South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605.773.3495
FAX: 605.773.5246
WEB: dss.sd.gov

South Dakota Medicaid
Thursday, July 23, 2026
12:00 MT / 1:00 CT
Medicaid Advisory Committee Agenda
Sioux Falls One Stop
1501 S. Highline, Sioux Falls, SD 57110
Join via Microsoft Teams
Meeting ID: 237 858 004 872 0 Password: PL9JD2CV

Welcome and Overview

- Introductions
- Welcome New MAC Member
  - Pam VanMeeteren
- Opening Remarks

Updates and Committee Discussion

- Review April Meeting Minutes
- Review Annual Report and Vote to approve/amend
- State Plan Amendments
- HR1 Updates
- Rural Health Transformation Plan Update
- Program Integrity
- Juvenile Justice Targeted Case Management

Public Comment

Closing Remarks

Future Meetings:

- 10/22/2026 – Pierre – Kneip Building
- 01/28/2027 – Virtual

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South Dakota Medicaid
Thursday, April 23, 2026
Medicaid Advisory Committee Meeting Minutes

Medicaid Advisory Council (MAC) Attendees
Dr. David Basel, Population Health Officer, Avera Health; **Darren Crowe**, Consultant, Rosebud Sioux Tribe; **Mikki Donelson,** Beneficiary Advisory Council; **Dr. Jennifer Haggar**, Pediatrician, Sanford Health; **Dr. Scott Kennedy,** Optometrist, Lifetime Eyecare; **Mary Johnle**, Program Administrator, South Dakota Economic Assistance; **Erik Nelson,** Government Relations, AARP of South Dakota**; Jacob Parsons,** Director of Advocacy and Reimbursement, South Dakota Association of Healthcare of Organizations; **Alan Solano**, Vice President of Government Affairs, Monument Health; **Shelly Ten Napel,** CEO, Community Healthcare Association of the Dakotas (CHAD); **Dr. Karli Williams**, Black Hills Pediatric Dentistry

Could not attend: Julie Kopp, Beneficiary Advisory Council

Other Attendees
Matthew Ballard, Deputy Director, South Dakota Medicaid; **Dr. Clarissa Barnes**, Chief Medical Officer, South Dakota Medicaid; **Danielle Frank**, Quality Assurance, Division of Long Term Services and Supports, Department of Human Services; **Renae Hericks,** Policy and Program Manager, South Dakota Medicaid**; Ashley Lauing**, Policy Strategy Manager, South Dakota Medicaid; **Kara Peery**, Medical Program Specialist, South Dakota Medicaid; **Heather Petermann**, Director, South Dakota Medicaid; **Shawnie Rechtenbaugh**, Cabinet Secretary, South Dakota Department of Human Services; **Ben May** and **Sharon Chontos**, MAC Coordinators, North Star Solutions

Guests
Bethany Curtis, Beneficiary Advisory Council; Naomi Gaspard, Policy Manager, AIDS Institute; Leah Belgarde, Intergovernmental Affairs Liaison, Great Plains Tribal Leaders' Health Board

Welcome and Overview
Ashley Lauing, Policy Strategy Manager with South Dakota Medicaid, welcomed the MAC members. Heather Petermann, Director of South Dakota Medicaid, thanked the MAC members for their feedback and guidance.

MAC Meeting Minutes
The MAC members reviewed the minutes and did not have suggested edits. The January 2026 MAC minutes can be found on the MAC website.

Beneficiary Advisory Council (BAC) Meeting Overview
Ben May, MAC Coordinator, reported the BAC meeting covered the following topics:

- HOPE Waiver
- Cost Sharing
- HR1 Communications
- Medical Frailty
- Rural Health Transformation Plan

The BAC members provided several recommendations on public facing documents. Overall, their feedback was invaluable. There are two individual positions that are termed out. If you have a recommendation of an individual for the BAC, let Ben know and he will forward them an application form.

HOPE Waiver Renewal
Danielle Frank, Quality Assurance, Department of Human Services – Division of Long-Term Services and Supports reviewed the HOPE waiver. The waiver was out for public comments through April 24, 2026. The MAC members did not have any feedback or questions. The slides can be found on the MAC website.

State Plan Amendments
Renae Hericks**,** Policy and Program Manager, South Dakota Medicaid, covered the state plan amendments outlined in the slides. The slides can be found on the MAC website.

Q: Crowe. Will tribes be able to negotiate the care coordination supplemental payments?

A: 638 providers can participate in care coordination agreements/shared savings contracts; however, they have not participated thus far.

Q: Basel. How much funding is allocated for the Primary Accountable Care Transformation (PACT) Quality Payment in the Rural Health Transformation (RHT) program?

A: $7M for PACT and $2M for Care Connect. RHT provides an excellent opportunity to accelerate the PACT program and tying payment with quality.

Cost Sharing
Matthew Ballard, Deputy Director, South Dakota Medicaid, presented the cost sharing federal requirements and Soth Dakota Medicaid's draft proposals. The slides can be found on the MAC website.

Q: Basel. Ideally, it would be good to require cost share from non-urgent emergency department visits. However, I understand the administrative burden in doing so.

A: Emergency services are federally exempt. Non-emergent emergency department services could have a cost share. Initial analysis suggested the volume is low for non-emergent emergency department services for individuals that will be subject to cost sharing.

Q: Basel. Is the intent to curb inappropriate costs or comply to federal law?

A: The department has to comply with the cost share provisions in HR1. As cost sharing was previously removed for a variety of reasons, the intent is to implement a reasonable policy that is considerate of stakeholder challenges related to cost sharing.

Comment: Ten Napel. I would recommend not adding more than what is already proposed as it will be an administrative burden to collect the cost share.

Q: Parsons. When cost share was removed, it significantly lessened administrative burden. With cost share back in place, it will cost more than $5 or $20 to collect it. If it is too difficult or impossible to collect, can it be waived?

A: The law allows providers to waive cost sharing. It is possible CMS may release further guidance regarding this provision.

Comment: Basel. If providers can leverage PACT to address non-urgent emergency department visits, that would be best for the provider and the patient.

