

South Dakota Medicaid Report SFY19

South Dakota Department of Social Services (DSS)

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

October 2019



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 54% of our parents and grandparents in nursing homes are dependent upon Medicaid to pay for their care. 31% 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. While federally defined as optional, these services are integral to providing healthcare and include preventive care that helps people avoid more intensive, higher-cost services. All optional services, when medically necessary, are mandatory for children under age 21.

<i>Medicaid Mandatory Services (examples)</i>	<i>South Dakota Optional Services (examples)</i>
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Physician assistants • Psychologists and independent mental health practitioners • Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) • 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 • Preventive and Rehabilitative Services • Health Homes

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 53% of all nursing home residents.

Who is Covered?

Medicaid is one of the largest healthcare insurers in South Dakota with 144,401 individuals participating in the program during State Fiscal Year 2019. The average monthly enrollment in State Fiscal Year 2019 was 116,709.

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 2019 Federal Poverty Level Guidelines

Family Size	Annual Income				
	100% FPL	116% FPL	138% FPL	182% FPL	209% FPL
1	12,490	14,489	17,237	22,732	26,105
2	16,910	19,616	23,336	30,777	35,342
3	21,330	24,743	29,436	38,821	44,580
4	25,750	29,870	35,535	46,865	53,818

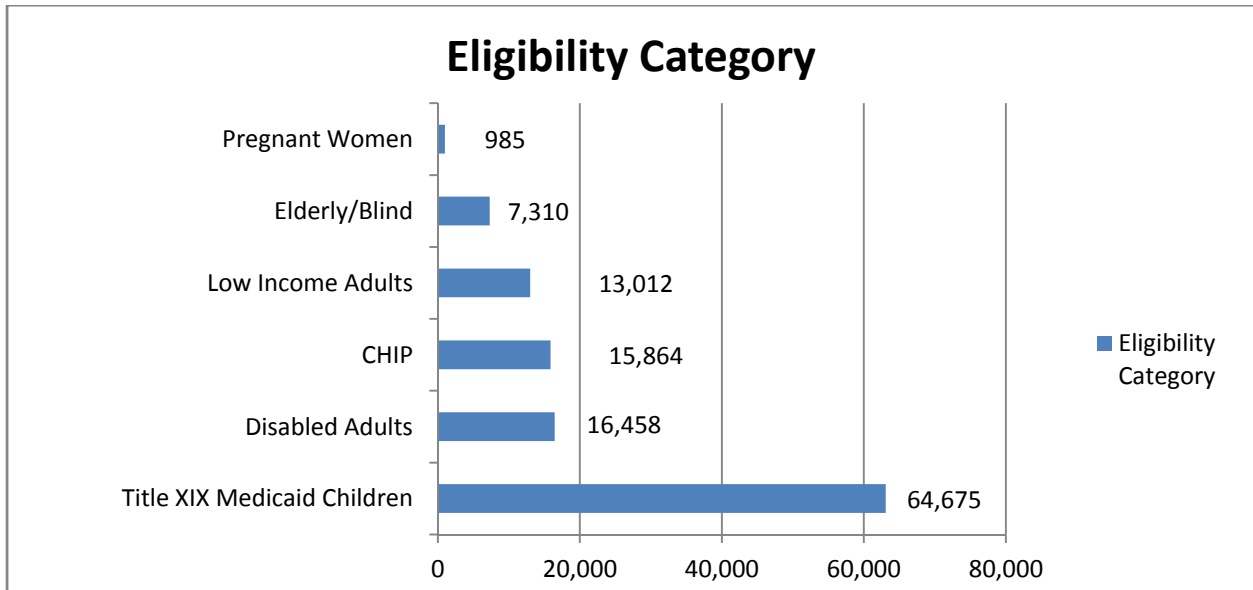
Table 2. South Dakota Eligibility by Percent of Federal Poverty Level

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

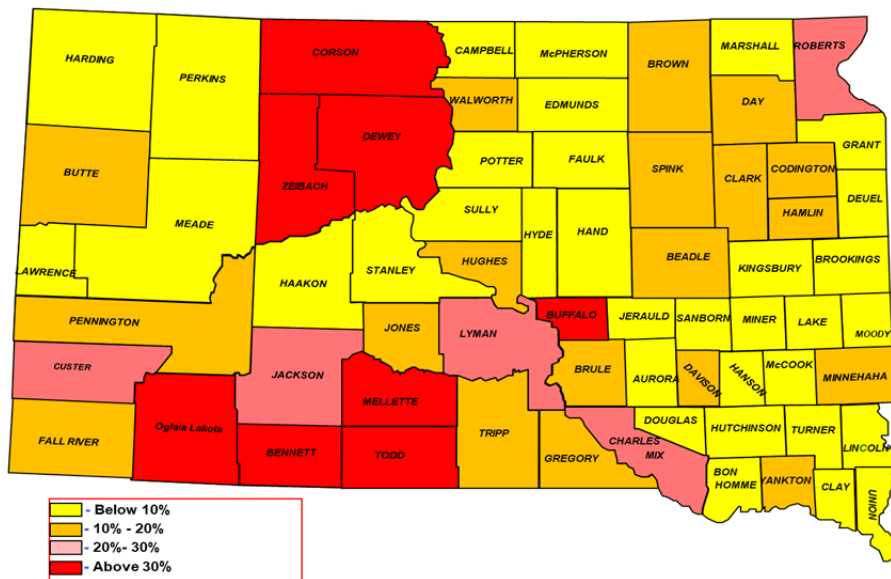
For the Medicaid Program as a whole, two-thirds of enrollees are children and one-third of enrollees are adults. The latter category is comprised of pregnant women (pregnancy-related services only), individuals who are elderly or disabled, and parents in very low income families (e.g., a family of three has an annual income of \$10,620 which is 50% 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 2019



