

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,

James W. Ellenbecker

(Signature of Single State Agency Director, Date Signed)

6/3/98

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuance's of the Department.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per person, include 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: HCFA, P. O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

Proposed Effective Date 7/01/98

1

Submittal Date 6/02/98

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

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3. A combination of both the above.

*CHIP implementation represents an expansion of Medicaid eligible persons by raising the income level of children ages 6-18 ~~from~~ 100% to 133% ~~of~~ the Federal Poverty Level (FPL). The current expansion under CHIP represents seamless coverage **for** all children of families with incomes under 133% ~~of~~ the FPL. It is projected that the first years **CHIP** enrollment will be **7,352** children. Medicaid eligibility will also include the full EPSDT benefits available to all Medicaid children, and the mandatory participation in the **PRIME** Primary Care Case Management (PCCM) program the Department operates under 1915(b) waiver authority. The new eligibility level, active outreach and beneficiary enrollment are scheduled to begin on July 1, 1998.*

Proposed Effective Date 7/01/98

2

Submittal Date 6/02/98

Section 2. General Background and Description of State Approach to Child Health Coverage
(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 section 2110 (C)(2)). 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).

Overview of South Dakota's Population

South Dakota is the 16th largest land area of all the states and is also one of the least densely populated, with an average population density of 9.2 people per square mile. According to the Census Bureau, the total population is estimated to be 749,046. Thirty-four of the state's 66 counties are classified as frontier (Less than 6 persons per square mile) while thirty-one are considered rural (6 to 99 persons per square mile). Only one county is classified as urban (100 or more persons per square mile).

South Dakota's population is concentrated on the ends of the age spectrum. South Dakota is ranked 9th in the nation for highest percentage of children under the age of 19, 13th for ages 65 - 74, and 6th for ages 75 and over. The consequence of this bi-polar age distribution is South Dakota ranks last among the states in population ages 19 - 64. Statewide, South Dakota's population is 91.6% White, 7.3% Native American, with 1.1% classified as Other.

Based on averages of 1993 through 1995 data, South Dakota has 228,000 children under the age of 19, at all income levels. Of that total, 102,000 are estimated to be at or below 200% of poverty, 71,240 below 150%, 60,780 below 133%, and 41,996 below the poverty level.

The most populous counties have the lowest percentages of persons below 200% of poverty level. The highest concentration of poverty in South Dakota is in the thirteen counties that have Indian reservations. The average percentage of people under 200% of poverty level living in those counties is 63.3%, with the highest being 87.3%.

Figures 1 and 2 are state maps indicating percentages of people under 100% and 200% of poverty, respectively.

Figure 1
 Percent of People Under 100% of Poverty, 1990
 U.S. Rate = 13.1% South Dakota = 15.9%

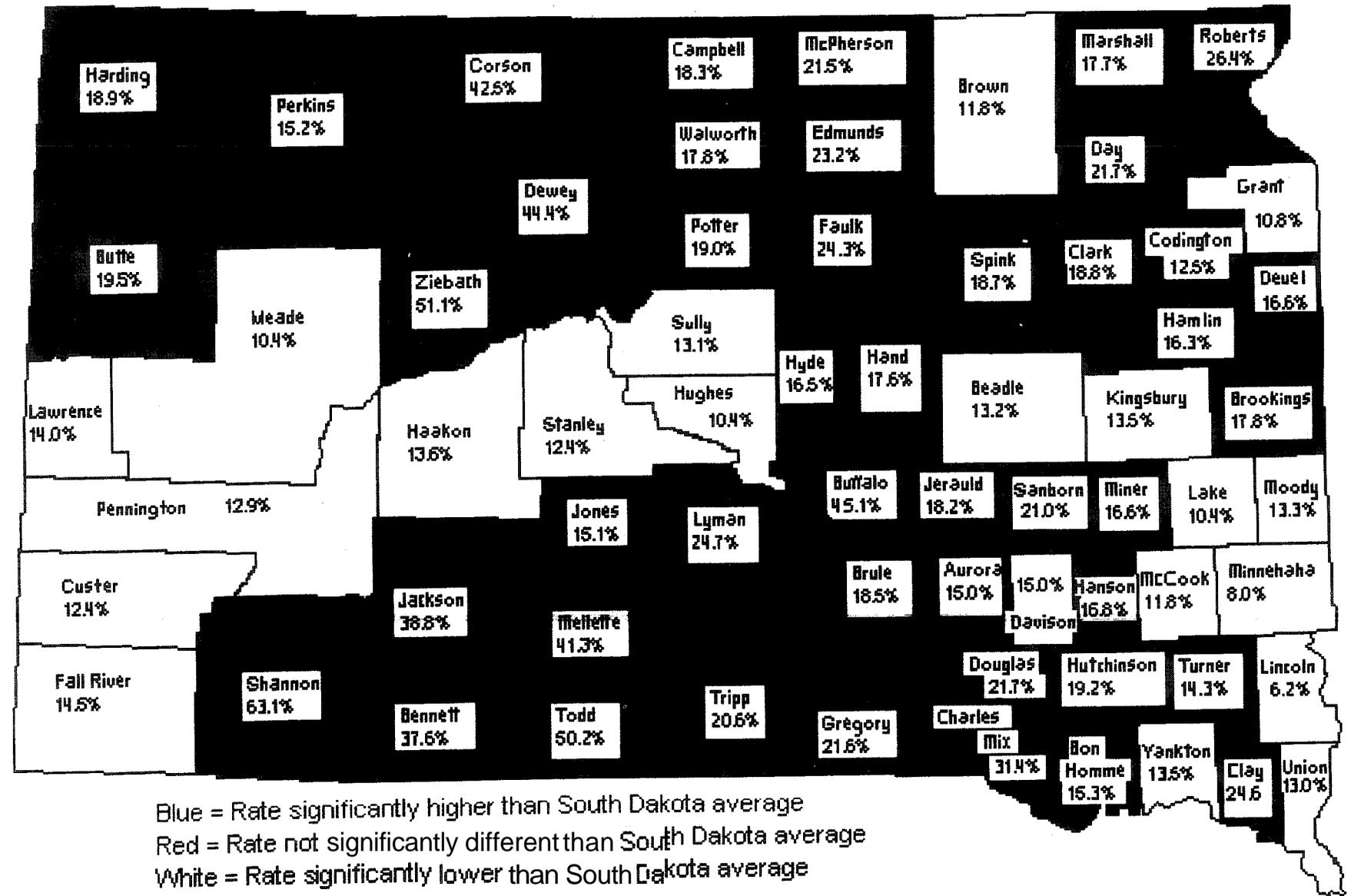
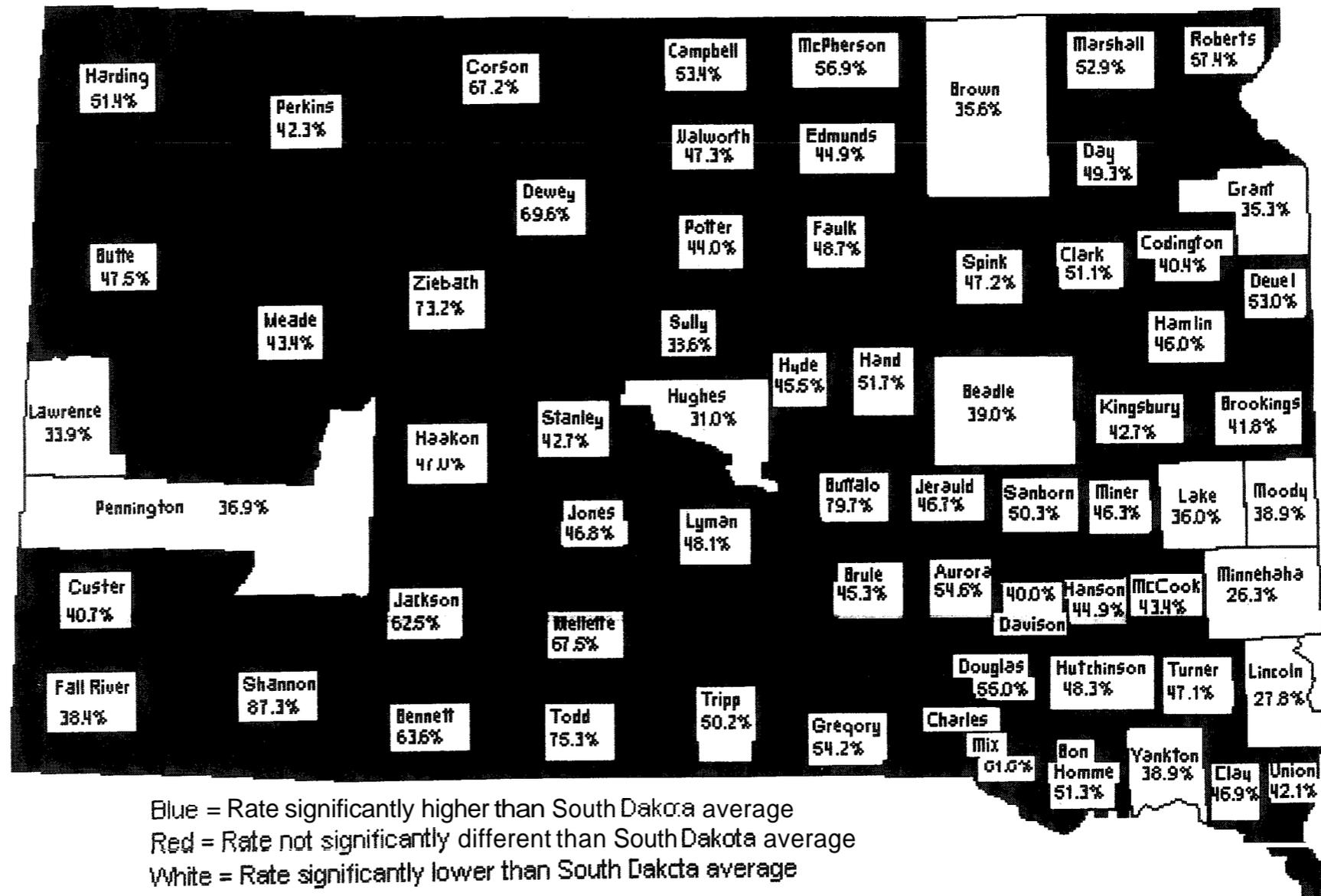


