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State/Territory Name: SD

State Plan Amendment (SPA) #: 26-0001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

August 13, 2026

Heather Petermann
Medicaid Director
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

RE: TN 26-0001

Dear Director Petermann,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed South Dakota State Plan Amendment (SPA) to Attachment 4.19-B TN: #26-0001, which was submitted to CMS on May 21, 2026. This plan amendment proposes to make revisions to the state's Rural Health Clinic's (RHC's) and Federal Qualified Health Center's (FQHC's) state plan payment methodology.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2026. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Matthew Klein at 214-767-4625 or via email at matthew.klein@cms.hhs.gov

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26 — 0001

2. STATE: SD

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
Section 1902(bb)(6) of the Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 1,359,008
b. FFY 2027 $ 5,436,034

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Pages 2 and 2a-2f of Attachment 4.19-B

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Pages 2 and 2a of Attachment 4.19 (TN# 04-02)
Page 2b of Attachment 4.19 (TN# 16-005)

9. SUBJECT OF AMENDMENT
Clarifies criteria for determining a change in scope of services, outlines the application and review process for rate adjustments, and defines the change-in-scope rate calculation for RHCs and FQHCs, and implements an Alternative Payment Methodology (APM) for FQHCs based on a legislative appropriation.

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Heather Petermann

13. TITLE
Director

14. DATE SUBMITTED
May 21, 2026

15. RETURN TO
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291

FOR CMS USE ONLY

16. DATE RECEIVED
May 21, 2026

17. DATE APPROVED
August 13, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2026

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Instructions on Back

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

2b. Rural Health Clinics

Prospective Payment System (PPS)
Payment for Rural Health Clinic (RHC) services conforms to Section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

All covered Rural Health Clinic services furnished on or after January 1, 2001, and each succeeding fiscal year are reimbursed using a prospective payment system.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse RHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

Payment is set prospectively using the RHC's reasonable costs of providing Medicaid-covered services during RHC Fiscal Years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during RHC fiscal year 2001.

The baseline per visit rate is determined for each RHC by (1) calculating a per visit rate for RHC Fiscal Year 1999 and RHC Fiscal Year 2000, (2) adding the two rates together, and (3) dividing the sum by two. The RHC per visit rate is inflated forward from the endpoint of RHC Fiscal Year 1999 to the midpoint of State Fiscal Year 2001.

For newly qualified RHCs after Federal Fiscal Year 2000, the initial payments are determined by the statewide average per visit rate, updated each year using the Medicare Economic Index (MEI). A prospective rate for newly qualified RHCs shall be calculated after the provider has submitted a Medicaid cost report for two full years, according to the methodology described above.

Beginning in Federal Fiscal Year 2002 (October 1, 2001), and for each calendar year thereafter, the per visit payment rate is increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the RHC.

The MEI will be applied January 1st of each year.

RHC Change in Scope of Services
A change in the scope of services is defined as adding a new service into the current per diem service base, or removing a service that is in the existing service base. A change in the cost of a service is not considered in and of itself a change in the scope of services.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

A change in the scope of services shall occur if the addition of a new service not incorporated in the provider's PPS rate or deletion of a service incorporated in the provider's PPS rate. South Dakota Medicaid considers the addition or deletion of a specific ambulatory RHC benefit covered in Supplement to Attachment 3.1-A as triggering a change in scope.

A change in scope is also considered to have occurred if one or more of the following type, intensity, duration, and/or amount changes occurs and the change(s) are associated with change in cost of +/- 5% in the rate per encounter over the year prior to implementation:

- The addition or removal of specialty providers with a corresponding change in the services provided by the provider; or
- A transition from mid-level providers to physicians or vice versa with a corresponding change in the services provided by the provider;
- Changes in service due to adding or removing clinical equipment utilized by the provider that results in more or less resource-intensive visits;
- Changes in types of patients served that require more intensive and frequent care.

The following changes are not considered a change in scope:

- An increase or decrease in the cost of supplies or existing services;
- Normal and expected cost increases;
- An increase or decrease in the number of encounters without a change is services provided;
- Changes in office hours or location;
- Changes in equipment or supplies not directly related to a change in the scope of service;
- Expansion, remodel or other capital expenditures of locations unless the change directly impacts the ability to provide additional services;
- The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services as other locations;
- The addition or removal of administrative staff;
- The addition or removal of staff members to or from an existing service with the exception of removal of staff that results in the deletion of a service;
- Changes in salaries and benefits;
- A change in ownership; and
- Addition or deletion of services that are not paid at the PPS rate.

The RHC must supply the following application materials to the department for any adjustments in the rate resulting from any increases or decreases in the scope of services. The application may be filed if initial reporting requirements were met, the change in scope has existed a full six months, and the provider can provide the following application materials:

- Completed Change in Scope Request form prescribed by South Dakota Medicaid, including a brief narrative description of the change in scope of services including how services were provided both before and after the change and an attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the RHC.
- Historical and budgeted information showing the provider's expenses before and after the change in scope of services including the applicable Medicare cost report prior to the change and after the change.
- The projected increase or decrease in the number of encounters due to the change.

