



**First Meeting**  
**2009 Interim**  
**July 7, 2009**

**Room 413**  
**State Capitol Building**  
**Pierre, South Dakota**

### Tuesday, July 7, 2009

The first meeting of the Medicaid Reimbursement Study Committee was called to order by the Chair, Representative Tim Rave, at 9:00 a.m. (CDT) in Room 413 of the State Capitol, Pierre, South Dakota.

A quorum was determined with the following members answering the roll call: Senators Thomas Dempster (Vice Chair), and Tom Hansen; and Representatives Susy Blake, H. Paul Dennert, Marc Feinstein, Peggy Gibson, Noel Hamiel, Larry Lucas, Nick Moser, Tim Rave (Chair), Fred Romkema, and Darrell Solberg. Senator Stanford Adelstein and Representatives Thomas Deadrick and Carol Pitts were excused.

Staff members present included: Jacque Storm, Principal Legislative Attorney; Sue Cichos, Senior Fiscal Analyst; and Lisa Shafer, Legislative Secretary.

(NOTE: For purpose of continuity, the following minutes are not necessarily in chronological order. Also, all referenced documents distributed at the meeting are attached to the original minutes on file in the Legislative Research Council (LRC). This meeting was web cast live. The archived web cast is available at the LRC web site at <http://legis.state.sd.us> under "Interim Information – Minutes and Agendas.")

### **Medicaid 101**

**Ms. Deb Bowman**, Secretary of the Department of Social Services (DSS), and **Mr. Jerry Hofer**, Secretary of the Department of Human Services (DHS), provided the committee with an overview of Medicaid. Distributed to the committee was a presentation entitled "South Dakota Medicaid Overview." (**Document #1**)

Secretary Bowman introduced the staff members from DSS that were present at the meeting – Ms. Kim Malsam-Rysdon, Deputy Secretary; Ms. Brenda Tidball-Zeltinger, Chief Financial Officer; Mr. Larry Iverson, Director of Medicaid; and Ms. Sharon Sonnenschein, Director of Economic Assistance. Secretary Hofer introduced the DHS staff members present at the meeting – Mr. Dan Lusk, Deputy Secretary; Mr. John Hansen, Director of Budget and Finance; and Ms. Sacha Wise, Grants Manager.

Secretary Bowman told the committee that Medicaid is a federal/state partnership that has been in existence since 1965. The federal government mandates certain healthcare coverage to certain categories of individuals and allows states to cover optional categories and services at their discretion. South Dakota is a more conservative state in terms of who is covered and what is provided.

Each state submits a state Medicaid plan that needs to be approved by the federal government. Most Medicaid policy changes do not go through the state Legislature because

all amendments to the state Medicaid plan must go through the federal amendment process. Secretary Bowman stated that it is becoming tougher to make any changes to the state Medicaid plan because the federal government is trying to control costs.

Medicaid is an entitlement program and is different than other federal funding sources. Secretary Bowman informed the committee that an entitlement is an open program so a state is able to receive more federal funds as long as there are state general funds to provide the match.

Secretary Bowman said that Medicaid is one of the largest healthcare insurers in South Dakota with 130,000 unduplicated individuals participating in the program during FY2008.

The Children's Health Insurance Program (CHIP) is a federal block grant program. Coverage for CHIP is limited to children with family incomes higher than allowed with Medicaid who still cannot obtain insurance.

**Representative Larry Lucas** asked if there are ways to subsidize Medicaid to get more children on dental and vision insurance. Secretary Bowman said that she will research the issue and provide the committee an answer at the next meeting.

In FY2008, the state expended \$720.2 million in total healthcare services and administration of the Medicaid programs, which includes \$266 million in match from all sources. Five major areas of healthcare constitute the majority of the Medicaid expenditures – inpatient hospital, outpatient hospital, physician services, prescription drugs, and long-term care services.

The Federal Medical Assistance Percentage (FMAP) determines how much the federal and state government pays for the vast majority of Medicaid services. The FMAP rate is determined by the federal government with a formula using the last three years' personal income for each state. Secretary Bowman said that South Dakota's current FMAP is 62.55 percent federal and 37.45 percent state matching funds.

