Table of Contents

State/Territory Name: South Dakota

State Plan Amendment (SPA) #: SD-20-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

December 13, 2021

Sarah Aker
CHIP Director
Division of Medical Services
South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291

Dear Ms. Aker:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), SD-20-0004, has been approved. SD-20-0004 demonstrates compliance with section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. This SPA has an effective date of October 24, 2019.

Section 5022 of the SUPPORT Act added Section 2103(c)(5) to the Social Security Act (the Act) and requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders. Additionally, Section 2103(c)(5)(B) of the Act requires that these behavioral health services be delivered in a culturally and linguistically appropriate manner. South Dakota demonstrates compliance by providing the necessary assurances and benefit descriptions that the state covers a range of behavioral health services in a culturally and linguistically appropriate manner.

Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
E-mail: Joyce.Jordan@cms.hhs.gov

If you have additional questions, please contact Emily King, Deputy Director, Division of State Coverage Programs at (443) 478-6811. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Amy Lutzky/

Amy Lutzky
Deputy Director

OMB #: 0938-0707

Exp. Date:

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 displaysa 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. ☒ 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 (FPL). 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 ☐ 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 ☐ 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

SPA# SD-16-0002: This state plan amendment establishes coverage for unborn children from conception to birth when the mother is not eligible for Medicaid.

Effective Date: July 1, 2016

SPA# SD-16-0006: This state plan amendment provides proposed program specifics to the state's CHIP state plan for unborn children from conception to birth.
Effective Date: July 1, 2016

SPA# SD-16-0007: This state plan amendment updates the state's exemptions from its waiting period to include coverage for unborn children.
Effective Date: July 1, 2016

SPA# SD-17-0009: This state plan amendment clarifies that the Mental Health Parity and Addiction Equity Act requirements are satisfied through the EPSDT benefit.
Effective Date: October 1, 2017

SPA# SD-20-0004: This state plan amendment provides assurances that the state is in compliance with section 5022 of the SUPPORT Act, which made behavioral health services a required benefit for CHIP.
Effective Date: October 24, 2019

Superseding Pages of MAGI CHIP State Plan Material

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
SD-13-0016 Approval Date: 11/18/13 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS15	Eligibility – Targeted Low Income Children MAGI-Based Income Methodologies	Superseded sections 4.1.1, 4.1.2, and 4.1.3 Incorporated in section 4.3.2
SD-13-0020 Approval Date: 12/18/13 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Superseded section 4.1.3
SD-13-0017 Approval Date: 11/18/13 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporated in section 4.1.10
SD-13-0018 Approval Date: 12/18/13 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Superseded the sections 4.3, 4.4.1, 4.4.2, and 4.4.3
SD-13-0019 Approval Date: 11/18/13 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20	Non-Financial Eligibility – Residency Non-Financial Eligibility – Citizenship Non-Financial Eligibility – Social Security Number Non-Financial Eligibility –	Superseded section 4.1.5 Superseded section 4.1.5 Superseded section 4.1.9

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
			Substitution of Coverage	Superseded part of section 4.4.4.1
SD-14-008 Approval Date: 09/22/14 Effective Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
SD-16-0002 Approval Date: 12/15/16 Effective Date: July 1, 2016	MAGI Eligibility & Methods	CS9	Eligibility - Coverage from Conception to Birth	Incorporated into the current section 4.1.9
SD-16-0007 Approval Date: 12/15/16 Effective Date: July 1, 2016	Non-Financial Eligibility	CS20	Non-Financial Eligibility – Substitution of Coverage	Supersedes the current section 4.4.4.1

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. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

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. Effective January 1, 2014, the implementation of the affordable care act required states to convert the established income limits to a Modified Adjust Gross Income (MAGI) equivalent. The MAGI equivalents are as follows:

M-SCHIP uninsured children 6 to 19 – 111% to 181%
M-SCHIP uninsured children 0 to 5 – 147% to 181%
CHINP-NM uninsured children 0 to 19 – 182% to 204%

Effective July 1, 2016 South Dakota added coverage of unborn children of pregnant women with incomes from 0% FPL and up to and including 133% FPL not otherwise eligible for Medicaid due to citizenship requirements. 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.

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☐ No, the State does not use a managed care delivery system for any CHIP populations.

☒ Yes, the State uses a managed care delivery system for all CHIP populations.

