PREGNANCY PROGRAM

ELIGIBLE PROVIDERS

The following providers are eligible to enroll in the Pregnancy Program:

- Physician;
- Physician Assistant;
- Certified Nurse Practitioner;
- Certified Nurse Midwife;
- Clinics certified as a Rural Health Clinic (RHC);
- Clinics certified as a Federally Qualified Health Center (FQHC); and
- Clinics designated as an Indian Health Services Clinic/Tribal 638

Pregnancy Program providers are required to be enrolled with Medicaid and maintain credentials with a birthing hospital if the provider intends to perform the birth or maintain a relationship and communication with another provider or facility who can perform the birth including a process for timely transition of care.

Providers wishing to enroll as a Pregnancy Program provider must complete the following forms:

- Pregnancy Program Provider Application
- Pregnancy Program Provider Addendum
- Barriers to Care Initiative

ELIGIBLE RECIPIENTS

Recipients that Medicaid is aware are pregnant may be eligible for the Pregnancy Program. Medicaid recipients who are 20 weeks or less gestation and reside in an area with a Pregnancy Program provider are eligible to participate in the program.

In certain instances, Medicaid may not be aware a recipient is pregnant. Providers may request a pregnant recipient be added to their Medicaid caseload if they the recipient is 20 weeks or less gestation. Providers who want to add a recipient to their caseload should contact South Dakota Medicaid at 605.773.3495. Recipients being added to a provider's caseload will appear on their caseload list the first of the following month.

Exempt Recipients

Pregnant Medicaid recipients in the following aid categories will not automatically be enrolled in the program: 11-13, 15-16, 21-23, 30, 31(under the age of 19), 32-33, 35-38, 53-54, 57, and 67. These recipients may choose to opt into the program.

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

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

End of Program Eligibility

At the end of the recipient's pregnancy, they will remain eligible for the Pregnancy Program for 3 months. For the purposes of the 3-month period, month 1 is the month after the pregnancy ended. For example, if the recipient delivered in July, month 1 would be August. If a recipient experiences an unexpected end to their pregnancy such as a miscarriage or spontaneous termination, the provider should notify South Dakota Medicaid. Recipients will be kept in the program for 3 months regardless of how the pregnancy ended.

PROGRAM GOALS AND OUTCOMES

The goal of the Pregnancy Program is to improve health outcomes for pregnant woman and the unborn child. South Dakota Medicaid will measure the following:

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

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

GENERAL CARE REQUIREMENTS

As a condition of participating in the program the provider agrees to provide care in accordance with ACOG Guidelines. Participation in this program does not obligate providers to provide services that are not covered or not authorized by Medicaid.

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

Providers also agree to have an initial visit with caseload members before 12 weeks gestation if feasible. If the recipient is past 12 weeks gestation, the provider agrees to schedule within two weeks of the date the recipient contacts the provider. Provider agrees to attempt to contact all recipients on their caseload within four weeks of being added to the caseload if a recipient has not scheduled and attended an appointment. If the recipient does not initiate care after the initial contact attempt, the provider agrees to contact the recipient three additional times via two different communication methods.

As a condition of participation in the program, the provider also agrees to no elective deliveries before 39 weeks of gestation.

ROUTINE PRENATAL CARE REQUIREMENTS

In addition to the general requirement to provide care in accordance with ACOG guidelines, the following is an overview of care expected to be delivered by participating providers:

