SUPPLEMENT TO ATTACHMENT 3.1-A

1. Inpatient Hospital.
2.a. Outpatient Hospital.
2.b. Rural Health Clinics (RHCs).
2.c. Federally Qualified Health Clinics (FQHCs).

For Inpatient Hospital, Outpatient Hospital, Rural Health Clinics (RHCs), and Federally Qualified Health Clinics (FQHCs), services not payable include:

1. Abortion, unless the life of the mother is threatened;
2. Cosmetic surgery when not incidental to the prompt repair of an accidental injury;
3. All procedures or items which are considered non-proven medical value practices or which may be of questionable effectiveness or long-term benefit;
4. All procedures and items, including prescribed drugs, considered experimental by the United States Department of Health and Human Services or any other appropriate Federal agency; and
5. All procedures and items, including prescribed drugs, provided as part of a control study approved by the appropriate Federal agency to demonstrate whether the item, prescribed drug, or procedure is safe and effective in curing, preventing, correcting, or alleviating the effects of certain medical conditions.

All procedures and items, including prescribed drugs, which may be subject to question but that are not covered in 1 through 5 above, will be evaluated by the State agency's designated medical review organization. The medical (professional) review organization designated by the State agency will evaluate and determine whether any procedure or items that are questioned fall within the provisions of items 1 through 5 above, inclusive. This review does not require prior authorization but may be done after a questioned service has been provided.

Outpatient hospital services are provided in accordance with 42 CFR 440.20. In addition, under the provisions of 42 CFR 440.20(a)(4), outpatient hospital services payable do not include outpatient psychiatric services or outpatient chemical dependency treatment services. Inpatient chemical dependency treatment is not a payable hospital service.

3. Other Lab and X-Ray

No limitations.

4a. Nursing Facility Services

No limitations.

4b. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Any Medicaid eligible child under 21 years of age, pursuant to Section 1905(r)(5) of the Act, has access to necessary health care, diagnostic services, treatment and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services whether or not such services are covered under this State plan.

Payment will also be allowed under EPSDT for the following medically necessary services for children less than 21 years of age even though these services are not a benefit for Medicaid eligible adult beneficiaries:

1. Nutrition items, prior authorization required for total parenteral nutrition.
2. Orthodontic services, prior authorization required.
3. Private duty nursing services, prior authorization required.

Payment will also be made for any medically necessary services in excess of any limitations indicated under this supplement provided to children less than 21 years of age.

4c. Family Planning Services

The following services are not payable:

1. Agents to promote fertility.

2. Procedures to reverse a previous sterilization.

3. Removal of implanted contraceptive capsules when done to reverse the intent of the original implant.

SUPPLEMENT TO ATTACHMENT 3.1-A

5a. Physician Services

Physician services not payable include:

1. Abortion unless the life of the mother is threatened.
2. Cosmetic surgery when not incidental to the prompt repair of an accidental injury.
3. All procedures or items which are considered non-proven medical value practices, which may be of questionable effectiveness or long term benefit.
4. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.
5. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug, or procedure is safe and effective in curing, preventing, correcting, or alleviating the effects of certain medical conditions.
6. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in 1 through 5 above, will be evaluated by the Department's designated medical review organization.

5b. Medical Services by a Dentist

See section 5a of this attachment.

6a. Podiatrist Services

Covered services are limited to surgical and nonsurgical podiatry services within the licensed podiatrist's scope of practice under state law.

Podiatrists' services must be determined medically necessary by the state. Routine foot care, including cutting or removal of corns or calluses, trimming of nails and preventative or hygienic care of the feet, is covered for recipients diagnosed with metabolic, neurologic, or peripheral vascular disease.

Services not covered include stock orthopedic shoes unless they are part of a leg brace, treatment of flatfoot, treatment of fungal infection of the toenail, and surgical or non-surgical treatment of subluxations of the foot undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity.

6b. Optometrist Services

Eye examinations and refractions.

6c. Chiropractic Services

Chiropractic services payable are limited to manual manipulation of the spine to correct a subluxation which is demonstrated by an x-ray to exist. Manual manipulations are limited to no more than 30 during a 12-month period.

6d. Other Licensed Practitioner Services

1. Services of a licensed physician assistant. See service limitations under section 5a of this attachment.

2. Services of a licensed certified nurse practitioner other than pediatric or family nurse practitioners. See service limitations under section 5a of this attachment.

3. Services of a licensed certified registered nurse anesthetist. See service limitations under section 5a of this attachment.

4. Services of a licensed registered nurse or licensed practical nurse which are determined medically necessary by the Department, and are limited to no more than 18 hours of nursing during a calendar quarter.

5. Services of a licensed psychologist, licensed professional counselor – mental health, licensed professional counselor working toward a mental health designation, licensed clinical nurse specialist, licensed certified social worker – PIP, licensed certified social work – PIP candidate, or licensed marriage and family therapist provided within their scope of licensure.

6. Services of a licensed nutritionist and licensed dietician provided within their scope of licensure.

7. Home Health Services

a, b, d. The following home health services are not payable:

1. Home health agency services provided to individuals residing in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

7C. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place are provided in accordance with federal regulations at 42 CFR 440.70(b)(3) based on medical necessity.

Rental equipment is no longer covered when any of the following conditions exist:

1. The prescription for the equipment is not valid;
2. The equipment has been returned to the provider; or
3. The recipient is no longer using the equipment.

Supplies necessary for the effective use or proper functioning of covered medical equipment are covered when:

1. The equipment is covered by Medicaid;
2. The recipient's condition meets the coverage criteria for equipment; and
3. The equipment is owned by the recipient.

Supplies for rented durable medical equipment are included in the Medicaid rental payment, unless specifically listed on the department's billing guidance website.

Replacement of medical equipment is allowed only when a medical condition exists which necessitates the replacement of the particular piece of equipment. The prescribing physician must determine whether a medical necessity exists and must document the need on the prescription for the replacement equipment.

Non-covered items may be requested by the recipient's physician. Requests for non-covered items must demonstrate medical necessity and be prior authorized by the department.

8. Private Duty Nursing Services

Not provided.

