Table of Contents

State/Territory Name: South Dakota

State Plan Amendment (SPA) #: 22-0010

This file contains the following documents in the order listed:

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

Financial Management Group

November 1, 2022

Laurie R. Gill
Cabinet Secretary
Department of Social Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Re: South Dakota 22-0010

Dear Ms. Gill:

We have reviewed the proposed amendment to Attachment 4.19-A and Attachment 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 22-0010. Effective for services on or after July 1, 2022, this amendment implements inflationary rate increases, rebases select services and clarifies long-term acute care hospital reimbursement.

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 22-0010 is approved effective July 1, 2022. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at christine.storey@cms.hhs.gov or Matthew Klein at matthew.klein@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
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: 22-0010

2. STATE: SD

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.201 and Subpart C, and Section 1923 of the Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 3,953,961
b. FFY 2023 $ 15,815,842

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, pages 1, 5, 7, 8, 10a, and 10b, and Attachment 4.19-B, Introduction page 1 and page1a

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, pages 1, 5, 7, 8, 10a, and 10b, TN# 21-009
Attachment 4.19-B, Introduction page 1 TN# 22-0008 and page1a TN#21-009

9. SUBJECT OF AMENDMENT

Implements inflationary rate increases, rebases select services, and clarifies long-term acute care hospital reimbursement.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Laurie R. Gill

13. TITLE
Cabinet Secretary

14. DATE SUBMITTED
August 5, 2022

15. RETURN TO
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291

FOR CMS USE ONLY

16. DATE RECEIVED
August 5, 2022

17. DATE APPROVED
November 1, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

INPATIENT HOSPITAL PAYMENT METHODOLOGY

GENERAL

The South Dakota Medicaid program has reimbursed hospitals for inpatient services under a prospective Diagnosis Related Groups (DRGs) methodology, with a few exceptions, since January 1, 1985. The State uses the federal definitions of DRGs, classifications, weights, geometric mean lengths of stay, and outlier cutoffs. The DRG Grouper is updated annually effective January 1 each year each year. The agency provides a link to Medicare's DRGs on its website at http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. The agency calculates Medicaid-specific weight and geometric mean length of stay factors annually using the latest three years of non-outlier claim data, this three-year claims database updated annually to establish new weight and geometric length of stay factors with each new grouper.

The agency developed hospital-specific costs per Medicaid discharge amounts for all instate hospitals using Medicare cost reports and non-outlier claims data for the hospitals' fiscal years ending after June 30, 1996 and before July 1, 1997. The agency applied an inflation factor, specific to each hospital's fiscal year end, 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 most recently completed federal fiscal year. There is a cap on the hospitals' target amounts, under which no hospital is allowed a target amount that exceeds 110% of the statewide weighted average of all target amounts.

South Dakota Medicaid reimburses out-of-state hospitals at 44.15% of the provider's usual and customary charges. The State may reimburse out-of-state hospitals on the same basis as the Medicaid agency where the hospital is located if the hospital's home state Medicaid agency agrees to calculate the claim payment.

Payment is for individual discharge or transfer claims only. Out of state specialty hospitals are reimbursed at 44.15% of billed charges unless otherwise approved by the state. There is no annual cost settlement with out-of-state hospitals or instate DRG hospitals unless an amount is due the South Dakota Medicaid program.

For claims with dates of service beginning July 1, 2022, instate DRG hospitals' target and capital/education amounts are increased by 6.0 percent. OPPS hospitals that did not receive an inflationary increase to their OPPS conversion factor are receiving DRG target and capital/education increase of 6.0 percent plus an additional hospital specific DRG target and capital/education increase. The hospital specific DRG rate increase was calculated to provide the hospital the equivalent of the additional annual reimbursement amount the hospital would have received if their OPPS conversion factor was increased by 6.0 percent.

SPECIFIC DESCRIPTION

Each year the agency calculates a hospital's target amounts for non-outlier claims by dividing the hospital's average cost per discharge for non-outlier claims by the hospital's case mix index. To ensure budget neutrality, the agency adjusts annually a hospital's target amount for any change in that hospital's case mix index resulting from the establishment of new program specific weight factors. For each hospital, the case mix index is the calculated result of accumulating the weight factors for all claims submitted during the base period and dividing by the number of claims.

