**SOUTH DAKOTA COUNTY’S**

**WELFARE/MEDICAL MANUAL**

**Updated January, 2015**

INTRODUCTION

This manual and the accompanying forms are intended to serve as a guide for use in administering a county’s medical assistance program. They are not intended to dictate program design or mandate certain medical coverage. This manual is an attempt to provide guidance to a county as the county deals with hospital notices, requests for payment, and the determination of eligibility.

A county is obligated under South Dakota law to cover emergency hospital care for qualifying individuals. In addition to the emergency hospital care, a county may also be asked to provide general medical assistance on behalf of the qualifying individual. Please note that not all counties provide general medical assistance. Each county is responsible for developing its own set of guidelines that relate to the optional medical services covered by the county. When a county establishes its scope of coverage for medical services, the county must be prepared to defend its guidelines as being “reasonable.” (SDCL 28-13-1.1) The county guidelines used in conjunction with the state statutes at SDCL chapter 28-13 will provide the basis of the county’s medical assistance program.

Because of the complexities of the different welfare systems (Medicare, Medicaid, SSI, SSD, IHS, and VA), it is suggested that each county designate at least one individual who could act as the central contact for the county for issues relating to medical assistance available under the county’s poor relief program. Participation in and attendance at the South Dakota Association of County Welfare Directors’ meetings is highly encouraged. Because the county is considered to be the payer of last resort, the county contact person, or caseworker, is responsible for keeping up to date on medical program changes at the local, state, and federal level. Attendance at these meetings provides on-going educational opportunities in these areas.

When processing an application for assistance, it is very important that the designated county contact person maintain a case file on the individual. Contacts with the individual, other individuals, or medical providers on the individual’s behalf must be carefully documented in the individual’s file. The case file should also document any actions taken by the county in relation to the individual’s application. The case file can be a very essential and useful tool if the county has to defend its actions in court. In addition, information from the file may be needed when submitting a claim to the Catastrophic County Poor Relief Program for reimbursement.

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CHAPTER 1

GENERAL PROVISIONS

SCOPE OF CHAPTER: This chapter contains guidelines a county must use when determining eligibility for the payment of hospital expenses by the county. These guidelines may also be applied when determining eligibility for the payment of other medical expenses, such as physician, lab, x-ray, medications, or out-patient surgical services. Each case must be considered on its own merits and the county should conduct a thorough investigation when determining eligibility.

1000 DEFINITIONS

Terms used in this manual mean:

1. “Caseworker,” the individual(s) designated by the county commissioners as being the county’s primary contact person in matters relating to medical assistance available through the county’s poor relief program;
2. “CCPR,” the Catastrophic County Poor Relief Program administered by the South Dakota Association of County Commissioners on behalf of the counties.
3. “CHIP,” the Children’s Health Insurance Program for certain children under the age of 19 administered by the Department of Social Services;
4. “COBRA,” the Consolidated Omnibus Budget Reconciliation Act of 1986 which contains health benefit provisions under which terminated employees or those who lose coverage because of reduced work hours may be able to buy group coverage for themselves and their families for a limited period of time;
5. “DSS,” the Department of Social Services;
6. “Household,” the patient, the patient’s spouse, minor children of the patient living with the patient, and anyone else living with the patient to whom the patient has the legal right to look for support;
7. “IHS,” the Indian Health Services program administered by the Public Health Services, Bureau of Indian Affairs;
8. “Major medical insurance,” a major medical insurance policy is any policy which provides benefits which are actuarially equivalent to or exceed the basic plan as was approved and adopted by rule by the director pursuant to chapter 1-26. Policies which are not certified pursuant to this section and which are not major medical policies may not be used as a substitute for major medical policies and must provide for adequate disclosure of the scope of the benefits contained therein (SDCL 58-18B-55); also as defined by the ACA.
9. “Medicaid,” often referred to as Title XIX, medical assistance provided under Title XIX of the Social Security Act and administered by the Department of Social Services;
10. “The Midland Group” aka “Disability Professionals,” the business that contracts with hospitals and other medical providers to secure a payment source for an individual’s medical bills;
11. “Notice of hospitalization,” the notice required by SDCL 28-13-34.1 that is sent by the hospital to an individual’s county of residence informing the county that the individual was an emergency admission to the hospital;
12. “Purchase Referred Care,” as defined in 42CFR136: health services provided at the expense of the Indian Health Services (IHS) from public or private medical or hospital facilities other than those of the Service. Formerly known as Contract Health Services.
13. “Ratio of cost to charge” or “statute billing,” the actual cost to a hospital of providing hospital services to a medically indigent person, determined by applying the ratios of costs to charges appearing on the statement of costs required in SDCL 28-13-28 to charges at the hospital in effect at the time the hospital services are provided;
14. “Reasonable,” an amount that is neither extreme nor excessive when compared to the household’s circumstances;
15. “SSD,” or “SSDI”, the Social Security Disability program administered by the Social Security Administration;
16. “SSI,” the Supplemental Security Income program administered by the Social Security Administration;
17. “TANF,” the Temporary Assistance for Needy Families program administered by the South Dakota Department of Social Services;
18. “Title XIX,” often referred to as Medicaid, medical services provided under Title XIX of the Social Security Act and administered by the Department of Social Services;
19. “UB-04,” the uniform billing statement used by hospitals; and

20. “1500 claim form,” the health insurance claim form used for medical billing for services other than hospital.

21. “VA,” the Veterans’ Administration.

22. “ACA,” the Affordable Care Act, aka Obamacare. The health care act with beginning implementation in 2010 and having progressive stages. Includes the “Marketplace” or “Exchange” upon which persons can enroll for health insurance benefits.

1100 OBLIGATION OF ONE INDIVIDUAL TO SUPPORT ANOTHER

State law requires a spouse to support a spouse (SDCL 25-7-1), an adult child to support a parent (SDCL 25-7-27), and a parent to support his/her child (SDCL 25-7-6.1). When determining eligibility for county poor relief, there must be a legal obligation for one individual to support another. If that legal obligation does not exist, the county may not hold an individual responsible for the payment of another individual’s expenses. There is no legal obligation for a parent to support an “adult” child. The parent can always “choose” to provide support and pay expenses for an adult child, but no legal obligation exists.

1200 CHILDREN

If a notice of hospitalization involves a child under the age of 19, the county should contact the family to determine whether an application has been made for Medicaid. If there is no application pending, work with the family to get an application filed as soon as possible. Because of the medical programs available for children, it is very rare that a county is liable for the payment of a child’s medical expenses. Keep in mind that applications must be made in a timely manner in order to guarantee coverage if the individual is ultimately determined eligible.

1300 RESIDENCY

When the county receives a notice of hospitalization, a request for payment of a medical bill, or a request for prior approval of a scheduled medical procedure, it is necessary to determine if the individual covered by the notice is a resident of the county. The individual must have resided in the county for at least 60 days (SDCL 28‑14‑2.1) and established residency as provided in SDCL 28‑13‑3 to 28‑13‑14, inclusive. If the individual recently moved into the county from another South Dakota county and does not meet the residency requirements, notify the hospital that the individual is not a resident of the county and inform the hospital of the correct county of residence, if known. Remember to document the contact with the hospital.

The 60-day time limit required in SDCL 28-14-2.1 does not apply if an individual moves into the county from out-of-state and has established residency in a South Dakota county. The county is responsible for the individual’s medical expenses if the individual is otherwise qualified. NOTE: Not having established residency is not necessarily a reason to deny an application or a request for payment. The county will need to consider the reasons the individual is in the county and the individual’s intent to remain in the county and establish residency.

An individual who is residing in a health care, transitional or correctional facility is not a resident of the county in which the facility is located unless the individual had established residency in the county before entering the facility. In this case, residency is with the county in which the individual resided before entering the facility. (SDCL 28‑13‑14)

1310 RESIDENCY – COLLEGE STUDENTS

An individual who is living in the county for the express purpose of attending a post-secondary educational program is not considered a resident of the county in which the educational program is located. A student may be considered a county resident if the student otherwise establishes residency within the county, is not claimed on the parents’ income tax, and is not living in a dorm setting. A student who lives in a dorm for most of the year or a student who temporarily leaves the county but continues to rent temporary living quarters off campus is not considered a resident of the county in which the college is located unless the student is otherwise qualified.

1320 RESIDENCY – CHILDREN

A child has the same residency as the parents, the individual who has been granted legal custody of the child pursuant to a court order or a decree, or as fixed by the child’s guardian. (SDCL 28‑13‑5)

1330 RESIDENCY -- TRANSIENTS

You may have a homeless person in the community or an individual who is passing through who has not established residency. In these cases, the county assumes immediate responsibility of emergency hospital bills incurred on behalf of these individuals, as long as there are no other third-party payment sources available or residency cannot be established in another county. NOTE: If the individual is a veteran, the caseworker should contact the county’s Veterans Services Officer to determine whether the individual is eligible for benefits through the Veterans Administration, including funding through the Homeless Program administered by the Veterans Administration.

1340 RESIDENCY – ALIENS, REFUGEES AND IMMIGRANTS

An “alien” is an individual who is not a citizen or national of the United States who is residing either permanently or temporarily in the United States.

A “permanent resident alien” is an individual who has immigrated to the United States intending to reside here indefinitely. The individual may or may not choose to become a citizen. This legal status is also known informally as “having a green card.”

A “refugee” is the term for an individual who left his or her country of origin because of “a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group or political opinion.” A refugee has the right to work and, after one year, can apply to become a permanent resident.

An “immigrant” is the term for an individual who has left his or her country of origin to take up permanent residence in another country, not leaving their country of origin out of a well-founded fear.

If the individual is an alien, refugee, or immigrant the county must request documentation from the individual that shows the individual has been authorized by the United States government to work and live in the United States. If the individual is able to produce sufficient documentation, the county would process an application for assistance. If the individual doesn’t have proof of status, the county should contact the Immigration & Customs Enforcement (ICE), Sioux Falls office at 605-330-4276.

Usually, an alien, refugee or immigrant is not eligible for Medicaid coverage until they have been in the United States for at least five years. If, however, the alien, refugee or immigrant incurs medical expenses as a result of an emergency, the individual may be eligible for Medicaid. Contact must be made with the Department of Social Services and the individual must complete an application for medical assistance. Once the emergency has passed, the individual will no longer be eligible for Medicaid. Keep in mind that the application must be made in a timely manner in order to guarantee coverage if the individual is ultimately determined eligible.

In 1996, the Social Security Administration changed its policy on assigning non-work social security numbers. A social security number will not be assigned or a replacement card issued to anyone who is not a citizen and who does not have authorization from ICE to work in the United States unless the individual has a valid non-work reason for needing a social security number. Meeting the eligibility requirements for TANF, SNAP, or Medicaid benefits that require the individual to provide a social security number in order to receive assistance is a valid reason for needing a non-work social security number.

Due to continuous law changes regarding alien, refugee and immigrant status, for current information it is recommended to contact Immigration & Customs Enforcement (ICE), Sioux Falls office at 605-330-4276.

1400 INDIVIDUAL MUST BE “MEDICALLY INDIGENT” (SDCL 28-13-1.3; 28-13-32.3)

Before an individual may qualify for medical services, the county must have determined that the individual is “medically indigent”. An individual is considered to be medically indigent if the individual meets the following criteria:

1. The individual requires medically necessary hospital services for which no public or private third-party coverage is available to cover the cost of hospitalization. Third party coverage includes, but is not limited to, coverage such as insurance, veterans’ assistance, Medicaid, or Medicare;
2. The individual has no ability or only limited ability to pay a debt for hospitalization;
3. The individual has not voluntarily reduced or eliminated ownership or control of an asset for the purpose of establishing eligibility;
4. The individual is not “indigent by design”; and
5. The individual is not a veteran or a member of a Native American tribe who is eligible or would have been eligible for services through the Veterans’ Administration or the Indian Health Service if the services would have been applied for within 72 hours of the person’s admission.

If the individual fails to meet any one of these tests, the individual is not “medically indigent” and the county is not responsible for the payment of the individual’s hospital bill.

1410 MEDICAL NECESSITY (SDCL 28-13-27.1)

Services billed to the county must be “medically necessary”. In order to be considered medically necessary, the services must meet the following criteria:

1. The services must be consistent with the individual’s symptoms, diagnosis, condition, or injury;
2. The services must be recognized as the prevailing standard and must be consistent with generally accepted professional medical standards of the provider’s peer group;
3. The services must be provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition which would result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing standards for the diagnosis or condition;
4. The services must not be furnished primarily for the convenience of the person or the provider; and
5. There may be no other equally effective course of treatment available or suitable for the person needing the services, which is more conservative or substantially less costly.

A county must rely on the attending physician’s determination as to medical necessity (Appendix T) unless evidence exists to the contrary. In those instances in which the county questions the need for emergency room treatment, a hospital admission, a transfer, a continued stay, or an inpatient surgical procedure, the county may request the Department of Social Services to review the claim on the county’s behalf. The county may want to consider using the Medical Necessity Form (Appendix T) to verify that the service is medically necessary. (SDCL 28‑13‑37.1)

1420 TRANSFER OF ASSETS

An individual may not have voluntarily reduced or eliminated ownership or control of an asset for purposes of establishing eligibility. (SDCL 28-13-27(e)) An individual who assigns or transfers any property for the purpose of establishing eligibility for county poor relief may be charged with a Class 1 misdemeanor. (SDCL 28-13-43) When determining if a transfer has occurred, the county may look back to the 60-month period immediately prior to the onset of the individual’s illness and continue through the period of time for which the individual is requesting services. If the individual transferred assets to establish eligibility, the individual is not medically indigent.

1430 INDIVIDUAL INELIGIBLE IF “INDIGENT BY DESIGN” (SDCL 28‑13‑27.6)

An individual may not be considered medically indigent if the person is “indigent by design”. An individual is indigent by design if the individual meets any one of the following criteria:

1. The individual is able to work but has chosen not to work; [The individual must be employable and must have chosen not to work. This will not affect those individuals who are between jobs through no fault of their own. It will, however, affect those who have voluntarily terminated employment before acquiring another job. A county needs to be realistic when making this determination. An individual who is chronically mentally ill or who has a history of long-term alcohol or drug abuse may, quite simply, be “unable” to work. If the case involves a two-parent household in which one of the parents has chosen not to work in order to care for the parents’ child(ren), the county should consider whether the household would truly benefit from the parent’s employment before making a determination that the parent is “indigent by design”. For example: if requiring the parent to work would result in additional, unmet household expenses, such as child care, it would be reasonable to determine that the parent is not “indigent by design”. If, however, the parent is employable, employment is available, and the income from the employment would meet or exceed the household’s additional needs resulting from the employment but the individual has simply chosen not to work in order to care for the parents’ child(ren), the county could determine the parent to be “indigent by design”. When there is an issue of child care, remember that the Department of Social Services has a child care services program under which the department will pay all or a portion of the household’s child care expenses. The level of coverage is dependent on the household’s income.
2. The individual is a student at a postsecondary institution and has chosen not to purchase health insurance; [The individual must be attending school and taking the minimum credits to qualify for the insurance. The individual’s financial aid package can be designed to include the insurance premium. The student may select coverage for a semester at a time or may choose coverage for the entire year. NOTE: The State Division of Insurance considers the insurance offered to college students through the colleges as “substandard” coverage. Because of that, the division is attempting to ensure that individuals who have a major medical insurance plan don’t drop those plans for a “substandard” plan such as the colleges are offering. As an incentive to maintain current major medical policies, the Division of Insurance is requiring insurance carriers offering “substandard” coverage to deny coverage when the individual has been covered by a major medical insurance policy within the past 63 days. Because of this, counties must check to see if the reason the college student doesn’t have insurance through the college is because the student wasn’t eligible due to the 63-day requirement. If the student has been without insurance for 64 days or longer, the student is indigent by design.]
3. The individual has failed to purchase or elect major medical health insurance or health benefits made available through an employer-based health benefit plan although the person was financially able, pursuant to SDCL 28‑13‑32.11, to purchase or elect the insurance or health benefits; A county must be realistic when making this determination. It would be normal to expect that the employee would participate in the employer’s health plan. It may not, however, be possible for the individual to purchase the additional spousal or family coverage due to the cost.
4. The individual has failed to purchase available major medical health insurance although the individual was insurable and was financially able, pursuant to SDCL 28‑13‑32.11, to purchase the insurance. This includes health insurance benefits that would have been affordable through the ACA Marketplace. An individual is presumed insurable unless the individual can produce sufficient evidence to show that the individual was declined major medical insurance by the insurance company and the individual did not qualify for any guarantees of major medical insurance available through any legal or contractual right that was not exercised; or
5. The individual has transferred resources for the purpose of establishing eligibility for medical assistance. When making this determination, the look-back period includes the 60-month period immediately prior to the onset of the individual’s illness and continues through the period of time for which the individual is requesting county assistance.

An individual who is determined to be indigent by design is ineligible for medical assistance and no other criteria may be used to determine eligibility. (SDCL 28‑13‑32.10)

1440 COUNTY IS RESOURCE OF LAST RESORT -- THIRD-PARTY PAYMENT SOURCES

Before a person may be eligible for medical assistance the individual must have exhausted all other payment sources, including but not limited to Medicare, Medicaid, private insurance, Veterans’ benefits, Indian Health Services, and the Affordable Care Act Marketplace. When taking an application for assistance, it is always necessary to verify whether any of these resources are, or would have been, available to the individual. This may mean that the individual will need to apply for assistance through another agency, such as the Social Security Administration or the Department of Social Services. The process of determining eligibility on applications made through the Social Security Administration can become very lengthy. The county may need to consider providing assistance until a final determination is made by the other agency. The county should maintain an accurate ledger of expenditures made on behalf of the individual. This ledger can then be used to track reimbursements from the third-party source if the individual is subsequently determined eligible for coverage by the other source. If the individual is eligible for assistance through another agency but the individual chooses not to take advantage of that resource, the county is not responsible for the individual’s medical expense. The county must be able to prove that there was another resource available, that the individual would have been eligible for that resource, and that the individual chose not to use it.

1500 BANKRUPTCY

The fact that an individual (or couple) has filed a petition for bankruptcy or has received a discharge in bankruptcy has no bearing on whether the individual is medically indigent. The county should handle these cases just like any other case being reviewed for eligibility purposes. (SDCL 28-13-44)

There are four types of bankruptcy:

1. Chapter 7 - Liquidation;

2. Chapter 11 - Reorganization;

3. Chapter 12 - Farm Reorganization; and

4. Chapter 13 - Individual Reorganization.

Chapter 7 - Liquidation is the most common type of bankruptcy. It is available to individuals, partnerships, corporations, and other business entities. The debtor's property goes into a pot and is divided among creditors on the basis of their claims as a percentage of total claims.

Chapter 11 - Is most often used by a business that wants to keep operating during the bankruptcy proceeding. Most creditors just end up with adjusted interest rates.

Chapter 12 - Is rarely, if ever used.

Chapter 13 - Is available to individuals, not corporations or partnerships. The individual filing bankruptcy must have regular income that can be used to make payments. As a result of the reorganization, payments are made to creditors based on a plan and are handled by a trustee.

The moment a Petition for Bankruptcy is filed with the Bankruptcy Clerk, an automatic stay kicks in that stops debt collection activity. The county auditor is generally the individual within a county who is served with a copy of the bankruptcy papers. This is not always the case, however, and it is recommended that the county establish a county-wide policy that directs employees to route all incoming bankruptcy-related papers to a single office. If you receive a Notice of Creditors' Meeting, the county is not required to attend unless the county wants to appear and ask the debtor questions about what property the individual owns. The only reason the county would do this would be to identify property which the county intends to foreclose on after the bankruptcy is complete.

Once an individual has filed a bankruptcy petition, the county may send the individual a simple statement that informs the individual what is owed, but any efforts to collect the debt, such as past-due notices, calls, or contacts from a collection agency, violate the automatic stay and could get the county in legal trouble with the bankruptcy court. Keep in mind, however, that if the individual wants poor relief, they must provide the county with information about their income, resources, etc. The county is not collecting this information to seek repayment, but to determine eligibility for county payment to the hospital. In addition, when a hospital requests payment from the county, the individual is not a party to the case. Rather, the individual is a witness, once again, providing only that information needed to determine their eligibility for relief - not information about collecting the hospital bill from the individual. If an individual has filed bankruptcy but refuses to provide the information needed to determine eligibility, they are ineligible simply because the county does not have the information needed to determine eligibility.

An individual's retirement account can be exempted from the bankruptcy estate; however, counties can still treat the pension as an asset for non-bankruptcy purposes, such as determining if a person is eligible for poor relief.

The only liens that are discharged under a bankruptcy petition are those that were not "perfected" before the petition was filed. Once the county pays a claim on behalf of an individual, the debt attaches to the property in the form of a lien. The attachment of that lien is "perfected" and enforceable only when it is filed with the Register of Deeds. A lien that is perfected before a bankruptcy petition is filed survives bankruptcy. The county should object to any attempt to discharge a lien that was perfected before the bankruptcy. If the county resists the discharge, the lien will remain in place, failure to object will likely result in discharge of the lien.

