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

December 2015

DSS
Strong Families – South Dakota's Foundation and Our Future
South Dakota Department of Social Services

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 56% of our parents and grandparents in nursing homes are dependent upon Medicaid to pay for their care. 29.5% 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.

Table of Contents

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 56% of all nursing home residents.

Who is Covered?

Medicaid is one of the largest healthcare insurers in South Dakota with 146,736 individuals participating in the program during State Fiscal Year 2015. The average monthly enrollment in State Fiscal Year 2015 was 117,346.

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 2015 Federal Poverty Level Guidelines

Family Size	Annual Income				
	100% FPL	116% FPL	138% FPL	182% FPL	209% FPL
1	$11,770	$13,653	$16,242	$21,421	$24,599
2	$15,930	$18,479	$21,983	$28,993	$33,294
3	$20,090	$23,304	$27,724	$36,564	$41,988
4	$24,250	$28,130	$33,465	$44,135	$50,683

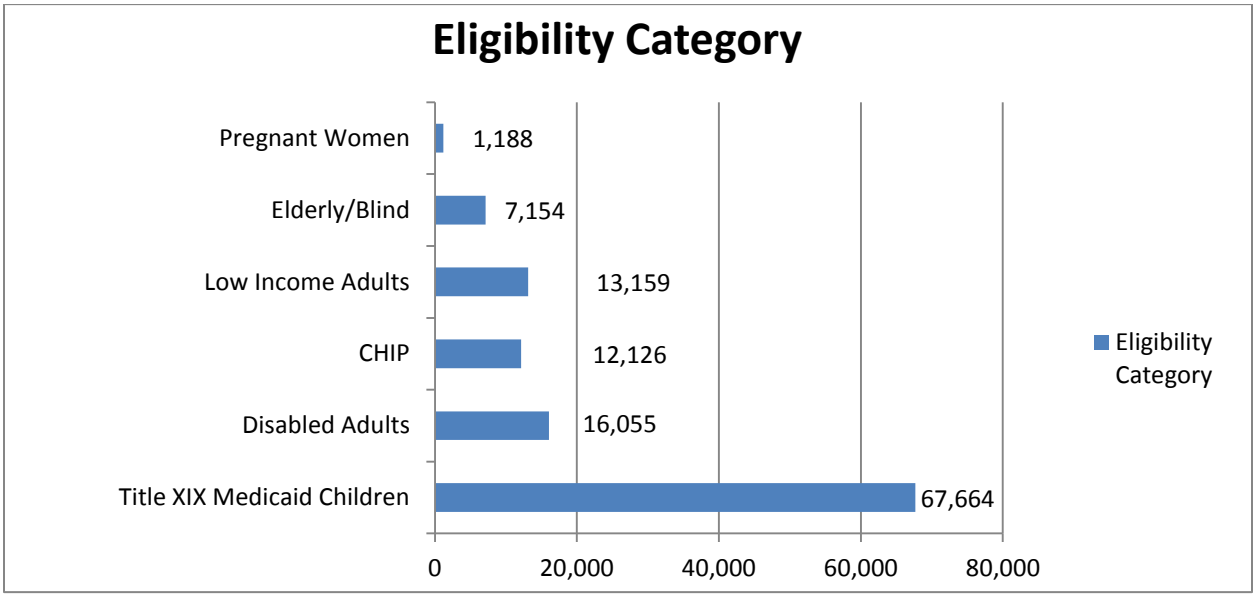
Table 2. South Dakota Eligibility by Percent of Federal Poverty Level

Eligibility Group	% FPL
Pregnant Women	138%*
Children Under Age 6	182%*
Children Age 6 – 19	116%*
Parent/Caregiver/Relatives of Low Income Children	53%*
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

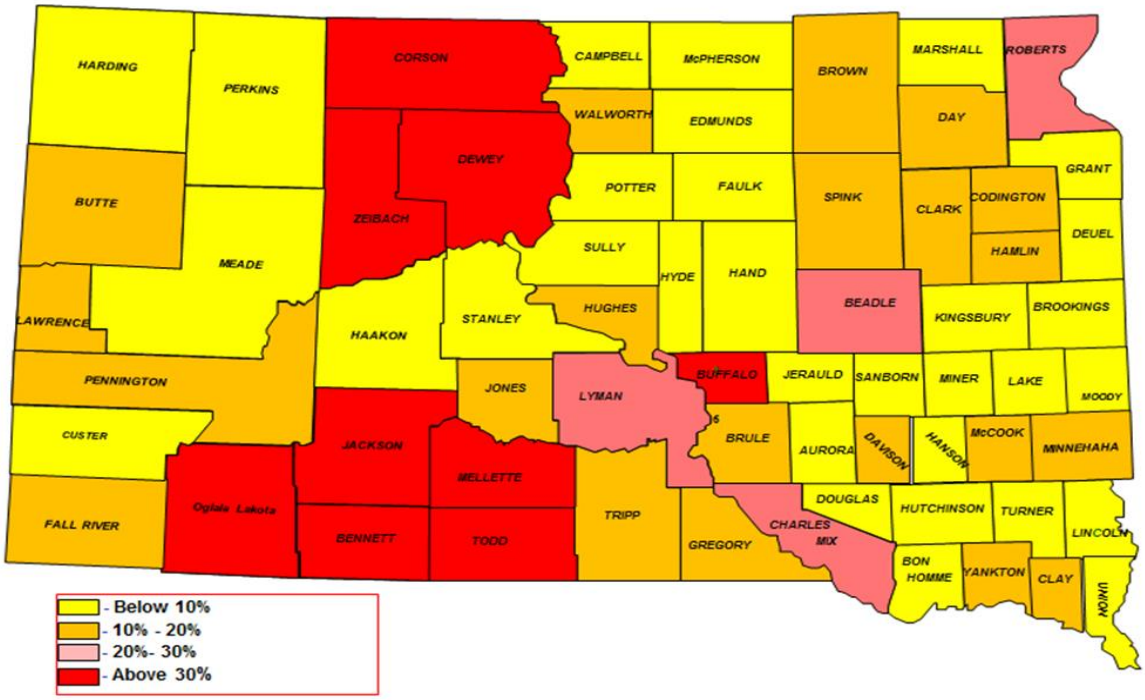
For the Medicaid Program as a whole, two-thirds of enrollees are children and one-third of enrollees are adults. The latter category is comprised of pregnant women (pregnancy-related services only), individuals who are elderly or disabled, and parents in very low income families (e.g., a family of three has an annual income of $10,648, which is 53% 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 2015



