



South Dakota
Department of
Social Services

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605.773.3495
FAX: 605.773.5246
WEB: dss.sd.gov

June 29, 2026

RE: South Dakota Medicaid State Plan Amendment #SD-26-0008

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 inflationary rate increases appropriated by the state legislature during the 2026 legislative session effective July 1, 2026.

The following services otherwise not subject to a targeted increase or rate rebase are receiving a 1.4% inflationary increase:

- Ambulatory Surgical Centers
- Supplies, Orthotics and Prosthetics with no Medicare rate
- Durable Medical Equipment (Not including items subject to Section 1903(i)(27)) of the Social Security Act)
- Dental Services including Dentures
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Optometric Services
- Chiropractic Services
- Occupational, Speech, and Physical Therapy
- Nutritionists and Dietician Services
- Clinic Services
- Eyeglasses
- Free Standing Birth Centers
- Diabetes Self-Management Training
- Nurse Midwife Services
- Community Transportation
- Home Health Agencies
- Independent Mental Health Practitioners Services
- Physician Services
- Nursing Facility Services
- Physician Administered Drugs with no Medicare rate
- Community Health Worker Services
- Doula Services
- Targeted Case Management Services
- Child Private Duty Nursing Services
- Applied Behavior Analysis Services
- Disproportionate Share Hospital Payment Pools
- Graduate Medical Education Payment Pools
- PCP and Pregnancy Care Management Program Per Member Per Month Payments

All professional service reimbursement rates that were above 100% of Medicare or that would exceed 100% of Medicare with inflation applied were limited to 100% of the Medicare allowable amount. This was applied using the South Dakota Medicare non-qualifying APM conversion factor rate. In addition, rates were capped using both Medicare's non-facility and facility rates.

The following services are receiving a targeted rate increase or are being rebased:

Service	Type	Rate/Method
Air Ambulance	Targeted Increase	<ul style="list-style-type: none"> Procedure codes were rebased to 80% of Medicare
Community and Secure Transportation Services	Targeted Increase	<ul style="list-style-type: none"> A0100 - \$5.20 A0120 - \$5.20 A0130 - \$43.39 S0209 - \$2.61 S0215 - \$1.04 T2001 - \$2.60 T2005 - \$109.66 T2049 - \$2.61
Physician Services	Targeted Increase	<ul style="list-style-type: none"> Procedure codes with rates below 96.5% of Medicare increased 96.5% of Medicare

The SPA also updates the BabyReady program postpartum eligibility from three months to two months based on provider feedback that recipients are generally transitioned to a primary care provider after two months. Savings generated by this change were reinvested to increase the prenatal care enhanced payment (HCPCS Code G9151) rate for achieving adequate or adequate plus prenatal care. The new rate for G9151 is \$333.30.

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

<http://dss.sd.gov/medicaid/providers/feeschedules/dss/>. South Dakota Medicaid providers should continue to submit claims and bill South Dakota Medicaid as they did prior to July 1, 2026. Fee schedules are the maximum allowable reimbursement amount; per ARSD 67:16:01:09 payment for services is limited to the provider's usual and customary charge.

The proposed SPA revises Page 45 of Supplement to Attachment 3.1-A, Pages 7, 8, 10a and 10b of Attachment 4.19-A, Introduction Page 1 of Attachment 4.19-B, and page 7, 9, and 10 of Attachment 4.19-D of the South Dakota Medicaid State Plan. The Department intends to make this SPA effective July 1, 2026.

