HEALTH HOME PROGRAM

OVERVIEW

Health Home is a person-centered care management model designed to address a recipient's medical, behavioral health and social service needs by forming a team of health care professionals around the recipient. Health Home services are provided through a Designated Provider selected by the recipient or assigned by the state. At the center of a Health Home is a dedicated care manager who oversees and coordinates the services a recipient needs for optimal health status.

The Health Home program is one of three South Dakota Medicaid Care Management programs. The other Care Management programs are the Primary Care Provider program and the BabyReady program. Recipients cannot be a part of multiple programs at the same time. Providers are allowed to participate in multiple Care Management programs.

Health Home Program Goals

Goals of the Health Home program include:

- Reducing avoidable health care costs, including preventable hospital admissions/readmissions and avoidable emergency room visits;
- Providing timely post discharge follow-up; and
- Improving patient outcomes by addressing primary medical, specialist, long-term care, home health and behavioral health care needs through direct provision, or through arrangements with appropriate service providers of comprehensive integrated services.

ELIGIBLE PROVIDERS

Designated Provider

Designated providers for Health Homes include providers licensed by the State of South Dakota and enrolled in South Dakota Medicaid, who practice as:

- Primary care physician, (e.g., family practice, internal medicine, pediatrician or OB/GYN); or
- Physician assistants; or
- Certified nurse practitioner; and
- Working in a Federally Qualified Health Center, Rural Health Clinic, Indian Health Service Unit (IHS) or clinic group practice, or a mental health professional working in a Community Mental Health Center.

The designated provider is responsible for providing all the recipient's health care needs or taking responsibility for appropriately arranging care (monitoring, arranging, and evaluating appropriate evidence based and/or evidence informed preventive services) with other qualified professionals. The designated provider should provide same day appointments, timely clinical advice by telephone during office hours, and document clinical advice in the medical record.

Health Home Care Team
The designated provider leads a team of health care professionals and support staff that may include a primary care physician, physician assistant, certified nurse practitioner, behavioral health provider, a health coach/care coordinator, chiropractor, pharmacist, support staff, and other community-based services or professionals as appropriate.

New Health Home Start Date
Clinics can apply to become a Health Home at any time. New clinics are enrolled at the start of a new quarter. Existing Health Home clinics can add new designated providers at any time.

New Health Home Start Dates:

- January 1
- April 1
- July 1
- October 1

Once a Health Home application has been reviewed and approved, the Health Home provider will receive a letter of notification from South Dakota Medicaid indicating their status as a designated Health Home. Any contingencies to the designation will be identified and described in the letter

Changes and Updates
Medicaid must be notified immediately if the following occur:

- Provider additions or deletions
- Care Coordinator/Health Coach changes.

Notifications can be sent via, email or fax to:

Health Homes Program
Fax: 605-773-5246
Email: CMforms@state.sd.us

Termination from the Program
Medicaid works collaboratively with Health Homes to comply with the requirements of the Health Home Program. Health Homes must comply with program requirements. Health Homes that fail to comply with the program requirement may be disenrolled. Compliance issues that may lead to disenrollment include:

- Failure to complete required reports in a timely manner for a year.
- Failure to respond to requests for charts for the Quality Assurance Review.
- Failure to substantially meet other requirements of the program identified by the Quality Assurance Review.

Health Homes will receive a warning letter that outlines the issues and will be asked to submit an Improvement Plan. Failure to respond to the Improvement Plan will be cause for termination at the end of the current month in which the Improvement Plan is due.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using the Medicaid Portal.

Health Home services are provided to full coverage Medicaid/CHIP recipients with complex chronic health and/or behavioral health needs. This population includes Medicaid and Medicare/Medicaid dually eligible beneficiaries who meet Health Home criteria.

Recipients can qualify for the Health Home program be meeting one of the two following two criteria:

1. Recipients with two or more chronic conditions or recipients with one chronic condition who are at risk for a second chronic condition.
    - Qualifying Chronic Conditions: Mental Health Condition, Substance Use Disorder, Asthma, Chronic Obstructive Pulmonary Disorder (COPD), Diabetes, Heart Disease, Hypertension, Obesity, Musculoskeletal and Neck/Back disorders.
    - Qualifying At-risk Conditions: Pre-Diabetes, tobacco use, Cancer, Hypercholesterolemia, Depression, and use of multiple medications (6 or more classes of drugs).
2. Recipients who have a Serious Mental Illness or Serious Emotional Disturbance as defined by ARSD 67:62:12:01 and SDCL 27A-15-1.1, respectively.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

Recipients cannot be in the Health Home Program if they are participating in a Chronic Care Management (CCM), Transitional Care Management (TCM) and Collaborative Care Model (CoCM)

RECIPIENT ENROLLMENT IN HEALTH HOMES

Recipients are determined eligible for the Health Home program based on claims data from the previous 15 months using the Chronic Illness and Disability Payment System (CDPS

Claims data is also used to determine if recipients in Tiers 2-4 have established care with an enrolled Health Home provider. If care has been established, the recipient is automatically assigned to that provider and the recipient is put in the Health Home Program after a 30-day waiting period, effective the first day of the following month. During the 30-day waiting period, recipients may opt out of the program if they do not wish to participate, or they may change Health Home providers if they wish to have a different provider.

Recipients who have not established care are sent a letter requesting the recipient to pick a provider. The recipient can also choose to opt out of the program. If the recipient does not pick a provider within the 30-day period, the recipient may be assigned to a provider.

Each month Medicaid publishes a caseload list on the Medicaid Portal that includes recipients assigned to the Health Home. Providers should regularly review the caseload list for newly assigned recipients, recipients that have opted-out of the program or lost eligibility.