State Plan under Title XIX of the Social Security Act

State/Territory: South Dakota

Section 1905(a)(9) Clinic Services

The state provides coverage for this benefit as defined at section §1905(a)(9) of the Social Security Act (the Act) and 42 C.F.R. 440.90 and as described as follows:

General Assurances

[Select all three checkboxes below.]

- [x] The state assures services are furnished by a facility that is not part of a hospital in accordance with 42 C.F.R. 440.90.
- [x] The state assures that services are furnished by facilities that are organized and operated to provide medical care to outpatients in accordance with 42 C.F.R. 440.90.
- [x] The state assures that services are furnished under the direction of a physician or dentist in accordance with 42 C.F.R. 440.90(a).

Types of Clinic Services and Limitations in Amount, Duration, or Scope

[Select if applicable, describe below, and indicate if limits may be exceeded based upon state determined medical necessity criteria.]

- [ ] Limitations apply to all services within the benefit category.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Supplement to | **Attachment 3.1-A**

15a

State Plan under Title XIX of the Social Security Act

State/Territory: South Dakota

Section 1905(a)(9) Clinic Services

Types of Clinics and Services:

[**Select all that apply and describe below as applicable]**

☐ Behavioral Health Clinics **[Describe the types of behavioral health clinics below and select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

☑ IHS and Tribal Clinics **[Select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria].**

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State Plan under Title XIX of the Social Security Act State/Territory:

Section 1905(a)(9) Clinic Services South Dakota

☑ Renal Dialysis Clinics **[Select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

☑ Other Clinics **[Describe the types of clinics, if any limitations apply, and select below if applicable.]:**

a. Family planning clinics;
b. Ambulatory surgical centers which meet conditions for Medicare participation as evidenced by an agreement with the Federal Department of Health and Human Services.
c. Maternal and child health clinic
d. Rural Emergency Hospital (REH) Clinic services, provided by clinics certified by Medicare as REHs, include emergency department and observation services."

☑ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

Fertility treatments and related services are not covered.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act

State/Territory: South Dakota

Section 1905(a)(9) Clinic Services

Four Walls Exceptions

The state assures that the following services may be furnished outside of the clinic. **[Select the first and second checkbox; Do not select the second checkbox if the state does not enroll IHS or Tribal facilities as providers of clinic services.]:**

☑ Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address in accordance with 42 C.F.R. 440.90(b).

☑ Services furnished outside a clinic that is a facility of the Indian Health Service, whether operated by the Indian Health Service (IHS) or by a Tribe or Tribal organization (as authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. 93-638), by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(c).

The state elects to cover the following services outside of the clinic **[Select all that apply.]:**

☐ Services furnished outside of a clinic that is primarily organized for the care and treatment of outpatients with behavioral health disorders, including mental health and substance use disorders, by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(d) **[Describe the types of behavioral health clinics such exception applies to below.]:**

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Supplement to | **Attachment 3.1-A**

15d

State Plan under Title XIX of the Social Security Act

State/Territory: South Dakota

Section 1905(a)(9) Clinic Services

☐ Services furnished outside of a clinic that is located in a rural area and is not a rural health clinic (as referenced in section §1905(a)(2)(B) of the Act and 42 C.F.R. 440.20(b) of this subpart) by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(e) **[Select one of the checkboxes below and describe the definition of a rural area that applies to this exception.]:**

☐ A definition adopted and used by a federal governmental agency for programmatic purposes **[Describe below.]:**

☐ A definition adopted by a state governmental agency with a role in setting state rural health policy **[Describe below.]:**

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Supplement to | **Attachment 3.1-A**

15e

State Plan under Title XIX of the Social Security Act

State/Territory: South Dakota

Section 1905(a)(9) Clinic Services

The state attests that **[Select the checkbox if the state elects to cover services outside of a clinic that is located in a rural area.]:**

☐ The selected definition of a rural area best captures the population of rural individuals that meets more of the four criteria that mirror the needs and barriers to access experienced by individuals who are unhoused:

- The population experiences high rates of behavioral health diagnoses or difficulty accessing behavioral health services;
- The population experiences issues accessing services due to lack of transportation;
- The population experiences a historical mistrust of the health care system; and
- The population experiences high rates of poor health outcomes and mortality.

Additional Benefit Description (Optional)

At its option the state may provide additional descriptive information about the benefit, beyond what is included in the federal statutory and regulatory definitions and descriptions. **[Describe below.]:**

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10. Dental Services

Dental services for adults age 21 and over are limited to the following categories of service:

a. Routine diagnostic and preventive services:
    (1) Prophylaxis visits are limited to twice per state fiscal year;
    (2) Examination visits are limited to twice per state fiscal year; and
    (3) Radiographs:
        i. Bitewings are limited to twice per state fiscal year;
        ii. Full mouth or panoramic films are covered if medically necessary and are limited to once in a five-year period.

b. Routine restorative services:
    (1) Restoration of decayed or fractured teeth with amalgam fillings or composite fillings - one time in 12 months for composites or amalgams;
    (2) Stainless steel and temporary crowns;
    (3) Emergency treatment by report;
    (4) Oral surgery; and
    (5) General anesthesia or sedation.

c. Endodontic services:
    (1) Root canal therapy; and
    (2) Re-treatments.

d. Periodontal services including root planing and scaling and maintenance therapy.

e. Major services, which are beyond routine and restorative:
    (1) Build-ups, posts, and cores (posts and cores are a benefit in only the same teeth qualifying for root canal therapy);
    (2) Recementation of cast restorations is limited to once per lifetime of recipient; and
    (3) Permanent crowns are limited to placement on anterior teeth.

The limitations provided above may be exceeded based on medical necessity if authorized by the State.

Dental services for adults 21 years of age and older are limited to a total of $2,000 per adult Medicaid recipient per state fiscal year. The following services may be exempt from the limit:

a. Some preventive services, including two exams, two cleanings, and two sets of bitewings.
b. Emergent dental services medically necessary to immediately alleviate severe pain, acute infection, or trauma.
c. General anesthesia and sedation associated with treatment for immediate relief of severe pain, acute infection, or trauma.
d. Problem focused evaluations and related radiographs associated with treatment for immediate relief of severe pain, acute infection, or trauma (not all problem focused evaluations are considered emergent). Other services associated with treatment for immediate relief of severe pain, acute infection, or trauma as describes in the Emergent Care section of this manual.
e. Dentures, partial dentures and interim dentures. (Replacement of interim partial dentures are not exempt from the maximum)
f. Alveoloplasty in conjunction with approved dentures.