The department estimates the total annual aggregate increase in expenditures by service type will be the following:

- Physician Services including EPSDT Screenings/Treatment, and Professional Services Provided in a Freestanding Birth Center - \$3,652,079
- Dental Services including Orthodontic Services and Dentures - \$639,891
- Optometric - \$59,490
- Chiropractic Services - \$34,922
- Disproportionate Share Hospital Payments - \$16,259
- Graduate Medical Education Payments - \$50,462
- Other Medical Services - \$717,733
 - Ambulatory Surgical Center Services
 - Independent Mental Health Practitioners Services
 - Nutritionists and Dietician Services
 - Supplies, Orthotics and Prosthetics
 - Durable Medical Equipment
 - Clinic Services
 - Physical Therapy
 - Occupational Therapy

- Speech, Hearing, or Language, Disorder Services
- Prosthetic Devices
- Eyeglasses
- Diabetes Self-Management Training
- Nurse Midwife Services
- Community Transportation
- Secure Medical Transportation
- Air and Ground Ambulance Transportation
- Nutrition Items
- Home Health Services
- Personal Care Services
- Child Private Duty Nursing
- Community Health Worker Services
- Nursing Facility Services –\$176,151

The total fiscal impact for the combined services associated with the Medicaid SPA is \$530,783 in State funds and \$805,964 in Federal funds, totaling \$1,336,747 in Federal Fiscal Year 2026 (July 1, 2026, to September 30, 2026) and \$2,123,133 in State funds and \$3,223,855 in Federal funds, totaling \$5,346,988 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 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

Medicaid State Plan Amendment Proposal

Transmittal Number: SD-26-0008

Effective Date: 7/1/26

Brief Description: The SPA primarily implements the inflationary rate increases appropriated by the state legislature during the 2026 legislative session effective July 1, 2026.

Area of State Plan Affected: Supplement to Attachment 3.1-A, Attachment 4.19-A, Attachment 4.19-B, and Attachment 4.19-D.

Page(s) of State Plan Affected: Page 45 of Supplement to Attachment 3.1-A, Pages 7, 8, 10a and 10b of Attachment 4.19-A, Introduction Page 1 of Attachment 4.19-B, and page 7, 9, and 10 of Attachment 4.19-D of the South Dakota Medicaid State Plan.

Estimate of Fiscal Impact, if Any: FFY26: \$1,336,747
 FFY27: \$5,346,988

Reason for Amendment: Implement inflationary rate increases appropriated by the state legislature during the 2026 legislative session effective July 1, 2026.

Comment Period: June 29, 2026 through July 29, 2026.

PUBLIC NOTICE

South Dakota Medicaid Program

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SUPPLEMENT TO ATTACHMENT 3.1-A

27. 1905(t) Primary Care Case Management Services**Service Description**

Pursuant to 42 CFR 440.250 (p), the Pregnancy Primary Care Case Management (PCCM) Program is a medical home for pregnant Medicaid recipients that provides case management services to affect positive changes in the delivery of prenatal care and pregnancy outcomes. Pregnant recipients will be eligible for the program from the time of conception through two months after the end of the pregnancy.

The program is designed to promote a Primary Care Case Management relationship through selection of a Pregnancy PCCM provider by Medicaid recipients to provide, through an ongoing patient/provider relationship, pregnancy care services and referral for all necessary services. The following services will be located, coordinated, and monitored by participating providers through a referral process:

1. Physician services;
2. Clinic services;
3. Mental health services;
4. Substance use disorder services;
5. Inpatient hospital services
6. Outpatient hospital services;
7. Home health services;
8. Durable medical equipment services;
9. Ambulatory surgical center services;
10. Other licensed practitioners services;
11. Psychiatric residential treatment facilities;
12. Physical therapy services;
13. Occupational therapy services; and
14. Services for individuals with speech, hearing, or language disorders.

Care Coordination Requirements

Providers must have staffing to provide adequate care coordination services for the provider's attributed 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. Providers agree that the following required care coordination services will be available and offered to recipients on the provider's caseload.

