



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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June 29, 2026

RE: South Dakota Medicaid State Plan Amendment #SD-26-0004

The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan to implement the inflationary rate increases for the Care Connect (formerly known as Health Home) program appropriated by the state legislature during the 2025 legislative session.

The Care Connect quality incentive payment pool and PMPM payment rates will receive a 1.4 percent inflationary increase. The Care Connect tier PMPM payment rates were initially rebased prior to applying the inflationary increase to better align the payments with cost avoidance by tier and make the tier payments uniform for both Community Mental Health Center and Primary Care Provider Care Connect providers. PMPM tier payments will be the following effective July 1, 2026:

- Tier 1: \$35.15
- Tier 2: \$58.99
- Tier 3: \$99.54
- Tier 4: \$166.35

The changes represent an increase in the PMPM for Tiers 1, 2, and 3 and a decrease for Tier 4 from current PMPM amounts. In the aggregate, the changes are budget neutral prior to application of the 1.4 percent inflationary increase.

The updated fee schedule will be posted on the department's website at:

<http://dss.sd.gov/medicaid/providers/feeschedules/dss/>.

The estimated expenditures associated with this amendment are solely due to rate increases. No rates are being decreased. The department estimates the fiscal impact will be \$9,122 in State funds and \$9,370 in Federal funds, totaling \$18,492 in Federal Fiscal Year 2025 (July 1, 2026 to September 30, 2026) and \$36,488 in State funds and \$37,480 in Federal funds, totaling \$73,968 in Federal Fiscal Year 2026 (October 1, 2026 to September 30, 2027). The department intends to make this SPA effective July 1, 2026.

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
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PIERRE, SD 57501-2291

The public comment period will start June 29, 2026 and end July 29, 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

PUBLIC NOTICE

South Dakota Medicaid Program

Notice is hereby given that the South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan to implement the inflationary rate increases for the Care Connect (formerly known as Health Home) program appropriated by the state legislature during the 2025 legislative session.

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SD - Submission Package - SD2026MS0001O - (SD-26-0004) - Health Homes

[Summary](#) [Reviewable Units](#) [News](#) [Related Actions](#)

CMS-10434 OMB 0938-1188

Package Information

Package ID	SD2026MS0001O	Submission Type	Official
Program Name	MIGRATED_HH.South Dakota Health Homes	State	SD
SPA ID	SD-26-0004	Region	Denver, CO
Version Number	1	Package Status	Pending

1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | SD2026MS00010 | SD-26-0004 | MIGRATED_HH.South Dakota Health Homes

Package Header

Package ID	SD2026MS00010	SPA ID	SD-26-0004
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	7/1/2026
Superseded SPA ID	SD-25-0010 System-Derived		

Payment Methodology

The State's Health Home payment methodology will contain the following features

- Fee for Service
 - Individual Rates Per Service
 - Per Member, Per Month Rates
 - Fee for Service Rates based on
 - Severity of each individual's chronic conditions
 - Capabilities of the team of health care professionals, designated provider, or health team
 - Other
 - Comprehensive Methodology Included in the Plan
 - Incentive Payment Reimbursement
 - Fee for Service Rates based on
 - Severity of each individual's chronic conditions
 - Capabilities of the team of health care professionals, designated provider, or health team
 - Other

Describe below

South Dakota will provide a supplemental quality incentive payment to Health Homes when the Health Home intervention produces at least \$3 million in savings through efficiencies. Savings through efficiencies is calculated by determining the per member per month (PMPM) for Health Home participants and individuals eligible for Health Homes that do not participate in the program. The PMPMs are multiplied by the number of Health Home member months and the numbers are compared to determine the amount of savings through efficiencies. South Dakota Medicaid worked with a subgroup of the Implementation Workgroup to identify a payment methodology. The payment methodology is targeted to:

- Incentivize providers with small caseloads usually in rural and frontier areas to continue to participate in the program; and

- Reward providers who make progress towards reaching the established targets or meet/exceed the established target.

To receive either payment type, providers must have participated in the Health Home program during the outcome measurement year, be in good standing with the program by providing a core service to at least 50% of their caseload and reporting outcome measures for each recipient that was provided a core service. Payments are based on outcomes reported on a calendar year basis and average annual caseload and tier are calculated on a calendar year basis.

The amount is divided into the small caseload incentive payment and the clinical outcome measure payment. The small caseload incentive payment amount is divided equally between each qualifying designated Health Home.