Recipient Opt-Out
Health Home recipients have the right to opt-out of the Health Home program using the Decline to Participate Form. Health Homes may complete this form based on a verbal request from the recipient that the recipient wishes to be removed from the program. Verbal requests must be documented in the Electronic Health Record. Forms may be faxed to (605) 773-5246 or sent to CMforms@state.sd.us.

Recipient Changing Health Homes
Health Home recipients may switch Health Home providers. Providers can assist the recipient in instance where they have documented verbal consent.

If the recipient would like to change their Primary Care Provider/Health Home Provider:

- Document their request in the Electronic Health Record (EHR); and
- Make the requested change using the online selection tool https://pcphhselection.appssd.sd.gov/.

Requesting a Recipient be Added
Health Homes may recommend recipients for the Health Home Program by completing the Manual Tiering Document. The document must be accompanied by medical records that support the medical conditions indicated on the Manual Tiering Document. This allows the Department of Social Services to determine eligibility and tier in a consistent manner. Documents may be sent via secure email or fax to:

Health Homes Program
Fax: 605-773-5246
Email: CMforms@state.sd.us

RECIPIENT TIERING IN HEALTH HOMES

Eligible recipients are tiered using the CDPS. Recipients may be in Tier 1, 2, 3, or 4. A higher tier is reflective of the recipient having more chronic conditions and higher costs.

Annual Re-tiering
Medicaid re-tiers recipients on an annual basis in the month of December. The new tier will begin in January the following year. The new tier is created by looking at the average of the previous 6 months. The average tier will be compared to the current tier and moved up or down one. Recipients with a current tier of 1 and an average tier of 0 will be removed from the Health Home Program on December

31 of the current year, Providers will be provided a caseload with the tier of every recipient on the caseload. Recipients who fall to a tier 1 should be contacted by the provider to determine if the program is still needed. If it is not, the provider should submit a decline form.

CASELOAD AND CLAIMS REPORTS

Members of the Health Home team can use the Medicaid Portal to perform many functions of the Health Home Program. Information about how to sign-up or login to the Medicaid Portal is available here: https://dss.sd.gov/medicaid/portal.aspx. Information available on the online portal includes:

- Caseload reports
- Claims paid reports
- Re-tier reports
- Core Services reports

Caseload Report

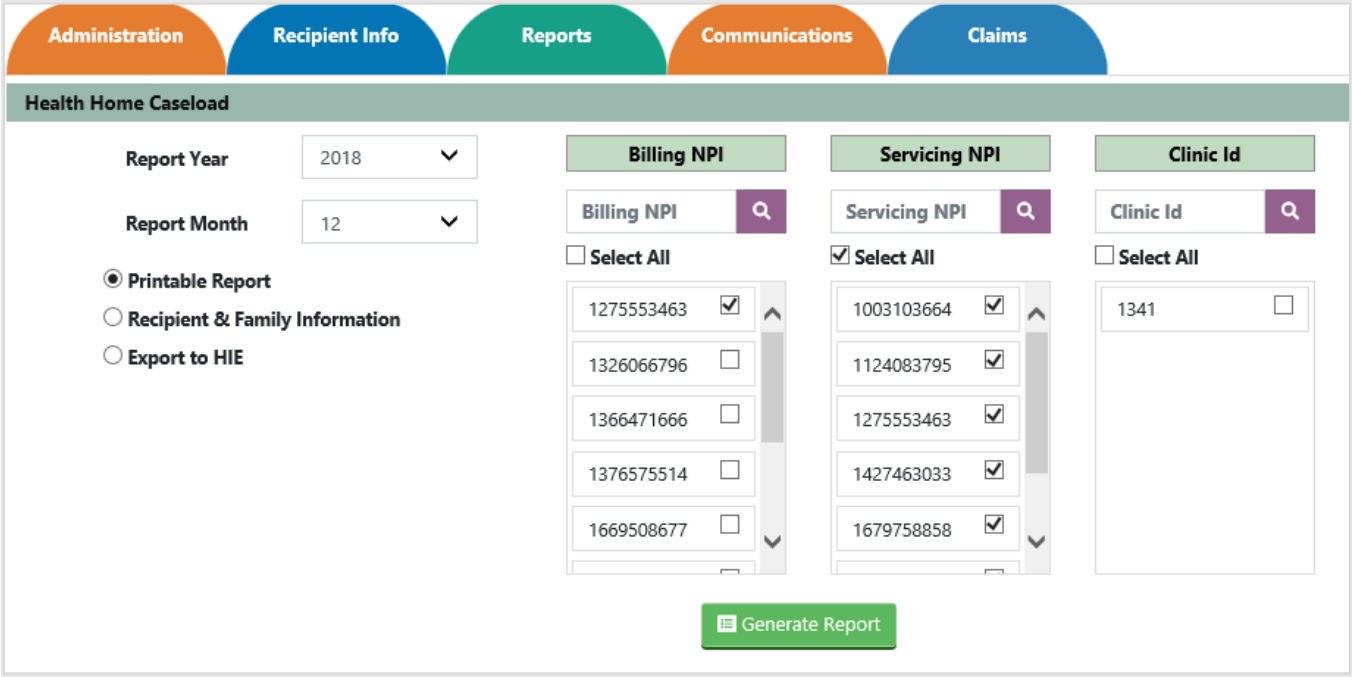
A Caseload report provides important information about each recipient on each provider's panel. There are three types of caseload reports available in the Medicaid Portal:

1. Printable Report which provides all the information about each recipient in a format that can be printed;
2. The Recipient and Family Information which provides all the information about each recipient in a format which can be exported to Excel and stored in an electronic format or exported into some other system; and
3. The Export to Health Information Exchange which provides a limited set of information that can be exported into the HIE e to allow clinics to receive notifications on certain recipients.

