South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
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July 20, 2026

RE: South Dakota Medicaid State Plan Amendment # SD-26-0006

The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan to add a new Primary Care Program (PCP) value-based payment. The proposed amendment implements a $7 million quality-based payment pool for qualifying healthcare providers currently enrolled in the Medicaid Primary Care Provider (PCP) program. Payments are based on provider performance on specific primary care quality metrics during 2026 and 2027 with funding established under the federal One Big Beautiful Bill Act (Public Law 119-21, Section 71401) and as appropriated by the state legislature during the 2026 legislative session. The payment is part of phase one of Medicaid's Primary Accountable Care Transformation (PACT) initiative.

The funds will be awarded for provider performance on the following quality metrics in the CY2025 South Dakota Medicaid PCP Provider Scorecard:

1. Adult Preventative Visit (Adults age 21 to 64 w/ a preventative visit during the performance period)
2. Breast Cancer Screening (BCS-AD)
3. Colorectal Screening (CCS-AD)
4. Well-Child Visits in the First 15 Months of Life (W30-CH, Rate 1)
5. Well-Child Visits in the First 30 Months of Life (W30-CH, Rate 2)
6. Child and Adolescent Well-Care Visits (WCV-CH)
7. Lead Screening (LSC-CH)
8. Pediatric ER Utilization (Number of ED visits per 1,000 beneficiary months for children age 0 to 19)
9. Adult ER Utilization (Number of ED visits per 1,000 beneficiary months for adults 20 years of age or older)

Payments are anticipated to be made in Fall 2026.

The proposed State Plan Amendment (SPA) has an effective date of August 1, 2026. The amendment revises pages 1-3, of Attachment 3.1-F of the Medicaid State Plan.

The department estimates the fiscal impact will be $0 in State funds and $7,000,000 in Federal funds, totaling $7,000,000 in Federal Fiscal Year 2026 (August 1, 2026 to September 30, 2026) and $0 in State funds and $7,000,000 in Federal funds, totaling $7,000,000 in Federal Fiscal Year 2027 (October 1, 2026 to September 30, 2027).

The SPA is available to view on the department's website at http://dss.sd.gov/medicaid/medicaidstateplan.aspx. Copies of the proposed SPA pages are also available at the Department of Social Services, Division of Medical Services. Written requests for a

copy of these changes, and corresponding comments, may be emailed to MedicaidSPA@state.sd.us or sent to:

DIVISION OF MEDICAL SERVICES
DEPARTMENT OF SOCIAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291

The public comment period will start July 20, 2026 and end August 19, 2026.

Sincerely,

Matt Ballard

Matthew Ballard
Deputy Director
Division of Medical Services
South Dakota Department of Social Services

CC: Matt Althoff, Cabinet Secretary
Heather Petermann, Director

Medicaid State Plan Amendment Proposal

Transmittal Number: SD-26-0006

Effective Date: 08/01/2026

Brief Description: Implements new quality-based payments to healthcare providers enrolled in the Medicaid Primary Care Provider (PCP) program. Payments are based on provider performance on specific primary care quality metrics and funded under the Rural Health Transformation Plan as part of part of phase one of Medicaid's Primary Accountable Care Transformation (PACT) initiative.

Area of State Plan Affected: Primary Care Case Managers (PCCM) 1932(a) Pre-print Pages

Page(s) of State Plan Affected: Pages 1-3, of Attachment 3.1-F of the Medicaid State Plan.

Estimate of Fiscal Impact, if Any: FFY26: $7,000,000
FFY27: $7,000,000

Reason for Amendment: Award and incentivize the delivery of quality primary care services.

Anticipated Impact to Tribes: New incentive payment opportunity for participating Primary Care Providers, which can also be used to funder further quality initiatives and preparation for the PACT model.

Comment Period: July 20, 2026 to August 19, 2026

PUBLIC NOTICE

South Dakota Medicaid Program

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The public comment period will start July 20, 2026 and end August 19, 2026.

State: South Dakota

Citation	Condition or Requirement

1932(a)(1)(A) A. Section 1932(a)(1)(A) of the Social Security Act.

The State of South Dakota enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted 42 CFR under each entity type.

