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CY25 IHS Encounter Rate

- The federal government published the new CY25 IHS encounter rates.
- Medicaid Encounter rates for CY25 are:
  - Outpatient
    - $801
  - Inpatient Hospital
    - $5,580
- Reimbursement rates are updated in Medicaid’s claims processing system effective January 1, 2025

2

Permanent Crowns Update

- Medicaid dental coverage includes coverage of stainless steel crowns and permanent crowns.
- Prior to January 1, 2025 permanent crown coverage was limited to front teeth for both adults and children as well as bicuspids for children.
- Effective January 1, 2025 permanent crown coverage was extended to all teeth with the exception of 2nd and 3rd molars.
- Providers are recommended to get a predetermination from Delta Dental for permanent crowns.
- See our dental providers manuals for additional coverage details: https://dss.sd.gov/medicaid/providers/billingmanuals/default.aspx

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4

Juvenile Justice Medicaid Coverage

The Consolidated Appropriations Act (CAA) 2023, section 5121 requires states to provide select services 30-days prior to release for Medicaid enrolled juveniles and those in the FFCY aid category (54) effective January 1, 2025.

The goal is to help provide seamless transitions to medical, dental, vision, and behavioral health providers upon re-entry.

Updates since last Tribal Consultation

Eligible Carceral Status: the youth must be incarcerated through a legal system (federal, state, local, or tribal), must be post-adjudication (post-legal ruling or judgement in a legal case), and be held in an eligible carceral setting.

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

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Eligible Providers

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

- Members of a care team of Medicaid enrolled providers supervised by a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, certified addiction counselor, licensed independent mental health practitioner or licensed social worker; or
- Staff employed by a Public Safety Organization; or
- Certified Community Health Workers employed by an enrolled CHW Agency.

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Required Services

Screenings and Diagnostic: In the 30 days prior to release (or not later than one week, or as soon as practicable, after release), in coordination with the public institution, provision of any screening or diagnostic service (including a behavioral health screening or diagnostic service) which meets reasonable standards of medical and dental practice, as determined by the state.

Targeted Case Management: In the 30 days prior to release and for at least 30 days following release, provide Targeted Case Management to include the following:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services;
- Development (and periodic revision) of a specific person-centered care plan based on the information collected through the assessment;
- Referral and related activities
- Monitoring and follow-up activities.

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Pre-Release Services

Targeted Case Managers, in conjunction with the carceral setting, will help schedule a full wellness exam/physical through a Medicaid enrolled provider in the 30-days prior to release from a carceral setting to any non-carceral setting, or as soon as practical after release.

The wellness exam should include appropriate immunizations according to age and health history and the following screenings:

- Behavioral Health screening and, as applicable, referrals for services;
- Dental screening;
- Hearing screening; and
- Vision screening;

Additional diagnostic and treatment services prior to release are not covered by Medicaid and are subject to payment recoupment.

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Targeted Case Management

Targeted case management services include services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services which include the following:

Assessment and Reassessment
Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services.

Care Plan
Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment.

Referrals and Related Activities
Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services.

Monitoring and Follow-up Activities
Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs.

Feedback

Further questions or feedback may be directed to Ashley Lauing, Policy Strategy Manager at Ashley.Lauing@state.sd.us.

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§ 431.12 – Final Rule

Rules effective July 9, 2025

- States will be required to make revisions to the Medicaid Advisory Committee (MAC) and establish a new Beneficiary Advisory Council (BAC);
- States must develop and publish, by posting publicly on their website, bylaws for governance of the MAC and BAC along with a current list of members.
- Establishment of the revised MAC and new BAC: 1 year after the effective date of the final rule (July 9, 2025).
- At a minimum, the MAC and BAC must determine, in collaboration with the State, which topics to provide advice on related to:
  - Additions and changes to services;
  - Coordination of care;
  - Quality of services;
  - Eligibility, enrollment, and renewal processes;
  - Beneficiary and provider communications by State Medicaid agency and Medicaid MCOs, PIHPs, PAHPs, PCCM entities or PCCMs as defined in § 438.2;
  - Cultural competency, language access, health equity, and disparities and biases in the Medicaid program;
  - Access to services; and
  - Other issues that impact the provision or outcomes of health and medical care services in the Medicaid program as determined by the MAC, BAC, or State.