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;
9. Specialized Surgical Hospitals;
10. Long-Term Acute Care Hospital.

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, long-term acute care hospitals 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 66 percent of usual and customary charges for ancillary services and 60 percent of usual and customary charges for room and board. Payable procedures include, but are not limited to: 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.

Payments to Indian Health Service inpatient hospitals will be per diem and based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services, Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

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 July 1, 2022, the amount of reimbursement for psychiatric hospitals, rehabilitation hospitals, perinatal units, psychiatric units, rehabilitation units, children's care hospitals, and long-term acute care hospitals will be increased 6.0% over the July 1, 2021 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.

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 payment schedule on the Department's website, http://dss.sd.gov/medicaid/providers/feeschedules/, effective July 1, 2022.

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 than 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 payment schedule on the Department's website, http://dss.sd.gov/medicaid/providers/feeschedules/, effective July 1, 2022.

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 payment schedule on the Department's website, http://dss.sd.gov/medicaid/providers/feeschedules/, effective July 1, 2022.

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 last quarter of 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 2552-10, cost reports. Specifically, worksheet E-4 (Line 1.00) 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 for the previous state fiscal year's costs to DMS prior to the end of the current state fiscal year. The agency will make payments for costs incurred in the previous state fiscal year, as defined below, annually prior to the end of the current state fiscal year. Payments will be made 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. The payment will appear on the facility's remittance advice. Each hospital will also 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. The Federal share of payments made in excess will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

A hospital that applied for GME funding in the previous 24 months must provide written notice to DMS no less than 30 days prior to the effective date it intends to terminate operation of a GME program. A hospital must provide written notice to DMS by January 1 if it will not be applying for GME funding for the previous state fiscal year's costs.

The agency will determine the annual lump sum, onetime payment pool. The annual payment will be made during the last quarter of the state fiscal year. The pool will be distributed based upon the allocation percentage of each hospital. The hospital allocation percentage will be developed using prior year total Medicaid inpatient 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 the following:

	(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

Total state funds available for payment through the pool are listed on the department's website, http://dss.sd.gov/medicaid/providers/feeschedules/, effective July 1, 2022. The FMAP at the time the annual payment is made will be applied to the state portion of the payment.

Rural Residency Program

The Center for Family Medicine is eligible for payment of direct GME via a separate funding pool for its operation of a rural family medicine residency program. The Center for Family Medicine must be accredited by the ACGME to be eligible for health profession education payments.

The state will make equal interim payments to providers on a quarterly basis. Costs must be submitted on a quarterly basis to validate costs for the previous quarter using the state developed South Dakota Rural Residency Program Cost Report and Rural Residency Cost Report Guidelines. The payment will be made to the Center for Family Medicine through the MMIS system. Payments will be made directly to the provider through a supplemental payment mechanism and will appear on their remittance advice. The Center for Family Medicine will receive written notification at the time of payment of the payment amount from DMS.

GME payments made in error that cannot be adequately addressed through adjustment of future quarterly payments will be recovered via a supplemental recovery mechanism and will appear on the provider's remittance advice. The agency will notify the provider in writing explaining the error prior to the recovery. The Federal share of payments made in excess will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

The Center for Family Medicine must provide written notice to DMS no less than 30 days prior to the effective date it intends to terminate operation of its GME program or written notice to DMS no less than 30 days prior to the effective date it will no longer be applying for GME funding.

The agency will determine the annual rural residency program payment pool for the upcoming state fiscal year prior to the start of the fiscal year on July 1. The total state funds available for payment through the rural residency program pool are listed on the department's website, http://dss.sd.gov/medicaid/providers/feeschedules/, effective July 1, 2022. The FMAP at the time the quarterly payment is made will be applied to the state portion of the payment.

