South Dakota Medicaid
State Plan Amendments and 1115 Demonstration Applications

As of July 24, 2024

State plan amendments are available on our website at https://dss.sd.gov/medicaid/medicaidstateplan.aspx

SPAs in Tribal Consultations

SPA #	SPA Description	Date Effective	Tribal Consultation Start Date	Date Public Comment Period Ends
24-0013	Health Home Inflationary Increase and Assurance *Implements the inflationary rate increases appropriated by the state legislature during the 2024 legislative session and assures that the requirements for general and annual reporting of child and adult core sets are met.*	07/01/24	06/17/24	07/17/24
24-0014	SFY25 Inflationary Increase and Clean-Up *Implements the inflationary rate increases appropriated by the state legislature during the 2024 legislative session effective July 1, 2024, and updates multiple areas of the State Plan to align with South Dakota Administrative Rule and current practice.*	07/01/24	06/17/24	07/17/24

Anticipated SPAs

SPA Description	Anticipated Start of Tribal Consultation
School District Services and Reimbursement *Adds school-district services and reimbursement to the State Plan to reflect current coverage.*	Fall 2024
Doula Coverage *Implements coverage of Doula services.*	Fall 2024

SPAs Being Prepared for CMS Submission

SPA #	SPA Description	Date Effective	Tribal Consultation Start Date	Date Public Comment Period Ends
24-0012	Elimination of Recipient Cost Share for Medical Services *Exempts cost-sharing for Medicaid recipients and medical services that are currently subject to cost-sharing.*	07/01/24	05/28/24	06/28/24

SPAs in CMS Review

SPA #	SPA Description	Date Effective	Tribal Consultation Start Date	Tribal Consultation End Date	Date Submitted to CMS
24-0011	SFY25 Behavioral Health Inflationary Increase *Implements community mental health center (CMHC) and substance use disorder (SUD) agency inflationary increases appropriated by the state legislature during the 2024 legislative session.*	06/01/2024	05/28/2024	06/28/2024	06/28/2024
24-0010	CY23 Care Coordination Supplemental Payment *Updates the care coordination provider list and supplemental payment amounts.*	06/01/2024	05/28/2024	06/28/2024	06/28/2024
24-0009	Substance Use Disorder Treatment Coverage *Restores permanent coverage of substance use disorder (SUD) services provided to eligible individuals in institutions for mental disease (IMDs).*	10/01/2023	04/02/2024	05/02/2024	05/09/2024

Approved SPAs

SPA #	SPA Description	Date Effective	Tribal Consultation Start Date	Tribal Consultation End Date	Date Submitted to CMS	Date Approved
24-0008	Prescription Drug Coverage *Allows for coverage of select over-the-counter drugs manufactured by a firm that does not have a signed rebate agreement with the United States Department of Health and Human Services, including iron supplements for pregnant women. The SPA also allows for South Dakota Medicaid to enter into value-based agreements with manufacturers on a voluntary basis.*	04/01/2024	03/18/2024	04/17/2024	05/03/2024	07/11/2024
23-0006	Continuous Coverage Eligibility for Children - CHIP *Provides 12 months of continuous eligibility (CE) for children under the age of 19 in CHIP as required by Section 5112 of the Consolidated Appropriations Act, 2023.*	01/01/24	01/22/24	02/21/24	03/04/24	05/15/24

1115 Waiver Demonstrations

1115 Description	Date Submitted to CMS
Career Connector *Promotes work and community engagement for adults recipients age 19-59 living in Minnehaha and Pennington County.*	08/18/18
Improving American Indian Health *Requests expansion of the IHS network to include Urban Indian Health Clinics in Pierre and Sioux Falls as well as FQHCs located in Mission and Rapid City.*	04/15/19

South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605.773.3495
FAX: 605.773.5246
WEB: dss.sd.gov

June 17, 2024

RE: South Dakota Medicaid State Plan Amendment #SD-24-0013

The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan to implement the inflationary rate increases appropriated by the state legislature during the 2024 legislative session and assure that the requirements for general and annual reporting of child and adult core sets are met.

The Health Home Quality Incentive Payment pool and the Per Member Per Month payments will receive a 4.0 percent inflationary increase. The updated fee schedule will be posted on the department's website at: http://dss.sd.gov/medicaid/providers/feeschedules/dss/.

The proposed amendment adds the Health Homes reporting assurance pages to the State Plan and updates the Health Homes fee schedule effective dates in the State Plan. The department estimates the fiscal impact will be $19,316 in State funds and $28,950 in Federal funds, totaling $48,266 in Federal Fiscal Year 2024 (July 1, 2021 to September 30, 2024) and $77,264 in State funds and $115,800 in Federal funds, totaling $193,064 in Federal Fiscal Year 2025 (October 1, 2024 to September 30, 2025). The Department intends to make this SPA effective July 1, 2024.

The SPA is available to view on the department's website at http://dss.sd.gov/medicaid/medicaidstateplan.aspx. Copies of the proposed SPA pages are also available at the Department of Social Services, Division of Medical Services. Written requests for a copy of these changes, and corresponding comments, may be emailed to MedicaidSPA@state.sd.us or sent to:

DIVISION OF MEDICAL SERVICES
DEPARTMENT OF SOCIAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291

The public comment period will start June 17, 2024, and end July 17, 2024.

Sincerely,

Matt Ballard

Matthew Ballard
Deputy Director
Division of Medical Services
South Dakota Department of Social Services

CC: Matt Althoff, Cabinet Secretary
Heather Petermann, Director

Medicaid State Plan Amendment Proposal

Transmittal Number: SD-24-0013

Effective Date: 7/1/24

Brief Description: The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan to implement the inflationary rate increases appropriated by the state legislature during the 2024 legislative session and assure that the requirements for general and annual reporting of child and adult core sets are met.

Area of State Plan Affected: Health Homes MACPro payment methodology and reporting pages.

Page(s) of State Plan Affected: Health Homes MACPro payment methodology and reporting pages.

Estimate of Fiscal Impact, if Any: The estimated expenditures are solely due to rate increases. No rates are being decreased. The fiscal impact associated with this SPA is estimated to be $48,266 in FFY 2024 and $193,064 in FFY 2025.

Reason for Amendment: Implement inflationary increases appropriated by the state legislature and provide assurance that reporting requirements are met.

PUBLIC NOTICE

South Dakota Medicaid Program

Notice is hereby given that the South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan to implement the inflationary rate increases appropriated by the state legislature during the 2024 legislative session and assure that the requirements for general and annual reporting of child and adult core sets are met.

The Health Home Quality Incentive Payment pool and the Per Member Per Month payments will receive a 4.0 percent inflationary increase. The updated fee schedule will be posted on the department's website at: http://dss.sd.gov/medicaid/providers/feeschedules/dss/.

The proposed amendment adds the Health Homes reporting assurance pages to the State Plan and updates the Health Homes fee schedule effective dates in the State Plan. The department estimates the fiscal impact will be $19,316 in State funds and $28,950 in Federal funds, totaling $48,266 in Federal Fiscal Year 2024 (July 1, 2021 to September 30, 2024) and $77,264 in State funds and $115,800 in Federal funds, totaling $193,064 in Federal Fiscal Year 2025 (October 1, 2024 to September 30, 2025). The Department intends to make this SPA effective July 1, 2024.

