Workgroup Recommendations

1. **Workforce workgroup recommends childhood healthcare experiences.**

   Partner with childcare programs (such as summer or after-school programs) to provide hands on healthcare career experiences to elementary-aged children. Potential barriers include young professionals entering the healthcare workforce and building long-term care ties to community as employers. The requirements and questions around insurance, precise location within health care facilities, staff involvement, depth, and complexity of curriculum, OSHA/HIPPA, potential for transmission of disease, and overall supervision need to be developed further.

   Key Strategies:

   - Create a toolkit that childcare programs could use to build a health careers experience curriculum or day.
   - Encourage Healthcare facilities to become engaged with childcare providers in their communities.
   - Assess opportunities within a 60-mile radius of small rural communities to foster collaboration and engagement.

   Resources Needed:

   - Potentially offer funding to childcare programs to assist with launching a program (transport and food costs, etc.).
   - Use existing structures/tools for Scrubs camps/camp meds, under already-developed models that have proven successful.

   Fiscal Impact:

   - There is likely a fiscal impact to the state general fund or other state funds of up to $70,000. The Department of Health would need $20,000 for developing the toolkit, and then $50,000 for providing grants to the organizations implementing the program. The opportunity cost of time could be a cost as a state employee(s) would spend time on this program instead of another program.

Childhood Healthcare Experiences		
Description		*Amount*
Toolkit		
	Offset staff time, pay contractors, assist with cost of communication and marketing. Funding can also come from Office of Rural Health Budget.	**20,000.00**
Grants		
	Assist with implementation costs, either on a short term basis, or over several years based on data from providers.	**50,000.00**

2. **Workforce workgroup recommends the power of proximity: elementary-aged students + eldercare setting = future workforce.**

   For years, researchers have studied care programs for children and older adults sharing the same building or campus and fostering relationships across generations. Although shared sites vary widely, the most common model pairs preschools with adult day care or long-term care living settings like nursing homes or assisted living centers.

   Potential Barriers:

   - This is difficult care model to pull off, complicated by funding silos and regulations.
   - Most funding supports care facilities focused on either childcare or eldercare, forcing operators of shared sites to seek and manage separate funding sources.

- The staffing plans, emergency evacuation procedures, and other regulations governing care sites for younger people differ from those designed for older populations.

Key Strategies:

- Increase awareness of the benefits of shared sites.
- Sharing data and stories about the positive effects on participants.
- Research shows older adults in shared sites feel more accomplished, improve cognitively and physically, and find new purpose in their daily lives.
- Children thrive under the extra attention they receive.
- Attracting and retaining staff—a chronic problem in the care industry—is less of an issue at shared sites, because employees can more easily meet their own family caregiving needs.
- Engage community champions through an awareness and story-telling campaign.
- Research into innovative ways to share resources and funding options.
    - Older Americans Act, Community Foundations, Grants, and Fundraising.
- Explore ways to navigate age-segregated licensing and accreditation rules.
    - Develop new policies and standards that align with relevancy Partners/Resources Needed.

Resources Needed:

- Pilot Program(s) to show and tell how this could and might work.
    - The Village at Harmony Hill in Watertown.
    - Tiezen Memorial Home in Marion.

Fiscal Impact:

- There likely would be a fiscal impact to the state general fund or other state funds. The DOH has identified budget assumptions totaling $650,000 for this recommendation. A comprehensive study could cost $300,000, community engagement plan for stakeholder sessions and outreach costing $150,000 and a pilot program and partnership plan costing $200,000. The opportunity cost of time could be another cost as a state employee(s) would spend time on this program instead of another program.

3. Workforce workgroup recommends creation of a healthcare workforce coalition.

Create a standing coalition with diverse representation to convene regularly regarding healthcare workforce and program needs. Other states have created similar healthcare workforce groups.

The Department of Health currently operates the Healthcare Workforce Center. The purpose of the Center is to function as a clearinghouse for healthcare workforce-related data and information. The Center is also designed to develop and implement programs and projects to assist individuals, agencies, and facilities in their efforts to address current and projected workforce needs. The center operates several programs including: the recruitment assistance program, rural healthcare facility recruitment assistance program, and the state loan repayment program. The Center produced a report in 2018 on healthcare workforce in South Dakota.

Barriers Addressed:

- Entry into healthcare workforce.
- Barriers to education.
- Clinical skills training.

Key Strategies:

- Determine membership makeup.
- Create group charter.
- Determine meeting cadence and standing agenda resources.

Resources Needed:

- Legislative authority for the coalition to make recommendations.
- Funding to support member engagement.

Fiscal Impact:

- There is likely a marginal fiscal impact to the state general fund or other state funds. The state would likely incur expenses to reimburse attending members for meals, lodging, and mileage. There could be an opportunity cost of time as a state employee(s) would spend time on this program instead of another program.

4. **Workforce workgroup recommends creation of a central clinical experience repository.**

   Provide a software platform to connect healthcare studies students needing clinical skills training with preceptors willing to host students for clinical experiences. Barriers addressed include professional students being able to find clinical experience placement to complete clinical skills training.

   Key Strategies:

   - Partner with a contractor to seek a software vendor offering this type of service.
   - Management of the platform at the Department of Health (DOH).
   - Identify key data points to collect regarding preceptor challenges in South Dakota.

   Resources Needed:

   - Funding to purchase the platform.
   - Annual software maintenance/subscription fee.
   - Authority/ programmatic staff to maintain and manage.

   Fiscal Impact:

   - There will likely be a fiscal impact to the state general fund or other state funds. The state would incur expenses to purchase a software platform and have ongoing costs relating to an annual subscription fee. The DOH provided a budget proposal for a software platform at $100,000 and annual ongoing costs of $75,000. It is unclear at this time if DOH would need additional staff.

