

***Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF 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.

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF 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)).

William A. Prince (signed by Elizabeth Fuller, Deputy Director)
(Signature of Agency Head)

SCHIP Program Name(s): Partners for Healthy Children

SCHIP Program Type:
 Medicaid SCHIP Expansion Only
 Separate SCHIP Program Only
 Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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Submission Date: December 28, 2001

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002) Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility

During FFY 2001, the South Carolina Department of Health and Human Services (SCDHHS) changed budgeting policy concerning blended families. South Carolina defines a blended family as, a family unit when two people marry, each with children of their own, and no children in common.

Previously blended families were considered as separate family units. Now, with the new policy, blended families are budgeted most advantageously for the family. This means the blended family can be budgeted as two separate families or as one family, using the method that would provide eligibility for the most children.

B. Enrollment process

NC

C. Presumptive eligibility

NC

D. Continuous eligibility

NC

E. Outreach/marketing campaigns

SC Covering Kids (SCCK) started at the end of FFY 1999. During FFY 2000, they established and met several outreach/marketing goals. They hired a professional marketer and have provided slick professional looking brochures and posters, as well as a number of small promotional items that can be distributed at community events. They also had the Community Resource Guide, developed by SCDHHS, printed in a usable, attractive format.

During FY 2001, SCCK worked with SCDHHS concentrating on three statewide goals.

1. Design and conduct outreach programs that identify and enroll 25,000 additional eligible children into Medicaid/PHC.
 - A. *To identify eligible children—enrolled and unenrolled.* In collaboration with the Office of Research and Statistics, SC Covering Kids worked to link data at various agencies to identify the number and demographics of children who potentially qualified for Medicaid/PHC, but remained unenrolled.
 - B. *Develop and implement a public awareness campaign.* The Marketing Task Force worked towards raising the awareness of PHC eligibility among low income working families in South Carolina. Activities during FFY 2001 included.
 - The development and distribution of printed materials in English and Spanish which included a series of four posters about Partners for Healthy Children (PHC) and a brochure about the PHC health insurance program. Distribution sites can be found under question 2.4 Outreach—“Summary of Outreach Initiatives FY 2001”.
 - Promotional items, such as pencils, rulers, pens, and koozies printed with the Partners for Healthy Children logo and toll-free number, were developed and distributed for the use of outreach.
 - Nine billboards were posted in the three pilot areas and Sumter County in late March. There were two in Greenwood, Sumter, Orangeburg and three in the Berkeley/Charleston area. There was a Spanish board in Greenwood and Berkeley. All boards were up for six months to help with the Back-to-School campaign. They are vinyl boards, which means they can be used again.
 - Production of a radio spot took place March 21. This radio spot was one written by Greer, Margolis, Mitchell & Burns (GMMB) called "Hard Choices." It was produced in English and Spanish. The radio spot ran for 13 weeks beginning in mid July. Additional radio tapes were provided to the pilot areas should they be able to secure public service time. The initial time was purchased to ensure target populations were reached. The spots were aired on three stations 3-5 times per day, Monday – Sunday 6 a.m. –7 p.m.

- A letter of intent was submitted to GMMB to be considered for a large multi-media campaign promoting PHC during back to school. Although not selected, we did utilize materials prepared through GMMB for back-to-school activities.

2. Simplify the enrollment process.

To identify barriers to enrollment and design a strategy to address the barriers.

Since July 1999, SC Covering Kids has contributed to the enrollment of more than 82,000 children in Medicaid/PHC. SC Covering Kids helped identify barriers to application and re-enrollment processes that uninsured families faced. These barriers included issues with income verification and documentation, re-enrollment processes, and inappropriate closures. A SCCK Task Force worked to address some of the policy barriers to a simplified application and process. Recommendations made during FY 2000, regarding simplification of the application have been implemented. The Task Force has explored re-determination policies, procedures and experiences in the state. Examination of the HCFA 64 indicated alarming numbers of children's cases were closed as compared to numbers of approvals in the same time periods. To address this problem the state developed the "passive" renew process, addressed in 1.1 G—Eligibility redetermination process.

3. To coordinate with existing programs for low-income children.

To identify eligible children through other programs, as well as referral to other services for which they qualify. The Outreach Task Force worked to coordinate efforts with other programs and to guide local outreach efforts. Activities for FFY 2001 included:

- A. Collaboration with DHHS to develop state plan for PHC outreach.
- B. Contracted with Tuomey Regional Medical Center to place an outreach worker in Sumter County through the HealthReach Tuomey program.
- C. Worked with Lexington Medical Center, McLeod Regional Medical Center, and Spartanburg Regional Medical Center to place outreach workers in Lexington, Florence, and Spartanburg counties.
- D. Established four work groups (child care, faith communities, local communities, and schools) to target areas of emphasis for outreach.
- E. Established partnerships with other organizations to promote PHC to include faith community group, Hold Out the Lifeline; Department of Social Services (DSS) Childcare Licensure; and SC Association of School Administrators; and SCDHHS ABC Enhanced Childcare program.

Since SCDHHS partnered with SC Covering Kids in covering the target communities throughout the state, SCDHHS refocused its outreach efforts to concentrate more on the professional organizations and Historically Black Colleges/Universities (HBCU) throughout the state. A state revenue decrease contributed to an agency budget shortfall, which necessitated a decreased effort in eligibility outreach in the later part of FFY 2001.

1. To coordinate with professional organizations to identify and enroll additional eligible children in Medicaid/PHC.

A. *Coordinate with school conferences.* All of the school conferences, listed below, were identified because each specific group works with children directly or indirectly. Even with the Adult Educators, they are working with the parents or guardians of the very children that need health insurance. Children within the education system that meet Medicaid requirements could be identified through the free or reduced lunch program, if the proper linkage and agreements were in place.

- SC School Nurses.
- SC Association of School Administrators.
- Adult Educators.
- Summer Leadership Conference.
- Early Childhood Institute.
- Superintendents Summer Conference.

B. *Coordinate with other professional entities/community organizations.* Other professional entities/community organizations were identified because they already had existing programs in many of the targeted communities. Instead of being redundant, SCDHHS felt there would be a better chance of saturating the targeted areas if we piggybacked. Some of the existing entities worked with were:

- Partnership for Midlands Youth: A group made up of representatives of other South Carolina state agencies and private as well as non-profits, all working with and for children who are without the financial and social advantages to have positive influences in their lives.
- Hope for Kids/Worldwide: A non-profit charity---their mission is to: ***bring hope to a hurting world.*** The children's program gives children hope for a productive and fulfilling future by providing

healthcare, education, opportunities for development, mentoring, counseling, foster care and adoption.