Medicaid enrollment varies considerably by county. For the entire state of South Dakota, 14% of the population was eligible for Medicaid in SFY 2015 (see Map 1 – refer to Appendix A for complete details).

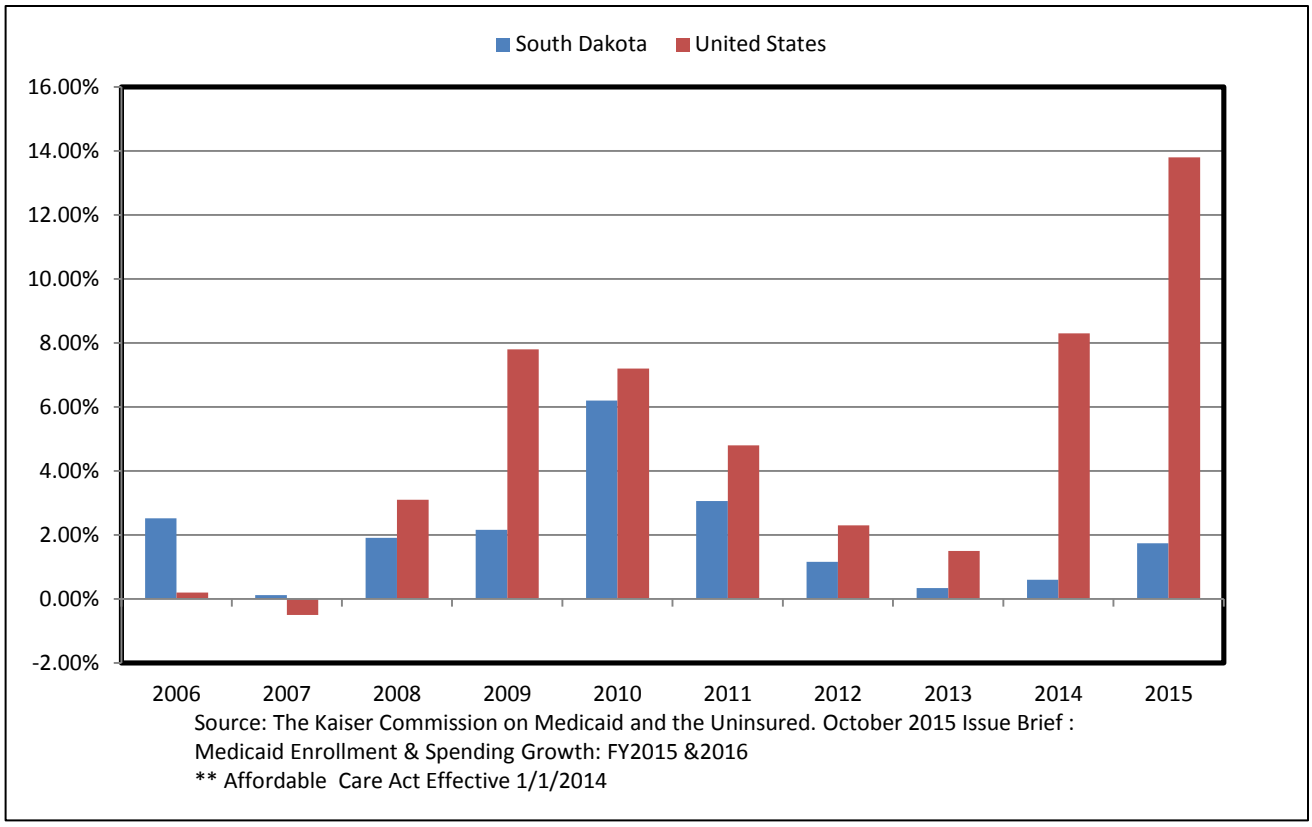
Map 1. Percent of County Population Enrolled in Medical Services 2015



