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MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN=S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: South Dakota
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

James W. Ellenbecker
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children=s Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Damian L Prunty Position/Title: Program Administrator
Name: Larry Iversen Position/Title: Assistant Program Administrator
Name: Rick LaBrie Position/Title: Program Manager

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. Providing expanded benefits under the State=s Medicaid plan **(Title XIX)**; **OR**

1.1.3. X A combination of both of the above.

Since July 1, 1998 South Dakota has provided SCHIP benefits to uninsured children by providing expanded eligibility under the State's Medicaid plan. The original SCHIP plan included children age 6 through 18 from 100% to 133% of the Federal Poverty Level. The initial SCHIP program was approved on August 5, 1998, and a subsequent eligibility expansion with Medicaid occurred on April 1, 1999 that increased eligibility from 133% FPL to 140% FPL for children from birth to age 19 for both Medicaid and SCHIP program. South Dakota refers to its original SCHIP program, with subsequent expansion as M-SCHIP.

Subsequently, in July 2000, South Dakota added a State operated SCHIP program for targeted uninsured children from families with income levels higher than previously approved SCHIP eligibility levels. The new eligibility level, active outreach and beneficiary enrollment began on July 1, 2000. There was no corresponding amendment to the Medicaid State Plan submitted in conjunction with the SCHIP expansion at that time as Medicaid eligibility income levels remained unchanged. South Dakota refers to its separate child health program as CHIP-NM. Collectively, M-SCHIP and CHIP-NM are referred to throughout this document as SCHIP.

This State Plan Amendment does not seek to replace the approved SCHIP State Plan materials, but will add the appropriate information describing the additional requirements and assurances mandated as a result of the final SCHIP federal regulations. This State Plan Amendment will also update the existing pages of the current SCHIP State Plan. .

The Secretary of the Department of Social Services is the authorized State Official signing and submitting this State Plan Amendment. The Official responsible for program administration and financial oversight is Damian Prunty, Administrator, Office of Medical Services, South Dakota Department of Social Services, 700 Governors Drive, Pierre, South Dakota 57501 2291.

1.2 Γ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

The State assures specific legislative authority to operate an expansion of the SCHIP program under Title XXI of the Social Security Act was granted by Act of the South Dakota Legislature and signed into law by the Governor of South Dakota.

The authority for M-SCHIP was granted by Act of the South Dakota Legislature and signed into law by the Governor of South Dakota, effective July 1, 1998. No expenditures for child health assistance were claimed for M-SCHIP prior to July 1, 1998.

The authority for CHIP-NM was granted by Act of the South Dakota Legislature and signed into law by the Governor of South Dakota, effective July 1, 2000. No expenditures for child health assistance were claimed for CHIP-NM prior to July 1, 2000.

1.3 Γ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

With this State Plan submission the State assures that it will comply with all civil rights requirements including Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date: M-SCHIP became effective July 1, 1998 / CHIP-NM became effective July 1, 2000

Implementation date: M-SCHIP was implemented July 1, 1998 / CHIP-NM was implemented July 1, 2000

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

South Dakota's original SCHIP state plan provided a complete description of South Dakota's population, estimates of the uninsured population and information on the populations served by the Medicaid program and IHS. Little has changed in the basic demographic profile of the State in the years that have elapsed. This SCHIP state plan amendment will recap the increases in enrollment in creditable health coverage and the corresponding reductions that have taken place in South Dakota since the 1998 SCHIP State Plan was implemented.

The following table shows the number of Medicaid and SCHIP eligible children from just prior to SCHIP implementation and for the last day of each quarter through March of 2002. . The number of Medicaid eligible children does not include children eligible in SSI categories.

Quarter Ending	*Medicaid Children*	*SCHIP Children*
06/30/1998	*32,859*	*0*
09/30/1998	*34,290*	*903*
12/31/1998	*35,320*	*1,407*
03/31/1999	*36,435*	*1,710*
06/30/1999	*36,866*	*2,039*
09/30/1999	*37,158*	*2,488*
12/31/1999	*37,768*	*2,790*
03/31/2000	*39,195*	*3,179*
06/30/2000	*39,538*	*3,725*
09/30/2000	*39,887*	*4,681*
12/31/2000	*40,841*	*5,555*
03/31/2001	*42,550*	*6,277*
06/30/2001	*43,974*	*6,729*
09/30/2001	*44,658*	*7,171*
12/31/2001	*45,712*	*7,666*
03/31/2002	*46,805*	*7,972*

Source: SD MMIS 1998,1999,2000,2001,2002

Beginning July 1, 1998 eligibility levels for Medicaid and M-SCHIP were increased to include children ages 6 through 18 in families with incomes above 100% but not exceeding 133% of the FPL. Beginning April 1, 1999 the income eligibility levels for Medicaid and M-SCHIP increased from 133% to 140% of the FPL for children from birth through age 18. Beginning July 1, 2000, eligibility levels for SCHIP were increased and included children birth through age 18 from 141% to 200% of the FPL, with implementation of CHIP-NM.

Children from families with incomes in the expanded levels, who were uninsured and not otherwise eligible for Medicaid, received SCHIP coverage. All others who were eligible received Medicaid. The chart shows that the number of children with qualified coverage from Medicaid or SCHIP increased by 21,918 during the time period of SCHIP operation.

During this time period, 83% of the Medicaid enrolled children had no other health coverage when enrolled in the Medicaid program. All SCHIP enrolled children were, by definition, uninsured. Using this information the following table shows the number of uninsured children who received qualified coverage since SCHIP implementation.

Medicaid-SCHIP Enrollment of Uninsured Children				
Baseline Year	*Reporting Period*	*Uninsured Medicaid*	*SCHIP*	*Total*
1999	*06/30/1998-09/30/1998*	*1,188*	*903*	*2,091*
2000	*10/01/1998-09/30/1999*	*2,381*	*1,585*	*3,966*
2000	*10/01/1999-09/30/2000*	*2,265*	*2,192*	*4,457*
2001	*10/01/2000-09/30/2001*	*3,960*	*2,490*	*6,450*
2002	*10/01/2001-03/31/2002*	*1,782*	*801*	*2,583*
Totals		*11,576*	*7,971*	*19,547*

Source: MR63

The Census Bureau Current Population Survey reported 13,000 uninsured children under 200% of the FPL for South Dakota based upon its three year averages from 1996,1997 and 1998. South Dakota believes the CPS estimate was the best source of baseline data available for the number of uninsured children when SCHIP was implemented. The data in the preceding table indicates the actual enrollees into the Medicaid or SCHIP programs that were uninsured prior to enrollment. In 2001, South Dakota was one of nine states awarded a one-year Health Resources and Services Administration grant to develop a plan for expanding access to affordable health coverage to all state residents. The State contracted with The Lewin Group to collect and analyze information about the uninsured and underinsured in South Dakota. The Lewin Group concluded that South Dakota's uninsured population for children under

the age of 19 is considerably less than the CPS estimates. The Lewin Group estimates that 9,600 children under the age of 19 are uninsured in South Dakota as of the year 2000 . South Dakota believes that number to be further reduced, as evidenced by the preceding table for inclusion of enrollment of uninsured children in the years 2001 and 2002. South Dakota believes the enrollment of nearly 20,000 uninsured children into Medicaid or SCHIP, since implementation of SCHIP in July of 1998, has had a major impact on the number of uninsured children in South Dakota.

Minority enrollments have also increased significantly under the State's SCHIP efforts. The most recent Statistical Enrollment Data System (March 2002) indicates that South Dakota had 1,839 American Indian children enrolled in the SCHIP program. This represents over 23% of the total number of children enrolled in the SCHIP program. Enrollment of American Indian children in Medicaid and SCHIP collectively, has grown by 44% from July 1, 1998 to March of 2002. It is the Department's opinion that SCHIP efforts have been successful in increasing the number of American Indian children with creditable health coverage.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

State efforts to enroll uninsured children prior to the implementation of the SCHIP program in South Dakota are documented in the original SCHIP plan. Medicaid was the primary public health insurance program at that time and the SCHIP program efforts built upon the existing Medicaid program. The key relationships with other DSS programs, Public Health, Education, Human Services and IHS will continue to be in place and are a vital part of SCHIP outreach efforts.

The enrollment of SCHIP eligible children is greatly enhanced by the widespread availability of Medicaid eligibility throughout the state. Coordinated delivery of multiple programs from the Department of Social Services using generalized co-located eligibility workers and automated information systems enhance the identification and enrollment of children into SCHIP and Medicaid. Access to program coverage is greatly assisted by the widespread availability of participating Medicaid providers throughout the state.

Established relationships with other public health programs operated by the State of South Dakota also provide numerous opportunities to identify and enroll children into Medicaid and SCHIP. Interagency agreements between the

Departments of Health and Social Services establish referral mechanisms between the programs operated by the agencies. WIC, Community Health Services, Baby Care, MCH, Title V and Children's Special Health Services programs are key referral sources for families seeking medical coverage for children. South Dakota's Federally Qualified Health Centers, community and migrant health centers are very involved as sources of information about the State's medical assistance programs to assist in identifying and enrolling uncovered children, in addition to serving as primary care providers.

Interagency agreements also exist with the Department of Education and the Department of Human Services to provide for the referral of children to the Department of Social Services for medical coverage. Individual school districts in the State also participate as direct services providers under Medicaid and therefore have incentives to identify and assist enrolling children in Medicaid and SCHIP programs.

Close collaboration between the Department of Social Services and the Indian Health Service to identify and enroll Medicaid and SCHIP eligible children is a key priority for both agencies. The Department of Social Services recognizes the critical importance of the IHS as a service provider in the Indian reservation areas of the State. The IHS as a provider and payer of services, relies very heavily upon third party funding for services they are responsible for, and therefore is a proven referral source for potentially eligible children.