Medicaid enrollment varies considerably by county. For the entire state of South Dakota, 14% of the population was eligible for Medicaid in SFY 2018 (see Map 1 – refer to Appendix A for complete details).

Map 1. Percent of County Population Enrolled in Medical Services 2019
Average Monthly Enrolled by County

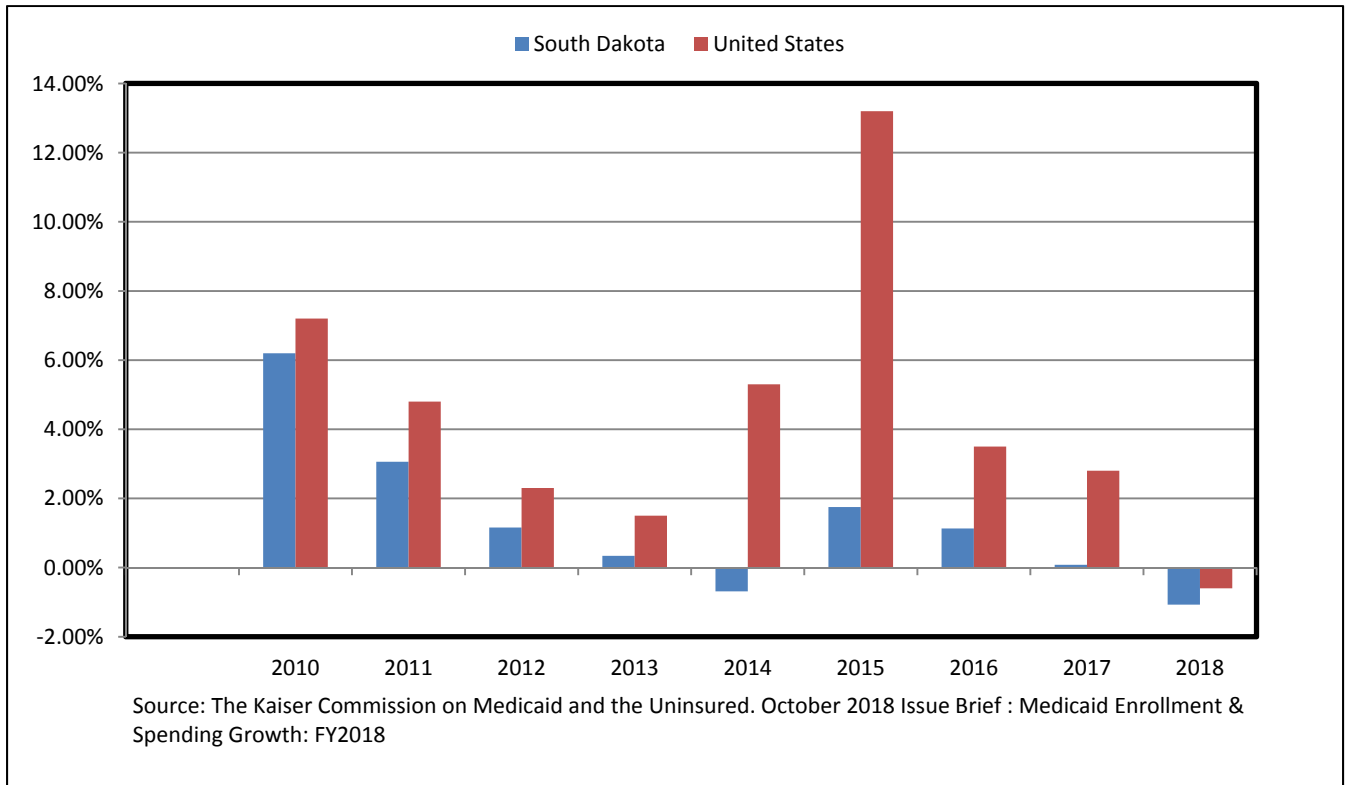


**Average monthly Enrolled – DSS

**County Population FY 2017 Estimates - Census Bureau

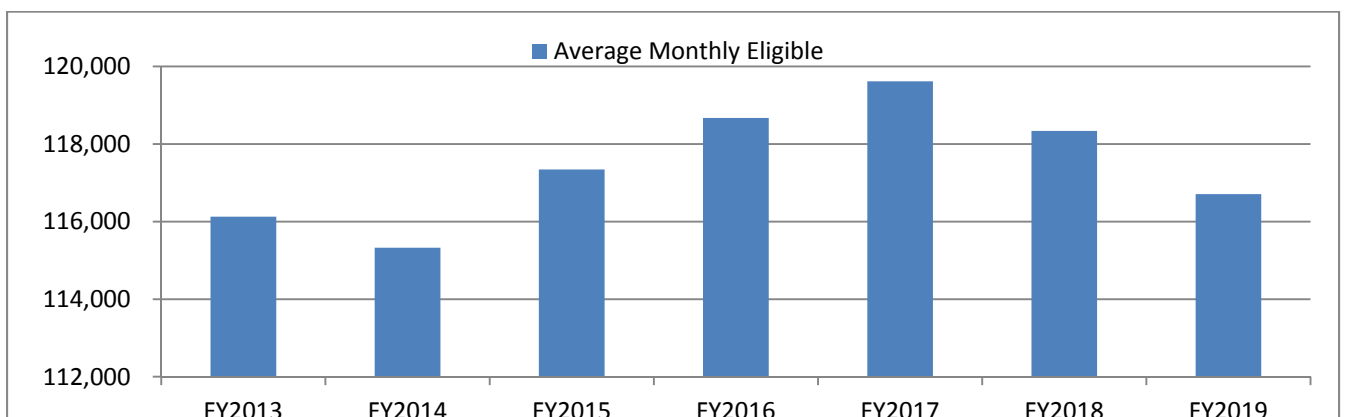
Enrollment in the South Dakota’s Medicaid program has also generally experienced less annual growth than the United States as a whole (see Graph 2).

