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State/Territory Name: South Dakota

State Plan Amendment (SPA) #: 19-0006

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TN: SD-19-0006 Approval Date: 09/16/2019 Effective Date: 04/01/2019
Financial Management Group

September 16, 2019

Amy Iversen-Pollreisz
Interim Cabinet Secretary
Department of Social Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Re: South Dakota 19-0006

Dear Ms. Iversen-Pollreisz:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 19-0006. Effective for services on or after April 1, 2019, this amendment implements inflationary rate increases appropriated by the state legislature during the 2019 legislative session.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 19-0006 is approved effective April 1, 2019. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044 or Kristin Michel at (303) 844-7036.

Sincerely,

Kristin Fan
Director
The amendment implements inflationary rate increases appropriated by the state during the 2019 legislative session.
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 program has been updated annually as of October 1 of each year beginning with the Medicare grouper version 15 (effective October 1, 1997). 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 in-state 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 on the same basis as the Medicaid agencies in the states where the hospitals are located. If the hospital’s home state refuses to provide the amount they would pay for a given claim, the payment will be at 44.15% of billed charges. 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 in-state DRG hospitals unless an amount is due the South Dakota Medicaid program.

For claims with dates of service beginning April 1, 2019, the reimbursement for in-state DRG hospitals and all out-of-state hospitals not paid the above-stated percentage of charges is increased by 1.5 percent over what the calculated amounts were for State fiscal year 2018 after any cost sharing amount due from the patient and any third party liability amounts have been deducted, and after computation of any cost outlier payment. The agency will increase reimbursements to South Dakota hospitals classified as Medicare Critical Access or Medicaid Access Critical by 1.5 percent for claims with dates of service on and after April 1, 2019.

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.

TN # 18-006
Supersedes
TN # 18-003
Approval Date: SEP 16 2019
Effective Date: 04/01/19
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; and
9. Specialized Surgical Hospitals.

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/sdmex/includes/providers/feeschedules/dss/index.aspx

Payment for psychiatric hospitals, psychiatric units, rehabilitation hospitals, rehabilitation units, perinatal units, 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 based upon group assignments. Payment rates are effective April 1, 2019 and will be listed on the agency’s website http://dss.sd.gov/sdmex/includes/providers/feeschedules/dss/index.aspx. 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 April 1, 2019, the amount of reimbursement for psychiatric hospitals, rehabilitation hospitals, perinatal units, psychiatric units, rehabilitation units, children's care hospitals, and specialized surgical hospitals will be increased 1.5% over the April 1, 2018 calculations after any cost sharing amounts due from the patient, 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.
ATTACHMENT 4.19-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/](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.

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TN# 19-06
SUPERCEDES
TN# 19-05
Approval Date **SEP 16 2019**
Effective Date **04/01/19**
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 April 1, 2019, Medicare Prospective
   Payment System hospitals paid using the Medicaid Agency’s OPPS will be increased by 1.5 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 only if
the services provided are different or if they have different diagnosis codes.

TN # 19-006
SUPERSEDES
TN # 18-003

Approval Date, **SEP 16 2019**

Effective Date 4/1/19