MYERS AND STAUFFER LC

South Dakota Department of Social Services (DSS)

Inpatient and Outpatient Hospital Reimbursement

Recommendations Report

June 2026

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Report Limitations and Caveats

The findings and recommendations presented in this report are based on the most current information available as of the date of the report. Certain components of this project remain under review and are preliminary and subject to change. Therefore, it is important to note the following considerations regarding the information contained in this report:

1. Fiscal Impact Modeling Results

The fiscal impact modeling included in this report was developed using historical Medicaid claims data and hospital cost report data to estimate the potential impacts of the proposed modernization of South Dakota Medicaid's hospital reimbursement methodologies.

- These figures represent directional estimates, intended to help the South Dakota Department of Social Services (DSS), providers, and other stakeholders understand potential shifts in reimbursement under the new methodologies.
- Because the projections are based on past data, they do not reflect changes in utilization, service mix, or policy decisions that may occur between the modeling period and targeted implementation on July 1, 2026.
- Final fiscal outcomes will also depend on:
    - Updates to provider-submitted cost reports.
    - System configuration and claims processing at go-live.
    - CMS review and approval of methodology changes through the Medicaid State Plan Amendment (SPA) process.

Accordingly, financial estimates presented in this report should be treated as illustrative planning tools and not final payment amounts.

2. Lifescape Children's Specialty Hospital Cost Report Review

DSS and Myers and Stauffer are currently reviewing cost report information submitted by Lifescape Children's Specialty Hospital ("Lifescape").

- This review is critical to establishing appropriate reimbursement levels for Lifescape's specialized services.
- Final recommendations regarding Lifescape's rates will be updated upon completion of this review and incorporated into DSS's final policy decisions. Information regarding Lifescape in this report may change.

3. Interpretation of Fiscal Data

Until all reviews are complete and approvals obtained:

- All fiscal estimates, tables, and charts in this report should be interpreted as preliminary and for illustrative purposes only.
- Financial amounts do not represent final reimbursement amounts, nor do they constitute official DSS policy.
- Actual fiscal outcomes may differ from projections due to:
    - Changes in Medicaid enrollment or utilization.
    - Provider service mix adjustments.
    - Policy updates made after this report.
    - CMS review and required modifications.

The final reimbursement methodologies, base rates, and fiscal impacts will be determined through DSS's formal rate-setting process and approved by CMS before implementation.

4. Purpose of This Report

This report is intended to:

- Guide planning and stakeholder engagement.
- Provide transparency around DSS's methodology modernization efforts.
- Offer a data-driven framework for decision-making as South Dakota prepares for go-live on July 1, 2026.

Until all reviews are complete and final approvals are received, this report should be considered preliminary and non-binding.

Executive Summary

Purpose

South Dakota DSS is seeking to modernize Medicaid inpatient and outpatient hospital reimbursement methodologies to address outdated systems, payment inequities, and potential compliance risk. Through this modernization effort, DSS intends to replace fragmented, reimbursement methodologies with prospective payment system (PPS) methodologies that are equitable, transparent, and aligned with national best practices.

Goals of this modernization project include:

- Ensure equitable and transparent reimbursement across all hospitals.
- Align with CMS standards to maintain compliance and achieve consistency with peer state methodologies and best practices.
- Protect access to care, especially in rural areas served by Critical Access Hospitals (CAHs).
- Simplify administration for both DSS and providers.
- Lay a foundation for future innovation, including value-based purchasing.

The new methodologies are scheduled to go live on July 1, 2026, representing a historic step forward for South Dakota Medicaid.

Background

South Dakota's hospital network includes general acute care hospitals, Critical Access Hospitals (CAHs), specialty hospitals, Indian Health Service (IHS) facilities, rehabilitation hospitals, psychiatric hospitals, and out-of-state referral hospitals. Many facilities, especially rural providers, operate with narrow financial margins and play a vital role in access to care.

Historically, DSS has used the following fragmented mix of payment methodologies:

- Medicare Severity (MS)-DRG and percent-of-charge payments for inpatient services.
- Hospital-specific ambulatory payment classification (APC) base rates and percent-of-charge for outpatient services.
- Per diem rates for rehabilitation hospitals and long-term acute care hospitals.
- Separate rules for out-of-state hospitals and special facilities such as Lifescape.

While these systems have been functional, they create:

- Payment inequities across hospitals and services.
- Administrative complexity for DSS and providers.

- Potential compliance risk under 42 CFR §447.272 (inpatient UPL) and §447.321 (outpatient UPL).

These factors prompted DSS to launch a modernization initiative to standardize, simplify, and strengthen its hospital reimbursement framework.

Methodology Overview

DSS, with support from Myers and Stauffer, developed a set of recommendations based on:

- Historical Medicaid claims and hospital cost report data.
- Peer state research and best practices from other rural/frontier states.
- Fiscal impact modeling to project provider-level effects.
- Stakeholder input through meetings, FAQs, and provider education sessions.

The modernization plan focuses on three areas:

Inpatient Hospital Reimbursement

- Transition from MS-DRG to APR-DRG, providing greater clinical accuracy and severity adjustments.
- Establish a single statewide DRG base rate, with targeted add-ons for out-of-state hospitals. The statewide DRG base rate is modeled at $11,430.74.
- Implement a cost-based outlier methodology for high-cost cases.
- Move CAHs to interim payments with interim rates set to equal 100% costs or 95% of charges.

Outpatient Hospital Reimbursement

- Replace hospital-specific APC base rates with a single statewide base rate. The statewide base rate is modeled at the 2026 National Medicare Rate of $91.42.
- Transition CAHs to the same approach as inpatient services.
- Align reimbursement for dialysis services with Medicare.
- Begin reimbursing trauma services using APC methodology.

Systemwide Governance and Compliance

- Establish annual processes for PPS updates, CCR refreshes, and other adjustments.
- Require annual cost report submissions from CAHs and Lifescape (Medicare 2552-10 format).
- Strengthen data validation and audit readiness for CMS compliance.

Key Methodology Changes

The table below captures the key methodology changes:

Policy Area	Current State	Modernized Approach
Inpatient Grouper	MS-DRG	APR-DRG with four severity of illness (SOI) levels
Inpatient Base Rate	Hospital-specific rates	Single statewide rate of $11,430.74, with add-ons
Outpatient Base Rate	Hospital-specific APC rates	Single statewide APC base rate of $91.42
CAH Payment Logic	Percent-of-charge/MS-DRG, no settlement	Interim rates, calculated to hit a floor of 100% estimated reimbursement
Out-of-State Hospitals	Percent-of-charge	PPS-aligned APR-DRG/APC with enhanced base rate
Dialysis Services	Percent-of-charge / Fee schedule	Fee Schedule with an all-inclusive code 90999
Trauma Care	Not reimbursed	APC-based reimbursement
Outlier Payments	Charge-based	Cost-based inpatient; unchanged outpatient

Fiscal Impact (Preliminary)

Fiscal impact modeling provides a projection of the impact of transitioning to the modernized methodologies. Results are presented at three levels:

- Inpatient Provider Fiscal Impact – Effects of APR-DRG transition and CAH Percent of Charge.
- Outpatient Provider Fiscal Impact – Effects of single APC rate, trauma care addition, dialysis update to fee schedule only, and CAH percent of charge.
- Combined Fiscal Impact – Total impact by provider and hospital type.

Category	Projected Change
Total Inpatient Spending	$11,828,213
Total Outpatient Spending	($5,210,966)
Combined Total Impact	$6,617,246

The figures above represent a one year estimation with a one year inflation increase applied and are for illustrative purposes only.

