

## **FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

### **Preamble**

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

The framework is designed to:

- ❖ Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- ❖ Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- ❖ Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- ❖ Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

**FRAMEWORK FOR THE ANNUAL REPORT OF  
THE STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

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

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

\_\_\_\_\_  
(Signature of Agency Head)

SCHIP Program Name(s): Partners for Healthy Children

SCHIP Program Type:

- SCHIP Medicaid Expansion Only  
 Separate Child Health Program Only  
 Combination of the above

Reporting Period: **Federal Fiscal Year 2002** *Note: Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02.*

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Submission Date: **December 27, 2002**

*(Due to your CMS Regional Contact and Central Office Project Officer by January 1<sup>st</sup> of each year)  
Please copy Cynthia Pernice at NASHP ([cpernice@nashp.org](mailto:cpernice@nashp.org))*

## SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

- 1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to comment why, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility	From		% of FPL for infants		% of FPL	From		% of FPL for infants		% of FPL
	From	134	% of FPL for children ages 1 through 5	150	% of FPL	From		% of FPL for children ages 1 through 5		% of FPL
	From	101	% of FPL for children ages 6 through 17	150	% of FPL	From		% of FPL for children ages 6 through 16		% of FPL
	From	101	% of FPL for children ages 18	150	% of FPL	From		% of FPL for children ages 17 and 18		% of FPL
Is presumptive eligibility provided for children?	No <input checked="" type="checkbox"/>					No				
	Yes, for whom and how long?					Yes, for whom and how long?				
Is retroactive eligibility available?	No					No				
	Yes, for whom and how long? <input checked="" type="checkbox"/>  A retroactive period of three months is allowed for new applicants who meet stated criteria, the assumption is made that the family has the same income during the retroactive period as reported on the application. Then all of the children in the budget group for PHC during the retroactive period are approved if <ul style="list-style-type: none"> <li>• All PHC eligibility criteria are met at application, and</li> <li>• The applicant reports that medical services were received by at least one of the children in the budget group during the three months prior to application.</li> </ul>					Yes, for whom and how long?				
Does your State Plan contain authority to implement a waiting list?	Not applicable					No				
						Yes				
Does your program have a mail-in application?	No					No				
	Yes <input checked="" type="checkbox"/>					Yes				
Does your program have an application on your website that can be printed, completed and mailed in?	No					No				
	Yes <input checked="" type="checkbox"/>					Yes				
Can an applicant apply	No <input checked="" type="checkbox"/>					No				

	SCHIP Medicaid Expansion Program				Separate Child Health Program					
for your program over phone?	<input type="checkbox"/> Yes				<input type="checkbox"/> Yes					
	<input checked="" type="checkbox"/> No				<input type="checkbox"/> No					
Can an applicant apply for your program on-line?	Yes – please check all that apply				Yes – please check all that apply					
	<input type="checkbox"/>	Signature page must be printed and mailed in			<input type="checkbox"/>	Signature page must be printed and mailed in				
	<input type="checkbox"/>	Family documentation must be mailed (i.e., income documentation)			<input type="checkbox"/>	Family documentation must be mailed (i.e., income documentation)				
	<input type="checkbox"/>	Electronic signature is required			<input type="checkbox"/>	Electronic signature is required				
	<input type="checkbox"/>	No Signature is required			<input type="checkbox"/>	No Signature is required				
Does your program require a face-to-face interview during initial application	<input checked="" type="checkbox"/> No				<input type="checkbox"/> No					
	<input type="checkbox"/> Yes				<input type="checkbox"/> Yes					
Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	<input checked="" type="checkbox"/> No				<input type="checkbox"/> No					
	<input type="checkbox"/> Yes Note: this option requires an 1115 waiver Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6				<input type="checkbox"/> Yes Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6					
	specify number of months				specify number of months					
Does your program provides period of continuous coverage <u>regardless of income changes?</u>	<input type="checkbox"/> No				<input type="checkbox"/> No					
	<input checked="" type="checkbox"/> Yes				<input type="checkbox"/> Yes					
	specify number of months		12		specify number of months					
	Explain circumstances when a child would lose eligibility during the time period in the box below				Explain circumstances when a child would lose eligibility during the time period in the box below					
Does your program require premiums or an enrollment fee?	<input checked="" type="checkbox"/> No				<input type="checkbox"/> No					
	<input type="checkbox"/> Yes				<input type="checkbox"/> Yes					
	Enrollment Fee		\$			Enrollment Fee		\$		
	Premium Amount		\$		\$		Yearly cap			
	Briefly explain fee structure in the box below				Briefly explain fee structure in the box below					
Does your program impose copayments or coinsurance?	<input checked="" type="checkbox"/> No				<input type="checkbox"/> No					
	<input type="checkbox"/> Yes				<input type="checkbox"/> Yes					
Does your program require an assets test?	<input checked="" type="checkbox"/> No				<input type="checkbox"/> No					
	<input type="checkbox"/> Yes				<input type="checkbox"/> Yes					
	If Yes, please describe below				If Yes, please describe below					
Is a preprinted renewal form sent prior to eligibility expiring?	<input type="checkbox"/> No				<input type="checkbox"/> No					
	Yes, we send a form to the family asking if key information has changed and				Yes, we send out form to family with their information precompleted and					

SCHIP Medicaid Expansion Program	Separate Child Health Program
<input type="checkbox"/> ask for confirmation	<input type="checkbox"/> ask for confirmation
<input checked="" type="checkbox"/> do not require a response unless income or other circumstances have changed	<input type="checkbox"/> do not require a response unless income or other circumstances have changed

