

**SOUTH DAKOTA STATE PLAN ATTACHMENT 4.19-D
REIMBURSEMENT FOR NURSING FACILITIES
(OTHER THAN STATE-OPERATED FACILITIES)**

Section A—General:

1. The purpose of this plan is to define the methodology to establish reimbursement rates for nursing facilities participating in the State's Medicaid program. Provisions of and payments under this reimbursement plan began July 1, 2004.
2. The Department of Social Services requires each Medicaid participating nursing facility to complete and submit a uniform report, known as the "Statistical and Cost Summary for Nursing Facilities," to the Department within 150 days following the close of each facility's fiscal year. The facilities shall complete the reports following generally accepted accounting procedures, the Medicare Provider Reimbursement Manual (CMS Publication 15), and/or instructions from the Department and using the accrual method of accounting.
3. To establish the reimbursement rates to be effective July 1, 2008, the Department of Social Services will use the cost reporting period based on the nursing facility year-end cost report(s) from April 30, 2006, through March 31, 2007, commonly referred to as the "2006 cost reports." Beginning with the rates effective July 1, 2009, the Department will establish reimbursement rates using the facilities' year-end cost report(s) from the April 30 through March 31 period immediately prior to July 1.
4. All providers shall keep all financial and statistical records for a minimum of six years following the submission of cost reports and these records must be made available to the Department of Social Services, Medicaid Fraud Unit (MFCU), and Department of Health and Human Services (HHS) upon request. No facility may knowingly destroy any of the records required by this paragraph when an audit exception is pending.
5. The Department of Social Services will maintain in files all cost reports submitted by facilities for a minimum of six years or until any audit exceptions are cleared, whichever is longer.

6. Participation in the program as a provider of nursing facility services is limited to those facilities that accept as payment in full the reimbursement established under this Plan for the services covered by the Plan.
7. All nursing facilities must meet nursing facility requirements and OBRA requirements as required under certification and licensure standards.
8. The Department will conduct field audits of cost reports that meet or exceed the scope of Title XVIII specifications. All facility cost reports are subject to desk audit, with field audits conducted as necessary. Additionally, the department may audit any facility prior to any ownership change, the scope of the audit to be determined by the Department.
9. The Department will account for all audit exceptions on the CMS 64 in accordance with the State Medicaid Manual, Part 1, Section 2500.

Section B—Cost Reporting Conditions:

1. Rent paid to a related organization is disallowed and actual cost of ownership must be reported. For purposes of this plan, cost of ownership is defined as mortgage interest, plus depreciation on building(s), plus depreciation on equipment, plus repairs to building(s), plus repairs to equipment, plus insurance on building(s), plus insurance on equipment, plus property taxes.
2. The provider shall identify all related organizations to which reported operating costs were paid. Identification of the amount of these costs, the services, facilities, supplies furnished by or interest paid to a related organization shall be attached to the annual cost report. Allowable costs reported may not exceed the lesser of actual cost paid to the related organization or the open market cost.
3. Allowable costs are based upon criteria as defined in CMS 15, Provider Reimbursement Manual, except as otherwise described below.

Routine services. Routine services are those services and items which are necessary in meeting the care, treatment and comfort of the residents. The following items and services will be considered to be routine for purposes of Medicaid cost reporting and included in the Medicaid per diem rate (services provided for extraordinary recipients subject to Section D, Provision Number 13):

- a. All routine nursing services, including administration of oxygen and medications; handfeeding; care of the incontinent; tray service; normal personal hygiene which includes bathing, skin care, hair care, nail care, shaving, and oral hygiene; etc.;
- b. Items used in the care and treatment of residents, such as alcohol, applicators, cotton balls, Band-Aids, linen savers, colostomy supplies, catheters, catheter supplies (e.g. bag), irrigation equipment, needles, syringes, I.V. equipment, support hose, hydrogen peroxide, enemas, screening tests (such as: Clinitest, Testape, Ketostix, etc.), tongue depressors, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, toothbrushes, toothpaste, denture cups and cleaner, mouthwash, peri-care products, etc.) and over-the-counter medications;

- c. Items which are utilized by individual residents but which are reusable and expected to be available, such as resident gowns, water pitchers, bedpans, ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, etc.;
- d. Social services and activities including supplies for these services;
- e. At least 3 meals/day planned from the Basic Four food groups in quantity and variety to provide the medically prescribed diets. This includes special oral, Enteral, or parenteral supplements for dietary use for meal or nourishment supplementation, even if written as prescription items by a physician—as these supplements have been classified by the FDA as a food rather than a drug;
- f. Laundry services;
- g. Therapy services when provided by facility staff or by a consultant under contract with the facility;
- h. Transportation services necessary to meet the medical and activity needs of the residents exclusive of commercial ambulance and specialized wheelchair transportation services.

