South Dakota Department of Social Services

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

April 13, 2026

RE: South Dakota Medicaid State Plan Amendment # SD-26-0003

The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan regarding hospital reimbursement methodologies including inpatient and outpatient hospital services for both instate and out-of-state hospitals. The proposed amendment implements updated hospital reimbursement methodologies and incorporates a $8.6 million hospital budgetary increase appropriated by the legislature during the 2026 legislative session.

The overall impact of the changes is anticipated to be higher aggregate reimbursement for in-state hospitals including rural hospitals. This will occur due to more standardization of methodologies and underlying payment components, which will help ensure access to high quality healthcare for Medicaid recipients.

The State conducted a comprehensive review of the Medicaid hospital methodologies in conjunction with Myers & Stauffer, LLC and hospital stakeholders. In many cases hospital methodologies had not been comprehensive reviewed and updated in decades. This resulted in underlying payment components that did not properly value relative hospital resources associated with rendering services. The proposed changes align hospital methodologies more closely with industry standards, help ensure more equitable reimbursement amongst similarly situated providers, and better align per claim payment amounts with the hospital resources associated with rendering the services.

Inpatient Hospital Changes
The following is an overview of inpatient hospital changes:

- Transitions the following hospitals to the All Patient Refined Diagnosis-Related Groups (APR-DRG) methodology:
  - In-State Acute Care Hospitals,
    - Currently reimbursed using MS-DRG
  - Out-of-State Acute Care Hospitals,
    - Currently paid 44.15% of billed charges
  - Out-of-State Critical Access Hospitals
    - Currently paid 44.15% of billed charges
  - Specialized Surgical Hospitals
    - Currently paid 66% of billed charges for ancillary services and 60% of billed charges for room and board
  - Neonatal Intensive Care Units (NICU)
    - Currently paid a per diem
  - Psychiatric Unit
    - Currently paid using MS-DRG or a per diem

- APR-DRG version 43 is being implemented. The APR-DRG base payment is anticipated to be $11,430.74. Add-ons to the base payments will be applied to out-of-state hospitals that provide care not available in South Dakota and out-of-state critical access hospitals to ensure access to care for South Dakota Medicaid recipients.

- In-state critical access hospitals are held harmless or are anticipated to see an increase in reimbursement if they are currently below 100% of cost coverage.

- Rebases per diem rates for rehabilitation hospitals and rehabilitation hospital units to an anticipated per diem rate of $1,743.70.

- Rebases per diem rates for long term acute care hospitals to an anticipated per diem rate of $1,956.01.

Outpatient Hospitals and Dialysis Changes
The following is an overview of outpatient hospital changes:

- Transitions out-of-state outpatient hospitals from percent of charge methodology to the Outpatient Prospective Payment System (OPPS) using Ambulatory Payment Classifications (APC) methodology. Updates the APC base rate to $91.42. Out-of-state critical access hospitals will have a base rate add-on to ensure access to care.

- In-state critical access hospitals are held harmless or are anticipated to see an increase in reimbursement if they are currently below 100% of cost coverage.

- Outpatient hospital dialysis units and dialysis clinics will be reimbursed a composite rate which will bundle all dialysis related services into one payment. The composite rate is anticipated to be $550.35. Dialysis units owned by a critical access hospitals will be reimbursed at their outpatient percent of charge rate.

The proposed State Plan Amendment (SPA) has an effective date of July 1, 2026. The amendment revises pages 1-5, 11, and 12 of Attachment 4.19-A and Introduction page 1, and pages 1a-1b of Attachment 4.19-B of the Medicaid State Plan.

The department estimates the fiscal impact will be $851,980 in State funds and $1,306,638 in Federal funds, totaling $2,158,618 in Federal Fiscal Year 2026 (July 1, 2026 to September 30, 2026) and $3,407,921 in State funds and $5,226,553 in Federal funds, totaling $8,634,473 in Federal Fiscal Year 2027 (October 1, 2026 to September 30, 2027).

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

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

The public comment period will start April 13, 2026 and end May 13, 2026.

Sincerely,

Matt Ballard

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

CC: Matt Althoff, Cabinet Secretary
Heather Petermann, Director

Medicaid State Plan Amendment Proposal

Transmittal Number: SD-26-0003

Effective Date: 07/01/2026

Brief Description: Implements changes to inpatient and outpatient hospital reimbursement methodologies for both instate and out-of-state hospitals.