Portal Instructions for Caseload Reports

Users with permission can pull a month caseload report using the following instructions:

1. Under Reports, Health Homes, Caseload
2. Select the report year and month
3. Select the type of report. Printable Report, Recipient & Family Information, or Export to HIE as they are defined above. The system will generate the Billing NPIs (BNPI) for which the user has access and the User will need to either select a BNPI or BNPIs and then NPIs of the providers for which they wish to generate a caseload.
4. Click on Generate Report.



5. The system will generate the type of report or download you requested and display the report for the user to be printed or downloaded.

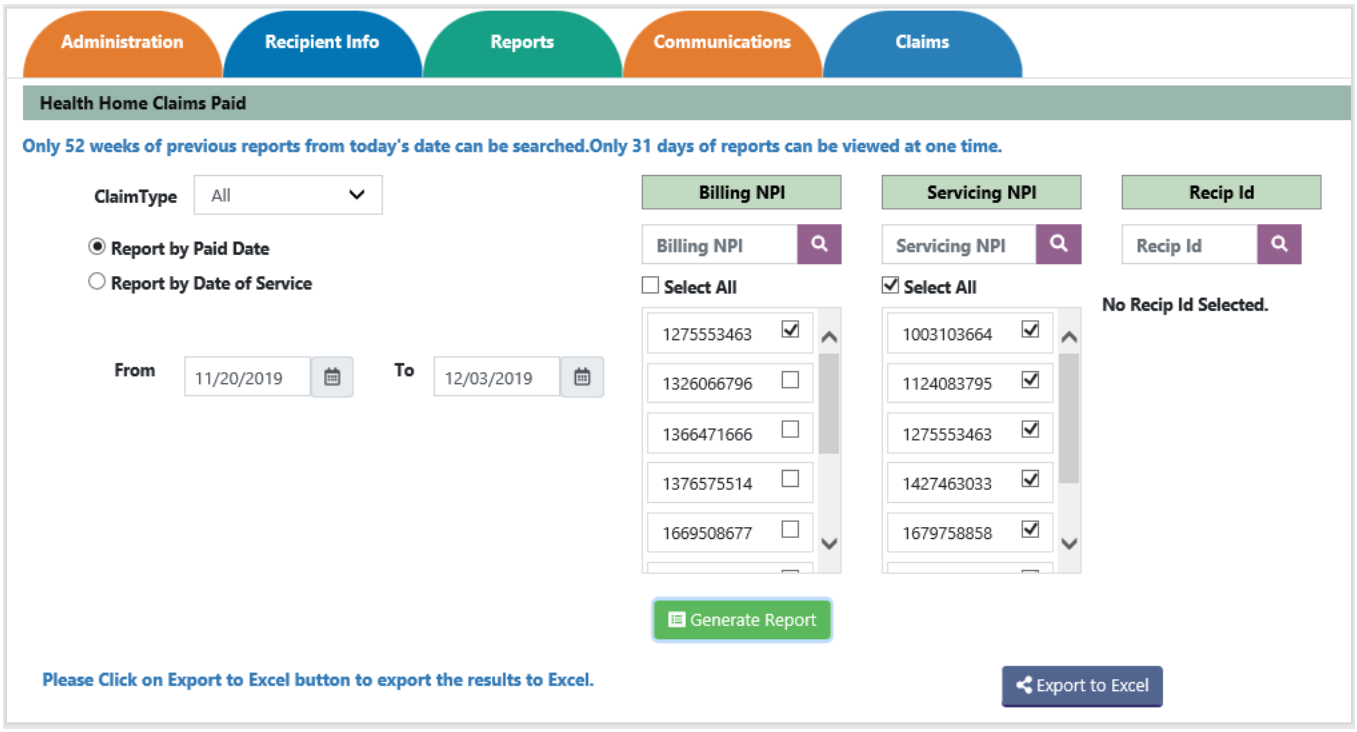
Claims Paid Report

The Claims Paid Report provides information about the claims filed for each recipient on the caseload report. This report can be generated by Claim Type and user can also choose to generate the report by paid date or date of service. Report can be generated for one provider or a group of providers under a BNPI.

Portal Instructions for Claims Paid Report

Users with Permission can also download the Claims Paid Report described above using the following steps:

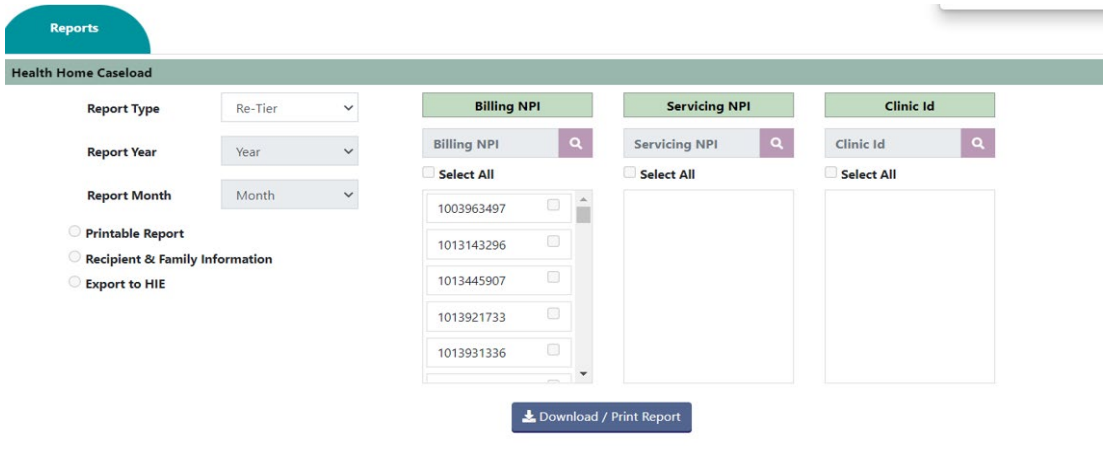
1. Select Reports, Health Home, Claims Paid
2. Select All or choose specific claim types
3. Choose between Report by Paid Date or Report by Date of Service.
4. The system will display the accessible BNPI/s, select the BNPI/s to be displayed then either select all or specific Servicing NPI/s (SNPI) to be displayed. Claims can also be identified by recipient
5. Select Generate Report.
6. Select Export to Excel



