

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. 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 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.

Health Home services are provided through a Designated Provider selected by the recipient or assigned by the state. The Health Home Program is one of two of South Dakota Medicaid's Care Management programs. The other Care Management Program is the Primary Care Provider Program. Recipients cannot be part of both programs at the same time but may move between the two programs if eligible. Providers may be both a Health Home designated provider and a primary care provider in the Primary Care Provider Program.

ELIGIBLE PROVIDERS

Designated providers for Health Homes include 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 Health Home status 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. A contingently designated Health Home 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.

Health Home Program Goals

A Health Home 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.

Health Home Qualifications

To qualify as a provider, Health Homes must:

- Enroll in the South Dakota Medicaid program and agree to comply with all Medicaid program requirements, including those outlined in the Health Home Provider Standards and the Health Home Core Services definitions found on page 3-4.
- Directly provide, or arrange for the provision of, Health Home services. The Health Home 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 Health Home 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 Health Home 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 Health Home 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 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 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.

Health Home Provider Standards

Under South Dakota's approach to Health Home implementation, a Health Home 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 Health Homes 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;
- Health Home Care Manager monitors recipients and population health status and service use to determine adherence to or variance from treatment plan;
- Health Home Health Coach develops and disseminates reports that indicate progress toward meeting outcomes for recipient satisfaction, health status, service delivery and costs; and
- Health Home 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 Health Home care manager or care management team is responsible for the management of the recipient's overall care plan. The Health Home 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:

- Health Home Health Coach monitors and evaluates the recipient's continuing needs, including health maintenance, prevention and wellness, long term care services and supports;
- Health Home Health Coach coordinates and/or arranges services for the recipient;
- Health Home Health Coach conducts referrals and follow-up monitoring;
- Health Home Health Coach supports the recipient's compliance with treatment recommendations;
- Health Home Care Manager participates in hospital discharges; and
- Designated provider and Health Home 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 Health Home care manager or health coach will provide health promotion activities. Specific activities may include, but are not limited to the following:

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

- Health Home Health Coach provides education regarding the importance of immunizations and screenings, and child physical and emotional development; and
- Health Home 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:

- Health Home Care Manager facilitates interdisciplinary collaboration among providers during transitions;
- Health Home 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;
- Health Home Care Manager provides comprehensive transitional care activities, including, whenever possible, participating in discharge planning;
- Health Home 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
- Health Home 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:

- Health Home Health Coach advocates for recipients and families;
- Health Home 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;
- Health Home Health Coach coordinates or provides transportation to medically necessary services; and
- Designated provider or Health Home 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 Health Home 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:

- Health Home 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);
- Health Home Health Coach provides assistance to obtain and maintain eligibility for health care, disability benefits, etc.;
- Health Home Health Coach supports effective collaboration with community-based resources and
- Health Home Care Manager and/or Health Home Health Coach assess long-term care and other support services.

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.

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
Health Homes Program
700 Governors Drive
Pierre, SD 57501
605.773.3495
Fax: 605-773-5246
Email: CMforms@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.

Health Home 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 Health Home 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 Health Home 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 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 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 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 must be faxed to (605) 773-5246.

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)
- Make the requested change using the online selection tool <https://pcphhselection.appssd.sd.gov/>.

Re-tier

DSS will re-tier 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.

MEDICAID ONLINE PORTAL

Members of the Health Home team can use the [Portal](#) to perform many functions of the Health Home Program. Information about how to sign-up or login to the Portal is available here:

<https://dss.sd.gov/medicaid/portal.aspx>. 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

The screenshot shows a web application interface for generating a Health Home Caseload report. At the top, there are five navigation tabs: Administration (orange), Recipient Info (blue), Reports (green), Communications (orange), and Claims (blue). Below the tabs is a header for "Health Home Caseload". The main area contains several input fields and selection options:

- Report Year:** A dropdown menu set to "2018".
- Report Month:** A dropdown menu set to "12".
- Report Type:** Three radio button options: "Printable Report" (selected), "Recipient & Family Information", and "Export to HIE".
- Billing NPI:** A search box with a magnifying glass icon, a "Select All" checkbox (unchecked), and a list of NPIs with checkboxes: 1275553463 (checked), 1326066796 (unchecked), 1366471666 (unchecked), 1376575514 (unchecked), and 1669508677 (unchecked).
- Servicing NPI:** A search box with a magnifying glass icon, a "Select All" checkbox (checked), and a list of NPIs with checkboxes: 1003103664 (checked), 1124083795 (checked), 1275553463 (checked), 1427463033 (checked), and 1679758858 (checked).
- Clinic Id:** A search box with a magnifying glass icon, a "Select All" checkbox (unchecked), and a list with one entry: 1341 (unchecked).