In response to **Representative H. Paul Dennert's** question pertaining to stimulus funds, Secretary Bowman said that the state received an additional 6.2 percent federal funds and 1.8 percent federal share increase for the unemployment insurance fund. The additional funding significantly helped the state. The savings were used to balance the state budget.

The services provided at an Indian Health Services (IHS) facility are eligible for 100 percent federal funding. However, many services are not available at state IHS facilities, so the person is referred to a contract provider. When this occurs, the state pays the match for all IHS referrals to contract providers. Secretary Bowman noted that an action seeking 100 percent funding for contract providers was taken to the appellate court in St. Louis but was unsuccessful.

**Representative Tim Rave** asked how much the state's match for contract providers is. Secretary Bowman said she didn't have a current number, but years ago it was \$4 million.

**Representative Peggy Gibson** inquired about the cost of the lawsuit. Secretary Bowman will get that information to the committee.

**Senator Thomas Dempster** asked about the funding for IHS. Secretary Bowman responded that IHS has not been adequately funded for many years.

Secretary Hofer stated, in response to the question posed by Senator Dempster, that there is a disagreement with regard to the treaties. The tribes believe that according to the treaty, the federal government is responsible for all healthcare needs. In contrast, the federal government states that the treaty requires the federal government to have some responsibility to provide healthcare, but not all.

#### ADMINISTRATION OF MEDICAID

The current claims processing system, Medicaid Management Information System (MMIS), was implemented in 1979. The replacement system, called SD MEDX, will be much more than a claims processing system because the technology will:

- Provide better customer service for providers and recipients;
- Provide robust data mining capabilities;
- Use data to predict future high cost claimants;
- Identify disease management opportunities;
- Pay claims more accurately; and
- Increase cost-avoidance.

Secretary Bowman said that the design and development of SD MEDX began in July 2008. The scheduled date of implementation for claims adjudication is set for July 2010, with the provider enrollment module going live in February 2010.

#### ELIGIBILITY

The Division of Economic Assistance determines eligibility for all people applying for Medicaid in the state. Medicaid eligibility depends on:

1. Whether a person meets a specific eligibility category;
2. Resources; and
3. Income.

The federal government has requirements for states to provide coverage to certain individuals. The first is for low income families with children. The family household income has to be approximately 52 percent of the federal poverty level (FPL); which is equivalent to \$796 per month for a family of three. The household also cannot have resources that exceed \$2,000. Secretary Bowman noted that the FPL is based on the July 1996 AFDC standard for gross income. She stated that the states are asking for this standard to be changed to relate to current economic times.

Another required coverage is Medicaid for children under age 19. For children ages 0-5 to qualify, the family income limit is 133 percent of the FPL and for children ages 6-19, 100 percent of the FPL. There is no resource limit.

Other required categories, which are listed on pages 17-23 of Document #1, include:

- Transitional Medicaid Benefits;
- Low income children in foster care/adoptive placement;
- Pregnant women;
- Automatic newborn coverage for babies up to age 1 that are born to mothers covered by Medicaid;
- Social Security Insurance recipients and related disability categories; and

- Medicare savings programs:
  - Qualified Medicare beneficiary, and
  - Specified low income Medicare beneficiary and qualifying individuals.

In addition to the required eligibility categories, South Dakota covers optional categories. The categories are listed on pages 21-23 of Document #1 and include:

- Medicaid for children under age 19;
- Children's Health Insurance Program;
- Children age 18-21 who age out of the foster care program;
- Individuals who need long-term care;
- Home and community-based waivers;
- Medical assistance for working disabled; and
- Breast and cervical cancer program for uninsured women who have been screened for and found to be in need of treatment through the Department of Health (DOH).

Representative Lucas requested the department provide the figures if the coverage for pregnant women was increased from 133 percent of the FPL to 150 percent of the FPL and 200 percent of the FPL. Secretary Bowman later stated that to increase the coverage for pregnant woman to 200 percent of FPL it would be \$3 million in general funds and \$5.2 million in federal funds.

Representative Dennert asked if owning a home was considered a resource. Secretary Bowman said that home ownership is considered a resource and thus it is difficult to qualify for Medicaid.

