

**~~OFFICE MEMORANDUM FOR STATE EVALUATIONS~~
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: South Carolina

(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

Original Signed by: J. Samuel Griswold, Ph.D.

(Signature of Agency Head)

Date: March 31, 2000

Reporting Period: FFY 1998 and FFY 1999

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

A new baseline was calculated for 1997 of approximately 162,500 potentially eligible children below our Partners for Healthy Children (PHC) eligibility standard of 150% of poverty. Almost 104,000 children have been added to Medicaid through PHC from program inception to June, 1999. The South Carolina Department of Health and Human Services (DHHS) estimated that as of July 1999, there were still almost 58,600 uninsured children potentially eligible at the current income eligibility level of 150% of poverty. These numbers include both Title XXI SCHIP and Title XIX regular Medicaid. They were derived from the 1995, 1996, 1997 CPS average estimated number of uninsured children below 200% of poverty, with consideration of the standard error. This is different than the initial target of 75,000 children under 150% of poverty and the revised target of 85,000 submitted in the 1998 annual report. The current estimate was designed to adjust for identified problems with the data, as outlined below.

South Carolina looked at several estimates of uninsured children in the process of formulating our State Plan, including those by Employee Benefit Research Institute (EBRI), the Southern Institute on Children and Families (both of which used the CPS numbers for analysis) and the Current Population Survey (CPS). Since the FFY 1998 and subsequent annual allotments under the program were to be based on the average of three years CPS data, South Carolina decided to use this CPS average as the basis of its official baseline for uninsured children under 200% of poverty. The official estimate for FFY 1998 (CPS 1993, 1994, 1995) was 110,000. Since our initial CHIP program was a Medicaid expansion to 150% of poverty, we needed a target estimate for the number of children we expected to cover with Partners for Healthy Children (PHC). We considered the ratio of the estimated number of children above Medicaid income eligibility levels but below 150% of poverty to those above Medicaid eligibility but below 200%. That number was about 70% of the 110,000 uninsured children under 200% of poverty, or 75,000 children under 150% of poverty.

Problems with the target and the projection process began to surface in the fall of 1998. Enrollment in Partners for Healthy Children passed 75,000 for September and for December 1998, exceeded a revised target of 85,000 submitted with the first annual report. When the Census dropped 1993 and added 1996 to their three year average, numbers of uninsured children changed substantially for most states, some rising while others fell. It became apparent that, while CPS probably produced valid and reliable estimates on a national basis, the samples for individual states were not

large enough to allow reliable estimates even when three years were averaged to decrease random variations. Unfortunately, CPS was and is the best tool available to this state.

Another problem with doing projections of uninsured children is that population projections are based on the 1990 Census. Even if the Census was correct when it was done, after seven or eight years, projections become unreliable. It is acknowledged, however, that the 1990 Census undercounted South Carolina's population, particularly minorities and those at low income levels. Estimates of the undercount range from about 4% to as much as 20%. Unfortunately, the populations undercounted are exactly the ones most important to our projections.

A third area of difficulty arises from the income disregards which are applied before comparing income to eligibility limits. While the eligibility limit is listed as 150%, children in families with incomes above 150% are often eligible after income disregards are applied. Those disregards are \$100/month of earned income per working parent and \$200/month/child under age 12 in child care. After examining various family sizes and configurations and applying appropriate disregards, it was calculated that, on average, application of the disregards adds about 25 percentage points to the eligibility limit. So, if the stated limit is 150%, the average actual limit would be 175% and the population at or below that income level should be the base for projections.

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

The problems with the Census and Current Population Survey numbers, combined with enrollment exceeding targets, led SCDHHS to reconsider the projection methods. Lacking good alternatives, the agency continued to use the CPS, but with consideration of the standard error. For the latest projections of children still potentially eligible but not enrolled at 150% of poverty, estimates started with the number of uninsured under 200 % of poverty according to CPS. The CPS three year average for 1995, 1996, 1997 was 139,000, but the standard error was listed as 24,600. The standard error was added to the estimate before using it to calculate a percent uninsured. That percent uninsured was applied to the July 2000 projected number of children under 175% of poverty (The average actual poverty level after consideration of income disregards).