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DIVISION OF MEDICAL SERVICES
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The public comment period will start June 17, 2024, and end July 17, 2024.

SD - Submission Package - SD2024MS0001O - (SD-24-0013) - Administration, Health Homes

CMS-10434 OMB 0938-1188

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Administration, Health Homes | SD2024MS0001O | SD-24-0013 | MIGRATED_HH.South Dakota Health Homes

Package Header

Package ID	SD2024MS0001O	**SPA ID**	SD-24-0013
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	7/1/2024
Superseded SPA ID	SD-23-0017 System-Derived		

Payment Methodology

The State's Health Homes payment methodology will contain the following features

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
    - [x] Fee for Service Rates based on
      - [x] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [ ] Other
  - [ ] Comprehensive Methodology Included in the Plan
  - [x] Incentive Payment Reimbursement
    - [x] Fee for Service Rates based on
      - [ ] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [x] Other

Describe below

South Dakota will provide a supplemental quality incentive payment to Health Homes when the Health Home intervention produces at least $3 million in savings through efficiencies. Savings through efficiencies is calculated by determining the per member per month (PMPM) for Health Home participants and individuals eligible for Health Homes that do not participate in the program. The PMPMs are multiplied by the number of Health Home member months and the numbers are compared to determine the amount of savings through efficiencies. South Dakota Medicaid worked with a subgroup of the Implementation Workgroup to identify a payment methodology. The payment methodology is targeted to:

- Incentivize providers with small

caseloads usually in rural and frontier areas to continue to participate in the program; and

- Reward providers who make progress towards reaching the established targets or meet/exceed the established target.

To receive either payment type, providers must have participated in the Health Home program during the outcome measurement year, be in good standing with the program by providing a core service to at least 50% of their caseload and reporting outcome measures for each recipient that was provided a core service. Payments are based on outcomes reported on a calendar year basis and average annual caseload and tier are calculated on a calendar year basis.

Total state funds available for the quality incentive payment are listed on South Dakota Medicaid's website effective July 1, 2024: http://dss.sd.gov/medicaid/providers/feeschedules/. The amount is divided into the small caseload incentive payment and the clinical outcome measure payment. The small caseload incentive payment amount is divided equally between each qualifying designated Health Home.

South Dakota has 66 counties; only 2 of the 66 counties are urban. For statewide implementation, smaller providers in rural and frontier areas must participate. The small caseload payment promotes access to the Health Home program across the state by incentivizing participation when a caseload may not be large enough to support independent adoption of the program. This encourages health systems to implement the Health Home program in all locations, regardless of size.

To determine if a Health Home should receive the small caseload payment, South Dakota Medicaid will average the caseload receiving a Health Home core service for each Health Home for every month of the measurement year. To qualify for this payment, providers must have been an active Health Home Provider during the outcome measurement year and have an average caseload that received a core service of 15 or less.

The clinical outcome measure payment is based on the clinical outcome measures submitted by each clinic to South Dakota Medicaid. These measures help demonstrate the successful provision of core services to Health Home recipients and demonstrates the provider's successful implementation of the Health Home model. South Dakota Medicaid worked with a subgroup to establish targets for each of the outcome measures. The outcome measure payment recognizes

quality of care by rewarding providers who either improved from the previous calendar year on a specified measure or met/exceeded the established the target for each measure.

South Dakota Medicaid chose two types of measures for the new methodology:

1. Measures that showed successful implementation of the Health Home Model, where the clinic had complete control over the outcome.
2. Measures were also selected which required recipient compliance.

South Dakota worked with our stakeholder group to weight each measure appropriate. The weights of the 10 measures totaled 100. Once weights were assigned, the past year's and the current year's outcomes were compared for each of the measures and if they improved from the previous year, they were awarded a 0.5 points for the measure and if the met or exceeded the target, they were awarded a 1.00 point for the measure.

A Severity Score was calculated for each clinic based on the average number of recipients in each Tier whom they provide a core service every month and applied to each measure. Scores were assigned to each Tier as follows:

- Tier 1 - 0.25
- Tier 2 - 0.50
- Tier 3 - 0.75
- Tier 4 – 1.00

The severity score was calculated as follows [number of recipients in Tier 1*0.25] + [number of recipients in Tier 2 * 0.50] + [number of recipients in Tier 3 * 0.75] + [number of recipients in Tier 4 * 1.00].

A score was calculated for each measure using the following equation. (Improvement or attainment score * weight) * severity score.

The scores for each measure were added together to get a composite score for each clinic. The composite scores for each clinic were added together. Dollars are awarded for each point in the composite score by taking the dollars for the Clinical Outcome Payment and dividing it by the total composite score for all clinics. Then the dollar amount per point is multiplied by the composite score for each clinic to get the total payment for the Clinical Outcome Payment. A Health Home's total payment is the sum of the Small Caseload Incentive Payment and the Clinical Outcome Measure Payment.

The calculation and distribution methodology utilizes a payment pool. The calculation is attached as Attachment 1.

The supplemental quality incentive payment (Small Caseload Incentive

Payment, Clinical Outcome Measure Payment) is distributed as an annual, lump sum amount. Payments will be made within 18 months following the end of the outcome measurement calendar year. The payment will be made to the provider through the MMIS system. Payments will be made directly to the qualifying provider through a supplemental payment mechanism and will appear on their remittance advice. Each provider will receive written notification at the time of payment of the payment amount from DMS.

Payments made in error 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.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Each of the four tiers will have an individual per member per month (PMPM) payment. South Dakota will update the tier of each active recipient annually. PMPM payments were based on the estimated Uncoordinated Care Costs (UCC) for the eligible recipients. UCC includes the following: non-emergent ER usage, all cause readmission and ambulatory sensitive conditions. These estimates were developed from FY 2012 claims data and will serve as the baseline. Health Home services will be provided by Community Mental Health Centers (CMHC) and Primary Care Providers (PCP). The agency's rates are effective January 1, 2024 for services provided on or after that date. All rates are posted on the agency website at https://dss.sd.gov/medicaid/providers/feeschedules/dss/. The state developed fee schedules are the same for both governmental and private providers.

- [ ] PCCM (description included in Service Delivery section)
- [ ] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Administration, Health Homes | SD2024MS0001O | SD-24-0013 | MIGRATED_HH.South Dakota Health Homes

Package Header

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Superseded SPA ID	SD-23-0017		
	System-Derived		

Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ◉ Comprehensive methodology included in plan
- ○ The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Administration, Health Homes | SD2024MS0001O | SD-24-0013 | MIGRATED_HH.South Dakota Health Homes

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	System-Derived		

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Each of the four tiers will have an individual per member per month (PMPM) payment. PMPM payments were based on the estimated Uncoordinated Care Costs (UCC) for the eligible recipients. UCC includes the following: non-emergent ER usage, all cause readmission and ambulatory sensitive conditions. These estimates were developed from FY 2012 claims data and will serve as the baseline. In order to receive the PMPM payment, designated providers must provide at a minimum one core service per quarter. Core services provided must be documented in the EHR and responses must be submitted online following each quarter through the DSS online provider portal. The agency's rates are effective July 1, 2024 for services provided on or after that date. All rates are posted on the agency website at https://dss.sd.gov/medicaid/providers/feeschedules/dss/. The state developed fee schedules are the same for both governmental and private providers.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Administration, Health Homes | SD2024MS0001O | SD-24-0013 | MIGRATED_HH.South Dakota Health Homes

Package Header

Package ID SD2024MS0001O

Submission Type Official

Approval Date N/A

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System-Derived

SPA ID SD-24-0013

Initial Submission Date N/A

Effective Date 7/1/2024

Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved South Dakota has taken care to ensure the reimbursement model is designed to only fund Health Home Services that are not covered by any of the currently available Medicaid funding mechanisms.