☐ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- 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); 42 CFR 457.490(a))
- The utilization control 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); 42 CFR 457.490(b))

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

☐ No
☒ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

The following services are exempt from the State's PCCM program:

- *Emergency services for a condition that if not immediately diagnosed and treated could cause a person serious physical or mental disability, continuation of severe pain, or death;*
- *Pharmacy;*
- *Family planning services;*
- *Dental/orthodontic services including related services, such as a physical prior to oral surgery;*
- *Substance use disorder treatment;*
- *Podiatry services;*
- *Optometric/optical services (routine eye care);*
- *Chiropractic services;*
- *Immunizations;*
- *Mental health services for individuals who are diagnosed with a serious emotional disturbance or serious mental illness;*
- *Ambulance;*
- *Other Transportation;*
- *Anesthesiology;*
- *Independent radiology/pathology;*
- *Independent lab/x-ray services (when sending samples or specimens to any outside facility for analysis only); and*
- *Up to 4 urgent care visits per State fiscal year.*

American Indian recipients may receive services at an IHS facility without a referral from their PCCM.

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☐ Managed care organization (MCO) (42 CFR 457.10)
  ☐ Capitation payment
  Describe population served:

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
  ☐ Capitation payment
  ☐ Other (please explain)
  Describe population served:

☐ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
  ☐ Capitation payment
  ☐ Other (please explain)
  Describe population served:

☒ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
  ☒ Case management fee
  ☐ Other (please explain)

☐ Primary care case management entity (PCCM Entity) (42 CFR 457.10)
  ☐ Case management fee
  ☐ Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
  ☐ Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

☐ Provision of intensive telephonic case management
☐ Provision of face-to-face case management
☐ Operation of a nurse triage advice line
☐ Development of enrollee care plans
☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
☐ Oversight responsibilities for the activities of FFS providers in the FFS program
☐ Provision of payments to FFS providers on behalf of the State
☐ Provision of enrollee outreach and education activities
☐ Operation of a customer service call center
☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement

☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers
☐ Coordination with behavioral health systems/providers
☐ Other (please describe)

3.1.2.2 ☐ The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

☐ The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

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 1932 state plan authority. 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.

3.2.1 ☒ The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 ☒ The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

3.2.4 ☐ The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

☐ Based on public or private payment rates for comparable services for comparable populations; and

☐ Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

☐ If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))

3.3.2 ☐ The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))

3.3.3 ☐ The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))

3.3.4 ☐ The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))

3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))

☐ No, the State does not require any MCO, PIHP, or PAHP to pay remittances.

☐ Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.

☐ Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

If the State requests some, but not all, MCOs, PIHPs, and PAHPs to pay remittances through the contract for not meeting the minimum MLR required by the State, please describe which types of managed care entities are and are not required to pay remittances. For example, if a state requires a medical MCO to pay a remittances but not a dental PAHP, please include this information.

If the answer to the assurance above is yes for any or all managed care entities,

please answer the next assurance:

☐ The State assures that it if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

- Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the Federal matching rate; and
- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

3.3.6 ☐ The State assures that each MCO, PIHP, and PAHP calculates and reports the medical loss ratio in accordance with 42 CFR 438.8. (42 CFR 457.1203(f))

3.4 Enrollment

☒ The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

- Accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(1));
- Will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(3)); and
- Will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. (42 CFR 457.1201(d), cross-referencing to 438.3(d)(4))

3.4.1 Enrollment Process

3.4.1.1 ☒ The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

3.4.1.2 ☒ The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM

entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))

☒ Yes
☐ No

If the State uses a default enrollment process, please make the following assurances:

☒ The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))

☒ The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

3.4.2.1 ☒ The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))

3.4.2.2 ☒ The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))

3.4.2.3 ☒ If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

3.4.2.4 MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.

☒ The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

3.4.2.5 Enrollee Requests for Disenrollment.

Does the State limit disenrollment from an MCO, PIHP, PAHP, PCCM and PCCM entity by an enrollee? (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

☐ Yes
☒ No

If the State limits disenrollment by the enrollee from an MCO, PIHP, PAHP, PCCM and PCCM entity, please make the following assurances (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)):

☐ The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))

☐ The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))

☐ The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

3.4.2.6 ☐ The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 ☒ The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 ☒ The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 ☐ The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 ☐ The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
- Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5 ☒ If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6 ☐ The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State,

and in each MCO, PIHP, PAHP, or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
  - That oral interpretation is available for any language and written translation is available in prevalent languages;
  - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
  - How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☒ The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:
- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;
- Covered benefits including:
  - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
  - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service;
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP,

PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

3.5.8 ☐ The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9 ☐ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

3.5.10 ☐ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
  - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
  - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
  - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity

must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;

- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes an emergency medical condition and emergency services;
  - The fact that prior authorization is not required for emergency services; and
  - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
  - The right to file grievances and appeals;
  - The requirements and timeframes for filing a grievance or appeal;
  - The availability of assistance in the filing process; and
  - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

3.5.11 ☐ The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

3.5.12 ☐ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

3.5.13 ☐ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))

3.5.14 ☐ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:

- Which medications are covered (both generic and name brand); and
- What tier each medication is on.