Applying the percent uninsured to the projected children's population yielded an estimate of 127,300 uninsured. Our PHC program had added 68,703 children to Medicaid between the end of 1997 and June 1999. Since those children would have been considered part of the uninsured when the 1997 CPS was done and we knew they were now covered, that number was subtracted from the product of the percent uninsured and the projected children's population. This left about 58,500 children still potentially eligible as of July 1999. Adding this 58,500 to the 104,000 already added under PHC, gives a pre-PHC baseline of 162,500. These adjustments were designed to account for the identified problems with earlier projections.

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

The state is **very** uncomfortable with the reliability of the baseline and other estimates derived from CPS and Census data. Each new three year average showed substantial increases in the number of uninsured low-income children. By the end of FFY 1999, South Carolina had already enrolled more children using a 150% poverty level than the first three year average showed in the entire state under 200% of poverty. The standard error for the three year CPS averages is consistently high. It is 24,600 for the 1995, 1996, 1997 average.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

By September 1999, over 112,000 children had been added (net addition) to the state=s Medicaid program enrollment. Of that total net addition, 48,046 (43%) were eligible under Title XXI (SCHIP). The remaining 64,336 (57%) were eligible under Title XIX (regular Medicaid), but were enrolled as a result of the overall Partners for Healthy Children (PHC) outreach efforts.

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

These are not estimates. They come from reports pulled from our Medicaid eligibility files which present the number of eligible children for Medicaid and SCHIP each month since the inception of PHC.

1.2.2 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 statement above.

1.3 What progress has been made to achieve the State=s strategic objectives and performance goals for its CHIP program(s)?

There has been extensive outreach to potentially eligible children. Schools, other state agencies, numerous private-non-profit community organizations and providers have supported and participated in these efforts.

South Carolina has exceeded its original goal of providing health coverage to an additional 75,000 children and its revised goal of 85,000. In September, 1999, the net additional children enrolled in Medicaid since the inception of Partners for Healthy Children was 112,382. Of this net increase, 48,046 were eligible under Title XXI/SCHIP and the remainder were eligible under Title XIX/regular Medicaid.

The medical home programs have grown substantially. By the end of FFY 1999, there were 43 enrolled PEP (Physician Enhanced Program) providers in 17 counties, 391 HOP (Healthy Options Program) providers in 38 counties plus adjacent counties in Georgia and North Carolina. There were 11,282 clients enrolled in PEPs. At the end of SFY 99 there were 32,260 unduplicated recipients in HOP.

Immunization levels have been difficult to measure. EPSDT utilization by SCHIP children, however, was actually better than regular Medicaid in 1998.

Access for children to medical care in appropriate settings has improved markedly. Inappropriate use of the emergency room has decreased by 67%. Uncompensated care for children in hospital settings has declined by at least 27%.

Management of asthma, the most common chronic condition among children, has improved. Hospitalization of children for asthma has decreased about 25%.

Please complete Table 1.3 to summarize your State=s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State=s strategic objectives for the CHIP program, as specified in the 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, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
<p>Reduce the number and proportion of uninsured and under-insured children in the state.</p>	<p>1.1 Market the PHC program.</p>	<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:</p> <p><u>Applications distributed:</u> >3,000,000</p> <p><u>Source of applications:</u> >60,000 received in Central Application Processing (Mail-in); applications also taken at county DSS office. See exhibit 1 - <u>Analysis of Application Sources</u></p> <p><u>Targeted Outreach:</u> See <u>Outreach</u> in Section 3.4.1</p>

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)

