

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations, CMSO

Mr. Larry Iversen, Administrator
Medical Services
Department of Social Services
Kneip Building
700 Governors Drive
Pierre, SD 57501-2291

AUG 13 2009

Re: South Dakota 09-007

Dear Mr. Iversen:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-007. Effective for services on or after April 17, 2009, this amendment eliminates obsolete and outdated language pertaining to the per diem reimbursement methodology for nursing facilities.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-007 is approved effective April 17, 2009. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please contact Christine Storey at (303) 844-7044.

Sincerely,

 Cindy Mann
Director
Center for Medicaid and State Operations

cc: Deborah K. Bowman, Secretary
Department of SD Social Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 09-7	2. STATE SOUTH DAKOTA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 17, 2009	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.250 through 447.280		7. FEDERAL BUDGET IMPACT: a. FFY09--\$0 b. FFY10--\$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Pages 2, 5, 6, 12, and 14		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19- D, Pages 2, 5, 6, 12, and 14	
10. SUBJECT OF AMENDMENT: This is a State Plan Amendment to clarify reimbursement methodology and remove obsolete timelines and reimbursement provisions for reimbursement of nursing facilities.			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
13. TYPED NAME: Deborah K. Bowman		Department of Social Services Division of Medical Services 700 Governors Drive Pierre SD 57501-2291	
14. TITLE: Department Secretary			
15. DATE SUBMITTED:			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: 8-13-09	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 17 2009		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: William Lasowski		22. TITLE: Deputy Director, CMSO	
23. REMARKS:			

6. Participation in the program as a provider of nursing facility services is limited to those facilities that accept as payment in full the reimbursement established under this Plan for the services covered by the Plan.
7. All nursing facilities must meet nursing facility requirements and OBRA requirements as required under certification and licensure standards.
8. The Department will conduct field audits of cost reports that meet or exceed the scope of Title XVIII specifications. All facility cost reports are subject to desk audit, with field audits conducted as necessary. Additionally, the department may audit any facility prior to any ownership change, the scope of the audit to be determined by the Department.
9. The Department will account for all audit exceptions on the CMS 64 in accordance with the State Medicaid Manual, Part 1, Section 2500.

TN #09-7
Supersedes
TN #08-8

Approval Date AUG 13 2009

Effective Date 4/17/09

Non-Routine Services. These services are considered ancillary for Medicaid payment. The costs of these services should be accounted per instructions for completing the Statistical and Cost Summary Report. The costs of these services must be billed by the physician, laboratory, pharmacy, agency, supplier, or therapist providing the service:

- a. Prescription Drugs;
 - b. Physician services for direct resident care;
 - c. Laboratory and Radiology;
 - d. Mental Health Services;
 - e. Therapy services when provided by someone other than a facility employee;
 - f. Prosthetic devices and supplies for prosthetic devices provided for an individual resident; and
 - g. Services provided by independent medical practitioner for the direct care of patients.
4. Reasonable costs shall be "appropriately documented allowable costs" that do not exceed the following limitations:
- a. Direct care costs (as defined in the Medicaid Cost Report and Instructions) shall be Case Mix adjusted and limited as follows:
 - 1) The Department will calculate median cost based on a case mix acuity level of 1.00 or more;
 - 2) The Department will then establish a minimum ceiling at 115% of the median and a maximum ceiling at 125% of the median;
 - 3) The Medicaid Program will pay 80% of the costs between the 115% ceiling and the 125% ceiling.

Any costs in excess of 125% will not be recognized. The ceiling limitations will apply to all nursing facilities participating in the State Medicaid program.

- b. Health and subsistence costs (consist of the categories of Health & Subsistence, Plan/Operation, and Other Operating as defined in the State Medicaid Cost Report) shall be limited as follows:
 - 1) The Department will calculate median cost based on a case mix acuity level of 1.00 or more;
 - 2) The Department will then establish a minimum ceiling at 105% of the median and a maximum ceiling at 110% of the median;
 - 3) The Medicaid Program will pay 80% of the costs between the 105% ceiling and the 110% ceiling.

Any costs in excess of 110% will not be recognized. The ceiling limitations will apply to all nursing facilities participating in the State Medicaid program.