A county lien attaches to all the individual's real and personal property for the amount of assistance provided. This includes property held in joint tenancy and homestead interests. SDCL 28-14-6 specifies that the lien applies to all property of the individual’s spouse too, even if the spouse is the sole owner, as long as both names appear on the lien statement.

The county aid lien attaches to property - not to the person who received the county-paid services. Thus, the county can decide to foreclose on a lien against property now owned by somebody else. If the new owner of the property purchased title insurance, it will be up to the title insurer or the abstractor to clear up the county aid lien. Even if the county does not foreclose, the lien should show up at a future property transfer (or mortgage), and the county should still eventually get its lien satisfied.

The recent changes made to the bankruptcy law should not affect counties. The changes were intended to make it tougher for an individual/business to go into bankruptcy.

1600 THE MIDLAND GROUP (aka DISABILITY PROFESSIONALS)

The Midland Group is an organization that has contracts with several South Dakota hospitals and other medical providers to pursue third-party payment sources on behalf of individuals needing help paying for medical services. This organization has benefit specialists that are very knowledgeable about programs that may be available to assist the individual in paying medical bills. These benefit specialists are also very knowledgeable in the eligibility criteria that an individual must meet in order to qualify for the various programs. Midland specializes in applications for both Supplemental Security Income (SSI) and Social Security Disability (Title II). Midland will assist the patient in applying for benefits through these programs and through the appeals process, if they feel an appeal is warranted. This organization is very successful in locating third-party payers. A county can pretty much assume that if Midland is approaching the county for payment of a claim, that it has already exhausted all other types of payment sources.

Midland has its main offices in Lawrence, KS and local offices located in Sioux Falls and Rapid City. Questions concerning patients in one of these health-care facilities may be directed to the Rapid City office (605) 355‑6900 or the Sioux Falls office (605) 339-3310. Midland deals only with cases that are potentially eligible for programs such as Medicaid, VA, Supplemental Security Income, Social Security Disability or IHS.

1700 HEALTH INSURANCE – GENERAL

Health insurance programs allow workers and their families to take care of essential medical needs. These programs can be one of the most important benefits provided by the employer. There was a time when group health coverage was available only to full time workers and their families. That changed in 1986 with the passage of the health benefits provisions in the Consolidated Omnibus Budget Reconciliation Act (COBRA). Now, terminated employees or those who lose coverage because of reduced work hours may be able to buy group coverage for themselves and their families for limited periods of time.

If an individual is entitled to COBRA benefits, the individual’s health plan must provide the individual with a notice explaining the right to choose to continue benefits provided by the plan. The individual has 60 days to accept coverage or lose all rights to benefits. Once COBRA coverage is chosen, the individual or a third party payer is required to pay for the coverage. Along with COBRA, the individual may also want to look at the Affordable Care Act Marketplace.

1710 HEALTH INSURANCE – COBRA

In 1986, Congress passed landmark health benefit provisions in the Consolidated Omnibus Budget Reconciliation Act (COBRA). This law amended the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and the Public Health Service Act to provide continuation of group health coverage that would otherwise be terminated.

COBRA contains provisions giving certain former employees, retirees, spouses, and dependent children the right to continue health coverage temporarily, at group rates. This coverage, however, is only available in specific instances. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, usually because the employer was paying a part of the premium. It is ordinarily less expensive than individual health coverage.

The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. It applies to plans in the private sector and those sponsored by state and local governments. The law does not, however, apply to plans sponsored by the federal government and certain church-related organizations.

Group health plans sponsored by private sector employers generally are welfare benefit plans governed by ERISA and subject to its requirements for reporting and disclosure, fiduciary standards, and enforcement. ERISA neither establishes minimum standards or benefit eligibility for plans nor mandates the type or level of benefits offered to plan participants. It does require that these plans have rules outlining how workers become entitled to benefits.

Under COBRA, a group health plan ordinarily is defined as a plan that provides medical benefits for the employer’s own employees and their dependents through insurance or otherwise (such as a trust, health maintenance organization, self-funded pay-as-you-go basis, reimbursement, or combination of these). Medical benefits provided under the terms of the plan and available to COBRA beneficiaries may include inpatient and outpatient hospital care, physician care, surgery and other major medical benefits, prescription drugs, and any other medical benefits, such as dental and vision care. COBRA does not cover life insurance.

1720 HEALTH INSURANCE – AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA, and generally referred to as Obamacare – is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will “continue to be rolled out over the next four years.” Key provisions are intended to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage due to [pre-existing conditions](http://www.healthinsurance.org/glossary/pre-existing-condition/)

There is enrollment assistance throughout the State from various agencies/entities that employ either “Navigators” or “Certified Application Counselors, (CAC’s)”. These individuals are knowledgeable about the ACA, it’s requirements, rules, etc. and can assist with computer tasks that need to be accomplished. At any time a County medical worker encounters a persons who is not enrolled in the Marketplace, but needs that connection it is beneficial for the County to make a referral to a Navigator or CAC.

For the best detailed information on the ACA and for help to enroll persons in the Marketplace go to <https://www.healthcare.gov/>.

1730 HEALTH INSURANCE – PAYMENT OF PREMIUM BY COUNTY

In some cases, it may be very beneficial for the county to pay an individual’s health insurance premium. For example, an individual who has become disabled and is in a position of exercising his/her option to continue health insurance coverage under COBRA provisions but is not able to afford the premium. Depending on the case, it may be to the county’s benefit to continue paying the health insurance premium on behalf of the individual/family.

In cases where the county has determined it would be beneficial to assist an individual with payment of the health insurance premium, it is recommended that the county take the following steps:

1. Contact the employee's Human Resource Department or the individual responsible for the agency's employee insurance plan;

2. Request written verification of the monthly insurance premium;

3. Due to the county vouchering system and the sensitivity of the premium due date, inquire about making quarterly payments rather than monthly payments;

4. Request verification of the effective date of COBRA coverage. This is very important information. It is likely there will be a time when the individual will come to your office on the 59th day and the COBRA application must be completed by day 60. In cases where there is limited time to submit the application, the county needs to act immediately. Determine if the COBRA application can be hand-delivered, faxed, or mailed via over-night delivery in order to meet the application deadline. Clarify where the COBRA application should be sent and remember mail services will not deliver overnight mail to a post office box;

5. Request the full address (street address and post office box) where the premium needs to be mailed. Do not assume the premium is sent to the employer or where the COBRA application was sent. Receipt of the premium by the due date is critical. If payment of the premium is not received within the due date, the individual will lose coverage. Again, overnight delivery is recommended when necessary; however, remember you cannot overnight to a post office box. If the county does not currently have a policy to address situations when immediate payment is necessary, recommend that the county begin discussing establishing such a policy. Paying a premium late could be financially catastrophic to the county. State statutes require the county to determine if there was affordability to have purchased COBRA. If the individual completes a county application on day 59 and there is eligibility, it is in the county's best interest to do what it can to meet the COBRA application or premium deadline. This action may mean the difference between paying an insurance premium and paying for catastrophic medical expenses;

1. Hand deliver the insurance premium to the employer or the employer's agent and obtain written verification that the premium was paid. If hand delivery is not possible, mail the premium by certified mail. This will be the only proof that payment was made before the deadline. Certified mail can be sent to a post office box. It is important to note that any information regarding the individual's COBRA plan is mailed to the individual and not to the county. This can include premium increases, reimbursements, policy changes, address changes, etc. Not having this information can be detrimental to the individual's coverage and could affect the county's liability. It is crucial that the county establishes a relationship with the individual and require that the individual make all communications relating to the individual's COBRA coverage immediately available to the county. The county should make it clear that if it is unaware of any policy changes, such as increased premiums, the individual's coverage will be terminated. If the individual does not have the physical `or mental capacity to understand the significant of this information, the county needs to be prepared to develop a plan to ensure it stays in the loop; and

1740 MEDICARE BENEFITS

Medicare is a federal health insurance program administered by the federal Center for Medicare and Medicaid Services (CMS). If an individual is eligible for both Medicare and Medicaid, the individual is termed a "dual-eligible" individual. Generally, people who are age 65 or over, people under age 65 who have been entitled to disability benefits under the Social Security or Railroad Retirement program for 24 months, and people eligible for the Social Security Administration End Stage Renal Disease program are eligible for Medicare.

1741 MEDICARE PART A (HOSPITAL INSURANCE)

Medicare Part A covers medically necessary inpatient hospital services and care in a skilled nursing facility after hospitalization (not long-term care), home health care, and hospice care.

1742 MEDICARE PART B (SUPPLEMENTARY MEDICAL INSURANCE)

Medicare Part B covers medically necessary physician services received as an inpatient or outpatient, outpatient medical services including emergency hospital care, outpatient therapy services, ambulance transportation, laboratory, X-rays, equipment, medical supplies, and some home health care. Medicare Part B also covers limited prescription drugs, including injectable drugs, hemophilia clotting factors, Erythropoietin or Epoetin Alfa needed to treat anemia in end-stage renal disease, osteoporosis drugs, some antigens, and certain oral cancer or oral anti-nausea prescription drugs.

1743 MEDICARE PART C (MEDICARE ADVANTAGE PLANS)

Medicare Part C is a way to get Medicare coverage through a private health plan. Medicare Advantage Plans may have benefits that are not covered by the traditional Medicare Plan. These health plans may be offered by a Health Maintenance Organization (HMO), Point-of-Service (POS) plan, or local Preferred Provider Organization (PPO). Medicare Advantage Plans do not exist in all areas of the country. A person must have Medicare Part A and Part B to join a Medicare Advantage plan. The Medicare Advantage Plan may or may not have a monthly premium, but the Medicare beneficiary must continue to pay their Medicare Part B premium to Medicare. If a person has joined a Medicare Advantage Plan, they will use the health care card issued by the plan instead of the red, white, and blue Medicare card.

1744 MEDICARE PART D (PRESCRIPTION DRUG PLAN)

Medicare Part D is the prescription drug insurance program that was implemented on January 1, 2006. Anyone who is entitled to Medicare Part A or enrolled in Medicare Part B is eligible to enroll for Medicare Part D drug coverage benefit. Effective January 2006, Medicare Part D stopped covering prescription drugs for those Medicare beneficiaries who are also qualified for full coverage under Medicaid.

1745 MEDICARE PREMIUMS

Most people who have Medicare hospital insurance do not pay monthly premiums for Part A because they are insured due to Medicare taxes they paid while working. Individuals who begin receiving Social Security at age 62 will be automatically enrolled for Medicare Part A at age 65. Individuals who begin receiving Social Security at age 65 are automatically enrolled for Medicare Part A at the same time. Individuals who receive Social Security Disability are automatically enrolled in Part A after 24 months. Those eligible for, but not receiving Social Security at age 65 must apply to enroll in Medicare Part A.

Those individuals, who did not pay enough Medicare taxes to be insured for premium Part A, must pay a monthly premium unless they declined enrollment. The Medicare Part A premium is paid for Medicaid recipients eligible for buy-in. If the Medicare premium is not paid for by the state, the Medicare premium may be deducted from a long-term care recipient’s or Home and Community Based Services (HCBS) recipient's income before income is applied to the cost of care.

Individuals receiving Supplemental Security Income benefits based on disability who are ineligible for Social Security Disability are not eligible for Medicare Part A. Once they reach age 65, they may be eligible for Medicare Part A, but must pay a premium due to their uninsured status, unless they are eligible for buy-in. The identification code following the Social Security number will usually indicate whether a person is insured or uninsured for Medicare Part A. If the individual is insured on his/her own record or the spouse's records the most common indicator of insured status is an "A". If the individual is uninsured, the common indicator is an "M". Other indicators include J3, J4, K3, K4, and T.

There is a monthly premium for Medicare Part B. Individuals receiving Social Security or Railroad Retirement benefits are automatically eligible for Medicare Part B at age 65 unless they decline enrollment. Individuals who are not receiving Social Security or Railroad Retirement benefits at age 65 must apply for Medicare Part B. Individuals receiving SSI benefits based on disability who are ineligible for Social Security Disability are not eligible for Medicare Part B until age 65.

The state pays the Medicare Part B premium for Medicaid recipients eligible for buy-in. If the Medicare premium is not paid by the state, the Medicare premium may be deducted from a long-term care or HCBS recipient's income before income is applied to the cost of care.

1. MEDICARE ENROLLMENT

Except for individuals who are entitled to Medicare Part A and are automatically enrolled for Medicare Part A, an application to the Social Security Administration is necessary. Anyone who does not apply for Medicare Part A during their initial enrollment period must wait for an open enrollment period to enroll. There is an open enrollment period from January to March of each year.

Everyone who is eligible to enroll in Medicare Part B must apply and pay a premium. If the applicant is a Medicaid recipient eligible for state buy-in, an application for Medicare Part B can be made anytime during the year. Other individuals are restricted to the open enrollment period in January, February, and March if they refused Medicare Part B at the initial enrollment.

If the individual is not entitled to Medicare Part A, they must be referred to the Social Security Administration to make a conditional enrollment application, contingent upon buy-in. If a Medicaid recipient has Part A, but previously refused Part B, an application for Part B is not necessary if the Medicaid recipient is in the buy-in group.

Individuals of any age who qualify for the End-Stage Renal Disease program need to file an application for Medicare Part A. If entitled to Part A, Part B enrollment is automatic.

Applications for Medicare can be made by calling the Social Security office serving the area.

1. EXTRA HELP (LOW INCOME SUBSIDY)

An individual who is on Medicare and has limited income and resources may qualify for a program called "extra help" or the "low income subsidy program". This is a program available through the Social Security Administration and assists with the payment of an individual's Medicare prescription drug coverage costs, including the drug plan's monthly premium, the yearly deductible, and prescription co-payments. The amount of extra help an individual may receive is based on the individual's income and resources. There are separate income and resource limits for the individual or a couple and these limits are increased annually due to cost of living adjustments. The following individuals automatically qualify to receive extra help:

1. An individual who is on Medicare and is covered under the Department of Social Services' Qualified Medicare Beneficiary (QMB) program or the Special Low Income Medicare Beneficiary (SLMB) program; and
2. An individual who has both Medicare and Medicaid.

Medicare will mail a letter to these individuals informing them they automatically qualify for extra help. An individual who does not automatically qualify for extra help and is already receiving assistance through the Department or, has an application pending with the Department may contact the local Department of Social Services office for assistance. Other individuals should contact the Senior Health Information and Insurance Education (SHINE) Program for assistance with an application. Additional information may be obtained by looking at www.Medicare.gov. If you are attempting to resolve issues relating to an individual who was automatically enrolled and have questions regarding the individual plans available, you can contact the local Department of Social Services office or use the federal website [www.cms.gov](http://www.cms.gov) to obtain additional information.

1748 LIMITED INCOME NEWLY ELIGIBLE TRANSITION (NET) PROGRAM

The program previously known as the WellPoint Point-of-Sale Facilitated Enrollment (POS FE) process has been redesigned by CMS. Effective 1/1/2010, it will become the Limited Income NET Program, administered by Humana.

Background: The Limited Income NET Program (or LI NET) is designed to eliminate any gaps in coverage for low-income individuals transitioning to Medicare Part-D drug coverage.

Immediate need prescription drug coverage: The LI NET Program will ensure that individuals with Medicare’s low-income subsidy (LIS), or “extra help,” who are not yet enrolled in a Part-D prescription drug plan are still able to obtain immediate prescription drug coverage. This includes:

1. Beneficiaries with Medicare and Medicaid, also known as “dual eligibles;” and
2. Those with Medicare who also receive Medicare’s low-income subsidy.

For additional information on CMS’ website, go to:

[http://www.cms.hhs.gov/LowIncSubMedicarePresCov/03\_MedicareLINET.asp#TopOfPage](http://www.cms.hhs.gov/LowIncSubMedicarePresCov/03_MedicareLINET.asp" \l "TopOfPage)

If you are working with a pharmacy, you may have them contact:

LINET Program: 1-800-783-1307

Menu Options:

Pharmacy Provider: Press 1, then for:

Claim Rejections: Press 1

Part B vs. Part-D Drug: Press 2

Eligibility Verification: Press 3

Repeat Options: Press 4

1800 COLLECTION OF PREVIOUSLY PAID MEDICAL EXPENSES – INDIVIDUAL DETERMINED ELIGIBLE FOR SSI OR MEDICAID

It is not unusual for an individual to be determined retroactively eligible for Supplemental Security Income or Medicaid after the county has already paid medical claims on behalf of an individual. If this happens, the county must notify the medical providers immediately that the individual has been determined eligible. The county should supply a copy of the notice of eligibility and the individual’s recipient identification number to the provider and ask the provider to submit a claim to South Dakota Medicaid for reimbursement. Claims for retroactive eligibility must be submitted as hard copy with either a copy of the notice of eligibility attached or a note explaining that the claim is for an individual who has been determined to be retroactively eligible. NOTE: claims for retroactive eligibility must be submitted within six months of the determination of retroactive eligibility. Claims submitted beyond that time frame will be denied.

After Medicaid has paid the provider, the provider must reimburse the county for the claims previously paid by the county. Medicaid constitutes payment in full and a provider may not balance bill back to the county. In other words, if the county paid a claim and Medicaid subsequently pays the provider a lower rate, the provider must refund to the county the amount paid by the county and is prohibited from keeping any portion of the county payment to make up the difference between the billed charge and the Medicaid rate of payment.

Sometimes, providers are reluctant to complete the necessary paperwork and submit the claim to Medicaid because the claim has already been paid and the provider stands to gain nothing by submitting the claim. Because of this, the county may want to add a statement to its notice of approval under which, as a condition of accepting payment from the county, the provider agrees to submit claims to Medicaid if the individual is subsequently determined to be eligible for SSI or Medicaid.

NOTE: When working with possible retroactive Medicaid claims, the county may want to utilize the following forms:

1. Potential Retroactive Medicaid Claim – Appendix DD
2. Retroactive Medicaid Approved – Appendix EE
3. Checklist for Retroactive Medicaid – Appendix CC
4. Authorization for Payment – Appendix Y

1900 HIPAA OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that allows people to keep their health insurance when they change jobs (portability) and strengthens enforcement of federal laws against health care fraud (accountability). One piece of the law established standards to ensure the confidentiality of individually identifiable health information. These national standards are designed to protect an individual's Protected Health Information (PHI) and give individuals increased access to their medical records.

"Individually identifiable health information," is health information (including demographic information) that identifies or can be used to identify the individual. It includes any information, oral or recorded, relating to the health of the individual, the health care provided to an individual, or payment for health care provided to an individual.

"Individually identifiable health information”, "protected health information" or "PHI" Covered entities were required to implement policies and procedures to protect and guard against the misuse of individually identifiable health information by April 14, 2003. The federal rules:

1. Give patients more control over their health information;
2. Set boundaries on the use and release of health records;
3. Establish appropriate safeguards that health care providers and others must achieve to protect the privacy of health information;
4. Hold violators accountable with civil and criminal penalties that can be imposed if there is a violation of a patient's privacy rights;
5. Strike a balance when public responsibility supports disclosure of some forms of data; for example, to protect public health;
6. Enable patients to find out how their information may be used and about certain disclosures of their information that have been made;
7. Limit the release of information to the minimum reasonably needed for the purpose of the disclosure;
8. Give patients the right to examine and obtain a copy of their own health records and request corrections; and
9. Empower individuals to control certain uses and disclosures of the individual's health information.

The privacy rules establish a floor of safeguards to protect the confidentiality of medical information. State laws that provide stronger privacy protection will continue to apply over and above the new federal privacy standards.

HIPAA applies to and considers the following to be "covered entities":

1. A Health Plan - any individual or group plan, private or governmental, that provides or pays for medical care;
2. A Health Care Clearinghouse - a public or private entity, including a billing service, re-pricing company, community health management information system or community health information system that processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity; and
3. A Health Care Provider - any person or organization who furnishes, bills, or is paid for health care in the normal course of business and transmits any health information in electronic form relating to the provision of a health care service.

A county is considered a health plan and, therefore, a covered entity if it meets one of the following requirements:

1. It has a self-insured health plan;

2. It provides or pays for the medical care of inmates; or

3. It provides or pays for the medical care needed by the county indigent population.

Covered entities must comply with HIPAA requirements.

HIPAA allows covered entities to use or disclose PHI, without an authorization, for purposes of:

1. Treatment - the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another;
2. Payment - the activities by a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits, and of a health care provider or health plan to obtain or provide payment for the provision of health care. This includes eligibility determinations, billing, claims management, utilization and quality review, etc.; and
3. Operations - include a covered entity's daily activities as they relate to the provision of health care.

If a use or disclosure is not within these purposes, it requires a written authorization from the patient. An "authorization" is a written document that gives permission to obtain and use information from third parties for specified purposes or to disclose information to a third party specified by the individual. Covered entities must have an authorization from the individual before using or disclosing PHI for the purposes other than treatment, payment, or health care operations, such as marketing, fundraising, or the disclosure of psychotherapy notes in order to obtain payment.