**Average monthly Enrolled – DSS
**County Population FY 2014 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).

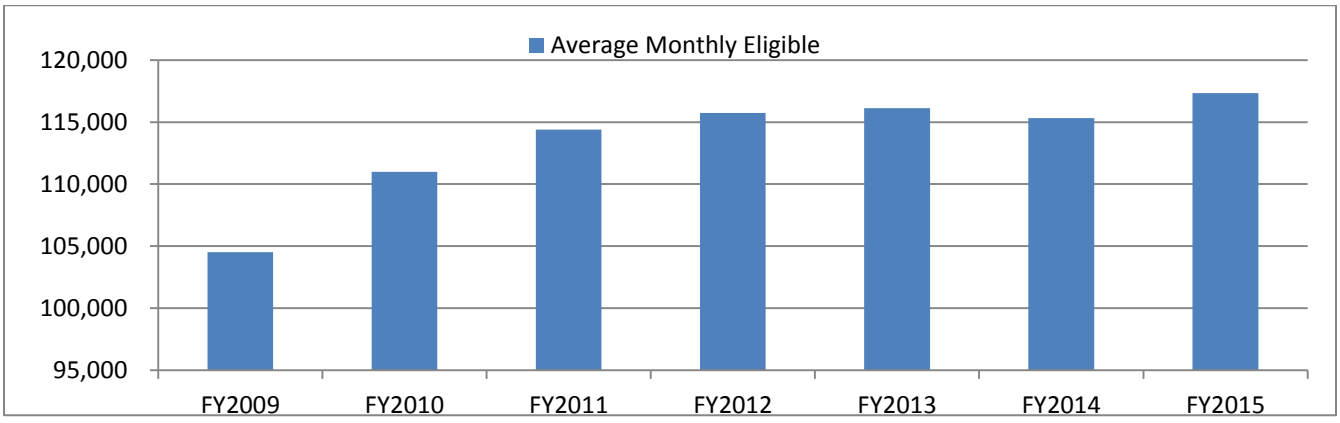
Graph 2. Annual Change in Medicaid Enrollment in 50 States and DC, 2006 to 2015



Source: The Kaiser Commission on Medicaid and the Uninsured. October 2015 Issue Brief : Medicaid Enrollment & Spending Growth: FY2015 &2016
** Affordable Care Act Effective 1/1/2014

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.

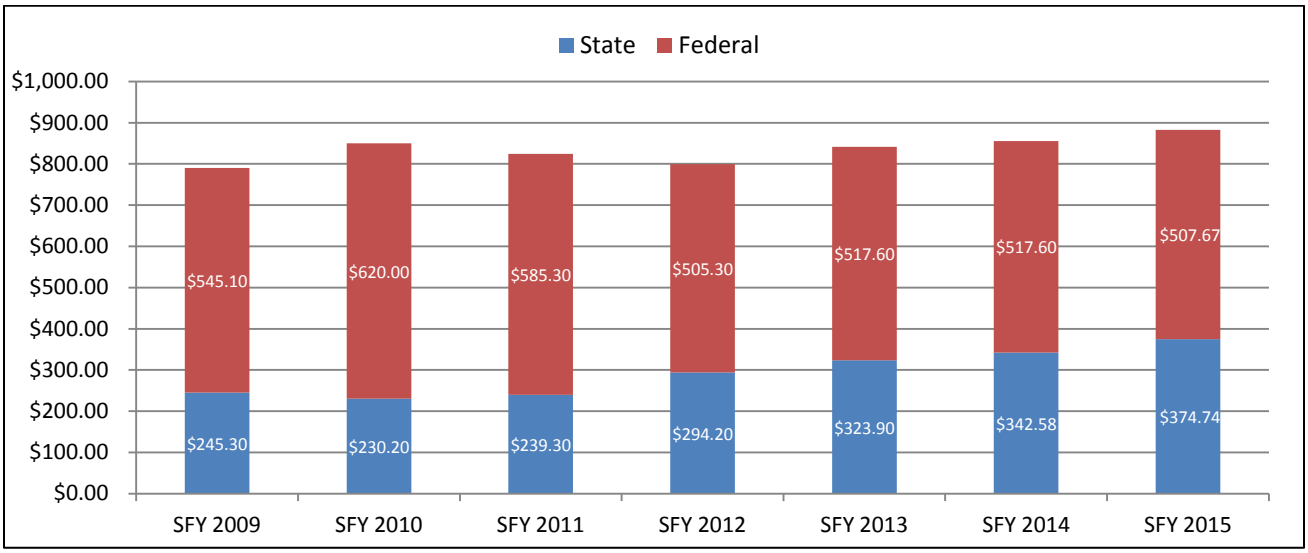
Graph 3. South Dakota Medicaid Average Monthly Eligible, SFY 2009 – 2015



How Much Does the Program Cost?

South Dakota experienced unprecedented growth in Medicaid Eligible during SFY 2009-2010 when the recession hit the state, which in turn, affected expenditures. Rates of growth in recent years have leveled off. In SFY 2015, South Dakota's Medicaid expenditures were $882.4 million (see Graph 3-A).