- Initial Visit
  - Comprehensive history and physical exam.
  - Provide immunizations as appropriate and document refusals of any recommended immunizations.
  - Perform initial labs to include Syphilis testing, STI testing, and Hepatitis C testing.
  - The provider must complete a risk assessment at the initial visit. Refer pregnant women to applicable medical and social services and supports identified in the risk assessment(s). The referrals must include, but are not limited to the following conditions:
    - Mental health;
    - Substance abuse;
    - Oral health; and
    - Social determinants of health.
  - Social determinants of health screenings should be completed using the AHC Health-Related Social Needs Screening Tool, the PRAPARE Screening Tool, the Short Patient Social Needs Screening Tool, or a similar screening tool.
  - The provider agrees to report the initial visit using CPT code 0500F within 15 days of the initial prenatal visit. This code is reimbursed on a fee-for-service basis.
- 12 to 24 weeks - Visits every 4-6 weeks
  - Complete early testing for patients who screen as high-risk for gestational diabetes.
  - Offer first trimester screening.
- 24 to 28 weeks
  - Perform glucose screening with either a 1 or 2 step screen.
  - Perform a complete blood count test.
  - Perform Syphilis and human immunodeficiency virus tests.
  - Perform Rh antibody titer and Rhogam if indicated.
- 28 to 36 weeks -Visits every 2-3 weeks
  - Perform a mental health screening and substance use disorder screening.
  - Perform one Group B Strep testing between 26-38 weeks.
- 36 to 40 plus weeks – Visits every 1-2 weeks
  - Perform a mental health screening and substance use disorder screening.

REQUIRED CARE COORDINATION SERVICES

Provider must have the staffing to provide adequate care coordination services for the provider's caseload. Care coordination staffing may be at the health system or clinic level but must be available to assist women served by individual participating providers. Examples of staff that may be utilized to

provide care coordination services include RNs, LPNs, community health workers, social workers, and other staff qualified and trained to deliver a specific care coordination service.

Pregnancy Program providers agree that the following care coordination services will be available and offered to recipients on the provider's caseload:

- Person-centered care plan;
- Health education and promotion;
- Health system and resource navigation; and
- Transitional care coordination

Person-Centered Care Plan
Providers agree to develop a person-centered care plan for active participants that coordinate and integrates all their clinical and non-clinical health care-related needs and services. For individuals with an identified substance use disorder the care plan must include a plan to address the substance use disorder and the provider must monitor the progress of that plan.

Care Plan Elements:

- Measurable goals related to treatment, wellness and recovery including intended outcomes;
- Preferences and Strengths related to treatment, wellness, and recovery goals;
- An emergency/natural disaster/crisis plan;
- Key community and/or social services that address identified needs;
- Planned care coordination interventions; and
- Documentation of key providers included in care plan development and/or key care team members.

Health Education and Promotion
Providers agree to provide education that encourages and supports healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self-manage their health. All active participants must be provided education regarding the importance of prenatal care, postpartum care, safe sleep practices for infants, and the importance of well-child visits.

Health System and Resource Navigation
Providers agree to provider the following health system and resource navigation services:

- Conduct outreach and encourage recipients on their caseload to utilize prenatal and postpartum care;
- Assist recipients on their caseload with scheduling medical appointments;
- Help arrange transportation to medical appointments;
- Coordinate access to supports including referral to community resources and social determinants of health supports; and
- Coordinate access to mental health and substance use disorder services.

Transitional Care Coordination
Providers agree to provide the following transitional care coordination services:

- Make appropriate referrals and follow-up as appropriate following transfer to another care provider including maternal-fetal medicine specialists or a birthing hospital;
- Assist active participants on their caseload with the selection of the recipient's Primary Care Provider at the end of their participation in program;
- Assist active participants with selecting a pediatrician prior to delivery;
- Assist active participants with scheduling an initial well-child visit; and
- Complete a transition plan at the end of the postpartum period for active participants. The transition care plan should contain the following information:
    - Identification of the recipients PCP provider and their scheduled appointment to establish care;
    - Identification of the newborns PCP and their scheduled well child visit(s);
    - Any necessary specialty appointments that need to be made;
    - Documentation that the PCP has recipient's medical records or access to their records; and
    - Identification any known follow up needed with regards to labs, imaging, etc.

COMMUNITY HEALTH WORKER SERVICES

Community health worker services are a separate and distinct benefit that is covered for Medicaid recipients and reimbursed to enrolled CHW agencies on a fee-for-service basis. CHW services are generally considered duplicative of the Pregnancy Program care coordination. CHW services may be used to supplement care coordination services which pregnancy providers are required to provide in the following circumstances:

- The CHW services were initiated for a qualifying health condition or health barrier prior to the woman becoming pregnant;
- The individual has intensive care coordination needs, qualifies for CHW services as described in the CHW manual, and the pregnancy program provider orders the CHW services due to one of the following:
    - The recipient has a high-risk pregnancy; or
    - The individual has two or more chronic conditions or one or more chronic conditions and at risk for a second chronic condition.