Routine uses and disclosures must be limited to the minimum necessary to achieve the purpose of the use or disclosure

HIPAA provides individuals with certain enumerated rights regarding their protected health information, including the following:

1. The right to adequate notice of the uses and disclosures of PHI that may be made by covered entities; and the individual's rights and the covered entities' legal duties with respect to the individual's protected health information;
2. The right to access protected health information. An exception to this is for psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and information maintained by a covered entity that is either subject to or exempt from certain provisions of the Clinical Laboratory Improvements Amendments of 1988;
3. The right to request amendment and/or correction of protected health information;
4. The right to request and receive an accounting of disclosures of protected health information; and
5. The right to request restrictions on the use and/or disclosure of protected health information; and the communication of protected health information.

HIPAA privacy regulations mandate certain administrative requirements that covered entities must implement. Such requirements include the following: Designation of a privacy official. The designation of a Privacy Official is essential to ensure a central point of accountability within each covered entity;

1. Establishment of a complaint mechanism. The covered entity must provide a process for individuals to make complaints about alleged failures to comply with HIPAA requirements or their policies and procedures;
2. Implementation of workforce training. A covered entity must train all members of its workforce with respect to HIPAA privacy requirements, as necessary and appropriate for the members of the workforce to carry out their function within the covered entity. Workforce includes employees, volunteers, trainees, and other individuals whose conduct, in the performance of work for a covered entity is under the direct control of the covered entity. Existing workforce members must be trained prior to the implementation date of the privacy regulations. Thereafter, new workforce members will need to be trained within a reasonable time from their start date;
3. Enforcement of sanctions. Covered entities must have appropriate sanctions against members of its workforce who fail to comply with the privacy regulations' requirements or the covered entities' privacy policies and procedures;
4. Mitigation of harmful effects of inappropriate disclosures. Covered entities have a duty to mitigate, to the extent practicable, any harmful effect that is known to the covered entity from a use or disclosure of protected health information in violation of their policies and procedures or of the HIPAA requirements by a covered entity or a business associate;
5. Implementation of appropriate safeguards. A covered entity must implement appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. Such safeguards must be designed to protect PHI from accidental or intentional use or disclosure that is a HIPAA violation and to protect against inadvertent disclosure of PHI to persons other than the intended recipient;
6. Refrainment from retaliation. A covered entity may not intimidate, threaten, coerce, discriminate against, or take any retaliatory action against individuals for exercising their rights granted by the privacy regulations or for participating in any complaint or other process established by the privacy regulation;
7. No requirement of waivers. A covered entity may not require individuals to waive their rights to file complaints with the department or to waive any of their other privacy rights as a condition for the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits;
8. Implementation of policies and procedures. A covered entity must formulate and adopt written policies and procedures to comply with the HIPAA standards; and
9. Appropriate documentation. A covered entity must maintain their policies and procedures in written or electronic form.

If an agency subject to HIPAA fails to comply with the HIPAA privacy requirements, HIPAA provides for fines of up to $250,000 and criminal penalties of up to ten years in prison, making non-compliance a potentially serious matter.

For additional information on HIPAA, go to: <http://www.hhs.gov/ocr/privacy/index.html>

CHAPTER 2

HOSPITAL CARE

SCOPE OF CHAPTER: This chapter contains guidelines for a county to use when dealing with care provided by a hospital. The requirements contained in Chapter One - General Provisions must also be applied to hospital services.

2000 EMERGENCY HOSPITAL SERVICES

To qualify as an emergency hospital service, the physician, physician's assistant, or nurse practitioner on duty or on call must determine that the individual requires emergency hospital care. The need for emergency hospital care is established if the absence of emergency care is expected to result in death, additional serious jeopardy to the individual's health, serious impairment to the individual’s bodily function, or serious dysfunction of any bodily organ or part. The term does not include care for which treatment is available and routinely provided in a clinic or physician's office. (SDCL 28-13-27[2])

If the admission to the hospital was an event arranged prior to the admission, even though medically necessary, the admission would not constitute an emergency.

The county always has the right to review the need for the emergency services before paying the claim, and a licensed physician must conduct the review. To accomplish the review, the county may request assistance from the Department of Social Services (DSS) at 605-773-6375.

2010 EMERGENCY ROOM SERVICES

Emergency room services are reimbursable by the county if the individual is medically indigent and the services and the individual are otherwise qualified. If the hospital determines the individual does not have the ability to pay for the emergency room services and intends to look to the county for payment, the hospital must send a Notice of Hospitalization on the emergency room admission to the individual's county of residence.

Emergency room charges that result in hospitalization are added to the inpatient bill and are eligible for reimbursement as part of the inpatient bill once the individual is determined medically indigent. Emergency room treatment provided to an individual who is subsequently transferred to another facility for treatment would be reimbursable as long as the receiving facility sends the appropriate notice to the county and the individual is otherwise eligible.

NOTE: An emergency room service is not eligible for reimbursement if the treatment is available and routinely provided in a clinic or physician's office (SDCL 28-13-27[2]). This exception does not apply if it is after hours or on a weekend and the clinic is not open.

2020 EMERGENCY HOSPITAL CARE

Hospital services are divided into ''emergency" and "non-emergency" services. If the hospitalization is an emergency, the hospital is entitled to reimbursement from the county if all of the following conditions are met:

1. The individual is currently a resident of the county, having resided in the county for 60 days, previously resided in the county within the past 60 days (SDCL 28‑14‑2.1), or a transient;
2. The hospitalization was for an emergency service;
3. The services provided were medically necessary;
4. The hospital notified the patient's county of residence within 15 days of the emergency admission;
5. The hospital notice met the legal requirements of SDCL 28-13-34.1;
6. An application has been made with the county either by the patient needing assistance or by the hospital on behalf of the patient. An application made by the patient must be completed within two years of the date of discharge. An application submitted by the hospital on behalf of the patient must be completed within one year of the date of discharge;
7. The patient is otherwise medically indigent and the county has determined that the individual has no ability or only a limited ability to pay the emergency hospital bill; and
8. The hospital has demonstrated to the county that it has exhausted all avenues of payment, including accepting reasonable monthly payments from the patient.

2100 NOTICE OF HOSPITALIZATION

If a hospital intends to bill a county for emergency hospital expenses, the hospital must mail, fax, or e-mail a Notice of Hospitalization (Appendix A) to the county of residence within 15 days of the date of admission. (SDCL 28-13 34.1) For purposes of calculating this 15-day period, do not count the day of admission. The first day counted would be the day after the date of admission, including a Saturday, Sunday, or legal holiday. If the 15th day falls on a Saturday, Sunday, or legal holiday, the period does not expire until the end of the next day which is not a Saturday, Sunday, or legal holiday (SDCL 15-6-6[a]). If the hospital's notice fails to meet the required timeline, date stamp the notice and retain the envelope with the postal date stamp as proof that the timeline was not met. Regardless of whether or not the notice was timely, the county may want to retain the envelope in which the notice was mailed or the coversheet when a notice is faxed in case questions arise while the claim is pending.

If service of the notice is made by facsimile transmission, service must be completed by 5:00 p.m. receiver's time on a weekday, which is not a legal holiday. Service made after 5:00 p.m. is considered to be made on the following weekday, which is not a legal holiday. (SDCL 15-6-6[a]).

Some counties have arranged with their local hospitals to have the notices faxed directly to the county welfare office, this gives the county office an opportunity for the notices to be reviewed on a daily basis. An arrangement such as this benefits both the county and the hospital because the county is in a position to react to the hospitalization quicker.

The Notice of Hospitalization must contain the following information:

1. The name and last known address of the patient or the patient's guardian;
2. The name and address of the responsible party, if known;
3. The name of the attending physician;
4. The nature and degree of severity of the illness;
5. The anticipated diagnostic or therapeutic services required;
6. The location at which the services are to be provided;
7. The estimated reimbursement for the services; and
8. A statement that the hospital has asked the patient or the responsible party if known, whether the patient has served in any branch of the military, is potentially eligible for Indian Health Service benefits, or is a member of a Native American tribe and a statement of the information received in response to the inquiry. (SDCL 28-13-34.1)

When the county receives a Notice of Hospitalization, the county needs to be proactive in dealing with the notice. Services for medical emergencies such as a stroke, motor vehicle accident, or aneurysm, which are commonly very high-cost cases, should be dealt with immediately. Begin by establishing that the notice was filed timely. If the notice was not filed timely, the result is an automatic denial. Next, check to see if the individual is a current resident of the county, a resident of the county within the past 60 days, or a transient. If the notice was timely and the individual meets the residency requirements, the county caseworker may consider sending a letter to the individual's home address indicating that the hospital has served notice on the county that the individual is hospitalized and that the county may be requested to pay the bills incurred. In addition, a phone call may be made to a family member who would be in a position to discuss the individual's condition and explain whether a third-party payment source may be involved. If that appears unlikely, request that the individual complete an application for assistance and execute a new release of information for both financial and medical records so the county can begin determining eligibility. If the individual is transferred to a hospital outside the individual’s county of residence, the county of residence may want to request the receiving county to lend assistance with the application process.

2200 RELEASE OF INFORMATION (SDCL 28-13-34.2)

The hospital must make every reasonable effort to secure from the patient, and to include with the notice, a release of information form that has been signed by the patient or the patient’s authorized representative. Currently, there are two separate releases. The first release is a Release of Medical Information (Appendix B), which authorizes the hospital or other medical provider to release to the county the medical information related to the individual’s medical condition and hospital stay. The second is a Release of Financial Information (Appendix C), which authorizes financial institutions to release to the county information related to the individual's (or household's) financial holdings. (SDCL 2B-13-34.2) A county may choose to use an alternate release, as long as that release is acceptable to the hospital involved. When requesting information from a financial institution, remember that the individual may be a joint owner or a co-owner of an account. For example, the individual may have a joint checking account with somebody who may not even reside in the same household. Or, the individual may be a co-owner of a Certificate of Deposit. For this reason, it is important that the request for information be in writing and specifies that the search include ALL accounts that carry the individual's name.

In many cases, the hospitals are not obtaining these releases. In some instances, even when the hospital does obtain the releases, the hospitals are not accepting the releases they had previously obtained and forwarded to the county. They state that they will only accept a release that has been signed subsequent to the hospitalization. Regardless, if the hospital refuses to provide the county with the medical information needed to determine eligibility and the amount of reimbursement, simply remind the hospital that HIPAA allows a provider to supply the needed documentation for the purpose of payment, and that as a potential payer, the county, is entitled to the information. If the hospital still refuses to supply the needed documentation, the county should inform the hospital it cannot proceed to work on the case until it has the needed information. The county should document in the client's file its attempt to obtain the information and the hospital's subsequent refusal. Depending on the case, the county may want to request that all adult household members sign a release of information form. NOTE: Failure to receive a release of information does not constitute a reason to deny either an application for assistance or a request for payment.

If the individual has failed to make an application with the county but the hospital has made an application on the individual's behalf under the provisions of SDCL 28-13-32.4, the county cannot determine an individual's eligibility without a completed application. If the individual continues to refuse to cooperate, the county should simply inform the hospital that the county is unable to make a determination of eligibility because the individual has failed to complete the required application. The burden of proving that the individual is eligible for county poor relief rests with the hospital and this may well be the point at which the hospital sues the county and then attempts to subpoena the individual for a deposition. It is through this process the hospital can obtain the information from the individual that is necessary to complete the application. The county state’s attorney together with a county representative who is familiar with the file should appear at the deposition to make sure all necessary questions are asked and answered so the county can determine eligibility.

2300 APPLICATION SUBMITTED BY HOSPITAL (SDCL 28-13-32.4)

A hospital may apply for county assistance on the individual's behalf. The Hospital Application for County Assistance (Appendix E) and Request for Payment (Appendix Q) must be submitted by the hospital to the county auditor within one year of the individual’s discharge from the hospital. This application or request for payment does not replace the notice of hospitalization required by SDCL 28-13-34.1. The hospital must have complied with the notice requirements. It is possible for a hospital to submit both the notice of hospitalization and the application for county assistance or request for payment at the same time. If this happens, this might be an indication to the county that the hospital has not attempted to establish a reasonable payment plan with the individual and/or has not investigated other third-party payment sources such as Medicaid, VA, or IHS. If this appears to be the case, the county may want to contact the hospital to inquire as to what attempts the hospital has made to establish a reasonable payment plan or to seek out other third-party payers. The application for assistance must contain the following information:

1. The notice of hospitalization required by SDCL 23-13-34.1;
2. The dates of hospitalization;
3. The final diagnosis;
4. The cost of hospital services;
5. Any financial information in the possession of the hospital concerning the patient or the responsible party, including the availability of insurance coverage.

(SDCL 23-13-32.4)

If a hospital applies on behalf of an individual, the county should notify the individual on whose behalf the hospital application was made. The notice should advise the individual that the hospital is looking to the county for payment. Because the hospital’s application does not contain all the information necessary to determine eligibility, the county must request that the individual complete and return the county's application for assistance.

2400 OTHER PAYMENT SOURCES

While the burden of locating another third-party payment source is on the hospital, the county should always be pro-active when it receives a Notice of Hospitalization. The county may wish to contact The Midland Group to request their assistance in seeking available third-party payment sources. In addition, the county should conduct a thorough investigation, including interviews with the individual and a review of medical documents submitted by the individual's physician, to determine if an application for SSI or SSD would be appropriate. The county may also want to contact the VA or IHS to determine potential eligibility under either of these programs, if applicable. Being pro-active at this point has the potential of saving the county thousands of dollars.

2410 OTHER PAYMENT SOURCES - NATIVE AMERICANS (SDCL 23-13-1.3(5))

If the hospital notice indicates that the individual is a member of a Native American Tribe, it is the hospital’s responsibility to pursue eligibility through IHS. An individual is not medically indigent if the individual is eligible or would have been eligible for assistance through Indian Health Services if the services had been applied for within 72 hours of the individual's admission. A county is encouraged to assist the hospital and work through these particular cases.

To determine if someone may be eligible for Indian Health Services at a facility other than an IHS facility, a contact will need to be made with Contract Care at the Indian Health Services Office in the area within 72 hours of the individual's admission. Although the hospital may have made contact, IHS prefers to have either the individual or a family member contact them. This is a crucial step in the process of contract health and the individual, family member, or other representative should not rely on the hospital to make that call. If it is impossible for the individual to call at that time, someone acting on the individual’s behalf should call. The representative will need to inform IHS that the individual is unable to call at this time due to whatever circumstances exist and that the individual or a family member will call as soon as they are able to do so. The individual making the call must have available the hospitalized individual's complete name, as well as any aliases, and the individual’s social security number and date of birth. If the inquiry is for services provided in a facility other than an IHS facility, provide the name of the facility where the services are being (or were) provided and the dates of those services. Contacts with IHS should be documented in case the claim is later questioned or denied by IHS.

The individual or family always has the right to appeal IHS' decision to deny a claim. However, appeals must be made within 30 days from the date of the denial. If appealing a claim, gather together the hospital bills and the doctor’s report. The individual, a family member, or a representative must send a letter to the IHS requesting an appeal. The letter should contain information that would support the reasons for the appeal, such as explaining the surrounding circumstances, specifying the reasons the claim should be considered, providing proof of residency, providing an explanation of why contact was not made within the 72-hour period, or providing verification of who made the contact, the date of contact, and with whom the contact was made.

If the claim was denied because the individual had not utilized IHS within the past three years, the individual or family will need to include in either narrative form or an actual verification that the individual has resided within the service area. Documentation could include items such as rent receipts, copies of lease agreements; proof of receipt of housing, SNAP, or TANF assistance, or school or work records which indicate the county of residence.

The information should be sent by certified mail to your area IHS center. The county should maintain, in the individual's case file; a copy of the documentation sent and should track the case until a final disposition has been made by IHS.

If the individual is requesting pre-authorization for services, the county should check out all possibilities for other third-party payment sources, including IHS and Medicaid. If the individual indicates that he/she is not eligible for IHS, the county should verify whether the individual really is not eligible or simply has failed to enroll for IHS benefits.

IHS contact person is: Karla Hall (Health Systems Specialist), Aberdeen, SD – (605)-226-7286

2420 OTHER PAYMENT SOURCES - VETERANS (SDCL 28-13-1. 2(5))

If the hospital notice indicates that the individual served in the military, it is the hospital’s responsibility to pursue eligibility through the Veterans' Administration. An individual is not medically indigent if the individual is eligible or would have been eligible for assistance through the Veterans' Administration if the services had been applied for within 72 hours of the individual's admission. The county is encouraged to assist the hospital work through these particular cases.

The county caseworker should always contact the County Veterans' Services Officer when there are questions concerning a veteran and that veteran's eligibility tor VA services.

Please refer to the section in the manual on Veterans for more information.

2430 OTHER PAYMENT SOURCES - SSI

Supplemental Security Income (SSI) is a needs-based program for individuals who are age 65 or older or are blind or disabled and who have very limited income and resources. When an individual is determined eligible for SSI the individual becomes eligible for Medicaid. The Medicaid program will pay medical expenses incurred by the individual as long as the services meet Medicaid's criteria and are covered services.

If the individual appears to meet the above-mentioned criteria, the county should refer the individual to the Social Security Administration to apply for assistance.

2440 OTHER PAYMENT SOURCES - SSD (SSDI)

Social Security Disability (SSD) (SSDI) is a federal program that pays subsistence benefits to the individual. The individual must be disabled, have a sufficient work history, and have paid Social Security taxes.

If the individual appears to meet the above mentioned criteria, the county should refer the individual to the Social Security Administration to apply for assistance.

NOTE: Individuals who qualify for SSD (SSDI) are not eligible for medical benefits for a period of 24 months. Once that 24-month period expires, the individual is eligible for Medicare Parts A, B, and D.

2450 OTHER PAYMENT SOURCES - ADULTS

If a hospitalization involves an adult, the county should consider other third-party payment sources, including Indian Health Services, VA, Supplemental Security Income (SSI), Medicare, and Social Security Disability (SSD). Keep in mind that applications for payment by other sources must be made timely in order to guarantee coverage if the individual is ultimately determined to be eligible under one of those programs.

2460 OTHER PAYMENT SOURCES - CHILDREN

If a hospitalization involves a child under the age of 19, the county should contact the family to determine whether an application has been made for Children’s Health Insurance Program (CHIP) - Medicaid. If there is no application pending, the county caseworker should work with the family to get an application filed as soon as possible. Because of the medical programs available for children, it is very rare that a county is liable for the payment of a child's medical expenses. Keep in mind that an application for Medicaid must be made timely in order to guarantee coverage if the individual is ultimately determined to be eligible.

2470 OTHER PAYMENT SOURCES - STUDENTS IN POST-SECONDARY EDUCATION (SDCL 23-13-27[b])

If the hospitalization involves a student in a post-secondary education program, the county should inquire whether the student pursued the following options:

1. School insurance;
2. Parent’s insurance through age 26;
3. Affordable Care Act Marketplace;
4. Medicaid; or
5. Any other coverage available.

If the student did not qualify for any of the above options, the county should proceed with the application process.

2500 HOSPITAL TO EXHAUST PAYMENT SOURCES (SDCL 28-13-33.2)

If a hospital submits a bill to a county for hospital services provided on behalf of an individual who is medically indigent, the hospital must first demonstrate that it has exhausted all avenues of payment, including accepting reasonable monthly payments from the person who does not have the ability to pay the hospital in one lump sum at the time of discharge.

A "reasonable” payment must take into consideration the individual’s disposable income which can be calculated according to the Ability to Pay Form - Appendix F, and the size of the hospital bill. It would be unreasonable to expect an individual to pay $800 a month when the individual's disposable income is limited to $900 a month and the total amount of the bill is $5,000. The individual could repay this bill with a lower rate of payment over a longer period of time. On the other hand, it would be unreasonable to expect a hospital to accept a $300 a month payment for a $100,000 hospital bill. Again, both the county and the hospital must be ''reasonable” when making this determination.

Even though the burden is on the hospital to exhaust other payment sources, the county should continue to be pro-active and should investigate the claims to determine if there may be other potential third-party payment sources. Applications for these payment sources must be made timely in order to guarantee coverage if the individual is ultimately determined to be eligible.

* 1. NON-EMERGENCY HOSPITAL CARE

If the hospitalization is not an emergency the county is not mandated to cover the medical expense pursuant to SDCL 28-13-33. The hospital is entitled to reimbursement if all of the following requirements are met:

The county approved the non-emergency hospitalization before the services were provided. (SDCL 28-13-33)

1. The Individual is a resident of the county;
2. The services are medically necessary;
3. The individual is otherwise medically indigent and the county has determined that the individual has no ability or only a limited ability to pay the hospital bill; and
4. The individual is not eligible for any other third-party coverage, such as VA, IHS, SSI, SSD, Medicare, or Medicaid.

When considering whether to approve a non-emergency medical expense, the county is encouraged to take into consideration the medical need for the requested treatment and whether or not the treatment is medically necessary for the individual to maintain or obtain employment. If the procedure can wait, the county is in a better position to work with the individual to check out other payment sources such as VA, SSI, or Medicaid. In addition, the county should look at the ramifications to the individual and the county if the treatment is not provided. For example, denial of an angioplasty could result in a heart attack and the inability of the individual to work for a prolonged period of time, if at all. To deny prior approval of the angioplasty may actually result in higher medical expenses due to an emergency hospitalization. The county may end up paying for open-heart surgery.

2610 PRIOR APPROVAL OF NON-EMERGENCY CARE (SDCL 28-13-33)

If the service is not an emergency and the county is involved as a payer state law requires that the affected county must approve the non-emergency hospital service before the service is provided.