Graph 3-A. South Dakota Medicaid Expenditures, SFY 2009 – 2015



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 2015 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:

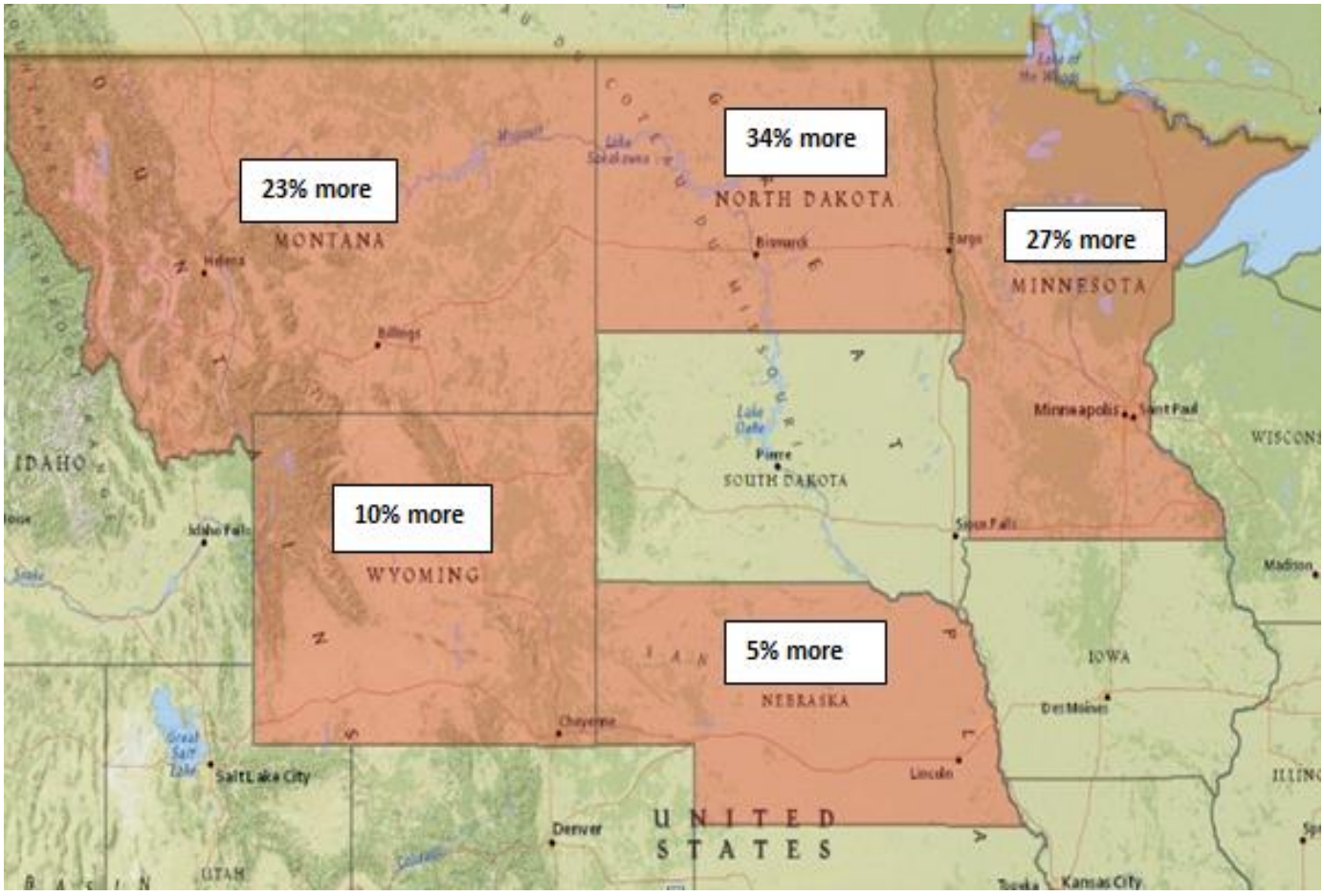
Table 3-B. Majority of Expenses by Provider Type, SFY 2015

Provider	SFY 2015 Expense (Millions)	% of Total
Hospital	$191.3	23.9%
Nursing Homes/Assisted Living Providers/Hospice	$150.5	18.8%
Community Support Providers	$120.1	15.0%
Physicians, Independent Practitioners and Clinics	$103.9	13.0%
Indian Health Services	$70.3	8.8%
Pharmacies	$35.1	4.4%
South Dakota Developmental Center and Human Services Center	$35.3	4.4%
Substance Abuse, Mental Health and Other Community Support Providers	$23.3	2.9%
Psychiatric Residential Youth Care Providers	$28.9	3.6%
Dentists	$20.9	2.6%
Durable Medical Equipment Providers	$10.4	1.3%
In-Home Service Providers for the Elderly and Skilled Home Health	$ 10.3	1.3%
Total for Majority of Expenses	**$800.3**	

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 2.7% of South Dakota Medicaid inpatient hospital recipients are responsible for 49% 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