Notification must be provided within 9 months of the date of the addition or deletion of the service. Only one change in scope of service adjustment will be calculated per year. However, more than one change in scope in scope of services may be included in a single application. Failure to notify DSS of removal of a service from an existing service base may result in

recoupment of payment. The State may initiate a change in scope review if it has reason to believe a service included in a provider's encounter rate is no longer being provided.

A change in scope of services is limited to a review of the costs for the specific service added or removed from the existing service base or other qualifying changes. It will not result in an evaluation of the costs for other RHCs services or a rate rebase.

The change in scope will utilize cost reports and other information provided to identify the cost associated with the change. The identified cost associated with the change in scope cost will be added on or subtracted from the base rate. The added or subtracted cost will be applied to all of the provider's sites.

$$\text{Cost per encounter before the change in scope of service} = \frac{\text{Total inflation adjusted allowable costs before the change in scope of service}}{\text{Total encounters before the change in scope of service}}$$

$$\text{Cost per encounter after the change in scope of service} = \frac{\text{Total allowable costs after the change in scope of service}}{\text{Total encounters after the change in scope of service}}$$

Incremental change due to the change in scope of service (positive or negative) = (Cost per encounter after the change in scope of service) - (Cost per encounter before the change in scope of service). Current baseline PPS rate + Incremental change due to the change in scope of service = New PPS rate.

Upon the department's determination of a change in the scope of services, the effective date for the new rate will be 30 days after receipt of the change in scope request and the associated applications materials. If the change in scope request is not adjudicated by this date, the rate will be retroactively set to this date and claims will be reprocessed at the new encounter rate.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

2c. Federal Qualified Health Centers

Prospective Payment System (PPS)
Payment for Federally Qualified Health Center (FQHC) services conforms to Section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

All covered Federally Qualified Health Center services furnished on or after January 1, 2001, and each succeeding fiscal year are reimbursed using a prospective payment system.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse FQHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

Payment is set prospectively using the FQHC's reasonable costs of providing Medicaid-covered services during FQHC Fiscal Years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during FQHC fiscal year 2001.

The baseline per visit rate is determined for each FQHC by (1) calculating a per visit rate for FQHC Fiscal Year 1999 and FQHC Fiscal Year 2000, (2) adding the two rates together, and (3) dividing the sum by two. The FQHC per visit rate is inflated forward from the endpoint of FQHC Fiscal Year 1999 to the midpoint of State Fiscal Year 2001.

For newly qualified FQHCs after Federal Fiscal Year 2000, the initial payments are determined by the statewide average per visit rate, updated each year using the Medicare Economic Index (MEI). A prospective rate shall be calculated after the provider has submitted a Medicaid cost report for two full FQHC fiscal years, according to the methodology described above.

If the newly qualified FQHC is a subsidiary of an entity that submits Medicaid consolidated cost reports, the newly qualified FQHC will receive that entity's prospective payment rate. For these newly qualified FQHCs, the facility shall continue to receive the consolidated rates, updated each year using the MEI, unless the newly qualified FQHC has a material change in the scope of services provided. A prospective rate shall be calculated after the provider has submitted a Medicaid cost report for two full FQHC fiscal years, according to the methodology described above.

Beginning in Federal fiscal year 2002 (October 1, 2001), and for each calendar year thereafter, the per visit payment rate is increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the FQHC.

The MEI will be applied January 1st of each year.

Alternative Payment Methodology (APM) – Medical Services
Effective July 1, 2026, FQHCs may elect to be reimbursed under the Alternative Payment Methodology (APM). The APM is intended to provide enhanced cost coverage relative to a FQHC's current prospective payment rate. Providers agreeing to the APM will receive enhanced encounter rates informed by the statewide cost-based weighted-average encounter rates. Rates were calculated based on an analysis of FQHC's cost reports. The medical APM encounter rate effective July 1, 2026 will be $336.71.

Beginning in July 1, 2027, and annually thereafter, the APM rates are increased by the percentage increase in the current calendar year Medicare Economic Index for primary care services. The medical and dental APMs will be re-evaluated at a minimum of every 5 years through a provider cost report analysis. The Department may consider initiating an earlier review of the APM if submitted

and approved PPS Change in Scope requests indicate there may have been a significant change in the scope of services for multiple FQHCs.

An FQHC must agree to the APM in order to receive the APM payment. The APM encounter rates will be at least equal to the FQHC's PPS rate. FQHC providers who elect to be reimbursed under the APM shall make the request to the Department in writing on a form specified by the Department.

Alternative Payment Methodology (APM) – Dental Services

Effective July 1, 2026, FQHCs may elect to be reimbursed under the Alternative Payment Methodology (APM). The APM is intended to provide enhanced cost coverage relative to a FQHC's current prospective payment rate. Providers agreeing to the APM will receive enhanced encounter rates informed by the statewide cost-based weighted-average encounter rates. Rates were calculated based on an analysis of FQHC's cost reports. The dental APM encounter rate effective July 1, 2026 will be $390.36.