1. Social determinant of health screenings to inform the person-centered care plan and care provided.
2. Developing a person-centered care plan that coordinates and integrates all the recipient's clinical and non-clinical health care-related needs and services.
3. Health education and promotion that encourages and supports healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self-manage their health. Health education and promotion must include the importance of prenatal care, postpartum care, safe sleep practices for infants, and the importance of well-child visits.
4. Health system and resource navigation including, but not limited to:
 - a. Conducting outreach and encourage recipients on their caseload to utilize prenatal and postpartum care;
 - b. Assisting recipients on their caseload with scheduling medical appointments;
 - c. Helping arrange transportation to medical appointments;
 - d. Coordinating access to supports including referral to community resources and social determinants of health supports; and
 - e. Coordinating access to mental health and substance use disorder services.
5. Transitional care coordination including, but not limited to:
 - a. Making appropriate referrals and follow-up as appropriate following transfer to another care provider including maternal-fetal medicine specialists or a birthing hospital;
 - b. Assisting recipients with the selection of the recipient's Primary Care Provider at the end of their participation in program;
 - c. Assisting recipients with selecting a pediatrician prior to delivery;

Group 2, psychiatric hospitals operated by the State of South Dakota; and
Group 3, other hospitals (any hospital not in Group 1 or 2).

Payments to Group 1 hospitals qualifying under the Medicaid inpatient utilization method are based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 1 hospitals qualifying under the low-income utilization method are based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payments to Group 1 hospitals will be made according to the payment schedule on the Department's website, <http://dss.sd.gov/medicaid/providers/feeschedules/>. Payment rates are set and effective for services provided on or after July 1, 2026. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

The amount of payment for each hospital is calculated as follows:

The Department determines the number of facilities qualifying at greater than the mean, greater than 1 standard deviation above the mean, greater than 2 standard deviations above the mean, and greater than 3 standard deviations above the mean. The total amount of funding budgeted for disproportionate share payments is then allocated starting with those facilities qualifying at greater than the mean. Facilities qualifying at greater than 1 standard deviation, greater than 2 standard deviations, and greater than 3 standard deviations above the mean are paid double, triple, and quadruple, respectively, the amount for facilities qualifying at greater than the mean. The payment amounts are adjusted until all the budgeted funds are spent.

The proposed disproportionate share payment for each facility is then compared to the payment limit that has been established for each facility. If the payment limit is less than the proposed disproportionate share payment, then the payment limit amount will be the disproportionate share payment for that particular facility. The sum of the payments made to the facilities where the payment limit was met is then subtracted from the total amount budgeted. The remaining budgeted funds are then allocated equally among the facilities where the payment limits have not been met. The subsequent allocation again is determined to ensure that facilities qualifying at greater than 1 standard deviation, greater than 2 standard deviations, and greater than 3 standard deviations above the mean are paid double, triple, and quadruple, respectively, the amount for facilities qualifying at greater than the mean.

Payments to Group 2 hospitals qualifying under the Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 2 hospitals qualifying under the low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals.

Payments to Group 2 hospitals will be made according to the payment schedule on the Department's website, <http://dss.sd.gov/medicaid/providers/feeschedules/>. Payment rates are set and effective for services provided on or after July 1, 2026. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

Payments to Group 3 hospitals qualifying under the Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 3 hospitals qualifying under the low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payments to Group 3 hospitals will be made according to the payment schedule on the Department's website, <http://dss.sd.gov/medicaid/providers/feeschedules/>. Payment rates are set and effective for services provided on or after July 1, 2026. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

If necessary, payments to qualified hospitals will be adjusted for the projected impact of the hospital's specific disproportionate share hospital payment limit as required by OBRA '93.

The agency will make disproportionate share hospital program payments to qualifying hospitals prior to the end of the State fiscal year. If the total of disproportionate share payments to all qualified hospitals for a year is going to exceed the State disproportionate share hospital payment limit, as established under 1923(f) of the Act, the following process will be used to prevent overspending the limit: First, the amount of over- expenditure will be determined; Then the over-expenditure amount will be deducted from the total payments to Group 2 hospitals; and Payments to individual Group 2 hospitals will be reduced based on their percentage of Group 2 total payments.