Representative Rave asked about the difference between the South Dakota Risk Pool and the medical assistance available for the working disabled. Secretary Bowman responded that the South Dakota Risk Pool is a program for people who lose their insurance through no fault of their own. The medical assistance for the working disabled program is for people who never had insurance and would not qualify for the risk pool.

For FY2008, there were 102,310 people eligible each month on average for Medicaid coverage in South Dakota. The recipients consisted of 7,146 elderly, 15,748 disabled, 55,045 children of low-income families, 2,682 pregnancy only women, 10,218 low-income adults, and 11,471 for CHIP. Secretary Bowman noted that the majority of people served are children in low-income families.

It is estimated that those eligible for Medicaid will continue to increase. It is estimated that there will be 103,645 people eligible in FY2009 and 104,980 eligible in FY2010.

### COVERED SERVICES

Secretary Bowman stated that all services funded through Medicaid must be medically necessary, as defined in administrative rules. The services required by the federal government are listed on pages 27 – 29 of Document #1. Secretary Bowman noted that the Medicare Part D payment, known as the "clawback," was \$14.9 million in general funds for FY2008.

South Dakota also provides options for services covered by Medicaid. Those services are listed on pages 30 – 32 of Document #1.

### PROVIDERS

Secretary Bowman stated that there are very few providers in South Dakota that do not participate in Medicaid. Other states have a greater access issue than South Dakota. There are approximately 10,600 enrolled Medicaid providers in the state.

Representative Dennert asked about the percentage of providers that have stepped-up to provide Medicaid services. Secretary Bowman said that the number is in the high 90s, but she will provide the committee the information.

**Representative Suzy Blake** asked if providers limit the number of Medicaid patients they see. Secretary Bowman answered affirmatively, but stated it is frowned on. She noted that Medicaid is a prompt and reliable payor, which providers appreciate.

**Representative Noel Hamiel** requested that the department provide a percentage comparison of the providers that participate in Medicaid to the providers that do not participate. Secretary Bowman said that the information will be researched and presented at the August meeting.

#### ENSURING FISCAL RESPONSIBILITY

If a person has health insurance in addition to Medicaid, then Medicaid is the payor of last resort in most cases. The third party insurance is billed before Medicaid. The DSS also seeks recovery from other third parties for medical expenses such as liability insurers.

Secretary Bowman stated that Medicaid recipients need to have some responsibility and ownership. To ensure this, the adults on Medicaid pay co-payments for certain services. Some of the services are listed on page 35 of Document #1.

The DSS is required to operate an estate recovery program for long-term care services. The program recoups the costs after a person dies and can also place liens on property owned by the person.

Secretary Hofer said that there are four Home and Community Based Services (HCBS) waivers that extend Medicaid eligibility and additional services to individuals who may not otherwise qualify for Medicaid. The four waivers are:

- SD CHOICES – Mentally Retarded/Developmentally Disabled Waiver;
- Family Support Waiver;
- Assistive Daily Living Services Waiver; and
- Elderly Waiver.

All the waivers, except the Elderly Waiver, are under the DHS supervision.

Representative Gibson requested information on the cost savings for the state in the area of institutional care versus community based services. Secretary Hofer said that the costs are tracked with the federal government waivers, and the department will provide the information at the next meeting.

**Representative Fred Romkema** asked about the funding for the IHS providers. Secretary Bowman responded that the care is not inadequate, but the IHS facilities do not offer all the needed services. The department will provide further information at the next meeting.

**Representative Darrel Solberg** asked about the statistic that 50 percent of the children in South Dakota will be on Medicaid or CHIP during the first year of their life. Secretary Bowman said that this figure is comparable to other states. The reason the figure is high is due to a large number of people across the nation that are poor who have children that become Medicaid eligible due to the income level.

Representative Solberg requested that the department provide the cost comparison for the first year of children to the cost of long-term adults. Secretary Bowman stated that it is far less expensive to cover the children for the first year. The department will provide the information at the next meeting.

