South Dakota Department of Social Services

January 25, 2011
What is Medicaid?

• Federal / State Partnership since 1965
• Federal government mandates certain healthcare coverage to certain categories of individuals and allows states to cover optional categories and services at their discretion
• Medicaid is governed by federal regulations and each state’s approved Medicaid State Plan—essentially a contract with the federal government
• Medicaid is an entitlement program
What is CHIP?

• Children’s Health Insurance Program

• Federal allocation is block grant

• Coverage limited to children with higher incomes than Medicaid levels, can’t have insurance

• Runs as a “Medicaid look alike” program - same services provided to children eligible through Medicaid or CHIP
Who is covered by Medicaid?

69 percent are children and 31 percent are adults

- Low income children, pregnant women, adults and families
  - very low income families (family of three $9,552 annual income/52% FPL)
- Elderly or disabled
- Children in Foster Care

• Average monthly eligibility for FY10 in total 111,005
  - Elderly – 6,957
  - Disabled – 16,856
  - Children of low-income families – 61,275
  - Pregnant women (pregnancy only) – 2,829
  - Low-income adults – 10,900
  - Children’s Health Insurance Program – 12,188

• Total unduplicated for FY10 = 139,666
Medical Services
Medicaid Ave. Monthly Eligible Totals

<table>
<thead>
<tr>
<th>Year</th>
<th>CHIP Children</th>
<th>XIX Children</th>
<th>XIX Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2006</td>
<td>32,899</td>
<td>56,279</td>
<td>100,274</td>
</tr>
<tr>
<td>FY2007</td>
<td>32,776</td>
<td>56,387</td>
<td>100,393</td>
</tr>
<tr>
<td>FY2008</td>
<td>33,114</td>
<td>57,725</td>
<td>102,310</td>
</tr>
<tr>
<td>FY2009</td>
<td>33,309</td>
<td>59,393</td>
<td>104,520</td>
</tr>
<tr>
<td>FY2010</td>
<td>34,534</td>
<td>64,283</td>
<td>111,005</td>
</tr>
<tr>
<td>Budget</td>
<td>104,534</td>
<td>68,280</td>
<td>115,160</td>
</tr>
</tbody>
</table>

Legend:
- CHIP Children
- XIX Children
- XIX Adults
Eligibility for Medicaid

- Medicaid eligibility depends on whether a person meets specific eligibility criteria, resources, and income limits.
- States cannot cut eligibility. The Patient Protection & Affordable Care Act (PPACA) includes a Maintenance of Effort (MOE) requirement. States must maintain all current eligibility standards until January 2014 and standards for children until October 2019.
  - States also cannot implement or increase existing premiums.
Services Covered by Medicaid - Required Services

Services federally required to be covered by Medicaid:

• Services to children through “Early, Periodic, Screening, Diagnosis and Treatment”, or EPSDT.
  • Inpatient and outpatient hospital
  • Physician services
  • Nursing facility services for individuals age 21 or older
  • Emergency dental services
  • Emergency medical transportation
  • Lab and X-Ray
  • Skilled home health services
• FQHC/Rural Health Care Center Services
  • For certain people eligible for Medicare- Medicaid must pay co-insurance/deductibles; buying them into Part A or B. Medicare Part D Clawback
Services Covered by Medicaid - Optional Services

- Physician assistants
- Psychologists and independent mental health practitioners
- Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

Other Services for Adults
- 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
Medicaid Expenditures

• From SFY04 through SFY10, despite the 23% growth in eligibles our Medicaid expenditure growth averaged 5.85%.

• From FY09 to FY10, the national average growth in Medicaid expenditures was 8.8%; in SD, the growth was 7.6%.

• Thirty other states spend more per Medicaid enrollee than South Dakota.

• Compared to our neighboring states we spend the least amount per Medicaid enrollee.
  
