



Medicaid 101

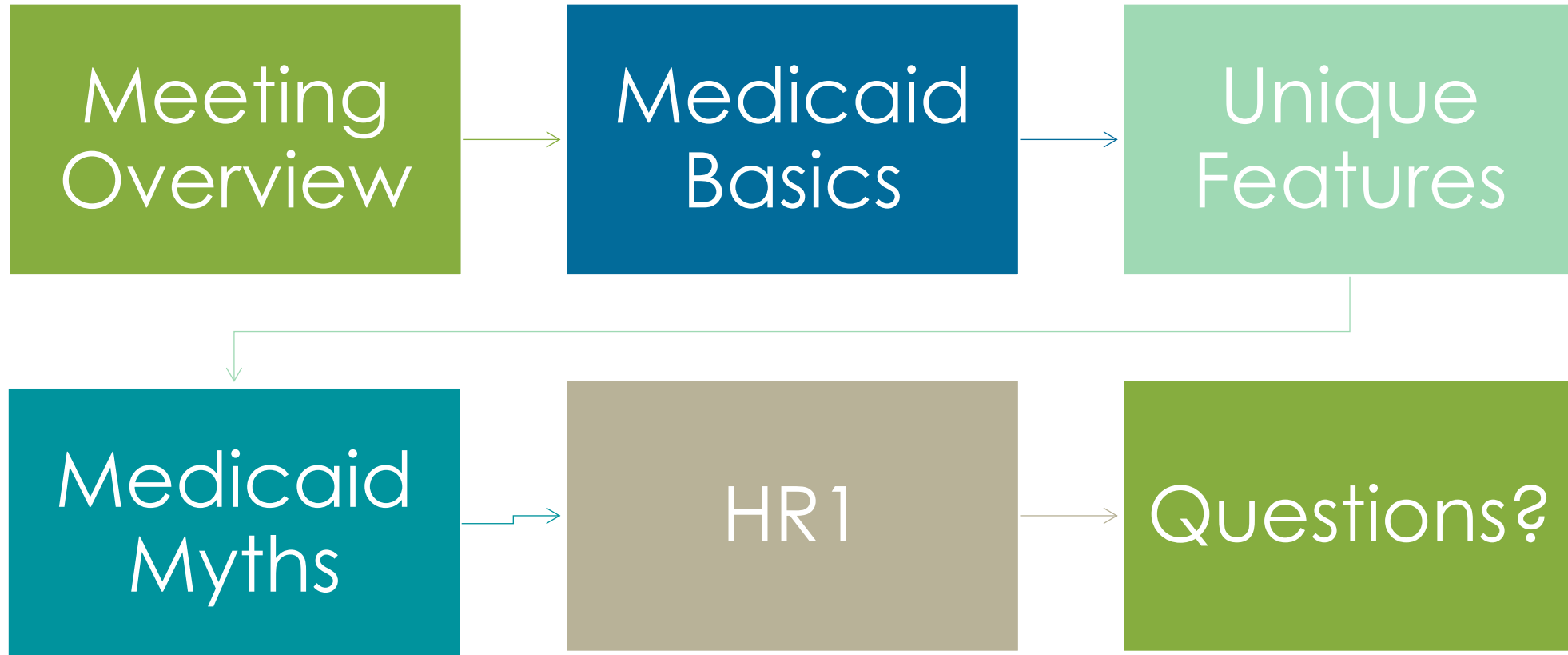




WELCOME!

Case Management/Social Worker Medicaid Workshop

Agenda



Meeting Overview

Meeting Notes

>170 RSVPs

Wide Variety of Levels of Care
On-site and Virtual

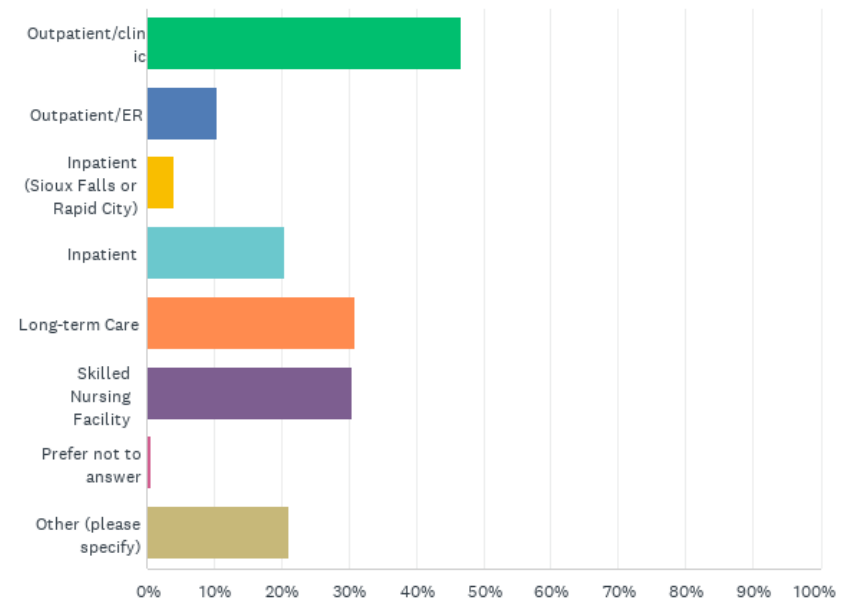
Goals:

- 1) Benefits/Services/Programs available
- 2) How to access them
- 3) Who to go to with questions

Slides

Survey and Post-meeting
Suggestions?

Q7 What level of care is relevant to the work you do? (Pick all that apply)



Agenda

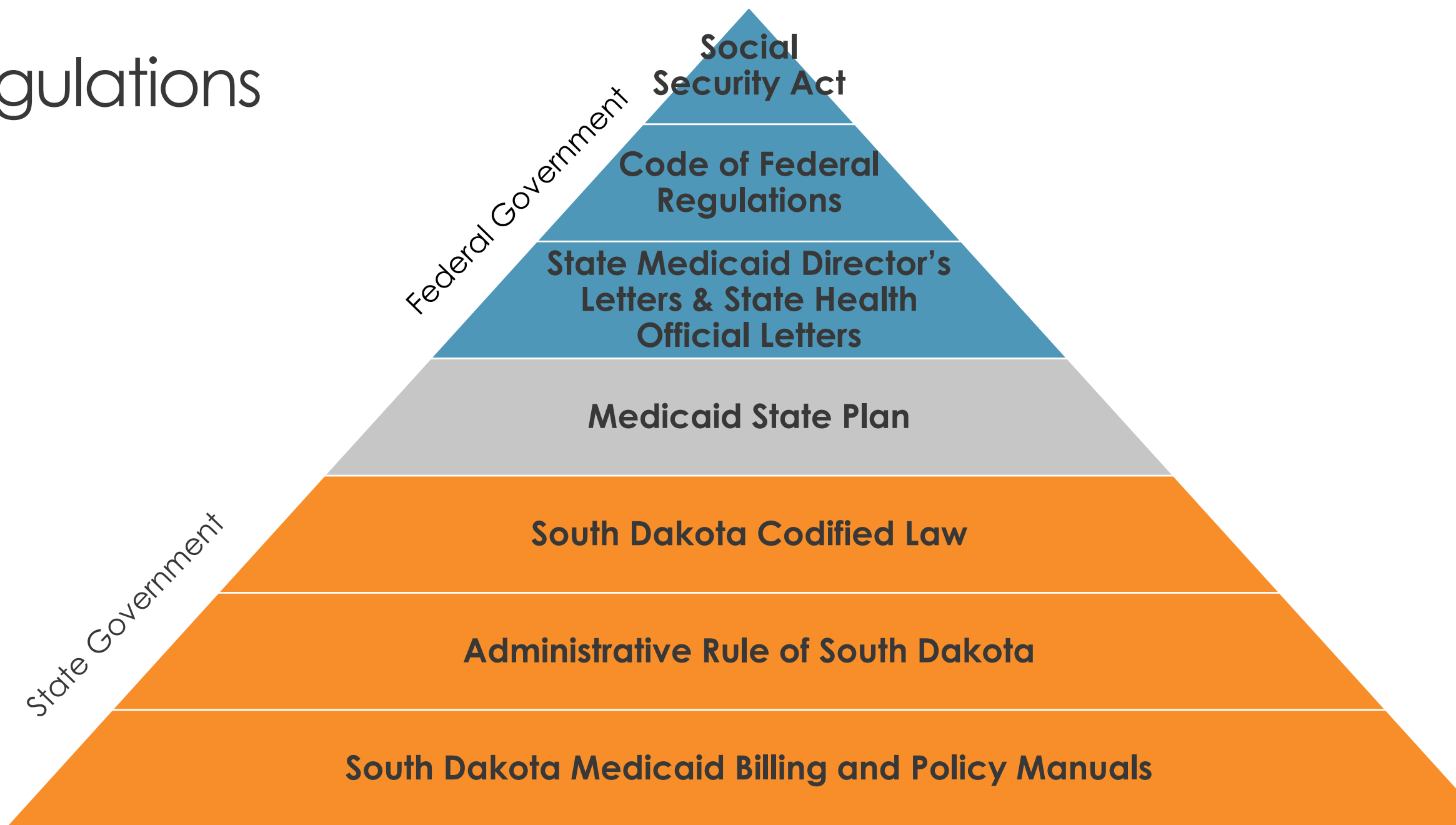
Topic	Time	Presenter(s)
Welcome and Intro to Medicaid	9:00 am	Clarissa Barnes, MD, MBA, FACP, Chief Medical Officer South Dakota Medicaid
Enrollment	9:30 am	Kristin McNeely, Medicaid Eligibility Program Specialist Kate Derrick, Medicaid Eligibility Program Specialist
Non-Emergent Medical Transportation (NEMT)	10:30 am	Giezelle Brown - Policy/Data Analyst, EBT & Non-Emergency Medical Travel
Pharmacy Basics: Outpatient and Physician Administered Drugs	11:00 am	Taylor Koerner, PharmD, BCPS – Clinical Pharmacist Mike Jockheck, RPh - Pharmacy Director
Case Management (Health Home, PCP program, Baby Ready, Care Coordination Agreements and Shared Savings)	11:30 am	Cassie Long, BSN, RN - IPA Nurse Consultant and Care Management Nurse Specialist Chris Soukup, Care Management Program Administrator Valerie Kelly, BabyReady Program Manager Leslie Wilson, DNP, CNP - IPA Nurse Supervisor
LUNCH	12:15 pm	On Your Own
Prior Authorizations	1:15 pm	Nicole Bartel RN, RHIT, Nurse Manager
Inpatient Rehabilitation and Long-Term Acute Care Hospitals (LTACH)	2:00 pm	Sara Gloe, RN Nurse Consultant
Skilled Nursing Facilities (SNF) and Long-Term Care (LTC)	2:30 pm	Michelle Hudecek, RN-Nurse Consultant Program Manager-Division of Long-Term Services and Supports, Department of Human Services Krista Miller, RN-Nurse Consultant-Division of Long-Term Services and Supports, Department of Human Services
Waiver Services	3:00 pm	Caillin Clarey - HCBS Program Manager, Division of Long Term Services and Supports Carrie Geppert - Family Support Manager, Department of Human Services, Division of Developmental Disabilities Augusta Wiese - CHOICES Manager, Department of Human Services, Division of Developmental Disabilities
Home Again	4:00 pm	Ashley Lauing, MPH, Policy Strategy Manager
Questions/Wrap-Up	4:30 pm	

Medicaid Basics

What is Medicaid?

- Medicaid is the nation's publicly financed health care coverage program for low-income people enacted in 1965 under Title XIX of the Social Security Act and Title XXI the Children's Health Insurance Program (CHIP) enacted in 1997
 - An entitlement program that requires all eligibles to receive services and is funded through federal and state dollars.
 - Provides health coverage for low-income children and families who lack access to private health insurance; and people with chronic illnesses or disabilities
 - Expansion, which started enrolling in SD in July 2023, means now includes low-income adults are included (138% FPL)
 - It is a Federal – State partnership.
- States administer the Medicaid program
 - Each state plan is different due to optional services provided making it difficult to compare states side-by-side
- Medicaid is separate from Medicare
 - Medicare is for individuals 65 years and older for all incomes, and for people with disabilities
 - Medicare is a federally administered and funded program

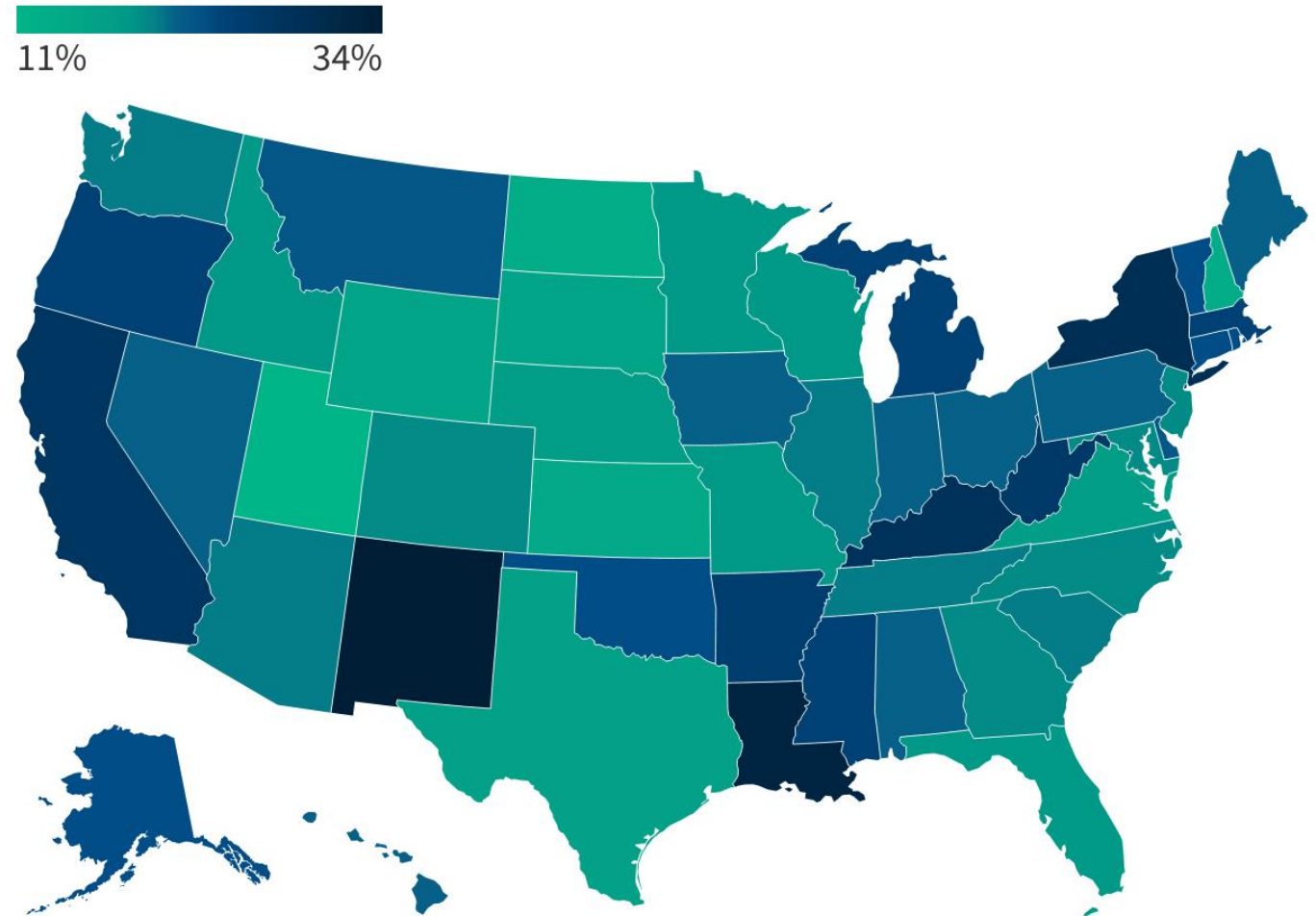
Regulations



Who is Covered by Medicaid?

Nationally, One in Five People Have Medicaid, but This Varies Across the States

Share of people enrolled in Medicaid by state



Note: This figures includes people who are covered by Medicaid-only as well as those who have both Medicaid and another type of coverage.

Source: KFF State Health Facts, Health Insurance Coverage of the Total Population, 2023

What is FMAP?

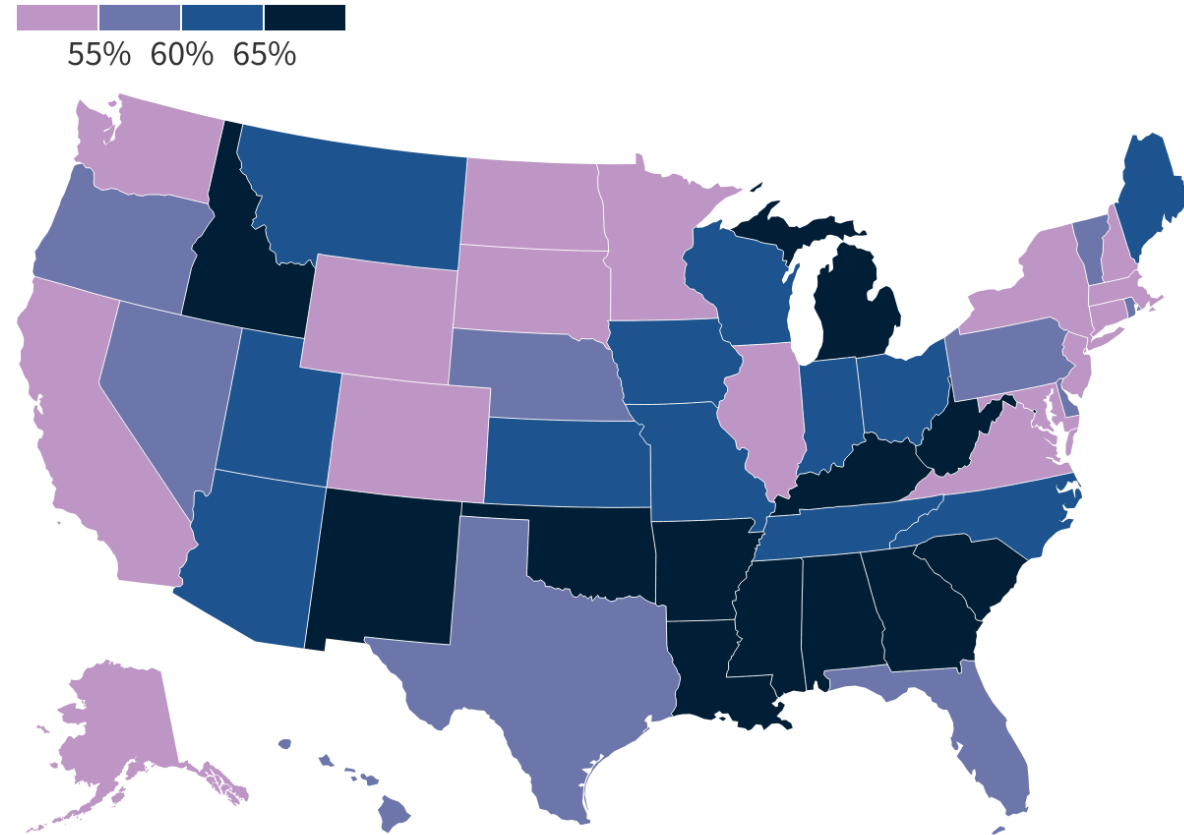
Enhanced FMAP

Some services and coverage groups have statutorily higher FMAPs than the state's regular FMAP.

- Children's Health Insurance Program (CHIP) Recipients
- Medicaid Expansion Recipients
- Family Planning Services
- Services Received through Indian Health Service or a Tribal 638 Provider

Medicaid is Jointly Financed by the Federal Government and States

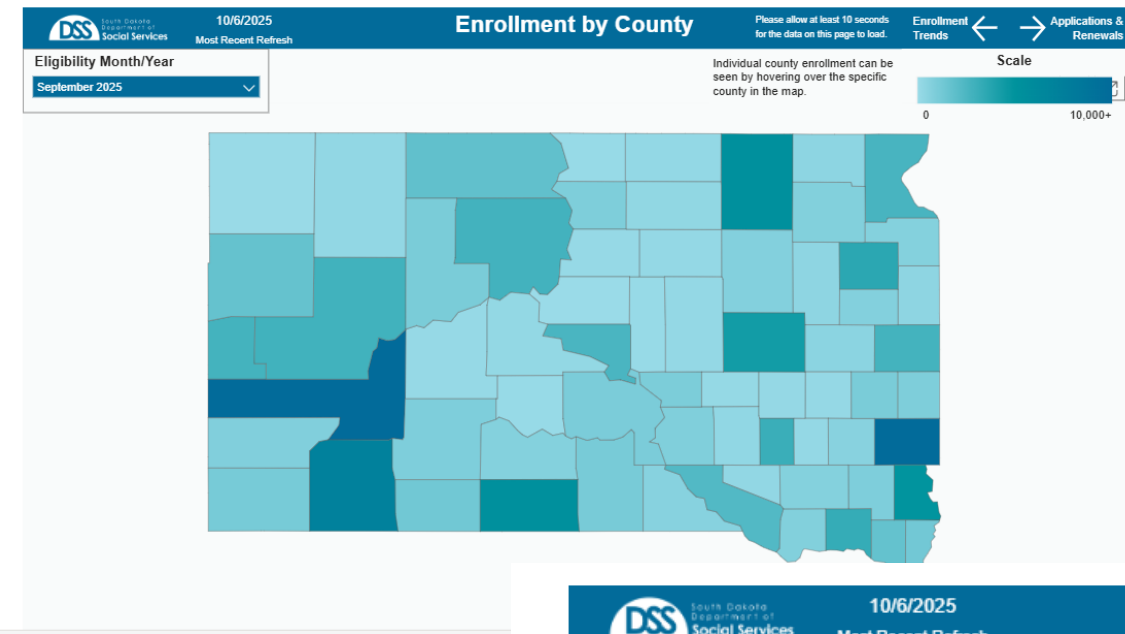
Federal Medicaid Assistance Percentage (FMAP) for traditional Medicaid spending, FFY 2026



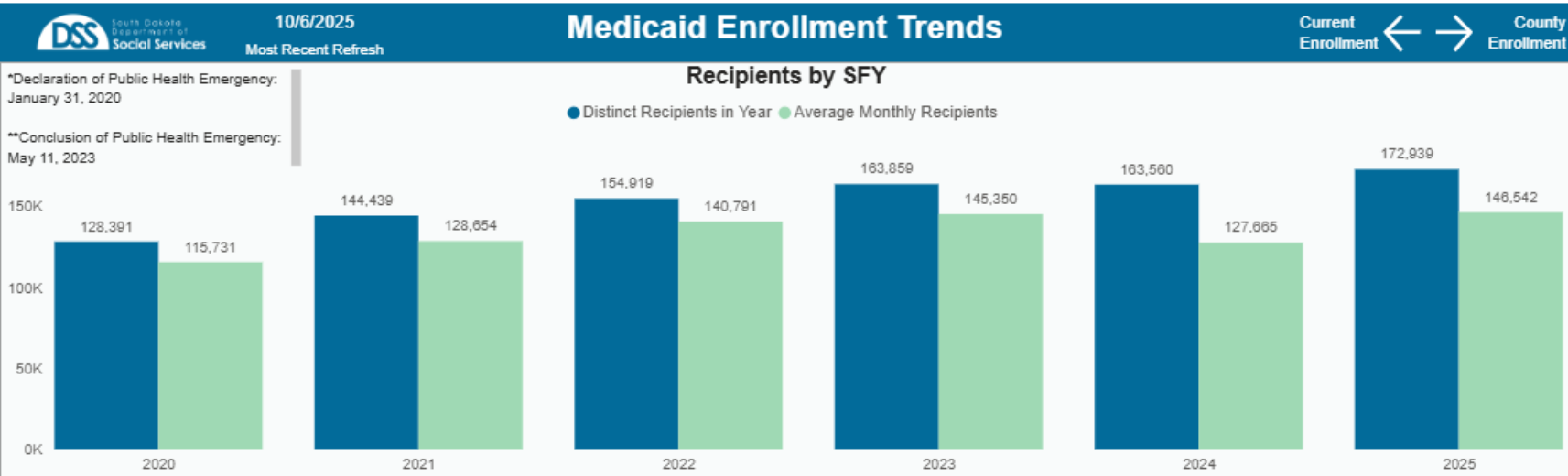
Note: FFY = federal fiscal year. These rates are in effect October 1, 2025 - September 30, 2026. These FMAPs are determined by a formula set in statute and are for services used by people eligible through traditional Medicaid, which includes individuals who are eligible as children, low-income parents, because of disability, or because of age (65+). The formula is designed so that the federal government pays a larger share of program costs in states with lower average per capita income.

