



DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE SECRETARY
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3165
FAX: 605-773-4855
WEB: dss.sd.gov

December 16, 2011

Richard Allen
Associate Regional Administrator
Centers for Medicare and Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202

Re: South Dakota Medicaid State Plan Amendment TN 11-13

Dear Mr. Allen:

Please find enclosed South Dakota State Plan Amendment (SPA) Transmittal Number (TN) 11-13 proposing a technical correction or clarification of the language in our State Plan referring to the hospital categories Medicare Critical Access and Medicaid Access Critical. This SPA amends page 1b of our Attachment 4.19-B, the payment methodology for outpatient and other providers. The effective date for this SPA is December 19, 2011. There is no fiscal effect associated with this SPA.

The State's Tribal Consultation process on this SPA began this fall, and the written part of our process concluded with notification sent via email and United States Postal Service on October 31, 2011. We also published the proposed SPA's page on our website at <http://dss.sd.gov/tribalconsultation/index.asp>. The Department received no comments or requests for revision from the Tribes. We published public notice via the South Dakota Legislature's *REGISTER*, which is read by the institutions, their associations, legislators, and the public, on December 12 at the website (<http://legis.state.sd.us/rules/register/12122011.pdf>).

The following are answers to the traditional five questions asked of payment methodology SPAs:

1. All Medicaid providers in South Dakota retain all of the Medicaid payments, including the Federal and State share;
2. The Legislature appropriates the state share of funding; there are no intergovernmental transfer agreements or certified public expenditures (CPEs) in South Dakota;
3. This SPA proposes no supplemental or enhanced payments for providers;
4. We do not believe upper payment limits apply to the provisions of this SPA as it is merely a technical change to language in the Plan; and
5. No governmental provider of these services receives payments that in the aggregate exceed their reasonable costs of providing services.

Finally, nothing in this SPA will create for recipients any barriers to access to care.

If you have any questions regarding this package, please contact Mark Zickrick at the Division of Medical Services, 700 Governors Drive, Pierre, SD 57501-2291, e-mail mark.zickrick@state.sd.us, or telephone (605)773-3495.

Sincerely,

A handwritten signature in cursive script that reads "Kim Malsam-Rysdon".

Kim Malsam-Rysdon
Cabinet Secretary

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

4. The agency will make interim payments to outpatient hospitals based upon Medicare principles and the above exceptions using the CMS 2552 Report, Worksheet C, Part 1 lines 37-68 as submitted by the hospitals to determine the Medicare outpatient cost-to-charge ratios (CCRs) for the ancillary cost centers for each hospital. The agency applies the hospital-specific CCRs to claims detail from the agency's MMIS pertaining to the Medicaid outpatient hospital charges associated with claims from each provider for the same dates of services as reported on the Medicare cost reports to calculate Medicaid limits per cost center. The agency uses the lesser of Medicaid costs or charges and subtracts from that amount any third party resource payments to arrive at the net Medicaid amount for each hospital and compares that amount to the total of interim payments to the hospital. Once the agency has calculated the difference between interim payments to the hospitals and the net Medicaid costs, only the calculations showing cost settlement amounts that are owed to the South Dakota Medicaid program will result in retroactive cost adjustments, those amounts being due the agency. All participating hospitals must submit their Medicare cost reports to the agency within 150 days following the end of their fiscal year.

The remaining in-state 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.

For claims with dates of service from July 1, 2011 through June 30, 2012, the amount of reimbursement for in-state DRG hospitals and all out-of-state hospitals will be reduced by 11.48 percent after any cost sharing amount due from the patient and any third party liability amounts have been deducted. This does not apply to South Dakota hospitals that are classified as Medicare Critical Access or Medicaid Access Critical.