2. Are the income disregards the same for your Medicaid and SCHIP Programs?  Yes  No

3. Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs?  Yes  No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program,		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)		<input checked="" type="checkbox"/>		
b) Application	<input checked="" type="checkbox"/>			
c) Benefit structure		<input checked="" type="checkbox"/>		
d) Cost sharing structure or collection process		<input checked="" type="checkbox"/>		
e) Crowd out policies		<input checked="" type="checkbox"/>		
f) Delivery system		<input checked="" type="checkbox"/>		
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	<input checked="" type="checkbox"/>			
h) Eligibility levels / target population		<input checked="" type="checkbox"/>		
i) Eligibility redetermination process		<input checked="" type="checkbox"/>		
j) Enrollment process for health plan selection		<input checked="" type="checkbox"/>		
k) Family coverage		<input checked="" type="checkbox"/>		
l) Outreach	<input checked="" type="checkbox"/>			
m) Premium assistance		<input checked="" type="checkbox"/>		
n) Waiver populations (funded under title XXI)		<input checked="" type="checkbox"/>		
Parents		<input checked="" type="checkbox"/>		
Pregnant women		<input checked="" type="checkbox"/>		

Childless adults

	√		
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o) Other – please specify

- a. Services Provided
- b. Child/Incapacitated Adult Care
- c. Responsibility for Eligibility Determination

√			
√			
√			

5. For each topic you responded yes to above, please explain the change and why the change was made, below.

a) Applicant and enrollee protections <small>(e.g., changed from the Medicaid Fair Hearing Process to State Law)</small>	
b) Application	In addition to the PHC application we have another combined application that can be used. See Attachment 1.
c) Benefit structure	
d) Cost sharing structure or collection process	
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process <small>(including implementing a waiting lists or open enrollment periods)</small>	<p><b>Maintaining cases in Central Eligibility Processing Division</b> Effective February 26, 2002, the Division of Central Eligibility Processing was assigned a new location code. As of this date, the Division has kept and maintained all cases processed. Input/Output assigns cases to workers . Prior to this time, cases were completed and sent to county DSS offices for maintenance.</p> <p><b>Workers dedicated to SCHIP</b> Due to the change in eligibility determination, the Division of Partners for Healthy Children’s (PHC) name was changed to the Division of Central Eligibility Processing. Refer to Section I 4.O: Responsibility of Eligibility Determination.</p> <p>The name change was prompted due to the expanded number of categories the area is determining such as SCHIP, Medicaid, and Family Planning. The division is no longer responsible for just determining PHC eligibility.</p> <p><b>MEDS</b> Three (3) counties, Anderson, Newberry and Spartanburg, were phased in as pilot counties for the new Medicaid Eligibility Determination System (MEDS) system in May 2002. Consequently, the Central Eligibility Processing Division was also a pilot group for MEDS. We did eligibility in both MEDS and the old system, Client Information System (CIS), depending on whether the county was a MEDS pilot or not. MEDS was fully implemented in October, for all counties. At that time, there were no workers who were “data entry” staff. All staff was changed to eligibility staff and processed Medicaid and SCHIP determinations in MEDS.</p>

h) Eligibility levels / target population	
i) Eligibility redetermination process	
j) Enrollment process for health plan selection	
k) Family coverage	
l) Outreach	Refer to Section III "Outreach"
m) Premium assistance	
n) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
o) Other – please specify	
a. Services Provided	<p>Effective December 01, 2001, the South Carolina Department of Health and Human Services (SCDHHS) eliminated counseling and behavioral health services by paraprofessionals under the supervision of a physician ( procedure codes S0150, S0151, S0152, S0153). Medicaid recipients may still receive mental health services either through the Community Mental Health center or through a practicing psychiatrist.</p> <p>Effective December 01, 2001, SCDHHS decreased the rate of reimbursement to primary care providers for certain evaluation and management CPT codes to 75% for the Medicare fee Schedule.</p> <p>Effective February 01, 2002, DHHS increased the reimbursement for Medicaid sponsored deliveries from \$700.00 to \$1200.00 for procedure codes 59409, 59514, 59612, and 59620.</p>
b. Child/Incapacitated Adult Care	<p>Effective May 1, 2002, for each child up to age 12 or incapacitated adult, verification of ABC Child Care assistance or dependent care expenses paid is required. The actual expenses paid by the parent/guardian out of pocket will be deducted from the individual's monthly income. This deduction does not include the amount of money paid by ABC Child Care assistance, only the amount the parent/guardian is required to pay. The allowable deduction is up to \$200 per month per child or incapacitated adult for whom care is paid. The childcare expense, as well as the ABC Child Care assistance must be verified by payment voucher, notification/approval letter, receipt, cancelled check, or verbal and documented contact with the childcare provider. Declaration of the recipient, signed or verbal is not acceptable as verification. The method of verification must be documented in the case record.</p> <p>Prior to this change, a deduction of \$200 per child or adult was allowed without actual verification being required.</p>

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c. Responsibility for Eligibility Determination	<p>Prior to the establishment of the Department of Health and Human Services (DHHS), the Department of Social Services (DSS) was the state Medicaid agency. When DHHS was established and designated as the state Medicaid agency, eligibility determination was retained at DSS under a contract between the two agencies because most Medicaid recipients at that time were eligible by virtue of being welfare recipients. Due to welfare reform, the de-linking of Medicaid eligibility from welfare assistance and implementation of the Children's Health Insurance Program (CHIP), the composition of the Medicaid population has changed from predominantly welfare recipients to low income, working families. Recognizing that nearly two thirds of the Medicaid population no longer had a direct link to DSS and the need to contain cost in the program, DHHS, DSS, and the Governor took steps to consolidate the management of the Medicaid program in one agency. State DSS eligibility workers were officially transferred to DHHS on July 1, 2002.</p>
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## SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List your State's strategic objectives for your SCHIP program.  
 Column 2: List the performance goals for each strategic objective.  
 Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Specify if the strategic objective listed is new/revised or continuing, the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