Source: Federal Register, November 29, 2024 (Vol 89, No. 220), pp 94742-94745

Medicaid coverage by county

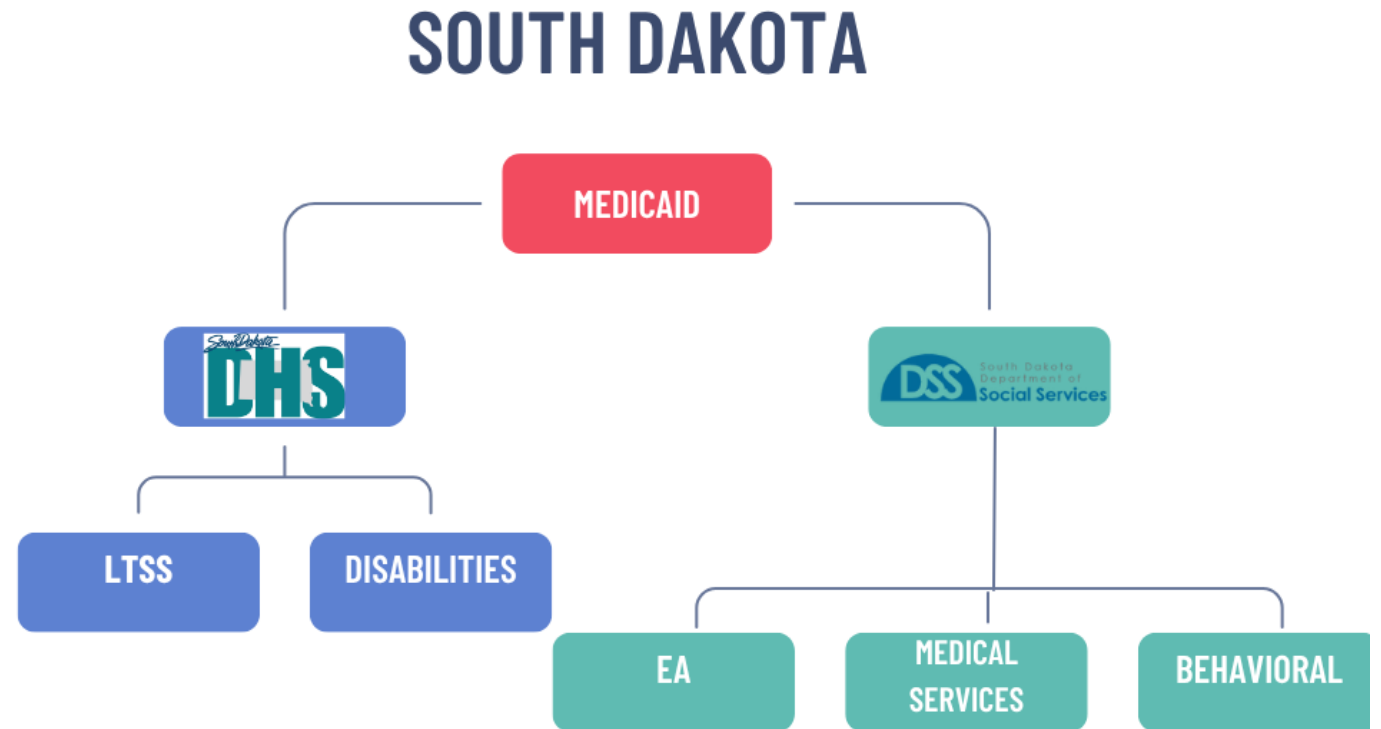


Overall numbers have been increasing



Medicaid spans Departments

Heather Petermann is the Medicaid Director and is also the head of Medical Services in the Department of Social Services



DOH also provides services –WIC/Bright Start

Don't forget DSS includes more than Medicaid including SNAP, Child Support, and CPS

Unique Features

Medicaid-Covered Services Not Typically Offered by Medicare/Commercial Plans

-  **Non-Emergency Medical Transportation (NEMT)**
 - Transport to medical appointments for eligible beneficiaries
 - Especially important for patients with chronic illnesses or disabilities
 - May include ride-shares, vans, or public transit vouchers
-  **Long-Term Services and Supports (LTSS)**
 - Includes home- and community-based services (HCBS)
 - Nursing home care and personal attendant services
 - A critical support for elderly and disabled populations
-  **Behavioral Health Services**
 - Often more comprehensive than Medicare or commercial coverage
 - Includes case management, peer support, community mental health services
-  **Enhanced Pediatric Services (EPSDT)**
 - Early and Periodic Screening, Diagnostic, and Treatment
 - Covers all medically necessary services for children under 21
 - Broader scope than typical pediatric commercial plans
-  **Waiver Programs**
 - Allows states to cover services beyond federal Medicaid rules
 - Tailored services for specific populations (e.g., autism, HIV/AIDS, TBI)

Out- of- State Services



State Medicaid plans will generally prefer services provided in-state.



This means out of state outpatient services and/or inpatient transfers may require Prior Auth (if not urgent/emergent)



Out of state services may have a different payment methodology but providers still need to be enrolled

Medicaid Coverage

Medicaid Mandatory Services

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
 - All Medically Necessary care for eligible children under age 21
- Nursing facility services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

South Dakota Services

- Rehabilitation Services (CMHCs/SUD)
- Physician assistants
- Psychologists and independent mental health practitioners
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Podiatry
- Prescription Drugs
- Optometry
- Chiropractic services
- Durable medical equipment
- Dental services
- Physical, occupational, speech therapy, audiology
- Prosthetic devices and eyeglasses
- Hospice care, nursing services
- Personal care services and home health aides
- Community Health Workers
- Dietician/Nutrition Services

Medicaid Myths

Common Medicaid Misconceptions

Myth

"Medicaid is only for people who don't work."

"Medicaid is the same in every state."

"Medicaid doesn't cover much."

"Medicaid is just like Medicare."

"Undocumented immigrants can enroll in Medicaid."

Reality

Many Medicaid recipients are employed, especially in low-wage or part-time jobs without employer health benefits.

Each state runs its own Medicaid program with different benefits, eligibility rules, and provider networks.

Medicaid covers a broad range of services, including hospital care, physician visits, and (often) prescriptions, mental health, and long-term care.

Medicaid is income-based and varies by state. Medicare is federally run and based on age or disability. They can overlap, but they are distinct programs.

Undocumented individuals are not eligible for Medicaid, but hospitals may request compensation for emergency services provided via Medicaid under strict circumstances.

HR1

HR1

- **What:** Work requirements
Who: People ages 21 to 64 who do not have dependent children, are not pregnant and are not receiving Medical Assistance based on a disability (Expansion- NA/AI excluded)
When: Jan. 1, 2027
- **What:** More frequent renewals
Who: People ages 21 to 64 who do not have dependent children, are not pregnant and are not receiving Medical Assistance based on a disability
When: Jan. 1, 2027
- **What:** Limits on retroactive coverage
Who: People who apply for Medical Assistance on or after Jan. 1, 2027
When: Jan. 1, 2027
- **What:** Cost sharing on some services
Who: Some people ages 21 to 64 who do not have dependent children, are not pregnant and are not receiving Medical Assistance based on disability
When: Oct. 1, 2028
- **What:** Change in eligibility for some immigrants
Who: Only certain lawful permanent residents, Cuban and Haitian entrants, and Compact of Free Association (COFA) migrants will be eligible.
When: Oct. 1, 2026



Clarissa Barnes, MD, MBA, FACP

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South Dakota Medicaid & CHIP



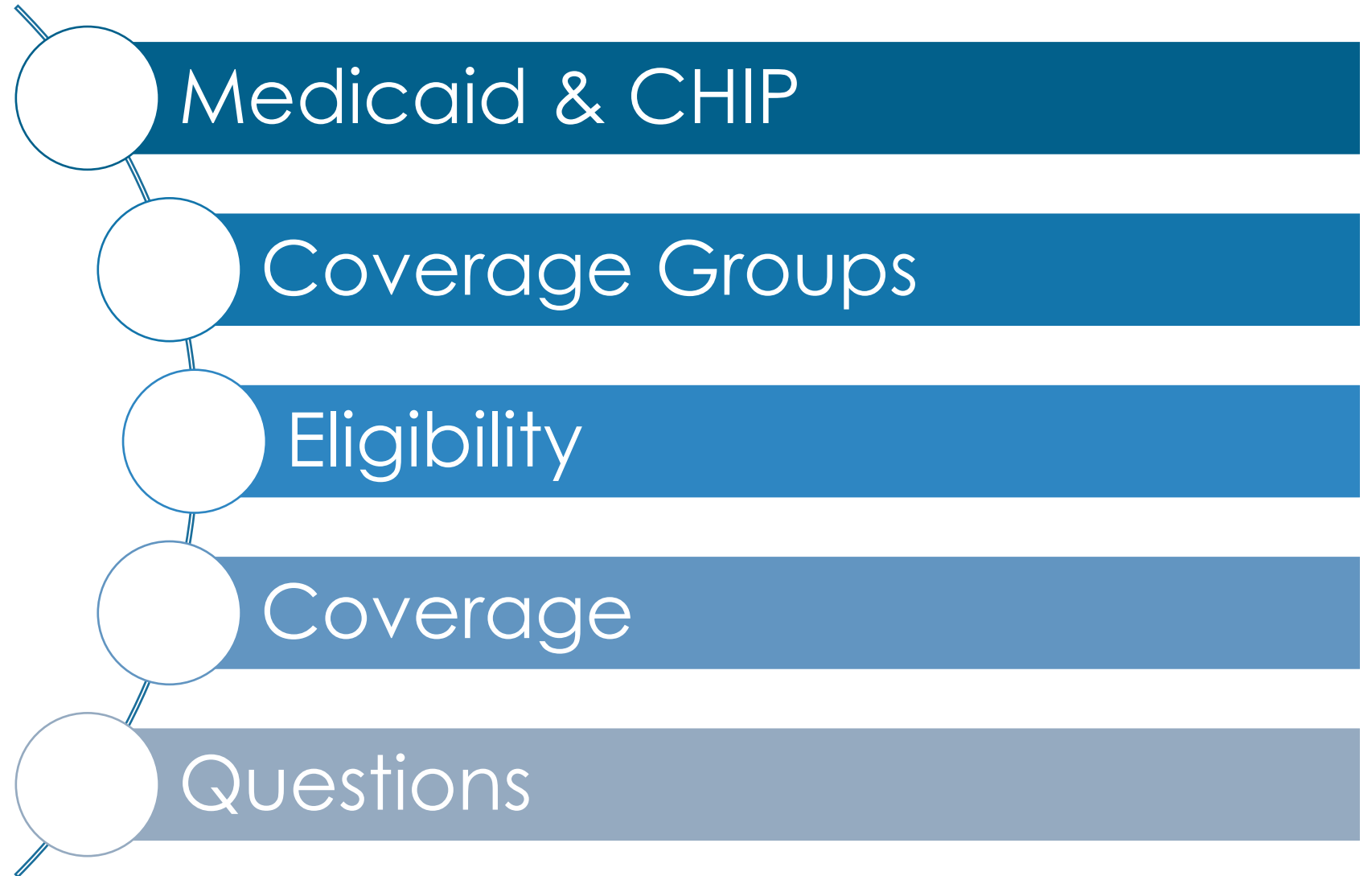


Our Vision and Mission

Strong families – South Dakota's foundation and our future

The South Dakota Department of Social Services is dedicated to strengthening families to foster health, wellbeing, and independence.

Agenda



Medicaid & CHIP

What is Medicaid?

Medicaid and CHIP provide access to health care to about 150,000 South Dakotans through partnerships with nearly 16,000 enrolled Medicaid providers.

- An entitlement program that requires all eligibles to receive services and is funded through federal and state dollars.
- Provides health coverage for low-income children and families who lack access to private health insurance; and people with chronic illnesses or disabilities
- It is a Federal – State partnership.

States administer the Medicaid program

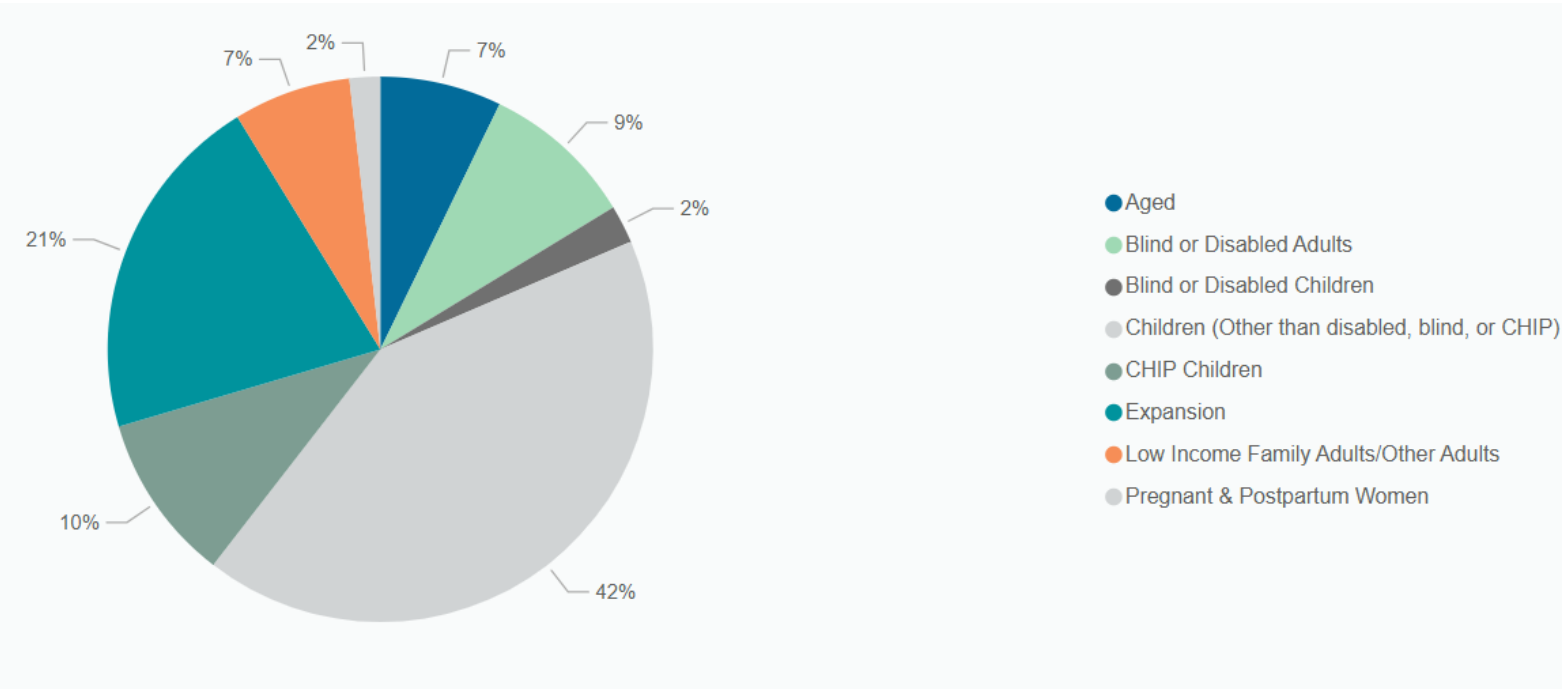
- Each state plan is different due to optional services provided making it difficult to compare states side-by-side

Medicaid is separate from Medicare

- Medicare is for individuals 65 years and older for all incomes, and for people with disabilities
- Medicare is a federally administered and funded program

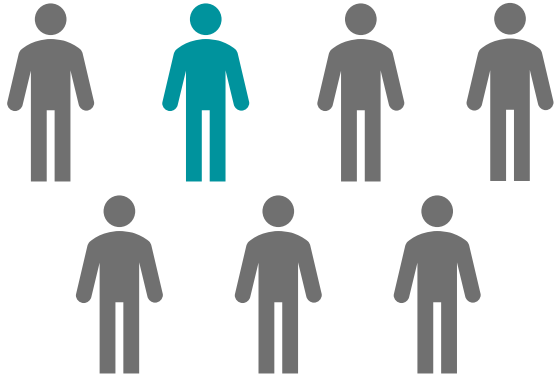


Who is covered by Medicaid?



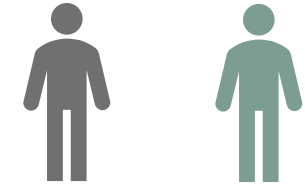
See more statistics at <https://dss.sd.gov/keyresources/statistics.aspx#fmap>.

Who We Serve



Over 1 in 7 South Dakotans in any given month will have health coverage through Medicaid or CHIP

More than 1 of every 3 children under the age of 19 in South Dakota has health coverage through Medicaid or CHIP and 40% of children born in South Dakota will be on Medicaid or CHIP during their first year of life



55% of all nursing home residents receive long-term care coverage through Medicaid

Points of Contact

Regions

There are eight (8) regions across the state for Medicaid. Workers in any region can assist in processing cases for other regions.

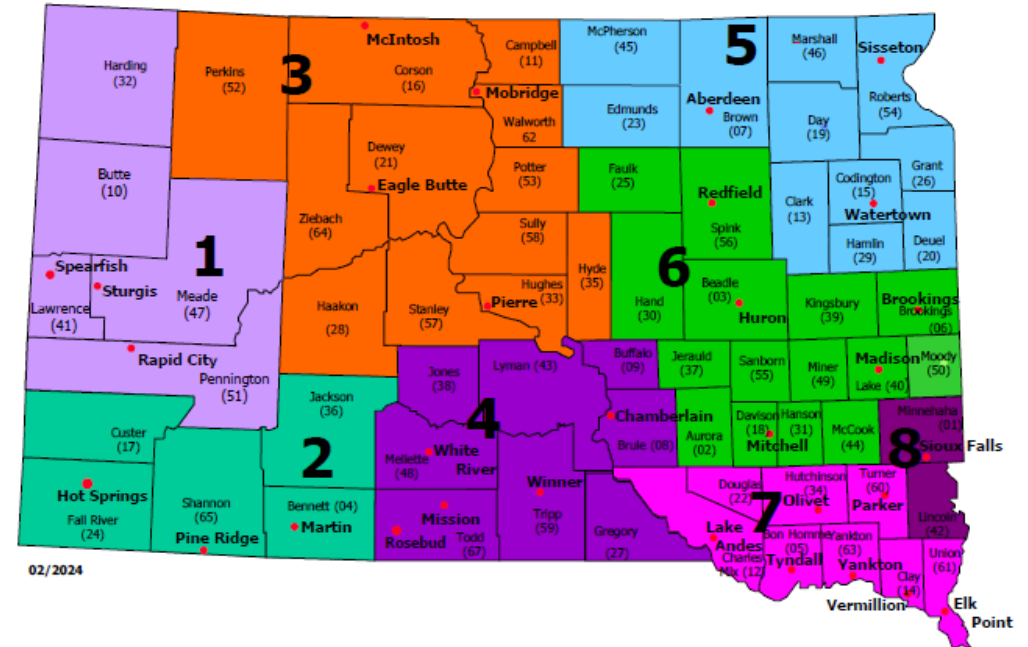
Economic Assistance Benefits Specialists

Cases are assigned to benefits specialists or a team of benefits specialists based on the county their application falls into.

Customers and providers may also use the general Medicaid email inbox for their region.

Medical Program Staff

Customers, providers, or stakeholders with concerns they feel have not been addressed by the benefits specialist or supervisor can contact Medical Program Staff by calling 605-773-4678.



Offices

Region 1 – Rapid City/Spearfish/Sturgis

Region 2 – Pine Ridge/Hot Springs/Martin

Region 3 – Pierre/Eagle Butte/Mobridge

Region 4 – Chamberlain/Mission/Winner/Rosebud/White River

Region 5 – Aberdeen/Sisseton/Watertown

Region 6 – Brookings/Huron/Mitchell

Region 7 – (Vermillion/Elk Point) / (Lake Andes/Olivet/Tyndall) / (Yankton/Parker)

Region 8 – Sioux Falls

Regional Email Inbox

RCMedTeam@state.sd.us

DSSEARegion2Med@state.sd.us

DSSEARegion3EA@state.sd.us

DSSRegion4EA@state.sd.us

DSSRegion5EA@state.sd.us

DSSHUMEDLTC@state.sd.us

[DSSEAVermillion@state.sd.us](mailto:(DSSEAVermillion@state.sd.us)) / [DSSEALakeAndes@state.sd.us](mailto:(DSSEALakeAndes@state.sd.us)) / [DSSYanktonEA@state.sd.us](mailto:(DSSYanktonEA@state.sd.us))

SFMEd@state.sd.us

Points of Contact

Regions

There are three (3) Long Term Care regions with nine (9) specialists in each region. Regions are divided by counties.