ENHANCED PRENATAL AND POSTPARTUM PAYMENTS

In order to incentivize and reward providers for successfully providing prenatal and postpartum care, the Pregnancy Program will make enhanced payments to providers for prenatal and postpartum care. These payments are in addition to traditional fee-for-service payments for prenatal and postpartum care.

Prenatal Care Enhanced Payment
Pregnancy Program providers are eligible for a prenatal care enhanced payment when the following criteria is met:

- The recipient participated in the Pregnancy Program and was on the provider's caseload;
- Prenatal care was initiated prior to the 18th week of gestation. Confirmation of weeks gestation should be done utilizing ACOG guidelines; and
- The woman had 80% or more of the expected number of visits based on the ACOG prenatal standard for uncomplicated pregnancies.

This criteria is based on the Kotelchuck Index. Providers are responsible for determining whether the care they provided qualifies for an enhanced prenatal care payment. The enhanced prenatal care payment is reimbursed on a fee-for-service basis in addition to the traditional fee-for-service payment and is billed using G9152. The table below can be used to calculate the required number of visits.

Adequate Prenatal Care by Gestational Age					
Months Prenatal Care Began	**Gestational Age of Delivery**	**# of Visits Required**	**Months Prenatal Care Began**	**Gestational Age of Delivery**	**# of Visits Required**
1 - 2	23	3	3 - 4	23	3
1 - 2	24	4	3 - 4	24	3
1 - 2	25	4	3 - 4	25	3
1 - 2	26	4	3 - 4	26	3
1 - 2	27	4	3 - 4	27	3
1 - 2	28	5	3 - 4	28	4
1 - 2	29	5	3 - 4	29	4
1 - 2	30	6	3 - 4	30	5
1 - 2	31	6	3 - 4	31	5
1 - 2	32	7	3 - 4	32	6
1 - 2	33	7	3 - 4	33	6
1 - 2	34	8	3 - 4	34	7
1 - 2	35	8	3 - 4	35	7
1 - 2	36	8	3 - 4	36	8
1 - 2	37 or more	10	3 - 4	37 or more	10

Comprehensive Postpartum Visit

Providers should encourage recipients to attend their comprehensive postpartum visits. The visit is an opportunity for the provider to assess the recipient's physical and emotional health, address any concerns, provide guidance on postpartum care, and complete the transitional care plan.

Providers can submit a claim for the comprehensive postpartum visit enhanced payment once the comprehensive postpartum visit has been completed. The enhanced comprehensive postpartum visit is reimbursed on a fee-for-service basis in addition to the traditional fee-for-service payment and is billed using G9152.

Post Payment Review
Providers should ensure they have met the requirements to bill for enhanced payments and that visits are documented in the recipient's medical record. Medicaid payments are subject to post payment review. Medicaid instructs FQHCs, RHCs, and IHS to bill for prenatal care and postpartum care using EM codes due to the encounter reimbursement methodology. These providers should include the TH modifier with the EM code to help Medicaid identify these visits as prenatal or postpartum visits.

Barriers to Care Initiatives Requirements

Pregnancy program providers must implement and support at least one initiative to reduce barriers to care impacting the Medicaid population served under this program. Initiatives may be developed at the health system level or clinic level but must be available to assist women served by individual participating providers. Initiatives must either be new or an expansion of an existing initiative and must not duplicate activities that are required care coordination activities.

Providers must select and implement one of the initiatives as outlined in the Barriers to Care Initiative form as a condition of participation in the Pregnancy Program.

Examples of potential Barriers to Care Initiative:

- Clinic-based food pantry
- Incentive programs for attending prenatal appointments
- Providing childcare during medical appointments
- Paying for Lyft/Uber to prenatal and postpartum visits

Implementation and Tracking
Providers must implement a barrier-to-care initiative within 6 months of receiving their first caseload. Initiatives should be implemented using a framework such as Plan Do Study Act (PDSA). Implementation is considered to have occurred when the service or intervention is available to members on the provider's caseload who can benefit from the initiative.

