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State/Territory Name: South Dakota

State Plan Amendment (SPA) #: 19-0004

This file contains the following documents in the order listed:

1) Approval Letter
2) Additional Companion Letter
3) CMS 179 Form
4) Approved SPA Pages

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

April 22, 2019

Amy Iversen-Pollreisz
Interim Cabinet Secretary
Department of Social Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Re: South Dakota 19-0004

Dear Ms. Iversen-Pollreisz:

We have reviewed the proposed amendment to Attachment 4.19-A, 4.19-B and 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 19-0004. Effective for services on or after January 1, 2019, this amendment clarifies the payment methodology for outpatient hospital dialysis units, state operated psychiatric hospitals and nursing facilities. The amendment also clarifies approved telemedicine originating sites.

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 and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 19-0004 is approved effective January 1, 2019. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044 or Kirstin Michel at (303) 844-7036.

Sincerely,

[redacted]

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
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April 22, 2019

Amy Iversen-Pollreisz
Interim Cabinet Secretary
Department of Social Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Re: South Dakota 19-0004

Dear Ms. Iversen-Pollreisz:

This letter is being sent as a companion to the Centers for Medicare and Medicaid Services' approval of SD-19-0004, which was submitted to update telemedicine sites and to add language to clarify that outpatient hospital dialysis units are reimbursed based upon the approved outpatient hospital payment methodology. As part of the SPA review process, CMS is obligated to review any complete page submitted for compliance with federal statutes and regulations. Our review of this amendment included an assessment of Attachment to 4.19B, page 6, section 5a and Attachment to 4.19B, page 1b, section 4.

Our review identified the following same-page issues:

Attachment to 4.19B, page 6, section 5a (Physician Services):

1) 5a. Physician Services

   a. Item a. Services other than Clinical Diagnostic Laboratory Service
      a. Please remove the old effective date and fee schedule language. This includes the effective date language, the annual/periodic adjustment language, and public/private provider language.

   b. Item b. Anesthesia Services
      a. Please remove the entire paragraph, starting with "the fee schedule" and ending with "date" but retain the service header, anesthesia services, and payment is the lower of billed charges or the fee established by the state agency.

   c. Item c. Clinical Diagnostic Laboratory Services
      a. Section 1903(i)(7) of the Social Security Act (the Act) limits Medicaid reimbursement for clinical diagnostic laboratory services to the amount paid by Medicare on a per-test basis. CMS learned through the review process that South Dakota currently utilizes a state-developed fee schedule to reimburse for

these services instead of following the currently approved reimbursement methodology in the State Plan. In order to comply with Section 1903(i)(7) of the Act, South Dakota will need to revise its current practices and submit a state plan amendment to revise their payment methodology. Specifically, the state will need to:

i. Remove outdated language in section 3 referring to tests for which Medicare has not established a rate and add language describing a comprehensive methodology for rates are not included on the Medicare fee schedule; and
ii. Remove any language related to annual/period adjustments and subsequent adjustments.

d. Item d. Deductibles/coinsurance charges under the Medicare program
    a. Please remove this language from this page.
e. Item e. Procedure modifier adjustments

CMS learned through the review process that South Dakota maintains procedure modifier adjustments that impact provider fee schedule rates in their state administrative rules (ARSD § 67:16:02:03.02) and an authorized modifier fee schedule posted to their website. Per 42 Code of Federal Regulations 430.10, please revise the language in this item to make the payment methodology comprehensive.

f. Item f. Payment for Physician Services Provided via Telemedicine
    a. Please remove the effective date language. This includes all language related to public/private providers, annual adjustments, websites, and dates.

2) At the bottom of page 6, please add a reference that applies to all the services on this page: *Payment will be the lower of billed charges or the fee established on the State agency's fee schedule published on the agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. The rates are effective for services on or after the date listed on the Attachment 4.19B Introduction Page, Page 1.*

Please respond within 90 days of receipt with a corrective action plan describing how South Dakota will resolve the issues described in this letter. During this 90-day period, CMS welcomes the opportunity to work with you and your staff to resolve these issues. Should you or your staff have any questions regarding this request, please contact Kirstin Michel at (303) 844-7036 or at Kirstin.Michel@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

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: SD-19-004

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
January 1, 2019

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:

SSA § 1902(a) and 42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2019: $ 0.00
b. FFY 2020: $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A page 5, Attachment 4.19-B pages 1b and 6, and Attachment 4.19-D page 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A page 5, Attachment 4.19-B pages 1b and 6, and Attachment 4.19-D page 15

10. SUBJECT OF AMENDMENT:

The proposed state plan amendment clarifies the payment methodology for outpatient hospital dialysis units, state operated psychiatric hospitals, and nursing facilities. The state plan amendment also clarifies approved telemedicine originating sites.