  • South Dakota Medicaid spends 4% less than Iowa
  • South Dakota Medicaid spends 14% less than Wyoming
  • South Dakota Medicaid spends 22% less than Nebraska
  • South Dakota Medicaid spends 28% less than Montana
  • South Dakota Medicaid spends 47% less than North Dakota
  • South Dakota Medicaid spends 55% less than Minnesota

• South Dakota Medicaid expends the 2nd lowest amount in the nation on administration of the program.
Recipient Responsibility- Co-Payments

• Federal regulations do not allow co-pays to be assessed in certain situations
  • Children are exempt from co-payments per federal requirements
    • Children are 69% of all eligibles
  • American Indians receiving services through IHS or upon IHS referral are exempt from co-payments
  • Certain services such as psychiatric inpatient and rehab services are exempt from co-payments
• This results in a small number of individuals and services that can be assessed a “nominal” co-payment
  • 17,171 eligibles last month
    • 5,697 disabled adults
    • 11,555 low-income adults
Recipient Responsibility- Co-Payments

• Co-payment amounts are reduced from the amount Medicaid pays the provider

• Co-pay amounts must be approved by CMS

• SD Medicaid co-payment amounts:
  - Non-generic prescription drugs - $3
  - Durable Medical Equipment - 5%
  - Non-emergency dental services - $3
  - Inpatient Hospital - $50 per admission
  - Non-emergency outpatient hospital services, includes emergency room use for non-emergent care
    - 5% of billed charges, maximum of $50

• South Dakota’s co-payment amounts are consistent with other states
Preventing Fraud and Abuse

• South Dakota utilizes a number of quality assurance approaches to maintain program integrity and prevent fraud and abuse
• Includes both internal and external evaluation

Internal approaches:
  • Surveillance and Utilization Review Unit – federally mandated; conducts post-payment provider reviews; recovered $1.08 million in overpayments in FY10.
  • Quality Improvement Organization – reviews inpatient hospital claims to insure quality services and correct coding; recovered $297,000 in FY10.
  • Office of Recoveries and Fraud Investigations – conducts investigations of recipient fraud and recovers payments from third liability sources; recovered $7.3 million in FY10.
  • Drug Utilization Review – partnership with SDSU; retrospective review of recipient’s drug claims and education of physicians.
Preventing Fraud and Abuse

External approaches:

- Medicaid Integrity Contractors – began in 2009; federal contractors conduct independent audits of providers; total recoveries to date $100,000
- Payment Error Rate Measurement Program – federal program where contractors review medical records, eligibility records, and paid claims; 2008 cycle was last year SD was in; second lowest claims processing and eligibility determination error rate in nation - .87%; next cycle is occurring now.
- Medicaid Fraud Control Unit – located in SD Attorney General’s Office; in FY09 and FY10 $1.4 million recovered from pharmaceutical manufacturer settlements, $51,000 provider fraud recoveries, and $190,000 in conjunction with federal Office of Inspector General audits.
- South Dakota Healthcare Fraud Task Force – operated by federal Office of Inspector General; works with AG’s Office to coordinate Medicaid recoveries as a result of Medicare fraud cases; recovered $28,000 in FY10.
Care Management

• SD has the primary care case management (PCCM) program
  • Uses primary care providers to act as gatekeepers for specialty services
  • Started in 1996
  • 79% of eligibles part of program
• Effect on inappropriate use of Emergency Rooms
  • 1996: 4.3% Emergency room visits- elective
  • 2010: 2.9% Emergency room visits- elective
• ER Diversion Grant
  • Testing ways to reduce non-emergency ER use
Care Management

• Efforts underway to provide **care utilization management** for certain services
  • Out of state service prior authorization
  • Prior authorization of certain services
    • Back surgeries, certain Durable Medical Equipment
  • Notification of lengthy hospital stays
    • Assistance with difficult placements

• Future opportunities
  • Development of health homes for people with chronic health conditions
  • Changes to reimbursement methodologies
### 2010 Federal Poverty Guidelines