OBJECTIVES RELATED TO CHIP ENROLLMENT

<p>Reduce the number and portion of uninsured and under-insured children in the state.</p>	<p>1.2 Enroll targeted low-income children in Partners for Healthy Children (PHC).</p>	<p>Data Sources: MMIS, CPS & Census; HCFA 64.21E & 64.EC at quarter ended 09-30-99</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: 112,382 Regular Medicaid = 64,336 SCHIP Medicaid = 48,046</p> <p>Denominator: Baseline number of uninsured below eligibility standard: Initial target was 75,000; revised to 85,000, then 162,500.</p> <p>Progress Summary: $112,382/162,500 = 69\%$</p>
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Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
<p>Reduce the number and portion of uninsured and under-insured children in the state.</p>	<p>1.2 Enroll targeted low-income children in Partners for Healthy Children (PHC).</p>	<p>Data Sources: MMIS, CPS & Census; HCFA 64.21E & 64.EC at quarter ended 09-30-99</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: 112,382 Regular Medicaid = 64,336 SCHIP Medicaid = 48,048</p> <p>Denominator: Baseline number of uninsured below eligibility standard: Initial target was 75,000; revised to 85,000, then 162,500.</p> <p>Progress Summary: $112,283/162,500 = 69\%$</p>

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)

<p>Establish medical homes for children under the Medicaid/PHC programs.</p>	<p>3.0 Recruit and orient physicians for participation in HOP, PEP, and HMO programs.</p>	<p>Data Sources: Internal program report Methodology: Compare number of Medicaid enrolled practices and primary care physicians participating in medical home programs at 1997 baseline and 1999. 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 1999. Numerator: (1999 Number - 1997 Number) Denominator: 1997 Number Progress Summary: <u>Physicians Participating in Medicaid Home Programs</u> HMOs $(431 - 291) / 291 = 48\%$ Increase PEP $(43 - 3) / 3 = 1,300\%$ Increase</p>
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Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
		<p>HOP $(391 - 40) / 40 = 878\%$ Increase <u>Medicaid PHC Children in Formal Medical Homes</u> HMOs & PEP $(16,687 - 4,076) / 4,076 = 309\%$ Increase HOP $(32,260 - 528) / 528 = 6,010\%$ Increase</p>
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Increase access to preventive care for PHC children.	<p>4.1 Immunize pre-school children in PHC at the same rate as age-comparable groups in the general population.</p> <p>4.2 Deliver EPSDT services to children enrolled</p>	<p>Data Sources: Not yet available Methodology: Compare complete series immunization rates for PHC children to those for the general population of two year olds in sample. Numerator: Denominator: Progress Summary: Numerous approaches have been explored to measure immunization rates for Medicaid/PHC children, but nothing workable has been identified and implemented.</p> <p>Data Sources: HCFA - 416 Reports Methodology: Compare percent of PHC/SCHIP children to percent of regular Medicaid children ages 6 - 20 receiving recommended screens.</p>

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
	in PHC/SCHIP at the same rate as children enrolled in regular Medicaid.	<p>Numerator: Number actual screens received. Denominator: Number expected screens. 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 have been changes in how South Carolina's EPSDT program was administered and billed in the past year. In addition, the reporting criteria for the HCFA 614 changed. The intent is to consider FY 1999 screening ratios before developing plans to address this performance goal.</p>