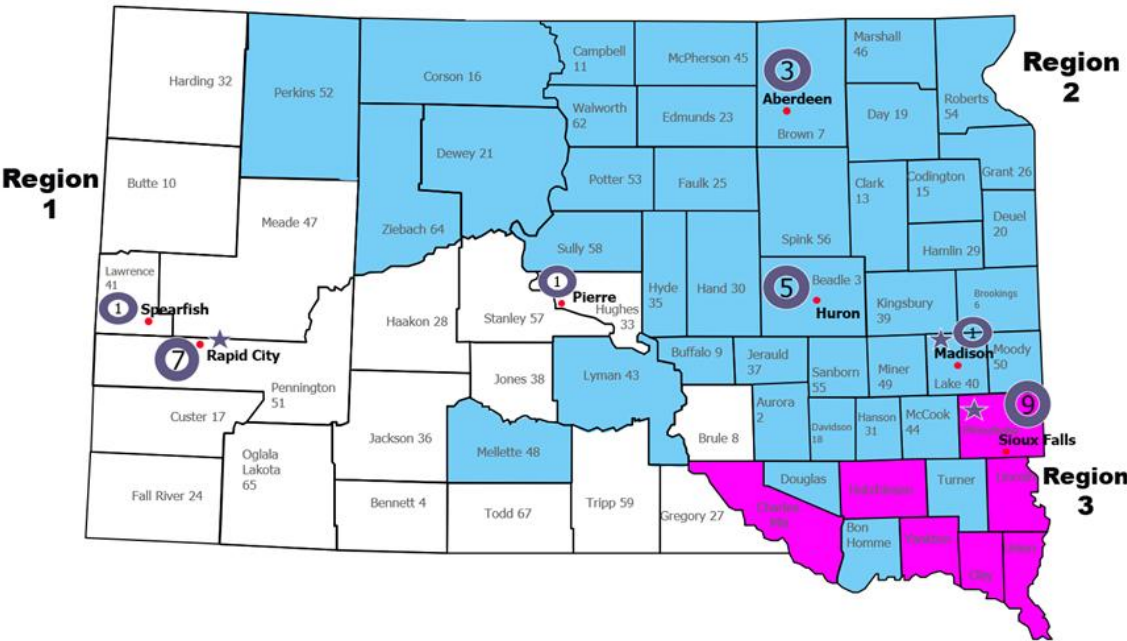
Long Term Care Benefits Specialists

Each provider is assigned a specific Long Term Care Benefits Specialist as their point of contact.

Customers and providers may also use the general LTC email inbox for their region or contact the supervisor in their region.

Medical Program Staff

Customers, providers, or stakeholders with concerns they feel have not been addressed by the benefits specialist or supervisor can contact Medical Program Staff by calling 605-773-4678.



Supervisor	Regional Inbox	Phone	Supervisor Email
Region 1 – Angie Reichert	LTCMedRegion1@state.sd.us	605-308-0072	Angie.Reichert@state.sd.us
Region 2 – Kristi Mattke	LTCMedRegion2@state.sd.us	605-317-3746	Kristi.Mattke@state.sd.us
Region 3 - Amber Devries	LTCMedRegion3@state.sd.us	605-961-4717	Amber.Devries@state.sd.us

Coverage Groups

Children, Family, & Adult Programs

Medicaid Expansion – Adult Group

Coverage for adults aged 19 to 64 with income up to 138% FPL who are not entitled to or enrolled in Medicare and not eligible for another mandatory coverage group.

Parents & Other Caretaker Relatives

Coverage for parents or other caretaker relatives (grandparent, brother, sister, stepparent, etc.) with a dependent child(ren).

Pregnant & Postpartum Women

Coverage for pregnant individuals with income up to 138% FPL (includes 12 months postpartum).

Medicaid & CHIP for Children Under 19

Coverage for insured children (187% FPL) & uninsured children (209% FPL).

Newborns

Coverage for child(ren) born to a woman enrolled in SD Medicaid at birth.

Former Foster Care Youth

Coverage for youth aged 18 up to 26 that are leaving State or Tribal foster care after their 18th birthday.

Refugee Medical Assistance

A short-term wholly federally funded transitional program available to ensure refugees receive medical care needed while they transition to living in the U.S.



Aged, Blind, & Disabled Programs

Adults Currently & Formerly Receiving Supplemental Security Income (SSI)

Individuals currently receiving SSI are automatically eligible for full coverage Medicaid.

Some individuals who formerly received SSI may still be eligible for full coverage Medicaid if they currently receive Title II benefits and meet other financial and non-financial criteria.

Breast & Cervical Cancer Program

The Breast and Cervical Cancer Program is full coverage for uninsured South Dakota women who need treatment for breast or cervical cancer, including pre-cancerous conditions and early-stage cancer. The Department of Health determines eligibility for this program.



Disabled Children's Program

This program provides full coverage for children under 19 with disabilities who have medically fragile conditions requiring skilled nursing care in a medical facility if they were not being cared for at home. Only the child's income and resources are considered when determining eligibility.

Medicaid for Workers with Disabilities

This full coverage program is for individuals with income below 250% FPL and resources under \$8,000 who have disabilities and are working.

Chronic Renal Disease

This state-funded limited-coverage program is for individuals without a third-party payer who are experiencing chronic renal failure with income less than 150% FPL.

Long-Term Care Coverage Groups

These coverage groups for the aged, blind, and disabled require individuals to meet a nursing facility level of care. They provide institutional and home and community-based services (HCBS).

Long Term Care

- Skilled nursing facility, swing bed, & hospice
- Intermediate Care for the Intellectually Disabled (ICF)

State-Funded Programs

- Adult Foster Care (AFC)
- Regular Assisted Living (ASL)

HCBS Waivers

- CHOICES Waiver
- Family Support 360 Waiver (FSW)
- Assistive Daily Living Services (ADLS) Waiver
- HOPE Waiver: In-Home, Structured Family Caregiving, Assisted Living, & Community Living Homes



Medicare Savings Programs

Resource Limits

QMB, SLMB, & QI have a 2025 resource limit of \$9,660 for an individual and \$14,470 for a couple.

Qualified Medicare Beneficiary (QMB)

- Income Limit 2025: \$1,325 for an individual and \$1,783 for a couple
- Coverage: Part A & B premiums; deductibles, coinsurance, and copayments (for services/items Medicare covers).
- *Coverage cannot be backdated*

Specified Low-Income Medicare Beneficiary (SLMB)

- Income Limit 2025: \$1,585 for an individual and \$2,135 for a couple
- Coverage: Part B premiums (must have both Part A and Part B to qualify.)
- Coverage can be backdated up to 3 months if eligible

Qualified Individual (QI-1)

- Income Limit 2025: \$1,781 for an individual and \$2,400 for a couple
- Coverage: Part B premiums (must have both Part A and Part B to qualify.)
- Coverage can be backdated up to 3 months if eligible
- *Cannot be eligible for QI if eligible for Medicaid*

Qualified Disabled & Working Individual (QDWI)

- Income limit 2025: \$5,032 for an individual and \$7,135 for a couple
- Coverage: Part A premiums only
- Resource limit is \$4,000 for an individual and \$6,000 for a couple

Eligibility

Eligibility Criteria

The eligibility requirements for Medicaid can be split into two basic categories:

Non-Financial and Financial

Non-financial requirements are those that are not related to the income or resources of an applicant.

Non-Financial Requirements Include:

- Must be a resident of South Dakota;
- Must be a U.S. citizen or qualified alien;
- Must provide a Social Security Number;
- Must assign rights for medical support and payment; and
- For certain groups individuals must have medical needs that are such that they require a level of care provided in a long-term care facility.
- Financial requirements are related to the income and resources of an applicant.



Eligibility Methodology

Most eligibility determinations are made using the following methodologies:

- Modified Adjusted Gross Income (MAGI)
- Non-Modified Adjust Gross Income (Non-MAGI)

MAGI

MAGI only considers taxable income and does not have any resource test. Individuals determined eligible under this methodology are typically children and families (e.g., pregnant women, parents of dependent children, adults between the ages of 19-64).



Non-MAGI

Non-MAGI is based on gross income and includes a resource test. Individuals determined eligible under this methodology are typically aged, blind or disabled and require an institutional level of care (e.g., nursing home, assisted living or home and community-based services).

MSP is based on Supplemental Security Income methods and includes a resource test. You must be entitled to, but not necessarily enrolled, in Medicare to be eligible.

**SD BEHAVIORAL
HEALTH**

Department of Social Services

Take Note: Help is Here
Start the conversation
around behavioral health.

Start Here

Contact
us

Apply
Online

Find your
local office

Forms and
Publications

News

It's easy to apply! Applications are available:

1. **Online:** <http://dss.sd.gov/applyonline>
2. **DSS website:** <http://dss.sd.gov/formsandpubs/>
3. **All Department of Social Services offices**
4. **Most South Dakota Medicaid providers**

Where to Apply

The application process for Medicaid can be done entirely by mail or online. No interview is required.

An application for one Medicaid program is considered an application for all programs.

There's no wrong way to apply.

SSI recipients are automatically eligible for the South Dakota Medicaid program and do not need to apply.

Individuals can reapply at any time.

Application Process

Once the Department receives the signed application, they begin working on it promptly. The applicant will be sent a “Request for Information” if items are needed from them. Once a determination of eligibility is made, the applicant is notified. In most cases, applicants must receive a determination within 45 days of applying. The average response time is usually two weeks.

Applicants who have a Customer Portal account can opt to receive notifications by text or email when a notice is issued to them. They can use the portal to view those notices and upload documents.

Eligibility Start Date

Eligibility will begin on the first day of the month in which the application was received.

Eligibility may also begin up to 3 months prior to application if the recipient met the eligibility criteria in those months *and* received covered services.

Medicaid applications ask the question “Do you have medical bills from the past 3 months?” If an applicant answers “yes”, we will review eligibility in the prior 3 months. Applicants do not have to be eligible in all 3 months. They could just be eligible in one of the three months and receive coverage.

Approvals

South Dakota Medicaid Card

If an applicant is approved for any Medicaid or CHIP coverage group, they receive a South Dakota Medicaid card.



Primary Care Provider (PCP) Program

Individuals approved for expansion coverage are required to participate in the PCP program. This program is designed to improve access to medical care as well as improve the quality of care they receive by giving them a medical home.

Medicaid recipients are required to receive non-emergent primary care provider services from their PCP. A referral (permission) is required for non-emergent specialty and hospital services. Some services are exempt from a referral and are outlined in the [Medicaid Recipient Handbook](#).

Choosing a Primary Care Provider (PCP)

Shortly after approval, Medicaid recipients should receive a letter with instructions on how to choose a PCP online using the [Online Provider Selection Tool](#). If a PCP is not chosen, DSS will choose one for the recipient.

Federal Health Insurance Marketplace

Denials and Losses of Coverage

If an individual is found ineligible for Medicaid or CHIP, their information is automatically transferred to the Marketplace, which sends a [letter](#) with application directions. They can create or start an account with the Marketplace at [Healthcare.gov](https://www.healthcare.gov) to start or complete an application for Marketplace plans and help with costs.

The Marketplace will send reminder letters 30 to 45 days after their initial letter to those who have not signed up for coverage. They may also be assigned to a local assistor, or navigator, who will outreach the individual.

Marketplace Savings

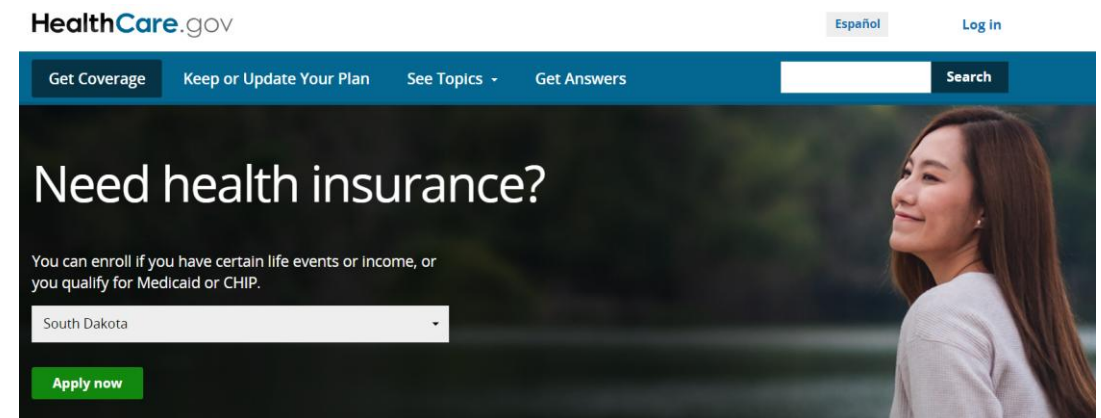
The American Rescue Plan Act of 2021 expanded financial assistance for coverage through the Marketplace and now 4 out of 5 individuals locate health care coverage for **\$10 or less after subsidies**.

Special Enrollment Period (SEP)

Individuals who are disenrolled from Medicaid are eligible for an SEP and do not need to wait until Open Enrollment.

Marketplace Questions

Visit [Healthcare.gov](https://www.healthcare.gov) or contact the Marketplace directly at 800.318.2596 (TTY 855.889.4325).



Renewals & Redeterminations of Eligibility

Annual Renewal

Medicaid recipients are subject to an annual review of their eligibility. Renewal dates are set one year from the first day of the month in which DSS received the application that resulted in approval.

DSS attempts to renew eligibility based on available information and electronic sources prior to requesting information from the recipient. These are called *ex parte* or administrative reviews. If eligibility cannot continue, the recipient is sent a renewal form and additional information may be requested.

Changes in Circumstances

Recipients are required to report any changes in their circumstances (e.g., income, resources, private health insurance, address, household composition, etc.) once they become aware of the change.

Redeterminations

The Division of Economic Assistance will re-evaluate eligibility for Medicaid at renewal or when there is a change of circumstance. If a recipient is no longer eligible, their coverage will be terminated at the end of the first month the Department is able to provide 10-day advance notice.

A recipient whose eligibility is terminated can reapply at any time and may also appeal any decision with which they do not agree.

Coverage

Provider Information



Verifying Eligibility

Providers can verify eligibility in a variety of methods:

- Electronic data exchange with South Dakota Medicaid
- Medicaid Online Portal Recipient Eligibility Inquiry
- Interactive Voice Response / Claims Unit: 1-800-452-7691
- Medicaid Eligibility Verification System

Claims Assistance

South Dakota Medicaid publishes provider manuals that provide in-depth coverage information and requirements for coverage and billing on the DSS website. All provider manuals are available on the website at:

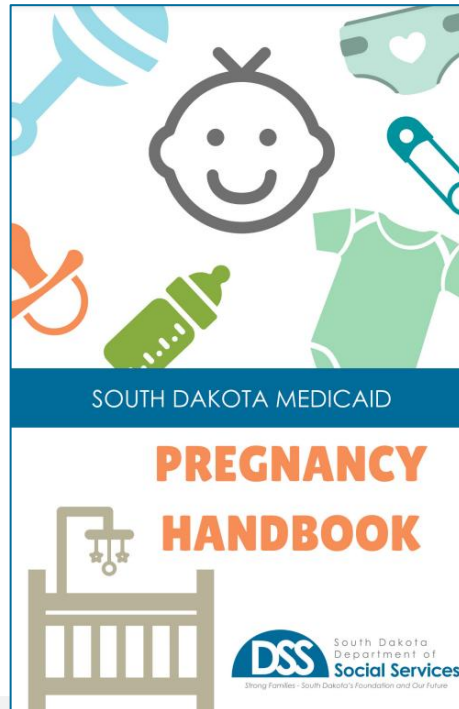
<https://dss.sd.gov/medicaid/providers/billingmanuals/>

Medicaid Coverage



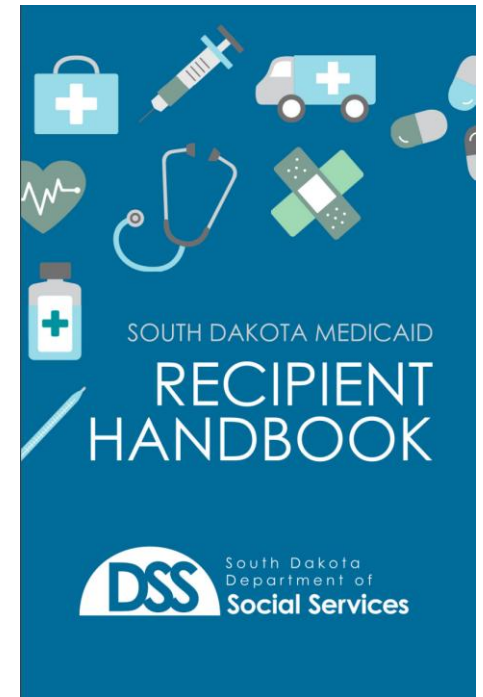
Medicaid Recipient Handbook

Handbooks are also available at every local DSS office. Individuals can also view the handbook online or order a copy of the handbook for free online.



Medicaid Pregnancy Handbook

The Medicaid Pregnancy Handbook explains Medicaid coverage, prenatal care basics, an appointment checklist, helpful resources, warnings signs, well-child visits and immunizations, and more.



Care Management



Primary Care Case Management: PCP Program

The Primary Care Provider (PCP) Program is designed to improve access to medical care by connecting individuals to a primary care provider. Primary care providers are required to deliver primary care services to the recipient and are responsible for coordinating and referring other care to Medicaid providers.

Health Home Program

South Dakota's health home program offers enhanced health care services to Medicaid recipients with chronic medical or behavioral health conditions. The Health Home Program provides 6 core services designed to reduce hospitalization and ER visits, increase integration between primary care and behavioral health services, and enhance transitional care between institutions and community-based care.

BabyReady: Medicaid Whole Pregnancy Care

BabyReady is a program covering all checkups, labor, and delivery from the start of pregnancy, with coverage continuing through Medicaid until 12 months after baby is born. With BabyReady, individuals receive a mom-centered personalized care team to help answer questions, connect families to resources, and provide confidence and assurance throughout pregnancy.



Questions?

dss.sd.gov



605-773-4678



MedElig@state.sd.us





SD MEDICAID NON-EMERGENCY MEDICAL TRAVEL (NEMT)

October 2025



The South Dakota Department of Social Services

is one of the state's largest agencies with more than 1,500 employees working in 42 communities across South Dakota.

Our Guiding Principles



Focus on Impact:

We focus on important issues and challenges to maximize impact.



Customer Centric:

We treat customers with respect and provide a "no wrong door" approach.



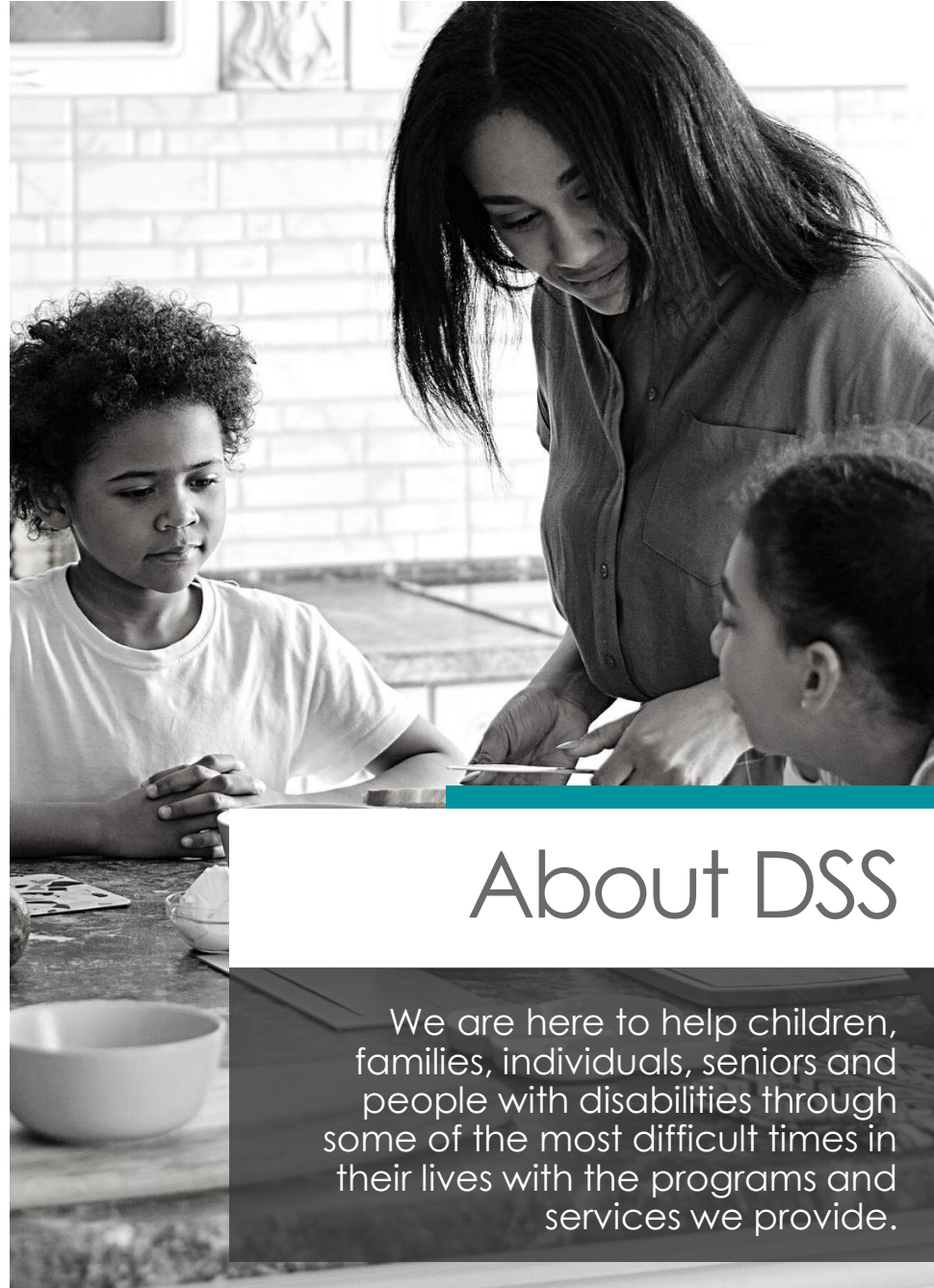
Build Partnerships to Maximize Results:

We believe collaboration, teamwork, and partnerships are key to delivering results.



Develop Our People:

We promote professional growth and development by empowering staff.



About DSS

We are here to help children, families, individuals, seniors and people with disabilities through some of the most difficult times in their lives with the programs and services we provide.



Our Vision and Mission

Strong families – South Dakota's foundation and our future

The South Dakota Department of Social Services

is dedicated to
strengthening families to
foster health, wellbeing,
and independence.

The SD Medicaid NEMT Program

helps with eligible recipients with non-emergency medical travel. The program reimburse travel-related expenses such as mileage, lodging, and meals when recipients need to travel outside their city of residence for medically necessary care.

SD Medicaid Non-Emergency Medical Travel (NEMT)

- NEMT provides reimbursement for eligible travel costs for the recipient and one escort at the current rate of payment.

➤ Mileage

- Mileage must be outside of the recipient's city of residence, which is limited to the actual miles between the two cities and does not include miles driven within the city.
- Only one mileage allowance is payable for each trip regardless of the number of recipients being transported.
- Mileage is a reimbursable service only if a trip is completed.
- Airline
- Bus

➤ Per Diem

- Per Diem includes lodging and/or meals and is reimbursable when the provider is at least 150 miles from the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay.

SD Medicaid Non-Emergency Medical Travel (NEMT)

Current Rate of Payment

The NEMT Program may reimburse for mileage, lodging and meals at the current rate of payment:

Mileage	:	\$0.66 per mile	
Per Diem	:	In-State Lodging:	\$110.00 per night
		Out-Of-State Lodging:	\$110.00 per night
		Recipient meals:	\$40.00 per day
		Escort meals:	\$40.00 per day

*****An additional \$40.00 per day will be paid for medically necessary escort, except when the recipient is an in-patient in a hospital or medical facility.*****

NEMT staff will work with the commercial carrier to pre-authorize and arrange the travel. Payment is limited to the actual cost of the fare.