☑ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
Health Home Payment Calculation Methodology with Example	5/19/2023 2:48 PM EDT	

Medicaid State Plan Administration

General Administration

Reporting

MIGRATED_HH.South Dakota Health Homes

Package Header

Package ID	SD2024MS0001O	**SPA ID**	SD-24-0013
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	7/1/2024
Superseded SPA ID	N/A		

A. General Reporting

The agency submits all reports in the form and with the content required by the Secretary and complies with any provisions that the Secretary finds necessary to verify and assure the correctness of all reports.

☑ 1. The agency assures that all requirements of 42 CFR 431.16 are met.

B. Annual Reporting on the Child and Adult Core Sets

☑ 1. The agency assures that all requirements of 42 CFR 437.10 through 437.15 are met.

☑ 2. The agency reports annually, by December 31, on:

a. All measures on the Child Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

b. All behavioral health measures on the Adult Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

C. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 6/4/2024 11:42 AM EDT

South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605.773.3495
FAX: 605.773.5246
WEB: dss.sd.gov

June 17, 2024

RE: South Dakota Medicaid State Plan Amendment #SD-24-0014

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 2024 legislative session effective July 1, 2024, and update multiple areas of the State Plan to align with South Dakota Administrative Rule and current practice. Amendments include the following:

Coverage and Eligibility

- Increases the personal needs allowance for individuals in nursing or intermediate care facilities. The increase is from $60 to $100 for individuals and from $120 to $200 for couples.

Services

- Updates podiatry services to reflect routine footcare may be covered.
- Clarifies that transportation to or from a covered medically necessary service is covered and is not limited to “appointments”
- Removes obsolete Durable Medical Equipment certificate of medical necessity criteria as a certificate of medical necessity is no longer required.

Inpatient Hospital Payment Methodology

- Updates the inpatient Diagnosis Related Groups (DRG) aggregate charges threshold amount for revenue codes 275 or 278 to $50,000 to reflect current practice.
- Updates the disproportionate share program payment timing and options to return or redistribute the federal share for overpayments to provide increased flexibility.
- Clarifies out-of-state reimbursement for Psychiatric Residential Treatment Facilities to reflect current practice.

Payment of Medicare Deductible/Coinsurance

- Adds Medicaid coverage of premiums and cost-sharing for certain categories of dual eligible beneficiaries who elect Medicare Advantage Plans (Medicare Part C) to reflect current practice.

Payment Methods for Physician & Other Services

- Updates the reimbursement methodology for anesthesia aligning the conversion factor to Medicare and moves the anesthesia modifier (AD, QK, QX, and QY) payment effect towards alignment with Medicare over a two-year implementation period as follows: 75% in year one, effective July 1, 2024 and 50% in year two, effective July 1, 2025.
- Updates the Prosthetics, Orthotics, and Supplies rate methodology of rebasing to 90% of Medicare’s DMEPOS payment file on an annual basis.

Inflationary Increases

The following services otherwise not subject to a targeted increase or rate rebase are receiving a 4.0% inflationary increase:

- Instate DRG Inpatient Hospital Services, Instate DRG Exempt Inpatient Hospitals/Hospital Units, and Instate APC Outpatient Hospital Services
- Ambulatory Surgical Center Services

- Supplies, Orthotics and Prosthetics with no Medicare rate
- Durable Medical Equipment (Not including items subject to Section 1903(i)(27)) of the Social Security Act)
- Optometric Services
- Chiropractic Services
- Occupational, Speech, and Physical Therapy
- Nutritionists and Dietician Services
- Clinic Services
- Eyeglasses
- Free Standing Birth Centers
- Diabetes Self-Management Training
- Nurse Midwife Services
- Community Transportation
- Secure Medical Transportation
- Air and Ground Ambulance Transportation
- Home Health Agencies
- Independent Mental Health Practitioners Services
- Nutrition Items
- Physician Administered Drugs with no Medicare rate
- Community Health Worker Services
- Child Private Duty Nursing Services
- Applied Behavior Analysis Services
- Disproportionate Share Hospital Payment Pools
- Graduate Medical Education Payment Pools
- PCP and Pregnancy Care Management Program Per Member Per Month Payments

The following services are receiving a targeted rate increase or are being rebased:

Service	Type	Method
Private Duty Nursing Services	Targeted Increase	• Code S9122 - $43.52 • Code S9123 - $90.40 • Code S9124 - $75.32
Home Health Services	Targeted Increase	• Code G0156 - $10.88 • Code G0299 - $22.60 • Code G0300 - $18.83 • Other procedure codes are subject to a 4% inflationary increase
Personal Care Services	Targeted Increase	• Code S5130 - $10.88 • Code T1000 - $22.60 (RN) • Code T1000 - $18.83 (LPN) • Code T1019 - $10.88
Nursing Facility Services	Targeted Increase	• 4.3% Increase
DRG Exempt Pediatric Medically Complex Rehabilitation, and Pediatric Rehabilitation Transition Unit	Targeted Increase	• Per diems rebased based on cost
Dental Services	Targeted Increase	• Endodontic codes rebased to 80% of market rate

		• Other procedure codes are subject to a 4% inflationary increase
Prosthetics, Orthotics, and Supplies	Rebased	• Prosthetic, Orthotic, and Supply procedure codes rebased to 90% of Medicare

Anesthesia Services	Rebased	• Conversion Factor to 100% of Medicare.
		• Modifiers AD, QK, QX, and QY to align with Medicare over a two-year implementation period as follows:
		  ○ 75% in year one, effective July 1, 2024
		  ○ 50% in year two, effective July 1, 2025

Physician Services	Rebased	• Evaluation and Management codes (99202-99215) to 90% of Medicare • Preventative Services codes (99381-99397) to 100% of Medicare • Procedure codes with rates between 100% - 112.49% to 100% of Medicare • Procedure codes with rates between 112.5% - 125% to 112.5% of Medicare • Procedure codes with rates over 125% to 125% of Medicare • Procedure codes with rates below 90% of Medicare to 90% of Medicare • Procedure codes with no rate to 90% of Medicare • Other procedure codes are subject to a 4% inflationary increase
Physician Administered Drugs	Rebased	• Procedure codes with no rate to the Wholesale Acquisition Cost
Independent Mental Health Services	Rebased	• Procedure codes rebased to 90% of Medicare

The updated fee schedules will be posted on the department's website at: http://dss.sd.gov/medicaid/providers/feeschedules/dss/. South Dakota Medicaid providers should continue to submit claims and bill South Dakota Medicaid as they did prior to July 1, 2024. Fee schedules are the maximum allowable reimbursement amount; per ARSD 67:16:01:09 payment for services is limited to the provider's usual and customary charge.