Figure 2
 Percent of People Under 200% of Poverty, 1990
 U.S. Rate = 30.9% South Dakota = 40.9%



Estimates of the Number of Insured/Uninsured Children in South Dakota

According to 1995 U.S. Census Bureau data, it is estimated that South Dakota had **15,000** children under the age of **19**, at or below 200% of poverty level, who were without health insurance. This represents **14.7%** of the children at or below 200% of poverty who are under the age of **19** and **6.6%** of all children under **19**. Although nationally, South Dakota ranks very well in the proportion of kids with insurance or Medicaid, the number of uninsured is still substantial.

At this time we estimate 46,500 children under 200% FPL have some kind of private health insurance. This figure is derived as follows: Total children 102,000, Medicaid 35,000, 15,000 uninsured, 5,500 with other public coverage.

Creditable Health Insurance Coverage for South Dakota Children

Medicaid

Current Medicaid coverage of children up through age 18 is 35,681. Eligibility levels for children age 0 - 5 is at 133% of poverty level and children age 6 - 18 is at 100%. The following table indicates the number of eligibles during the most recent month of coverage.

Medicaid Coverage by Years of Age

	5/98	%
Age < 1	3,509	10%
Age One	2,686	7%
Age Two	2,559	7%
Age Three	2,345	6%
Age Four	2,374	7%
Age Five	2,418	7%
Age 6 to 13	14,134	40%
Age 14 to 18	5,656	16%
<i>Totals</i> (1)	35,681	100%

Medicaid Coverage by Race and Age

	Age <1	Age 1 - 5	Age 6 - 14	Age 15 - 18	Totals
Eligible					
FFY1997	6,489	17,780	120,929	15,026	150,224
White	63.2%	57.1%	50.0%	58.0%	57.1%
Native American	31.0%	37.8%	46.1%	38.5%	38.4%
Other	5.8%	5.1%	3.9%	3.5%	4.5%

Figure 3 is a map indicating Medicaid Coverage by County for children through age 18.

The traditional information systems and reports which support the Medicaid program do not enable the state to specify the income and/or poverty level of children who are enrolled in the program. However, we are able to break out current trends by category of eligibility. By far, the largest category is Poverty Related, comprising 48.8% of eligible children under age 19. The following chart details category of eligibility:

Coverage by Category of Eligibility and Age

	Age <1	Age 1 - 5	Age 6 - 14	Age 15 - 18	Totals	Percent
Receiving Cash Assistance						
Blind/Disabled - Child (SSI)	116	571	1,670	218	2,575	5.1%
TANF - Child	1,220	4,476	6,276	1,414	13,383	26.6%
TANF Unemployed - Child	7	19	24	3	53	<1%
Poverty Related						
Child	1,279	10,623	10,364	2,268	24,534	48.8%
Other (Categorically Related)						
Blind/Disabled - Child (SSI)	3,843	1,867	1,937	909	8,556	17.04%
Foster Care Child	24	224	661	214	1,123	2.2%
Totals (1)	3,489	17,780	20,929	5,026	50,224	

(1) Unduplicated count from HCFA 2082 over FFY 97.

Indian Health Services

South Dakota has nine Indian reservations and a statewide American Indian population of approximately 55,000 (U.S. Census). This population represents special challenges in health care, particularly for those American Indian individuals who reside on the reservations. Shortages of providers, transportation issues, and high incidents of certain risk factors can test the healthcare facilities available on the reservations. According to fiscal year 1997 data received from IHS, the active registrants for each reservation are as follows:

Reservation	IHS Active Registrants (1)	American Indian Residents on Reservation (2)
Cheyenne River	7,603	5,099
Crow Creek	3,534	1,365
Flandreau-Santee Sioux	1,658⁽³⁾	527
Lower Brule	1,925	1,051
Pine Ridge	21,389	10,569
Rosebud	12,750	6,882
Sisseton - Wahpeton	5,543	3,018
Standing Rock	9,177⁽⁴⁾	2,034
Yankton-Wagner	4,571	1,990
Rapid City	11,155⁽⁵⁾	5,857

(1) Obtained from 1996 and 1997 IHS data.

(2) Figures based upon Census data and county data received from SD Dept of Health.

(3) The Flandreau Sioux Reservation is located in South Dakota, while the Santee Sioux Reservation is located in Nebraska

(4) The Standing Rock Reservation is located in North and South Dakota. A large portion of the reservation population lives in North Dakota.