The initial implementation of the SCHIP program provided a number of opportunities for improved outreach and a greater opportunity for outreach partners to participate in SCHIP outreach. Administrative changes were some of the most significant improvements made with the implementation of SCHIP. Notable among these administrative changes were the development of a new, shorter application form for Medicaid and SCHIP, dropping the requirement for face to face interviews, elimination of assets testing, reduced documentation requirements and direction for DSS eligibility staff to actively participate in program outreach.

The new application form for Medicaid low income children and SCHIP eligibility has been reduced to 3 pages from a form that had been over 30 pages in length. The new form, because of its size and simplicity has been widely distributed to outreach sites including other government agencies, schools, primary care and specialty health care providers, advocacy groups, tribal programs, and day care centers. In addition to the shortening of the form, and eliminating assets information the new form also has reduced documentation requirements as only earnings and childcare expenses need to be verified by the applicant family.

The completed eligibility forms may be mailed or faxed to DSS eligibility offices without the need for a face to face interview. However, DSS caseworkers are available at DSS offices to assist with completing the applications if necessary. Workers at some outreach sites are also trained to assist with basic questions regarding Medicaid and SCHIP eligibility.

Redetermination for low income Medicaid and SCHIP has also been simplified. Redeterminations are conducted annually for eligible families and are initiated by DSS caseworkers that mail the redetermination materials to the families a month in advance. The redetermination materials do not require more information than the application process, and can be completed through the mail or fax.

Eligibility for individuals applying for Food Stamps, TANF, or other Medicaid programs is also simplified, as an additional application form is not required to obtain low income Medicaid or SCHIP coverage.

There is significant evidence to support the assertion that the changes to the application process have facilitated the identification and enrollment of uncovered children. Face value evidence exists in the growth in the number of uninsured children in Medicaid and SCHIP. Annual surveys conducted of the families of children enrolled in the Medicaid and SCHIP programs in 1998 and 1999 reported that 95% and 98% respectively, responded positively to the question on the ease of the application process.

Since the inception of the SCHIP program the State has used a number of approaches to conduct outreach to clients in addition to collaboration with other health or children's programs. Included among the outreach approaches are direct mailings by the State to clients, the use of brochures and posters, client education sessions, an eligibility 800-telephone number, ads on public access television, paid radio announcements and public service announcements. Most effective among these efforts are the education sessions, direct mailings, and collaborations with other programs and the use of brochures. Least effective have been the radio and public access television ads.

Department of Social Services staff and collaborating agencies have conducted client outreach in many different settings. Included as some of the most effective settings for outreach are community health centers, health care provider locations, schools and adult education sites, Tribal agencies, social service agencies, local government offices, Headstart programs, and local charities. Many other locations such as laundries, fast food restaurants, libraries and senior centers have also been tried with less effectiveness.

Surveys of SCHIP enrollees were conducted to assist in evaluating SCHIP implementation in South Dakota in both 1998 and in 1999. One of the items surveyed was outreach effectiveness. In the 1998 survey 76% of the respondents indicated that they had obtained information about the coverage program from the Department of Social Services. However, in comparison to the 1999 survey it appears the community based outreach efforts were increasing in effectiveness as only 55% of the respondents indicated the Department of Social Services was their source of information about SCHIP. Increasing in outreach effectiveness from 1998 to 1999 were community health nursing, health care providers and schools. Tribal health agencies also contributed effective outreach in both surveys.

American Indians are the largest minority population living in South Dakota. Approximately 7% of South Dakota's population is American Indian, primarily residing on the 9 Indian Reservations within the States boundaries. For this reason specific outreach approaches have been considered for this population. Among the efforts specifically directed at American Indian persons are Consultation meetings held between the State and Tribal Government and Tribal Health officials. In addition, the Department has invited both Tribal Government and the IHS to be represented on the Medicaid Advisory Committee that assists in the monitoring of the Medicaid and SCHIP programs, and both entities are participating.

Some Tribal health departments have requested specific training of the their Community Health Representative staff in the SCHIP program and this training was provided by Department eligibility staff. One reservation even adapted the SCHIP radio ad to use in reaching the Indian population on their reservation.

Outreach brochures, posters and logos for SCHIP were designed with a culturally sensitive logo depicting children of varying ethnic backgrounds in an effort to convey that the program is intended for all races of children.

South Dakota has also had a successful applicant for the "South Dakota Covering Kids Initiative" through grant funding from the Robert Wood Johnson foundation for a three-year period of time from July 1, 2000 through June 30, 2003. The Community Healthcare Association of Sioux Falls, SD was the successful applicant. The South Dakota Covering Kids Initiative has four goals. They are: designing and conducting outreach programs to identify and enroll children in the Medicaid and SCHIP programs; continuing to simplify access to and completion of enrollment information and applications; assisting in coordinating coverage programs for low income, uninsured children; and designing programming specifically targeted to Native Americans and other

special populations. The program will feature statewide initiatives to meet these goals and also pilot programs to address specific geographic areas and special populations.

The Community Healthcare Association of Sioux Falls does not contribute any funds to the State of South Dakota for the operation of the Covering Kids Initiative. This organization conducts their own outreach and targets Native American and other special populations in specific geographical areas of the state. This grant money is not being used to match any federal dollars for SCHIP.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

When South Dakota implemented its SCHIP program in July of 1998, the South Dakota Caring Program for Children was a public-private partnership to make very limited services available to eligible children. The Program operated on an annual donation from Wellmark Blue Cross Blue Shield of South Dakota, administrative support from the South Dakota Department of Health, and private donations. The Caring Program did not provide qualified health care coverage, did not operate in all parts of South Dakota, and covered only a very limited number of children under 133% of FPL. No Caring for Children benefits would have ever been available to children expected to be served by the CHIP-NM program. The South Dakota Caring for Children Program ceased to exist in 1999, long before action by the state to implement a CHIP-NM program.

South Dakota counties continue to be required to provide medical services for persons in the State who are determined medically indigent. Eligibility is restricted to persons with very limited income and resources. Services are restricted to coverage of emergency hospital services only, with the exception of two counties, Minnehaha and Pennington which operate community health centers to make primary care clinic services available. As such, the County Indigent Program is not a health resource available to low income uninsured children with needs for full coverage of primary and preventive health care. All counties operate as the payer of last resort and provide referrals and assistance with Medicaid applications.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*

(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

The key programs providing creditable coverage for low-income children in South Dakota are the Medicaid and M-SCHIP programs that are jointly administered by the South Dakota Department of Social Services. The interagency agreements identified in Section 2.2.1 on page 8 serve as the referral procedures that the State uses to accomplish the coordination with Title V, WIC and MCH for both the Medicaid and SCHIP programs. The interagency agreements serve to assure the services provided under Title V, WIC, MCH, Title XIX and Title XXI are consistent with the needs of recipients and both the Department of Social Services and the Department of Health's objectives and requirements to promote high quality health care and services.

There are no other State programs that provide creditable coverage for low-income children. The South Dakota Caring for Children program had existed as a private effort to provide very limited health coverage to low-income children, however operations under that program ceased in 1999. There are no other private programs that offer creditable coverage for low-income children in South Dakota.

The Indian Health Service continues as a provider of creditable coverage to Indian children. The IHS functions as a provider of services and also provides coverage for certain specialty services through their contract health program. Coordination with the IHS will continue in the same way as coordination with the Medicaid program. The IHS will be reimbursed for the direct services they provide to SCHIP children at the same rate of payment as the South Dakota Medicaid program. Since the IHS contract care program is the payer of last resort under Federal Regulations, the SCHIP program will be primary to IHS contract care. Benefit coordination will be accomplished by the IHS denying claims they receive and causing the claims to be submitted to the SCHIP program for payment just as currently happens with Medicaid. Payment for those services under the SCHIP program will be on the same basis as established for the Medicaid program.

The IHS also plays a very important role in the delivery of outreach services to facilitate the identification and enrollment of low-income children for Medicaid and SCHIP . This role will continue for potentially eligible SCHIP children using the established means to

interface with the Department of Social Services medical assistance programs.

There are no other public programs providing creditable coverage to low-income children. Children potentially eligible for other public programs will be referred to those programs for services in addition to those provided by Medicaid, M-SCHIP or CHIP-NM.

Children covered by Medicare will not be enrolled in SCHIP as they have creditable coverage.

Section 3. Methods of Delivery and Utilization Controls **(Section 2102)(a)(4))**

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan**, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

South Dakota's original implementation of SCHIP began in July of 1998 with the expansion of the State's Medicaid program to include children age 6 through 18 from 100% to 133% of the Federal Poverty Level. Under this program expansion eligible children with insurance coverage were enrolled in Medicaid and uninsured children not otherwise eligible for Medicaid were enrolled in SCHIP. In April of 1999, SCHIP implementation via Medicaid expansion continued as the income level for eligibility was increased from 133% of the FPL to 140% for children from birth to age 19 for both the Medicaid and M-SCHIP programs. Again, insured children received Medicaid benefits, and targeted uninsured children received M-SCHIP.

South Dakota's third effort under Title XXI to expand coverage to targeted uninsured children included the method of delivering child health assistance is through a state administered program. The State Administered program, called CHIP NM, is operated directly by the South Dakota Department of Social Services. Children to be covered under the CHIP-NM program are uninsured children from birth to age 19 in families with incomes above 140% of the FPL and not exceeding 200% of the FPL. As the single state agency for Medicaid the Department is jointly administering CHIP-NM with the Medicaid and M- SCHIP programs using DSS eligibility, outreach, benefit payment, reporting and management resources. General Funds have been appropriated by the South Dakota State Legislature to provide matching funds for Federal Title XXI funds.

