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
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June 23, 2025

RE: South Dakota Medicaid and CHIP State Plan Amendments #SD-25-0012 and #SD-25-0014

The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan to implement inflationary rate increases appropriated by the state legislature during the 2025 legislative session effective July 1, 2025, and coverage and reimbursement for Rural Emergency Hospitals under the Clinic Services benefit.

The South Dakota Department of Social Services also intends to make changes to the South Dakota CHIP State Plan to clarify that certain services covered under the Medicaid state plan are also covered under the CHIP state plan. This includes pregnancy-related doula services including prenatal, labor and delivery, and postpartum supports, community health worker (CHW) services, and peer support services to align with benefits under the Medicaid State Plan.

Medicaid State Plan
The following services otherwise not subject to a targeted increase or rate rebase are receiving a 1.25% inflationary increase:

- Instate DRG Inpatient Hospital Services, Instate DRG Exempt Inpatient Hospitals/Hospital Units, and Instate APC Outpatient Hospital Services
- Ambulatory Surgical Center Services
- Supplies, Orthotics and Prosthetics with no Medicare rate
- Durable Medical Equipment (Not including items subject to Section 1903(i)(27)) of the Social Security Act)
- Dental Services
- Optometric Services
- Chiropractic Services
- Occupational, Speech, and Physical Therapy
- Nutritionists and Dietician Services
- Clinic Services
- Eyeglasses
- Free Standing Birth Centers
- Diabetes Self-Management Training
- Nurse Midwife Services
- Community Transportation
- Secure Medical Transportation
- Air and Ground Ambulance Transportation
- Home Health Agencies
- Independent Mental Health Practitioners Services
- Nutrition Items
- Physician Services
- Physician Administered Drugs with no Medicare rate
- Community Health Worker Services
- Doula Services
- Child Private Duty Nursing Services

- Applied Behavior Analysis Services
- Disproportionate Share Hospital Payment Pools
- PCP and Pregnancy Care Management Program Per Member Per Month Payments

All professional service reimbursement rates that were above 100% of Medicare or that would exceed 100% of Medicare with inflation applied were limited to 100% of the Medicare allowable amount.

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

Service	Type	Rate/Method
Transportation Services	Targeted Increase	• Code A0100 - $5.00 • Code A0120 - $5.00 • Code A0130 - $41.72 • Code A0425 - $8.32 • Code A0430 - $2,460.84 • Code A0431 - $2,861.09 • Code A0436 - $18.63 • Code S0215 - $1.00 • Code T2001 - $2.50 • Code T2005 - $105.44
Physician Services	Targeted Increase	• Procedure codes with rates below 90% of Medicare increased 90% of Medicare
Physician Administered Drugs	Rebased	• Procedure codes with no Medicare rate set at the Wholesale Acquisition Cost

The updated fee schedules will be posted on the department's website at: http://dss.sd.gov/medicaid/providers/feeschedules/dss/. South Dakota Medicaid providers should continue to submit claims and bill South Dakota Medicaid as they did prior to July 1, 2025. Fee schedules are the maximum allowable reimbursement amount; per ARSD 67:16:01:09 payment for services is limited to the provider's usual and customary charge.

The proposed SPA revises Page 15b of Supplement to Attachment 3.1-A, Pages 1, 5, 7, 8, and 10b of Attachment 4.19-A, Introduction Page 1, Page 1a and 15 of Attachment 4.19-B, and page 7, 9, and 10 of Attachment 4.19-D of the South Dakota Medicaid State Plan. The Department intends to make this SPA effective July 1, 2025.

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

- Inpatient Hospital Services - $2,146,012
- Outpatient Hospital Services - $1,591,744
- Physician Services including EPSDT Screenings/Treatment, and Professional Services Provided in a Freestanding Birth Center - $713,575.67
- Dental Services including Orthodontic Services and Dentures - $464,645
- Optometric - $44,157
- Chiropractic Services - $20,588
- Disproportionate Share Hospital Payments - $14,339
- Other Medical Services - $2,766,762
    - Ambulatory Surgical Center Services
    - Independent Mental Health Practitioners Services
    - Nutritionists and Dietician Services
    - Supplies, Orthotics and Prosthetics

    - Durable Medical Equipment
    - Clinic Services
    - Physical Therapy
    - Occupational Therapy
    - Speech, Hearing, or Language, Disorder Services
    - Prosthetic Devices
    - Eyeglasses
    - Diabetes Self-Management Training
    - Nurse Midwife Services
    - Community Transportation
    - Secure Medical Transportation
    - Air and Ground Ambulance Transportation
    - Nutrition Items
    - Home Health Services
    - Personal Care Services
    - Child Private Duty Nursing
    - Community Health Worker Services
- Nursing Facility Services –$155,336

Professional service rates that were limited to 100% of Medicare's rates are estimated to result in a reduction of $1,716,755 in expenditures.

Rural Emergency Hospitals will continue to be reimbursed for outpatient services as if they were a critical access hospital.

The total fiscal impact for the combined services associated with the Medicaid SPA is $751,334 in State funds and $798,767 in Federal funds, totaling $1,550,101 in Federal Fiscal Year 2025 (July 1, 2025, to September 30, 2025) and $3,005,336 in State funds and $3,195,068 in Federal funds, totaling $6,200,404 in Federal Fiscal Year 2026 (October 1, 2025, to September 30, 2026).

CHIP State Plan
The proposed SPA revises pages amends pages 5-6, 72-73, 77, and 104 of the South Dakota CHIP State Plan. The proposed State Plan Amendment (SPA) will have an effective date of January 1, 2025.