Area of State Plan Affected: Inpatient and Outpatient Hospital Reimbursement

Page(s) of State Plan Affected: Pages 1-5 and 12 of Attachment 4.19-A and Introduction page 1, and pages 1a-1b of Attachment 4.19-B of the Medicaid State Plan.

Estimate of Fiscal Impact, if Any: FFY26: $2,158,618
FFY27: $8,634,473

Reason for Amendment: To modernize and streamline hospital reimbursement methodologies and align methodologies with industry standards.

Anticipated Impact to Tribes: No impact as the Indian Health Service reimbursement is unchanged.

Comment Period: April 13, 2026 to May 13, 2026

PUBLIC NOTICE

South Dakota Medicaid Program

Notice is hereby given that the South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan regarding hospital reimbursement methodologies including inpatient and outpatient hospital services for both instate and out-of-state hospitals. The proposed amendment implements updated hospital reimbursement methodologies and incorporates a $8.6 million hospital budgetary increase appropriated by the legislature during the 2026 legislative session.

The overall impact of the changes is anticipated to be higher aggregate reimbursement for in-state hospitals including rural hospitals. This will occur due to more standardization of methodologies and underlying payment components, which will help ensure access to high quality healthcare for Medicaid recipients.

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INPATIENT HOSPITAL PAYMENT METHODOLOGY

1. **Acute Care Hospitals**

In-State Acute Care Hospitals: Effective for discharges on or after July 1, 2026, South Dakota Medicaid will reimburse inpatient hospital services unless exempted using the All-Patient Refined Diagnosis Related Group (APR-DRG) methodology.

a. Weights: The State will use the national APR-DRG Hospital Specific Relative Value (HSRV) weight set.

b. Base Rate: Hospitals will be reimbursed using a single statewide base rate. The base rate is published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/.

c. Average Length of Stay: The State will use the APR-DRG Trimmed Arithmetic Average Length of stay.

d. DRG Base Payment: The DRG base payment will be calculated as Base Rate * APR-DRG HSRV national weight.

e. Cost Outlier Payments: Claims will qualify for an outlier payment if the hospital's estimated costs are greater than the DRG Base Payment + the fixed loss threshold published on the State's fee schedule website (https://dss.sd.gov/medicaid/providers/feeschedules/). A claim's estimated costs are calculated by multiplying hospital's assigned cost to charge ratio (CCR) by the allowed charges submitted on the claim. The amount of the outlier payment is calculated as the (Estimated Cost – (DRG Base Payment + the fixed loss threshold)) * 60 percent. The outlier payment is in addition to the base payment.

f. Transfer Payments: Payment is allowed to the transferring hospital whenever a patient is transferred to another hospital, regardless of whether the receiving hospital is paid under the DRG system or is an exempt hospital or unit. The amount of payment made to the transferring hospital is a prorated payment, not to exceed full DRG payment, for hospital-to-hospital transfers calculated with Medicaid covered days + 1. The prorated payment amount is calculated as the (DRG base payment / APR-DRG National Average Length of Stay) * (Covered days + 1). The receiving hospital will be paid a normal DRG payment unless the patient is again transferred to another hospital, in which case the hospital is paid under the transfer payment logic stated above. A list of discharge codes the transfer payment methodology applies to is included on the State's billing guidance website: https://dss.sd.gov/medicaid/providers/billingmanuals/.

Out-of-State Acute Care Hospitals: Effective for discharges on or after July 1, 2026 South Dakota Medicaid reimburses out-of-state hospitals using the APR-DRG in section one unless specifically exempted. Out-of-State children's hospitals with 30+ claims in the period January 1, 2022 to December 31, 2024 and tertiary hospitals may be paid using an enhanced base rate to ensure access to service not available in South Dakota. The base rates are published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/.

2. **Critical Access Hospitals**

Peer Group 1 In-State Critical Access Hospitals: Peer group 1 critical access hospitals (CAHs) will be reimbursed the greater of a percent of charge prospective payment methodology intended to approximate 100% of total reasonable allowable costs or actual total reasonable allowable costs. Payment rates will be unique to each individual hospital. Peer group 1 providers and their corresponding rate are published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/. Hospitals 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 hospital's state fiscal year. The rate will be updated annually to approximate a 100% prospective payment rate. The effective date of the new rate will be no later than 90 days after the department receives and accepts the cost report.