ATTACHMENT 4.19-B
INTRODUCTION

Payment rates for the services listed below are effective for services provided on or after the corresponding date. Fee schedules are published on the Department's website at http://dss.sd.gov/medicaid/providers/feeschedules/. Effective dates listed on the introductory page supersede the effective dates listed elsewhere in Attachment 4.19-B. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

Service	Attachment	Effective Date
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Attachment 4.19-B, Page 4	July 1, 2022
Physician Services	Attachment 4.19-B, Page 6	July 1, 2022
Optometrist Services	Attachment 4.19-B, Page 9	July 1, 2022
Chiropractic Services	Attachment 4.19-B, Page 10	July 1, 2022
Independent Mental Health Practitioners	Attachment 4.19-B, Page 11	July 1, 2022
Nutritionist and Dietician Services	Attachment 4.19-B, Page 11	July 1, 2022
Home Health Services	Attachment 4.19-B, Page 12	July 1, 2022
Durable Medical Equipment	Attachment 4.19-B, Page 13	July 1, 2022
Clinic Services	Attachment 4.19-B, Page 15	July 1, 2022
Dental Services	Attachment 4.19-B, Page 16	July 1, 2022
Physical Therapy	Attachment 4.19-B, Page 17	July 1, 2022
Occupational Therapy	Attachment 4.19-B, Page 18	July 1, 2022
Speech, Hearing, or Language Disorder Services	Attachment 4.19-B, Page 19	July 1, 2022
Dentures	Attachment 4.19-B, Page 21	July 1, 2022
Prosthetic Devices	Attachment 4.19-B, Page 22	July 1, 2022
Eyeglasses	Attachment 4.19-B, Page 23	July 1, 2022
Diabetes Self-Management Training	Attachment 4.19-B, Page 26	July 1, 2022
Community Health Workers	Attachment 4.19-B, Page 26	July 1, 2022
Community Mental Health Centers	Attachment 4.19-B, Page 26	June 1, 2022
Substance Use Disorder Agencies	Attachment 4.19-B, Page 26	June 1, 2022 *
Nurse Midwife Services	Attachment 4.19-B, Page 31	July 1, 2022
Transportation	Attachment 4.19-B, Page 38	July 1, 2022
Personal Care Services	Attachment 4.19-B, Page 38	July 1, 2022
Freestanding Birth Centers	Attachment 4.19-B, Page 39	July 1, 2022
Professional Services Provided in a Freestanding Birth Center	Attachment 4.19-B, Page 39	July 1, 2022

*Room and board is not included in these rates.

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

South Dakota Medicaid will make payments to medical providers who sign agreements with the State under which the provider agrees: (a) to accept as payment in full the amounts paid in accordance with the payment structures of the State; (b) to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State Plan; and (c) to furnish the State Agency with such information, regarding any payments claimed by such person or institution for services provided under the State Plan, as the agency may request from time to time.

The following describes policy and methods the agency uses to establish payment rates for each type of care and service, other than inpatient hospital or nursing home services, included in the State Plan. In no instance will the amount of payment under the provisions of this attachment exceed the payment made by the general public for identical services.

1. Inpatient Hospital Services (See Attachment 4.19-A)

2a. Outpatient Hospital Services

Effective August 2, 2016, Medicare Prospective Payment System hospitals will be paid using the Medicaid Agency's Outpatient Prospective Payments System (OPPS). Under OPPS, services are reimbursed using Ambulatory Payment Classifications. Effective August 2, 2016, the Department will establish a conversion factor and discount factor specific to each hospital. The hospital specific conversion factor and discount factors are published on the State agency's website at http://dss.sd.gov/medicaid/providers/feeschedules/dss/. Effective July 1, 2022, the conversion factor for Medicare Prospective Payment System hospitals paid using the Medicaid Agency's OPPS will be increased by 6.0 percent for hospitals with a conversion factor less than the Medicare conversion factor.

South Dakota Medicaid will pay remaining participating outpatient hospitals with more than 30 Medicaid inpatient discharges during the hospital's fiscal year ending after June 30, 1993 and before July 1, 1994 on the basis of Medicare principles of reasonable reimbursement with the following exceptions:

1. Costs associated with certified registered nurse anesthetist services are allowable costs. These costs are identified on the CMS 2552-10 on Worksheet A-8 and included in the facilities' costs.

2. All capital and education costs incurred for outpatient services are allowable costs. These costs are identified on the CMS 2552-10 on Worksheet D Part III and included in the facilities' costs.

3. Payments to Indian Health Service outpatient hospitals will be per visit and based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services, Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). The State agency will make payments for visits of the same type of service on the same day at the same provider location only if the services provided are different or if they have different diagnosis codes.