[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

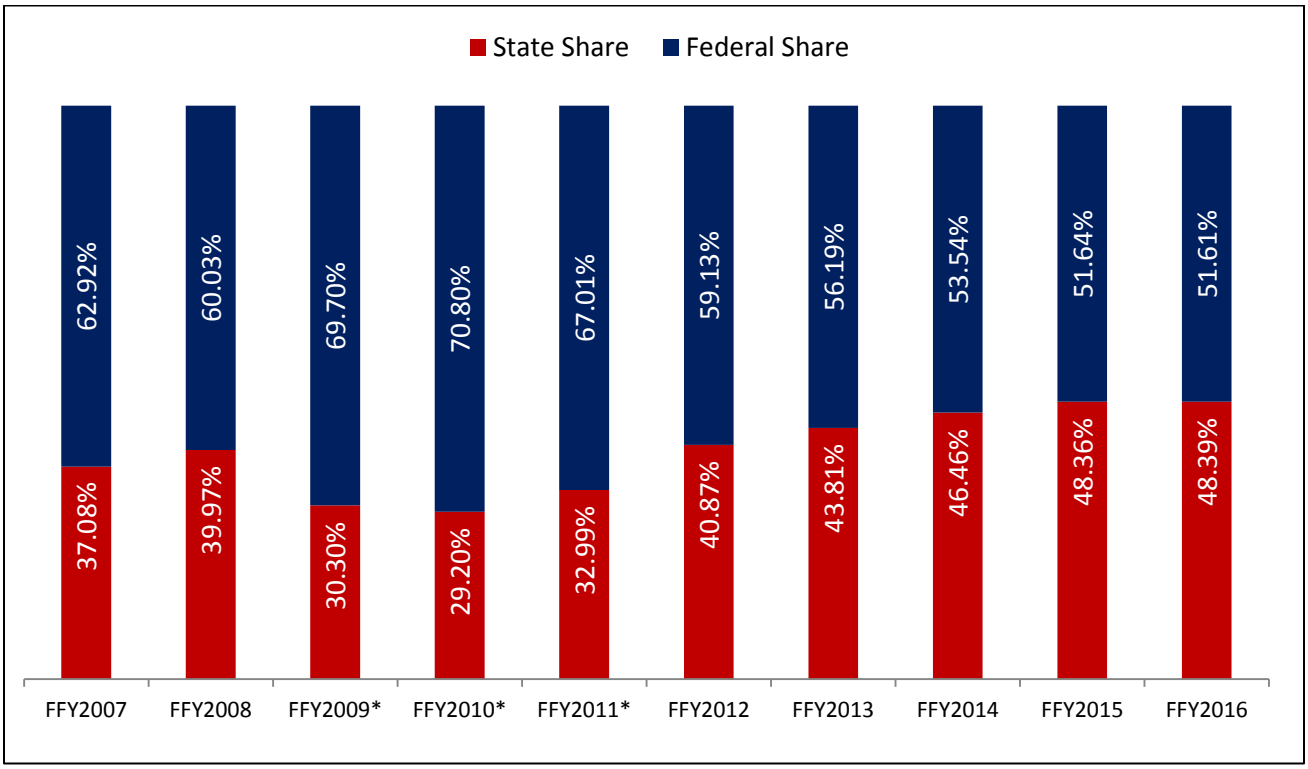
What is the Role of Federal Funding in South Dakota's Medicaid Program?

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 15-31)

In FFY 2015, the FMAP for South Dakota was 51.64%. South Dakota continues to face substantial FMAP decreases. In FFY 2015 South Dakota experienced a 1.9% percentage point decline from FFY 2014 rate of 53.54%. For FFY 2016 the FMAP will decrease another .03% to 51.61%. 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. The South Dakota's enhanced CHIP match rate for FFY 2016 is 89.13% federal. For FFY2016 the enhanced CHIP rate will increase 22.98% to 89.13%.