The $2,000 limit may be exceeded if medically necessary with a prior authorization.

11a. Physical Therapy

No limits.

11b. Occupational Therapy

No limitations.

11c. Services for Individuals with Speech, Hearing, or Language Disorders

No limitations.

12a. Prescribed Drugs

Any covered outpatient drug may be subject to prior authorization, and the agency maintains a list of drugs requiring prior authorization. Prescribing physicians, pharmacists, and/or designated representatives may contact the Medicaid Prior Authorization Unit via 1-800 phone or fax lines, mail or encrypted e-mail to request prior authorization. The program will issue responses within 24 hours of the request. Pharmacies may dispense a 72-hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in OBRA 1990 and 1993 pertaining to prior authorization programs.

Supplemental and Value-Based Rebates

Pursuant to Section 1927 of the Act, the State has the following policies for Medicaid supplemental rebates:

South Dakota participates in the Sovereign States Drug Consortium (SSDC) Medicaid multi-State purchasing pool. SSDC will negotiate supplemental rebates for South Dakota. The state retains all options to accept or reject offers. Drugs of manufacturers who do not participate in the supplemental rebate program will still be available to Medicaid recipients.

A model rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid population, submitted to the Centers for Medicare & Medicaid Services (CMS) with SPA TN # 22-0012, and entitled “SSDC South Dakota Medicaid Supplemental Drug Rebate Agreement” has been authorized by CMS. Any substantive modification to the agreement will be submitted to CMS for authorization.

CMS has authorized the state of South Dakota to enter into value-based agreements with pharmaceutical manufacturers, on a voluntary basis, for drugs provided to Medicaid beneficiaries using the value-based supplemental rebate agreement beginning April 1, 2024.

Savings recognized from value-based purchasing and supplemental rebate agreements received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

All drugs covered by the value-based agreement, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement.

Per Section 1927 (b)(3)(D) of the Social Security Act the unit rebate amount is confidential and cannot be disclosed. Funds received from supplemental rebate agreements will be reported to CMS. The state will remit the federal portion of any supplemental rebates collected.

Over-the-Counter Drugs

Select over-the-counter (OTC) drugs are covered. The list of covered OTC drugs can be found in the Pharmacy Provider Manual.

Excluded Items

The program does not cover the following items:

1. Agents when used for the treatment of sexual or erectile dysfunction;
2. Drugs manufactured by a firm that has not signed a rebate agreement with the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services except for select OTC dietary supplements;
3. Drugs and biologicals which the federal government has determined to be less than effective;
4. Experimental items.

The program does not cover any Medicare Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B. (See **Attachment 3.1-A.1** for specific coverage.)

b. Agents when used for the symptomatic relief of cough and colds:

(1) Brompheniramine/Pseudoephedrine
Bromphiramine/Pseudoephedrine/DM
(2) Dexbrompheniramine/Pseudoephedrine
(3) Dextromethorphan/Pseudoephedrine
(4) Guaifensesin Syrup (AC, DAC, DM, Plain)
(5) Promethzine with codeine
(6) Benzonatate

c. Non-prescription (OTC) drugs:

(1) Loratadine
(2) Loratadine with Pseudoephedrine

d. Barbituates—All

e. Benzodiazepenes—All

f. Prescription Vitamins and Minerals:

(1) Vitamin B
(2) Vitamin D
(3) Vitamin K
(4) Iron
(5) Iodine
(6) Zinc
(7) Multivitamin Preparations

g. Smoking Cessation Drugs (except dual eligibles, as Part D will cover)—All

12b. Dentures

Dentures are covered according to the following criteria and limits:

a. Immediate dentures and initial placement of all initial complete dentures do not require prior authorization. Prior authorization is required for replacement of dentures within 5 years of initial placement;
b. Initial and replacement of partial dentures are limited to recipients with no more than eight posterior teeth in occlusion (not limited to natural teeth). Replacement or a recipient's partial dentures is covered once in a five-year period;
c. Denture relines and rebases, for either complete or partial dentures, are covered once in a five-year period;
d. Adjustments of complete or partial dentures are limited to two adjustments per denture per 12-month period and only after six months have elapsed since initial placement of denture or partial denture;
e. Interim prostheses (flippers) are covered only once in a five-year period and if the existing denture/partial is no longer serviceable; and
f. Tissue conditioning is only covered the recipient is eligible for rebase, reline, or new prosthesis.

All dentures, partial dentures, and interim prostheses must be billed on the date of placement.

12c. Prosthetic Devices

Experimental devices are not payable.

12d. Eyeglasses

Corrective vision eyeglasses; contact lenses when necessary for the correction of irregular astigmatism, anisometropia in excess of 4 diopters or myopia in excess of 6 diopters; replacement eyeglasses after a minimum of 9 months since the old glasses were received or there is a change in correction needed of at least .5 diopters; and replacement contact lenses are limited to no more than two replacement lenses per year.

13a. Diagnostic Services

Not provided.

13b. Screening Services

Not provided.

13c. Preventive Services

1. Diabetes Self-Management Training

Diabetes Self-Management Training is a preventive health service for persons diagnosed with diabetes. The service requires a physician referral. The training will increase the individual's understanding of diabetes progression and enable monitoring skills to prevent complications, disease progression, and disability

Training content is based upon the American Diabetes Association and South Dakota Department of Health standards. Enrolled diabetes education training providers must be capable of offering instruction in each of the content areas as established by the American Diabetes Association and Department of Health standards. Examples include, but are not limited to, diabetes overview, nutrition, exercise and activity, foot care, skin care, dental care, medications, and medication management.

Covered Services
The following services are covered:

a. Individual diabetes self-management training
b. Group diabetes self-management training

Practitioner Qualifications
Outpatient diabetes self-management education must be provided by a diabetes education team that is certified or recognized by the American Diabetes Association or the South Dakota Department of Health. The team must consist of licensed RNs and licensed dieticians to meet certification standards. Claims must be submitted by an enrolled provider.