Graph 2. Annual Change in Medicaid Enrollment in 50 States and DC, 2010 to 2018



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.

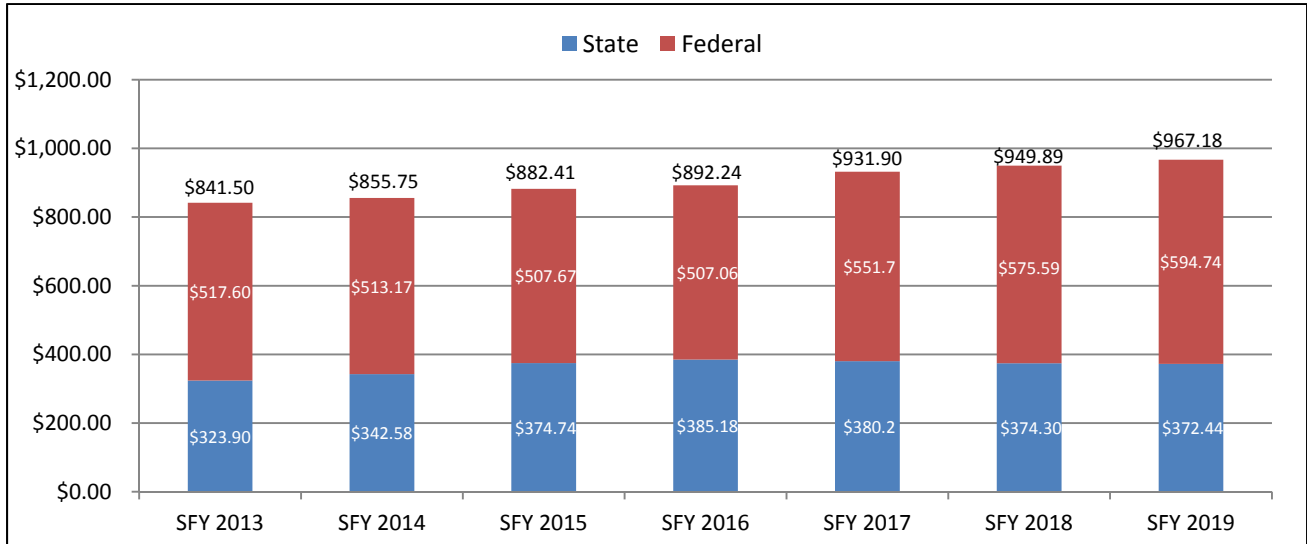
Graph 3. South Dakota Medicaid Average Monthly Eligible, SFY 2013 – 2019



How Much Does the Program Cost?

In SFY 2019, South Dakota’s Medicaid expenditures were \$967.18 million. Rates of growth in recent years have been fairly level. (See Graph 3-A).

Graph 3-A. South Dakota Medicaid Expenditures, SFY 2013-2019



The providers with the largest percentage of total Medicaid expenditures in South Dakota in SFY 2018 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:

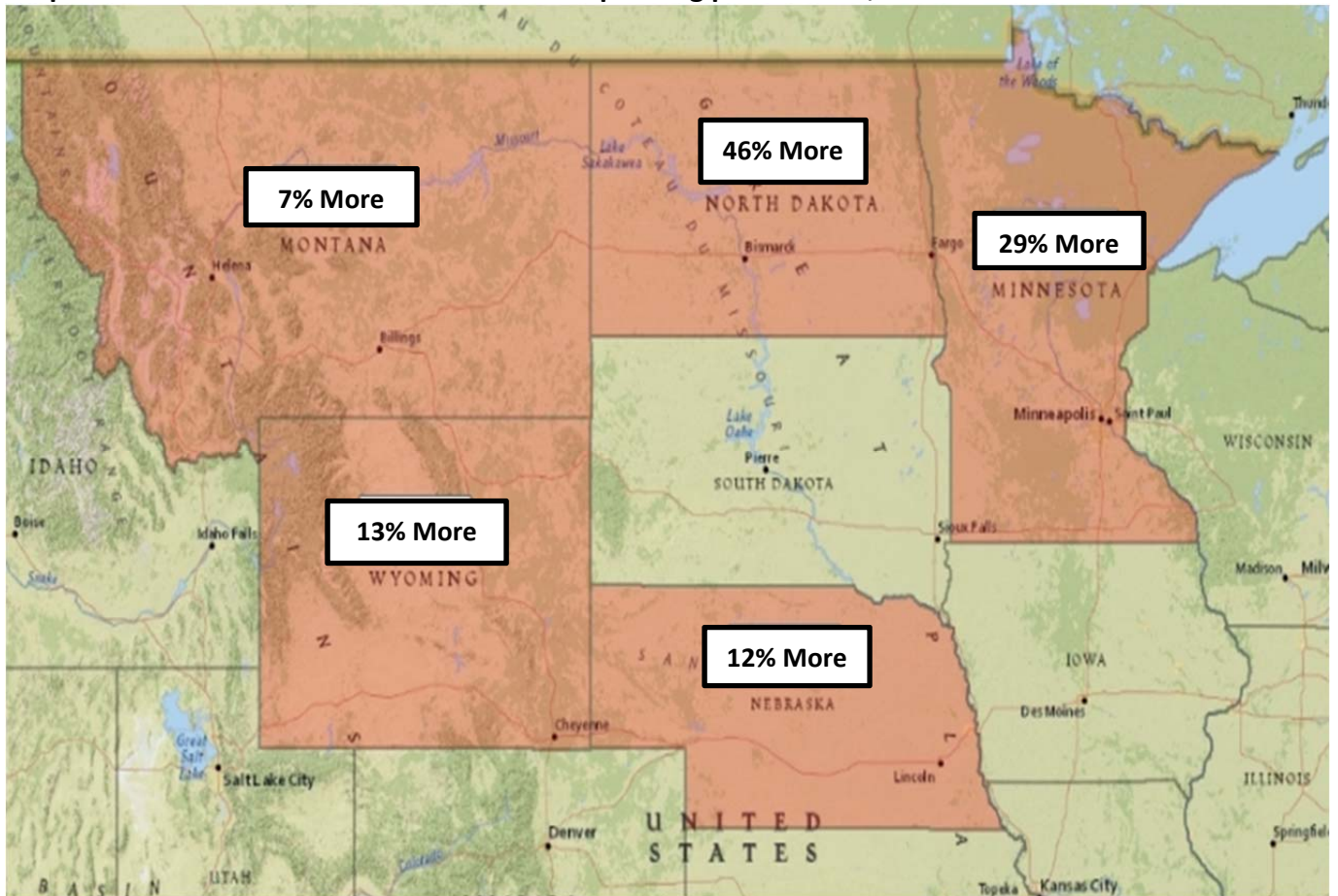
Table 3-B. Majority of Expenses by Provider Type, SFY 2019

Provider	SFY 2019 Expense (Millions)	% of Total
Hospital	\$228.60	25.7%
Nursing Homes/Assisted Living Providers/Hospice	\$164.10	18.4%
DHS Community Support Providers (DD & ADLS Waivers, & Community ICF)	\$144.90	16.3%
Physicians, Independent Practitioners and Clinics	\$107.50	12.1%
Indian Health Services	\$68.10	7.6%
Pharmacies	\$26.50	3.0%
South Dakota Developmental Center and Human Services Center	\$32.40	3.6%
Substance Use Disorder and Mental Health Community Support Providers	\$21.00	2.4%
Psychiatric Residential Youth Care Providers	\$31.60	3.5%
Dentists	\$22.30	2.5%
Durable Medical Equipment Providers	\$12.40	1.4%
In-Home Service Providers for the Elderly and Skilled Home Health	\$20.20	2.3%
Emergency Transportation	\$10.80	1.2%
Total for Majority of Expenses	\$890.40	

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 Medicaid 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 63% 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 13% more per Medicaid enrollee; Nebraska pays 12% more; Montana pays 7% more; North Dakota pays 46% more; and Minnesota pays 29% more.³ The % compared to other states is just the health care costs which does not include other agencies DHS, DOC, etc.

