South Dakota Department of Social Services

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South Dakota Medicaid
Hospital Reimbursement Methodology Changes
Frequently Asked Questions

Last Revised 8.28.2025

General Questions

1. **What hospital methodologies are changing?**

   South Dakota Medicaid contracted with Myers & Stauffer to complete a review of inpatient and outpatient hospital methodologies. Recommended methodology changes include:

   - Transitioning inpatient prospective payment hospitals from MS-DRG to APR-DRG.
   - Reimbursing in-state critical access hospitals 100% of allowable costs through cost settlement, which will be transitioned to through a phase-in period.
   - Including out-of-state hospitals in the APR-DRG and APC methodologies.

   Additional details regarding changes are described throughout this document.

2. **What hospital methodologies are <u>not</u> changing?**

   Certain methodologies were recommended to continue to be used including per diem methodologies for rehabilitation units/hospitals, long term acute care hospitals, and IHS hospitals as well as APC for prospective payment outpatient hospitals. In some cases, although the methodology is not changing, the payment components such as the per diem amount or the base rate may be changing.

3. **Why are these hospital methodology changes being made?**

   Changes are being made to streamline, modernize, and simplify payment methodologies as well as address known issues. Issues with current methodologies include:

   - MS-DRG is primarily intended for the Medicare population and is not ideal for pricing certain types of claims more common amongst the Medicaid population.
   - A large percentage of current DRG payments are associated with cost outlier claims.
   - Current percent of charge methodologies do not provide Medicaid adequate controls to contain costs.

- Reimbursement for prospective payment hospitals is hospital-specific resulting in the State paying different amounts for similar services.

4. **When will the hospital methodology changes be implemented?**

   South Dakota Medicaid is targeting implementing methodology changes January 1, 2026, pending completion of claims payment system programming.

5. **What is the fiscal impact of the hospital methodology changes?**

   Changes are intended to be budget-neutral for the State. Similarly classified hospitals will be paid using the same methodology/rate. For example, outpatient prospective payment hospitals will all be paid under the APC methodology using a $89.17 base rate. In this example, some hospitals will experience increased Medicaid revenue and others will experience decreased revenue depending on their current hospital-specific base rate.

   In the aggregate, the methodology changes are projected to result in in-state Medicaid hospital reimbursement increasing by 5 percentage points due to inclusion of out-of-state providers in the APR-DRG and APC methodologies.

6. **Will the methodology changes include a hold harmless provision to prevent hospitals from receiving less Medicaid revenue than before?**

   No. An objective of the methodology changes is to pay similar hospitals the same amount for similar outpatient hospital services and inpatient hospitalizations. Currently, Medicaid's reimbursement for a similar inpatient hospitalization in Sioux Falls is different depending on which hospital the patient was hospitalized at. Similarly, outpatient hospital services provided in Rapid City, Sioux Falls, Aberdeen, and Bismarck are all reimbursed at different amounts.

   As noted above, in the aggregate, the methodology changes are projected to result in in-state Medicaid hospital reimbursement increasing by 5 percentage points due to inclusion of out-of-state providers in the APR-DRG and APC methodologies.

7. **What tools or information to the methodologies will providers have access to?**

   South Dakota will publish fee schedules with prospective payment base rates and per diem rates, provider manuals with descriptions of the methodologies and payment components, and an APR-DRG calculator that includes the ability for providers to price a claim with an assigned DRG.

Inpatient Hospital Questions

8. **How will in-state inpatient prospective payment system hospitals be paid?**

   In-state prospective payment hospitals will transition from the MS-DRG methodology to the APR-DRG methodology. Hospitals will be paid at the same base rate. Current modeling estimates the base rate to be $11,302.23. The final base rate is to be determined based on final modeling.

9. **How will out-of-state prospective payment system providers be paid?**

Out-of-state prospective payment system providers will also be paid under the APR-DRG methodology. Most hospitals will be paid at the in-state base rate. Out-of-state pediatric and specialty care hospitals will be paid at an enhanced base rate to help ensure access to care for services not available in South Dakota.

10. What grouper version and weight set is Medicaid going to use?

Medicaid will use APR-DRG version 42 and Solventum HSRV national weight.

11. Is there a different APR-DRG base rate for different service lines such as psychiatric units?

No, the base rates will be the same for all service lines.

12. Will any policy adjustors be used?

No, Medicaid is not anticipating applying any policy adjustors for the January 1 implementation.