5. **Workforce workgroup recommends the Department of Health, Labor and Regulation, the Board of Nursing, Technical Colleges, and Tribal Colleges continue efforts to create more opportunities for needed healthcare apprenticeships.**

   Healthcare apprenticeships have been implemented in other states. As this report has stated multiple times, the long-term care faces several problems. Apprenticeships provide income and course credit to students, on the job.

   South Dakota does not have apprenticeships in healthcare. Healthcare requires clinicals, which are hands on experience, as part of the coursework. This, however, is not paid. For students unsure of whether they can afford to put time into something without being paid, participating in a clinical that is also a registered

apprenticeship can offer a solution. Currently, these apprenticeships are funded through a grant from the federal Department of Labor. One state currently doing this is Texas.

South Dakota currently is working on a program run by Lake Area Tech containing aspects of this idea. It is not currently available as part of accredited coursework. Rather, it is approved as a *Clinical Enrichment Program* meaning that the student is supervised, and in a healthcare facility. The student can be paid. This is subject to an agreement between the student and the facility; the Board of Nursing is not involved. Should the idea of a federally registered apprenticeship take hold, this program might serve as a pilot.

Fiscal Impact:

- There is likely no fiscal impact to the state general fund or other state funds. This apprenticeship recommendation would likely be funded with a federal grant.

6. **Workforce workgroup recommends legislation to join compacts for APRN, social workers, counselors, and psychologists.**

   The workforce workgroup recommends the state of South Dakota pass legislation to join interstate compacts licensing APRNs, social workers, psychologists, and counselors. This increased flexibility accommodates increased rates of moving and anticipates federal support of these initiatives. Rural healthcare, and e-healthcare providers, can make good use of these initiatives as well. The Board of Nursing has expressed an ongoing commitment to keep standards in nursing education at the present levels, and compacts do not inherently jeopardize this.

   Fiscal Impact:

   - Implementing compacts will likely reduce other fund fee revenue for the state. It is likely fewer people from out of state will be paying fees to be licensed in SD with compacts in place.

APRN compact					
% in SD		*APRNs in 2023*		**245,480**	Revenue without joining compact
68.42%	In-State	1,768		**167,960**	Revenue retained after joining
31.58%	Out of State	816		**77,520**	Revenue lost after joining

$95	*Fee revenue per APRN per year*

7. **Workforce workgroup recommends the Dakota Corps and Build Dakota Scholarship Boards include long-term workforce and behavioral health for traditional and non-traditional students in their scholarships.**

   The Dakota Corps and Build Dakota Scholarships have been instrumental in bringing traditional candidates into the healthcare workforce and have been effective at recruiting and retaining nontraditional candidates. The Workforce Workgroup supports the expansion of these efforts.

   The Dakota Corps program funds post-secondary education, contingent on the individual remaining in SD for three years after graduating. Individuals entering what the Board of Regents (BOR) refers to as "critical need occupation(s)" are overtly prioritized via this program. The Build Dakota program partners with employers on a per student basis, with the student's education partially paid by the employer, with the expectation the student will come work for the employer, using the degree, post-graduation.

Fiscal Impact:

- There is likely no fiscal impact to the state general fund or other state funds.

8. **Workforce workgroup recommends an elderly waiver in long-term care for adult daycare in other licensed healthcare facilities.**
   - South Dakota can use a §1915(c) Medicaid waiver similar to the Elderly Waiver in MN (0025.R09.00) to allow licensed nursing home or assisted living facilities to take five or fewer people, who are neither residents nor patients, as adult daycare recipients. This option would be available to all licensed facilities in South Dakota. This could diversify revenue streams for smaller facilities and could allow increased revenue without increasing proportionally the required number of skilled nursing staff. The Minnesota statute focuses on small facilities and makes small changes to them by adding only up to five people per facility. Additionally, the reimbursement rate for adult day care is lower than for nursing care. For facilities not using available space because of staffing issues, this offers a way to use space and generate revenue while not increasing the need for skilled nursing staff.

     South Dakota DHS like Minnesota has a Medicaid wavier in place in long term care. It is called the HOPE waiver in SD. Title III funding may be available for adult day services provided in Assisted Livings and Nursing home settings, with no maximum limit of residents. The providers must be contracted with DHS and meet all appliable provider provisions (which includes a staffing minimum).

     Adult day services are also available through the HOPE Waiver; however, due to the CMS HCBS Final Settings Rule, the HOPE waiver funds may not be utilized to pay for adult day services in nursing homes. Adult day services may be provided in assisted livings to HOPE waiver participations as longs as the assisted living is determined compliant with the HCBS Settings Final Rule and the provider is contracted with DHS.

     Fiscal Impact:

     - There would likely be a fiscal impact of state general funds for this recommendation as there could be increased utilization of the adult day services rate. The rate for adult day services is $14.12 per hour. The analysis below assumes various utilization rates for a facility. The number of facilities implementing the recommendation is not predictable, which is why the cost is provided on a facility basis. It is unclear if this recommendation would increase utilization, shift utilization, or a combination of both. Expenses for this recommendation would be paid from state general funds and federal funds, separated out in the chart below.