Nursing facilities shall participate in the planning, development, and implementation of coordinated transportation efforts. Failure to participate in such efforts may result in disallowance of costs.

- i. Oxygen, regulators, tubing, masks, tents, and other equipment necessary for the administration of oxygen;
- j. Oxygen concentrators; and
- k. Respiratory services and supplies.

- Non-Routine Services. These services are considered ancillary for Medicaid payment. The costs of these services should be accounted per instructions for completing the Statistical and Cost Summary Report. The costs of these services must be billed by the physician, laboratory, pharmacy, agency, supplier, or therapist providing the service:
- a. Prescription Drugs;
 - b. Physician services for direct resident care;
 - c. Laboratory and Radiology;
 - d. Mental Health Services;
 - e. Therapy services when provided by someone other than a facility employee;
 - f. Prosthetic devices and supplies for prosthetic devices provided for an individual resident; and
 - g. Services provided by independent medical practitioner for the direct care of patients.
4. Reasonable costs shall be “appropriately documented allowable costs” that do not exceed the following limitations:
- a. Direct care costs (as defined in the Medicaid Cost Report and Instructions) shall be Case Mix adjusted and limited as follows:
 - 1) The Department will calculate median cost based on a case mix acuity level of 1.00 or more;
 - 2) The Department will then establish a minimum ceiling at 115% of the median and a maximum ceiling at 125% of the median;
 - 3) The Medicaid Program will pay 80% of the costs between the 115% ceiling and the 125% ceiling.

Any costs in excess of 125% will not be recognized. The ceiling limitations will apply to all nursing facilities participating in the State Medicaid program.

- b. Health and subsistence costs (consist of the categories of Health & Subsistence, Plan/Operation, and Other Operating as defined in the State Medicaid Cost Report) shall be limited as follows:
- 1) The Department will calculate median cost based on a case mix acuity level of 1.00 or more;
 - 2) The Department will then establish a minimum ceiling at 105% of the median and a maximum ceiling at 110% of the median;
 - 3) The Medicaid Program will pay 80% of the costs between the 105% ceiling and the 110% ceiling.

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

- c. Administrative costs (as defined in the Medicaid Cost Report) shall be limited as follows:
- 1) The Department will calculate median cost of all freestanding non-chain organization affiliated nursing facilities;
 - 2) The Department will then establish a minimum ceiling at 105% of the median and a maximum ceiling at 110% of the median;
 - 3) The Medicaid Program will pay 80% of the costs between the 105% ceiling and the 110% ceiling.

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 \$12.01 per resident day for all nursing facilities participating in the State Medicaid Program. (See Section C, Provision Number(s) 3, 4, 5, and 6). Beginning July 1, 2006, and annually thereafter, the capital cost limitation will be inflated by one-half the annual percentage of cost change from the previous year to the current year, calculated by using the Means Building Index for South Dakota.
5. 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.
6. 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).
7. 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.
8. 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.

Section C—Limits and Ceilings:**1. Direct Care Case Mix Adjusted Cost—115% to 125%**

The method used to determine the Direct Care Case Mix Adjusted Cost will be: (1) Calculate the average Case Mix Score for each facility during the cost reporting period, (Section A, Provision Number 3); (2) Determine the per diem Case Mix Component Cost for each facility from the cost report (Section A, Provision Number 3); and (3) Divide each facility's per diem Case Mix Component cost by its Case Mix Score to arrive at the facility's Case Mix Adjusted Per Diem Cost. The Case Mix Adjusted Per Diem Cost will then be used to establish a minimum ceiling at 115% of the median and a maximum ceiling at 125% of the median. The Medicaid Program will only pay a stated percentage of all costs in excess of the 115% (Section B, Provision Number 4a). Any costs in excess of 125% will not be recognized. The ceiling limitations will apply to all nursing facilities participating in the State Medicaid Program.

2. Non-Direct Care Cost—105% to 110%

The Non-Direct Care Cost components will consist of: (1) General Administrative; (2) Health and Subsistence; (3) Other Operating; (4) Plant/Operational; and Capital. The Non-Direct Care Costs will not be subject to Case Mix Adjustment.

