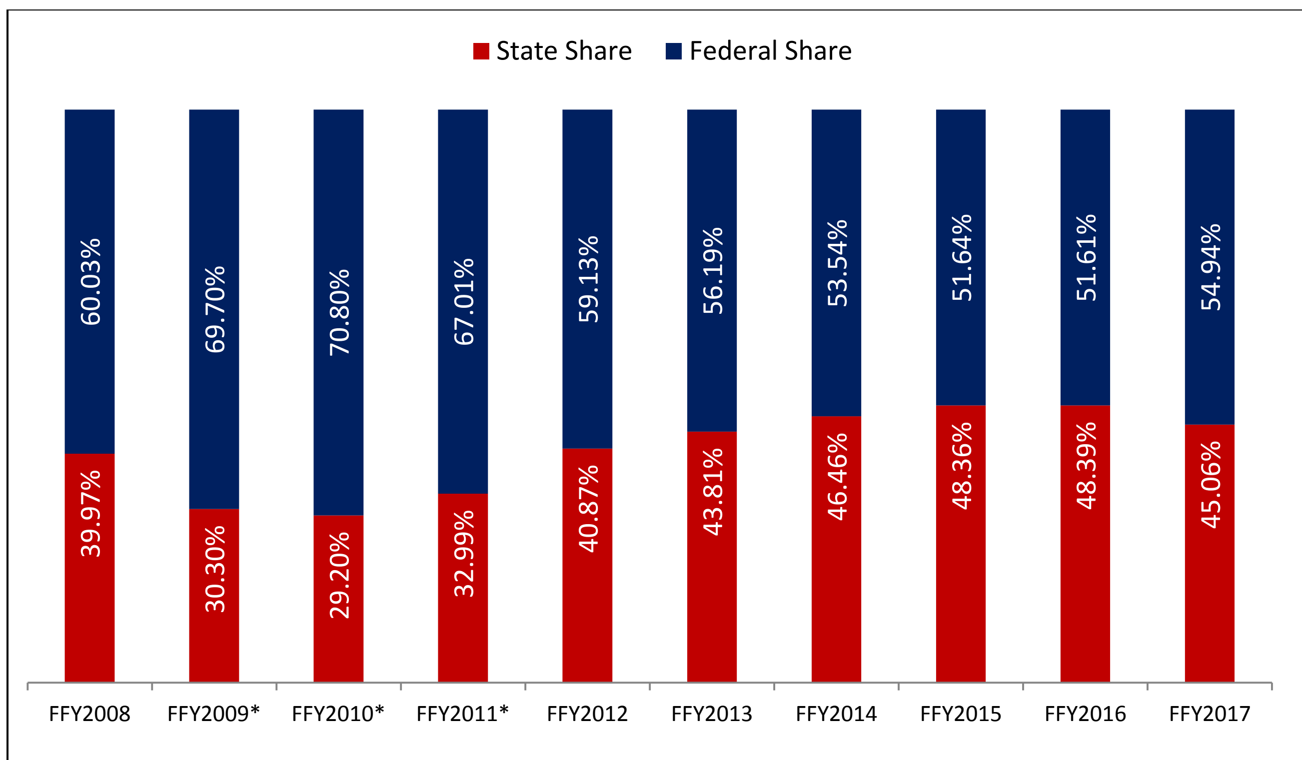
What is the Role of Federal Funding in South Dakota's Medicaid Program?

The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP). The remainder is referred to as the nonfederal share, or state share. Determined annually using the previous three years personal income data for each state, the FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). FMAP rates differ by state and range from the minimum 50% federal share in states with higher per capita income like Massachusetts up to 74.63% in states with lower per capita income like Mississippi. (FFIS Issue Brief 16-14)

In FFY 2016, the FMAP for South Dakota was 51.61%. For FFY 2017 the FMAP will increase by 3.33% to 54.94%. It is estimated that a one percentage point change can reduce or increase South Dakota's funding responsibility by about $8 million.

