Table of Contents

State/Territory Name: South Dakota

State Plan Amendment (SPA) #: SD-11-012

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

FEB - 6 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 11-012

Dear Ms. Malsam-Rysdon:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-012 Effective for services on or after October 1, 2011, this amendment updates the reimbursement methodology for inpatient hospitals participating in South Dakota Medicaid. Specifically, this amendment updates the annual Medicare Diagnostic Related Group (DRG); modifies cost outlier thresholds; and provides for other minor clarifications.

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 11-012 is approved effective October 1, 2011. 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	1. TRANSMITTAL NUMBER: 11 -12	2. STATE: South Dakota
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	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 October 1, 2011	

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:	7. FEDERAL BUDGET IMPACT:
42 CFR 430.10 447.250-447.252 and 447 256-447.272	a. FFY 2011: $0 b. FFY 2012: $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 1, 2, 3, and 5	Attachment 4.19-A, Pages 1, 2, 3, and 5

10. SUBJECT OF AMENDMENT:
This is a State Plan Amendment to update inpatient hospital reimbursement methodology for the annual Medicare DRGs Grouper change.

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

■ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
Kim Malsam-Rysdon	DEPARTMENT OF SOCIAL SERVICES DIVISION OF MEDICAL SERVICES 700 GOVERNORS DRIVE PIERRE, SD 57501-2291
13. TYPED NAME: KIM MALSAM-RYSDON	
14. TITLE: Department Secretary	
15. DATE SUBMITTED: 12-16-11	
17. DATE RECEIVED:	18. DATE APPROVED: FEB - 6 2012
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2011	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM CMS-179 (07-92)

INPATIENT HOSPITAL PAYMENT METHODOLOGY

GENERAL

The South Dakota Medicaid program has been reimbursing hospitals for inpatient services, with a few exceptions, under a prospective Diagnosis Relate Group (DRG) methodology since January 1, 1985. South Dakota uses the federal definitions of DRGs, DRG classifications, weights, geometric mean lengths of stay, and outlier cutoffs as used for the Medicare prospective payment system. The DRG grouper program is updated annually as of October 1 of each year, beginning with the Medicare grouper version 15 (effective October 1, 1997), and the agency provides a link to Medicare's DRGs on its website at this address. http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. The State agency calculates Medicaid Program specific weight and geometric mean length of stay factors annually using the latest three years of non-outlier claim data, this three year claim database updated annually in order 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 claim 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 hospital is paid by the Medicaid agency in the state in which the hospital is located. If the hospital's home state refuses to provide the amount they would pay for a given claim, the payment will be at 50% of billed charges. Payment will be for individual discharge or transfer claims only; there will be no annual cost settlement with out-of-state hospitals or with instate DRG hospitals unless an amount is due the South Dakota Medicaid program.

For claims with dates of service from July 1, 2011 through June 30, 2012, the amount of reimbursement for instate DRG hospitals and all out-of state hospitals, will be reduced by 11.48 percent after any cost sharing amount due from the patient, any third party liability amounts have been deducted, and other computation of any cost outlier payment. This does not apply to South Dakota hospitals that are classified as Medicare Critical Access or Medicaid Access Critical

SPECIFIC DESCRIPTION

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

The average cost per discharge for non-outlier claims was calculated by subtracting the charges for ancillary services on outlier claims, multiplied by the average ancillary cost to charge ratio, from the total allowable ancillary charges for the hospital Total Medicaid days and discharges were reduced by the number of days and discharges from outlier claims to calculate the routine costs for non-outlier claims. Routine costs and ancillary costs related to non-outlier claims were added and then the total allowable costs were divided by the number of non-outlier discharges during the base period The agency will publish the annually updated cost outlier figure and a link to Medicare's DRGs on its website at http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx

CAPITAL COSTS

Interim payments for capital and education costs will be made to instate hospitals that had more than thirty (30) Medicaid discharges during the hospitals' fiscal year ending after June 30, 1996 and before July 1, 1997 on a per diem basis. The agency will calculate hospital-specific interim rates using the most recently reviewed Medicare cost report, with reimbursements being reduced 11.46% for the year beginning July 1, 2011, and ending June 30, 2012. This does not apply to South Dakota hospitals that are classified as Medicare Critical Access or Medicaid Access Critical.

TRANSFER PATIENTS

Payment will be 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 will be on a per diem basis. The per diem rate will be calculated by dividing the standard DRG payment for the particular stay by the geometric mean length of stay for the DRG. The per diem rate will then be multiplied by the number of days stay prior to the transfer. In no instance will the payment to the transferring hospital be any higher than the full DRG payment amount if the patient had been discharged home. The daily capital/education pass-through will be added to the DRG payment.

The receiving hospital will be paid a normal DRG payment unless the patient is again transferred to another hospital.

COVERED DIAGNOSTIC RELATED GROUPS

South Dakota will adopt all DRGs, except DRG 522, established in the version of the grouper program being used by the Department as of the admission date on the claim.

SERVICES COVERED BY DIAGNOSTIC RELATED GROUP PAYMENTS

The Department will adopt Medicare's definition of inpatient hospital services covered by DRG payment. As a result, billing for physician services must be made on a separate CMS 1500 form

OUTLIER PAYMENTS

The Department will make additional payments to hospitals for discharges which meet the criteria of an "outlier." An outlier is a case with extremely high charges which exceed cost outlier thresholds

A claim will qualify for a cost outlier payment when 70% of the claim's total billed charges exceed the larger of the cost outlier amount published on the agency's website at http://dss.ad.gov/admedx/includes/providers/feeschedules/dss/index.aspx or 1.5 times the DRG payment for the claim. The additional payment allowed for a cost outlier will be 90% of the difference between 70% of billed charges and the larger of the published outlier amount or 1.5 times the DRG payment.

The total payment allowed for an outlier claim will be the DRG payment plus the outlier payment plus the daily capital/education amount for each day of the hospital stay.

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 the above instate exempt facilities and/or units, except for psychiatric hospitals, psychiatric units, Indian Health Service Hospitals, specialized surgical hospitals, and instate hospitals with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1993, and before July 1, 1994, 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

Psychiatric hospitals, psychiatric units, rehabilitation hospitals, rehabilitation units, perinatal units, and children's care hospitals will be paid on a per diem basis based on the facility's reported, allowable costs, as established by the State. This per diem amount will be 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.

Specialized Surgical Hospitals will be reimbursed on a per diem basis equal to twice the per diem rate allowable for swing-bed hospitals as established in Attachment 4 19-D – Other, Provision 10.

Indian Health Service hospitals will be paid on a per diem basis as established by CMS

Instate hospitals with less than 30 discharges during the hospital's fiscal year ending after June 30, 1993, and before July 1, 1994, will be paid 95% of billed charges.

For claims with dates of service from July 1, 2011, through June 30, 2012, the amount of reimbursement for psychiatric hospitals, rehabilitation hospitals, perinatal units, psychiatric units, rehabilitation units, and specialized surgical hospitals will be reduced 11.48 percent, and payments for children's care hospitals will be reduced by 4.5%, after any cost sharing amount 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

Hospitals that are classified as Medicare Critical Access or Medicaid Access Critical will be reimbursed at the greater of actual allowable cost or the payment received under the provisions contained in this Attachment.

UPPER LIMITS

FEB – 6 2012