In response to Senator Dempster's question about placing some certain services such as inpatient services, outpatient services, and prescription drugs on a competitive bid for Medicaid, Secretary Bowman said that DSS and DHS are not able to do that because people have a freedom of choice of providers. There would need to be a freedom of choice waiver and applying for one could take up to two years. However, the department will look into the issue and report back to the committee.

Representative Dennert asked about an estimated number for the return rate of the children who are born to mothers that do not receive prenatal care and the extensive care. Secretary Bowman said that the department will research the topic and report back to the committee.

In response to **Senator Tom Hansen's** question about people being medically needy, **Mr. Larry Iverson** stated that, in some states, people are able to deduct their medical expenses from their net income. This would reduce their income below the eligibility poverty levels and allow them to qualify for Medicaid.

Representative Lucas asked if there are incentives for people that are financially able to afford the care for themselves. Secretary Bowman said that she does not know about incentives, but the long-term partnership program helps people keep more of their assets.

The committee recessed at 11:02 a.m. and reconvened at 11:16 a.m.

### **Provider Reimbursement**

Distributed to the committee was a handout entitled "Medicaid Reimbursement." (**Document #2**) Ms. Brenda Tidball-Zeltinger said that the goal of any effective rate-setting methodology is to include all allowable and reasonable costs and allow the provider to cover the cost incurred for the provision of the service. Since not all programs and services offered are the same, there is no one-set method or formula to establish the rates. However, there are federal guidelines and uniform standards that are used when establishing reimbursement rates. They are: OMB Circular A-87, CMS Publication 15-1 and 15-2 Provider Reimbursement Manual, and South Dakota's Medicaid State Plan.

Not all costs are allowable for Medicaid reimbursement, such as advertising. Rate setting cannot be completed in isolation. Ms. Tidball-Zeltinger said that the DSS works hard to have a collaborative effort approach using financial workgroups of administrators to develop rate setting models.

While specific models may vary for different services, South Dakota establishes reimbursement rates based on the costs reported to the department and the use of Medicare or other fee schedules.

Ms. Tidball-Zeltinger said that under a cost settlement method reimbursement is made on either a per diem or percent of billed usual and customary charges. The provider submits a cost report which reflects the actual costs and unit of service provided for the reporting period. The difference between reimbursement made and costs incurred can result in an overpayment or underpayment to the provider. Any underpayment/overpayment is recovered through a retroactive rate adjustment.

Under an alternative cost reporting method, a prospective rate based on historical costs, the reimbursement rate is paid on an hourly or daily basis or a percent of billed usual and customary charges. The providers submit cost reports on an annual basis. The historical cost data is used to develop a reimbursement model to pay rates in a future period. Since there is a lag in time between the cost report period and when the cost data can be used for rate setting, costs are typically inflated forward to the period when the rates will be paid. The annual cost report data can be used to measure how well the model performed and if adjustments need to be made.

Ms. Tidball-Zeltinger said that some of the pros for using the prospective rate based on historical costs include the ability to incentivize aspects of service delivery and the cost basis that offers incentives to control costs. A negative aspect of the reimbursement method is that providers that have access to other resources will report potentially higher costs than providers with limited resources, creating disparity among providers.

The reimbursement approach of using Medicare or other fee schedules is typically utilized where the collection of cost data would not be feasible or for services provided out-of-state. The Medicare fee schedule is based on data collected at the federal level and then regionalized to South Dakota. Other approaches include the use of a percentage of billed usual and customary charges and the use of other fee schedules such as a commercial dental fee schedule.

The discussion then turned to reimbursement methods by facility type. Ms. Tidball-Zeltinger said that the number and type of services offered by each facility determines the reimbursement method used. The facilities that deliver one type of service may be reimbursed using one method. However, because certain facilities provide multiple types of services, they may be reimbursed using a variety of methods.

Mr. Iverson said that for reimbursement purposes, facilities are classified as the following types: Diagnosis-related Group (DRG), Non-DRG, Specialized Surgical, and Out-of-State.