- **Lead Advisory Committee:** The Lead Advisory Committee consists of a group of representatives from several agencies including DHHS, School Nurses, MUSC, USC School of Medicine, CDC contact in Atlanta, Homeowners Mortgage, City of Columbia, Trident/Environmental Health, Greenville Technical College, Department of Commerce, AAA-Environmental, Hope Worldwide, Richland Memorial Hospital, Greenville Pediatrics and numerous representatives from Department of Health and Environmental Control (DHEC) offices throughout the state. All work with low-income families to inform them of prevention measures, risk, signs, and treatment of lead poisoning.
 - **Freedom Group Insurance:** A good resource for us to distribute applications to, because many of the clients that they cannot serve, due to low family incomes, qualify for Medicaid/PHC.
 - **St. Francis Hospital in Greenville:** They reach such a large number of people through their own outreach, close to 7,000 a year. A lot of the outreach is with children or the parents of Medicaid/PHC eligible children and PHC is a major marketing tool for them. They help to identify the kids and help them to establish a medical home and then when they need a hospital, they will go to St. Francis.
 - **Community Development Coordinating Council (CDCC):** The CDCC was established in 1999 under the now defunct Division of Community Development at DHEC. The purpose of the council was to create collaboration and cooperation among local, regional and state organizations addressing community development needs. The group was comprised of interagency professionals who share updates about their program with the group. The meetings provided a forum to give regular updates on PHC.
- C. *Coordinate with faith-based organizations.* The purpose for identifying faith-based organizations was to create a lay health training program for leaders working in churches. It was based on the train-the-trainer model. Trained local leaders would take the materials back to their communities and churches to share with others.

Hold Out the Lifeline (HOTL) is the most prominent faith-based organization with which SCDHHS is collaborating. HOTL began at DHEC in the mid-eighties and now has five pilot sites across the state

implementing the health training program. The program is recognized for its emphasis on faith-based health awareness and education. SCDHHS utilizes this network of local health advocates to spread the word about PHC. The SC Primary Health Care Association (SCPHCS) has pledged to work with the HOTL as the fiscal sponsor to help launch this new partnership with SCDHHS. Charles Johnson of SCDHHS staff is a member of the statewide advisory committee that helps to coordinate the program activities.

D. *Coordinate with Hispanic and migrant organizations.* The need to identify this group was to address the health and human needs of Hispanics and migrants in South Carolina.

- Taskforce for Ecumenical Action for Migrants in the Midlands (TEAMM): The Catholic Charities Midlands Regional Office (located at St. Peter's Catholic Church) Diocese of Charleston, South Carolina sponsors TEAMM. The TEAMM groups have been meeting since 1999 to address the health and human needs of migrants in the Midlands. The majority of migrants in the state are Hispanics. The group is comprised of agency professionals whose work addresses Hispanic issues. The Diocese of Charleston is the sponsoring organization with regional offices in other parts of the state. Monthly meetings, held at St. Peter's Catholic Church, have provided opportunities to learn about Hispanic issues, and meet Hispanic professionals.
- Hispanic Health Coalition: The Hispanic Health Coalition was established as a result of the Governor's Task Force on Hispanic Human Service Issues. The health subcommittee formed during the task force has now become the Hispanic Health Coalition. The group is comprised of agency professionals, Hispanics, and other concerned lay individuals. It meets on a monthly basis at various organizations to coordinate the works of the group. Their immediate goal is to become a statewide (501)(C)(3) nonprofit organization addressing the health and human service needs of Hispanics and Latinos in South Carolina. The meetings have provided an opportunity to share information about PHC.

2. To coordinate with Historically Black Colleges/Universities to develop different outreach teams in rural and underserved areas in South Carolina, to identify and enroll additional eligible children in Medicaid/PHC. This project was started in the fall of 2000 and continues at the present. The U.S. Centers for Medicare and Medicaid Services (CMS) is the governmental entity funding the project. The focus of the project is to provide outreach and enrollment for children eligible for PHC's free health insurance program, as well as those seniors who are considered

to be dual eligible under Medicare and Medicaid. Morris and Voorhees Colleges were selected as the target areas of South Carolina.

During the 2000/2001 fiscal year the college programs were organized and conducted numerous outreach activities. Students have been the focal point in the outreach process. SCDHHS staffers have conducted training sessions with college staff and students in order to equip them with the skills to do an effective job. The colleges continue to learn how to plan, organize and implement effective outreach activities. Accessing various communities and implementing outreach takes time and persistence. Beginning with the 2001/2002 fiscal year the colleges have expanded the program into neighboring counties.

Most notably, the colleges received awards for their outreach efforts at the 2001 National Customer Service Convention in St Louis, MO. The programs have become recognized among college presidents, faculty, and staff.

F. Eligibility determination process

Previously, supervisors screened applications for completeness before sending them to be processed. If the applications were incomplete, they were forwarded to a specific person to call the applicant to request the needed information. Once the information was received, the case was sent to be processed.

Now, the applications are forwarded directly to eligibility determination staff. The eligibility determination staff checks the applications for completeness, calls clients to request any additional information or researches available resources to obtain the missing information, and processes the case.

Partners for Healthy Children staff are using Employment Security Commission (ESC) Wage Match to verify income only when proof of wages is not attached. ESC Wage Match is used to check zero income cases as well as the income status of applicants who are currently in the system. ESC Wage Match is used as a lead if match occurs when applicant indicated no income. Prior to the change, ESC Wage Match was only used when proof of wages was not attached to the application.

G. Eligibility redetermination 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 1). All PHC redeterminations are conducted annually.

Recipient families are mailed a review 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. Client Information System (CIS) 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 CIS is updated appropriately. Cases requiring closure will receive adequate and timely notice prior to closure.

Families not returning the form or contacting the office within 30 days of the mailing date are presumed to have had no change in circumstances and continued eligibility will be authorized automatically by the system.

H. Benefit structure

NC

I. Cost-sharing policies

NC

J. Crowd-out policies

NC

K. Delivery system

NC

L. Coordination with other programs (especially private insurance and Medicaid)

NC

M. Screen and enroll process

NC

N. Application

The application for Partners for Healthy Children was revised to include a question that asks what language does the applicant use most. Responses include English, Chinese, Russian, Sign Language, Spanish, Vietnamese, and Other.

O. Other

Primary Care and Physicians Enhanced Program (PEP) Rate Changes

Effective January 1, 2001, the South Carolina Department of Health and Human Services

increased the rate of reimbursement to primary care providers for certain evaluation and management CPT codes to 65% of usual and customary charges. SCDHHS based this increase on 81.25% of the Medicare fee schedule.

Primary care providers include Family Practitioners, General Practitioners, Internists, Osteopaths, OB/GYN, Nurse Midwives, Pediatricians, Neonatologists, and Nurse Practitioners. Nurse Practitioners will continue to receive reimbursement at 80% of the physician's rate.