The proposed amendment revises page 4a of Attachment 2.6-A, page 1 of Supplement 12 to Attachment 2.6-A, pages 8, 13, and 43 of Supplement to Attachment 3.1-A, pages 1, 3, 5, 7, 8, 8a, 9, 10a, and 10b of Attachment 4.19-A, Introduction Page 1, Introduction Page 1a, 1b, 6, 13, and 22 of Attachment 4.19-B, pages 1-3 of Supplement 1 to Attachment 4.19-B, and page 7, 9, and 10 of Attachment 4.19-D. The Department intends to make this SPA effective July 1, 2024.

The department estimates the total annual aggregate increase in expenditures by service type will be the following:

- Inpatient Hospital Services - $7,831,690
- Outpatient Hospital Services - $4,604,501
- Physician Services including EPSDT Screenings/Treatment, and Professional Services Provided in a Freestanding Birth Center - $5,525,859
- Dental Services including Orthodontic Services and Dentures - $1,392,204
- Optometric - $132,025
- Chiropractic Services - $62,247
- Disproportionate Share Hospital Payments - $44,117

- Graduate Medical Education Payments - $138,634
- Other Medical Services - $1,504,815
    - Ambulatory Surgical Center Services
    - Independent Mental Health Practitioners Services
    - Nutritionists and Dietician Services
    - Supplies, Orthotics and Prosthetics
    - Durable Medical Equipment
    - Clinic Services
    - Physical Therapy
    - Occupational Therapy
    - Speech, Hearing, or Language, Disorder Services
    - Prosthetic Devices
    - Eyeglasses
    - Diabetes Self-Management Training
    - Nurse Midwife Services
    - Community Transportation
    - Secure Medical Transportation
    - Air and Ground Ambulance Transportation
    - Nutrition Items
    - Home Health Services
    - Personal Care Services
    - Child Private Duty Nursing
    - Community Health Worker Services
- Nursing Facility Services –$770,778
- Personal Needs Allowance - $1,486,560

The total fiscal impact for the combined services associated with this SPA is $2,445,032 in State funds and $3,428,326 in Federal funds, totaling $5,873,358 in Federal Fiscal Year 2024 (July 1, 2024, to September 30, 2024) and $9,780,128 in State funds and $13,713,302 in Federal funds, totaling $23,493,430 in Federal Fiscal Year 2025 (October 1, 2024, to September 30, 2025).

The SPA is available to view on the department's website at http://dss.sd.gov/medicaid/medicaidstateplan.aspx. Copies of the proposed SPA pages are also available at the Department of Social Services, Division of Medical Services. Written requests for a copy of these changes, and corresponding comments, may be emailed to MedicaidSPA@state.sd.us or sent to:

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Sincerely,

Matt Ballard

Matthew Ballard
Deputy Director
Division of Medical Services
South Dakota Department of Social Services

CC: Matt Althoff, Cabinet Secretary
Heather Petermann, Director

Medicaid State Plan Amendment Proposal

Transmittal Number: SD-24-0014

Effective Date: 7/1/24

Brief Description: The SPA implements the inflationary rate increases appropriated by the state legislature during the 2024 legislative session, increases the personal needs allowance for individuals in nursing or intermediate care facilities, updates podiatry services to reflect routine footcare may be covered, clarifies that transportation to or from a covered medically necessary service is covered and is not limited to “appointments”, removes obsolete Durable Medical Equipment certificate of medical necessity, updates the inpatient Diagnosis Related Groups (DRG) aggregate charges threshold amount, updates the disproportionate share program payment timing and options to return or redistribute the federal share, clarifies out-of-state reimbursement for Psychiatric Residential Treatment Facilities, adds Medicaid coverage of premiums and cost-sharing for certain categories of dual eligible beneficiaries who elect Medicare Advantage Plans (Medicare Part C), updates the reimbursement methodology for the anesthesia conversion factor and modifiers, and updates the Prosthetics, Orthotics, and Supplies rate methodology.

Area of State Plan Affected: Attachment 2.6-A, Supplement 12 to Attachment 2.6-A, Supplement to Attachment 3.1-A, Attachment 4.19-A, Attachment 4.19-B, Supplement 1 to Attachment 4.19-B, and Attachment 4.19-D.

Page(s) of State Plan Affected: Page 4a of Attachment 2.6-A, page 1 of Supplement 12 to Attachment 2.6-A, pages 8, 13, and 43 of Supplement to Attachment 3.1-A, pages 1, 3, 5, 7, 8, 8a, 9, 10a, and 10b of Attachment 4.19-A, Introduction Page 1, Introduction Page 1a, 1b, 6, 13, and 22 of Attachment 4.19-B, pages 1-3 of Supplement 1 to Attachment 4.19-B, and page 7, 9, and 10 of Attachment 4.19-D.

Estimate of Fiscal Impact, if Any: FFY24: $5,873,358
FFY25: $23,493,430

Reason for Amendment: Implement inflationary rate increases appropriated by the state legislature during the 2024 legislative session effective July 1, 2024, and update multiple areas of the State Plan to align with South Dakota Administrative Rule and current practice.

PUBLIC NOTICE
South Dakota Medicaid Program

Notice is hereby given that 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 2024 legislative session effective July 1, 2024, and update multiple areas of the State Plan to align with South Dakota Administrative Rule and current practice. Amendments include the following:

Coverage and Eligibility

- Increases the personal needs allowance for individuals in nursing or intermediate care facilities. The increase is from $60 to $100 for individuals and from $120 to $200 for couples.

Services

- Updates podiatry services to reflect routine footcare may be covered.
- Clarifies that transportation to or from a covered medically necessary service is covered and is not limited to “appointments”
- Removes obsolete Durable Medical Equipment certificate of medical necessity criteria as a certificate of medical necessity is no longer required.

Inpatient Hospital Payment Methodology

- Updates the inpatient Diagnosis Related Groups (DRG) aggregate charges threshold amount for revenue codes 275 or 278 to $50,000 to reflect current practice.
- Updates the disproportionate share program payment timing and options to return or redistribute the federal share for overpayments to provide increased flexibility.
- Clarifies out-of-state reimbursement for Psychiatric Residential Treatment Facilities to reflect current practice.

Payment of Medicare Deductible/Coinsurance

- Adds Medicaid coverage of premiums and cost-sharing for certain categories of dual eligible beneficiaries who elect Medicare Advantage Plans (Medicare Part C) to reflect current practice.

Payment Methods for Physician & Other Services

- Updates the reimbursement methodology for anesthesia aligning the conversion factor to Medicare and moves the anesthesia modifier (AD, QK, QX, and QY) payment effect towards alignment with Medicare over a two-year implementation period as follows: 75% in year one, effective July 1, 2024 and 50% in year two, effective July 1, 2025.
- Updates the Prosthetics, Orthotics, and Supplies rate methodology of rebasing to 90% of Medicare’s DMEPOS payment file on an annual basis.