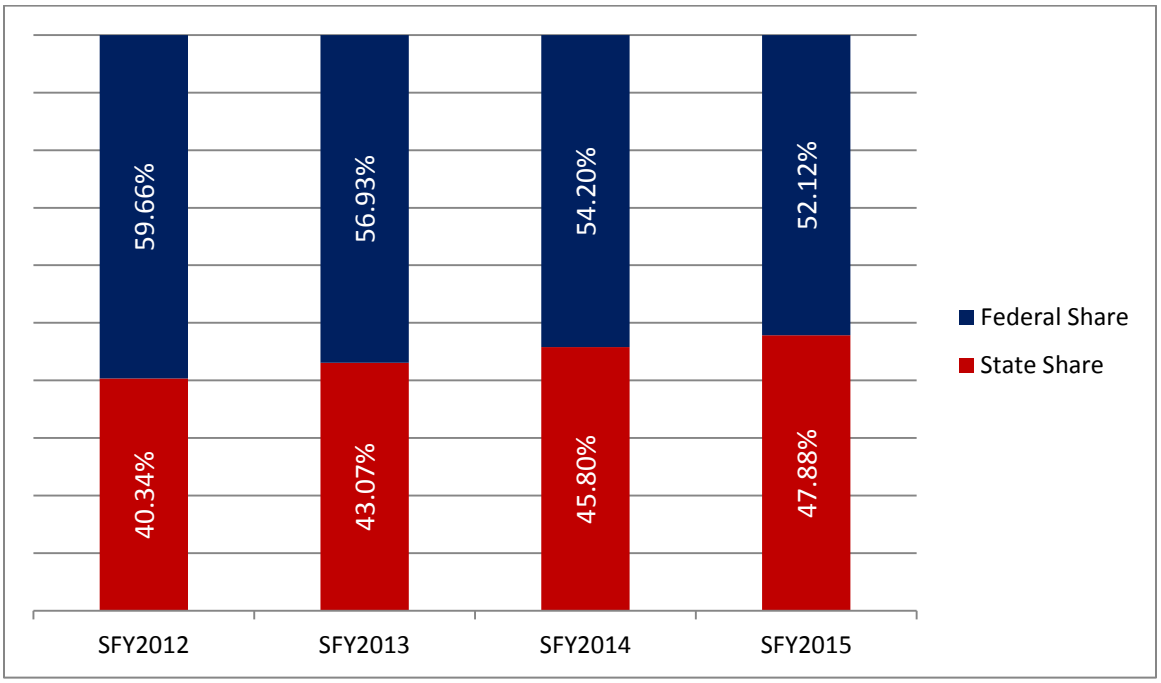
Graph 4. South Dakota Federal Medical Assistance Percentage (FMAP), FFY2007 to FFY2016



* 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 SFY2015



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 SFY15, an average of 41,682 American Indians were on Medicaid every month, which represents 35.6% of all the individuals eligible for Medicaid. This percentage has remained fairly consistent over the course of the last 9 years, despite the fact that American Indians comprised only about 10% of the state's population. During SFY15 total expenditures for typical healthcare services (medical services) provided to American Indians, including services at the Indian Health Services, totaled $208 million*. Approximately $69 million of that was 100% federally funded.

*(excludes long term care, Medicare Part A, B, and D, home and community based waiver services, 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

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 SFY15 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.

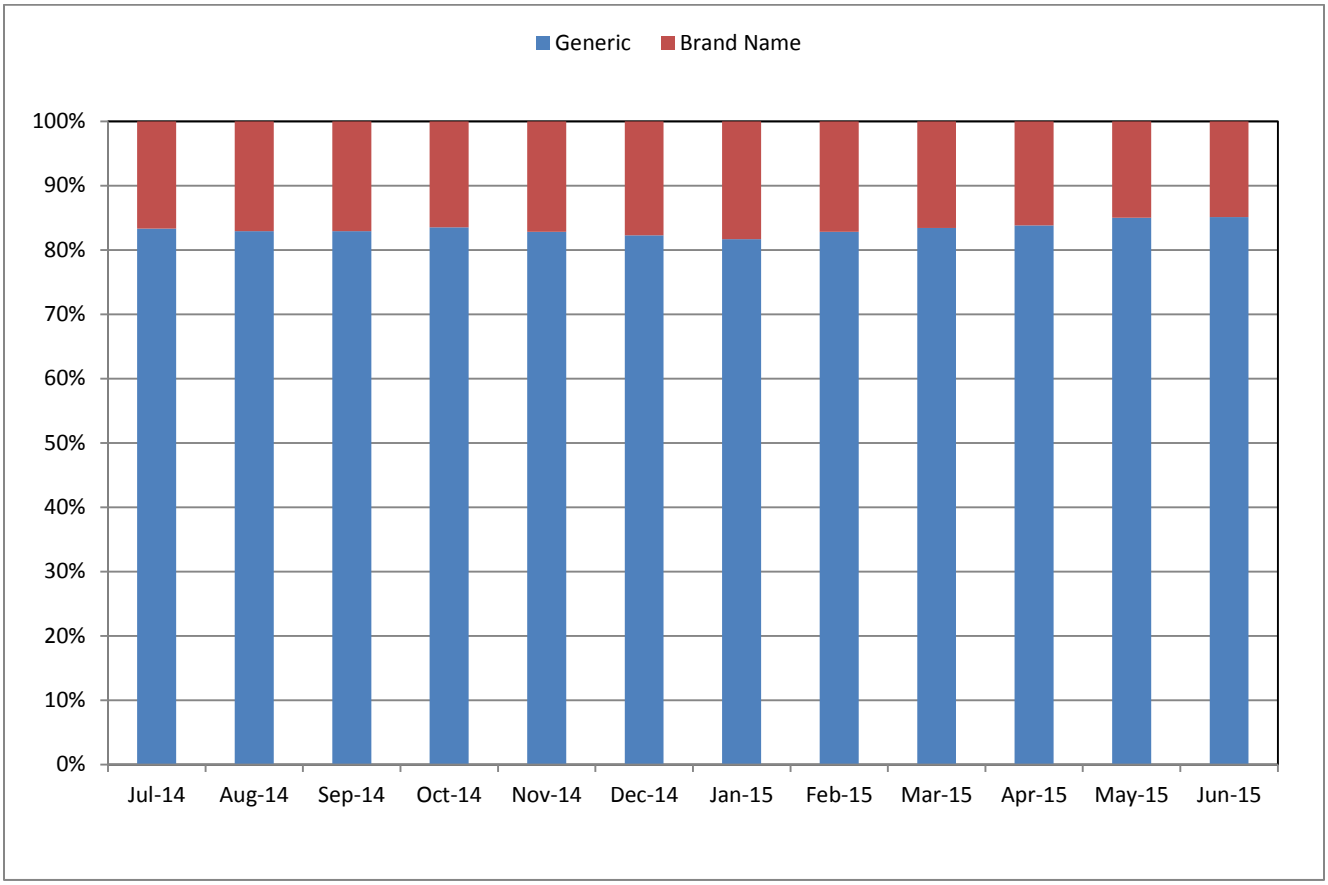
Health Home services are available through more than 100 primary care clinics including 11 Indian Health Service facilities and 23 Federally Qualified Health Care Centers. There are also 11 Community Mental Health Centers that are also participating. In total, there are 555 Health Home providers serving over 100 locations.