Q: Petermann. At the BAC we discussed if there are other services that should include cost sharing. Does the MAC have any feedback on this?

Response: No other services were suggested by the MAC members.

Comment: Donelson. During the BAC meeting, we agreed that paying $20 versus thousands of dollars for a surgery is completely fair. Yes, it may be difficult if it was $5 or $20 but it is much better than paying the entire bill.

Comment: Williams. Dental procedures are a proposed cost share. The dentists already lose money on Medicaid reimbursements and are frustrated. The cost share will add further administrative burden.

HR1 Communications

Mary Johnle, Program Administrator, South Dakota Medicaid, reviewed the communication materials and encouraged the MAC members to provide further feedback. The attachments can be found on the MAC website.

Q: Donelson. Will you send both the letter and the brochure regarding community engagement? They may not read the letter. They will likely read the brochure.

A: Yes, we will use several venues to communicate with the beneficiaries.

Q: Ten Napel. This is an enormous lift for everyone working with patients. How do we manage exemptions? Can we have deep dive conversations with South Dakota Medicaid on this topic? I would like to have my team weigh in.

A: We anticipate this will be a standing topic for the MAC / BAC going forward. We are waiting for CMS guidance before we can finalize processes and have a larger conversation. We will have town hall webinars for patients, providers, and stakeholders this summer. We have also drafted communications including a form that could be used for community engagement validation which will be signed by an authorized representative of the agency.

Medical Frailty

Dr. Clarissa Barnes, Medical Director, South Dakota Medicaid, reviewed the definition of medical frailty and CMS guidance. The slides can be found on the MAC website.

Q: Basel. We will participate and meet the requirements as defined. Is there any way to remove the burden to the patients and providers?

A: We have the same goal to reduce burden for both patients and providers and will aim to do so.

Comment: Hagger. I agree with this proposed policy. There may be some ambiguity for physicians. The clearer the guidelines, the better. We want to protect the relationship between providers and patients.

Q: Parsons. How many individuals do you anticipate this will impact?

A: The proposed policy will only impact the expansion population; therefore, the numbers will be very small.

Q: Solano. I agree that it will be important to minimize the burden on patients and providers. If the department transmitted to providers, there may be a gap in identifying providers.

A: We will take this into account when developing processes.

Q: Ten Napel. What types of diagnosis are included?

A: Refer to the slides provided. We will develop code sets that consider the impact if there is a gap in services. However, diagnosis such as hypertension and Type 2 diabetes will not be included.

Q: Ten Napel. What happens if there is no or delayed claims data?

A: Economic Assistance will develop a workflow for enrollment and screening. The goal will be to attain all or most of the information at the front end. If needed, we have them fill out a medical screener.

Q: Crowe. Trauma leads to medical frailty diagnosis. How will that be accounted for?

A: The Native American population is excluded. However, trauma can impact anyone. We recognize this may be a challenge.

Rural Heath Transformation (RHT) Plan
Matthew Ballard, Deputy Director, South Dakota Medicaid, reviewed the status of the RHT program. The RFPs should be released in second quarter of 2026. The slides can be found on the MAC website.

Q: Ten Napel. What do you envision for the population health and case management tool?

A: The goal of the shared case management tool and population health tool is to support the shared case management option. We envision small clinics, particularly those that may not have the resources to procure such a system independently, may also be able to use it.

Comment: Basel. There are vendor solutions on the market for case management and population health tools.

Q: Basel. What is the status of Nexus SD? Is there a proposed project to link community-based organizations with providers?

A: Nexus SD is no longer supported. There is currently no project within the DSS component of the RHT programs that links community-based organizations with provider partners.

MAC Membership
Two MAC members are leaving after reaching their term limits. Dr. Scott Kennedy and Jacob Parsons were thanked by South Dakota Medicaid for their service over the past year. When the MAC was reestablished last year, member terms staggered at one, two, and three years. Moving forward, all new members will serve three-year terms. Individuals may reapply one year after completing their service on the MAC.

Closing Remarks
Ashley concluded the meeting by thanking the MAC members for attending the meeting and providing valuable feedback. If MAC members have any questions, they are welcome to reach out via email or a phone call to discuss.

Future Meetings:

- 07/23/2026 – Sioux Falls – One Stop Building
- 10/22/2026 – Pierre – Kneip Building
- 01/28/2027 – Virtual

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South Dakota Medicaid
Medicaid Advisory Committee Annual Report SFY2026
July 1, 2025 – June 30, 2026

Executive Summary

State Fiscal Year (SFY) 2026 marked the first full year of the South Dakota (SD) Medicaid Advisory Committee (MAC) under revised federal regulations. Throughout the year, the MAC served as a collaborative advisory body bringing together healthcare providers, tribal representatives, beneficiary representatives, advocacy organizations, health systems, policymakers, and state agencies to discuss key Medicaid initiatives and provide formal and informal feedback on proposed policies and operational changes.

The MAC met quarterly during SFY2026, utilizing a hybrid engagement structure that included in-person meetings in Pierre and Rapid City as well as virtual participation opportunities to maximize statewide accessibility. Meetings consistently emphasized dialogue, feedback, and stakeholder-driven discussion. SD Medicaid leadership repeatedly reinforced the goal of making the MAC an active opportunity for discussion, collaboration, and continuous improvement.

Major policy and operational topics were reviewed throughout the year, including:

- Rural Health Transformation Program (RHTP)
- Primary Accountability Care Transformation (PACT) and value-based care models
- HR1 Medicaid eligibility requirements including community engagement and associated medical frailty policies
- HR1 Medicaid cost sharing requirements
- Hospital reimbursement methodologies
- State Plan Amendments (SPAs)

The MAC provided substantial feedback on communication materials, operational implementation strategies, provider impacts, beneficiary burden reduction, reimbursement methodologies, transportation challenges, and rural healthcare sustainability. The committee also elevated the importance of provider engagement, tribal consultation, beneficiary input, and phased implementation approaches across multiple initiatives.