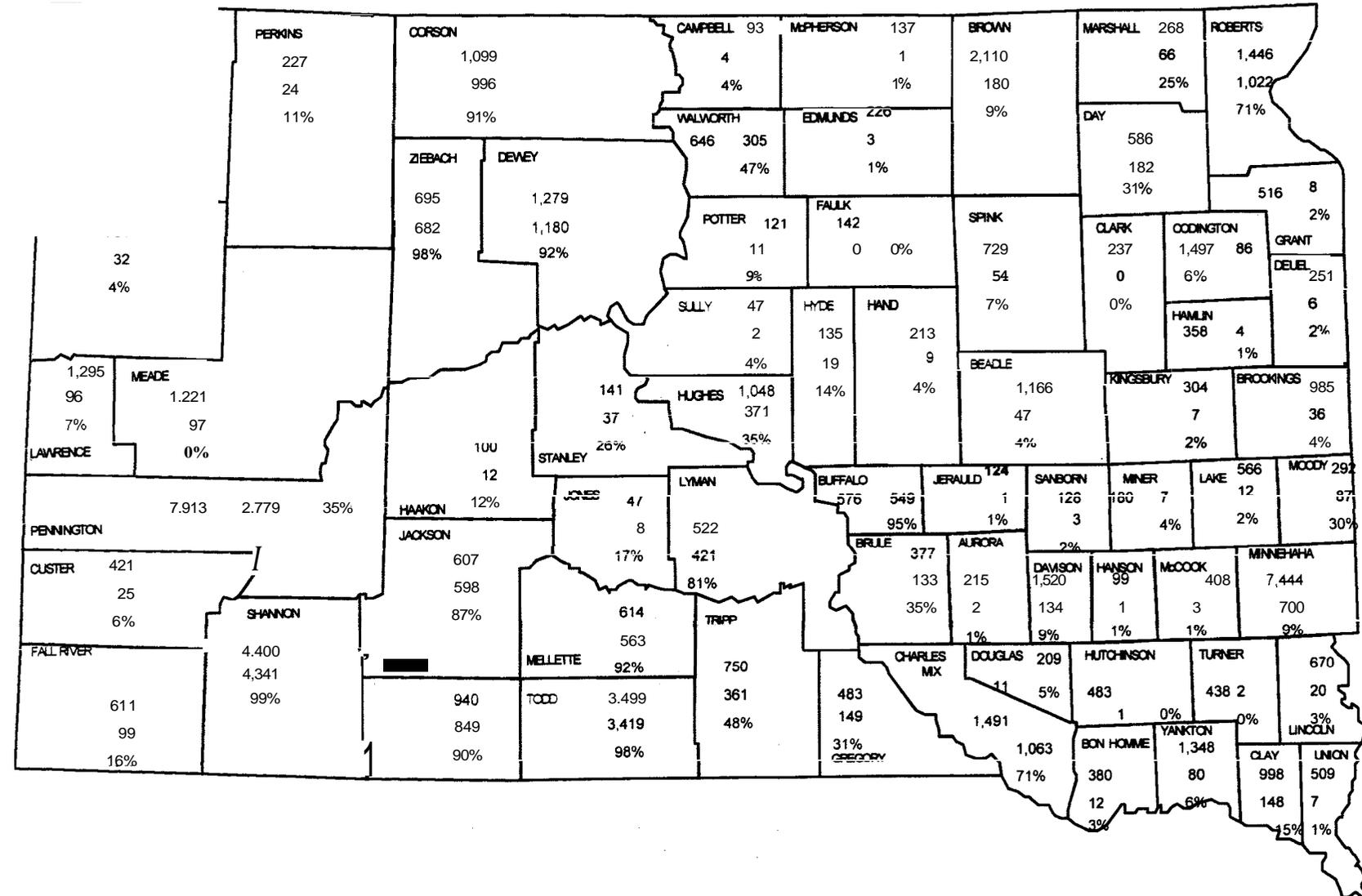
(5) Rapid City is not an Indian Reservation. It is the second largest city in South Dakota and is a large service area for American Indians due to the relatively close proximity to the Pine Ridge Reservation and an IHS Hospital is located there.

The number of total active registrants for these reservations exceeds the total South Dakota American Indian population because active registrants live outside the service areas and possibly outside of South Dakota. The age distribution of registrants on the reservations is 12% up to age 4, 13% ages 5 to 9, 12% ages 10 to 14, and 11% ages 15 to 19.

About 32,500 or 59% of all Native Americans in South Dakota live on an Indian Reservation. The average percentage of American Indian Medicaid recipients in the thirteen counties containing reservations (out of all Medicaid eligibles in those counties) is 65%. Since the overwhelming numbers of American Indian Medicaid recipients statewide are children, 16,000 out of 22,000, we can presume the participation rate among children is higher than 65%. Accurate data indicating the age groups of American Indian children on the reservations is not available. However, according to IHS officials, Medicaid enrollment penetration of children on reservations might be as high as 90%. See Figure 4 for a map of Medicaid coverage of American Indians throughout the state.

Figure 4
South Dakota Medicaid Eligibles

Blue = December 1997 Total Eligibles (59,461 Statewide)
 Red = December 1997 Indian Eligibles (22,167 Statewide)
 Green = Percentage Indians of Total Eligibles (37% Statewide)



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

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):

South Dakota currently operates a Medicaid program as a publicly funded program to provide comprehensive health care coverage to children. The Department of Social Services (DSS) has widespread availability throughout the state with 41 full time and 22 itinerant offices staffed by DSS eligibility staff. In addition to DSS availability, applications for Medicaid are also available at each Disproportionate Share Hospital and FQHC participating in the program. Figure 5 shows the location and current number of Medicaid and CHIP eligibility staff. It also indicates the locations of the nine Indian Reservations in South Dakota.

Most persons eligible for Medicaid in South Dakota participate in a primary care case management program called PRIME. This program operates under waiver authority granted by HCFA under Section 1915(b)(1) of the Social Security Act. Generally, most Medicaid eligible persons with the exception of those residing in institutions, having Medicare coverage or in the custody of the State participate in this program. Each participating individual must choose a primary care provider to provide their primary care, refer for specialty services and provide case management and 24 hour access. South Dakota Medicaid has operated this program statewide since 1993 and is currently in the process of renewal with HCFA seeking approval for three additional years of operation.

The waiver process requires that Medicaid agencies conduct studies of cost effectiveness, quality and access to care focused clinical studies and independent assessments of the programs operation. South Dakota conducts these efforts on an ongoing basis and includes the results in renewal applications to HCFA. The results of these studies indicate that the program is cost effective, is well accepted by Medicaid individuals and Medicaid providers, and offers high quality services.

Most of the primary care providers in the PRIME program are physicians specializing in general practice, family practice, pediatrics, internal medicine, or obstetrics/gynecology. Rural health clinics, federally qualified health centers, and Indian Health Service clinics also participate as PCPs. The services included under the waiver include physician services, inpatient and outpatient hospital services, prescription drugs, mental health and other medical services. Emergency services, family planning, dental, vision, chiropractic, nursing facility and other specialized services are not included in the managed care program and recipients have free choice of provider.

The State also operates many other programs that provide benefits to children. The Medicaid program has entered into a number of partnerships with these programs to extend Medicaid coverage to low income children. Key partnerships include:

South Dakota Department of Social Services has generalized eligibility workers who work with the Medicaid, Food Stamp and TANF programs. The Department has a combined, automated eligibility system for all of these programs to allow for sharing of information and communication among workers. This strategy assists the state's efforts to identify and enroll children for Medicaid at the same location and time families are seeking other assistance.

The South Dakota Office of Child Protection Services also assists families and individuals obtain Medicaid coverage as the State's IV-E agency. This is a proven resource in identifying and obtaining Medicaid coverage for children with specialized needs. A monthly average of 6,671 children are served by the Office of Child Protection services. Almost half, (46% or 3,059) are between ages 6 and 18, so this program will continue to be an important referral source for Medicaid eligibility.

The Department of Health and DSS have an Interagency Agreement to establish and assure referral mechanisms between agencies. The intent of the agreement is to maximize utilization of services and assure that the services provided under Title XIX and Title V are consistent with the needs of recipients. The agreement also assures that the two programs' objectives and requirements are being fulfilled.

South Dakota Department of Health (DOH) operates a number of programs vital to the health of children in South Dakota. The Department has a number of information and referral mechanisms to assist in the identification and enrollment of eligible children for Medicaid eligibility. The WIC program is a good example, as WIC in South Dakota serves approximately 19,000 children per year.

WIC (A supplemental nutrition program for Women, Infants, and Children) facilitates referrals and links applicants with services so that families can access Medicaid, as well as other health and social programs. In addition to the State program there are 3 tribally operated WIC programs on the Cheyenne River, Rosebud, and Standing Rock Indian reservations. Coordination between the WIC and Medicaid program occurs as all Medicaid eligibility approvals of pregnant women are automatically reported to the WIC program on a weekly basis. All WIC applicants are also given a packet of information on the Medicaid program and instructions on how and where to apply for Medicaid.