Occasionally, an individual who is on Medicaid and is scheduled to lose Medicaid benefits at the end of the month will need medical care. In these cases, the county should work with the medical providers and attempt to reschedule appointments, etc., during the month the individual is Medicaid eligible. Likewise, if an individual is in need of medical care and will become eligible for a program such as Medicare or Medicaid, the county should work with the medical providers to ascertain whether the services can be delayed until the individual becomes eligible for the other program.

2620 PRIOR APPROVAL OF REHAB SERVICES

When an individual is discharged from an acute care hospital bed and admitted to a rehab unit, the admission to the rehab unit is considered a new admission. Rehab services are not considered emergency services and are subject to prior authorization by the county. Failure of the hospital to obtain prior approval from the county can result in a denial of the claim for services. The county should keep in mind, however, that an extended stay in an acute care facility will probably result in higher costs than those paid in rehab units.

2700 HOSPITALIZATION FOR CHILDBIRTH

Traditionally, counties do not cover the costs of hospitalization for childbirth. Even though childbirth constitutes an "emergency", the parent has had nine months to prepare for the birth of the child and the county does not participate in the costs of delivery. In addition, most of these cases qualify under programs offered by the Department of Social Services and the hospital and the county should refer the household to the Department of Social Services for purposes of applying for those particular programs.

2800 OUT – OF - STATE HOSPITALIZATION (SDCL 28-13-38.1)

It is not unusual for individuals living close to the state's borders to obtain medical care across state lines. This is allowable when the services are not available in South Dakota or the individual's county of residence has approved the hospital because it provides a reasonable or cost-effective service. As with in-state hospitals, non-emergency care requires prior approval while emergency care requires a notice from the hospital to the county within 15 days of the date of admission. If a county, because of its location, traditionally works with a specific out-of-state hospital, the county should inquire whether the facility has complied with the provisions of SDCL 28-13-28 (hospital cost statements). If the facility has not filed its cost statement with the South Dakota Department of Social Services, the county should instruct the facility to complete the necessary paperwork so payment may be calculated. An out-of-state facility may be involved because a county resident is in need of an organ transplant. In cases such as these, the county should have a written agreement with the facility as to the payment of the hospital bill. Usually these agreements are "all inclusive" and the final payment is based on a straight percentage reduction off the billed charge or the other state's Medicaid rate. When negotiating a rate of payment with the out-of-state facility, the county should make contact with the South Dakota Department of Social Services Medicaid program to determine the current percentage of billed charges paid to an out-of-state facility. The agreement should be in writing and, if payment is at the other state’s Medicaid rate; specify that the facility is responsible for obtaining the Medicaid pricing. In addition, if the individual is a potential Medicaid or SSI recipient, the county should include a clause that makes it clear the county expects the facility to bill South Dakota Medicaid if the client should become Medicaid eligible. In the event the individual does eventually qualify for Medicaid and Medicaid becomes a payer, the agreement should specify that the county will not supplement the Medicaid payment.

Services not available in South Dakota and provided by an out of state hospital may be considered by a county at South Dakota Medicaid rates with the submission on a UB-04.

CHAPTER 3

APPLICATION PROCESS

3000 COMPLETING THE APPLICATION FOR ASSISTANCE

If an individual has called to schedule an appointment to complete an application for county assistance, the county should provide to the individual, prior to the scheduled appointment, a list of documentation (Appendix H) that the individual will need in order to complete the application. Once the information is complete, the county should assist the individual in completing the Application for Assistance (Appendices J & K). It is very important that the county have information available that relates to the individual's resources, income, and expenses. Every one of these figures can ultimately affect whether the individual has any ability to pay the hospital bill. It is also important that the county maintain documentation on how it made its final determination. If the county denies coverage and is later involved in a contested-case action, the county will have to be able to support its determination of ineligibility. Likewise, if the county finds the individual has an ability to pay a portion of the bill, the county must be able to support its determination. When the individual has finished the application form, the individual and the individual’s spouse, if any, should sign the completed application.

The county needs to determine what type of assistance is being requested. If the request is for help with a hospital bill that has already occurred, check to make sure the admission was an emergency and a notice of hospitalization was received. REMEMBER: If the hospital failed to serve a notice of hospitalization on the county or if the notice failed to meet the statutory timeline and statutory requirements, this is a bona fide reason for immediately denying the hospital's request for reimbursement.

When the hospital applies on the individual's behalf, the hospital has up to one year from the date of discharge to make the application. (SDCL 23-13-32.4) When the individual is applying on his or her own behalf or somebody (other than the hospital) is applying on behalf of the individual, the individual or the person applying on the individual's behalf has up to two years from the date of discharge lo file the application. (SDCL 28-13-32.3)

The need for emergency hospital care is established if the absence of emergency care is expected to result in death, additional serious jeopardy to the individual's health, serious impairment to the individual's bodily functions, or serious dysfunction of any bodily organ or part. Emergency hospital care does not include care for which treatment is available and routinely provided in a clinic or physician's office (SDCL 28-13-27[2]). If the hospitalization was a scheduled procedure that has already taken place, the county could choose to deny coverage since state statutes (SDCL 28-13-33) specify that non-emergency medical care must be approved by the county before the services are provided.

When all of the information needed to complete the application is collected and the application is complete, the county should complete the Ability to Pay Form (Appendix F) using the information supplied by the individual on the application form. Complete the Ability to Pay Form to determine whether the individual has any ability to pay the bill and, ultimately, the county’s level of participation, if any.

It is important, when reviewing the application, to pay particular attention to indications that the individual had property, but transferred, sold, or gave the property away within the 60 months immediately prior to the onset of the individual’s illness. In such cases, the county should pursue this to find out what the circumstances were surrounding the transfer, sale, or gift. For example, if within the prior 36 months the individual sold some land, the county should request information as to the reason for the sale, who purchased the land, the selling price, the value of the property, and the purchase price. If there was a substantial sum gained from the sale, another legitimate question might be what happened to the money received as a result of the sale.

If a resource was transferred within 60 months and the transfer was completed for purposes of becoming eligible, the county shall consider the value of the resources transferred and deduct the value of the resource from the county's share as calculated according to the Ability to Pay Form.

3010 MEETING ADA REQUIREMENTS

Subtitle A of Title II of the Americans with Disabilities Act, Pub. L. 101-336, prohibits discrimination on the basis of disability by public entities. Subtitle A protects qualified individuals with disabilities from discrimination on the basis of disability in the services, programs, or activities of all state and local governments. It extends the prohibition of discrimination to all activities of state and local governments, including those that do not receive federal financial assistance.

Depending on the disability, the county could consider using tools such as Braille, large print documents, sign language, or interpreter services to help establish a line of communication between the county and the client.

3100 SIGNED RELEASES

As part of the application process, the county is encouraged to have the individual sign a Release of Medical Information (Appendix B) and a Release of Financial Information (Appendix C). This will ensure that if the hospital failed or was unable to obtain these releases, the county will now have these signed documents in the case file. Requests for either financial or medical information must be done in writing and a copy of the applicable release form must accompany the request for information. NOTE: In lieu of the forms located in the appendices, the county may use another form that provides for the release of the needed information as long as that form is accepted by the hospital involved. (Appendix D)

Even though the hospitals are required by law to make every reasonable effort to obtain the patient's signature on these releases, in many cases, the hospitals are not obtaining these releases. In some instances, even when the hospital does obtain the releases, the hospitals are not accepting the releases they had previously obtained and forwarded to the county. They state that they will only accept a release that has been signed subsequent to the hospitalization. Regardless, if the hospital refuses to provide the county with the medical information needed to determine eligibility and the amount of reimbursement, the county should simply remind the hospital that HIPAA allows a provider to supply the needed documentation for purposes of payment and, that as a potential payer, the county is entitled to the information. If the hospital still refuses to supply the needed documentation, the county should inform the hospital it cannot proceed with the work on the case until it has the needed information. The county should document in the client's file its attempt to obtain the information and the hospital’s subsequent refusal. In addition, the county may want to request that the individual sign a General Release of Information (Appendix D). This will allow the county to obtain from and share with other agencies other types of information needed to determine eligibility.

In relation to financial issues, the county is encouraged to verify the financial information provided to the county by the individual. In addition, the county may make an inquiry at area financial institutions to seek financial information concerning the individual/household requesting assistance. A request for information should always be in writing with a copy of the appropriate release of information attached. A sample of a Request for Financial Information may be found in Appendix H.

NOTE: There may be instances in which the individual is a joint owner or a co-owner of an account. For example, the individual may have a joint checking account with somebody who may not even reside in the same household, or the individual may be a co-owner of a Certificate of Deposit. When seeking information from financial institutions, it is important that the request be made in writing and that it specifies that the search include all accounts that carry the individual's name.

1. APPLICATIONS FROM STUDENTS IN POST-SECONDARY EDUCATION

If the individual applying for assistance is a student in a post-secondary education program, the individual is considered to be indigent by design if the student failed to pursue the following options:

* 1. School insurance;
  2. Parent’s insurance through age 26;
  3. Affordable Care Act Marketplace;
  4. Medicaid; or
  5. Any other coverage available.

If the student applying for assistance falls within this category, the county should deny the application and notify both the hospital and the individual of the reason for the denial.

NOTE: Full time attendance at a post-secondary education institution does not make the student a resident of the city or the county in which the institution is located. If the student is claiming to be a resident of the county in which the institution is located, the student must have achieved resident status in that county.

3300 APPLICATIONS FROM UNMARRIED COUPLES

If the individual requesting assistance is living with another person who is not the individual's spouse, the county will need to determine the individual's total household income (Ability to Pay Form, Lines 14 through 25) and then determine the percentage of income the individual requesting assistance is contributing to the household. Remember: For purposes of determining payment of a hospital debt, a "household" includes only the patient, the patient's spouse, minor children of the patient living with the patient, and anyone else living with the patient to whom the patient has the legal right to look for support. For purposes of this section, the “other individual" who is not the patient’s spouse is not included as a household member; however, contributions made by the “other individual" to the household will be considered when determining the applicant's ability to pay.

3400 VERIFICATIONS

After completing the interview with the individual, completing the application for assistance, and obtaining a signed release of information, the county is now in a position to verify the information that has been reported. Information subject to verification may include items such as employment history, income, resources, health insurance information, and the medical necessity of the requested service. Verification is necessary if the individual has supplied either no or inadequate documentation as to the individual's circumstances. The information needed to complete the case will vary from case to case. A well-documented case is essential for both making a determination and supporting that determination if the case ends up in litigation. One of the ways to start gathering needed documentation is to request the information using a written request.

3410 FINANCIAL VERIFICATION

Use the Financial Verification form (Appendix H) to verify financial information reported by the individual or to search for additional resources that may not have been reported. When requesting financial information, the county must include a copy of the Release of Financial Information form (Appendix C) signed by the individual.

3420 EMPLOYMENT VERIFICATION

Use the Employment Verification form (Appendix S) to verify wages and employment status. When requesting employment verification, the county must include a copy of the Release of Information form (Appendix D) signed by the individual.

3430 EMPLOYER INSURANCE VERIFICATION

Use the Insurance Verification form (Appendix S) to request information from past or present employers concerning the availability of insurance through the employer. Requesting information from past employers will help to determine whether the individual had the option of purchasing COBRA coverage.

If the county determines that insurance was available, the county will then need to determine whether the insurance was affordable for the household.

When requesting information concerning the individuals insurance, the county must include a copy of the Release of Information form (Appendix D) signed by the individual.

3435 AFFORDABLE CARE ACT MARKETPLACE VERIFICATION

When checking to see if health insurance benefits are or would have been available through the Marketplace the standard used should be those of a Silver Plan. To see if a person might qualify for a subsidy (tax credit) for their insurance an estimate can be obtained either through <https://www.healthcare.gov/>, or <http://kff.org/interactive/subsidy-calculator/>.

3440 VERIFICATION OF MEDICAL NECESSITY

Use the Verification of Medical Necessity form (Appendix T) when determining whether the requested service is medically necessary. This form requests written documentation from the physician verifying the medical necessity. When requesting information concerning the medical necessity of a planned procedure, the county must include a copy of the Release of Information form (Appendix D) signed by the individual.

In those instances in which the county questions whether the service was medically necessary, the county may request the Department of Social Services to review the claim to verify that the services were medically necessary. It is recommended that the county request a review only for those cases that appear to be rather unusual or questionable. A request for a review should not be used as a routine procedure to determine eligibility.

3500 NOTIFICATION OF ELIGIBILITY DETERMINATION

If the county determines that the individual has either no ability or limited ability to pay the bill, the county should provide written notification to both the hospital and the individual informing them of the results calculated on the Ability to Pay Form. A sample of the Notice of County/Patient Share may be found in Appendix AA.

If the county determines that the individual is not eligible for coverage under the county poor program, the county should provide written notification to both the hospital and the individual informing them that the individual is not eligible for services and the reason the individual was determined to be ineligible. In addition, the county should refer the individual back to the hospital to apply for any funds, community benefit grants, charity care, or to other third-party liability sources to apply for assistance. A sample of the Notice of Ineligibility may be found in Appendix N.

3600 APPEALS

Notices that are adverse to the individual should contain information concerning the individual's right to appeal the county's decision; the right to appear in person at the time of the hearing; to be assisted at the hearing by a friend, relative, or lawyer at the individual's own cost; to call witnesses; and to present information concerning the application for assistance. The notice must also contain the procedures necessary for making such appeal. Suggested procedures include the following steps:

1. The individual must notify the county welfare director or county auditor (if the county does not have a welfare director), in writing, within ten (10) business days following the notice of adverse action. If the county desires, it can allow a greater number of days within which an individual may provide notice of appeal. It is recommended that it be at least ten but not more than 30 business days following the notice of adverse action;
2. Within five (5) calendar days following the request for an appeal, the county auditor or county welfare director shall set a time and place for the appeal hearing, usually no later than the next regularly scheduled board meeting;
3. The board must consider the appeal, taking into consideration the information used to make the initial determination of ineligibility as well as any additional information that is presented at the time of the appeal; The auditor must keep a record of the hearing; and
4. Within five (5) calendar days following the hearing, the board should enter its decision based on the facts presented at the hearing and shall notify the individual of the decision in writing. If the hearing does not provide the relief desired or requested by the individual the notice must contain information indicating that the individual may seek relief as provided in SDCL 28-13-40.

Appeal hearings are not open to the public and may be attended only by the individual making the appeal, persons the individual has asked to represent him or her, the county official(s) who participated in the action complained of, and the witnesses for the individual and the county (See SDCL 28-13-41 and 28-13-42 on issues relating to the confidentiality of information relating to poor relief recipients).

3700 APPEALS HEARD BY BOARD OF COMMISSIONERS

When a medical claim or an appeal is presented to the Board, the process which limits the potential for any legal ramifications of disclosing protected health information is to conduct those proceeding in executive session. At the very least, the claimant’s name should never be disclosed and remain anonymous. This could be done by creating a claims numbering system. As a word of caution, especially in a smaller community, the medical information and circumstance could easily be linked to the claimant, even under a numbering system, ultimately disclosing protected health information.

When considering your county’s preferred process, it is recommended to discuss this with your states attorney to ensure all statute and federal guidelines are followed.

For your information refer to:

1. Statute SDCL 28-13-42;
2. Case law under SDCL 28-13-27: Notes of Decision, Case Number 4;
3. HIPPA laws as it refers to disclosure of protected health information; and
4. Senate Bill 104.

Senate Bill 104 refers to full disclosure of printed material relating to an agenda item. Excluded from Senate Bill 104 are materials to be heard in closed or executive meetings. If materials are prepared for any governing board of an agenda item, the material must be made available to the public at least 24 hours in advance either through a website or printed material. Again, executive session would be the least potential for a violation of protected heath information.

CHAPTER 4

WORKING THE ABILITY TO PAY FORM

The following is a step-by-step explanation for completing the Ability to Pay Form (Appendix F) once the individual has completed the application for county assistance.

4000 PART I - PROCESS OF ESTABLISHING INCOME GUIDELINE

(SDCL 28-13-32.5; 28-13-32.6)

This part can be ignored. It no longer has a function in determining eligibility or the ability to pay.

PROCESS OF ESTABLISHING ELIGIBILITY

4100 PART II (Step I) - DETERMINING ASSETS/RESOURCES (SDCL 28-13-32.8)

For the purpose of determining a household's resources, the county shall consider all resources available to the household. For purposes of determining eligibility, household includes the patient, minor children of the patient living with the patient, and anyone else living with the patient to whom the patient has the legal right to look for support.

When two individuals live together, are not married to each other, and neither has a legal obligation to provide support to the other, consider only the applicant’s household's interest in the property.

Remember that an individual who has transferred resources for purposes of establishing eligibility for medical assistance is considered "indigent by design". (SDCL 28-13-27[6] [d])

Line #3: Enter the equity value of the household's primary residence minus $60,000. In addition, add the equity value of other real property. The equity value is the current fair market value of the property less encumbrances of record as of the date of valuation. The $60,000 deduction represents the homestead exemption provided under SDCL 43-45-3(2).

Line #4: Enter the equity value of recreational and leisure equipment owned by members of the household. Leisure and recreational equipment includes but is not limited to water craft, campers, recreational vehicles, all-terrain vehicles, and snowmobiles. A leisure and recreational vehicle that is not used for the purpose of self-sufficiency and self-support.

Line #5: Enter the equity value of motor vehicles owned by the household that exceed $5,000. Equity value is defined as the current fair market value less encumbrances of record as of the date of valuation. To determine a vehicle’s fair market value, a county could use the NADA (National Automobile Dealers Association) guidebook or a local car dealership. There are also sources available through the internet, such as [www.nada.com](http://www.nada.com) that can be used to place a value on a vehicle once the vehicle's value is established, deduct the encumbrances of record. The result is the equity value. Any equity value that exceeds $5,000 must be included on line #5.

Line #6: Enter the total amount of cash the household has that exceeds one-half the household's gross monthly income.

Line #7: Enter the total amount of assets owned by the household. Assets include savings, CDs, stocks, securities, accounts, and notes due to a member of the household, the cash value of life insurance policies, collectible judicial judgments in favor of a household member, cash value of life insurance, judgments receivable, monetary gifts, and capital gains. If the individual owns the account, consider the funds available. An individual who has joint ownership of a bank account and is legally able to withdraw funds from that account is considered to have unrestricted access to the funds. If the individual is only an "authorized signer” on an account owned by someone else, consider that the individual's access to the account is restricted and the funds are not available and therefore cannot be considered by the county. If it is clearly established that all funds in an account are legally accessible to the individual only after the owner has died, consider that the individual’s access to the account is restricted and the funds may not be considered a resource until the individual actually receives them.

Line #8: Enter the equity value of business property, including real estate, equipment, and inventory. Equity value is defined as the current fair market value less encumbrances of record as of the date of valuation. Once you have established the property's fair market value, deduct the encumbrances of record. The result is the equity value. Remember: depreciation is not an allowable deduction.

Line #9: Enter the equity value of household goods and personal property beyond that which can reasonably be considered essential for everyday living and self-support. If a question arises as to whether or not the property should be considered “essential,” the county should ask the individual to identify the item and describe its use. It is up to the county to decide whether it will include or exclude the property.

Line #10: Enter one-time gains including lump sum settlements, inheritances, winnings, etc.

Line #11: Total lines 3 through 10. The total equals the amount of the household's net assets and resources.

Line #12: Subtract $5,000 from the household’s net assets and resources (Line #11). This deduction is allowed so as not to impoverish the household. The result equals the household's adjusted resources.

Line #13: The result appearing on this line equals the household's adjusted resources.

4200 PART II (Step II) - DETERMINING MONTHLY INCOME (SDCL 28-13-32.7)

When determining a household's income, the county must consider all sources of income, including seasonal layoff income, seasonal overtime income, temporary unemployment due to hospitalization, and temporary loss or gain of income due to special circumstances. For individuals who are employed seasonally or self-employed, the county will need to determine the monthly amount of income. To do this, consider the year-to-date income and prorate it or take the household’s income tax and prorate it.

When two individuals live together, are not married to each other, and neither has a legal obligation to provide support to the other, consider only the applicant’s household income.

Depreciation is not an allowable deduction from income. If the household's tax return indicates that depreciation was allowed, the county must add back in the amount of the depreciation claimed on the tax form.

If the household receives income because of child support payments, the county should make sure it has a good estimate of the amount of child support received. If the child support is not received on a regular basis, the county may be overestimating the amount of the household's income.

Line #14: Enter the total income received by the household for salary, wages, commissions, bonuses, etc. A federal income tax return is the preferred source for determining earnings. If a tax return is not representative of current earnings, the county could ask for pay stubs that include gross and net earnings or the county could obtain the information from the employer(s).

Line #15: Enter the total income received by the household in the form of self-employment income. When determining the income received, allow for business losses. Business losses can be verified by reviewing current and prior income tax forms.

Line #16: Enter the amount received through pension plans, social security payments, VA disability benefits, Supplemental Security Income (SSI), railroad retirement, or black lung benefits. While these benefits are legally exempt from execution, levy, attachment, or garnishment, this income is considered available to the household to meet the household's needs and nothing prohibits the household from using these benefits to pay their medical expenses.

