September 12, 2022

RE: South Dakota Medicaid State Plan Amendment #SD-22-0014

The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan to clarify the premium assistance program policies and align them with current practice. If an individual who has been determined eligible for Medicaid has significant medical bills, the program assists the individual with maintaining private health insurance in addition to their Medicaid coverage. The private health insurance acts as the primary payer of the medical bills and Medicaid is the secondary payer, which results in costs savings for the Medicaid program.

The proposed State Plan Amendment (SPA) clarifies how the program determines if premium assistance is estimated to be cost effective. The SPA amends page 70 of section 4.22 of the South Dakota Medicaid State Plan and adds Attachment 4.22-C page 1 and 2.

The Department intends to make this SPA effective October 1, 2022. The Department estimates there will be no fiscal impact associated with this SPA in Federal Fiscal Year 2022 and Federal Fiscal Year 2023.

Please contact me within 30 days of receipt of this message with any questions or comments.

Sincerely,

Matthew Ballard
Deputy Director
Division of Medical Services
South Dakota Department of Social Services

CC: Laurie R. Gill, Cabinet Secretary
    Sarah Aker, Director
Medicaid State Plan Amendment Proposal

Transmittal Number:  SD 22-0014

Effective Date:  10/1/2022

Brief Description:  The proposed State Plan Amendment aligns program policies with current practice and clarifies how the program determines if premium assistance is expected to be cost effective.

Area of State Plan Affected:  Section 4.22 and Attachment 4.22-C

Page(s) of State Plan Affected:  Amends section 4.22 page 70 and adds Attachment 4.22-C pages 1 and 2.

Estimate of Fiscal Impact, if Any:  FFY22: $0.00  
                                  FFY23: $0.00

Reason for Amendment:  To clarify how premium assistance cost effectiveness is determined.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
State/Territory: SOUTH DAKOTA

SECTION 4. GENERAL PROGRAM ADMINISTRATION

Citation 4.22 Third Party Liability (continued)

42 CFR 433.151(a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

____ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

____ Other appropriate State agency(ies) —
  DSS-Office of Recoveries & Fraud Investigations

____ Other appropriate agency(ies) of another state —

____ Courts and law enforcement officials.

Section 1902(a)(60) of the Act (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under Section 1908 of the Act.

1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following:

____ The secretary’s method as provided in the State Medicaid Manual, Section 3910.

____ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.
State/Territory: South Dakota  
State Methodology of Determining Cost-Effectiveness of Individual and Group Health Plans

Enrollment in the Premium Assistance Program is voluntary. For Medicaid eligible recipients, enrollment in the Premium Assistance Program does not change the recipient’s eligibility for benefits through the state plan or cost sharing obligations under the state plan. Individuals enrolled in the Premium Assistance Program are afforded the same beneficiary protections provided to all other Medicaid enrollees.

I. South Dakota Medicaid determines the cost-effectiveness for payment of qualifying group or individual market health insurance premiums using the following methodology:

1. Any Medicaid-eligible recipient who has an existing, ongoing, and medically-confirmed medical condition determined by the South Dakota Medicaid to be considered a cost-effective condition is deemed to meet the cost-effective criteria.

2. When the criteria of 1. is not met, cost-effectiveness will be calculated as follows for recipients who are anticipated to have a minimum of $20,000 in annual anticipated Medicaid claims payments:
   a. Determine:
      i. The annual anticipated cost for Medicaid services generally covered by the private health insurance based on the recipient’s claim history and other relevant information.
      ii. Total the results of each of the following calculations:
         a. The portion of the group or individual market health insurance premium payable by the Premium Assistance Program.
         b. A predetermined annual administration cost per participant.
         c. The expected cost to South Dakota Medicaid for any deductibles, coinsurance and/or copayments.
   b. Subtract the result of ii. from the result of i.
   c. If the result is a cost savings greater than or equal to $1,000, the policy is considered cost-effective.
   d. If the result is less than $1,000 in cost savings, the policy is not considered cost-effective.

3. When the criteria of 1. and 2. are not met, specific information relating to the individual circumstances of the Medicaid-eligible recipient may be provided. On a case-by-case basis and at the sole discretion of South Dakota Medicaid, a determination of cost-effectiveness can be made if sufficient evidence is provided to demonstrate savings to South Dakota Medicaid.

II. Redetermination Review

1. South Dakota Medicaid will complete a redetermination review at least yearly for all Premium Assistance Program enrollees. The yearly review shall consist of:
   a. Verifying South Dakota Medicaid eligibility; and
   b. Completing a cost-effective analysis using the cost-effectiveness methodology.
2. South Dakota may re-determine eligibility at any point if:
   a. The monthly premium of the group or individual market health insurance increases;
   b. There is a change in eligibility category or status for South Dakota Medicaid;
   c. The services offered by the group or individual market health insurance decrease;
   d. There is a change in the deductible, co-insurance or any other cost-sharing provisions of the group or individual market health policy; or
   e. There is reason to believe a change has occurred which may affect eligibility for the Premium Assistance Program.

3. Failure to submit required documents for redetermination or failure to meet the cost effectiveness criteria may result in disenrollment from the Premium Assistance Program.

III. Coverage of Non-South Dakota Medicaid Family Members
   1. The Premium Assistance Program will pay the premiums for additional family members who are not South Dakota Medicaid eligible, if the individual’s premium amount cannot be separated from the family premium amount. In this circumstance, the entire amount of the family’s premium will be used to calculate cost effectiveness.

   2. South Dakota will not pay a deductible, copayment, or coinsurance obligation on behalf of non-Premium Assistance Program individuals covered under a family’s insurance.

IV. Purchasing or paying for health insurance coverage is deemed not cost effective when:
   1. A recipient is also enrolled in Medicare;
   2. A recipient is enrolled in a limited benefits Medicaid program;
   3. Payment of health insurance premiums have been fully reimbursed or offset by a third party, including, but not limited to:
      a. An employer.
      b. An individual court-ordered to provide medical support.
   4. The group or individual market health insurance only provides catastrophic, limited benefit, limited duration, or indemnity coverage.