

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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I. General Provisions

South Dakota Medical Assistance's Managed Care Program, Provider and Recipient in Medicaid Efficiency Program (PRIME), is based on the primary care case management (PCCM) model. The program is operational statewide, is applicable for recipients eligible under Title XIX and Title XXQ of the Social Security Act and is administered by South Dakota Department of Social Services Office of Medical Services (OMS). Reimbursement is based on fee for service plus a monthly case management fee.

The basic concept is to allow Medical Assistance enrollees to select one primary care provider (PCP). The PCP will provide, through an ongoing patient/physician relationship, primary care services and referrals for all necessary specialty services. The PCP is responsible for monitoring the health care and utilization of managed care covered services. All services other than the case management fee are billed and reimbursed to the provider who renders the service.

II. Beneficiaries

A. Population

1. **Mandatory Populations:**
With the exceptions of the excluded and optional populations, the population identified in Supplement 1 is required to participate in the program.
2. **Excluded Populations:**
The populations identified in Supplement 1 as Excluded Populations are not allowed to participate in the program.
3. **Optional Populations:**
The populations identified in Supplement 1 as Optional Populations are not required to participate in the program.
4. **American Indian Mandatory Populations:**
In accordance with 1932(a)(1) and (2) of the Act, permitting mandatory enrollment of Medical Assistance enrollees into the PCCM, OMS assures IHS facilities, Urban Indian Health clinics and tribal clinics that offer primary care within the state will be PCPs, thus allowing American Indians to be mandatory-enrolled.

II. Beneficiaries (continued)

B. Enrollees Defined

1. Potential Enrollees:

Recipients who are required to participate in the PCCM program but are not enrolled with a specific PCP. Potential enrollees are recipients in the process of selecting or being assigned a PCP.

2. Enrollees:

Recipients who are required to participate in the PCCM program and are enrolled with a specific PCP.

C. Beneficiary Information

The State shall ensure that beneficiaries receive information according to 42 CFR 438.10(e). (See **Supplement 2**.) All information materials will be provided according to timeframes described under 42 CFR 438.10(f)(3). Information materials are included with "enrollment packages" described below and are provided at least ten days prior to a recipient's initial requirement to enroll with a PCP.

D. Enrollment Process

The State administers the enrollment process through both the county social services offices and OMS. SSI eligible recipients receive notices and complete enrollment packages directly from OMS. Recipients eligible under programs other than SSI receive notices and complete enrollment packages from their respective county social services offices. All recipients are provided a minimum of ten days to select a PCP before the State will assign a PCP. (See **Supplement 3**.)

E. Enrollment Process

Beneficiaries have specific rights and are required to access managed care services through their PCCM according to program rules. (See **Supplement 4**.)

III. Primary Care Providers (PCPs)

All PCPs must meet provider enrollment conditions and agree to requirements set forth in the *Provider Agreement* and *Addendum to the Provider Agreement*. All PCPs must have a signed *Provider Agreement* and signed *Addendum to the Provider Agreement* on file with OMS. These agreements meet Federal and State contracting requirements.

III. Primary Care Providers (PCPs) (continued)

All Medical Assistance providers are assigned a unique identifier and will be HIPPA compliant when required. The reimbursement methodology (fee-for-service) of South Dakota Medical Assistance Program requires that the provider who actually provides the medical service to be an enrolled provider. Therefore, subcontracting, associations with debarred providers, and associations with providers excluded by Medicare, Medicaid or SCHIP, are not described in this SPA, as all providers eligible for FFP through the Medical Assistance Program must meet provider enrollment requirements.

Providers are notified of procedures for enrollment and re-enrollment, program requirements, and contact provisions. This information is made available through: PCP Introductory Letter, *South Dakota Medicaid Managed Care Provider Manual*, and *Addendum to the Provider Agreement*.

All Federal and State contracting laws and regulations (including SMM 2080) will be followed as they apply to this SPA to ensure compliance with contracting and renegotiating procedures.

A. Reimbursement

PCPs are reimbursed on a fee-for-service basis plus a case management fee. All other providers are reimbursed fee-for-service as long as the services meet program requirements. Management fees are not paid to RHC, FQHC, or IHS facilities, as these expenses are included in the encounter fee paid to these facilities.

B. PCP Requirements

PCPs are required to provide medial care or refer enrolled beneficiaries to other providers for non-exempt covered medical services. (See **Supplement 5**.)

C. Marketing

Direct and indirect marketing activities specifically intended to attract beneficiary enrollment or dis-enrollment with a specific PCP are not allowed.

D. Termination and Dis-enrollments

Terminations: PCPs must inform OMS within 15 days of the next enrollment deadline (first of the next month) of their intent to terminate their PCP agreement.

Dis-enrollments: OMS must receive written notification from a beneficiary's PCP that he/she wishes to terminate the PCP/enrollee relationship. The reason must be approved by OMS, be generally applied by the PCP for all patients regardless of the payer source, and be non-discriminatory. The PCP must ensure access to medical

III. Primary Care Providers (PCPs) (continued)

care until enrollment with a new PCP is established. (See **Supplement 5—PCP Requirements.**)

IV. Services

Services under the plan can be designated under two categories: Managed Care and Exempt.

A. Managed Care Services

Managed care services are covered services that must be provided or referred by the PCP. All covered services identified in section 3.1 of the State Plan are managed care services unless specifically listed as exempt. (See **Supplement 6** for referral requirements.)

B. Exempt Services

Exempt services are covered services that may be provided by any qualified Medical Assistance enrolled provider without a PCP referral. (See **Supplement 7.**)

C. Provider Notifications

The State provides PCPs with periodic information regarding the program in general, and specific information to their caseload. (See **Supplement 8.**)

V. State Monitoring and Interventions

The State conducts a number of activities to ensure that beneficiaries have access to quality medical care and are appropriately enrolled with a qualified PCP.

A. Monitoring

The State conducts activities to monitor the quality and access to covered necessary medical care. (See **Supplement 9.**)

B. Interventions and Sanctions

OMS may conduct a variety of intervention activities and sanctions to ensure that beneficiaries have access to appropriate medical care. (See **Supplement 10.**)

VI. Complaints, Grievances, and Fair Hearings

The State utilizes both informal (internal) and formal (external) grievance and appeals processes.

A. Informal Grievances and Appeals (Internal)

OMS utilizes an informal grievance and appeals process for the PCCM program. (See **Supplement 11.**)

B. Formal Grievances and Appeals (External)

All requests for Fair Hearings are considered formal grievances/appeals and are handled through our Office of Administrative Hearings. Fair Hearings are utilized for department-wide issues and are fully described in Administrative Rule. (See **Supplement 12.**)

VII. Fraud and Abuse

The State produces paid claims reports each month and provides them to PCPs for review. PCPs are instructed to review these reports and report to this office any services that are not authorized by them. Managed care staff investigates all reported services not authorized by PCPs and refer discrepancies to Surveillance Utilization and Review staff (SURS) for further measures.

Managed care staff conduct periodic referral and emergency coding reviews on managed care paid claims. The focus of these reviews is to determine if providers are complying with managed care procedures. Corrective action is initiated for providers not in compliance according to **Supplement 10.**

Provider contact or visits by Managed Care staff as a result of provider claims analysis offers another opportunity for our staff to provide education to our providers and prevent abuse. In addition, SURS conducts a full range of monitoring activities to ensure provider compliance with program rules and regulations as identified in section 4.5 of the State Plan.