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:
Amy Iversen-Pollreisz

14. TITLE:
Interim Cabinet Secretary

15. DATE SUBMITTED:
January 31, 2019

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: APR 22 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN 01 2019

20. S[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM CMS-179 (07-92)

5. Rehabilitation Units (only upon request and justification);
6. Children's Care Hospitals;
7. Indian Health Service Hospitals;
8. Hospitals with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1993, and before July 1, 1994; and
9. Specialized Surgical Hospitals.

Payment for rehabilitation hospitals and units, perinatal units, and children's care hospitals will continue on the Medicare retrospective cost base system with the following exceptions:

1. Costs associated with certified registered nurse anesthetist services that relate to exempt hospitals and units will be included as allowable costs.
2. Malpractice insurance premiums attributable to exempt units or hospitals will be allowed using 7.5% of the risk portion of the premium multiplied by the ratio of inpatient charges to total Medicaid inpatient charges for these hospitals or units.

The agency provides a link to Medicare's DRGs on its website at
http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx

Payment for psychiatric hospitals, psychiatric units, rehabilitation hospitals, rehabilitation units, perinatal units, and children's care hospitals is on a per diem basis based on the facility's reported, allowable costs, as established by the State. This per diem amount is updated annually as directed by the Legislature based on review of economic indices and input from interested parties not to exceed the rate as established by the medical care component of the Consumer Price Index of the most recent calendar year. The per diem for state operated psychiatric hospitals is updated annually based on facility's reported allowable costs, as established by the state.

Specialized surgical hospitals payments for payable procedures will be based upon group assignments. Payment rates are effective April 4, 2017 and will be listed on the agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. The fee schedule is subject to annual/periodic adjustment. Payable procedures include: nursing, technician, and related services; patient's use of facilities; drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the surgical procedures; diagnostic or therapeutic services or items directly related to the surgical procedures; administrative and recordkeeping services; housekeeping items and supplies; and materials for anesthesia. Items not reimbursable include those payable under other provisions of State Plan, such as physician services, laboratory services, X-ray and diagnostic procedures, prosthetic devices, ambulance services, orthotic devices, and durable medical equipment for use in the patient's home, except for those payable as directly related to the surgical procedures.

Indian Health Service hospitals are paid on a per diem basis as established by CMS.

Instate hospitals with less than 30 discharges during the hospital's fiscal year ending after June 30, 1993, and before July 1, 1994, are paid 95% of billed charges.

For claims with dates of service on and after April 1, 2018, the amount of reimbursement for psychiatric hospitals, rehabilitation hospitals, perinatal units, psychiatric units, rehabilitation units, children's care hospitals, and specialized surgical hospitals will be increased 0.5% over the State fiscal year 2017 calculations after any cost sharing amounts due from the patient, any third-party liability amounts have been deducted and other computation of any cost outlier payment.

EXCEPTION TO PAYMENT METHODOLOGIES FOR ACCESS-CRITICAL AND AT-RISK HOSPITALS

South Dakota Medicaid will reimburse hospitals classified as Medicare Critical Access or Medicaid Access Critical at the greater of actual allowable cost or the payment received under the provisions contained in this Attachment.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

5a. Physician Services

a. Services other than clinical diagnostic laboratory tests.

1. Payment will be the lower of billed charges or based upon a fee schedule established by the State agency for procedures provided ten or more times in the base year without a procedure modifier indicated on the claim. The fee schedule will be published on the agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx along with any subsequent adjustments. The state agency's rates were set as of January 1, 2013 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment. Payment amounts will be the same for all public and private providers.
2. Payment for procedures provided less than ten times in the base year will be the amount allowed under the Medicare program effective January 1, 1993. If there is no Medicare fee established the payment will be 40% of billed charges.
3. Supplies will be paid at 90% of the provider's usual and customary charge.

b. Anesthesia services. Payment will be the lower of billed charges or the fee established by the State agency. The fee schedule will be published on the agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx along with any subsequent adjustments. The state agency's rates were set as of October 1, 2014 and are effective for services rendered on or after that date.

c. Clinical diagnostic laboratory tests.