Anticipated Benefits

Implementing these reforms will:

- Promote Equity: Ensure consistent payment across hospital types and services.
- Strengthen Compliance: Reduce audit risk under federal UPL rules.
- Protect Access: Stabilize rural hospitals and trauma care services.
- Simplify Administration: Streamline billing and oversight processes.
- Support Innovation: Create a foundation for future quality-based and value-based payment models.

Conclusion

The modernization of South Dakota Medicaid's hospital reimbursement system will replace outdated, fragmented payment methodologies with equitable, transparent, and sustainable PPS frameworks.

By implementing these changes on July 1, 2026, DSS will:

- Protect access to essential services in rural and urban areas.
- Ensure compliance with CMS standards.
- Position South Dakota for long-term innovation and quality improvement.

Through careful planning, provider engagement, and strong governance, these reforms will create a stronger Medicaid program that meets the needs of today and builds for the future.

Background

The South Dakota DSS, Division of Medical Services, administers the state's Medicaid program, providing health care coverage to South Dakota's most vulnerable populations, including low-income families, children, pregnant women, individuals with disabilities, and the elderly.

Due to the state's rural and frontier geography, DSS faces unique challenges in ensuring access to high-quality hospital services, particularly for specialized care such as neonatal intensive care, behavioral health, rehabilitation, and trauma services. The state's large geographic footprint, low population density, and reliance on small rural hospitals make equitable reimbursement policies vital to sustaining provider networks and ensuring Medicaid beneficiaries receive appropriate care.

South Dakota's hospital network is diverse and includes general acute care hospitals, critical access hospitals (CAHs), specialty hospitals, Indian Health Service (IHS) facilities, rehabilitation hospitals, long-term care hospitals, and out-of-state referral hospitals. Many of these facilities are lifelines for their communities, often operating on narrow financial margins. As a result, the Medicaid reimbursement methodology plays a pivotal role in sustaining access to care while ensuring that state and federal funds are used efficiently and equitably.

Need for Modernization

Over time, South Dakota's hospital reimbursement methodologies have become increasingly fragmented, relying on multiple, often outdated approaches. This has resulted in a system that is difficult for DSS to efficiently manage, lacks transparency, and does not fully reflect the unique needs of the Medicaid population.

Currently, the state uses a combination of:

- MS-DRG system and percent-of-charge payments for general acute care hospitals, with exclusions for certain services such as psychiatric, neonatal intensive care, and rehabilitation services.
- Per diem rates for long-term care hospitals, specialty pediatric facilities, and other select services.
- Hospital-specific base rates and percent-of-charge methodologies for outpatient services, including dialysis and trauma care.

While these methodologies have historically met the state's needs, they now face several key limitations:

- Limited reflection of Medicaid populations: Current systems do not adequately represent pediatric, obstetric, and behavioral health cases, which are often underrepresented in Medicare-focused payment designs.

- Payment inequities: Significant variation exists across hospital types and between in-state and out-of-state facilities, leading to inequities for providers delivering similar services.
- Administrative burden: It is challenging for DSS to maintain and update multiple methodologies, including challenges with DRG/APC versioning, aligning policies with CMS guidance, and reconciling cost and payment data.
- Compliance risks: Current structures increase the risk of non-compliance with Upper Payment Limit (UPL) demonstrations and federal matching requirements under 42 CFR §447.272 and §447.321.

These challenges have created an urgent need for comprehensive modernization. DSS has therefore launched a multi-year initiative to redesign its hospital reimbursement systems to align with national best practices, improve payment equity, and ensure the long-term sustainability of South Dakota's Medicaid program.

Project Objectives

To support this effort, DSS engaged Myers and Stauffer LC, a nationally recognized certified public accounting (CPA) and consulting firm specializing in Medicaid reimbursement and financing strategies. Myers and Stauffer has partnered with South Dakota Medicaid since 1988, providing a range of services including hospital UPL demonstrations, disproportionate share hospital (DSH) examinations, rate setting, and reimbursement methodology design.

This longstanding relationship has given Myers and Stauffer valuable insight into South Dakota's Medicaid program, its provider network, and the operational realities faced by DSS staff and hospital leadership.

The goals of this initiative include:

- Modernizing reimbursement methodologies to better reflect the clinical complexity and service needs of Medicaid beneficiaries.
- Ensuring equitable and transparent payment structures across all hospital types, including CAHs, specialty hospitals, and out-of-state providers.
- Aligning with CMS-approved prospective payment systems (PPS), such as, APR-DRG for inpatient services and APC for outpatient services, to promote national consistency and defensibility.
- Maximizing federal financial participation (FFP) while maintaining compliance with state and federal regulations.
- Simplifying administration and oversight through standardized rates, streamlined processes, and more reliable reporting.
- Building a sustainable framework for ongoing maintenance and periodic updates to ensure the system remains accurate and relevant over time.

Stakeholder Engagement and Data Analysis

From the outset, DSS and Myers and Stauffer prioritized stakeholder involvement and data-driven decision-making to ensure that the recommended changes reflect both policy goals and operational realities.

This process included:

- Historical data review – Analysis of two to three years of Medicaid paid claims, hospital cost reports, and MMIS data to understand current payment patterns and trends.
- Assessment of excluded services – Evaluation of psychiatric, neonatal intensive care unit (NICU), and rehabilitation units to determine the feasibility of integrating these services into DRG-based methodologies.
- Fiscal impact modeling – Simulations to assess how proposed changes would affect both individual hospitals and the system overall, ensuring that reforms would not destabilize providers.
- Peer state benchmarking – Comparisons to other rural and frontier states, such as Montana, North Dakota, and Wyoming, to identify best practices and align South Dakota's approach with similar markets.
- Provider engagement and transparency – Ongoing dialogue through meetings, webinars, and outreach to gather feedback, explain modeling results, and build support for the transition.

This collaborative process ensured that recommendations were practical, data-informed, and provider-sensitive, laying the groundwork for smoother implementation.

Alignment with National Trends and Best Practices

South Dakota's modernization efforts are part of a broader national movement to replace outdated, charge-based reimbursement systems with standardized, transparent PPS methodologies. Many states have already adopted models such as APR-DRG for inpatient care and APC or enhanced ambulatory payment group (EAPG) systems for outpatient services.

These systems are recognized for:

- Providing more accurate, equitable payments for similar services across hospitals.
- Incorporating severity adjustments that better reflect patient complexity, especially for Medicaid populations.
- Supporting data-driven policy decisions and integration with quality measurement and value-based purchasing initiatives.
- Reducing reliance on outdated and inconsistent methodologies like percent-of-charge and per diem payments.

By aligning with these best practices, South Dakota Medicaid can:

- Manage costs more effectively while protecting access to essential services.
- Improve transparency and predictability in hospital reimbursement.
- Strengthen compliance with CMS expectations, reducing audit risk and financial exposure.
- Establish a strong foundation for future innovation, including value-based purchasing and quality incentive programs.

Purpose of This Report

This report presents the results of the comprehensive review of South Dakota Medicaid's inpatient and outpatient hospital reimbursement methodologies. It outlines a step-by-step plan for transitioning to modernized systems that will take effect for services delivered on or after July 1, 2026.

The recommendations outlined in this report are designed to simplify administration and oversight for DSS and providers, ensure equitable, sustainable payments across all hospital types, and position South Dakota Medicaid for long-term success in delivering high-quality, accessible care to beneficiaries.