Fiscal impact of Elderly Waiver-style 1915(c) Adult Day in licensed facilities					
Assumed Utilization (people/day)	Adult Day Services Rate	Assumed Utilization (weeks)	Weekly Funding per Facility	Total Funds Needed per Facility	State General Funds Needed per Facility	Federal Funds Needed
5	$ 14.12	52	$ 2,824	$ 146,848	$ 68,211	$ 78,637
5	$ 14.12	26	$ 2,824	$ 73,424	$ 34,105	$ 39,319
2.5	$ 14.12	52	$ 1,412	$ 73,424	$ 34,105	$ 39,319
2.5	$ 14.12	26	$ 1,412	$ 36,712	$ 17,053	$ 19,659
1.25	$ 14.12	52	$ 706	$ 36,712	$ 17,053	$ 19,659
1.25	$ 14.12	26	$ 706	$ 18,356	$ 8,526	$ 9,830

9. **Workforce workgroup recommends changing critical teaching scholarship to critical workforce scholarship.**

   The workforce workgroup recommends expanding the awarding of scholarships to a broader set of critical workforces including those in long-term care.

   The critical teaching scholarship was established during the 2013 Legislative Session under Senate Bill 233. The purpose of the program is to encourage South Dakota's high school graduates to obtain their postsecondary education in South Dakota for teaching, to remain in the state upon completion of their education, and to contribute to the state and its citizens by working in a critical need teaching area. The South Dakota Critical Teaching Needs Scholarship Program shall be administered by the Critical Teaching Needs Scholarship Board. The secretary of education shall routinely collect data from school districts to determine the critical need teaching areas, and the board shall use this data when selecting eligible critical need teaching areas. The Board of Regents has been appointed to provide administrative support to the board and the scholarship program. The workforce workgroup recommends the scholarship be expanded to a broader critical workforce.

   Fiscal Impact:

   - There is likely no fiscal impact to the state general fund or other state funds as the workgroup did not recommend any changes to the amount of funding for the scholarship.

10. **Innovation workgroup recommends the state study and support a state program of all-inclusive care for the elderly (PACE) program.**

    A Medicare program and Medicaid state option provides community-based care and services to people 55 or older who otherwise would need a nursing home level of care. PACE covers all Medicare- and Medicaid-covered care and services, and anything else the health care professionals in your PACE team decide you need to improve and maintain your health. This includes prescription drugs and any medically necessary care.

    Resources Needed:

    - Fund a study to assess the feasibility of PACE program in South Dakota for approximately $65,000.
    - Add language to SDCL and Administrative Rules for PACE programs.
    - Amend the State Medicaid Plan to elect PACE as a voluntary state option and seek CMS approval.

    Fiscal Impact:

    - There will likely be a fiscal impact to the state general fund or other state funds associated with studying and implementing a state PACE program. State general funds or other state funds in the amount of $65,000 could be needed to complete a feasibility study of implementing a PACE program in South Dakota. A feasibility study would likely identify the state costs for implementing the program. It is unknown what the cost for implementing a state PACE program would cost.

11. Innovation workgroup recommends funding for technology grants.

Technology is one of the key factors that will help long term facilities to care for more patients using less resources. This can include telehealth, health and position monitoring, and remote room control including windows and lights. Technology grants would allow providers to apply for money to add impactful technology for their staff and residents. The appropriation would go to the Department of Human Services who would assess proposals for use of the technology grants. The grants would then go to any long-term facilities following a successful application. The Department of Human Services would be required to give regular reports on who is using the grants and how the grants are being used. Improvements in technology can help long-term facilities monitor patients using less resources while improving the patients in long term care.

Resources Needed:

- Special appropriation bill outlining the proposal and how the moneys can be used.

Fiscal Impact:

- Based on the recommendation from the workgroup, state general funds of $5.0 million would be needed to administer and award technology grants for long-term care providers.

12. Innovation workgroup recommends improving the Dakota at Home resources registry.

The Dakota at Home registry is a service anyone in South Dakota can use to find specific services for long term care. The workgroup identified for the registry to be effective, it needs to be up to date and easy to use and the Dakota at Home registry is not up to date and lacks search functionality. The workgroup recommends an appropriation to the Department of Human Services (DHS) to allow the department to contract with a vendor to create a registry to improve the current Dakota at Home registry. The improvements include a continuously updated list of services and a searchable database.

Fiscal Impact:

- There would likely be no fiscal impact to the state general fund or other state funds. DHS currently publishes the registry on its website, there is a searchable resource directory, and there is a software vendor supporting the updating of the registry. The information in the resource registry is updated annually via a contracted vendor, or upon request by a provider. DHS indicates no additional moneys are needed currently.

13. Innovation workgroup recommends a study to address add-on payments and behavior program concerns.

Currently, facilities are provided compensation for taking on extraordinary patients who would otherwise go to the Human Services Center. This program is underutilized with about 140 residents using the program. The recommendation requires DHS to provide a report on utilization, rates, barriers to utilization, and any recommendation to improve and streamline the process. By understanding the rates and identifying the problems, the Legislature can enact solutions to those problems.

Resources Needed:

- Legislation requiring DHS to provide an annual report to the legislature on the utilization and rates of add-on payments for extraordinary care and behavior programs.

Fiscal Impact:

- There would likely be no fiscal impact to the state general fund or other state funds. There could be an opportunity cost of time as a state employee(s) would spend time on this instead of other work.

14. **Regulatory workgroup recommends having a round table discussion with members of the South Dakota delegation in Washington on federal regulations impacting South Dakota facilities.**

    The committee would extend an invitation to the South Dakota representatives in D.C. to take part in the next committee meeting to discuss issues coming up with federal regulations. A resolution could be drafted which address concerns from all the workgroups regarding federal regulations impacting South Dakota facilities. Addressing telehealth services is of a high importance, as well as addressing proposed federal regulation changes to require a minimum staffing rule where a registered nurse would need to be on site 24/7. Bringing these issues to the attention of the state's D.C. representation could bring these concerns to the forefront of the representatives' attention and possible reform.