*Note: If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<b>Objectives related to Reducing the Number of Uninsured Children</b>		
Reduce the number and proportion of uninsured children in the state.  New/revised _____ Continuing <input checked="" type="checkbox"/>	<b>1.1</b> Market the PHC program.   Note: Attachment 2 will not be available until January 2003. Once it is received it will be forwarded, there is a "Placement Hold" sheet where attachment 2 should be located.	<b>Data Sources:</b> Internal records and tracking system  <b>Methodology:</b> Analysis of the number of applications distributed, source of applications received, and targeted outreach activities  <b>Numerator:</b>  <b>Denominator:</b>  <b>Progress Summary:</b> >39,000 (20%) Spanish and 155,000 (80%) English  <u>Source of application:</u> >100,000 received in Central Application Processing (mail-in) from program inception through September 30, 2002; applications also taken at county DSS offices.  <b>Note:</b> Analysis of Application Source Report omits some applications received before source question was added. County Activity Summary has a more complete count. See attachment 2 -"Analysis of Applications Sources" & "County Activity Summary" <u>Targeted Outreach:</u> See "Outreach" in Section III.
<b>Objectives Related to SCHIP Enrollment</b>		
Reduce the number and proportion of uninsured children in the state.  New/revised _____ Continuing <input checked="" type="checkbox"/>	<b>1.2</b> Enroll targeted low-income children in Partners for Healthy Children (PHC).	<b>Data Sources:</b> MMIS, CPS & Census, HCFA 64.21E & 64.EC at quarter ended 09-30-02  <b>Methodology:</b> Reports of eligible children compared to enrollment baseline for July 1997. Difference = net addition.  <b>Numerator:</b> Net additional number of children in Medicaid/PHC: 232,951 September 2002  Regular Medicaid = 189,715 SCHIP Medicaid = 43,236  <b>Denominator:</b> Baseline number of uninsured children below eligibility standard: Initial target was 75,000; revised to 85,000, then 162,500. Refer to Section III "Enrollment" 5.A for explanation of

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		<p>baseline.</p> <p><b>Progress Summary:</b> 232,951/162,500 = 117.5% (September)</p> <p><b>Note:</b> Not all retroactive cases have been included in enrollment as of report date, December 4, 2002.</p>
<b>Objectives Related to Increasing Medicaid Enrollment</b>		
<p>Reduce the number and proportion of uninsured children in the state.</p> <p>New/revised _____ Continuing <input checked="" type="checkbox"/></p>	<p><b>1.2</b> Enroll targeted low-income children in Partners for Healthy Children (PHC).</p>	<p><b>Data Sources:</b> MMIS, CPS &amp; Census, HCFA 64.21E &amp; 64.EC at quarter ended 09-30-02</p> <p><b>Methodology:</b> Reports of eligible children compared to enrollment baseline for July 1997. Difference = net addition.</p> <p><b>Numerator:</b> Net additional number of children in Medicaid/PHC: 232,951 September 2002</p> <p>Regular Medicaid = 189,715 SCHIP Medicaid = 43,236</p> <p><b>Denominator:</b> Baseline number of uninsured children below eligibility standard: Initial target was 75,000; revised to 85,000, then 162,500. Refer to Section III "Enrollment" 5.A for explanation of baseline.</p> <p><b>Progress Summary:</b> 232,951/162,500 = 117.5% (September)</p> <p><b>Note:</b> Not all retroactive cases have been included in enrollment as of report date, December 4, 2002. Refer to Section III "Enrollment" 5.C for explanation of baseline.</p>
<b>Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)</b>		
<p>Establish medical homes* for children under the Medicaid/PHC programs.</p> <p>New/revised _____ Continuing <input checked="" type="checkbox"/></p> <p>* See attachment 3 for definition of medical home and programs.</p>	<p><b>3.0</b> Recruit and orient physicians for participation in HMO, HOP, and PEP programs.</p>	<p><b>Data Sources:</b> Internal program reports</p> <p><b>Methodology:</b> Compare number of Medicaid enrolled practices and primary care physicians participating in medical home programs at 1997 baseline and 2002. Compare number of Medicaid/PHC children enrolled in the HMO and PEP programs and number of children receiving services through a HOP physician practice for baseline 1997 year and 2002.</p> <p><b>Numerator:</b> (2002 Number-1997 Number)</p> <p><b>Denominator:</b> 1997 Number</p> <p><b>Progress Summary:</b> Physicians Participating in Medical Home Programs HMO's: (537-291)/291=84.5% PEP: (47-3)/3 = 1466.6% HOP: (551-40)/40 = 1277.5%</p> <p>Between FFY 2001 and FFY 2002 there was a 14% decrease in the number of physicians participating in the HMO program from 626 in 2001 to 537 in 2002. This change is due to the fact that there was a major enrollment drive done by Select Health in 2001, which was discontinued. Between FFY 2001 to FFY 2002 there was an 11% increase in the number of enrolled PEP providers, from 42 in 2001 to 47 in 2002. The number of HOP enrolled physicians increased by .3% between FFY's 2001 and 2002, from 549 to 551. Since FFY 2001, children enrolled in HMO and PEP programs increased by</p>

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		<p>53%, from 45,122 to 68,886 and children enrolled in the HOP program have decreased 8%, from 47,007 to 43,382.</p> <p>Medicaid PHC Children in Formal Medical Homes HMO's &amp; PEP: <math>(68,886-4,076)/4,076 = 1590\%</math> HOP: <math>(69,512-528)/528 = 13065\%</math></p> <p>Note: The large increase in the number of HMO and PEP enrolled recipients is due to the reliance on the CCA 2900 instead of relying on internal reports that capture and report a snapshot of enrollees by county. The CCA 2900 is an internal report that captures and reports monthly and year-to-date service utilizations and expenditures by general and specific service types for all recipients and for specific recipient eligibility categories. We feel that this report captures and reports a more realistic number of enrolled recipients. <b>See attachment 4 for Previous Years Revisions</b></p>

**Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)**

<p>Increase access to preventive care for PHC children.</p> <p>New/revised _____ Continuing <u>  √  </u></p>	<p><b>4.1</b> Immunize two-year-old children enrolled in PHC at the same rate as two-year-old children in the general population.</p> <p>* See attachment 5 for Two-Year-Old Immunization Coverage of SC Children 2001 report.</p> <p>Note: Attachment 5 will not be available until January 2003. Once it is received it will be forwarded, there is a "Placement Hold" sheet where attachment 5 should be located.</p>	<p><b>Data Sources:</b> South Carolina Department of Health and Environmental Control's (SCDHEC) "Two-Year-Old Immunization Coverage of SC Children 2001" *</p> <p><b>Methodology:</b> Compare complete 4313 series immunization rates for Medicaid/PHC children to those for the general population of two-year-olds in sample.</p> <p>Medicaid/PHC rate = 84.8% General Population (Non-Medicaid/PHC rate) = 90%</p> <p><b>Progress Summary:</b> Based on DHEC's 2001 immunization coverage survey, the rate of series 4313 complete Medicaid/PHC children is 5.2% lower than the rate of series 4313 complete for general population Non-Medicaid/PHC children.</p> <p>4313 series = 4DTP, 3Polio, 1MMR, 3Hib</p>
<p>Increase access to preventive care for PHC children.</p> <p>New/revised _____ Continuing <u>  √  </u></p>	<p><b>4.2</b> Deliver EPSDT services to children enrolled in PHC/SCHIP at the same rate as children enrolled in regular Medicaid.</p>	<p><b>Data Sources:</b> HCFA 416 Reports--4313 series = 4DTP, 3Polio, 1MMR, 3Hib</p> <p><b>Methodology:</b> Compare the percent of PHC/SCHIP children to the percent of regular Medicaid children age 6-20 receiving recommended screenings.</p> <p><b>Progress Summary:</b> In SFY 1998, the screening ratio for regular Medicaid dropped below the 1997 baseline. The SCHIP screening ratio of 43%, however, was slightly above Medicaid's 1997 level. There were changes in how South Carolina's EPSDT program was administered and billed in 1999. In addition, the reporting criteria for the HCFA 416 changed. The 1999 &amp; 2000 screening ratios were less than earlier years, although the SCHIP ratio of 0.34 for 1999 and 0.24 for 2000 were higher than regular Medicaid at 0.27 for 1999 and 0.21 for 2000. For FY 2001 there was no change for SCHIP but there was a decrease for regular Medicaid. The SCHIP ratio of 0.24 remained the same but was still slightly higher than the regular Medicaid ratio of 0.20. EPSDT ratios for 2002 will not be available until spring 2003.</p>

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<b>Other Objectives</b>		
<p>Improve access for children to medical care delivered in the most appropriate setting.</p> <p>New/revised _____ Continuing <input checked="" type="checkbox"/></p>	<p><b>2.1</b> Decrease the over all percent of Medicaid/PHC children's emergency room visits for non-emergent conditions.</p>	<p><b>Data Sources:</b> MMIS</p> <p><b>Methodology:</b> Compare % of non-emergent ER visits for 1997 baseline and 2001</p> <p><b>Progress Summary:</b> In SFY 1997 the percent of Medicaid children's emergency room visits for non-emergent conditions was 13.4%. In 1998 it decreased to 4.4% and remained the same in SFY 1999. Unfortunately in 2000 the percent was slightly higher at 4.9%. In 2001 there was a percent decrease to 4.5% and again in 2002 to 4.4%. This 4.4% reflects an overall decrease of 67% since the beginning of the PHC program.</p>
<p>Improve access for children to medical care delivered in the most appropriate setting.</p> <p>New/revised _____ Continuing <input checked="" type="checkbox"/></p>	<p><b>2.2</b> Decrease uncompensated care delivered to children in hospital settings.</p>	<p><b>2.2.1. Inpatient Admissions</b></p> <p><b>Data Sources:</b> Office of Research &amp; Statistics, Hospital Discharge Data Set</p> <p><b>Methodology:</b> Compare % of children's inpatient admissions without insurance as pay source for 1997 baseline and 2001.</p> <p><b>Progress Summary:</b> In SFY 1998, the percent of children's inpatient admissions without insurance as the expected pay source, dropped to 4.5%, a decrease of almost 20%. In SFY 1999, the percent dropped to 3.5%, another 20% decrease. In SFY 2000, however, there was an increase to 4.0%, up 15% over the previous two years. In SFY 2001, there was an increase to 5% from last years 4%. For SFY 2002 the exact opposite occurred in comparison to SFY 2001. There was a 12% yearly decrease from 5%, last year, to 4%, this year. Thus led to an overall decrease from the baseline of 19.8%.</p> <p><b>2.2.2 Emergency Room Visits</b></p> <p><b>Data Sources:</b> Office of Research &amp; Statistics, Emergency Department Data Set</p> <p><b>Methodology:</b> Compare % of children's inpatient admissions without insurance as pay source for 1997 baseline and 2001.</p> <p><b>Progress Summary:</b> In SFY 1998, the percent of children's emergency room visits without insurance was 18.8%, representing almost a 9% decrease. In SFY 1999, it had dropped to 15.0%, a decrease of about 20%. In SFY 2000 it dropped another 15% to 12.7%. In SFY 2001 it also dropped another 1.5% to 12.5%. For SFY 2002 it dropped 16% to 10.5%. Overall, the percent of uncompensated care for children's visits to the emergency room has decreased by 49% from the baseline.</p>
<p>Improve management of chronic conditions among PHC enrolled children.</p> <p>New/revised _____ Continuing <input checked="" type="checkbox"/></p>	<p><b>5.0</b> Decrease the incidence of children hospitalized for asthma among Medicaid/PHC enrolled children by 2%.</p>	<p><b>Data Sources:</b> Office of Research &amp; Statistics</p> <p><b>Methodology:</b> Compare incidence rates for State fiscal year (SFY) 96/97 &amp; 97/98, 97/98 &amp; 98/99, 98/99 &amp; 99/00, 99/00 &amp; 00/01, and 96/97 &amp; 00/01.</p> <p><b>Numerator:</b> (1<sup>st</sup> year rate-2<sup>nd</sup> year rate)</p> <p><b>Denominator:</b> 1<sup>st</sup> year rate</p> <p><b>Progress Summary:</b> From SFY 96/97 &amp; 97/98, the rate decreased</p>

