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State/Territory Name: South Dakota

State Plan Amendment (SPA) #: SD-12-004

This file contains the following documents in the order listed:

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 CHIP Services

Ms. Kim Malsam-Rysdon
Department Secretary
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

SEP 19 2012

Re: South Dakota 12-004

Dear Ms. Malsam-Rysdon:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-004. Effective for services on or after June 30, 2012, this amendment updates State plan language by adjusting the payment amounts to qualifying disproportionate share hospitals, in addition to graduate medical education payments, so that total expenditures remain within the appropriated amount.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a) and 1923 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 12-004 is approved effective June 30, 2012. We are enclosing the CMS-179 and the amended plan pages.

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

Sincerely,

[redacted]

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 12 -4

2. STATE: South Dakota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
June 30, 2012

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:

1902(a)(13)(A), 1902(a)(30), and 1923 of the Act, and 42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2012: $0
b. FFY 2013: $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pp. 6, 7, 8, 10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pp. 6, 7, 8, 10

10. SUBJECT OF AMENDMENT:

This State Plan Amendment revises payment methodologies for disproportionate share hospitals (DSH) and graduate medical education to provide links to the Department of Social Services' website where payment levels for hospitals qualifying for the DSH program's payments per standard deviations and the current fiscal year's pool for graduate medical education may be found. No changes to the actual methodologies are proposed by this SPA.

11. GOVERNOR'S REVIEW *(Check One)*:

■ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

[redacted]

13. TYPED NAME:
KIM MALSAM-RYSDON

14. TITLE:
Department Secretary

15. DATE SUBMITTED:
6/22/12

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: SEP 19 2012

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUN 30 2012

20. SIGNATURE OF REGIONAL OFFICIAL:

[redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM CMS-179 (07-92)

UPPER PAYMENT LIMITS

Payments in aggregate for inpatient hospital services will not exceed the amount that would be paid for services under Medicare principles.

APPEALS

The Department of Social Services has administrative review procedures to meet the need for provider appeals required by 42 CFR 447.253(e).

ACCESS AND QUALITY OF CARE

All hospitals located in South Dakota participate in the Medicaid program which results in the best possible access to hospital services for the Medicaid recipient. The South Dakota Professional Review Organization monitors quality of care.

DISPROPORTIONATE SHARE PAYMENTS

The program allows an additional payment to any qualifying hospital that has a disproportionate share of low-income patients. The threshold at which an individual hospital is deemed to be serving a disproportionate share of low-income patients is when either the Medicaid inpatient utilization rate, as defined in section 1923 (b)(2), is above the mean Medicaid inpatient utilization rate for hospitals receiving the Medicaid payments in the state or the low-income utilization rate, as defined in section 1923 (b)(3), exceeds 25%. To qualify as a disproportionate share hospital a hospital must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetric services to individuals entitled to Medicaid service. This requirement does not apply to hospitals whose patients are predominately under 18 years of age or that do not offer non-emergency obstetric services to the general population. For hospitals located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. A hospital must also have a Medicaid utilization rate of at least one percent to qualify for disproportionate share hospital payment.

To identify qualifying hospitals, the Department mails a survey to all hospitals by April 30 of each year. Hospitals have until May 15 to reply, but the Department verifies returns to ensure no qualifying hospital is excluded. If a hospital qualifies for disproportionate share payment under both the Medicaid inpatient utilization rate and the low-income utilization rate, the payment will be based on whichever utilization rate will result in the higher payment. Only one disproportionate share payment is allowed to a hospital. The Department notifies qualifying hospitals of their disproportionate share payments prior to June 30.

The agency groups qualifying disproportionate share hospitals into one of the following three groups, with each hospital group's surveys calculated independently of the other groups' surveys:

Group 1, acute care hospitals;

Group 2, psychiatric hospitals operated by the State of South Dakota; and
Group 3, other hospitals (any hospital not in Group 1 or 2).

Payments to Group 1 hospitals qualifying under the Medicaid inpatient utilization method are based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 1 hospitals qualifying under the low-income utilization method are based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payments to Group 1 hospitals will be made according to the following payment schedule:

Qualifying Rate	Greater than the mean rate to less than 1 standard deviation above the mean	1 standard deviation above the mean to less than 2 standard deviations above the mean	2 standard deviations above the mean to less than 3 standard deviations above the mean	3 or more standard deviations above the mean
Payment Amount	$20,919.55	$41,839.10	$62,758.65	$83,678.20

The amount of payment for each hospital is calculated as follows:

The Department determines the number of facilities qualifying at greater than the mean, greater than 1 standard deviation above the mean, greater than 2 standard deviations above the mean, and greater than 3 standard deviations above the mean. The total amount of funding budgeted for disproportionate share payments is then allocated starting with those facilities qualifying at greater than the mean. Facilities qualifying at greater than 1 standard deviation, greater than 2 standard deviations, and greater than 3 standard deviations above the mean are paid double, triple, and quadruple, respectively, the amount for facilities qualifying at greater than the mean. The payment amounts are adjusted until all the budgeted funds are spent.