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§ 431.12 – Final Rule

Medicaid Advisory Committee – Prior Requirements

- Prior Requirements – Membership
  - Board-certified physicians and other representatives of the health professions;
  - Members of consumer groups including Medicaid beneficiaries, and consumer organizations such as labor unions, cooperatives, consumer sponsored prepaid group practice plans, and others; and
  - The director of the public welfare department or public health department whichever agency does not have the Medicaid agency.

Medicaid Advisory Committee – New Requirements

- 25% of MAC members must come from the BAC.
- Remaining committee members must include representation from at least one of each of the following:
  - State or local consumer advocacy groups or other community-based organizations that represent the interests of or provide direct service to Medicaid beneficiaries clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries
  - As applicable participating Medicaid MCO, PIHP, PHP, PCCM or PCM entities, or a health plan associated with representing more than one such plan
  - Other state agencies that serve Medicaid beneficiaries as ex-officio (non-voting) members.

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§ 431.12 – Final Rule

Beneficiary Advisory Council

- States must form and support a Beneficiary Advisory Council (BAC) to advise the state regarding their experience with the Medicaid program.

- The BAC, which can be an existing beneficiary group, is comprised of:
  - Current Medicaid beneficiaries.
  - Former Medicaid beneficiaries.
  - Individuals with direct experience supporting Medicaid beneficiaries.
    - Family members
    - Paid caregivers of those enrolled in Medicaid
    - Unpaid caregivers of those enrolled in Medicaid

- The BAC must meet separately from the MAC on a regular quarterly basis and in advance of each MAC meeting.

Feedback

Further questions or feedback may be directed to Ashley Lauing, Policy Strategy Manager at Ashley.Lauing@state.sd.us.

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Background

Core Service Definitions were created in 2013 with the assistance of the Implementation Workgroup prior to guidance issued by CMS.

Determining what is a core service has long been a concern to the Care Coordinators.

The need to clarify the definitions and what constitutes a core service became clear with the results of the Quality Assurance Review and the 2024 Sharing Sessions.

Did a complete review to provide better guidance on what could be considered a core service. Used guidance issue by CMS to assist as well as other states.

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Six Core Services Criteria

- The Core Service Criteria was clarified to address the following
  - To whom can a core service be provided?
  - How can a core service be provided?
  - What is a core service? (more clearly defined in our definitions)
  - Who can provide a core service?
  - Documentation Requirements.
  - How the core service relates to the care plan.
- Revisions were updated in the Health Home Billing Manual and on our website.
- The full definition of core services can be found at https://dss.sd.gov/docs/medicaid/PCP_Core_Services_Specific.pdf.

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Six Core Services Criteria

Core Services must meet the following criteria

- The Core Service is provided directly to the recipient or to the recipient's guardian for the direct benefit of the recipient;
- The Core Service must be provided either in person, via telemedicine, or via telephone.
- The Core Service is related to individualized goals in the care plan. There may be some exceptions to this requirement such as development of the care plan and assisting with transitional care;
- The Core Service is documented in the EHR including a description of the Core Service and the applicable category of Core Service;
- The Core Service is not reimbursed by South Dakota Medicaid as part of another service;
- The Core Service meets the description of one of the six Core Service categories;
- The Core Service is provided by the Health Home Care Coordinator or another member of the Health Home Care Team. It is anticipated that Core Services would be provided by clinic staff that cannot directly enroll and bill Medicaid.