OTHER OBJECTIVES - ON NEXT PAGE

Improve access for children to medical care delivered in the most appropriate setting.	<p>2.1 Decrease the overall 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 Methodology: Compare % of non-emergent ER visits for 1997 baseline and 1999. Numerator: Number of non-emergent emergency room visits Denominator: Number of emergency room visits Progress Summary: In SFY 1998 the percent of Medicaid children's emergency room visits for non-emergency conditions was 4.4%. It remained the same in SFY 1999, so the overall decrease was 67%.</p> <p>2.2.1. Inpatient Admissions Data Sources: Office of Research & Statistics, Hospital Discharge Data Set Methodology: Compare % children's inpatient admissions without insurance as pay source for 1997 baseline and 1999. Numerator: (% for 1997 - % for 1999)</p>
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<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>Denominator: % for 1997 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. The overall decrease from the baseline is 38% over two years. 2.2.2. Emergency Room Visits Data Sources: Office of Research & Statistics, Emergency Department Data Set Methodology: Compare % children's emergency room without insurance as pay source for 1997 baseline and 1999. Numerator: (% for 1997 - % for 1999) Denominator: % for 1997 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% . Overall, the percent of uncompensated care for children's visits to the emergency room has decreased by 27% from the baseline.</p> <p>Data Sources: Office of Research & Statistics Methodology: Compare incidence rates for State fiscal years (SFY) 96/97 & 97/98, 97/98 & 98/99, and 96/97 & 98/99 to calculate percent change. Numerator: (1st year rate - 2nd year rate) Denominator: 1st year rate Progress Summary: From SFY 96/97 to SFY 97/98, the rate decreased 7%; from SFY 97/98 to SFY 89/99, the rate decreased 20%; from SFY 96/97 to SFY 98/99, the rate decreased a total of 26%.</p>
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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:

- < Number of applications distributed through non-traditional sites.
- < **Baseline:** 0 (FFY 1997)
- < **Target:** 1 million (FFY 1998); 2 million (FFY 1999)

Progress: Over three million applications had been distributed by the end of FFY 1999. The vast majority were sent home with children by their schools, though the Department of Social Services (DSS) and the Department of Health and Environmental Control (DHEC) also were the source of substantial numbers of applications.

Barriers and Future Plans: A few schools didn't receive their applications or didn't distribute all of them. SCHIP staff will continue to work with schools to make sure that all schools, including new ones, receive enough applications for all students and understand what needs to be done with them. It is intended that school distributions will be phased throughout the school year in the future to avoid large fluctuations in the number of applications received.

- < Number of targeted outreach initiatives.
- < **Baseline:** 0 (FFY 1997)
- < **Target:** 10 (FFY 1998); 20 (FFY 1999)

Progress: SCHIP staff have conducted outreach activities with schools, the faith community, providers and their professional associations, government agencies, child care providers, and numerous community organizations. Please see the summary provided in section 3.4.

Barriers and Future Plans: Targeted outreach efforts will continue, with emphasis on harder to reach populations. Covering Kids sites will be concentrating on Hispanic children, adolescents and rural residents. There will be coordination with a couple of the Historically Black Colleges and Universities to utilize students for outreach to surrounding rural areas. Training will be stepped-up within the faith community, particularly those denominations with high numbers of minority members.

Performance Goal 1.2:

Enroll targeted low income children in Partners for Healthy Children(PHC).

Performance Measures:

- < Percent of 75,000 targeted low income children enrolled in PHC.
- < **Baseline:** 0 (FFY 1997)
- < **Target:** 50% or 37,500 (FFY 1998); 85,000 (FFY 1999)

Progress: Over 112,000 additional children were enrolled in Medicaid at the end of FFY 1999 compared to the baseline of July 1997. SCHIP enrollees totaled 48,046 or 43% of the total. The outreach efforts also brought in an additional 64,336 children who were eligible for regular Medicaid, but had not enrolled.

Barriers and Future Plans: There have been anecdotal reports of barriers perceived by the Hispanic population, which will be addressed by changes in the application regarding questions about Social Security Number and citizenship, focused efforts by Covering Kids to identify Abest practices[®] for this population, and wider dissemination of Immigration and Naturalization Service (INS) policy regarding public charge. Staff are working to improve the Spanish version of the application, but it may be difficult to devise a single version appropriate for the Hispanic populations from the various countries and regions of origin. DHHS has recently subscribed to a telephone translation service to improve services of the toll free line for non-English speakers.

Strategic Objective 2:

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

Performance Goal 2.1:

Decrease the overall percent of Medicaid/PHC childrens emergency room visits for non-emergent conditions.

