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State/Territory Name: South Dakota CP

State Plan Amendment (SPA) #: 25-0012

This file contains the following documents in the order listed:

1) Approval Letter
2) Original Approval Letter
3) Original Companion Letter
4) CMS 179 Form/Summary Form (with 179-like data)
5) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

October 30, 2026

Heather Petermann
Director
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Re: South Dakota State Plan Amendment SD-25-0012

Dear Director Petermann:

Enclosed please find a corrected approval package for South Dakota State Plan Amendment (SPA) submitted under transmittal number 25-0012. This SPA, which implements a 1.25% inflationary increase to various services not otherwise subject to a targeted rate increase or rate rebase and adds coverage and reimbursement for Rural Emergency Hospitals under the Clinic Services benefit, was originally approved on October 8, 2026. The approval package sent to South Dakota included the following errors:

- Item f. Rural Emergency Hospitals on page 15 of Attachment 4.19-B did not reflect the current version.

The enclosed corrected package contains the original signed letter, the CMS-179, and the corrected SPA page.

If you have any questions, please contact Rhonda Gray at (410) 786-6140 or via email at Rhonda.Gray@cms.hhs.gov.

Sincerely,

MEGAN K. BUCK -S

Digitally signed by MEGAN K. BUCK -S
Date: 2026.10.30 12:33:45 -05'00'

Megan K. Buck
Director, Division of Program Operations

Enclosures

cc: Renae Hicks
Matthew Ballard

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

October 9, 2026

Heather Petermann
Director
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Re: South Dakota State Plan Amendment SD-25-0012

Dear Director Petermann:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number SD-25-0012. This State Plan Amendment which implements a 1.25% inflationary increase to various services not otherwise subject to a targeted rate increase or rate rebase and adds coverage and reimbursement for Rural Emergency Hospitals under the Clinic Services benefit.

We conducted our review of your submittal according to statutory requirements in 42 CFR §440.90 and 447.201 and Title XIX of the Social Security Act. This letter is to inform you that South Dakota Medicaid SPA TN 25-0012 was approved on October 8, 2026, with an effective date of July 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the South Dakota State Plan.

If you have any questions, please contact Rhonda Gray at (410) 786-6140 or via email at Rhonda.Gray@cms.hhs.gov.

Sincerely,

MEGAN K. BUCK -S

Digitally signed by MEGAN K. BUCK -S
Date: 2026.10.09 11:58:14 -05'00'

Megan K. Buck
Director, Division of Program Operations

Enclosures

cc: Renae Hericks
Matthew Ballard

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

October 9, 2026

Heather Petermann
Director
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Re: Payments to Hospitals for Medical Education and Payment Methodologies for Out-of-State Providers in SPA SD-25-0012

Dear Director Peterman:

This letter is being sent as a companion to our approval of South Dakota Medicaid state plan amendment (SPA) 25-0012 which implements a 1.25% inflationary increase to various services not otherwise subject to a targeted rate increase or rate rebase and adds coverage and reimbursement for Rural Emergency Hospitals under the Clinic Services benefit.

During our review of this SPA, the Centers for Medicare & Medicaid Services (CMS) identified issues with graduate medical education costs payments. Section 1902(a)(10) of the Social Security Act (the Act) requires that the Medicaid state plan "provide for making medical assistance available" for eligible individuals. Medical assistance is defined at 1905(a) of the Act as "payment of part or all of the cost of the following care and services, or the care and services themselves, or both." Section 1905(a)(1) of the Act as well as implementing regulations at 42 CFR 440.10 and 42 CFR 440.2 provide authority for the provision of inpatient hospital services in the Medicaid program. Section 1902(a)(30)(A) of the Act requires that the state plan provide for methods and procedures relating to the payment for care and services under the plan to "assure that payments are consistent with efficiency [and] economy."

CMS reviewers evaluated a South Dakota state plan amendment covering the rural residency GME program and clinic payment updates and reviewers flagged that the payment methodology in the plan proposed to make a payment to a clinic under the inpatient hospital benefit under section 1905(a)(1) of the Act as well as implementing regulations at 42 CFR 440.10 and 42 CFR 440.2. Further, CMS has concerns that the payments were not economic and efficient under section 1902(a)(30)(A) of the Act. As a result, CMS discussed extensively with the state and have agreed that an 18-month sunset period was reasonable given the methodology's original 2018 approval, accepting a companion letter under SPA 25-0012 to set a sunset date for the following South Dakota SPA, 26-0008, which would take effect July 1, 2026, and sunset December 31, 2027.

As a result, CMS is issuing this companion letter acknowledging that the state will add to a "sunset date" of December 31st, 2027, to SPA SD-26-0008, to end these payments. We are taking this approach of approving the SPA with a companion letter instead of disapproving SPA 25-0012 to allow the state a limited but sufficient amount of time to wind down the graduate medical education payments that we cannot determine are connected to the provision of Medicaid-covered care and services, and if needed move the rural residency payments to the clinic services pages.

