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 is updated annually effective January 1 each year each year. 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 at 44.15% of the provider's usual and customary charges unless otherwise approved by the State. The State may reimburse out-of-state hospitals on the same basis as the Medicaid agency where the hospital is located if the hospital's home state Medicaid agency agrees to calculate the claim payment.

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 instate DRG hospitals unless an amount is due the South Dakota Medicaid program.

For claims with dates of service beginning July 1, 2025, instate DRG hospitals' target and capital/ education amounts are increased by 1.25 percent.

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 increased 2.7% for the year beginning July 1, 2016.

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 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 State agency has adopted Medicare's definition of inpatient hospital services covered by DRG payment. Providers must submit claims for reimbursement for physician services on a separate CMS 1500 form.

OUTLIER PAYMENTS

The State agency will calculate additional payments to hospitals for discharges which meet the criteria of an "outlier," a case with extremely high charges which exceed cost outlier thresholds set by the agency. To qualify for a cost outlier payment, 70% of the claim's total billed charges must exceed the larger of the cost outlier amount published on the agency's website at http://dss.sd.gov/sdmedx/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.

SURGICALLY-IMPLANTED DEVICES AND APPLIANCES

The Medicaid program will reimburse claims submitted for inpatient hospital services by in-state acute care hospitals that had more than 30 Medicaid discharges during the hospitals' fiscal year ending after June 30, 1996, and before July 1, 1997, that are considered to be cost outlier claims as defined by ARSD 67:16:03:01(3) and contain revenue codes 275 or 278 according to the following guidelines:

1. The State agency will limit reimbursements for aggregate charges in excess of $50,000 associated with revenue codes 275 or 278 to the providers' actual costs plus 10%; and
2. The agency will remove the aggregate charges for revenue codes 275 or 278 in excess of $50,000 from the calculation of the claim and charges associated with the remainder of the claim will be reimbursed according to ARSD 67:16:03:06.

For use by the agency in the reimbursement calculations, the provider must submit to the agency as documentation copies of the suppliers' invoices for items associated with revenue codes 275 and 278.

PRIOR AUTHORIZATION OF SERVICES

Payment for the following procedures and services will be allowed only after authorization and approval by the Department of Social Services prior to admission. Procedures and services requiring prior authorization are:

1. Heart Transplants
2. Liver Transplants
3. Bone Marrow Transplants
4. Psychiatric Care in DRG Exempt Units
5. Neonatal Intensive Care in DRG Exempt Units
6. Rehabilitation Care in DRG Exempt Units

Approval or denial of the proposed procedures and services may be obtained by contacting the Department of Social Services, and providing appropriate supporting documentation.

INAPPROPRIATE SERVICES

When the medical need for a transfer cannot be demonstrated, payment will be limited to one DRG payment to the discharging hospital. To safeguard against these and other inappropriate practices, the Department of Social Services will monitor admission practices and quality of care issues through the South Dakota Peer Review Organization (PRO). Payment for inappropriate long term hospital care as determined by the PRO will be made on the basis of the current swing bed rate in South Dakota for the level of care the patient requires. In addition, all claims will continue to be subject to the review of the Department's physician consultant. The physician will refer questionable claims to the PRO for review/investigation.

If an abuse of the prospective payment system is identified, payment will be denied and the matter will be handled in an appropriate fashion.

EXEMPT HOSPITALS, UNITS, AND/OR PROCEDURES

As a result of their unique patient population, certain instate facilities and/or units may, upon request and showing the ability to provide cost and statistical data for the facility and/or unit, be exempted from the DRG system. The Department may require certain instate facilities to be exempted from the DRG system. In South Dakota exemptions include only the following:

1. Psychiatric Hospitals;
2. Rehabilitation Hospitals;
3. Perinatal Units (Only upon request and justification) that have
    a. The capability of providing care for infants under 750 grams;
    b. The capability of providing care for infants on ventilators;
    c. The capability of providing major surgery for newborns;
    d. Twenty-four hour coverage of a neonatologist; and
    e. A maternal neonatology transport team;
4. Psychiatric Units (only upon request and justification);

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;
9. Specialized Surgical Hospitals;
10. Long-Term Acute Care Hospital.

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

Payment for psychiatric hospitals, psychiatric units, rehabilitation hospitals, rehabilitation units, perinatal units, long-term acute care hospitals 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 66 percent of usual and customary charges for ancillary services and 60 percent of usual and customary charges for room and board. 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 July 1, 2025, the amount of reimbursement for psychiatric hospitals, rehabilitation hospitals, perinatal units, psychiatric units, rehabilitation units, children's care hospitals, and long-term acute care hospitals will be increased 1.25% over the July 1, 2024 calculations after 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.