HEALTH PROFESSION EDUCATION

The Department of Social Services supports the direct graduate medical education (GME) of health professionals through the use of Medicaid funds. All in-state, private hospitals which are accredited by the Accreditation Council for Graduate Medical Education (ACGME) are eligible for health profession education payments. Those hospitals are identified through the use of their most recently-filed Medicare 2552-10, cost reports. Specifically, worksheet E-4 (Line 1.00) is utilized to identify the number of weighted full-time equivalents for primary care physicians at participating facilities. The agency calculates the Medicaid hospital patient days using the Division of Medical Services (DMS) Cost Settlement Details report of adjudicated claims for the same period as the Medicare 2552 cost report.

Hospitals seeking GME payments must submit an application for the previous state fiscal year's costs to DMS prior to the end of the current state fiscal year. The agency will make payments for costs incurred in the previous state fiscal year, as defined below, annually prior to the end of the current state fiscal year. Payments will be made through the state's Medicaid Management Information System (MMIS) payment system. Payments will be made directly to the qualifying hospitals through a supplemental payment mechanism. The payment will appear on the facility's remittance advice. Each hospital will also receive written notification at the time of payment of the payment amount from DMS.

GME payments made in error will be recovered via a supplemental recovery mechanism and will appear on the facility's remittance advice. The agency will notify the facility 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.

A hospital that applied for GME funding in the previous 24 months must provide written notice to DMS no less than 30 days prior to the effective date it intends to terminate operation of a GME program. A hospital must provide written notice to DMS by January 1 if it will not be applying for GME funding for the previous state fiscal year's costs.

The agency will determine the annual lump sum, onetime payment pool. The annual payment will be made during the last quarter of the state fiscal year. The pool will be distributed based upon the allocation percentage of each hospital. The hospital allocation percentage will be developed using prior year total Medicaid inpatient days and weighted intern and resident (I & R) full time equivalency (FTE). The state uses the prior year's cost report data as a proxy for the current year. For example, the state fiscal year 2008 calculation of allocations from the payment pool was the following:

	(a) Weighted I & R FTEs	(b) Medicaid Hospital Patient Days	(c) (a*b) Weighted FTE Days	(d) Hospital Allocation Percentage	Payment Pool Total
Hospital A	17	11,450	194,650	35.34%	\$1,052,009
Hospital B	22	10,692	232,230	42.16%	\$1,255,116
Hospital C	23	5,342	123,988	22.51%	\$670,107
Totals	62	27,484	550,868	100.00%	\$2,977,233

Total state funds available for payment through the pool are listed on the department's website, <http://dss.sd.gov/medicaid/providers/feeschedules/>, effective July 1, 2026. The FMAP at the time the annual payment is made will be applied to the state portion of the payment.

TN# 26-0008
Supersedes
TN# 24-0014

Approval Date

Effective Date 07/01/26

Rural Residency Program

The Center for Family Medicine is eligible for payment of direct GME via a separate funding pool for its operation of a rural family medicine residency program. The Center for Family Medicine must be accredited by the ACGME to be eligible for health profession education payments.

The state will make equal interim payments to providers on a quarterly basis. Costs must be submitted on a quarterly basis to validate costs for the previous quarter using the state developed South Dakota Rural Residency Program Cost Report and Rural Residency Cost Report Guidelines. The payment will be made to the Center for Family Medicine through the MMIS system. Payments will be made directly to the provider through a supplemental payment mechanism and will appear on their remittance advice. The Center for Family Medicine will receive written notification at the time of payment of the payment amount from DMS.

GME payments made in error that cannot be adequately addressed through adjustment of future quarterly payments 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.

The Center for Family Medicine must provide written notice to DMS no less than 30 days prior to the effective date it intends to terminate operation of its GME program or written notice to DMS no less than 30 days prior to the effective date it will no longer be applying for GME funding.

The agency will determine the annual rural residency program payment pool for the upcoming state fiscal year prior to the start of the fiscal year on July 1. Payments through the rural residency program are listed on the department's website, <http://dss.sd.gov/medicaid/providers/feeschedules/>. Payment rates are set and effective for services provided on or after July 1, 2026. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers. The FMAP at the time the quarterly payment is made will be applied to the state portion of the payment.