1. Payment will be the lower of billed charges or the fee set by Medicare.

2. Payments will be the same for all public and private providers.
3. Tests for which Medicare has not established a fee will be paid at 60% of billed charges.
4. Fees will be published on the State agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx, as well as any subsequent adjustments and updates. The state agency's rates were set as of July 1, 2012 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment.

d. Deductible and co-insurance charges under the Medicare program will be paid at the amount indicated by the Medicare carrier.

e. Payment levels for procedures reported with a procedure modifier may be paid at a lower or higher amount than the fee established in "a" or "c" above, depending on the modifier used by the provider when submitting the claim.

f. Payment for physician services provided via telemedicine is made as follows:
1. Only providers eligible to enroll in the Medicaid program are eligible for payment of telemedicine services. Providers must bill the appropriate CPT procedure code with the modifier "GT" indicating the services were provided via telemedicine.
2. Originating sites, the physical location of the recipient at the time the service is provided, are paid a facility fee per completed transmission, according to the fee schedule. All originating sites must be an enrolled provider. Approved originating sites are:
    i. Office of a physician or practitioner.
    ii. Outpatient Hospitals.
    iii. Critical Access Hospitals.
    iv. Rural Health Clinics. The facility fee is not considered an encounter and will be reimbursed according to the fee schedule.
    v. Federally Qualified Health Centers. The facility fee is not considered an encounter and will be reimbursed according to the fee schedule.
    vi. Indian Health Service (IHS) Clinics. The facility fee is not considered an encounter and will be reimbursed according to the fee schedule.
    vii. Community Mental Health Centers.
    viii. Nursing Facilities.
    ix. School Districts.
3. Distant sites, the physical location of the practitioner providing the service, are reimbursed the lesser of the established rate on the Department's fee schedule or the provider's usual and customary charge.

Payment amounts will be the same for all public and private providers of telemedicine. The State agency publishes the fee schedule and all subsequent updates on its website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx.The state agency's rates were last published on January 1, 2013 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

4. The agency will make prospective payments to outpatient hospitals based upon Medicare principles and the above exceptions using the CMS 2552-10 Report, Worksheet C, Part 1 lines 50-200 as submitted by the hospitals to determine the Medicare outpatient cost-to-charge ratios (CCRs) for the ancillary cost centers for each hospital. All participating hospitals must submit their Medicare cost reports to the agency within 150 days following the end of their fiscal year. For each hospital, the agency will use average of the ancillary CCRs for that hospital to calculate the hospital-specific reimbursement percentage to apply to outpatient charges from that hospital to determine the prospective Medicaid payment.

The remaining instate hospitals will be reimbursed at 90% of billed charges. Hospitals' charges shall be uniform for all payers and may not exceed the usual and customary charges to private pay patients.

Reimbursement for outpatient services at out-of-state hospitals is calculated at 38.2% of the hospitals' usual and customary charges.

Reimbursement for outpatient hospital dialysis units will be based on the applicable above-stated outpatient payment methodology.

11. The Department may allow an add-on payment for the In-state care of recipients needing extraordinary care. This payment is designed to recognize and compensate providers for patients who require an inordinate amount of resources due to the intensive labor involved in their care that is not captured in the normal case mix reimbursement methodology. Such an add-on payment requires prior authorization. The individual requiring extraordinary care must be a South Dakota Medicaid recipient and must meet nursing facility level of care as defined in ARSD 67:45:01.

    Extraordinary care recipients are:

    a. Chronic Ventilator Dependant Individuals—Individuals who are ventilator dependant due to major complex medical disease or other accidents.

    b. Chronic Wound Care Recipients—Individuals who need therapeutic dressings/treatments/equipment that are designed to actively manipulate the sound healing process.

    c. Behaviorally Challenging Individuals—Individuals who meet the following criteria:

        1. Have a history of regular/recurrent, persistent disruptive behavior which is not easily altered. Behaviors which require increased resource use or nursing facility staff must exist, and

        2. Have an organic or psychiatric disorder of thought, mood, perception, orientation, memory, or social history which significantly affects behavior and is interfering with care and placement. Social history refers to convicted sexual offenders, inmates, or individuals who are otherwise challenging due to past behaviors.

    Individuals receiving specialized rehabilitation services are excluded from this rate.

    d. Traumatic Brain or Spinal Cord Injured—Individuals who have had an injury to the skull, brain, or spinal cord. The injury may produce a diminished or altered state of consciousness resulting in impairment in cognitive abilities or physical functioning, as well as behavioral and/or emotional functioning. The individual must have completed an acute rehabilitation program in another facility and must be continuing the rehabilitation plan.

    e. Individuals requiring total parenteral nutritional therapy—Individuals who meet the following criteria:

        1. Have an internal body organ or body function such as severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the individual's general condition.

        2. Have a physician's order or prescription for the therapy and medical documentation describing the diagnosis and the medical necessity for the therapy.

        3. The therapy is the only means the individual has to receive nutrition.