Benefits delivered to targeted uninsured children under the CHIP-NM state administered program are identical to the benefits offered under the State's Medicaid and M-SCHIP programs, including EPSDT benefits. Health care services are delivered using the existing delivery and payment systems including primary care case management and access to specialty health service providers, as approved under the State's 1915(b) waiver under Medicaid. South Dakota will request the managed care waiver be incorporated into it's Medicaid and SCHIP state plans. The State can assure that children receiving services under SCHIP will receive the same beneficiary protections as children receiving Medicaid coverage including grievances and appeals, privacy and confidentiality, respect and non-discrimination, access to emergency services, and an opportunity to participate in health care treatment decision and choice of providers. The State can also assure that it is providing SCHIP services in an effective and efficient manner by using Medicaid policies and procedures.

Children are considered uninsured if they do not qualify for Medicaid and have not had group health plan coverage in the three months immediately prior to application for the SCHIP program.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

Services provided under SCHIP will share the utilization controls used by the Medicaid program to ensure that only health care services that are appropriate, medically necessary, and approved by the State are used. Children covered under SCHIP will be enrolled into a primary care case management system to ensure access to primary care and to provide monitoring and authorization for required specialty medical services. The primary care case management system used will be the PRIME program operated for Medicaid and SCHIP children in South Dakota, authorized by CMS under a 1915(b)(1) waiver. South Dakota will request the managed care waiver be incorporated into it's Medicaid and SCHIP state plan.

The SCHIP program will also share the Medicaid SURS resources for post payment review of services provided to SCHIP children. Appropriateness and necessity for care are also monitored by the Department through a contract with the Professional Review Organization (PRO), also used by the Medicaid and Medicare programs in South Dakota. Pharmacy services for SCHIP will be dispensed via a Medicaid point of service computer system that provides prospective drug utilization review on each

prescription filled. Additionally, specialized medical services requiring prior authorization under the Medicaid program will also require prior authorization under the SCHIP program.

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. **X** Geographic area served by the Plan: Statewide.

4.1.2. **X** Age: Birth to age 19 will be served.

4.1.3. **X** Income: Children from families with incomes over 140% FPL up to 200% FPL. The plan will use current Medicaid definitions of income, and allows deductions for child support paid and actual child care expenses for employment related daycare up to $500 per month for the family. In addition, the first $50 of current child and spousal support paid to the family unit, and earned income of children under 19 years old who are living with a caretaker, are also deducted. For children from families with incomes under 140% FPL, the additional income disregards are 20% of earned income and actual daycare costs associated with employment.

4.1.4. ~ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. **X** Residency (so long as residency requirement is not based on length of time in state) : Children must be residents of the State of South Dakota and meet the citizenship and immigration status requirements applicable to Medicaid.

4.1.6. ~ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. **X** Access to or coverage under other health coverage: Children must not be eligible for Medicaid or covered under any other health insurance or group health plan. Children may not have had insurance coverage under a group health plan in the three months immediately prior to CHIP-NM application unless such coverage was dropped for good cause or access to care not available under the policy.

4.1.8. **X** Duration of eligibility: Eligibility is based on a month to month basis and is redetermined annually for all children. Eligibility may begin up to the first day of the third month prior to the application. Families are required to report all changes that may effect their eligibility, when the change occurs.

4.1.9. **X** Other standards (identify and describe): Families must cooperate with the Department to determine the actual or potential existence of third party coverage for medical expenses, and to establish initial or ongoing eligibility. The Department requires the social security numbers for individuals who are requesting assistance under the SCHIP Medicaid expansion option.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. **X** These standards do not discriminate on the basis of diagnosis.

4.2.2. **X** Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. **X** These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

The SCHIP program follows the same eligibility process that is used by the Medicaid program for low-income children. . The process begins with potentially eligible individuals obtaining and completing an application form obtained from the Department of Social Services, or from any of the many local entities that are participating with outreach for the Medicaid and SCHIP programs. The short application form must be completed and signed by the head of household or parent of the children. The forms may then be mailed or delivered to the client's local office from among the 41 Department of Social Services offices through out the State. Assistance in completing the forms is available from the Department of Social Services, including assistance for persons with Limited English Proficiency or disabilities.

Families applying for medical assistance, including the SCHIP program are provided with a pamphlet that explains SCHIP eligibility, the scope of covered services, and the limited cost sharing. The pamphlets are written in accurate, easy to understand language to assist families in making a decision to apply for medical assistance.

Information collected on the form includes identifying information of the parents of the children under age 19 requesting medical assistance, the children in the home who are under age 19, health insurance information for the persons requesting medical assistance, income information, child support payment information, and child care expense information. Verifications of income, childcare expenses paid so a person can work, and child support paid (unless paid to the child support enforcement office) must be included with the application. The application form also contains a simplified financial work sheet to assist potentially eligible persons make an estimate of their income, relative to the eligibility guidelines to assist them in making a decision to apply for benefits.

Department of Social Services caseworkers will make the eligibility determinations based on the information reported on the applications, other information available to the department, and Department regulations and policies. The Department will make decisions within 45 days of the receipt of the application with written notification of the result directly to the applicant parent or head of household.

Upon approval, families will be notified of the eligible children, receive an information packet including information on covered services, the primary care case management program, EPSDT benefits, and other important information. This information includes a description of the scope and duration of covered benefits, and access to emergency services. Clients are also notified of the need to choose a primary care provider and given a listing of the provider's names and locations in their area. Clients are also notified of their rights to appeal and grievance processes, non-discrimination, and the confidentiality of client/patient information. SCHIP beneficiaries receive the same beneficiary information and protections as beneficiaries of the Medicaid program as both are delivered by the Department of Social Services.

Ongoing eligibility is monitored by requiring families to report changes that might affect their eligibility when they occur. The reporting procedures and forms for reporting changes under SCHIP are the same as those used for Medicaid.

Annual redeterminations are completed after 12 months of eligibility. The Department, during the 11th month of eligibility, initiates the redetermination process by mailing a redetermination packet to families. The information required and the redetermination process is very similar to the initial enrollment process. The redetermination process is completed prior to the end of the original eligibility period so families receive timely notice and there is no break in coverage if eligibility continues. Eligibility for Medicaid, and SCHIP will be reviewed during the redetermination process and the children enrolled in the appropriate coverage program. Children who had been eligible for SCHIP will have Medicaid eligibility reviewed at redetermination, and if Medicaid eligible, will be enrolled in the Medicaid

program.

4.3.1 Describe the state=s policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

X Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

The application form for SCHIP medical assistance in South Dakota also is used for the Medicaid program. Verifications of income and income deductions must be provided with the application. Information on the insurance status of individuals requesting assistance is required on the application form. Clients completing the form do not have a choice for a particular program of medical assistance. Department of Social Services caseworkers determine eligibility for each of the States' medical assistance programs, Medicaid, M-SCHIP and CHIP-NM and make the decisions on which program is providing coverage.

Caseworkers use statewide procedures and a uniform, statewide eligibility database. Automated editing of intake data provides assistance to the caseworkers. The statewide database allows caseworkers to do follow up screening on applications to access eligibility information from other DSS programs, IEVS verifications, and an individual's prior eligibility history. Insurance information including type of coverage, name and address of carrier, policy numbers and dates of coverage are part of the automated database maintained by the department for third party liability and eligibility purposes.

The caseworker will decide the appropriate category or program of coverage for the children depending on income and insurance status as follows:

- *Uninsured children birth to age 19 from families with incomes from over 140% to 200% of the FPL will receive CHIP-NM;*
- *Uninsured children age 6 through 18 from families with incomes from over 100% of FPL to 140% of FPL will receive M-SCHIP;*
- *Uninsured children under age 6 from families with incomes from over 133% to 140% of FPL will receive M-SCHIP;*
- *Insured children, children age 6 through 18 from families with incomes below 100% of FPL, and children under age 6 from families with incomes below 133% of FPL will receive Medicaid.*
- *Children otherwise eligible for Medicaid under other eligibility categories will receive Medicaid.*
- *Children who are residents of public institutions will not be eligible for any coverage.*
- *Income eligible children who are residents of Institutions for Mental Disease will receive Medicaid.*

After making an eligibility decision, the caseworkers will enroll the eligible children in the appropriate program for health coverage. Children who are potentially eligible for Medicaid other than under low-income categories based on the information that has been submitted on the short form will not be approved for SCHIP . Denied applications will receive a notice that includes the reason for the denial, a notification of fair hearing, and a form to submit additional information to pursue Medicaid eligibility on another basis of eligibility.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

Children found eligible for Medicaid are enrolled in the Medicaid program as described in 4.4.1.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Children found ineligible for Medicaid enrollment may be enrolled in M-SCHIP or CHIP-NM as described in 4.4.1. All Medical Assistance Programs are jointly administered by the Department of Social Services. A new application is not required if there is not break from Medicaid to SCHIP enrollment.

4.4..4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. **X** Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

SCHIP has specific measures to prevent the program from substituting for coverage under group health plans. The first measure is simply that persons covered by insurance providing hospital and medical services or HMO's are not eligible for benefits under SCHIP. Another measure to prevent substitution is that children are ineligible if they have been covered by a group health plan in the 3 months immediately preceding the application for SCHIP. The Department has adopted a definition of group health plan that includes employers, self-employed plans, employee organizations, and self insured plans that provide health care directly or otherwise. There are exceptions to the 3-month rule when the parents providing the insurance die, become disabled, lose their jobs, or start new jobs without coverage. Exceptions will also be made if care is not accessible under the group plan, or group plan coverage costs more than 5% of the SCHIP family's gross income.

The Department also requires that insurance information on the persons seeking medical assistance coverage be provided on the application for SCHIP as a measure to avoid substitution for group health coverage. The Department also requires that members of the SCHIP unit cooperate with the Department to determine the availability of coverage. Failure to cooperate may result in loss of eligibility for the unit.