The following sections will describe the current reimbursement landscape, identify gaps and opportunities for improvement, and provide detailed recommendations for methodology changes, fiscal impacts, and implementation strategies. These recommendations are grounded in robust data analysis, peer state comparisons, and extensive stakeholder input, ensuring that South Dakota's Medicaid program is prepared to meet both current and future healthcare challenges.

Review of Current Reimbursement

The reimbursement methodologies currently used by South Dakota Medicaid for inpatient and outpatient hospital services have evolved over time in response to federal requirements, state policy decisions, and provider feedback. While these methodologies have been successful in ensuring access to services, they have also created a complex landscape with multiple payment systems operating simultaneously. The result is a patchwork of rules that vary by hospital type, service category, and geographic location, leading to challenges in payment equity, administrative efficiency, and compliance with federal guidelines.

This section provides a detailed review of the current methodologies, establishing a clear baseline for modernization efforts. Understanding these existing policies is critical before moving forward with recommendations for systemic reform.

Overview of the Current Payment Environment

South Dakota's hospital network is composed of a diverse mix of facilities, including general acute care hospitals, critical access hospitals (CAHs), specialty hospitals and units, Indian Health Service (IHS) hospitals, and out-of-state referral hospitals. These facilities play different roles in the state's healthcare delivery system.

- General acute care hospitals primarily serve larger urban areas and are more likely to provide a full range of inpatient and outpatient services.
- CAHs are small, rural hospitals designed to maintain access to emergency and essential services in frontier areas.
- Specialty hospitals focus on specific populations or service types, such as psychiatric or rehabilitation services.
- IHS facilities serve tribal communities under federal funding arrangements.
- Out-of-state hospitals are used when South Dakota residents require services not available within state borders.

Because of this diversity, South Dakota Medicaid has historically used different reimbursement approaches for each facility type, resulting in a fragmented payment structure. This fragmentation has led to varying levels of cost coverage, difficulty in comparing payment rates across providers, and a lack of transparency in the system.

Inpatient Hospital Reimbursement

South Dakota currently uses a mix of DRG-based reimbursement, percent-of-charge methods, and per diem payments for inpatient hospital services. The approach varies based on hospital type and service provided, creating multiple parallel methodologies within the state's Medicaid program. The table below contains the current inpatient payment methodologies.

Summary of Inpatient Payment Methodologies	
Hospital Type	**Current Methodology**
General Acute Care	MS-DRG or Percent of Charges
Critical Access	MS-DRG or Percent of Charges
Rehabilitation Hospital & Units	Per Diem
Psychiatric Hospital & Units	Per Diem
Neonate ICU	Per Diem
Long Term Care	Per Diem
Children's Hospital (Lifescape)	Per Diem
Specialized Surgical Hospital	Percent of Charges
Out of State Acute Care Hospitals	Percent of Charges
Out of State Rehabilitation Care Hospitals & Units	Percent of Charges
Out of State Long Term Care Hospitals	Percent of Charges

Payment by Hospital Type

For general acute care hospitals, South Dakota primarily relies on the Medicare Severity Diagnosis-Related Group (MS-DRG) system. This methodology groups inpatient stays into clinically similar categories based on the patient's diagnoses, procedures, and comorbidities. Each DRG is assigned a relative weight, which reflects the expected resource utilization for that type of case. The payment is then calculated by multiplying the DRG weight by a hospital-specific base rate.

However, many hospitals and services are excluded from DRG-based reimbursement. These exclusions include psychiatric hospitals and units, rehabilitation hospitals and units, neonatal intensive care services (NICU), long-term acute care hospitals (LTCH), and certain specialty facilities like Lifescape Children's Hospital. These excluded facilities are reimbursed using per diem rates, which provide a fixed daily payment regardless of the specific services provided.

Some hospitals, such as some in state CAHs, specialized surgical hospitals, and out-of-state facilities, are reimbursed based on a percent-of-charge methodology. For out-of-state hospitals, this percent-of-charge is set at approximately 44.15% of usual and customary charges under the state's current Medicaid plan. While administratively straightforward, this method does not tie payments directly to cost or resource use, making it less precise than a DRG-based system.

The result of this mix of approaches is inconsistency in how similar services are reimbursed, depending on where and by whom they are provided. For example, two hospitals delivering the same service to similar patients may receive very different payments simply because one hospital is paid under DRG logic while another is paid per diem or percent-of-charge.

DRG Payment Components

Where DRGs are currently applied, South Dakota's approach includes several key components:

- Grouper: The state uses the MS-DRG system, which was originally designed for Medicare beneficiaries and does not fully capture the complexity of the Medicaid population, particularly pediatrics, obstetrics, and behavioral health.
- Weights: South Dakota currently maintains state-specific DRG weights, which are updated periodically to reflect local data.
- Base Rates: Each hospital has its own hospital-specific base rate, incorporating adjustments for capital and education components. This leads to wide variation in base rates across hospitals.
- Outlier Payments: For unusually costly cases, additional payments are made using a charge-based outlier formula. This approach calculates payment by comparing billed charges to a fixed threshold and paying a percentage of the amount above that threshold. While this provides financial protection to hospitals, it can also result in unpredictable reimbursement and misaligned incentives.
- Transfers: When a patient is transferred from one facility to another, the transferring hospital receives a prorated payment based on covered days and the average length of stay.

This structure reflects a traditional, Medicare-aligned DRG system but has not been updated to include the advanced features of more modern Medicaid DRG methodologies such as APR-DRGs.

Critical Access Hospitals (CAHs)

CAHs play a vital role in maintaining healthcare access in rural and frontier areas. Under the current system, CAHs are paid based on either MS-DRG or hospital-specific percent of charges for inpatient services and hospital-specific percent of charges for outpatient services.

Unlike Medicare, South Dakota Medicaid does not currently perform annual cost settlements to reconcile these payments to actual costs. South Dakota Medicaid also does not set rates at a percentage of costs. This has resulted in significant variation in cost coverage across CAHs, with some facilities reimbursed at only 60% of their costs, while others receive payments well above 200% of cost.

This variation undermines equity and transparency, as similarly situated CAHs can have different financial outcomes based on historical reimbursement patterns rather than actual service costs. The absence of cost reconciliation also limits the state's ability to ensure that payments are accurate and sustainable over time.

Outpatient Hospital Reimbursement

Like inpatient reimbursement, the current outpatient methodology is fragmented, with different approaches applied depending on hospital type and service category. This fragmentation has created challenges with equity, transparency, and administrative complexity, and has contributed to variation in how similar services are reimbursed across facilities.

The primary mechanism used for outpatient reimbursement is an APC system, which was originally developed by Medicare to group outpatient procedures and services based on clinical similarity and resource use. However, South Dakota's implementation of the APC methodology differs from the standard national model, resulting in a system that is customized for the state but difficult to maintain and administer. The table below contains the current outpatient payment methodologies.

Summary of Outpatient Payment Methodologies	
Hospital Type	**Current Methodology**
General Acute Care	APC – Fee Schedule
Critical Access	Percent of Charge
Children's Hospital (Lifescape)	Percent of Charge
Specialized Surgical Hospital	APC – Fee Schedule
Out of State Acute Care Hospitals	Percent of Charges

Payment by Hospital Type

South Dakota currently uses a mix of APC-based payments, percent-of-charge methodologies, and fee schedule logic for outpatient services. The reimbursement method varies by hospital type, leading to inconsistencies across the provider network.