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		7%; from SFY 97/98 & 98/99, the rate decreased 20%; from SFY 98/99 & 99/00, the rate increased 7%; from SFY 99/00 & 00/01, the rate decreased 9% and from SFY 00/01 & SFY 01/02 the rate decreased 3%. The overall rate from SFY 96/97 & 01/02 decreased 30%.

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found?

South Carolina is using the Performance Goals related to increasing access to care, use of preventive care, and access to services delivered in the most appropriate setting as proxies for quality. See the above goals.

3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available?

South Carolina plans to request system work to generate reports that will provide information regarding the number of children who are and are not receiving primary care visits and/or preventive services.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special health care needs or other emerging health care needs? What have you found?

None.

5. Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings.

None.

## SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

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### ENROLLMENT

1. Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4<sup>th</sup> quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).

55,892 SCHIP Medicaid Expansion  
Program (SEDS form 64.21E)

         Separate Child Health Program  
(SEDS form 21E)

Note: This number is from our September 30, 2002 Preliminary report and does not include all retroactive.

2. Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.

Any evidence used to present progress toward reducing the number of uninsured low income children in South Carolina would come from CPS data. It should be noted that CPS data is subjected to relatively high standard errors. The new three-year average for low income (under 200% FPL) uninsured children in our state for 1999, 2000, 2001 is down to 69,000 (standard error 15,000). The previous year average for 1998, 1999, 2000 was 83,000 (standard error 18,600). Our income eligibility is set at 150%.

***(States with only a SCHIP Medicaid Expansion Program, please skip to #4)***

3. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.
4. Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?

Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State's progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes or if the program eligibility levels used to determine the baseline have changed.

  √   No, skip to the Outreach subsection, below

         Yes, please provide your new baseline          And continue on to question 5

5. On which source does your State currently base its baseline estimate of uninsured children?

  √   The March supplement to the Current Population Survey (CPS)

         A State-specific survey

         A statistically adjusted CPS

         Another appropriate source

- A. What was the justification for adopting a different methodology?

South Carolina intended to use the new CPS data in combination with new population by age and income level from the 2000 Census. However, problems were encountered with data from both sources and have inhibited efforts to develop a new estimate.

In exploring options with our State Data Center and Covering Kids, we also discovered:

1. When the State Data Center did an estimate of population under 19 by poverty levels--applying 1990 poverty distributions and rates to 2000 Census counts by age--there still were more children enrolled in Medicaid (466,000+, as of December 4, 2002) than the formula indicated to be in the state under 175% of poverty (413,153).
2. The Census Bureau recently released the population by age and poverty level data from 2000. The state data center is working with that data to develop population estimates for children under 19 at various poverty levels for year 2000 and projections for years beyond that. Once those projections are available, work with state data center on developing the new estimates of uninsured children will continue. There is, however, poverty rate information available at 100% only from the Census 2000 Supplemental Survey. Comparison of the poverty rate from 1990 Census, 2000 Supplemental Census, and March 2001 CPS indicates that the rate was higher (21.0%) in 1990 than 2000 (19.8%) and both were higher than March CPS (15.9%). So it appears that the number of children under 19 under 175% of poverty may be even lower than the State Data Center's estimate using 2000 population by age and 1990 poverty rates.

Currently other options are being explored and efforts will continue to develop a new estimate.

- B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

See Above.

- C. Had your State not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

See Above.

## OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

South Carolina has discontinued active outreach efforts. However, information and applications will continue to be provided upon request. Newly directed outreach activities educate current Medicaid beneficiaries regarding how to access and appropriately use medically necessary services. Outreach shall also be directed toward linking current Medicaid beneficiaries to primary care providers that promote prevention, and early detection, intervention and treatment.

2. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Making the applications available from commonly visited locations and getting applications into the hands of parents of potentially eligible children has been most effective. South Carolina has a simplified application, which is reader friendly and simple to complete. The application offers a toll free number where potential recipients can get assistance and the address where the application can be mailed.

3. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Word of mouth continues to be a very popular means of awareness for low-income populations. In spite of discontinuing active outreach, requests for information and applications continue.

With the inception of the program South Carolina concentrated on building numerous partnerships with organizations at the grassroots level. These organizations participated enthusiastically and effectively in identifying potentially eligible children, making sure their parents got an application and assistance with completing the application.

The organizations below were instrumental in reaching target populations.

Pre-school aged children: Alliance for SC's Children, SC Head Start, First Steps, Stand for Children, and HOPE for Kids.

Child Advocates/Low income housing: Family Connection of South Carolina, South Carolina Covering Kids, SC Head Start, Low Country Healthy Start, HOPE for Kids, KOBAN, Partnerships for Midland Youth, Drew Park, Gonzales Gardens and Hyatt Park.

School aged children: Family Connection of South Carolina, South Carolina Covering Kids, Alliance for SC's Children, HBCU, United Way of SC, Stand for Children, Community Health Alliance, SC First Steps, SC Association for Rural Education, American Academy of Pediatrics, Lexington School District, Housing Authorities, Palmetto Youth Partnerships, Partnerships for Midlands Youth, Healthy Schools/Healthy South Carolina Network and St. Francis Health System.