Line #17: Enter amounts received through an annuity or through a trust instrument. Trusts create special problems and must be assessed to determine whether the income from the trust is an available resource. When the terms of a trust allow modification or changes to the document it is considered a revocable trust and the entire trust principal is considered an available resource. Income generated by the principal is considered when paid to the beneficiary or paid on behalf of the beneficiary. Other payments from the trust, not to the beneficiary or on the beneficiary's behalf, are considered assets or resources transferred without compensation.

A trust is irrevocable when, by its terms, the document may not be modified or changed under any circumstances. Any portion of the principal or accrued income that could be paid to the beneficiary is considered a resource. Any payment from the trust, except for that portion considered a resource, to the beneficiary or on behalf of the beneficiary is considered income. Other payments from the trust, not to the beneficiary or on behalf of the beneficiary, are considered a transfer without compensation.

Line #18: Enter the amount received by the household in the form of interest payments, dividends, rents, royalties, and investment gains. The amount to be considered as income from rental property will be the "net” income available after a deduction has been made for allowable expenses. Allowable expenses include items such as interest payments on the mortgage, insurance premiums, property taxes, repairs (not capital expenditures), advertising costs, lawn care, snow removal, water, utilities (if not paid by tenant), trash removal (if not paid by tenant), and real estate management costs. Non-allowable costs include depreciation, payments on the mortgage principal, personal expenses not related to the rental income, and capital expenditures (replacing a roof, constructing a new driveway, rewiring a house, installing a new plumbing system, replacing a stove).

Line #19: Enter the amount received as a result of unemployment compensation or strike benefits.

Line #20: Enter the amount received as a result of workers compensation benefits or settlements.

Line #21: Enter the amount received by the household for alimony or child support.

Line #22: Enter the amount of school grants and stipends that are used for food, clothing, and housing but not for books and tuition. A financial award letter from the post- secondary school will indicate grants or stipends in excess of the actual college costs.

Line #23: Total lines 14 through 22 to obtain the household's unadjusted gross monthly income.

Line #24: There is no need to complete this line.

Line #25: There is no need to complete this line.

4300 PART III - PROCESS OF ESTABLISHING ABILITY TO PAY (CO-PAYMENT)

A county is financially responsible only for the hospitalization expense that is beyond the household’s ability to pay. The following steps are used to determine whether or not the household has an ability to pay all or a part of the hospital bill.

4310 Calculating Deductions from monthly Income (SDCL 28-13-32.9[1])

When two individuals live together, are not married to each other, and neither has a legal obligation to provide support to the other, consider only the deductions made from the applicant's household's monthly income.

Line #26: Determine the household's contributions for taxes, social security, and Medicare. This information can usually be obtained from the pay stub or may be obtained by contacting the employer(s) directly. A household's contribution for taxes is limited to the amount of taxes payable for the actual number of dependents in the household. If the individual is self-employed, the county will need the previous year's tax return to find out how much is to be paid in for taxes for the year. Prorate the total to determine the monthly total. If the tax form is not indicative of current earnings, the county should adjust the amount accordingly.

Line #27: Determine the contribution made to standard retirement programs by the household members. Five percent is an average standard retirement contribution.

Line #28: Compute the total contributions for taxes and retirement.

4320 Calculating Monthly Expenses (SDCL 23-13-32.9(2))

Line #29: Determine the household's expenses, including actual out-of-pocket rent paid or scheduled principal and interest payments for a personal residence, plus property taxes, and homeowner's or renters insurance costs. When two individuals live together, are not married to each other, and neither has a legal obligation to provide support to the other, prorate the rent based on each individual's income.

Line #30: Enter the household’s actual out-of-pocket monthly utility expense.

Utilities include water, electricity, gas/fuel, and basic telephone service. Because of the extreme weather conditions in South Dakota, the county may want to consider averaging the utility costs. When two individuals live together, are not married to each other, and neither has a legal obligation to provide support to the other, prorate the utilities based on each individual's income.

Line #31: Enter the household's actual out-of-pocket employment-related childcare expenses paid by the household. When two individuals live together, are not married to each other, neither has a legal obligation to provide support to the other, and have children in common, prorate the childcare expenses for the children in common based on each individual's income. If the applicant has children, for whom the other individual has no legal obligation to support, consider the actual childcare expenses paid by the applicant for that child.

Line #32: Enter an allowance for the household's monthly grocery expenses plus an allowance for the household's supplies and toiletries. The maximum that can be allowed for grocery expenses is the amount allowed under the SNAP Thrifty Food Plan (Appendix W) for a household of the same size. NOTE: The Thrifty Food Plan is updated annually. The county needs to ensure this appendix is kept current. To calculate an amount allowable for the household's supplies and toiletries, the county may wish to consider using ten percent of the Thrifty Food Plan amount. The county could also allow the household to make a “self-declaration” for supplies and toiletries as long as it is reasonable for the size of the household. Whichever method the county uses should be applied consistently on all applications for assistance.

When two individuals live together, are not married to each other, and neither has a legal obligation to provide support to the other, count the applicant and members of the applicant's household.

When two individuals live together, are not married to each other, neither has a legal obligation to provide support to the other and have children in common, count ALL of the individuals. Calculate the benefit level using the Thrifty Food Plan divide this amount by the number of individuals to obtain the "share” for each individual. Allow a share for the applicant and, except for any children in common, a share for each of the applicant’s children. Add to that amount a half of a share for each child in common.

EXAMPLE: Betty and Phil live together. Betty and Phil are not married to each other. Betty is requesting county assistance. Betty is divorced and has two of her children living with her. Phil is also divorced and has one of his children living with him. In addition, Betty and Phil have one child in common. To determine the size of this unit, count Betty, Phil, and all the children. This would constitute a unit of six. Assuming that the Thrifty Food Plan amount for a unit of six was $600, divide that by the number of individuals in the unit (six) to establish an individual's "share.” In this case, an individual share would be $100. Allow a share for the applicant and, except for children in common, a share for each child (Betty + two children = $300). To this amount, add a half of a share for children in common ($50). The monthly grocery expense for the applicant and the applicant's household is $350. NOTE: The amount allowed for a common child is limited to half of a share because both parents are in the home and each parent is charged with an equal responsibility to support that child.

Line #33: Enter an amount that will cover the household’s monthly basic auto expenses, gasoline, and upkeep. This allowance is allowed for vehicles used for work and/or necessary household transportation, or used by children for purposes of attending school. The county should take into consideration the year, make, and model of the vehicle(s) and the fluctuating price of gas when determining this allowance. As always, the allowance should be reasonable.

When two individuals live together, are not married to each other, neither has a legal obligation to provide support to the other, and share a vehicle, prorate the car expenses based on each individual's income. If the applicant has his or her own vehicle, allow the applicant’s expenses for that vehicle. Regardless of which method is used, the applicant is limited to a deduction for one vehicle.

Line #34: Enter the amount paid by the household for health, life, and auto insurance. If the household is paying towards a burial fund or burial policy, include that.

Line #35: Calculate the amount the household pays monthly towards its medical bills. When determining this amount, include past payments that can be verified as existing, outstanding debts with a payment history, and current or anticipated installment payments of the other medical charges incurred because of this request and not paid by the county. Do not include a monthly allowance for the current hospital bill. The current and anticipated installment payments must be reasonable in relation to the household's income. A household cannot make themselves eligible by over-inflating the amount of the anticipated installment payments.

When two individuals live together, are not married to each other, and neither has a legal obligation to provide support to the other, allow only the applicants medical payments.

When two individuals live together, are not married to each other, neither has a legal obligation to provide support to the other, and the individuals have children in common, prorate the children's medical expenses based on each individual’s income.

If the applicant makes installment payments on behalf of the applicant’s child and the child is not living with the applicant, allow the monthly payment made by the applicant on behalf of that child.

Line #36: Enter the recurring expenses that a household spends for maintenance medications and regular/routine medical care. For example: if a member of the household is on blood thinner and needs to have regular blood work done, this would be considered regular/routine medical care and the county should include these expenses. If a household member is a diabetic the household will incur approximately the same costs every month for the insulin syringes, alcohol wipes, and test strips. These costs should be included. Other medical care could include medical equipment, oxygen, the rental cost of equipment, and special furniture and appliances.

When two individuals who live together, are not married to each other and neither has a legal obligation to provide support to the other, allow only the applicant's medical payments.

When two individuals live together, are not married to each other, neither has a legal obligation to provide support to the other, and the individuals have children in common, prorate the children’s medical expenses based on each individual's income.

If the applicant makes monthly payments on behalf of the applicant's child, and the child is not living with the applicant, allow the monthly payment made by the applicant on behalf of that child.

Line #37: Enter the amount the household pays out for court-ordered child support and alimony payments.

Line #38: Enter the amount of the installment payment for one vehicle. When there are multiple vehicle installment payments, the county should use the higher vehicle installment payment as long as the vehicle is used for employment or necessary household transportation. (Refer to the explanation for Line #39 for consideration of an additional vehicle.)

When two individuals live together, are not married to each other, and have no legal obligation to provide support to the other, and have joint ownership in the vehicle, prorate the car expenses based on each individual's income. If the applicant has his or her own vehicle, allow the applicants installment payment for that vehicle.

Line #39: Calculate an amount to cover "other" expenses of the household. "Other" expenses might include clothing, installment debt, or student loans. Clothing allowance must be reasonable in relation to the household's income and debt. An amount allowed as an installment debt must be necessary, essential to everyday living needs, and reasonable in relation to the household's income and debt. A gambling debt charged to a credit card is not considered necessary and essential to everyday living. If an applicant declares a clothing expense, the county should take into consideration the size of the household and its circumstances in relation to the household's income. The county may choose to consider the costs of an additional vehicle when the vehicle is used for purposes of employment or attending school. The county must establish a method of determining the amount of "other” household expenses and must apply the method consistently on all applications for assistance.

Line #40: Calculate the total basic monthly expenses.

4300 Calculating Monthly Discretionary Income & Debt Load (SDCL 28-13-32.9[3])

Line #41: Determine the household's discretionary income by deducting the household’s monthly expenses from the unadjusted monthly gross income.

Line #42: Calculate one-half of the household's discretionary income. So as not to impoverish the household, the county will only consider 50 percent of the household's discretionary income when determining ability to pay. The remaining 50 percent is excluded to allow the household to pay for all other expenses not allowed under other portions of the Ability to Pay Form.

Line #43: Calculate the amount of debt, which can be amortized over 60 months at 12 percent annual interest per dollar of payment. The amount of $44.96 represents the amount of medical or hospital expenses that can be amortized over 60 months at 12 percent annual interest per dollar of payment. This five year, 12 percent calculation does not represent a prescribed payment for either the hospital or the county. The applicant must make arrangements directly with the hospital as to a payment plan.

4340 Calculating Household's Ability to Pay (SDCL 28-13-32.9)

Line #44: Enter the amount of the household's adjusted assets/resources.

Line #45: Enter the household's debt load.

Line #46: This amount equals the household's ability to pay the debt and constitutes the household's share of the hospital bill.

4350 Calculating County's Share (SDCL 28-13-32.9)

Line#47: Enter the hospital charge as computed according to SDCL 23-13-29. This statute specifies that the county's responsibility is the lesser of the hospital’s ratio of cost to charge or the Medicaid rate as calculated by the Department of Social Services. The hospital charge entered on this line should always be the lower calculation.

Line #48: Subtract the amount of the household's ability to pay from the lowest hospital charge used in Line #47.

Line #49: This line equals the county's obligation, if any, to pay the hospital as computed according to SDCL chapter 28-13.

4400 USING THE FORM TO DETERMINE AFFORDABILITY OF INSURANCE (SDCL 28-13-32.11)

To determine whether insurance was affordable, use the Ability to Pay Form (Appendix E) and work the formula through Line #42 to determine the household's discretionary income. Subtract the amount of the monthly insurance premium from the household's discretionary income. If the result is negative, the health insurance was not affordable. If the result is positive, health insurance was affordable and the household is considered “indigent by design" and ineligible for assistance.

To determine the amount of the insurance premium, obtain an estimate from two major medical insurance carriers doing business in the state.

When obtaining estimates from major medical insurance carriers the premium quoted must be for a policy that has a benefit that equals or exceeds the Affordable Care Act regulations minimum requirements.

4500 USING THE FORM TO DETERMINE ABILITY TO PAY EMERGENCY HOSPITAL SERVICES

To determine whether the individual has any ability to pay the emergency hospital bill, complete the Ability to Pay Form located in Appendix F. Follow the instructions contained in this chapter for completing the form. If the individual has any ability to pay, that amount must be deducted from the hospital bill calculated according to SDCL 23-13-29 before the county pays the bill. The individual's share of the bill is payable directly to the hospital.

Effective July 1, 1997, the county's rate of reimbursement to a hospital is the actual cost of hospitalization (determined according to the hospital's cost statement) or the amount payable under the state's Medicaid system, whichever is lower.(SDCL 28-13-29) When determining an individual's ability to pay, the county should always use the lowest rate available.

4600 USING THE FORM TO DETERMINE ABILITY TO PAY NON-EMERGENCY HOSPITAL SERVICES

When an individual is requesting prior approval of a non-emergency hospital service, the individual will need to complete an application for assistance. The county caseworker should contact the hospital and request an estimate of the charges. The caseworker will then need to work the ability to pay form up to Line #47. Based on the estimate of hospital charges, the county should be able to determine whether it will be participating in the cost of care. The county should notify the hospital that the individual is potentially eligible for county assistance and that the amount of county participation will not be determined until after the hospital submits the bill to the county.

4700 USING THE FORM TO ESTABLISH ELIGIBILITY FOR OPTIONAL SERVICES

If the county chooses to provide other medically necessary optional services, the county could use the Ability to Pay Form to determine eligibility for and the amount of optional medical assistance for which the individual may be eligible to receive. Work the formula down through Line #42. The amount appearing on this line represents the household's discretionary income that would be available to pay for the requested service. NOTE: When completing Line #35 and Line #36, do not include the cost of the service for which the household is requesting assistance.

4800 DETERMINING AVAILABILITY OF INSURANGE

For information relative to whether or not insurance is considered to have been “available" to the individual, refer to Insurance Verification.

CHAPTER 5

OPTIONAL SERVICES

The services contained in this chapter are services that a county may choose to cover. Because these are optional services, the county may require approval before the services are provided. When determining whether to cover the service, the county should consider the medical necessity of the requested service. For example, while a county may not normally provide dental services, it may be requested to pay for the extraction or repair of teeth pending open-heart surgery or an organ transplant surgery. A county should refer to SDCL 23-13-1, 28-13-1.1 and 23-13-1.2 when establishing its guidelines. If the county covers any of the optional services contained in this chapter, the county should have the individual sign a Release of Financial and Medical Information (Appendices B & C) and complete an Application for Assistance (Appendices J & K).

5000 DENTAL SERVICES

Occasionally a county is asked to provide assistance with the payment of dental services. Usually a county does not provide assistance with routine dental check-ups or fillings. An individual may request assistance with the payment of emergency dental services due to an immediate need such as pain or an accident that has resulted in damage to the mouth or teeth. In addition, the county may want to consider providing assistance to an individual who must have work done on their teeth before certain medical or surgical procedures can be completed. This is common for heart, cancer, and transplant patients. A county may want to consider paying a dental bill for an individual who has abscessed teeth and is unable to work due to the pain or the unsightliness of the individual’s teeth.

There is a shortage of dental providers in South Dakota and many dentists have full caseloads and are unable to accept any more patients. The county should encourage the individual to locate a dentist who will complete the necessary dental work. Remind the individual of the following guidelines:

1. Be on time for the appointment.
2. If the individual cannot make the appointment, the individual must contact the dentist and cancel the appointment as soon as possible. The individual could lose their dentist if the individual fails to keep an appointment without canceling it.
3. Be courteous and respectful with dentist and dental office staff.
4. Follow the dentist's treatment plan.
5. Be considerate of other patients in the office.

The state Medicaid program has a contract with Delta Dental of South Dakota to administer the state's dental plan for Medicaid recipients. If a Medicaid recipient requests assistance with dental services because the Medicaid recipient cannot find a dentist to provide the needed services, refer the individual to Delta Dental at (605)-224-7345. If the Medicaid recipient requests assistance with dental services that are not covered by the Medicaid program, the county must determine if the requested service is eligible for payment by the county and if the individual meets the eligibility criteria.

Medicaid has dental programs for both children and adults. In addition, a county should check with local service clubs to see whether they would consider covering the needed service.

The Ronald McDonald Care Mobile is a fully equipped, modern dental office on wheels that will bring dental care directly to children who do not otherwise have access to care, regardless of their ability to pay. It is a collaborative effort between Ronald McDonald House Charities of South Dakota, Delta Dental Plan of South Dakota, and the State Department of Health. The Care Mobile is supported by paid staff and by volunteer dental professionals who provide care on the unit. In each community it visits, Care Mobile staff will work with local site partners like Head Start, schools, rural community health centers, and local social service agencies to identify and schedule patients and promote the Care Mobile. The county may want to consider partnering with local agencies to get the Care Mobile to come into areas where there are unmet dental needs.

When paying a claim for dental services, the county may wish to utilize Medicaid's rules and payment methodology when approving dental services and reimbursing dental providers.

5100 MEDICAL EQUIPMENT

A county may be asked to pay for the rental or purchase of medical equipment. Equipment includes items such as canes, crutches, walkers, hospital beds, oxygen concentrators, suction machines, nebulizers, hearing aids, wheelchairs, kidney dialysis equipment, blood glucose monitors, and lymphedema pumps. Medicare and Medicaid will cover some medical equipment if certain criteria are met. When determining whether or not the county will participate in the payment of medical equipment, the county should consider whether or not the equipment is medically necessary and whether there is alternative equipment available that will meet the individual’s needs.

Keep in mind that other community service organizations provide certain medical equipment for individuals in need and depending on the equipment, the county may wish to contact these organizations to request assistance on the individual's behalf.

If an individual is in a nursing home and on Medicaid, the nursing home is responsible for providing the medical equipment needed by the Medicaid recipient. The repair and maintenance of medical equipment owned by the Medicaid recipient is covered by Medicaid.

If an individual resides in an assisted living facility and is Medicaid eligible, Medicaid will pay for the cost of medically necessary equipment as long as the equipment is a covered item under the Medicaid program.

5200 EYEGLASSES

A request for glasses should first be referred to the nearest Lions Club or other community service organizations. Eyeglasses and certain other optometric services are covered under the Medicaid program. The Veterans Administration and Indian Health Services provide limited coverage for eyeglasses. There may be an immediate need for glasses that cannot wait. For example, the individual who needs glasses to perform his/her job and is unable to work without the glasses.

5300 HOME IV TREATMENT

Home IV treatment has become a very popular form of treatment since it could save the county the expense of a costly hospital stay. A county may have a situation in which one provider supplies the medication for the IV and another provider actually administers the medication. In some cases, a relative or friend can administer the medications; other cases require the services of a registered nurse. The county will need to sort these things out when determining whether it will cover the service. There may be a case in which the individual is eligible for Medicare but Medicare will not cover the cost. It may be more affordable to meet the individual's co-payment for a hospital stay versus covering the cost of the IV therapy in the home setting.

5400 TRAVEL ASSISTANCE

A county may be asked to assist with an individual’s transportation expenses when the individual is traveling to a medical facility outside of the individual's community. The county should check with local service clubs and organizations. Oftentimes, these groups will provide assistance to an individual needing to travel to a medical facility. Assistance could include help with meals, gas, and lodging. If travel is to an out-of-state facility, the county should contact the social worker at the out-of-state facility and arrange lodging and meals through that facility. If the individual is on Medicaid, the county should contact the transportation service coordinator for the Department of Social Services in Pierre, at (605)-773-3586, to request coverage of the transportation service to enable the individual to obtain the needed services. For these cases, the Department of Social Services should be making the bulk of the arrangements. Usually, lodging is not a problem because the Department of Social Services can be billed directly by the facility. Meals can be more difficult to arrange to have billed directly to the Department of Social Services. Transportation and meals are not reimbursed by the Department of Social Services until after the fact. In most cases, a county can be reimbursed for the costs of assisting a Medicaid recipient with travel expenses.

In most cases it is best to coordinate care with a Social Worker at the out-of-state facility as that person is much more familiar with services in their area. It is not common that a County will assist with costs for out-of-state care, but it can be done if the policies /procedures of that particular County allow it.

5500 AMBULANCE SERVICES

It is recommended that the county follow the Medicaid provisions relating to covered ambulance services. Air or ground ambulance services are limited to transporting the recipient locally or to the nearest medical provider that is equipped or trained to provide the necessary service. Services may be either basic life support (BLS) or advanced life support (ALS). An air ambulance may be accomplished using either a fixed-wing plane or a helicopter. Ground ambulance service is limited to the transportation of an individual to or from a medical provider or between medical facilities when other means of transportation would endanger the life or health of the patient. Air ambulance services must be medically necessary because of time, distance, emergency, or other factors or when transportation by any other means is contraindicated.