UPPER PAYMENT LIMITS

Payments in aggregate for inpatient hospital services will not exceed the amount that would be paid for services under Medicare principles.

APPEALS

The Department of Social Services has administrative review procedures to meet the need for provider appeals required by 42 CFR 447.253(e).

ACCESS AND QUALITY OF CARE

All hospitals located in South Dakota participate in the Medicaid program which results in the best possible access to hospital services for the Medicaid recipient. The South Dakota Professional Review Organization monitors quality of care.

DISPROPORTIONATE SHARE PAYMENTS

The program allows an additional payment to any qualifying hospital that has a disproportionate share of low-income patients. The threshold at which an individual hospital is considered to be serving a disproportionate share of low-income patients is when either the Medicaid inpatient utilization rate, as defined in section 1923 (b)(2), is above the mean Medicaid inpatient utilization rate for hospitals receiving the Medicaid payments in the state, or the hospitals low-income utilization rate, as defined in 1923 (b)(3), is above the mean Medicaid low-income utilization rate for hospitals receiving the Medicaid payments in the state. To qualify as a disproportionate share hospital a hospital must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetric services to individuals entitled to Medicaid service. This requirement does not apply to hospitals whose patients are predominately under 18 years of age or that do not offer non-emergency obstetric services to the general population. For hospitals located in a rural area, the term “obstetrician” includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. A hospital must also have a Medicaid utilization rate of at least one percent to qualify for disproportionate share hospital payment.

To identify qualifying hospitals, the Department will mail a survey to all hospitals each State Fiscal year. The Department will verify returns to ensure no qualifying hospital is excluded. If a hospital qualifies for disproportionate share payment under both the Medicaid inpatient utilization rate and the low-income utilization rate, the payment will be based on whichever utilization rate will result in the higher payment. Only one disproportionate share payment is allowed to a hospital. The Department notifies qualifying hospitals of their disproportionate share payments prior to June 30.

The agency groups qualifying disproportionate share hospitals into one of the following three groups, with each hospital group’s surveys calculated independently of the other groups’ surveys:

Group 1, acute care hospitals;

Group 2, psychiatric hospitals operated by the State of South Dakota; and
Group 3, other hospitals (any hospital not in Group 1 or 2).

Payments to Group 1 hospitals qualifying under the Medicaid inpatient utilization method are based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 1 hospitals qualifying under the low-income utilization method are based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payments to Group 1 hospitals will be made according to the payment schedule on the Department's website, http://dss.sd.gov/medicaid/providers/feeschedules/. Payment rates are set and effective for services provided on or after July 1, 2025. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

The amount of payment for each hospital is calculated as follows:

The Department determines the number of facilities qualifying at greater than the mean, greater than 1 standard deviation above the mean, greater than 2 standard deviations above the mean, and greater than 3 standard deviations above the mean. The total amount of funding budgeted for disproportionate share payments is then allocated starting with those facilities qualifying at greater than the mean. Facilities qualifying at greater than 1 standard deviation, greater than 2 standard deviations, and greater than 3 standard deviations above the mean are paid double, triple, and quadruple, respectively, the amount for facilities qualifying at greater than the mean. The payment amounts are adjusted until all the budgeted funds are spent.

The proposed disproportionate share payment for each facility is then compared to the payment limit that has been established for each facility. If the payment limit is less than the proposed disproportionate share payment, then the payment limit amount will be the disproportionate share payment for that particular facility. The sum of the payments made to the facilities where the payment limit was met is then subtracted from the total amount budgeted. The remaining budgeted funds are then allocated equally among the facilities where the payment limits have not been met. The subsequent allocation again is determined to ensure that facilities qualifying at greater than 1 standard deviation, greater than 2 standard deviations, and greater than 3 standard deviations above the mean are paid double, triple, and quadruple, respectively, the amount for facilities qualifying at greater than the mean.

Payments to Group 2 hospitals qualifying under the Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 2 hospitals qualifying under the low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals.

Payments to Group 2 hospitals will be made according to the payment schedule on the Department's website, http://dss.sd.gov/medicaid/providers/feeschedules/. Payment rates are set and effective for services provided on or after July 1, 2025. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

Payments to Group 3 hospitals qualifying under the Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 3 hospitals qualifying under the low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payments to Group 3 hospitals will be made according to the payment schedule on the Department's website, http://dss.sd.gov/medicaid/providers/feeschedules/. Payment rates are set and effective for services provided on or after July 1, 2025. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

If necessary, payments to qualified hospitals will be adjusted for the projected impact of the hospital's specific disproportionate share hospital payment limit as required by OBRA '93.