Inflationary Increases

The following services otherwise not subject to a targeted increase or rate rebase are receiving a 4.0% inflationary increase:

- Instate DRG Inpatient Hospital Services, Instate DRG Exempt Inpatient Hospitals/Hospital Units, and Instate APC Outpatient Hospital Services
- Ambulatory Surgical Center Services
- Supplies, Orthotics and Prosthetics with no Medicare rate

- Durable Medical Equipment (Not including items subject to Section 1903(i)(27)) of the Social Security Act)
- Optometric Services
- Chiropractic Services
- Occupational, Speech, and Physical Therapy
- Nutritionists and Dietician Services
- Clinic Services
- Eyeglasses
- Free Standing Birth Centers
- Diabetes Self-Management Training
- Nurse Midwife Services
- Community Transportation
- Secure Medical Transportation
- Air and Ground Ambulance Transportation
- Home Health Agencies
- Independent Mental Health Practitioners Services
- Nutrition Items
- Physician Administered Drugs with no Medicare rate
- Community Health Worker Services
- Child Private Duty Nursing Services
- Applied Behavior Analysis Services
- Disproportionate Share Hospital Payment Pools
- Graduate Medical Education Payment Pools
- PCP and Pregnancy Care Management Program Per Member Per Month Payments

The following services are receiving a targeted rate increase or are being rebased:

Service	Type	Method
Private Duty Nursing Services	Targeted Increase	• Code S9122 - $43.52 • Code S9123 - $90.40 • Code S9124 - $75.32
Home Health Services	Targeted Increase	• Code G0156 - $10.88 • Code G0299 - $22.60 • Code G0300 - $18.83 • Other procedure codes are subject to a 4% inflationary increase
Personal Care Services	Targeted Increase	• Code S5130 - $10.88 • Code T1000 - $22.60 (RN) • Code T1000 - $18.83 (LPN) • Code T1019 - $10.88
Nursing Facility Services	Targeted Increase	• 4.3% Increase
DRG Exempt Pediatric Medically Complex Rehabilitation, and Pediatric Rehabilitation Transition Unit	Targeted Increase	• Per diems rebased based on cost
Dental Services	Targeted Increase	• Endodontic codes rebased to 80% of market rate

		• Other procedure codes are subject to a 4% inflationary increase
Prosthetics, Orthotics, and Supplies	Rebased	• Prosthetic, Orthotic, and Supply procedure codes rebased to 90% of Medicare

Anesthesia Services	Rebased	• Conversion Factor to 100% of Medicare.
		• Modifiers AD, QK, QX, and QY to align with Medicare over a two-year implementation period as follows:
		  ○ 75% in year one, effective July 1, 2024
		  ○ 50% in year two, effective July 1, 2025

Physician Services	Rebased	• Evaluation and Management codes (99202-99215) to 90% of Medicare • Preventative Services codes (99381-99397) to 100% of Medicare • Procedure codes with rates between 100% - 112.49% to 100% of Medicare • Procedure codes with rates between 112.5% - 125% to 112.5% of Medicare • Procedure codes with rates over 125% to 125% of Medicare • Procedure codes with rates below 90% of Medicare to 90% of Medicare • Procedure codes with no rate to 90% of Medicare • Other procedure codes are subject to a 4% inflationary increase
Physician Administered Drugs	Rebased	• Procedure codes with no rate to the Wholesale Acquisition Cost
Independent Mental Health Services	Rebased	• Procedure codes rebased to 90% of Medicare

The updated fee schedules will be posted on the department's website at: http://dss.sd.gov/medicaid/providers/feeschedules/dss/. South Dakota Medicaid providers should continue to submit claims and bill South Dakota Medicaid as they did prior to July 1, 2024. Fee schedules are the maximum allowable reimbursement amount; per ARSD 67:16:01:09 payment for services is limited to the provider's usual and customary charge.

The proposed amendment revises page 4a of Attachment 2.6-A, page 1 of Supplement 12 to Attachment 2.6-A, pages 8, 13, and 43 of Supplement to Attachment 3.1-A, pages 1, 3, 5, 7, 8, 8a, 9, 10a, and 10b of Attachment 4.19-A, Introduction Page 1, Introduction Page 1a, 1b, 6, 13, and 22 of Attachment 4.19-B, pages 1-3 of Supplement 1 to Attachment 4.19-B, and page 7, 9, and 10 of Attachment 4.19-D. The Department intends to make this SPA effective July 1, 2024.

The department estimates the total annual aggregate increase in expenditures by service type will be the following:

- Inpatient Hospital Services - $7,831,690
- Outpatient Hospital Services - $4,604,501
- Physician Services including EPSDT Screenings/Treatment, and Professional Services Provided in a Freestanding Birth Center - $5,525,859
- Dental Services including Orthodontic Services and Dentures - $1,392,204

- Optometric - $132,025
- Chiropractic Services - $62,247
- Disproportionate Share Hospital Payments - $44,117
- Graduate Medical Education Payments - $138,634
- Other Medical Services - $1,504,815
    - Ambulatory Surgical Center Services
    - Independent Mental Health Practitioners Services
    - Nutritionists and Dietician Services
    - Supplies, Orthotics and Prosthetics
    - Durable Medical Equipment
    - Clinic Services
    - Physical Therapy
    - Occupational Therapy
    - Speech, Hearing, or Language, Disorder Services
    - Prosthetic Devices
    - Eyeglasses
    - Diabetes Self-Management Training
    - Nurse Midwife Services
    - Community Transportation
    - Secure Medical Transportation
    - Air and Ground Ambulance Transportation
    - Nutrition Items
    - Home Health Services
    - Personal Care Services
    - Child Private Duty Nursing
    - Community Health Worker Services
- Nursing Facility Services –$770,778
- Personal Needs Allowance - $1,486,560

The total fiscal impact for the combined services associated with this SPA is $2,445,032 in State funds and $3,428,326 in Federal funds, totaling $5,873,358 in Federal Fiscal Year 2024 (July 1, 2024, to September 30, 2024) and $9,780,128 in State funds and $13,713,302 in Federal funds, totaling $23,493,430 in Federal Fiscal Year 2025 (October 1, 2024, to September 30, 2025).

The SPA is available to view on the department's website at http://dss.sd.gov/medicaid/medicaidstateplan.aspx. Copies of the proposed SPA pages are also available at the Department of Social Services, Division of Medical Services. Written requests for a copy of these changes, and corresponding comments, may be emailed to MedicaidSPA@state.sd.us or sent to:

DIVISION OF MEDICAL SERVICES
DEPARTMENT OF SOCIAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291

The public comment period will start June 17, 2024, and end July 17, 2024.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH DAKOTA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement

(B) Post-eligibility Treatment of Institutionalized Individuals' Incomes (continued)

Section 1924 of the Act 42 CFR 435.725
42 CFR 435.733
42 CFR 435.832

2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:

   Personal Needs Allowance (PNA) of not less than $30 for individuals and $60 for couples for all institutionalized persons.

   a. Aged, blind, disabled:

      Individuals $ 100.00
      Couples $200.00

      For the following persons with greater need:

      SUPPLEMENT 12 TO ATTACHMENT 2.6-A describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met and, where appropriate, identifies the organization unit which determines that a criterion is met.

   b. AFDC related:

      Children $ 60.00
      Adults $ 60.00

      For the following persons with greater need:

      SUPPLEMENT 12 TO ATTACHMENT 2.6-A describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met and, where appropriate, identifies the organization unit which determines that a criterion is met.

   c. Individual under age 21 covered in the plan as specified in Item B.7 of ATTACHMENT 2.2-A:

      $60.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH DAKOTA

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

In addition to the personal needs allowance of $100 (individual) / $200 (couples), the personal needs allowance will include the following:

For institutionalized individuals with earned income, the personal needs allowance will also be the gross earnings up to $75.00.

For individuals paying court ordered child or spousal support, the personal needs allowance will also be the amount actually paid out for the support payment, up to the court ordered amount.