3.5.15 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).

3.5.16 ☐ The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.

3.5.17 ☐ The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

3.5.18 ☐ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

3.6.1 ☒ The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)

3.6.2 ☒ The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.3 ☐ The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

3.6.4 ☐ The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.5 ☐ The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:

- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
- Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
- Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)

3.6.6 ☐ The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))

3.6.7 ☐ The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

3.6.8 ☐ The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

3.6.9 ☐ The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 ☐ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☐ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:

- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and

- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

3.6.12 ☐ Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:

- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

3.6.13 ☐ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

3.6.14 ☐ The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

3.6.15 ☐ The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)

3.6.16 ☐ The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated

as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

3.6.17 ☐ The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.

3.6.18 ☐ The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))

3.6.19 ☐ The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:
- Is in accordance with applicable State quality assurance and utilization review standards;
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

3.6.20 ☐ The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

3.7.1 ☒ The State assures that it has established a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorders providers and requires each MCO, PIHP and PAHP to follow those policies. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(b)(1))

3.7.2 The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:

- ☐ Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
- ☐ MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));
- ☐ MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));
- ☐ If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and
- ☐ MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3 The State assures that each contracted MCO, PIHP, and PAHP complies with the subcontractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

- ☐ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;

☐ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;

☐ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions; and

☐ The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 ☐ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

3.7.5 ☐ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))

3.7.6 ☐ The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.7 ☐ The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.8 ☐ The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the

State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)

3.7.9 ☐ The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

3.8 Beneficiary Protections

3.8.1 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

3.8.2 ☒ The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

3.8.3 ☐ The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
- Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

3.9.1 ☐ The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 ☐ The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 ☐ The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?
☐ Yes
☐ No

3.9.5 ☐ The State assures that the external medical review is:
- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
- Independent of both the State and MCO, PIHP, or PAHP;
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

3.9.6 ☐ The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))

3.9.7 ☐ The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

3.9.8 ☐ The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))

3.9.9 ☐ The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.

3.9.10 ☐ The State assures that the notice of an adverse benefit determination explains:
- The adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR

438.404(b))

3.9.11 ☐ The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))

3.9.12 ☐ The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

3.9.13 The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

- ☐ Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
- ☐ Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:
  - An appeal of a denial that is based on lack of medical necessity.
  - A grievance regarding denial of expedited resolution of an appeal.
  - A grievance or appeal that involves clinical issues.
- ☐ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- ☐ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- ☐ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
- ☐ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 ☐ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15 ☐ The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

3.9.16 ☐ The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

3.9.17 ☐ The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 ☐ The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 ☐ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 ☐ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☐ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
  - The right to request a State review, and how to do so.
  - The right to request and receive benefits while the hearing is pending, and how to make the request.
  - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

3.9.22 ☐ For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))

3.9.23 ☐ The State assures that if it offers an external medical review:

- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
- The review is independent of both the State and MCO, PIHP, or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))

3.9.24 ☐ The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))

3.9.25 ☐ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260,

cross-referencing to 42 CFR 438.414)

3.9.26 ☐ The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)

3.9.27 ☐ The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:

- ☐ Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;
- ☐ Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and
- ☐ Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)

3.10.2 ☐ The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 ☐ The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 ☐ The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

3.10.5 ☐ The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))

3.10.6 ☐ The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))

3.10.7 ☐ The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))

3.10.8 ☒ The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))

3.10.9 ☒ The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

3.10.10 ☒ The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

3.10.11 ☒ The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)

3.10.12 The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:

☐ Encounter data in the form and manner described in 42 CFR 438.818.

☐ Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.

☐ Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.

☐ Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.

☒ Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.