The Department also maintains a database on persons with insurance coverage for persons applying for or receiving medical assistance from the Department under Medicaid, M-SCHIP or CHIP-NM. The database includes type of coverage, name and address of carrier, policy numbers, plan sponsor, premium payer, and dates of coverage. Information from this database is available to caseworkers to explore potential group health coverage. Caseworkers also have the opportunity to update the information on this database to keep the information up to date.

Targeted, low-income children belonging to employees of State government in South Dakota will not be eligible for SCHIP coverage

since the State provides indirect assistance for the coverage of dependants in excess of the cost to cover the employee alone, regardless of the coverage choices made by the family. Children of employees of other government entities in South Dakota will have the coverage evaluated to ensure that there is no meaningful (exceeding $10.00 per month) employer contribution for group health coverage to dependent children.

The Department will monitor whether or not coverage under SCHIP is substituting for coverage under group health plans by conducting survey random surveys. The surveys contain questions relating to insurance coverage, and specifically asks questions in order that 'crowd out' can be measured. In addition to the department's random survey, the South Dakota Department of Health conducts a Behavioral Risk Factor Surveillance Survey (BRFSS), as described in Section 9.3, that asks specific questions regarding the dropping of private health insurance for public assistance programs. The responses of both surveys are computed, documented and are included in the SCHIP annual report to measure the affect of crowd-out.

The State also monitors the number of SCHIP applicants who are denied eligibility due to substituting coverage under group health plans within 3 months prior to application. Additionally, the State monitors the number of SCHIP applicants who are denied or closed due to existing health insurance. This information is captured in a reporting mechanism that is also included in the SCHIP annual report to measure whether recipients are trying to substitute private health insurance for public assistance.

4.4.4.2. Γ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. Γ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. Γ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4..5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

SCHIP is available to all targeted low-income Indian children in South Dakota regardless of tribal membership, enrollment, or affiliation. Inasmuch as the program is a statewide program, SCHIP is also made available to children living on Indian reservations within the State's borders. Indian children not living on reservations are also potentially eligible for SCHIP coverage. The availability of services through the Indian Health Service is not considered insurance for the Medicaid, M-SCHIP or CHIP-NM program.

To help assure SCHIP is provided to Indian eligible children the Department has outreach efforts directed towards the Indian reservation areas of the state. The Indian Health Services currently plays and will continue to play a very important outreach role for targeted, low- income Indian children. Applications, enrollment assistance, and program information for SCHIP is available at IHS, Tribal, and Urban Indian Health locations in South Dakota.

SCHIP services will be provided to Indian children in the state eligible to receive services from the Indian Health Service as the Indian Health Service facilities and providers are enrolled as health care providers for the SCHIP program and eligible for reimbursement for services provided to SCHIP children. Tribal clinics and other providers are also eligible for reimbursement for covered services under SCHIP as are Urban Indian Health clinics.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

The CHIP-NM program built on the existing programs of coverage for low income, and low-income uninsured children, (Medicaid and M-SCHIP), to provide health coverage for additional uncovered children in South Dakota. Outreach for these programs in South Dakota was implemented with a strategy for statewide outreach coordination and a local outreach strategy. Statewide outreach was accomplished with the participation of other programs offered by the Department of Social Services, other State agencies and the Indian Health Service. Outreach at this level relied on interagency agreements to facilitate referrals and the use of automated systems for information sharing on potentially eligible children. Administrative reforms of the eligibility process, publicity materials and advertising were also part of this outreach.

Local coordination has been effectively done in communities and service areas of the State by Department of Social Services eligibility staff establishing connections with local resources to facilitate the identification and enrollment of children. Health care providers, schools, Tribal agencies, and many others have been very involved in distributing materials, providing applications and information, and assisting with enrollment.

Outreach for CHIP-NM program built on the successful outreach strategies already in place for the State's medical assistance efforts. However, recognizing the differences in the income levels of the families targeted by CHIP-NM new efforts were made to supplement existing outreach, to help reach those potentially eligible for CHIP-NM. These additional outreach efforts began with a statewide training of Department of Social Services eligibility staff prior to the implementation of the program. New materials were developed for distribution and use around the state to prepare for the operation of the program including application forms, information sheets, brochures, and posters. Local Department of Social Services staff renewed connections with outreach partners to inform them of the new program and expanded eligibility levels. Medicaid and M-SCHIP providers were notified of the new program of coverage so they will be prepared to deliver health services.

The Department will also consider expanding the range of outreach partners to include entities not traditionally involved in outreach for publicly financed health care programs including the South Dakota Department of Labor, Job Service and other

employment agencies, large and small employers and job training programs.

Section 6. Coverage Requirements for Children=s Health Insurance **(Section 2103)**

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ~ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ~ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ~ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ~ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ~ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3. ~ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If Aexisting comprehensive state-based coverage≅ is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for Aexisting comprehensive state-based coverage.≅

6.1.4. **X** Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. **X** Coverage the same as Medicaid State plan

6.1.4.2. Θ Comprehensive coverage for children under a Medicaid

Section 1115 demonstration project

6.1.4.3. Θ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. Θ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. Θ Coverage that is the same as defined by Aexisting comprehensive state-based coverage≅

6.1.4.6. Θ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. Θ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

Services provided under SCHIP are identical to the benefits covered under the South Dakota Medicaid program for low-income children in amount, scope and duration. As such the benefits include all mandatory Medicaid services for the categorically needy and ESPDT benefits as well as all the optional services covered under the South Dakota Medicaid program.

Most medical services provided to children under South Dakota Medicaid are accessed through a primary care case management managed care system approved for Medicaid under a 1915(b) waiver. South Dakota will request the managed care waiver be incorporated into its Medicaid and SCHIP state plans. Children eligible for services under SCHIP will also be required to participate in the primary care case management system (PCCM). Under this program, a primary care physician (PCP) provides primary care services. Specialty services within the scope of the managed care program require a referral from the PCP. Emergency services, family planning services, and non-medical services (dental, chiropractic, optometry, podiatry, immunization and transportation), are exempt from all PCCM requirements. Non-waiver services are accessed directly by recipients. All services are reimbursed on a fee for service basis. There is no cost sharing for services provided to children under this plan.

Generally, all services provided under the Medicaid program must be "medically necessary". SCHIP services must also meet the requirements of the definition of medically necessary used by Medicaid. Medically necessary services are those that:

- *are consistent with the recipient's symptoms, diagnosis, condition, or injury*
- *are recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group*
- *are provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition*
- *are not furnished primarily for the convenience of the recipient or the provider*
- *there is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.*

6.2.1. **X** Inpatient services **(Section 2110(a)(1))**

Inpatient services include services provided in general acute care hospitals and specialty hospitals including rehabilitation, long term care, surgical specialty, psychiatric and children's hospitals. Specialized units of acute care hospitals including neonatal intensive care, rehabilitation and psychiatric units are also covered. Inpatient hospital services are included as PCCM services requiring referrals. Psychiatric, Rehabilitation, and Long Term Care hospitals require prior authorization. Emergency psychiatric hospitalizations are authorized after admission. Inpatient surgeries that are normally performed in outpatient settings must be prior authorized. The Department monitors neonatal Intensive Care Services. There are no limitations on services provided.

6.2.2. **X** Outpatient services **(Section 2110(a)(2))**

Outpatient hospital services include laboratory services, X ray and other radiology services, emergency room services, medical supplies used during treatment at the facility, physical therapy, speech therapy, and occupational therapy when furnished or supervised by a licensed therapist and periodically reviewed by a physician, whole blood or packed red cells, drugs and biologicals which cannot be self-administered, dialysis treatments, services of hospital-based physicians, and outpatient surgical procedures. Outpatient hospital services are included as PCCM services. There are no limitations on services provided.

6.2.3. **X** Physician services **(Section 2110(a)(3))**

Physician services include medical and surgical services; services and supplies furnished incidental to the professional services of a physician; psychiatric services; drugs and biologicals administered in a physician's office which cannot be self-administered; routine physical examinations; routine visits to a facility, home and community-based provider, or home; and family planning services. Services provided by nurse practitioners, physician assistants, nurse midwifes, and certified registered nurse anesthetists within their scope of practice are also covered. Specialty services are included as PCCM services requiring referrals. There are no limitations on services provided.

6.2.4. **X** Surgical services **(Section 2110(a)(4))**

Surgical services covered in addition to those provided under hospital or physician services include those services provided in ambulatory surgical centers (ASC) to patients who do not require hospitalization. Services include nursing, technician, use of ASC facilities, drugs, biologicals, surgical supplies, equipment, diagnostic and therapeutic services directly related to the provision of surgical procedures. Surgery services are included as PCCM services. There are no limitations on services provided.

6.2.5. **X** Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative items services provided by federally qualified health centers and rural health or services under the medical direction of a physician and provided at the clinic or center. Clinic and center services are included as PCCM services and clinics and centers are eligible to be primary care providers. Services are limited to two visits per day, if the second visit is due to illness or injury sustained after the first visit.