The Community Health Services (CHS) program is a source of health information and immunizations for children in South Dakota. Available in

most communities of the State, CHS staff including nurses, dieticians, and nutrition educators informs families of Medicaid availability and facilitate enrollment in Medicaid by referral, The Immunization Program is very successful in vaccinating many children in South Dakota. In Calendar year **1998** the program expects to immunize or provide immunizations for **217,280** individuals under age **18**. Of these immunizations **65,807** will be children eligible for the Vaccines for Children Program.

The Community Health Services also operates a "Baby Care" program with Medicaid financing to identify and screen high-risk pregnant women. High-risk women are then offered case management services and assistance with obtaining Medicaid eligibility to finance the case management and all other pregnancy related health services. These services are available in all counties where the Department of Health has nursing staff available. This includes most South Dakota counties that are not located within Indian reservation boundaries. In **1996** the Baby Care program risk assessed **3,218** pregnant women. Of those risk assessed, case management services were provided to **1,843** risk Medicaid, and **634** non-Medicaid high-risk pregnancies.

The Department of Health also offers services for children through the Children's Special Health Services Program. Coordination with Medicaid includes the identification of persons possibly eligible for Medicaid and referral for the determination of Medicaid eligibility. The Department of Health reports that they served **75,245** children under this program in the **1996** MCH Block Grant annual report.

County welfare programs in South Dakota are also a referral source for families seeking medical coverage.

Indian Health Services (IHS) is a vital business partner of the South Dakota Medicaid program. Regular coordination between the IHS and Medicaid program occurs with the Aberdeen Area Office of the Indian Health Services. The meetings are used to establish the policies used by the IHS to access Medicaid revenues and to optimize the coordination of benefits from the programs. Regular data exchanges take place with information on eligibility and PCCM enrollment being exchanged. This allows the IHS to better serve IHS eligible persons and facilitates the identification of children who are potentially Medicaid eligible.

Each Indian Health Service location is an enrolled Medicaid service provider and the physicians employed by the IHS are primary care case managers. Each IHS Service Unit has procedures in place to verify Medicaid eligibility and allow for the referral of potentially eligible persons to the Department of Social Services for application and eligibility determination. Through these arrangements the IHS has been very successful in enrolling American Indian children in the Medicaid program.

Urban living American Indians in South Dakota are also served by Urban Indian Health Clinics that are enrolled as Federally Qualified Health Centers (FQHC) service providers by the South Dakota Medicaid program. Each Urban Indian Health Clinic is located in a community with a DSS eligibility office nearby. As FQHC's, the clinics have the potential to accept a Medicaid application and refer it to the DSS office for an eligibility determination.

South Dakota also has a number of partnerships aimed at extending Medicaid coverage to children with special needs. Key partnerships here include:

South Dakota Division of Special Education and the local School Districts in South Dakota. Under the IDEA Act, schools are required to plan for each child's free and appropriate education. As children with special educational needs are identified, school districts can refer to the DSS for eligibility determination. School districts are also encouraged to enroll as providers with the Medicaid program for coverage of some of the therapies identified in children's education plans. The availability of a payment source is an incentive for schools to identify and enroll Medicaid eligible children. In calendar year 1997 there were 172 school districts enrolled as Medicaid providers. These school districts provided services to 907 children with medical needs identified on their individual education plans.

South Dakota Department of Human Services-Division of Mental Health works very closely with Community Mental Health Centers to make services available to children with severe emotional disturbances. Medicaid is a key funding source for services provided to these children who are often low-income, uninsured or disabled. The location of each South Dakota Mental Health Center and the number of children served are shown in the chart on the next page.

--	--	--	--

South Dakota Medicaid Enrolled Mental Health Facilities

Provider Name	Location	<u># of Title XIX Children Served in CY1997</u>
Human Service Agency	Watertown, SD	116
Southeastern Mental Health	Sioux Falls, SD	164
Northeastern Mental Health	Aberdeen, SD	214
Lewis & Clark Mental Health	Yankton, SD	55
East Central Mental Health	Brookings, SD	30
Community Counseling Service	Huron, SD	99
Capital Area Counseling Service	Pierre, SD	60
Behavior Management Systems	Rapid City, SD	360
Dakota Mental Health Center	Mitchell, SD	131
Southern Plains Mental Health	Winner, SD	49
Professional Consultation	Lemmon, SD	123

South Dakota is also served by a number of Federally Qualified Health Centers located throughout the state. The FQHC's participate in Medicaid as primary care providers. The FQHC's also participate as "casemangers" in the Primary Care Case Management program the Medicaid program offers for most eligibility categories. FQHC's services locations are also available to assist individuals applying for Medicaid, a practice that will be greatly enhanced by the shortened application and by mail in applications. The following table shows the location of each FQHC in the State and the number of children served.

South Dakota Medicaid Enrolled Federal Qualified Health Centers (FQHC's)

Provider Name	Location	<u># of Title XIX Children Served in CY1997</u>
Sioux River Valley community Health	Sioux Falls, SD	549
Howard Clinic	Howard, SD	64
Lake Preston Clinic	Lake Preston, SD	14
Bryant Clinic	Bryant, SD	37
Family Health Center	Eagle Butte, SD	232
Rapid City Community Health	Rapid City, SD	467
Alcester Medical Clinic	Alcester, SD	21
Communtiy Health Clinic	Elk Point, SD	63
Isabel Community Clinic	Isabel, SD	58
Jerauld County Clinic	Wessington Springs, SD	75
Aurora County Clinic	Plankinton, SD	46
Whiting Memorial Clinic	Woonsocket, SD	22
Faith Community Health Center	Faith, SD	67
Onida Clinic	Onida, SD	26
Highmore Clinic	Highmore, SD	78
Jones County Clinic	Murdo, SD	30
Bell Medical Services	DeSmet, SD	47
SD Urban Indian Health	Pierre, SD	33
SD Urban Indian Health	Aberdeen, SD	42
Siouxland Community Health Center	Sioux City, IA	6

Proposed Effective Date 7/01/98

16

Submittal Date 6/02/98

The Indian Health Service of the United States Department of Human Services, Public Health Service also provides health coverage to many children in South Dakota, including children who are not Medicaid eligible. Indian Health Services programs available for Indian children include Direct Services and when appropriate Contract care services. The IHS also provides public health services on Indian reservations and consultation to Tribal Governments on public health and health issues.

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:

The South Dakota Caring Program for Children is a public-private partnership to make certain services available to eligible children. The Program operates 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. Providers electing to participate in this program accept reduced reimbursement and thereby greatly enhance coverage. Eligibility is presently designed to cover children over age 6 and under 133% of the federal poverty level. Services covered include primary and preventive health care services including immunizations, physician's examinations, and limited other outpatient services. Children who are not eligible for Medicaid, IHS or other public programs and meet the age and income restrictions are eligible. Outreach for the program is conducted by the Department of Health, Wellmark Blue Cross Blue Shield of South Dakota and participating providers. Outreach efforts include the distribution of pamphlets and other informational materials, public service announcements, and direct mailings to schools. Referrals also come from the Department of Social Services when children are ineligible for Medicaid due to age or income. County welfare programs also provide referrals to the Caring Program.

The South Dakota Caring Program for Children recognizes that the State's CHIP program will cover the current Caring target population. The Caring Program is actively evaluating alternatives for eligibility and remains committed to providing primary health care to uninsured children in South Dakota. The availability of this public-private resource and the contributions of participating providers will continue as a valuable compliment to the South Dakota CHIP program.

