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
9:00MT / 10:00CT
Beneficiary Advisory Council Agenda
Sioux Falls One Stop

Welcome and Overview

- Introductions
- Welcome New BAC Members
- Opening Remarks

Updates and Committee Discussion

- Review April Meeting Minutes
- Review Annual Report and Vote to approve/amend
- HR1 Website
- CHIP State Plan Goals
- Juvenile Justice Targeted Case Management

Closing Remarks

Future Meetings:

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

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, April 23, 2026
Beneficiary Advisory Council Meeting Minutes

Beneficiary Advisory Council (BAC) Attendees
Bethany Curtis, Sioux Falls, SD; **Mikki Donelson,** Sioux Falls, SD; **Marissa Garza,** Rapid City, SD; **Alex Helvin,** Sioux Falls, SD; **Jeannette Wellman,** Hot Springs, SD

Could Not Attend: Larissa Deedrich, Sioux Falls, SD; Julie Kopp, Box Elder, SD

Other Attendees
Matthew Ballard, Deputy Director, South Dakota Medicaid; **Dr. Clarissa Barnes**, Chief Medical Officer, South Dakota Medicaid; **Misty Black Bear**, Assistant Director of Long Term Services, South Dakota Department of Human Services; **Renae Hericks,** Policy and Program Manager, South Dakota Medicaid**; Lee Hosman,** Division of Economic Assistance; South Dakota Department of Social Services; **Sarah Houska**, Care Management Program Manager South Dakota Medicaid, **Mary Johnle**, South Dakota Economic Assistance, South Dakota Department of Social Services; **Ashley Lauing**, Policy Strategy Manager, South Dakota Medicaid; **Kara Peery**, Medical Program Specialist, South Dakota Medicaid; **Heather Petermann**, Director, South Dakota Medicaid; **Chris Soukup**, Care Management Administrator, South Dakota Medicaid; **Ben May** and **Sharon Chontos**, BAC Coordinators, North Star Solutions

Welcome and Overview
Ashley Lauing, Policy Strategy Manager with South Dakota Medicaid, welcomed the BAC members. She welcomed attendees to Rapid City, especially those who traveled to attend the meeting.

Heather Petermann, Director of South Dakota Medicaid, thanked the BAC members for their role in shaping policy and improving communication with beneficiaries. She noted that their feedback and recommendations are carefully considered and incorporated as the department develops and refines language that affects Medicaid beneficiaries across South Dakota.

Review January 2026 Meeting Minutes
Ben reviewed the January 2026 meeting minutes and asked for questions or corrections. Hearing none, the BAC accepted the minutes as presented. The January 2026 minutes can be found online at the BAC website.

Benefits Guide
Matthew Ballard, Deputy Director, South Dakota Medicaid, thanked the BAC members for their suggestions on how to improve the benefits guide and display the guide on the website. The BAC members said they liked the design of the benefits guide and it was easy to follow. They also appreciated the list of frequently asked questions. The handouts can be found on the BAC website.

Q: Petermann. Is the benefits guide in the recipient manual?
A: Yes; however, it is in a different format. In the next update of the recipient manual, we will look at aligning it with this design.

Q: Donelson. I would concur with aligning the recipient manual with this design. There are a handful of ways people can sign up for Medicaid or refer to benefits. It may be good to have this benefits guide at the Economic Assistance offices and providers offices. It is also good to have a phone number to call.

Q: Helvin. I agree that a phone number should be added. For example, I tried to go online and the site was down. The nurse helped me. Also, selecting a provider is a big decision. Many people do not know who their primary care provider is.
A: We will add a phone number. We appreciate the feedback.

HOPE Waiver Renewal
Misty Black Bear, Assistant Director of Long-Term Services, South Dakota Department of Human Services, reviewed the HOPE Waiver. The waiver was out for public comments through April 24, 2026. The comments will be considered for language updates. The slides can be found on the BAC website.

Q: Helvin. Will this be aligned with kids that need home care?
A: No, this only applies to those age 65 and older with qualifying disability.

Cost Sharing
Matthew Ballard, Deputy Director, South Dakota Medicaid, presented the cost sharing federal requirements and Soth Dakota Medicaid's draft proposals. He reported there are approximately 142,000 individuals enrolled in Medicaid of which 30,000 are eligible through Medicaid expansion. Of those 30,000, preliminary information indicates about 10,000 will be subject to the cost sharing. The slides can be found on the BAC website.