For in-state general acute care hospitals, outpatient services are reimbursed using the APC methodology. Unlike Medicare and most other states, South Dakota has opted to maintain hospital-specific APC base rates, which creates significant variation in payment levels for the same service. This approach adds complexity for both DSS and providers and makes it difficult to compare costs or establish standardized benchmarks.

In-state Critical Access Hospitals (CAHs) are reimbursed under a percent-of-charge model, similar to their inpatient reimbursement structure. While this approach provides predictable cash flow for hospitals, it does not ensure alignment between payments and actual service costs.

The Lifescape Children's Specialty Hospital is reimbursed at 100% of billed charges for outpatient services. This unique approach reflects the specialized nature of Lifescape's services but further adds to the diversity of reimbursement models in the system.

For out-of-state hospitals, outpatient services are reimbursed at a fixed 38.2% of charges. This rate is substantially lower than in-state rates and does not incorporate any form of cost-based reconciliation or national APC methodology. Out-of-state Critical Access Hospitals are similarly reimbursed on a percent-of-charge basis, and in some cases may require manual repricing when claims are processed.

Summary of Current Outpatient Payment by Hospital Type:

- In-State General Acute Care: APC methodology with hospital-specific base rates.

- In-State CAHs: Percent-of-charge with no reconciliation to actual costs.
- Lifescape Children's Specialty Hospital: 100% of billed charges.
- Out-of-State Hospitals (non-CAH): Fixed 38.2% of billed charges.
- Out-of-State CAHs: Percent-of-charge, sometimes requiring manual pricing.

This tiered approach reflects historical policy decisions, but it has also resulted in inequities between providers and complexity for DSS to manage and update.

APC Pricing Components

The APC system was designed to standardize outpatient reimbursement by grouping clinically similar services into payment classifications. Each APC has an associated relative weight, which reflects the expected resource consumption for that service. The relative weight is then multiplied by a base rate to determine the final payment.

In South Dakota, several key components define the current APC methodology:

Grouping and Weights

- Services are grouped into APCs based on procedure codes and clinical relationships.
- Standard APC relative weights are applied, consistent with Medicare rules.

Base Rates

- Unlike most states, South Dakota maintains hospital-specific APC base rates instead of a single, standardized statewide rate.
- These base rates range significantly — in some cases from $46.55 to $146.96, depending on the hospital.
- The variation in base rates makes it challenging to ensure equitable reimbursement across providers.

Bundling and Packaging Rules

- Certain services are considered "packaged" or "bundled" within other services.
- For example, services marked with status indicator N are not reimbursed separately but are included in the payment for a primary procedure.
- This follows standard Medicare bundling practices, but it adds complexity for hospitals trying to predict payment amounts.

Non-APC Services

- When a service does not fit within the APC grouper, it is reimbursed using a separate fee schedule or other reference pricing logic.
- This ensures coverage for unique services but creates additional administrative burden for DSS and providers.

Challenges with the Current APC System

While the APC methodology provides a structured framework for outpatient reimbursement, South Dakota's customized implementation introduces several challenges:

1. Inequitable Payments Across Hospitals

The use of hospital-specific base rates means that two hospitals can be paid different amounts for the same service. This has led to payment inequities, where some hospitals are reimbursed well above cost while others struggle to cover their expenses. These disparities are particularly problematic for smaller rural hospitals competing with larger urban facilities.

2. Administrative Complexity

Managing and updating multiple hospital-specific base rates requires significant administrative effort. DSS must update each base rate individually when changes occur, such as annual rate adjustments or policy updates. This increases the risk of errors and delays in implementation.

3. Lack of Transparency

The complexity of the current APC system makes it difficult for providers to understand how their payments are determined. This lack of transparency can lead to disputes and undermines trust between hospitals and the state.

4. Misalignment with National Trends

Most other state Medicaid programs have moved toward standardized statewide APC rates to promote consistency and equity. South Dakota's approach diverges from these best practices, making it harder to compare performance across states and to implement value-based payment initiatives.

Out-of-State Hospitals

Out-of-state hospitals play a critical role in providing services that are not available within South Dakota. However, their reimbursement structure is significantly different from that of in-state facilities.

- Inpatient Services: Out-of-state hospitals are generally paid a fixed 44.15% of billed charges for inpatient services, with no cost settlement or DRG-based pricing.
- Outpatient Services: For outpatient services, these hospitals are reimbursed at 38.2% of billed charges, regardless of service type or cost.
- Out-of-State CAHs: These facilities follow a similar percent-of-charge model, and in some cases, claims must be manually repriced by DSS.

This approach is administratively simple but creates stark inequities between in state and out-of-state hospitals. It also does not reflect actual resource utilization or costs, making it difficult to ensure appropriate reimbursement.

Administrative and Operational Challenges

The complexity of having multiple reimbursement methodologies creates significant challenges for DSS and providers:

- System Maintenance: Supporting different logic streams (DRG, APC, per diem, percent-of-charge) increases the burden on the Medicaid Management Information System (MMIS) and requires frequent programming updates.
- Data Integrity: Claims data validation is complicated by voids, replacements, and adjustments, making it difficult to track true costs and payments.
- Provider Burden: Hospitals must navigate a complex set of billing rules, leading to errors, disputes, and administrative inefficiencies.
- Transparency Issues: Hospitals and DSS face difficulty explaining and justifying reimbursement outcomes to stakeholders, including CMS.

Summary of Current Challenges

The current outpatient reimbursement system has several strengths, including the use of APCs for in-state hospitals and adherence to Medicare bundling rules. However, the challenges outweigh these strengths, particularly in terms of equity and sustainability.

South Dakota's outpatient reimbursement system reflects a legacy of incremental policy decisions. While the APC methodology provides a foundation for structured payment, its customized implementation with hospital-specific base rates has introduced inequities and operational inefficiencies. The reliance on percent-of-charge payments, particularly for CAHs and out-of-state hospitals, further complicates the landscape and undermines alignment with modern Medicaid best practices.

These issues underscore the need for modernization. Moving toward a standardized, equitable, and transparent outpatient reimbursement methodology will not only improve fairness but also simplify administration and position the state for future innovations such as value-based purchasing and quality incentives.

Gap Analysis and Peer State Comparison

South Dakota's hospital reimbursement methodologies have been shaped by decades of incremental changes, resulting in a complex and multi-faceted payment system. While these legacy policies have helped maintain access to care, they also create administrative inefficiencies, payment inequities, and compliance risks.

To chart a path forward, DSS and Myers and Stauffer reviewed peer state Medicaid programs, compared South Dakota's current approach to national best practices, and identified gaps and opportunities for modernization. This analysis provides a clear view of how South Dakota compares to similar frontier and rural states and establishes a foundation for the recommendations presented in this report.

The analysis focused on four primary domains:

- Inpatient Hospital Methodologies
- Outpatient Hospital Methodologies
- Critical Access Hospital (CAH) Policies
- Out-of-State (OOS) Hospital Reimbursement

Inpatient Hospital Reimbursement – Gap Assessment

Current Approach

South Dakota currently relies on a combination of MS-DRG, per diem, and percent-of-charge methodologies for inpatient hospital reimbursement.

- General acute care hospitals are paid primarily under the MS-DRG system, using hospital-specific base rates.
- Certain facilities including CAHs, psychiatric units, rehabilitation units, NICUs, and long-term acute care hospitals (LTCHs) are excluded from DRG payment and reimbursed using per diem or percent-of-charge methodologies.
- Outlier payments are based on billed charges rather than cost, creating volatility and making high-cost cases difficult to predict.
- Transfer policies prorate payments based on covered days and average length of stay.