Services funded through the Children's Health Insurance Program (CHIP) receive an enhanced FMAP rate subject to the availability of funds from a state's federal CHIP allotment. The enhanced FMAP is the increased federal share that results from reducing each state's Medicaid share of 30%. In FFY16-FFY19 the ACA further increases states' FMAP by 23 percentage points. South Dakota's enhanced CHIP match rate for FFY 2017 is 91.46% federal.

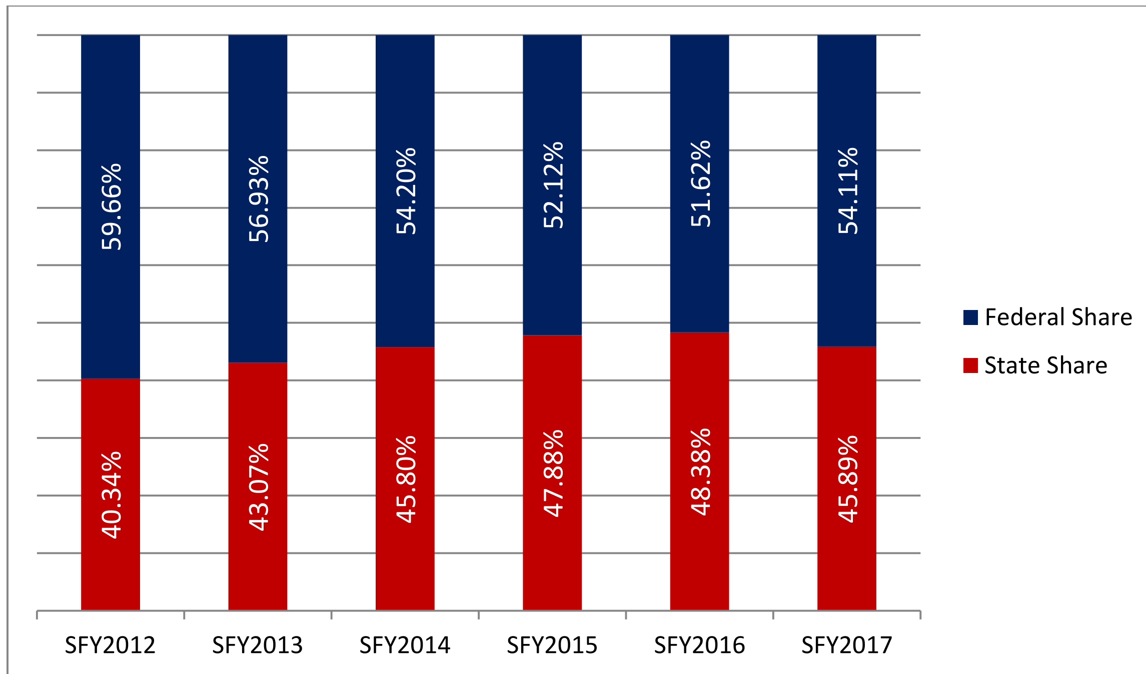
Graph 4. South Dakota Federal Medical Assistance Percentage (FMAP), FFY 2008 to FFY 2017



* Notes: From SFY09-SFY11, state general fund matches were impacted by enhanced federal funding through the American Reinvestment and Recovery Act (ARRA).

For budgeting purposes, a "blended" FMAP rate is calculated using the FMAP rate in effect for each quarter. This includes a blend of 1 quarter from one federal fiscal year and 3 quarters from another federal fiscal year (see Graph 5).

Graph 5. South Dakota Blended Federal Medical Assistance Percentage (FMAP), SFY2012 to SFY2016



What is the Relationship of Medicaid to the Indian Health Services?

While Indian Health Services (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 SFY16, an average of 42,429 American Indians were on Medicaid every month, which represents 35.75% of all the individuals eligible for Medicaid. This percentage has remained fairly consistent over the course of the last 10 years, despite the fact that American Indians comprised only about 10% of the state's population. During SFY16 total expenditures for typical healthcare services (medical services) provided to American Indians, including services at the Indian Health Services, totaled $214 million*. Approximately $67 million of that was 100% federally funded.