Comment: Helvin. By stating the dollar amounts (e.g., $5, $20), it is clear what the expectations are for the beneficiaries. This is much clearer than health plan language that lists 20% of services. It is not clear how much 20% will be for a particular service. I appreciate how primary care services are covered. However, some people do not know who their primary care doctor is and they do not know the difference between primary care providers and specialists.

Comment: Donelson. These are feasible costs. Most people have the means to get $5 - $20. It will be easier to convince people to get the care they need.

Comment: Helvin. Yes, it is easier to pay the $5 cost share than the entire claim. The expectations are clear.

Q: Garza. Will the cost share requirements align with specific medical codes?

A: Yes, the cost share would be triggered off claims information, which may include diagnosis codes or procedure codes. For example, some in-patient hospital stays could be exempt such as newborn deliveries.

Q: Donelson. What happens when a patient leaves the hospital and then comes back right away?

A: If the hospitalization is within 72 hours, it should be just one claim. We are still considering the scenario if they transfer to another hospital.

Comment: Wellman. In that case, transferring to a hospital for more advanced services would be continuation of care.

Comment: Helvin. If a patient begins their journey in one hospital and they need an ambulance to be transferred to the second hospital, they will stop the process and not want to be transferred if there is an additional cost.

Q: Garza. Is the intent per visit or date of services.

A: The intent is per visit.

Q: Garza. Could there be two or more claims during one visit?

A: We need to consider this and reconcile with claims programming considerations.

Comment: Helvin. Each procedure should clearly outline how cost-sharing is applied. For example, the cost-share structure for surgical wisdom tooth extraction could differ from that of a crown, and these distinctions should be explicitly defined.

Comment: Donelson. Dentures are very expensive. A higher cost share would be fair. For example, $20.

Comment: Wellman. Dentures require multiple fittings. Again, it would be nice to have each service outline.

Q: Petermann. Guidance from the CMS indicates that cost sharing must be implemented. Are there additional services we should evaluate for the application of cost sharing?

Q: Garza. Durable medical equipment (DME) can be expensive.

A: Some DME is rental and some is purchased, which adds to programming complexity.

Q: Garza. What would fall under school district?

A: School nurses administer care to medically complex students. Beneficiaries under 21 years old are exempt so we could not implement cost share there.

Q: Donelson. Are beneficiaries who are institutionalized or transitional housing required to participate in cost share?

A: The state is not proposing cost sharing related to these services.

Comment. Graza. South Dakota Medicaid could include auditory and podiatry.

Q: Wellman. Hearing aid fittings and testing are like dental services. If this was included, would it be per visit or bundled?

A: If proposed, we could review programming requirements further.

Comment: Garza, Wellman, Donelson. We believe $20 for this bundle (e.g., hearing aid) would be fair and reasonable. “I would be so relieved to be only charged $20.”

Comment: Garza. Radiology may be an option. $5 cost share for a $1,400 charge.

Comment: Donelson. Other potential services for cost sharing would be chiropractor, occupational therapy, physical therapy, and speech therapy.

Comment: Garza. I would not recommend chiropractor and therapy services.

Summary: Consider audiology, podiatry, surgical, and radiology services for cost sharing.

HR1 Communications

Mary Johnle, Program Administrator, South Dakota Economic Assistance asked the BAC members for feedback on the content of the community engagement brochure. The brochure and program is being developed in partnership with the Helpline Center and South Dakota Department of Labor. The handouts can be found on the BAC website.

Q: Donelson. Do people need to have a doctor’s appointment and letter if they cannot work?

A: People who are exempt due to disability or a medically frail condition are not required to participate in this program.

Q: Donelson. Can you combine work with community service hours? For example, 20 hours a month of work and 60 hours a month of community service?

A: Yes, a combination of work and community service is acceptable. Also, they can combine school with community service.

Q: Wellman. Some people may criticize volunteering; however, volunteering gets people outside their house and into the community helping others.

Comment: All BAC members. The brochure makes sense as is. Add one or two examples, especially combinations of school, work, and community service.

Comment: Helvin. There may be a need for messaging that encourages community involvement by explaining both the personal benefits and the impact to the community. Explain how participation can improve individual well-being, build connections, and provide a sense of purpose, while also contributing to the community.

Comment: Donelson. Provide options for volunteering.

Q: Donnelson. How does this policy impact the recently incarcerated?
A: Beneficiaries have six months after release from prison to be on this program.
Comment: Donnelson. That works. That would give them time to get qualifications and get a job.

Q: Garza. How is community service validated?
A: Community service will be validated by a volunteer manager. DSS staff will outreach by email to the volunteer manager to validate hours of service.