1. ☐ MCO
   a. ☐ Capitation
   b. ☐ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☒ PCCM (individual practitioners)
   a. ☒ Case management fee
   b. ☐ Other (please explain below)

Primary care providers (PCPs) are reimbursed on a fee-for-service basis plus a case management fee. All other providers are reimbursed fee-for-service as long as the services meet program requirements.

Effective July 1, 2026, in relation to South Dakota's Rural Health Transformation Grant, South Dakota Medicaid will implement phase 1 of the Primary Accountable Care Transformation (PACT) initiative, which provides for a value-based payment pool for PCP providers. The funds will be awarded for provider performance on quality metrics. Annual payments will be made in calendar year quarter three in 2026 and calendar year quarter three in 2027 pending CMS approval of the state plan amendment. The quality metrics utilized to determine the payment are based on measures in the South Dakota Medicaid PCP Scorecard. After the 2027 payment, it is anticipated the State will propose implementation of phase 2 of PACT under a different Medicaid authority and that the State will propose inclusion of a value-based payment under the new authority.

Performance Period
The performance period for the 2026 payment is calendar year 2025. The performance period for the 2027 payment is calendar year 2026.

Attribution Methodology
Recipients are attributed to a PCP clinic on the basis of being on the PCP's caseload for at least 7 months of applicable performance period.

Primary Care and Preventative Measures
A $6.5 million annual payment pool will be utilized for primary care and preventative measures listed below.

1. ***Adult Preventative Visit (Adults age 21 to 64 w/ a preventative visit during the performance period)***
2. ***Breast Cancer Screening (BCS-AD)***
3. ***Colorectal Screening (CCS-AD)***
4. ***Well-Child Visits in the First 15 Months of Life (W30-CH, Rate 1)***
5. ***Well-Child Visits in the First 30 Months of Life (W30-CH, Rate 2)***
6. ***Child and Adolescent Well-Care Visits (WCV-CH)***
7. ***Lead Screening (LSC-CH)***

The proposed methodology for this calculation of primary care and preventative measures involves scoring each member on the caseload. For example, for breast cancer screening, if a Medicaid recipient qualifies for inclusion in the measurement denominator and met the requirements for inclusion in the numerator (meaning they had a mammogram), that is considered a quality outcome.

Example Calculation

1. ***The total $6.5 million payment pool is divided by the total number of quality outcomes to arrive at a payment amount per quality outcome***
    a. ***Example: $6,500,000 payment pool / 32,000 quality outcomes = $203.13 per quality outcome.***
2. ***The payment per quality outcome is multiplied by a clinic's number of quality outcomes to arrive at their Primary Care and Preventative Measure payment amount.***
    a. ***Example: $203.13 per quality outcome * 100 quality outcomes = $20,312.50 Primary Care and Preventative Measure payment amount.***

Emergency Room Utilization Measures
The second pool of $500,000 is awarded by comparing like-clinics (divided into 3 groupings) on their performance related to child and adult ER utilization measures listed below.

1. ***Pediatric ER Utilization (Number of ED visits per 1,000 beneficiary months for children age 0 to 19)***
2. ***Adult ER Utilization (Number of ED visits per 1,000 beneficiary months for adults 20 years of age or older)***

The proposed methodology for this calculation of ER utilization measures involves scoring each clinic based on their performance related to achieving a better (in this case, lower) score than their group's target, as well as their own performance in comparison to the previous year. The target is defined as a minimally statistically significant improvement, at a 95% confidence level, from the mean. The mean was calculated as the average of the measure outcomes for the last 3 years to account for uncontrollable variability year to year.

Points were awarded in the following manner separately for each of the pediatric and adult ER utilization measures:

- ***1 point: the clinic met the target without declining 2 percentage points or more in performance from the previous year.***
- ***0.5 points: the clinic met the target but declined in performance 2 percentage points or more from the previous year.***
- ***0.5 points: the clinic did not meet the target but improved in performance from the previous year.***

Example Calculation

1. ***The $500,000 funding pool is divided by the sum of each clinic's score to arrive at a payment amount per point.***
    a. ***Example: $500,000 payment pool / 200 points = $2,500 per point.***
2. ***The payment per point is multiplied by a clinic's total score for each measure to arrive at the Emergency Room Utilization payment amount.***
    a. ***Example : $2,500 * 1.5 points = $3,750 Emergency Room Utilization payment amount.***

3. ☐ PCCM entity
    a. ☐ Case management fee
    b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
    c. ☐ Other (please explain below)