6.2.6. **X** Prescription drugs **(Section 2110(a)(6))**

Prescription drug services include the following drugs, biologicals, and related items and services that are prescribed:

- *Legend eye preparations, vaginal therapeutics, otic pharmaceutical preparations, or inhalations for asthmatic conditions;*

- *Antibiotic products which are known, either by sensitivity test or product information, to be the single item of choice for the diagnosis;*
- *All other legend prescription drugs and biologicals, except for the items listed below.*
- *Insulin;*
- *Concentrated cryoprecipitate used in the home treatment of hemophilia;*
- *Legend vitamins prescribed for the prenatal care of pregnant women;*
- *Calcitriol if used for renal impairment and determined medically necessary by the prescriber;*
- *Spacers, such as Aerochamber and InspirEase, and solutions that are medically necessary for the administration of legend drugs used for the delivery of respiratory or inhalation therapy;*
- *Syringes and needles for the administration of medication covered under this chapter;*
- *Urine and blood testing items for a diabetic, except for glucometers, which are covered as medical equipment;*
- *Family planning items; and*
- *Smoking cessation drugs.*

Non-covered services include:

- *Non-legend prescription drugs and over-the-counter items and medical supplies except for those specifically listed above;*
- *Medical supplies or delivery charges;*
- *Legend oral vitamins except for legend vitamins prescribed for the prenatal care of pregnant women.*
- *Items prescribed for weight control or appetite depressants;*

- *Agents to promote fertility or treat impotence;*
- *Agents used for cosmetic purposes;*
- *Hair growth products;*
- *Items or drugs manufactured by a firm that has not signed a rebate agreement with the CMS ;*
- *Items which exceed a 34-day supply, except for family planning items and prenatal vitamins;*
- *Services, procedures, or drugs which are considered experimental;*
- *Drugs and biologicals which the federal government has determined to be less than effective.*

Prescription drug services are included as PCCM services, with the exception of family planning drugs and items. Azidothymidine is available only for persons diagnosed with HIV. Clozaril and growth

hormones are prior authorized.

6.2.7. **X** Over-the-counter medications **(Section 2110(a)(7))**

See 6.2.6.

6.2.8. **X** Laboratory and radiological services **(Section 2110(a)(8))**

Covered under 6.2.1, 6.2.2, 6.2.3, 6.2.4, 6.2.5 for diagnostic and treatment purposes. Coverage includes materials and services of technicians. Laboratory services are not included as PCCM services. There are no limitations on services provided.

6.2.9. **X** Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

Covered under 6.2.3, 6.2.5,6.2.6. Family planning and prenatal maternity care services are fully covered. Family planning services are exempt from PCCM requirements. There are no limitations on services provided.

6.2.10. **X** Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

Inpatient mental health services are provided in three different service settings. Psychiatric Inpatient Hospital services are covered under 6.2.1 and include psychiatric care in general acute care hospitals, psychiatric distinct part units, and free standing psychiatric hospitals, including a state operated adolescent psychiatric unit.

Inpatient psychiatric facility services are provided to children, with prior authorization. These services are exempt from PCCM requirements. There are no limitations on services provided.

Inpatient residential treatment services for children are covered in residential treatment facilities. Coverage is limited to the treatment services provided and does not include room and board costs. Services are prior authorized. There are no limitations on services provided.

6.2.11. **X** Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental

hospital and including community-based services **(Section 2110(a)(11)**

Outpatient mental health services are covered in 6.2.3 when provided by physicians.

- *Outpatient mental health services are covered in community mental health centers and include the following services:*
- *Evaluations completed by a psychiatrist;*
- *Evaluations or testing completed by a psychologist;*
- *Comprehensive evaluations completed utilizing the expertise of more than one mental health professional;*
- *Therapy provided to an individual;*
- *Therapy provided to groups of two or more individuals, not exceeding ten persons;*
- *Therapy provided to a family unit;*
- *Partial day care services for a duration of three to six hours a day, including various types of therapy elements; and*
- *Consultation with a psychiatrist, psychologist, or other mental health professional or physician concerning the patient's diagnosis or plan of treatment.*
- *Outpatient mental health services are also available from licensed psychologists, certified social workers in private independent practice, and licensed professional counselors-mental health. Services include psychiatric evaluation, diagnostic interviews, individual, group and family therapy, and psychological testing. Services are limited to the equivalent of 40 hours of individual therapy per 12 month period, unless additional services are prior authorized.*

Outpatient mental health services are included as PCCM services, unless provided to a person diagnosed as chronically mentally ill.

6.2.12. **X** Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

Durable medical equipment is covered and includes devices and assistive technology including:

- *devices for persons confined to beds, including hospital beds, bed pans, urinals, commodes, trapeze, lifts, standers, and pressure reduction therapy devices if extensive pressure sores exist;*

- *mobility devices including wheelchairs and accessories (seats, trays, cushions, and positioning devices), canes, crutches and walkers;*
- *oxygen and respiratory equipment and supplies;*
- *glucose monitoring equipment and supplies;*
- *dialysis equipment;*
- *apnea monitors;*
- *infusion pumps;*
- *hearing aids and augmentative communication devices;*

Medical equipment is purchased or rented at the discretion of the Department and requires documented medical necessity. Some devices have specific coverage criteria and limitations. Disposable supplies used with the equipment are included in coverage.

Prosthetic devices, except dental, are included for coverage, including braces, artificial limbs, artificial eyes, augmentative communication devices, items to replace all or part of an internal body organ, and the replacement of such devices required by a change in the patient's condition.

Eyeglasses and contact lenses are included in coverage and may be obtained from optical providers, physicians as described in 6.2.3, and optometrists along with professional services. Eyeglasses are limited to replacement after 15 months, unless significant vision changes have occurred.

Durable Medical Equipment and prosthetic devices are included in the PCCM program. Eyeglasses and services of vision professionals are not included in the PCCM program.

6.2.13. **X** Disposable medical supplies **(Section 2110(a)(13))**

Disposable medical supplies are covered when medically necessary under each of the forms of coverage in Section 6.2.

6.2.14. **X** Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

Home and community based services are covered when medically necessary and ordered by a physician and provided by a home health agency or qualified professional. Home health services include medical supplies, skilled nursing services, home health aide services,

physical therapy, speech therapy, occupational therapy, respiratory therapy when ventilator dependant, and medical social services. Individuals receiving these services must be unable to leave home without considerable effort. Services are of an intermittent nature, not more than once per day or 4 times per week. There is no limit on the number of visits a person may receive.

Extended home health aide services and private duty nursing services are covered when more than 3 consecutive hours of care are necessary. These services must be prior authorized.

Home based therapy services are also covered for children with mental disorders or who are seriously emotionally disturbed. A treatment plan must exist that documents the need for home based therapy services. Covered services include diagnostic assessment, individual therapy, family therapy, and collateral services. Services must be prior authorized.

6.2.15. **X** Nursing care services (See instructions) **(Section 2110(a)(15))**

Nursing care services are covered as described in 6.2.1, 6.2.2, 6.2.3, 6.2.4, 6.2.5 and 6.2.14.

6.2.16. **X** Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

Coverage is the same as Medicaid coverage.

6.2.17. **X** Dental services **(Section 2110(a)(17))**

Dental services are covered including diagnostic services (oral examinations and x-rays), preventive services (prophylaxis, topical fluoride, and sealant), restorative services (amalgam restorations, resin restorations, and crowns to anterior teeth), endodontics, prosthodontics (complete and partial dentures, adjustments, and repairs).

Medical/Dental procedures are also covered including oral surgery for extraction, surgical extractions and tooth reimplantation, treatment of fractures, reduction of TMJ dysfunction, and periodontics. Medically necessary orthodontic procedures including diagnosis, minor treatment, interceptive orthodontic treatment and treatment of dentition are covered.

Dental exams, prophylaxis, and topical fluoride are limited to two services in a 12-month period, sealants are limited to once in a three year period. Orthodontic services in excess of $500 must be prior authorized.

All dental services are exempt from the PCCM program.

6.2.18. **X** Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

Inpatient treatment for substance abuse services are covered in certified facilities designed specifically for chemically dependent adolescents. Services are not included in the PCCM program, however, referrals from a physician or court are required. Services are prior authorized. Services are limited to 45 days in a 12 month period. Programs designed for substance abusing pregnant women are covered.

6.2.19. **X** Outpatient substance abuse treatment services **(Section 2110(a)(19))**

Outpatient treatment for substance abuse services are covered in certified facilities designed specifically for chemically dependent adolescents. Programs designed for substance abusing pregnant women are covered. Services are not included in the PCCM program however, referrals from a physician or court are required. Services are prior authorized. Services are limited to 60 hours in a 12-month period.

6.2.20. **X** Case management services **(Section 2110(a)(20))**

Case management services are provided to all SCHIP children through the primary care case management program. Each program enrollee select or is assigned a primary care case management physician to provide the management and treatment of medical conditions and provide for referral for specialty care services. The primary care case manager can be either a physician (Family Practice, Internal Medicine, Pediatrics, OB-GYN, General Practice) or rural health clinic, federally qualified health center, or IHS facility. Services excluded from case management are emergency services, family planning, dental, podiatry, optometry, chiropractic, immunization, transportation and mental health services for chronically mentally ill clients.

Targeted case management services are available to severely and persistently mentally ill individuals at least 18 years of age when obtained from a certified case manager. The case managers provide face to face services including client identification and follow up, coordination of needs assessments, development of a case management plan, service mobilization, linkage and case monitoring. Services must include at least four units of service per month and non face to face services are limited on a monthly basis.

6.2.21. ~ Care coordination services **(Section 2110(a)(21))**

6.2.22. **X** Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders are covered when provided under forms of coverage in 6.2.1, 6.2.2, 6.2.4, 6.2.5, and 6.2.14. The services are also available from individual providers within their scope of practice when referred by physicians and required to diagnose or treat a medical condition. These services may also be provided by school districts when medically necessary and identified as part of a child's individual education program. The services are included in the PCCM program. There are no limitations on the services provided.

6.2.23. **X** Hospice care **(Section 2110(a)(23))**

Hospice benefits will follow the amount, duration and scope of coverage as identified in the State Medicaid manual.

6.2.24. **X** Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

Other medical services included in the plan are Chiropractic Services, Vision Services, Podiatry Services, Nutritional Services, Nursing Facility Services, Diabetes Self-management training programs, Vaccination Services and certain Organ Transplant Services.

Chiropractic services are limited to examinations and manual manipulations required to correct a subluxation of the spine. Services are outside of the PCCM program and limited to no more than one visit per day and thirty visits in a twelve-month period.