Q: Donelson. Will the volunteer validation be on the website? Can I print it off and get the volunteer manager signature?
A: Yes

Q: Garza. Where can the volunteers work? Are there restrictions?
A: We are waiting for CMS guidance. We do not know if it needs to be a registered nonprofit.

Q: Garza: What happens if they do not meet community engagement requirements?
A: If they are subject to community engagement requirements, they will not qualify for Medicaid benefits.

Q: Donelson. How often do they need to turn in their paperwork?
A: Every 6 months.

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 BAC website.

Q: Helvin. I assume the doctor needs to validate or write a letter regarding medical status.
A: If we don't know who their doctor is, we may need to ask the patient if we don't have claims data yet.

Comment: Wellman: Would it be possible to trigger an automatic response from the doctor's office to Medicaid or from Medicaid to the doctor's office?

Comment: Donelson. When the patient is sick and stressed, it may be hard for them to coordinate validation between the doctor and Medicaid.

Comment: Helvin. Self-attesting would work for some people. However, it may be better to come from a doctor. They have the patient's medical records and can back up their recommendations based on appointments, diagnosis, medications, and care plans. In that way, the doctor can advocate for their patient.

Comment: Curtis. I would recommend examining the workflow between the doctor and Medicaid. How can the patient, CHW, patient advocate, or nurse help with that process?

Recommendation: Examine and recommend an optimum workflow between the doctor through their portal. Define what conditions would trigger the form.

Rural Health Transformation 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 BAC website.

Q: Wellman: Can hospitals apply for the Rural Strong program?

A: Any hospital in South Dakota can apply. However, hospitals in urban areas need to explain how the project will impact rural populations outside their counties.

Closing Remarks
Ashley announced that two BAC members, Larissa Deedrich and Marissa Garza, are leaving the BAC as they have met their one-year term. Ashley and the South Dakota Medicaid team thanked Larissa and Marissa for their service. They may reapply to be on the BAC in one year.

Q: Helvin. I have three additional questions for South Dakota Medicaid. While working with patients, the SD BEES system would not upload files, and it would also stop in the middle of filling out forms and logging out. Also, we have received feedback from beneficiaries that the autorenewals are not happening. Finally, people assume that the SNAP and Medicaid systems speak with each other; however, I have submitted information to one system and found the other system did not receive that information.

A: Thank you for bringing this up. Others have brought this to our attention as well. We will address the portal issues. Additionally, the SNAP and Medicaid teams should be sharing between the two systems. We are working with the regional managers to ensure that happens.

Comment: Donelson. I can validate the portal has not worked consistently. People will fill out a portion of the form and then get kicked out. We have had to have people fill out the paper form.

Comment: Helvin. Some people do not have emails or phones. My agency will set them up with an email address but then they cannot do multi-authentication because they do not have a phone to receive a text.

Ashley and the Medicaid team acknowledged the issues reported above and will follow-up. In the meantime, Ashley encouraged the BAC members to reach out directly for help or addressing questions right away, rather than waiting for a meeting. Additionally, BAC members can add agenda items to the next meeting.

Future Meetings:

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

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
Beneficiary Advisory Council Annual Report SFY2026
July 1, 2025 – June 30, 2026

Executive Summary

The South Dakota (SD) Medicaid Beneficiary Advisory Council (BAC) completed its first year of meetings in alignment with the South Dakota State Fiscal Year (July 1, 2025 – June 30, 2026). Throughout the first year, the BAC established a straightforward and collaborative structure for beneficiary engagement consistent with the Centers for Medicare & Medicaid Services (CMS) recommendations. The BAC was created to ensure Medicaid beneficiaries and individuals with lived experience have a direct role in informing Medicaid policy, communication strategies, program design, and implementation efforts across SD Medicaid.

During its first year, the BAC evolved from an introductory advisory group into an active, collaborative discussion where Medicaid recipients, caregivers, and individuals with lived experience provided direct feedback on major SD Medicaid initiatives, operational challenges, communication strategies, and future policy development. The BAC met four (4) times throughout the first year through both in-person/hybrid and virtual meetings, allowing broad participation from members across the state. Meetings were intentionally structured to support open discussion, shared learning, and engagement between beneficiaries and SD Medicaid leadership.