Re-tier Report

Users with the appropriate permissions can access the Re-tier Report on the Portal using the following steps:

1. Select Reports, Health Home, Caseload.
2. Select Re-tier under Report type.
3. Enter the year and the month.
4. If you have more than 1 BNPI, choose a BNPI or select all, then select all servicing NPIs.
5. Click on Download and Print Report.



HEALTH HOME BASIC REQUIREMENTS

Health Homes must adhere to the Health Home provider qualification and standards, functional requirements, and guidelines as outlined by the Centers for Medicare and Medicaid Services (CMS) in (SMDL) #10-024, Health Home for Enrollees with Chronic Conditions.

Access Requirements

Health Homes are responsible for assuring that their recipients receive all medically necessary care, including primary, specialty, and behavioral health care either through direct provision of services or by referral to another provider. Health Homes must provide same day appointments and 24 hour/7 day a week access by telephone to page an on call medical professional to handle medical situations during non-office hours. A plan for after-hour care must be communicated with the recipient and documented in the recipient's electronic health record. If the health home is affiliated with a calling network to serve as the after-hours contact, this may be utilized for general information calls only.

Quality Care Requirements

Health Homes are required to meet the following care requirements:

- Provide quality driven, cost effective, culturally appropriate and person-and family center health home services;
- Coordinate and provide access to high quality health care services informed by evidence based clinical practice guidelines;
- Coordinate and provide access to preventative and health promotion services including, substance use disorders and mental health promotion;
- Coordinate and provide access to mental health and substance use disorder treatment services;
- Coordinate and provide access to comprehensive care management, care coordination and transitional care across settings. Transitional care includes appropriate follow-up when transferring from a pediatric to an adult system of health care;
- Coordinate and provide access to chronic disease management including self-management support to individuals and their families;
- Coordinate and provide access to individual and family supports including referral to community, social support and recovery services;
- Coordinate and provide access to long-term care supports and services;
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services; and
- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes and quality of care outcomes.

Referral Requirements

Referrals given to recipients through calling networks (e.g. referring recipients to seek medical attention in the emergency room) must be approved by the recipient's health home designated provider or designated covering provider. All referrals must be documented in the recipient's electronic health

record. For more information on referrals please refer to the Referrals Manual. An example referral form for CMHC Health Homes is available.

EHR Requirements
Health homes must use Health Information Technology (HIT) to link services as feasible and appropriate. Complete Electronic Health Record (EHR) implementation and use the EHR as its primary medical record solution prior to becoming a Health Home provider. This includes the capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices as feasible and appropriate.

Reporting Requirements
Electronically report to South Dakota Medicaid, in the manner defined by South Dakota Medicaid, information about the provision of Core Services and the outcome measures.

Medicaid Collaboration Requirements
Collaborate with South Dakota Medicaid on an as needed basis to evaluate and continually improve the South Dakota Health Home model to achieve accessible, high-quality care, and demonstrate cost-effectiveness. Provides must also Attend all required Health Home trainings.

Confidentiality Requirements
In addition to HIPAA and other applicable confidentiality requirements, Health Home providers are required to Comply with 42 CFR Part 2 as it pertains to sharing data for recipients with substance use disorders.

PERSON-CENTERED CARE PLAN

Health Homes are required to develop a person-centered care plan for each individual on their caseload that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services. The Patient-Centered Care Plan should be developed with active participation from the recipient and their supports if applicable. Development of the care plan is considered to be a Core Service.

The person-centered care plan must include the following:

- Basic recipient information (Name, DOB, etc.).
- Medical conditions.
- Medications or document that the medications listed in the EHR were reviewed and/or updated.
- A summary of the recipient's health-related social needs (housing, employment, transportation etc.).
- A summary of durable medical equipment needs if applicable.
- Goals to improve health and overcome barriers.
- Progress notes documenting progress made towards achieving goals.
- Family members/friends involved in care.
- Behavioral health needs if applicable including documenting:

  - Last depression screening (date and/or results)
  - Last substance use screening (date and/or results)
  - Whether they are engaged in active treatment and when their most recent appointment occurred
- Community resources the recipient was referred to.
- Indicate if the recipient can self-manage their conditions including if they are using self-management tools to record the results.
- Specialist the recipient was referred to including documentation that an electronic summary of care was provided to the specialist.
- Documentation of future appointments including:
  - Next primary care provider appointment, if known.
  - Other healthcare appointments
- The dates when care plan was originally created.
- The date the care plan was last updated/reviewed.

Health Homes are not required to use a specific form for the Patient-Centered Care Plans.

CORE SERVICES

South Dakota Health Homes are reimbursed for providing Core Services. Core Services are intended to be enhanced care services that go above and beyond the care that is generally provided to patients as part of a standard office visit or routine care. The primary intent of Core Services is to help individuals achieve better health outcomes by achieving or making progress towards the individualized goals in the recipient's person-centered care plan.