At the bottom center, there is a green "Generate Report" button.

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

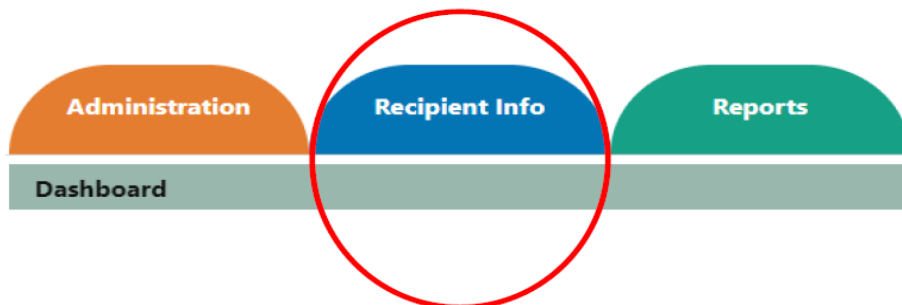
Users with Permission can also download the Claims Paid Report described above using the following steps:

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:

Cost Share Type

Dates of Service

Search Option # 1 :

Search Option # 2 :

3 out of 4 are required for a search.

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:

Recipient Eligibility Inquiry										
IHS	Eligibility	Coverage	Recipient ID	First Name	Last Name	SSN	Birth Date	From Date	To Date	Action
			123456789	Jane	Doe			06/01/2023	06/30/2023	

This is not a guarantee of benefits or payment. The data shown is the latest information available. All payments are subject to any limitation or exclusions that are in effect at the time the patient receives services.

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

Recipient Eligibility Inquiry										
IHS	Eligibility	Coverage	Recipient ID	First Name	Last Name	SSN	Birth Date	From Date	To Date	Action
N	ACTIVE	Full	123456789	Jane	Doe		09/04/1969	06/01/2023	06/30/2023	<input type="button" value="View"/>

This is not a guarantee of benefits or payment. The data shown is the latest information available. All payments are subject to any limitation or exclusions that are in effect at the time the patient receives services.

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:

06/05/2023	Recipient Eligibility Inquiry	South Dakota Medicaid Online Portal
		Page 1 of 1

Insured Information

Recipient ID: 001234567	Recipient Name: JANE DOE
Gender: F	1234 RIVER RUN AVE,
Date of Birth: 09/26/1975	SIOUX FALLS, SD, 571101234
	Case Number: 123456789

Eligibility **Dates are valid for current query.**

40-Active Coverage: Medicaid - Full Coverage

Eligibility : 6/1/2023 - 6/30/2023

Primary Care Provider/Health Home Provider

Primary Care Location	Primary Care Provider	Eligibility : 6/1/2023 - 6/30/2023
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AVERA MEDICAL GROUP INTERNAL ME 1301 S CLIFF AVE STE 400 SIOUX FALLS, SD 57105-1023 (605) 322-5750	MILLER, RYAN	Primary Care Co-pay: \$0.00
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* Cost share amounts exceeding \$0.00 apply to non-PCP/HH provider visits only.

Providers should use this screen to verify active eligibility. Providers may review the Primary Care Provider/Health Home 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.