There are 26 DRG hospitals in South Dakota. The facilities are located in close proximity to areas with higher Medicaid cases. Mr. Iverson said that DRG hospitals have over 30 Medicaid discharges in a given year. The DRG methodology is a system developed for Medicare use to classify hospital admissions into one of over 740 groups. When a claim is submitted, it is assigned to a specific DRG based upon the diagnosis, procedures, age, sex, discharge status, and presence of complications. Each DRG has a South Dakota specific weight to account for

acuity, and each hospital has a specific target amount used to calculate the reimbursement of the hospital stay.

Mr. Iverson said that inpatient services are reimbursed using the prospective payment, and outpatient services are reimbursed through an annual cost settlement process. The percent of billed charges is adjusted annually based on the cost report information and the cost to charge ratios for the various cost centers.

There are 26 Non-DRG facilities in South Dakota. The providers are paid at 95 percent of usual and customary charges for inpatient and 90 percent for outpatient services. Mr. Iverson informed the committee that nine of the 26 facilities have been designated Access Critical for Medicaid reimbursement purposes and are cost settled to ensure the state meets the costs.

There are ten Specialized Units (DRG-exempt) in the state. The Specialized Units are reimbursed using the cost settlement method. Mr. Iverson said that the providers are paid a percentage of charges and then an annual cost settlement is conducted.

Mr. Iverson told the committee that the state utilizes 96 out-of-state facilities that account for 19 percent of inpatient expenditures or \$13.5 million. The out-of-state services are a result of services that cannot be performed in-state, are an emergency, or are provided by border facilities, such as in Valentine, Nebraska. The reimbursement for inpatient and outpatient services is paid using a percent of billed usual and customary charges, with the exception of North Dakota where their state DRG methodology is used.

Community Based Services are provided by both DSS and DHS. Pages 23 and 24 of Document #2 show the annual expenditures, annual numbers served, and number of providers.

Ms. Tidball-Zeltinger said that community based services base the prospective rate on historical cost. The providers submit an annual cost report subject to audit. Because of the time lag between the submission of the cost report and the use of the information for rate setting, costs are typically inflated. The state has been successful in adopting a uniform reporting period for consistency; however, most providers have not been able to implement it.

In addition to cost report data, additional information may be collected through surveys or other tools for use in model development. Survey data could include time spent to update care plans, travel time for home based services, average vacation or other leave days used, etc.

Senator Dempster asked if there are incentives to reward facilities for innovation and efficiency. Ms. Tidball-Zeltinger responded that efficiency incentives are not offered and facilities can be penalized for being efficient. The departments are looking at ways to get around this with the tools and approaches imputed into the formula. However, with the current methodology, she is not certain if this problem can be solved.

For Community Support Services, formally known as Adjustment Training Centers, a service based rate system was developed in 1996 and implemented in 1997. Mr. Lusk said that the system establishes an individualized rate for every person supported within the system based upon each person's needs. Those with higher needs receive a higher rate. A person's needs are determined through a standardized tool called the Inventory for Client and Agency

Planning (ICAP). The ICAP is completed annually by Community Support Provider staff and reviewed and tested by state staff.

Representative Gibson asked when the Community Support Providers were rebased. Mr. Lusk said that the system was rebased on 2005 with \$596,000 added for community support providers. A rebasing was discussed in 2007, but a rebasing was not supported based on the cost reports. The DHS is currently in the middle of remodeling the reimbursement rates. This would be a perfect time to address rebasing.

The committee recessed at 11:58 a.m. and reconvened at 1:16 p.m.

Mr. Lusk informed the committee that the cost reported for Community Support Services are used to compile a system-wide average cost for services such as service coordination/case management, day services, supported employment, residential services, and nursing. Activity logging is used to determine the number of units of service provided to each person and multiplied by the average cost to determine a cost of service for each person. Multiple regression is used to formulate a model which predicts the cost of services an individual needs based on the services they receive and their ICAP. The model generates an individualized rate for each person.

The family support offered by Community Support Services include service coordination, specialized equipment, respite care, personal care, companion care, nutritional supplements, and supported employment. The reimbursement for services is based upon an established fee schedule and the actual costs of services and support as approved in the individualized service plan.