Core Services must meet the following criteria:

- The Core Service is provided directly to the recipient or to the recipient's guardian for the direct benefit of the recipient;
- The Core Service must be provided either in person, via telemedicine, or via telephone.
- The Core Service is related to individualized goals in the care plan. There may be some exceptions to this requirement such as development of the care plan and assisting with transitional care;
- The Core Service is documented in the EHR including a description of the Core Service and the applicable category of Core Service;
- The Core Service is not reimbursed by South Dakota Medicaid as part of another service;
- The Core Service meets the description of one of the six Core Service categories described below;
- The Core Service is provided by the Health Home Care Coordinator or another member of the Health Home Care Team. It is anticipated that Core Services would be provided by clinic staff that cannot directly enroll and bill Medicaid.

Duplicative Services

Federal regulations prohibit Medicaid from paying twice for the same service. Core Services must be separate and distinct from other services that providers bills to Medicaid. For example, obtaining history

or providing education as part of an evaluation and management service does not constitute a Core Service. The separate and distinct standard applies to services reimbursed on a per diem basis. In this instance, a Core Service provided on the same day as the encounter services is reportable if it is separate and distinct from services reimbursed as part of the encounter visit.

Non-Covered Services

The following services are not considered Core Services and cannot be reported to generate a Health Home Core Service payment:

- Services that are separately billed for and reimbursed by Medicaid on a fee-for-service, per diem, or other basis.
- Outreach attempts such as phone calls that are unsuccessful in reaching the recipient.
- Emails, texts, letters, and other written forms of communication; Updates to the person-centered care plan after initial development;
- Administrative work such as reviewing data or records; and
- Services that are generally beneficial for the implementation or success of a Health Home, but that are not directly provided to or for an individual recipient on the Health Home's caseload.

Allowable Settings

Core Services may be provided in a home, community, clinic, or institutional setting. Core Services provided in institutional settings must be above the level of service the institutional setting was already obligated to furnish.

Core Service Categories

Medicaid covers/reimburse the following categories of Core Services:

1. Comprehensive Care Management;
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support
6. Referrals to Community and Social Support Services

Health Home Core Services

All Health Homes are required provide the following Core Services. The term "Care Coordinator" is used throughout. This term refers to the position that manages the Health Home Program in your clinic. The South Dakota Health Homes Core Services are defined as follows:

1. **Comprehensive Care Management**
   Comprehensive Care Management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral, specialty health care, and community support services. Comprehensive care management requires developing a comprehensive person-centered care plan which addresses all clinical and non-clinical needs. Examples:
   a. Conducting outreach activities to gather information from the recipient, the recipient's caregiver, and other primary and specialty care providers;

b. Completing a comprehensive needs assessment which includes, behavioral health screenings such as depression and substance use, social determinants of health screening, and other screenings as determined necessary by the team.
c. Developing a comprehensive person-centered care plan including individualized goals and action steps to achieve the goals.

2. **Care Coordination**
Care coordination is the implementation of the person-centered care plan. The plan must be implemented through appropriate linkages, referrals, coordination, and follow-up to needed services and supports. Examples:
   a. Monitoring progress towards goals in the person-centered care plan;
   b. Coordinating with other healthcare providers;
   c. Assisting and supporting the recipient with scheduling health appointments with other healthcare providers;
   d. Supporting the recipient's compliance with treatment recommendations; and
   e. Communicating and consulting with other providers and recipient/caregiver as appropriate.

3. **Health Promotion**
Health promotion services encourage and support healthy ideas and concepts. The intent of the service is to motivate recipients to adopt healthy behaviors and enable recipients to self-manage their health. The Care Coordinator will provide health promotion activities. Examples:
   a. Providing health education to recipients and their caregivers specific to the recipient's chronic conditions;
   b. Conducting medication reviews and regimen compliance;
   c. Teaching self-management skills; and
   d. Promoting healthy lifestyle interventions for substance use and prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.

4. **Comprehensive Transitional Care**
Comprehensive transitional care services are for individuals transitioning between levels of care and ensures the recipient/caregiver is supported during those transitions. This includes post-discharge education, follow-up appointments, and access to community resources. Examples:
   a. Contacting the recipient/caregiver within five business days discharge from the hospital or emergency department;
   b. Providing post-discharge contact with recipient/caregiver to ensure discharge orders are understood and action taken;
   c. Coordinating with the recipient/caregivers and providers to ensure smooth transitions to new settings; and
   b. Ensuring a follow-up visit with the primary care provider.

5. **Individual and Family Support**
   Recipient/caregiver or family support services reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes using methods that are educationally and culturally appropriate. This includes assessing the barriers to care and working with the recipient/caregiver/family to overcome barriers such as medication adherence, transportation, and keeping appointments. Examples:
   a. Providing education and guidance in support of self-advocacy;
   b. Identifying resources for recipient/caregiver/family to support the recipient in attaining their highest level of health and functionality in their families and in the community;
   c. Coordinating transportation for the recipient/caregiver/family to medically necessary services; and
   d. Helping recipient/caregiver to access long-term care and other support services.

6. **Referrals to Community and Social Support Services**
   Referral to community/social supports is providing information and assistance to refer the recipient/caregiver to community-based resources that support the needs identified on the recipient's person-centered care plan. Examples:
   a. Providing referral and information assistance to obtain community-based supports or social service supports (may include housing, personal need, and legal services);
   b. Assisting recipient/caregiver to obtain and maintain eligibility for health care, disability benefits, etc.
   c. Supporting effective collaboration with community-based resources; and
   d. Identifying resources to reduce barriers to help recipient in achieving their highest level of function and independence.

CORE SERVICE REIMBURSEMENT AND REPORTING

Health Homes are paid a Per Member Per Month (PMPM) Payment on a quarterly basis for all Core Services rendered to a recipient in a quarter. The PMPM is calculated based on:

- The Health Home reporting a Core Service was provided;
- The number of months the recipient was in the Health Home during the quarter; and
- The tier of the recipient.