Limitations

a. Outpatient diabetes self-management education is limited to ten hours of comprehensive education for newly-diagnosed recipients and follow-up education sessions of two hours per year based upon assessment of need and documented physician order. Limits can be exceeded if determined medically necessary by the state.
b. Diabetes self-management education is not separately covered when:
    1) The individual is institutionalized and the training is not delivered in an outpatient setting; or
    2) The individual receives this service in a FQHC or RHC.

2. Community Health Worker Services

Community Health Worker services is a preventive health service to prevent disease, disability, and other health conditions or their progression for individuals with a chronic condition or at risk for a chronic condition who are unable to self-manage the condition or for individuals with a documented barrier that is affecting the individual's health.

Community health worker services must be ordered by a physician, physician assistant, nurse practitioner, certified nurse midwife, or dentist and delivered according to a care plan. Services must berelated to a medical intervention outlined in the individual's care plan and may include the following:

a. Health system navigation and resource coordination includes helping a recipient find Medicaid providers to receive a covered service, helping a recipient make an appointment for a Medicaid covered service, arranging transportation to a medical appointment, attending an appointment with the recipient for a covered medical service, and helping a recipient find other relevant community resources such as support groups.
b. Health promotion and coaching includes providing information or training to recipients that make positive contributions to their health status such as cessation of tobacco use, reduction in the misuse of alcohol or drugs, improvement in nutrition, improvement of

physical fitness, family planning, control of stress, pregnancy and infant care including prevention of fetal alcohol syndrome.

c. Health education and training to train and/or promote to recipients methods and measures that have been proven effective in avoiding illness and/or lessening its effects including, but not limited to, immunizations, control of high blood pressure, control of sexually transmittable disease, prevention and control of diabetes, control of toxic agents,occupational safety and health, and accident prevention. The content of the education must be consistent with established or recognized healthcare standards.

The following services are non-covered services:

a. Advanced care planning;
b. Advocacy on behalf of the recipient;
c. Case management/care management;
d. Child care;
e. Chore services including shopping and cooking;
f. Companion services;
g. Employment services;
h. Exercise classes;
i. Helping a recipient enroll in government programs or insurance;
j. Interpreter services;
k. Medication, medical equipment, or medical supply delivery;
l. Personal care services/homemaker services;
m. Respite care;
n. Services not listed in the recipient's care plan;
o. Services provided prior to the recipient's care plan being finalized;
p. Services provided to non-Medicaid patients;
q. Services that duplicate another covered Medicaid service;
r. Socialization;
s. Transporting the recipient; and
t. Travel time.

Community Health Worker Qualifications

Providers must be enrolled with South Dakota Medicaid as a community health worker agency. Individual community health workers must be employed and supervised by an enrolled community health worker agency.

Community Health Worker Certification

Effective January 1, 2023, CHWs must be certified by the Community Health Worker Collaborative of South Dakota in order for the service to be covered. For services to be covered prior to January 1, 2023 CHWs must either be certified by the Community Health Worker Collaborative of South Dakota or have completed one of the following: Indian Health Services Community Health Representative basic training, a community health worker program approved by the South Dakota Board of Technical Education, the South Dakota Board of Regents, the Community Health Worker Collaborative of South Dakota, or a Community Health Worker training program approved by the department.

Continuing Education

Community Health Workers must complete a minimum of 6 hours of continuing education training annually.

3. Vaccines and Vaccine Administration

   Vaccines and vaccine administration are covered without cost-sharing as described in section 1905(a)(13)(B) of the Act. Coverage and billing code changes are made on a quarterly basis to comply with the Advisory Committee on Immunization Practices (ACIP) recommendations.

SUPPLEMENT TO ATTACHMENT 3.1-A

4. Doula Services

Doula services will be used to provide support for pregnant recipients throughout the prenatal and postpartum periods. Pursuant to 42 C.F.R. Section 440.130(c), doula services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent perinatal complications and/or promote the physical and mental health of the beneficiary.

Doula services are covered for pregnant recipients with a pregnancy confirmed by a medical provider. Services are covered through the postpartum period. Postpartum doula services may be provided up to 365 days after the end of the pregnancy contingent upon the recipient maintaining eligibility for South Dakota Medicaid.

Covered Services

Covered Doula services include:

1. Prenatal and postpartum counseling, education, and support including providing information regarding self-care and infant care to help achieve positive health outcomes for the recipient and the baby. Services also include development of birth and postpartum plans;
2. Labor and delivery support; and
3. Care coordination to link the recipient to health care providers and community-based services and supports.

One labor and delivery care visit is covered per recipient, per pregnancy. Labor and delivery services must be provided in conjunction with prenatal and/or postpartum doula services.

Provider Qualifications

A doula is a trained professional who provides emotional, physical, and informational support during the prenatal, labor, delivery, and postpartum periods. Doulas are non-clinical and do not provide medical care. Doulas services do not replace the services of licensed and trained medical professionals.

Doula services may provided by qualified individuals who:

1. Are at least 18 years of age; and
2. Maintain up-to-date certification through a doula certification program approved by South Dakota Medicaid.

13d. Rehabilitative Services

Rehabilitation services are medical and remedial services that have been recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level and furnished by one of the following practitioners:

1. Community Mental Health Centers (CMHCs) accredited by the state mental health authority. Services are covered for an individual for whom an integrated assessment has been prepared that includes a primary diagnosis of a mental illness. Services must be medically necessary and provided in accordance with a treatment plan.