    Resources Needed:

    - Dialog and coordination with stakeholders to schedule a meeting to discuss issues with federal regulations.

    Fiscal Impact:

    - There would likely be no fiscal impact to the state general fund or other state funds.

15. **Regulatory workgroup recommends increasing the amount permitted for the personal needs allowance (PNA) under SDAR 67:46:06:05.**

    The workgroup heard concerns by family members of Medicaid recipients regarding the current amount of personal needs allowance is believed to be insufficient to meet the personal needs of the recipients. The workgroup recommends increasing the personal needs allowance. The current personal needs allowance amount set under SDAR 67:46:06:05 is $60 and was last adjusted in 2004. The national average amount set for PNAs is $62 per month, with South Dakota having the 20th highest PNA. The allowance may be used by recipients toward personal items and services, such as clothing, shoes, snacks, haircuts, toiletries, and cell phone bills. A recipient's allowance cannot be used toward items or services paid for by Medicaid. An increase in the amount could help ensure the personal needs of elderly residents are being met without needing to be supplemented by family members or staff in the facilities where the residents live.

    Resources Needed:

    - Rule change to change South Dakota's personal needs allowance, a change would need to be made to SDAR 67:46:06:05.

    Fiscal Impact:

    - There could likely be a cost of $217,256 to $869,025 to the state general fund depending on the increase in the personal needs allowance. The following tables provide the PNA increase amount and state general fund cost for assisted living and skilled nursing facilities.

Assisted Living PNA					
PNA Amount	$ 60	$ 70	$ 80	$ 90	$ 100
PNA Increase	$ -	$ 10	$ 20	$ 30	$ 40
Monthly Avg. # of Waiver Clients	757	757	757	757	757
Additional General Funds Needed	**$ -**	**$ 90,840**	**$ 181,680**	**$ 272,520**	**$ 363,360**

Skilled Nursing PNA					
PNA Amount	$ 60	$ 70	$ 80	$ 90	$ 100
PNA Increase	$ -	$ 10	$ 20	$ 30	$ 40
Monthly Avg. $ of Waiver Clients	2,340	2,340	2,340	2,340	2,340
Additional Total Funds Needed	-	280,800	561,600	842,400	1,123,200
Additional Federal Funds Needed		$ 154,384	$ 308,768	$ 463,152	$ 617,535
Additional General Funds Needed	**$ -**	**$ 126,416**	**$ 252,832**	**$ 379,248**	**$ 505,665**

Total Dollars Needed					
PNA Amount	$60	$70	$80	$90	$100
PNA Increase	$ -	$10	$20	$30	$40
Additional Total Funds Needed	-	371,640	743,280	1,114,920	1,486,560
Additional Federal Funds Needed		$154,384	$308,768	$463,152	$617,535
Additional General Funds Needed	**$ -**	**$217,256**	**$434,512**	**$651,768**	**$869,025**

16. **Community-based services workgroup recommends DHS amend and expand in-home services and establish new reimbursement rates.**

    These changes would provide individuals with more support at home, offer greater staff flexibility, and offer home care providers reimbursement for new services or services already being provided.

    Resources Needed:

    - Amend state Medicaid plan to provide a medication aide rate and allow virtual supervision of medication aide services. Currently no rate exists to reimburse medication aide services (except the personal care rate) and nurses are performing the services a medication aide is qualified to provide. Administrative rule 20:48:04.01:09.01 allows for the delegation of medication administration tasks to a nursing assistant and administrative rule 20:48:04.01:09 provides the requirements for delegating medication administration to a nursing assistant. Administrative rule 20:48:04.01:18 allows for the administration of one specific medication for someone who has not met the requirements of the previous rule.
        - Fiscal Impact: There likely could be State savings associated with this change if providers utilize the personal care rate instead of the LPN or RN rate. The State could see a general fund savings of $3.53 to $5.20 per billing instance of 15 minutes. At this time, we are unable to estimate the number of times this may occur as it is unclear how providers will utilize non-licensed aides with medication administration training.

    - Amend State Medicaid plan to provide mileage reimbursement for home care providers providing patient transportation services for medical appointments, assisting with living errands (groceries, hair care, other appointments), etc. Currently home care providers are doing these services and not receiving direct reimbursement.

- Fiscal Impact: This fiscal analysis looks at increasing the mileage reimbursement component by 100%. Other amounts can be calculated by taking a percent of the increase. An increase in general fund of $127,333 could result from an increase of 100% in the mileage reimbursement component; however, this does not consider growth in billed units. The current Nursing RN and LPN, homemaker, and personal care rates include a mileage component built into the rate. The current mileage component adds $1.79 for nursing and $1.48 for non-nursing to the overall rate. An increase of 100% of the current amount would add an additional $1.79 or $1.48 of mileage reimbursement on top of the existing mileage built into the rate now.

Bill Code	Service	Times Billed in FY23	Assumed Increased	State General Funds Needed	Federal Funds Needed	Total Funds Needed
Multiple	Homemaker	134,797	$ 1.48	$ 131,193	$ 68,292	$ 199,485
T1019	Personal Care	93,999	$ 1.48	$ 64,621	$ 74,498	$ 139,119
S5125	Personal Care	40,263	$ 1.79	$ 33,477	$ 38,594	$ 72,071
T1000	Nursing RN/LPN	34,999	$ 1.79	$ 29,100	$ 33,548	$ 62,648
				$ 258,391	**$ 214,932**	**$ 473,322**

- Amend DHS in-home services provider provisions to offer greater unit flexibility for unexpected/urgent situations. Providers receive authorization to perform services in fifteen minute "units," and may only "spend" the number of units authorized. Example: A provider is authorized for 12 units for a client's weekly house cleaning. After the 12 units are completed during the week, the client has an accident requiring further house cleaning, which takes an additional 4 units. Currently, a provider can be authorized for the additional 4 units by contacting the LTSS Service Coordinator, but the provider must notify by the next business day, or the additional units will not be approved and may not be billed.
    - Fiscal Impact: There is likely a minimal cost in state general funds regarding this change and the cost will depend on utilization by providers and the service (nursing, homemaker, personal care) rate billed to the State. The table below assumes an increase in utilization of 1% for billed units of each service.