☐ The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

☒ It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))

☒ It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and

☒ It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))

3.10.15 ☒ The State assures that services are provided in an effective and efficient manner. (Section 2101(a))

3.10.16 ☒ The State assures that it operates a Web site that provides:

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability

and accessibility of services;
- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

3.11.1 ☐ The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2 ☐ The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3 ☐ The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?
☐ Yes
☒ No

3.11.5 ☐ The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))

3.11.6 ☐ The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))

3.11.7 ☐ The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

3.12.1 Quality Strategy

3.12.1.1 ☐ The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42

CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

3.12.1.2 ☐ The State assures that the goals and objectives for continuous quality improvement in the quality strategy are measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(2))

3.12.1.3 ☐ The State assures that for purposes of the quality strategy, the State provides the demographic information for each CHIP enrollee to the MCO, PIHP or PAHP at the time of enrollment. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(6))

3.12.1.4 ☐ The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))

3.12.1.5 ☐ The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).

3.12.1.6 ☐ The State assures that it will submit to CMS:

- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
- A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 ☐ Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:

- Make the strategy available for public comment; and
- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

3.12.1.8 ☐ The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

3.12.2.1.1 ☐ The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:

- Standard performance measures specified by the State;
- Any measures and programs required by CMS (42 CFR 438.330(a)(2);
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
- Mechanisms to detect both underutilization and overutilization of services; and
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

3.12.2.1.2 ☐ The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
- Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

3.12.2.1.3 ☐ The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality

assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:

- Standard performance measures specified by the State;
- Mechanisms to detect both underutilization and overutilization of services; and
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

3.12.2.2.1 ☐ The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 ☐ The State assures that it annually requires each MCO, PIHP, and PAHP to:
1) Measure and report to the State on its performance using the standard measures required by the State;
2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

3.12.2.2.3 ☐ The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:

- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

3.12.3.1 ☐ The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or PAHP has received accreditation by a private independent accrediting agency, that the MCO, PIHP, and PAHP authorizes the private independent accrediting entity to provide the State a copy of its recent accreditation review that includes the MCO, PIHP, and PAHP's accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(a) and (b)).

3.12.3.2 ☐ The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

☐ The State assures that it will implement and operate a quality rating system that issues an annual quality rating for each MCO, PIHP, and PAHP, which the State will prominently display on the Web site required under 42 CFR 438.10(c)(3), in accordance with the requirements set forth in 42 CFR 438.334. (42 CFR 457.1240(d))

3.12.5 Quality Review

☐ The State assures that each contract with a MCO, PIHP, PAHP, or PCCM entity requires that a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP or PCCM entity, except as provided in 42 CFR 438.362. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(a))

3.12.5.1 External Quality Review Organization

3.12.5.1.1 ☐ The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

3.12.5.1.2 ☐ The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a),

cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

3.12.5.2.1 ☐ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))

3.12.5.2.2 ☐ The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State's quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)

3.12.5.2.3 ☐ The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

3.12.5.2.4 ☐ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

3.12.5.3.1 ☐ The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

3.12.5.3.2 ☐ The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).

3.12.5.3.3 ☐ The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:

- The EQRO has sufficient information to use in performing the review;
- The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
- For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
- The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))

3.12.5.3.4 ☐ The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
  - Objectives;
  - Technical methods of data collection and analysis;
  - Description of data obtained, including validated performance

measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
    - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 ☐ The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 ☐ The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 ☐ The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 ☐ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

3.12.5.3.9 ☐ The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))

3.12.5.3.10 ☐ The State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(d))

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. ☒ Geographic area served by the Plan: See SPA page CS7 for geographic area served by the State Plan.

4.1.2. ☒ Age: See SPA page CS7 for age standards under the State Plan.

4.1.3. ☒ Income: See SPA page CS3 and CS7 for income standards under the State Plan.

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

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): See SPA pages CS17 and CS18 for residency requirements.

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

4.1.7. ☒ 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. ☒ 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. ☒ 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 state provides coverage for unborn children in households with income up to and including 133% FPL whose mothers are not otherwise eligible for Medicaid. The unborn child or children are counted as if born and living with the mother in determining family group size. See SPA page CS19 for additional standards.

4.1.10 Children ineligible for Medicaid as a result of the elimination of income disregards: See SPA page CS14 for this information.

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. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ 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. ☒ 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)**

See SPA page CS24 for eligibility process for the State Plan.

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

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

4.3.2 MAGI-based income methodologies: See SPA page CS15 for MAGI-based income methodologies.

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))**

See SPA page CS24 for screening and redetermination processes.

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))**

See SPA page CS24 for procedures in place.

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))**

See SPA page CS24 for this information.

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

See SPA page CS20 for information regarding substitution of coverage.

4.4.4.2. ☐ 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. ☐ 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. ☐ 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 an existing 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 existing comprehensive state-based coverage.