SD Medicaid Non-Emergency Medical Travel (NEMT)

NEMT Eligibility

- The recipient must be enrolled in a medical assistance program that provides Medicaid coverage. Trips made prior to recipients' eligibility date are not eligible for reimbursement.

NEMT Requirements

- Travel must be to the closest medical facility or provider capable of offering the necessary services, unless the recipient has a referral or authorization from their medical provider.
- The service must be covered by SD Medicaid and provided by a medical provider enrolled in the medical assistance program.
- Trips to medical specialty providers other than a PCP (Primary Care Provider), HHP (Health Home Provider) or BabyReady Provider require a referral.
- NEMT must receive a completed reimbursement claim within six months following the month the service was provided.

SD Medicaid Non-Emergency Medical Travel (NEMT)

Travel to Primary Care, Health Home, BabyReady Provider, and Specialty Care

- **Primary Care, Health Home, or BabyReady Provider:**
Travel to the nearest provider is reimbursable. However, lodging and meals are not reimbursable.
- **Specialty Care:**
Travel to specialty providers requires a referral. Lodging and meals are reimbursable if the provider is 150 miles or more and if the trip involves an overnight stay.

SD Medicaid Non-Emergency Medical Travel (NEMT)

Out-of-State Travel Requirements

- Prior authorization must be approved before out-of-state travel expenses can be approved or paid by the NEMT Program.
- The services must be a Medicaid covered service, and travel must be to the closest medical facility or medical provider capable of providing the necessary services, unless otherwise authorized.

SD Medicaid Non-Emergency Medical Travel (NEMT)

NEMT Charitable Organization/Entity

A charitable organization or entity that has an agreement with the department to advance expenses for non-emergency medical travel services on behalf of SD Medicaid recipients.

A charitable organization or entity must not act as a community transportation provider for the same trip.

- Ronald McDonald House
- Children's Miracle Network
- Tribal Support Services

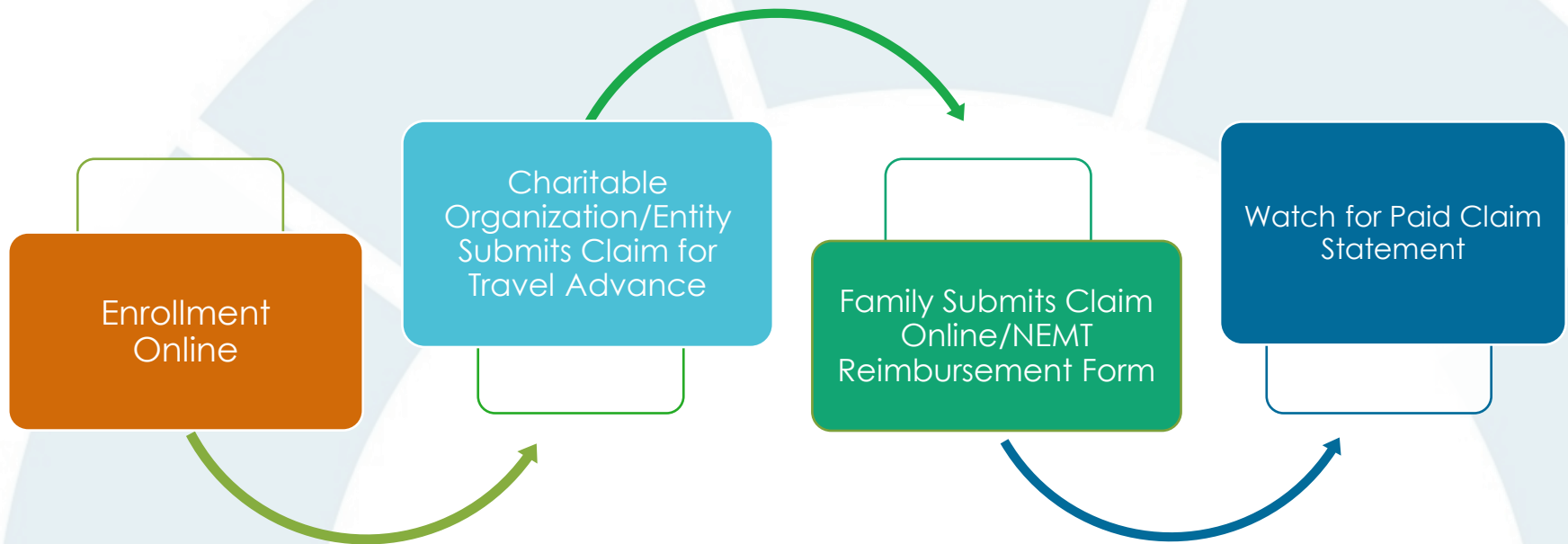
Organization/Entity must enroll online to NEMT Portal

Must enter a Direct Deposit Account

NEMT Provider Questionnaire/Agreement

SD Medicaid Non-Emergency Medical Travel (NEMT)

NEMT Charitable Organization/Entity Process



SD Medicaid Non-Emergency Medical Travel (NEMT)

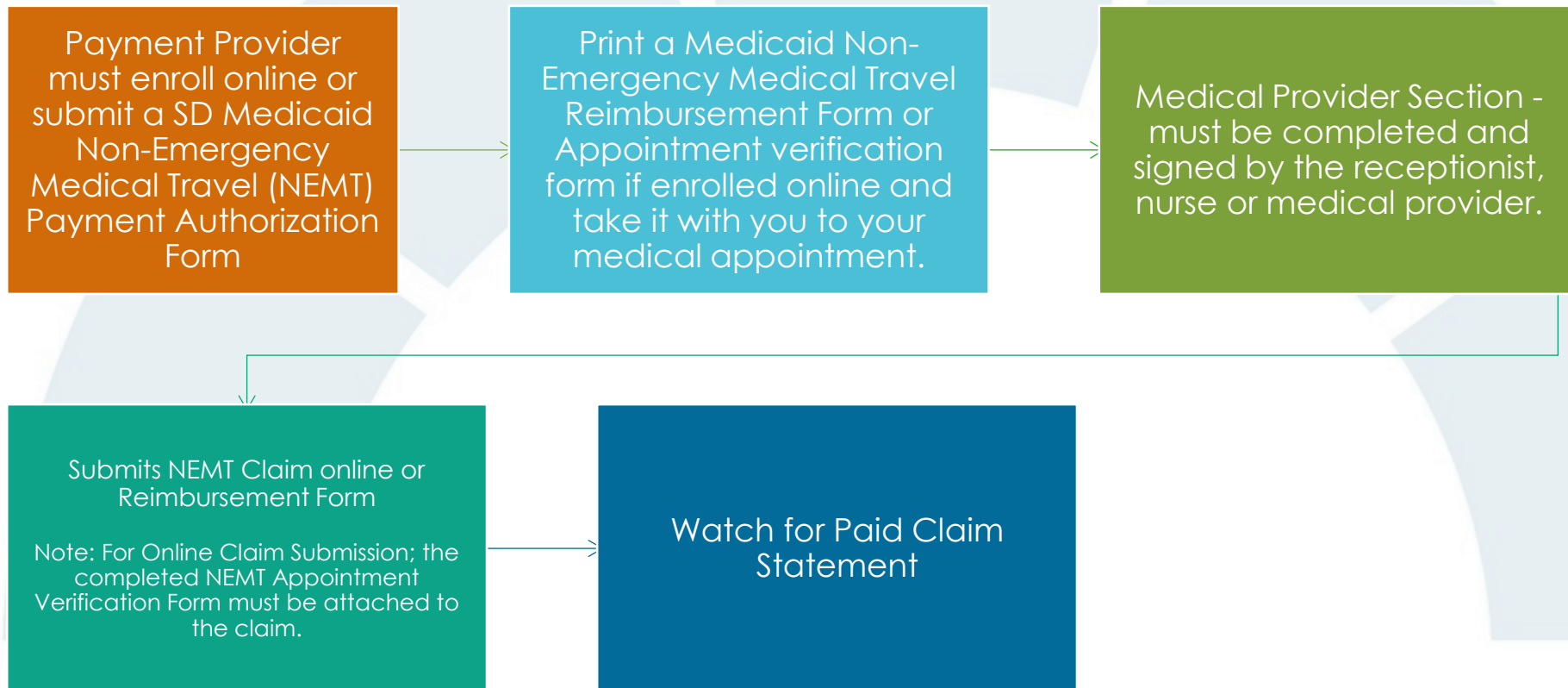
• NEMT Charitable Organization Process

- Enroll online <https://dss.sd.gov/nemt>
 - Submit the Travel Advance claim when the assistance is provided to the recipient.
 - **This is not a guarantee of reimbursement.**
- After the trip is completed, the recipient/family MUST submit a Medicaid Non-Emergency Medical Travel Reimbursement Claim along with any supporting documentation.
- NEMT will associate the Travel Advance to the appropriate NEMT claim.
- NEMT will determine the trip value and reimburse the organization first and any remaining balance will be reimbursed to the recipient/family (payment provider).

Note: Travel Advances not processed within 30 days of submission may be resubmitted with a billing from the organization and a completed NEMT Appointment verification form attached. NEMT will review the billing and determine if reimbursement can be made or if additional documentation is needed.

SD Medicaid Non-Emergency Medical Travel (NEMT)

Recipient/Family Process



SD Medicaid Non-Emergency Medical Travel (NEMT)

Recipient/Family

- A NEMT Payment Provider must enroll online or complete a NEMT Payment Authorization form and submit to NEMT. NEMT Payment Provider only needs to enroll or submit NEMT Payment Authorization form once.
- A SD Medicaid Non-Emergency Medical Travel Reimbursement Form/Online Claim must be completed and submitted for each medical trip. The travel reimbursement must be submitted within six months following the month the service was provided.
 - The travel reimbursement form/online claim must be completed and signed by the recipient, parent or guardian.
 - Medical Provider Section - must be completed and signed by the doctor, nurse, receptionist or pharmacist.
- Forms are available at any local DSS Offices or on the web at: <http://dss.sd.gov/medicaid/recipients/title19transportation.aspx> or calling toll free to 1-866-403-1433.

SD Medicaid Non-Emergency Medical Travel (NEMT)

NEMT Payments

All claims are worked in the order they are received in the office.

- Payment provider will receive a Paid Claims Statement showing specific travel dates and amounts in the mail (claims submitted paper) or email (claims submitted online) once claim has been paid.
- If we need additional information, we will contact the recipient or family and any non-profit organization/entity that assisted with the trip.

SD Medicaid Non-Emergency Medical Travel (NEMT)

NEMT has created a way to submit and track your claims, keep your correspondence and paid claims statements all in one place.

The online [NEMT Portal](#) will allow you to:

- Update and maintain your personal and banking information.
 - Submit claims online.
 - Track the status of your claim.
 - Receive and review correspondence and Paid Claims Statements.
- Before you begin using the online portal, select the appropriate instructional video that will help you navigate the [NEMT Portal](#).

Individual Instructional Videos (for family) and Entity Instructional Videos (for charitable organizations)

- Use this link to watch the videos
<https://dss.sd.gov/medicaid/recipients/title19transportation.aspx>

SD Medicaid Non-Emergency Medical Travel (NEMT)

All claims must be submitted online to the NEMT Portal or forms with any necessary documentation must be turned in to a local Department of Social Services office or mailed, faxed or emailed directly to:

Department of Social Services
Office of Finance/EBT
700 Governor's Drive
Pierre, SD 57501

FAX: (605) 773-8461

EMAIL: DSS.EBTSTATEOFFICE@STATE.SD.US

Phone: 1-866-403-1433

Website: <http://dss.sd.gov/medicaid/recipients/title19transportation.aspx>



Thank You

Giezelle Brown



605.773.6527



dss.ebtstateoffice@state.sd.us



dss.sd.gov





Pharmacy

10/28/25



Pharmacy

- The Pharmacy benefit is split in to two categories.
 - Outpatient Retail. Traditional Pharmacy, ex. Corner Drug Store. What we will talk about today.
 - “Medical” or physician administered drugs (PADs). Drugs administered by a healthcare professional in facility setting, ex. clinic, hospital.

Pharmacy

- OptumRx is the contracted vendor for processing outpatient pharmacy claims.
- “Medical” drug claims are processed by the MMIS as part of the appropriate claim type.

OptumRx Services

- Pharmacy claim processing;
- Prior authorization (PA) processing for outpatient pharmacy;
- Provider call center for claim questions and PA's;
- Support the Medicaid Pharmacy & Therapeutics Committee;
- Federal rebate invoicing system.

What OptumRx Can Not Do

- Pay pharmacies, they are paid weekly as part of the regular MMIS payroll process;
- Answer remittance advice (RA) questions, OptumRx does not generate RA's or have access to our MMIS or provider portal;
- Answer questions regarding payment, ex. check number, check date, etc.;
- Process PA's for "medical" drugs;
- Answer questions about J codes, other HCPC codes, or medical claims in general.

Covered

- Must have a federal rebate;
- FDA approved;
- Not investigational;
- Can be self-administered by patient, ex. insulin;
- Over the Counter (OTC) covered meds very limited, lice treatments, some antihistamines, iron formulations for children less than 3yo, aspirin for pregnant women experiencing preeclampsia;
- A prescription from a valid prescriber is required.

Not Covered

There are not many drugs Medicaid does not cover under the pharmacy benefit.

- Drugs considered cosmetic, ex. Botox;
- Drugs for hair loss, ex. Rogaine;
- Drugs for sexual dysfunction, ex. Viagra;
- Drugs without a federal rebate;
- Devices, ex. nebulizer;
- “Medical” drugs;
- Durable Medical Equipment (DME), ex. crutches;
- Infant formula, Ensure, etc.;
- Drugs for recipients eligible for Medicare Part D coverage, except some antihistamines and Vitamin D;
- Vacation supplies.

Copay Exemptions

- No copays for any recipient.
- Effective July 1, 2024.

Retro Eligibility

- Voluntary by pharmacy;
- Requires pharmacy to submit an override code to bypass the standard 6 month timely filing limit;
- Forward pharmacy to Pharmacy Director to obtain override code and instructions.

Interesting Facts

- Pharmacy claims are adjudicated real time. Average is less than 0.2 seconds.
- Electronic PA's for some drugs;
- System is called the POS which stands for Point of Sale.
- Only about 18% of recipients fill a prescription in a given month;
- On Average:
 - Over 1,000,000 paid claims per year including IHS
 - Over \$215,000,000 per year including IHS
 - PADs \$80,000,000 per year
 - Generics accounted for 90% of non-IHS paid claims but only 10% of ingredient dollars paid.

Contacts

- Mike Jockheck, Pharmacy Director
- Taylor Koerner, Clinical Pharmacist
- Susan Oh, OptumRx Pharmacist
- Sean Hansen
(sean.hansen@optum.com), to request password reset.
- OptumRx Provider Call Center (855-401-4262)

Questions?



Physician Administered Drug (PAD) Program Overview

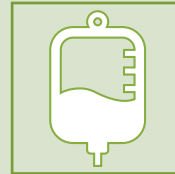
10/28/25



What are PADs?



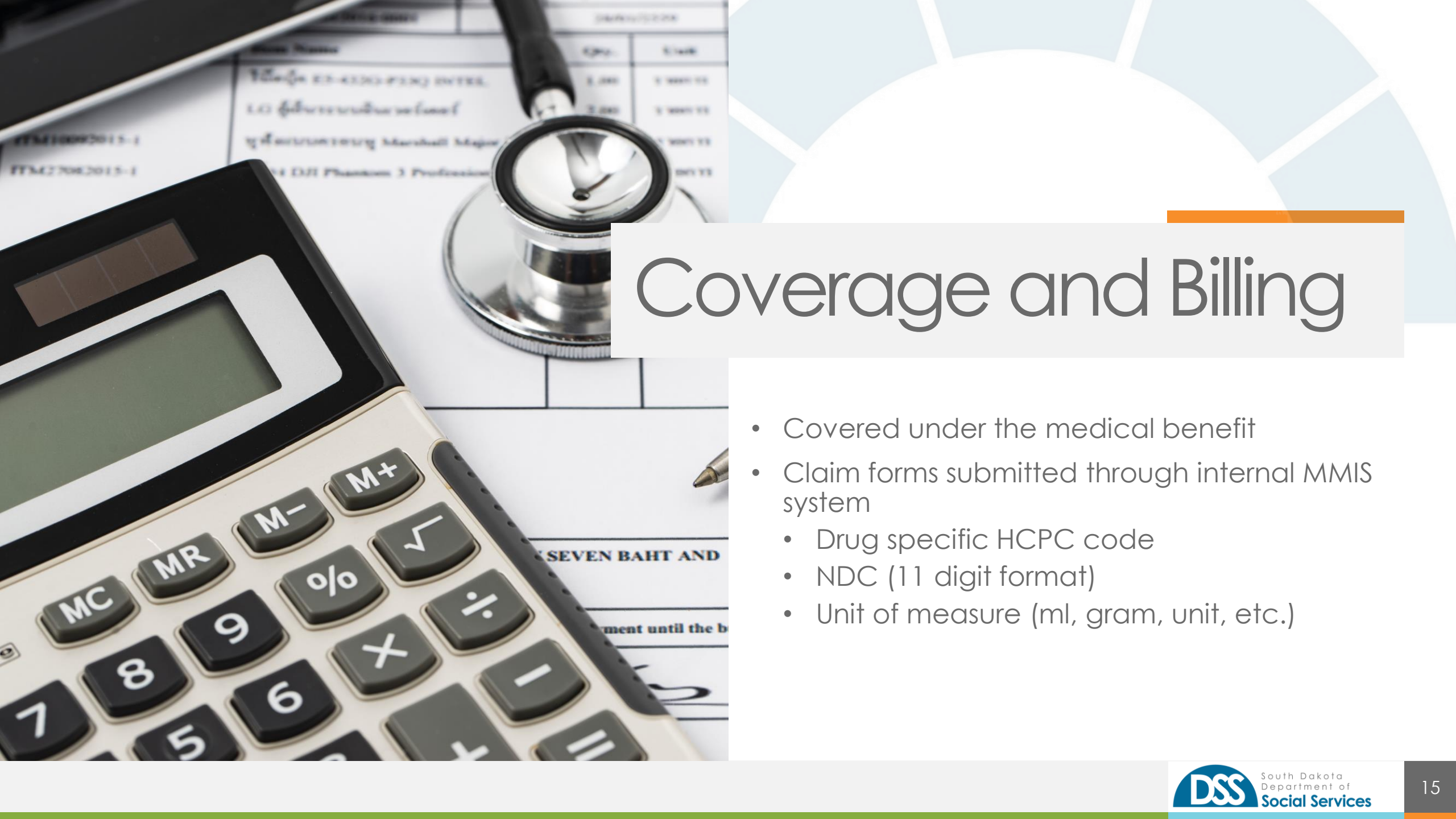
Definition: drugs administered by a healthcare provider



Examples: IV infusions, chemotherapy, vaccines



Settings: clinics, infusion centers, hospitals



Coverage and Billing

- Covered under the medical benefit
- Claim forms submitted through internal MMIS system
 - Drug specific HCPC code
 - NDC (11 digit format)
 - Unit of measure (ml, gram, unit, etc.)

Prior Authorization

Required for certain high-cost drugs

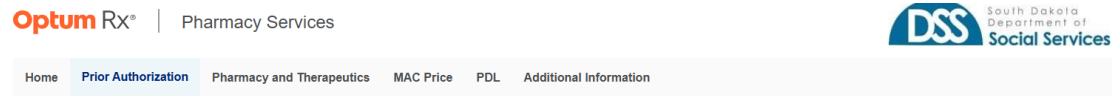
Managed internally by our medical team – handled separate from PA process through the POS (Optum) side

Ensures patient meets appropriate criteria for use

Checking PA Status – POS vs. PAD

POS – OptumRX Website

<https://sdm.pharmacy.optum.com/>



[Home](#) > [Prior Authorization](#)

Prior Authorization

South Dakota Medicaid supports [ePA](#) effective 1/1/2023.

South Dakota Medicaid requires Prior Authorization for the following drugs. All criteria algorithms and forms are in .pdf format. You must have Adobe Acrobat Reader to view the forms. If you do not have Adobe Acrobat Reader, we recommend downloading and installing the latest version.

[Expand All](#)

▼	Administrative PA
▼	Acne - Topical Agents
▼	Allergen Extract - Oral
▼	Altabax
▼	Antidepressants
▼	Antiemetics
▼	Antihistamines
▼	Antipsychotics
▼	ARBS
▼	Amrix, Fexmid



PAD – DSS Website

<https://dss.sd.gov/medicaid/providers/pa/default.aspx>

All Prior Authorization requests and inquiries need to be emailed to DSSMedicaidPA@state.sd.us until further notice

Prior Authorization

The division has 30 days to make a prior authorization determination. However, in most circumstances authorizations can be completed in less time, usually around 2 weeks. Prior authorization is only required for the *elective* services listed on this webpage. Any urgent or emergent care is exempt from prior authorization requirements. Retro authorizations can be requested after the service is provided if care was suspected to be urgent/emergent at the time, but will be billed as elective.

Listed below are all services requiring prior authorization and the associated Prior Authorization Request Form. Prior Authorization criteria and detailed instructions regarding forms and submission of prior authorization requests are located in the [Prior Authorization Manual](#).

Durable Medical Equipment
Bone Growth Stimulators
Continuous Glucose Monitoring
Continuous Passive Motion Devices
Cough Stimulating Devices
Cranial Remolding Helmets
High-Frequency Chest Wall Oscillation Device
Low Air Loss Mattress / Pressure Reduction Therapy
Lymphedema pumps
Non-covered Items < age 21 (EPSDT)
Specialty Mobility Devices
Speech Generating Devices / Augmentative Communication Devices
Wound Vacs
Incontinence Supplies
• ADLS Waiver
• Family Support 360 Waiver
• HOPE Waiver
• CHOICES Waiver
Durable Medical Equipment Prior Authorization Request Form
Home Health
Inpatient Hospitalization
Nutrition
Out-of-State Services
Other Outpatient Services
Other Procedures
Physician Administered Drugs, Vaccines and Immunizations
Surgical Procedures

Key Resources

[Diagnosis Look-up Tool](#)
[Fee Schedules](#)
[Prior Authorizations](#)
[Procedure Code Look-up Tool](#)
[Provider Manuals](#)
[Provider Enrollment](#)

Other Information

[Cost Reports](#)
[Frequently Asked Questions](#)
[HomeAgainSD](#)
[Care Management](#)
[Home and Community Based Services](#)
[Join our Listserv](#)
[Pharmacy](#)
[Phone Listing](#)
[Report Medicaid Fraud](#)
[School Based Medicaid Program](#)

Best practice is to check BOTH sides for PA status

What needs PA?

Generally determined based off drug cost, potential for misuse, therapy indication, dosing frequency, use, etc.