**Annual Amount at Various Percentage Levels**

<table>
<thead>
<tr>
<th>Family Size</th>
<th>100%</th>
<th>130%</th>
<th>133%</th>
<th>140%</th>
<th>150%</th>
<th>160%</th>
<th>200%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,830</td>
<td>$14,079</td>
<td>$14,404</td>
<td>$15,162</td>
<td>$16,245</td>
<td>$17,328</td>
<td>$21,660</td>
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<tr>
<td>2</td>
<td>$14,570</td>
<td>$18,941</td>
<td>$19,378</td>
<td>$20,398</td>
<td>$21,855</td>
<td>$23,312</td>
<td>$29,140</td>
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<tr>
<td>3</td>
<td>$18,310</td>
<td>$23,803</td>
<td>$24,352</td>
<td>$25,634</td>
<td>$27,465</td>
<td>$29,296</td>
<td>$36,620</td>
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<tr>
<td>4</td>
<td>$22,050</td>
<td>$28,665</td>
<td>$29,327</td>
<td>$30,870</td>
<td>$33,075</td>
<td>$35,280</td>
<td>$44,100</td>
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<tr>
<td>5</td>
<td>$25,790</td>
<td>$33,527</td>
<td>$34,301</td>
<td>$36,106</td>
<td>$38,685</td>
<td>$41,264</td>
<td>$51,580</td>
</tr>
<tr>
<td>6</td>
<td>$29,530</td>
<td>$38,389</td>
<td>$39,275</td>
<td>$41,342</td>
<td>$44,295</td>
<td>$47,248</td>
<td>$59,060</td>
</tr>
<tr>
<td>7</td>
<td>$33,270</td>
<td>$43,251</td>
<td>$44,249</td>
<td>$46,578</td>
<td>$49,905</td>
<td>$53,232</td>
<td>$66,540</td>
</tr>
<tr>
<td>8</td>
<td>$37,010</td>
<td>$48,113</td>
<td>$49,223</td>
<td>$51,814</td>
<td>$55,515</td>
<td>$59,216</td>
<td>$74,020</td>
</tr>
<tr>
<td>Each Additional approximately</td>
<td>$3,740</td>
<td>$4,862</td>
<td>$4,974</td>
<td>$5,236</td>
<td>$5,610</td>
<td>$5,984</td>
<td>$7,480</td>
</tr>
</tbody>
</table>

**Program Eligibility:**
- Medicaid (Pregnant Women) 133%
- Medicaid 140%
- CHIP Children’s Health Insurance Program 200%
- SNAP 130%
- Energy Assistance 200%
- Child Care 200%
Thank you!