- c. Administrative costs (as defined in the Medicaid Cost Report) shall be limited as follows:
 - 1) The Department will calculate median cost of all freestanding non-chain organization affiliated nursing facilities;
 - 2) The Department will then establish a minimum ceiling at 105% of the median and a maximum ceiling at 110% of the median;
 - 3) The Medicaid Program will pay 80% of the costs between the 105% ceiling and the 110% ceiling.

TN #09-7
Supersedes
TN #04-1

Approval Date **AUG 13 2009**

Effective Date 4/17/09

Section D—Other:

1. In computing annual per diem rates, costs subject to inflation which are submitted to the Department on the "Statistical and Cost Summary for Nursing Facilities" (Section A, Provision Number 3) shall be inflated in the statewide aggregate three percent annually. [Obsolete, effective July 7, 2009.]
2. Allowances may be made for known future costs due to new or revised Federal or State laws, regulations, and/or standards having an impact on costs incurred by nursing facilities. An explanation of costs of this nature must be attached to the "Statistical and Cost Summary for Nursing Facilities" if they are to be given consideration.
3. [Reserved.]
4. Statewide averages and allowable per diem rates shall be set annually prior to July 1, using cost reports submitted to the Department per Section A, Provision Number 3.

TN #09-7
Supersedes
TN #09-6

AUG 13 2009
Approval Date _____

Effective Date 4/17/09

8. The Department may establish provisional per diem rates for newly-constructed facilities and for facilities experiencing major expansion based upon projected costs. Facilities must submit their estimates of projected costs to the Department prior to the opening date of a newly-constructed or expanded facility.

Provisional per diem rates are effective for six (6) months, with rates being adjusted retroactively on the basis of actual costs. All rates discussed in this section shall be determined in accordance with the provisions of this Plan.

For a facility acquired through purchase or a capital lease, the daily rate of reimbursement is the amount paid to the facility under the previous operator. The rate shall be adjusted by inflation or other increases as allowed by the existing provisions of this Plan until the facility's new required financial reports are used to calculate rates. A change in operational ownership occurs when all of the following criteria are met:

- a. The legal right to make management, executive, operating, and planning decisions for the existing facility is transferred to a new organization;
 - b. The new organization is a separate organization and is not a parent, subsidiary, or related party of the existing facility; and
 - c. Neither the individuals associated with the existing facility nor the existing organization have the power, directly or indirectly, to influence or direct the actions or the policies of the new organization.
9. The reimbursement rate for out-of-state facilities providing nursing services to residents of the State of South Dakota shall be the lesser of the Medicaid rate established by the state in which the facilities are located or the South Dakota statewide average Medicaid rate for all in-state facilities. Payment to out-of-state facilities for care not available at in-state facilities shall be at the rate recognized for the facility by the Medicaid agency in the state in which the facility is located.
 10. Swing-bed hospitals shall be reimbursed on a per diem basis equal to the average Medicaid payment, excluding therapies, paid to nursing facilities during the previous calendar year, excluding intermediate care facilities for the mentally retarded. Swing-bed hospitals shall be reimbursed for assisted living care at the current maximum rate paid for assisted living care.

OS Notification

State/Title/Plan Number: South Dakota 09-007

Type of Action: SPA Approval

Required Date for State Notification: September 3, 2009

Fiscal Impact: FFY 2009 \$ 0
FFY 2010 \$ 0

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: This amendment provides for removal of obsolete and outdated language pertaining to per diem rate reimbursement for nursing facilities. Specifically, it removes obsolete provisions specific for the calculation of per diem rates to waived and non-waived facilities; removes historical timelines; and, clarifies methodology for provisional rates set for facilities that change operational status. There is no change to the existing State plan reimbursement methodology. The effective date for this proposed amendment is April 17, 2009. Public not was adequate and timely. State share of expenditures for all services under 4.19-D is from SD appropriated State General Fund dollars approved through the legislature. SD does not utilize IGTs, CPEs or provider taxes to provide the state share for payments made under 4.19D of the State plan and CMS has no other funding concerns at this time, specific to this amendment or otherwise.

Other Considerations: This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor. This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

CMS

Contact: Christine Storey, (303) 844-7044
National Institutional Reimbursement Team