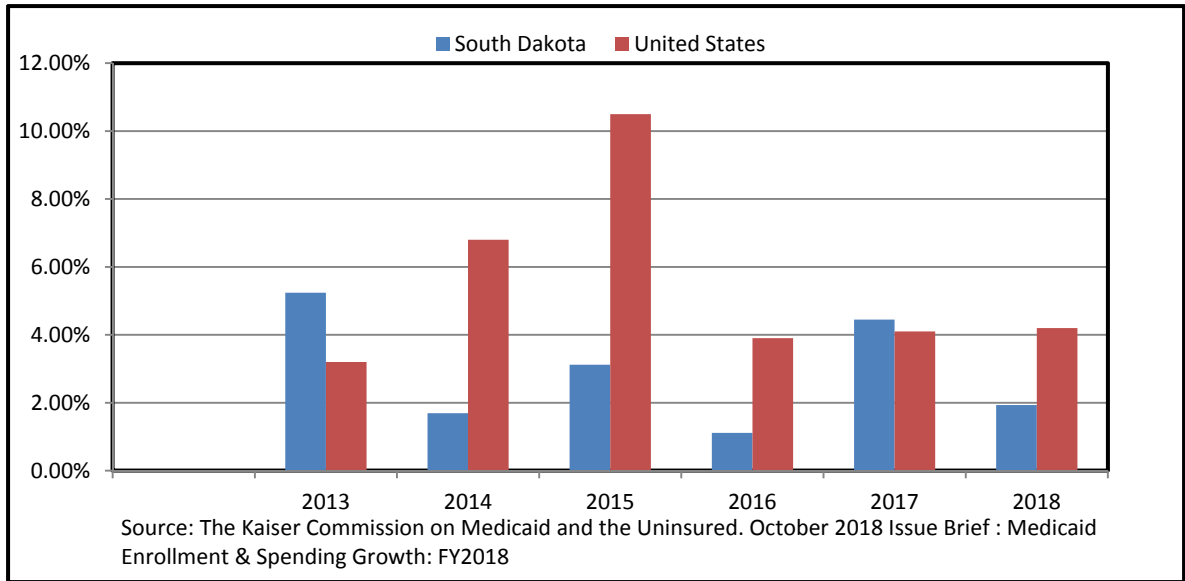
Map 2. South Dakota's Variance in Medicaid Spending per Enrollee, FY2014



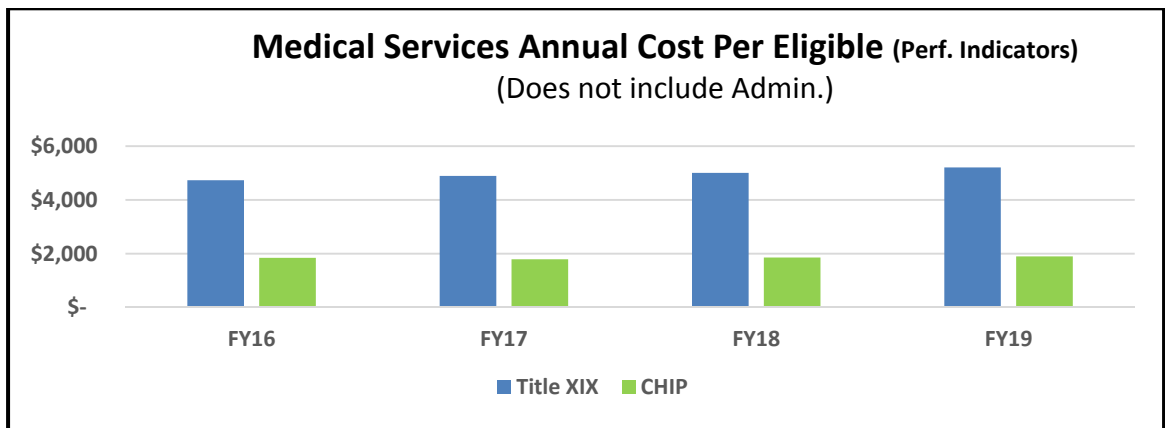
² Steven B. Cohen, PhD Statistical Brief #392: The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2009-2010 (November 2012) http://meps.ahrq.gov/data_files/publications/st392/stat392.pdf

³ Kaiser Family Foundation, Statehealthfacts.org

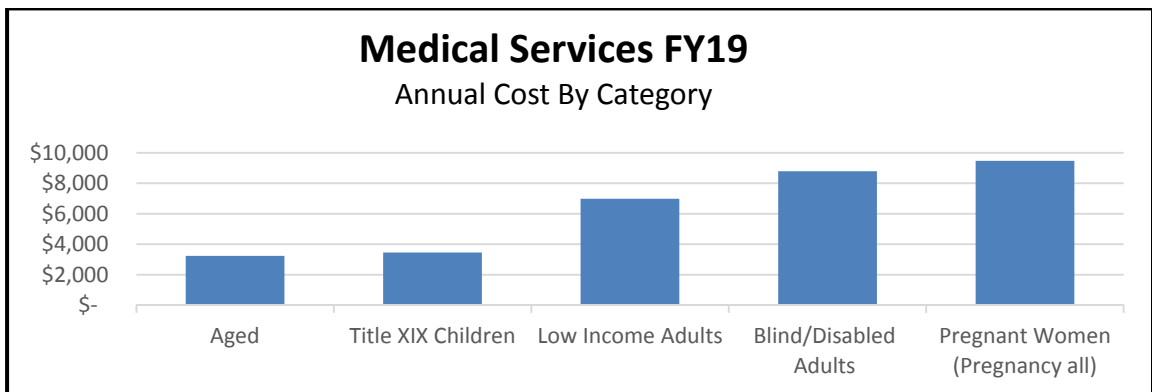
Graph 4. Annual % Change in Total Medicaid Spending in 50 States and DC, 2013 to 2018