Currently required PAs through PAD benefit (not all inclusive):

- Gene therapies
- Diabetic macular edema treatments
 - Ex. Eylea, Vabysmo
- Botox
- CAR-T Therapies
- Treatments for various musculoskeletal disorders (Ex. SMA, DMD, gMG)

NOT requiring PA through PAD benefit (not all inclusive):

- Oncology agents
- Hemophilia agents
- IVIG
- Enzyme replacement therapies

PAD Prior Authorization Info

- Agents requiring PA are regularly on our website
- Procedure code Look-Up Tool
 - Searchable database that allows you to search PA status by HCPC code
- Accordion entries
- Drug policies & forms are specific to each product
- Concerns regarding PA criteria can be submitted via the Medicaid Portal

[General Information](#)[Eligibility](#)[Recipients](#)[Providers](#)[Provider Enrollment Portal](#)[Medicaid Portal](#)

Physician Administered Drugs, Vaccines and Immunizations

Prior Authorization

Listed below are physician administered drugs, vaccines and immunizations that require prior authorization. Each product has a qualifying criteria document and an associated prior authorization request form to use for submission requests. For products that have multiple treatment indications, please use the appropriate form for the patient's condition.

All prior authorization criteria is developed with the understanding that coverage is inclusive of services that are deemed medically necessary as outlined in the [South Dakota Administrative Rules \(SDAR 67:16:01:06.02\)](#). Determination of prior authorization status for all physician administered drugs can be done via the use of the [Procedure Code Look-Up Tool](#).

For concerns regarding prior authorization criteria, please submit a coverage request using the [Medicaid Portal](#).

Submission

Prior Authorization requests should be submitted to South Dakota Medicaid via secure email. Use secure email to send completed documentation to DSSMedicaidPA@state.sd.us.

If secure email is unavailable, mail or fax completed documentation to:

South Dakota Department of Social Services
Division of Medical Services
Attn: Prior Authorization
700 Governors Drive
Pierre SD 57501
Fax 605.773.5246

[A - J \(Generic Name\)](#)[K - N \(Generic Name\)](#)[O - T \(Generic Name\)](#)[U - Z \(Generic Name\)](#)[Find your local office](#)

Key Resources

- [Diagnosis Look-up Tool](#)
- [Fee Schedules](#)
- [Prior Authorizations](#)
- [Procedure Code Look-up Tool](#)
- [Provider Manuals](#)
- [Provider Enrollment](#)

Other Information

- [Cost Reports](#)
- [Frequently Asked Questions](#)
- [HomeAgainSD](#)
- [Care Management](#)
- [Home and Community Based Services](#)
- [Join our Listserv](#)
- [Pharmacy](#)
- [Phone Listing](#)
- [Report Medicaid Fraud](#)
- [School Based Medicaid Program](#)

PA Process

- Review Approval Criteria

**SOUTH DAKOTA MEDICAID
PRIOR AUTHORIZATION CRITERIA**
Physician Administered Drugs, Vaccines, and Immunizations

Casimersen (Amondys 45) – PA Criteria

HCPC: J1426

Casimersen (Amondys 45) is an antisense oligonucleotide indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have confirmed genetic mutation of the DMD gene that is amenable to exon 45 skipping. It is covered with a prior authorization from South Dakota Medicaid when the following criteria are met:

** All requests under this policy require SD medical director review in addition to meeting specified criteria below **

- **Initial Therapy (must meet all):**
 - Therapy is prescribed by a neurologist with expertise in neuromuscular disorders
 - Individual must have a diagnosis of DMD with documentation of confirmed mutation that DMD gene is amenable to exon 45 skipping (submission of medical records, genetic testing, etc.)
 - If ambulatory, documentation of baseline values for **one** of the following is provided no longer than one month prior to beginning Amondys 45
 - North Star Ambulatory Assessment (NSAA)
 - 6 Minute Walk Test (6MWT)
 - If non-ambulatory, documentation is submitted indicating Brooke upper extremity scale is ≤ 5
 - Documentation is submitted indicating forced vital capacity of $\geq 30\%$ and stable cardiac function with left ventricular ejection fraction (LVEF) of $>40\%$
 - Individual is not ventilator dependent
 - Therapy is not being used in conjunction with other exon skipping therapies for DMD (ie Vyondys 53, Exondys 51, Viletpso)
 - Therapy is initiated before the age of 14
 - Individual has been on a stable dose of corticosteroids for 6 months unless contraindicated or adverse effects were previously experienced
 - Individual has not received previous gene therapy for the treatment of DMD
 - Approval duration: 6 months
- **Continuation of Therapy (must meet all):**
 - Individual continues to meet initial criteria
 - Individual will continue to have follow-up with neurology provider and/or neuromuscular clinic
 - Documentation of response to therapy is recorded every 6 months and shows stability or improvement in **both** of the following:
 - 6-minute walk or NorthStar Ambulatory Assessment (or Brooke Upper Extremity if non-ambulatory)
 - Forced Vital Capacity
 - Approval duration: 6 months

A clinical benefit of AMONDYS 45 has not been established. AMONDYS 45 is FDA-approved for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 45 skipping. This indication is approved under accelerated approval based on an increase in dystrophin in skeletal muscle observed in some patients treated with AMONDYS 45. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.



Last Reviewed: 7/28/25

- Fill out and submit drug specific PA form before treating the patient



South Dakota
Department of
Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-22941

PHONE: 605-773-3495 | FAX: 605-773-5246

WEB: [DSS Medicaid Prior Authorizations](#) | EMAIL: DSSMedicaidpa@state.sd.us

AMONDYS 45 PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPT INFORMATION		
Medicaid ID:	Date of Birth:	Sex: M ☐ F ☐
Last Name:		First Name:
GENERAL INFORMATION		
First Date of Service:	Last Date of Service:	
Primary Diagnosis Code:	HCPC Code:	
Drug Name:	Dose & Frequency:	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	Phone:	Fax:
<small>Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.</small>		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	Taxonomy:	
Phone:	Fax:	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	Taxonomy:	
Phone:	Fax:	

Submission & Review

- PA requests should be submitted via secure email to DSSMedicaidPA@state.sd.us
- If secure email is unavailable, mail or fax completed documentation to:

South Dakota Department of Social Services

Division of Medical Services

Attn: Prior Authorization

700 Governors Drive

Pierre SD 57501

Fax: 605-773-5246

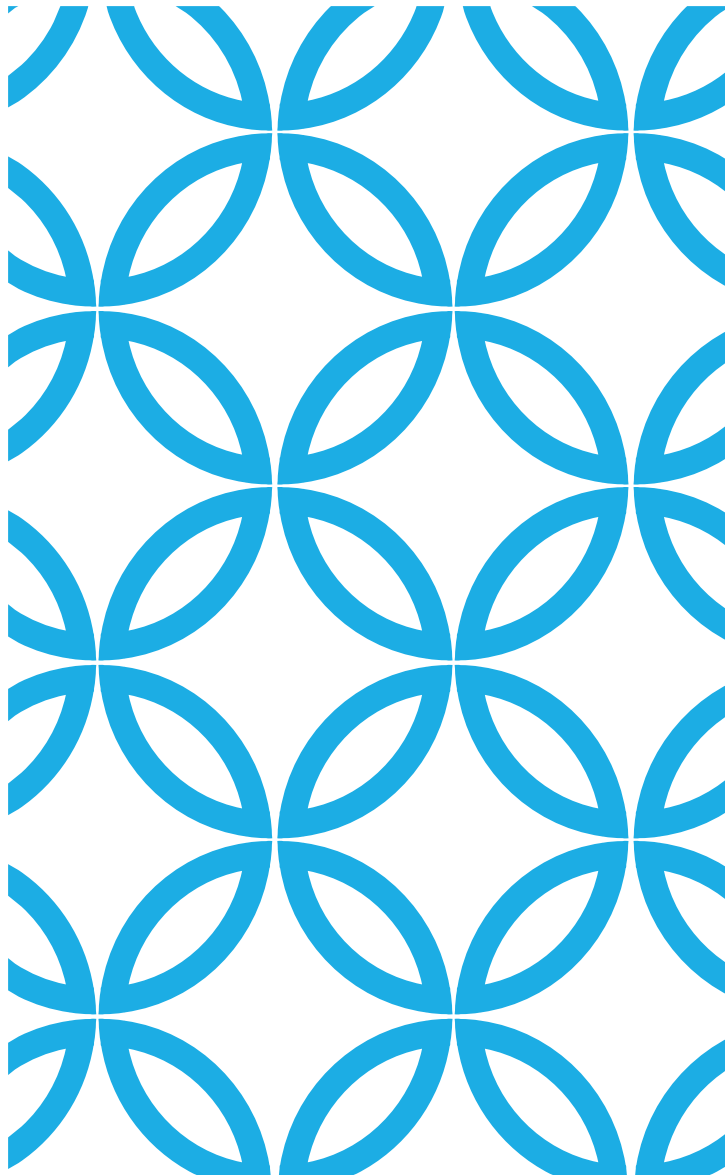
- Coverage response will be returned within 2 weeks of submission

Contacts

- DSSMedicaidPA@state.sd.us



Questions?



CASE MANAGEMENT PROGRAMS

Department of Social Services
Medical Services

CASE MANAGEMENT PROGRAMS

Health Homes

Assists in management of high risk high-cost population with multiple comorbidities

Must meet core services and develop a care plan

Providers must do quarterly and outcome measure reporting

Provides additional reimbursement to providers

BabyReady

Mandatory program for pregnant women when specific criteria is met

Provides care coordination, person centered care plan, transitional care plan

Partner with DOH and Barrier to Care Initiative must be developed

Provides additional reimbursement to providers

IHS Care Coordination

Provides additional care coordination services for IHS and Medicaid dual eligible individuals

Allows for a wider range of services that IHS can refer to outside entities with the same reimbursement methodology

Provides shared savings with providers and additional case management staff to IHS



HEALTH HOME OVERVIEW



WHAT IS A HEALTH HOME?



Partnership with Medicaid Providers to help manage the high risk, high-cost recipients.



Team Based approach that supports the whole person.



Designed to affect change in the Health Home recipient's health status and reduce utilization of high-cost services.



Based on the provision of the six Core Services outlined by CMS and defined by the Health Home Implementation Workgroup.

PROVIDER INFRASTRUCTURE

Two Types of Health Homes

Primary Care Provider

Primary Care Physician

PA/Advance Practice Nurse

Working in a

Federally Qualified Health Center

Rural Health Clinic

Clinic Group Practice

IHS/Tribal 638

Behavioral Health

Mental Health Provider working in a
Community Mental Health Center (CMHC)

Team

- Care Coordinator
- Primary Care Provider
- Pharmacist
- Support Staff
- Other services as needed
- Behavioral Health Specialist

- **Any Medicaid Recipient** who has.....
 - Two or more chronic conditions or one chronic and one at risk condition (Defined separately below)
 - **Chronic Conditions include:** Mental Illness, Substance Abuse, Asthma, COPD, Diabetes, Hypertension, Obesity Musculoskeletal and neck and back disorders
 - **At Risk Conditions include:** Pre-diabetes, tobacco use, cancer, hypercholesterolemia, depression and use of multiple medications (6 or more classes of drugs)
 - One Severe Mental Illness or Emotional Disturbance.
- Eligibility based on 15 months of claims data based on diagnosis.
- Recipients who meet the eligibility criteria are stratified into four tiers based on the recipient illness severity using the Chronic Illness and Disability Payment System (CDPS).

SIX CORE SERVICES

- Six Core Services must be provided to the level appropriate for each recipient. More in-depth definitions at:
 - https://dss.sd.gov/docs/medicaid/PCP_Core_Services_Specific.pdf
1. Comprehensive care management
 2. Care coordination
 3. Health promotion
 4. Comprehensive transitional care/follow-up
 5. Patient and family support
 6. Referral to community and social support services

KEY ELEMENTS OF A CARE PLAN

- Care Plans are an integral part of serving recipients in Health Homes.
- Each clinic or Health System can choose a template for their Care Plan, but a Care Plan must be completed for each recipient in Health Homes.
- If behavioral health needs are identified in the assessment, Care Plan should include plan to address.
- Care Plans should be developed with active participation from the recipient and their supports if applicable.

HEALTH HOME

- Health Home recipients will be required to obtain a referral prior to seeing a provider other than their designated provider.
- Health Homes should implement a process for obtaining resulting medical records, test results and/or procedure summaries when providing a referral.
- If the Health Home is the Community Mental Health Centers (CMHCs), the referral **must** start with CMHC.

QUARTERLY CORE SERVICE REPORTING

- DSS uses a retrospective payment system for the HH program. Services will be provided and then after the quarter is complete, DSS will pay for all recipients where the Health Home has provided at least one core service within the quarter.
- DSS will upload all recipients enrolled in the clinic's Health Home to the DSS Online Portal each quarter.
- The Health Home will use the data provided to indicate if a core service was provided by clicking yes or no and submitting the report
- One Core Service must be provided within the quarter, or the Health Home will not be paid for any of the months in that quarter.

Quarter	Submission Date
Jan – March	April 30
April – June	July 31
July – Sept	October 31
Oct – Dec	January 31

HEALTH OUTCOME MEASURE REPORTING

- Health Homes report outcome measures for each recipient for whom a core service is claimed.
- Each Health Home will submit data electronically at the individual level every 6 months.
- Vendor sends out a list of recipients to whom a core service was provided. Health Homes will need to submit data by a specified date
<https://dss.sd.gov/healthhome/outcomemeasures.aspx>.
- Vendor will provide clinic level data back to the HH

Period	Due Date
Jan- June	Set by Vendor
July – Dec	Set by Vendor



QUESTIONS?



THANK YOU

Chris Soukup



605.674.5781



Chris.Soukup@state.sd.us



dss.sd.gov





BABYREADY OVERVIEW FOR SOCIAL WORKERS & CASE MANAGERS

October 28, 2025



Overview

BabyReady Program

- The BabyReady program is one of the Three Care Management programs
- BabyReady recipients, like PCP recipients, must acquire referrals to see other providers outside of their clinic
- BabyReady recipients, unlike the PCP program, are outreached by their assigned provider
- BabyReady program participation is not optional
 - The only way a recipient is not eligible for the program is if they select a non-participating BabyReady provider
- BabyReady recipients have access to a mom-centered personalized care team to help connect them with local resources, care plan development, education, and healthcare system navigation.

Provider Enrollment & Enhanced Payments

Provider Enrollment

To enroll as a BabyReady clinic, the clinic must complete an application and Barriers to Care Initiative form.

- An addendum must be completed and signed by each individual provider listed on the application.

Enhanced Payment Services

Code	Description	Fee
NA	Care Coordination PMPM	\$ 42.31
NA	Barriers to Care PMPM	\$ 10.00
S0280	Person-centered Care Plan	\$ 100.00
S0281	Transitional Care Plan	\$ 50.00
G9151	Prenatal Care Enhanced Payment	\$ 200.00
G9152	Postpartum Visit Enhanced Payment	\$ 100.00

Recipient Eligibility

Pregnant Medicaid-eligible recipients less than 32 weeks gestation are eligible for the BabyReady Program.

Providers may submit a BabyReady Opt-In and Selection form for those 32 weeks or more and have not yet delivered.

Recipients will be transitioned from the program to the PCP program 3 months after the end of their pregnancy.

- Miscarriages are included

Care Coordination Services

Care Coordination

The provider must have sufficient staffing to provide the required care coordination services for recipients on the providers' caseload. Care coordination staffing may be at the health system or clinic level but must be available to assist women served by individual participating providers. All care coordination services must be documented.

- Care coordination staff may include RNs, LPNs, CHWs, SW's or other staff qualified and trained to deliver a specific care coordination service.
- Care coordination services may include:
 - Person-Centered Care Plan
 - Health Education and Promotion
 - Health System and Resource Navigation
 - Transitional Care Coordination
 - Transitional Care Plan

Care Plans

The Person-Centered and Transitional Care plan can be developed by a member of the Care Management team and signed off on by the provider

Person-Centered Care Plan

Person-Centered Care Plan Elements:

- Measurable goals related to treatment, wellness and recovery including intended outcomes;
- Preferences and Strengths related to treatment, wellness, and recovery goals;
- An emergency/natural disaster/crisis plan;
- Key community and/or social services that address identified needs;
- Planned care coordination interventions; and
- Documentation of key providers included in care plan development and/or key care team members.

Transitional Care Plan

The Transitional Care Plan should contain the following information:

- Identification of the recipients PCP provider and their scheduled appointment to establish care;
- Identification of the newborns PCP and their scheduled well child visit(s);
- Any necessary specialty appointments that need to be made;
- Documentation that the PCP has recipient's medical records or access to their records; and
- Identification any known follow up needed with regards to labs, imaging, etc.

DOH Collaboration

DOH:

Assigns a nurse(s) to each enrolled clinic
Provides participating providers with promotional materials regarding these programs and training upon request to facilitate this requirement.
Follows-up on recipients receiving in-home services as needed

Provider:

Share relevant health and social determinants of health information with the DOH nurse
Promotes and refers recipients to the DOH programs which support pregnant women.

- Bright Start,
- Pregnancy Care, and
- Women, Infants & Children (WIC) Program.

Barriers to Care Initiatives

Barriers to Care Initiatives

Providers (clinic level or system level) would select and implement one of the following initiatives:

- Initiatives to improve initiation and attendance at prenatal and postpartum visits
- Initiatives to reduce transportation barriers that prevent women from receiving prenatal and postpartum care.
- Initiatives to address social determinants of health that impact the woman's and unborn child's health or
- Initiatives to facilitate childcare during appointments and deliveries or to facilitate the provision of services with children present at the clinic or facility.
- Other initiatives to address barriers of care as determined by the provider



THANK YOU

Valerie Kelly

605-773-3495

Valerie.Kelly@state.sd.us



Care Coordination and IPA Nurses

2025



Care Coordination

- In 2016, Health and Human Services changed national Medicaid funding policy to cover more services for IHS and Medicaid eligible American Indians with 100% federal funds when going outside of IHS for services
- This was to allow for a wider range of services to be provided
- For the services to be reimbursed with 100% federal funds specific criteria have to be met
 - Care Coordination Agreement
 - Referral for outside services by the IHS provider
 - Medical record sharing
- IHS must maintain responsibility for the patient's care by reviewing the outside records and taking any necessary action if needed
- Due to this policy change, the State of SD and Great Plains IHS met and discussed how to best utilize this change in funding

Care Coordination Investments

- Increase use of telehealth services to support emergency departments and support increased access to primary and specialty care consultation and treatment in through Indian Health Service and Tribal Programs
- Develop a formal Community Health Worker/Community Health Representative program under the Medicaid State Plan.
- Expand support for prenatal and postpartum care to support healthy birth outcomes
- Expand capacity for mental health and chemical dependency services through Indian Health Service and Tribal Programs.
- Expand Medicaid eligible providers of behavioral health and substance use disorder (SUD) treatment services.
- Add evidence-based behavioral health services and supports for children and families, including supporting the provision of functional family therapy as a Medicaid state plan service.
- Embed nurses and mid-level practitioner within I.H.S. to help support care coordination efforts and connections back to communities as a way to fully use funding I.H.S. cannot receive directly
- Funds being reinvested by enrolled providers that receive shared savings payments

Care Coordination Agreements

- Current agreements in place in SD since 2017-2019
 - Avera
 - Sanford
 - Monument
 - Dialysis Management Group
 - Bennett County Hospital
 - Mobridge Regional Hospital
 - Black Hills Surgical Hospital
 - Children's Home Society
 - Brookings Health System
 - Abbott House
 - Aurora Plains Academy
 - Lutheran Social Services
 - Our Home
 - Avantara Nursing Facilities

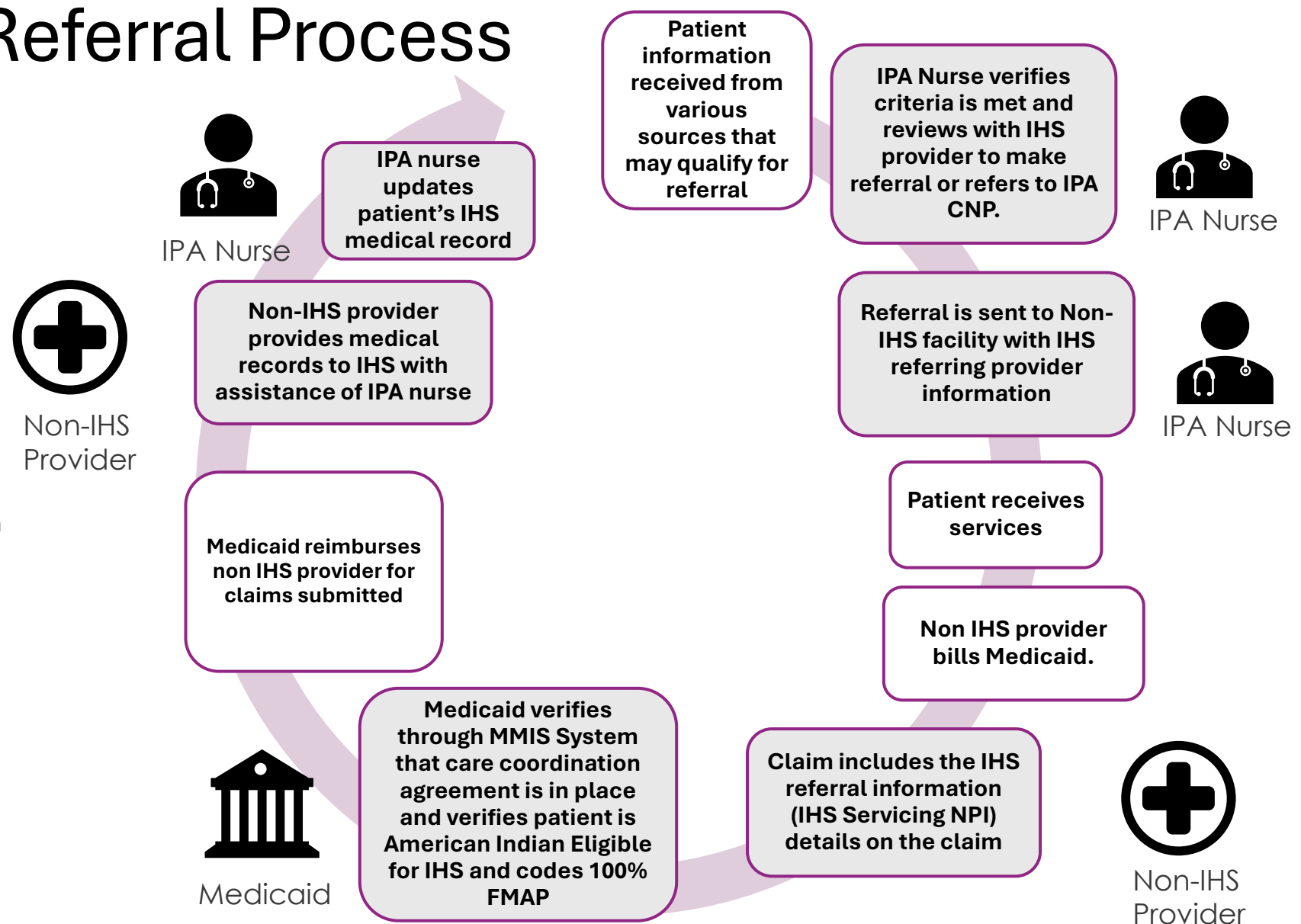
Intergovernmental Personnel Act (IPA) Agreements

- IPA Agreements create a partnership between the State of South Dakota and Indian Health Service facilities to increase access to care, strengthen continuity of care and care coordination to improve the health of Medicaid-eligible American Indians.
- Goals include:
 - Reducing the cost to IHS for completing care coordination and enhancing IHS case management resources
 - Coordinating patient care and managing medical records between outside facilities and IHS
 - Reducing the State's general fund expenditures for Medicaid-eligible American Indians
 - Coordinating access to and ensuring follow-up to specialty services, PCP, and long-term care services
 - Assist IHS in other case management duties to enhance patient outcomes

IPA Nurses

- The State of South Dakota has been able to hire nursing staff to work in and assist IHS facilities with case management duties and the Medicaid Care Coordination referrals
- Three RNs work in the high referral service units and also assist at other units
 - Samantha Hall, RN - Pine Ridge IHS and assists Fort Thompson and Fort Yates
 - Cassie Long, RN - Rosebud IHS and assists Lower Brule and McLaughlin
 - Lillian Jefferson, RN - Cheyenne River IHS and assists Sisseton and Wagner
- IPA Nurse Practitioner, Leslie Wilson, CNP, work with all nine service units to assess patients and provide IHS referrals for those that have not been evaluated at an IHS recently or to establish care with NICU babies
- General email set up to contact the IPA team at CCAReferral@state.sd.us

IPA Nurse Referral Process



Where does the patient information come from?