ATTACHMENT 4.19-B
INTRODUCTION

Payment rates for the services listed below are set and effective for services provided on or after the corresponding date. Fee schedules are published on the Department's website at <http://dss.sd.gov/medicaid/providers/feeschedules/>. Effective dates listed on the introductory page supersede the effective dates listed elsewhere in Attachment 4.19-B. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

Service	Attachment	Effective Date
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Attachment 4.19-B, Page 4	July 1, 2026
Physician Services	Attachment 4.19-B, Page 6	July 1, 2026
Optometrist Services	Attachment 4.19-B, Page 9	July 1, 2026
Chiropractic Services	Attachment 4.19-B, Page 10	July 1, 2026
Independent Mental Health Practitioners	Attachment 4.19-B, Page 11	July 1, 2026
Nutritionist and Dietician Services	Attachment 4.19-B, Page 11	July 1, 2026
Home Health Services	Attachment 4.19-B, Page 12	July 1, 2026
Durable Medical Equipment	Attachment 4.19-B, Page 13	July 1, 2026
Clinic Services	Attachment 4.19-B, Page 15	July 1, 2026
Dental Services	Attachment 4.19-B, Page 16	July 1, 2026
Physical Therapy	Attachment 4.19-B, Page 17	July 1, 2026
Occupational Therapy	Attachment 4.19-B, Page 18	July 1, 2026
Speech, Hearing, or Language Disorder Services	Attachment 4.19-B, Page 19	July 1, 2026
Dentures	Attachment 4.19-B, Page 21	July 1, 2026
Prosthetic Devices	Attachment 4.19-B, Page 22	July 1, 2026
Eyeglasses	Attachment 4.19-B, Page 23	July 1, 2026
Diabetes Self-Management Training	Attachment 4.19-B, Page 26	July 1, 2026
Community Health Workers	Attachment 4.19-B, Page 26	July 1, 2026
Doula Services	Attachment 4.19-B, Page 26	July 1, 2026
Community Mental Health Centers	Attachment 4.19-B, Page 26	June 1, 2026
Substance Use Disorder Agencies	Attachment 4.19-B, Page 26	June 1, 2026 *
Nurse Midwife Services	Attachment 4.19-B, Page 31	July 1, 2026
Pregnancy PCCM Program	Attachment 4.19-B, Page 39a	July 1, 2026
Targeted Case Management	Attachment 4.19-B, Page 33	July 1, 2026
Transportation	Attachment 4.19-B, Page 38	July 1, 2026
Personal Care Services	Attachment 4.19-B, Page 38	July 1, 2026
Freestanding Birth Centers	Attachment 4.19-B, Page 39	July 1, 2026
Professional Services Provided in a Freestanding Birth Center	Attachment 4.19-B, Page 39	July 1, 2026

*Room and board is not included in these rates.

TN# 26-0008
SUPERCEDES
TN# 26-0002

Approval Date:

Effective Date: 07/01/26

Any costs in excess of the 110% limitation will not be recognized. The ceiling limitations will apply to all nursing facilities participating in the State Medicaid Program.

- d) Capital costs shall be limited to \$20.95 per resident day, effective July 1, 2023, for all nursing facilities participating in the State Medicaid Program. (See Section C, Provision Number(s) 3, 4, 5, and 6). Effective July 1, 2026, the capital cost limitation will be inflated by 1.4 percent as provided for in the State legislative appropriation. The appropriation for the inflationary percentage adjustment is included as part of the annual appropriation act for the ongoing and current expenses of state government. The act is approved by the legislative appropriation committee, the legislature, and Governor. The state plan will be updated to incorporate the actual adjustments once the adjustments are officially determined by the state's legislature.
3. A return on net equity shall be an allowable cost for proprietary facilities. The allowable rate of return shall be the average mid-point of the prime interest rate and the rate of 180-day U.S. Treasury Bills, as reported on the last business day of June, September, December, and March. The rate of return shall not exceed 10% and will be calculated on the provider's fiscal year-end balance sheet of the cost report required in Section A, Provision Number 3.
4. Building depreciation shall be limited to 3% on masonry and 4% on frame buildings and shall be calculated on the straight-line method. Generally-accepted accounting procedures will be used in determining the life of any addition(s) and improvements to primary structures. Effective July 1, 1999, the capital basis for depreciation of new construction, major renovation, and or any facilities acquired through purchase, must be subject to a salvage value computation of at least 15% (Section C, Provision Number 6).
5. Depreciation on fixed equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item(s) purchased after January 1, 1987.
6. Depreciation on major moveable equipment, furniture, automobiles, and specialized equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item purchased after January 1, 1987. Deviation from the AHA Guidelines may be granted in those instances in which facilities can provide the Department with documented historical proof of useful life.