Hispanic: SC Covering Kids, Catholic Charities, Hispanic Outreach Center and SC Head Start.

Professional/Community Organizations: SC School Nurses, Partnership for Midlands Youth, St. Francis Hospital, Hope Worldwide, Lead Advisory Committee, Stand for Children, SC Association of School Administrators, Summer Leadership Conference, Early Childhood Institute, Superintendents Summer Conference, Babies-R-Us, K-Mart, Wal-mart, March of Dimes, Freedom Group (Insurance Group In Greenville, SC), Bethel Church and Historically Black Colleges/Universities (HBCU).

The number of partners that joined in this effort increased over time, until the focus of outreach was changed. Some of the organizations continue to do outreach on their own initiatives. In the first quarter of FFY'02, before the outreach focus was changed, outreach efforts were targeted as listed below.

DHHS and/or Covering Kids partnered with, participated in and exhibited at the following outreach efforts, in the first quarter of FFY'02.

Partnered with:

- Spartanburg Regional Healthcare System
- St. Francis Hospital
- Health Connections
- SC Primary Health Care Association
- Partnerships for Midlands Youth
- Clemson Extension
- SC Association of School Administrators

Participated in Health Fairs/Conferences:

- Tender Years Child Development Center
- Hold Out the Lifeline
- Supporting Families
- Brown Chapel AME Church
- Bethel AME Church
- School Psychologists
- School Nurses
- Family Physicians
- SC Primary Health Care Association
- Supporting Families

Exhibited at:

- Lakeview Community Center
- School Psychologists Conference
- SC Association for Education of Young Children
- K-Mart
- March of Dimes "Make a Difference Day"
- SC Medical Association Maternal, Infant and Child Health

## **SUBSTITUTION OF COVERAGE (CROWD-OUT)**

***All States must complete the following 3 questions***

1. Describe how substitution of coverage is monitored and measured.

At the eligibility level of 150% of poverty, crowd-out is not a particularly worrisome concern. If an income eligible family has health insurance at the time the application is submitted, the children are eligible under Title XIX rather than Title XXI. Even if there is health insurance, the benefit structure is usually inferior to Medicaid in providing such things as well child care and screenings for vision, hearing, and developmental progress. South Carolina does not want to encourage families to drop existing coverage in order to be eligible for more comprehensive services and prefers to provide wrap around coverage to supplement existing benefits.

The application asks for information about any health insurance coverage the family already has and verifies that information with the employers and record matches under regular Medicaid TPL procedures. The state also looks at the number of recipient children who would have been SCHIP eligible, but were enrolled under Title XIX because they had insurance coverage. The state generates a report that separates children who have third party coverage from those who do not. Children without coverage go into SCHIP, while children with coverage are put into regular Medicaid, so that appropriate match is drawn.

2. Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP?

In June 2002, there were 9,429 recipients who would have been SCHIP eligible but were in the category of expansion children—regular match because they had insurance. Those who have insurance when they enroll are encouraged to retain that insurance coverage so that Medicaid is the secondary payer.

3. At the time of application, what percent of applicants are found to have insurance?

As of June 2002, 17.12% of the applicants had insurance.

***States with separate child health programs over 200% of FPL must complete question 4***

4. Identify your substitution prevention provisions (waiting periods, etc.).

***States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.***

5. Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

***States with waiting period requirements must complete question 6. (This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)***

6. Identify any exceptions to your waiting period requirement.

## **COORDINATION BETWEEN SCHIP AND MEDICAID**

***(This subsection should be completed by States with a Separate Child Health Program)***

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

South Carolina's SCHIP is a Medicaid expansion so all the same procedures are used.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain.

The system uses indicators such as age and poverty level to determine whether a child is eligible for SCHIP or Medicaid. If the indicator is changed, the system counts them correctly as SCHIP or Medicaid. There is no "transfer."

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes the delivery systems---managed care, partially capitated and fee for service---are the same for SCHIP and Medicaid.

## ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? *Check all that apply.*

- Follow-up by caseworkers/outreach workers
- Renewal reminder notices to all families, *specify how many notices and when notified*  
 Passive Renew Process: Effective September 1, 2001, all Partners for Healthy Children (PHC) case reviews were to be conducted using a "passive" renew process.
- The process relies upon a computer generated and mailed redetermination form, DSS 3299 (see attachment 6). All PHC redeterminations are conducted annually.
- Recipient families are mailed a renewal form and asked to complete and return it to the county office only if there have been changes in either the family's income, household composition or payments made for child care. MEDS generates and mails the form one year after initial approval date. Recipient families returning the form to the county office within 30 days of the mailing date will be evaluated for continuing Medicaid eligibility and MEDS is updated appropriately. Cases requiring closure will receive adequate and timely notice prior to closure.
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- Targeted mailing to selected populations, *specify population* \_\_\_\_\_
- Information campaigns
- Simplification of re-enrollment process, *please describe* See above Renewal Reminder notices to all families
- Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, *please describe* \_\_\_\_\_
- Other, *please explain* \_\_\_\_\_
- Assumptive eligibility: South Carolina uses assumptive eligibility to approve applications missing income documentation. For complete applications, which have income listed at a level that would result in eligibility but are missing the pay stubs or other documentation of income, it is assumed the child is eligible and the case is entered in the Medicaid Eligibility Determination System. The parent receives a letter of approval, but also receives a sequence of notices that they must send required documentation of income within a specified timeframe or the case will be closed. Eligibility is continued if the family remains income eligible and income documentation is received. A notice is sent to close the case if the family income exceeds eligibility limits or if documentation is not received within 30 days. If an assumptive case is closed, eligibility may not be determined using the assumptive process for a period of six months.
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2. Which of the above measures have been effective? Describe the data source and method used to derive this information.

In South Carolina, passive renew has been the most effective.