The agency will make disproportionate share hospital program payments to qualifying hospitals prior to the end of the State fiscal year. If the total of disproportionate share payments to all qualified hospitals for a year is going to exceed the State disproportionate share hospital payment limit, as established under 1923(f) of the Act, the following process will be used to prevent overspending the limit: First, the amount of over- expenditure will be determined; Then the over-expenditure amount will be deducted from the total payments to Group 2 hospitals; and Payments to individual Group 2 hospitals will be reduced based on their percentage of Group 2 total payments.

The Department will recover any disproportionate share payments in excess of hospital-specific limits made to qualifying hospitals from those qualifying hospitals. The federal share of the amount recovered may either be returned or redistributed to the remaining qualifying hospitals proportionately based upon their low-income utilization rate or Medicaid inpatient utilization rate (whichever utilization rate results in a higher payment) by using how many standard deviations above the mean the hospital qualified.

The State has in place a public process which complies with the requirements of Section 1902 (a) (13) (A) of the Social Security Act.

Psychiatric Residential Treatment Facilities

The Department will pay facilities based on a per diem rate prospectively calculated based upon the State fiscal year. The Department will use the same methodology for governmental and private facilities.

Providers must submit a cost report on forms designated by the Department identifying allowable costs incurred during the fiscal year. The Department will calculate rates for the facilities based upon each facility's actual allowable costs. Allowable costs include those costs that are ordinary, necessary, reasonable, and adequate to meet costs incurred by those facilities that are related to resident care services in conformance with State and Federal laws and regulations. Allowable cost centers include salaries and benefits for facilities' personnel, payroll taxes, professional fees and contract services, travel/transportation, supplies, occupancy, equipment, depreciation, and other. Non-allowable costs include bad debt, advertising, public relations, and costs not incurred by the facility including the value of donated goods and services.

Providers must maintain a daily census report that identifies the number of residents that received services on any particular day. The Department divides allowable and reasonable costs by the census data to calculate the payment rate for the next rate setting period. The census data for a resident is limited to those days in which the resident is actually present in the facility, and is subject to audit by the Department to verify its accuracy in conjunction with the submitted cost report.

Each facility must submit an annual Department-approved cost report by September 30 of each year identifying actual, previous State fiscal year historical costs. All cost reports are subject to desk review by the Department. If audit adjustments are made, the facility is notified immediately either by telephone, in writing, or electronic mail. The Department will establish desk audit rates for each facility based on the cost report desk review.

The Department calculates the final rate using a minimum occupancy limit of 90% so facilities with occupancy less than 90% will receive per diem rates based upon 90% occupancy. The rate calculated is considered payment in full for all allowable services delivered by the provider to eligible Medicaid recipients.

South Dakota Medicaid will pay out-of-state facilities based upon the rate for comparable services established by the Medicaid agency in the state where the facility is located. If no rate is established by the Medicaid agency in that state, then the per diem rate payable to the out-of-state facility will be the lower of billed charges or the average of the per diem rates in effect for in-state facilities at the time the services are first provided by the out-of-state facility.

For extraordinary or unusual circumstances South Dakota Medicaid may negotiate a higher per diem on a case-by-case basis. Negotiated per diem rates may not exceed the cost of the services provided by the facility.

HEALTH PROFESSION EDUCATION

The Department of Social Services supports the direct graduate medical education (GME) of health professionals through the use of Medicaid funds. All in-state, private hospitals which are accredited by the Accreditation Council for Graduate Medical Education (ACGME) are eligible for health profession education payments. Those hospitals are identified through the use of their most recently-filed Medicare 2552-10, cost reports. Specifically, worksheet E-4 (Line 1.00) is utilized to identify the number of weighted full-time equivalents for primary care physicians at participating facilities. The agency calculates the Medicaid hospital patient days using the Division of Medical Services (DMS) Cost Settlement Details report of adjudicated claims for the same period as the Medicare 2552 cost report.

Hospitals seeking GME payments must submit an application for the previous state fiscal year's costs to DMS prior to the end of the current state fiscal year. The agency will make payments for costs incurred in the previous state fiscal year, as defined below, annually prior to the end of the current state fiscal year. Payments will be made through the state's Medicaid Management Information System (MMIS) payment system. Payments will be made directly to the qualifying hospitals through a supplemental payment mechanism. The payment will appear on the facility's remittance advice. Each hospital will also receive written notification at the time of payment of the payment amount from DMS.