*(excludes long term care, Medicare Part A, B, and D, home and community based waiver services, Behavior Health, Health Home Per Member Per Month, and other state agencies)

What is the Responsibility of Medicaid Recipients to Share in the Cost of Services?

States have the option to charge premiums and to establish out of pocket spending (cost sharing) requirements for Medicaid enrollees. Out of pocket costs may include copayments, coinsurance, deductibles, and other similar charges. Certain vulnerable groups, such as children and pregnant women, are exempt from most out of pocket costs, and copayments and coinsurance cannot be charged for certain services. In addition, American Indians receiving services through IHS or upon IHS referral are exempt from copayments. Copayments are also waived for American Indians who have ever received care or are eligible to receive care from IHS, Urban Indian Health or another Tribal facility.

As a result of South Dakota's limited eligibility policy, and the broad exemptions included in federal law, the state has a very low number of Medicaid enrollees to whom copayments are applicable.

Within these parameters, South Dakota imposes significant cost sharing requirements on its consumers to promote the efficient use of services. Examples of South Dakota Medicaid copayment amounts include the following:

- Non-generic prescription drugs: $3.30
- Generic prescription drugs: $1.00
- Durable Medical Equipment: 5%
- Non-emergency dental services: $3 co-pay, $1,000 annual limit for adults
- Inpatient Hospital: $50 per admission
- Non-emergency outpatient hospital services, which includes emergency room use for non-emergent care: 5% of billed charges, maximum of $50

Section 2: Medicaid Programs and Operations

This section of the report will provide general information relating to South Dakota's Managed Care Program known as PRIME, Health Home program, as well as information about South Dakota's management of the Pharmacy program and other key operational activities.

PRIME and Health Home Program Overviews	
Referral/Authorization is Required:	**Referral/Authorization is NOT Required:**
Physician/Clinic	Pharmacy
Psychiatry/Psychology	True Emergency Services
NPs, PAs	Family Planning
Residential Treatment	Dental Services
Nurse Midwives	Optometric (Routine eye care)
Durable Medical Equipment	Podiatry
Ophthalmology (not refractive)	Ambulance/Transportation
Therapy (Physical/Speech)	Anesthesiology
Community Mental Health Center	Chiropractic
Inpatient/Outpatient Hospital Services	Independent Radiology/Pathology
Pregnancy Related Services	Immunizations
Ambulatory Surgical Center	Chemical Dependency Treatment
Lab/X-Ray Services (at another facility)	*Independent Lab/X-Rays (when sending samples or specimens to any outside facility for analysis only)
Medicaid will only pay for medically necessary covered services authorized by the primary care provider. Managed care and Health Home services provided which are not authorized are the recipient's responsibility to pay.	

PRIME

PRIME (Provider and Recipient in Medicaid Efficiency Program)is South Dakota's primary care case management program, which consists of Primary Care Providers who render primary care and are responsible for managing the enrollees' health care in preauthorizing, locating, coordinating and referring visits to other Medicaid providers. Approximately 80% of South Dakota Medicaid consumers, including children, low-income families, pregnant women, and disabled recipients are required to enroll in the program and choose one primary care provider (PCP) to be their health care case manager.

Pursuant to this program, participating primary care physicians (PCPs) are responsible for directing all Managed Care designated services, providing referrals for specified non-emergent specialty and hospital services, and for guaranteeing 24 hours a day, 7 days a week access to medical care. The PCPs are reimbursed under the usual fee-for-service system. In addition, PCPs receive a monthly case management fee of $3.00 per member per month. This program is designed to improve access, availability, and continuation of care while reducing inappropriate utilization, over-utilization, and duplication of Medical Assistance Program covered services while operating a cost-effective program.

Health Home Program

To improve patient outcomes and experiences, the Department implemented the Health Home program in July 2013. It delivers customized and enhanced health care services to meet the specific needs of Medicaid recipients with chronic medical or behavioral health conditions.