In analyzing the SCHIP data from the HCFA 64.21E, a decreasing trend was found in the quarter-to-quarter final reports after passive renewal was enacted, except for quarter ending Jun. 30, 2002. To determine this we compared the ratio of Unduplicated Disenrolles to Unduplicated Ever Enrolled and of Unduplicated Disenrolles to New Enrollees.

Before passive renew the quarter-to-quarter analysis for Jun 30, 2001 to Sep. 30, 2001, showed an increase of 16.80% for the Unduplicated Disenrolles to Unduplicated Ever Enrolled and 9.93% for Unduplicated Disenrolles to New Enrollees. After passive renewal was enacted, however, the analysis showed a quarter-to-quarter decrease, for Sep. 30, 2001 to Dec. 31, 2001 of 30.17% for the Unduplicated Disenrolles to Unduplicated Ever Enrolled and of 25.60% for Unduplicated Disenrolles to New Enrollees; for Dec. 31, 2001 to Mar. 31, 2002, of 10.96% for the Unduplicated Disenrolles to

Unduplicated Ever Enrolled and of 3.90% for Unduplicated Disenrolles to New Enrollees; and for Mar. 30, 2002 to Jun. 30, 2002, of 8.90% for the Unduplicated Disenrolles to Unduplicated Ever Enrolled.

An exception to the decreasing trend was found in the Unduplicated Disenrolles to New Enrollees for quarter ending Jun. 30, 2002, this analysis showed a quarter-to-quarter increase of 2.25%. Yet, it does still reflect an overall decrease of 43.36% for Unduplicated Disenrolles to New Enrollees and an overall decrease of 26.90% for Disenrolles to Unduplicated Ever Enrolled and of Unduplicated Disenrolles to New Enrollees. See attachment 7 for actual ratios.

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or how many move?)? If so, describe the data source and method used to derive this information.

Not since 2000.

### **COST SHARING**

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

South Carolina does not charge premiums or enrollment fees.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

South Carolina does not apply cost sharing.

### **FAMILY COVERAGE PROGRAM UNDER TITLE XXI**

1. Does your State offer family coverage through a family coverage waiver as described in 42 CFR §457.1010?

\_\_\_\_\_ Yes, briefly describe program below  
\_\_\_\_\_ and continue on to question 2.                       No, skip to the Premium Assistance Subsection.

2. Identify the total State expenditures for family coverage during the reporting period.
3. Identify the total number of children and adults covered by family coverage during the reporting period. (Note: If adults are covered incidentally they should not be included in this data.)  
\_\_\_\_\_ Number of adults ever enrolled during the reporting period  
\_\_\_\_\_ Number of children ever enrolled during the reporting period
4. What do you estimate is the impact of family coverage on enrollment, retention, and access to care of children?
5. How do you monitor cost effectiveness of coverage? What have you found?

### **PREMIUM ASSISTANCE PROGRAM UNDER SCHIP STATE PLAN**

1. Does your State offer a premium assistance program through SCHIP?

Note: States with family coverage waivers that use premium assistance should complete the Family Coverage Program subsection. States that do not have a family coverage waiver and that offer premium assistance, as part of the approved SCHIP State Plan should complete this subsection and not the previous subsection.

\_\_\_\_\_ Yes, briefly describe your program below and continue on to question 2.

\_\_\_\_\_√ No, skip to Section IV.

2. What benefit package does your state use? e.g., benchmark, benchmark equivalent, or secretary approved
3. Does your state provide wrap-around coverage for benefits?
4. Identify the total number of children and adults enrolled in your premium assistance SCHIP program during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

\_\_\_\_\_ Number of adults ever enrolled during the reporting period

\_\_\_\_\_ Number of children ever enrolled during the reporting period

5. Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program.
6. Indicate the effect of your premium assistance program on access to coverage.
7. What do you estimate is the impact of premium assistance on enrollment and retention of children?

## SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below. *Note: This reporting period = Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02). If you have a combination program you need only submit one budget; programs do not need to be reported separately.*

### COST OF APPROVED SCHIP PLAN

Benefit Costs	Reporting Period	Next Fiscal Year	Following Fiscal Year
Insurance payments	1,167,499	1,493,712	1,493,712
Managed Care			
Per member/Per month rate @ # of eligibles			
Fee for Service	46,437,424	59,226,288	59,226,288
<b>Total Benefit Costs</b>	47,604,923	60,720,000	60,720,000
<i>(Offsetting beneficiary cost sharing payments)</i>			
<b>Net Benefit Costs</b>	<b>\$47,604,923</b>	<b>\$60,720,000</b>	<b>\$60,720,000</b>

### Administration Costs

Personnel			
General Administration	5,289,436	5,200,000	5,200,000
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other			
<b>Total Administration Costs</b>	5,289,436	5,200,000	5,200,000
<b>10% Administrative Cap</b> (net benefit costs ÷ 9)	5,289,436	6,746,666	6,746,666

<b>Federal Title XXI Share</b>	41,543,230	52,284,000	52,284,000
<b>State Share</b>	11,351,129	13,636,000	13,636,000

<b>TOTAL COSTS OF APPROVED SCHIP PLAN</b>	<b>52,894,359</b>	<b>65,920,000</b>	<b>65,920,000</b>
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2. What were the sources of non-Federal funding used for State match during the reporting period?

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants
- Private donations (such as United Way, sponsorship)
- Other (specify)

## SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility				HIFA Waiver Demonstration Eligibility			
Children	From		% of FPL to	% of FPL	From		% of FPL to	% of FPL
Parents	From		% of FPL to	% of FPL	From		% of FPL to	% of FPL
Childless Adults	From		% of FPL to	% of FPL	From		% of FPL to	% of FPL
Pregnant Women	From		% of FPL to	% of FPL	From		% of FPL to	% of FPL

2. Identify the total number of children and adults ever enrolled your demonstration SCHIP program during the reporting period.