Pediatric Sub-Specialty Rate Changes

Effective January 1, 2001, the South Carolina Department of Health and Human Services increased the rate of reimbursement to pediatric sub-specialist providers for certain evaluation and management CPT codes to 120% of Medicare.

Pediatric sub-specialist are defined as those physicians who:

1. In his/ her practice has at least 85% of their patients who are children 18 years or younger;
2. Practice in the field of Adolescent Medicine, Cardiology, Cardio-thoracic Surgery, Critical Care, Emergency Medicine, Endocrinology, Gastroenterology/Nutrition, Genetics, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Neurological Surgery, Ophthalmology, Orthopedic Surgery, Otolaryngology, Psychiatry, Pulmonology, Rhematology, Surgery, Urology and such other pediatric sub-specialty areas as may be determined by the Department of Health and Human Services after consultation with the Children's Hospital Collaborative; and
3. Are affiliated through appointment, privileges or other contractual arrangement for services with a Children's Hospital/healthcare system which meets criteria for institutional or associate membership established by the National Association of Children's Hospitals and Related Institutions (NACHRI) or which is affiliated with a NACHRI qualified institution.

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

- A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

In September 2000, the net addition of children to the state's Medicaid program was over 142,788. In September 2001 the net addition had grown to 190,855 more children with health insurance coverage. Of that total net addition, over 46,000 (24%) were eligible under Title XXI (SCHIP). The remaining additions, over 144,000 (76%) were eligible

under Title XIX (regular Medicaid), but were enrolled as a result of Partners for Healthy Children's outreach efforts.

(Data source is internal reports from MMIS on Medicaid Eligible Children under 19 Years Old by County by Month and Report on Payment Category 88. The number of SCHIP eligible children for a month is subtracted from the total number of children under 19 enrolled in Medicaid that month).

- B. How many children 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.

Since the beginning of PHC outreach activities and enrollment simplification, there have been over 144,000 children enrolled in Title XIX (regular Medicaid) as a result of SCHIP (PHC) outreach efforts.

(Data source is internal reports from MMIS on Medicaid Eligible Children under 19 Years Old by County by Month and Report on Payment Category 88. The number of SCHIP eligible children for a month is subtracted from the total number of children under 19 enrolled in Medicaid that month).

- C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

Any other 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 1998, 1999, 2000 is down to 83,000 (standard error 18,600). The previous year average for 1997, 1998, and 1999 was 128,000 (standard error 23,500). Our income eligibility is set at 150%.

- D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

No, skip to 1.3

Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

It is our intention to change our baseline estimate of uncovered, low-income children from the number reported in our March 2000 Evaluation since South Carolina has increased net enrollment of children in Medicaid by more than the number used in that report. For September 2001, the total enrollment under age 19 was 424,145, of which 46,923 were SCHIP. This represents a net increase of 190,855 children since the inception of PHC.

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. We have, however, encountered problems

with data from both sources that have inhibited efforts to develop a new estimate.

When we received the results of the March 2001 CPS survey (covering the year 2000), we knew there were problems with it because:

1. It indicated only 9,000 children under 200% of poverty, or 1.3% without health insurance in South Carolina.
2. The population under 19 estimated from the survey was considerably less than the count our State Data Center had from the 2000 Census--717,000 versus 1,070,503.

The Census Bureau confirmed that there was a problem with the weighting of the sample for several states, including South Carolina. The biggest impact of the weighting error was on children and for African Americans. They were working on a correction and expected to publish it in early December, but it hadn't been published on the website by December 17, 2001. Those numbers were used to derive the three year average (for 1998, 1999, and 2000) published by the Census. Those numbers showed South Carolina with 919,000 children under 19, and 83,000 children uninsured under 200% of poverty, or 8.2%.

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

1. Even though the March 2001 CPS survey included an expanded sample--85% greater than previous years for SC--the replies from the expansion were not included in the three year average numbers published. They are studying the expansion results and expect to publish them "in the winter of 2001-2002".
2. 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--we still had more children enrolled in Medicaid (424,000+) than the formula indicates to be in the state under 175% of poverty (413,153).
3. The Census Bureau hasn't released the population by age and poverty level data from 2000. 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 our 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.

We are still exploring several other options and will continue to work on developing a new estimate.

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

See Above.

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.

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, 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, as specified in your State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, 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 reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
Reduce the number and proportion of uninsured children in the state.	1.1 Market the PHC program.	<p>Data Sources: Internal records and tracking system</p> <p>Methodology: Analysis of number of applications distributed, source of applications received, and targeted outreach activities.</p> <p>Numerator:</p> <p>Denominator:</p> <p>Progress Summary: <u>Applications distributed:</u> >109,000 (17% Spanish and 522,000 (83%) English)</p> <p><u>Source of application:</u> >98,873 received in Central Application Processing (mail-in) from program inception through September 30, 2001; applications also taken at county DSS offices.</p> <p>Note: 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”</p> <p><u>Targeted Outreach:</u> See “Outreach” in Section 2.4</p>
Objectives Related to SCHIP Enrollment		
Reduce the number and proportion of uninsured children in the state.	1.2 Enroll targeted low-income children in Partners for Healthy Children (PHC).	<p>Data Sources: MMIS, CPS & Census, HCFA 64.21E & 64.EC at quarter ended 09-30-01</p> <p>Methodology: Reports of eligible children compared to enrollment baseline for July 1997. Difference = net addition.</p> <p>Numerator: Net additional number of children in Medicaid/PHC: 190,855 September 2001</p> <p>Regular Medicaid = 144,232 SCHIP Medicaid = 46,623</p> <p>Denominator: Baseline number of uninsured children below eligibility standard: Initial target was 75,000; revised to 85,000, then 162,500. Refer to 1.2D for explanation of baseline determination.</p>

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
and programs.		<p>PEP: $(42-3)/3 = 1300.0\%$ HOP: $(549-40)/40 = 1273.5\%$</p> <p>Between FFY 2000 and FFY 2001 there was a 54% increase in the number of physicians participating in the HMO program from 405 in 2000 to 626 in 2001. This change is due to the fact that there was an enrollment drive done by Select Health and that they added Fairfield County to the counties being served in South Carolina. Between FFY 2000 to FFY 2001 there was a 2% decrease in the number of enrolled PEP providers, from 43 in 2000 to 42 in 2001. The number of HOP enrolled physicians increased by 30% between FFY's 2000 and 2001, from 421 to 549. Since FFY 2000, children enrolled in HMO and PEP programs have increased 35% (from 33,495 to 45,122) and children enrolled in the HOP program have decreased 8% (from 47,007 to 43,382).</p> <p><u>Medicaid PHC Children in Formal Medical Homes</u> HMO's & PEP: $(45,122-4,076)/4,076 = 1007.0\%$ HOP: $(43,382-528)/528 = 8116.3\%$</p> <p>Note: Number enrolled in HOP is likely undercounted due to reliance on sick codes to identify enrolled children.</p>
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
Increase access to preventive care for PHC children.	<p>4.1 Immunize two year old children enrolled in PHC at the same rate as two year olds in the general population.</p> <p>* See Attachment 4 for two-year old immunization coverage survey report.</p> <p>4.2 Deliver EPSDT services to children enrolled in PHC/SCHIP at the same rate as</p>	<p>Data Sources: South Carolina Department of Health and Environmental Control's (DHEC) "Two-Year Old Immunization Coverage of SC Children 2000"</p> <p>Methodology: 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) = 91.1%</p> <p>Progress Summary: Based on DHEC's 2000 immunization coverage survey, the rate of series 4313 complete Medicaid/PHC children are 6.3% 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>Data Sources: HCFA 416 Reports</p>