- State Review Team for PRTF referrals
- LTSS Medical Review Team Nurses
- Behavioral Health
- IHS Case Management/Discharge tracking
- Prior Auth Nurses (6 day tracking) for prolonged hospitalizations and possible transitions to another level of care
- PRTFs or SNFs directly
- NICUs directly
- SD Medicaid Reports

IPA Nurse Duties

RN

- Referrals
 - Maintain IHS EHR with new progress notes, immunizations, procedures, and preventative care measures
 - Monitor and review Medicaid billing claims
- Care Coordination
- Health Homes
 - Contact patients for follow-up
 - Schedule follow-ups
 - Assist with mandatory reports and core measures
- STI tracking
- Immunizations
 - update EHR thru SDIIS
 - assisting with Maven information, tracking, contact information
 - coordinating events, assisting with chart reviews from SDIIS to EHR
- Case Management
 - ER transfers, receiving discharge summaries, contacting patient's for follow up, scheduling, scanning records
 - Medicaid Referrals for outside facilities
- Contact for IHS and Care Coordination facilities for available State and IHS resources

CNP

- Establish (reestablish) care with patients in person and via telemedicine and document visit in the IHS EHR
- NICU Referrals
 - Baby is seen while at the NICU and new patient paperwork is filled out by the parent(s)/guardian
 - Discuss needs or assistance that could be available through State of SD (DOH, DHS, DSS- Medicaid, Economic Assistance etc.)
 - Offer additional information on substance use disorders if applicable
 - Public Health Nurse Consults
 - Follow post discharge to ensure follow-up appt attended and all other specialty follow-ups
- Psychiatric Residential Facilities and Substance Use Disorder Facilities
 - Care coordination agreements are with facilities that treat children
 - Available to assist with care coordination at discharge
- Long Term Care
 - Assist with any needs at discharge for shorter term stays
 - Keep them connected with their primary IHS
- Contact for IHS and Care Coordination facilities for available State and IHS resources

Shared Savings

- Savings are used to accomplish the following:
 - Address service gaps in Medicaid primarily focusing on American Indians as discussed at South Dakota Healthcare Solutions Coalition
 - Increase rates for Medicaid providers
 - Shared Savings with participating providers
 - A portion of the savings each care coordination facility generates each year is paid out yearly
 - Additional information can be found on the DSS website then click on Medicaid – DSS Statistical Information – FMAP Savings Report Data'



Questions?

dss.sd.gov

IPA Team Email

CCAReferral@state.sd.us





Prior Authorizations

Process, website, communications



Nurse Consultant Team

Prior Authorizations

- Medical Services has 7 full time Nurse Consultants that make determinations on prior authorizations (PAs).
- 2 Nurses are in our Pierre office and 3 are in a Sioux Falls office, one in Rapid City, and one in Madison.
- The nurses also monitor lengthy in-state hospital stays. Referred to as 6 day tracking, hospitals send notification of any acute admissions lasting 6 days or longer.

Prior Authorization

Process

- PA request forms and medical records are emailed to us from the requesting medical providers. DSSMedicaidPA@state.sd.us
- These requests are scanned to File Director and the information is added to a routing and tracking database and emailed to the nurse who handles that service type or out of state location.
- The nurses review and enter the approval or denial in the MMIS system and send notification to the providers and recipients.
- The request and determination notices are all scanned and kept in File Director

Prior Authorization

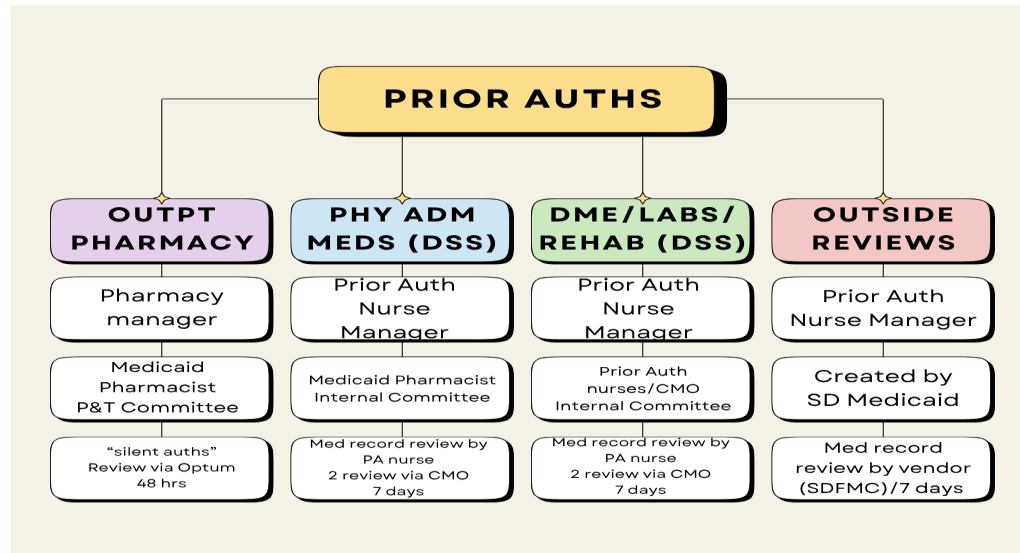
Timeline

- The division has 7 days to make a prior authorization determination. However, in most circumstances authorizations are completed in less time, usually in a few days.
- Sometimes the nurses will request additional information that is needed to make a determination. After additional information is requested, it is up to the provider to send that within the timeline included in that request and the 7-day timeline restarts when that information is received.
- Retro authorizations can be requested after the service is provided if care was suspected to be urgent/emergent at the time but will be billed as elective.

Prior Authorization

Services

- Only certain elective services require prior authorization. Emergent or urgent care does not require a PA.
- A list of services requiring prior authorization is available online:
<http://dss.sd.gov/medicaid/providers/pa/>
- There is also a procedure code look-up tool available here:
https://dss.sd.gov/medicaid/providers/procedure_code.aspx
- See PA groups and processes below:



Prior Authorization

Website tutorial

- PA website
- Forms
- Physician administered meds (separate presentation)
- Pharmacy (patient pick up at pharmacy – separate PA process)
- Policy and criteria manuals – Reconsiderations reviews
- Transportation providers
- Fee schedule
- Data
- Provider enrollment
- Recipient information

Prior Authorization

Appeal options

- We will always re-review when new information submitted.
- Providers and recipients can request a physician level review – Please provide extra documentation or clarification in writing. This can occur within 7 days
- Formal appeal with Office of Administrative Hearing (OAH)
 - Must be made by recipient/guardian or on behalf of recipient/guardian with their intent to show up.
 - Corporations must be represented by an attorney
 - Must be within 30 days of the date of determination
 - OAH to decide what qualifies for a hearing
 - Hearings are typically schedule about a month out, depending on volume and schedules.
 - During the hearing, the state and recipient/representatives testify in front of an administrative law judge. The prior authorization criteria and information received is provided by the state. Afterwards, the judge will issue a determination if the prior authorization determination was appropriately issued according to policy and administrative rule.
- Policy and criteria reconsideration requests have a different process located in the Reconsiderations Review manual on our website.

Prior Authorization

Communications

Calls: 605-773-3495 Because prior authorization cases can involve sensitive and a detailed medical information, the process below is utilized to ensure the Nurse Consultants have the necessary information to review a case and then assist the caller.

Calls are not forwarded as that does not allow us to respond to the caller with the right person or the most correct and up to date information.

Voicemails are most helpful when all the following information is left.

- **We collect the following identifying information:**
 - Recipient Name
 - Recipient ID#
 - Name, relationship(provider, parent, recip), and phone number of the caller
 - Prior Authorization type/Service being requested
 - Location of that service (SD or Another State or Mayo)
 - Date of anticipated service
- **The person taking your call will share this information with the nurse assigned to the case and they will call them back.**
- Emails – you can email DSSMedicaidPA@state.sd.us with any PA related questions.

Prior Authorization

FAQ

Recipients with Medicare? If the patient has Medicare in addition to South Dakota Medicaid, please follow the Medicare requirements, as South Dakota Medicaid's payments are contingent upon Medicare's determination. A PA from South Dakota Medicaid is required for the recipient to receive assistance with transportation, food, and lodging reimbursement out of state even if there is no need for South Dakota Medicaid to reimburse the medical service.

What if there appointment is already scheduled? Submit the [Prior Authorization Request Form](#) and supporting medical records as soon as possible to allow South Dakota Medicaid time to review the situation and issue a determination prior to the scheduled service. Recipients should not schedule travel until an authorization has been approved by SD Medicaid.

Who is responsible to obtain an out-of-state (OOS) PA? The referring provider is expected to initiate the out-of-state prior authorization request and provide supporting documentation. This responsibility should not be delegated to the recipient. When referring a Medicaid recipient to services out-of-state, the prior authorization request form should be submitted upon referral and must include an explanation of the need for care out-of-state when an in-state option is available.

If the recipient has PHI, a PA is still required from SD Medicaid.

How are physician services covered during an OOS hospital stay? Only one prior authorization is needed for the hospital stay. Physician services are included as part of the prior authorization for the inpatient stay. A prior authorization will be issued to the prior authorization contact for the inpatient facility for the dates of the approved hospital stay. In addition to the hospital facility, this authorization must be shared with all physicians to use for visits billed during that hospital stay.

Emergent inpatient admissions and urgent situations outside of office hours: If the inpatient hospitalization is the result of an emergency, the prior authorization may be granted retroactively. In the case of inpatient hospitalizations, hospitals must submit the Prior Authorization Request Form to South Dakota Medicaid within 48 hours and an expedited determination on these cases will be made within two business days. Providers should also expect to provide at least weekly updates on hospitalizations to South Dakota Medicaid after notification.

Recipient Handbook

Out of State Services

See page 20

Out-of-State Services

Prior approval is needed for out-of-state services

Most medical services (appointments, procedures, hospitalizations) that happen out of South Dakota require prior authorization. Your referring provider will have to submit a prior authorization request and medical records to Medicaid. If the services requested are available from a provider in South Dakota, Medicaid requires you to go to an in-state provider first.

Remember:

- Wait for an approval notice from Medicaid before making travel plans.
- You are responsible for paying for all services provided out-of-state that have not been approved.
- If you are in a PCP program or health home program, you need a referral from your PCP or HHP and prior authorization approval from Medicaid.
- Medicaid cannot pay for medical services outside the United States and its territories.

Exceptions:

- Services provided within 50 miles of the South Dakota border and Bismarck, North Dakota, do not need prior authorization.
- Certain lab, radiology or pathology services, durable medical equipment and pharmacy services do not need prior authorization.

Out-of-State Emergencies

Medicaid will cover out-of-state emergency services with the same limits as in-state services if the provider accepts South Dakota Medicaid.

- Make sure the provider is, or is willing to become, a South Dakota Medicaid Provider.
- If the provider is not enrolled or willing to become enrolled with South Dakota Medicaid, you are responsible for paying for all services provided to you and your family.

More information is available at <http://dss.sd.gov/medicaid/providers/pa/>.

Recipient Notification

- Out-of-State Prior Authorization expectations are provided to recipients through the Recipient Handbook.

<http://dss.sd.gov/formsandpubs/docs/MEDSRVCS/MedicalAssistanceRecipientHdbk.pdf>

Prior Authorization

What information is helpful and sometimes missed

- For out-of-state requests:
 - What was tried in South Dakota first, especially if like specialists and services are available
 - What SD specialists were considered/contacted and wait times if applicable
- Genetic testing
 - Medical records documenting the needed testing and how it will impact the treatment plan.
- Durable Medical Equipment
 - What more conservative options have been tried and how they've failed.

6 day Inpatient Tracking

Monitoring lengthy hospital stays that do not require a PA

- Inpatient stays in SD that do not require an authorization are still reported and monitored by the nurse consultants.
- Providers located within 50 miles of the SD border and Bismarck, ND are exempted from out of state PAs. They must also report any acute care hospital stays that are 6 days or longer instead.
- Providers log on to the portal and select the Clinical Reviews, 6 day reporting tab to access the submission form to report admissions and discharges.

Prior Authorization

Common misconceptions explained

- Medications are covered separately for individuals in skilled nursing facilities. Skilled nursing facilities are not responsible for the cost. A Medicaid enrolled pharmacy can bill SD Medicaid for the recipient's medications.
- Swing Bed coverage is not limited to a certain number of days and payment is available for ancillary service charges in addition to the daily rate.
- Rehab/therapy services are available in skilled nursing facilities.
- Transports do not require prior authorization. Finding an enrolled provider is key. They will also need the physician prescription and justification for that mode of transport.
- Prior authorization is needed in addition to a referral. There is additional criteria to be met when services require a prior authorization.



Thank You

Nicole Bartel



605.773.3495



DSSMedicaidPA@state.sd.us



dss.sd.gov





Long Term Acute Care (LTAC) and Inpatient Rehabilitation (IPR) Units

Sara Gloe, RN, Nurse Consultant

Private Health Insurance / Medicare

- Private Health Insurance
 - SD Medicaid MUST provide approval for IPR/LTAC services prior to the recipient admitting to the unit.
- Medicare
 - While no PA is initially provided, a PA request must be submitted/approved prior to Medicare's benefits being exhausted.

Discharge Assistance

- Please reach out to SD Medicaid as soon as it is identified that there is or possibly could be discharge difficulty regardless of if SD Medicaid is primary or secondary.
- Lower level of care referrals should begin as soon there is any inclination that the recipient is not able to return to the previous living setting

Inpatient Rehabilitation Units (IPR)

- Prior authorization criteria for IPR units can be located in SD Medicaid's Inpatient Hospital Services Manual (starting on page 16) at:
https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Institutional/Inpatient_Hospital_Services.pdf
- Prior Authorization request form can be found on SD Medicaid's prior authorization page at:
https://dss.sd.gov/formsandpubs/docs/MEDSRVCS/PA-100_General.pdf

Inpatient Rehabilitation, cont.

- The recipient requires a multidisciplinary team (ST, OT, PT, nursing, and physician monitoring)
- Able to tolerate 3 hours of therapy services
 - Denial example: Documentation states recipient is not able to participate in therapy (e.g. limited by fatigue, pain)
 - Denial Example: Recipient isn't participating in therapy or is not following all of the therapy recommendations
- Able to make weekly functional gains
- An alternate level of care can meet recipient's needs
 - Denial Example: TCU/SNF/Outpatient services can meet recipient's needs

Long Term Acute Care (LTAC)

- Prior authorization criteria for LTAC units can be located in SD Medicaid's Inpatient Hospital Services Manual (starting on page 12) at:
https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Institutional/Inpatient_Hospital_Services.pdf
- Prior Authorization request form can be found on SD Medicaid's prior authorization page at:
<https://dss.sd.gov/formsandpubs/docs/MEDSRVCS/PA-112 LTC-OOS-Rehab.pdf>

Long Term Acute Care, cont.

- Medically Complex (e.g. vent weaning, trach decannulation, multiple wounds/drains, multiple IV medications, needs daily physician monitoring)
 - Denial Example: Unable to vent wean, decannulate
 - Denial Example: Minimal wound care
- Hospital level of care for an “extended period of time” (2 plus weeks) and medical/functional gains are identified during admission
 - Denial Example: More appropriate for a lower level of care (TCU, SNF, rehab)
- Recipient is medically stable with no further (near future) care is recommended (e.g. scans, surgeries)
 - Denial Example: Still acute/plan of care is still ongoing (abnormal vitals, plan of care not complete/still unknown)

Questions/Contact Information

Sara Gloe:

Phone: (605) 773-8081

Fax: (605) 773-5246

Email: sara.gloe@state.sd.us

Please note that all formal PA requests/documentation must be submitted to DSSMedicaidPA@state.sd.us or via fax for review.



Thank You

Sara Gloe



605.773.



dssinfo@state.sd.gov



dss.sd.gov





Long Term Services & Supports-LTSS Add-Pay Program



dhs.sd.gov/ltss



dakotaathome@state.sd.us



1 (833) 663-9673

Add-Pay Program-What does it do?

- Improves availability of care in South Dakota (SD);
- Promotes a positive rapport with residents, families, and community members by keeping residents closer to home and their families;
- Reduces extra cost of transporting and caring for individuals out of state.
- Additional reimbursement to SD nursing homes for providing extraordinary cares such as equipment and services not otherwise covered under normal Medicaid reimbursement methodology.



Add-Pay Program - How is criteria met?

- ✓ SD Medicaid must be the primary reimbursement source;
- ✓ Individual must meet nursing facility level of care and reside in a nursing home;
- ✓ Individual must have a care need resulting in a cost above and beyond the normal Medicaid reimbursement methodology. Add-pay cannot cover routine services (see administrative rule 67:16:04:41).

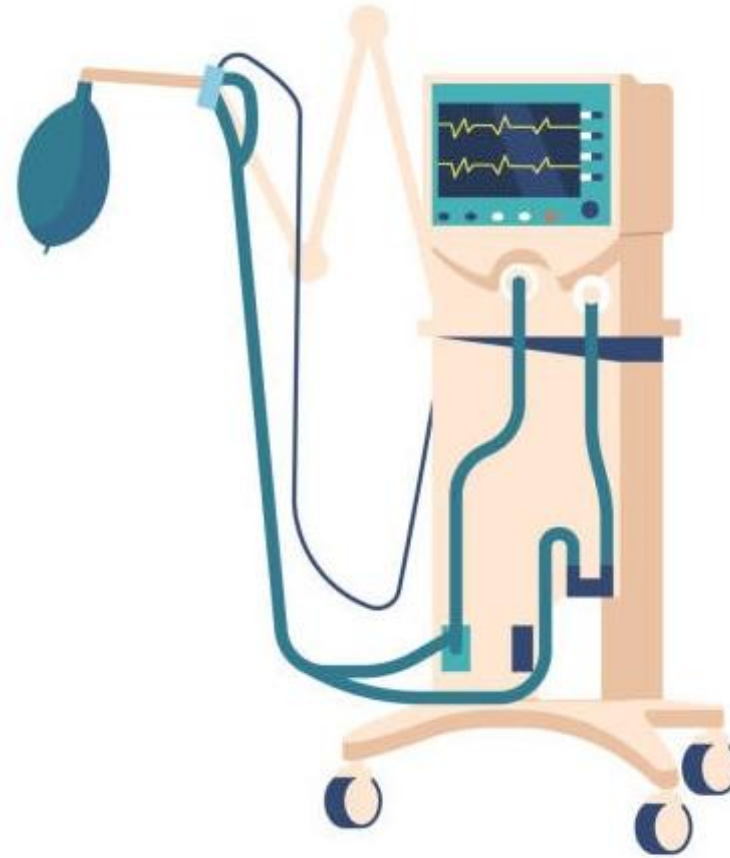


Add-Pay Program - Categories

- 7 categories
 - Chronically Ventilator Dependent Individuals
 - Spinal Cord Injuries
 - Total Parenteral Nutrition (TPN)
 - Specialized Skin or Wound Care
 - Multiple Chronic Complex Medical Conditions
 - Traumatic Brain Injuries
 - Behaviorally Challenging Individuals



**Chronically Ventilator
Dependent**-individuals must
be ventilator dependent due
to major complex medical
disease or accident.

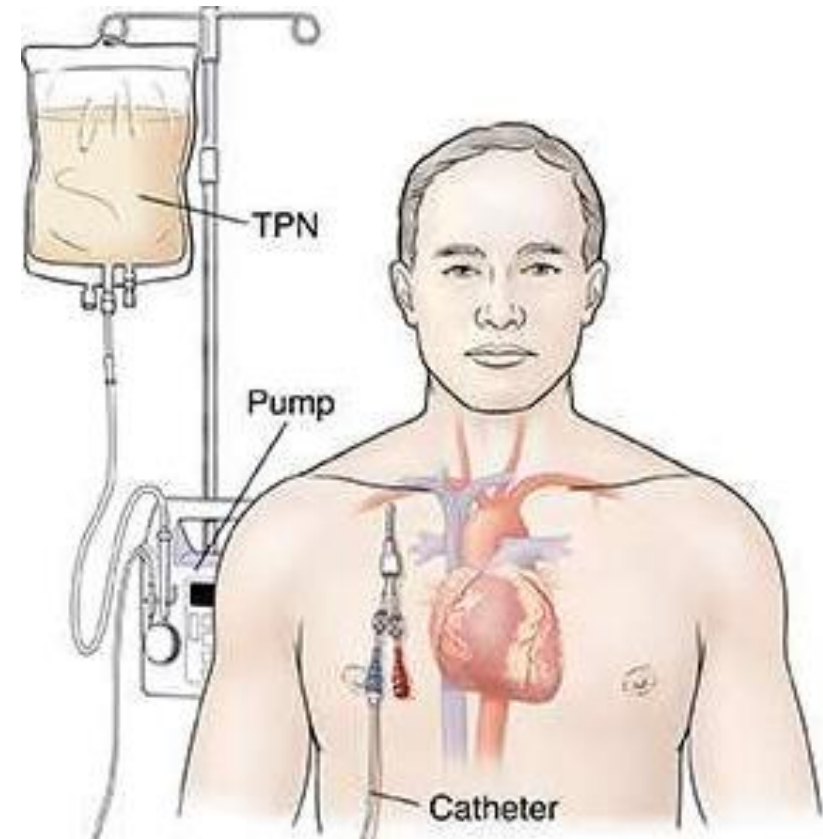


Spinal Cord Injuries-individuals with a recent diagnosis of spinal cord injury with diminished physical functioning who require skilled therapy.

1. Must have completed an acute rehabilitation program in another facility and be continuing the rehabilitation plan or,
2. If the individual does not qualify for an acute rehabilitation program, they must have a physiatry consultation documenting the ability and willingness to participate in and benefit from therapy. Documentation must also show that the individual is alert and able to follow simple directions, medically stable, and no longer needing acute level of care.