Bill Code	Service	Times Billed in FY23	FY24 Rate	Utilization Increase	State General Funds Needed	Federal Funds Needed	Total Funds Needed
Multiple	Homemaker	134,797	$ 10.22	1.0%	$ 9,060	$ 4,716	$ 13,776
T1019	Personal Care	93,999	$ 10.22	1.0%	$ 4,462	$ 5,144	$ 9,607
S5125	Personal Care	40,263	$ 10.22	1.0%	$ 1,911	$ 2,204	$ 4,115
T1000	Nursing RN	34,999	$ 21.42	1.0%	$ 2,612	$ 3,011	$ 5,623
T1000	Nursing LPN		$ 17.82	1.0%	$ 724	$ 835	$ 1,559
					$ 18,770	**$ 15,910**	**$ 34,680**

- Eliminate duplicative DHS assessments and agency/provider assessments. When an individual applies for DHS services, DHS completes an assessment to determine if the individual is eligible for services. Thereafter, if/when DHS refers the individual to a provider for services, the provider will complete their own assessment of the individual and their living arrangements.

- Fiscal Impact: There is likely no cost to the State regarding this change. Providers are likely to continue to perform the assessments regardless of whether they are required or not for liability reasons. The State cannot rely on an assessment done by a provider.

- Establish a centralized location for bathing assistance and nail care to reduce the number of individual visits and improve efficiency.
    - Fiscal Impact: There is likely no cost to the State associated with this change as the same number of services are likely to be utilized. Though not reimbursable through the homemaker program, nail and hygiene care is available at central locations and is reimbursable through adult day services.

- Establish in rule an aide rate for nail care services. Providers indicate only nurses are performing nail care due to diabetes/wound concerns and liability issues. While there is no rule that specifically states an unlicensed aide may provide nail care, such care is not explicitly disallowed--see ARSD 20:48:04.01:07, listing nursing tasks that may not be delegated. Nail care is not among those included. A non-licensed aide can provide nail care services at the personal care rate.
    - Fiscal Impact: There is likely to be State savings associated with this change if providers utilize the personal care rate instead of the LPN or RN rate. The State could see a general fund savings of $3.53 to $5.20 per billing instance of 15 minutes. At this time, we are unable to estimate the number of times this may occur as it is unclear how providers will utilize non-licensed aides to provide nail care services.

- Amend state Medicaid plan to provide urban and rural reimbursement rates for homecare providers to compensate for additional travel time and mileage in rural settings. For example, a provider based in Mitchell is dispatched to Gregory. The provider does not receive additional mileage reimbursement or dollars for the additional time spent traveling outside of the Mitchell area.
    - This fiscal analysis looks at increasing the mileage reimbursement component by 100%. Other amounts can be calculated by taking a percent of the increase. An increase in general funds of $258, 391 could result from an increase of 100% in the mileage reimbursement component; however, this does not consider growth in billed units. The current Nursing RN and LPN, homemaker, and personal care rates include a mileage component built into the rate. The current mileage component adds $1.79 for nursing and $1.48 for non-nursing to the overall rate. An increase of 100% of the current amount would add an additional $1.79 or $1.48 of mileage reimbursement on top of the existing mileage built into the rate now.
    - More time and data are needed to establish a rural mileage rate. A rural mileage rate could be established, and then allocated, by designing a formula factoring in zip code, GPS location of zip code, and population of zip code, all compared against its neighbors within a specific radius. This formula could generate a single numeric score for each zip code and establish where within the resulting range of scores does a particular zip code become rural.

17. **Community-based services workgroup recommends DHS provide greater reimbursement for remote patient monitoring services.**

    Remote patient monitoring is a healthcare delivery method using technology to monitor patient health outside of a traditional clinical setting by electronically transmitting information between patients and

providers. Commonly used devices include glucose monitors, blood pressure cuffs, scales, and wearable activity trackers tracking steps, heart rate, fall risk, or sleep. Providing reimbursement for these types of remote patient monitoring devices would encourage greater implementation of the technology and allow more individuals to stay in their home and improve access to in-home services in rural areas.

Resources Needed:

- Amend state Medicaid plan to provide more robust reimbursement rates for remote patient monitoring services, including sensor technologies, vital readings, etc.
- Provide more education and clearer guidelines to providers on what telehealth and home modifications can currently be reimbursed.

Fiscal Impact:

- There is likely to be an increase in state general funds for remote patient monitoring services. It is likely in-home providers will begin to bill for remote patient monitoring services as this likely qualifies as specialized medical equipment and supplies (billing code T2029 and T5999). The table below provides the expected cost to the State assuming a 50% increase in utilization but does not consider growth in billing.

Bill Code	Item	Times Billed in FY23	Assumed Utilization Increase	Avg. Cost per Item Billed	State General Funds Needed	Federal Funds Needed	Total Funds Needed
T2029	Specialized Medical Equip	306	50%	$ 288.12	$ 20,476	$ 23,606	$ 44,082
T5999	Specialized Medical Supplies	44	50%	$ 66.14	$ 676	$ 779	$ 1,455
					$ 21,152	**$ 24,385**	**$ 45,537**

18. Community-based services workgroup recommends DHS provide additional education on and increase public awareness of the Structured Family Caregiving program.