PRIME and Health Home Program Overviews	
Referral/Authorization is Required: Physician/Clinic Psychiatry/Psychology NPs, PAs Residential Treatment Nurse Midwives Durable Medical Equipment Ophthalmology (not refractive) Therapy (Physical/Speech) Community Mental Health Center Inpatient/Outpatient Hospital Services Pregnancy Related Services Ambulatory Surgical Center Lab/X-Ray Services (at another facility)	**Referral/Authorization is NOT Required:** Pharmacy True Emergency Services Family Planning Dental Services Optometric (Routine eye care) Podiatry Ambulance/Transportation Anesthesiology Chiropractic Independent Radiology/Pathology Immunizations Chemical Dependency Treatment *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.	

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 83%. 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, July 2014 – June 2015



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, $916.00 in SFY2015, and Assisted Living Waiver, $981.84 in SFY2015, compared to $3,491.09 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
2013	407	$3,096,654	$634.00
2014	414	$4,072,132	$820.00
2015	454	$4,990,267	$916.00

Table 5. HCBS Waiver Assisted Living Services

State Fiscal Year	Fiscal Year Monthly Average Clients	Fiscal Year Expenditures	Average Monthly Expenditure Per Client
2013	662	$7,759,493	$976.77
2014	688	$7,808,825	$945.84
2015	704	$8,287,850	$981.04

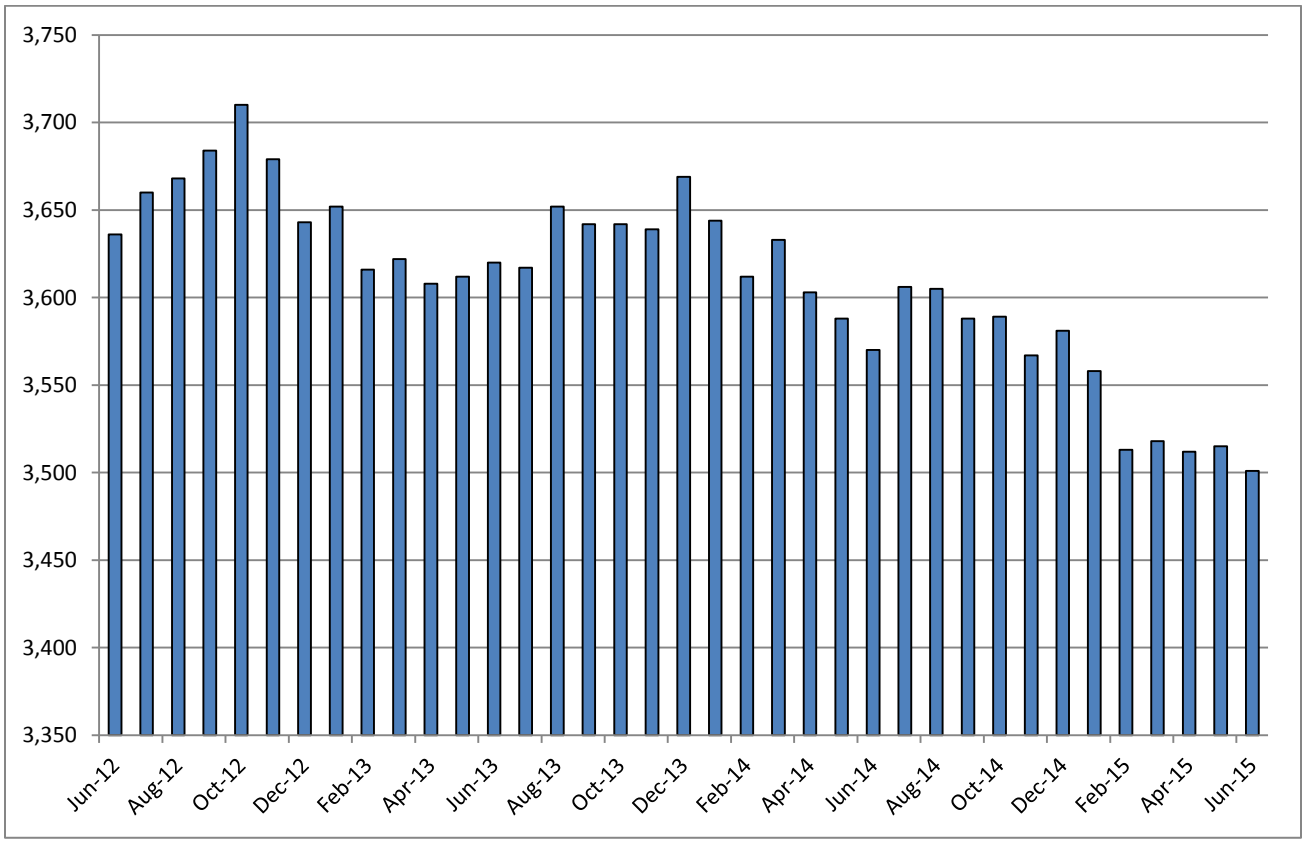
Table 6. Nursing Home Services (DSS Only)