Throughout SFY2026, the BAC reviewed and provided feedback on a wide range of Medicaid topics including, but not limited to:

- Medicaid communication and beneficiary notices
- Medicaid eligibility changes under H.R.1
- Community engagement/work requirement communications
- HR1 Medicaid cost sharing requirements
- Primary Accountability Care Transformation (PACT)
- Rural Health Transformation (RHT) Program funding initiatives
- Care Connect/Health Home redesign
- Benefits guides and recipient materials

The BAC demonstrated strong engagement and collaborative discussions, with members consistently sharing their beneficiary perspective and highlighted operational

barriers affecting Medicaid recipients across South Dakota. Discussions frequently focused on accessibility, clarity of communication, continuity of care, rural healthcare access, provider navigation challenges, and the need for simplified administrative processes.

Key accomplishments during the first year included:

- Conducting four (4) formal BAC meetings, with two meetings held virtually, and one meeting being held in Pierre and one in Rapid City, both with virtual options available as well
- Establishing and approving BAC bylaws and governance structures
- Appointing two (2) BAC representatives to the Medicaid Advisory Committee (MAC) for one (1) year terms
- Providing extensive beneficiary-centered feedback on Medicaid communication materials and policy implementation strategies
- Influencing updates to benefits guide design and communication approaches
- Informing early development discussions for the PACT primary care transformation initiative
- Identifying operational challenges related to eligibility systems, provider referrals, and recipient communication
- Supporting SD Medicaid's implementation planning related to federal H.R.1 requirements
- Creating direct communication channels between Medicaid leadership and beneficiaries

A significant accomplishment of the BAC's first year was the establishment of a collaborative meeting format. Rather than limiting feedback to formal recommendations alone, the BAC functioned as an ongoing advisory partner throughout policy development and operational planning. Members were encouraged to raise real-world experiences, identify barriers, propose solutions, and assist in refining materials before public implementation.

As SD Medicaid prepares for SFY2027, the BAC is positioned to continue expanding its role in beneficiary-centered policy development. Upcoming priorities include continued work related to H.R.1 implementation, PACT and development and implementation, communication modernization, and other efforts to streamline and improve recipient experience.

Membership and Representation

The SFY2026 Beneficiary Advisory Council consisted of seven (7) appointed members representing different geographic regions, lived experiences, and perspectives from across SD Medicaid populations. Members included Medicaid beneficiaries (including past Medicaid beneficiaries), caregivers and family members of current and past Medicaid beneficiaries. Some members also have additional perspectives due to professional experience working directly with populations served by Medicaid programs.

BAC members represented multiple communities across South Dakota, specifically: Sioux Falls, Rapid City (including the Rural Rapid City Area near Box Elder), and Hot Springs. The BAC members' geographic representation helped ensure both urban and rural perspectives were incorporated into discussions. Members frequently highlighted challenges unique to rural communities, including provider access, transportation, technology barriers, and healthcare navigation challenges.

Several BAC members also brought direct professional experience working with Medicaid populations in areas such as:

- Housing services
- Care coordination/healthcare navigation (including two BAC members being trained Community Health Workers)
- Patient advocacy
- Disability services
- Guardianship support

To support the launch of the BAC, SD Medicaid implemented a broad outreach and recruitment strategy designed to ensure awareness of the opportunity across healthcare, behavioral health, social services, advocacy, and community-based organizations throughout the state. Recognizing the importance of including individuals with lived Medicaid experience and trusted community voices, the recruitment process prioritized both transparency and wide distribution.

Multiple recruitment emails were distributed to more than 800 individuals and organizations statewide. Recipients included healthcare providers, hospitals, federally qualified health centers (FQHCs), behavioral health organizations, social service agencies, and other community partners who regularly serve Medicaid beneficiaries. Outreach efforts encouraged these organizations and professionals to share the BAC application opportunity directly with Medicaid recipients, caregivers, family members, and individuals with lived experience navigating Medicaid services.

To support recruitment efforts, SD Medicaid also developed and distributed a one-page overview document explaining the purpose of the BAC, the roles and expectations of BAC members, meeting structures and frequency, as well as basic information about how to apply. This one-page document helped organizations and potential applicants better understand the goals of the BAC and encouraged participation from individuals who may not traditionally engage in formal advisory structures.

In addition to direct email outreach, recruitment information was shared through professional networks, organizational partnerships, and online communication channels to broaden visibility and reach underserved populations. These efforts were intended to support geographic diversity, rural representation, and inclusion of individuals with varied Medicaid experiences and backgrounds.

SD Medicaid established staggered term lengths to ensure continuity of membership and prevent complete turnover in any single year. The initial appointments included two (2) one-year terms, two (2) two-year terms, and three (3) three-year terms. This staggered structure aligned with CMS guidance and supports long-term sustainability of the advisory body to ensure staggered changes in BAC membership.