Vision services, in addition to the services of physicians in 6.2.3 include the services of optometrists. Covered services include examinations, removal of foreign bodies from the eye, vision screenings, and refractive services, eyeglasses and contact lenses. Services are outside of the PCCM program. Eyeglasses are limited to replacement after 15 months unless significant vision changes have occurred.

Podiatry services include the surgical and non-surgical diagnosis and treatment of conditions of the feet and lower extremities, excluding routine foot care. Services are outside of the PCCM program. There is no limit on the number of services provided.

Nutritional services are covered for children not able to obtain necessary nutrition through oral means. Enteral and perenteral nutrition are covered services. Perenteral nutrition services are prior authorized. Nutritional supplements are covered when physician ordered for conditions that exceed normal nutritional requirements.

Nursing Facility services are covered when medically necessary and individuals meet level of care and financial eligibility criteria for long term care. Nursing facility services are prior authorized.

Immunization services include all recommended vaccinations and are covered under Section 6.2.6, prescription drugs.

Organ transplant services include Kidney, Cornea, Bone Marrow, Liver and Heart Transplants. All transplant services are covered only when all other medical and surgical treatments have been exhausted, patients are free from adverse factors and there is likelihood of success or survival. Transplants are limited to the transplantation of human organs. With the exception of kidney and cornea transplants, transplant procedures are prior authorized.

6.2.25. ~ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. **X** Medical transportation **(Section 2110(a)(26))**

Medical transportation includes medically necessary air ambulance, ground ambulance, wheelchair transportation and other medical transportation. Ambulance services are necessary when other forms of transportation may endanger a person's life or health. Ground

ambulance includes advanced life support and basic life support services and attendants. Air ambulance includes fixed wing emergency transportation, rotary emergency transportation, and medical air transportation. Air ambulance must be medically necessary because of time, distance and emergency. Wheelchair transportation includes transportation services to persons that are confined to wheelchairs or stretchers to and from medical services.

Other transportation services are available to assist persons obtain necessary medical services. These services include reimbursement for the use of private automobiles, meals and lodging, community transportation providers, tribal transportation providers and commercial carriers.

6.2.27. ~ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ~ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. **X** The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ~ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ~ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28.** **(Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** **(Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ~ **Purchase of Family Coverage.** Describe the plan to purchase

family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

The SCHIP program will use the methods that exist for the Medicaid program to assure quality and appropriateness of care since the programs will be jointly administered and delivered. There are numerous strategies that South Dakota uses under these programs to monitor quality and appropriateness of care including both external and internal sources.

The most comprehensive mechanism used by the State in the SCHIP program is the Primary Care Case Management system. Under this program each recipient of SCHIP selects a primary care physician or clinic (PCP) to provide primary care and authorize and manage all specialty medical care through a referral process. Under this program each PCP receives a monthly report of all the medical services used by each client enrolled with that PCP. In this way each PCP is able to provide case management services and monitor the appropriateness of services provided to

enrollees.

The state also monitors the performance of each PCP with regard to the number of clients enrolled with each PCP, the proportion of services provided directly or referred by each PCP, and the satisfaction of clients with PCPs via a complaint and disenrollment process used by recipients to change PCP's. Case file reviews will be conducted on quality complaints. This program operates for Medicaid recipients under waiver authority from CMS . The waiver process provides for a biannual review of the program by CMS , and a number of focussed clinical studies to be completed each renewal period. Monitoring of this program by CMS has been ongoing since 1993, with the third and most recent renewal expiring September 30, 2002. . South Dakota will request the managed care waiver be incorporated into its Medicaid and SCHIP state plans. All of the quality and appropriateness monitoring available to Medicaid for the PCCM program will also be provided to the SCHIP program.

External reviews of medical, surgical and hospital services are conducted by the Professional Review Organization (PRO) in South Dakota. A large sample of services is selected for review each month on a variety of criteria, including specific diagnoses and random selections. Services provided to SCHIP clients will also be included in the sample selected for PRO review. The PRO reports to each provider and to the State the results of each review recommending approval, denial, changes or improvements to service delivery, action by the Medicaid program or referral to other entities for action.

Drug utilization review activities will also be made available to SCHIP clients through the pharmacy benefit management system used by the Department to provide prescription drug coverage. Each drug prescription is processed through a prospective drug use review protocol prior to authorizing a pharmacist to dispense a drug product. This point of service process checks for drug to drug interactions, contraindications, duplicate therapy, dosage, early refill, and days-supply edits to help assure appropriate and quality prescription drug services. The drug utilization review requirements are purchased from a national vendor and incorporated into the Department's system. A licensed pharmacist employed by the Department oversees the operation of the DUR system.

The SCHIP program will also make use of the capabilities of the MMIS claims processing system to process and pay claims for SCHIP clients using the same procedures and rates as the Medicaid program. The MMIS claims systems has numerous edits, reports and capabilities to assist in assuring appropriate and quality services are delivered to SCHIP clients. The MMIS is the source for the Medicaid reporting of EPSDT screening services to CMS , and these reporting capabilities will be available to report on the SCHIP children also.

Surveillance and utilization review system (SURS) capabilities used by the Department to monitor Medicaid services will also be used to monitor the services obtained by SCHIP clients for fraud and abuse. This will provide the SCHIP program a capacity for the full investigation, referral to appropriate law enforcement, and reporting of sanctions as required. The SURS is the designated unit in the Department of Social Services for investigation of fraud, and collaboration with the South Dakota Attorney General's office and U.S. Attorney. A toll free fraud reporting telephone number is also available to provide a convenient means to report fraud.

Surveys and quality assurance reports will also be used to monitor the quality and appropriateness of services provided the SCHIP clients. Client surveys have been an important part of the SCHIP annual reporting that has been completed by South Dakota for each year of the SCHIP program. . Specific questions are addressed to the families of SCHIP children asking about the quality and satisfaction that families have with the services provided. These surveys and the specific questions will continue under the Medicaid and SCHIP programs.

A number of quality assurance reports based on the HEDIS model have been completed for the SCHIP eligible children covered under South Dakota's SCHIP program. These reports specifically address the key areas of immunization, well child and well baby. In addition to reports on those subjects reports have been completed on Dental, Optometry, Asthma, Substance Abuse, and Eating Disorders. Plans include repeating these measure to monitor progress and also to expand the number of measures under the HEDIS to be completed for the SCHIP children in South Dakota.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. **X** Quality standards

The state will establish standards for the performance of PCP's to meet for the well child screenings and immunization levels for children in the CHIP NM program.

7.1.2. **X** Performance measurement

The state will conduct HEDIS based measurement studies for immunization, dental, well child screenings, optometry, substance abuse and mental health services.

7.1.3. ~ Information strategies

7.1.4. ~ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

In addition to inclusion on the HCFA 416 report that measures utilization of EPSDT services, South Dakota, as part of its SCHIP general satisfaction survey of recipients routinely asks recipients access to care questions. The survey instrument specifically asks questions relating to well child care, immunizations, vision services, substance abuse and dental services. The surveys provides excellent feedback regarding recipients access to care. Parents of SCHIP kids are routinely provided with educational materials relating to EPSDT services to inform them on the importance of preventive healthcare.

Access to quality primary and preventive health services will be measured by the number of new SCHIP children enrolled in medical assistance primary care case management system. Utilization based studies for immunization, dental, well child screenings, optometry, substance abuse and mental health services will be used to provide additional measurement of access to services. Further, additional measurements are collected in accordance with Section 9.3.7 of this state plan and are included in the SCHIP annual reports.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR ∋457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

SCHIP will use the same delivery system, provider network and covered services as the Medicaid program in South Dakota. One of the benefits of this arrangement is the excellent provider participation for all types of service providers in the State. Nearly all primary care and specialty physicians participate in the program, all inpatient and outpatient hospitals participate, nearly all pharmacies participate, and participation from allied health providers is also very good. Using the PCCM system for SCHIP facilitates access to primary care and the use of PCP's to provide referrals for non-emergency specialty services enhances access to specialty services as referral arrangements with PCP's are established and specialists are not accessed for primary care purposes.

The selected SCHIP program structure allows the maximum use of the available rural providers to enhance access to services in the rural areas of South Dakota. The Indian Health Service and Tribal services are key

resources in the most under-served areas of the State. Each IHS service unit has participating PCP providers in the PCCM program. The SCHIP program is also structured so those eligible clients have maximum access to IHS programs without a referral from another PCP if the individuals have selected a non-IHS PCP. Tribal clinics are also eligible to be PCP providers as federally qualified health centers (FQHC's). Rural areas outside of American Indian reservation are served by rural health clinics and federally qualified health centers that are also enrolled as PCP entities to enhance service availability. Favorable reimbursement mechanisms are in place for all of these provider types to ensure the availability of services.

Under the PCCM program the Department of Social Services carefully monitors the capacity of each participating PCP and presently averages about 85 enrollees per PCP entity, with very few PCP's closed to new enrollees. PCP's are limited to a maximum of 750 enrollees. County and sub-state areas are also monitored for PCP availability. Most PCCM participants select their own PCP's and have free choice of providers for non-PCCM services. Time and distance standards ensure that PCCM enrollees do not have to travel more than 75 miles to their PCP. Routine monitoring of PCP performance also includes an analysis of PCP provided services versus referred services with the dual purpose of ensuring PCP's are accessible and providing services to enrolled clients, and also not withholding appropriate referrals for specialty care.

The Department also carefully monitors the PCP changes and disenrollment reasons to assure that access to care issues are resolved. In addition, the Department randomly monitors PCP compliance with 24 hour per day, seven day per week requirement for PCP availability.

The SCHIP program uses the definition and procedure for accessing emergency services that applies to Medicaid that are consistent with Federal law.