Graph 5. Medical Services Annual Cost Per Eligible



Graph 6. Medical Services Annual Cost by Category



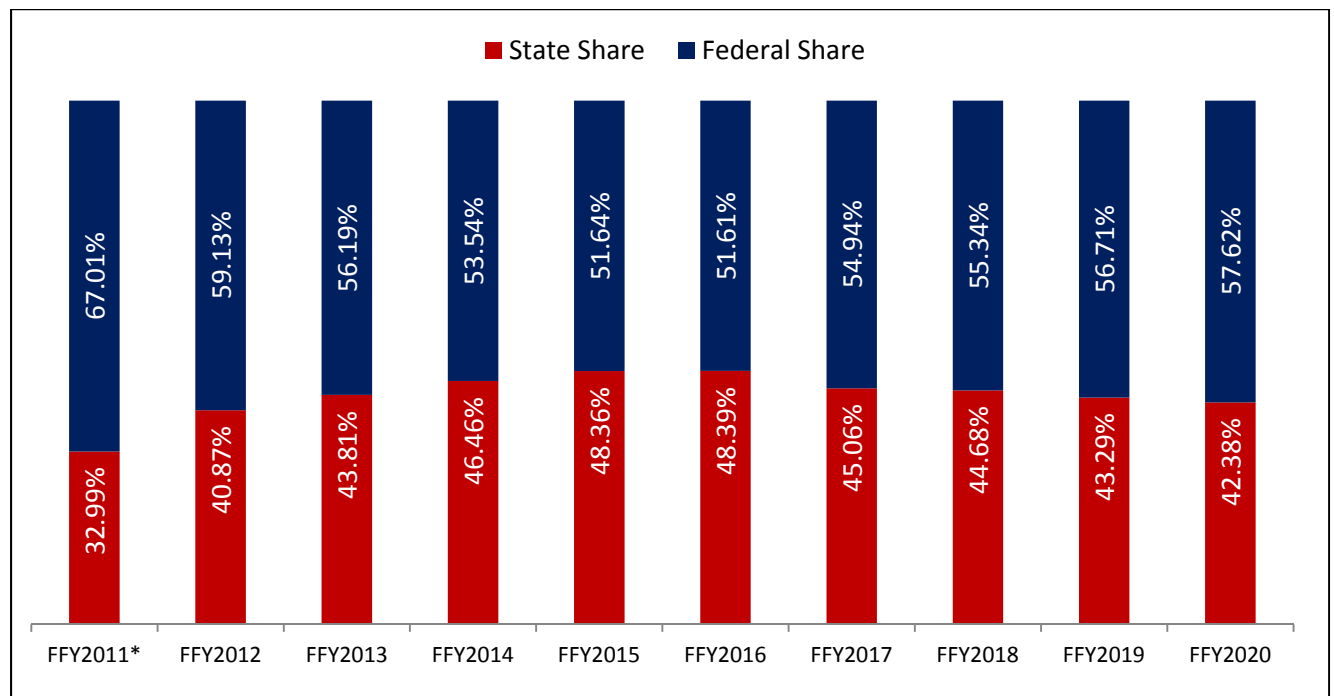
What is the Role of Federal Funding in South Dakota’s Medicaid Program?

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 76.39% in states with lower per capita income like Mississippi. (FFIS Issue Brief 18-11)

In FFY 2019, the FMAP for South Dakota was 56.71%. For FFY 2020 the FMAP will increase by 0.91% to 57.62%. 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 increased states’ FMAP by 23 percentage points. South Dakota’s enhanced CHIP match rate for FFY 2020 is 81.83% federal.

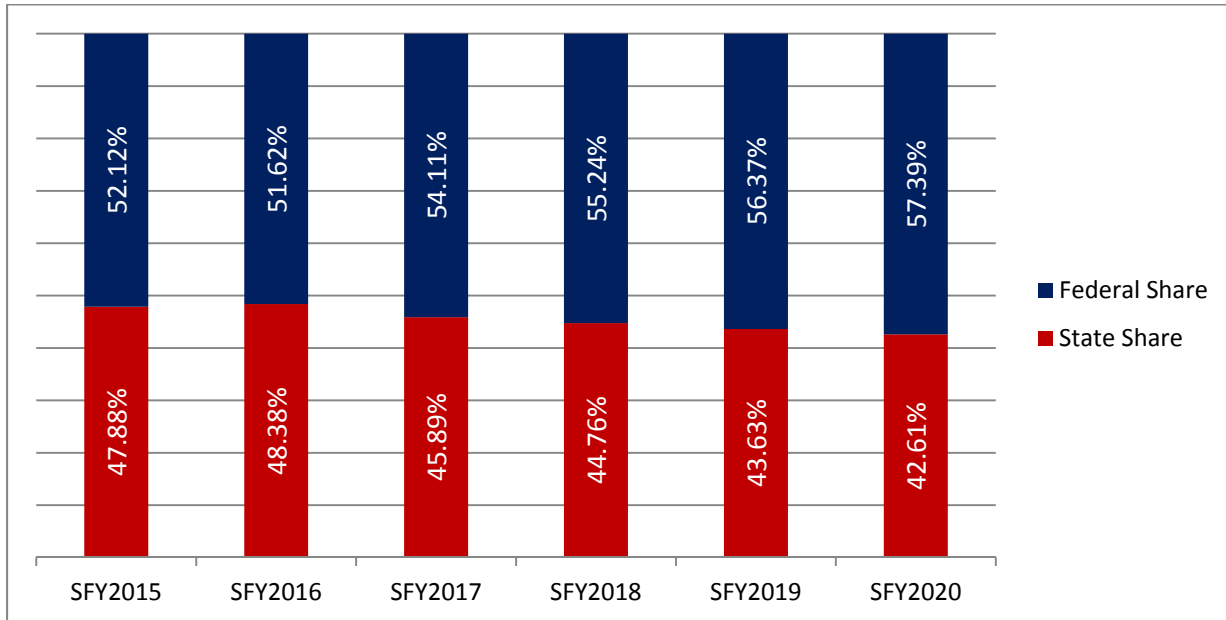
Graph 7. South Dakota Federal Medical Assistance Percentage (FMAP), FFY 2011 to FFY 2020