Additionally, two (2) BAC members were appointed to serve on the Medicaid Advisory Committee (MAC) for the first year, and all members participated in governance and bylaws discussions and approvals. Members whose terms were only one-year terms were informed of opportunities for future reapplication following the staggered terms.

The BAC maintained strong engagement and retention during its first year. Attendance remained consistently high throughout the reporting period, including during virtual meetings. BAC members actively participated in discussion, question-and-answer sessions, and policy feedback activities with SD Medicaid leadership and program staff regularly attended meetings as well.

Activities and Topics of Discussion

During SFY2026, the SD Medicaid BAC conducted a series of structured meetings designed to highlight beneficiary voices and incorporate lived experience into Medicaid policy and operational discussions. The BAC 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
- Story sharing and lived experience examples
- Emailed survey questions/ documents for feedback
- Draft material review and discussion

A major strength of the BAC's first year was the consistent level of participation and engagement from members. BAC members shared lived experiences, identified barriers facing beneficiaries, proposed solutions, and collaborated with Medicaid leadership to improve communication, reduce administrative burden, and strengthen access to care. These activities helped establish a strong foundation for ongoing beneficiary engagement and collaborative policy development within SD Medicaid.

Throughout the year, BAC members reviewed and discussed several major Medicaid initiatives and policy areas, including Medicaid communication and notices, provider referral requirements, Care Connect program updates, Medicaid eligibility changes under H.R.1, community engagement/work requirements including medical frailty processes, cost sharing proposals, Rural Health Transformation (RHT), Primary

Accountability Care Transformation (PACT), and technology access barriers related to Medicaid systems and portals.

The BAC also participated in activities focused on reviewing draft beneficiary-facing materials, including benefits guides, brochures, and communication documents. Members provided detailed recommendations to improve readability, accessibility, formatting, and clarity for Medicaid recipients. Additional engagement activities included follow-up surveys distributed after meetings to collect more detailed input on communication strategies, value-based care concepts, and H.R.1 implementation planning.

Consensus building within the Beneficiary Advisory Council (BAC) was seen in open discussion, shared lived experience, and collaborative problem-solving. During meetings, SD Medicaid staff facilitated roundtable-style conversations that encouraged all members to share perspectives, ask questions, and provide feedback on proposed policies, communications, and operational changes. BAC members frequently built upon one another's comments, identified common concerns, and discussed potential solutions together before recommendations were summarized by Medicaid leadership. Consensus was typically reached through dialogue and informal agreement rather than formal voting, allowing members to identify shared priorities while also recognizing differing experiences and viewpoints. This collaborative approach helped ensure recommendations reflected practical beneficiary experiences and supported transparent, beneficiary-centered decision-making.

Recommendations and State Responses

The main recommendations of the BAC members throughout the year involved Medicaid communication challenges. BAC members reported that Medicaid letters and notices can be confusing, anxiety-inducing, and challenging to understand from their perspective/experience.

As BAC members reviewed Medicaid communications they continued to provide feedback regarding challenges, including:

- Reading level
- Need for clear action steps
- Overwhelming formatting
- Limited language accessibility
- Reliance on websites and email
- Limited internet access
- Limited phone access
- Multi-factor authentication barriers
- Portal usability challenges

BAC members emphasized that many Medicaid beneficiaries experience significant stress when receiving official notices and may not understand what actions are required. BAC members suggested the following recommendations:

- Using simplified language
- Adding clear checklists
- Highlighting due dates and required actions
- Providing translated materials
- Including phone numbers prominently
- Offering paper-based alternatives
- Improving consistency across programs
- Providing examples and visual aids

The BAC also discussed challenges related to primary care provider (PCP) requirements, referrals, and care coordination. Members noted that assigned PCP relationships can sometimes create barriers when recipients have not established care with their provider or do not fully understand referral requirements.

BAC discussions highlighted the importance of:

- Improving care navigation
- Simplifying referral processes
- Increasing clarity regarding covered services
- Strengthening relationships between beneficiaries and providers
- Supporting care coordination through community-based roles such as CHWs

BAC members also emphasized the importance of designing programs around real patient experiences rather than administrative convenience alone.