Access and availability to services are presently monitored under Medicaid. This monitoring will also include SCHIP enrollees. Surveys of participants to measure access to services, waiting times, and satisfaction with service availability will continue to be completed with all Medicaid and SCHIP children.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not

adequate for the enrollee=s medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Individuals with special healthcare needs are exempt from managed care requirements. As such, these individuals are not restricted under the SCHIP program. All SCHIP recipients have the same access to specialists as private pay individuals or individuals with private health insurance.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

Decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. The prior authorization policy is consistent with the prior authorizations under the South Dakota Medicaid Program. Oftentimes, the request for prior authorization does not contain sufficient documentation to make a determination. When that occurs, the physicians are contacted, additional documentation is requested, and the determination is made upon receipt of the additional documentation. The department maintains a database of prior authorizations, and monitoring of the determination within 14 days of receipt can be easily documented.

Section 8. Cost Sharing and Payment **(Section 2103(e))**

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ~ YES
8.1.2. **X** NO**, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:
8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:
8.2.4. Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ~ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ~ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 Γ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family=s income for the length of the child=s eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

Γ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

Γ The disenrollment process affords the enrollee an opportunity to show that the enrollee=s family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**

Γ In the instance mentioned above, that the state will facilitate enrolling

the child in Medicaid or adjust the child=s cost-sharing category as appropriate. **(42CFR 457.570(b))**

Γ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. **X** No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. **X** No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. **X** No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. **X** Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. **X** No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. **X** No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

South Dakota implemented CHIP-NM as an additional effort to address the objectives stated in the original M-SCHIP state plan. Those objectives are:

1. *Achieve a measurable reduction in the number of uninsured children in South Dakota beginning July 1, 1998.*

2. *Improve access to quality primary and preventive health care services under Medicaid for approved SCHIP eligibles, new Medicaid eligibles, and previously non-enrolled children on July 1, 1998.*

3. *Develop better measurement capabilities of health insurance coverage, and health care service availability and quality to children in South Dakota, beginning July 1, 1998.*

Effective July 1, 2000 each objective will include the CHIP-NM program.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

1. *Achieve a measurable reduction in the number of uninsured children in South Dakota.*

1.1 Implement CHIP-NM to provide coverage to an additional 2,400 targeted, uninsured children in families with incomes from 140% to 200% of the federal poverty level beginning July 1, 2000.

1.2 Continue to extend Medicaid to children age zero through eighteen at Medicaid eligibility levels in effect prior to July 1, 1998, and other low income children from 133% to 140% of the federal poverty level as amended effective April 1, 1999.

1.3 Continue to extend SCHIP benefits to targeted, uninsured, non-Medicaid eligible children age 6 through 18 in families with incomes from 100% to 133% of the federal poverty levels, and to targeted, uninsured, non Medicaid eligible children age 0 through 18 in families with incomes from 133% to 140% as amended effective April 1, 1999.

1.4 Continue to utilize a systematic approach to identify uninsured children with low incomes using Department data resources, partnerships with other public programs, and local involvement of interested parties including schools, providers, and others.

1.5 Expand the simplified medical assistance application process to include CHIP-NM the same as the Medicaid and M-SCHIP medical assistance

programs.

2. *Improve access to quality primary and preventive health care services for CHIP-NM eligible children.*

   2.1 *Enroll 95% of all newly approved CHIP-NM children in the South Dakota medical assistance primary care case management program within 1 month of their enrollment, beginning July 1, 2000.*

   2.2 *Ensure each new CHIP-NM enrollee receives covered services, cost sharing and EPSDT information at the time that their eligibility is approved.*

   2.3 *Include CHIP-NM eligible children in the quality measurement mechanisms that are used for Medicaid and M-SCHIP including measures of immunization, well child care, adolescent well care, satisfaction and other measures of health care quality. Measures will come from the HCFA 416 report, the Department of Health Immunization tracking system, and the evaluation process used in South Dakota's PRIME managed care program operated under 1915(b) waiver authority. This evaluation process also uses client and provider surveys independent evaluations and clinical studies to report cost effectiveness and quality to CMS for waiver renewal purposes, and annual SCHIP reporting requirements. South Dakota will request the managed care waiver be incorporated into its Medicaid and SCHIP state plans.*

3. *Develop better measurement capabilities of health insurance coverage, health care service availability and quality to children in South Dakota.*

   3.1 *Modify the Medicaid Management Information System to make CHIP-NM tracking and reporting capabilities available to measure enrollment, service, utilization, and overall program effectiveness. This enhancement will make all MARS and CMS reports available for CHIP-NM.*

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state=s performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

1. *Achieve a measurable reduction in the number of uninsured children in South Dakota.*

The success of this objective will be determined by the number of uninsured children in South Dakota who receive health insurance coverage as the result of the CHIP-NM State Plan amendment, M-SCHIP, or Medicaid coverage. Evidence of this reduction will come from South Dakota medical assistance enrollment figures, estimates provided by the United States Census Bureau and supported with survey data from the Behavioral Health Survey and other publications. (The South Dakota Behavioral Risk Factor Surveillance System (BRFSS) is designed to collect information on the health behaviors in the State. The survey was initiated in 1987 by the South Dakota Department of Health with the assistance of the Centers for Disease Control and Prevention, and has been on-going since 1987. For the SCHIP Program in South Dakota, the BRFSS surveys South Dakotans to assist in measurements as to why a child is without health insurance, whether coverage such as Medicaid and SCHIP have been considered for those who respond that the child is uninsured, crowd out issues, etc. to determine effectiveness of outreach promotions.)

2. *Improve access to quality primary and preventive health care services under Medicaid for CHIP-NM eligible children.*

   Access to quality primary and preventive health services will be measured by the number of new CHIP-NM children enrolled in medical assistance primary care case management system. Utilization based studies for immunization, dental, well child screenings, optometry, substance abuse and mental health services will be used to provide additional measurement of access to services.

3. *Develop better measurement capabilities of health insurance coverage, and health care service availability and quality to children in South Dakota.*

   Adequate data is available for the completion of annual reports and evaluations for CHIP-NM as well as the original M-SCHIP program in compliance with Section 9.5 of this State Plan Amendment.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. **X** The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. **X** The reduction in the percentage of uninsured children.
9.3.3. **X** The increase in the percentage of children with a usual source of care.
9.3.4. **X** The extent to which outcome measures show progress on one or more

of the health problems identified by the state.

9.3.5. ~ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ~ Other child appropriate measurement set. List or describe the set used.

9.3.7. **X** If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. **X** Immunizations – CPT range 90700 through 90749
- 9.3.7.2. X Well child care – SD EPSDT code W8630, CPT range 9981 through 99383 and 99391 through 99393
- 9.3.7.3. **X** Adolescent well visits – CPT codes 99384 through 99394
- 9.3.7.4. **X** Satisfaction with care
- 9.3.7.5. **X** Mental health – CPT codes 90804 through 90899
- 9.3.7.6. **X** Dental care – Codes covering exams, x-rays, and certain treatments
- 9.3.7.7. **X** Other, please list: Optometric and Substance Abuse – Range of SD codes W7500 through W7507m W8500, W8600, W8601 and W8620 through W8624

9.3.8. X Performance measures for special targeted populations.

9.4. **X** The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. **X** The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state=s plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

The South Dakota Department of Social Services will evaluate the operation and effectiveness of its State Children's Health Insurance Program (SCHIP) on an ongoing basis and report the findings to CMS by January 1 of each year.. A variety of data sources will be utilized to evaluate South Dakota's program. These data sources will include, but will not be limited to, US Bureau of Census, South Dakota Department of Health, South Dakota Medical Assistance, and Indian Health Services. Annual reports will follow the format as specified by CMS .

9.6. **X** The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. **X** The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. **X** Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. **X** Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. **X** Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. **X** Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

The SCHIP program was initiated and authorized by specific action of the 1998 and 2000 South Dakota State Legislature which authorized the Department of Social Services to develop a program for low income uninsured children up to 200% of the Federal Poverty Level under the Federal Title XXI program.

Pursuant to this direction from the Legislature the Department of Social Services developed Administrative Rules for the administration and delivery of the SCHIP process. These rules were promulgated, heard, and implemented with the public process specified in the South Dakota Administrative Procedures Act. Public Notice was made in several newspapers and a Public Hearing was conducted to inform the public of the new program, eligibility, covered services, and other provisions of the SCHIP program.

Further public involvement was obtained by presentation of the SCHIP program to the Medical Advisory Committee, (meets semi-annually) and the Board of Social Services (meets quarterly) prior to implementation. The Medical Advisory Committee and the Board of Social Services are advisory groups that provide input into the design, implementation and operation of the Medical Assistance Program. (Titles XIX and XXI)

Inasmuch as the State Plan Amendment does not include a reduction in services or increase in cost sharing, but rather an expansion of services and coverage under the SCHIP program a public process is not required. However, with the public action of the South Dakota Legislature and the requirements of the Administrative Procedures

Act, the Department has, in its judgement, allowed adequate public input in the design and implementation of SCHIP .

The Department recognizes that the SCHIP program does not differ significantly from the current delivery system and coverage under medical assistance programs in South Dakota, with the exception of expanded eligibility.

The Department will continue to actively solicit public involvement in the delivery of the Medical Assistance Program benefits under Titles XIX and XXI. The Department will ensure ongoing public involvement in the design and implementation of the SCHIP state plan through the processes described above.

In addition, the Department continues it's long-standing policy to provide for ongoing public involvement in the operation of the Medical Assistance Program. (Titles XIX and XXI) The Department has regular contacts with advocacy groups, and an open door policy to provide advocacy groups and individuals the opportunity to present input and feedback on the operation of the program. The Department meets with advocacy groups and individuals that request such a meeting.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR ∋457.125. **(Section 2107(c)) (42CFR 457.120(c))**

Consultation meetings have been held between the State and Tribal Government and Tribal Health officials. In addition, the Department has invited both Tribal Government and the IHS to be represented on the Medicaid Advisory Committee that assists in the monitoring of the Medicaid and SCHIP programs, and both entities are participating.