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	enrolled in PHC/SCHIP at the same rate as children enrolled in regular Medicaid.	<p>Methodology: Compare the percent of PHC/SCHIP children to the percent of regular Medicaid children age 6-20 receiving recommended screens.</p> <p>Numerator: Number of actual screens received.</p> <p>Denominator: Number of expected screens.</p> <p>Progress Summary: 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 screening ratios were less than earlier years, though the SCHIP ratio of 0.34 was higher than regular Medicaid at 0.27. The same occurred for FY 2000 screening ratios calculated for both SCHIP and regular Medicaid. The SCHIP ratio of 0.24 is still slightly higher than the regular Medicaid ratio of 0.21. EPSDT ratios for 2001 will not be available until spring 2002.</p>
Other Objectives		
Improve access for children to medical care delivered in the most appropriate setting.	<p>2.1 Decrease the over all percent of Medicaid/PHC children's emergency room visits for non-emergent conditions.</p> <p>2.2 Decrease uncompensated care delivered to children in hospital settings.</p>	<p>Data Sources: MMIS</p> <p>Methodology: Compare % of non-emergent ER visits for 1997 baseline and 2001</p> <p>Numerator: Number of non-emergent emergency room visits</p> <p>Denominator: Number of emergency room visits</p> <p>Progress Summary: 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 the percent decreased to 4.5%, which reflects a 0.4% decrease from 2000. This 4.5% reflects an overall decrease of 66% since the beginning of the PHC program.</p> <p>2.2.1. Inpatient Admissions</p> <p>Data Sources: Office of Research & Statistics, Hospital Discharge Data Set</p>

<p>Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)</p>	<p>(2) Performance Goals for each Strategic Objective</p>	<p>(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)</p>
<p>Improve management of chronic conditions among PHC enrolled children.</p>	<p>5.0 Decrease the incidence of children hospitalized for asthma among Medicaid/PHC enrolled children by 2%.</p>	<p>Methodology: Compare % of children’s inpatient admissions without insurance as pay source for 1997 baseline and 2001.</p> <p>Numerator: (% for 1997-% for 2001)</p> <p>Denominator: % for 1997</p> <p>Progress Summary: 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. For SFY 2001, there was an increase to 5% from last years 4%. Thus led to an overall decrease from the baseline of 8.2 %</p> <p>2.2.2 Emergency Room Visits</p> <p>Data Sources: Office of Research & Statistics, Emergency Department Data Set</p> <p>Methodology: Compare % of children’s inpatient admissions without insurance as pay source for 1997 baseline and 2001.</p> <p>Numerator: (% for 1997-% for 2001)</p> <p>Denominator: % for 1997</p> <p>Progress Summary: 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%. For SFY 2001 it also dropped another 1.5% to 12.5%. Overall, the percent of uncompensated care for children’s visits to the emergency room has decreased by 39% from the baseline.</p> <p>Data Source: Office of Research & Statistics</p> <p>Methodology: Compare incidence rates for State fiscal year (SFY) 96/97 & 97/98, 97/98 & 98/99, 98/99 & 99/00, 99/00 & 00/01, and 96/97 & 00/01.</p> <p>Numerator: (1st year rate-2nd year rate)</p>

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Denominator: 1 st year rate Progress Summary: From SFY 96/97 & 97/98, the rate decreased 7%; from SFY 97/98 & 98/99, the rate decreased 20%; from SFY 98/99 & 99/00, the rate increased 7%; and from SFY 99/00 & 00/01, the rate decreased 9%. The overall rate from SFY 96/97 & 00/01 decreased 27%.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Strategic Objective 1:

Reduce the number and proportion of uninsured and under-insured children in the state.

Performance Goal 1.1: Market the Partners for Healthy Children (PHC) insurance program.

Performance Measures:

- Applications Distributed

Barriers:

Applications were mailed en mass to most distribution organizations used in previous years. SCDHHS did not do a mass mail-out of applications for every student to each school this year. Instead each school was mailed 50 applications and bright yellow flyers (with PHC name, logo, toll free number and notation that children eligible for free or reduced school lunch may be eligible for PHC) for distribution to each student, in the first quarter (October-December 2000) of FFY 2001. If schools requested additional applications to distribute, staff filled those requests.

Applications were sent for each child, however, at all Head Start and child care facilities. SCHIP staff has coordinated all requests for applications by groups and organizations that plan to distribute.

- Targeted Outreach

Barriers:

Targeted outreach efforts continued, with emphasis on harder to reach populations. SCDHHS and SCCK concentrated on Hispanic children, adolescents, rural residents, professional organizations, and HBCU. Additional training was conducted within faith communities, particularly those denominations with high numbers for minority members.

Performance Goal 1.2: Enroll targeted low income children in Partners for Healthy Children (PHC)

Barriers:

There have been anecdotal reports of barriers perceived by the populations with English as a second language, many of which we hope have been addressed by changes in the application regarding questions about what language does the applicant use most, focused efforts by SCCK to identify “best practices” for this population, and wider dissemination of Immigrations and Naturalization Service (INS) policy regarding public charge. SCDHHS had the Spanish version of the application translated by the HABLA Project at the University of South Carolina because they utilize combined efforts of four translators from different geographic and cultural backgrounds. Even with this translation, however, we have still received a few comments about “inaccuracies”, demonstrating the difficulty in devising a single version appropriate for all the Hispanic populations. The telephone translation service (Language Line) has improved services of the toll free line for non-English speakers. On average, this services is used about 30 times per month, with average time per month of 188 minutes.

Strategic Objective 2:

Improve access for children to medical care delivered in the most appropriate setting.

Performance Goal 2.2: Decrease uncompensated care delivered to children in hospital settings.

Performance Measures:

- Percent of children’s inpatient admissions without insurance as expected pay source.

Barriers:

None noted; Performance Goal met. Although there was a small up turn in uncompensated care for children’s inpatient admissions, it is anticipated this measure will remain low as more children are enrolled in SCHIP and regular Medicaid.