Performance Measure:

- < % of Medicaid/PHC children seen in the emergency room for non-emergent conditions.
- < **Baseline:** 13.4% (SFY 1997) (recalculated for methodological consistency)
- < **Target:** Decrease by 2% for FFY 1998

Progress: In SFY 1998 the percent of Medicaid childrens emergency room visits for non-emergent conditions was 4.4%. It remained the same in SFY 1999, so the over overall decrease was 67%.

Barriers and Future Plans: Since the decrease has been so dramatic, DHHS will simply strive to maintain the current level.

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.

< **Baseline:** 5.6 % (SFY 1997)

< **Target:** Decrease by 2% for FFY 1998

Progress: 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. The overall decrease from the baseline is 38% over two years.

Barriers and Future Plans: It is anticipated that the rate of uncompensated care for children's inpatient admissions will continue to drop, though the rate of change may slow down.

< Percent of children's emergency room visits without insurance as expected pay source.

< **Baseline:** 20.6% (SFY 1997)

< **Target:** Decrease by 2% for FFY 1998

Progress: 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%. Overall, the percent of uncompensated care for children's visits to the emergency room has decreased by 27% from the baseline.

Barriers and Future Plans: It is expected that uncompensated care for children's emergency room visits will continue to decrease as more children are enrolled in PHC.

Strategic Objective 3:

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

In 1996, the Department of Health and Human Services began an initiative to establish medical homes for medicaid recipients. A Medical Home is defined as a licensed medical professional enrolled either directly or indirectly with the S.C. Medicaid Program who **accepts responsibility** for the

provision and/or coordination of primary, preventive, and/or specialty care for a medicaid recipient, including providing and/or facilitating access to medical consultation and/or needed medical care 24 hours per day, 7 days per week. Accepting responsibility for care means:

*Providing or arranging primary and preventive care needed by the Medicaid recipient.

*Establishment of a mechanism that allows the Medicaid recipient to reach an on-call person 24 hours per day, 7 days per week who is responsive to questions about health care problems and directs them to appropriate care alternatives.

*Coordinating with other health care providers and public and private agencies to obtain needed health care services for the Medicaid recipient, and appropriate information about care provided.

*Maintaining a comprehensive, unified and accessible patient record that captures services coordinated, arranged or provided to the Medicaid recipient.

*Providing education to the Medicaid recipient on the importance of healthy lifestyles, preventive and primary health care, and appropriate use of the health care delivery system, especially emergency room care.

Participation in medical home initiatives is voluntary for both physicians and Medicaid recipients. Three configurations are used currently to provide medical homes: the Medicaid Health Maintenance Organization (HMO) program, the Physician Enhanced Program (PEP), and the Healthy Options Program (HOP). Clients who enroll in HMOs are required to select a primary care physician or have one assigned for them and the HMO provides the medical home.

The Physician Enhanced Program (PEP) was implemented in May, 1996 as a pilot project. The PEP is an alternative reimbursement plan through which physicians provide a minimum package of basic services for a monthly fee. PEP physicians are responsible for providing primary prevention and treatment and arranging and/or prior authorizing most other services (i.e. specialists, emergency room care, hospital, etc.). In June of 1997, based on the success of the PEP pilots, expansion of the PEP program began on a region by region basis.

The Healthy Options Program (HOP) was established in August, 1997 as an enhanced fee-for-service reimbursement option for physicians who agree to provide a medical home for Medicaid eligible children under the age of nineteen. HOP physicians are required to sign an agreement confirming their understanding of and willingness to meet the requirements of providing a medical home. Medicaid recipients (or their parent or guardian) also sign an agreement acknowledging their participation in the program.

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.

<	Target:		(September 30, 1998)	(September 30, 1999)
		HMO Primary Care Physicians	350	
		PEP Enrolled Practices	15	30
		HOP Participating Physicians	200	300

Progress: For FFY 1998, there were 561 HMO primary care physicians, 21 PEP enrolled practices, and 290 HOP participating physicians. At the end of FFY 1999, there were 431 HMO primary care physicians, 43 enrolled PEP providers in 17 counties, and 391 HOP participating physicians in 38 counties.