The Structured Family Caregiving program provides a stipend and ongoing coaching and oversight for a family member who cares for an individual in the individual's home or in the caregiver's home. To qualify for Structured Family Caregiving, the individual must be age 65 or older or age 18 or older with a disability, live in their own home or in the caregiver's home, and qualify for the HOPE waiver. Currently the program is underutilized, with only 361 caregivers receiving the stipend in FY23. Many individuals are likely providing care that would otherwise qualify for the Structured Family Caregiving program. Increasing advertising and public awareness of the Structured Family Caregiving program would help support current and future in-home care and meet client needs.

Resources Needed:

- Provide more education and outreach on the Structured Family Caregiving program.

Fiscal Impact:

- There is likely no fiscal impact to the state general fund or other state funds as the workgroup did not recommend any changes to the amount of funding. There may be a fiscal impact associated

with this recommendation as it could be an opportunity cost of time as a state employee(s) would spend time on this instead of other work.

19. Community-based services workgroup recommends DHS establish new eligibility for community support provider services for traumatic brain injury patients over age 22.

Per federal regulation, individuals with a traumatic brain injury (TBI) do not qualify for Medicaid coverage unless the TBI occurs before age 22. Therefore, TBI patients whose injury occurred on or after their 22nd birthday are not eligible for community support provider (CSP) services in South Dakota. Currently, the only TBI facilities in South Dakota are Sunset Manor Avera in Irene (8 beds) and Brown Health Program in Rapid City (3 beds). If TBI patients became eligible for Medicaid CSP services, more TBI services could be offered throughout the state. DHS served 1,300 people with an acquired brain injury during FY22 with some being care for out of state. It is unknown how many people with a TBI are not served by DHS today. DHS is currently partnering with USD – Center of Disabilities on a survey of TBI survivors and their families to get more information on any existing service gaps and to find pertinent solutions.

Resources Needed:

- Establish a new 1915(c) HCBS waiver for adult TBI patients - requires approval from CMS. Other states offering adult TBI waivers include Indiana, Massachusetts, Minnesota, Mississippi, Nebraska, New York, North Carolina, and West Virginia.

Fiscal Impact:

- There is likely to be State savings associated with this recommendation because instead of most of the costs billed to state general funds, 46.5% of the cost would be billed to state general funds and the remainder to Medicaid. Currently, we are unable to estimate the dollar amount as we did not receive information on the expenses of TBI patients. However, there could be considerable savings considering the number of patients and expense for treating TBI patients.

20. Community-based services workgroup recommends DHS update Dakota@Home processes.

The workgroup concluded the below changes would help streamline the Dakota@Home process, reduce redundancies between providers and agencies, and provide greater clarity for Dakota@Home users.

Resources Needed:

- Eliminate duplicative DHS assessments and agency/provider assessments.
- Include a waiver for release of information for agencies so the agency can continue to assist clients with best referred services.
- Provide greater transparency in the Dakota@Home process so providers and clients can see where an individual is at in the process.
- Integrate advance care planning duties to allow case managers to secure appropriate documents for clients and distribute to all appropriate providers.

Fiscal Impact:

- There would be a fiscal impact to Implement a software system to allow transparency to citizens in the long-term care application process. The cost and time associated is unknown. There would be a significant increase in resources needed for case managers to add advance care planning duties, such as securing appropriate documents and distributing to providers. Further, who assumes the responsibility/liability when the client updates those documents.

21. Community-based service workgroup recommends draft legislation regarding palliative care.

Palliative care is medical care for individuals living with a serious illness. Palliative care is focused on providing relief from the symptoms and stress of illness with the goal of improving quality of life for both the patient and family. Effective palliative care is delivered by a trained team of doctors, nurses, social workers, chaplains, and other health professionals who collaborate to provide an extra layer of support. Based on the needs of the patient, not on prognosis, palliative care is appropriate at any age and any stage of serious illness and may be provided alongside curative treatments in primary and specialty settings.

Palliative care is not hospice care. Hospice is specialized medical care for people with a life-limiting illness who are no longer seeking curative treatment and their caregivers. Per Medicaid definition, hospice is provided to an individual whose doctor believes has six months or less to live if the illness runs its natural course.

Community-based palliative care is interdisciplinary team care provided wherever a person with a serious illness calls home, or in a clinic setting. Currently, interdisciplinary team palliative care is not reimbursed under South Dakota Medicaid. Providing home-based interdisciplinary team palliative care to LTSS waiver and Medicaid recipients living with serious illness would improve quality of life and reduce stress on patients and caregivers and reduce Medicaid expenditures through reduction in hospitalization and ER visits. Several states have implemented palliative care benefits into their respective state Medicaid plans.

Resources Needed:

- Legislation defining palliative care in state regulations, with the definition including entire interdisciplinary team, *i.e.*, physician, advance practice provider, registered nurse, social worker, and chaplain, in order to appropriately reimburse the entire team.
    - Thereafter, the state can make amendments to state waivers or other provider payment methods to incorporate reimbursement for palliative care, provided by an interdisciplinary team.
- Existing billing codes within the state plan should be defined differently to be improve utilization and promote access to palliative care services, and other codes not currently covered in South Dakota should be incorporated in the Medicaid fee schedule.

Fiscal Impact:

- There could be a considerable fiscal impact to state general funds as the recommendation provides adding palliative care services not currently part of the State Medicaid Plan. The cost to the state will depend on the utilization of palliative care services in a long-term care setting. This analysis uses the amount of clients in skilled nursing facilities, assumes a 50% utilization rate, uses cost data from two states offering palliative care services, and provides the cost based on the current FMAP. The utilization of services and billed services should be research further to identify a more exact cost estimate.