This mix of methods makes it challenging to compare payments across facilities and maintain consistency in rate updates.

Best Practice Trends

Across the country, Medicaid agencies are modernizing inpatient reimbursement by adopting APR-DRG systems and moving away from the Medicare-based MS-DRG system as well as cost-based or charge-

based approaches. Among peer frontier states such as Wyoming, North Dakota, and Montana, the following trends are evident:

- APR-DRG adoption is increasing because its severity tiers better reflect the Medicaid population, including pediatrics, obstetrics, and behavioral health.
- National APR-DRG weights are used to simplify maintenance and ensure alignment with CMS standards.
- Statewide or peer-grouped base rates are replacing hospital-specific base rates to promote transparency and equity.
- Cost-based outlier payments are becoming standard, reducing volatility and aligning payments with actual resource use.
- Standard transfer logic ensures appropriate reimbursement when patients move between facilities.

Gaps Identified

- Clinical misalignment: MS-DRG does not accurately capture the complexity of Medicaid populations, particularly for pediatric and behavioral health cases.
- Payment inequities: Hospital-specific base rates lead to wide disparities in payments for similar services across different hospitals.
- Unpredictable reimbursement: Charge-based outliers amplify variability and create budgeting challenges for both DSS and providers.
- Administrative burden: Maintaining multiple carve-outs and outdated policies increases MMIS programming complexity and slows updates.

Implications

Moving to APR-DRG with a standardized base rate and cost-based outlier methodology would significantly improve alignment with Medicaid best practices and reduce systemic complexity.

Outpatient Hospital Reimbursement – Gap Assessment

Current Approach

South Dakota uses an APC-based reimbursement system for outpatient services at in-state hospitals.

- Unlike Medicare, South Dakota assigns hospital-specific APC base rates, which vary significantly by facility.
- Bundling and packaging rules generally follow Medicare standards, meaning certain services are included in the payment for a primary procedure.

- Some services that do not fit the APC model are reimbursed via fee schedule or other reference pricing.
- Critical Access Hospitals (CAHs) and out-of-state hospitals are often reimbursed using percent-of-charge methodologies, creating inconsistency within the outpatient framework.
- Lifescape is reimbursed at 100% of billed charges for outpatient care.

This results in a patchwork of outpatient reimbursement approaches, with significant variation in payment for similar services.

Best Practice Trends

Nationally, Medicaid programs are moving toward uniform outpatient methodologies:

- Single statewide APC base rates are now common, with targeted adjustments for specific populations such as children's hospitals or rural facilities.
- States using EAPG systems follow similar principles, emphasizing packaging and grouping logic to encourage efficiency and reduce administrative burden.
- High-cost drugs and observation services are clearly defined and reimbursed consistently, avoiding reliance on charges.

Gaps Identified

- Payment inequities: Hospital-specific APC base rates create wide variation in reimbursement levels, even for the same service.
- Administrative complexity: Updating and maintaining dozens of individual base rates is time-consuming and increases the risk of errors.
- Policy inconsistency: Percent-of-charge methodologies for CAHs and out-of-state hospitals break alignment with the APC model.
- Transparency issues: The current system is difficult for providers to understand, limiting trust and collaboration with DSS.

Implications

A single statewide APC base rate, coupled with standardized policies for CAHs and out-of-state hospitals, would promote fairness, streamline administration, and improve transparency.

Critical Access Hospitals (CAHs) – Gap Assessment

Current Approach

South Dakota reimburses CAHs for inpatient services using MS-DRG or hospital-specific percent-of-charges methodology and outpatient services using a percent-of-charge methodology. Unlike Medicare,

South Dakota Medicaid does not set cost based rates or perform annual cost settlements to reconcile interim payments to actual costs.

This has led to significant variation in cost coverage, with some CAHs receiving only 60% of their costs and others receiving more than 200%.

- The lack of cost based rates creates uncertainty and undermines the sustainability of rural hospitals.
- It also limits DSS's ability to ensure that payments are accurate, equitable, and compliant with federal rules.

Best Practice Trends

Peer rural states have adopted cost-based reimbursement models for CAHs:

- Interim rates are set using recent cost report data.
- At the end of each fiscal year, payments are settled to 100% of allowable costs.
- Rates are recalibrated every two years to reflect changes in service levels or cost structures.
- Some states have implemented phase-in periods to transition hospitals gradually to the new model.

Gaps Identified

- Wide cost coverage variation: The current percent-of-charge system lacks consistency and accountability.
- Lack of reconciliation: Without annual review of cost based rates, DSS cannot ensure that payments are accurate or equitable.
- Compliance concerns: Federal auditors expect mechanisms to demonstrate cost alignment, which are absent today.

Implications

Moving to a cost-based model with interim rates would stabilize rural hospital financing and align South Dakota with peer states.

Out-of-State Hospital Reimbursement – Gap Assessment

Current Approach

South Dakota relies on a percent-of-charge methodology for out-of-state hospitals:

- Inpatient services are reimbursed at approximately 44.15% of billed charges.
- Outpatient services are reimbursed at approximately 38.2% of billed charges.

- There is no reconciliation or PPS alignment, and in some cases, claims require manual repricing.

While administratively simple, this approach creates significant disparities between in-state and out-of-state reimbursement and does not reflect actual costs or resource utilization.

Best Practice Trends

Many states have moved toward aligning out-of-state reimbursement with their in-state PPS methodologies:

- Out-of-state hospitals are paid using APR-DRG for inpatient and APC for outpatient, ensuring consistency with in-state logic.
- Some states apply a modest enhanced base rate or policy factor to recognize the administrative burden and access needs associated with out-of-state services.

Gaps Identified

- Inconsistency: Different reimbursement structures for in-state vs. out-of-state hospitals make it difficult to compare costs and ensure equity.
- Overreliance on charges: Percent-of-charge logic fails to tie payment to actual resource use.
- Transparency challenges: Providers and DSS lack a clear, defensible rationale for OOS rates.

Implications

Aligning OOS reimbursement to APR-DRG and APC logic, with targeted enhancements where appropriate, would improve transparency and reduce inequities.

Summary of Gaps and Opportunities

Payment Area	Current State	Best Practice Trend	Gap Identified
Inpatient Grouper	MS-DRG	APR-DRG with severity tiers	Clinical alignment
Base Rate Logic	Hospital-specific	Statewide or peer-group base	Equity and transparency
Outlier Methodology	Charge-based	Cost-based fixed-loss	Predictability and defensibility
Outpatient Base Rate	Hospital-specific APC rates	Single statewide base	Simplification and fairness
CAH Reimbursement	% of charge/MS-DRG, no settlement	Interim ≈ cost	Equity and stability
OOS Hospital Payment	% of charge	PPS-aligned APR-DRG/APC with enhancement	Consistency

This analysis highlights several high-priority modernization opportunities:

- Transition inpatient services to APR-DRG with cost-based outlier payments and standardized transfer logic.
- Establish a single statewide APC base rate for outpatient services, replacing hospital-specific rates.
- Transition CAHs to cost-based reimbursement with interim rates.
- Align out-of-state hospital reimbursement with in-state PPS methodologies, using targeted enhancements where needed.
- Implement a governance framework for regular updates, provider engagement, and compliance monitoring.

These opportunities form the foundation of the recommendations section of this report where we will detail specific policy changes, financial impacts, and implementation strategies.