South Dakota counties are 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 how the new State Title XIX program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered.
(Section 2102)(a)(3)

The enhanced State Medicaid program represents an expansion of eligible persons by raising the income level of children ages 6-18 from 100% to 133% of the federal poverty level. In 1995, the State had already accelerated the coverage of persons over age 12 and under age 19 to 100% of FPL, and exceeded the Federal Medicaid eligibility minimums. The current expansion under CHIP represents seamless coverage for all children of families with incomes under 133% of the FPL. Medicaid eligibility will also include the full EPSDT benefits available to all Medicaid children, and the mandatory participation in the PRIME primary care case management program the Department operates under 1915(b) waiver authority. The new eligibility level, active outreach and beneficiary enrollment are scheduled to begin on July 1, 1998.

Eligibility will continue, however, to be the responsibility of the Department of Social Services as only DSS staff will be making eligibility determinations. This will avoid problems of incorrectly enrolling non-targeted children in CHIP. In addition to a complete verification of income, an eligibility screening will be completed to detect the presence of other insurance coverage. A very key advantage of the choice of Medicaid expansion for CHIP is that children who would otherwise be turned away from coverage because of the existence of another, non-comprehensive, or high deductible insurance policy, will still be eligible for Medicaid. Third-party liability (TPL) and benefit coordination for those children will insure that private dollars continue to be used for the health care costs of children, but that the availability of Medicaid's broad coverage of primary and preventive services makes services accessible and affordable for more children. Families with private insurance and Medicaid-eligible children will be encouraged to retain their private insurance to maximize coverage for the children and to avoid "crowding" out of private insurance resources.

Medicaid eligibility will be determined in a uniform manner using a statewide database. This will ensure uniform eligibility processing statewide and also continuity of coverage as families move around the state. Edits in the system will assist workers in the correct assignment of eligibility categories so individuals are appropriately assigned to regular Medicaid or to CHIP. If private insurance is detected, a child will be assigned to the Medicaid program and eligibility workers will attempt to gather information on the private insurance coverage for benefit coordination and TPL requirements.

The State of South Dakota operates its own MMIS claims processing system. The system is being modified to provide that only claims adjudicated on behalf of CHIP eligibles will be allocated to the CHIP program. Expenses for other Medicaid eligible children will be charged using the existing MMIS coding for appropriate federal financial participation.

The DSS has an appeals process in place for Medicaid recipients. A recipient may request a fair hearing regarding Department decisions of eligibility or denial of certain services, if the recipient believes their rights have been violated, or if they believe they are entitled to additional benefits or their assistance has been calculated incorrectly. The recipient has the right to cross examine witnesses, be represented by counsel, and

produce their own testimony and witnesses. An impartial hearing examiner reviews all the facts of the case and makes a recommendation to the Department. If the Department does not reverse their decision based upon the hearing examiners recommendation, the recipient may appeal to Circuit Court.

The DSS has in place guidelines and policies regarding civil rights. Complaints received regarding any type of discrimination are fully investigated. Corrective action is taken to resolve any problems regarding discrimination. If a pattern of complaints is received, the information is passed on to the South Dakota Division of Human Rights. DSS offices comply with standards of accessibility for the handicapped and provide bilingual services where necessary.

Nearly all of the children that will be eligible under CHIP will be enrolled in South Dakota Medicaid's PRIME Managed Care Program. Approximately two-thirds of South Dakota Medicaid's population is currently enrolled in PRIME. In 1997, 451 PRIME enrollees were surveyed during face-to-face interviews. The survey was aimed at determining the satisfaction and quality of the services they received under PRIME. Following are some of the outcomes of this survey:

- *86% were satisfied with the care they received from their Primary Care Provider;*
- *Only 4% reported that they went without medical care while in PRIME;*
- *77% believed their Primary Care Provider always listens to their concerns, 19% believe their Primary Care Provider sometimes listens to their concerns;*
- *and, 46% believed their care would be worse without the PRIME Program, 44% were just happy to have health care, 3% believed their care would be better without the PRIME Program.*

Section 3. General Contents of State Child Health Plan (Section 2102 (a) (4))

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

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

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))

4.1.1. Geographic area served by the plan: _____

4.1.2. Age: _____

4.1.3. Income: _____

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

4.1.5. Residency: _____

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: _____

4.1.8. Duration of eligibility: _____

4.1.9. Other standards (identify and describe):

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))

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))
- 4.4. Describe the procedures that assure:
- 4.4.1. Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))

 - 4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

 - 4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(D))

 - 4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian health Care Improvement Act, **25 U.S.C. 1603 (c)**). (Section 2102)(b)(3)(D))

 - 4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

Section 5. Outreach and Coordination (Section 2102 (c))

Describe the procedures used by the state to accomplish:

- 5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102 (c)(1))

The Department of Social Services has an outreach strategy that will operate on a Statewide and on a local basis, Statewide strategies will include the use of centralized computer systems and statewide policy changes as well as continuing the development and maintenance of program partnerships, many of which were described in Section 2.2. Local Strategies will involve using local resources to target outreach efforts to locations accessed by children and/or their parents.

Statewide Outreach Strategy

Many of the children potentially eligible for the CHIP program are already known to the Department of Social Services. These children may previously have had Medicaid eligibility, have siblings with Medicaid eligibility, or be eligible for other programs offered by the State at different levels of income, including the Food Stamp or TANF programs. The Department has the capability of identifying potentially eligible children and mailing applications directly to their families for completion.

The partnerships identified in 2.2.1 will continue to be relied on to assist with outreach. Partnerships crafted at the State level will provide for the coordination of programs to provide a framework so that local offices can obtain, share and use information uniformly to identify and enroll potentially eligible children.

Very significant changes are being made to statewide eligibility policy to improve and simplify the eligibility process. A new, shorter Medicaid low-income application form will be used to improve the application process. The much shortened form will be used by both Medicaid and CHIP low income children as they apply for Medicaid coverage. For these eligibility categories, the new form replaces a much longer form that had been used for all Medicaid categories. Another very significant policy change will be the acceptance of mail in applications for the low income and CHIP children. This will allow for the placement of applications at many locations where they can be obtained by families and sent to the Department. This is a substantial improvement over the previous method where applications were only obtained at limited locations, and a personal interview was required for eligibility.

Training of Department of Social Services field staff by State Office Personnel will begin in early June, as local Field Program Specialists will travel to Pierre and be trained in the new low income application form, mail in applications and the State's new CHIP program. These individuals will then bring the training materials back to their local offices and train the staff they supervise. In this fashion all of the State's

Medicaid eligibility workers will be trained in the new program and the new procedures before the end of June and program start up, July 1, 1998.

In addition to the policy changes, more personnel resources are being hired by the Department of Social Services to assist in outreach and the processing of applications for eligibility. An additional nurse consultant will also be added to the Office of Medical Services in State Once to bolster partnerships with health programs, assist in measuring and improving access and quality of services, and to provide direction to case management activities.

Local Outreach Strategy

New efforts to bolster the identification and enrollment of children eligible for Medicaid and CHIP will be made by the Department using other programs the Department operates. These programs are the Child Care Services and Child Support Enforcement programs. Staff from these programs will be trained in the availability of Medicaid benefits to assist families in applying for the programs. The staff of these programs are often co-located in the local office with Medicaid eligibility staff to enhance the availability and sharing of information at each DSS office location.

Staff from the Office of Child Care services who work directly with day care providers will be an important source of information to the day care providers regarding the availability of Medicaid services. South Dakota is joining the "Healthy Child Care America" national initiative. This is a nationally focused initiative sponsored by the U.S. Dept. of Health and Human Services. Under this program, local networks of training resources for child care providers will be developed. Participating in this network are child care providers, child welfare workers, health care providers, head start, child care research and referral, education, Part H, nutrition, mental health and substance abuse prevention programs and Indian Tribal grantees. Through this network CHIP information and enrollment materials can be distributed to children and families.