   CMHC Covered Services

   a. Outpatient services are nonresidential diagnostic and treatment services that are distinct from specialized outpatient services for children, specialized outpatient services for adults, and assertive community treatment services.

      i. Integrated assessment, evaluation, and screening. Contact where the primary purpose is to develop information regarding a recipient's emotional state, and social history for use in formulating a treatment plan. Screening and evaluation includes psychosocial, psychological, and psychiatric examinations for diagnosis and treatment recommendations. An assessment may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.
      ii. Individual therapy. Therapeutic contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals. There may be times when, based on the clinical judgment, that a collateral contact may participate in the therapy for the direct benefit of the recipient or the recipient is not present for the delivery of the service, but remains the focus of the service.
      iii. Group therapy. Therapeutic contact between a therapist and two or more individuals in which the therapist delivers therapies/counseling to multiple individuals, and in which the therapist and the group seek to assist progress towards treatment goals. Group therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery. There may be times when, based on clinical judgment, the recipient is not present during the delivery of the service, but remains the focus of the service.
      iv. Family education, support, and therapy. Therapeutic contact between one or more family members and the therapist in which the therapist delivers direct therapy relating to the identified recipient's therapeutic goals. Family therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identifiedin the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery. There may be times when, based on the clinical judgment, the recipient is not present during the delivery of the service, but remains the focus of the service.
      v. Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals. There may be times when, based on the clinical judgment, that a collateral contact may participate in the service for the direct benefit of the recipient or the recipient is not present for the delivery of the service, but remains the focus of the service.

   b. Specialized Outpatient Services for Children are comprehensive services and support provided to a child or youth under age 21 with serious emotional disturbance (SED) and the child or youth's family, including a child or youth with a co-occurring disorder.

i. Integrated assessment, evaluation, and screening. Contact where the primary purpose is to develop information regarding a recipient's emotional state, and social history for use in formulating a treatment plan. Screening and evaluation includes psychosocial, psychological,and psychiatric examinations for diagnosis and treatment recommendations. An assessment may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.

ii. Care coordination. Care coordination is a collaborative process which assesses, plans,implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs as identified in the treatment plan Care coordination may include contact with a collateral, when it is for the direct benefit of the recipient.

iii. Individual therapy. Therapeutic contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals. There may be times when, based on the clinical judgment, that a collateral contact may participate in the therapy for the direct benefit of the recipient or the recipient is not present for the delivery of the service, but remains the focus of the service.

iv. Group therapy. Therapeutic contact between a therapist and two or more individuals in which the therapist delivers therapies/counseling to multiple individuals, and in which thetherapist and the group seek to assist progress towards treatment goals. Group therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery There may be times when, based on clinical judgment, the recipient is not present during the delivery of the service, but remains the focus of the service.

v. Parent or guardian group therapy. Goal directed therapeutic intervention with the parents/guardians of a recipient and one or more parents/guardians who are treated at the same time. Parent or guardian group therapy services to the recipient's family and significantothers is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting inthe recipient's recovery. There may be times when, based on clinical judgment, the recipient is not present during the delivery of the service, but remains the focus of the service.

vi. Family education, support, and therapy. Therapeutic contact between one or more family members and the therapist in which the therapist delivers direct therapy, education relating to the identified child's condition, or support services to develop coping skills for the parents and family members, in regards to the identified child. Family education, support, and therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery. There may be times when, based on clinical judgment, the recipient is not present during the delivery of the service, but remains the focus of the service.

vii. Crisis assessment and intervention services. An immediate therapeutic response available 24 hours a day 7 days a week that involves direct telephone or face-to-facecontact with a recipient exhibiting acute psychiatric symptoms and/or inappropriate behavior that left untreated, presents an immediate threat to the recipient or others. The service may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.

viii. Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals. There may be times when, based on the clinical judgment, that a collateral contact may participate in the service for the direct benefit of the recipient or the recipient is not present for the delivery of the service, but remains the focus of the service.

ix. Psychiatric nursing services. Includes components of physical assessment, medication assessment and monitoring, and medication administration for recipients unable to self administer their medications. The service may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.

c. Specialized outpatient services for adults are medically necessary related treatment, and rehabilitative and support services to a recipient age 18 or older with serious mental illness(SMI), including those with co-occurring disorders. The individual must have at least one functional impairment as a result of the SMI.

i. Integrated assessment, evaluation, and screening. Contact where the primary purpose is to develop information regarding a recipient's emotional state, and social history for use in formulating a treatment plan. Screening and evaluation includes psychosocial, psychological, and psychiatric examinations for diagnosis and treatment recommendations.

ii. Crisis assessment and intervention services. An immediate therapeutic response available 24 hours a day 7 days a week that involves direct telephone or face-to-face contact with a recipient exhibiting acute psychiatric symptoms and/or inappropriate behavior that left untreated, presents an immediate threat to the recipient or others.

iii. Care coordination. Care coordination is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs as identified in the treatment plan.

iv. Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals.

v. Psychiatric nursing services. Includes components of physical assessment, medication assessment and monitoring, and medication administration for recipients unable to self-administer their medications.

vi. Symptom assessment and management. Assessment of an individual recipient's symptoms and providing education regarding managing their symptoms including medication and monitoring education.

vii. Individual therapy. Therapeutic contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals.

viii. Group therapy. Therapeutic contact between a therapist and two or more individuals in which the therapist delivers therapies/counseling to multiple individuals, and in which the therapist and the group seek to assist progress towards treatment goals. Group therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.

ix. Recovery support services. Supportive counseling/psychotherapy (when diagnostically indicated) and the development of psychosocial and recovery skills may be provided to help the recipient cope with and gain mastery over symptoms and disabilities, including those related to co-occurring disorders, in the context of daily living.

x. Psychosocial rehabilitation services. Provided on an individual or group basis to assist the recipient to gain or relearn self-care, interpersonal, and community living skills needed to live independently, sustain psychiatric stability, and progress towards recovery.

d. Assertive community treatment (ACT) services. Designed for an individual age 18 or older with a serious mental illness and functional impairments as a result of the serious mental illness. ACT provides medically necessary related treatment, rehabilitative, and support services to an eligible recipient who require more intensive services than can be provided by specialized outpatient services for adults.

i. Integrated assessment, evaluation, and screening. Contact where the primary purpose is to develop information regarding a recipient's emotional state, and social history for use in formulating a treatment plan. Screening and evaluation includes psychosocial, psychological, and psychiatric examinations for diagnosis and treatment recommendations.

ii. Crisis assessment and intervention services. An immediate therapeutic response available 24 hours a day 7 days a week that involves direct telephone or face-to-face contact with a recipient exhibiting acute psychiatric symptoms and/or inappropriate behavior that left untreated, presents an immediate threat to the recipient or others.