For individuals with a trust, the personal needs allowance will also be the amount paid for attorney, guardian or conservator fees to maintain the trust up to the amount specified by the courts; or, if the court does not specify an amount, up to an amount considered reasonable by the State Medicaid agency.

Disclosure Statement for Post-Eligibility Preprint

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is #0938-0673. The time required to complete this information collection is estimated at 3 hours per response, including the time to review instructions, searching existing data resources, gathering the data needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, MD, 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC, 20503.

SUPPLEMENT TO ATTACHMENT 3.1-A

6a. Podiatrist Services

Services not payable include stock orthopedic shoes unless they are part of a leg brace, treatment of flatfoot, treatment of fungal infection of the toenail, and surgical or non-surgical treatment of subluxations of the foot undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity.

7C. Medical supplies, equipment, and appliances suitable for use in the home are provided in accordance with federal regulations at 42 CFR 440.70(b)(3) based on medical necessity.

Rental equipment is no longer covered when any of the following conditions exist:

1. The prescription for the equipment is not valid;
2. The equipment has been returned to the provider; or
3. The recipient is no longer using the equipment.

Supplies necessary for the effective use or proper functioning of covered medical equipment are covered when:

1. The equipment is covered by Medicaid;
2. The recipient's condition meets the coverage criteria for equipment; and
3. The equipment is owned by the recipient.

Supplies for rented durable medical equipment are included in the Medicaid rental payment, unless specifically listed on the department's billing guidance website.

Replacement of medical equipment is allowed only when a medical condition exists which necessitates the replacement of the particular piece of equipment. The prescribing physician must determine whether a medical necessity exists and must document the need on the prescription for the replacement equipment.

Non-covered items may be requested by the recipient's physician. Requests for non-covered items must demonstrate medical necessity and be prior authorized by the department.

24. Any Other Medical Care and Any Other Type of Remedial Care Recognized Under State Law, Specified by the Secretary

a. Transportation.

Ground and air ambulance services are covered if other methods of transportation are contraindicated by the recipient's condition.

Secure medical transportation to or from a covered medically necessary service is covered for recipients who are confined to a wheelchair or stretcher. Community transportation to or from a covered medically necessary service is covered. Purchase of tickets from commercial carriers (airlines, bus, etc.) to or from a covered medically necessary appointment outside the recipient's city of residence is covered. Mileage incurred by the recipient or a volunteer driver to or from a covered medically necessary service outside the recipient's city of residence is covered. Meals and Lodging incurred as a result of travel of at least 150 miles or more one way from the recipient's city of residence to receive covered specialty care or treatments and that results in an overnight stay is covered for the recipient and if necessary one escort or volunteer driver.

Transportation must be to the closest medical facility or medical provider capable of providing the necessary services, unless the recipient has a written referral or a written authorization from the recipient's medical provider to seek treatment at a different facility or from a different provider.

b. Services provided in religious non-medical home health care institutions.
Not provided.

c. Reserved.

d. Nursing facility services for patients under 21 years of age.

No limitations.

e. Emergency hospital services.

No limitations.

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 unless otherwise approved by the State. 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, 2024, instate DRG hospitals' target and capital/education amounts are increased by 4.0 percent. OPPS hospitals that did not receive an inflationary increase to their OPPS conversion factor are receiving DRG target and capital/education increase of 4.0 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 4.0 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.

SERVICES COVERED BY DIAGNOSTIC RELATED GROUP PAYMENTS

The State agency has adopted Medicare's definition of inpatient hospital services covered by DRG payment. Providers must submit claims for reimbursement for physician services on a separate CMS 1500 form.

OUTLIER PAYMENTS

The State agency will calculate additional payments to hospitals for discharges which meet the criteria of an "outlier," a case with extremely high charges which exceed cost outlier thresholds set by the agency. To qualify for a cost outlier payment, 70% of the claim's total billed charges must exceed the larger of the cost outlier amount published on the agency's website at http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx or 1.5 times the DRG payment for the claim. The additional payment allowed for a cost outlier will be 90% of the difference between 70% of billed charges and the larger of the published outlier amount or 1.5 times the DRG payment.

The total payment allowed for an outlier claim will be the DRG payment plus the outlier payment plus the daily capital/education amount for each day of the hospital stay.

SURGICALLY-IMPLANTED DEVICES AND APPLIANCES

The Medicaid program will reimburse claims submitted for inpatient hospital services by in-state acute care hospitals that had more than 30 Medicaid discharges during the hospitals' fiscal year ending after June 30, 1996, and before July 1, 1997, that are considered to be cost outlier claims as defined by ARSD 67:16:03:01(3) and contain revenue codes 275 or 278 according to the following guidelines:

1. The State agency will limit reimbursements for aggregate charges in excess of $50,000 associated with revenue codes 275 or 278 to the providers' actual costs plus 10%; and
2. The agency will remove the aggregate charges for revenue codes 275 or 278 in excess of $50,000 from the calculation of the claim and charges associated with the remainder of the claim will be reimbursed according to ARSD 67:16:03:06.

For use by the agency in the reimbursement calculations, the provider must submit to the agency as documentation copies of the suppliers' invoices for items associated with revenue codes 275 and 278.

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, 2024, 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 4.0% over the July 1, 2023 calculations after 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, 2024.

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, 2024.

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, 2024.

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 prior to the end 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.

The Department will recover any disproportionate share payments in excess of hospital-specific limits made to qualifying hospitals from those qualifying hospitals. The federal share of the amount recovered may either be returned or redistributed to the remaining qualifying hospitals proportionately based upon their low-income utilization rate or Medicaid inpatient utilization rate (whichever utilization rate results in a higher payment) by using how many standard deviations above the mean the hospital qualified.

The State has in place a public process which complies with the requirements of Section 1902 (a) (13) (A) of the Social Security Act.

Psychiatric Residential Treatment Facilities

The Department will pay facilities based on a per diem rate prospectively calculated based upon the State fiscal year. The Department will use the same methodology for governmental and private facilities.

Providers must submit a cost report on forms designated by the Department identifying allowable costs incurred during the fiscal year. The Department will calculate rates for the facilities based upon each facility's actual allowable costs. Allowable costs include those costs that are ordinary, necessary, reasonable, and adequate to meet costs incurred by those facilities that are related to resident care services in conformance with State and Federal laws and regulations. Allowable cost centers include salaries and benefits for facilities' personnel, payroll taxes, professional fees and contract services, travel/transportation, supplies, occupancy, equipment, depreciation, and other. Non-allowable costs include bad debt, advertising, public relations, and costs not incurred by the facility including the value of donated goods and services.

Providers must maintain a daily census report that identifies the number of residents that received services on any particular day. The Department divides allowable and reasonable costs by the census data to calculate the payment rate for the next rate setting period. The census data for a resident is limited to those days in which the resident is actually present in the facility, and is subject to audit by the Department to verify its accuracy in conjunction with the submitted cost report.

Each facility must submit an annual Department-approved cost report by September 30 of each year identifying actual, previous State fiscal year historical costs. All cost reports are subject to desk review by the Department. If audit adjustments are made, the facility is notified immediately either by telephone, in writing, or electronic mail. The Department will establish desk audit rates for each facility based on the cost report desk review.

The Department calculates the final rate using a minimum occupancy limit of 90% so facilities with occupancy less than 90% will receive per diem rates based upon 90% occupancy. The rate calculated is considered payment in full for all allowable services delivered by the provider to eligible Medicaid recipients.