- Percent of children’s emergency room visits without insurance as expected pay source.

Barriers:

None noted; Performance Goal met.

Strategic Objective 3:

Establish medical homes for children under the Medicaid/PHC programs.

Performance Goal 3: Recruit and orient physicians for participation in HOP, PEP, and HMO programs.

Performance Measures:

- Number of Medicaid enrolled practices and primary care physicians participating in medical home programs.
- Number of Medicaid/PHC children enrolled in the HMO and PEP programs.
- Number of children receiving services through a HOP physician practice.

Barriers:

Performance Goal met previously, however, a large portion of physicians were enrolled during FFY 2001, due to Select Health actively seeking new physicians and adding another county to the coverage areas. DHEC still continues to recruit physicians for Medicaid enrollment and increased participation levels and their staff advocates for the medical home programs in particular.

Strategic Objective 4:

Increase access to preventive care for PHC enrolled children.

Performance Goal 4.1: Immunize two year old children enrolled in PHC at the same rate as two year olds in the general population.

Performance Measure:

- Percent of two year old children enrolled in PHC and regular Medicaid receiving all recommended immunizations.

Barriers:

The percent of Medicaid/PHC two-year olds with a complete immunization series is slightly lower than that of the same age group in the general population. The DHEC immunization data collection system, named the Statewide Immunization Information System (SIIS), originally developed and intended for use when the Performance Goal has been completed. Integration of the system into the health care community is currently under way. Health district teams have been trained to install the software in private physicians' offices and a number of private practices are online. Equipment is being fine-tuned to improve the slow response time and DHEC staff expects the system to be fully operational in the near future. Data from the system is currently available through requests to DHEC's IT Department.

Performance Goal 4.2: Deliver EPSDT services to children enrolled in PHC/SCHIP at the same rate as children enrolled in regular Medicaid.

- Percent of SCHIP and regular Medicaid children ages 6-20 eligible for screening who receive recommended EPSDT screenings.

Barriers:

Because we already are considerably more successful in screening children under 6 and most of the children in our targeted expansion group are over age 6, we have chosen to concentrate on children age 6-18 in this measure. We will continue current efforts to screen those under 6. For older children, the recommended screening schedule does not include a screening every year. Also, it is more difficult to get older children to comply with recommended screenings, as evidenced by the baseline numbers for current Medicaid eligibles aged 6-20. All these factors have influenced the target selected for this measure. The HCFA 416 data showed screening ratios for 2000 continued to decline. There were changes in how the SC EPSDT program was administered and billed in 1999, in addition to reporting criteria for the 416 report. SCDHHS needs to investigate other reasons for this continued decline and, if it is not related to reporting criteria or similar changes, develop strategies to remedy.

Strategic Objective 5:

Improve management of chronic conditions among PHC enrolled children.

Performance Goal 5: Decrease the incidence (# per 1000 children) of children hospitalized for asthma among Medicaid/PHC enrolled children through identification and dissemination of effective patient education and disease management strategies to physicians.

Performance Measure:

- Incidence of children's inpatient admission for asthma.

Barriers and Future Plans:

Performance Goal met previously. Use of the emergency room and inpatient hospitalization should not be necessary if asthma is properly controlled. Efforts will continue to drive down hospitalizations and to decrease use of the emergency room as well.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

NA

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

SCDHHS will focus more attention on the EPSDT rates in order to identify reasons for the declines. The agency will investigate reporting/systems contributors as well as addressing the rates as measured. Staff will begin to develop education strategies to increase rates if that is appropriate.

The agency will continue to monitor progress in getting the Statewide Immunization Information System operational. The system is producing data but they are still fine tuning the entire system.

1.7 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.

No attachments except those referenced in Table 1.3.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: Not Offered

- A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.
- B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?
_____ Number of adults
_____ Number of children
- C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in: Not Offered

- A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).
- B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?
_____ Number of adults
_____ Number of children

2.3 Crowd-out:

- A. How do you define crowd-out in your SCHIP program?

At our 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.

- B. How do you monitor and measure whether crowd-out is occurring?

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.

- C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

In June 2001, there were 9,287 recipients who would have been SCHIP eligible but were in the category of expansion children—regular match because they had insurance.

- D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

South Carolina has not done any studies regarding the effectiveness of crowd-out strategies.

2.4 Outreach:

- A. 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. Clients voice positive comments about the quick turn around time (a one week time period) in processing applications for approval within.

- B. 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.

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

The organizations below are 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: South Carolina 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). Refer to Section 1.1E.

The number of partners that have joined in this effort has increased since the inception of this program.

- C. Which methods best reached which populations? How have you measured effectiveness?

Partnerships with state agencies, rural health centers, and schools yield the best method for disseminating and receiving completed application, see attachment 5 for Summary of Outreach Initiatives FY 2001.

The number of completed applications received is our best indicator of success.

2.5 Retention:

- A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

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 Client Education 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.

DSS and DHEC have instituted pre-closure outreach efforts targeting families that have incomplete applications, deemed babies and denied and closed cases. Incomplete applications are applications received that are lacking essential information needed to determine the eligibility. Deemed babies are babies who received eligibility for the first year of their life via Optional Coverage for Women and Infants (OCWI). Denied and closed cases are cases that have come up for re-certification and the client has failed to provide essential information needed for re-certification or cases that are denied initial eligibility.

Incomplete Applications Report:

Upon receiving an incomplete application two attempts to reach the client via telephone are made. Once the client is reached, made aware of what information is needed and what documentation will fulfill that need, a letter stating the needed information is sent to the applicant, within five days of the contact date. If the client can not be reached, a letter stating the information needed and the original application are sent back within four days of the original application's arrival date. Those who have not returned requested information are listed on the Incomplete Applications Report, which goes to DHEC for follow-up.

Deemed Babies Report:

A simplified one-page redetermination form specific to deemed babies is mailed to families when their child is nine months old. This provides a three-month window prior to the end of a baby's eligibility under OWCI during which families can return the requested information and the caseworker can process the case. If the family has not responded to the initial contact by the baby's 11th month, DSS staff will make a second attempt to secure the necessary information. The second contact may be made by phone or by mail, depending on the circumstances of the case. In some counties, if the family still does not respond and the baby's case is closed, DSS contacts the local or district DHEC office to coordinate outreach efforts. Those who have not responded are listed on the Deemed Babies Report that goes to DHEC for follow-up.

Denied and Closed Report:

Before a case is closed the client receives prior notification specifying the reason for closure, effective closure date, and a copy of the manual section supporting the closure action. The same procedures are taken with denied cases except prior notification is not needed because services were never granted. In both cases the clients are made aware of

their right to appeal any closure and denial case. Those who have not responded are listed on the Denied and Closed Report that goes to DHEC for follow-up.