\_\_\_\_\_ Number of children ever enrolled during the reporting period in the demonstration

\_\_\_\_\_ Number of parents ever enrolled during the reporting period in the demonstration

\_\_\_\_\_ Number of pregnant women ever enrolled during the reporting period in the demonstration

\_\_\_\_\_ Number of childless adults ever enrolled during the reporting period in the demonstration

3. What do you estimate is the impact of your State's SCHIP section 1115 demonstration waiver is on enrollment, retention, and access to care of children?

4. Please complete the following table to provide budget information. Please describe in narrative any details of your planned use of funds. *Note: This reporting period (Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02).*

<b>COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)</b>	<b>Reporting Period</b>	<b>Next Fiscal Year</b>	<b>Following Fiscal Year</b>
<b>Benefit Costs for Demonstration Population #1 (e.g., children)</b>			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
<b>Total Benefit Costs for Waiver Population #1</b>			
<b>Benefit Costs for Demonstration Population #2 (e.g., parents)</b>			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
<b>Total Benefit Costs for Waiver Population #2</b>			
<b>Benefit Costs for Demonstration Population #3 (e.g., pregnant women)</b>			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
<b>Total Benefit Costs for Waiver Population #3</b>			
<b>Total Benefit Costs</b>			
(Offsetting Beneficiary Cost Sharing Payments)			
<b>Net Benefit Costs</b> (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)			
<b>Administration Costs</b>			
Personnel			
General Administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other (specify)			
<b>Total Administration Costs</b>			
<b>10% Administrative Cap</b> (net benefit costs ÷ 9)			
<b>Federal Title XXI Share</b>			
<b>State Share</b>			
<b>TOTAL COSTS OF DEMONSTRATION</b>			

## **SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS**

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1. Please provide an overview of what happened in your State during the reporting period as it relates to health care for low income, uninsured children and families. Include a description of the political and fiscal environment in which your State operated.

### Pharmacy Point of Sale

A pharmacy Point of Sale/Prospective Drug Utilization Review (POS/Pro-DUR) system was implemented November 1, 2000. Pharmacy claims are now submitted via POS for adjudication in an on-line, real-time environment. The POS system captures, edits, and adjudicates pharmacy claims at the point of sale. Providers receive immediate, on-line information regarding eligibility, prescription coverage, and Medicaid reimbursement amount.

Additionally, the on-line, real-time Pro-DUR, electronically reviews claims at the point of sale for potential drug therapy problems. Pro-DUR results in improved quality of Medicaid-reimbursed health care services, improved quality of health outcomes, and cost avoidance by precluding issuance of a prescription, which may result in health problems and/or have to be discarded because of contraindication. Prior to POS, all pharmacy authorizations (PAs) were submitted to the program area for manual evaluation and pricing. This entirely manual process greatly limited DHHS' abilities to expand the PA program.

In the current POS environment, many PAs are processed electronically through the POS system while the POS contractor's clinicians review those PAs requiring intervention. With these processes in place, DHHS was able to expand its PAs to include a number of other high cost drugs.

### Implementation of Plastic Medicaid Cards

The Medicaid program experienced significant growth in the early months of FY02, indicating a need for the agency to contain costs through policy and program changes in order to remain within budget. To contain cost DHHS implemented the new plastic Medicaid card to replace the old paper Medicaid card.

DSS, under contract with DHHS, formerly issued and mailed approximately 400,000 paper Medicaid cards per month at an annual cost of \$1.6 million. The initial one-time production and distribution cost for the plastic cards and a new client Medicaid handbook was \$572,000. The on-going cost of issuing plastic cards and handbooks to new eligibles is estimated at \$25,000 per month. The net annual savings beyond the first year is estimated at \$1.3 million. Not only did the plastic card save money, it also makes it possible to provide accurate, up-to-date information to service providers regarding eligibility and service limits; thereby avoiding inappropriate Medicaid billing.

Effective January 2002, no paper Medicaid cards were issued. The new plastic Medicaid cards were implemented December 2001. Initially, those eligible for Medicaid in December 2001 received both a plastic and paper Medicaid card. Approximately 752,000 plastic Medicaid cards were sent in the initial release.

### Responsibility for Eligibility Determination Change

Prior to the establishment of Department of Health and Human Services (DHHS), the Department of Social Services (DSS) was the state Medicaid agency. When DHHS was established and designated as the state Medicaid agency, eligibility determination was retained at DSS under a contract between the two agencies because most of the Medicaid recipients at that time were eligible by virtue of being welfare recipients. Due to welfare reform, the de-linking of Medicaid eligibility from welfare assistance and implementation of the Children's Health Insurance Program (CHIP), the composition of the Medicaid population has changed from predominantly welfare recipients to low income, working families. Recognizing that nearly two thirds of the Medicaid population no longer had a direct link to DSS and the need to contain cost in the program, DHHS, DSS, and the Governor took steps to

consolidate the management of the Medicaid program in one agency. State DSS eligibility workers were officially transferred to DHHS on July 1, 2002.

#### Outreach Refocused

South Carolina has discontinued active outreach efforts. However information and applications continue to be provided upon request. Newly directed outreach activities educate current Medicaid beneficiaries regarding how to access and appropriately use medically necessary services. Outreach shall also be directed toward linking current Medicaid beneficiaries to primary care providers that promote prevention, and early detection, intervention and treatment.

#### Eligibility Process

Due to budgetary shortfalls and encouragement from the legislative, the state is planning to address, its concerns about, the integrity of the eligibility process. The state wants to take steps to ensure that only those eligible for the program get enrolled. The state is contemplating a number of changes in the eligibility process to ensure its maximum efficiency.

2. During the reporting period, what has been the greatest challenge your program has experienced?

Maintaining adequate state funding.

3. During the reporting period, what accomplishments have been achieved in your program?

Increasing the number of enrolled children and avoiding state budget cuts to the programs.