Non-Direct Care Costs will be limited by establishing three separate cost categories and establishing ceiling limitations for each.

a. Health & Subsistence Costs—105% to 110%

This category will consist of the cost categories of Health & Subsistence, Plant & Operation and Other Operating, as defined in the Medicaid Cost Report. The median cost is based on all Level I non-waivered nursing facilities that have a case mix acuity level of 1.0 or more. A minimum ceiling will be established at 105% of the median and a maximum ceiling will be established at 105% of the median and a maximum ceiling will be established at 110% of the median. The Medicaid Program will only pay a stated percentage of costs in excess of the 105% limitation (Section B, Provision Number 4b). Any costs in excess of the 110% limitation will not be recognized.

- b) The maximum allowable capital costs for facilities with a valid lease prior to June 30, 1999, shall be the capital cost as recognized (subject to limitations) by the Department on July 1, 1998.
 - c) 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 \$12.01 per resident day for all participating nursing facilities. Beginning July 1, 2006 and annually thereafter, the capital cost limitation will be inflated by one-half the annual percentage of cost change from the previous year to the current year, calculated by using the Means Building Index for South Dakota.
3. Leased Facility—maximum capital costs for a leased facility are limited to the following:
- a) The maximum capital costs for facilities negotiating new leases and facilities renewing existing leases after June 30, 1999, is limited to the lower of actual costs or to the capital cost limitation per Section C, Provision Number 2.c. 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 rental 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) The maximum allowable capital costs for facilities with a valid lease prior to June 30, 1999, shall be the capital cost as recognized (subject to limitations) by the Department on July 1, 1998.
 - d) No reimbursement shall be allowed for additional costs related to sub-leases.
4. 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 of the Department of Social Services to break the lease.
5. The maximum allowable capital cost for an owner-managed facility shall be limited to \$12.01 per resident day for all nursing facilities. Beginning July 1, 2006, and annually thereafter, the capital cost limitation will be inflated by one-half the annual percentage of cost change from the previous year to the current year, calculated by using the Means Building Index for South Dakota.
6. 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 of Social Services, 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.

7. For facilities acquired through purchase or a capital lease on or after July 18, 1984, the buyer's or lessee's allowable historical cost of property is limited to the lower of the following:
 - a) The actual cost to the new owner;
 - b) The appraised value at the time of the sale as stated by an appraiser who meets the qualifications of an appraisal expert as contained in CMS-15;
 - c) The seller's or lessor's acquisition cost increased by the lesser of one-half of the percentage increase as contained in the "Dodge Construction System Costs for Nursing Home," or one-half of the increase in the United States city average consumer price index for all urban consumers. Any additional allowable capital expenditures incurred by the buyer or lessee subsequent to the date of transaction shall be treated in the same manner as if the seller or lessor had incurred the additional capital expenditure. The allowable depreciation expense shall be calculated on the buyer's or lessee's allowable historical cost. In no case is interest expense, excluding working capital interest, allowed on a principal amount in excess of the buyer's or lessee's allowable historical expense. Acquisition cost (including legal and/or brokerage fees, accounting and administrative costs, travel costs, and the cost of feasibility studies) related to the purchase of any existing facility or the transfer of an existing lease of any facility shall not be allowed.
8. The occupancy factor used in calculating per diem rates shall be the greater of actual or 3% less than the statewide average for all nursing facilities. The occupancy factor will be determined in accordance with the year-end cost reporting period identified in Section A, Provision Number 3. The occupancy factor shall be waived for the first twelve months of operation for a newly-constructed facility. For the second twelve months of operation, the occupancy factor used to establish the facility's rate will be the greater of 3% less than the state-wide average or the last quarter of the first year of operation, prorated to twelve months.
9. Medicaid Rate Limitation—Effective July 1, 1999, and for all future reimbursement periods, individual nursing facilities will be limited to no greater than an 8% rate increase in their overall combined Direct Care Case Mix Adjusted Rate and Non-Direct Care Rate. If the facility's rate exceeds this limitation the department shall amend the facility's non-direct care rate to equalize the rates to the allowable limit.

Section D—Other:

1. In computing annual per diem rates, costs subject to inflation which are submitted to the Department on the “Statistical and Cost Summary for Nursing Facilities” (Section A, Provision Number 3) shall be inflated in the statewide aggregate three percent annually. [Obsolete, effective July 7, 2009.]
2. Allowances may be made for known future costs due to new or revised Federal or State laws, regulations, and/or standards having an impact on costs incurred by nursing facilities. An explanation of costs of this nature must be attached to the “Statistical and Cost Summary for Nursing Facilities” if they are to be given consideration.
3. Facilities designated as Access Critical and facilities operated under 93-638 PL are not subject to the ceilings and limits stated in Section C. The facilities are reimbursed using the following methodologies:
 - a) Facilities designated as Access Critical in accordance with South Dakota Codified Law 34-12-35.5 are reimbursed using cost reports submitted to the Department per Section A, Provision Number 3 and shall be calculated to recognize additional direct care, non-direct care, and overall costs incurred by the facility.
 - b) The reimbursement rate for facilities operated under 93-638 PL will be calculated based on historical costs reported by the facility and reasonable and allowable prospective costs that support quality and access to care.
4. Statewide averages and allowable per diem rates shall be set annually prior to July 1, using cost reports submitted to the Department per Section A, Provision Number 3.