13. Are you targeting a specific cost outlier expenditure?

Current DRG cost outlier expenditures account for a significant percentage of overall DRG expenditures. The State is targeting reducing outlier expenditures to approximately 5 to 6 percent of DRG expenditures.

14. What is the new outlier methodology logic?

Claims will qualify for an outlier if the hospital's estimated costs are greater than the DRG Base Payment + the fixed loss threshold, which is anticipated to be $53,000. A claim's estimated costs are calculated by multiplying a hospital-specific cost-to-charge ratio (CCR) by the charges submitted on the claim. The amount of the outlier payment is calculated as the (Estimated Cost – (DRG Base Payment + the fixed loss ratio)) * 50 percent. The outlier payment is in addition to the base payment.

15. What is the new transfer payment logic?

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 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.

16. What hospital/hospital units are exempt from the APR-DRG methodology?

The following hospitals/hospital units will be exempt from DRGs:

- Critical Access Hospitals;
- Rehabilitation Hospitals and Rehabilitation Hospital Units;
- Long Term Acute Care Hospitals;
- Indian Health Services Hospitals; and
- Human Services Center Hospital.

Critical Access Hospitals (CAHs) Questions

17. What is the in-state CAH phase in methodology?

Based on feedback from providers Medicaid will phase-in the in-state CAH cost-based methodology pending CMS approval of the methodology. The phase-in period will be from January 1, 2026 to June 30, 2027. During the phase-in, CAH interim rates will be set using a ceiling of 125% of costs and a floor of 100% of costs.

- Providers with estimated cost coverage of 125% or more during the CY22-24 claim set will have interim rates established that approximate 125% cost coverage.
- Providers with estimated cost coverage of less than 125% and more than 100% during the CY 22-24 claims set will have interim rates established that approximate the provider's cost coverage during that time period.
- Providers with estimated total hospital cost coverage of less than 100% or during the CY22-24 claim set will have interim rates established that approximate cost coverage of 100%.

Both inpatient and outpatient hospital services interim rates are established using a percent of charge. For dates of service in the phase-in period, CAHs will be paid the greater of their interim payment amount or 100% of actual allowable costs using a cost settlement process. Payments during the phase in period in excess of 100% of costs will not be recouped.

Medicaid anticipates using the phase-in period to also explore a Rural Health Clinic alternative payment methodology that brings reimbursement rates for these services closer to cost and work with the Department of Human Services to bring swing-bed rates closer to nursing facility rates.

A high-level fiscal impact of the methodology change and the interim percent of charge can be requested by emailing Medicaid at DSS.Medicaid@state.sd.us.

18. After the phase-in period what will the in-state CAH reimbursement methodology be?

In-state CAHs will be reimbursed on an interim basis using a percent of charge methodology that approximates 100% cost coverage. Services will be cost-settled to 100% of allowable costs.

19. What is the timeline of implementation of the cost settlement?

<u>January 2026</u>

- New payment methodologies implemented.

<u>2025 Cost Report Submissions (submitted in 2026)</u>

- Providers must submit 2025 cost reports no later than 5 months after the fiscal year end, but not before January 1, 2026.
    - Example 1: Fiscal year ends December 31, 2025, → report due by May 31, 2026
    - Example 2: Fiscal year ends June 30, 2025, → report due by January 31, 2026

<u>2026 and forward Cost Report Submissions</u>

- Providers must submit cost reports no later than 5 months after the fiscal year end.
    - Example 1: Fiscal year ends December 31, 2026 → report due by May 31, 2027
    - Example 2: Fiscal year ends June 30, 2026 → report due by November 30, 2026

Cost Settlement Process Begins

- Annual settlement payments occur every July, starting July 2027.

July 2027 Cost Settlement

- Based on 2026 calendar year claims, using the 2026 cost report.
- Applies only to providers paid less than 100% of cost.
- Interim rates reset to 100% of 2025 reported costs.

July 2028 Cost Settlement

- Based on 2027 calendar year claims, using the 2027 cost report.
- Applies only to providers paid less than 100% of cost.
- Interim rates reset to 100% of 2026 reported costs.

July 2029 Cost Settlement and forward

- Based on 2028 calendar year claims, using the 2028 cost report.
- Applies to all critical access providers (not just those under 100%).
- Interim rates reset to 100% of 2027 reported costs.