Staff from the Office of Child Support Enforcement (OCSE) will routinely provide CHIP information and referrals for the low income, uninsured children that are in families served by the Office of Child Support Enforcement. The South Dakota OCSE offices are generally co-located with the Department's eligibility staff, which will enhance the effectiveness of referrals. The South Dakota Office of Child Support Enforcement estimates that they serve over 44,000 children in 20,000 current support cases each year. Training for the OCSE staff in CHIP and the application process will occur June 8, and 9 as part of their annual statewide training conference.

DSS Local office staff will be working in their communities to make information about the CHIP program available to populations the local offices can target. Among the entities local office eligibility staff will be working with to distribute information and enrollment materials are schools, community health centers, physician offices and clinics, hospitals, Indian Health Service Facilities, county health and welfare programs, tribal health programs, state and local health departments, Urban Indian Health Clinics, and other interested groups and associations. Interested groups such as the South Dakota Coalition for Children have volunteered to support CHIP outreach efforts, and other volunteers will be locally solicited.

--	--	--

DSS staff is located on or near each of the Indian reservations in South Dakota have very significant caseloads of Indian people. See Figure 5 for the proximity of DSS field offices to Indian Reservations. The long history our local offices have of working with Indian people and Tribal governments in all of the programs operated by the state are valuable in promoting culturally sensitive outreach and enrollment. Outreach materials specific for Indian children are being developed for use in outreach on reservation areas.

The local office staff will also be available to assist individuals enrolling in our primary care case management program, to choose a primary care provider, and to make recipients aware of their opportunities and responsibilities.

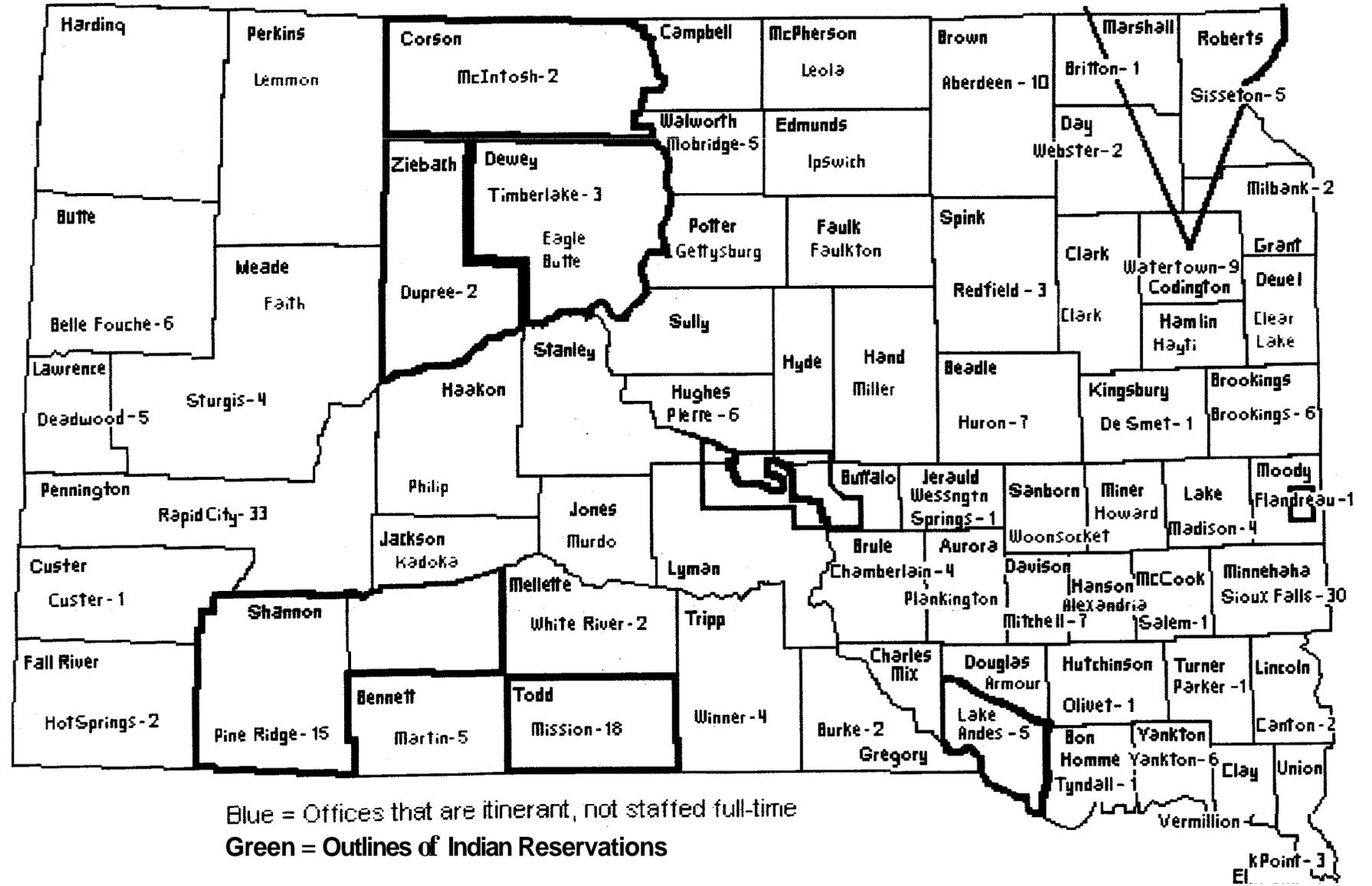
5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102 (c)(2))

Medicaid expansion is the option selected by South Dakota for its Child Health Insurance Program. As such, all Medicaid regulations, policies and procedures continue to apply for CHIP-eligible children. All Medicaid benefit coordination procedures will also apply to CHIP-eligible children. There will be limited benefit coordination for CHIP children with private health insurance, as children meeting the eligibility criteria but having private health insurance coverage will be enrolled as regular, low income Medicaid eligible. However, third-party liability policies in Medicaid/CHIP will continue to be enforced where possible (accidents, etc.). The principle area where coordination will occur will be with the Indian Health Service.

The Indian Health Service is the largest public program for children that the Medicaid program coordinates benefits with in South Dakota. Coordination with the IHS will not change as a result of the CHIP program. The twelve Indian Health Services service units in South Dakota will continue as direct service providers and will be reimbursed by the South Dakota Medicaid program for CHIP children. In addition, IHS Service Units are responsible for making contract care services available for IHS eligible beneficiaries when service needs are beyond the direct care resources of the IHS. The Indian Health Services Contract Care Program is the payer of last resort and, in most cases, the IHS provides benefit coordination by denying the claim and causing the claim to be submitted to the South Dakota Medicaid program for payment. This will also continue for children eligible for Medicaid under CHIP.

In order to maximize IHS resources and provide the best possible coverage for beneficiaries, the IHS is very attentive to identifying and facilitating the enrollment of potentially Medicaid eligible individuals into the Medicaid program. The IHS has electronic and manual means to interface with the Medicaid agency to verify eligibility for Medicaid and to expedite enrollment.

Figure 5
Caseworkers in DSS Field Offices



The IHS clinic locations in each Medicaid service area are also identified as primary care physicians under the South Dakota PRIME program of primary care case management for certain Medicaid eligibles. In the capacity of primary care physicians, IHS providers can refer for Medicaid as well as IHS services and optimize the access to care for American Indian children. Of course, American Indian Medicaid beneficiaries who have selected non-IHS primary care physicians still have full access to IHS direct and contract care services without referral from their primary care physician.

In addition, the IHS Area Office and the Medicaid agency in the Department of Social Services coordinate closely on many administrative issues to improve access, availability, and quality of services.

Tribal Health programs will interface with Medicaid/CHIP and Medicaid in much the same fashion as IHS facilities. To the extent that Tribal Health programs offer IHS services under "638" contracts, they will be treated exactly as an IHS provider. At the present time, there is only one such provider in South Dakota.

Coordination of all programs serving children in South Dakota state government occurs through a close working relationship of the various members of the Governor's cabinet. This coordination between the Departments of Health, Social Services, Education, Human Services and Corrections optimizes resource utilization to make the most services available to children. These efforts are facilitated by regular cabinet meetings and a number of interagency work groups that are focused on coordinating benefits.