i. Care coordination. Care coordination is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs as identified in the treatment plan.
ii. Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals.
iii. Psychiatric nursing services. Includes components of physical assessment, medication assessment and monitoring, and medication administration for recipients unable to self-administer their medications.
iv. Symptom assessment and management. Assessment of an individual recipient's symptoms and providing education regarding managing their symptoms including medication and monitoring education.
v. Individual therapy. Therapeutic contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals.
vi. Group therapy. Therapeutic contact between a therapist and two or more individuals in which the therapist delivers therapies/counseling to multiple individuals, and in which the therapist and the group seek to assist progress towards treatment goals. Group therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
vii. Recovery support services. Supportive counseling/psychotherapy (when diagnostically indicated) and the development of psychosocial and recovery skills may be provided to help the recipient cope with and gain mastery over symptoms and disabilities, including those related to co-occurring disorders, in the context of daily living.
viii. Psychosocial rehabilitative services. Provided on an individual or group basis to assist the recipient to gain or relearn self-care, interpersonal, and community living skills needed to live independently, sustain psychiatric stability, and progress towards recovery.

b. Peer Support Services. Peer support workers provide nonclinical individual or group support throughout all stages of the mental health rehabilitation process in support of the beneficiary's recovery and treatment goals. Through lived experience peer support workers help beneficiaries become and stay engaged in the recovery process and reduce the likelihood of relapse by providing the following services:
   i. Advocating for people in recovery
   ii. Sharing resources and building skills
   iii. Linking to resources, services, and supports
   iv. Leading recovery groups
   v. Mentoring and setting goals

Non-covered CMHC Services

a. The following are non-covered CMHC services:
   i. Vocational counseling and vocational training at a classroom or job site;
   ii. Academic educational services;
   iii. Services that are solely recreational in nature;
   iv. Services for individuals other than an eligible recipient or a recipient's family if the recipient is receiving specialized outpatient services for children;
   v. Services provided to recipients who are in detoxification centers.
   vi. Services provided to recipients who are incarcerated in a correctional facility;
   vii. Services provided to recipients who are in juvenile detention facilities;
   viii. Services provided to recipients who are in psychiatric residential treatment facilities, inpatient psychiatric hospital, or institutions for mental disease; and
   ix. Transportation services.

SUPPLEMENT TO ATTACHMENT 3.1-A

CMHC Practitioners and Qualifications

All CMHCs must have a clinical supervisor. A clinical supervisor is a mental health professional who has at least a master's degree in psychology, social work, counseling, or nursing and currently holds a license in that field. The clinical supervisor must have two years of supervised postgraduate clinical experience in a mental health setting. Individuals with an associate, bachelors, or master's degree that do not meet the definition of a clinical supervisor must be supervised by a clinical supervisor. Registered nurses and licensed practical nurses must comply with state regulations regarding supervision. The table below lists the provider qualifications for furnishing mental health services:

Services	**Practitioner Qualifications**
• Psychiatric services	• A licensed physician or psychiatrist, or a licensed physician assistant or licensed certified nurse practitioner.
• Individual therapy; • Group therapy; • Family therapy; and • Parent or guardian therapy.	• A master's degree in psychology, social work, counseling, or nursing; a social work license.
• Care coordination; and • Symptom assessment and management.	• A minimum of a high school diploma or equivalent and is supervised by a clinical supervisor; or • A master's degree in psychology, social work, counseling, or nursing; a social work license; or bachelor's degree in a human services field and two years of related experience; or • A licensed physician or psychiatrist, or a licensed physician assistant or licensed certified nurse practitioner; or • A registered nurse or licensed practical nurse to provide psychiatric nursing services.
• Family education and support; • Recovery support services; and • Psychosocial rehabilitation services.	• A minimum of a high school diploma or equivalent and is supervised by a clinical supervisor; or • A master's degree in psychology, social work, counseling, or nursing; a social work license; or bachelor's degree in a human services field and two years of related experience.
• Crisis assessment and intervention	• A master's degree in psychology, social work, counseling, or nursing; a social work license; or bachelor's degree in a human services field and two years of related experience.
• Psychiatric nursing services	• A registered nurse or licensed practical nurse to provide psychiatric nursing services.
• Integrated assessment, evaluation, and screening	• A master's degree in psychology, social work, counseling, or nursing; a social work license; or bachelor's degree in a human services field and two years of related experience; or • A licensed physician or psychiatrist, or a licensed physician assistant or licensed certified nurse practitioner; or • A registered nurse or licensed practical nurse to provide psychiatric nursing services.
• Peer Support Worker	• A minimum of a high school diploma or equivalent with self-attestation of lived experience and ongoing recovery from a mental health diagnosis, has completed a Department-approved training and is supervised by a mental health professional (as defined by the state) or a peer with at least two years of direct experience providing peer services. Mental health professionals and experienced peers may supervise upon completion of state-approved Supervising Peer Support training. Supervisors will provide regularly scheduled supervision of peer support specialists.

2. Substance use disorder agencies accredited by the single state agency for substance abuse. Services are covered foran individual for whom an integrated assessment has been prepared that includes a primary diagnosis of substance use disorder. The agency must prepare an individual treatment plan as a result of the integrated assessment. Crisis intervention services do not require an integrated assessment or individual treatment plan.

