

South Dakota Medicaid moved from a prospective cost-based case mix methodology to a patient-driven payment model-based case mix index on July 1, 2023. The new methodology was developed by the Department of Human Services, their contractor, Myers & Stauffer, and a workgroup comprised of key stakeholders. The reimbursement methodology changes included the following:

- Rebased the rates using 2021 cost data. The last system rebasing was in 2015.
- Implemented patient-driven payment model (PDPM)-based case mix index calculations.
- Removed the occupancy rule from direct care rate component.
- Removed the overall rate increase limit.
- Updated the way inflation factors are calculated, including moving to a nursing facility specific market basket.

In 2019, CMS moved to the PDPM methodology for Medicare, which led to the new South Dakota Medicaid Nursing Facility methodology being implemented in July of 2023. PDPM focuses on the unique, individualized needs, characteristics, and goals of each patient. There are five components that are case mix adjusted, including physical therapy, occupational therapy, speech-language therapy, non-therapy ancillary, and nursing. For Medicaid, the PDPM nursing component is most beneficial for nursing facilities, which includes [25 categories that residents can be classified into based on their care needs](#). Once the case mix is determined, the rate can be determined with the following calculation:

$$\left( \frac{\text{Facility Direct Care Rate} \times \text{Resident Case Mix Weight}}{\text{Care Rate}} \right) + \text{Facility Non Direct Care Rate} = \text{Resident Daily Rate}$$

## Daily Base Rate

A facility's daily base rate is the individual facility daily direct care rate plus the facility daily non-direct care rate as calculated from the facility's cost report. Each nursing facility's direct, non-direct, and total base rate are listed on the [South Dakota Medicaid Nursing Facility Fee Schedule](#). Total base rates range from \$162.10 to \$321.46, excluding Tribal 638 facilities. The median base rate for State Fiscal Year 2025 is \$246.16.

Since Medicaid uses a prospective system, rates are based on actual costs incurred prior to when the rate is in effect. Costs are inflated forward from the facility's cost report year to the rate year based on the projected increase in the Global Insight Nursing Facility Market Basket.

To calculate the daily rate, the facility's reported costs are divided by resident days. Medicaid assumes a minimum occupancy of 3% below the statewide average of occupied beds when calculating the daily

rate for each facility, so that facilities are incentivized to align licensed bed capacity closely with actual occupancy. When South Dakota moved to the PDPM model in July 2023, the rate methodology also removed the annual rate increase ceiling, which was previously 8%.

## Direct Care Rate

Direct Care Costs include allowable costs directly related to the care of the resident such as salary cost for registered nurses, licensed practical nurses, nurse aides, nursing supplies, and therapies. The move to PDPM-based case mix calculations eliminated the exclusion of case mix index (CMI) of less than 1.0 from the direct care median calculation.

Direct care costs are calculated based on allowable costs as reported in the NF's cost report and were rebased to 2021 cost report data. The median cost will be based on a case mix acuity level of 1.00 or more. The rate methodology applies both a minimum and maximum ceiling to direct care rates. The minimum is 115% of the statewide median cost; the maximum is 125% of the statewide median cost. Facilities are reimbursed 80% of their costs within the 115% - 125% range. Costs exceeding 125% are not recognized.

## Non-Direct Care Rate

Non-direct care costs include allowable costs related to health and subsistence, administrative, and capital costs. Each category of costs has a minimum and maximum ceiling tied to the statewide median cost.

**Health and Subsistence:** Aggregate costs from Health & Subsistence, Plan/Operation, and Other Operating Costs categories in the Medicaid Cost Report. This includes the salary and costs associated with medical records, activities, social services, chaplains, barber and beautician, consultants, dietary and food supplies, laundry, staff training, maintenance, housekeeping, utilities, and vehicles. The minimum ceiling is 105% the statewide median; the maximum is 110% of the statewide median. Facilities are reimbursed 80% of costs within the 105% – 110% range. Costs exceeding 110% are not recognized.

**Administrative:** Medicaid calculates the median cost of freestanding facilities not associated with a chain organization. Administrative costs include salaries for administrators, assistants, office staff and supplies, fees paid to Board of Directors, postage, telephone, advertising, dues, fees, licenses and subscriptions, legal and accounting costs, and professional liability coverage. The minimum ceiling is 105% of the freestanding median; the maximum is 110% of the

## UNALLOWABLE COSTS

Certain costs are considered unallowable by CMS and Medicaid for calculating nursing facility rates. Unallowable costs are reported separately on the cost report and are described in Chapter 21 of the CMS Provider Reimbursement Manual.

Examples of unallowable costs include:

- Luxury Accommodations, Items or Services
- Private Duty Personnel
- Dental Services
- Vocational and Scholastic Training for Patients
- Noncompetition Agreement Costs
- Reserving Beds or Services
  - Allowed 5 hospital and 15 therapeutic leave bed days
- Unsuccessful Beneficiary Appeals
- Management Employee Meals
- Employee Travel not related to Patient Care
- Gifts or Donations
- Entertainment
- Employee's Personal Use of Motor Vehicles
- Fines or Penalties
- Employee Spousal or Dependent Education

freestanding median. Facilities are reimbursed 80% of costs within the 105% - 110% range. Costs exceeding 110% are not recognized.

**Capital Costs:** Capital costs include building insurance, building depreciation, furniture and equipment depreciation, amortization of organization and pre-operating costs, mortgage interest, rent on facility and grounds, equipment rent, and return on net equity. South Dakota Medicaid applies a maximum per day limit to capital costs. The limit was set in 2024 and is inflated by the percentage adjustment provided for in the State legislative appropriation. The capital cost limit was \$20.95 in SFY25.

