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State/Territory Name: South Dakota

State Plan Amendment (SPA) #: SD-09-012

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations, CMSO

DEC 17 2009

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

RE: South Dakota 09-012

Dear Mr. Iversen:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-012. Effective for services on or after October 1, 2009, this amendment updates the reimbursement methodology for inpatient hospitals participating in South Dakota Medicaid. Specifically, this amendment incorporates the annual Medicare DRG Grouper change and revises cost outlier thresholds.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 09-012 is approved effective October 1, 2009. The HCFA-179 and the amended plan pages are attached.

If you have any questions, please call 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: **09-12**

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: **October 1, 2009**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.10 447.250-447.252 and 447.256-447.272

7. FEDERAL BUDGET IMPACT:
a. FFY10--$0
b. FFY11--$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 1 and 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 1 and 3

10. SUBJECT OF AMENDMENT:
This is a State Plan Amendment to update inpatient hospital reimbursement methodology for the annual Medicare rates grouper change.

11. GOVERNOR'S REVIEW *(Check One)*:
■ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Deborah K. Bowman

14. TITLE:
Department Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre SD 57501-2291

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 12-17-09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 1 - 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSO

23. REMARKS:

INPATIENT HOSPITAL PAYMENT METHODOLOGY

INTRODUCTION

The South Dakota Medicaid Program has been reimbursing hospitals for inpatient services, with a few exceptions, under a prospective Diagnosis Related Group (DRG) methodology since January 1, 1985.

GENERAL

South Dakota has adopted the federal definitions of DRGs, the DRG classifications, weights, geometric mean length of stay, and outlier cutoffs as used for the Medicare prospective payment system. The grouper program is updated annually as of October 1 of each year. Beginning with the Medicare grouper version 15 (effective October 1, 1997), South Dakota Medicaid Program specific weight and geometric mean length of stay factors will be established using the latest three years of non-outlier claim data. This three year claim database will be updated annually in order to establish new weight and geometric length of stay factors with each new grouper.

Hospital specific costs per Medicaid discharge amounts were developed for all instate hospitals using Medicare cost reports and non-outlier claim data for these hospitals' fiscal year ending after June 30, 1996 and before July 1, 1997. An inflation factor, specific to the hospitals' fiscal year end, was applied to the cost per discharge amounts of all hospitals with more than thirty (30) Medicaid discharges during the base year to establish target amounts for the period of October 1, 2009 through September 30, 2010.

A cap on the target amounts has been established. Under this cap no hospital will be allowed a target amount that exceeds 110% of the statewide weighted average of all target amounts.

Out-of-state hospitals will be reimbursed on the same basis as the hospital is paid by the Medicaid agency in the state in which the hospital is located. If the hospital's home state refuses to provide the amount they would pay for a given claim, payment will be at 55% of billed charges. Payment will be for individual discharge or transfer claims only; there will be no annual cost settlement with out of state hospitals.

SPECIFIC DESCRIPTION

Target amounts for non-outlier claims were established by dividing the hospital's average cost per discharge for non-outlier claims by the hospital's case mix index. To ensure budget neutrality, a hospital's target amount will be adjusted annually for any change in that hospital's case mix index resulting from the establishment of new program specific weight factors.

The case mix index for a hospital was calculated by accumulating the weight factors for all claims submitted during the base period and dividing by the number of claims.

SERVICES COVERED BY DIAGNOSTIC RELATED GROUP PAYMENTS

The Department will adopt Medicare's definition of inpatient hospital services covered by DRG payment. As a result, billing for physician services must be made on a separate CMS 1500 form.

OUTLIER PAYMENTS

The Department will make additional payments to hospitals for discharges which meet the criteria of an "outlier." An outlier is a case with extremely high charges which exceed cost outlier thresholds.

A claim will qualify for a cost outlier payment when 70% of billed charges exceed the larger of $49,620 or 1.5 times the DRG payment for the claim. The additional payment allowed for a cost outlier will be 90% of the difference between 70% of billed charges and the larger of $49,620 or 1.5 times the DRG payment.

The total payment allowed for an outlier claim will be the DRG payment plus the outlier payment plus the daily capital/education amount for each day of the hospital stay.