Substance Use Disorder Agency Services

a. Integrated assessment. The integrated assessment includes both functional and diagnostic components. The assessment shall establish the historical development and dysfunctional nature of the recipient's alcohol and drug abuse or dependence and shall assess the recipient's treatment needs.
b. Crisis intervention services. Crisis intervention services are provided to a recipient in a crisis situation related to the recipient's use of substances, including crisis situations where co-occurring mental health symptoms may be present. The focus of the intervention is to restore the recipient to the level of functioning before the crisis or provide means to place the recipient into a secure environment. The service may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.
c. Early intervention services. Nonresidential services provided to individuals that may have substance use related problems, but do not meet the diagnostic criteria for a substance use disorder. The service may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient. The following services at a minimum must be included:
    i. Initial screening and planning within 48 hours of initial contact.
    ii. Crisis intervention services as described above in item b.
    iii. Individual or family counseling regarding substance abuse and dependence. Family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
    iv. Discharge planning services to include continued care planning and counseling, referral to and coordination of care with other resources that will assist a client's recovery, including educational, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services which includes the availability of tuberculosis and human immunodeficiency virus services.
d. Outpatient treatment services provided by an accredited nonresidential program to a recipient or a person harmfully affected by alcohol or other drugs through regularly scheduled counseling services. The following services are covered:
    i. Individual, group and family counseling regarding substance abuse and dependence. Group and family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery. There may be times when, based on the clinical judgment, that a collateral contact may participate in the therapy for the direct benefit of the recipient or the recipient is not present for the delivery of the service, but remains the focus of the service.
    ii. Discharge planning services to include continued care planning and counseling, referral to and coordination of care with other resources that will assist a client's recovery, including educational, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services which includes the availability of tuberculosis and human immunodeficiency virus services. The service may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.

e. Intensive outpatient treatment services are provided by an accredited nonresidential program providing services to a recipient in a clearly defined, structured, intensive outpatient treatment program on a regularly scheduled basis. The following services are covered:
    i. Individual, group, and family counseling regarding alcohol and drug abuse and dependence. Group and family counseling services to the recipient's family and significant others is for thedirect benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery. There may be times when, based on the clinical judgment, that a collateral contact may participate in the therapy for the direct benefit of the recipient or the recipient is not present for the delivery of the service, but remains the focus of the service.
    ii. Discharge planning which must include continued care planning and counseling, referral to and coordination of care with other resources that will assist a recipient's recovery, including education, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services to include the availability of tuberculosis and human immunodeficiency virus services availability of tuberculosis and human immunodeficiency virus services. The service may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.

c. Day treatment services are provided by an accredited program providing services to a recipient in a clearly defined, structured, intensive treatment program. The following services are covered:
    i. Individual, group, and family counseling regarding alcohol and drug abuse and dependence. Group and family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
    ii. Discharge planning which must include continued care planning and counseling, referral to and coordination of care with other resources that will assist a recipient's recovery, including education, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services to include the availability of tuberculosis and human immunodeficiency virus services.

d. Clinically-managed low-intensity residential treatment services provided by an accredited residential program providing services to a recipient in a structured environment designed to aid re-entry into the community. Clinically-managed, low-intensity residential treatment programs are not institutions for mental diseases as described in 42 CFR 435.1010. The following services are covered:
    i. Individual, group, and family counseling regarding alcohol and drug abuse and dependence. Group and family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
    ii. Discharge planning to continued care planning and counseling, referral to and coordination of care with other resources that will assist a recipient's recovery, including education, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services to include the availability of tuberculosis and human immunodeficiency virus services.

e. Medically-monitored intensive inpatient treatment programs are an accredited residential program providing services to a recipient in a structured environment. These medically-monitored intensive inpatient treatment program may be provided to eligible individuals in an eligible IMD as allowed in Attachment 3.1-L-SUD/IMD. The following services are covered:
    i. Individual, group, and family counseling regarding alcohol and drug abuse and dependence. Group and family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
    ii. Discharge planning to include continued care planning and counseling, referral to and coordination of care with other resources that will assist a recipient's recovery, including education, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services to include the availability of tuberculosis and human immunodeficiency virus services.

f. Peer support services provide nonclinical individual or group support throughout all stages of the substance use rehabilitation process in support of the beneficiary's recovery and treatment goals. Through lived experience peer support workers help beneficiaries become and stay engaged in the recovery process and reduce the likelihood of relapse by providing the following services:
    i. Advocating for people in recovery
    ii. Sharing resources and building skills
    iii. Linking to resources, services, and supports
    iv. Leading recovery groups
    v. Mentoring and setting goals

Substance Use Disorder Agencies Non-Covered Services

The following services are non-covered for substance use disorder agencies:

a. Treatment for a diagnosis of substance use disorder that exceeds the limits established by the division, unless prior authorization is approved by the division;
b. Out-of-state substance use disorder treatment unless the division determines that appropriate in-state treatment is not available;
c. Treatment for a gambling disorder;
d. Room and board for residential services;
e. Substance use disorder treatment before the integrated assessment is completed;
f. Substance use disorder treatment after 30 days if the treatment plan has not been completed;
g. Substance use disorder treatment if a required review has not been completed;
h. Court appearances, staffing sessions, or treatment team appearances; and
i. Substance use disorder services provided to a recipient incarcerated in a correctional facility.

Substance Use Disorder Agencies Practitioners and Qualifications

All agency staff providing addiction counseling must meet the standards for addiction counselors or addiction counselor trainees in accordance with South Dakota Board of Addiction and Prevention Professionals requirements. Each agency must have a clinical supervisor that supervises clinical services. Clinical supervisors must be licensed as either a certified addiction counselor or licensed addiction counselor. The table below lists the services each provider can provide, provider qualifications, and supervisory requirements:

Practitioner Type	**Services Furnished**	**Qualifications**	**Supervisory Requirements**
Licensed Addiction Counselor	• Integrated assessment; • Crisis intervention; • Early intervention services; • Individual, group, and family counseling; and • Discharge planning.	Must meet be licensed as a Licensed Addiction Counselor by the South Dakota Board of Addiction and Prevention Professionals.	None
Certified Addiction Counselor	• Integrated assessment; • Crisis intervention; • Early intervention services; • Individual, group, and family counseling; and Discharge planning.	Must meet be certified as a Certified Addiction Counselor by the South Dakota Board of Addiction and Prevention Professionals.	None
Addiction Counselor Trainee	• Integrated assessment; • Crisis intervention; • Early intervention services; • Individual, group, and family counseling; and • Discharge planning.	Must meet be recognized as an Addiction Counselor Trainee by the South Dakota Board of Addiction and Prevention Professionals.	Must be supervised by a certified addiction counselor or licensed addiction counselor.
Peer Support Services	• Individual or group peer supports	A minimum of a high school diploma or equivalent with self-attestation of lived experience and ongoing recovery from a mental health diagnosis and has completed a Department-approved training.	Must be supervised by a certified addiction counselor, licensed addiction counselor or a peer with at least two years of direct experience providing peer services. Certified addiction counselors, licensed addiction counselors, and experienced peers may supervise upon completion of state-approved Supervising Peer Support training. Supervisors will provide regularly scheduled supervision of peer support specialists.