Additionally, this companion letter addresses that some of the previously approved payment methodologies that pay out-of-state providers differently (noted in "same page" review) may be problematic in light of the D.C. Circuit opinion in Asante v. Kennedy, No. 23-5055 (D.C. Cir.2025), petition for cert. denied (U.S. Mar. 23, 2026) (No. 253-61). By approving the corresponding SPA, CMS is expressly not approving any payment methodologies that would violate Asante. At this time, CMS will not take enforcement action against the state over such payment methodologies provided that the state does not implement such methodologies in a manner that conflicts with Asante. CMS is currently exploring options for how to proceed with this issue, which may include rulemaking.

CMS appreciates the state's partnership with addressing the issues identified with this SPA, and we are available to provide any required technical assistance should the state wish to submit any future SPAs.

We are requesting your response within 60 days from the date of this companion letter.

If you have any questions, please contact Rhonda Gray at Rhonda.Gray@cms.hhs.gov.

Sincerely,

MEGAN K. BUCK -S

Digitally signed by MEGAN K. BUCK -S
Date: 2026.10.09 13:29:46 -05'00'

Megan K. Buck
Director, Division of Program Operations

cc: Renae Hericks
Matthew Ballard

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: 25-0012

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, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR §440.90 and 447.201

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 798,767
b. FFY 2026 $ 3,195,068

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Page 15b of Supplement to Attachment 3.1-A
Pages 1, 5, 7, 8, and 10b of Attachment 4.19-A
Attachment 4.19-B, Introduction Page 1
~~Page 1a and 15~~ of Attachment 4.19-B, Pages 1a, 1b, and 15
Page 7, 9, and 10 of Attachment 4.19-D

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Page 15b of Supplement to Attachment 3.1-A (TN# 25-0008)
Pages 1, 5, 7, 8, and 10b of Attachment 4.19-A (TN# 24-0014)
Attachment 4.19-B Introduction Page 1 (TN# 25-0007)
~~Page 1a of~~ Attachment 4.19-B, Pages 1a & 1b (TN# 24-0014)
Page 15 of Attachment 4.19-B (TN# 17-1)
Page 7, 9, and 10 of Attachment 4.19-D (TN# 24-0014)

9. SUBJECT OF AMENDMENT
Implements a 1.25% inflationary increase to various services not otherwise subject to a targeted rate increase or rate rebase and adds coverage and reimbursement for Rural Emergency Hospitals under the Clinic Services benefit.

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
Heather Petermann

12. TYPED NAME
Heather Petermann

13. TITLE
Director

14. DATE SUBMITTED
07/31/2025

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

FOR CMS USE ONLY

16. DATE RECEIVED
July 31, 2025

17. DATE APPROVED
October 8, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
MEGAN K. BUCK -S Digitally signed by MEGAN K. BUCK -S Date: 2026.10.09 11:59:25 -05'00'

20. TYPED NAME OF APPROVING OFFICIAL
Megan K. Buck

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS
Blocks 7 & 8: State approved pen and ink changes on 07/17/26.

State Plan under Title XIX of the Social Security Act State/Territory:

Section 1905(a)(9) Clinic Services South Dakota

☑ Renal Dialysis Clinics **[Select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

☑ Other Clinics **[Describe the types of clinics, if any limitations apply, and select below if applicable.]:**

a. Family planning clinics;
b. Ambulatory surgical centers which meet conditions for Medicare participation as evidenced by an agreement with the Federal Department of Health and Human Services.
c. Maternal and child health clinic
d. Rural Emergency Hospital (REH) Clinic services, provided by clinics certified by Medicare as REHs, include emergency department and observation services."

☑ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

Fertility treatments and related services are not covered.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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, 2025, instate DRG hospitals' target and capital/ education amounts are increased by 1.25 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.

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, 2025, 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 1.25% over the July 1, 2024 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/. Payment rates are set and effective for services provided on or after July 1, 2025. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

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/. Payment rates are set and effective for services provided on or after July 1, 2025. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

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/. Payment rates are set and effective for services provided on or after July 1, 2025. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

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.