Key accomplishments during the first year included:

- Establishment and approval of formal MAC bylaws
- Successful launch of recurring quarterly meetings
- Integration of Beneficiary Advisory Council (BAC) representatives into MAC discussions
- Development of stakeholder feedback processes for major Medicaid transformation initiatives
- Incorporation of MAC feedback into communications planning and policy development

The MAC also played an important role in supporting SD Medicaid's preparation for significant federal policy changes, particularly those related to HR1 requirements and cost sharing implementation. Members consistently focused on minimizing administrative burden for providers and beneficiaries while preserving access to care.

While many initiatives discussed during SFY2026 remain in development phases, the MAC successfully established itself as a trusted advisory structure that supports transparency, stakeholder collaboration, and meaningful dialogue between SD Medicaid and impacted communities.

Membership and Representation

The SFY2026 MAC included representation from a broad range of healthcare sectors, beneficiary advocates, tribal organizations, provider associations, health systems, and public agencies. Membership was intentionally structured to ensure statewide and cross-sector perspectives were represented in discussions related to Medicaid policy and operations.

Membership included representatives from:

- Rural hospitals and health systems
- Federally Qualified Health Centers (FQHCs)
- Pediatric care
- Optometry
- Dentistry
- Tribal health organizations
- Aging advocacy organizations

The MAC also incorporated direct beneficiary feedback through participation from BAC members, who attended and participated in MAC meetings throughout the year. This structure helped ensure that lived experience perspectives informed policy discussions alongside provider and administrative expertise.

Overall, the MAC had a successful first year and served as a valuable partner for Medicaid policy development and implementation in South Dakota.

Recruitment and Retention

SD Medicaid conducted outreach and recruitment activities to update the MAC and form the new BAC. Recruitment efforts focused on securing representation from multiple sectors and geographic areas. Previous MAC members were provided the opportunity to apply to serve on the revised MAC structure established in alignment with updated federal Medicaid requirements. SD Medicaid conducted outreach and promotion efforts through professional organizations, healthcare associations, stakeholder networks, and partner agencies to encourage broad participation and representative membership across the state. Interested individuals completed an application process that helped ensure the committee included diverse perspectives from providers, advocacy organizations, tribal representatives, beneficiaries, and healthcare systems while maintaining geographic and sector representation across South Dakota.

The update MAC also began operating under staggered term structures to ensure continuity while allowing for ongoing membership rotation and new perspectives. SD Medicaid initiated staggered one-, two-, and three-year terms at the time the MAC was reconstituted. Moving forward, new members will serve standardized three-year terms.

Retention remained strong during the reporting period, with consistent participation across quarterly meetings. Attendance remained high despite travel demands and scheduling challenges associated with statewide representation.

Activities and Topics of Discussion

The MAC held four (4) formal meetings between September 2025 and April 2026 using a combination of in-person and virtual formats to maximize accessibility and participation across the state. Discussion and feedback were obtained using the following methods:

- Open discussion forums
- Question-and-answer discussions
- Draft material review and discussion

Meetings utilized multiple engagement strategies, including:

- Large group discussion
- Open question-and-answer sessions
- Stakeholder feedback discussions
- Beneficiary feedback integration
- Roundtable discussion
- Public comment opportunities
- Review of draft communication materials

- Policy implementation feedback sessions

Attendance rates remained consistently strong throughout the reporting year, with participation from MAC members, BAC representatives, and SD Medicaid leadership.

The MAC also benefited from strong executive leadership engagement. Medicaid leadership, including the Medicaid Director, Deputy Director, Chief Medical Officer, and Policy Strategy Manager attended all meetings and actively participated in discussions.

During SFY2026, the MAC discussed a wide range of Medicaid policy, operational, and healthcare topics impacting beneficiaries, providers, and healthcare systems across South Dakota. One area of engagement was the Rural Health Transformation Program (RHTP), including how federal funding could support rural healthcare access, workforce sustainability, transportation, care coordination, population health tools, and provider infrastructure improvements. MAC members provided feedback on grant flexibility, tribal participation, transportation barriers, and long-term sustainability strategies while emphasizing the importance of outcomes-based approaches and stakeholder collaboration. The committee also reviewed the development of the Primary Accountability Care Transformation (PACT) initiative and broader value-based care concepts designed to improve patient outcomes while supporting providers through shared care management, analytics, and care coordination models.

The MAC also spent considerable time discussing implementation of new federal Medicaid requirements under HR1, particularly community engagement requirements and cost sharing provisions affecting portions of the Medicaid Expansion population. Members raised concerns regarding administrative burden, communication challenges, provider workflow impacts, and potential barriers to care for beneficiaries. Discussions focused heavily on how SD Medicaid could implement the federal requirements in a manner that minimized confusion and hardship for recipients while remaining compliant with federal law. MAC members reviewed draft communication materials, discussed beneficiary outreach strategies, and provided recommendations regarding provider education, exemptions, medical frailty criteria, and methods to reduce operational complexity for both healthcare providers and Medicaid recipients.

Another major area of discussion involved State Plan Amendments (SPAs) and reimbursement methodologies. The MAC reviewed anticipated changes to hospital reimbursement models, federally qualified health center and rural health clinic payment methodologies, and updates related to school-based administrative claiming and substance use disorder treatment templates. Committee members discussed how reimbursement changes could impact providers, especially rural hospitals, federally qualified health centers, and specialty providers. Members emphasized the need for ongoing stakeholder involvement. The MAC also discussed legislative developments related to Medicaid Expansion, Medicaid financing, and state budget priorities, with several members expressing support for preserving Medicaid Expansion due to its positive impact across South Dakota.

Throughout the year, the MAC demonstrated strong engagement and collaborative dialogue between Medicaid leadership, providers, beneficiary representatives, tribal organizations, advocacy groups, and other stakeholders. Members consistently emphasized themes such as reducing administrative burden, improving beneficiary communication, supporting rural healthcare access, maintaining flexibility in implementation approaches, and ensuring stakeholder voices remained integrated into decision-making processes.