More specifically, the initiative provides six core services:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Patient and Family Support
- Referral to community and support services

By utilizing these core services, the Health Home initiative aims to reduce inpatient hospitalization and emergency room visits, increase the integration between physical and behavioral health services, and enhance transitional care between institutions and the community.

In SFY16 around 6,000 recipients received services in Health Homes. Recipients are placed in one of four tiers based on the severity of illness and risk of future costs.

Health Home services are available through more than 100 primary care clinics including 11 Indian Health Service facilities and 23 Federally Qualified Health Care Centers. There are also 11 Community Mental Health Centers that are also participating. In total, there are 584 Health Home providers serving over 100 locations.

Preliminary Clinical Outcomes

Population health and care management programs include a very small subset of the larger population. Longitudinal data collected over time is necessary to identify both clinical outcomes and cost effectiveness.

National studies suggest that outcomes and cost of care for health home programs are challenging with smaller numbers of health home participants. Health Homes report 43 data elements which make up 31 outcome measures. Although these are preliminary, clinical outcomes for the years FY14-FY15 showed improvement on 11 outcome measures and several additional measures collected during this period will establish a baseline for future measurement and reporting.

Preliminary Health Home Clinical Outcomes FY14-FY15

Musculoskeletal

- 21.85% increase in adults with pain assessment using a standardized tool and documentation of a follow-up plan when pain is present.
- Slight reduction in un-necessary imaging studies for low back pain. Measure shows a reduction in imaging studies done within 28 days of diagnosis.

Hypertension

- 7.48% increase in adult recipients BP was adequately controlled
- Slight decrease among adult recipients with diabetes (-.85%)

Diabetes

- 5.5% increase in adults with diabetes mellitus who had most recent hemoglobin A1c less than 8.0%

High Cholesterol/ Heart Disease

- Slight decrease – 1% in recipients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and who's most recent LDL-C level was in control (less than 100 mg/dL)

Severe Mental Illness (specific CMHC Measure)

- 8.9% increase in filled prescriptions at least 85% of the time (12 and older)

Depression

- 26.4% increase in adults screened for clinical depression
- 3.7% increase in children screened for clinical depression using an age appropriate standardized tool and follow-up documented

Substance Abuse Screening

- 9.8% increase in recipients (12 years and older) screened for tobacco, alcohol and other drug dependencies.

Care Transitions tracked

- 17.5% increase in discharge notification and records transmission within 24 hours of discharge.

Transforming Care

- 7% increase in counseling sessions with recipients /families to adopt healthy behaviors associated with disease risk factors (tobacco use, nutrition, exercise & activity)

Pharmacy Management Program

South Dakota also aggressively manages the pharmacy benefit. This management approach includes a strong clinical prior authorization process, as well as the utilization of a Pharmacy and Therapeutics (P&T) Committee and Drug Utilization and Review (DUR) Committee comprised of pharmacists and physicians. Members of both the P&T and DUR Committees have served for many years and have significant knowledge of the South Dakota marketplace. As a result of these activities, South Dakota's generic utilization is approximately 85% compared to the national average of nearly 80%. High utilization of generic drugs, which are typically much less expensive than brand drugs, is generally considered evidence of successful pharmacy management programs. South Dakota continues to aggressively pursue generic drug utilization and continues to see a steady increase in generic drug use.

Graph 6: Generic vs. Brand Name Drug Utilization, FY2011-FY2016

Home and Community Based Services (HCBS)

South Dakota Medicaid also provides home and community-based service options to individuals 60 years of age and older and 18 years of age and older with qualifying disabilities who meet financial and level of care eligibility requirements. The focus of these services is to enable these South Dakotans to live independent and meaningful lives while maintaining close family and community ties. The home and community based waiver program promotes in-home and community-based services to prevent or delay premature or inappropriate institutionalization.