Recommendations

The comprehensive review and gap analysis highlighted several key areas where South Dakota's hospital reimbursement methodologies diverge from peer states and national best practices. Modernization is essential not only to improve payment equity and transparency, but also to simplify administration, strengthen compliance, and ensure long-term sustainability of the Medicaid program.

This section outlines the recommended changes to South Dakota Medicaid's inpatient and outpatient hospital reimbursement methodologies. These recommendations are based on extensive fiscal modeling, peer state benchmarking, and stakeholder engagement. The proposed reforms aim to modernize the state's reimbursement processes, promote equitable payments across hospital types, ensure compliance with federal regulations, and improve administrative efficiency.

Inpatient Hospital Recommendations

Transition to APR-DRG Methodology

South Dakota currently utilizes the MS-DRG system for many inpatient services. While functional, MS-DRG is primarily Medicare-focused and does not fully account for the pediatric, obstetric, and behavioral health populations served by Medicaid.

We recommend transitioning to the APR-DRG grouper, which includes:

- 332 base DRGs, each stratified into four severity-of-illness levels.
- Enhanced alignment with Medicaid populations, especially NICU, pediatric, and psychiatric patients.
- Integration with quality and performance measurement systems used by other states.

Transitioning to APR-DRG will improve the accuracy of clinical classification and resource allocation, with minimal disruption to most hospitals while providing a clearer reflection of patient complexity

Statewide DRG Base Rate with Policy Add-Ons

Currently, South Dakota uses hospital-specific base rates, which create inequities and administrative burden. We recommend establishing a statewide base rate of $11,430.74, with targeted policy add-ons for select hospital peer groups.

Hospital Category	Proposed Add-On
Out-of-State Critical Access Hospitals	$19,475
Out-of-State Specialty Hospitals (including Children's Hospitals with ≥30 discharges)	$15,200

This structure simplifies rate setting and ensures fair, transparent payment across providers.

DRG Weights

Currently, South Dakota Medicaid uses DSS-specific weights, which are resource-intensive to maintain. We recommend transitioning to the Solventum hospital-specific relative value (HSRV) national weight set, which:

- Uses robust national data for consistent, defensible weights.
- Supports future case mix index (CMI) adjustments.
- Reduces administrative effort for ongoing maintenance.

Outlier Payments

Outlier payments are currently charge-based, which can lead to inflated or inconsistent results. We recommend a cost-based outlier methodology:

- Fixed Loss Threshold: $53,000, targeting 5–10% of total DRG expenditures.
- Marginal Cost Percentage: 60%, applied to costs above the fixed loss threshold.
- Hospital-Specific CCRs:
    - In State Providers: CCRs derived from an estimation of costs using Medicare Cost Reports and detail line items in the dataset.
    - Out of State Providers: CCRs are assigned the South Dakota Statewide Urban Operation + Capital CCR found in the most recent CMS Public Use File at the time of update.

This ensures payments reflect actual resource use while preventing extreme variability.

Transfer Policy Update

We recommend updating the transfer payment formula to reflect higher initial day costs. The new formula would be as follows:

$$(\text{DRG Base Payment} \div \text{ALOS}) \times (\text{Covered Days} + 1)$$

This refinement brings South Dakota in line with national Medicaid and Medicare practices.

APR-DRG Methodology Future Updates

To ensure a successful and accurate rebasing process, we recommend the following comprehensive approach, developed based on industry best practices and tailored to the SD system. Below, we've outlined a streamlined plan for data preparation, cost estimation, budget development, CCR calculation, and rate setting for future rebases.

1. Data Preparation

A robust rebasing process begins with compiling a complete and accurate dataset. We recommend using two to three years of inpatient claims data from both in-state and out-of-state providers, ensuring that out-of-state specialty hospitals such as children's hospitals with 30+ claims and Critical Access Hospitals

(CAHs) are included. Claims from providers that have closed, merged, or changed IDs should also be incorporated, assuming patients from these facilities are now being served elsewhere, to maintain data continuity.

Certain exclusions are necessary to ensure data integrity. These include Medicare crossover claims and claims categorized as ungroupable under both current and updated DRG versions. Before removing ungroupable claims, however, it's essential to review them for accuracy to avoid unintentional exclusions. Key reference data should also be incorporated, such as current DRG rates, cost-to-charge ratios (CCRs), Solventum APR-DRG metrics (including HSRV relative weights and trimmed ALOS values), and hospital cost reports (HCRIS).

2. Cost Estimation

Accurate cost estimation involves linking and processing claims with corresponding cost report data. To achieve this, Medicare IDs should be used to link HCRIS hospital cost reports with the claims data, while a revenue code crosswalk (whether hospital specific or statewide) will align cost report cost centers with line-item claims data revenue codes. Estimated costs for routine services can be calculated by multiplying per diem rates by the number of benefit days, while ancillary services costs are derived by applying CCRs to charges. All calculated costs should then be adjusted for inflation using the Hospital Market Basket index to align with the implementation timeline.

3. Budget Development

The development of an accurate budget is critical to the rebasing process. Initially, inpatient claims should be grouped under the current DRG version to calculate payments using the current system rates, weights, and CCRs, following the APR-DRG methodology. These calculations will form the baseline for the target budget, which should include appropriate inflationary increases to reflect anticipated financial needs for the rebased payment system.

4. Cost-to-Charge Ratio (CCR) Development

CCR calculations will leverage costed claim line items. For in-state providers, detailed CCRs will be calculated. For out-of-state providers, publicly available CMS data will be used to establish appropriate CCRs. This includes applying the South Dakota statewide urban operating and capital CCRs found in Table 8 of the Final Rule published by CMS.

5. Rate Setting

The final phase focuses on recalibrating rates to align total payments with the target budget. Using updated DRG groupings and HSRV weights, payment simulations will be run with parameters updated to reflect the new system. Current rates will serve as the baseline for these simulations, with policy adjustments incorporated as needed. To ensure accurate statewide base rates, charge caps will be temporarily disabled during initial calculations.

An iterative calibration process will adjust factors such as the statewide base rate, outlier thresholds, fixed loss thresholds (FLT), and marginal cost percentages. Each adjustment will be evaluated to ensure total payments meet the target budget while maintaining outlier payments within acceptable proportions. This process will continue until all payments are aligned with the target parameters and budgetary goals.

Timeline for Rebasing Process – Example Plan for DRG Rates to be effective 7/1/2027

Fall 2026

The initial phase focuses on data collection and preparation to build a strong foundation for the rebasing process. During this period, claims data for the most recent and complete timeframe available should be collected. Additionally, HCRIS cost reports for the appropriate fiscal year will need to be gathered to ensure accurate cost estimation.

In preparation for rate setting, inpatient claims should be grouped using both the current APR-DRG Version and the updated APR-DRG Version, which is scheduled for annual release on October 1st each year. This dual grouping allows for a comprehensive comparison and assessment of the financial impact of transitioning to the updated DRG version. Current reimbursement rates and cost-to-charge ratios (CCRs), should also be compiled to support the analysis.

Winter 2026 – Spring 2027

Using the collected data and preliminary analyses, the focus during this phase shifts to calculating and finalizing the new rates. By following the outlined methodology, the payment system will be recalibrated to align with the target budget. An iterative process will refine key elements such as the statewide base rate, outlier thresholds, fixed loss thresholds, and other relevant parameters to ensure alignment with policy goals and financial benchmarks.

By the conclusion of this phase, the finalized rates will be prepared for implementation, ensuring a smooth and efficient transition to the updated payment system.