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Core Services

Comprehensive Care Management

- Comprehensive Care Management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral, specialty health care, and community support services. It requires **developing a comprehensive person-centered care plan** which addresses all clinical and non-clinical needs

Care Coordination

- Care coordination is the **implementation of the person-centered care plan**. The plan must be implemented through appropriate linkages, referrals, coordination, and follow-up to needed services and supports

Health Promotion

- Health promotion services **encourage and support healthy ideas and concepts**. The intent of the service is to motivate recipients to adopt healthy behaviors and enable recipients to self-manage their health. The Care Coordinator will provide health promotion activities

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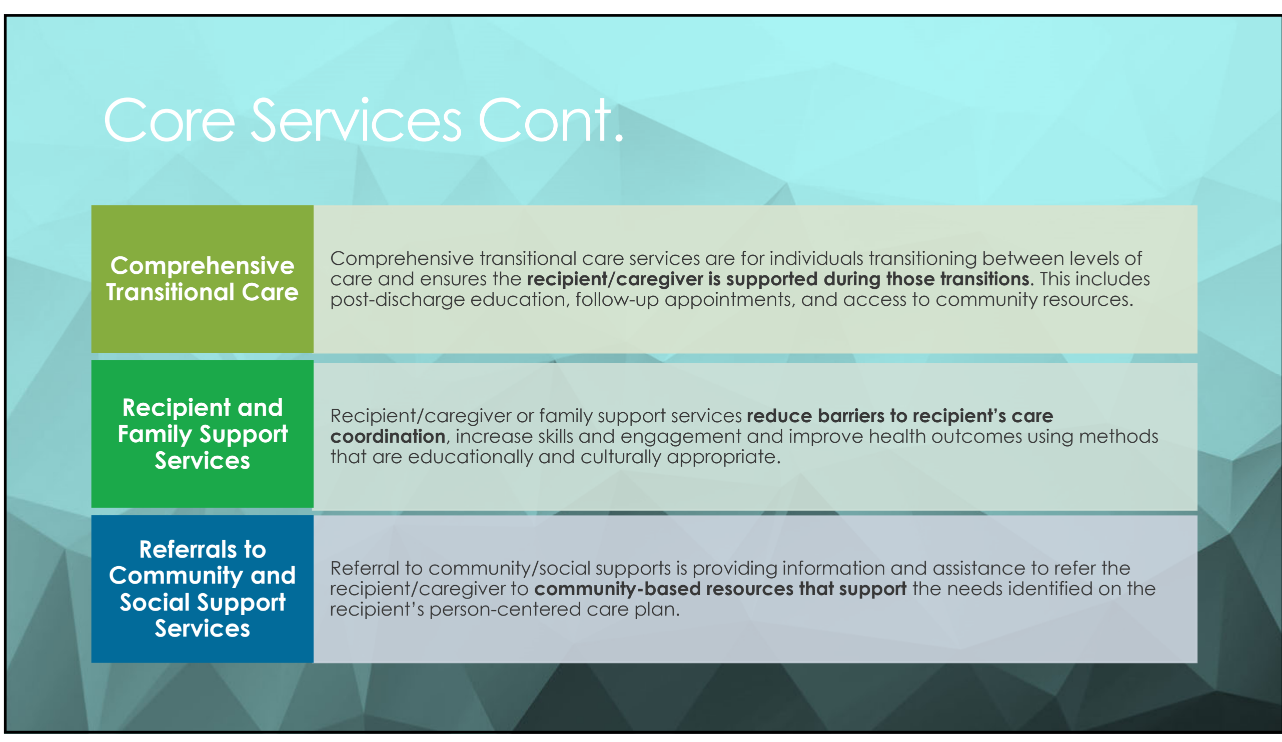

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DakotaPlex Housing Units

With 95% of South Dakota’s communities having populations of under 5,000, the need for affordable rental housing has never been greater. To help, Home Again has partnered with SD Housing to build accessible DakotaPlex rentals in rural South Dakota. Home Again will is offering a grant for developers to receive up to $200,000 to help cover the costs of purchasing a DakotaPlex housing unit.

To qualify for the funding, developers must meet the following criteria:

- DakotaPlex must be located within city limits.
- The city must have a population of 5,000 or less.
- Housing must address a documented housing need (via study or market analysis).
- Must be purchased, owned, or managed by a city, nonprofit, or developer.
- Intended for use as affordable rental housing.

Developers will need to sign special terms and conditions to qualify for the funding and will need to include those special terms and conditions when submitting their application to the South Dakota Housing Authority.

The terms and conditions can be found at homeagain.sd.gov/partners.

Feedback

Further questions or feedback may be directed to Ashley Lauing, Policy Strategy Manager at Ashley.Lauing@state.sd.us.

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