Beginning in July 1, 2027, and annually thereafter, the APM rates are increased by the percentage increase in the current calendar year Medicare Economic Index for primary care services. The medical and dental APMs will be re-evaluated at a minimum of every 5 years through a provider cost report analysis. The Department may consider initiating an earlier review of the APM if submitted and approved PPS Change in Scope requests indicate there may have been a significant change in the scope of services for multiple FQHCs.

An FQHC must agree to the APM in order to receive the APM payment. The APM encounter rates will be at least equal to the FQHC's PPS rate. FQHC providers who elect to be reimbursed under the APM shall make the request to the Department in writing on a form specified by the Department.

FQHC Change in Scope of Services

A change in the scope of services is defined as adding a new service into the current per diem service base, or removing a service that is in the existing service base. A change in the cost of a service is not considered in and of itself a change in the scope of services.

A change in the scope of services shall occur if the addition of a new service not incorporated in the provider's PPS rate or deletion of a service incorporated in the provider's PPS rate. South Dakota Medicaid considers the addition or deletion of a specific ambulatory FQHC benefit covered in Supplement to Attachment 3.1-A as triggering a change in scope.

A change in scope is also considered to have occurred if one or more of the following type, intensity, duration, and/or amount changes occurs and the change(s) are associated with change in cost of +/- 5% in the rate per encounter over the year prior to implementation:

- The addition or removal of specialty providers with a corresponding change in the services provided by the provider; or
- A transition from mid-level providers to physicians or vice versa with a corresponding change in the services provided by the provider;
- Changes in service due to adding or removing clinical equipment utilized by the provider that results in more or less resource-intensive visits;
- Changes in types of patients served that require more intensive and frequent care.

The following changes are not considered a change in scope:

- An increase or decrease in the cost of supplies or existing services;
- Normal and expected cost increases;
- An increase or decrease in the number of encounters without a change is services provided;

- Changes in office hours or location;
- Changes in equipment or supplies not directly related to a change in the scope of service;
- Expansion, remodel or other capital expenditures of locations;
- The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services as other locations unless the change directly impacts the ability to provide additional services;
- The addition or removal of administrative staff;
- The addition or removal of staff members to or from an existing service with the exception of removal of staff that results in the deletion of a service;
- Changes in salaries and benefits;
- A change in ownership; and
- Addition or deletion of services that are not paid at the PPS rate.

The FQHC must supply the following application materials to the department for any adjustments in the rate resulting from any increases or decreases in the scope of services. The application may be filed if initial reporting requirements were met, the change in scope has existed a full six months, and the provider can provide the following application materials:

- Completed Change in Scope Request form prescribed by South Dakota Medicaid, including a brief narrative description of the change in scope of services including how services were provided both before and after the change and an attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC.
- Historical and budgeted information showing the provider's expenses before and after the change in scope of services including the applicable Medicare cost report prior to the change and after the change.
- The projected increase or decrease in the number of encounters due to the change.

Notification must be provided within 9 months of the date of the addition or deletion of the service. Only one change in scope of service adjustment will be calculated per year. However, more than one change in scope in scope of services may be included in a single application. Failure to notify DSS of removal of a service from an existing service base may result in recoupment of payment. The State may initiate a change in scope review if it has reason to believe a service included in a provider's encounter rate is no longer being provided.

A change in scope of services is limited to a review of the costs for the specific service added or removed from the existing service base or other qualifying changes. It will not result in an evaluation of the costs for other FQHC services or a rate rebase.

The change in scope will utilize cost reports and other information provided to identify the cost associated with the change. The identified cost associated with the change in scope cost will be added on or subtracted from the base rate. The added or subtracted cost will be applied to all of the provider's sites.

$$\text{Cost per encounter before the change in scope of service} = \frac{\text{Total inflation adjusted allowable costs before the change in scope of service}}{\text{Total encounters before the change in scope of service}}$$

$$\text{Cost per encounter after the change in scope of service} = \frac{\text{Total allowable costs after the change in scope of service}}{\text{Total encounters after the change in scope of service}}$$

Incremental change due to the change in scope of service (positive or negative) = (Cost per encounter after the change in scope of service) - (Cost per encounter before the change in scope of service). Current baseline PPS rate + Incremental change due to the change in scope of service = New PPS rate

Upon the department's determination of a change in the scope of services, the effective date for the new rate will be 30 days after receipt of the change in scope request and the associated applications materials. If the change in scope request is not adjudicated by this date, the rate will be retroactively set to this date and claims will be reprocessed at the new encounter rate.

3. Other Lab and X-Ray

See Physician Services—Section 5 of this attachment.

4. Specialized Surgical Hospitals

Effective August 2, 2016, Specialized Surgical Hospitals will be reimbursed on the same basis as Medicare Prospective Payment System hospitals for outpatient services.