Services available under the HCBS Waiver include in-home services and assisted living:

In-home service Services:

- Homemaker Services
- Personal Care Services (Bathing and Personal Hygiene)
- Adult Day Services
- Personal Emergency Response Systems
- Meals and Nutritional Supplements
- Specialized Medical Equipment/Supplies including Telehealth
- Medication Administration Devices
- Respite Care
- Adult Companion Services
- Environmental Accessibility Adaptations

Assisted Living Services:

- Assistance with daily living including
    - eating, bathing, dressing, and personal care, and meals
    - supervision of self-administration of medications
    - laundry and housekeeping assistance
- 24 hour staffing

Home and community-based services are instrumental to reducing nursing home utilization and to improving the quality of independent living for aging seniors. Providing services under the Waiver are proven to be cost-effective. The following tables (Tables 4 – 6) reflect the average monthly expenditures provided per client under the Title XIX In-Home Waiver, $922.00 in SFY2016, and Assisted Living Waiver, $1,017.58 in SFY2016, compared to $3,722.16 during the same timeframe utilizing Nursing Home services.

Table 4. HCBS Waiver In-Home Services

State Fiscal Year	Fiscal Year Monthly Average Clients	Fiscal Year Expenditures	Average Monthly Expenditure Per Client
2014	414	$4,072,132	$820.00
2015	454	$4,990,267	$916.00
2016	469	$5,189,582	$922.00

Table 5. HCBS Waiver Assisted Living Services

State Fiscal Year	Fiscal Year Monthly Average Clients	Fiscal Year Expenditures	Average Monthly Expenditure Per Client
2014	688	$7,808,825	$945.84
2015	704	$8,287,850	$981.04
2016	686	$8,376,689	$1,017.58

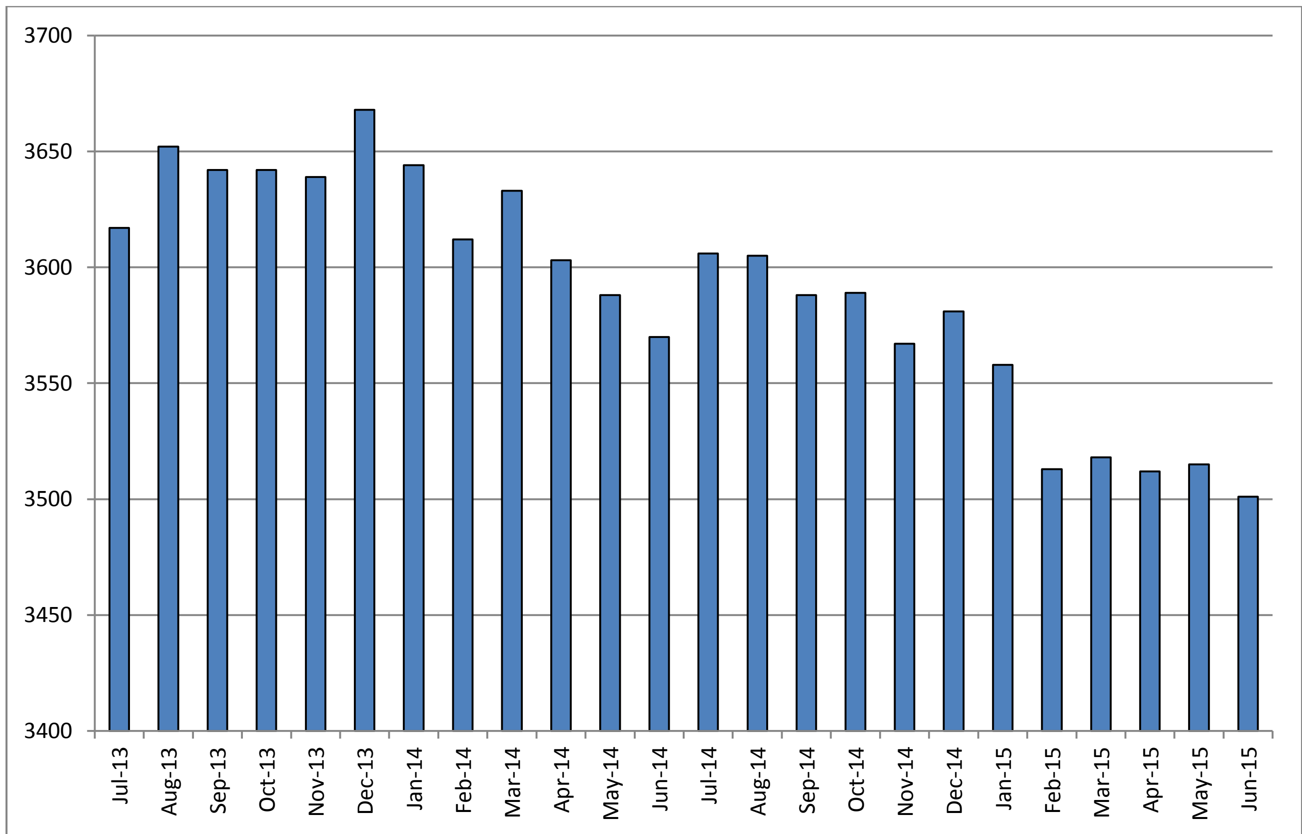
Table 6. Nursing Home Services (DSS Only)