5. In the Case Mix Reimbursement System, two per diem rates shall be established: (1) the Case Mix Adjusted Direct Care Rate, and (2) the Non-Direct Care Rate. Both rates will be established per facility and paid for every Medicaid-eligible resident in that facility, excluding those classified as Assisted Living Care.
 - a) The Case Mix Adjusted Direct Care Rate will be determined prior to July 1 of each year and payment will be subjected to the residents' level of care needs, determined by the South Dakota M3PI Index System and the Case Mix weights assigned to each classification.
 - b) The Non-Direct Care Rate will be determined prior to July 1 of each year and payment will be applied to all eligible residents.
6. Nursing facilities which elect to participate in the Medicaid program must notify the Department of their average per diem charge to individuals who are not presently receiving nursing facility benefits under Medicare, Medicaid, or Veterans Administration programs. Medicaid reimbursement will be limited to the lower of the facility's average private pay per diem charge or the facility's Medicaid per diem rate (Direct and Non-Direct Care Rate), as established by the Department prior to July 1, of each year. The Department will make a pro-rata adjustment to both the Direct Care Rate and the Non-Direct Care Rate in limiting the Medicaid per diem rate. Each nursing facility has until the first (1st) day of the third month following notification regarding the Medicaid per diem rate to report this information to the Department.
7. Annual rates established prior to July 1 of each year shall be effective for the full twelve-month period, July 1 through June 30. All payments as established through rate setting procedures outlined in this plan and Department rules shall be final. Interim rate adjustments may be made for the following reasons only:
 - a) Adjustments for erroneous cost or statistical reporting discovered during the course of an audit;
 - b) Amended cost reports which reflect changes in information previously submitted by a provider shall be allowed when the error or omission is material in amount and results in a change in the provider's rate of \$.05 or more per patient day;
 - c) New or revised federal or state laws, regulations and/or standards having an impact on costs incurred by nursing facilities become effective during the twelve-month period for which rates have been established.

8. The Department may establish provisional per diem rates for newly-constructed facilities and for facilities experiencing major expansion based upon projected costs. Facilities must submit their estimates of projected costs to the Department prior to the opening date of a newly-constructed or expanded facility.

Provisional per diem rates are effective for six (6) months, with rates being adjusted retroactively on the basis of actual costs. All rates discussed in this section shall be determined in accordance with the provisions of this Plan.

For a facility acquired through purchase or a capital lease, the daily rate of reimbursement is the amount paid to the facility under the previous operator. The agency may adjust the rate by inflation or other increases as allowed by the existing provisions of this Plan until the facility's new required financial reports are used to calculate rates. A change in operational ownership occurs when all of the following criteria are met:

- a. The legal right to make management, executive, operating, and planning decisions for the existing facility is transferred to a new organization;
 - b. The new organization is a separate organization and is not a parent, subsidiary, or related party of the existing facility; and
 - c. Neither the individuals associated with the existing facility nor the existing organizations have the power, directly or indirectly, to influence or direct the actions or the policies of the new organization.
9. The reimbursement rate for out-of-state facilities providing nursing services to residents of the State of South Dakota is the lesser of the Medicaid rate established by the state in which the facilities are located or the South Dakota statewide average Medicaid rate for all in-state facilities. Payment to out-of-state facilities for care not available at in-state facilities is at the rate recognized for the facility by the Medicaid agency in the state in which the facility is located.
 10. South Dakota Medicaid reimburses swing-bed hospitals on a per diem basis equal to the average Medicaid payment, excluding therapies, paid to nursing facilities, excluding intermediate care facilities for the mentally retarded, during the previous state fiscal year. The reimbursement for swing-bed hospitals for assisted living care is at the current maximum rate paid for assisted living care.

11. The Department may allow an add-on payment for the In-state care of recipients needing extraordinary care. This payment is designed to recognize and compensate providers for patients who require an inordinate amount of resources due to the intensive labor involved in their care that is not captured in the normal case mix reimbursement methodology. Such an add-on payment requires prior authorization. The individual requiring extraordinary care must be a South Dakota Medicaid recipient and must meet nursing facility level of care as defined in ARSD 67:45:01.

