



# South Dakota Medicaid Overview

## for the Birth to Three Connections Program

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## What is Medicaid?

- Federal / State Partnership in healthcare since 1965.
- Mandates healthcare coverage to certain categories of individuals and allows states to cover optional categories and services at their discretion.
- When you've seen one Medicaid program, you've seen one Medicaid program. All 50 states and many U.S. territories have a Medicaid program – all have different eligibility criteria, covered services, and methods of administering the program.
- One of the largest healthcare insurers in South Dakota with 130,000 unduplicated individuals participating in the program during FY08.

## Who does South Dakota Medicaid cover?

Medicaid provides coverage for the elderly, low-income families (children and individuals), low-income pregnant women, and people with disabilities.

Average monthly eligibility for FY08:

- Elderly – 7,146
- Disabled – 15,748
- Children of low-income families – 55,045
- Pregnant women – 2,682\*
- Low-income adults – 10,218
- Children's Health Insurance Program – 11,471

\*Women eligible in this category receive pregnancy-related services only.

## South Dakota Medicaid – Promoting Healthy Families

- Nearly 1 of every 8 persons in any given month will have health coverage by Medicaid or CHIP.
- 1 of every 3 persons under the age of 19 in South Dakota has health coverage by Medicaid or CHIP.
- South Dakota Medicaid pays for 40% of the deliveries in the state and 50% of the children born in South Dakota will be on Medicaid or CHIP during the first year of their life.
- Continued growth in Medicaid eligibles is expected.

## South Dakota Medicaid Covered Services

- Inpatient and outpatient hospital
- Physician services (Including PT, OT, ST)
- Prescription drugs
- Nursing facility services for individuals age 21 or older
- Medical and surgical dental services
- Home health care
- Rural health clinic services
- Laboratory and radiology services
- Medical transportation services
- Adult optometric services and eyeglasses
- Durable medical equipment and prosthetic devices
- Hospice care
- Personal care services
- Chiropractic services
- Mental health and chemical dependency services

## South Dakota Medicaid Optional Services

- Prescription drugs for adults
- Medical care or remedial care:
  - Psychologists – adults only
  - Independent mental health practitioners – adults only
  - Podiatrists – adults only
  - Optometrists – adults only
  - Chiropractors and physician assistants
- Adult dental services
- Physical, occupational, speech therapy, audiology for adults
- Prosthetic devices and eyeglasses for adults
- Hospice care, nursing services for adults
- Personal care services and home health aides
- Chiropractic services
- Durable medical equipment for adults

## How do we provide services?

- Through a healthcare delivery system of over 11,000 Medicaid providers and processing over 4 million claims annually.
- Primary Care Case Management (PCCM) managed care program where 75% of the Medicaid population is enrolled and have a primary care physician.
- Five major areas of healthcare constitute the majority of the Medicaid expenditures – inpatient hospital, outpatient hospital, physician services, prescription drugs, and long term care services.

## South Dakota Medicaid Expenditures

- In FY08, the state expended \$700.2 million in total on healthcare services and administration of the Medicaid program. The \$260.5 in general funds match represented 22.7% of the entire state budget.
- Federal / State partnership includes a cost sharing arrangement:
  - The Federal government pays the majority of cost in South Dakota, this is known as the Federal Medical Assistance Percentage or “FMAP.”
  - The State is responsible for the remainder of the cost and that is known as the “match.”

## Federal Medical Assistance Percentage (FMAP)

- FMAP is determined by formula using last 3 years personal income from each state, compared to personal income levels in other states.
- South Dakota's current FMAP for Medicaid is 62.55% federal, with the remaining 37.45% state matching funds.
- Enhanced FMAP for the Children's Health Insurance Program is 73.79% federal and 26.21% state general funds.
- Federal participation in administrative costs are either 50/50, 75/25, or 90/10 depending upon the administrative service provided.

## Provider Enrollment

A provider who renders a covered service to an eligible South Dakota Medicaid recipient, and wishes to participate in the Medical Assistance Program must apply to become an enrolled provider.

- Provider enrollment information and forms can be found on-line at <http://dss.sd.gov/medicalservices/providerinfo/forms.asp>
- Contact provider enrollment at 773-3495 if you have questions or difficulties completing the application.
- Separate enrollment for Birth to Three providers.