Some Tribal health departments have requested specific training of the their Community Health Representative staff in the SCHIP program and this training was provided by Department eligibility staff. One reservation even adapted the SCHIP radio ad to use in reaching the Indian population on their reservation.

Outreach brochures, posters and logos for SCHIP were designed with a culturally sensitive logo depicting children of varying ethnic backgrounds in an effort to convey that the program is intended for all races of children.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in ∋457.65(b) through (d).

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

The following budget figures represent the estimated cost of serving the CHIP-NM, and M-SCHIP children for FFY 2000, FFY 2001, and FFY 2002. ***All of the funds used to operate the SCHIP programs by matching the federal funds have been allocated from the State's General fund, as part of the General Appropriation bill. The State assures no general funds have been raised from impermissible provider taxes or donations, and that the State is in compliance with Section 1903 (w) of the Social Security Act.*** *Three budget sheets are presented, one for the CHIP-NM , one for the existing M-SCHIP program, and the total for South Dakota SCHIP.*

A three year CHIP-NM budget is presented. FFY2000 budget amounts are estimated using three months of FFY 2000 from July to September of 2000. Estimates for FFY2001 and FFY2002 represent a full year of operation. This budget assumes 600 clients for FFY 2000, 2,400 clients for FFY 2001, and 2,700 for FFY 2002.

The CHIP-NM service budget is based upon funds appropriated by the South Dakota Legislature. This appropriation was based on an average cost of $991 per eligible child per year. Amounts were then allocated to service categories using utilization figures from currently eligible M-SCHIP children from July, 1999 through April, 2000. Administrative costs for CHIP-NM are calculated at 10% of the allowable service and administration costs. The percentages allocated to administrative categories reflect the best estimates of actual anticipated expenditures by the State.

Recognizing that South Dakota currently operates a M-SCHIP program, an updated 3 year budget for M-SCHIP is also presented for all of FFY 2000, FFY 2001, and FFY 2002. This budget is based on 3,839 clients for FFY 2000, 3,839 clients for FFY 2001, and 4,139 clients for FFY 2002. The average cost per client for FFY 2000 and FFY 2001 is $1,033 per child, per year based on actual costs from July-April of SFY 2000. Amounts have been allocated to service categories using utilization figures from the same time period. Administrative costs are estimated at 10% of the allowable expenditures for services and administration. These costs are based upon current state estimates of anticipated expenditures.

A total SCHIP budget for South Dakota for the three federal fiscal years is also presented. This budget is the sum of the anticipated expenditures for CHIP-NM and M-SCHIP in South Dakota.

CHIP-NM THREE YEAR BUDGET PROJECTION

Federal Fiscal Year Budget Estimates --- CHIP-NM	**FFY 2000**	**FFY 2001**	**FFY 2002**
Medical Services Purchased			
Physician	$33,149	$530,383	$614,582
Inpatient Hospital	$33,208	$531,335	$615,684
Outpatient Hospital	$18,938	$303,008	$351,111
Prescription Drugs	$17,288	$276,608	$320,519
Preventive Services (EPSDT)			
Screening	$580	$9,276	$10,748
Dental and Orthodontic	$9,989	$159,828	$185,201
Optometric	$6,035	$96,563	$111,892
Treatment	$23,353	$373,647	$432,963
Mental Health	$4,787	$76,584	$88,742
All Other	$1,323	$21,168	$24,529
Total Services	$148,650	$2,378,400	$2,755,971
Administration			
Personal Services	$11,727	$187,629	$217,416
Outreach	$2,147	$34,355	$39,808
Data Collection	$1,487	$23,784	$27,560
Computer Services	$1,156	$18,499	$21,435
Total Administration	$16,517	$264,267	$306,219
Total Budget	$165,167	$2,642,667	$3,062,190
Federal Share	$128,995	$2,056,523	$2,331,858
State Share	$36,172	$586,144	$730,332

M-SCHIP THREE YEAR BUDGET PROJECTION

Federal Fiscal Year Budget Estimates--- M-SCHIP	**FFY 2000**	**FFY 2001**	**FFY 2002**
Medical Services Purchased			
Physician	$746,133	$884,348	$982,069

Inpatient Hospital	$747,471	$885,934	$983,830
Outpatient Hospital	$426,266	$505,229	$561,056
Prescription Drugs	$389,127	$461,209	$512,173
Preventive Services (EPSDT)			
Screening	$13,049	$15,466	$17,175
Dental and Orthodontic	$224,844	$266,494	$295,942
Optometric	$135,843	$161,007	$178,798
Treatment	$525,639	$623,009	$691,852
Mental Health	$107,738	$127,695	$141,805
All Other	$29,778	$35,295	$39,195
Total Services	$3,345,887	$3,965,687	$4,403,896
Administration			
Personal Services	$263,953	$312,849	$347,418
Outreach	$48,329	$57,282	$63,612
Data Collection	$33,459	$39,657	$44,039
Computer Services	$26,024	$30,844	$34,253
Total Administration	$371,765	$440,632	$489,322
Total Budget	$3,717,652	$4,406,319	$4,893,218
Federal Share	$2,903,486	$3,428,997	$3,726,186
State Share	$814,166	$977,322	$1,167,032

TOTAL SOUTH DAKOTA SCHIP THREE YEAR BUDGET PROJECTION

Federal Fiscal Year Budget Estimates -- - Total SCHIP	**FFY 2000**	**FFY 2001**	**FFY 2002**
Medical Services Purchased			
Physician	$779,282	$1,414,731	$1,596,650
Inpatient Hospital	$780,680	$1,417,269	$1,599,514
Outpatient Hospital	$445,204	$808,237	$912,167

Prescription Drugs	$406,415	$737,817	$832,693
Preventive Services (EPSDT)			
Screening	$13,629	$24,742	$27,923
Dental and Orthodontic	$234,833	$426,323	$481,143
Optometric	$141,878	$257,570	$290,691
Treatment	$548,992	$996,656	$124,815
Mental Health	$112,524	$204,280	$230,548
All Other	$31,101	$56,462	$63,723
Total Services	$3,494,537	$6,344,087	$7,159,867
Administration			
Personal Services	$275,680	$500,478	$564,834
Outreach	$50,477	91,637	$103,420
Data Collection	$34,945	$63,441	$71,599
Computer Services	$27,180	$49,343	$55,688
Total Administration	$388,282	$704,899	$795,541
Total Budget	$3,882,819	$7,048,986	$7,955,408
Federal Share	$3,032,482	$5,485,521	$6,058,043
State Share	$850,337	$1,563,465	$1,897,365

∃ Planned use of funds, including --

- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.

∃ Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. **X** The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. **X** The state assures it will comply with future reporting requirements as they are

developed. **(42CFR 457.710(e))**

10.3. **X** The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

Γ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan**, and continue to Section 12.

11.1 **X** The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. **X** 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. **X** Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. **X** Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. **X** Section 1128A (relating to civil monetary penalties)
- 11.2.5. **X** Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. **X** Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

Γ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state=s Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR ∋457.1120.

Recipients of SCHIP have the same rights as recipients of the South Dakota Medicaid Program. The South Dakota Medical Assistance Program (T-19 & T-21) uses a program specific review process for eligibility and enrollment matters. The South Dakota Department of Social Services, Office of Administrative Hearings, is the impartial and external entity that conducts the administrative hearings to determine whether applications for assistance are correctly denied.

An applicant for public assistance whose application for assistance is denied may appeal the action or inaction as provided in Administrative Rules of South Dakota. Individual's rights are printed on all applications of public assistance and on all formal notices issued by the Department of Social Services concerning action taken. Department workers explain to applicants their rights to a hearing at the time the application is submitted and informs the applicant or recipient of the right to a fair hearing at any time an action is taken affecting the rights or status of an application or recipient. Department workers also explain to applicants that they have the right to review all files relevant to their appeal, the right to appear in person at the time of the hearing, the right to be assisted at the hearing by a friend, relative, or lawyer at the applicant's or recipient's own cost, and the right to withdraw or abandon the hearing. Department workers explain to applicants that the request for hearing may be written or oral but that it has to be made within 30 days after the action complained of or 30 days after action should have been taken as provided by law or rule. The Department also provides an explanation of the circumstances under which eligibility may continue pending the review process. Applicants have the right to be present for all proceedings and the right to present evidence and testify at all proceedings. Applicants or recipients have the right to a written final decision within 90 days after the hearing request.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR э457.1120.

Recipients of SCHIP have the same rights as recipients of the South Dakota Medicaid Program. The South Dakota Medical Assistance Program (T-19 & T-21) uses a program specific review process for eligibility and enrollment matters. The South Dakota Department of Social Services, Office of Administrative Hearings, is the impartial and external entity that conducts the administrative hearings to determine whether medical benefits are correctly denied.

A recipient of public assistance whose medical benefits are denied may appeal the action or inaction as provided in Administrative Rules of South Dakota. Individual's rights are printed on all handbooks that are provided to the recipient. Recipients may

appeal the denial by requesting a fair hearing at any time an action is taken affecting the benefits of a recipient. Department workers also explain to applicants that they have the right to appear in person at the time of the hearing, the right to be assisted at the hearing by a friend, relative, or lawyer at the applicant's or recipient's own cost, and the right to withdraw or abandon the hearing. Department workers explain to recipients that the request for hearing may be written or oral but that it has to be made within 30 days after the action complained of or 30 days after action should have been taken as provided by law or rule. Recipients have the right to review all files relevant to their appeal, the right to be present for all proceedings and the right to present evidence and testify at all proceedings. Recipients have the right to a written final decision within 90 days after the hearing request.

Recipients have the right to an expedited fair hearing upon presenting documentation to support that any delays under the standard time frame could jeopardize the individual's life or health. In these situations, the Office of Administrative Hearings will schedule and conduct the review within 72 hours.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR ∋457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.