Extraordinary care recipients are:

- a. Chronic Ventilator Dependent Individuals—Individuals who are ventilator dependent due to major complex medical disease or other accidents.
- b. Chronic Wound Care Recipients—Individuals who need therapeutic dressings/treatments/equipment that are designed to actively manipulate the sound healing process.
- c. Behaviorally Challenging Individuals—Individuals who meet the following criteria:
 1. Have a history of regular/recurrent, persistent disruptive behavior which is not easily altered. Behaviors which require increased resource use or nursing facility staff must exist, and
 2. Have an organic or psychiatric disorder of thought, mood, perception, orientation, memory, or social history which significantly affects behavior and is interfering with care and placement. Social history refers to convicted sexual offenders, inmates, or individuals who are otherwise challenging due to past behaviors.

Individuals receiving specialized rehabilitation services are excluded from this rate.

- d. Traumatic Brain or Spinal Cord Injured—Individuals who have had an injury to the skull, brain, or spinal cord. The injury may produce a diminished or altered state of consciousness resulting in impairment in cognitive abilities or physical functioning, as well as behavioral and/or emotional functioning. The individual must have either 1) completed an acute rehabilitation program in another facility and be continuing the rehabilitation plan or, 2) if an individual does not qualify for an acute rehabilitation program, they must have a physiatry consultation documenting the ability and willingness to participate in and benefit from therapy. Documentation must also show that the individual is alert and able to follow simple directions, medically stable, and no longer needing acute level of care. If an individual already resides in a skilled nursing facility and is not able to receive a physiatry consultation (either face to face or virtual), a licensed therapist may also perform the assessment.
- e. Individuals requiring total parenteral nutritional therapy—Individuals who meet the following criteria:
 1. Have an internal body organ or body function such as severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the individual's general condition.
 2. Have a physician's order or prescription for the therapy and medical documentation describing the diagnosis and the medical necessity for the therapy.
 3. The therapy is the only means the individual has to receive nutrition.

- f. Individuals with multiple chronic complex medical conditions requiring specialized equipment and/or increased staff resources—Individuals who meet the following criteria:
 - 1. Require increased resources of nursing facility staff.
 - 2. Have physician-documented diagnoses of multiple complex medical conditions to document the co-morbidities.
 - 3. Require specialized, non-standard equipment or services that would not be encompassed by Routine Services addressed in Part 1 Section B of this attachment.

Medicaid reimbursement for services provided to an extraordinary recipient in state shall be the per diem rate (case mix rate) plus a negotiated rate to cover the additional cost of medically necessary services and supplies associated with the treatment of extraordinary recipients to encompass but not exceed the total cost of care for the individual.

- a. The Department will negotiate with providers on a case-by-case basis to determine the negotiated rate and the billing procedures for extraordinary recipients.
- b. Prior to such negotiations, the provider shall submit:
 - 1. A treatment plan including a physician's order documenting the medical necessity of the treatment, and
 - 2. A proposed reimbursement rate, including all relevant financial records for services provided to an extraordinary recipient as requested by the Department.
- c. The Department may request, and the provider shall furnish before a negotiated rate is established, additional information to document the medical necessity for services and equipment provided to an extraordinary recipient.
- d. The negotiated rate is the rate agreed upon by the provider and the Department for medically necessary services and equipment.
- e. The Department shall reevaluate the condition of an extraordinary recipient after the first thirty days and at least every ninety days thereafter. The facility must obtain reauthorization monthly for chronic wound care. Reauthorization is at the discretion of Department staff. The Department may require the provider to submit any appropriate medical and other documentation to support a request for reauthorization. The renegotiated rate shall reflect any changes in the recipient's condition.
- f. Providers must notify the Department of significant changes in an individual's condition. A new rate may be negotiated when this change occurs.

The negotiated rate shall be an all-inclusive reimbursement rate for all services and supplies furnished by the facility in the care and treatment of the extraordinary recipient, except as otherwise agreed by the Department.

The negotiated rate may not exceed the actual cost of the services provided to the extraordinary recipient.

Until the Department agrees in writing to a negotiated rate, reimbursement for services provided to an extraordinary recipient shall be limited to the facility's per diem rate.

The facility shall maintain records of the costs it incurs in furnishing services to each extraordinary recipient.