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. Payments through the rural residency program are listed on the department's website, http://dss.sd.gov/medicaid/providers/feeschedules/. Payment rates are set and effective for services provided on or after July 1, 2025. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

ATTACHMENT4.19-B
INTRODUCTION

Payment rates for the services listed below are set and 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, 2025
Physician Services	Attachment 4.19-B, Page 6	July 1, 2025
Optometrist Services	Attachment 4.19-B, Page 9	July 1, 2025
Chiropractic Services	Attachment 4.19-B, Page 10	July 1, 2025
Independent Mental Health Practitioners	Attachment 4.19-B, Page 11	July 1, 2025
Nutritionist and Dietician Services]	Attachment 4.19-B, Page 11	July 1, 2025
Home Health Services	Attachment 4.19-B, Page 12	July 1, 2025
Durable Medical Equipment	Attachment 4.19-B, Page 13	July 1, 2025
Clinic Services	Attachment 4.19-B, Page 15	July 1, 2025
Dental Services	Attachment 4.19-B, Page 16	July 1, 2025
Physical Therapy	Attachment 4.19-B, Page 17	July 1, 2025
Occupational Therapy	Attachment 4.19-B, Page 18	July 1, 2025
Speech, Hearing, or Language Disorder Services	Attachment 4.19-B, Page 19	July 1, 2025
Dentures	Attachment 4.19-B, Page 21	July 1, 2025
Prosthetic Devices	Attachment 4.19-B, Page 22	July 1, 2025
Eyeglasses	Attachment 4.19-B, Page 23	July 1, 2025
Diabetes Self-Management Training	Attachment 4.19-B, Page 26	July 1, 2025
Community Health Workers	Attachment 4.19-B, Page 26	July 1, 2025
Doula Services	Attachment 4.19-B, Page 26	July 1, 2025
Community Mental Health Centers	Attachment 4.19-B, Page 26	June 1, 2025
Substance Use Disorder Agencies	Attachment 4.19-B, Page 26	June 1, 2025 *
Nurse Midwife Services	Attachment 4.19-B, Page 31	July 1, 2025
Pregnancy PCCM Program	Attachment 4.19-B, Page 39a	July 1, 2025
Targeted Case Management	Attachment 4.19-B, Page 33	July 1, 2025
Transportation	Attachment 4.19-B, Page 38	July 1, 2025
Personal Care Services	Attachment 4.19-B, Page 38	July 1, 2025
Freestanding Birth Centers	Attachment 4.19-B, Page 39	July 1, 2025
Professional Services Provided in a Freestanding Birth Center	Attachment 4.19-B, Page 39	July 1, 2025

*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)

2. Outpatient Hospital Services

   a. In-state Acute Care Hospitals: 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, 2025, the conversion factor for Medicare Prospective Payment System hospitals paid using the Medicaid Agency's OPPS will be increased by 1.25 percent.

   b. In-state Critical Access Hospitals: South Dakota Medicaid will pay 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:

      i. 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.

      ii. 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.

      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 critical access 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.

c. Out-of-State Outpatient Hospitals: 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.

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

e. Indian Health Services: 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 onlyif the services provided are different or if they have different diagnosis codes.

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

9. Clinic Services

Payments for clinic services will be the same for all public and private providers by type of clinic service and are further subject to these limitations for specific types of clinic services:

a. Family planning clinics.
Payment for services will be the lowest of usual and customary charges or the amount established on the State agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. The State agency's rates are effective for services on or after July 1, 2016.

b. Ambulatory surgical centers.
Payments for payable procedures will be based upon group assignments. Payment rates will be listed on the agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. The State agency's rates are effective for services on or after July 1, 2016. Payable procedures include: 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.
Room and board are not eligible for reimbursement.

c. Endstage renal disease clinics.
Payments for services will be the lowest of usual and customary charges or the amount established on the State agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. The State agency's rates are effective for services on or after July 1, 2016.

d. Indian Health Service clinics.
Payments to Indian Health Service Clinics 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.

e. Maternal Child Health Clinics.
Payment for services will be at the lowest of usual and customary charges or the amount established on the State agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. The State agency's rates are effective for services on or after July 1, 2016.

f. Rural Emergency Hospitals
Rural Emergency Hospitals (REH) will be reimbursed on an interim basis at a facility-specific outpatient cost-to-charge ratio based on the facility's most recently filed Medicare cost report.

A facility-specific outpatient cost-to-charge ratio paid during the course of a REH's fiscal year shall be designed to result in reimbursement, at the REH's fiscal year end, equaling 100% of a facility's total allowable Medicaid REH costs incurred during the REH fiscal year. Laboratory Services will be paid at a fee schedule rate in compliance with 1903(i)(7) of the Social Security Act. The Laboratory Services fee schedule is published at https://dss.sd.gov/medicaid/providers/feeschedules/.

REH's must submit a cost report annually using the CMS Cost Report form ID CMS-2552-10 or the most current version. The cost report is due within 5 months of the end of the REH's state fiscal year. After review and acceptance of a REH's submitted cost report, the department will settle reimbursement to the facility equal to 100% of the facility's allowable Medicaid REH costs incurred in the corresponding fiscal year.

Room and board are not included in the rates for these REH services.

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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, 2025, the capital cost limitation will be inflated by 1.25 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.

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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, 2025, the capital cost limitation will be inflated 1.25 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.

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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, 2025, the capital cost limitation will be inflated by 1.25% 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.