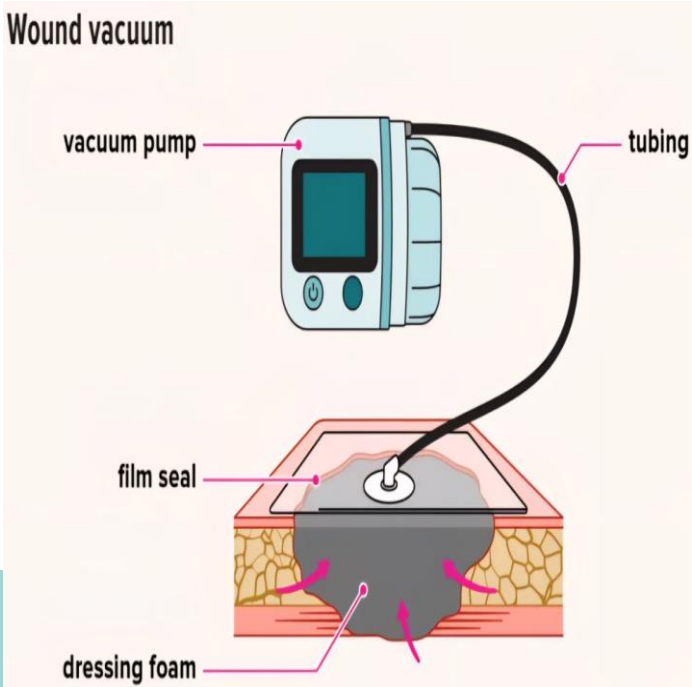
Total Parenteral Nutrition-
individual must have an internal
body organ or body function
which does not allow absorption
of sufficient nutrients to
maintain weight and strength,
with a physician prescription
stating that it is the only means
to receive nutrition.



Example of Time Study

- **Two pathways**-can apply for either or both pathways.
 1. Wound vac and dressings rate
 2. Time study rate

- **Two pathways**-can apply for either or both pathways.
 1. Wound vac and dressings rate
 2. Time study rate



Multiple Chronic Complex Medical Conditions (MCCMC)- individual must have diagnoses of multiple complex medical conditions and require specialized equipment and/or increased staff resources.

Three pathways-can apply for any or all pathways.

1. Single room rate
2. Time study rate
3. Specialty Equipment-not considered routine per ARSD 67:16:04:41



Traumatic Brain Injuries-individuals with a recent diagnosis of brain injury with diminished cognitive and/or physical functioning who require skilled therapy.

1. Will consider other injuries to the brain, not just traumatic.
2. Must have completed an acute rehabilitation program in another facility and be continuing the rehabilitation plan or,
3. If the individual does not qualify for an acute rehabilitation program, they must have a physiatry consultation documenting the ability and willingness to participate in and benefit from therapy. Documentation must also show that the individual is alert and able to follow simple directions, medically stable, and no longer needing acute level of care.



Behaviorally Challenging- individual must have a history of regular/recurrent, persistent disruptive behaviors, which are not easily altered; and an organic or psychiatric disorder of thought, mood, perception, orientation, memory, or a social history (i.e. convicted criminal) which significantly affects behavior and is interfering with care and/or placement.

Two pathways-can apply for either or both pathways.

1. Single room rate
2. Time study rate



Add-Pay Program - Clarifications

- Nursing home residents on hospital stays, skilled Medicare A/Medicare Advantage Plan stays, or who are admitted to Hospice do not qualify for add-pay.
- SD Medicaid must be the primary source of reimbursement.
- Individuals must meet nursing facility level of care and reside in a SD nursing home.
- Individuals must have a care need resulting in a cost above and beyond the normal Medicaid reimbursement methodology. Add-pay cannot cover routine services (see administrative rule 67:16:04:41).



Out of State Nursing Home Approval Process

- Prior to any out-of-state nursing home placement approval, it is necessary to ensure the services the SD Medicaid recipient needs are not available in SD.
- Hospitals with patients who are SD Medicaid recipients and are stable and requiring nursing home placement but have barriers to placement should complete an Add-Pay Screening Tool and send the completed tool to both: Krista.Miller@state.sd.us and Michelle.Hudecek@state.sd.us.
- If prior approval for an add-pay category is received, referrals offering add-pay to all SD nursing homes must be completed. A list of state-wide denials with denial reasons must be submitted to Krista and Michelle before an out of state nursing home search can be approved.
- Using the LTSS approved referral list is not mandatory, but it will help expedite determinations.
- When nursing homes do not respond to referrals, three dated and timed documented attempts to get a response will be accepted to help save hospital staff time.
- If an out of state nursing home search is approved, and an accepting out of state nursing facility is found, the accepting nursing facility must be enrolled or agree to become enrolled as a South Dakota Medicaid provider. They must also establish a current FY contract agreement with Department of Human Services (DHS) and work with the Audit Manager-Budget & Finance to negotiate a daily rate. Please direct accepting out of state nursing homes to Krista and Michelle for contact information and questions on the process.



Add-Pay Screening Tool



DEPARTMENT OF HUMAN SERVICES
Division of Long Term Services & Supports
Hillsview Plaza, 3800 East Highway 34
c/o 500 East Capitol Avenue
Pierre, SD 57501
PHONE: 605-773-3656 or
1-866-854-5465
FAX: 605-773-4085
WEB: dhs.sd.gov

Add-Pay Screening Tool

- A. Add-Pay offers additional reimbursement to nursing homes for providing extraordinary cares such as equipment and services not otherwise covered under normal Medicaid reimbursement methodology. Offering Add-Pay to South Dakota nursing homes may help overcome barriers to finding nursing home placement for individuals with extraordinary care needs. To meet criteria for Add-Pay, an individual must:
- ☐ Have South Dakota Medicaid as their primary reimbursement source,
 - ☐ Meet nursing facility level of care and reside in a nursing home, and
 - ☐ Have a care need resulting in a cost above and beyond the normal Medicaid reimbursement methodology.
- B. There are seven categories of Add-Pay. If the individual meets all of the above criteria and you answer yes to at least one of the questions below, the individual may meet criteria for one of the Add-Pay categories.
- ☐ Does the individual have a wound vac?
Does the individual have wound cares that require more than one staff and/or greater than 20 minutes?
Does the individual have a morbid obesity diagnosis and require multiple pieces of bariatric equipment?
Does the individual have multiple chronic complex medical needs and require more than 2 staff to provide cares?
 - ☐ Is the individual a registered sex offender?
Does the individual require a chronic ventilator and is unable to be weaned?
Does the individual have an organic or psychiatric disorder with related behaviors that are persistent, disruptive, and interfere with care and placement?
 - ☐ Does the individual have a recent traumatic brain injury (TBI) or spinal cord injury (SCI), not meet criteria for an acute in-patient rehabilitation program, and have the ability and willingness to participate in and benefit from therapy in a lower level of care such as a nursing home?
- C. If you answered yes to all three questions in bullet A. and are able to answer yes to at least one question in bullet B., please send this completed form to [Krista and Michelle](#) with Long Term Services and Supports (LTSS) or call Krista Miller (605-295-3891) or Michelle Hudecek (605-280-5543) to review your scenario and verify the potential for Add-Pay. Once LTSS has been notified and you receive a tentative Add-Pay approval, LTSS recommends including the potential for Add-Pay with your nursing home referrals to aid in finding placement in South Dakota.

Medicaid recipient's name:
Recipient's Medicaid number:
If not yet approved for Medicaid, where is the individual at in the Medicaid approval process?
Date of Birth:
Name of submitting facility:
Discharge planner name and job title:
Discharge planner email address and phone number:
Individual's prior living arrangement:
What brought the individual to the hospital?
Individual's discharge goal:
Does the individual have support from family/friends?
Has a Dakota at Home referral been made?

Add-Pay Screening Tool/January 2024



dhs.sd.gov/ltss



dakotaathome@state.sd.us



1 (833) 663-9673

Add-Pay Approval Process for Nursing Homes

- Complete and submit the applicable Initial Add-Pay Request form to start the process.
<https://dhs.sd.gov/en/provider-portal/long-term-services-and-supports-provider-portal>
- Contact
Krista.Miller@state.sd.us
and
Michelle.Hudecek@state.sd.us
for guidance and/or questions.

- 2025-2026 ACL Application Materials
 - [Application](#)
 - [Application Announcement](#)
 - [2025-2026 Annual Meal Projections](#)
 - [Budget Justification Sample Template Instructions](#)
- 2025 OAA Title III Grant Application Materials
 - [Application](#)
 - [Application Announcement](#)
 - [OAA Title III Grant Q & A](#)
- [Request to Amend Contracts \(Title III or SHINE Program Only\)](#)
- [Claims Resolution Request](#)
- [DHS Subrecipient Questionnaire](#)
- [South Dakota Streamlined Sales Tax Agreement](#)
- [Nursing Facility Challenging Behavior Add-Pay Request and Renewal Form](#)
- [Nursing Facility Chronically Ventilator Dependent Add-Pay Request and Renewal Form](#)
- [Nursing Facility Specialized Skin or Wound Care Add-Pay Request and Renewal Form](#)
- [Nursing Facility Spinal Cord Injuries Add-Pay Request and Renewal Form](#)
- [Nursing Facility Traumatic Brain Injuries Add-Pay Request and Renewal Form](#)
- [Nursing Facility Multiple Chronic Complex Medical Conditions Add-Pay Request and Renewal Form](#)
- [Nursing Facility Total Parenteral Nutrition Add-Pay Request and Renewal Form](#)
- [Nursing Facility Add-Pay Time Study Template](#)
- [Nursing Facility Add-Pay Time Study Template Instructions](#)
- [Request for Approval for Alternative IT System for EVV](#)
- [Request for Approval of Alternative Background Check](#)
- [702 Mental Health Certificate of Medical Necessity](#)
- [681 LTSS Critical Incident Report](#)
- [Facility Bed Availability](#)
- [LTSS Materials Order Form](#)



QUESTIONS?

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**Department of Human Services
Division of Rehabilitation Services
Assistive Daily Living Services Waiver**



Assistive Daily Living Services Waiver is...

- Physical disability waiver that allows individuals with significant disabilities to manage and self-direct their services and to live as independently as they choose in their home, community and workplace.
- ▶ State/Federal Partnership
- ▶ The State defines the services and how they are delivered

Assistive Daily Living Services (ADLS) Eligibility

- ❖ Must have quadriplegia defined as a substantial functional limitation in all 4 extremities;
- ❖ 18 years of age or older;
- ❖ Require assistance with ADLs
- ❖ Must be medically stable;
- ❖ be able to manage and self-direct services or select a representative to manage and direct their services;
- ❖ SSI/Medicaid eligible.
- ❖ NH LOC

Assistive Daily Living Services (ADLS) Eligibility

Individuals must also be determined financially eligible:

- 300% of SSI
- \$2000 or less in resources
- Long Term Care application approved by the Division of Economic Assistance
 - The application is located at:

<https://dss.sd.gov/formsandpubs/docs/MEDELGBLTY/EA240.pdf>

Assistive Daily Living Services – Services Offered

❖ Personal Attendant Services–

- ❖le: bathing, dressing, ROM, transfers, etc.

- ❖Home making services are allowable for the participant who lives alone

❖ Consumer Preparation Services– services provided by the provider agency to assist the participant with self direction

- ❖le: coordinating health services, hiring and managing staff, identifying changes to the care plan

Assistive Daily Living Services - Services cont.

- ❖ In-Home Nursing Services

- ❖ Nursing services order by a physician

- ❖ Respite Services

- ❖ Relief services provided to a primary care taker

- ❖ Respite worker can not live in the home

- ❖ Respite services can not be used while the primary care taker is working

Assistive Daily Living Services - Services cont.

❖ Environmental Accessibility Adaptations

- ❖ Physical adaptations to the persons or a close relatives home such as widening doorways, installing grab bars, ramps (permanent or portable) or walk in showers

❖ Vehicle Modifications

- ❖ Physical adaptations to the persons vehicle or a close relatives who transports them regular basis that could include wheel chair tie downs, ramps for loading, hand controls, etc.

Assistive Daily Living Services - Services cont.

- ❖ Specialized Medical Equipment and Supplies

- ❖ Devices or controls that allow the participant to live more independently or interact with their environment

- ❖ le: automatic door opener, shower/commode chair, reachers, specialized feeding or cooking utensils

- ❖ Emergency Response Services

- ❖ Monitored emergency response service connected to a call center

ADLS Self-Direction Philosophy

- ADLS philosophy supports the concept that participants may achieve greater independence by having control over their personal attendant staff and schedule.

Self Direction is the ability to recruit, screen, interview, select, schedule, train, supervise, arrange for emergency coverage, determine the attendant's competency to perform the needed services, direct the attendant to do the task, resolve conflict, and, if necessary, terminate the attendant if the conflict cannot be resolved, all with only a minimal amount of assistance or direction from or collaboration with the Provider Agency.

Responsibilities of ADLS participants

Must be able to independently direct and manage their care by:

- Recruiting Personal Attendants
- Screen, interview and select Personal Attendants to hire as their employee
- Determine attendant's competency to perform the needed services
- Schedule Personal Attendants to perform needed activities of daily living as identified in the Service Plan.
- Train Personal Attendants in duties to assist in performing activities of daily living.
- Supervise and direct the attendant to perform the task
- Arrange for emergency and backup coverage
- Resolve conflict and terminate attendant, if necessary
- **Consumer Prep Specialist can support and assist the participant in these activities

ADLS Providers

- ▶ Services are provided statewide through four qualified in-home providers who are contracted by the Department of Human Services
- ▶ Providers serve as “employer of choice” for waiver participants.

Who to Contact?

Jennifer Lewis
ADLS Waiver Manager
Pierre South Dakota

Jennifer.Lewis@state.sd.us

605-773-3195

[https://dhs.sd.gov/en/rehabilitation-
services/services-for-people-with-
quadruplegia](https://dhs.sd.gov/en/rehabilitation-services/services-for-people-with-quadruplegia)

HCBS Waiver Overview

Division of
Developmental
Disabilities



ID/DD Eligibility

- Disability eligibility requirements outlined in Administrative Rules of South Dakota (ARSD) 67:54:04:05
 - An individual is considered developmentally disabled if the individual meets all of the following criteria:
 - 1) The individual has a severe, chronic disability attributable to intellectual disability, cerebral palsy, epilepsy, head injury, brain disease, or autism or any other condition, other than mental illness, closely related to intellectual disability and requires treatment or services similar to those required for individuals with intellectual disabilities. To be closely related to intellectual disability, a condition must cause impairment of general intellectual functioning or adaptive behavior similar to that of intellectual disability;
 - 2) The disability manifested itself before the individual reached age 22; and
 - 3) The disability is likely to continue indefinitely.
- Utilize the diagnostic requirements outlined in the Diagnostic and Statistical Manual of Medical Disorders (DSM)- 5
- Must be receiving SSI or be aged, blind, or disabled and have income less than 300 percent of the SSI standard benefit amount



Family Support 360

- Family Support 360 provides participants with an individualized budget used to self-direct services and supports
 - Assists with identifying natural and paid supports to keep their family together and supported in their home and community.
 - Each individual receiving FS 360 services chooses a Family Support Coordinator who assists the individual and their family make an individualized service plan



Family Support 360 Waiver Services

Waiver Service	Overview
Support Coordination	Facilitation and development of a comprehensive person-centered individualized support plan
Respite Care	Short-term, intermittent breaks for primary caregivers
Companion Care	Include supervised integrated socialization, role modeling, and independent living skill development.
Personal Care	Provides a range of assistance to enable waiver participants to accomplish tasks including assistance with eating, bathing, personal hygiene, and activities of daily living.
Supported Employment	Supports to sustain paid employment at or above minimum wage in an integrated setting in the general workforce

Family Support 360 Waiver Services

Waiver Service	Overview
Vehicle Modification	Adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant.
Specialized Medical Adaptive Equipment and Supplies	Devices, controls or appliances specified in the plan of care which enable participants to increase or maintain their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live
Nutritional Supplements	Products that are used to complement a participant's dietary needs
Environmental Accessibility	Include those physical adaptations to the home, which are necessary to ensure the health, welfare, and safety of the participant, or which enable the participant to function with greater independence in the home

Family Support 360 Providers

- Benchmark
- BHSSC
- CFI
- DM
- LifeScape
- LifeQuest
- SESDAC
- VOA

Approximately 1,300 people supported

CHOICES

- Community, Hope, Opportunity, Independence, Careers, Empowerment, Success (CHOICES)
- The CHOICES waiver is a comprehensive waiver program
 - Goal is to assist individuals in leading healthy, independent and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of the state of South Dakota; and promote the integrity of their families.

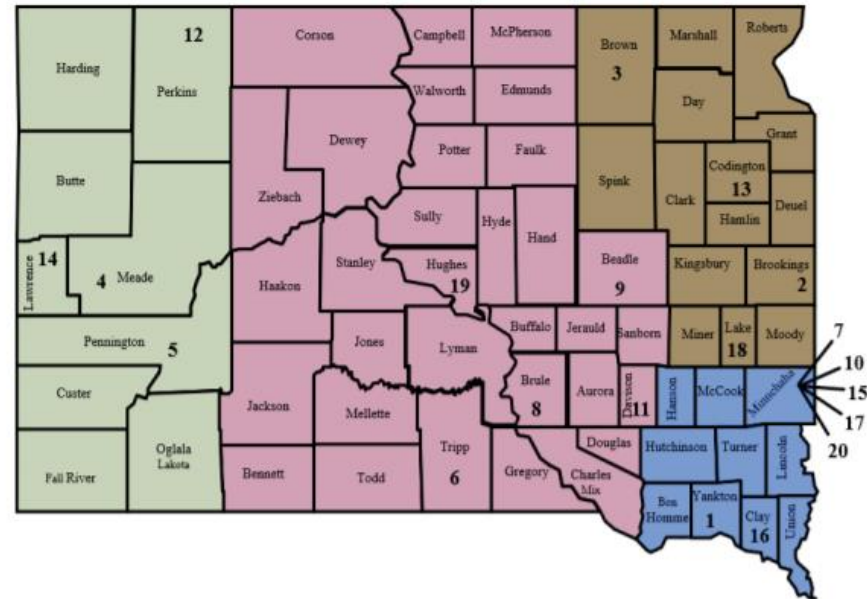


CSP/SP/CM

- CHOICES waiver
 - 20 Community Support Providers
 - 4 Case Management Providers
 - Approximately 2,700 people supported



CHOICES Community Support Provider Map



1.	Ability Building Services, Inc.	605.665.2518
2.	ADVANCE	605.692.7852
3.	ASPIRE	605.229.0263
4.	Black Hills Special Services Cooperative	605.423.4444
5.	Black Hills Works	605.343.4550
6.	Community Connections, Inc.	605.842.1708
7.	DakotAbilities	605.334.4220
8.	Dakota Milestones	605.734.5542
9.	Huron Area Center for Independence	605.352.1005
10.	LifeScape	605.336.7100
11.	LifeQuest	605.996.2032
12.	LIVE	605.374.3742
13.	New Horizons	605.884.3500
14.	Northern Hills Training Center	605.642.2785
15.	RHD-Shared Living	605.371.6490
16.	SESDAC, Inc.	605.624.4419
17.	Southeastern Directions for Life	605.336.0510
18.	Valiant Living	605.256.6628
19.	Vista Care	605.224.4501
20.	Volunteers of America	605.367.4293

CHOICES Waiver Services

Waiver Service	Overview
Nursing	Screenings and assessments, nursing diagnosis, treatment, staff training for individuals who provide services to participants, scheduling medical appointments, monitoring of medical care and related services, providing health education/prevention, policy and procedure development and review and response to medical illnesses and emergencies.
Specialized Medical Equipment and Drugs	Devices, controls or appliances specified in the plan of care which enable participants to increase or maintain their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live
Other medically related services- speech, hearing, and language	Implementation of direct therapies, treatment and services which are limited to those not available under the State Plan.

CHOICES Waiver Services

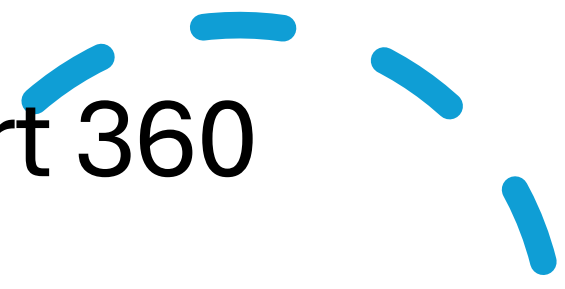
Case Management	Facilitation and development of a comprehensive person-centered individualized support plan
Residential Supports	Options range from 24/7 supervision and support to intermittent support throughout the day or week in a person's private apartment or house. This includes Shared Living
Day Services	Intended to assist the person to gain opportunities for meaningful life experiences in coordination with the person's personal goals and supports and agreed upon by the ISP team
Supported Employment Individual & Group	Supports to sustain paid employment at or above minimum wage in an integrated setting in the general workforce
Career Exploration	Designed to assist participants in identifying and developing skills that prepare them for integrated competitive

CHOICES vs Family Support 360

- DDD certifies and funds 20 Community Support Providers (CSP) and 4 Case Management Organizations to deliver CHOICES waiver services
 - Of those providers, 7 Community Support providers and 1 Case Management Organization are also certified to deliver Family Support 360
 - Benchmark- Case Management Organization
 - BHSSC, CFI, Dakota Milestones, LifeQuest, LifeScape, SESDAC, VOA- CSP



CHOICES vs Family Support 360



CHOICES (Comprehensive Waiver)	Family Support 360 (Self-Directed Waiver)
Case Management	Support Coordination
Residential Habilitation	Personal Care
Career Exploration	Respite Care
Day Services	Companion Care
Supported Employment	Supported Employment
Medical Equipment and Drugs	Specialized Medical Adaptive Equipment and Supplies
Nursing	Nutritional Supplements
Other Medically Related Services- Speech, Hearing & Language	Environmental Accessibility Adaptations
	Vehicle Modification

HOPE Waiver

Department of Human Services Division of Long Term Services and Supports



LTSS
LONG TERM SERVICES & SUPPORTS



LONG TERM SERVICES & SUPPORTS

MISSION FOR SERVICES

As a Division of South Dakota's Department of Human Services, Long Term Services and Supports (LTSS) promotes opportunities to enhance the quality of life for South Dakota's older adults, adults with disabilities, and their caregivers. LTSS provides home and community-based services to people aged 60 and older, as well as adults with disabilities who are age 18 and older.

Individuals applying for services may be asked to complete a resource and income form to determine financial eligibility, and whether the individual will share the monthly cost of their services. To learn more about your eligibility for LTSS's services, please contact Dakota at Home.



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1 (833) 663-9673



LONG TERM SERVICES & SUPPORTS

HOPE Waiver

The Home and Community-Based Options and Person-Centered Excellence (HOPE) waiver provides home and community-based services to people who need nursing facility level of care. The waiver allows people age 65 and older, and people age 18 and older who have a qualifying disability, to live at home or in the setting that is most independent for them.

*There is assistance available in completing the Medicaid or LTSS Application.