Throughout the year, SD Medicaid staff continued incorporating BAC feedback into updating communication materials, future communication planning, and policy discussions. Feedback provided by BAC members directly informed updates to beneficiary-facing materials, including benefits guides, program letters, and educational resources, with a strong emphasis on improving clarity, accessibility, readability, and reducing barriers for Medicaid recipients navigating the system. Feedback regarding challenges regarding the PCP program are being incorporated into the design of the PACT program, which is anticipated to replace the PCP program in 2028.

BAC recommendations were accepted by the Medicaid program. As noted above some changes have multi-year implementation timelines. Some recommendations were unable to be implemented due to State and Federal guidelines or program requirements, in those instances the State provided clear explanations to help members understand the legal, fiscal, or operational reasons behind those limitations.

The BAC also served an important role in “closing the loop” between Medicaid beneficiaries and state leadership. SD Medicaid leadership consistently returned to the

BAC with updates on prior questions, policy developments, implementation considerations, and draft materials for additional review. This iterative process strengthened trust, transparency, and accountability between Medicaid recipients and the agency.

Operational and Engagement Successes

Throughout the year, BAC members consistently emphasized the experiences of individuals who struggle to navigate Medicaid systems, particularly those facing literacy challenges, language barriers, housing instability, or limited internet and technology access. This ongoing advocacy for improved and simplified communications has led SD Medicaid, over the last year, to continue to enhance communications to be clear, consistent, and easy to understand.

While the BAC and SD Medicaid did not formally co-create policies or programs during the first year, BAC members played an important role in improving how Medicaid information and resources were written and presented to beneficiaries. Through feedback on letters, brochures, benefits guides, and other recipient-facing materials, BAC members helped identify confusing language, formatting challenges, and communication barriers that could make Medicaid information difficult to understand. This feedback supported ongoing revisions focused on making materials clearer, easier to read, and more accessible for Medicaid recipients and their families.

Attendance and participation remained exceptionally strong throughout the first year of the Beneficiary Advisory Council. All seven (7) appointed BAC members attended each of the first three (3) meetings, demonstrating a high level of engagement and commitment to the council's work. During the fourth meeting, five (5) of the seven (7) members attended, with others unable to attend. To facilitate attendance the State provided supports for members including travel reimbursement and lodging logistics for in-person meetings. Overall, the BAC maintained consistent participation and active involvement across meetings, discussions, and feedback activities throughout SFY2026.

Conclusion and a Look Ahead

The BAC's first year demonstrated the value of sustained beneficiary engagement in SD Medicaid policy development and operational planning. Through open dialogue, shared experiences, and collaborative problem-solving, the BAC provided meaningful insight that will continue shaping SD Medicaid programs and beneficiary experiences moving forward.

SD Medicaid has identified the following topics for the coming year, based on previous discussion and feedback received from BAC members:

- Continued H.R.1 implementation planning

- Community engagement/work requirement communications
- PACT operational development
- Rural Health Transformation implementation
- Continued benefits and recipient material and technology refinement

Overall, the inaugural year of the SD Medicaid Beneficiary Advisory Council was highly successful in establishing strong member engagement, meaningful collaboration, and valuable beneficiary feedback, creating a strong foundation for continued growth and impact in year two.

Measuring Performance and CHIP Goals

South Dakota Department of Social Services

Measuring Performance

The State uses a few mechanisms to measure performance and quality as an insurance provider.

- HEDIS (Healthcare Effectiveness Data and Information Set) Measures
  - 6 core domains with over 90 measures – Compiled into the Medicaid and CHIP Scorecard https://www.medicaid.gov/state-overviews/scorecard/welcome
- CAHPS (Consumer Assessment of Healthcare Providers and Systems
  - Consumer Experience of Care survey – samples approximately 5,500 unique recipients
  - Asks questions such as how satisfied with your health plan are you and were you able to access care.

Why national measure sets and not our own?

- Uniform reporting – allows us to compare our metrics across other states in an "apples to apples" scenario and seek technical assistance from those states who may be performing well in an area.

CHIP State Plan Goals

- The CHIP state plan is required to include goals related increasing high-quality coverage for low-income children.
- Current goals in the plan date back to initial implementation of the program in the late1990s and need to be updated.
- Objective
  - Update goals to better reflect relevant quality measures
  - Leverage existing quality measures and data sources
    - CAHPS Survey
    - HEDIS Measures

CHIP Background

- CHIP is the Children's Health Insurance Program.

- CHIP is operated by the Medicaid agency as a look-a-like program.
  - Extends eligibility to additional children under age 19.

- The CHIP state plan is the agreement between the federal government and the State regarding operation of the CHIP program.

Draft Measures for Discussion

Ensure the CHIP plan provides timely and satisfactory health coverage for eligible children.