The department estimates the fiscal impact associated with this SPA to be $80,629 in State funds and $164,818 in Federal funds, totaling $245,447 in Federal Fiscal Year 2025 (January 1, 2025 – September 30, 2025) and $112,219 in State funds and $215,045 in Federal funds, totaling $327,263 in Federal Fiscal Year 2026 (October 1, 2025 – September 30, 2026).

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

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

The public comment period will start June 23, 2025, and end July 23, 2025.

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-25-0012

Effective Date: 7/1/25

Brief Description: The SPA implements the inflationary rate increases appropriated by the state legislature during the 2025 legislative session effective July 1, 2025, and coverage and reimbursement for Rural Emergency Hospitals under the Clinic Services benefit.

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

Page(s) of State Plan Affected: Page 15b of Supplement to Attachment 3.1-A, Pages 1, 5, 7, 8, and 10b of Attachment 4.19-A, Introduction Page 1, Page 1a and 15 of Attachment 4.19-B, and page 7, 9, and 10 of Attachment 4.19-D.

Estimate of Fiscal Impact, if Any: FFY25: $1,550,101
FFY26: $6,200,404

Reason for Amendment: Implement inflationary rate increases appropriated by the state legislature during the 2025 legislative session effective July 1, 2025, and implement coverage and reimbursement for Rural Emergency Hospitals under the Clinic Services benefit.

Comment Period: June 23, 2025 through July 23, 2025.

PUBLIC NOTICE
South Dakota Medicaid and CHIP Program

Notice is hereby given that the South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan to implement inflationary rate increases appropriated by the state legislature during the 2025 legislative session effective July 1, 2025, and coverage and reimbursement for Rural Emergency Hospitals under the Clinic Services benefit.

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The public comment period will start June 23, 2025, and end July 23, 2025

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 Hospitals

☑ 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/, effective July 1, 2025.

The amount of payment for each hospital is calculated as follows:

The Department determines the number of facilities qualifying at greater than the mean, greater than 1 standard deviation above the mean, greater than 2 standard deviations above the mean, and greater than 3 standard deviations above the mean. The total amount of funding budgeted for disproportionate share payments is then allocated starting with those facilities qualifying at greater than the mean. Facilities qualifying at greater than 1 standard deviation, greater than 2 standard deviations, and greater than 3 standard deviations above the mean are paid double, triple, and quadruple, respectively, the amount for facilities qualifying at greater than the mean. The payment amounts are adjusted until all the budgeted funds are spent.

The proposed disproportionate share payment for each facility is then compared to the payment limit that has been established for each facility. If the payment limit is less than the proposed disproportionate share payment, then the payment limit amount will be the disproportionate share payment for that particular facility. The sum of the payments made to the facilities where the payment limit was met is then subtracted from the total amount budgeted. The remaining budgeted funds are then allocated equally among the facilities where the payment limits have not been met. The subsequent allocation again is determined to ensure that facilities qualifying at greater than 1 standard deviation, greater than 2 standard deviations, and greater than 3 standard deviations above the mean are paid double, triple, and quadruple, respectively, the amount for facilities qualifying at greater than the mean.

Payments to Group 2 hospitals qualifying under the Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 2 hospitals qualifying under the low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals.

Payments to Group 2 hospitals will be made according to the payment schedule on the Department's website, http://dss.sd.gov/medicaid/providers/feeschedules/, effective July 1, 2025.

Payments to Group 3 hospitals qualifying under the Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 3 hospitals qualifying under the low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payments to Group 3 hospitals will be made according to the payment schedule on the Department's website, http://dss.sd.gov/medicaid/providers/feeschedules/, effective July 1, 2025.

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. The total state funds available for payment through the rural residency program pool are listed on the department's website, http://dss.sd.gov/medicaid/providers/feeschedules/, effective July 1, 2025. The FMAP at the time the quarterly payment is made will be applied to the state portion of the payment.

ATTACHMENT4.19-B
INTRODUCTION

Payment rates for the services listed below are effective for services provided on or after the corresponding date. Fee schedules are published on the Department's website at http://dss.sd.gov/medicaid/providers/feeschedules/. Effective dates listed on the introductory page supersede the effective dates listed elsewhere in Attachment 4.19-B. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

Service	Attachment	Effective Date
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Attachment 4.19-B, Page 4	July 1, 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)

2a. Outpatient Hospital Services

Effective August 2, 2016, Medicare Prospective Payment System hospitals will be paid using the Medicaid Agency's Outpatient Prospective Payments System (OPPS). Under OPPS, services are reimbursed using Ambulatory Payment Classifications. Effective August 2, 2016, the Department will establish a conversion factor and discount factor specific to each hospital. The hospital specific conversion factor and discount factors are published on the State agency's website at http://dss.sd.gov/medicaid/providers/feeschedules/dss/. Effective July 1, 2025, the conversion factor for Medicare Prospective Payment System hospitals paid using the Medicaid Agency's OPPS will be increased by 1.25 percent.

South Dakota Medicaid will pay remaining participating outpatient hospitals with more than 30 Medicaid inpatient discharges during the hospital's fiscal year ending after June 30, 1993 and before July 1, 1994 on the basis of Medicare principles of reasonable reimbursement with the following exceptions:

1. Costs associated with certified registered nurse anesthetist services are allowable costs. These costs are identified on the CMS 2552-10 on Worksheet A-8 and included in the facilities' costs.

2. All capital and education costs incurred for outpatient services are allowable costs. These costs are identified on the CMS 2552-10 on Worksheet D Part III and included in the facilities' costs.

3. Payments to Indian Health Service outpatient hospitals will be per visit and based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services, Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). The State agency will make payments for visits of the same type of service on the same day at the same provider location 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

Payment for services will follow the Critical Access Hospital reimbursement methodology for similarly classified providers as described in Attachment 4.19-B. .

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.

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.

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.