The incomplete application, deemed babies, and denied and closed reports are distributed to the local DSS and DHEC offices to coordinate outreach to re-enroll families that have lost eligibility but may still qualify for the programs. Also, the “passive” renew process will reduce the number of children’s cases being closed.

In addition, children approved for Medicaid/SCHIP are given continuous eligibility for one year. Even if circumstances change during that one year period that would generally cause a case to be closed in the past, children now retain their Medicaid coverage throughout the one year period of eligibility.

- B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?
- Follow-up by caseworkers/outreach workers
 - Renewal reminder notices to all families
 - Targeted mailing to selected populations, specify population
 - Information campaigns
 - Simplification of re-enrollment process, please describe (see 1.1G-Redetermination)
 - Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe
 - Other, please explain

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 1). All PHC redeterminations are conducted annually.

Recipient families are mailed a review 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. Client Information System (CIS) 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 CIS is updated appropriately. Cases requiring closure will receive adequate and timely notice prior to closure.

Families not returning the form or contacting the office within 30 days of the mailing date are presumed to have had no change in circumstances and continued eligibility will be authorized automatically by the system.

- C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Passive review is being used only for payment category 88, which includes all Title XXI and many Title XIX children. Other Title XIX children are still required to report to the local DSS offices for the renewal process.

- D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Continuous eligibility is most effective. Another system change was also effective. Earlier in the program, we found that many children were dropping from enrollment when they turned one year old. Procedures were changed so that reminders were issued to the parent at several points before their child's first birthday and cases were not closed automatically. Also DHEC receives lists of these deemed babies and performs follow-ups to facilitate completion and submission of forms to DSS. We anticipate that the new passive review will also be very effective.

- E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Based on a small study of PHC disenrollees (which included both SCHIP and regular Medicaid children), done in the summer of 2000, 45% of those disenrollees have no insurance. Almost as many, however, have obtained insurance coverage through their parents' work (43%). The small remainder left the state, did not respond, or had only dental coverage.

Those who had insurance generally had coverage for doctor sick visits, hospitalizations, ER and drugs. Dental was covered for 87%, but well-child, eye care, and other therapies were covered for only a little over half.

See attachment 6, for a summary of the findings. The sample was small and drawn from a single month and the response rate was only 28%, so results should be viewed accordingly.

2.6 Coordination between SCHIP and Medicaid:

- A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

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

- B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

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.”

- C. 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.

2.7 Cost Sharing:

- A. 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.

- B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

South Carolina does not apply cost sharing.

2.8 Assessment and Monitoring of Quality of Care:

- A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Performance goals are used to monitor several aspects of quality of care. One of our performance goals is focused on appropriate use of the ER and another on making sure as many children as possible have medical homes. Both are proxies for aspects of quality care. A child with a medical home receives comprehensive coordinated care (primary, preventive, and specialty) with better continuity and access. Encouraging use of the ER for emergencies, not for primary care, utilizes resources more efficiently and results in primary care being provided in a more appropriate setting. South Carolina PHC appears to be doing well on these two performance goals. EPSDT screening rates are the focus of another performance goal. Information on these rates can be found in Table 1.3 and in “B” below.

The primary study addressing quality of care was submitted with the March 2000/2001 evaluation. It was “A Utilization Focused Evaluation of the Children’s Health Insurance Program (CHIP) of the State of South Carolina Under Title XXI of the Social Security Act,” September 1999, pgs.38-42, indicate that the quality of services received is very good. On a scale of 0 to 10, families rated the quality of health care as 8.7 and 42% rated the healthcare received by their child as a 10. Sixty-two percent of Medicaid respondents said they always saw the health professional they wanted to see. Almost 80% said the medical staff is always courteous. Over seventy percent responded that their child’s doctor always listens to them and explains things to them. A slightly lesser percent , but

still over 60%, felt that the doctor always spent enough time and knew their child's medical history. Almost 85% reported always being involved in decisions. A little over 70% reported that their child got needed tests. More than 90% said there was no problem getting needed referrals and over half whose child was referred said the doctor definitely knew the results of the referral.

When asked whether their healthcare provider discussed basic preventive health issues with them, parents indicated that 86% had discussed immunizations, 80% nutrition and rest, 69% home safety, 67% normal child development, and half had discussed how to handle behavior problems. Parents of children under six were asked about age-relevant issues discussed with them. Seventy percent had discussed WIC, but only 56% had mentioned EPSDT. Discussion of using child safety seats was high at 79%. Parents of older children were asked different questions. Over half reported use of seatbelts, bicycle helmets, and keeping children away from guns being discussed.

The PHC Disenrollee Survey also asked a few questions about customer satisfaction. Overall the response was 'good', with minimal negative comments. Only 3% of the respondents were dissatisfied with the quality of services and care received. Of those responding, 94% were either very satisfied or satisfied with the quality of care received from his/her doctor or nurse in the PHC program.

- B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

The primary focus of quality of care monitoring for the fee-for-service segment of SCHIP enrollees is contained within the performance goals and measures. Factors such as medical homes, immunizations, and screenings are covered. Plans for more in-depth study are outlined in "C"

For SCHIP children enrolled in managed care, there is more systematic, on-going monitoring of quality. In addition to client satisfaction surveys and complaint/grievance reviews, there are case file reviews, independent peer reviews, and HEDIS performance measurements.

- C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

SCDHHS had a contract with the Camcare Health Education and Research Institute for a study on medical care utilization among children enrolled in the South Carolina Medicaid program. The contracted study would have covered a three-year time period, July 1, 1996 thru June 30, 1999. The broad target population of Medicaid eligible children would have been broken down into coverage categories, including SCHIP, and the research questions were to be applied independently to each category.

One aspect of the study would have focused on quality of care issues. Relative to quality of care, the following items were to be considered for the study:

- 1) Are Medicaid enrolled children receiving appropriate primary care?
 - What percentage of children is receiving recommended preventive services?
 - What percentage of children is receiving treatment that follows recommended protocols for chronic disease management, for acute illnesses, and for injuries?
- 2) Is the emergency room being utilized appropriately? (i.e., not for primary care)
- 3) Are there differences by geographic region in the appropriateness of services provided?
- 4) If appropriateness of care varies by region and/or coverage category, are these differences related to variations between the regions in:
 - Demographic characteristics of the children in the program (e.g., age, sex, race)
 - Health problems of the children (e.g., more chronic conditions in region compared to other regions)
 - Physician group characteristics (e.g., size of group, specialty mix)
 - Hospital characteristics (e.g., ownership).

Ideally the results of the study would have provided a framework for use in improving access and quality of care for children enrolled in the South Carolina Medicaid program.

SCDHHS did enter into a contract with Camcare Health Education and Research Institute, but unfortunately the contract was terminated before any useful results about access and quality of care were provided.