1. CAHPS survey rating of health plan. (Baseline 84.6%).
   - Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months?

2. CAHPS survey rating Getting Care Quickly (Baseline 90.6%)
   - In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?
   - In the last 6 months, how often did you get an appointment for a check-up or routine care for your child as soon as your child needed?

3. CAHPS survey rating Getting Needed Care (Baseline 86.4%)
   - In last 6 months, how often was it easy to get the care, tests, or treatment your child needed.
   - In the last 6 months, how often did you get appointments for your child with a specialist as soon as he or she needed?

A quality score for item 1 is 8 or higher. A quality score for questions associated with items 2 and 3 is "Usually" or "Always."

Draft Measures for Discussion

Ensure the CHIP plan provides timely and satisfactory health coverage for eligible children.

4. Number of enrolled Medicaid and CHIP children by SFY

5. Average days to disposition of new monthly Medicaid/CHIP applications by SFY

6. US Census Bureau survey of uninsured low-income children (Baseline 10.6%)

Draft Measures for Discussion

Ensure the CHIP plan design and reimbursement lead to quality primary and oral health outcomes.

1. Well-child visit first 15 months, 6+ visits (Baseline 56.5%)
2. Well-child visits 15 to 30 months, 2+ visits (Baseline 64.5%)
3. Well-child visits age 3 to 21 (Baseline 49.4%)
4. Accessing dental/oral health services (Baseline 52.6%).
5. Percent of Medicaid/CHIP primary care expenditures that are value-based (Baseline 14%)

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.

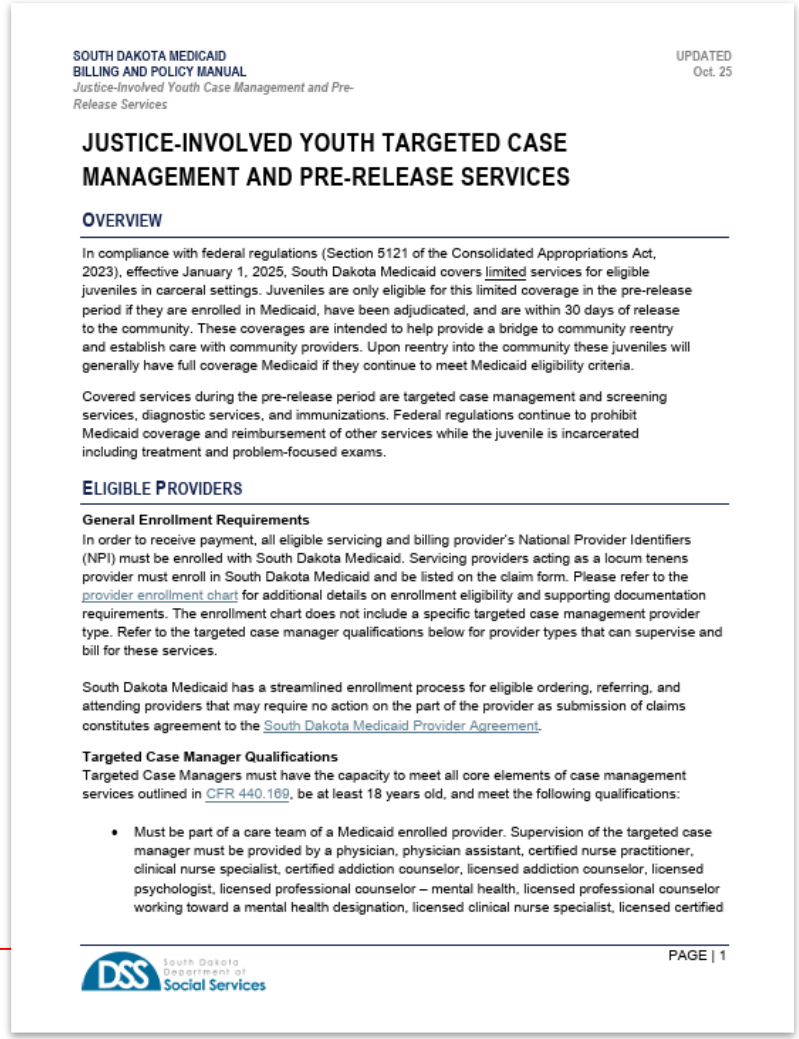
Juvenile Detention Centers (JDC): South Dakota has 7 JDCs	Beadle County, Brown County, Codington County, Hughes County, Minnehaha County, Pennington County, and Roberts County
Tribal Juvenile Carceral Settings*: South Dakota Tribes have 4 JDCs	Wanbli Wiconi Tipi JDC – Rosebud Reservation, Rosebud Sioux 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