South Dakota has 66 counties; only 2 of the 66 counties are urban. For statewide implementation, smaller providers in rural and frontier areas must participate. The small caseload payment promotes access to the Health Home program across the state by incentivizing participation when a caseload may not be large enough to support independent adoption of the program. This encourages health systems to implement the Health Home program in all locations, regardless of size.

To determine if a Health Home should receive the small caseload payment, South Dakota Medicaid will average the caseload receiving a Health Home core service for each Health Home for every month of the measurement year. To qualify for this payment, providers must have been an active Health Home Provider during the outcome measurement year and have an average caseload that received a core service of 15 or less.

The clinical outcome measure payment is based on the clinical outcome measures submitted by each clinic to South Dakota Medicaid. These measures help demonstrate the successful provision of core services to Health Home recipients and demonstrates the provider's successful implementation of the Health Home model. South Dakota Medicaid worked with a subgroup to

establish targets for each of the outcome measures. The outcome measure payment recognizes quality of care by rewarding providers who either improved from the previous calendar year on a specified measure or met/exceeded the established the target for each measure.

South Dakota Medicaid chose two types of measures for the new methodology:

1. Measures that showed successful implementation of the Health Home Model, where the clinic had complete control over the outcome.
2. Measures were also selected which required recipient compliance.

South Dakota worked with our stakeholder group to weight each measure appropriate. The weights of the 10 measures totaled 100.

Once weights were assigned, the past year's and the current year's outcomes were compared for each of the measures and if they improved from the previous year, they were awarded 0.5 points for the measure and if the met or exceeded the target, they were awarded 1.00 point for the measure.

A Severity Score was calculated for each clinic based on the average number of recipients in each Tier whom they provide a core service within the evaluation period and applied to each measure. Scores were assigned to each Tier as follows:

- Tier 1 - 0.25
- Tier 2 - 0.50
- Tier 3 - 0.75
- Tier 4 - 1.00

The severity score was calculated as follows $[\text{number of recipients in Tier 1} * 0.25] + [\text{number of recipients in Tier 2} * 0.50] + [\text{number of recipients in Tier 3} * 0.75] + [\text{number of recipients in Tier 4} * 1.00]$.

A score was calculated for each measure using the following equation. $(\text{Improvement or attainment score} * \text{weight}) * \text{severity score}$.

The scores for each measure were added together to get a composite score for each clinic. The composite

scores for each clinic were added together. Dollars are awarded for each point in the composite score by taking the dollars for the Clinical Outcome Payment and dividing it by the total composite score for all clinics. Then the dollar amount per point is multiplied by the composite score for each clinic to get the total payment for the Clinical Outcome Payment. A Health Home's total payment is the sum of the Small Caseload Incentive Payment and the Clinical Outcome Measure Payment.

The calculation and distribution methodology utilizes a payment pool. The calculation is attached as Attachment 1.

The supplemental quality incentive payment (Small Caseload Incentive Payment, Clinical Outcome Measure Payment) is distributed as an annual, lump sum amount. Payments will be made within 18 months following the end of the outcome measurement calendar year. The payment will be made to the provider through the MMIS system. Payments will be made directly to the qualifying provider through a supplemental payment mechanism and will appear on their remittance advice. Each provider will receive written notification at the time of payment of the payment amount from DMS.

Payments made in error will be recovered via a supplemental recovery mechanism and will appear on the provider's remittance advice. The agency will notify the provider in writing explaining the error prior to the recovery. The Federal share of payments made in excess will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Each of the four tiers will have an individual per member per month (PMPM) payment. South Dakota will update the tier of each active recipient annually. PMPM payments were based on the estimated Uncoordinated Care Costs (UCC) for the eligible recipients. UCC includes the following: non-emergent ER usage, all cause readmission and ambulatory sensitive conditions. These estimates were developed from FY 2012 claims data and will serve as the baseline. Health Home services will be provided by Community Mental Health Centers (CMHC) and Primary Care Providers (PCP). The agency's rates are set and effective July 1, 2026 for services provided on or after that date. All rates are posted on the agency website at <https://dss.sd.gov/medicaid/providers/feeschedules/dss/>. The state developed fee schedules are the same for both governmental and private providers of health home services.

- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

1945 Health Home Payment Methodologies

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Agency Rates

Describe the rates used

- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date

1945 Health Home Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Each of the four tiers will have an individual per member per month (PMPM) payment. PMPM payments were based on the estimated Uncoordinated Care Costs (UCC) for the eligible recipients. UCC includes the following: non-emergent ER usage, all cause readmission and ambulatory sensitive conditions. These estimates were developed from FY 2012 claims data and will serve as the baseline. In order to receive the PMPM payment, designated providers must provide at a minimum one core service per quarter. Core services provided must be documented in the EHR and responses must be submitted online following each quarter through the DSS online provider portal. The agency's rates are set and effective July 1, 2026 for services provided on or after that date. All rates are posted on the agency website at <https://dss.sd.gov/medicaid/providers/feeschedules/dss/>. The state developed fee schedules are the same for both governmental and private providers of health home services.

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Assurances

The State provides assurance that it will ensure non-duplication of payment for services similar to Health Home services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.


Describe below how non-duplication of payment will be achieved South Dakota has taken care to ensure the reimbursement model is designed to only fund Health Home Services that are not covered by any of the currently available Medicaid funding mechanisms. Quality assurance reviews by our vendor are in place to help ensure that there's no duplication of payment. Additionally, upon enrollment and annually thereafter, each Health Home receives training on the definition and criteria of a core service. This training specifies that a core services may not have already been billed to South Dakota Medicaid using a fee for service, encounter, or daily rate.

The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
Health Home Payment Calculation Methodology with Example	6/4/2026 4:55 PM EDT	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 6/4/2026 5:17 PM EDT

South Dakota Health Home

Quality Incentive Payment Methodology

Health Home Composite Scoring

- To qualify for the Quality Incentive Payment, a clinic must have met a minimum threshold of providing at least one half of their yearly caseload with a core service.
- South Dakota worked with our stakeholder group to weigh each measure appropriately. The measure weights range from 12 to 25 and total 100.
- Once measure weights were assigned, the past year's and the current year's outcomes were compared for improvement or attainment. Each measure is reviewed for additional points, either 0.5 points for improvement or 1.0 point for attaining and/or exceeding the target.
- Caseload Severity Scores were assigned by the average number of recipients in each tier who had received a core service everyquarter. Caseload Severity Score Tier calculations are as follows: [number of recipients in Tier 1*0.25] + [number of recipients in Tier 2 * 0.50] + [number of recipients in Tier 3 * 0.75] + [number of recipients in Tier 4 * 1.00].
- Measure Total was calculated using the following equation:
 $(\text{Weight} * \text{Improvement or Attainment}) * \text{Caseload Severity Score} = \text{Measure Total Score}$
- The Clinic Composite Score is the sum of all Measure Total Scores.

Health Home Composite Scoring					
Measure	Weight	Improvement	Attainment	Caseload Severity Score	Measure Total
Depression Follow-Up Plan Doc	15	0.5		20.75	155.63
Active Care Plan	25		1	20.75	518.75
BMI in Control	12	0		20.75	0.00
Mammogram up to date	12		1	20.75	249.00
Colonoscopy up to date	12		1	20.75	249.00
Blood Pressure in Control	12	0.5		20.75	124.50
Face to face visits missed	12	0.5		20.75	124.50
CLINIC COMPOSITE SCORE					1421.38

Distribution of Incentive Dollars

- Dollars per point were assigned by taking the Clinical Outcome Payment Dollars (Payment Pool = \$556,500) divided by the combination of all Clinic Composite Scores.
- The Clinical Outcome Payment is calculated by multiplying Clinic Composite Score * Dollars per point.
- Small Clinic Payment (Payment Pool = \$75,000) is equally divided amongst the clinics that qualify. No changes are being made to the small clinic payment pool or methodology.
- A Health Home's total payment is the sum of the Clinical Outcome Payments and Small Clinic Payment.

Example: Distribution of Incentive Dollars Total \$556,500

Small Clinic Payment = \$75,000

Clinical Outcome Payment Dollars = \$481,500

CLINIC	Clinic Composite Score	Dollars per point	Clinical Outcome Payment	Small Clinic Payment	Health Home Total Payment
1	1421.38	\$60.01	\$85,297.36	\$25,000.00	\$110,297.36
2	2110.00	\$60.01	\$126,621.62	\$25,000.00	\$151,621.62
3	1820.75	\$60.01	\$109,263.65	\$0.00	\$109,263.65
4	1220.75	\$60.01	\$73,257.51	\$25,000.00	\$98,257.51
5	1450.75	\$60.01	\$87,059.86	\$0.00	\$87,059.86
Totals	8023.63	\$60.01	\$481,500.00	\$75,000.00	\$556,500.00