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

- 6.1.4.1. ☒ Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT).
- 6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6. ☐ 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. ☐ 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. 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.*

Covered Services for Unborn Children

South Dakota provides coverage for unborn children in households with income up to and including 133% FPL whose mothers are not otherwise eligible for Medicaid due to citizenship status. Unborn children receive coverage that is the same as EPSDT services provided through the Medicaid State Plan. Coverage includes pregnancy related services provided through the Medicaid State Plan for uninsured pregnant women. Benefits to unborn children are delivered through the same delivery and utilization control systems.

South Dakota uses a bundled payment methodology for prenatal services, labor and delivery, and postpartum visits. The bundled payment is billed on the date of birth of the baby so the postpartum visit is prepaid. If the state is unable to use a bundled payment for any reason, the services are paid fee-for-service.

CHIP level FFP is available for all services provided during the pregnancy and for the bundled payment. No CHIP level FFP is available for non-bundled non-emergency services provided during the postpartum period.

6.2.1. ☒ 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. ☒ 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. ☒ 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. ☒ 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. ☒ 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. ☒ 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*

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

See 6.2.6.

6.2.8. ☒ 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. ☒ 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. ☒ 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. Not applicable to the unborn.

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.

6.2.11. ☒ 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.

6.2.12. ☒ 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 dependent, 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.

6.2.13. ☒ 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.

6.2.14. ☒ 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.

6.2.15. ☒ 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.

6.2.16. ☒ Vision screenings and services **(Section 2110(a)(24))**

Vision screenings and 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.

6.2.17. ☒ Hearing screenings and services **(Section 2110(a)(24))**

Hearing screenings and services are limited to services provided by a physician as described in 6.2.3 or a clinical audiologist if the recipient has a referral from a physician or other licensed practitioner and the services are necessary to diagnose or treat a medical problem.

6.2.18. ☒ 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.

6.2.19. ☐ Care coordination services **(Section 2110(a)(21))**

6.2.20. ☒ 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.

6.2.21. ☒ Hospice care **(Section 2110(a)(23))**

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

6.2.22. ☒ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

Any Medicaid eligible child under 21 years of age, pursuant to Section 1905(r)(5) of the Act, has access to necessary health care, diagnostic services, treatment and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services whether or not such services are covered under this State plan. Medically necessary services not specifically covered under the state plan can be accessed by requesting coverage of the service and receiving prior authorization from the department.

Payment will also be allowed under EPSDT for the following medically necessary services:

1. Nutrition items, prior authorization required for total parenteral nutrition.
2. Orthodontic services, prior authorization required.
3. Private duty nursing services, prior authorization required.

Payment will also be made for any medically necessary services provided to children less than 21 years of age in excess of service limitations applicable to adult Medicaid recipients.

6.2.22.1 ☒ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

6.2.23. ☒ 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, 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.

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.

6.2.24. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.25. ☒ 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.

6.2.26. ☒ Enabling services (such as transportation, translation, and outreach services **(Section 2110(a)(27))**

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

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

☐ State-developed schedule
☒ American Academy of Pediatrics/ Bright Futures
☐ Other Nationally recognized periodicity schedule (please specify:)
☒ Other (please describe: *For pregnant women South Dakota covers AAP/Bright Futures and USPSTF A and B graded recommended behavioral health screenings and behavioral health preventive services.)*

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each

benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

6.3.1.2- BH ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

South Dakota's strategy to facilitate the use of age appropriate validated behavioral health screening tools will include adding a requirement to the PCCM addendum to the provider agreement that PCCMs use tools recommended by the AAP, USPSTF, or tools otherwise considered a validated behavioral health screening tool. South Dakota also added information regarding the utilization of validated tools to its providers manuals to facilitate the use of these tools in primary care settings and provided links to the AAP and USPSTF websites. In addition, the state also communicated information to providers regarding utilizing validated tools in our Summer 2020 Provider Newsletter, which was sent to South Dakota's listserv and posted on our website.

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

6.3.2.3- BH ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

6.3.2.3.2- BH ☒ Alcohol Use Disorder

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☐ Peer Support
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.5- BH ☐ Caregiver Support
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.6- BH ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.7- BH ☒ Intensive in-home services
Provided for: ☒ Mental Health ☐ Substance Use Disorder

Substance use disorder intensive outpatient treatment services can be provided in-home. South Dakota does not consider this a unique service based on the location the services are rendered.