* Notes: From 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 8. South Dakota Blended Federal Medical Assistance Percentage (FMAP), SFY2015 to SFY2020



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 SFY19, an average of 43,698 American Indians were on Medicaid every month, which represents 37.44% 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 SFY19 total expenditures for typical healthcare services (medical services) provided to American Indians, including services at the Indian Health Services, totaled \$235 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)

In February of 2016 the federal government changed national Medicaid funding policy to cover more services for people eligible for care through both IHS and Medicaid with 100% federal funds if care is coordinated and certain other conditions are met. A stakeholder group was formed to leverage this change in policy to maximize federal funding for Medicaid. State funds totaling \$8.4 million were saved in SFY19 due to care coordination activities that qualified for 100% federal funding under the new federal policy. These savings were used to strengthen Medicaid for people who are already eligible, to support increased provider reimbursement rates, and to share savings back with the providers that helped to generate the savings.

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. Copayments are administered by netting the recipient's copayment responsibility off of the total amount paid to the provider; the provider is responsible for collecting the copayment from the recipient. 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	
<p>Referral/Authorization is Required:</p> <ul style="list-style-type: none"> 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) 	<p>Referral/Authorization is NOT Required:</p> <ul style="list-style-type: none"> 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)
<p><i>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.</i></p>	

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.

Access to Healthcare

- Survey by Centers for Medicare/Medicaid Services of South Dakota Medicaid recipients shows South Dakota meets or exceeds the national average across four key measures of access to healthcare for children.
 - Ability to see a specialist when needed
 - Ability to get care, tests or treatment
 - Ability to get an appointment for routine care when needed
 - Ability to get an appointment for immediate care

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 SFY19 around 5,500 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 119 primary care clinics including 11 Indian Health Service facilities and 24 Federally Qualified Health Care Centers. There are also 9 Community Mental Health Centers that are also participating. In total, there are 767 Health Home providers serving 132 locations.

Preliminary Clinical and Financial 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. However, preliminary outcome data indicates improved health outcomes across several key clinical measures and cost avoidance as a result of health homes

Caring for People in the Most Cost Effective Manner

About 5,500 Medicaid recipients with high-cost chronic conditions and risk factors participate in the Health Home program. The goal of the program is to improve health outcomes and avoid high-cost care and includes incentive-based payments to high performing providers. Most recent results show the program is approaching the target for participants with a person-centered care plan, and for participants who visited a primary care provider (PCP) in the last six months. The program led to \$7.3 million in net cost avoidance in CY 2018, primarily due to a reduction in avoidable inpatient admissions and emergency department visits.

Compared to the control group, HH enrollees had 16% fewer inpatient visits and 23% less ED visits.

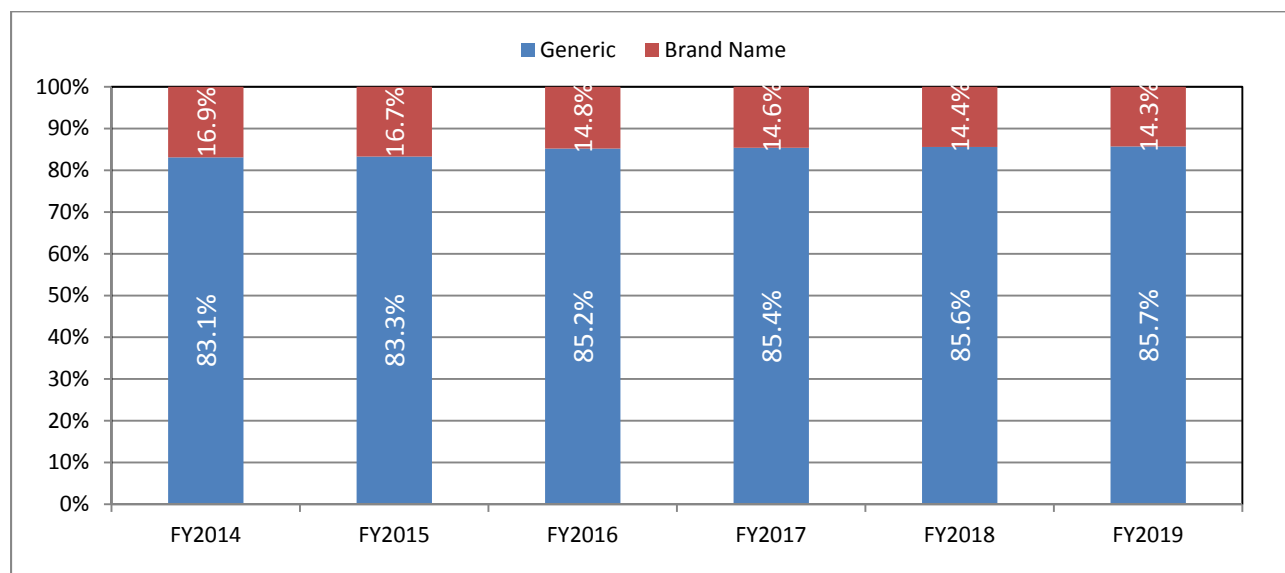
To learn more about the health home program, you can go to our website at:

<http://dss.sd.gov/healthhome/dashboard.aspx>

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 9: Generic vs. Brand Name Drug Utilization, FY2014-FY2019



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. South Dakota Medicaid enrolls providers on the basis of National Provider Identifiers (NPIs). There were 16,862 unique NPIs that were known to be enrolled during some portion of FY19. The majority of these NPIs were for individual practitioners. Approximately 3,000 unique billing NPIs were on claims paid during FY19.

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 2019, South Dakota's system:

- Processed more than 5.9 million claims
- Answered more than 85,000 calls from providers

Medicaid On-Line Portal

The Medicaid On-Line Portal allows providers to look up information online 24 hours a day, seven days a week. Providers can use the on-line portal to check whether a patient is eligible for Medicaid, view the status of a claim, or even submit claims electronically.

In FY 2019:

- 239,119 eligibility inquiries to the portal
- 6,596 active users on the portal

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. During SFY19 recovered \$9.2 million in third party liability was recovered.

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.

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 SFY 2019 this department recovered \$311,014 in restitution for the Medicaid Program.

Appendix A: Percent of County Population Enrolled in Medical Services 2019

County	Average Monthly Eligibles	Estimated 2018 Census	Percent of Population
Aurora	276	2,801	9.9%
Beadle	3,693	18,883	19.6%
Bennett	1,356	3,468	39.1%
Bon Homme	577	6,980	8.3%
Brookings	2,339	35,232	6.6%
Brown	4,463	39,316	11.4%
Brule	813	5,229	15.5%
Buffalo	874	2,036	42.9%
Butte	1,707	10,222	16.7%
Campbell	89	1,377	6.5%
Charles Mix	2,178	9,338	23.3%
Clark	435	3,739	11.6%
Clay	1,379	14,041	9.8%
Codington	3,308	28,015	11.8%
Corson	1,748	4,165	42.0%
Custer	643	2,726	23.6%
Davison	2,670	19,790	13.5%
Day	729	5,505	13.2%
Deuel	391	4,337	9.0%
Dewey	2,384	5,904	40.4%
Douglas	280	2,935	9.5%

Edmunds	297	3,875	7.7%
Fall River	892	6,758	13.2%
Faulk	185	2,330	7.9%
Grant	706	7,147	9.9%
Gregory	672	4,212	16.0%
Haakon	150	1,918	7.8%
Hamlin	760	6,111	12.4%
Hand	209	3,262	6.4%
Hanson	210	3,376	6.2%
Harding	68	1,249	5.4%
Hughes	2,294	17,650	13.0%
Hutchinson	690	7,380	9.3%
Hyde	91	1,282	7.1%
Jackson	980	3,307	29.6%
Jerauld	167	2,043	8.2%
Jones	106	928	11.4%
Kingsbury	475	4,919	9.7%
Lake	933	13,057	7.1%
Lawrence	2,421	25,741	9.4%
Lincoln	2,561	58,807	4.4%
Lyman	853	3,821	22.3%
Marshall	389	5,112	7.6%
McCook	533	5,546	9.6%
McPherson	22	2,407	9.1%

Meade	2,351	28,294	8.3%
Mellette	743	2,042	36.4%
Miner	204	2,213	9.2%
Minnehaha	22,851	192,876	11.8%
Moody	645	6,579	9.8%
Oglala Lakota	7,239	14,309	50.6%
Pennington	15,296	111,729	13.7%
Perkins	232	2,922	7.9%
Potter	191	2,207	8.7%
Roberts	2,328	10,447	22.3%
Sanborn	240	2,429	9.9%
Spink	774	6,495	11.9%
Stanley	209	3,022	6.9%
Sully	51	1,392	3.7%
Todd	5,296	10,283	51.5%
Tripp	1,065	5,478	19.4%
Turner	806	8,424	9.6%
Union	994	15,619	6.4%
Walworth	812	5,587	14.5%
Yankton	2,637	22,869	11.5%
Ziebach	1,081	2,742	39.4%
County Not Available	1,472		