Recommendations and State Responses

Throughout SFY2026, SD Medicaid maintained an open and collaborative approach to stakeholder engagement with the MAC. MAC members were consistently encouraged to provide feedback during meetings and between quarterly sessions, particularly on operational processes, communication materials, implementation strategies, and proposed policy changes. SD Medicaid leadership routinely welcomed questions, discussion, and recommendations from providers, beneficiary representatives, tribal organizations, advocacy groups, and other stakeholders. This ongoing dialogue helped create an environment where members felt comfortable raising concerns, sharing operational realities, and suggesting improvements related to Medicaid programs and initiatives.

SD Medicaid demonstrated a willingness to revise and improve communications, implementation approaches, and operational planning whenever feasible. Feedback from MAC members directly informed discussions surrounding beneficiary outreach materials, HR1 implementation planning, cost sharing proposals, RHTP activities, and value-based care initiatives such as the PACT model. Recommendations emphasizing clearer communication, reduced administrative burden, phased implementation, provider engagement, and flexibility for rural healthcare systems were positively received and frequently incorporated into ongoing planning efforts. SD Medicaid also committed to continued stakeholder involvement through future workgroups, webinars, public comment opportunities, and additional consultation processes.

Overall, the relationship between the MAC and SD Medicaid reflected a collaborative and solution-oriented partnership focused on improving Medicaid services and outcomes for South Dakotans. Recommendations made by MAC members were seriously considered and incorporated whenever possible. In circumstances where recommendations could not be fully implemented, SD Medicaid provided transparent explanations regarding federal requirements, legal limitations, operational barriers, fiscal constraints, or pending CMS guidance that restricted state flexibility. This transparent and responsive engagement process helped establish trust between committee members and SD Medicaid while supporting meaningful stakeholder participation during the MAC’s first full year of revised operation.

Operational and Engagement Successes

SD Medicaid established a strong operational structure for the reestablished MAC that emphasized accessibility, transparency, and statewide engagement. Meeting materials and presentations were consistently made available through the MAC website to support transparency and ongoing stakeholder engagement.

Attendance and participation throughout the year remained strong and demonstrated sustained member engagement. The September 2025 introductory MAC meeting included 13 attendees and focused on establishing bylaws, reviewing Medicaid operations, and identifying future discussion priorities. The October 2025 MAC meeting included 12 MAC attendees and expanded discussions into RHTP, value-based care, HR1 federal requirements, and State Plan Amendments. The January 2026 virtual MAC meeting included 12 MAC attendees, with extensive engagement regarding Rural Health Transformation funding, PACT development, HR1 cost sharing requirements, and legislative updates. The April 2026 MAC meeting included 11 MAC attendees, and focused on cost sharing proposals, HR1 communications, medical frailty policies, Rural Health Transformation implementation, and future membership planning. Overall attendance remained high throughout the reporting year, with active discussion and participation consistently occurring across meetings.

Engagement during meetings was highly collaborative and solution oriented. MAC members actively participated through questions, operational feedback, policy recommendations, and discussion of provider and beneficiary impacts. SD Medicaid leadership consistently encouraged members to provide additional feedback between meetings and invited continued collaboration through future workgroups, consultation opportunities, and public engagement activities. BAC feedback was also incorporated into MAC discussions, strengthening beneficiary-informed policymaking and communication development. Members regularly contributed perspectives related to reducing administrative burden, improving communication materials, supporting rural healthcare access, and ensuring implementation flexibility for providers and beneficiaries. The consistent level of dialogue, participation, and stakeholder collaboration demonstrated a successful first year for the MAC and established a strong foundation for future engagement and Medicaid policy development.

Closing and a Look Ahead

As SFY2026 concluded, the MAC identified several continuing priority areas for the coming year. Key anticipated priorities included:

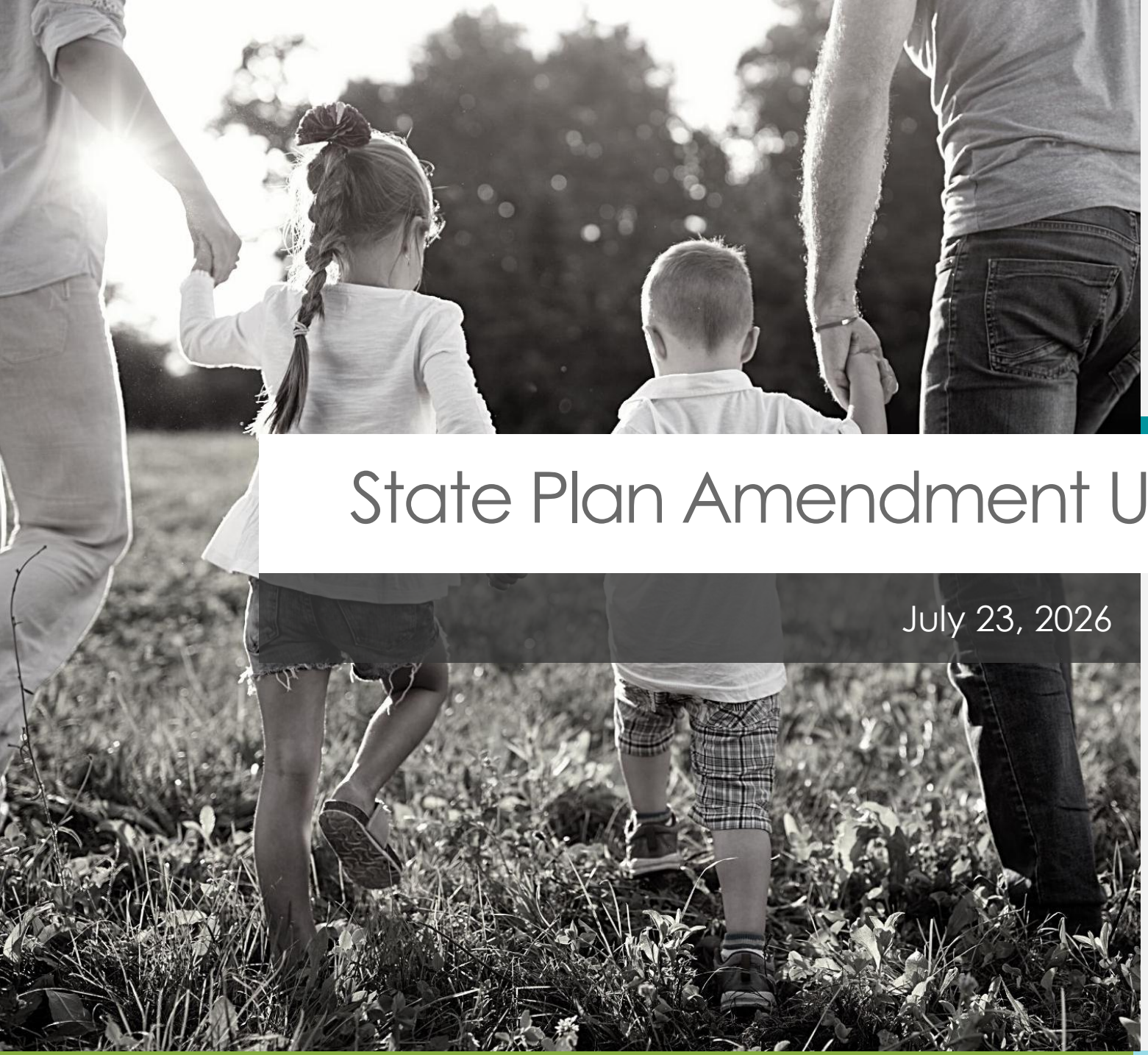
- Continued Rural Health Transformation implementation
- PACT operational workgroup development
- HR1 implementation planning
- Cost sharing policy finalization
- Medical frailty implementation
- Hospital reimbursement transition
- State Plan Amendment review
- Ongoing provider and stakeholder education