< Number of Medicaid/PHC children enrolled in the HMO and PEP programs.

< Number of children receiving services through a HOP physician practice.

Baseline:		(FFY 1997)
	HMO and PEP enrolled children	4,076
	Children receiving HOP physician services	528

<	Target:		(FFY 1998)	(FFY 1999)
<				HMO and PEP enrolled
				children
				6,200
		Children receiving HOP physician services	8,000	12,000

Progress: For FFY 1998, there were 10,548 children enrolled in HMOs or with PEP providers. There were 11,282 children enrolled in PEP, and 5,405 in HMOs, by the end of FFY 1999. Physicians who have chosen not to enroll in one of the three programs listed above may also provide a medical home; however, the number of children who are in a medical home under the fee-for-service option is not known.

Barriers and Future Plans: A large portion of the physicians who could participate in the medical home programs, have now heard about the programs or been contacted, so growth can be expected to slow in the future. DHEC still continues to recruit physicians for Medicaid enrollment and increased participation levels, however, and their staff advocates for the medical home programs in particular. HMO enrollment has been inhibited by the withdrawal of HMOs from Medicaid participation. Also, there was enrollment hiatus in the single remaining HMO during the period when the Plan was having financial difficulties and being acquired by new owners, which necessitated negotiation of a new contract.

Strategic Objective 4:

Increase access to preventive care for PHC enrolled children.

Performance Goal 4.1:

Immunize pre-school children enrolled in PHC at the same rate as age-comparable groups enrolled in regular Medicaid.

Performance Measure:

- < Percent of pre-school children enrolled in PHC and regular Medicaid receiving all recommended immunizations at ages 2 and 5 years.
- < **Baseline:** (FFY 1997) For PHC = unknown; for regular XIX: 2 years = 91.7%
- < 5 years = 98%
- < **Target:** (FFY 1998) 2 years = 92%
- < 5 years = 98%

Progress: Numerous approaches have been explored to measure immunization rates for Medicaid/PHC children, but nothing workable has been identified and implemented.

Barriers and Future Plans: The DHEC immunization data collection system originally intended for use when the Performance Goal was developed is still being developed, but it is going much more slowly than planned. They anticipate training district teams in March 2000. Roll-out will begin after training. Medicaid paid claims no longer reflect what immunizations were administered, only that some immunization was given. Also, the Medicaid data is fragmented and incomplete because DHHS only has paid claims for periods when the child is eligible. DHHS is continuing to explore possible interim measures. The most promising involves use of the sample study of two year olds done by DHEC, matching identifiers against the Medicaid eligibility file. If this approach proves feasible, the goal will be modified to: **Immunize two year old children enrolled in PHC at the same rate as two year olds in the general population.**[@] The measure will become percent of two year olds enrolled in PHC and general population receiving all recommended immunizations. The measurement for 5 year olds will probably not be pursued since complete immunizations are required for first grade entry.

Performance Goal 4.2:

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

Performance Measure:

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

- < **Baseline:** For FY 1997, 42% of screenings due were accomplished for regular XIX ages 6 - 20.
- < **Target:** (FFY 1998) 42%

Progress: In 1998, the screening ratio for regular Medicaid dropped below the 1997 baseline to 36%. The SCHIP screening ratio of 43%, however, was slightly above Medicaid's 1997 level. There have been changes in how South Carolina's EPSDT program was administered and billed in the past year, as well as changes in reporting criteria for HCFA 416.

Barriers and Future Plans: The HCFA 416 data and screening ratios for 1999 need to be examined and compared to previous years as well as to enrollment/eligibility data to establish credibility. The intent is to consider those numbers before developing plans to address this performance goal.