GME payments made in error will be recovered via a supplemental recovery mechanism and will appear on the facility's remittance advice. The agency will notify the facility in writing explaining the error prior to the recovery. The Federal share of payments made in excess will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

A hospital that applied for GME funding in the previous 24 months must provide written notice to DMS no less than 30 days prior to the effective date it intends to terminate operation of a GME program. A hospital must provide written notice to DMS by January 1 if it will not be applying for GME funding for the previous state fiscal year's costs.

The agency will determine the annual lump sum, onetime payment pool. The annual payment will be made during the last quarter of the state fiscal year. The pool will be distributed based upon the allocation percentage of each hospital. The hospital allocation percentage will be developed using prior year total Medicaid inpatient days and weighted intern and resident (I & R) full time equivalency (FTE). The state uses the prior year's cost report data as a proxy for the current year. For example, the state fiscal year 2008 calculation of allocations from the payment pool was the following:

	(a) Weighted I & R FTEs	(b) Medicaid Hospital Patient Days	(c) (a*b) Weighted FTE Days	(d) Hospital Allocation Percentage	Payment Pool Total
Hospital A	17	11,450	194,650	35.34%	$1,052,009
Hospital B	22	10,692	232,230	42.16%	$1,255,116
Hospital C	23	5,342	123,988	22.51%	$670,107
Totals	62	27,484	550,868	100.00%	$2,977,233

Total state funds available for payment through the pool are listed on the department's website, http://dss.sd.gov/medicaid/providers/feeschedules/, effective July 1, 2024. The FMAP at the time the annual payment is made will be applied to the state portion of the payment.

Rural Residency Program

The Center for Family Medicine is eligible for payment of direct GME via a separate funding pool for its operation of a rural family medicine residency program. The Center for Family Medicine must be accredited by the ACGME to be eligible for health profession education payments.

The state will make equal interim payments to providers on a quarterly basis. Costs must be submitted on a quarterly basis to validate costs for the previous quarter using the state developed South Dakota Rural Residency Program Cost Report and Rural Residency Cost Report Guidelines. The payment will be made to the Center for Family Medicine through the MMIS system. Payments will be made directly to the provider through a supplemental payment mechanism and will appear on their remittance advice. The Center for Family Medicine will receive written notification at the time of payment of the payment amount from DMS.

GME payments made in error that cannot be adequately addressed through adjustment of future quarterly payments will be recovered via a supplemental recovery mechanism and will appear on the provider's remittance advice. The agency will notify the provider in writing explaining the error prior to the recovery. The Federal share of payments made in excess will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

The Center for Family Medicine must provide written notice to DMS no less than 30 days prior to the effective date it intends to terminate operation of its GME program or written notice to DMS no less than 30 days prior to the effective date it will no longer be applying for GME funding.

The agency will determine the annual rural residency program payment pool for the upcoming state fiscal year prior to the start of the fiscal year on July 1. Payments through the rural residency program are listed on the department's website, http://dss.sd.gov/medicaid/providers/feeschedules/. Payment rates are set and effective for services provided on or after July 1, 2025. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

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:

The Department of Social Services (DSS) supports ensuring access and proper coordination of care. The department will make supplemental payments to further these goals to the following private providers in the following amounts:

Provider	**Amount**
Abbot House Inc	$28,112
Aurora Plains Academy	$16,050
Avera	$475,337
Bennett County	$16,768
Black Hills Surgical	$385
Mobridge Regional	$9,104
Monument Health	$1,258,951
Lutheran Social Services	$24,127
Our Home	$20,397
Rushmore Ambulatory Surgery	$13,325
Sanford	$801,843
Children's Home Society of SD	$46,247

Effective on or after June 1, 2026, supplemental payments will be made using South Dakota Medicaid claims data calculated for the period of January 1, 2025 to December 31, 2025. Payments for the supplemental payment period will be made during the last quarter of the state fiscal year.

The payment will be made to the provider through the MMIS system. Payments will be made directly to the qualifying provider through a supplemental payment mechanism and will appear on their remittance advice. Each provider will receive written notification at the time of payment of the payment amount from the Division of Medical Services.

Payments made in error will be recovered via a supplemental recovery mechanism and will appear on the provider's remittance advice. The agency will notify the provider in writing explaining the error prior to the recovery. The Federal share of payments made in excess will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

The maximum aggregate payment to all qualifying providers shall not exceed the available upper payment limit in accordance with 42 CFR 447.272.