SD Medicaid also identified several operational improvements for the future of the MAC, including:

- Continued refinement of communication materials
- Greater integration of beneficiary feedback
- Further coordination with tribal partners and rural providers

The MAC's first year of an expanded function established a strong foundation for ongoing stakeholder collaboration and beneficiary-informed Medicaid policy development in South Dakota. The committee demonstrated the value of consistent engagement between Medicaid leadership, providers, beneficiaries, tribal organizations, and advocacy partners. Through open dialogue and collaborative problem-solving, the MAC helped shape discussions on some of the most significant Medicaid transformation efforts currently underway in South Dakota.

As implementation of major initiatives continues into SFY2027, the MAC is well-positioned to remain an important advisory structure supporting transparency, accountability, and improved healthcare outcomes for SD Medicaid beneficiaries.



State Plan Amendment Updates

July 23, 2026

South Dakota Department of Social Services

SFY27 Provider Inflationary Increase

SD-26-0008

Brief Description:
The SPA implements the 1.4% inflationary rate increases appropriated by the state legislature during the 2026 legislative session effective July 1, 2026.

Reason for Amendment:
The state legislature appropriated an inflationary increase of 1.4% for SFY27.

Important Dates:
Comment Period: June 29, 2026 through July 29, 2026.
Effective date: July 1, 2026

SFY27 Care Connect Inflationary Increase

SD-26-0004

Brief Description:
Implements a 1.4% inflationary rate increases for Care Connect payments (formerly known as Health Home) as appropriated by the state legislature during the 2026 legislative session and rebases the PMPM tier amounts.

Reason for Amendment:
The state legislature appropriated an inflationary increase of 1.4% for SFY27.

Important Dates:
Comment Period: June 29, 2026 through July 29, 2026.
Effective date: July 1, 2026

Primary Accountable Care Transformation (PACT) Quality Payment

Brief Description:
Implements a new quality-based payment to healthcare providers enrolled in the Medicaid Primary Care Provider (PCP) program. Payments are based on provider performance on specific primary care quality metrics during 2026 and 2027 and funded under the Rural Health Transformation Plan.

Reason for Amendment:
Distribution of funding tied to the Rural Health Transformation Plan.

Important Dates:
Comment Period: July 20, 2026 through August 19, 2026.
Effective date: August 1, 2026

South Dakota Medicaid
State Plan Amendments and 1115 Demonstration Applications

As of July 23, 2026

State plan amendments are available on our website at https://dss.sd.gov/medicaid/medicaidstateplan.aspx

SPAs in Public Comment Period

SPA #	SPA Description	Date Effective	Public Comment Period Start Date	Date Public Comment Period Ends
26-0008	**SFY27 Provider Inflationary Increase** *Primarily implements the inflationary rate increases appropriated by the state legislature during the 2026 legislative session effective July 1, 2026.*	07/01/2026	06/29/2026	07/29/2026
26-0004	**SFY27 Care Connect (Health Home) Inflationary Increase** *Implements the inflationary rate increases appropriated during the 2026 legislative session and rebases the PMPM tier amounts.*	07/01/2026	06/29/2026	07/29/2026
26-0006	**Primary Accountable Care Transformation (PACT) Quality Payment** *Implements a new quality-based payment to healthcare providers enrolled in the Medicaid Primary Care Provider (PCP) program. Payments are based on provider performance on specific primary care quality metrics during 2026 and 2027 and funded under the Rural Health Transformation plan.*	08/01/2026	07/20/2026	08/19/2026

Anticipated SPAs

SPA Description	Anticipated Start of Public Comment Period
None at this time.	

SPAs Being Prepared for CMS Submission

SPA #	SPA Description	Date Effective	Public Comment Period Start Date	Date Public Comment Period Ends
	None at this time.			