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 admissions for asthma.
- < **Baseline:** FFY 1997: 5.73 per 1000 Medicaid children

Target: Reduce incidence of children's hospitalization for asthma by 2%

Progress: Actual incidence of children's hospitalization for asthma decreased by about 7% from the baseline in SFY 1998. From SFY 1998 to SFY 1999, the decrease was significantly larger, at 20%. The overall decrease was 26% from the baseline year to 1999.

Barriers and Future Plans: Use of the emergency room and inpatient hospitalizations should not be necessary if asthma is properly controlled. Efforts will continue to drive down hospitalizations and to decrease use of the ER as well.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: Partners for Healthy Children

Date enrollment began (i.e., when children first became eligible to receive services):
August 1, 1997 (Enhanced match from Title XXI began October 1, 1997)

Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

Other - Family Coverage

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

Other - Employer-sponsored Insurance Coverage

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

___ Other-Wraparound Benefit Package

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

___ Other (specify):

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

2.1.2 If State offers family coverage: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.1.3 If State has a buy-in program for employer-sponsored insurance: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

**2.2 What environmental factors in your State affect your CHIP program?
(Section 2108(b)(1)(E))**

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Before SCHIP was enacted, public hearings were held for providers, consumers and advocates to give advice about how South Carolina should proceed with expansion of health care services for children. The consensus from all groups was that a Medicaid expansion was the best method. South Carolina wanted to provide comprehensive health care to these additional children as soon as possible. Use of the existing Medicaid program was the most efficient system to use to make health care coverage available to the most children as quickly as possible. The state was poised to expand Medicaid for children to 133% of poverty when SCHIP passed. The enhanced matching rate enabled SC to expand to 150% using SCHIP.

2.2.2 Were any of the preexisting programs AState-only@ and if so what has happened to that program?

No pre-existing programs were AState-only@

One or more pre-existing programs were AState only@! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that Aaffect the provision of accessible, affordable, quality health insurance and healthcare for children.@ (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

Changes to the Medicaid program

Presumptive eligibility for children

Coverage of Supplemental Security Income (SSI) children

Provision of continuous coverage (specify number of months 12)

Elimination of assets tests (for eligibility of children only)

Elimination of face-to-face eligibility interviews

Easing of documentation requirements

Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify): Welfare rolls in the state have dropped by over 65% from 50,035 in January 1995. Medicaid enrollment, however, has increased. **T**
overall increase was 14.42% in FFY 1998 and 11.89% in 1999. While AFDC/TANF categories decreased the categories of transitional Medicaid and low-income FI families increased to compensate. (Source: DSS & DHHS)

Changes in the private insurance market that could affect affordability of or accessibility to private health insurance. (Source: Department of Insurance; actuarial consultant; BC/BS; SC Alliance for Managed Care)

Health insurance premium rate increases: Health insurance premiums have begun to climb again after several years of relatively slow growth. HMO/managed care plans rates increased an average of 5.3% in

1999, but the weighted average increase was 9%. For medical plans, the average rate increase was 9.8% for 1999.

comprehensive major 11.2%, while the weighted average

Legal or regulatory changes related to insurance: Only minor changes occurred, with a new mandate for coverage of diabetes education equipment being enacted.

Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market): There were some significant withdrawals of carriers from the state in 1999, especially among companies offering small group coverage.

Changes in employee cost-sharing for insurance: Anecdotal reports indicate there were increases in the portion of their health care costs paid out-of-pocket by employees, both in terms of higher premiums and co-payments/deductibles. Even larger increases are expected next year.

Availability of subsidies for adult coverage

Other (specify):

Changes in the delivery system

Changes in extent of managed care penetration: (e.g., changes in HMO, IPA, PPO activity)

Changes in hospital marketplace (e.g., closure, conversion, merger): Two major hospitals in the central area of the state have merged. They have continued their commitment to serve low income and indigent people. A number of smaller rural hospitals have become private for profit. However, they are largely dependent on Medicaid for financial solvency; therefore, there has been no significant decrease in access associated with these changes. (Source: news reports)

Other (specify): The Medicaid program has developed two alternatives to managed care options and traditional fee-for-service. These are Healthy Options Program and Physicians Enhanced Program. These programs have increased the access for Medicaid (Title XIX and Title

XXI) eligible children to medical homes.