These workgroups include the State Interagency Coordinating Council (ICC). This work group consists of state agencies, private business, parents, and other interested parties that meet on the "Birth to Three" Program for early intervention to serve children and toddlers. Local ICC networks are organized under this initiative throughout the State. Another network is the Interagency Coordinating Network Council that meets to coordinate the needs of seriously emotionally disturbed children. The Department of Social Services, Department of Human Services, Department of Corrections, Department of Education are all part of this workgroup. A new network is also being created, targeted at the needs of FAS/FAE children.

Proposed Effective Date 7/01/98

27

Submittal Date 6/02/98

--	--	--

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.)

6.1.1. Benchmark coverage; (Section 2103(a)(1))

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)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**

6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to new York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial option 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))

- 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))
- 6.2.1. Inpatient services (Section 2110(a)(1))
 - 6.2.2. Outpatient services (Section 2110(a)(2))
 - 6.2.3. Physician services (Section 2110(a)(3))
 - 6.2.4. Surgical services (Section 2110(a)(4))
 - 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
 - 6.2.6. Prescription drugs (Section 2110(a)(6))
 - 6.2.7. Over-the-counter medications (Section 2110(a)(7))
 - 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
 - 6.2.9. Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
 - 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
 - 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
 - 6.2.12. 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))
 - 6.2.13. Disposable medical supplies (Section 2110(a)(13))
 - 6.2.14. Home and community based health care services (See instructions) (Section 2110(a)(14))
 - 6.2.15. Nursing care services (See instructions) (Section 2110(a)(15))
 - 6.2.16. 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))
 - 6.2.17. Dental services (Section 2110(a)(17))
 - 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

- 6.2.19 Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. Hospice care (Section 2110(a)(23))
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) Section 2110(a)(24))
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
- 6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3. **Waivers - 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 waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and (3))

6.3.1. **Cost Effective Alternatives.** 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:

6.3.1.1. 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))

- 6.3.1.2. 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; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))
- 6.3.1.3. 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(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))
- 6.3.2. **Purchase of Family Coverage.** Describe the plan to provide 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))
 - 6.3.2.1 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))
 - 6.3.2.2. 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))

--	--	--

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 immunization provided under the plan. (Section 2102(a)(7)(A))

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
- 7.1.2. Performance measurement
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (Section 2102(a)(7)(B))

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?

8.1.1. YES

8.1.2. NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:
(Section 2103(e)(1)(A))

8.2.1. Premiums: _____

8.2.2. Deductibles: _____

8.2.3. Coinsurance: _____

8.2.4. Other: _____

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: _____

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of 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))

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

8.4.3. No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))

8.4.5. No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))

8.4.6. 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))

- 8.4.7. 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))
- 8.4.8. 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))
- 8.4.9. 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))

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 annual income for the year involved: (Section 2103(e)(3)(B)): _____

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: _____

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

8.6.2. 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 6.3.2, of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:

--	--	--

Section 9. Strategic Objectives and Performance goals for the 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 217 (a)(2))**

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 CHIP 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.*

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

1. *Achieve a measurable reduction in the number of uninsured children in South Dakota.*
 - 1.1 *Implement Medicaid expansion to cover uninsured children age six through eighteen to 133% of the Federal Poverty Level through a CHIP State Plan on July 1, 1998, enrolling 7,352 children by June 30, 1999 and increasing enrollment by 5% each year after the initial year.*
 - 1.2 *Extend Medicaid to uninsured children age zero through eighteen at Medicaid eligibility levels in effect prior to July 1, 1998, enrolling 900 additional children by June 30, 1999 and increasing enrollment by 1% each year after the initial year.*
 - 1.3 *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 by July 1, 1998 and continuing each year.*
 - 1.4 *Simplify the Medicaid application process for low-income children using a shortened application and accepting mail-in applications by July 1, 1998.*
 - 1.5 *Increase the number of Department of Social Services personnel to support the enrollment of uninsured children by 12 full time equivalent workers by June 30, 1999.*

Proposed Effective Date 7/01/98

35

Submittal Date 6/02/98

2. *Improve access to quality primary and preventive health care services under Medicaid for CHIP eligibles, new Medicaid eligibles, and previously non-enrolled children.*
 - 2.1 *Enroll all newly approved CHIP children in the South Dakota Medicaid primary care case management program within 1 month of their enrollment, beginning July 1, 1998.*
 - 2.2 *Ensure each new CHIP enrollee receives EPSDT information at the time their eligibility is approved.*
 - 2.3 *Develop a quality measurement mechanism that includes 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 waiver authority. This evaluation process uses client and provider surveys, independent evaluations and clinical studies to report cost effectiveness and quality to HCFA for waiver renewal purposes.*

 3. *Develop better measurement capabilities of health insurance coverage, health care service availability and quality to children in South Dakota.*
 - 3.1 *Develop survey capabilities with the Department of Health to measure the insurance coverage of children in South Dakota by July 1, 1998. This goal includes developing the survey questions and executing a data collection contract with the Department of Health.*
 - 3.2 *Modify the Medicaid Management Information System to make CHIP tracking and reporting capabilities available to measure enrollment, service, utilization, and overall program effectiveness. This enhancement will make all MARS and HCFA reports available for CHIP.*
 - 3.3 *Develop capability to measure access to coverage for Indian children in South Dakota by working jointly with the Indian Health Service, Tribal governments and Urban Indian Health clinics by July 1, 2000.*
-

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))

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 State Plan, or Medicaid coverage. Evidence of this reduction will come from South Dakota Medicaid enrollment figures, survey data from the Behavioral Health Survey (described in Section 9.5), and use of estimates provided in national publications and the Census Bureau.

2. *Improve access to quality primary and preventive health care services under Medicaid for CHIP eligibles, new Medicaid eligibles, and previously non-enrolled children.*

The attainment of this objective will be realized by the number of new children in our primary care case management program as each child will be required to choose a primary care provider shortly after enrollment. This program operated under waiver authority requires quality assessment and independent evaluation as conditions of the waiver. The HCFA 416 report and data from the Department of Health Immunization system will evidence improvements in immunization and preventive screening rates.

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

By January 1, 2000, adequate data will be available for the completion of annual reports and evaluations in compliance with Sections 9.5 and 10 of this State Plan.

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. 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 99381 through 99383 and 99391 through 99393*

9.3.7.3. Adolescent well care - *CPT codes 99384 and 99394*

9.3.7.4. Satisfaction with care

9.3.7.5. Mental health - *Old CPT codes 90801 through 90899
New CPT codes 90804 through 90899*

9.3.7.6. Dental Care - *Codes covering exams, e-rays, and certain treatments*

9.3.7.7. Other, please list: Optometric and Substance Abuse - Range of SD codes - W7500 through W7507, 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))

9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))

The South Dakota Department of Social Services will evaluate the operation and effectiveness of its Children's Health Insurance Program (CHIP) on an ongoing basis and report the findings to HCFA 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, Medicaid, Indian Health Services, and CHIP.

A number of data sources will be key in the effort to determine the CHIP impact on increasing the number of children with creditable health coverage, The most current US Census data available will be utilized to identify the total

number of children in South Dakota by age, race, and level of family income. Department of Health data on uninsured children will be used to determine the number of insured and uninsured children by age, race, location, level of family income, and availability of other health insurance.

The Department of Social Services will work with the Department of Health to modify their existing capabilities to accurately estimate and monitor the number of uninsured children. A number of data elements will be needed to enable the determination of the number of children in South Dakota with creditable health coverage as well as to obtain demographic information on South Dakota's children.