Per Diem Methodology

Some specialized services are best reimbursed on a per diem basis due to their unique care patterns:

- We recommend continued per diem reimbursement for:
  - In-State Rehabilitation Hospitals/Units
  - In-State Long-Term Acute Care Hospitals
  - Lifescape Children's Specialty Hospital
- We recommend a transition to per diem reimbursement for:
  - Out-of-State Rehabilitation Hospitals/Units
  - Out-of-State Long-Term Acute Care Hospitals

Modeled rates were updated to achieve 100% cost coverage for in-state Rehabilitation facilities and 100% cost coverage for in-state Long Term Care facilities:

- Rehabilitation Hospitals: $1,743.70 per day (up from $1,259.22).
- Long-Term Acute Care Hospitals: $1,956.01 per day (down from $2,186.56 for Select Specialty).

For newly established in-state Long-Term Acute Care (LTAC) hospitals, we recommend using the average in-state LTAC hospital per diem rate as the interim reimbursement rate. Historically, there was only one

LTAC hospital in South Dakota (Select Specialty Hospital). As such the average in-state LTAC rate is equal to the Select Specialty Hospital per diem rate. This rate should be used until the new facility submits a Medicare cost report to HCRIS or the state, allowing a claims-based per diem rate to be established.

For out-of-state Long Term Acute Care Hospitals currently reimbursed under hospital-specific percentage-of-charge methodologies, we recommend transitioning to a per diem rate based either on the in-state Long Term Acute Care Hospital rate or the average of in-state rates, to ensure consistency and promote equity across facilities.

Critical Access Hospitals (CAHs) – Inpatient

Currently, in-state CAHs are reimbursed for inpatient services using MS-DRGs or percent-of-charge, resulting in inconsistent cost coverage that averages ~44% of allowable costs. This creates significant instability for rural hospitals and challenges for DSS in maintaining equity and compliance.

Recommendation:

Transition all inpatient CAH reimbursement to a percent of charge methodology:

- Group 1: Hospitals currently reimbursed under DRG Methodology
  - Transition to percent of charge methodology.
  - Interim Rates and Payments: Interim percent of charge rate calculated to reimburse current levels of reimbursement, with a floor of 100% of estimated costs for a given fiscal period (interim rate capped at 95%). Interim rates recalibrated every state fiscal year or sooner if significant changes occur.
- Group 2: Hospitals currently reimbursed under 95% of charges methodology
  - Continue percent of charge methodology.
  - Interim Rates and Payments: Continue at same level of reimbursement, rates set to 95% of charges.
- Interim rates recalibrated every state fiscal year or sooner if material changes occur.

Outpatient Hospital Recommendations

Transition to a Single Statewide APC Base Rate

South Dakota's current hospital-specific APC base rates range widely — from $46.55 to $146.96 — creating inequities for similar services. This variation complicates rate updates and obscures transparency for providers.

The recommended approach establishes a uniform statewide APC base rate of $91.42, consistent with the Medicare national rate, ensuring fairness and predictability across all non-CAH hospitals.

- Standardizes payments across all in-state non-CAH hospitals.

- Eliminates administrative burden of maintaining multiple base rates.
- Includes policy add-ons for certain hospital types to address unique service and access needs.

Hospital Type	Proposed APC Rate
In-State (non-CAH)	$91.42
Out-of-State CAH	$253.65
Out-of-State non-CAH	$91.42

Note that the $253.65 CAH base rate was modeled to achieve 100% of estimated costs for out-of-state CAHs in aggregate.

APC Base Rate Future Updates

We recommend that future updates to the state's APC system include rebasing the OPPS framework to align with current Medicare levels. This alignment will ensure that all hospitals operate on a level playing field, promoting equity and consistency across the system. Regularly updating the OPPS to reflect Medicare changes will reduce payment rate discrepancies among providers, fostering a more uniform and fair reimbursement methodology.

As part of these updates, we recommend leveraging a one- to two-year claims data set to model projected payments under the new Medicare conversion factor and APC weights. This modeling approach allows for a thorough assessment of the potential financial impact of these changes and ensures that the updated system will appropriately reflect the expected payment distribution. Incorporating this analysis will help stakeholders better understand the implications of the changes and make data-driven decisions.

Additionally, conducting routine evaluations of DSS budget increases will be essential to ensure the state can continue aligning its OPPS system with Medicare updates. By combining regular updates with robust data modeling, the state can establish a sustainable, equitable reimbursement system that adapts to federal updates and supports long-term financial stability for providers and the broader healthcare system.

Critical Access Hospitals (CAHs) – Outpatient

Outpatient CAH reimbursement is currently based on percent-of-charge, with two distinct groups, one set at 90% of billed charges and one set to hospital specific rates not currently measured to cost. This results in wide variation in cost coverage, from as low as 60% to more than 200%.

The same issues of equity, sustainability, and compliance apply across both inpatient and outpatient services.

Recommendation:

Continue reimbursing outpatient CAH under a percent of charge methodology, calculating interim rates as follows:

- Group 1: Hospitals currently reimbursed a percent of charge Methodology with hospital specific rates
    - Continue percent of charge methodology.
    - Interim Rates and Payments: Interim percent of charge rate calculated to reimburse current levels of reimbursement, with a floor of 100% of estimated costs for a given fiscal period (interim rate capped at 90%). Interim rates recalibrated every state fiscal year or sooner if significant changes occur.
- Group 2: Hospitals currently reimbursed under 90% of charges methodology
    - Continue percent of charge methodology.
    - Interim Rates and Payments: Continue at same level of reimbursement, rates set to 95% of charges.

Dialysis Services Modernization

Dialysis services are currently reimbursed using a mix of fee schedules and percent-of-charge, which complicates billing and reporting. This approach is outdated compared to peer states, where most have integrated dialysis into their outpatient PPS.

Recommendation (for free standing and non-CAH hospital based Dialysis units):

- Remove percent-of-charge methodologies and price only by fee schedule
- Restrict reimbursement eligibility to only HCPCS Code 90999 (formerly split between 90945 and 90999) and lines paying the AY modifier to the fee schedule.

Simplifies administration, ensures equity across providers, and aligns with CMS reporting requirements.

Trauma Care Payments

Trauma services are currently unreimbursed under South Dakota Medicaid, despite their critical role in emergency and specialty care, particularly in rural and frontier regions.

Recommendation:

- Begin reimbursing trauma services using APC methodology.
- Identify trauma services using revenue codes 68X, consistent with national standards.

This supports trauma centers and ensures sustainable access to high-intensity emergency care statewide.

Maintain Current Outlier Methodology

To minimize disruption during the transition, no changes are proposed to outpatient outlier calculations at this time.

Future updates may revisit this methodology once the broader APC transition is fully implemented.

Governance and Compliance

To maintain long-term sustainability, DSS must establish clear processes for annual updates and provider communication.

Recommended Actions:

- Annual refresh of APC grouper versions, fee schedules, and CCR updates.
- Transparent publication of base rates and policies for provider reference.
- Ongoing provider education through webinars, training sessions, and FAQs
- Alignment with 42 CFR §447.321 to ensure CMS compliance and defensibility.

Systemwide Recommendations

While previous discussion in this report addressed inpatient and outpatient methodologies, certain policies are system-wide and essential for ensuring the success and sustainability of modernization efforts.

Governance and Annual Updates

Without ongoing maintenance, the new inpatient and outpatient PPS systems will quickly become outdated. A structured governance process is essential to maintain alignment with CMS rules and to ensure transparency for providers.