Palliative Care Fiscal Impact Estimate					
Skilled Nursing Facility Clients	Assumed Palliative Care Utilization	Assumed Annual Billed Services per Client	Total State Expenses	State General Funds Needed	Federal Funds Needed
2,645	100%	$10,024	$ 26,514,009	$ 12,315,757	$ 14,198,252
2,645	50%	$10,024	$ 13,257,005	$ 6,157,879	$ 7,099,126
2,645	25%	$10,024	$ 6,628,502	$ 3,078,939	$ 3,549,563
2,645	10%	$10,024	$ 2,651,401	$ 1,231,576	$ 1,419,825

22. Location & infrastructure workgroup proposes a bill to amend the eligibilities for designation as a regional nursing facility and applicable reimbursement.

Nursing facilities are not presently reimbursed in a way allowing them to cover necessary capital costs, restricting their ability to update and improve their infrastructure. As of July 1, 2023, capital costs are limited to $20.95 per resident per day under Medicaid. For a facility with 60 residents on average, capital cost reimbursement would total $458,805 a year. Currently, each new nursing home room (with a single bed) costs approximately $300,000 to construct. For a facility to meet the minimum economies of scale to operate long-term, rooms for at least 60 beds are recommended. Thus, a new facility built to minimum efficiency would cost around $18 million.

The workgroup identified revamping the regional nursing facility model to address capital cost concerns. The potential changes would incentivize the construction of newer facilities by having the Department of Human Services (DHS) reimburse the full capital costs of constructing/remodeling, including equipment and furniture, a nursing facility over a period of around 30 years.

- SDCL 34-12-35.12 (enacted in 2021) sets out the process for designation as a regional nursing home. Upon approval after meeting five statutory criteria and completion of required construction/remodeling, the DHS shall designate the facility as a regional nursing facility. The only benefit from this process is ongoing Medicaid reimbursement in accordance with the regional nursing facility rate methodology. The rate incentives received for a regional nursing facility are the same received by access critical nursing facilities, but the latter designation does not require new construction or other capital expenditures (12 nursing homes are now designated as access critical). Yet, such financial incentives are not enough to stave off potential shortfalls, with the nursing facility in Martin closing this past year despite being an access critical nursing facility. While no facilities have yet been designated as regional nursing facilities, one application has been submitted to date.

- The current criteria for regional nursing home designation are:
  1. Be enrolled and in good standing with South Dakota Medicaid;

  2. Provide home and community-based services in the region through an affiliation or a contractual arrangement;

  3. Demonstrate intent to construct a new nursing facility or to substantially remodel an existing facility, upon merging with one or more health care facilities within a thirty-mile radius;

  4. Demonstrate that the newly constructed nursing facility or the substantially remodeled facility will:
     - Support a homelike environment with a cluster, neighborhood, or household model layout;
     - Contain single occupancy rooms and toilet areas;
     - Abide by best practices regarding infection control and prevention;
     - Allow for private visitation; and
     - Support other best practices related to aging; and

  5. Meet any other criteria set forth in rules promulgated by the department for the implementation of this section.

- The workgroup recommends changing the criteria for regional facility designation to the following:
    1. Be enrolled and in good standing with South Dakota Medicaid;

    2. Provide home and community-based services in the region through an affiliation or a contractual arrangement;

    3. Demonstrate intent to construct a new nursing facility or to substantially remodel an existing nursing facility, upon merging with one or more nursing facilities within a sixty-mile radius, unless no other nursing facilities exist within a sixty-mile radius;

    4. Demonstrate that the newly constructed or substantially remodeled nursing facility will:
        - Support a homelike environment;
        - Support access to a continuum of care;
        - Abide by best practices regarding infection control and prevention;
        - Allow for private visitation; and
        - Support other best practices related to aging to meet current market needs;

- Further, the DHS would reimburse regional nursing facilities for allowable capital costs to construct or substantially remodel the regional nursing facility and make rules establishing application procedures, defining allowable capital costs, and establishing the method for reimbursing allowable capital costs.

- It is currently unknown how many nursing facilities in the state would take advantage of this opportunity, but current market conditions suggest high potential for use. About 70 nursing homes are currently over 40 years of age. And as of July 1, 2023, capital costs are limited to $20.95 per resident per day under Medicaid. For a facility with 60 residents on average, capital cost reimbursement would total just $458,805 a year. This designation/reimbursement process is not intended to choose winners and losers; rather, nursing facilities interested in merging would bring their proposal to the DHS, with all proposals meeting the necessary criteria receiving reimbursement for their capital costs.

Resources Needed:

- A bill would need to be drafted amending SDCL 34-12-35.12 to reflect the changes to the designation eligibilities, process, and reimbursement. Ongoing funding will be needed in the DHS's budget to cover the reimbursement for newly designated regional nursing facilities. The amount of funding depends on how many facilities are expected to merge. The fiscal impact of this recommendation is explained below.

Fiscal Impact:

- Below are charts showing the additional ongoing cost needed to cover any number of potential mergers from 1 to 20.

  - The costs outlined below show the state and federal moneys needed for the first 7 years. These cost numbers do not consider expected savings due to improved economies of scale realized through the mergers. The ongoing cost to the state assumes the state share of FMAP is 46.45%.

  - The costs outlined below show the **total** costs, including both state **and** federal moneys, needed each year for the first 7 years and then each year for the following 23 years. This difference in cost between the first 7 and following 23 years assumes 22% of new building costs will be for furniture/equipment, and such costs would depreciate over 7 years instead of 30 years.