The proposed disproportionate share payment for each facility is then compared to the payment limit that has been established for each facility. If the payment limit is less than the proposed disproportionate share payment, then the payment limit amount will be the disproportionate share payment for that particular facility. The sum of the payments made to the facilities where the payment limit was met is then subtracted from the total amount budgeted. The remaining budgeted funds are then allocated equally among the facilities where the payment limits have not been met. The subsequent allocation again is determined to ensure that facilities qualifying at greater than 1 standard deviation, greater than 2 standard deviations, and greater thane 3 standard deviations above the mean are paid double, triple, and quadruple, respectively, the amount for facilities qualifying at greater than the mean.

Payments to Group 2 hospitals qualifying under the Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 2 hospitals qualifying under the low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals.

Payments to Group 2 hospitals will be made according to the following schedule:

If the qualifying rate is greater than the mean rate to 3 or more standard deviations above the mean--$751,299.

Payments to Group 3 hospitals qualifying under the Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 3 hospitals qualifying under the low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payments to Group 3 hospitals will be made according to the following schedule:

Qualifying Rate	Greater than the mean rate to less than 1 standard deviation above the mean	1 standard deviation above the mean to less than 2 standard deviations above the mean	2 standard deviations above the mean to less than 3 standard deviations above the mean	3 or more standard deviations above the mean
Payment Amount	$250	$500	$750	$1,000

If necessary, payments to qualified hospitals will be adjusted for the projected impact of the hospital's specific disproportionate share hospital payment limit as required by OBRA '93.

The agency will make disproportionate share hospital program payments to qualifying hospitals one time during the State fiscal year. If the total of disproportionate share payments to all qualified hospitals for a year is going to exceed the State disproportionate share hospital payment limit, as established under 1923(f) of the Act, the following process will be used to prevent overspending the limit: First, the amount of over-expenditure will be determined; Then the over-expenditure amount will be deducted from the total payments to Group 2 hospitals; and Payments to individual Group 2 hospitals will be reduced based on their percentage of Group 2 total payments.

HEALTH PROFESSION EDUCATION

The Department of Social Services supports the direct graduate medical education (GME) of health professionals through the use of Medicaid funds. All in-state, private hospitals which are accredited by the Accreditation Council for Graduate Medical Education (ACGME) are eligible for health profession education payments. Those hospitals are identified through the use of their most recently-filed Medicare 2552 cost reports. Specifically, worksheet E-3 (Line 3.07) is utilized to identify the number of weighted full-time equivalents for primary care physicians at participating facilities. The agency calculates the Medicaid hospital patient days using the Division of Medical Services (DMS) Cost Settlement Details report of adjudicated claims for the same period as the Medicare 2552 cost report.

Hospitals seeking GME payments must submit an application to DMS prior to the end of the State Fiscal Year. The agency will make payments, as defined below, annually prior to the end of the state fiscal year through the State's Medicaid Management Information System (MMIS) payment system. Payments will be made directly to the qualifying hospitals through a supplemental payment mechanism and will appear on the facility's remittance advice. Each hospital will receive written notification at the time of payment of the payment amount from DMS. GME payments made in error will be recovered via a supplemental recovery mechanism and will appear on the facility's remittance advice. The agency will notify the facility in writing explaining the error prior to the recovery. A hospital must notify DMS in writing within 30 days of the effective date if it intends to terminate operation of a GME program, and must notify DMS in writing prior to the end of the State Fiscal Year if it does not wish to participate in the funding pool regardless of whether it is continuing GME.

The agency will determine the annual payment pool prior to the beginning of each State Fiscal Year on July 1. State Fiscal Year 2007 was the first effective year of the payment pool and resulted in the payment of $3,002,252 being allocated to the teaching hospitals. The amount in the payment pool will be adjusted annually as indicated under the Target Amount Update section, page 2.

The pool will be distributed based upon the allocation percentage of each hospital. The hospital allocation percentage will be developed using prior year Medicaid patient days and weighted intern and resident (I & R) full time equivalency (FTE). The State uses the prior year's cost report data as a proxy for the current year. For example, the State Fiscal Year 2008 calculation of allocations from the payment pool was as follows:

	(a) Weighted I & R FTEs	(b) Medicaid Hospital Patient Days	(c) (a*b) Weighted FTE Days	(d) Hospital Allocation Percentage	Payment Pool Total
Hospital A	17	11,450	194,650	35.34%	$1,052,009
Hospital B	22	10,692	232,230	42.16%	$1,255,116
Hospital C	23	5,342	123,988	22.51%	$670,107
Totals	62	27,484	550,868	100.00%	$2,977,233

State funds available for payment through the pool are $1,225,700.