Ms. Tidball-Zeltinger stated that Medicaid pays for approximately 58 percent of nursing facility residents in South Dakota. The reimbursement method for nursing facilities and hospice care is a prospective rate based on historical costs. The state's reimbursement method pays a daily rate unique to each resident. Rates for residents with special or heavy care needs are higher, while those with fewer needs are lower. The care needs of each resident are identified through an assessment called the Minimum Data Set (MDS). The assessment includes data regarding the individual's functional capacity including basic self care. The nursing home staff completes the assessments and the state staff monitors the process. In addition to the individual resident assessment, a cost report is submitted by the facility and subject to audit annually. The nursing facilities utilize a range of timeframes for cost reporting with fiscal year ends ranging from December 31 to March 31. Ms. Tidball-Zeltinger said that the staggered fiscal year ends play a part in the lag time problem between the submission of the data and the use for rate setting. Ms. Tidball-Zeltinger said that for nursing facilities, there are some ceilings or limitations applied to allowable costs based on a comparison of costs in each category among all facilities. Ceilings are applied to all allowable costs and a facility specific direct care and non-direct care rate are established.

People that are in a transition period utilize a "swing bed," which is an inpatient hospital bed for people who are determined to need a nursing facility level of care and are waiting for placement in a nursing facility, or a person who is stepping down from an acute care admission and not quite ready to be discharged.

Mr. Iverson commented that clinics enrolled in a Medicaid reimbursement program include physicians and dental services provided at Federally Qualified Health Centers (FQHC) and

Rural Health Clinics (RHC). The clinics are paid on a per diem rate regardless of the services provided and are paid the same rate. The reimbursement is cost based and is inflated each calendar year by the Medicare Economic Index.

Medicaid also reimburses independent practitioners such as physicians and other practitioners in the areas of podiatry; optometric; psychology; chiropractic; and physical, occupational, and speech therapy. Those practitioners are reimbursed for services based on Medicare rates or other fees schedules.

Mr. Iverson said that the IHS facilities include services provided at five in-state inpatient hospitals and 32 outpatient, clinic, and specialty care facilities. The IHS facilities are reimbursed according to daily rates set by the federal government. The current inpatient rate is \$1,906 per day and the outpatient rate is \$268 per day. In response to **Representative Marc Feinstein's** question, Mr. Iverson said that the federal government provides 100 percent funding for services provided at an IHS facility; however, the state does pay a match for IHS contract providers.

Turning to school districts, Mr. Iverson noted that the direct care services of physical therapy, speech therapy, audiology, nursing, and psychiatric are reimbursed. The school districts are reimbursed for the Medicaid-related administrative costs. The general fund match is provided by the school district to receive federal Medicaid funds. Reimbursement rates are established according to the actual costs incurred by the school districts.

In response to Senator Dempster's inquiry about the direct care services provided at school districts, Mr. Iverson said that a school assessment is completed by a medical professional to identify the child's need. Secretary Bowman noted that a child in need of these services would have an individual education plan.

With regard to durable medical equipment (DME) and prosthetic devices, the reimbursement rate for these services are established using a set fee schedule based upon actual costs, Medicare, or a percentage of the usual and customary billed charges. DME and prosthetic devices allow individuals to remain in their homes and provide a level of functioning for the person to be active in their community. Some examples include wheelchairs, ventilators, and oxygen concentrators.

Home health agencies providing skilled private duty nursing and personal care/attendant care allow individuals to remain in their homes rather than be placed in a facility or institution. Services include wound care and ventilator care. The reimbursement rates for home health agencies are established based on a Medicare fee schedule or hourly nursing rates in order to be competitive in the market.

All prescription drugs where the manufacturer has signed a federal rebate agreement are covered, including some over the counter drugs. However, some drugs require prior authorization. The current reimbursement rate is the lesser of four payment formulas outlined on page 48 of Document #2.

Dental services are provided to adults and children and medically necessary orthodontic services are provided to children. Service to adults is optional, but mandatory for children. The reimbursement rates are established using South Dakota commercial rates as a benchmark. The current rate is 70 - 80 percent of commercial rates.

In response to Senator Dempster's question, Mr. Iverson said that over 80% of the dentists in the state are Medicaid providers.