South Dakota Medicaid will pay out-of-state facilities based upon the rate for comparable services established by the Medicaid agency in the state where the facility is located. If no rate is established by the Medicaid agency in that state, then the per diem rate payable to the out-of-state facility will be the lower of billed charges or the average of the per diem rates in effect for in-state facilities at the time the services are first provided by the out-of-state facility.

For extraordinary or unusual circumstances South Dakota Medicaid may negotiate a higher per diem on a case-by-case basis. Negotiated per diem rates may not exceed the cost of the services provided by the facility.

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, 2024. 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, 2024. 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, 2024
Physician Services	Attachment 4.19-B, Page 6	July 1, 2024
Optometrist Services	Attachment 4.19-B, Page 9	July 1, 2024
Chiropractic Services	Attachment 4.19-B, Page 10	July 1, 2024
Independent Mental Health Practitioners	Attachment 4.19-B, Page 11	July 1, 2024
Nutritionist and Dietician Services	Attachment 4.19-B, Page 11	July 1, 2024
Home Health Services	Attachment 4.19-B, Page 12	July 1, 2024
Durable Medical Equipment	Attachment 4.19-B, Page 13	July 1, 2024
Clinic Services	Attachment 4.19-B, Page 15	July 1, 2024
Dental Services	Attachment 4.19-B, Page 16	July 1, 2024
Physical Therapy	Attachment 4.19-B, Page 17	July 1, 2024
Occupational Therapy	Attachment 4.19-B, Page 18	July 1, 2024
Speech, Hearing, or Language Disorder Services	Attachment 4.19-B, Page 19	July 1, 2024
Dentures	Attachment 4.19-B, Page 21	July 1, 2024
Prosthetic Devices	Attachment 4.19-B, Page 22	July 1, 2024
Eyeglasses	Attachment 4.19-B, Page 23	July 1, 2024
Diabetes Self-Management Training	Attachment 4.19-B, Page 26	July 1, 2024
Community Health Workers	Attachment 4.19-B, Page 26	July 1, 2024
Community Mental Health Centers	Attachment 4.19-B, Page 26	June 1, 2024
Substance Use Disorder Agencies	Attachment 4.19-B, Page 26	June 1, 2024 *
Nurse Midwife Services	Attachment 4.19-B, Page 31	July 1, 2024
Pregnancy PCCM Program	Attachment 4.19-B, Page 39a	July 1, 2024
Transportation	Attachment 4.19-B, Page 38	July 1, 2024
Personal Care Services	Attachment 4.19-B, Page 38	July 1, 2024
Freestanding Birth Centers	Attachment 4.19-B, Page 39	July 1, 2024
Professional Services Provided in a Freestanding Birth Center	Attachment 4.19-B, Page 39	July 1, 2024

*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, 2024, the conversion factor for Medicare Prospective Payment System hospitals paid using the Medicaid Agency's OPPS will be increased by 4.0 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.

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

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

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

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

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

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

5a. Physician Services

The rates below are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page, Page 1.

a. Services other than clinical diagnostic laboratory tests.

1. Payment will be the lower of the provider's usual and customary charge or the amount established on the State agency's fee schedule published on the agency' s website https://dss.sd.gov/medicaid/providers/feeschedules/dss/. If there is no fee established, the payment will be 40% of the provider's usual and customary charge.
2. If there is no fee established for supplies furnished incidental to the professional services of a physician, the payment will be paid 90% of the provider's usual and customary charge.

b. Anesthesia services. Payment will be the lower of the provider's usual and customary charge or the amount established on the State agency's fee schedule published on the agency' s website https://dss.sd.gov/medicaid/providers/feeschedules/dss/. Effective July 1, 2024, the anesthesia conversion factor will be reimbursed at 100% of Medicare's established rate. The rate will be rebased annually on January 1. Anesthesia modifiers AD, QK, QX, and QY will be reimbursed in alignment with Medicare's payment effect over a two year implementation period as follows: For the period of July 1, 2024 to June 30, 2025 the payment effect will be 75% of the allowable amount. For the period of July 1, 2025 or later the payment effect will be 50%.

c. Clinical diagnostic laboratory tests.

1. Payment will be the lower of the provider's usual and customary charge or the amount established on the State agency's fee schedule published on the agency' s website https://dss.sd.gov/medicaid/providers/feeschedules/dss/. The established fee will not exceed Medicare's fee on a per test basis as required by Section 1903(I)(7) of the Social Security Act.
2. Tests for which Medicare has not established a fee will be paid the lower of a fee established by the State agency or priced by report. The reimbursement rate for these services is determined using one of a variety of different reimbursement methodologies. The reimbursement rates for services priced by report are determined using a similar service, product, or procedure that has an established rate, or a percentage of the provider's usual and customary charge. The specific methodology depends on the service, product, or procedure performed.

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

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

7c. Durable Medical Equipment, Medical Supplies, and Orthotic Devices

Payment will be the lower of the provider's usual and customary charge or the amount established on the State agency's fee schedule published on the agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. The rates are effective for services on or after the date listed on the Attachment 4.19B Introduction Page, Page 1.

Durable medical equipment (DME) subject to the limit described in Section 1903(i)(27) of the Social Security Act are reimbursed at the lesser of the provider's usual and customary amount or 90% of the Medicare South Dakota rural rate as published by Medicare effective January 2019 and then January of each year starting after 2019. If no rural rate exists, items subject to this limit will be reimbursed at the lesser of the provider's usual and customary amount or 90% of the Medicare South Dakota non-rural rate as published by Medicare effective January 2019 and then January of each year starting after 2019.

DME items not subject to Section 1903(i)(27) of the Social Security Act, and supplies are reimbursed at the lesser of the provider's usual and customary amount or the amount established on the State agency's fee schedule. If no fee is established on the state's fee schedule, payment will be 75 percent of the provider's usual and customary charge.

Reimbursement for rental items are reimbursed at the lesser of the provider's usual and customary amount or the amount established on the State agency's fee schedule. Rent to purchase equipment is considered purchased when 12 rental payments have been made without a break in the rental of 3 or more consecutive months. A new rental period begins following a break of 3 or more consecutive months. Items considered a continuous rental by the department are identified on the fee schedule.

Payment for equipment maintenance and repairs is the lesser of the provider's usual and customary charge or the purchase price of a new piece of equipment. Purchase price is established according to this section.

Payment for supplies necessary for the effective use or proper functioning of covered medical equipment are reimbursed at the lesser of the provider's usual and customary charge or the amount established on the State agency's fee schedule. Effective July 1, 2024, payment for supplies are reimbursed at the lesser of the provider's usual and customary amount or 90% of the Medicare South Dakota rural rate as published by Medicare effective July 2024 and then January of each year starting in 2025. If no rural rate exists, supplies are reimbursed at the lesser of the provider's usual and customary amount or 90% of the Medicare South Dakota non-rural rate as published by Medicare effective July 2024 and then January of each year starting in 2025. If no fee is established on the state's fee schedule, payment will be 90 percent of the provider's usual and customary charge.

Orthotic devices are reimbursed at the lesser of the provider's usual and customary charge or the amount established on the State agency's fee schedule. Effective July 1, 2024, payment for orthotic devices are reimbursed at the lesser of the provider's usual and customary amount or 90% of the Medicare South Dakota rural rate as published by Medicare effective July 2024 and then January of each year starting in 2025. If no rural rate exists, orthotic devices are reimbursed at the lesser of the provider's usual and customary amount or 90% of the Medicare South Dakota non-rural rate as published by Medicare effective July 2024 and then January of each year starting in 2025. If no fee is established on the state's fee schedule, payment will be 75 percent of the provider's usual and customary charge.

