CARE CONNECT PROGRAM

OVERVIEW

Care Connect 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. At the center of Care Connect is a dedicated care manager who oversees and coordinates the services a recipient needs for optimal health status. The provision of appropriate care management reduces avoidable emergency department visits and inpatient stays and improves health outcomes. With the recipient's consent, health records are shared among providers to ensure that the recipient receives needed unduplicated services.

Care Connect services are provided through a Designated Provider selected by the recipient or assigned by the state. The Care Connect Program is one of three of South Dakota Medicaid's Care Management programs. The other Care Management Programs are the Primary Care Provider Program and the BabyReady Program. Recipients cannot be part of two programs at the same time but may move between the three programs if eligible. Providers can serve as Care Connect designated providers, as well as Primary Care and BabyReady providers.

ELIGIBLE PROVIDERS

Designated providers for Care Connect includes providers licensed by the State of South Dakota who practice as a primary care physician, (e.g., family practice, internal medicine, pediatrician or OB/GYN), physician assistants, certified nurse practitioner, 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 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.

Clinics can apply for Care Connect status at any time. New clinics are enrolled at the start of a new quarter. Existing Care Connect clinics can add new designated providers at any time.

New Care Connect Start Dates:

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

Once a Care Connect application has been reviewed and approved, the Care Connect provider will receive a letter of notification from South Dakota Medicaid indicating their status as a designated Care Connect. Any contingencies to the designation will be identified and described in the letter. A contingently designated Care Connect is required to respond within the timeframe specified in the letter

with a plan that addresses any contingencies to the satisfaction of South Dakota Medicaid to become officially designated.

Care Connect Program Goals

A Care Connect designated provider is the central point for directing patient centered care and is tasked with the following goals:

- 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.

Care Connect Qualifications

To qualify as a provider, Care Connect programs must:

- Enroll in the South Dakota Medicaid program and agree to comply with all Medicaid program requirements, including those outlined in the Care Connect Provider Standards and the Care Connect Core Services definitions found on page 3-4.
- Directly provide, or arrange for the provision of, Care Connect services. The Care Connect designated provider remains responsible for all program requirements.
- Complete Electronic Health Record (EHR) implementation and use the EHR as its primary medical record solution prior to becoming a Care Connect provider.
- 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.
- Collaborate with South Dakota Medicaid on an as needed basis to evaluate and continually improve the South Dakota Care Connect model to achieve accessible, high-quality care, and demonstrate cost-effectiveness.
- Comply with 42 CFR Part 2 as it pertains to sharing data for recipients with substance use disorders.
- Attend all required Care Connect trainings.
- Provide the services as outlined in State Medicaid Director Letter (SMDL) 10-24:
    - Provide quality driven, cost effective, culturally appropriate and person-and family center Care Connect 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 e 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;
- Demonstrate a 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;
- 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.

Care Connect Provider Standards

Under South Dakota's approach to Care Connect implementation, a Care Connect designated provider is the central point for directing patient centered care and is accountable for reducing avoidable health care costs, specifically 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.

Core Services

South Dakota Care Connect Core Services must meet the following criteria:

- Recipient is engaged in the service; however, the service does not need to be in person;
- Service is tied to the care plan;
- Service is documented in the EHR;
- Service has not already been billed to South Dakota Medicaid using a fee for service, encounter, or daily rate; and
- The service meets one of the following definitions:

1. Comprehensive Care Management

Comprehensive Care Management is the development of an individualized care plan developed by the designated provider with active participation from the recipient and all health care team members. The individualized care plan should delineate the intensity of care coordination needed to meet the needs of each recipient. The designated provider is responsible for providing for all of 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. Comprehensive care management services may include but are not limited to the following:

- Designated provider uses clinical and claims information to assess potential level of participation in care management services;
- Designated provider assesses preliminary service needs including behavioral health needs and develops a treatment plan, which will include recipient's goals, preferences and optimal clinical outcomes;
- Care Connect Care Manager monitors recipients and population health status and service use to determine adherence to or variance from treatment plan;
- Care Connect Health Coach develops and disseminates reports that indicate progress toward meeting outcomes for recipient satisfaction, health status, service delivery and costs; and
- Care Connect Health Coach provides education to recipients on how to access care during office hours, appropriate utilization of urgent care and emergency room visits, specialty services and support services.

2. Care Coordination

Care coordination is the implementation of an individualized care plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. The individualized care plan should delineate how the intensity of care coordination needed to meet the needs of each recipient will be implemented. The Care Connect care manager or care management team is responsible for the management of the recipient's overall care plan. The Care Connect program should share key clinical information (problem list, medication list, allergies, diagnostic test results, etc.) with other providers involved in the care of recipients. If a recipient is being served in the primary care setting and has behavioral health needs the care management team will ensure that a behavioral health provider is part of the team. Vice versa, if a recipient with serious mental illness has co-morbid physical conditions the care management team will ensure that a primary care provider is part of the team. Specific activities may include, but are not limited to the following:

- Care Connect Health Coach monitors and evaluates the recipient's continuing needs, including health maintenance, prevention and wellness, long term care services and supports;
- Care Connect Health Coach coordinates and/or arranges services for the recipient;
- Care Connect Health Coach conducts referrals and follow-up monitoring;
- Care Connect Health Coach supports the recipient's compliance with treatment recommendations;
- Care Connect Care Manager participates in hospital discharges; and
- Designated provider and Care Connect Care Manager communicate with other providers and recipient/family members.

3. Health Promotion

Health promotion services encourage and support healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self-manage their health. The Care Connect care manager or health coach will provide health promotion activities. Specific activities may include, but are not limited to the following:

- Care Connect Health Coach provides health education to recipients and their family members specific to the recipient's chronic or behavioral health conditions;
- Care Connect Health Coach develops disease specific self-management plans;

- Care Connect Health Coach provides education regarding the importance of immunizations and screenings, and child physical and emotional development; and
- Care Connect Health Coach promotes healthy lifestyle interventions for substance misuse prevention, tobacco prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.

4. Comprehensive Transitional Care (including appropriate follow up from inpatient to other settings)

Comprehensive transitional care services are a process to connect the designated provider team and the recipient to needed services available in the community. A defined member of the designated provider care team has overall responsibility and accountability for coordinating all aspects of transitional care. Specific activities may include, but are not limited to the following:

- Care Connect Care Manager facilitates interdisciplinary collaboration among providers during transitions;
- Care Connect Care Manager facilitates interdisciplinary collaboration among providers during transitions;
- Designated provider encourages the PCP's, recipients and family/caregivers to play a central and active role in the formation and execution of the care plan;
- Care Connect Care Manager provides comprehensive transitional care activities, including, whenever possible, participating in discharge planning;
- Care Connect Care Manager collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the recipient's and family members' ability to manage care and live safely in the community; and
- Care Connect Health Coach shifts the use of reactive care and treatment to proactive health promotion and self-management

5. Individual and Family Support

Recipient and family support services reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes. A defined member of the designated provider care team is responsible for engaging and educating the recipient/family about implementing the care plan using methods that are educationally and culturally appropriate. This includes assessing the barriers to care and working with the recipient/family to overcome barriers such as medication adherence, transportation and keeping appointments. Specific activities may include, but are not limited to the following:

- Care Connect Health Coach advocates for recipients and families;
- Care Connect Health Coach identifies resources for recipients to support them in attaining their highest level of health and functionality in their families and in the community;
- Care Connect Health Coach coordinates or provides transportation to medically necessary services; and
- Designated provider or Care Connect Care Manager provides information on advance directives in order to allow recipients/families to make informed decisions.

6. Referrals to Community and Social Support Services

Referrals to community and social support services provide recipients with referrals to a wide array of support services that help recipients overcome access or service barriers, increase self-management skills and improve overall health. The Care Connect designated provider has responsibility for identifying available community-based resources and managing appropriate referrals. Specific activities may include, but are not limited to the following:

- Care Connect Health Coach coordinates or provides access to recovery services and social health services available in the community (may include housing, personal need and legal services);
- Care Connect Health Coach provides assistance to obtain and maintain eligibility for health care, disability benefits, etc.;
- Care Connect Health Coach supports effective collaboration with community-based resources and
- Care Connect Care Manager and/or Care Connect Health Coach assess long-term care and other support services.

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

DSS must be notified immediately if the following occur:

- Provider additions or deletions
- Transitional Care Contact changes

Notifications can be sent via mail, email or fax to:

Division of Medical Services
Care Connects Program
700 Governors Drive
Pierre, SD 57501
605.773.3495
Fax: 605-773-5246
Email: DSS.Medicaid@state.sd.us

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 (Portal). Instructions on how to access the Medicaid Portal and the Recipient Eligibility Inquiry function are provided in Medicaid Online Portal section of this manual.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.

Care Connect services are provided to Medicaid recipients with complex chronic health and/or behavioral health needs. This population includes Medicaid and Medicare/Medicaid dually eligible beneficiaries who meet Care Connect criteria:

1. Recipients with two or more chronic conditions or recipients with one chronic condition who are at risk for a second chronic condition.
    - Chronic Conditions: Mental Health Condition, Substance Use Disorder, Asthma, Chronic Obstructive Pulmonary Disorder (COPD), Diabetes, Heart Disease, Hypertension, Obesity, Musculoskeletal and Neck/Back disorders.
    - 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.

RECIPIENT ENROLLMENT

Recipients are determined eligible based on claims data from the previous 15 months. Eligible recipients are then tiered using the Chronic Illness and Disability Payment System (CDPS). The CDPS-generated score is divided into tiers. Recipients with more conditions and higher costs result in a higher tier.

The claims data is also used to determine if recipients in Tiers 2-4 have continuity of care with an enrolled Care Connect provider. Continuity of care is defined as having a history of care with that provider through claims data or as the individual's primary care provider. If continuity of care exists, the recipient is automatically assigned to that provider and are put in the Care Connect 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 Care Connect providers if they wish to have a different provider.

Recipients who do not have an identified continuity of care provider from the claims data 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 DSS publishes a caseload list on the Portal that includes recipients assigned to Care Connect. 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
Care Connect recipients have the right to opt-out of the Care Connect program using the Decline to Participate Form. Care Connects 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 must be faxed to (605) 773-5246.

Recipient Changing Care Connects Providers
Care Connect recipients may switch Care Connect providers. Providers can assist the recipient in instance where they have documented verbal consent.

If the recipient would like to change their Care Connect Provider:

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

Re-tier
DSS will re-tier recipients annually each December, with new tiers taking effect in January of the following year. The new tier is determined by calculating the average tier from the previous six months. The average tier is then compared to the recipient's current tier, and the current tier may move up or down by one level.

Providers will receive a caseload report that includes the tier for each recipient.

Recipients who have a current tier of 1 and an average tier of 0 will be removed from the Care Connect Program effective December 31st of the current year.

Recipients who fall to a tier 1 during the re-tier process will also be removed from the Care Connect Program effective December 31st of the current year. If a provider would like to keep a Tier 1 recipient in Care Connect, the provider should outreach the Care Management team to request that the recipient be added back into the program.

MEDICAID ONLINE PORTAL

Members of the Care Connect team can use the Portal to perform many functions of the Care Connect Program. Information about how to sign-up or login to the Portal is available at: https://dss.sd.gov/medicaid/portal.aspx. Please note that Care Connect, formerly known as Health Home, is still listed as Health Home within the Medicaid Online Portal. Medicaid online portal functions include the following:

Reviewing and/or Printing Caseload Reports
A Caseload report provides important information about each recipient on each provider's panel.

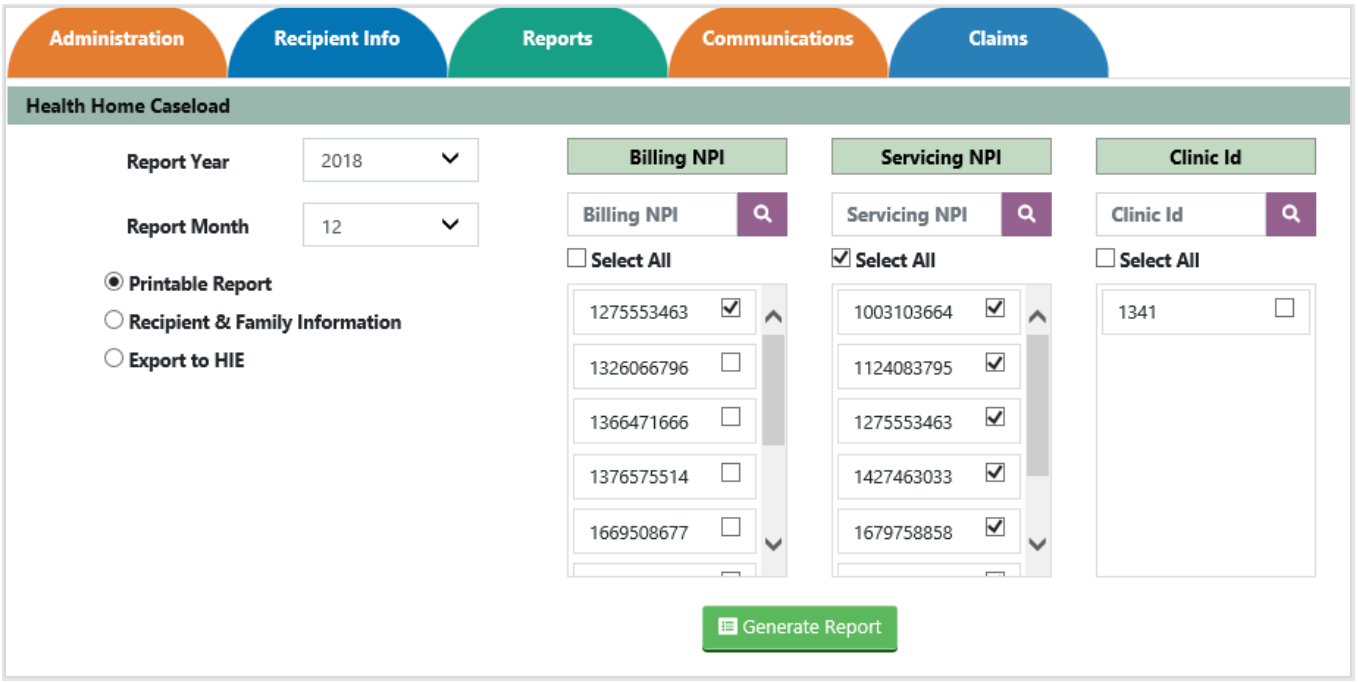
There are three types of caseload reports available in the Portal:

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.

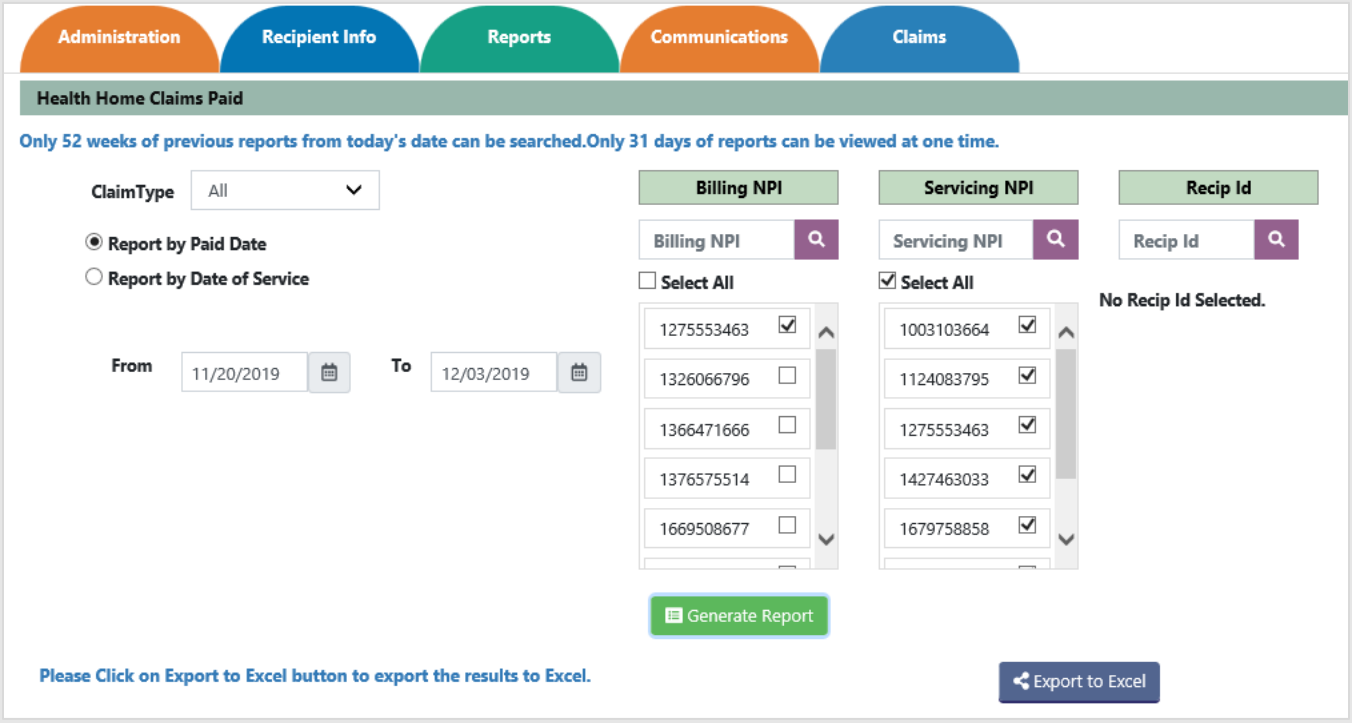
Claims Paid Report

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

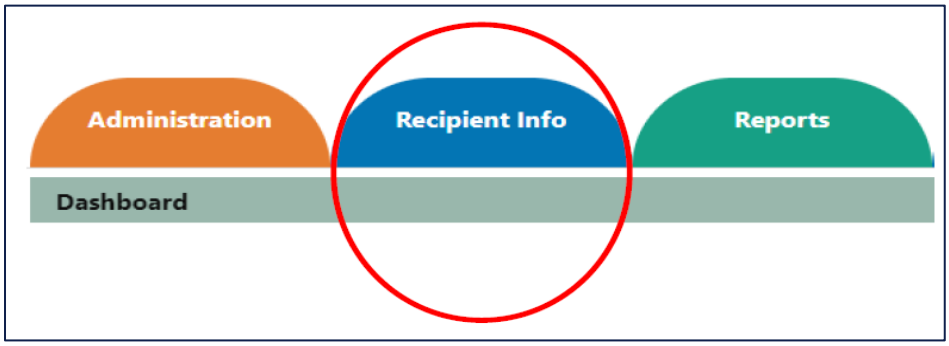
Users with Permission can also download the Claims Paid Report described above using the following steps:

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

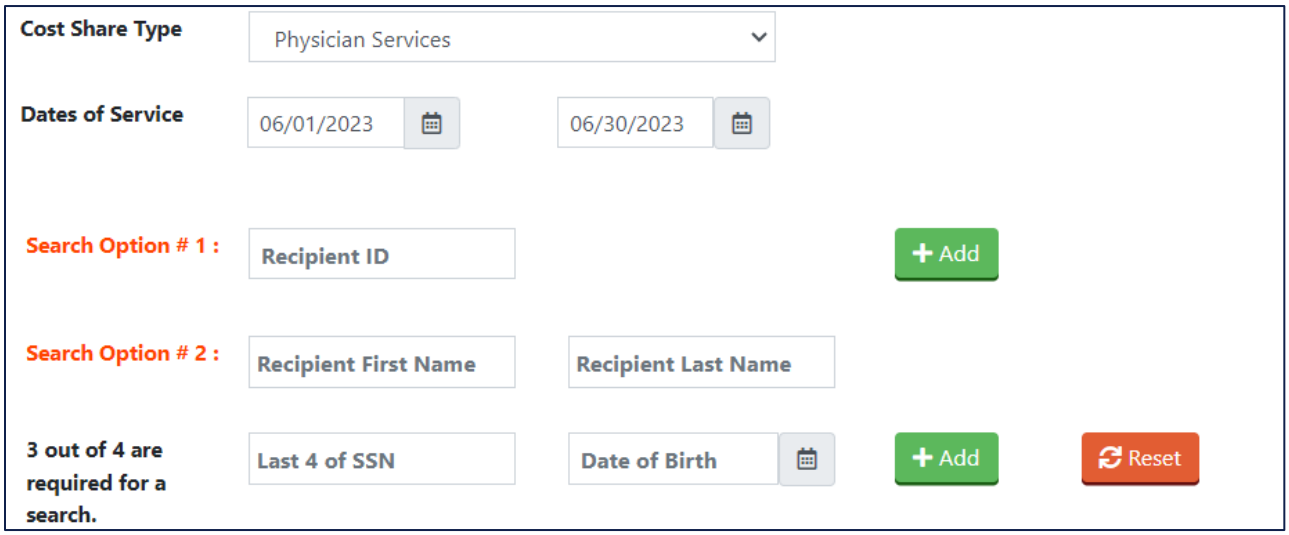


Recipient Eligibility Inquiry

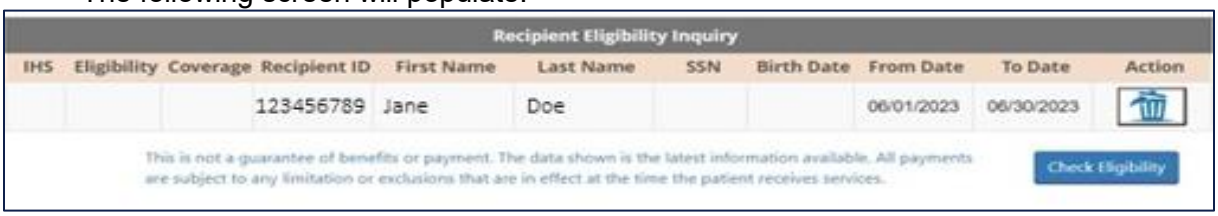
Determine if you have access to the eligibility inquiry functionality in the portal. If you see that you have the Recipient Info half-moon tab as shown below, you can access the information. If you do not see the half-moon tab you will need to request access to that functionality from the individual within your clinic or Health System who has Provider Admin permission in the portal.



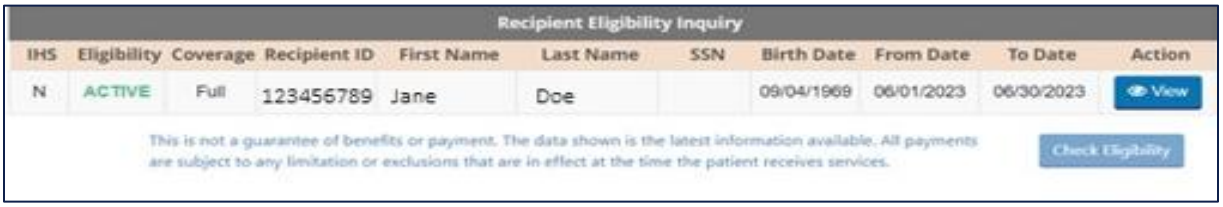
1. Click on the Recipient Info half-moon.
2. Click on Eligibility. The following screen will populate:



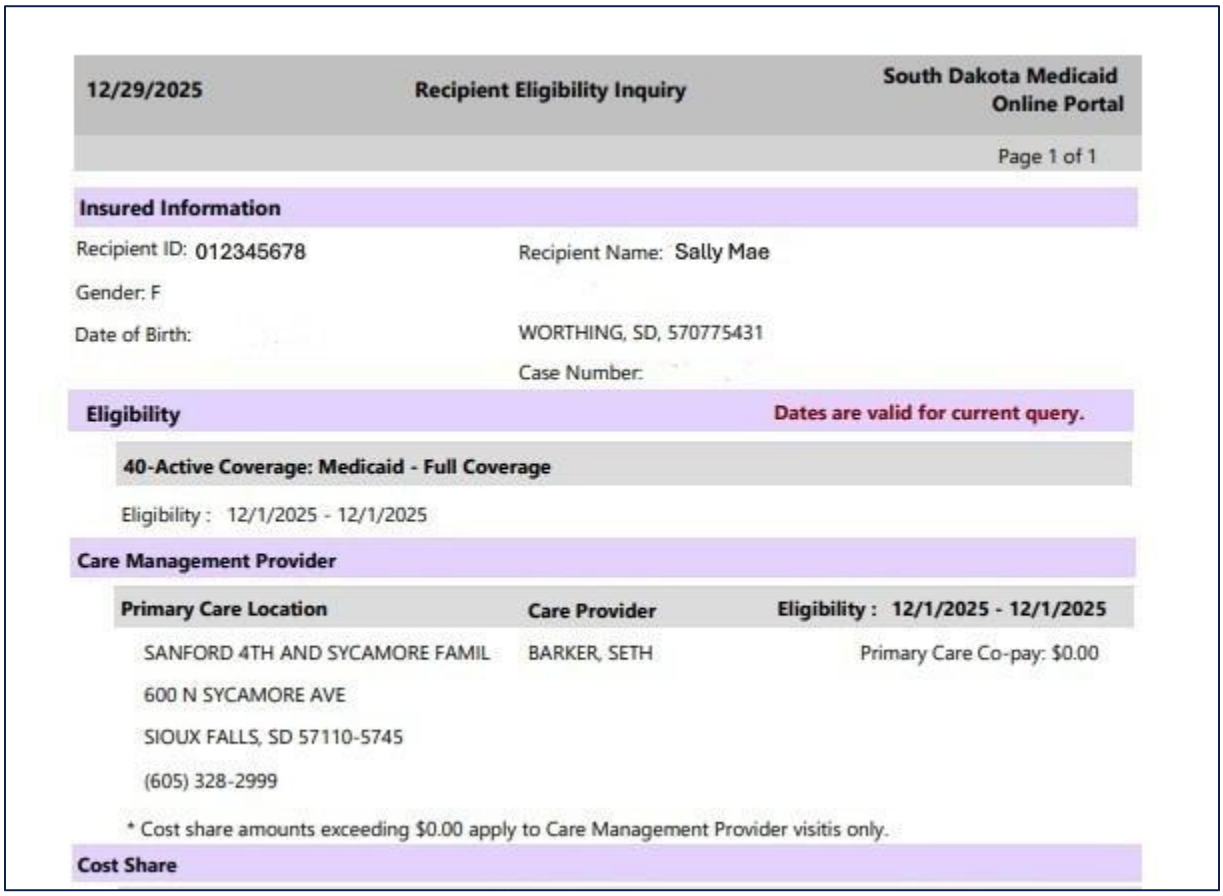
3. Complete the information requested:
   - Enter the Cost Share Type.
   - Enter the Dates of Service.
   - Enter recipient information using either:
     - Search Option 1 - Recipient ID and click the green Add button; or
     - Search Option 2 - First Name, Last Name, and Last 4 of SSN or Date of Birth and click the green Add button.
   - The following screen will populate:



4. Click on the Check Eligibility button. The following screen will populate:



5. The recipient/recipients will appear below the search options. Select View on the recipient you wish to verify. The following Recipient Eligibility Inquiry screen will populate:



Providers should use this screen to verify active eligibility. Providers may review the Care Management Provider section 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.

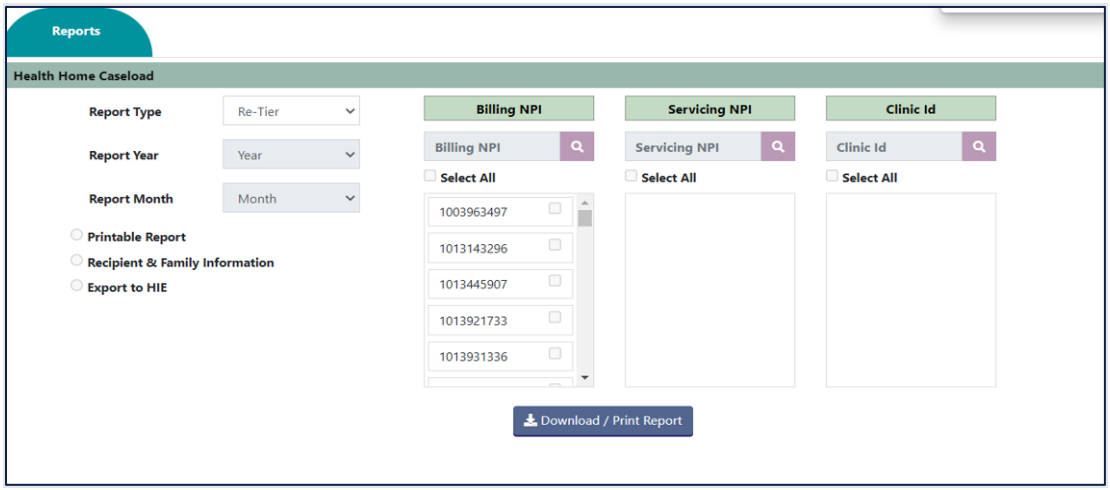
Suspension of Benefits

When the Medicaid Portal Recipient Eligibility Inquiry indicates possible suspension of benefits, eligibility for the specific date of service must be verified by contacting the South Dakota Medicaid Claims Advice and Processing (CAP) unit at 1-800-452-7691, option 2.

Portal Instructions for the 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.



Manual Tiering of Recipients

Care Connect clinics may recommend recipients for the Care Connect 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 mail, secure email or fax to:

Division of Medical Services
Care Connect Program
700 Governors Drive
Pierre, SD 57501
605.773.3495
Fax: 605-773-5246
Email: CMforms@state.sd.us

COVERED SERVICES AND REQUIREMENTS

Care Connect Core Services include:

1. Comprehensive care management;
2. Care coordination;
3. Health promotion;
4. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
5. Individual and family support, which includes authorized representatives; and
6. Referral to community and social support services if relevant.

Care Connect providers must use Health Information Technology (HIT) to link services as feasible and appropriate. Definitions of the six core service requirements are available on pages 3-6.

Care Connect providers 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. All referrals must be documented in the recipient's electronic health record. For more information on referrals please refer to the Referrals Manual.

Care Connect providers 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 Care Connect is affiliated with a calling network to serve as the after-hours contact, this may be utilized for general information calls only. Any 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 Care Connect designated provider or designated covering provider.

NON-COVERED SERVICES

A core service cannot be claimed for outreach attempts to engage recipients in the Care Connect Program. Core services may not be claimed for a service which may be individually billed to South Dakota Medicaid on a fee for service, daily or encounter rate.

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

Care Connect 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.

PERFORMANCE MEASURES

Care Connect Performance Measures are a critical factor in determining the success of Care Connect programs. Performance Measures are made up of Clinical Outcome Measures, Process Measures, and Utilization Measures. Performance measures must be submitted for every recipient that the Care Connect claimed a core service. In the absence of performance data, DSS will recoup the Per Member Per Month paid to the provider. Performance Measures and Data File Layouts can be found here.

Performance Measures are reported to DSS on a biannual basis:

Submission Deadline	Data to be Submitted
TBD by Vendor	July – December
TBD by Vendor	January - June

Each Care Connect 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. DSS will pull claims data to complete the remaining Performance Measures.

QUALITY ASSURANCE REVIEWS

South Dakota Medicaid will conduct quality assurance by requesting portions of a recipient's EHR. The quality assurance reviews help ensure that Care Connect providers are meeting Care Connect 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.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

When submitting a crossover claim for dual eligible Medicaid/Medicare recipients in the Care Connect 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

Reimbursement

Medical Services for enrolled Care Connect Program recipients are reimbursed on a fee-for-service basis. Providers will also be paid a Per Member Per Month (PMPM) Payment on a quarterly basis. The PMPM is designed to cover items typically not reimbursable by Medicaid. The PMPM will be calculated based on the number of months the recipient was in the Care Connect program during the quarter, the tier of the recipient, and reported provision of a core service.

Each recipient in Care Connects must receive one core service per quarter. If a core service is not provided, the PMPM payment cannot be claimed by the Care Connect program.

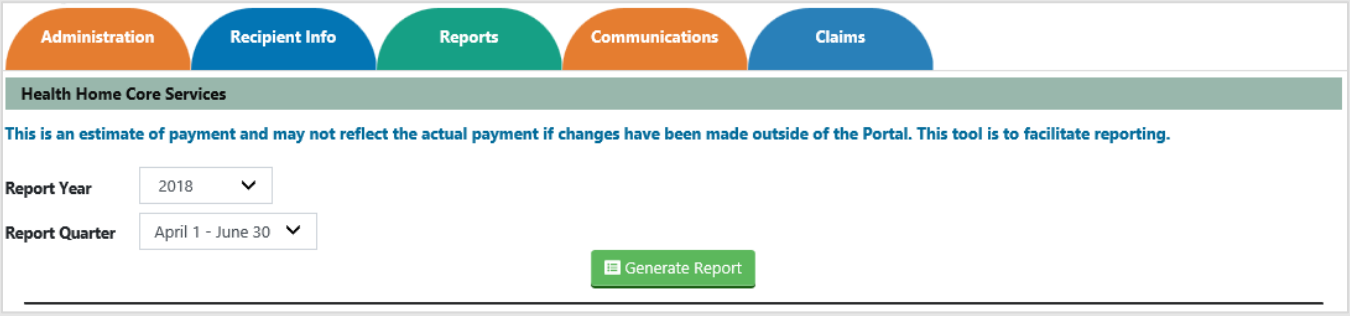
Care Connect providers are required to complete the quarterly core service report through Portal at the end of each quarter by the indicated submission date:

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

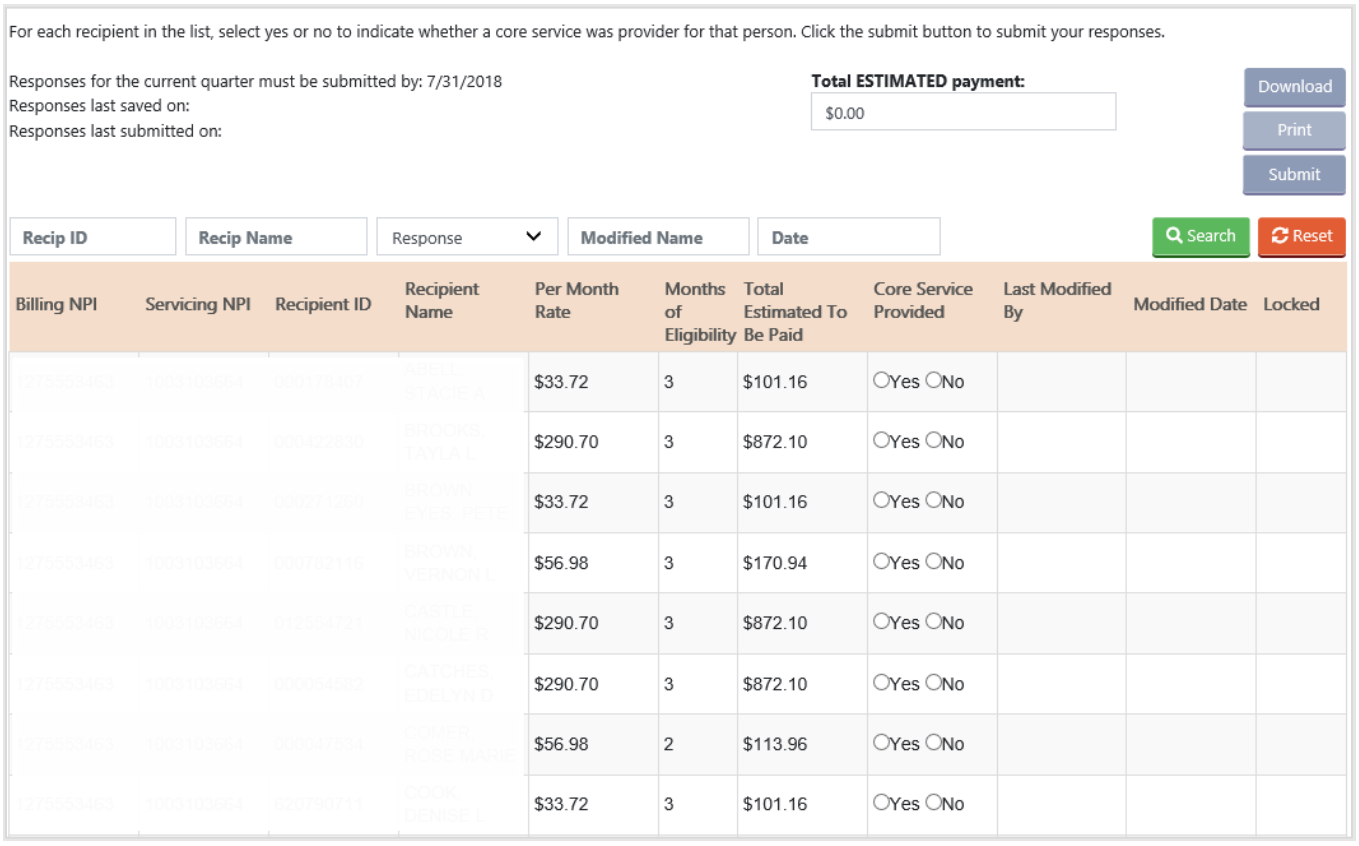
Portal Instructions for Completing the Core Services Report

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

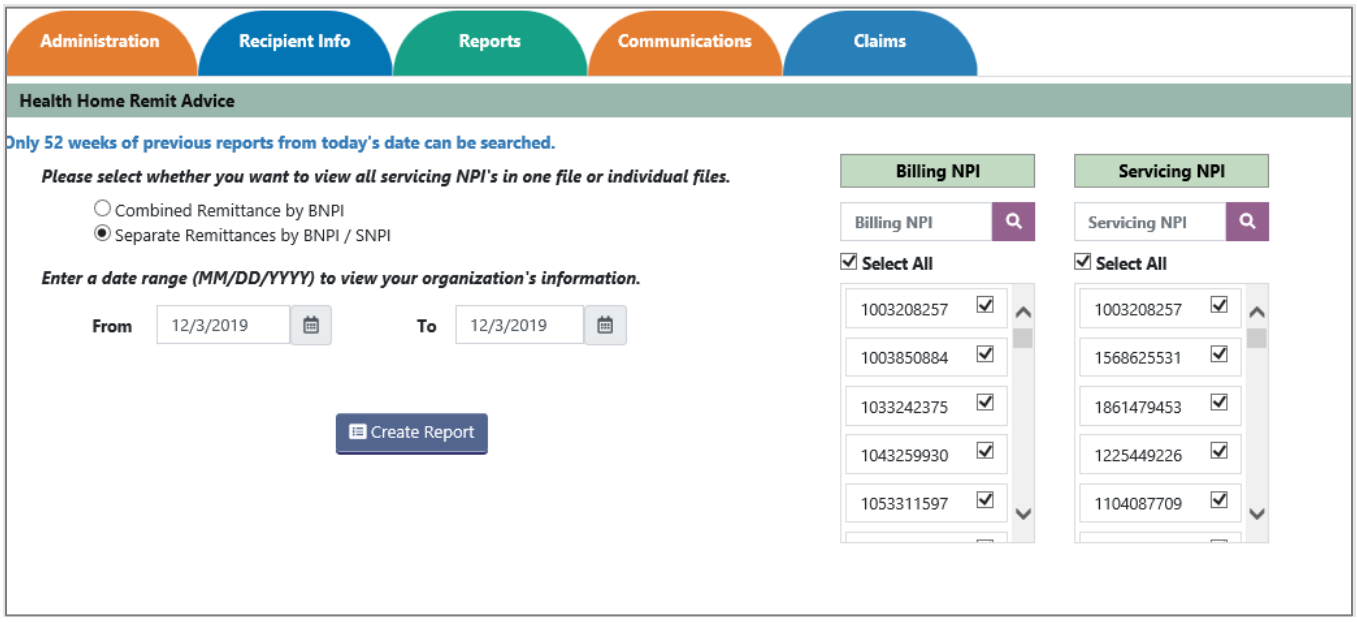
Billing NPI	Servicing NPI	Recipient ID	Recipient Name	Per Month Rate	Months of Eligibility	Total Estimated To Be Paid	Core Service Provided	Last Modified By	Modified Date	Locked
1275553463	1003103664	000178457	ABELL, STACIE A	$33.72	3	$101.16	Yes No			
1275553463	1003103664	000422830	BROOKS, TAYLA L	$290.70	3	$872.10	Yes No			
1275553463	1003103664	000271260	BROWN, ETES, PETE	$33.72	3	$101.16	Yes No			
1275553463	1003103664	000782116	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	000847544	COMER, ROSE MARIE	$56.98	2	$113.96	Yes No			
1275553463	1003103664	620790711	COOK, DENISE L	$33.72	3	$101.16	Yes No			

The PMPM payment for Care Connect Core Services will be made during the first full week after the due date of each quarterly core service report. Results of the payment can be found on the Remittance Advise, also available on the Portal.

Portal Instructions for Remittance Advice

Users with the appropriate permissions can access the Care Connect 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
4. Select BNPI/s and SNPI/s as appropriate
5. Select Create Report



REFERENCES

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

QUICK ANSWERS

1. **Can a provider disenroll from the Care Connect Program?**

   Yes, unless it is a closure situation, a Care Connect may discontinue providing Care Connects Services at the end of a quarter with a minimum of three months' notice to South Dakota Medicaid. Care Connect 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 Care Connect 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 athttps://dss.sd.gov/docs/medicaid/care_management/provider/no_contact.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/medicaid/care_management/provider/Behavior_Issues.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 Care Connect provider. A list of participating Care Connect 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 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 Care Connect provider?**

   Providers can determine a recipient's Care Connect provider using the Medicaid Online Portal Eligibility Inquiry. Care Connect 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 Care Connect provider. If they do not choose IHS/Tribal 638 as their Care Connect provider they can still receive services at any IHS/Tribal 638 facility without a referral from their Care Connect provider. For further instructions on referrals, see the Referral Manual.