Representative Dennert asked about the frequency of the case mix weight assessments performed at the nursing facilities. Ms. Tidball-Zeltinger said that there is an initial assessment, an annual assessment, and other assessments given if any substantial changes are noticed.

Mr. Iverson stated, in response to Representative Dennert's question, that not all school districts have a child that is in need of direct care services. The school district would enroll when they have a child that is in need.

In response to Representative Solberg's question, Secretary Bowman stated that if a school district was not able to provide the needed services for a child, the school district can refer the child to an appropriate provider. However, the school district is still responsible for the child.

The committee recessed at 1:58 p.m. and reconvened at 2:10 p.m.

### **Options for Generating Revenue for Matching Medicaid Dollars**

Secretary Bowman distributed a handout entitled "Options for Generating Revenue for Medicaid Match."**(Document #3)** She reminded the committee that Title XIX Medicaid is an entitlement program that does not have a federal cap on the federal dollars that states can access if the state has the general funds for the match. Currently, the state matching funds for Title XIX Medicaid come from the general revenues raised through taxes and fees.

There are really only two options for generating general fund revenue for use in leveraging matching federal Medicaid funds in South Dakota. Secretary Bowman stated that DSS does not advocate either of the choices. The two options are:

- Increased appropriation of general funds by the Legislature; and
- Increased revenues – if not broad-based then by implementing a provider tax/fee.

A provider tax/fee is a legal funding source eligible for federal matching funds when used to reimburse Medicaid covered services. Legislation can specifically target the use of the funds for a specific purpose. The three general requirements of this fee are:

1. Provider fees must be uniform, broad-based, and cannot directly or indirectly hold-harmless or guarantee repayment of fees directly back to providers;
2. Provider fees must apply to all facilities in the selected class of providers; and
3. The fee cannot exceed 5.5 percent of revenues or the state must seek federal approval with very stringent criteria.

There are eight classes of providers that can be assessed a tax/fee. The provider classes are listed on page 6 of Document #3. Many states have implemented a provider tax/fee on one or more categories of providers. Secretary Bowman stated that South Dakota implemented a provider tax on the Intermediate Care Facility for the Mentally Retarded (IFC/MRs) on July 1, 2007. The South Dakota Developmental Center in Redfield is the only such provider in the state.

Secretary Bowman said that acceptable reimbursement approaches include additional rate increases or enhancements to the existing Medicaid reimbursement methodology. Some of the possible options include:

- The percent of revenue would be implemented by assessing a percentage on gross revenue;
- A tax per resident day would be implemented by assessing a uniform tax per resident per day; and
- A tax per licensed or moratorium bed would be implemented by assessing a per licensed or per moratorium bed.

Representative Lucas asked what the FMAP will be if the economy remains the same. Secretary Bowman responded that she is not certain; however, Congress may look at implementing a ceiling on significant FMAP swings.

Representative Hamiel asked about the provider tax implemented on the IFC/MR in Redfield. Secretary Bowman said that the provider is Medicaid funded, and the state institution pays the tax unless there is a private pay person at the facility.

In response to **Representative Nick Moser's** question, Secretary Bowman said that the provider in Redfield was selected because both the DHS and DSS agreed and supported the implementation of the tax. People wanted more money for Medicaid and one of the ways to generate more revenue without causing conflict was to tax that provider. This is a legal process, and the state follows all federal rules.

Representative Dennert asked about assisted living. Secretary Bowman responded that an assisted living facility is a provider but not one that is considered taxable since it is a waiver service.

Secretary Hofer commented that DHS has workgroups that go through the cost reports to determine if the people's needs are being met. The program is not paying 100 percent of the cost, but the departments are working to try and meet the needs within the allocated budget.

### **Future Meetings**

The future meetings of the Medicaid Reimbursement Study Committee were scheduled for August 6, 2009, and the next day, if needed, and September 2, 2009, in Pierre, South Dakota.

### **Adjourn**

**SENATOR HANSEN MOVED, SECONDED BY REPRESENTATIVE GIBSON, THAT THE COMMITTEE ADJOURN. The motion passed unanimously on a voice vote.**

The committee adjourned at 3:03 p.m.



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