14. Services for individuals age 65 or older in institutions for mental diseases

a. Inpatient Hospital

Not provided.

b. Skilled nursing services

No limitations.

c. Intermediate care facility services

No limitations.

15a. Intermediate Care Facilities

No limitations.

15b. Intermediate Care Facilities for the Mentally Retarded

No limitations.

16. Inpatient Psychiatric Facility Services for Individuals Under Age 22

Preauthorization is required for service. Services provided must meet the requirements of 42 CFR 483.350 through 483.376. All facilities must be enrolled with the Department as Medicaid providers, surveyed and licensed by the South Dakota Department of Health, and provide attestations of accreditation by national organizations prior to licensure. Services fall within the regulations at 42 CFR 441.151.

17. Nurse-Midwife Services

No limitations.

18. Hospice Care

The hospice care benefit will follow the amount, duration, and scope of services as outlined in the State Medicaid Manual, Hospice Services, Section 4305.

19. Case Management Services

See targeted case management supplements to Attachment 3.1-A.

20. Extended Services to Pregnant Women

1905(t) Primary Care Case Management services are covered for pregnant women. See Pregnancy Primary Care Case Management (PCCM) Program in Section 27 of Supplement to Attachment 3.1-A.

21. Ambulatory Prenatal Care for Pregnant Women Furnished During a Presumptive Eligibility Period by a Qualified Provider

Not provided.

21. Ambulatory Prenatal Care for Pregnant Women Furnished During a Presumptive Eligibility Period by a Qualified Provider

Not provided.

22. Respiratory Care Services

Not provided.

23. Pediatric or Family Nurse Practitioners

See service limits under section 5a of this attachment.

24. Any Other Medical Care and Any Other Type of Remedial Care Recognized Under State Law, Specified by the Secretary

a. Transportation.

Ground and air ambulance services are covered if other methods of transportation are contraindicated by the recipient's condition.

Secure medical transportation to or from a covered medically necessary service is covered for recipients who are confined to a wheelchair or stretcher. Community transportation to or from a covered medically necessary service is covered. Purchase of tickets from commercial carriers (airlines, bus, etc.) to or from a covered medically necessary appointment outside the recipient's city of residence is covered. Mileage incurred by the recipient or a volunteer driver to or from a covered medically necessary service outside the recipient's city of residence is covered. Meals and Lodging incurred as a result of travel of at least 150 miles or more one way from the recipient's city of residence to receive covered specialty care or treatments and that results in an overnight stay is covered for the recipient and if necessary one escort or volunteer driver.

Transportation must be to the closest medical facility or medical provider capable of providing the necessary services, unless the recipient has a written referral or a written authorization from the recipient's medical provider to seek treatment at a different facility or from a different provider.

b. Services provided in religious non-medical home health care institutions.
Not provided.

c. Reserved.

d. Nursing facility services for patients under 21 years of age.

No limitations.

e. Emergency hospital services.

No limitations.

25. Personal care services

Personal care services are provided in accordance with 42 CFR 440.167.

Personal care services are limited to a maximum of 500 hours of services annually.

26.a. Licensed or otherwise State-approved freestanding birth centers

No limitations.

26.b. Licensed or otherwise State-recognized, covered professionals providing services in the freestanding birth center

Services provided in licensed or otherwise State-approved freestanding birth centers are limited to the following providers:

__X__ Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State Plan (i.e., physicians and certified nurse midwives).

_____ Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).

_____ Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).

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 three 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;

d. Assisting recipients with scheduling an initial well-child visit;
e. Completing a transition plan at the end of the postpartum period for active participants.

6. Implementation of a barriers to care initiative designed to reduce barriers that prevent recipients from receiving prenatal and postpartum care. Barriers to care initiatives may focus on increasing attendance at prenatal and postpartum visits, transportation barriers, social determinants of health barriers, childcare barriers, or other barriers as approved by South Dakota Medicaid.

Program Goals and Outcomes

The goal of the Pregnancy Program is to improve health outcomes for pregnant woman and the unborn child. South Dakota Medicaid will specifically measure the following with a goal and desired outcome to increase each percentage:

1. The percentage of recipients who received prenatal care during their pregnancy.
2. The percentage of recipients who initiated prenatal care early.
3. The percentage of recipients who had adequate or adequate plus prenatal care according to the Kotelchuck index.
4. The percentage of recipients who had a comprehensive postpartum visit.
5. The percentage of recipients who had at least two well-child visits within 42 days of birth.

In addition to the specific goals above, South Dakota Medicaid will also monitor and review maternal and perinatal HEDIS measures in the Child and Adult core sets. South Dakota Medicaid will publish an annual report regarding Pregnancy Program outcomes on dss.sd.gov.

Providers

Qualified providers must:

1. Meet Medicaid's qualifications for participation;
2. Be enrolled in South Dakota Medicaid and have a signed agreement to participate as a pregnancy PCCM provider; and
3. Provide care in accordance with accepted standards of care.

Pregnancy PCCM providers include licensed physicians, physician assistants, certified nurse practitioners, or certified nurse midwives practicing in one of the following:

1. Private clinic;
2. Rural health clinic;
3. Federally qualified health care center;
4. Tribal provider with a contract under public law 93-638; or
5. Indian Health Service clinic.

The provider must maintain credentials with a birthing hospital if the provider intends to perform the birth or maintain a relationship and communication with another provider or facility who can perform the birth including a process for timely transition of care.

Assurances

1. The State assures that all services are provided according to the provisions of 1905(t) of the Social Security Act including locating, coordinating, and monitoring of services.
2. The State assures that any marketing and/or other activities do not result in selective recruitment and enrollment of individuals with more favorable health status as prohibited in Section 1905(t)(3)(D) of the Act.
3. The State assures that upon attribution for purposes of payment calculation, the state notifies beneficiaries of the program, describes how personal information will be used, and discloses any correlative payment arrangements.

Quality Assurance Review

South Dakota Medicaid will conduct an annual quality assurance review process to ensure quality and compliance with program requirements.