SPAs in CMS Review

SPA #	SPA Description	Date Effective	Public Comment Period Start Date	Public Comment Period End Date	Date Submitted to CMS
26-0005	**CY26 Care Coordination Supplemental Payments** *Updates the care coordination provider list and supplemental payment amounts.*	06/01/2026	05/04/2026	06/03/2026	06/23/2026
26-0001	**FQHC/RHC Scope of Service and FQHC Alternative Payment Methodology** *Updates Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) criteria for scope of service changes and implements an Alternative Payment Methodology (APM) encounter rate informed by the statewide cost-based weighted-average for FQHCs as appropriated for by the legislature.*	07/01/2026	04/20/2026	05/20/2026	05/21/2026
26-0002	**SFY27 Behavioral Health Inflationary Increase** *Implements community mental health center (CMHC) and substance use disorder (SUD) agency rate increases appropriated by the state legislature during the 2026 legislative session effective June 1, 2026.*	06/01/2026	04/20/2026	05/20/2026	05/21/2026
26-0003	**Hospital Reimbursement** *Updates hospital reimbursement methodologies including inpatient and outpatient hospital services for both instate and out-of-state hospitals to modernize, streamline and more closely align the methodologies with industry standards.*	07/01/2026	04/13/2026	05/13/2026	05/21/2026
25-0012	**SFY26 Provider Inflationary Increase** *Implements inflationary rate increases appropriated by the state legislature during the 2025 legislative session effective July 1, 2025, and coverage and reimbursement for Rural Emergency Hospitals under the Clinic Services benefit.*	07/01/2025	06/23/2025	07/23/2025	07/31/2025

Approved SPAs

SPA #	SPA Description	Date Effective	Public Comment Period Start Date	Public Comment Period End Date	Date Submitted to CMS	Date Approved
25-0015	**SUD/IMD Template and School-Based Administrative Claiming** *Replaces the current Attachment 3.1-L Substance Use Disorders / Institutions for Mental Diseases State Plan pages with the new template pages provided by CMS and separately updates the random moment time study cost pool list of providers that may perform school-based direct services and/or administrative claiming activities..*	10/01/2025	09/29/2025	10/29/2025	11/07/2025	03/10/2026

Targeted Case Management Updates

Effective 1.1.25

South Dakota Department of Social Services

Background and Covered Services

The Consolidated Appropriations Act (CAA) 2023, section 5121 requires states to provide select benefits **30-days prior to release from a carceral setting** for Medicaid enrolled juveniles and up to 30-days post release from a carceral setting to a non-carceral setting **(SD DSS elected to extend up to 60-days post release).**

Screenings and Diagnostic (Pre-Release) Services: a wellness exam that includes the following screenings:

- Behavioral Health screening;
- Dental screening;
- Hearing screening; and
- Vision screening; and provide appropriate immunizations according to age and health history

Targeted Case Management Services: include assisting eligible individuals in gaining access to needed medical, social, educational, and other services.

- Healthcare Needs Assessment and Reassessment
- Person-Centered Care Plan Development
- Referrals and Related Activities
- Arranging Screening and Diagnostic Services
- Monitoring and Follow-up Activities

The goal is to provide seamless transitions to medical, dental, vision, and behavioral health providers upon re-entry while also addressing Social Determinants of Health (SDoH)

Targeted Case Management Services

Targeted Case Management Services: include assisting eligible individuals in gaining access to needed medical, social, educational, and other services by providing:

- Healthcare needs assessment and reassessment;
- Person-centered care plan development;
- Arranging screening and diagnostic services;
- Referrals and related activities; and
- Monitoring and follow-up activities.

Who can provide Justice-involved Youth Targeted Case Management Services for Reimbursement?

The following can provide Targeted Case Management Services for Reimbursement (assuming all qualifications on the next slide are met):

A Case manager who is part of a care team of and supervised by a Medicaid enrolled provider*.

OR

An individual employed by or under contract with the Public Safety Organization.

OR

A Certified Community Health Worker (CHW) or a social worker employed by an enrolled Community Health Worker Agency.

*Supervision of the case manager must be provided by the following provider types: a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, certified addiction counselor, licensed addiction counselor, licensed psychologist, licensed professional counselor – mental health, licensed professional counselor working toward a mental health designation, licensed clinical nurse specialist, licensed certified social worker – Private Independent Practice (PIP), licensed certified social work – Private Independent Practice (PIP) candidate, or licensed marriage and family therapist.

Carceral Settings – South Dakota

Definition: all types of carceral facilities where eligible juveniles may be confined as an inmate of a public institution post-adjudication. This includes federal, state, local and tribal jails and prisons, and all juvenile detention and youth corrections facilities.

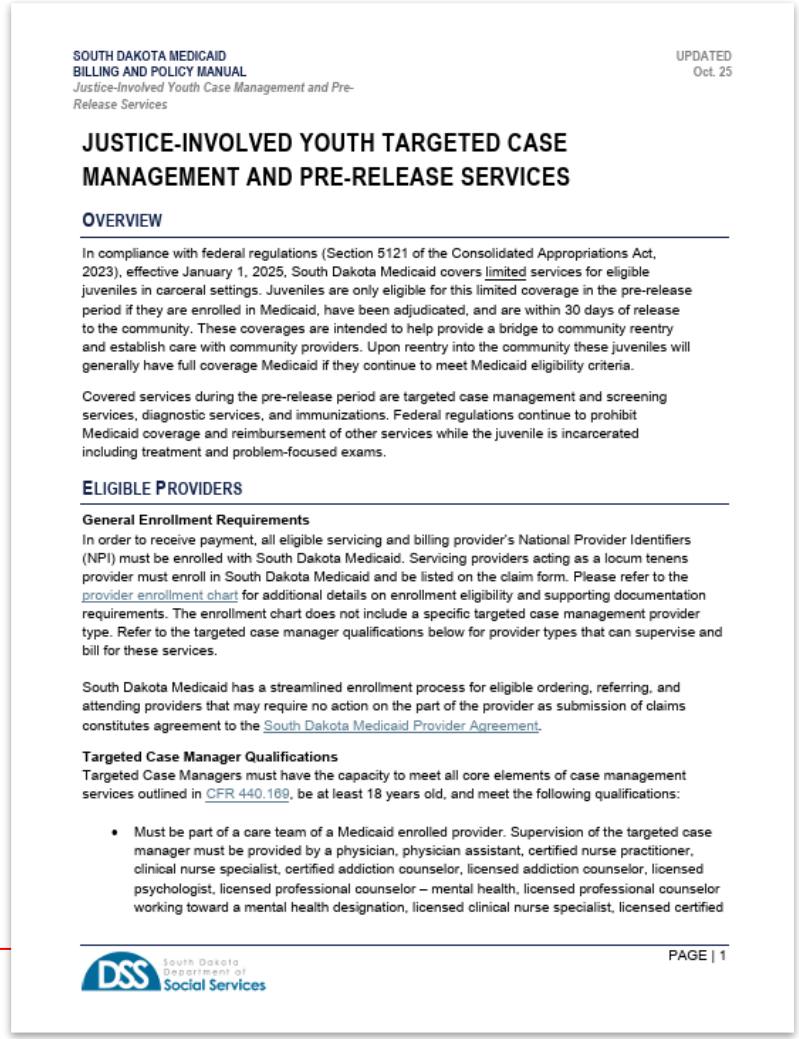
Juvenile Detention Centers (JDC): South Dakota has 7 JDCs	Beadle County, Brown County, Codington County, Hughes County, Minnehaha County, Pennington County, and Roberts County
Tribal Juvenile Carceral Settings*: South Dakota Tribes have 4 JDCs	Wanbli Wiconi Tipi JDC – Rosebud Reservation, Rosebud Sioux Tribe Kiyuksa O'Tipi Reintegration Center JDC – Pine Ridge Reservation, Oglala Sioux Tribe, Cheyenne River Sioux Tribe JDC, and Standing Rock Youth Services Center
County Jails: South Dakota has 20+ County Jails Across the 66 Counties in SD	City of Winner, Hughes County, Lawrence County, Minnehaha Couty, Pennington County, Pine Ridge DOC Adult Offender Facility*, Rosebud Sioux Tribe Adult Corrections – Jail*, Yankton County *(Jails with bed size greater than 100)*
Department of Corrections (DOC): Does not operate a stand-alone juvenile facility	Initial incarceration starts in a Juvenile Detention Center (JDC) or county jail. Most juveniles are moved to a Group Home setting or Psychiatric Residential Treatment Facility (PRTF).