South Dakota Department of Social Services
<table>
<thead>
<tr>
<th>Service</th>
<th>South Dakota</th>
<th>Iowa</th>
<th>Montana</th>
<th>North Dakota</th>
<th>Wyoming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>$50 per non-emergent admission.</td>
<td>No cost share</td>
<td>$100 per admission</td>
<td>$75 per admission</td>
<td>No cost share</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>5% of allowable payment amount, excluding laboratory services, for each non-emergent service.</td>
<td>No cost share</td>
<td>$5 per visit</td>
<td>$6 per non-emergent ER visit</td>
<td>No cost share</td>
</tr>
<tr>
<td>Physician Services</td>
<td>$3 per office visit, home visit, hospital admission, general ophthalmological service, or medical psychotherapy service.</td>
<td>$3 per total covered services provided in a physician office visit, rendered on a given date of service (for MD and DO)</td>
<td>$4 per visit</td>
<td>$2 per visit</td>
<td>$2 per office/home visit</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$3 per filled or refilled prescription for single-source or brand name drugs. $0 for generics or multi-source drugs.</td>
<td>$1 per generic and preferred brand-name drugs. $1 per nonpreferred brand-name drugs for which the cost to the state is no more than $25. $2 for nonpreferred brand-name drugs for which the cost to the state is $25.01-$50. $3 for nonpreferred brand-name drugs for which the cost to the state is $50.01 or more.</td>
<td>$1-$5 per prescription depending on drug cost, up to $25 maximum per month</td>
<td>$3 per prescription for brand name drugs</td>
<td>$1 per generic or preferred brand prescription. $3 per non-preferred brand prescription drugs.</td>
</tr>
<tr>
<td>Rural Health Clinics and Federally Qualified Health Centers</td>
<td>$3 per visit.</td>
<td>No cost share</td>
<td>$5 per visit</td>
<td>$3 per visit</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>5% of allowable payment amount.</td>
<td>$2 per total amount of service provided during a given date</td>
<td>$5 per service/item</td>
<td>No cost share</td>
<td>No cost share</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>5% of allowable payment amount.</td>
<td>$2 per total amount of service provided during a given date</td>
<td>$5 per service/item</td>
<td>No cost share</td>
<td>No cost share</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>$3 per procedure.</td>
<td>$2 per total amount of service provided during a given date</td>
<td>$3 per visit</td>
<td>$2 per visit</td>
<td>$2 per therapy service</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>$2 per supply.</td>
<td>$2 per total amount of service provided during a given date</td>
<td>$5 per service/item</td>
<td>No cost share</td>
<td>No cost share</td>
</tr>
<tr>
<td>Dental Services</td>
<td>$3 per procedure.</td>
<td>$3 per total amount of service provided during a given date</td>
<td>$3 per visit</td>
<td>$2 per visit</td>
<td>No cost share</td>
</tr>
<tr>
<td>Dentures</td>
<td>$3 per complete denture or rel ine.</td>
<td>No cost share</td>
<td>$5 denture-related visit</td>
<td>No cost share</td>
<td>No cost share</td>
</tr>
<tr>
<td>Optometric Services</td>
<td>$2 per visit.</td>
<td>$2 per total amount of service provided during a given date (same rate for opticians)</td>
<td>$2 per visit</td>
<td>$2 per visit</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Podiatrist Services</td>
<td>$2 per visit.</td>
<td>$1 per total amount of service provided during a given date</td>
<td>$4 per visit</td>
<td>$3 per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$1 per procedure.</td>
<td>$1 per total amount of service provided during a given date.</td>
<td>Not covered</td>
<td>$2 per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Nutritional Services</td>
<td>$2 per day for enteral nutritional services for individuals 21 or over. $5 per day for parenteral nutritional services for recipients 21 or older.</td>
<td>Not indicated</td>
<td>Not indicated</td>
<td>Not indicated</td>
<td>Not indicated</td>
</tr>
<tr>
<td>Diabetes Education</td>
<td>$3 per unit of service for recipients 21 or older.</td>
<td>Not indicated</td>
<td>Not indicated</td>
<td>Not indicated</td>
<td>Not indicated</td>
</tr>
<tr>
<td>Independently Practicing Physical Therapist</td>
<td>$3 per visit</td>
<td>$1 per total amount of service provided during a given date.</td>
<td>$2 per visit</td>
<td>$2 per visit</td>
<td>No cost share</td>
</tr>
<tr>
<td>Audiologists</td>
<td>$3 per visit.</td>
<td>$2 per total amount of service provided during a given date (same rate for opticians)</td>
<td>$2 per visit</td>
<td>$2 per visit</td>
<td>No cost share</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>No cost share</td>
<td>$2 for each date of service</td>
<td>No cost share</td>
<td>No cost share</td>
<td>No cost share</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>5% of allowable payment amount.</td>
<td>$3 per total amount of service provided during a given date</td>
<td>$2 per hearing aid</td>
<td>$3 per hearing aid</td>
<td>No cost share</td>
</tr>
</tbody>
</table>