Mergers	Add. General Ongoing Cost (Y 1-7)	Add. Fed. Ongoing Cost (Y 1-7)	Total State Ongoing Cost (Y 1-7)
1	$ 480,160	$ 553,554	$ 1,033,714
2	$ 960,321	$ 1,107,108	$ 2,067,429
3	$ 1,440,481	$ 1,660,662	$ 3,101,143
4	$ 1,920,641	$ 2,214,216	$ 4,134,857
5	$ 2,400,801	$ 2,767,770	$ 5,168,571
6	$ 2,880,962	$ 3,321,324	$ 6,202,286
7	$ 3,361,122	$ 3,874,878	$ 7,236,000
8	$ 3,841,282	$ 4,428,432	$ 8,269,714
9	$ 4,321,443	$ 4,981,986	$ 9,303,429
10	$ 4,801,603	$ 5,535,540	$ 10,337,143
11	$ 5,281,763	$ 6,089,094	$ 11,370,857
12	$ 5,761,923	$ 6,642,648	$ 12,404,571
13	$ 6,242,084	$ 7,196,202	$ 13,438,286
14	$ 6,722,244	$ 7,749,756	$ 14,472,000
15	$ 7,202,404	$ 8,303,310	$ 15,505,714
16	$ 7,682,565	$ 8,856,864	$ 16,539,429
17	$ 8,162,725	$ 9,410,418	$ 17,573,143
18	$ 8,642,885	$ 9,963,972	$ 18,606,857
19	$ 9,123,045	$ 10,517,526	$ 19,640,571
20	$ 9,603,206	$ 11,071,080	$ 20,674,286

Mergers	Add. Ongoing Cost (Y 1-7)	Add. Ongoing Cost (Y 8-30)
1	$ 1,033,714	$ 468,000
2	$ 2,067,429	$ 936,000
3	$ 3,101,143	$ 1,404,000
4	$ 4,134,857	$ 1,872,000
5	$ 5,168,571	$ 2,340,000
6	$ 6,202,286	$ 2,808,000
7	$ 7,236,000	$ 3,276,000
8	$ 8,269,714	$ 3,744,000
9	$ 9,303,429	$ 4,212,000
10	$ 10,337,143	$ 4,680,000
11	$ 11,370,857	$ 5,148,000
12	$ 12,404,571	$ 5,616,000
13	$ 13,438,286	$ 6,084,000
14	$ 14,472,000	$ 6,552,000
15	$ 15,505,714	$ 7,020,000
16	$ 16,539,429	$ 7,488,000
17	$ 17,573,143	$ 7,956,000
18	$ 18,606,857	$ 8,424,000
19	$ 19,640,571	$ 8,892,000
20	$ 20,674,286	$ 9,360,000

- Below are the same charts showing the additional ongoing cost needed to cover mergers with reimbursement based on the number of Medicaid beds. According to available data (which includes 2023 survey results from about 1/3 of nursing facilities in the state), 50.19% of all nursing facility beds hold Medicaid patients. While these costs represent an average per merger, the actual cost of each merger would depend on the up-to-date Medicaid bed data for the nursing facilities merging.

Mergers	Add. General Ongoing Cost (Y 1-7)	Add. Fed. Ongoing Cost (Y 1-7)	Total State Ongoing Cost (Y 1-7)
1	$ 247,763	$ 285,634	$ 533,397
2	$ 495,525	$ 571,268	$ 1,066,793
3	$ 743,288	$ 856,902	$ 1,600,190
4	$ 991,051	$ 1,142,535	$ 2,133,586
5	$ 1,238,814	$ 1,428,169	$ 2,666,983
6	$ 1,486,576	$ 1,713,803	$ 3,200,379
7	$ 1,734,339	$ 1,999,437	$ 3,733,776
8	$ 1,982,102	$ 2,285,071	$ 4,267,173
9	$ 2,229,864	$ 2,570,705	$ 4,800,569
10	$ 2,477,627	$ 2,856,339	$ 5,333,966
11	$ 2,725,390	$ 3,141,973	$ 5,867,362
12	$ 2,973,152	$ 3,427,606	$ 6,400,759
13	$ 3,220,915	$ 3,713,240	$ 6,934,155
14	$ 3,468,678	$ 3,998,874	$ 7,467,552
15	$ 3,716,441	$ 4,284,508	$ 8,000,949
16	$ 3,964,203	$ 4,570,142	$ 8,534,345
17	$ 4,211,966	$ 4,855,776	$ 9,067,742
18	$ 4,459,729	$ 5,141,410	$ 9,601,138
19	$ 4,707,491	$ 5,427,043	$ 10,134,535
20	$ 4,955,254	$ 5,712,677	$ 10,667,931

Mergers	Add. Ongoing Cost (Y 1-7)	Add. Ongoing Cost (Y 8-30)
1	$ 533,397	$ 241,488
2	$ 1,066,793	$ 482,976
3	$ 1,600,190	$ 724,464
4	$ 2,133,586	$ 965,952
5	$ 2,666,983	$ 1,207,440
6	$ 3,200,379	$ 1,448,928
7	$ 3,733,776	$ 1,690,416
8	$ 4,267,173	$ 1,931,905
9	$ 4,800,569	$ 2,173,393
10	$ 5,333,966	$ 2,414,881
11	$ 5,867,362	$ 2,656,369
12	$ 6,400,759	$ 2,897,857
13	$ 6,934,155	$ 3,139,345
14	$ 7,467,552	$ 3,380,833
15	$ 8,000,949	$ 3,622,321
16	$ 8,534,345	$ 3,863,809
17	$ 9,067,742	$ 4,105,297
18	$ 9,601,138	$ 4,346,785
19	$ 10,134,535	$ 4,588,273
20	$ 10,667,931	$ 4,829,761