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.9- BH ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☐ Substance Use Disorder

6.3.3- BH ☒ Day Treatment
Provided for: ☐ Mental Health ☒ Substance Use Disorder

6.3.3.1- BH ☐ Partial Hospitalization
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.4.1- BH ☒ Residential Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.4.2- BH ☒ Detoxification
Provided for: ☒ Substance Use Disorder

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Mental health crisis intervention and stabilization services are covered as part of South Dakota's coverage of specialized outpatient services for children.

6.3.6- BH ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Mental health continuing care services are covered as part of South Dakota's coverage of specialized outpatient services for children. Substance use disorder continuing care services are covered as part of all levels of care.

6.3.7- BH ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7.1- BH ☒ Intensive wraparound
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Mental health intensive wrap around services are covered as part of South Dakota's coverage of specialized outpatient services for children. Substance use disorder intensive wraparound services are covered as part of all levels of care.

6.3.7.2- BH ☒ Care transition services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

South Dakota provides Case Management services through the PCCM program and Health Homes Program.

6.3.9- BH ☐ Other
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☐ ASAM Criteria (American Society Addiction Medicine)
☐ Mental Health ☐ Substance Use Disorders

☐ InterQual
☐ Mental Health ☐ Substance Use Disorders

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☐ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☐ Mental Health ☐ Substance Use Disorders

☐ CASII (Child and Adolescent Service Intensity Instrument)
☐ Mental Health ☐ Substance Use Disorders

☐ CANS (Child and Adolescent Needs and Strengths)
☐ Mental Health ☐ Substance Use Disorders

☒ State-specific criteria (e.g. state law or policies) (please describe)
☒ Mental Health ☒ Substance Use Disorders

South Dakota's state-specific criteria is a comprehensive assessment integrating mental health and substance use disorder needs based on the ASAM criteria.

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

South Dakota requires both mental health and substance use disorder providers to use a state-specific comprehensive assessment that is based on ASAM criteria. Providers are required to use the state-specific criteria in order for the assessment and any subsequent treatment to be reimbursable. South Dakota requires providers to maintain a copy of the assessment. Failure to use the state-specific criteria or maintain documentation may result in recoupment of payment. The assessment criteria, requirement to use the state-specific assessment, and documentation requirements are communicated in the State's administrative rules and provider manuals. In addition, community mental health centers and substance use disorder agencies are required to use the state-specific criteria as a condition of accreditation by the Division of Behavioral Health.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

☒ International Classification of Disease (ICD)

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ Other (Describe:)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

☒ Yes

☐ No

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☒ Yes

☐ No

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☒ All children covered under the State child health plan.

☐ A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

☒ All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

☒ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

☒ All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

☒ Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

☒ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

☒ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

☒ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

☒ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

6.2.3.1.1 MHPAEA The State assures that:

☐ The State has classified all benefits covered under the State plan into one of the four classifications.

☐ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

☐ Yes

☐ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

6.2.3.2 MHPAEA The State assures that:

☐ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☐ No dollar limit is applied

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:)

☐ No

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year

after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☐ No

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

☐ Yes

☐ No

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☐ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

☐ Yes

☐ No

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

☐ State

☐ Managed Care entities

☐ Both

☐ Other

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

☐ State

☐ Managed Care entities

☐ Both

☐ Other

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. ☒ 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 focused 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. ☒ 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. ☒ 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 provide 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. ☒ 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: Unborn children are excluded from cost-sharing requirements.

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 ☐ 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:

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

8.8.2. ☒ 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. ☒ 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 this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ 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. ☒ 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. ☒ 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. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☒ 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. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. ☒ Immunizations – CPT range 90700 through 90749
- 9.3.7.2. ☒ Well child care – SD EPSDT code W8630, CPT range 9981 through 99383 and 99391 through 99393
- 9.3.7.3. ☒ Adolescent well visits – CPT codes 99384 through 99394
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☒ Mental health – CPT codes 90804 through 90899
- 9.3.7.6. ☒ Dental care – Codes covering exams, x-rays, and certain treatments
- 9.3.7.7. ☒ Other, please list: Optometric and Substance Abuse – Range of SD codes W7500 through W7507m W8500, W8600, W8601 and W8620 through W8624

9.3.8. ☒ Performance measures for special targeted populations.

9.4. ☒ 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. ☒ 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. ☒ 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. ☒ 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. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ 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

Preventative 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	$7,048,986	$7,955,408
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. ☒ 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. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ 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))

☐ **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 ☒ 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. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☒ Section 1128A (relating to civil monetary penalties)

11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

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

☐ **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 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 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.