Table of Contents

State/Territory Name: South Dakota

State Plan Amendment (SPA) #: SD-11-009

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

APR - 3 2012

Ms. Kim Malsam-Rysdon
Department Secretary
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

Re: South Dakota 11-009

Dear Ms. Malsam-Rysdon:

We have reviewed the proposed amendment to Attachment 4.19-A and Attachment 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 11-009. Effective for services on or after July 1, 2012, this amendment modifies the reimbursement methodology necessary to comply with CMS' regulations specific for provider preventable conditions.

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 (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 11-009 is approved effective July 1, 2012. The CMS-179 and the amended plan pages are attached.

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

Sincerely,

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 11 – 9

2. STATE: South Dakota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1902(a)(4) and 1902(a)(6) of the Act, 42 CFR Part 447, Section 2702 of the Affordable Care Act

7. FEDERAL BUDGET IMPACT:
a. ~~FFY 2011: $0*~~ FFY 2013: ($140,000)
b. FFY 2012: ~~$0*~~ ($35,000)
*Assumed savings, but undetermined amount.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A page 11–12
Attachment 4-19-B page 40

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

~~Attachment 4.19-A page 11~~ NEW
NEW

10. SUBJECT OF AMENDMENT:

This State Plan Amendment clarifies non-payment for health care- and hospital-acquired conditions (HACs).

11. GOVERNOR'S REVIEW *(Check One)*:

■ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. [redacted]

13. TYPED NAME:
KIM MALSAM-RYSDON

14. TITLE:
Department Secretary

15. DATE SUBMITTED:

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: APR – 3 2012

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL – 1 2012

20. SI[redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM CMS-179 (07-92)

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 DRG cases, the DRG payable calculation excludes the diagnoses for any HACs not present on admission. For non-DRG reimbursement calculations, the agency will reduce the number of payable days by the number of days associated with diagnoses for any HAC not present on admission. The number of excluded days is based on the average length of stay (ALOS) on the diagnosis tables published by the ICD vendor used by South Dakota Medicaid.

2. The agency will review discharges relating to HACs and make use of the "Present on Admission" (POA) indicator to identify HACs and deny reimbursement for any service associated with treating the HAC. For discharges with a HAC, the agency will request that the hospital resubmit the claim identifying all charges associated with the HAC as non-covered. The agency will determine the total payment (discharge payment plus outlier payment) for the covered portion of the claim and compare this payment to prior payment for the claim. If the total payment is less than what was originally paid for the claim, the agency will request a refund from the hospital for the difference. Denial of payment will be limited to the additional care required by the HAC. The agency requires hospitals to document a valid POA indicator for each inpatient diagnosis, pursuant to 42 CFR 412. The agency uses POA definitions as outlined by CMS, described in MLN Matters Number 5499, and detailed at http://cms.hhs.gov/transmittals/downloads/r1240cp.pdf .

3. The agency will not pay the approved inpatient hospital rates, or any other hospital payments including disproportionate share for HACs identified as non-payable by CMS. The agency will not be liable for payment of any services related to HACs identified as non-payable by CMS.

4. 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.

5. If individual cases are identified throughout the HACs implementation period, the agency will adjust reimbursements according to the methodology above.

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.

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:

The agency will deny payment for these conditions in any health care setting identified in this section of this State Plan and any other settings where these events may occur. For claims submitted with dates of service on or after July 1, 2012, the agency will follow the minimum CMS regulations in 42 CFR 447 and deny payment for all of the OPPCs identified in 42 CFR 447. If individual cases are identified throughout the OPPC implementation period, the agency will adjust reimbursements according to the methodology above. Denial of payment will be limited to the additional care required by the OPPC. The agency will review from time to time the list of OPPCs 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 OPPCs pursuant to this section of this State Plan.

___ Additional other provider-preventable conditions identified below:

Payment Adjustment for Other 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 Other Provider-Preventable Conditions (OPPCs).

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:

The agency will deny payment for these conditions in any health care setting or provider in this section of this State Plan. For claims submitted on or after July 1, 2012, the agency will follow the minimum CMS regulations in 42 CFR 447 and deny payment for all of the OPPCs identified in 42 CFR 447.

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

1. That no reduction in payment for an OPPC will be imposed on a provider when the condition defined as an OPPC for a particular patient existed prior to the initiation of treatment for that patient by that provider;

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

   i. The identified OPPCs 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 OPPCs.

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

If the individual cases are identified throughout the OPPCs implementation period, the agency will adjust reimbursements according to the methodology above. Denial of payment will be limited to the additional care required by the OPPC. The agency will review from time to time the list of OPPCs 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 OPPCs pursuant to this section of this State Plan.

___ Additional OPPCs identified below: