DEPARTMENT OF SOCIAL SERVICES
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DSS
Strong Families - South Dakota's Foundation and Our Future

March 26, 2018

RE: South Dakota Medicaid State Plan Amendment #SD-18-003

The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan to implement inflationary rate increases appropriated by the state legislature during the 2018 legislative session. The proposed State Plan Amendment (SPA) also clarifies the reimbursement methodology for out of state specialty hospitals. The proposed amendment revises Attachment 4.19-A, page 1 and Attachment 4.19-B, Introduction page 1.

We intend to make this SPA effective April 1, 2018. The proposed SPA increases the rate for most Medicaid services by 0.5 percent; certain community-based providers will receive a 2 percent increase for certain services. Changes to individual services are reflected in the April 1, 2018 fee schedules available on the department's website: http://dss.sd.gov/medicaid/providers/feeschedules/. The Department estimates the total expected increase in annual aggregate expenditures associated with this SPA to be $2,081,178.00.

Please contact me within 30 days of receipt of this message with any questions or comments.

Sincerely,

Sarah Aker
Deputy Director
Division of Medical Services
South Dakota Department of Social Services

CC: Lynne A. Valenti, Cabinet Secretary
Brenda Tidball-Zeltinger, Deputy Secretary
William Snyder, Director

Medicaid State Plan Amendment Proposal

Transmittal Number: SD-18-003

Effective Date: 4/1/2018

Brief Description: This State Plan Amendment implements inflationary rate increases appropriated by the state legislature during the 2018 legislative session.

Area of State Plan Affected: Attachment 4.19-A and Attachment 4.19-B

Page(s) of State Plan Affected: Attachment 4.19-A, page 1 and Attachment 4.19-B, Introduction page 1

Estimate of Fiscal Impact, if Any: The Department estimates the total expected increase in annual aggregate expenditures associated with this SPA to be $2,081,178.00.

Reason for Amendment: Implement inflationary increases appropriated by the state legislature.

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 program has been updated annually as of October 1 of each year beginning with the Medicare grouper version 15 (effective October 1, 1997). 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 on the same basis as the Medicaid agencies in the states where the hospitals are located. If the hospital's home state refuses to provide the amount they would pay for a given claim, the payment will be at 44.15% of billed charges. 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 April 1, 2018, the reimbursement for instate DRG hospitals and all out-of-state hospitals not paid the above-stated percentage of charges is increased by 0.5 percent over what the calculated amounts were for State fiscal year 2017 after any cost sharing amount due from the patient and any third party liability amounts have been deducted, and after computation of any cost outlier payment. The agency will increase reimbursements to South Dakota hospitals classified as Medicare Critical Access or Medicaid Access Critical by 0.5 percent for claims with dates of service on and after April 1, 2018.

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.

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	April 1, 2018
Physician Services	Attachment 4.19-B, Page 6	April 1, 2018
Optometrist Services	Attachment 4.19-B, Page 9	April 1, 2018
Chiropractic Services	Attachment 4.19-B, Page 10	April 1, 2018
Home Health Services	Attachment 4.19-B, Page 12	April 1, 2018
Durable Medical Equipment	Attachment 4.19-B, Page 13	April 1, 2018
Clinic Services	Attachment 4.19-B, Page 15	April 1, 2018
Dental Services	Attachment 4.19-B, Page 16	April 1, 2018
Physical Therapy	Attachment 4.19-B, Page 17	April 1, 2018
Occupational Therapy	Attachment 4.19-B, Page 18	April 1, 2018
Speech, Hearing, or Language Disorder Services	Attachment 4.19-B, Page 19	April 1, 2018
Dentures	Attachment 4.19-B, Page 21	April 1, 2018
Prosthetic Devices	Attachment 4.19-B, Page 22	April 1, 2018
Eyeglasses	Attachment 4.19-B, Page 23	April 1, 2018
Diabetes Self-Management Training	Attachment 4.19-B, Page 26	April 1, 2018
Nurse Midwife Services	Attachment 4.19-B, Page 31	April 1, 2018
Transportation	Attachment 4.19-B, Page 38	April 1, 2018
Personal Care Services	Attachment 4.19-B, Page 38	April 1, 2018
Freestanding Birth Centers	Attachment 4.19-B, Page 39	April 1, 2018
Professional Services Provided in a Freestanding Birth Center	Attachment 4.19-B, Page 39	April 1, 2018