12. When establishing annual per diem rates, the Department will use the total of the add-on payments made to a facility during the time period covered by the cost report as a credit adjustment to costs shown on the cost report.
13. For individuals who reside in a nursing facility and elect the hospice benefit, the Department will pay room and board costs, as defined in the State Medicaid Manual under subsection 4308.2, directly to the Medicare certified hospice organization.
14. The Department may withhold payment to facilities for non-compliance with any provision of this plan.

The Department of Social Services (DSS) supports ensuring access and proper coordination of care. The department will make supplemental payments to further these goals to the following private providers in the following amounts:

Provider	Amount
Avera	\$24,287
Bennett County	\$17,098
Monument Health	\$2,649
Sanford	\$24,075

Supplemental payments will be made using data calculated for the period of May 1, 2020 to December 31, 2020. Payments for the supplemental payment period will be made during the last quarter of the state fiscal 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 the Division of Medical Services.

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.

The maximum aggregate payment to all qualifying providers shall not exceed the available upper payment limit in accordance with 42 CFR 447.272.

**SOUTH DAKOTA STATE PLAN ATTACHMENT 4.19-D
REIMBURSEMENT FOR STATE-OPERATED NURSING FACILITIES
AND INTERMEDIATE CARE FACILITIES
FOR THE MENTALLY RETARDED**

1. The purpose of this plan is to define the methodology for establishment of reimbursement rates for state-operated nursing facilities and intermediate care facilities for the mentally retarded participating in the State's Medicaid program. Provisions of and payments under this reimbursement plan shall begin July 1, 2004.
2. A uniform report generated by the State's accounting system shall be submitted to the Department of Social Services within 30 days following the close of each facility's calendar quarter. The following criteria apply to all reports:
 - a. Reports shall be completed in accordance with accounting procedures established by the State of South Dakota.
 - b. Reports shall include costs allocated to each facility under the federally-approved statewide cost allocation plan.
 - c. Reports shall include Department of Human Services' administrative support costs allocated to each facility in accordance with that department's annual cost allocation plan submitted to and approved by the federal Department of Health and Human Services.
3. Facilities operating programs other than Medicaid-certified programs shall submit to the Department an annual cost allocation plan by August 1 of each year. This cost allocation plan will be the basis for allocation of costs among programs within a particular facility for the State fiscal year.
4. All providers shall be required to keep all financial and statistical records for a minimum of six years following the submission of accounting reports, and these records must be made available to representatives of the State and/or Department of Health and Human Services upon demand. In no instance may records be destroyed when an audit exception is pending.

5. All accounting reports referenced in Provisions #2 and #3 shall be maintained in Department files for a minimum of six years or until any audit exceptions are cleared, whichever is longer.
6. Participation in the Medicaid program as a provider of nursing facility or intermediate care facility services for the mentally retarded shall be limited to those facilities which accept as payment in full the reimbursement established under this plan for the services covered by this plan.
7. Allowable costs are based upon criteria as defined in CMS-15, Provider Reimbursement Manual, except as otherwise described in the plan. Allowable costs include the cost of meeting certification standards and routine services including, but not limited to: room, board, nursing services, nursing supplies, therapy services, habilitation services, oxygen, medical equipment, catheters and bags, special bed pads, supplies for incontinency, laundry of personal clothing, and all costs reflected on required accounting reports, as well as any other costs specifically listed in the plan. Allowable costs include taxes on providers, in accordance with the levying enactments of the Legislature and lower levels of government, and for which providers are liable for payment, five and one-half percent of net revenues. Tax expense allowed as cost may not include fines, penalties, either Federal or state income and excess profit taxes, or taxes in connection with financing, refinancing, or refunding operation, such as taxes in the issuance of bonds, property transfers, issuance or transfers of stocks, etc.
8. Building depreciation shall be limited to 3% on masonry and 4% on frame buildings and shall be calculated on the straight-line method. Additions to primary structures and/or major renovations may be reviewed individually and depreciated on the straight-line method. Generally accepted accounting procedures will be used to determine the life of any addition(s) to primary structures or major renovations. Depreciation on buildings shall be allowable only when funded, or when the proceeds are deposited to the State General Fund. Funded depreciation may only be used for support of capital expenditures which will benefit Title XIX eligibles.
9. Depreciation on equipment, furniture, automobiles, and specialized equipment shall be calculated on the straight-line method for all such equipment presently in use at a facility. Equipment, furniture, automobiles, and specialized equipment purchased by the State for less than \$25,000 and accounted for through the state accounting system shall be claimed and reported as a cost for the current period. Equipment, furniture, automobiles, and specialized equipment with an acquisition cost exceeding \$25,000 must be depreciated according to generally accepted accounting procedures. Depreciation on equipment, furniture, automobiles, and specialized equipment shall be allowable only when funded, or when the proceeds are deposited to the State General Fund.

