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State/Territory Name: South Dakota

State Plan Amendment (SPA) #: 23-0012

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

January 30, 2024

Brenda Tidball-Zeltinger
State Medicaid Director
Department of Social Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Re: South Dakota 23-0012

Dear Brenda Tidball-Zeltinger:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 23-0012. Effective for services on or after July 1, 2023, this amendment moves South Dakota Medicaid from the Resource Utilization Group Ill (RUG Ill) reimbursement model to the Patient Driven Payment Model (PDPM) reimbursement for Nursing Facility (NF)services. In addition reimbursement rates will be updated to the provider fiscal year 2021 cost report period and PDPM case mix data.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 23-0012 is approved effective July 1, 2023. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at christine.storey@cms.hhs.gov.

Sincerely,

Rory Howe

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0012

2. STATE: SD

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 6,784,719
b. FFY 2024 $27,138,874

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Pages 1, 4, 5, 7, 9-13, 15, and 16

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D:
Page 1, 7, 9-11 (TN# 08-8), Page 4 (TN# 05-10), Page 5 (TN# 09-7), Page 12 (TN# 17-006), Page 13 (TN# 00-9), Page 15 (TN# 21-0005), and Page 16 (TN# 12-11)

9. SUBJECT OF AMENDMENT
The SPA proposes to move South Dakota Medicaid from the Resource Utilization Group III (RUG III) reimbursement model to the Patient Driven Payment Model (PDPM) reimbursement model for Nursing Facility services. The reimbursement rates will also be updated to the provider fiscal year 2021 cost report period and PDPM case mix data.

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Sarah Aker

13. TITLE
Director

14. DATE SUBMITTED
June 6, 2023

15. RETURN TO
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291

FOR CMS USE ONLY

16. DATE RECEIVED: June 6, 2023

17. DATE APPROVED
January 30, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL Rory Howe

21. TITLE OF APPROVING OFFICIAL Director, Financial Management Group

22. REMARKS

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 are effective July 1, 2023.

2. The Department 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, 2023, the Department will use the cost reporting period based on the nursing facility year- end cost report(s) from April 1, 2021, through March 31, 2022, commonly referred to as the "2021 cost reports." Beginning with the rates effective July 1, 2024, reimbursement rate reviews will occur annually using the facilities' year-end cost report(s) from the April 1 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 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 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.

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;

k. Respiratory services and supplies such as continuous positive airway pressure machines, bilevel positive airway pressure machines, tracheostomy related supplies, supplies for suctioning; and

l. Batteries for hearing aids.

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.

2. Reasonable costs shall be “appropriately documented allowable costs” plus inflation calculated using the Skilled Nursing Facility Market Basket, applied from the midpoint of each provider’s cost report period to December 31, 2022, and that do not exceed the following limitations:

c. 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 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). Beginning July 1, 2024, and annually thereafter the capital cost limitation will be inflated by the percentage adjustment 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. Beginning July 1, 2024, and annually thereafter the capital cost limitation will be inflated by the percentage adjustment 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. Beginning July 1, 2024, and annually thereafter, the capital cost limitation will be inflated by the percentage adjustment 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.

5. 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 will be applied to all costs except Direct Care. 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.

6. Medicaid Rate Limitation—Individual nursing facilities will be limited to no greater than the percentage adjustment provided for in the State legislative appropriation 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. 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.

Section D—Other:

1. 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.

2. 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.

3. 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.

4. 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 Case Mix weights assigned to each nursing case mix group under the Patient Driven Payment Model classification system.

    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.

5. 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. Facilities designated as Access Critical and facilities operated under 93-638 PL are not subject to this provision.

6. 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.

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. The add-on payment is not available to individuals who are in the hospital, on a Medicare A or Medicare Advantage Plan skilled nursing stay, or are receiving hospice services.

    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.

    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.

        4. Reimbursement is limited to the Total Parenteral Nutrition solution and necessary supplies to administer the solution.

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 at least quarterly dependent upon the approved add-pay category, to determine continued need for specialized care reimbursement. Reauthorization is determined by 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.