The Department of Social Services, in conjunction with the Department of Health, is proposing to use the South Dakota Behavioral Risk Factors Surveillance System (BRFSS) survey to accurately estimate and monitor the number of uninsured children in the state. The BRFSS is a national public health survey conducted in all fifty states, the District of Columbia and three territories. It is designed and funded by the federal Centers for Disease Control and Prevention (CDC). The BRFSS is the largest, ongoing, telephone health survey in the world.

A separate set of questions, specifically designed to determine the number of uninsured children in our state, will be developed and added into the existing BRFSS survey. Also, in order to ensure statistically significant results, a greater number of households with children will be contacted.

The Centers for Disease Control and Prevention has indicated their willingness to assist state staff in question development and statistical analysis. It is anticipated data collection will begin in July of 1998.

Other data resources will also be utilized to evaluate our Title XXI program. Eligibility and expenditure data from the existing Medicaid program will be obtained from HFCA-37 and HFCA-2082/MSIS reports, the HCFA 416, as well as from existing MMIS reports. Indian Health Services data will be used to focus on the program's impact on American Indian children. And of course, CHIP eligibility and expenditure data will be used in comparison to that of Medicaid to ensure consistency and identify potential program deficiencies. The Department of Social Services will attempt to collect information available from other public and private health care programs for program evaluation.

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))

9.7.

The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

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))

- 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 payments)
- 9.8.3. Section 1903 (w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1115 (relating to waiver authority)
- 9.8.5. Section 1116 (relation to administrative and judicial review), but only insofar as consistent with Title **XIX**
- 9.8.6. Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7. Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8. Section 1128A (relating to civil monetary penalties)
- 9.8.9. Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10. 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))

The South Dakota Medicaid Advisory Council and the South Dakota Board of Social Services were informed of the availability of a CHIP program for South Dakota and the CHIP program was discussed prior to the formulation of the Governor's Medicaid recommendation to the Legislature. The availability of Children's Health Insurance Program federal funds was also discussed with the Governor's Health Advisory Committee, a committee that consists of many prominent provider and health care industry representatives prior to the Governor's legislative recommendation. Each of these groups had the opportunity to ask questions about the program and offer suggestions for program development.

Proposed Effective Date 7/01/98

40

Submittal Date 6/02/98

The Governor's Budget recommendations to the Legislature included funds to expand the Medicaid program by covering children up to age 19 whose family income is below 133% of the federal poverty level. This measure was fully discussed by the State Legislature during the Appropriations process and also in a number of specialized consultations with Legislative committees and party caucuses by the Governor's staff.

Both the DSS Board of Social Services and the Medicaid Advisory Committee were presented copies of the draft Children's Health Insurance Program plan and offered an opportunity to review the plan and offer comments and suggestions. These advisory discussions occurred prior to the release of the draft plan so that suggestions could be included before the draft was released to the public.

Public notice was published in the State's largest newspapers, and a newspaper widely read by Indian people in South Dakota. Two ads were published in the Argus Leader, two ads were published in the Lakota Times, and two ads were published in the Rapid City Journal. The ads announced the time and location of the public hearings and appeared two weeks and one week prior to the scheduled public hearing. The ads also specified that copies of the plan were available and that written comment could be made to the Department of Social Services. Notice of the draft plan's availability and the schedules of the three public hearings were also mailed directly to persons known to have interest in the CHIP plan in South Dakota.

A notice of the plan's availability, components, and comment opportunity was also made available on the Internet page for the South Dakota CHIP program.

A series of three public hearings to review the State Plan will be held to inform interested parties of the availability of a draft Children's Health Insurance Plan. These hearings will be held April 23, 1998, in Flandreau, South Dakota, April 30, 1998, in Sioux Falls, South Dakota and May 7, 1998, in Rapid City, South Dakota. The hearing in Flandreau was a special hearing in that it was directed primarily at Tribal leaders and also attended by officials from the Indian Health Service and Health Care Financing Administration's Region VIII office. Invitees to this hearing included Tribal chairmen, Tribal Health coordinators, Indian Health Service unit employees, Aberdeen Area Indian Health Services officers, Urban Indian Health clinics and others interested in the health care of American Indian children.

DSS local office staff has also been active in providing information locally in all service areas in South Dakota. They are making local connections to alert interested parties of the availability of the plan and the opportunity to provide input.

Ongoing public involvement will occur regularly for the CHIP program. Any rules governing the Medicaid or CHIP program must comply with public notice and hearing requirements. Since Medicaid expansion was selected as South Dakota's option, the Medicaid Advisory Committee will regularly review the program's operation. The Board of Social Services and the Governor's Health Care Advisory Committee have also asked to be kept informed of the operation of the Children's Health Insurance Program.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

A financial form for the budget is being developed, with input from all interested parties, for states to utilize.

The following budget figures represents the estimated costs of serving the projected 7,352 CHIP children in the first year of program operation. All of the funds used to operate the CHIP program by matching the federal funds have been allocated from the State's General fund, as part of the General Appropriation bill. The column labeled FY 98 includes figures for the last quarter of federal fiscal year 1998 beginning July 1, 1998, and ending September 30, 1998. The column labeled FY 99 includes figures for the same 7,352 children for a full year of CHIP operation. Costs for an anticipated increase in the number of non-CHIP, Medicaid eligible are not included.

Federal Fiscal Year Budget Estimates:

Medical Services Purchased:		
Physician	\$455,817	\$1,823,268
Inpatient Hospital	\$371,937	\$1,487,748
Outpatient Hospital	\$141,325	\$565,300
Prescription Drugs	\$150,130	\$600,520
Preventive Care (EPSDT)		
Screenings	\$12,256	\$49,024
Dental & Orthodontic	\$116,456	\$465,823
Optometric	\$35,395	\$141,579
Treatment	\$66,326	\$265,303
Mental Health	\$58,431	\$233,725
All Other	\$45,148	\$180,591
Total Medical Services Purchased	\$1,453,220	\$5,812,880
Personal Services	\$126,893	\$507,570
Outreach	\$12,500	\$50,000
Data Collection & Evaluation	\$12,500	\$50,000
Computer Services	\$5,000	\$20,000
Total Administration	\$156,893	\$627,570
Total Budget	\$1,610,112	\$6,440,450
Federal Share	\$1,246,710	\$4,986,840
State Share	\$363,402	\$1,453,609

ection 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))

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

10.1.2 Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

<u>Attributes of Population</u>	<u>Number of Children with Creditable Coverage</u>	<u>Number of Children without Creditable Coverage</u>	TOTAL
	XIX		
Income Level:			
< 100%	24,269		41,996
≤ 133%	50,224		60,780
≤ 185%			71,240
≤ 200%		15,000	102,000
> 200%			126,000
Age	50,224		228,000
0 - 1	6,489		
1 - 5	17,780		
6 - 14	20,929		
15 - 18	5,026		
Race and Ethnicity			
American Indian or Alaskan Native	19,286		
Asian or Pacific Islander	2,260		
Hispanic			
White, not Hispanic origin	28,678		
Location			
MSA	6,911 (Sioux Falls)		
Non-MSA	43,313		

Source: FFY 1997 HCFA 2082

- 10.2. State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below:
(Section 2108(b)(A)-(H))
- 10.2.1. An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
- 10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:
- 10.2.2.1. The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends
- 10.2.2.2. The quality of health coverage provided including the types of benefits provided;
- 10.2.2.3. The amount and level (including payment of part or all of any premium) of assistance provided by the state;
- 10.2.2.4. The service area of the state plan;
- 10.2.2.5. The time limits for coverage of a child under the state plan
- 10.2.2.6. The state's choice of health benefits coverage and other methods used for providing child health assistance, and
- 10.2.2.7. The sources of non-Federal funding used in the state plan.
- 10.2.3. An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
- 10.2.4. A review an assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5. An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6. A description of any plans the state has for improving the availability of health insurance and health care for children
- 10.2.7. Recommendations for improving the program under this Title.
- 10.2.8. Any other matters the state and the Secretary consider appropriate.

- 10.3. The state assures it will comply with future reporting requirements as they are developed.
- 10.4. 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.