10. One per diem rate shall be established for a facility and paid for every Medicaid-eligible resident in that facility. The State shall have discretion in what it charges non-Medicaid residents. The State will not pay for reserve bed days in State institutions.
11. No reimbursement shall be allowed for additional costs related to sub-leases.
12. Per diem rates shall be calculated on the basis of actual occupancy. Occupancy is defined as actual physical resident days.
13. A provisional per diem rate shall be established for the first quarter of each State fiscal year based upon each facility's operating budget and projected resident population. Provisional per diem rates shall be established for the second, third, and fourth quarters of each State fiscal year based upon actual allowable cost and actual physical resident days for the previous quarter. Allowances may be made for known future costs not incurred in the previous quarter if those costs will be incurred prior to the end of the subsequent quarter.
14. Following the end of each quarter, the Department shall re-calculate the Medicaid rate from the reports submitted in accordance with Provisions #2 and #3. This rate shall be compared to the provisional rate paid for that quarter, and a financial adjustment shall be made to adjust for any over or under payments.
15. Field audits of accounting reports shall be conducted that shall meet or exceed the scope of Title XVIII specifications. All facility cost reports may be desk audited, with field audits conducted as necessary.
16. All audit exceptions shall be accounted for on the CMS 64 in accordance with the State Medicaid Manual, Part 1, Section 2500.

17. For facilities acquired through purchase or a capital lease on or after July 1, 1989, the buyer's or lessee's allowable historical cost of property is limited to the lower of the following:
- a. The actual cost to the new owner;
 - b. The seller's or lessor's acquisition cost increased by the lesser of one-half of the percentage increase as contained in the "Dodge Construction System Costs for Nursing Homes," or one-half of the increase in the United States city average consumer price index for all urban consumers. Any additional allowable capital expenditures incurred by the buyer or lessee subsequent to the date of transaction shall be treated in the same manner as if the seller or lessor had incurred the additional capital expenditure. The allowable depreciation expense shall be calculated on the buyer's or lessee's allowable historical cost. In no case is interest expense excluding working capital interest allowed on a principal amount in excess of the buyer's or lessee's allowable historical expense.
18. The Department may withhold payment to facilities for non-compliance with any provision of this plan.

**SOUTH DAKOTA STATE PLAN ATTACHMENT 4.19-D
REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR
INDIVIDUALS WITH INTELLECTUAL DISABILITIES UNDER 16 BEDS**

1. The purpose of this plan is to define the methodology for the establishment of reimbursement rates for ICF/IID facilities under 16 beds participating in the State's Medicaid program. Provisions of and payments under this reimbursement plan shall begin July 1, 2004.
2. A uniform report furnished by the Department of Human Services, shall be completed and submitted to the Department within 138 days following June 30. The following criteria apply to all reports:
 - a. Reports shall be completed following generally accepted accounting procedures and the accrual method of accounting.
 - b. Reporting period shall cover the twelve month period, July 1 through June 30.
3. All providers shall be required to keep all financial and statistical records for a minimum of six years following the submission of cost reports and these records must be made available to the Department of Human Services and/or Medicaid Fraud Unit (MFCU) and/or Department of Health and Human Services (HHS) upon request. In no instance shall the records required by this paragraph be knowingly destroyed when an audit exception is pending.
4. All cost reports submitted will be maintained in Department files for a minimum of six years or until any audit exceptions are cleared, whichever is longer.
5. The provider shall identify all related organizations to whom reported operating costs were paid. Identification of the amount of these costs, the services, facilities, supplies furnished by or interest paid to a related organization shall be attached to the annual cost report. Costs shall not exceed the lesser of actual cost to the related organization or the open market cost.

6. Rent paid to a related organization shall be disallowed and actual cost of ownership shall be reported. For purposes of this plan, cost of ownership is defined as mortgage interest, plus depreciation on building(s), plus depreciation on equipment, plus repairs to building(s), plus repairs to equipment, plus insurance on building(s), plus insurance on equipment, plus property taxes.
7. Participation in the program as a provider of ICF/IID services shall be limited to those facilities which accept as payment in full the reimbursement established under this plan for the services covered by this plan.
8. Allowable costs are based upon criteria as defined in CMS-15, Provider Reimbursement Manual, and include Medicaid's portion of the tax on providers, in accordance with the levying enactments of the Legislature and lower levels of government, and for which providers are liable for payment, five and one-half percent of net patient service revenues. Tax expense allowed as cost may not include fines, penalties, either Federal or state income and excess profit taxes, or taxes in connection with financing, refinancing, or refunding operation, such as taxes in the issuance of bonds, property transfers, issuance or transfers of stocks, etc. Exceptions are described below.