Refer to the Health Home Fee Schedule for PMPM amounts. Health Home PMPM payment are in addition to services reimbursed on a fee-for-service or per diem basis.

Reporting

Health Homes are required to report their Health Home Core Services on quarterly basis through the Medicaid Portal. Each recipient in Health Homes must receive a minimum of at least one Core Service per quarter in order to report a Core Service for them. If a Core Service was not provided, the PMPM payment cannot be claimed by the Health Home.

Core Services for a quarter must be submitted by the submission date listed below. Providers who do not submit Core Services by the deadline will receive an email from a Care Management team member

providing a reminder to report the Core Service and a brief extension to complete the report. If services are not reported by the time the extension ends, the provider's entire panel for the Health Home will be marked as no Core Service provided. This will result in no payment for that quarter.

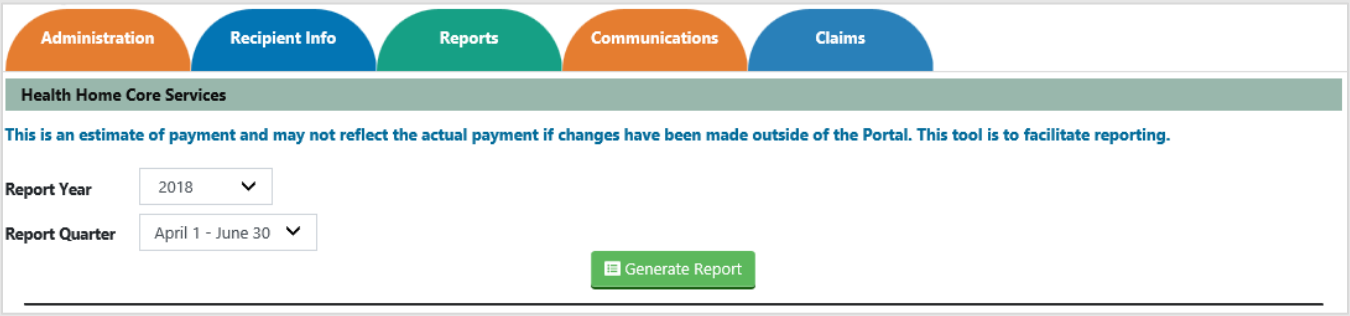
Submission Date	Submission Period
April 30	January 1 – March 31
July 31	April 1 – June 30
October 31	July – September 30
January 31	October 1 – December 31

The PMPM payment for Health Home Core Services will typically be made during the first full week after the due date of each quarterly core service report.

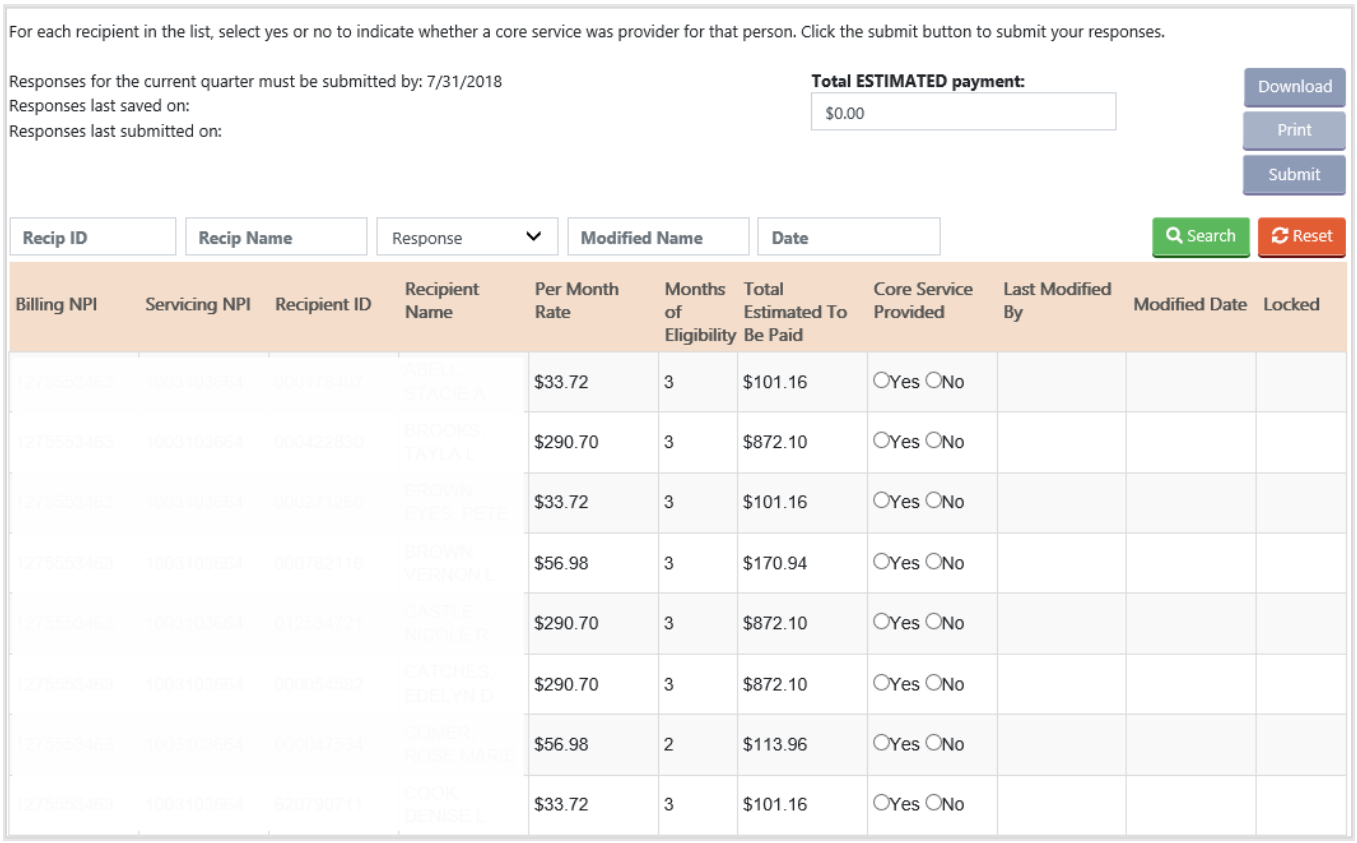
Core Service Report Portal Instructions

Users with permissions can complete the Core Services Report using the following steps:

1. Reports, Health Home, Core Service Report
2. Select the Report year and the report quarter that needs to be completed.
3. Select Generate Report.