Program staff is considering other available options for obtaining this information in light of a difficult budget situation.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

Although budget problems have been a barrier to expanding the eligibility level for PHC, and will continue to be within the next budget cycle, there have been changes to the eligibility process that constitute improvements for applicants. There were some budgeting changes made concerning blended families. The changes allowed blended families to be budgeted as two separate families or as one family, using the method that would provide eligibility for the most children. Also, PHC case reviews will be conducted using a "passive" renewal process. Recipient families are mailed a review form and asked to complete and return it to the county office if there have been changes in either the family's income, household composition or payments made for child care. Families not returning the form or contacting the office within 30 days of the mailing will be presumed to have had no changes in the circumstances and continued eligibility will be authorized.

B. Outreach

Work with SC Covering Kids, professional organizations, grassroots community groups and a wide range of providers has continued to contribute to the success South Carolina has had in enrolling children in both SCHIP and regular Medicaid. Also partnerships with other state agencies, rural health centers, and schools have contributed to the increased number of children enrolled in both programs.

C. Enrollment

SC children's Medicaid has seen a net increase in enrollment since the beginning of PHC of more than 190,000, with more than 46,000 of them being SCHIP. About 48,000 of the net increase took place in FFY 2001. SCHIP has experienced a much smaller growth in the last fiscal year, largely due to shifting of children from SCHIP to regular Medicaid.

D. Retention/disenrollment

The disenrollment rates on the HCFA 64.21E had increased last year, indicating that there may have been some unidentified barriers within that process. SC Covering Kids, DSS, and SCDHHS worked together to identify barriers and develop appropriate solutions. Through collaboration they found that children were being dropped in one particular month simply to be added, an average of two months later. Medicaid children being dropped monthly accounted for more than 5,000 children being without coverage. SCHIP children average disenrollment monthly is 1,700. To address this, and other barriers not associated with retention/disenrollment, they developed the “passive” review process. Description of “passive” review can be found in 1.1G.

E. Benefit structure

None noted.

F. Cost-sharing

NA

G. Delivery system

None noted, except in “J”.

H. Coordination with other programs

None noted.

I. Crowd-out

None noted.

J. Other

Since the South Carolina Department of Health and Human Services increased the reimbursement rates for primary care providers and pediatric sub-specialist, the number of Medicaid enrolled physicians has increased by more than 500%.

Primary care providers include Family Practitioners, General Practitioners, Internists, Osteopaths, OB/GYN, Nurse Midwives, Pediatricians, Neonatologists, and Nurse Practitioners. Nurse Practitioners will continue to receive reimbursement at 80% of the physician’s rate.

Pediatric sub-specialist are defined as those physicians who:

4. In his/ her practice has at least 85% of their patients who are children 18 years or younger;

5. Practice in the field of Adolescent Medicine, Cardiology, Cardio-thoracic Surgery, Critical Care, Emergency Medicine, Endocrinology, Gastroenterology/Nutrition, Genetics, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Neurological Surgery, Ophthalmology, Orthopedic Surgery, Otolaryngology, Psychiatry, Pulmonology, Rheumatology, Surgery, Urology and such other pediatric sub-specialty areas as may be determined by the Department of Health and Human Services after consultation with the Children's Hospital Collaborative; and
6. Are affiliated through appointment, privileges or other contractual arrangement for services with a Children's Hospital/healthcare system which meets criteria for institutional or associate membership established by the National Association of Children's Hospitals and Related Institutions (NACHRI) or which is affiliated with a NACHRI qualified institution.

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care per member/per month rate X # of eligibles	781,747	917,732	914,594
Fee for Service	54,287,015	63,711,268	63,493,406
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	55,068,762	64,629,000	64,408,000
Administration Costs			
Personnel			
General administration	6,118,751	2,765,000	2,765,000
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	6,118,751	2,765,000	2,765,000
10% Administrative Cost Ceiling	6,118,751	7,181,000	7,156,000
Federal Share (multiplied by enhanced FMAP rate)	48,516,408	52,924,000	52,932,000
State Share	12,671,105	14,461,000	14,232,000
TOTAL PROGRAM COSTS	61,187,513	67,385,000	67,164,000

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

N/A

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

State appropriations

County/local funds

Employer contributions

Foundation grants

Private donations (such as United Way, sponsorship)

Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

NO

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 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 do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name		
Provides presumptive eligibility for children	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Provides retroactive eligibility	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? 3 months.	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Makes eligibility determination	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input checked="" type="checkbox"/> Other (specify): <u>PHC Central Processing Unit for mail-in applications.</u>	<input type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify)
Average length of stay on program	Specify months: 3 months	Specify months
Has joint application for Medicaid and SCHIP	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has a mail-in application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can apply for program over phone	<input checked="" type="checkbox"/> No, but there is a toll free number for Assistance. <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can apply for program over internet	<input checked="" type="checkbox"/> No, but a form can be downloaded, Printed, completed and mailed in. <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
minimum amount of time prior to enrollment	What exemptions do you provide?	What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months: <u>12</u> Explain circumstances when a child would lose eligibility during the time period. Eligibility is terminated at the age of 19 and if a child moves out of state.	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify)	<input type="checkbox"/> No <input type="checkbox"/> Yes, how much? Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify)
Imposes copayments or coinsurance	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Provides preprinted redetermination process	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, we send out a simple form to family asking them to complete and mail in only if there have been changes: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input checked="" type="checkbox"/> do not request response unless income or other circumstances have changed	<input type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

While the initial application can be mailed in to the SCDHHS central processing unit or it can go through the local DSS office, all re-determinations are done by the local DSS offices. Prior to date of re-determination families are mailed a review 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. Recipient families returning the form to the county office within 30 days of the mailing will be evaluated for continuing Medicaid eligibility. Cases requiring closure will receive adequate and timely notice prior to closure.