## Fee Schedule

- A claim submitted must be submitted at the physician's usual and customary charge; PT/OT/ST providers are covered under the physician's services category.
- For this category payment is limited to the lesser of 40% of the usual and customary charge or the fee established by Medicaid.
- When Medicaid establishes a fee the Department reviews paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by providers.

Provider fee schedules can be found on-line at

<http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp>

## Surveillance and Utilization Review System

Code of Federal Regulations mandates the Medical Assistance Program establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit:

- Safeguards against unnecessary or inappropriate use of Medical Assistance Program services or excess payments;
- Assesses the quality of those services;
- Conducts post-payment reviews to monitor both the use of health services by recipients and the delivery of health services by providers under 42CFR 456.23.

For more information reference SDCL 22-45 and ARSD 67:16.

## Birth to Three and Medicaid

- Programs in other Departments rely on Medicaid to fund services.
- The Department of Education, seeking to take advantage of Medicaid as a funding source, instructed Birth to Three providers to enroll with Medicaid in the Fall of 2008. There are approximately 200 individual Birth to Three providers enrolled with Medicaid.
- No changes in providers or IFSP were required for the switch in funding. The IFSP drives the services to children and Medicaid is a potential funding source.
- School Districts providing services were also enrolled as Birth to Three providers and began billing Medicaid in March 2009. There are approximately 53 School Districts enrolled with Medicaid to bill for Birth to Three services.

## Service Requirements

Medicaid reimbursement for Birth to Three services, like all Medicaid services, must meet the following requirements:

- The child receiving services must be an eligible Medicaid recipient;
- The provider must be an eligible and enrolled Medicaid provider;
- The service provided must be ordered by a physician and medically necessary.

## Service Requirements (cont.)

- ARSD 67:16:01:06.02 Covered services must be medically necessary. To be medically necessary, the covered service must meet the following conditions:

- 1) It is consistent with the recipient's symptoms, diagnosis, condition, or injury;

- 2) It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;

- 3) 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;

## Service Requirements (cont.)

4) It is not furnished primarily for the convenience of the recipient or the provider; and

5) 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.

- Services must be physician ordered and children in managed care will need a referral for services from their primary care physician. (Note- Children receiving Medicaid via SSI eligibility are not in managed care)
- Services can be approved for up to twelve months, but the referral/order alone does not guarantee medical necessity.

## Frequently Asked Questions

- 1) Do all five conditions for medical necessity in ARSD 67:16:01:06.02 need to be met? **Yes**, however, number three is broke out into four subsections, of which, only one must be met.
- 2) Does the physician's referral/order guarantee medical necessity? **No**, services referred by the physician can be ordered for up to twelve months but the services provided still have to meet the five conditions for medical necessity.
- 3) Is medical necessity determined by the professional opinion of the service provider? **Yes**, using the ARSD requirements, evaluations, and scope of practice judgment.
- 4) Can there be 'medically necessary' checkbox on the physician referral form? **No**, services must be ordered/referred by a physician but this does not guarantee medical necessity.

## Frequently Asked Questions (cont.)

5. When a Medicaid recipient changes service providers, does the new provider have the right to do a new evaluation? **Yes, if the new provider deems a re-evaluation necessary to determine medical necessity and to develop a service plan.**
6. How does Medicaid define a medical condition? **ICD-9 or DSM-IV diagnosis are all considered medical conditions. In addition, any services that are provided to treat a medical condition must be medically necessary according to ARSD 67:16:01:06.02.**
7. If the child is not making progress towards their medical goals, are therapists allowed to continue seeing the patient for several months/years? **No, once 'maximum medical improvement' is reached goals and the frequency of service should be adjusted to prevent regression.**

## Provider Assistance

Medicaid providers who have questions or are experiencing difficulty completing their claim forms should consult the following resources:

- The Professional Services manual has valuable information to assist Medicaid providers and can be found at:  
<http://dss.sd.gov/medicalservices/docs/ProfessionalServicesManual.pdf>
- The Medicaid telephone service unit may be able to assist the provider, to speak to a representative call 1-800-452-7691.
- Additional assigned resource for Birth to Three providers: Revi Warne at 605-773-3495 or via email at [Revi.Warne@state.sd.us](mailto:Revi.Warne@state.sd.us)