State Fiscal Year	Fiscal Year Monthly Average Clients	Fiscal Year Expenditures	Average Monthly Expenditure Per Client
2014	3,332	$126,812,527	$3,171.58
2015	3,252	$136,236,366	$3,491.09
2016	3,167	$141,456,793	$3,722.16

Nursing Home Services

Medicaid provides funding for 55% of the individuals in nursing homes. In SFY2016 a monthly average of 3,167 individuals were funded through Medicaid. Nursing home utilization continues to decline. Graph 6 illustrates the decline in the number of authorized nursing home residents who are eligible for Title XIX during the period of July 2012 to June 2015.

Graph 7. Authorized Nursing Home Clients, July 2013– June 2016



Utilization Review Program

Medicaid services are subject to utilization review by clinical professionals within South Dakota's Medicaid Program. The purpose of the utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid recipients. Medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay (inpatient hospital). In addition, utilization data is used to identify the need for provider educational efforts, policy clarifications, or possible program integrity review efforts.

Program Operations

Provider Enrollment

Providers must meet a number of federal and state requirements in order to enroll as Medicaid providers and make updates to that information in order to remain an eligible provider. By the end of FY 2015, there were nearly 15,000 providers enrolled in the program of which 5,000 average monthly provided services.

Claims Processing

South Dakota operates its own claims processing and management information system. The system also processes payments in a timely fashion. On average, claims are paid within three days.

In FY 2015, South Dakota's system:

- Processed more than 5.3 million claims;
- Answered more than 90,000 calls from providers.

Rate Setting

The Department of Social Services is also responsible for setting payment rates for a large number of Medicaid providers, including hospitals, outpatient facilities, nursing homes, federally-qualified health clinics, and behavioral health providers, among many others.
South Dakota has adopted a DRG (Diagnostic Related Group) payment methodology for the majority of inpatient-hospital expenditures. Under the DRG system, hospitals are reimbursed based on the principal diagnosis or condition requiring the hospital admission. The DRG system is designed to classify patients into groups that are clinically coherent with respect to the amount of resources required to treat a patient with a specific diagnosis. Applicable additional payments are added for capital, medical education, and outliers. For outpatient services, larger outpatient hospitals bill Medicaid using the Ambulatory Payment Classification methodology. Smaller Critical Access Hospitals are reimbursed on a percentage of billed charges.

Other provider types are reimbursed using standardized fee schedules (e.g. physicians) or are reimbursed based on cost reports submitted by providers (e.g. nursing facilities).

* Fee Schedules are available online at: https://dss.sd.gov/medicaid/providers/feeschedules/dss/

Section 3: Program Integrity

Third Party Liability

As a condition of receiving Medicaid benefits, recipients agree to allow Medicaid to seek payment from available third party health care resources on their behalf. All other third party resources must be used before Medicaid dollars are spent. These resources, such as health and casualty insurance and Medicare, are important means of keeping Medicaid costs as low as possible. South Dakota is one of a handful of states that obtained an exemption from the Medicaid Recovery Audit (RAC) review process due to the low prevalence of provider fraud. During SFY16, more than $7.8 in third party liability was recovered.