*Department of Corrections does not oversee or have administrative control over tribal carceral settings

Provider Resources - https://dss.sd.gov/medicaid/providers/billingmanuals/default.aspx

Professional Provider Manuals

- Allergy Testing and Immunotherapy Services
- Anesthesia Services
- Applied Behavior Analysis
- Audiology Services
- Birth to Three Non-School District Services
- Child Advocacy Program
- Chiropractic Services
- Community Health Worker Services
  - Provider Enrollment Checklist
  - Provider Policy Requirements
- Community Mental Health Centers
- Diabetes Self-Management Training Services
- Dietician and Nutritionist Services
- Doula Services
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies
- Emergency Services
- Family Planning and Sterilization Services
- FQHC and RHC Services
- Health Department Clinics
- Home Health Agency Services
- Home Infusion Therapy Services
- Hysterectomy Services
- IHS and Tribal 638 Facilities
- IHS Care Coordination Agreements and Referrals
- Independent Mental Health Practitioners
- Justice-Involved Youth Targeted Case Management and Pre-Release Services
- Laboratory and Pathology Services



SOUTH DAKOTA MEDICAID
BILLING AND POLICY MANUAL
Justice-Involved Youth Case Management and Pre-Release Services

UPDATED
Oct. 25

JUSTICE-INVOLVED YOUTH TARGETED CASE MANAGEMENT AND PRE-RELEASE SERVICES

OVERVIEW

In compliance with federal regulations (Section 5121 of the Consolidated Appropriations Act, 2023), effective January 1, 2025, South Dakota Medicaid covers limited services for eligible juveniles in carceral settings. Juveniles are only eligible for this limited coverage in the pre-release period if they are enrolled in Medicaid, have been adjudicated, and are within 30 days of release to the community. These coverages are intended to help provide a bridge to community reentry and establish care with community providers. Upon reentry into the community these juveniles will generally have full coverage Medicaid if they continue to meet Medicaid eligibility criteria.

Covered services during the pre-release period are targeted case management and screening services, diagnostic services, and immunizations. Federal regulations continue to prohibit Medicaid coverage and reimbursement of other services while the juvenile is incarcerated including treatment and problem-focused exams.

ELIGIBLE PROVIDERS

General Enrollment Requirements
In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements. The enrollment chart does not include a specific targeted case management provider type. Refer to the targeted case manager qualifications below for provider types that can supervise and bill for these services.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Targeted Case Manager Qualifications
Targeted Case Managers must have the capacity to meet all core elements of case management services outlined in CFR 440.169, be at least 18 years old, and meet the following qualifications:

- Must be part of a care team of a Medicaid enrolled provider. Supervision of the targeted case manager must be provided by a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, certified addiction counselor, licensed addiction counselor, licensed psychologist, licensed professional counselor – mental health, licensed professional counselor working toward a mental health designation, licensed clinical nurse specialist, licensed certified

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DSS South Dakota Department of Social Services

Stakeholder Engagement Contractor

The South Dakota Department of Social Services (SD DSS) selected the Community Health Worker Collaborative of South Dakota to:

a) conduct stakeholder engagement
b) identify barriers and challenges
c) develop recommendations and an action plan for implementation of Justice-involved Youth Targeted Case Management and Pre-Release Services.
d) provide project management for implementation of recommendations and the action plan.

Stakeholders include, at a minimum, carceral settings, behavioral health professionals (including Community Mental Health Centers), other eligible providers, Youth Probation Officers, and Community Health Workers (CHWs).

*This project is supported by the South Dakota Department of Social Services through funding from the Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, under Grant No. 2T2CMS331980-01-00 (ALN 93.694).