PAGE | 1

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

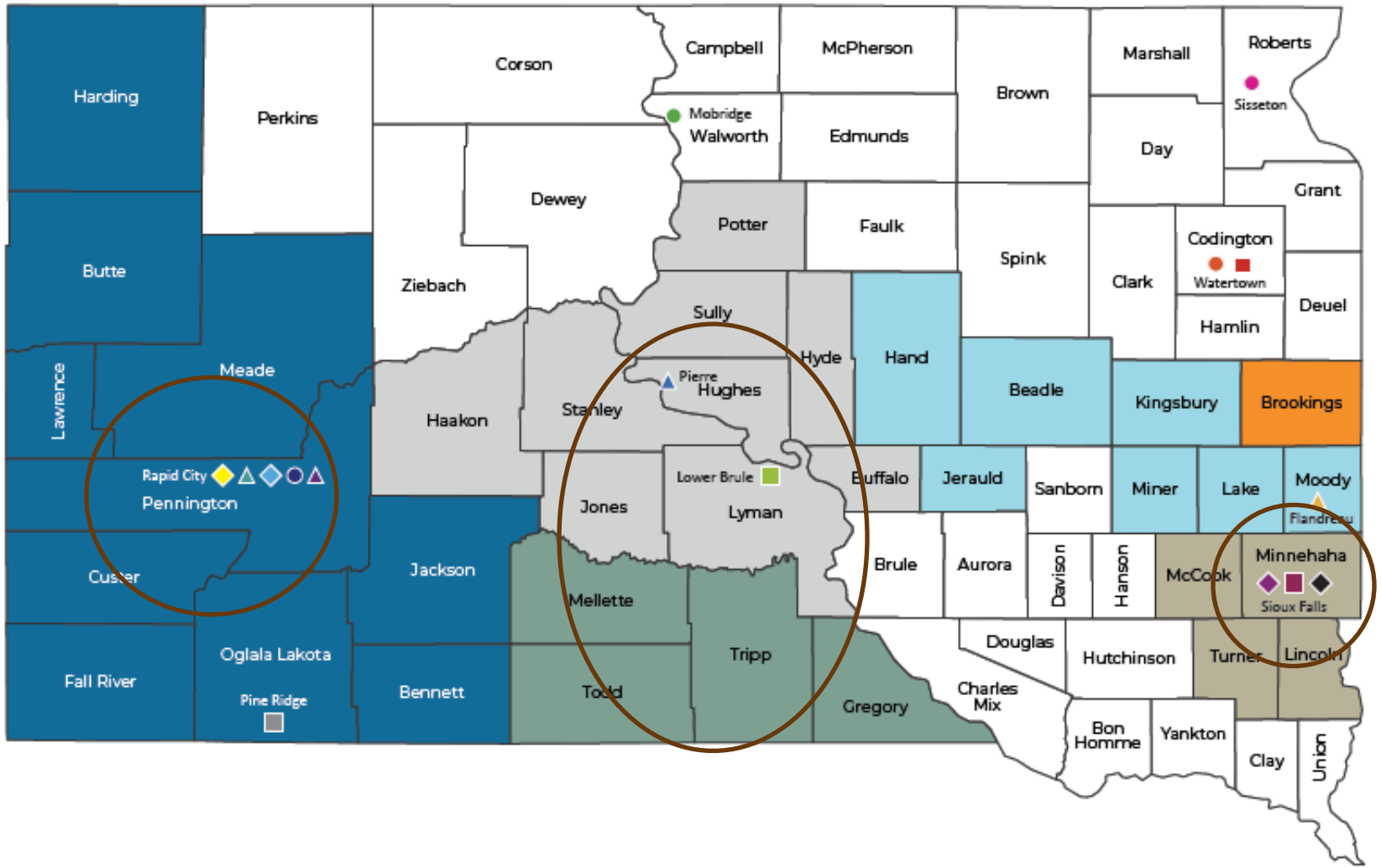
1. Meet Facilities Where They Are *(CHWSD and Medicaid Supported)*
2. Develop a Strong Statewide Targeted Case Manager Network Supported by Diverse Organizations *(CHWSD Supported)*
3. Standardize Referral and Engagement Workflows Across JDCs, Jails, and Probation Offices *(CHWSD Supported)*
4. Integrate 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

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).