Fraud and Abuse

South Dakota utilizes a number of approaches to maintain program integrity and prevent fraud and abuse that includes both internal and external approaches, as described below.

Internal approaches:

- ***Surveillance and Utilization Review Unit:*** This federally mandated review process conducts post-payment provider reviews.
- ***Quality Improvement Organization:*** This program reviews inpatient hospital claims to insure quality of services and correct coding.
- ***Office of Recoveries and Fraud Investigations:*** This division conducts investigations of recipient fraud and recovers payments from third party liability sources.
- ***Drug Utilization Review:*** In partnership with South Dakota State University, this program conducts a retrospective review of recipients' drug claims and provides education to physicians.

External approaches:

- ***Medicaid Integrity Contractors:*** This program involves federal contractors conducting independent audits of providers.
- ***Medicaid Fraud Control Unit:*** Located in The South Dakota Attorney General's Office, in FFY 2015 this department recovered $176,214 in restitution for the Medicaid Program.

Appendix A: Percent of County Population Enrolled in Medical Services 2016

County	Average Monthly Eligibles	Estimated 2015 Census	Percent of Population
Aurora	286	2,733	10.50%
Beadle	3,772	18,372	20.50%
Bennett	1,447	3,423	42.30%
Bon Homme	616	6,985	8.80%
Brookings	2,314	33,897	6.80%
Brown	4,410	38,785	11.40%
Brule	728	5,281	13.80%
Buffalo	902	2,095	43.10%
Butte	1,811	10,283	17.60%
Campbell	75	1,397	5.40%
Charles Mix	2,342	9,383	25.00%
Clark	369	3,659	10.10%
Clay	1,405	13,964	10.10%
Codington	3,443	27,939	12.30%
Corson	1,717	4,197	40.90%
Custer	687	8,446	8.10%
Davison	2,701	19,858	13.60%
Day	693	5,539	12.50%
Deuel	394	4,333	9.10%
Dewey	2,233	5,685	39.30%
Douglas	262	2,977	8.80%

Edmunds	265	3,999	6.60%
Fall River	891	6,867	13.00%
Faulk	168	2,337	7.20%
Grant	724	7,142	10.10%
Gregory	722	4,201	17.20%
Haakon	130	1,861	7.00%
Hamlin	783	6,047	12.90%
Hand	231	3,348	6.90%
Hanson	174	3,385	5.10%
Harding	58	1,267	4.60%
Hughes	2,111	17,555	12.00%
Hutchinson	704	7,301	9.60%
Hyde	97	1,397	6.90%
Jackson	1,034	3,321	31.10%
Jerauld	159	1,997	8.00%
Jones	115	924	12.40%
Kingsbury	463	4,990	9.30%
Lake	990	12,622	7.80%
Lawrence	2,506	24,827	10.10%
Lincoln	2,122	52,849	4.00%
Lyman	918	3,876	23.70%
Marshall	382	4,769	8.00%
McCook	585	5,599	10.40%
McPherson	198	2,415	8.20%

Meade	2,387	26,986	8.80%
Mellette	787	2,050	38.40%
Miner	194	2,236	8.70%
Minnehaha	24,072	185,197	13.00%
Moody	633	6,430	9.80%
Oglala Lakota	7,394	14,373	51.40%
Pennington	15,563	108,702	14.30%
Perkins	264	3,019	8.70%
Potter	177	2,320	7.60%
Roberts	2,213	10,311	21.50%
Sanborn	223	2,355	9.50%
Spink	769	6,524	11.80%
Stanley	269	2,954	9.10%
Sully	64	1,426	4.50%
Todd	5,403	9,959	54.30%
Tripp	1,047	5,434	19.30%
Turner	840	8,209	10.20%
Union	1,124	14,909	7.50%
Walworth	849	5,443	15.60%
Yankton	2,721	22,702	12.00%
Ziebach	1,060	2,803	37.80%
County Not Available	1,486		
Totals	118,676	858,469	13.80%