Recommendation:

- Annual DRG and APC version updates.
- Regular CCR refreshes.
- Public documentation of policies and rates.
- Routine provider communications (e.g., webinars, bulletins).

This will allow for predictable updates that build trust and maintain compliance.

Data Validation and Reporting

Modernized reimbursement methodologies depend on accurate, timely data to support rate setting, and compliance reporting. As South Dakota transitions both inpatient and outpatient CAHs to cost methodologies, a robust framework for collecting and validating hospital cost reports is essential.

In addition, specialized providers such as Lifescape Children's Specialty Hospital must submit standardized cost report data annually to ensure equitable reimbursement and consistent audit practices.

Recommendation:

DSS should implement a comprehensive data collection and reporting process to support modernized PPS operations and compliance.

CAH Cost Report Collection and Validation:

- Require all CAHs to submit annual cost reports using the Medicare 2552-10 format or an equivalent DSS-approved template.
- Establish submission deadlines no later than five months after the CAH's fiscal year-end, consistent with Medicare timelines.
- Validate reported costs against claims and financial data to ensure accuracy.
- Use cost report data to calculate interim rates, reconcile payments at year-end, and update hospital-specific factors during biennial recalibrations.

Lifescape Children's Specialty Hospital Reporting:

- Require Lifescape to submit an annual Medicare 2552-10 cost report, capturing all inpatient and outpatient services.
- These reports will be used to:
    - Update per diem rates and CCRs for rehabilitation and other specialized services.
    - Ensure that Lifescape's payments comply with federal UPL rules and DSS oversight requirements.
    - Provide transparent documentation for CMS audits.

Data Reporting Infrastructure:

- Develop DSS systems to track cost report submissions, interim rate outcomes, and historical trends.
- Integrate cost report data with PPS calculations for DRG and APC methodologies.
- Establish standardized data review protocols to support UPL demonstrations and fiscal modeling.

Outcome:

- Reliable data to support accurate CAH interim rates.

- Full visibility into Lifescape's costs and services for annual rate updates and compliance monitoring.
- Stronger alignment with CMS audit standards, reducing risk of disallowances.
- A consistent and transparent process for statewide hospital reimbursement oversight.

Summary of Key Changes

Policy Area	Current State	Proposed Modernization
Inpatient Grouper	MS-DRG	APR-DRG with severity tiers
Outpatient Base Rate	Hospital-specific APC	Single statewide APC base rate
CAH Payment Logic	Percent-of-charge/MS-DRG, no settlement	Percent of Charge Calculated at current reimbursement level with 100% Pay to Cost Floor
OOS Payment Logic	Percent-of-charge	PPS-aligned APR-DRG/APC
Dialysis Services	Percent-of-charge / Fee schedule	Fee schedule (Medicare rate)
Trauma Care	No reimbursement	APC-based reimbursement
Outlier Logic	Charge-based	Cost-based inpatient, unchanged outpatient

Anticipated Benefits

These reforms will:

- Promote equity by ensuring similar services are reimbursed consistently.
- Strengthen compliance with federal regulations under 42 CFR §447.272 and §447.321.
- Protect access to rural care by stabilizing CAH funding.
- Simplify administration, reducing provider burden and MMIS complexity.
- Prepare DSS for the future, enabling value-based payment models.

The recommendations outlined in this section provide a comprehensive blueprint for modernizing South Dakota Medicaid's hospital reimbursement methodologies. By addressing current gaps, aligning with federal requirements, and simplifying administration, these changes create a sustainable, equitable framework for the future.

In the next section, we translate these policy recommendations into fiscal impacts, demonstrating how the proposed reforms affect hospitals individually and statewide. This modeling provides critical insights to guide DSS leadership, policymakers, and stakeholders through final decision-making and implementation planning.

Ongoing Monitoring & Maintenance

Modernizing South Dakota Medicaid's hospital reimbursement systems is not a one-time event, but rather the foundation for continuous improvement and oversight.

This section outlines the key activities DSS must perform annually and quarterly to ensure the methodologies remain accurate, equitable, and compliant with federal and state requirements.

Purpose of Ongoing Monitoring

The primary objectives of ongoing monitoring are to:

- Maintain Accuracy and Relevance
  - Update APR-DRG and APC groupers annually to reflect medical advancements and coding changes.
  - Refresh hospital-specific factors such as CCRs.
- Ensure Fiscal Integrity
  - Monitor reimbursement levels to ensure budget neutrality and protect against unanticipated fiscal swings.
  - Support Upper Payment Limit (UPL) demonstrations and CMS reporting.
- Strengthen Provider Relationships
  - Provide regular updates to hospitals on changes and rate adjustments.
  - Foster transparency and trust through open communication.
- Support Future Innovation
  - Build a foundation for value-based purchasing and other quality-driven initiatives.

CAH Interim Rate Monitoring

To support the new CAH methodology, DSS must maintain strict oversight of interim rates.

- Cost Report Collection
  - Require annual Medicare 2552-10 submissions from CAHs and Lifescape.
  - Submissions due five months after hospital fiscal year-end, consistent with Medicare standards.
- Interim Rate Recalibration

    - Review and adjust CAH interim payment rates every state fiscal year, or sooner if there are significant changes.
- Data Validation
    - Validate cost reports prior to interim rate calculations to ensure accuracy and federal compliance.

Provider Engagement and Education

To maintain transparency and provider readiness, some activities DSS could consider include:

- Quarterly Webinars: Update hospitals on rate changes, upcoming policy adjustments, and fiscal trends.
- Annual Provider Manual Update: Publish detailed technical guidance and FAQs.
- Provider Feedback Loop: Create a channel for ongoing provider input on issues and potential improvements.

Continuous Compliance Monitoring

DSS must maintain a strong compliance program to ensure CMS alignment and audit readiness, including:.

- Regular review of UPL compliance under 42 CFR §447.272 (inpatient) and §447.321 (outpatient).
- Quarterly tracking of claims data and fiscal impact trends.
- Audit trail documentation for CMS and OIG reviews.

Once the foundational PPS systems are stable, DSS can consider next-generation initiatives, such as:

- Value-Based Purchasing (VBP): Introducing performance-based incentives tied to quality outcomes.
- Bundled Payments: Testing episodic payment models for services such as maternity care or behavioral health.
- Quality Reporting Integration: Using DRG and APC data to inform statewide quality improvement efforts.

These initiatives should be phased in gradually, with stakeholder engagement and CMS approval.

Next Steps

As the project transitions from planning to execution, DSS should focus on immediate priorities to ensure successful modernization and long-term sustainability.

Summary Table of Next Steps

Timeline	Priority Action
July 1, 2026	Launch recommended APR-DRG, Percent of Charges, and APC methodologies statewide.
August – December 2026	Monitor implementation of the updated methodologies and prepare for July 1, 2027 system updates.
January – June 2027	Calculate and finalize July 1, 2027 Annual Rate Updates
July 1, 2027	Implement the recommended annual rate updates.
July 2027	Complete and evaluate first annual CAH cycle.

Closing Statement

The modernization of South Dakota Medicaid's hospital reimbursement methodologies represents a historic step forward in ensuring equitable, transparent, and sustainable funding for hospitals across the state.

By following this roadmap and executing on these next steps, DSS will not only improve current operations but also create a solid foundation for future innovation, such as value-based purchasing and quality-driven initiatives.

This transformation will strengthen access to care, support rural hospitals, and ensure compliance with state and federal requirements well into the future.