12c. Prosthetic Devices

The agency's rates were set as of July 1, 2012, and are effective for prosthetic devices on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. The fee schedule is published on the agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx.

Effective July 1, 2024, payment for prosthetic devices are reimbursed at the lesser of the provider's usual and customary amount or 90% of the Medicare South Dakota rural rate as published by Medicare effective July 2024 and then January of each year starting in 2025. If no rural rate exists, supplies are reimbursed at the lesser of the provider's usual and customary amount or 90% of the Medicare South Dakota non-rural rate as published by Medicare effective July 2024 and then January of each year starting in 2025. If no fee is established on the state's fee schedule, payment will be 75 percent of the provider's usual and customary charge. Except as otherwise noted in the plan, the agency-developed fee schedule rates are the same for all governmental and private providers. Payments are based upon the published fee schedule unless the provider bills a lower amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH DAKOTA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
OTHER TYPES OF CARE

Payment of Medicare Part A, Part B, and Part C Deductible/Coinsurance

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters “SP”.

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters “MR”.

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item _____ of this attachment, for those groups and payments listed below and designated with the letters “NR”.

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item _____ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH DAKOTA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
OTHER TYPES OF CARE

Payment of Medicare Part A, Part B, and Part C Deductible/Coinsurance

QMBs:	Part A	**MR**	Deductibles	**MR**	Coinsurance
	Part B	**MR**	Deductibles	**MR**	Coinsurance
	Part C	**MR**	Deductibles	**MR**	Coinsurance
Other Medicaid Recipients:	Part A	**MR**	Deductibles	**MR**	Coinsurance
	Part B	**MR**	Deductibles	**MR**	Coinsurance
	Part C	**MR**	Deductibles	**MR**	Coinsurance
Dual: Eligible (QMB Plus):	Part A	**MR**	Deductibles	**MR**	Coinsurance
	Part B	**MR**	Deductibles	**MR**	Coinsurance
	Part C	**MR**	Deductibles	**MR**	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH DAKOTA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
OTHER TYPES OF CARE

Payment of Medicare Part A, Part B, Part C Deductible/Coinsurance

N/A

Any costs in excess of the 110% limitation will not be recognized. The ceiling limitations will apply to all nursing facilities participating in the State Medicaid Program.

d) Capital costs shall be limited to $20.95 per resident day, effective July 1, 2023, for all nursing facilities participating in the State Medicaid Program. (See Section C, Provision Number(s) 3, 4, 5, and 6). Effective July 1, 2024, the capital cost limitation will be inflated by 4.3 percent as provided for in the State legislative appropriation. The appropriation for the inflationary percentage adjustment is included as part of the annual appropriation act for the ongoing and current expenses of state government. The act is approved by the legislative appropriation committee, the legislature, and Governor. The state plan will be updated to incorporate the actual adjustments once the adjustments are officially determined by the state's legislature.

3. A return on net equity shall be an allowable cost for proprietary facilities. The allowable rate of return shall be the average mid-point of the prime interest rate and the rate of 180-day U.S. Treasury Bills, as reported on the last business day of June, September, December, and March. The rate of return shall not exceed 10% and will be calculated on the provider's fiscal year-end balance sheet of the cost report required in Section A, Provision Number 3.

4. Building depreciation shall be limited to 3% on masonry and 4% on frame buildings and shall be calculated on the straight-line method. Generally-accepted accounting procedures will be used in determining the life of any addition(s) and improvements to primary structures. Effective July 1, 1999, the capital basis for depreciation of new construction, major renovation, and or any facilities acquired through purchase, must be subject to a salvage value computation of at least 15% (Section C, Provision Number 6).

5. Depreciation on fixed equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item(s) purchased after January 1, 1987.

6. Depreciation on major moveable equipment, furniture, automobiles, and specialized equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item purchased after January 1, 1987. Deviation from the AHA Guidelines may be granted in those instances in which facilities can provide the Department with documented historical proof of useful life.

b) Capital Cost—Dollar Limitation
The Capital Cost Components will consist of: (1) Building insurance, (2) Building Depreciation, (3) Furniture and Equipment Depreciation, (4) Amortization of Organization and Pre-Operating Costs, (5) Mortgage Interest, (6) Rent on Facility and Grounds, (7) Equipment Rent and, (8) Return on Net Equity. The Capital Cost will be limited to $20.95 per resident day for all participating nursing facilities, effective July 1, 2023. Effective July 1, 2024, the capital cost limitation will be inflated 4.3 percent as provided for in the State legislative appropriation. The appropriation for the inflationary percentage adjustment is included as part of the annual appropriation act for the ongoing and current expenses of state government. The act is approved by the legislative appropriation committee, the legislature, and Governor. The state plan will be updated to incorporate the actual adjustments once the adjustments are officially determined by the state's legislature.

1. Leased Facility—maximum capital costs for a leased facility are limited to the following:

a) The maximum capital costs is limited to the lower of actual costs or to the capital cost limitation per Section C, Provision Number 2.b. The capital cost components for computing the above limit shall consist of: (a) rent on facility/grounds and equipment; (b)building insurance; (c) building depreciation; (d) furniture and equipment depreciation; (e) amortization of organization and pre-operating costs; (f) capital related interest; and, (g) return on net equity. The capital cost items are allowable only if incurred and paid by the lessee. Capital costs will not be recognized in any other manner than as outlined in this section if incurred by the lessor (owner) and passed on to the lessee.

b) The maximum allowable for lease payment(s) for facilities negotiating a new lease and facilities renewing existing leases after June 30, 1999, are limited to the lower of actual lease costs or 70% of the average per diem cost of the capital costs for owner managed facilities, excluding hospital affiliated facilities.

c) No reimbursement shall be allowed for additional costs related to sub-leases.

2. For reimbursement purposes outlined under this plan, any lease agreement entered into by the operator and the landlord shall be binding on the operator or his successor(s) for the life of the lease, even though the landlord may sell the facility to a new owner. For reimbursement purposes outlined under this plan, the only exceptions for permitting the breaking of a lease prior to its natural termination date shall be:

   a) The new owner becomes the operator; or

   b) The owner secures written permission from the Secretary to break the lease.

3. The maximum allowable capital cost for an owner-managed facility shall be limited to $20.95 per resident day for all nursing facilities. Effective July 1, 2024, the capital cost limitation will be inflated by 4.3% as provided for in the State legislative appropriation. The appropriation for the inflationary percentage adjustment is included as part of the annual appropriation act for the ongoing and current expenses of state government. The act is approved by the legislative appropriation committee, the legislature, and Governor. The state plan will be updated to incorporate the actual adjustments once the adjustments are officially determined by the state's legislature.

4. New construction notification—Effective July 1, 1999, all nursing facilities that are planning to undertake new construction of a nursing facility, and/or a major expansion, and/or renovation project are required to notify the Department in writing prior to the start of construction, regarding the scope and estimated cost(s) of the project. For purposes of this, notification requirement any improvement, repair or renovation project will be defined as any improvement or repair with an estimated cost of $125,000 or more.