4. Complete the report by clicking on yes or no for each recipient.
5. Select submit. The Submit button will not open until all responses are complete.
6. User should receive a message indicating the report was successfully submitted.
7. Report should be downloaded and/or printed for future use.



For each recipient in the list, select yes or no to indicate whether a core service was provider for that person. Click the submit button to submit your responses.

Responses for the current quarter must be submitted by: 7/31/2018
Responses last saved on:
Responses last submitted on:

Total ESTIMATED payment: $0.00

Download | Print | Submit

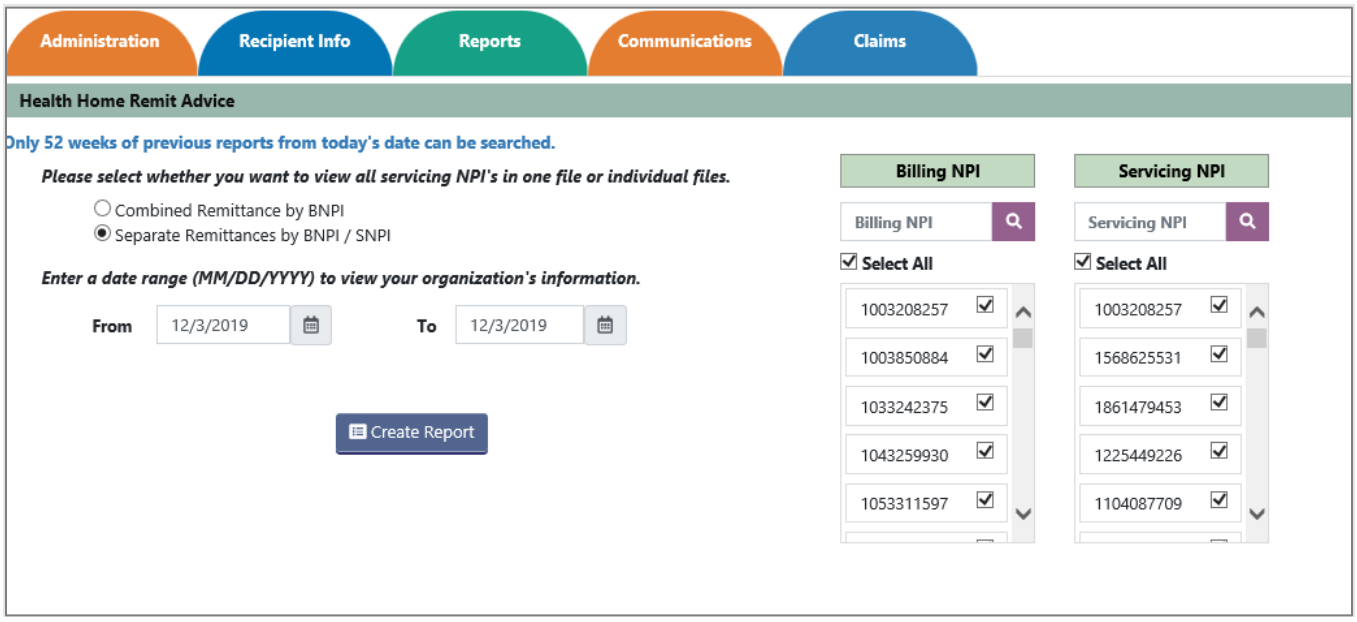
Recip ID | Recip Name | Response | Modified Name | Date | Search | Reset

Billing NPI	Servicing NPI	Recipient ID	Recipient Name	Per Month Rate	Months of Eligibility	Total Estimated To Be Paid	Core Service Provided	Last Modified By	Modified Date	Locked
1275553463	1003103664	000178457	ABELL, STACIE A	$33.72	3	$101.16	Yes No			
1275553463	1003103664	000422830	BROOKS, TAYLA L	$290.70	3	$872.10	Yes No			
1275553463	1003103664	000271260	BROWN, ETES, PETE	$33.72	3	$101.16	Yes No			
1275553463	1003103664	000732116	BROWN, VERNON L	$56.98	3	$170.94	Yes No			
1275553463	1003103664	912554721	CASTLE, NICOLE R	$290.70	3	$872.10	Yes No			
1275553463	1003103664	000054582	CATCHES, EDELYN D	$290.70	3	$872.10	Yes No			
1275553463	1003103664	000047544	COMER, ROSE MARIE	$56.98	2	$113.96	Yes No			
1275553463	1003103664	520790711	COOK, DENISE L	$33.72	3	$101.16	Yes No			

Remittance Advice Portal Instructions

Results of the Core Services payment can be found on the Remittance Advice, which is available on the Medicaid Portal. Users with the appropriate permissions can access the Health Home Remittance Advice on the Portal using the following steps:

1. Select Reports, Health Home, Remit Advice
2. Select if you want a combined Remittance by BNPI, or Separate Remittance by BNPI, SNPI
3. Select Date Range. Date range will be the date of the payment not the quarter for which the payment is made.
4. Select BNPI/s and SNPI/s as appropriate.
5. Select Create Report



PERFORMANCE MEASURE REPORTING REQUIREMENTS

Health Home Performance Measures are a critical factor in determining the success of Health Homes. Performance Measures are made up of Clinical Outcome Measures, Process Measures, and Utilization Measures. Performance measures must be submitted for every recipient that the Health Home claimed a core service.