5600 HOME HEALTH SERVICES

Home health services are nursing-related services, medical social services or home health aide services provided by a home health agency in an individual's home. A county may choose to provide home health services in an effort to avoid or delay a hospitalization or to allow an individual to be discharged from a hospital. When approving home health services, the county will need to work with the treating physician and the home health agency to determine the extent of the services to be provided, the length of time the services are required, and the rate of payment.

Because both Medicare and Medicaid cover home health services, inform the home health agency if the individual needing service is eligible for either program. If the cost of home health services is projected to exceed the cost of care if the individual was institutionalized, the county may wish to consider denying the request for home health assistance and recommend inpatient care.

5700 PHYSICAL OR OCCUPATIONAL THERAPY (REHAB SERVICES)

Outpatient physical or occupational therapy is not considered to be emergency services. Because of that, an individual in need of therapy services must have approval from the county before the services are provided. Failure to obtain prior approval from the county can result in a denial of the claim for services.

When an individual is hospitalized and is moved or transferred directly to an inpatient rehab unit, this constitutes a new admission and the hospital must have approval from the county before the services are provided. Failure to obtain prior approval from the county can result in a denial of the claim for services.

5800 ASSISTANCE WITH MEDICATIONS

A county may choose to provide assistance with medications. Often, medications can prevent a larger hospital bill and it could be a financially sound decision for the county to step in and pay for an individual's medications.

5810 EMERGENCY MEDICATIONS

There may be times when an individual is in need of immediate assistance with medications. A county could assist with a one-time medication fill to enable the individual time to complete the necessary paperwork for a formal application. The county should have this individual complete at least the “mini application”, (the Emergency Medication Assistance Application) located in Appendix G. This form includes the vital statistics of the individual needing the medication. NOTE: When the individual has completed the form, the caseworker should ensure that the individual has read the bottom of the form and explained to the individual that a lien will be placed on the individual's property for the cost of the services and /or supplies. Because it is entirely possible that the individual will not return to complete a formal application, it is important that the caseworker obtains the individual's signature on the bottom of the form that acknowledges that a lien will be filed. This provides proof that the county did instruct the individual as to the filing of the lien.

5820 ON-GOING MEDICATION NEEDS

In addition to completing an application for assistance and the releases of financial and medical information, the county should also have the individual complete a formal application if the individual needs on-going medications. The county should provide the individual with the list of paperwork the individual will need to supply to the county so the process of determining eligibility can be completed. The list of the Pre-Application Information needed to complete the application process, can be found in Appendix H. In addition, the individual needs to provide the county with a list of needed medications. A form for gathering this information may be found in Appendix R.

The county should establish a process of documenting what has been approved, for whom, for how long, and for notifying the pharmacy of the approval. The county will need to inform the pharmacy of the length of time the prescription can be filled /refilled. The length of approval is based on the individual's circumstances. For example, the individual may only need help with medications for one month because the individual is starting a new job and will have the income to pay for future medications. Other factors that affect the length of approval include a pending decision on a social security application or a pending application under the indigent drug program.

The county is encouraged to negotiate either a straight percentage reduction or payment at Medicaid rates.

The county could use the Ability to Pay Form found in Appendix F, (lines 14 through 42), to determine if the individual has the ability to make a partial payment on the medications. If the individual has the ability to make a partial payment, that payment should be made directly to the pharmacy.

NOTE: Because of problems experienced in the past, the county may want to consider adding a statement to its notice of approval. The statement should state that as a condition of accepting payment from the county, the provider agrees to submit claims to Medicaid if the individual is subsequently determined to be eligible for Social Security Income or Medicaid and further agrees to fully reimburse the county.

5830 INDIGENT DRUG PROGRAM

If the county receives a request for on-going or maintenance medications, it is important to ask if the individual has applied for assistance through the indigent drug programs provided by the pharmaceutical companies. The county should encourage the individual to discuss with the individual's physician about the possibility of using the indigent drug program. Some pharmaceutical manufacturers have established programs to help make some drugs available free of charge to needy individuals. These programs are not government sponsored programs and there is no guarantee an individual will qualify to receive the needed drugs. Each of these programs establishes a limit on the length of time the drugs will be provided. Not all medications are available through these programs. However, new programs and new drugs are continually being developed and added to the list of covered drugs. Each company determines its rules for qualifying. Many programs simply require the physician determine that the patient cannot afford the drugs prescribed. Other programs, especially those for very expensive drugs, require the individual to be below certain income levels. The existence of private health insurance or eligibility for Medicaid or Medicare may disqualify the individual from the indigent drug program. NOTE: Drug manufacturer's programs are updated annually. A current listing of drugs available through the drug companies can be found at [www.needymeds.org](http://www.needymeds.org) (Appendix I).

The county can assist the individual in working with the drug manufacturing companies, with other community agencies, or the county can facilitate the coordination of services through the Department of Social Services, Office of Adult Services and Aging. The Office of Adult Services and Aging administers the Rx Access Program. This Department of Social Services program works directly with the different drug manufacturers and can supply the necessary applications needed by the individual to complete their request for medication assistance.

This process does take time so the county will need to determine the individual's eligibility for county poor relief and then assist with the medications until the pharmaceutical company can make a final determination of eligibility. If the patient is determined eligible, the manufacturer will, in most cases, send the medication to the physician's office where it will be distributed.

5840 DRUGS AVAILABLE THROUGH THE VETERANS ADMINISTRATION

If the individual is a veteran, prescription drugs may be available for the individual through the Veterans Administration. A contact should be made with the county’s Veterans Service Officer to link the individual with Veterans Affairs for prescription drugs.

5841 DRUGS AVAILABLE THROUGH LOCAL PHARMACIES

A contact should be made to your local pharmacies to determine if they offer medication at a greatly reduced price. Many pharmacies, such as Wal-Mart, Target, Walgreens, and K-Mart provide a cross section of medications for a nominal fee. Most “chain” pharmacies offer this service.

CHAPTER 6

NATIVE AMERICANS

6000 DEFINITIONS

Terms used in this chapter have the following meanings:

1. “BIA,” Bureau of Indian Affairs

2. “Purchase Referred Care," health services provided at the expense of the Indian Health Services from public or private medical or hospital facilities other than those of the Indian Health Service;

3. “Emergency,” any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual;

4. “IHS," Indian Health Service;

5. ''Native American tribe," any Native American tribe, band, nation, group, Pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians;

7. "Reservation,” any federally recognized Native American tribe’s reservation, Pueblo or colony, including former reservations in Oklahoma, Alaska, and Native regions established pursuant to the Alaska Native Claims Settlement Act; and

8. “Service Unit Director,” the director of an IHS service unit area designated for  
purposes of administration of IHS programs.

6100 SERVICES AVAILABLE AT IHS FACILITIES

Services for the Native American community served by an IHS facility may include hospital and medical care, dental care, public health nursing and preventive care (including immunizations), and health examination of special groups, such as school children. Where services are available, services will be provided at IHS hospitals and clinics and at contract facilities. IHS does not provide the same service at each area served. The services provided to any particular Native American community will depend upon the facilities and services available from sources other than the IHS and the financial and personnel resources made available to IHS.

6200 ELIGIBLE INDIVIDUALS

IHS services will be made available, as medically indicated, to persons of Native American descent belonging to the Native American community served by the local facilities and program. IHS services will also be made available, as medically indicated, to a non- Native American woman pregnant with an eligible Native American’s child but only during the period of her pregnancy through postpartum (generally about six weeks after delivery). In cases where the woman is not married to the eligible Native American, paternity must be acknowledged in writing by the Native American or determined by order of a court of competent jurisdiction. IHS will also provide medically indicated services to non- Native American members of an eligible Native American’s household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard.

Generally, an individual is regarded to be within the scope of the IHS program if the individual is regarded as a Native American by the community in which the individual lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general BIA practices relating to jurisdiction.

If there is a question as to whether an individual applying for care is within the scope of the IHS program, the medical officer in charge shall obtain from the appropriate BIA officials information that can be used to determine whether the individual seeking IHS care has a continuing relationship to the Indian population group served by the local program. If the individual's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as a Native American beneficiary.

Priorities for care and treatment are determined on the basis of relative medical need and access to other arrangements for obtaining the necessary care.

6300 EMERGENCY CARE OF INELIGIBLE INDIVIDUAL

In case of an emergency, as an act of humanity, an individual who is not eligible for IHS care may receive temporary care and treatment at an IHS facility. If the Service Unit Director determines the ineligible individual is able to defray the cost of care and treatment, the individual shall be charged at rates approved by the Assistant Secretary for Health. Reimbursement from third-party payers may be arranged by the patient or by the IHS on behalf of the individual.

6400 PURCHASED/REFERRED CARE

Purchased/Referred Care are medical services provided at public or private medical facilities at the expense of the IHS. Contract health services will be made available as medically indicated when necessary health services by an IHS facility are not reasonably accessible or available to eligible individuals. Approval for Purchased/Referred Care must be obtained before the care is provided. If the services are an emergency, then IHS must be notified within 72 hours of initiation of the medical service.

6410 PURCHASED/REFERRED CARE DELIVERY AREA

A Purchased/Referred Care delivery area consists of a county that includes all or part of a reservation and any county or counties that have a common boundary with the reservation. When establishing a Purchased/Referred Care delivery area, the Public Health Services takes into consideration the number of Native American residing in the area proposed to be included, whether the tribal governing body has determined that Native Americans residing in the area near the reservation are socially and economically affiliated with the tribe, the geographic proximity to the reservation of the area whose inclusion or exclusion is being considered, and the level of funding which would be available for the provision of Purchase/Referred Care.

6420 PURCHASED/REFERRED CARE - ELIGIBILITY

To the extent that resources permit, Purchased/Referred Care will be made available as medically indicated when necessary health services by an Indian Health Service facility are not reasonably accessible or available. The individual must reside within the United States and on a reservation located within a Purchased/Referred Care delivery area or, if not residing on a reservation, must reside within a Purchased/Referred Care delivery area. The individual must be a member of the tribe located on that reservation or of the tribe for which the reservation was established or must maintain close economic and social ties with that tribe.

To determine if someone may be eligible for Purchased/Referred Care at a facility other than an IHS facility a contact must be made with Purchased/Referred Care at the Indian Health Services Office in the area within 72 hours of the individual’s admission. Although the hospital may have already made the contact, IHS prefers to have either the individual or a family member contact them. This is a crucial step in the process of Purchased/Referred Care and the individual, family member, or other representative should not rely on the hospital to make that call. If it is impossible for the individual to call at that time, someone acting on the individual's behalf must make the call or the hospital may be barred from receiving payment for contract services from IHS. The representative will need to inform IHS that the individual is unable to call at this time due to whatever extenuating circumstances exist and that the individual or a family member will call as soon as they are able to do so. The individual making the call must have available the hospitalized individual's complete name, as well as any aliases, and the individual's social security number and date of birth. If the inquiry is for services provided in a facility other than an IHS facility, provide the name of the facility where the services are being (or were) provided and the dates of those services. Any contacts that the county has with IHS should be documented in the individual's case file in case the claim is later questioned or denied.

6430 PURCHASED/REFERRED CARE - PRIOR AUTHORIZATION

No payment will be made for medical care and services obtained from non-service providers or in non-service facilities unless the applicable notice requirements specified below are met and a purchase order for the care and services has been issued to the medical care provider by the appropriate ordering official.

In non-emergency cases, an individual who is sick or disabled, an individual or agency acting on behalf of the individual, or the medical care provider must, prior to the provision of medical care and services, notify the appropriate ordering official of the need for services and supply information the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility.

The requirement for notice prior to providing medical care and services under this section may be waived by the ordering official if the notice and information are provided within 72 hours after the beginning of treatment or admission to a health care facility and the ordering official determines providing notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide the prior notice.

In emergency cases, an individual who is sick or disabled, or an individual or agency acting on behalf of the individual, or the medical care provider must notify the appropriate ordering official of the admission or treatment and provide the information necessary to determine the relative medical need for the services and the eligibility of the individual for the services. This notice must be made within 72 hours after the beginning of treatment for the condition or after admission to a health care facility. This 72-hour period may be extended if the ordering official determines notification within the prescribed period was impracticable or that other good cause existed for the failure to comply.

6440 PURCHASED/REFERRED CARE -- STUDENTS

Purchased/Referred Care services will be made available to students and transients who would be eligible for Purchased/Referred Care at the place of their permanent residence within a Purchased/Referred Care delivery area, but who are temporarily absent from their residence.

A student is eligible during the student's full-time attendance at programs of vocational, technical, or academic education, including normal school breaks (such as vacations, semester, or other scheduled breaks occurring during their attendance) and for a period not to exceed 180 days after the completion of the course of study.

6450 PURCHAED/REFERRED CARE --TRANSIENTS

An individual qualifies as a transient if the individual is absent from the individual's reservation or Purchased/Referred Care delivery area due to temporary employment (such as seasonal or migratory workers) or because the individual is traveling.

6460 PURCHASED/REFERRED CARE -- FOSTER CHILDREN

Native American children who are placed in foster care outside a Purchased/Referred Care delivery area by order of a court of competent jurisdiction and who were eligible for Purchased/Referred Care at the time of the court order shall continue to be eligible for Purchased/Referred Care while in foster care.

6470 PURCHASED/REFERRED CARE -- OTHER INDIVIDUALS

Individuals who leave their Purchased/Referred Care delivery area and are neither students nor transients are eligible for Purchased/Referred Care for a period not to exceed 180 days from such departure.

6480 PURCHASED/REFERRED CARE --PRIORITIES

When funds are insufficient to provide the volume of Purchased/Referred Care indicated as needed by the population residing in a Purchased/Referred Care delivery area, priorities for service shall be determined on the basis of relative medical need.

6490 PURCHASED/REFERRED CARE--APPEALS

When IHS denies Purchased/Referred Care, IHS will notify the individual in writing. The notice of the denial will contain the reason for the denial. The individual has 30 days from receipt of the notice to submit additional supporting information not previously submitted in order to obtain reconsideration by the appropriate Service Unit Director. If the individual wishes to pursue an appeal but does not have any additional information to submit, the individual may appeal the original denial by the Service Unit Director to the appropriate Area or Program Director. The request for reconsideration or appeal must be in writing and must set forth the grounds supporting the request for reconsideration or appeal.

If the original decision is affirmed on reconsideration, the individual will be notified in writing and advised an appeal may be made to the Area or Program Director within 30 days of receipt of the notice of the reconsidered decision. The appeal must be in writing and must set forth the grounds supporting the appeal.

If the original or reconsidered decision is affirmed on appeal by the Area or Program Director, the individual will be notified in writing and advised a further appeal may be made to the Director of IHS, within 30 days of receipt of the notice. The appeal must be in writing and must set forth the grounds supporting the appeal. The decision of the Director of IHS constitutes the final administrative action.

If appealing a claim, gather together the hospital bills and the doctor's report. The individual, a family member, or a representative must send a letter to the IHS requesting an appeal. The letter should contain information that would support the reasons for the appeal, such as explaining the surrounding circumstances, specifying the reasons the claim should be considered for payment, providing proof of residency within the past three years, providing an explanation of why contact was not made within the 72-hour period, or providing verification of who made the contact, the date of contact, and with whom the contact was made.

If the claim was denied because the individual had not utilized IHS services within the past three years, the individual or family would need to include either in narrative form or in actual verification that the individual has resided within the service area. Documentation could include items such as rent receipts, copies of lease agreements; proof of receipt of housing, SNAP, or TANF assistance; or school or work records which indicate the place of residence. The information should cover as much of the three-year period as possible.

The information should be sent by certified mail to the appropriate individual. The county should maintain, in the individual’s case file, a copy of the documentation sent and should track the case until IHS has made a final disposition.

6500 REQUEST TO COUNTY FOR PRIOR AUTHORIZATION OF SERVICES

If a Native American is requesting the county to pre-authorize services, the county will need to check out all possibilities for other third-party payment sources, including IHS and Medicaid. If the individual indicates they are not eligible for IHS services, the county should verify whether the individual really is not eligible or simply has failed to enroll for IHS benefits.

For purposes of county poor relief, an individual will not qualify as "medically indigent” if the individual is eligible or would have been eligible for services through Indian Health Services (IHS) if the hospital services had been applied for within 72 hours of the individual's admission (SDCL 28-13-1.3(5)). Effective July 1, 1997, a hospital must inquire whether the individual is a member of a Native American tribe or is potentially eligible for Indian Health Service benefits (SDCL 28-13-34.1(8)). If the response is “yes” it is the hospital's responsibility to pursue eligibility through the IHS. Counties are encouraged to assist the hospital when working through these particular cases.

6600 IHS - PAYER OF LAST RESORT

The Indian Health Service will not be responsible for or authorize payment for contract health services if the individual is eligible for alternate resources, would be eligible for alternate resources if the individual would apply for them, or would be eligible for alternate resources under state or local law or regulation but for the Indian's eligibility for contract health services or other health services from the Indian Health Service or Indian Health Service funded programs. If other resources are available and accessible, the patient must apply for and utilize the other resource as long as there is no cost to the patient.

The term "alternate resources" means health care resources other than those of the Indian Health Services. Such resources include health care providers and institutions and health care programs for the payment of health services including but not limited to programs under Titles XVIIl or XIX of the Social Security Act, state or local health care programs, and private insurance.

NOTE: A county would not be considered an alternate resource because county payment results in a lien on the individual's property and the individual is required to reimburse the county for any expenses paid. A county wishing to pursue payment through the IHS may want to consider contacting the Midland Group for assistance. It is not unusual for a case to be denied by IHS or Contract Health Services if the process for obtaining information and determining eligibility is going to be lengthy. The denial will be issued "pending receipt of requested information." The county should pursue any denials of contract care to ensure the county is the payer of last resort.

CHAPTER 7

VETERANS

An individual will not qualify as medically indigent if the individual is eligible or would have been eligible for assistance through the Veterans’ Administration (VA).

To qualify for routine care at non-VA facilities at VA expense (known as Fee Basis Care) the Veteran must first be given written referral by a VA provider (VA co-pay may be applicable). Emergency care must be pre-authorized by the VA. When the emergency care is not authorized in advance by VA, it may be considered as preauthorized care when the nearest VA medical facility is notified within 72 hours of admission, the veteran is eligible, and the care rendered is emergent in nature.

Effective July 1, 1997, a hospital must inquire whether the individual is a veteran (SDCL 28-13-34.1(8)). If the response is “yes,” it is the hospital’s responsibility to pursue eligibility through the VA. Counties are encouraged to assist the hospital with these particular cases.

7000 REFERRAL TO COUNTY VETERAN SERVICES OFFICER

When the county becomes aware that a veteran has been admitted to a hospital, a contact should be made with either the county’s Veterans’ Services Officer and/or the local VA medical facility Patient Services Office. The county caseworker should refer to the county’s Veterans’ Services Officer any discharge that is under “other than honorable” conditions. The County Veterans’ Services Officer should then check with the local VA medical facility Enrollment Coordinator for a decision as to eligibility for benefits.

1. ELIGIBILITY FOR VA HEALTH CARE BENEFITS

To be eligible to receive VA health care benefits, the veteran must be “enrolled” in the VA health care system. If not, the veteran will need to enroll. The caseworker should contact the county Veterans’ Services Officer or the local VA medical center Enrollment Coordinator who will assist with the enrollment process. In addition, a veteran may enroll by:

1. Contacting the local Veterans’ Services Officer or the VA medical center to get the forms to be completed for enrollment purposes;
2. Enroll on-line with the VA at [www.va.gov/healtheligibility](http://www.va.gov/healtheligibility);
3. Enroll on-line through the SD web site [www.mva.sd.gov](http://www.mva.sd.gov);

The numbers of the VA medical centers in South Dakota include the following:

1. Sioux Falls: 1-800-316-8387
2. Hot Springs: 1-800-764-5370
3. Fort Meade: 1-800-743-1070

Eligibility is based on income and family size.

7200 CO-PAY

A veteran with resources above a certain, established level will be required to make a co-payment for an in-patient hospital stay. There are two inpatient co-pay rates – the full rate and the reduced rate. The reduced inpatient co-pay rate, which is 80% of the full inpatient rate, applies to Veterans meeting specific income requirements. Both the full and reduced inpatient co-pay rate is computed over a 365-day period. Because the inpatient co-pay rates change each year, they are published separately and can be found on-line at [www.va.gov/healtheligibility/costs/inpatientcopay.asp](http://www.va.gov/healtheligibility/costs/inpatientcopay.asp) or contact the local VA medical center Business Office for current rates.

7300 TRANSFERS TO VA FACILITY

If a veteran is eligible for transfer to a VA facility but the facility has indicated there are no rooms available, the county should request the VA facility find another facility that will accept the veteran. Once a facility is located, the VA will arrange for the transporting of the veteran to the VA facility.

7400 PRESCRIPTION DRUG BENEFITS

If the veteran is in need of prescription drugs, contact should be made with the veterans’

VA medical provider.

Generally, prescription drugs are free if they are for a service-connected disability or if the veteran has a disability rating of at least 50 percent. Otherwise, the veteran is subject to a co-payment per prescription per 30-day fill. A VA physician must prescribe the medication and the veteran may also have to make a co-pay to see the VA physician in order to obtain the prescription.

If the veteran has a service-connected disability of at least ten percent or has been awarded the Purple Heart, the physician co-pay is waived.