## Access Critical Nursing Facilities

Access Critical Nursing Facilities are designed to ensure geographic access to nursing facility services in rural areas of the state by providing enhanced reimbursement to eligible nursing facilities to help the facility stay financially viable. The concept was developed as a result of the Continuum of Care Study in 2008 and was implemented in 2011.

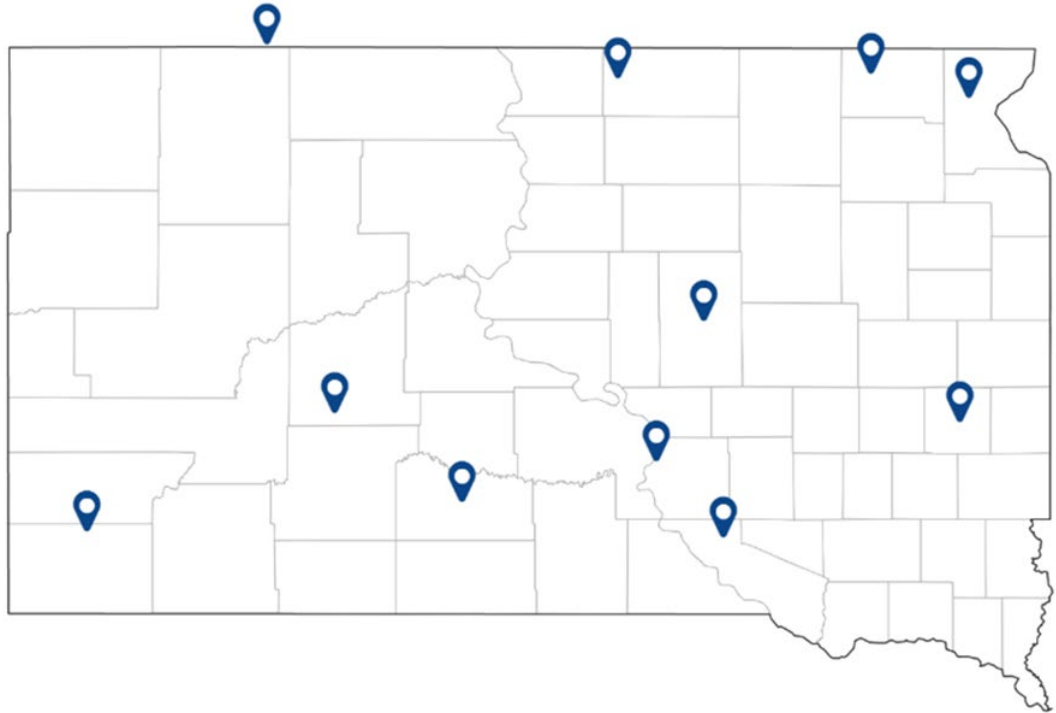
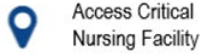
To be designated as an Access Critical Nursing Facility, a facility must meet the following criteria outlined in [SDCL 34-12-35.5](#) :

- (1) Be the only nursing facility within 20 miles;
- (2) Be located in the largest city within 35 miles, unless the next closest nursing facility is more than 50 miles from another other nursing facility;
- (3) Provide skilled nursing facility services;
- (4) Be integrated with other healthcare services through affiliation or formal agreement;
- (5) Be located in a county where the projected NF demand was less than 60 beds in 2015; and
- (6) Agree to release excess moratorium beds.

Access Critical Nursing Facilities are reimbursed an enhanced Medicaid rate. The Access Critical rate is calculated without ceilings applied to allowable costs and recognize additional direct care, non-direct care, and overall costs. Base rates for Access Critical facilities range from \$204.68 to \$321.46. The median base rate for State Fiscal Year 2025 is \$249.10.

South Dakota has twelve Access Critical Nursing Facilities located in Britton, Chamberlain, Eureka, Hot Springs, Lemmon, Madison, Miller, Phillip, Platte, Winner, Gettysburg, and Sisseton.

## SOUTH DAKOTA ACCESS CRITICAL NURSING FACILITIES



### Supplemental Payments for Extraordinary Care

South Dakota Medicaid makes special add-on payments for certain individuals with extraordinary care needs that require increased resource use from nursing facility staff:

- **Behaviorally Challenging Individuals** – Individuals who have a history of regular or recurrent persistent disruptive behavior which interfere with care and are not easily altered.
- **Chronically Ventilator Dependent Individuals** – Individuals who are ventilator dependent due to major complex medical disease or accident.
- **Skin Wound Care** – Individuals with a skin/wound issue demonstrating abnormal or delayed healing process with a physician order for treatment.
- **Spinal Cord Injuries** – Individuals with spinal cord injuries that impair cognitive abilities, or physical, behavioral or emotional functioning. Individuals must be continuing a rehabilitation plan from an acute rehabilitation facility.
- **Total Parental Nutrition** – Individuals with a permanently inoperative internal body organ that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the individual’s general condition. Individuals must have a physician order for parental nutrition therapy and it must be the individual’s only means to receive nutrition.
- **Traumatic Brain Injuries** – Individual who was 22 years of age or older at the time of injury with a diagnosed traumatic brain injury resulting in a diminished or altered state of consciousness, impairment in cognitive abilities or physical functioning or behavioral/emotional functioning. Individuals must be continuing a rehabilitation plan from an acute rehabilitation facility.

- **Multiple Chronic Complex Medical Conditions** – Individuals with physician documented diagnoses of multiple complex medical conditions that require specialized, non-standard equipment or services that exceed routine services as defined by the Medicaid State Plan.

Extraordinary care payments are made in addition to the calculated total daily rate. Extraordinary care days are only billable when the individual is residing in the NF, and are not available during hospital reserve days, therapeutic leave days, Medicare A stays, or when a resident elects hospice.

## SOURCES

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