Peer Group 2 In-state Critical Access Hospitals: Peer group 2 critical access hospitals will be reimbursed at 95% of billed charges. Peer group 2 providers and their corresponding rate are published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/. 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/. Hospitals 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 hospital's state fiscal year.

Peer Group 3 In-state Critical Access Hospitals: Peer group 3 critical access hospitals are hospitals that become licensed as a critical access hospitals in South Dakota on or after July 1, 2026. Peer group 3 hospitals will be paid using the same inpatient hospital reimbursement methodology as Peer group 1. If cost report data is not available, an interim rate will be established using an average of the peer group 1 rates. In the event, a provider is paid under the peer group 3 methodology, the provider and their corresponding rate will be published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/.

Out-of-State Critical Access Hospitals: Out-of-state critical access hospital will be reimbursed using the APR-DRG methodology in section one. Out-of-state critical access hospitals are paid using an enhanced base rate that is published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/.

3. **DRG Exempt Hospitals and Hospital Units**

Effective for discharges on or after July 1, 2026. The following hospitals/hospital units are exempt from the DRG methodology due to the nature or due to federal regulations prescribing a specific methodology:

a. In-state and Out-of-State Rehabilitation Hospitals and Rehabilitation Hospital Units;
b. Lifescape Children's Care Hospital;
c. In-state and Out-of-state Long Term Acute Care Hospitals;
d. In-state and Out-of-state Indian Health Services Hospitals; and
e. Human Services Center Hospital.

Exempt hospitals are reimbursed on a per diem basis.

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.).

The per diem for the Human Services Center, a state operated psychiatric hospital, is updated quarterly based on facility's reported allowable costs, as established by the state.

The per diem rates are published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/.

INAPPROPRIATE SERVICES

When the medical need for a transfer cannot be demonstrated, the total reimbursement for the combined care may not exceed 100 percent of the payment the transferring hospital would have received had all the needed services been provided by the transferring hospital. The rate of reimbursement for the receiving hospital is the difference between the transferring hospital's payment and the payment the transferring hospital would have received had the entire episode of care been provided by the transferring hospital. If the transferring hospital is eligible for 100 percent of the payment, no payment is made to the receiving hospital. To safeguard against these and other inappropriate practices, the Department of Social Services will monitor admission practices and quality of care issues through the South Dakota Peer Review Organization (PRO). Payment for inappropriate long term hospital care as determined by the PRO will be made on the basis of the current swing bed rate in South Dakota for the level of care the patient requires. In addition, all claims will continue to be subject to the review of the Department's physician consultant. The physician will refer questionable claims to the PRO for review/investigation.

If an abuse of the prospective payment system is identified, payment will be denied, and the matter will be handled in an appropriate fashion.

Payment Adjustment for Provider-Preventable Conditions

The State Medicaid Agency meets the requirements of 42 CFR Parts 434, 438, and 447 Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 of the Act with respect to non-payment for provider-preventable conditions (PPCs).

Health Care-Acquired Conditions
The agency identifies the following health care-acquired conditions (HACs) for non-payment under this section of the State Plan:

_X_ Hospital-acquired conditions as identified by Medicare other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement or hip replacement surgery in pediatric and obstetric patients.

The agency will adopt the baseline HACs as described above for inpatient hospital reimbursement:

1. For any claims with dates of service after July 1, 2012, the agency will follow the minimum CMS regulations in 42 CFR 447 and deny payment for all HACs identified in 42 CFR 447. The agency will limit denial of payment to the additional care required by the HAC. For APR-DRG cases, the APR-DRG payable calculation excludes the diagnoses for any HACs not present on admission indicated on the claim with a present on Admission (POA) Indicator of N or U, or as defined by CMS. For non-DRG reimbursement calculations, to the extent that the cost of the hospital acquired condition can be isolated, payment will not be made for the hospital acquired condition.

2. The agency will review from time to time the list of HACs and add to the list if the agency makes a medical finding using evidence-based guidelines. In such an event, the agency will disseminate to providers, through manuals or bulletins, a current list of HACs pursuant to this section of this State Plan.