7500 DENIAL OF VA BENEFITS – APPEALS

If a veteran is denied VA health care benefits, the veteran or the veteran’s family always has the right to appeal. To appeal a decision, the veteran must speak with a Patient Advocate at the VA health care facility. The patient advocate will work with the VA staff on the veteran’s behalf. If the issue cannot be resolved, the veteran can file a formal appeal to the Board of Veterans’ Appeals. The veteran has one year from the date of notification of the denial to file the appeal. The appeal must be in writing. The appeal must be filed through the medical center that made the unfavorable decision. The VA facility will prepare a statement of the case that will provide the veteran with a description of the facts, laws, and regulations used in deciding the case. To complete the request for appeal, the veteran must file a substantive appeal within 60 days of the mailing of the statement or within one year from the date the VA made its decision, whichever is later.

1. MILLENNIUM HEALTH CARE AND BENEFITS ACT

The Veterans’ Millennium Health Care and Benefits Act went into effect on May 29, 2000. This benefit is a safety net for enrolled Veterans who have no other means of paying a private facility emergency bill. To qualify the Veteran must meet all of the following criteria:

* Enrolled in VA healthcare system;
* Provided care by a VA clinician or provider within the last 24 months;
* Provided care in a hospital emergency department or similar facility providing emergency care;
* No other form of health insurance;
* No coverage under Medicare, Medicaid, or a state program;
* No coverage under any other VA program;
* VA or other Federal facilities are not feasibly available at time of emergency event;
* A reasonable lay person would judge any delay in medical attention would endanger your health or life;
* Veteran is financially liable to the provider of the emergency treatment for that treatment; and
* Veteran has no other contractual or legal recourse against a third party that will pay all or part of the bill.

The VA will pay for emergency care services in a private facility only until the condition is stabilized. If the Veteran is billed for emergency care services and believes the care should be covered under the Millennium Bill, the veteran should contact the local VA medical facility Fee Services Office and request payment for the emergency services under the provisions of the Millennium Health Care and Benefits Act. The Veteran is required to submit a copy of the bill and a statement the individual has no health insurance.

NOTE: The county caseworker should always contact the County Veterans’ Services Officer when there are questions concerning a veteran and that veteran’s eligibility for VA services.

CHAPTER 8

SPECIAL MEDICAID PROVISIONS

To be eligible for Medicaid, an individual must be a member of a coverage group. Some coverage groups are mandatory and some are optional.

In South Dakota most coverage groups consist of individuals who meet the following descriptions:

* 1. Child under the age of 19
  2. An adult relative caring for a child under the age of 19.
  3. Pregnant women.
  4. Blind or individuals determined disabled by the SSA or DSS.
  5. Aged (65 and older).

Individual coverage groups are defined in ARSD 67:46:01:02

8000 ELIGIBILITY REQUIRMENTS

The following individuals are eligible for medical assistance:

1. A parent /caretaker relative eligible for Medicaid under the provisions of chapter 67:46:12;
2. A person who is a recipient of a money payment under the SSI program;
3. A person under age 21 who would be a recipient of a money payment under the SSI program if not subject to paragraphs (A) and (B) of 42 U.S.C. 1382(c)(7);
4. A person who is in a hospital or intermediate care facility and would be eligible for a money payment under the SSI program upon leaving the facility;
5. A person under the age of 21 who is in the custody of the department and who meets the income requirements of § 67:46:12:15;
6. A person under the age of 21 who meets the income requirements of § 67:46:12:15, is in foster care, and whose financial responsibility has been assumed in full or in part by the department;
7. A person who is eligible under the provisions of chapters 67:46:02 to 67:46:06, inclusive;
8. A person who is eligible for transitional medical benefits under the provisions of chapter 67:46:13;
9. A child in a subsidized adoption;
10. A person who is currently receiving social security, who was entitled to and received social security and SSI concurrently after April 1977, who was terminated from SSI, and who currently would be eligible for SSI if the social security cost of living allowances back to the time of SSI ineligibility are disregarded;
11. A pregnant woman who meets the income requirements under the provisions of chapter 67:46:12;
12. A woman who applied for Medicaid while pregnant and who was eligible for and received Medicaid on the date the pregnancy ended. Eligibility continues to the end of the month 60 days after the pregnancy ends. Coverage is limited to postpartum care and family planning services;
13. A child under age 19 whose family income meets the income requirements under the provisions of chapter 67:46:12;
14. A child under age 19, who is eligible for the non-medicaid children's health insurance program covered under the provisions of chapter 67:46:14;
15. A pregnant woman whose meets the income requirements as established under the provisions of chapter 67:46:12. Eligibility continues throughout the pregnancy and to the end of the month 60 days after the pregnancy ends without regard to income changes. Services payable are limited to those services that are related to pregnancy, postpartum care, or family planning;
16. A person determined to be a qualified Medicare beneficiary under the provisions of chapter 67:46:11, with benefits limited to the part A and B premium, deductible, and coinsurance charges;
17. A person determined to be a Special Low-IncomeMedicare beneficiary under the provisions of chapter 67:46:11 whose income is at least 100 percent, but less than 120 percent of the federal poverty level. Benefits are limited to payment of part B Medicare premiums;
18. A person determined to be a qualified Medicare beneficiary under the provisions of chapter 67:46:11 whose income is at least 120 percent, but less than 135 percent of the federal poverty level, and who is not otherwise eligible for Medicaid. Benefits are limited to payment of part B Medicare premiums. The department may discontinue services provided under the provisions of this chapter if the department exhausts its financial resources for providing the services;
19. A person who is eligible for and is receiving services under the home and community-based services waiver program in chapter 67:44:03 or the home and community-based services program in chapter 67:54:04;
20. A disabled widow or a disabled widower who is at least age 50 but less than age 65, who was terminated from SSI due to receipt of social security benefits under Title II of the Social Security Act, as amended to July 1, 2014, who is not on Medicare part A, and who would continue to be eligible for SSI if the Title II benefits are disregarded;
21. A disabled adult who became disabled or blind before age 22 and was terminated from SSI due to entitlement to social security benefits as an adult disabled child, but who would remain SSI-eligible if the social security benefits are disregarded;
22. A child born to a woman eligible for and receiving Medicaid on the date of the child's birth. Eligibility continues for up to one year as long as the child remains a resident of the state;
23. A child under age 21 who is under the jurisdiction of the South Dakota Department of Corrections, is not an inmate of a public institution, does not reside with a parent, and meets the income requirements as established under the provisions of chapter 67:46:12;
24. A child under age 26 who, on the child's eighteenth birthday, was in foster care under the responsibility of the state; and
25. A woman over age 29 and under age 65 who was screened for breast and cervical cancer by the Department of Health's All Women Count Program and who is in need of treatment for breast or cervical cancer or a precancerous condition of the breast or cervix, is not covered under creditable coverage, and is not otherwise eligible for medical services.

For purposes of this rule, a qualified alien who arrived in the United States after August 21, 1996, and who meets the eligibility requirements contained in this section must also meet the requirements of § 67:46:01:10.

8010 REQUIREMENTS FOR MEDICAID

The requirements for Medicaid can be divided into two basic areas:

1. Non-Financial

* Must be a resident of South Dakota
* Must be a US citizen or qualified alien.
* Must provide a Social Security Numbers
* Assignment of rights to medical support and payment
* For certain groups, individuals must have medical needs that are such that they require a level of care provided in a long term care facility.

1. Financial

* Income

Earned Income (wages, salary)

Unearned Income (disability benefits, retirement benefits, unemployment benefits, etc.)

Resources

Cash or anything an individual owns that can be converted to cash

8015 DSS APPLICATIONS

Applications are available at:

1. The DSS website  
   <http://dss.sd.gov/medicaleligibility/familieschildren/medicalassistance.asp>
2. All Department of Social Services offices
3. Most SD Medicaid providers.
4. [http://Healthcare.gov](http://healthcare.gov/) Individuals assessed as potentially eligible for Medicaid/CHIP by the Federally Facilitated Marketplace will be forwarded to the Division of Economic Assistance for a Medicaid/CHIP eligibility determination.

The application process for Medicaid can be done entirely by mail.

An application for one medical program is considered an application for all programs.

Note: Individuals eligible for SSI payments are automatically eligible for Medicaid in SD, no application is necessary.

8020 INMATES OF PUBLIC INSTITUTIONS

Medicaid coverage may be available for an otherwise Medicaid eligible inmate who is admitted to a Medical institution for more than 24 hours if the following conditions are met:

1. The inmate must be hospitalized in a Medicaid eligible medical institution for at least 24 hours; and
2. It must be medically necessary for the inmate to be in a medical institution for more than 24 hours; and
3. The inmate must apply for and be found eligible for a Medicaid coverage group.

Medicaid is not available when medical care is provided to an inmate at a clinic, physician office, prison hospital, dispensary, or on an outpatient basis.

8030 CITIZENSHIP AND ALIENAGE

An alien who entered the United States before August 21, 1996 may be Medicaid eligible providing the alien is otherwise eligible for Medicaid. An alien who entered the United States after August 21, 1996 is ineligible for Medicaid for a period of five years from the date of entry. There are a few exceptions to this rule. When dealing with an alien, the county should contact a medical caseworker from the Department of Social Services to determine whether the alien might qualify for medical assistance.

8031 ALIEN/IMMIGRANT - ELIGIBILITY FOR EMERGENCY SERVICES

Medicaid may be provided on behalf of an ineligible alien for care and services that are necessary for the treatment of an emergency medical condition. The Social Security Act defines an "emergency medical condition” as "a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

8040 RETROACTIVE MEDICAL ELIGIBILITY (GENERAL PROVISIONS)

Under certain conditions, eligibility for medical assistance may be made retroactive to the first day of the third month prior to the month of application. For this reason, it is critical an application for initial eligibility be made as soon as possible to ensure coverage for the retroactive months in which the individual may have incurred medical expenses. An individual may be eligible all three months, or two months, or one month, depending on the Medicaid category of assistance being considered and whether the individual meets the eligibility criteria. All eligibility criteria must be met for each of the months for which eligibility is established. The basic concept of retroactive eligibility is "would the individual have been eligible if he/she had applied during the three-month period."

A separate application is not necessary. Individuals can simply ask to be assessed for retro eligibility. This is true for all groups.

8050 HOSPITALIZED LESS THAN 30 DAYS

An individual in a medical facility less than 30 days qualifies for Medicaid if the following conditions are met:

1. The individual’s/household’s income is between $0 and the current SSI standard benefit amount;
2. The individual’s/household’s resources do not exceed SSI's maximum  
   allowable limit; and
3. The individual would be eligible for SSI if the individual were not in a medical facility. This includes a disability determination that meets SSA criteria for those individuals under the age of 65.

This does not mean the individual must meet eligibility criteria the month prior to the month of hospitalization. Eligibility is considered for the month of hospitalization only. Parental deeming of income and resources applies to children confined less than 30 days. If a child is ineligible due to the parent’s income, the Department of Social Services will consider eligibility under another Medicaid category. The income and resources of a married couple are considered if confinement is less than 30 days. The individual does not have to be currently receiving SSI but would be eligible if application had been made. Regardless, a referral should be made to the Social Security Administration.

If there is a reason why the Social Security Administration will not determine eligibility for a cash payment (i.e. the individual died) the South Dakota Department of Social Services will take a long-term care application using SSI methodologies. If the individual was confined in a medical facility, a long-term care application is required in addition to the SSI application. The individual should be referred to both the Social Security Administration to apply for SSI and the Department of Social Services to apply for long-term care.

There must be a finding the individual is aged, blind, or disabled. If the individual is aged, there is no need to pursue a disability determination. A disabled individual must not be capable of engaging in substantial gainful activity.

There is no minimum length of stay as long as the individual's income is between $0 and the maximum SSI standard.

8060 HOSPITALIZED MORE THAN 30 DAYS

An individual in a medical facility over 30 days qualifies for medical assistance if income is between $0 and 300 percent of the current SSI standard benefit amount and if resource and disability criteria for long-term care are met. There must be a 30 consecutive-day confinement. For children under the age of 18, the Department will consider a parent's income for the partial month of hospitalization. Exception: The parent's income cannot be considered the month of birth for a child born in a medical facility and hospitalized over 30 days. The Department considers only the income and resources which are available to the child. This does not apply to children hospitalized less than 30 days. The income of a community spouse is not counted during any month if the hospitalized spouse is expected to remain institutionalized for at least 30 consecutive days. Spousal impoverishment provisions are applied after 30 consecutive days of confinement.

An applicant for long-term care assistance whose income meets the set percent of the SSI standard meets the requirement of being confined to a nursing or medical facility for 30 consecutive days when the reason for discharge prior to the 30-day period is death. In these cases, eligibility for long-term care begins with the date of admission to the facility. Eligibility for other Medicaid-covered services such as physician, pharmacy, and hospital services begins with the first day of the month for which long-term care eligibility begins.

8070 MEDICAID FOR DECEASED INDIVIDUAL

Applications may be made on behalf of a deceased individual who was in a hospital or medical facility prior to death. A medical or nursing facility includes the Human Services Center (Mickelson Center) and Veterans Hospitals. While Medicaid counts the days an individual was in these types of facilities, it does not pay for the services at those facilities. The application must be made with the Department of Social Services. Due to the retroactive eligibility period, the application must be made within three months of the individual's death. Depending on the length of time the individual was in the facility before dying (less than 30 days, more than 30 days), the Department will apply the applicable eligibility criteria.

The Social Security Administration does not determine SSI eligibility for deceased individuals. If an individual had a case pending with the Social Security Administration, the Social Security Administration will immediately close the case and all action will cease. At this point, an interested third party (preferably someone who has knowledge of the deceased person’s financial status and property) may make an application with the Department of Social Services. The Department's Disability/Incapacity Consultation Team will determine disability if the individual was not receiving a Social Security benefit prior to death due to disability, blindness, or age. If the Social Security Administration denied eligibility and the case was on appeal when the individual died, the Department of Social Services cannot overrule the Social Security Administration's decision. The Department can, however, review the case to see if there was a change in circumstances that would warrant a finding of eligibility. Again, the application must be made with the Department of Social Services within the three-month period immediately following the individual's death.

When the application is for a deceased newborn, where the Social Security Administration did not determine SSI eligibility, medical documentation will need to be obtained from the physician or the hospital to verify the date of birth, date of death, and cause of death. A deceased infant can become eligible only at the point that life existed. A stillborn child does not constitute a live birth and, therefore, is not eligible as a deceased infant. A birth record will be issued for any live birth, regardless of the length of life. If life did not exist, a fetal death certificate is issued and eligibility would be denied.

When an application is received on behalf of a deceased individual who had been in a long-term care facility prior to death, eligibility is determined as though the individual was alive. All income, resources, and disability criteria for long-term care must be met.

8100 REHAB SERVICES

For purposes of Medicaid reimbursement, a hospital must have an authorization from the Medicaid Care Manager before admitting an individual to a psychiatric unit, a neonatal unit, or a rehab unit. If the individual is admitted because the Medicaid Care Manager is not available, notice must be made to the Care Manager within one working day of the admission. Before care is authorized, the hospital must provide medical documentation that substantiates that the admission is medically necessary.

8200 LONG TERM CARE RELATED PROGRAMS

Long Term Care Includes:

* Hospital, swing-bed hospital, nursing home, assisted living, and adult foster care.
* Waiver Services including personal and nursing services provided to an individual in need of care in an institution, but who chooses to remain in his/her own home. Also included are people in Assisted Living who need help with medication administration.
* Specific services provided by community support providers (formerly known as adjustment training centers).

Income Limit:

* Individuals in a facility more than 30 days.
* Monthly income limit - $2,163 (300% of the Supplemental Security Income (SSI) standard benefit amount). Individuals with income exceeding this amount may establish an irrevocable income trust in order to become eligible. DSS has examples of income trusts available.
* Individuals confined less than 30 days.
* Monthly income limit - $741 (2014 SSI standard benefit amount).
* Resource Limit - $2,000 (transfer penalties may apply if resources are given away)
* Additional Rules apply for individuals with spouses.

1. MEDICARE SAVINGS PROGRAMS

There are three different Medicare Savings Programs:

1. Qualified Medicare Beneficiary Program (QMB)

* Pays for Part A (if not free) and B Premiums.
* Individuals on this program will receive a Medical ID Card, but benefits are limited to payment for Medicare’s deductibles, co-insurance and co-payments. If a service is not covered by Medicare this program will not cover either.

1. Specified Low-Income Beneficiary Program (SLMB)

* Pays for Medicare Part B Premium.

1. Qualified Individuals Program (QI)

* Pays for Medicare Part B Premium.

Monthly Income limit

1. QMB

* Have income under 100% of the federal poverty level and be entitled to, but not necessarily enrolled in, Medicare Part A.  
   $ 973 Single \* $ 1,313 Couple\*

1. SLMB

* Have income that exceeds 100% but less than 120% of the federal poverty level and be entitled to, but not necessarily enrolled in, Medicare Part A.  
   $ 1,167 Single\* $ 1,573 Couple\*

1. QI

* Have income between 120% and 135% of the federal poverty level and be entitled to, but not necessarily enrolled in, Medicare Part A. QI recipients cannot be eligible for any other Medicaid program.  
  $ 1,313 Single\* $ 1,770 Couple\*

\*2014 income limits – Increases each year with Federal Poverty Levels

Resource Limit - $7,160 Single or $10,750 Couple

8400 MEDICAL ASSISTANCE FOR WORKERS WITH DISABILITIES (MAWD)

MAWD provides healthcare coverage through Medicaid for individuals who are determined to be disabled through Social Security Administration or the MAWD disability determination process, who are working, have unearned income less than the SSI maximum, and total income less than established percentage of the federal poverty level. Countable resources of the individual must be less than $8,000. NOTE: The income and resources of the spouse and children are not counted.

Requirements for MAWD:

1. Must be a South Dakota resident;
2. Must be working, there is no minimum or maximum number of hours;
3. Must be within the income limits of the program (spousal income and resources are not countable);
4. Countable resources for the single individual may not exceed $8,000;
5. Must meet the program’s disability requirements which are the SSI standards. If the individual is already qualified for SSD, no disability determination is needed and the application is processed for financial eligibility only.

NOTE: For current income and resource limits, contact your local Department of Social Services for all programs outlined above.

DSS CONTACT PERSON: Jolene Brakke (Program Administrator) – (605)-773-4678

CHAPTER 9

SPECIALIZED SURGICAL HOSPITALS

9000 GENERAL PROVISIONS

The South Dakota Department of Health has created a new classification of "hospital" called a "specialized surgical hospital". A specialized surgical hospital can be a unit within a hospital that performs same-day surgery or it may be a stand-alone, same-day surgical center. The difference is these units/centers have added beds in which they can keep patients for very short stays (usually one or two days) following a surgical procedure.

Traditionally, the "same-day surgery centers" have been more cost effective. Their costs are lower because they are not considered a full-service hospital and are not required to maintain the extra services and staffing that a hospital would have.

Currently, DSS limits the services that may be performed in an ambulatory (or same-day) surgical center. Payments for surgical procedures performed at an ambulatory surgical center are much lower when compared to an in-patient hospital stay. Since the inception of the specialized surgical hospital, however, we are seeing ambulatory surgical centers move over into this new category. These facilities are treated like hospitals for purposes of reimbursement.

A specialized surgical hospital may provide both inpatient and outpatient services. You can determine the type of service by looking at block #4 on the UB-04. That block should contain a three-digit number, if it is an outpatient service, the middle digit will be a "3”. For example, if a code of 131 is reported, the middle digit tells us that the care being billed is for an outpatient service. For additional information regarding codes for UB-04, check the Center for Medicaid and Medicare Services (CMS) or UB-04 websites.

9100 REIMBURSEMENT FOR OUTPATIENT SERVICES

Surgical procedures covered by Medicaid are limited to those procedures listed on the DSS website: <http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp>

Medicaid reimbursement for an outpatient stay includes recovery and observation room charges unless the patient is required to stay in excess of 12 hours after the completion of the outpatient service. If the stay exceeds 12 hours, payment for the additional hours is based on a percentage of the billed charges. This percentage is established by DSS.

1. REIMBURSEMENT FOR INPATIENT SERVICES

If the service is an inpatient service, Medicaid reimbursement is calculated according to a percentage established by DSS.

The Department of Social Services will continue calculating the Medicaid rate of reimbursement on these claims for you.

9300 CALCULATING THE COUNTY RATIO OF COST TO CHARGE

A specialized surgical hospital must submit their cost statements to the Department of Social Services so a determination can be made as to the ratio of cost to charge. Failure to file a cost report with DSS results in non-payment from the county. Because payment is the lower of Medicaid or the county's ratio of cost to charge, you must have both calculations in order to determine the county's level of payment.

CHAPTER 10

PRICING CLAIMS

10000 HOSPITALS – INPATIENT (SDCL 28-13-29)

For purposes of calculating the individual’s “ability to pay” a hospital bill, the county must request from the hospital a completed UB-04 for the hospital stay. An example of this form may be found in Appendix M. Effective July 1, 1997, state statutes specify that the county’s rate of payment is limited to the actual cost of hospitalization or the Medicaid rate of payment, whichever is less. The county’s rate of payment is based on the cost statement that each hospital files with the Department of Social Services (DSS). These cost statements are usually filed annually; however, if a cost statement is not filed, the last cost statement filed remains in effect until the next cost statement is filed with and approved by DSS. It is important to note that an approved cost statement does not go into effect until DSS has approved the statement and 30 days have expired since the report was received.