Stakeholder Engagement

Carceral Settings

- Outreach completed to all JDCs in South Dakota – August – October 2025
- Outreach to all Jails (with a bed population over 100) in South Dakota – November 2025
- Outreach completed to all 7 Unified Judicial Circuit Chief Court Service Officers and two tribal probation officers

Prospective Targeted Case Management Providers

- Outreach completed to 9 of 11 Community Mental Health Centers (CMHCs) in South Dakota – November – December 2025
- Outreach completed to CHW programs, with 16 interviews completed with interested CHW programs and 9 additional CHW programs who do not have capacity at this time to support Targeted Case Management Services

Recommendations and Next Steps

Carceral Settings

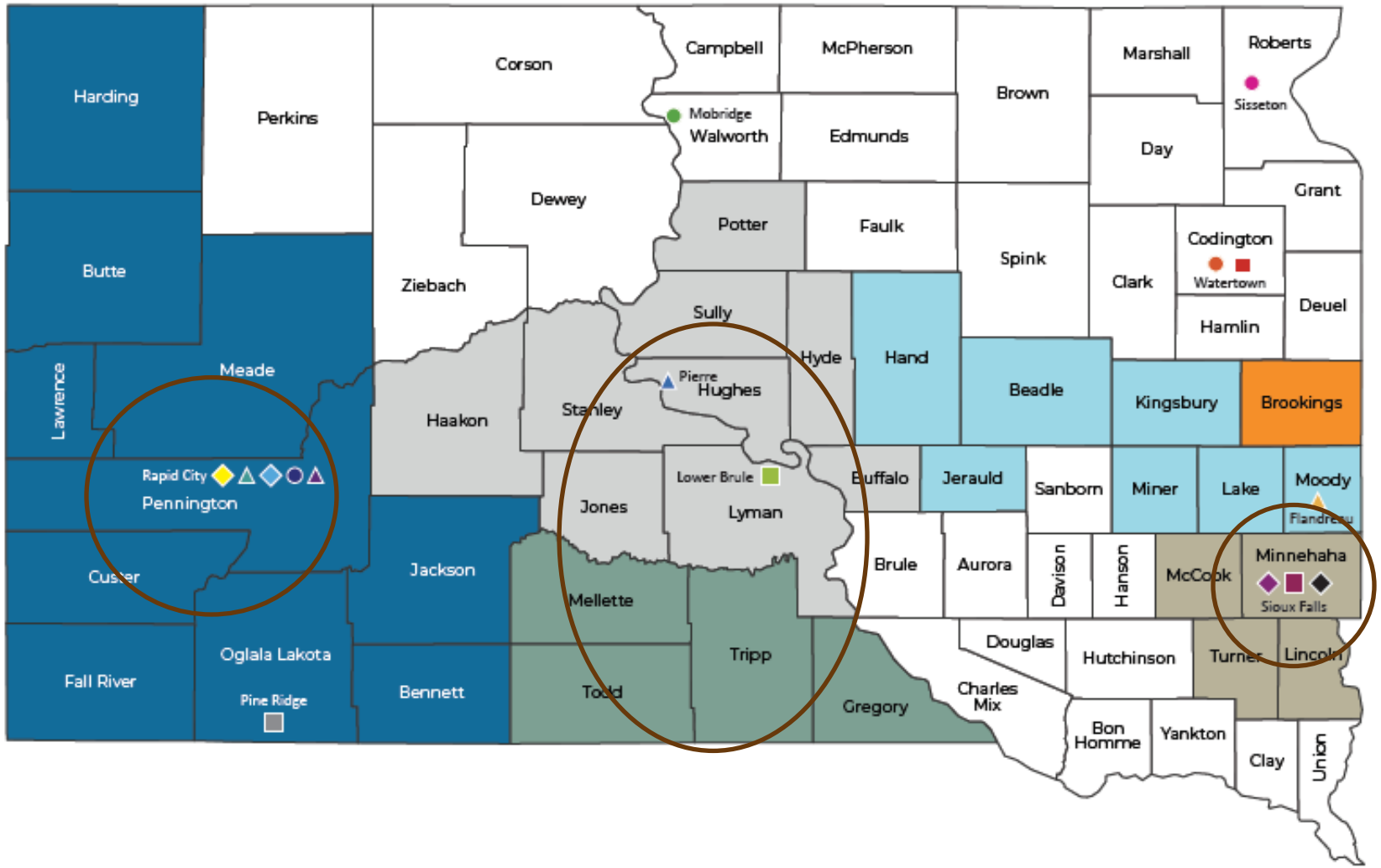
1. Meet Facilities Where They Are *(CHWSD and Medicaid Supported)*
2. Develop a Strong Statewide Targeted Case Manager Network Supported by Diverse Organizations *(CHWSD Supported)*
3. Standardize Referral and Engagement Workflows Across JDCs, Jails, and Probation Offices *(CHWSD Supported)*
4. Integrate Medicaid Verification and Targeted Case Management Referral Steps into Intake and Reentry *(CHWSD and Medicaid Supported)*
5. Provide Training on Targeted Case Management services and Develop Data Sharing Processes *(CHWSD Supported)*
6. Focus on Developing Referral and Workflow Strategies to Support Justice-involved Youth with Short Lengths of Stay in Carceral Settings *(CHWSD Supported)*
7. Launch Early Pilots and Build Evaluation Infrastructure *(CHWSD Supported)*

Recommendations and Next Steps

Prospective Targeted Case Management Providers

1. Clarify Program Eligibility, Scope, and Billable Services *(CHWSD and Medicaid Supported)*
2. Develop Consistent Referral Pathways for Justice-Involved Youth *(CHWSD Supported)*
3. Provide Technical Assistance and Support for Implementation, Documentation, and Billing *(CHWSD Supported)*
4. Pilot Targeted Case Management Implementation Using a Phased Approach *(CHWSD Supported)*
5. Establish Ongoing Learning and Feedback Mechanisms *(CHWSD Supported)*
6. Assess Reimbursement Adequacy and Programs' Sustainability Over Time *(Medicaid Supported)*

Pilot Communities/Regions



Pilot Communities/Regions

- Sioux Falls (Lincoln and Minnehaha Counties)
- Rapid City / Black Hills
- Pierre and Central/South Central South Dakota (including the Rosebud Sioux Tribe)

Questions

Ben May, Vicki Palmreuter, Julie Ten Haken

Contracted Project Managers

South Dakota Department of Social Services, Division of Medical Services

Justice-involved Youth Targeted Case Management and Pre-Release Services

Community Health Worker Collaborative of South Dakota

Ben@chwsd.org

Vicki@chwsd.org

Julie@chwsd.org

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