Families not returning the form or contacting the office within 30 days of the mailing will be presumed to have had no change in circumstances and continued eligibility will be authorized automatically by the system.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

- 6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?**
If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

**Title XIX Child Poverty-related Groups or
Section 1931-whichever category is higher**

185% of FPL for children under age 1
133% of FPL for children aged 1-5
100% of FPL for children aged 6-17
50% of FPL for children aged 18

Medicaid SCHIP Expansion

150% of FPL for children aged 1-18
 % of FPL for children aged
 % of FPL for children aged

Separate SCHIP Program

 % of FPL for children aged
 % of FPL for children aged
 % of FPL for children aged

- 6.2 As of September 30, 2001, what types and amounts of disregards and deductions does each program use to arrive at total countable income?** *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) Yes X No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	\$100/mo/working parent	\$100/mo/working parent	\$
Self-employment expenses	\$	\$ * varies	\$
Alimony payments Received	\$ NA	\$ NA	\$
Paid	\$ NA	\$ NA	\$
Child support payments Received	\$50/mo	\$50/mo	\$
Paid	\$ amount paid	\$ amount paid	\$
Child care expenses	\$200/mo/child under 12 years	\$200/mo/child under 12 years	\$
Medical care expenses	\$ NA	\$ NA	\$
Gifts	\$ NA	\$ NA	\$
Other types of disregards/deductions (specify)	\$	\$	\$

* **Conforms to IRS rules except depreciation, entertainment travel, meals and contribution expenses are not allowed.**

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

No Yes, specify countable or allowable level of asset test _____

Medicaid SCHIP Expansion program

No Yes, specify countable or allowable level of asset test _____

Separate SCHIP program

No Yes, specify countable or allowable level of asset test _____

Other SCHIP program _____

No Yes, specify countable or allowable level of asset test _____

6.4 Have any of the eligibility rules changed since September 30, 2001?

Yes No

During FFY 2001, the South Carolina Department of Health and Human Services changed budgeting policy concerning blended families. South Carolina defines a blended family as, a family unit when two people marry, each with children of their own, and no children in common.

Previously blended families were considered as separate family units. Now, with the new policy, blended families are budgeted most advantageously for the family. This means the blended family can be budgeted as two separate families or as one family, using the method that would provide eligibility for the most children.

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002(10/1/01 through 9/30/02)? Please comment on why the changes are planned.

- A. Family coverage
- B. Employer sponsored insurance buy-in
- C. 1115 waiver
- D. Eligibility including presumptive and continuous eligibility

Beginning with the last quarter of FFY 2002, SCDHHS will discontinue the contract with SCDSS for Medicaid eligibility determination and re-determination. The SCDHHS will begin performing those functions directly, using the new MEDS system. Greater emphasis will be placed on the use of mail-in applications. Workers currently performing Medicaid eligibility determination functions in DSS county offices will be transferred to SCDHHS, but will continue to be located in the county offices. This is a recent decision and operational details are still being developed.

The Medicaid Eligibility Determination System (MEDS) will replace the twenty-eight year old batch eligibility system operated by DSS with a real-time system operated on the same mainframe as the agency's Medicaid Management Information System (MMIS). The MEDS will be the central repository of Medicaid eligibility data for the state of South Carolina. Most of the system will operate in the online environment, providing real-time updating and query. The new system will:

1. Maximize Resources: Increase eligibility worker efficiency by reducing worker time per case.
2. Effectively Manage Resources: Enhance system support by reducing the time to implement system software changes.
3. Promote Quality Improvements: Improve the accuracy of eligibility determination by maintaining or reducing the error rate.
4. Promote Customer Service: Improve service to Medicaid applicants and recipients by lowering the average time to decision, providing timely notices, and providing notices with consistent language and manual citations. Improve services to providers by reducing the percent of claims suspended for correction of eligibility records.

E. Outreach

The agency's budget shortfall made any major outreach campaigns or other efforts, which could be expected to enroll large numbers of additional children, appear inappropriate. A reassessment resulted in a change in direction and new mission and functions for the Division of Client Education and Outreach Services. The new name is the Division of Health Promotion and Analysis. The new focus is on education outreach or health promotion, rather than eligibility outreach. It concentrates on developing programs that increase appropriate access to and use of Medicaid benefits and on promoting healthy behaviors. The division will continue to distribute PHC applications and materials when requests are received.

Since the purpose of Covering Kids remains the identification and enrollment of children eligible for Medicaid or SCHIP, that organization will continue eligibility outreach, but with modifications. Their outreach efforts will be scaled back to eliminate the mass media public awareness campaign. Instead they will concentrate on targeted outreach and the testing of approaches, strategies and materials with specific populations. The results will be useful when the budget crisis has passed and the agency can resume eligibility outreach efforts.

F. Enrollment/redetermination process

The Medicaid Eligibility Determination System (MEDS) will replace the twenty-eight year old batch eligibility system operated by DSS with a real-time system operated on the same mainframe as the agency's Medicaid Management Information System (MMIS). The MEDS will be the central repository of Medicaid eligibility data for the state of South Carolina. Most of the system will operate in the online environment, providing real-time updating and query.

In 1997 the agency established the MEDS project team to accomplish this initiative. SCDHHS plans to implement MEDS in pilot counties by May 28, 2002 and in the rest of the state by August 28, 2002.

The new system will:

1. Maximize Resources: Increase eligibility worker efficiency by reducing worker time per case.
2. Effectively Manage Resources: Enhance system support by reducing the time to implement system software changes.
3. Promote Quality Improvements: Improve the accuracy of eligibility determination by maintaining or reducing the error rate.
4. Promote Customer Service: Improve service to Medicaid applicants and recipients by lowering the average time to decision, providing timely notices, and providing notices with consistent language and manual citations. Improve services to providers by reducing the percent of claims suspended for correction of eligibility records.

G. Contracting

H. Other

Replacement of Paper Card with Plastic Cards

Effective December 2001, SCDHHS replaced the current monthly paper Medicaid card with a permanent plastic South Carolina Partners for Health Medicaid insurance card, see attachment 7. Thus ending the monthly mail out of hundreds of thousands of paper Medicaid cards.

The new permanent plastic SC Partners for Health Medicaid insurance card only has one person's name on it. If a family has more than one Medicaid recipient, each recipient receives his or her own card. The card includes the recipient's name, date of birth, and Medicaid health insurance number.

Possession of the card does not guarantee Medicaid eligibility. Recipients are advised to keep their Medicaid insurance card even if they lose eligibility. Recipients are advised to keep their card because many may become ineligible for Medicaid for a given month only to regain eligibility at a later date. It is possible that a recipient will present a card during a time of ineligibility. For this reason it is very important that providers verify Medicaid eligibility prior to providing services.

Prior verification can be done through the new Medicaid Interactive Voice Response System (IVRS). The IVRS is an alternative that enables providers to use a touch-tone phone to verify Medicaid Eligibility in real time. DHHS has contracted with GovConnect to maintain any and all updates to the IVRS system. Beginning in November 2001, providers may verify Medicaid eligibility by dialing a toll-free number. The number, 1-800-809-3040, is located on the back of each Medicaid insurance card. To access the IVRS providers must use their 6-character Medicaid Provider ID. There is a limit of ten verification transactions per call. Providers may also use the IVRS to access their most recent Medicaid payment information. There is no charge to the providers for this service.

If the providers choose to go more advanced they can utilize the Medicaid Eligibility Verification Services. The design of the new card includes a magnetic stripe on the back that may be utilized in Point of Sale (POS) devices. Several vendors offer POS devices, PC based software, and Internet or other eligibility verification services.

The new plastic card, coupled with Medicaid eligibility verification will grant the Medicaid providers in South Carolina real time information about patient eligibility, third party insurance, service limits, and waiver participation.