The provider must develop metrics to measure and track the progress of the initiative. Data and information regarding the initiatives must be shared with South Dakota Medicaid upon request. South Dakota Medicaid may request providers share information regarding initiatives at South Dakota Medicaid-sponsored provider learning and training sessions for participating providers.

Initiative Changes
Providers may change their initiative at their discretion. If the provider determines earlier than this based on qualitative or quantitative data that an initiative is not effective, they must alter the initiative or implement a different initiative in a timely manner. If a provider ends an initiative and is implementing a new initiative, they must file information regarding the new initiative with South Dakota Medicaid.

Department of Health Collaboration Requirements

Pregnancy program providers must promote and refer to the South Dakota Department of Health (DOH) programs supporting pregnant women to active participants on their caseload including Bright

Start, Pregnancy Care, and Women, Infants & Children (WIC) Program. DOH will provide participating providers with promotional materials regarding these programs and training upon request to facilitate this requirement.

DOH will assign a nurse(s) to each enrolled clinic. DOH will outreach providers regarding recipients and share relevant health and social determinants of health information to ensure the recipient has all supports to achieve the best pregnancy outcome.

The provider agrees to share relevant health and social determinants of health information with the DOH nurse. Examples of information that should be shared with the DOH nurse include but are not limited to:

- Recipients' adherence to medication;
- Compliance with prenatal visits;
- Identified health needs that DOH nurses can provide additional support to address;
- Assistance provided to the recipient by the clinic to overcome barriers to accessing recommended care.

Access to Care Requirements

Pregnancy Program providers agree to provide for reasonable and adequate hours of operation and make available 24-hour, 7 days per week access by telephone for information, referral, and treatment needs during non-office hours. In addition, they agree to provide services via audio-only or telemedicine modalities if appropriate.

Providers also agree to utilize the South Dakota Health Information Exchange (HIE) if they can connect to the HIE. The HIE will demonstrate interoperability with other healthcare systems to improve care coordination using an established connection with the South Dakota Health Information Exchange (HIE). This connection must include the following HL7 2.X interfaces: Admission, Discharge, Transfer (ADT), Continuity of Care Document (CCD), Laboratory (General lab, blood bank, microbiology, virology, pathology, newborn screening, etc.), Transcription (Notes), Radiology, and Pathology.

Referrals

Most Medicaid services are required to be provided by the Pregnancy Program provider or be referred by the Pregnancy Program provider. Medicaid's Referrals provider manual provides a full list of services that must either be provided by or referred by the Pregnancy Program provider. The provider is responsible for locating, coordinating, and monitoring these services. In addition, to the services listed in the referral manual providers are responsible for locating, coordinating, and monitoring substance use disorder services.

Provider Selection and Change

Recipients are informed of the responsibility to select a Pregnancy Program provider and how to select a provider. South Dakota Medicaid provides recipients the opportunity to locate Pregnancy Program

providers in their area via a GIS map. Recipients who do not to select a provider will be assigned a provider by South Dakota Medicaid.

Assignments
South Dakota Medicaid uses a manual assignment process to randomly assign the recipient to a participating provider in their area.

Provider Change
A Pregnancy Program selection or assignment may be changed at any time by the recipient. The provider can also change the Pregnancy Program with consent from the recipient which must be documented in the medical record. The Pregnancy Program selection or assignment remains in effect until the recipient, or the provider submits a written or verbal request to South Dakota Medicaid requesting a Pregnancy Program change. Recipients can submit a change request on the South Dakota Medicaid's website.

Provider Change Effective Date
Changes to a recipient's assigned Pregnancy Program provider are made at the beginning of the month following the month that the request was made. If the change is processed prior to the Per Member Per Month (PMPM) payment date, the most recent Pregnancy Program provider assignment will be removed or ended at the end of the previous month. If the request is received after the PMPM payment date, the assignment must remain and will be ended at the end of the current month.

If a provider, recipient, or caseworker can provide written documentation that the Pregnancy Program provider selection was a South Dakota Medicaid error, occurrences may be removed when payment has been processed.

Provider Change Notification
Once South Dakota Medicaid enters the Pregnancy Program provider information into the recipient's provider record the recipient will receive a system-generated notice informing the recipient of the change. At the bottom of each notice there is a perforated paper card which indicates each recipient's provider for the following month along with the provider's phone number.

Marketing Prohibition
Providers are prohibited from any marketing and/or other activities that result in selective recruitment and enrollment of individuals with more favorable health status.

MEDICAID ONLINE PORTAL

Providers can use the Portal to perform many functions of the Pregnancy Program in the same manner as the Primary Care Provider program. For questions about the portal refer to the Medicaid Online Portal section of the Primary Care Provider Program manual.

Providers should verify active eligibility prior to each prenatal visit. Providers may review the Pregnancy Program Provider section in the portal to see if a recipient has or had a provider for the time span for

which the search is completed. If there is a provider in this section and a referral is required, make sure a referral is obtained prior to seeing the recipient.

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.

Provider must document care coordination services provided. Providers must also ensure medical documentation is maintained for the purpose of verifying claims for enhanced payments.

Reimbursement and Claim Instructions

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
Pregnancy Program provider services are reimbursed through both a per member per month payment and fee-for-service payments that are in addition to payments for the underlying service. The table below provides information regarding how the reimbursement mechanism for various services:

Fee-For-Service Services	Per Member Per Month Services
Includes: • Social determinants of health risk assessment • Initial development of the person-centered care plan • Initial development of the transitional care plan for discharge at the end of the program • Enhanced payments for prenatal care • Enhanced payments for postpartum care	Includes: • Health education and promotion • Health system and resource navigation • Monitoring and updating the person-centered care plan • Transitional care coordination other than the initial development of the plan for discharge • Barriers to care initiatives

The Pregnancy Program reimbursement amounts are list on the Pregnancy Program fee schedule.

Barriers to Care
Providers should utilize funding from the Pregnancy Program to fund barriers to care initiatives. The PMPM rate development included a $10 amount specifically for barriers to care. Providers should utilize other reimbursement from the program as needed to ensure adequate funding of their barriers to care initiative.

Claim Instructions
Claims for the Pregnancy Program fee-for-service items must be submitted on a CMS 1500 claim form or via an 837P electronic transaction. Provider types requiring a referring provider, must be sure to populate their provider NPI in box 17b of the CMS 1500. Detailed claim form instructions are available on our website.

Providers that are paid at a per diem/encounter rate, please following correct coding guidelines and apply modifiers as needed when providing multiple services on the same day as your fee-for-service items. For additional information, please refer to the FQHC/RHC manual or the IHS manual.

DEFINITIONS

1. "Active Participants," Medicaid recipients assigned to a provider's caseload who are actively engaged in treatment with the provider.

2. "Caseload," Medicaid recipients attributed to a provider by the Medicaid agency.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **We have a patient who would like to schedule a prenatal visit but is currently not on South Dakota Medicaid. How do they apply for South Dakota Medicaid?**

   Pregnant recipients may apply online, via paper application, or visit a local South Dakota Department of Social Services office. Providers are welcome to assist patients with the enrollment process.

2. **If I only provide prenatal care in our clinic, can I refer the recipient to a delivering provider?**

   Yes, a Pregnancy Program provider can refer a recipient for delivery and any necessary prenatal visits.

3. **How do I change the Pregnancy Provider for the recipient?**

   The Pregnancy Provider can be changed by the recipient or the provider with documented consent from the recipient. The changes can be made using the online selection tool.

4. **My recipient is under the care of another provider. Should I have them removed from my caseload?**

   Yes, you should have them removed them from your caseload. Changes can be made using the online selection tool. If she is switching to a non-Pregnancy Program provider, please contact Medicaid at 607-773-3495.

5. **How can I help a recipient locate a dental provider?**

   All pregnant women should have a dental check-up and cleaning during pregnancy. If a recipient is having issues finding a provider, contact the Medicaid dental vendor (Delta Dental) to speak with a Dental Care Coordinator. The contact number for Delta Dental is 877-841-1478.