In order to obtain the lowest rate of payment, the county must send the original UB-04 that breaks out the hospital’s ratio of costs to charges for the county to the below address:

Denise Young

Department of Social Services

700 Governors Drive

Pierre, SD 57501-2291

(605) 773-6375

Once the UB-04 is priced, it will be returned to the county with the Medicaid pricing information attached. It is the county’s responsibility to maintain this pricing information in the individual’s file. If county payment is based on the Medicaid price, these documents constitute the evidence for the Medicaid pricing. The Department of Social Services does not maintain copies of these documents. If a hospital questions the pricing, it is the county’s responsibility to produce the documentation that substantiates the calculated price and to relay the pricing information back to the hospital.

Occasionally, DSS will note some inconsistencies in coding on the UB-04. If that happens, DSS will want to review the individual’s medical records from the hospital stay. (This is another very important reason why the county needs to ensure that the individual has signed a Release of Medical Information form.) It will be up to the county to contact the hospital, request the needed information, and forward the information to DSS. When the medical review has been completed, DSS will return all the records to the county together with the results of the review and the final pricing scheme.

10010 USING THE RATIO OF COST TO CHARGE STATEMENT

A hospital is required to annually file with DSS a report that details the hospital’s costs in relation to the hospital’s actual charges. This is called The Ratio of Cost to Charge Statement found in Appendix O and is one of two methodologies used to determine the county’s financial responsibility for the hospital expenses of an eligible individual. The report is based on the hospital’s costs for the hospital’s most recent fiscal year. For example, Rapid City Regional’s fiscal year runs from July 1 through June 30.

When the hospital submits the cost report to DSS, DSS investigates the report and either recommends amendments or approves the report as submitted. The report is not effective until DSS has approved the report and 30 days have expired since DSS received the report. Once this report is in effect, it remains in effect until the next statement of costs is filed with and approved by DSS.

To obtain Hospital Cost statements log into: <http://apps.sd.gov/applications/sw30login/> USERNAME: sdcounty

PASSWORD: costshare

The website will list the two latest cost statements.

Although the hospital will calculate the ratio of cost to charge for the particular claim involved, it is important the county audit the bill to determine if the hospital has used the correct ratio and room/bed rates when computing the claim. When determining the ratio of cost to charge on an eligible claim, it is important the correct hospital statement of cost is used. The effective day of the cost statement must coincide with the date of service on the hospital’s claim for reimbursement. Remember, the hospital’s cost statement is based on the prior year’s expenses and the resulting ratio of cost to charge statement must be applied prospectively to claims incurred after the hospital has filed its cost statement and it has been approved by DSS.

If a facility has failed to file a new cost statement, the county must use the most recent one on file with DSS. If a county’s residents traditionally use an out-of-state hospital to obtain their needed services, the county should ask the out-of-state hospital to complete a cost statement so a ratio of cost to charge can be applied on that hospital’s claims.

If an individual’s hospitalization spans two different cost statements, the county should apply the cost statement that was in effect on the date of admission.

10020 HOSPITALS – OUTPATIENT AND SAME-DAY SURGERY

Outpatient hospital claims should also be sent to DSS if the outpatient service is for a same-day surgical procedure or an MRI. Before sending this UB-04 for pricing, the county should check the UB-04 to ensure that any revenue codes (found in Block #42) of 300 (Laboratory) or 360 (OR Service) contain a HCPCS code in block #44. The claim cannot be priced without these codes.

When the county receives a hospital bill for an outpatient service, the county will need to ascertain whether the outpatient service includes a surgical procedure from the hospital’s same-day surgery unit. Check Block #43 to see if there is an O.R. service listed. If the UB-04 contains an O.R. service, check Block #44 to make sure there is a procedure code listed for the O.R. service. If that procedure code is missing, the county will need to call the hospital and obtain that code. Simply write the code on the UB-04 and forward the UB-04 together with the county ratio billing to DSS for pricing.

If there is no O.R. service listed and the bill contains only diagnostic services such as lab and radiology, there is no need to send the bill to DSS for pricing. If the county pays this bill, payment should be at the ratio of cost to charge.

10030 HOSPITALS – OUT-OF-STATE

An out-of-state hospital bill should be submitted on a UB-04.

10040 SPECIALIZED SURGICAL HOSPITALS

A claim from a specialized surgical hospital will either be submitted on a UB-04 or it may simply be a bill submitted on a county claim form. Whichever form is used, the claim must include the O.R. procedure code and the provider’s usual and customary charge. Once this is obtained, forward this documentation to DSS for pricing.

As with a full-service hospital, a specialized surgical hospital must submit its cost statement to DSS so a determination can be made as to the facility’s ratio of cost to charge. Failure to file a cost report with DSS results in the facility’s ineligibility to receive reimbursement from the county. Because payment is the lower of Medicaid or the ratio of cost to charge, the county must have both calculations in order to determine the correct rate of payment. If the specialized surgical hospital fails or refuses to provide the county with a ratio of cost to charge billing, the county must consider the entire bill at the ancillary rate reported on the specialized surgical hospital’s Ratio of Cost to Charge Statement (Appendix O) filed with DSS.

10100 AMBULATORY SURGICAL CENTERS

Services provided at an Ambulatory Surgical Center (ASC) should be priced according to Medicaid methodology. The surgical service must be identified by a procedure code. Use the reported procedure code and Chapter 67:16:28 of the Medicaid rules to determine the correct rate of payment.

10200 PHYSICIANS

A claim for a physician’s service should always include the CPT code, the date of service, the number of units supplied, and the physician’s usual and customary charge for the service. “CPT” stands for “Current Procedural Terminology”. The CPT is the code that identifies the procedure performed by the physician. The purpose of using a CPT code is that it provides a uniform language that accurately describes the medical, surgical, or diagnostic service provided. If Medicaid covers the procedure, Medicaid has a price for that particular code.

If a county agrees to pay a physician’s bill for services provided to an eligible individual, the county should calculate the rate of payment either according to Medicaid methodology or the county could negotiate with the provider for a straight percentage reduction. If a straight percentage reduction is taken, the reduction should be at least 30 percent of the billed charge. If a county rarely pays for a physician’s services, the county may choose to work directly with the physician to establish a percentage reduction from the billed charge. If the county chooses to use the Medicaid methodology, the county will need to obtain the pricing information from DSS website or the county may wish to request another county that is familiar with the Medicaid pricing scheme to price the claims for them.

A claim is priced by its procedure code. For each service billed, there must be a procedure code reported. Use that procedure code and the Medicaid rules located at Chapter 67:16:02 to price the claim. These codes and pricing schedules are updated periodically and the county will need to go to the website each time it prices a bill.

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

10300 DENTAL SERVICES

Payment for dental services may be calculated either according to the Medicaid payment methodology or the county could negotiate with the provider for a straight percentage reduction. If the county chooses to use the Medicaid methodology, the county will need to obtain the pricing information from DSS website. Dental claims are priced by procedure code. For each service billed, there must be a procedure code reported. Use the reported procedure code and the pricing information from DSS to calculate the rate of payment. Dental claims are subcontracted through Delta Dental, for questions regarding dental Medicaid pricing contact 1-800-627-3961.

If the county chooses to use a straight percentage reduction, the county should work directly with the provider to obtain an agreeable rate of reduction.

10400 AMBULANCE SERVICES

If a hospital provides an air ambulance service, the hospital must submit its claim to the county at the Ratio of Cost to Charge (Appendix Q). The claim must indicate whether the transport was made by a fixed-wing plane or by a helicopter and must include the number of loaded air miles. Medicaid reimbursement for an air ambulance is calculated according to § 67:16:25:03.04. The county’s liability is limited to the lesser of the ratio of cost to charge or the Medicaid rate.

If a ground ambulance was used to transport the individual from the hospital to the airport or from the airport to the hospital, the claim for the ground ambulance must be submitted by the ground ambulance provider.

Payment for a ground ambulance is based on the Medicaid rate of reimbursement and is calculated according to § 67:16:25:03 or 67:16:25:03.01, as applicable. The claim must indicate whether the service provided was Advanced Life Support (ALS) or Basic Life Support (BLS), it must specify the services provided, and it must specify the number of loaded miles traveled. These codes and pricing schedules are updated periodically and the county will need to make sure it is using the most current version of these schedules when pricing claims.

Charges for transporting an individual from the airport to the hospital or from the hospital to the airport should be billed by the ground ambulance and should not be included in the air ambulance charge. Charges for air ambulance services should be billed by the provider and should not be included in the individual’s hospital bill. The provider may bill only if the individual was actually transported. Medicaid payment limits for ambulance services are established in chapter 67:16:25 DSS rules.

10500 OTHER MEDICAL SERVICES

Payment for other medical services, such as x-ray, lab, or medical equipment, may be calculated either according to the Medicaid payment methodology or the county could negotiate with the provider for a straight percentage reduction.

If the county chooses to use the Medicaid methodology, the county will need to obtain pricing information from DSS website. For each service billed, there must be a procedure code reported. Use the reported procedure code and the pricing information from DSS to calculate the rate of payment.

CHAPTER 11

MEDICAL REVIEWS BY DEPARTMENT OF SOCIAL SERVICES

A medical review of a medical claim can occur three different ways:

1. The Department of Social Services (DSS) may need additional information so the hospital's claim for services (UB-04) can be priced;
2. The county may request DSS to review a claim for services; or
3. The county may have a request for prior approval of a service and would like DSS to review the request and make a determination of medical necessity.

The hospital's UB-04 (Appendix O) contains a series of numbers that identify such things as the type of admission; the hour of the admission; whether the patient was discharged home, to another facility, or died; the diagnostic codes; and the procedure codes. These numbers are fed into DSS’s computer system. The system reads the codes, assigns a Diagnostic Related Grouper (DRG) code, and prices the hospital stay. The system identifies some diagnostic codes as "complicating conditions” to the primary diagnosis. When these “complicating conditions" appear, the system calculates a higher rate of reimbursement to account for it. For example: an individual's UB-04 may contain a primary diagnosis of an acute myocardial infarction and secondary diagnoses of obesity and tobacco abuse. It is highly questionable whether during the course of care, anything was done to treat either the tobacco abuse or the obesity. DSS may request that the county send in a copy of the individual's discharge summary.

Once that information is obtained, DSS will review the medical documentation to determine whether the individual was treated for the secondary diagnoses. If no treatment was provided, DSS will remove those codes and re-price the UB-04.

The county could request a medical review of a hospital bill. For example: a county receives a UB-04 for an individual who was admitted for a sore throat. The county could question the need for the admission and whether or not it was really an emergency situation. The county could request DSS to review the claim for a determination of medical necessity. The county would need to obtain the medical records from the hospital and send the records and the UB-04 to DSS for review.

Lastly, the county may have a request from an individual or a hospital for prior approval of a scheduled procedure or for the acquisition of a prescribed medication. The county may question whether the surgery is medically necessary. The county could request the individual's medical records and forward the records to DSS along with a request for a review of medical necessity.

In order to obtain the needed medical records, the county will have to send to the hospital a copy of the Release of Medical Information (Appendix B) that has been signed by the individual. Requests for medical information should be made in writing to the hospital.

A county should request a review through DSS only when the county is not able to make the determination after it receives and reviews the requested documents.

In any case, medical reviews must be forwarded to the county liaison at the Department of Social Services and sent to:

Denise Young

Department of Social Services

700 Governors Drive

Pierre, SD 57501

(605) 773-3305

CHAPTER 12

CATASTROPHIC COUNTY POOR RELIEF PROGRAM

12000 GENERAL PROVISIONS

The Catastrophic County Poor Relief (CCPR) Program was created during the 1984 legislative session and was designed to allow counties to pool their resources into a central fund and to use those pooled funds to provide relief to counties faced with paying catastrophic medical expenses involving county poor relief recipients. A catastrophic medical expense is one that exceeds $20,000 during a twelve-consecutive-month period. The CCPR program is administered by the South Dakota Association of County Commissioners (SDACC) and a five-member board appointed by the executive board of the Association of County Commissioners. County participation in the program is optional. Issues concerning the CCPR program and contacts with and correspondence to the CCPR Board should be directed to the CCPR Program Administrator at the below address:

Kris Jacobsen, Administrator

Catastrophic County Poor Relief Program

South Dakota Association of County Commissioners

222 E Capitol Ave Suite 1

Pierre, SD 57501

(605) 224-4554

12100 CATASTROPHIC COUNTY POOR RELIEF CLAIMS

Because the county is the payer of last resort, a county must pursue the availability of a third‑party payment source before accepting responsibility for a catastrophic claim. A third‑party payment source is the obligation of an entity other than the county for either partial or full payment of the medical cost of injury, disease, or disability. Third‑party payment sources include coverage such as Medicare, Medicaid, private health insurance, workers' compensation, supplemental security income, disability insurance, and automobile insurance.

The county must be able to document pursuit of the availability of a third‑party payment source. The documentation must be maintained in the individual's record. When the claim is subsequently submitted to the CCPR program for payment, evidence of the third‑party payment or rejection must accompany the claim. (CCPR Procedure Manual Appendix GG))

The county’s rate of reimbursement to a hospital is the actual cost of hospitalization determined according to the hospital’s cost statement or the amount payable under the state’s Medicaid system, whichever is lower. The responsibility for reviewing, approving, and maintaining copies of the hospitals’ cost statements was transferred to the Department of Social Services. Questions’ relating to a hospital’s cost statement or requests for copies of cost statements should be directed to the following office:

Office of Provider Reimbursement & Audits

Department of Social Services

700 Governors Drive

Pierre, SD 57501

(605) 773-3643

Hospital claims covering both in-patient and same-day surgery cases must be submitted on both a UB-04 form and on the billing form which breaks out the hospital’s ratio of costs to charges for the county. To obtain the Medicaid pricing information, both of these forms must be forwarded to the South Dakota Department of Social Services at the below address:

South Dakota Department of Social Services

Medical Services

700 Governors Drive

Pierre, SD 57501

Once a claim is priced, the South Dakota Department of Social Services will return the claim to the County with the Medicaid pricing information attached. It is the county’s responsibility to maintain this pricing information in the individual’s file. If county payment is based on the Medicaid price, these documents constitute the evidence for the Medicaid pricing. The South Dakota Department of Social Services does not maintain copies of these documents. If a hospital questions the pricing, it is the county’s responsibility to produce the documentation that substantiates the calculated price and to relay the pricing information back to the hospital.

As soon as it appears to a county that the possibility of a catastrophic claim exists, the county is required to notify the CCPR program. Notification may be made either in writing or via a telephone call to the SDACC, 1-800-439-5672 or 1-605-224-4554.

12200 CATASTROPHIC COUNTY POOR RELIEF REIMBURSEMENT

Reimbursement from the CCPR fund for medical expenses is limited to those medical expenses that an individual has incurred over a 12-month period. This 12-month period is referred to as the individual’s “benefit period.” The 12-month benefit period begins with the first day an eligible individual incurs hospital or other medical expenses, as long as those expenses are used in establishing or computing a CCPR payment.

A county wishing to request reimbursement from the CCPR fund should do so on an Application for Reimbursement form (Appendix FF) and is also included in the CCPR Procedure Manual attachments.

The county should complete the Application for Reimbursement (Appendix FF) and return it, together with the necessary documentation/evidence, to the Administrator.

The amount of requested reimbursement for each provider should show the amount billed by the provider, the amount actually paid by the county, the required deductions ($20,000 + 10% county share), and the balance due from the CCPR fund. Regardless of the amount paid, the rate of reimbursement from the fund for a hospital expense incurred after June 30, 1997 may not exceed the hospital’s ratio of cost to charge or the Medicaid rate of reimbursement, whichever is lower.

EXAMPLE:

|  |  |  |
| --- | --- | --- |
|  | Actual Bill | Paid by County |
| Sanford Hospital | 40,000.00 | 28,000.00 |
| St. Mary Hospital | 60,000.00 | 51,000.00 |
| Smith’s Medical Supplies | 2,000.00 | 1,700.00 |
| Bill’s Pharmacy | 700.00 | 595.00 |
|  |  |  |
| TOTALS | 102,700.00 | 81,295.00 |
|  |  |  |
| LESS: |  |  |
|  |  |  |
| County Deductible |  | -20,000.00 |
| County Share (10% of balance) |  | -6,129.50 |
|  |  |  |
| Balance to be Paid by CCPR Fund |  | $55,165.50 |

If the county determined that the individual had an ability to pay part of the hospital bill, the

amount contained in the “Paid by County” column must reflect the county’s share after deducting

the client’s share.

The county must provide evidence that will substantiate the claim, the dates of service, the individual’s and the county’s share of the bill, and the amount paid by the county. Evidence supporting the individual’s and county’s share must consist of a copy of the county’s calculations made on the Ability to Pay Form (Appendix F). If county payment to a hospital was based on the Medicaid rate, the county must include a copy of the documentation from Medicaid that calculates the Medicaid payment rate. In order to expedite payment, the county should also transmit a voucher (Appendix FF) that has been signed in the lower left-hand corner by either the county board chair or vice chair.

A county may submit more than one voucher per individual but one voucher may contain claims for only one individual. A copy of the voucher will be returned to the county.

If this is the county’s first claim on behalf of an eligible individual, the evidence submitted by the county will need to show that the county has met its $20,000 share of the expenses for the individual for the 12-month period in which the services were provided.

If a county carries an individual into a new 12-month benefit period, the individual’s medical expenses for the new 12-month period must again exceed $20,000 before his/her medical expenses would again be eligible for reimbursement from the fund.

When a county submits a claim for reimbursement or voucher (Appendix DD), the following documents must be submitted with the claim:

1. A completed CCPR Application for Reimbursement (Appendix FF);
2. A copy of the hospital bill showing the dates of service and the charges;
3. A copy of the UB-04 pricing scheme if the county paid the hospital bill based on the Medicaid rate;
4. The application for county assistance or the completed ability to pay form that contains the individual’s and the county’s share of the hospital bill;
5. Evidence the county has paid the bill, together with an indication as to the amount paid;
6. If the claim is for an organ transplant, evidence of compliance with SDCL 28‑13A‑13;
7. Evidence the county has paid its $20,000 +10 percent share; and
8. A voucher which has been signed by either the county board chair or vice chair.

If, within the same 12-month period, the county submits subsequent claims on behalf of the same individual, the county does not have to re-establish the fact that the county has met its $20,000 share of the expenses.

For complete instructions, refer to the Catastrophic County Poor Relief (CCPR) Procedures Manual (Appendix GG).

NOTE: A claim for reimbursement from the CCPR program may be denied if eligibility is not determined according to the statutes and the CCPR guidelines.

TABLE OF APPENDICES

APPENDIX DESCRIPTION

A ……………….. NOTICE OF HOSPITALIZATION

B ………………. RELEASE OF MEDICAL INFORMATION

C ………………. RELEASE OF FINANCIAL INFORMATION

D ………………. COUNTY RELEASE OF INFORMATION FORM

E ………………. HOSPITAL APPLICATION FOR COUNTY ASSISTANCE

F ………………. ABILITY TO PAY FORM

G ………………. EMERGENCY MEDICATION ASSISTANCE APPLICATION

H ………………. MEDICAL FINANCIAL FORM

I ………………. NEEDYMEDS.COM

J ………………. GENERAL APPLICATION FOR COUNTY ASSISTANCE

K ………………. APPLICATION FOR COUNTY MEDICAL ASSISTANCE

L ………………. REQUEST FOR FINANCIAL INFORMATION

M ………………. NOTIFICATION OF COUNTY ASSISTANCE

N ………………. NOTICE OF INELIGIBILITY

O ………………. UB-O4

P ………………. 1500 CLAIM FORM

Q ………………. COUNTY COST-TO-RATIO FORM

R ………………. FORMS FOR MEDICATION ASSISTANCE

S ………………. EMPLOYMENT VERIFICATION FORM

T ………………. VERIFICATION OF MEDICAL NECESSITY

U ………………. WORK ABILITY FORM

V ………………. PRE-AUTHORIZATION ESTIMATE OF COST FORM

W ………………. PHYSICIAN REVIEW FORM

X ………………. MEDICAL CASEWORKER REFERRAL FORM

Y ………………. AUTHORIZATIONS FOR PAYMENT

Z ………………. SNAP BENEFIT AMOUNTS (EFFECTIVE 10/1/14)

AA ………………. NOTICE OF COUNTY/PATIENT SHARE

BB ………………. REQUEST FOR FINANCIAL INFORMATION

CC ………………. CHECKLIST FOR RETROACTIVE MEDICAID

DD ………………. POTENTIAL RETROACTIVE MEDICAID AGREEMENT TO REPAY COUNTY

EE ………………. NOTICE OF RETROACTIVE MEDICAID ELIGIBILITY

FF ………………. CATASTROPHIC COUNTY POOR RELIEF (CCPR) SUBMISSION FORMS

GG ………………. CCPR PROCEDURE MANUAL – 2010 VERSION