Performance Measures are reported to Medicaid on a biannual basis:

Submission Period	Submission Date
January – June	TBD by Vendor
July-December	TBD by Vendor

Each Health Home will export the Performance Measure data in a file format outlined in the template provided by the vendor for the list of recipients provided in the template. Medicaid will pull claims data to complete the remaining Performance Measures. Performance Measures and Data File Layouts can be found here.

Providers who do not submit performance measure data by the deadline will receive an email reminder from a Care Management team member providing a short extension to report the data. If the data is not reported by the time the extension ends, Medicaid will recoup the Per Member Per Month (PMPM) payments for the provider for that time period.

QUALITY INCENTIVE PAYMENTS

South Dakota Medicaid makes annual quality incentive payments to Health Homes. The payments include both a small clinic payment pool and a clinical outcome payment pool. Measures included in the clinical outcome payment pool include:

- Active care plan;
- Depression follow-up plan documented;
- BMI in control;
- Mammogram up to date;
- Colonoscopy up to date;
- Blood pressure in control; and
- Face to face visits missed.

More information about the measures is available on our website. The payment pool amounts are listed on the Health Home Quality Incentive Payment Fee Schedule.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Core Services

Health Home providers are required to maintain written documentation in the EHR that clearly documents the individualized care plan, supporting documentation for performance measures and core service requirements.

QUALITY ASSURANCE REVIEWS

South Dakota Medicaid conducts an annual quality assurance by requesting portions of a recipient's EHR. The quality assurance reviews help ensure that Health Homes are meeting program requirements. Reviews may include, but are not limited to the following:

- Core Services are being provided as indicated;
- Care Plans are being developed and followed as appropriate;
- Appropriate Notifications and contacts are completed for the recipient; and
- Mental Health and Substance Use Screenings are completed for each recipient.

REFERENCES

- South Dakota Medicaid State Plan
- Code of Federal Regulations
- Provider Enrollment Chart

QUICK ANSWERS

1. **Can a provider disenroll from the Health Home Program?**

   Yes, unless it is a closure situation, a Health Home may discontinue providing Health Homes Services at the end of a quarter with a minimum of three months' notice to South Dakota Medicaid. Health Home services may not be discontinued without an approved closure/services cessation plan, which includes proper procedures for clinically appropriate recipient transition.

2. **Can individuals who also have Medicare be a part of the Health Home Program?**

   Yes, however, the recipient must be eligible for full Medicaid coverage and meet the conditions to be eligible for the program. Qualified Medicare Beneficiaries (QMB) only and Specified Low-Income Medicare Beneficiaries (SLMB) only are not eligible for this program.

3. **How do recipients get added to the caseload list?**

   Recipients are placed on caseloads in the initial attribution process if the recipient meets the continuity of care requirement, the recipient can select a provider, or South Dakota Medicaid can assign them to a provider based on evidence in claims or past PCP Program history with the provider.

4. **How do I remove a recipient from my caseload list?**

   There are two approved ways to remove individuals from your caseload lists without a recipient's permission.
   a. Inability to contact the recipient. Once the requirements outlined at https://dss.sd.gov/docs/healthhome/disenrollment.pdf, are met, a Decline to Participate Form can be submitted and the recipient will be removed according to the procedures outlined above.
   b. Behavior. Once the requirements outlined at https://dss.sd.gov/docs/healthhome/recommendeddisenrollmentprocess.pdf, are met, a Decline to Participate Form can be submitted and the recipient will be removed according to the procedures outlined above.

   Providers can also facilitate a removal with a verbal request from the recipient.

5. **How can I help recipients choose another provider?**

   Upon receipt of verbal request from a recipient, providers can help facilitate the switch to a different Health Home. A list of participating Health Home providers can be found at http://apps.sd.gov/SW96PC01MED/Default.aspx?Code=H. Use the following website https://pcphhselection.appssd.sd.gov/ to help recipient choose a new provider.

6. **How can I get a new provider to show up in my permissions on the Portal?**

Permissions for the Medicaid Portal are clinic driven. To receive permission for a new provider, please contact the Provider Administrator in your clinic to ask for the new provider to be added to your list of permissions. If these permissions are not added, you will not be able to see any caseloads or complete the core services report associated with the new provider.

7. **How do providers know if a recipient has a Health Home provider?**

   Providers can determine a recipient's Health Home provider using the Medicaid Online Portal Eligibility Inquiry. Health Home providers can also review all Medicaid recipients on their caseload in the Medicaid Online Portal. Instructions on accessing eligibility and caseload information are included in the Medicaid Online Portal section above.

8. **Do American Indian recipients need a referral to see an IHS/Tribal 638 provider?**

   American Indian recipients may choose but are not required to choose Indian Health Services (IHS)/ Tribal 638 as their Health Home. If they do not choose IHS/Tribal 638 as their Health Home they can still receive services at any IHS/Tribal 638 facility without a referral from their Health Home. For further instructions on referrals, see the Referral Manual.

9. **Are there special instructions for clinics submitting crossover claims for individuals in a care management program such as the Health Home program?**

   When submitting a crossover claim for dual eligible Medicaid/Medicare recipients in the Health Home program, if the provider is a type two provider, the claim must still be submitted with the ordering/referring type one provider information on the claim to avoid a denial and to remain in alignment with Medicare guidance. For detailed claim instructions please refer to the applicable claim instructions.