State Fiscal Year	Fiscal Year Monthly Average Clients	Fiscal Year Expenditures	Average Monthly Expenditure Per Client
2013	3,360	$132,446,931	$3,284.89
2014	3,332	$126,812,527	$3,171.58
2015	3,252	$136,236,366	$3,491.09

Nursing Home Services

Medicaid provides funding for 56% of the individuals in nursing homes. In SFY2015 a monthly average of 3,252 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 2012 – June 2015



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 more than 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 5.2 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. Hospitals with lower numbers of Medicaid discharges are reimbursed on a percentage of billed charges. Outpatient hospital services 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).

Health Information Technology

South Dakota Medicaid has paid $45 Million dollars in federal funds to eligible providers and eligible hospitals as part of the Electronic Health Records (EHR) Payment Program since its inception in late 2011. Established by the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, the Medicaid EHR Incentive Payment Program provides incentive payments for eligible providers for the adoption and meaningful use of certified Electronic Health Records.

The program makes a series of payments to eligible providers based on the providers meeting and demonstrating the program objectives. Many South Dakota providers are receiving their second or third payments by demonstrating meaningful use of their EHR systems. The program ends in 2021.

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. During SFY15, more than $8.4 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 2014 this department recovered $362,813 in restitution for the Medicaid Program.

Appendix A: Percent of County Population Enrolled in Medical Services 2015

County	Average Monthly Eligibles	Estimated 2014 Census	Percent of Population
Aurora	261	2,745	9.5%
Beadle	3,637	18,169	20.0%
Bennett	1,449	3,430	42.2%
Bon Homme	645	7,023	9.2%
Brookings	2,396	33,314	7.2%
Brown	4,217	38,408	11.0%
Brule	739	5,309	13.9%
Buffalo	914	2,077	44.0%
Butte	1,715	10,298	16.7%
Campbell	66	1,386	4.8%
Charles Mix	2,379	9,287	25.6%
Clark	375	3,645	10.3%
Clay	1,469	13,932	10.5%
Codington	3,269	27,938	11.7%
Corson	1,761	4,182	42.1%
County N/A	1,481	N/A	N/A
Custer	666	8,445	7.9%
Davison	2,600	19,885	13.1%
Day	683	5,588	12.2%
Deuel	398	4,312	9.2%
Dewey	2,306	5,662	40.7%
Douglas	287	2,973	9.7%
Edmunds	285	3,983	7.2%
Fall River	890	6,845	13.0%
Faulk	155	2,357	6.6%
Grant	698	7,241	9.6%
Gregory	711	4,217	16.9%
Haakon	146	1,847	7.9%
Hamlin	774	5,989	12.9%
Hand	257	3,345	7.7%
Hanson	162	3,419	4.7%
Harding	51	1,250	4.1%
Hughes	2,106	17,642	11.9%
Hutchinson	682	7,200	9.5%
Hyde	106	1,396	7.6%
Jackson	996	3,274	30.4%
Jerauld	171	2,007	8.5%
Jones	111	975	11.4%
Kingsbury	422	5,075	8.3%
Lake	949	12,368	7.7%
Lawrence	2,483	24,657	10.1%
Lincoln	2,007	51,548	3.9%
Lyman	872	3,877	22.5%

County	Average Monthly Eligibles	Estimated 2014 Census	Percent of Population
McCook	594	5,649	10.5%
McPherson	180	2,429	7.4%
Marshall	371	4,683	7.9%
Meade	2,297	26,951	8.5%
Mellette	767	2,100	36.5%
Miner	211	2,316	9.1%
Minnehaha	23,960	182,882	13.1%
Moody	632	6,367	9.9%
Pennington	15,416	108,242	14.2%
Perkins	273	3,033	9.0%
Potter	176	2,340	7.5%
Roberts	2,117	10,374	20.4%
Sanborn	224	2,336	9.6%
Oglala Lakota	7,378	14,218	51.9%
Spink	790	6,598	12.0%
Stanley	236	2,983	7.9%
Sully	40	1,438	2.8%
Todd	5,330	9,882	53.9%
Tripp	1,043	5,512	18.9%
Turner	818	8,272	9.9%
Union	1,089	15,029	7.2%
Walworth	849	5,511	15.4%
Yankton	2,718	22,684	12.0%
Ziebach	1,099	2,826	38.9%