In compliance with 42 CFR 447.26(c) the agency provides:

1. That no reduction in payment for a HAC will be imposed on a provider when the condition defined as a HAC for a particular patient existed prior to the initiation of treatment for that patient by that provider indicated on the claim with a present on Admission (POA) Indicator of Y or W, or as defined by CMS.

2. That reductions in provider payment will be limited to the extent that the following apply:

   i. The identified HACs would otherwise result in an increase in payment.

   ii. The agency can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the HAC.

3. Assurance that non-payment for HACs does not prevent access to services for Medicaid beneficiaries.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under this section of this State Plan:

_**X**_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

The agency will adopt the baseline for OPPCs as described above. The following reimbursement changes will apply:

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, 2026
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, 2026
Substance Use Disorder Agencies	Attachment 4.19-B, Page 26	June 1, 2026 *
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 July 1, 2026, the Department will establish a statewide conversion factor for South Dakota hospitals. The conversion factor, APC weights, and payment rates for services not assigned to an APC are published on the State agency's website at https://dss.sd.gov/medicaid/providers/feeschedules/.

   b. Out-of-State Acute Care Hospitals: Effective July 1, 2026, out-of-state acute care hospitals will be reimbursed using the OPPS methodology in section 2a.

   c. Peer Group 1 In-State Critical Access Hospitals: Peer group 1 critical access hospitals (CAHs) will be reimbursed the greater of a percent of charge prospective payment methodology or actual total reasonable allowable costs. Payment rates will be unique to each individual hospital. Peer group 1 providers and their corresponding rate are published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/. 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/.

      Hospitals 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 hospital's state fiscal year. The rate will be adjusted annually if it does not approximate at least 100% prospective payment rate based on the most recent cost report analysis to achieve a 100% prospective payment rate. If the current percent of charge rate exceeds both 100% and the hospital's 2024 cost coverage level based on the most recent cost report analysis, the rate will be adjusted to approximate the hospital's 2024 cost coverage level. The effective date of the new rate will be no later than 90 days after the department receives and accepts the cost report.

   d. Peer Group 2 In-state Critical Access Hospitals: Peer group 2 critical access hospitals will be reimbursed at 90% of billed charges. Peer group 2 providers and their corresponding rate are published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/. 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/. Hospitals 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 hospital's state fiscal year.

e. Peer Group 3 In-state Critical Access Hospitals: Peer group 3 critical access hospitals are hospitals that become licensed as a critical access hospital in South Dakota on or after July 1, 2026. Peer group 3 hospitals will be reimbursed the greater of a percent of charge prospective payment methodology intended to approximate 100% of total reasonable allowable costs or actual total reasonable allowable costs. Payment rates will be unique to each individual hospital. If cost report data is not available, an interim rate will be established using an average of the peer group 1 rates. 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/. Hospitals 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 hospital's state fiscal year. The rate will be updated annually to approximate a 100% prospective payment rate. The effective date of the new rate will be no later than 90 days after the department receives and accepts the cost report. In the event, a provider is paid under the peer group 3 methodology, the provider and their corresponding rates will be published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/.

f. Out-of-State Critical Access Hospitals: Effective July 1, 2026, out-of-state critical access hospitals will be reimbursed using the OPPS methodology in section 2a. Out-of-state critical access hospitals are paid using an enhanced conversion factor that is published on the State's fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/.

g. Indian Health Services Hospitals: Indian Health Service outpatient hospitals will be reimbursed on a 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.

h. Lifescape Children's Care Hospital: Effective July 1, 2026, Lifescape will be reimbursed using a prospective percent of charge payment methodology that approximates 100% of total reasonable allowable Medicaid costs. Lifescape must submit a cost report annually using the CMS Cost Report form ID CMS-2552-10 or the most current agreed to version. The cost report is due within 5 months of the end of Lifescape's fiscal year . The rate will be updated annually to reflect 100% prospective payment for the year. The effective date of the new rate will be no later than 90 days after the department receives and accepts the cost report.

i. Dialysis Units: Outpatient hospital dialysis services are paid using a composite rate except for critical access hospitals. The composite rate is published on the State's Renal Dialysis fee schedule website: https://dss.sd.gov/medicaid/providers/feeschedules/. Critical access hospital dialysis units are reimbursed at the hospital outpatient methodology for the peer group the hospital containing the dialysis unit falls into.