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1 (833) 663-9673



HOPE Waiver Services

LONG TERM SERVICES & SUPPORTS

- Adult Day Services
- Chore
- Homemaker
- Personal Care
- In-Home Respite Care
- Residential Respite Care
- Specialized Medical Equipment
- Specialized Medical Supplies
- Adult Companion Services
- Assisted Living
- Environmental Adaptations
- In-Home Nursing Services
- Meals
- Nutritional Supplements
- Emergency Response System
- Community Transition Supports
- Community Transition Coordination
- Community Living Home
- Structured Family Caregiving





HOPE Waiver Eligibility

LONG TERM SERVICES & SUPPORTS

Who Is Eligible?

To qualify, a person must:

- Be age 65 and older or age 18 and older with a [qualifying disability](#) - a disability that results in needs requiring long-term supports and services that cannot be provided in a less restrictive environment
- Meet a [nursing facility level of care](#)
 - Continuing direct care services ordered by physician and provide by or under supervision of a licensed nurse (daily management, direct observation, monitoring or performance of complex nursing procedures)
 - Assistance of another person for the performance of any activity of daily living
 - Skilled therapeutic services
 - Physical, occupational, or speech therapy in any combination provided at least once a week
 - Continuing mental health services through CARE or IMPACT and a need for waiver services to prevent nursing facility placement
- Participate in an assessment of needs
- Not be a resident of a hospital, nursing facility, or an Intermediate Care Facility (ICF)
- Have an assessed need for one or more waiver services at least one time per month
- Meet financial eligibility as decided by [Economic Assistance](https://sdlegislature.gov/Rules/Administrative/67:44:03:02) (<https://sdlegislature.gov/Rules/Administrative/67:44:03:02>)



Level of Care Assessment Tool

LTSS uses the interRAI Home Care Assessment (HCA) when assessing individuals to determine if they meet the Nursing Facility Level of Care Criteria.

- The HCA is completed initially, annually, and when significant changes occur
- Assesses each participant's cognitive and functional status
- Provides “Triggers” that are addressed in the participant's Individual Support Plan



Level of Care Nurse Consultants



- A Nurse Consultant employed by the Department of Human Services determines if an individual meets Nursing Facility LOC
- The Level of Care is an impartial, objective determination based on information provided by the LTSS Case Management Specialist through the interRAI Home Care Assessment (HCA)



SERVICES

HOMEMAKER AND CHORE SERVICES

Homemaker services provide help with general household activities to maintain a safe and healthy living environment. This makes it possible for individuals to live in their own home, or return to their home, and receive assistance with day-to-day household tasks. Outdoor chore services homeowners are required to do by city or county ordinances may also be available.

Services can include:

- Grocery Shopping
- Laundry
- Light Housekeeping
 - Dusting
 - Dishes
 - Vacuuming
 - Taking Out Trash
 - Assisting with Mail
- Light Meal Preparation
- Medication Pickup
- Lawn Mowing
- Snow & Ice Removal



HEMOCARE SERVICES

PERSONAL CARE SERVICES

Personal care is provided to individuals who are unable to perform routine tasks independently.

This includes, but is not limited to, these day-to-day activities:

- Bathing
- Dressing
- Eating
- Using the Bathroom
- Assisting with Personal Hygiene



HEMOCARE SERVICES

ADULT COMPANION SERVICES

Assistance, supervision or socialization can be provided to an individual through Adult Companion Services.



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1 (833) 663-9673

HEMECARE SERVICES

NURSING SERVICES

Individuals may be eligible for nursing services if they live at home with a physical or chronic health problem that requires tasks to be completed by a Licensed Nurse.

Examples of nursing tasks our services could cover are:

- Catheter Care
- Consulting with Physicians and Pharmacists
- Drawing Blood
- Giving Injections
- Health Education
- Health Status Monitoring and Screening
- Setting Up, Dispensing, and Monitoring Medications
- Nutritional Assessments
- Physical Health Assessments
- Foot and Nail Care
- Wound Care



SAFETY AND MOVING AROUND

MEDICAL EQUIPMENT & SUPPLIES

Individuals with a disability or medical condition may receive medical equipment and supplies to help them stay safe and independent at home.



Equipment and supplies may include, but are not limited to, the following:

- Equipment Purchases or Rentals
 - Hospital Beds
 - Wheelchairs
 - Medication Administration Devices
 - Telehealth/Health Monitoring
- Disposable Supplies
 - Bed Pads
 - Urostomy Bags
 - Colostomy Bags
 - Ostomy Supplies
 - Diabetic Test Strips
 - Syringes
 - Bandages
 - Incontinence Pads/Briefs



SAFETY AND MOVING AROUND

ASSISTIVE DEVICES

Assistive devices are tools, devices or equipment that help people do everyday tasks. They can help make you more independent, move around, and do things like bathing safely at home. This includes Emergency Response Systems (ERS), which are devices that call for help when you need it. An ERS is important for people who are at risk of falling. These devices come with pendants that let you call for help from a pre-programmed number in an emergency.

The devices that may be provided to an individual include, but are not limited to the following:

- Bathroom Accessibility
 - Grab Bars
 - Toilet Risers
 - Shower Chairs & Bath Benches
- Improving Mobility
 - Wheelchairs/Scooters
 - Lift Chairs
 - Repairs to Existing Devices



SAFETY AND MOVING AROUND

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Additionally, adaptations can be made to an individual's home to help them stay safe and secure.

Services do not cover home repair—like carpeting, roof repair, central air conditioning, or others—that are not a direct medical benefit.

Available adaptations are as follows:

- Installing Ramps & Grab Bars
- Widening Doorways
- Modifying Bathroom Facilities
- Installing Electric or Plumbing Systems Needed to Accommodate Medical Equipment or Supplies



NUTRITION & MEALS

Nutritious meals may be available in a community setting—like a senior center, community building, restaurant, or local kitchen. A group dining atmosphere offers a great opportunity to socialize with others while having a nutritious meal. Meals may be delivered directly to someone's home depending on their needs. Additionally, nutrition screenings, supplements, education and counseling may be available.

Nutrition & Meals provide these benefits:

- Fulfills Up to One-Third of An Individuals Dietary Needs
- Offers a Variety of Food
- A Social Opportunity to Meet Others



CAREGIVER SUPPORT

STRUCTURED FAMILY CAREGIVING

Structured Family Caregiving provides a stipend for a family member who cares for an aging adult or an adult with a disability in the person's own home or in the caregiver's home. The goal is to enable the person to live in their community while getting needed care and supervision from a paid family caregiver. The caregiver receives ongoing support and training from a provider.



CAREGIVER SUPPORT

RESPIRE CARE

Respite care offers a primary caregiver temporary relief from providing continuous support to an older adult, or an adult with a disability. It can be used to give caregivers a break overnight, on weekends, to run errands, or to take vacations.

Respite Care may include:

- Completing Personal Hygiene Tasks
- Light Housekeeping
- Meal Preparation
- Providing Companionship



CAREGIVER SUPPORT

ADULT DAY SERVICES

Adult Day Services help people stay at home longer by offering activities, care, and supervision outside of the home for part of the day. This allows the main caregiver to work or pursue other daytime activities when they need to.

Locations are expanding to include the following communities:

- Sioux Falls
- Rapid City
- Belle Fourche
- Lake Norden
- Howard

With Adult Day Services, people can enjoy activities and nutritious meals. Some nursing services may also be available, like health checkups and help managing medication.

You can find Adult Day Services at a senior center, assisted living facility, or as a separate program.

There are more locations offered privately or through VA assistance.



RESIDENTIAL LIVING SERVICES

COMMUNITY LIVING HOMES

Community living homes promote independence for individuals through a combination of supportive services and assistance with activities in a homelike setting.



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dakotaathome@state.sd.us



1 (833) 663-9673

RESIDENTIAL LIVING SERVICES

ASSISTED LIVING

Assisted living services provide 24-hour staffing, three meals a day, housekeeping, laundry services, supervision and assistance with medication management. This allows people to live more independently while also getting supervision and socialization, while feeling safe and secure.

Assisted living centers help with:

- Daily Living Activities
 - Eating
 - Bathing
 - Dressing
 - Personal Care
- Social and Recreational Programming
- Laundry Service
- Housekeeping



Caitlin Clarey
HCBS Program Manager
Department of Human Services
Division of Long Term Services and Supports



LTSS

LONG TERM SERVICES & SUPPORTS

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 dhs.sd.gov/ltss

STEVENS AMENDMENT:

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On Your Own But Not Alone



homeagainSD

Orientation to Medical Services 10/28/2025

What is Home Again?

Home Again provides support and resources to help vulnerable South Dakotans live independently.



As a partner of the South Dakota Department of Social Services, we're able to provide one-time or short-term services that aren't typically covered by South Dakota Medicaid.

Our Services

Transition Services

You have the right to live how and where you want to. With the help of our transition coordinators, we can help you secure a housing unit, set up a new housing unit, or make minor modifications to a current unit. Once that's complete, you'll work with your transition coordinator to identify and select a transition team to help assist you in the journey home.



Transportation Services

Home Again services will help recipients with relocation services from their current address back to their community.

Once a recipient is back home, DSS has services to help with day-to-day transportation. To find community transportation you can visit the [Community Transportation Page](#).



Assistive Technology

Home isn't home if you're uncomfortable. With the help of Home Again, we can help someone gain access to available supplies and modifications to better support them in becoming independent in self-care. This may cover items such as daily sensors, medication dispensers, grab bars and more.



Eligibility Requirements

On the Path Back Home

You should have a say in where you live, and Home Again wants to help you get there. Participation in South Dakota's Home Again program is open to any adult, age 18 or older that meets the following criteria:

- ✓ Is a South Dakota resident.
- ✓ Is enrolled in Medicaid or has a pending Medicaid application.
- ✓ Resides in a nursing facility, ICF/ID or other qualifying institution for 60 or more consecutive days.
- ✓ Meets Medicaid level of care and financial eligibility criteria at least one day prior to transition.
- ✓ Will reside in qualified housing upon transition (a home, apartment, or group home with four individuals or less).*
- ✓ Is willing to enroll in and can be supported in the community through the provision of an existing [1915\(c\)HCBS waiver](#).
- ✓ Expresses a desire to live and receive services in a home and community-based setting.

Home Again South Dakota Eligibility Quiz

You should have a say in where you live. Home Again wants to help you get there. If you're unsure if you're eligible to receive services through Home Again, take this quiz.

*** Required Field**

Are you currently living or residing in a:*

- ☐ Medical or long-term care facility for 60 or more days
- ☐ Hospital for 60 or more days
- ☐ Other

Would you like to live and receive services in a home or community-based setting such as a group home?*

- ☐ Yes
- ☐ No

Are you 18 years or older?*

- ☐ Yes
- ☐ No

Are you a South Dakota resident?*

- ☐ Yes
- ☐ No

Do you currently have South Dakota Medicaid or will you be eligible for Medicaid at least one day prior to leaving your current residence?*

- ☐ Yes
- ☐ No
- ☐ I've applied for Medicaid

Note – Home Again recipients must be enrolled in Medicaid or have a pending Medicaid application.

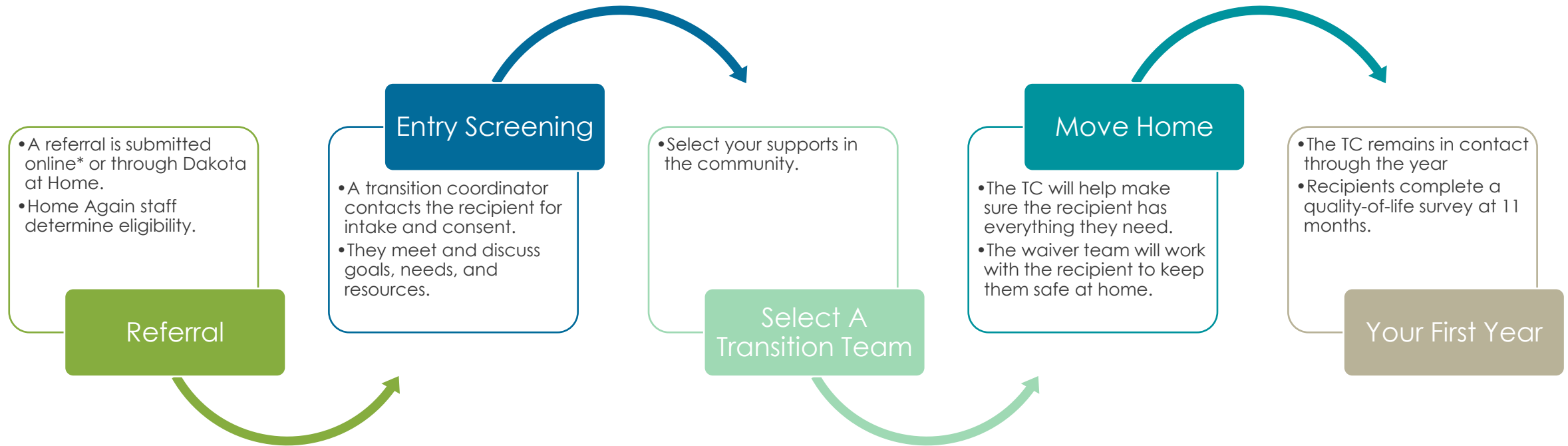
Are you willing to reside in qualified housing? (A home, apartment, or group home with four individuals or less)*

- ☐ Yes
- ☐ No

Are you willing to enroll in and be supported in the community through the provision of an existing 1915 (c) HCBS waiver?*

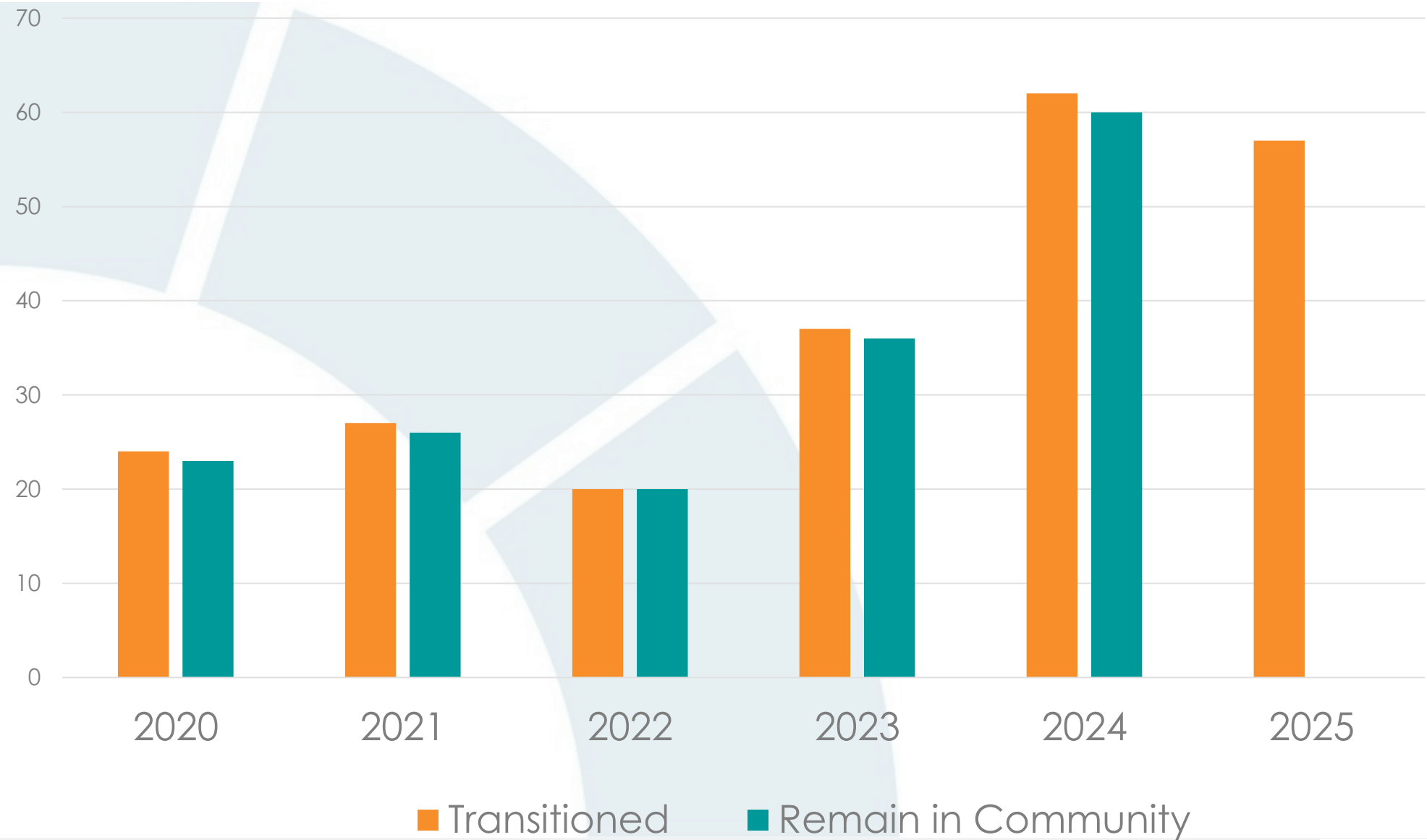
- ☐ Yes
- ☐ No

Home Again Process

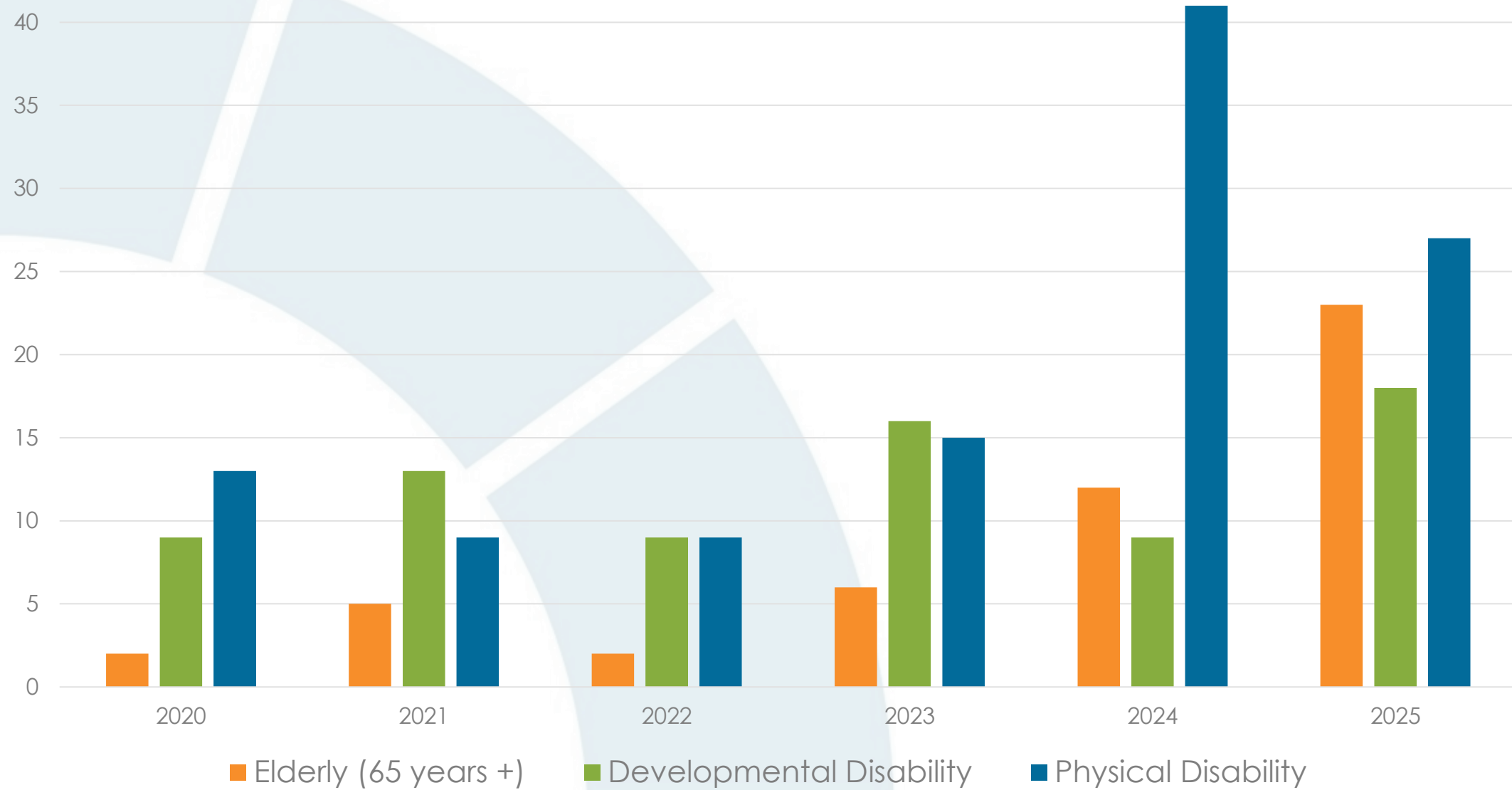


*<https://homeagain.sd.gov/get-started>

2020-2025* Transitions



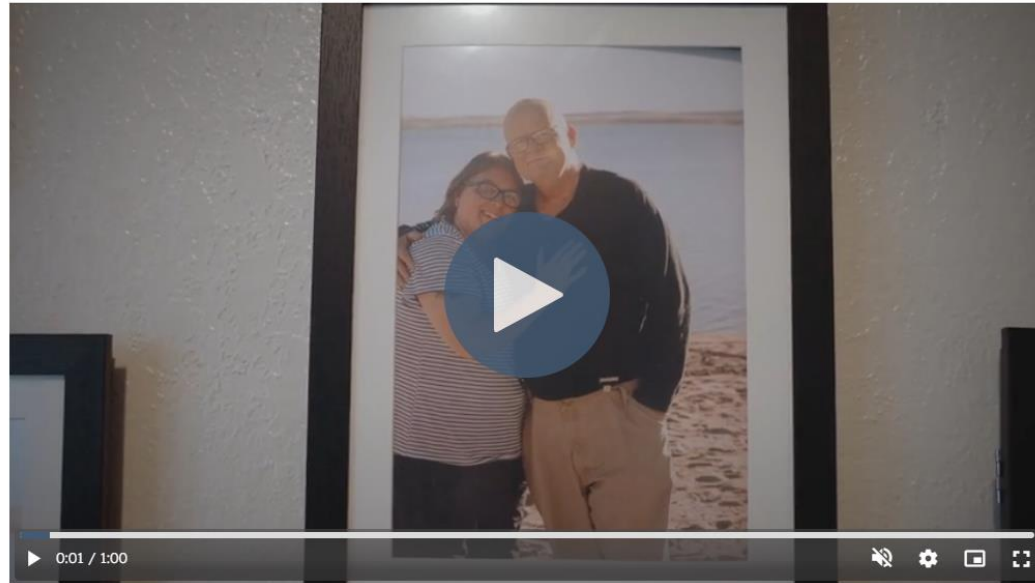
Target Populations



TESTIMONIALS

What People Are Saying

At Home Again, we know that getting the right support can feel overwhelming. That's why we've made it our job to help create a space to thrive and feel independent in self-care. But don't just take our word for it. Hear it from the people who took the first step to living the life they want with Home Again.





Thank You

Ashley Laving

Ashley.Laving@state.sd.us

Sara Spisak, Program Director

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