b) Capital Cost—Dollar Limitation

The Capital Cost Components will consist of: (1) Building insurance, (2) Building Depreciation, (3) Furniture and Equipment Depreciation, (4) Amortization of Organization and Pre-Operating Costs, (5) Mortgage Interest, (6) Rent on Facility and Grounds, (7) Equipment Rent and, (8) Return on Net Equity. The Capital Cost will be limited to \$20.95 per resident day for all participating nursing facilities, effective July 1, 2023. Effective July 1, 2026, the capital cost limitation will be inflated 1.4 percent as provided for in the State legislative appropriation. The appropriation for the inflationary percentage adjustment is included as part of the annual appropriation act for the ongoing and current expenses of state government. The act is approved by the legislative appropriation committee, the legislature, and Governor. The state plan will be updated to incorporate the actual adjustments once the adjustments are officially determined by the state's legislature.

1. Leased Facility—maximum capital costs for a leased facility are limited to the following:

- a) The maximum capital costs is limited to the lower of actual costs or to the capital cost limitation per Section C, Provision Number 2.b. The capital cost components for computing the above limit shall consist of: (a) rent on facility/grounds and equipment; (b) building insurance; (c) building depreciation; (d) furniture and equipment depreciation; (e) amortization of organization and pre-operating costs; (f) capital related interest; and, (g) return on net equity. The capital cost items are allowable only if incurred and paid by the lessee. Capital costs will not be recognized in any other manner than as outlined in this section if incurred by the lessor (owner) and passed on to the lessee.
- b) The maximum allowable for lease payment(s) for facilities negotiating a new lease and facilities renewing existing leases after June 30, 1999, are limited to the lower of actual lease costs or 70% of the average per diem cost of the capital costs for owner managed facilities, excluding hospital affiliated facilities.

- c) No reimbursement shall be allowed for additional costs related to sub-leases.
2. For reimbursement purposes outlined under this plan, any lease agreement entered into by the operator and the landlord shall be binding on the operator or his successor(s) for the life of the lease, even though the landlord may sell the facility to a new owner. For reimbursement purposes outlined under this plan, the only exceptions for permitting the breaking of a lease prior to its natural termination date shall be:
 - a) The new owner becomes the operator; or
 - b) The owner secures written permission from the Secretary to break the lease.
3. The maximum allowable capital cost for an owner-managed facility shall be limited to \$20.95 per resident day for all nursing facilities. Effective July 1, 2026, the capital cost limitation will be inflated by 1.4% as provided for in the State legislative appropriation. The appropriation for the inflationary percentage adjustment is included as part of the annual appropriation act for the ongoing and current expenses of state government. The act is approved by the legislative appropriation committee, the legislature, and Governor. The state plan will be updated to incorporate the actual adjustments once the adjustments are officially determined by the state's legislature.
4. New construction notification—Effective July 1, 1999, all nursing facilities that are planning to undertake new construction of a nursing facility, and/or a major expansion, and/or renovation project are required to notify the Department in writing prior to the start of construction, regarding the scope and estimated cost(s) of the project. For purposes of this, notification requirement any improvement, repair or renovation project will be defined as any improvement or repair with an estimated cost of \$125,000 or more.