Routine Services. Routine services shall be defined as those services and items which are necessary to meet the care of residents. The following items and services will be considered to be routine for purposes of Medicaid costs reported.

- a. All general nursing services, including administration of oxygen and medications; hand-feeding; care of the incontinent; tray service; normal personal hygiene which includes bathing, skin care, hair care, nail care, shaving, and oral hygiene; enema; etc.;
- b. Items which are furnished routinely and relatively uniformly to all residents, such as resident gowns, water pitchers, bedpans, etc.;
- c. Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually or in small quantities, such as alcohol, applicators, cotton balls, Band-Aids, linen savers, colostomy supplies, catheters and bags, irrigation equipment, needles, syringes, I.V. equipment, T.E.D. hose, hydrogen peroxide, over-the-counter enemas tests, tongue depressors, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, toothbrushes, toothpaste, denture cups and cleaner, mouthwash, peri-care products, etc.);

- d. Items which are utilized by individual residents but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, etc.;

Social Services and Activities including supplies for these services;

- e. At least 3 meals/day planned from the basic food groups in quantity and variety to provide the medically prescribed diets. This includes special oral, Enteral, or parenteral dietary supplements used for meal or nourishment supplementation, even if written as prescription item by a physician—as these supplements have been classified by the FDA as a food rather than a drug;
- f. Laundry Services;
- g. Active Treatment Services for developmentally disabled residents;
- h. Therapy Services;
- i. Transportation services necessary to meet the medical and activity needs of the residents exclusive of ambulance services and specialized wheelchair transportation services;
- j. Oxygen, regulators, tubing, masks, tents, and other equipment necessary for the administration of oxygen; and
- k. Oxygen concentrators.
- l. Mental Health Services;

Non-Routine Services. These services are considered ancillary for Medicaid payment. The costs of these services should be accounted per instructions for completing the cost report. Such billings are to be made by the supplier and not by the nursing facility. These services include, but are not limited to:

- a. Prescription Drugs;
- b. Physician services for direct resident care;
- c. Laboratory and Radiology;

- d. Prosthetic devices and supplies for prosthetic devices provided for an individual resident.
9. 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) to primary structures.
10. 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.
11. Depreciation on major movable 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. Deviations from the AHA Guidelines may be granted in those instances in which facilities can provide the Department with documented historical proof of useful life.
12. Allowances may be made for known future costs due to new or revised Federal or State laws, regulations and/or standards having an impact on costs incurred by long term care facilities. An explanation of costs of this nature must be attached to the Cost Report if they are to be given consideration.
13. Statewide averages and allowable per diem rates shall be set annually prior to July 1.
14. A per diem rate shall be established and paid for each Medicaid eligible resident in a facility.
15. Reserved.

16. Annual rates shall be established prior to July 1 of each year. Department rules, or policies, shall be final. Interim rate adjustments may be made for the following reasons only:
- a. Adjustments for erroneous cost or statistical reporting discovered during the course of an audit;
 - b. New or revised Federal or State laws, regulations and/or standards having an impact on costs effective during the twelve-month period for which rates have been established;
 - c. Special circumstances arise that warrant an interim rate adjustment. Requests for interim rate adjustments due to special circumstances shall be submitted in writing to, and shall be approved by, the Secretary of the Department of Human Services. Cost increases to meet existing laws or regulations or to provide appropriate care for residents admitted to a facility shall not justify an interim rate adjustment.
17. Provisional per diem rates shall be established for new providers, using 110% of the average rate of current providers. Providers experiencing new operational ownership shall receive the per diem rate of the previous owner.
18. 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 of the Department of Human Services to break the lease.
19. No reimbursement shall be allowed for additional costs related to sub-leases.

20. The reimbursement rate for out-of-state facilities providing ICF/IID services to residents of the State of South Dakota shall be the lesser of the Medicaid rate established by the state in which the facilities are located or the average Medicaid rate for the bed size and type of service level applicable to in-state facilities.
21. The occupancy factor used in calculating per diem rates shall be the number of resident days recognized by the department upon completion of the desk audit.
22. The facility's records shall be audited annually by an independent accountant. The audit shall meet all the requirements of the Office of Management and Budget Circular A-133 and be forwarded to the agency setting its rates.
23. All audit exceptions shall be accounted for on the CMS 64 in accordance with the State Medicaid Manual, Part 1, Section 2500.
24. The Department may withhold payment to facilities for non-compliance with any provision of this plan.

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