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State/Territory Name: South Dakota

State Plan Amendment (SPA) #: SD-13-004

This file contains the following documents in the order listed:

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 & CHIP SERVICES

APR 17 2014

Kim Malsam-Rysdon
Secretary
Department of Social Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Re: South Dakota 13-004

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) 13-004. Effective for services on or after July 1, 2013, this amendment provides updates to the reimbursement methodology for inpatient hospital services.

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 13-004 is approved effective July 1, 2013. The CMS-179 and the amended plan pages are attached.

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

Sincerely,

[redacted]

Cindy Mann
Director

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: SD-13-4

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, 2013

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:

1902(a)(13)(A), 1902(a(30), and 1923 of the Act, and 42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2013: $ 360,405
b. FFY 2014: $ ~~[illegible]~~ $1,081,214
Pen & Ink Approved - CStores

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Pages 1 and 2

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, Pages 1 and 2

10. SUBJECT OF AMENDMENT:

This State Plan Amendment replaces obsolete language pertaining to inpatient hospital reimbursement methodology used in State Fiscal Year 2013, replacing it with language to implement State Fiscal Year 2014 legislative budget appropriations.

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:
[redacted]

13. TYPED NAME:
Brenda Tidball-Zeltinger

14. TITLE:
DSS Chief Financial Officer

15. DATE SUBMITTED:
6/28/2013

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 17 2014

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director Policy + Financial Mgt CMCS

23. REMARKS:

FORM CMS-179 (07-92)

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 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 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 36.8% of billed charges. Payment is for individual discharge or transfer claims only. 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, 2013, the reimbursement for instate DRG hospitals and all out-of-state hospitals not paid the above-stated percentage of charges is decreased by 2.2% over what the calculated amounts were for State fiscal year 2013 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 3.0% for claims with dates of service on and after July 1, 2013.

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.

The agency calculates the average cost per discharge for non-outlier claims 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 are 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 are added and then the total allowable costs were divided by the number of non-outlier discharges during the base period. The agency publishes 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

South Dakota Medicaid makes interim payments for capital and education costs 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 calculates hospital-specific interim rates using the most recently-reviewed Medicare cost report for each hospital, with reimbursements decreased 2.2% for the year beginning July 1, 2013. South Dakota hospitals that are classified as Medicare Critical Access or Medicaid Access Critical will receive a 3.0% increase.

TRANSFER PATIENTS

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 on a per diem basis 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 is then 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 has adopted 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.