The screenshot shows a web application interface for generating reports. At the top left, there is a 'Reports' tab. Below it, the 'Health Home Caseload' section contains several filters: 'Report Type' (set to 'Re-Tier'), 'Report Year' (set to 'Year'), and 'Report Month' (set to 'Month'). There are also three radio buttons for report options: 'Printable Report', 'Recipient & Family Information', and 'Export to HIE'. The main area is divided into three columns: 'Billing NPI', 'Servicing NPI', and 'Clinic Id'. Each column has a search bar and a 'Select All' checkbox. The 'Billing NPI' column contains a list of NPI numbers: 1003963497, 1013143296, 1013445907, 1013921733, and 1013931336. At the bottom center, there is a blue button labeled 'Download / Print Report'.

Manual Tiering of Recipients

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 mail, secure email or fax to:

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

COVERED SERVICES AND REQUIREMENTS

Health Home 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.

Health homes 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.

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. 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.

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. 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 health home designated provider or designated covering provider.

NON-COVERED SERVICES

A core service cannot be claimed for outreach attempts to engage recipients in the Health Home 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

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.

REPORTING REQUIREMENTS

Core Services Reporting

Health Homes are required to report their Health Home Core Services on quarterly basis. Core services for a quarter must be submitted by the submission date stated on the next page.

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

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.

Performance Measures Reporting

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 DSS 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. DSS 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, DSS will recoup the Per Member Per Month (PMPM) payments for the provider for that time period.

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 Health Homes are meeting Health Home 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 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](#)

Reimbursement

Medical Services for enrolled Health Home 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 Health Home during the quarter, the tier of the recipient, and reported provision of a core service.

Each recipient in Health Homes must receive one core service per quarter. If a core service is not provided, the PMPM payment cannot be claimed by the Health Home.

Health Homes 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 provided 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:

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
1275503463	1000103664	000178407	ABELL, STACIE A	\$33.72	3	\$101.16	<input type="radio"/> Yes <input type="radio"/> No			
1275503463	1000103664	000422830	BROOKS, TAYLOR L	\$290.70	3	\$872.10	<input type="radio"/> Yes <input type="radio"/> No			
1275503463	1000103664	000271280	BROWN, EVELYN PETE	\$33.72	3	\$101.16	<input type="radio"/> Yes <input type="radio"/> No			
1275503463	1000103664	000782116	BROWN, VERNON L	\$56.98	3	\$170.94	<input type="radio"/> Yes <input type="radio"/> No			
1275503463	1000103664	012034721	CASTLE, NICOLE R	\$290.70	3	\$872.10	<input type="radio"/> Yes <input type="radio"/> No			
1275503463	1000103664	000054582	CATCHER, EDWARD	\$290.70	3	\$872.10	<input type="radio"/> Yes <input type="radio"/> No			
1275503463	1000103664	000007030	CUMPTON, MARIE	\$56.98	2	\$113.96	<input type="radio"/> Yes <input type="radio"/> No			
1275503463	1000103664	020730711	COOK, DENISE L	\$33.72	3	\$101.16	<input type="radio"/> Yes <input type="radio"/> No			

The PMPM payment for Health Home 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 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
4. Select BNPI/s and SNPI/s as appropriate
5. Select Create Report

Administration Recipient Info Reports Communications Claims

Health Home Remit Advice

Only 52 weeks of previous reports from today's date can be searched.

Please select whether you want to view all servicing NPI's in one file or individual files.

Combined Remittance by BNPI
 Separate Remittances by BNPI / SNPI

Enter a date range (MM/DD/YYYY) to view your organization's information.

From 12/3/2019 To 12/3/2019

Create Report

Billing NPI	Servicing NPI
<input checked="" type="checkbox"/> 1003208257	<input checked="" type="checkbox"/> 1003208257
<input checked="" type="checkbox"/> 1003850884	<input checked="" type="checkbox"/> 1568625531
<input checked="" type="checkbox"/> 1033242375	<input checked="" type="checkbox"/> 1861479453
<input checked="" type="checkbox"/> 1043259930	<input checked="" type="checkbox"/> 1225449226
<input checked="" type="checkbox"/> 1053311597	<input checked="" type="checkbox"/> 1104087709

GROUNDINGS FOR DISMISSAL OF A HEALTH HOME

Health Homes may be disenrolled by DSS due to failure to comply with the program requirement. This includes:

- 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.

DSS will work collaboratively with the Health Home to comply with the requirements of the Health Home Program.

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 [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](#).