20. Why are the in-state critical access hospital methodologies changing?

The methodology is being updated to more closely align with Medicare's cost-based methodology. The current methodologies are generally a percentage of charge with some CAHs being reimbursed using the MS-DRG methodology for inpatient hospitalizations. The current methodologies result in significant differences in cost coverage for CAHs with cost coverage ranging from reimbursement below cost for some CAHs to reimbursement well above cost for other CAHs. The revised methodology will better allocate Medicaid dollars to provide uniform cost coverage for CAHs.

21. Why are some in-state critical access hospitals experiencing a decrease in reimbursement?

This is primarily due to some in-state CAHs being reimbursed 90% of billed charges for outpatient hospital services and 95% of billed charges for inpatient hospital services. Most hospital charges allow for a sizeable profit margin when reimbursed at percentages that high. This is resulting in reimbursement for some CAHs that is more than double their cost.

22. How will out-of-state CAHs be reimbursed?

Out-of-State CAHs will be reimbursed using the APR-DRG and APC methodologies and an enhanced base rates to provide enhanced cost coverage. The enhanced base rates were modeled to provide aggregate 100% cost coverage for this peer group.

23. Why are out-of-state CAHs being paid differently?

Most out-of-state CAHs have low Medicaid volume, which makes cost settlement more administratively burdensome for the state and providers. The out-of-state methodologies are intended to provide enhanced cost coverage while maintaining administrative simplicity for providers and the Medicaid agency.

24. When do in-state CAHs need to submit cost reports?

Providers must submit annual cost reports, starting January 2026, using CMS Form 2552-10 (or the most current version) no later than five months after the end of their fiscal year. Cost reports must be submitted electronically to DSSFinancePRA@state.sd.us.

Example: For hospitals with a fiscal year ending December 31, 2025, the cost report must be submitted to the state no later than May 31, 2026.

25. How will the phase-in cost settlement process work?

The cost settlement will occur annually beginning in July 2027. For services reimbursed under the phase-in interim rates, providers that were paid less than 100% of their costs will receive additional payment to provide 100% cost coverage. No recoupment will be required for providers receiving over 100% cost coverage. A second cost settlement using these parameters will occur in July 2028.

26. How will the cost settlement process work after the phase-in?

Beginning with the July 2029 cost settlement, all participating providers will be subject to settlement to 100% of cost. Providers receiving less than 100% of their cost coverage will receive a payment, while those receiving more than 100% will be required to return the excess amount to South Dakota Medicaid within 30 days of the date on the settlement notification letter. Claims will be included in the settlement based on having a discharge date from January 1 through December 31 of the previous calendar year.

27. Will cost settlement include laboratory and surgical services?

Yes, both services are anticipated to be included in the cost settlement process.

28. Are swing-bed rates being updated?

Swing-bed rates are outside the scope of this rate review. Swing-bed services are part of the Department of Human Services budget and the rates are established by the Department of Human Services. Medicaid anticipates using the phase-in period to explore bringing swing-bed rates closer to nursing facility rates.

29. Are Rural Health Clinic rates being updated?

Rural Health Clinic rates are outside the scope of this rate review. A separate rate study is being completed for these clinics, which will inform a potential alternative payment methodology that would bring reimbursement rates for these clinics closer to cost than the current methodology.

Outpatient Hospital Questions

30. How is the outpatient hospital acute care methodology changing?

In-state outpatient hospitals will continue to be paid under the APC methodology. All hospitals will be paid using the same base rate rather than a hospital-specific base rate. The base rate is anticipated to be the Medicare national base rate of $89.17.

31. Why is the state moving to a single APC base rate?

Medicaid originally implemented APC in SFY 17 with individual provider base rates that were budget neutral to the provider. The rates were supposed to be revised annually over 5 years to achieve a uniform base rate. This did not occur and as such some hospitals are being paid more than other hospitals for the same outpatient hospital services. Under the revised base rate of $89.17 most hospital’s base rates will experience a rate increase.

32. How will out-of-state outpatient acute care hospitals be paid?

Out-of-state outpatient hospitals will transition from percent of charge reimbursement to payment under the APC methodology. The base rate is anticipated to be the Medicare national base rate of $89.17.

Additional Questions

33. **What is the best way to contact Medicaid regarding questions that were not answered in this document or to find out more about how the changes impact my hospital?**

    Please email additional questions to Medicaid at DSS.Medicaid@state.sd.us and include Hospital Reimbursement Methodology Updates in the subject line. In addition to the public stakeholder meetings South Dakota Medicaid has held, the agency will meet with individual hospitals upon request.