Healthy Options Program - This program pays an enhanced fee for service to physicians who accept children into their practice and provide a medical home for them. They must provide 24 hour, seven

day a week access and be responsible for comprehensive preventive and sick care. The Healthy Options Program is offered for children only.

Physicians Enhanced Program - This program pays the primary care physician a set rate per month based on age and sex. It is open to Medicaid recipients of all ages who are not dually eligible Medicare/Medicaid. The payment is made at the end of the month of services, rather than being prepaid. The set rate pays for a core set of primary care services and gate keeper oversight. The primary care physician must refer the Medicaid recipient to specialists and for non-emergency hospitalizations in order for the Medicaid program to pay for such services.

Both programs are voluntary for the providers and the recipients.

___ Development of new health care programs or services for targeted low-income children (specify):

X Changes in the demographic or socioeconomic context: (Source: news reports; Employment Security Commission)

X Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify): There has been no significant change, however, the very small Hispanic population is increasing at a rate much greater than the rest of the population.

X Changes in economic circumstances, such as unemployment rate (specify): Unemployment declined from 4.5% in 1997 to 3.8% in 1998, but returned to 4.5% in 1999.

___ Other (specify):

___ Other (specify):

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter N/A.

	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide		
Age	1 to 19 years old (children under age 1 are eligible for the regular Medicaid program up to 185 % of poverty)		
Income (define countable income)	150% of FPL (Income exclusions: \$100 per month for each parent who is working and \$200 per month for each dependent adult or child under the age of 12 in child care)		
Resources (including any standards relating to spend downs and disposition of resources)	NA		
Residency requirements	State resident		
Disability status	NA		
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	If child has TPL, eligibility is under Title XIX rather than XXI		
Other standards (identify and describe)			

*Make a separate column for each other program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select insert and choose a column.

Addendum to Table 3.1.1 Countable Income

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999**. Also, if the rules are the same for each program we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here **9** and indicate who you passed it along to:
 Name: _____, phone/e-mail: _____

3.1.1.1 For each program do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	___ Gross	<u> X </u> Net	___ Both
Title XXI Medicaid SCHIP Expansion	___ Gross	<u> X </u> Net	___ Both
Title XXI State-Designed SCHIP Program	___ Gross	___ Net	___ Both
Other SCHIP program _____	___ Gross	___ Net	___ Both

3.1.1.2 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.

Title XIX Child Poverty-related Groups	<u>185%</u> of FPL for children under age <u>1</u> <u>133%</u> of FPL for children aged <u>1 thru 5</u> <u>100%</u> of FPL for children aged <u>6 thru 15</u>
Title XXI Medicaid SCHIP Expansion	<u>150%</u> of FPL for children aged <u>1 thru 18</u> ___% of FPL for children aged ___% of FPL for children aged
Title XXI State-Designed SCHIP Program	___% of FPL for children aged ___% of FPL for children aged ___% of FPL for children aged
Other SCHIP program _____	___% of FPL for children aged ___% of FPL for children aged ___% of FPL for children aged

3.1.1.3 Complete Table 1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter AY@ for yes, AN@ for no, or AD@ if it depends on the individual circumstances of the case.

Table 3.1.1.3				
Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHP Expansion	Title XXI State-designed SCHP Program	Other SCHP Program*
Child, siblings, and legally responsible adults living in the household	Y	Y		-----
All relatives living in the household	N	N		
All individuals living in the household	N	N		
Other (specify):				

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.

Enter AC@ for counted, ANC@ for not counted and ANR@ for not recorded.

Table 3.1.1.4				
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHP Expansion	Title XXI State-designed SCHP Program	Other SCHP Program [†] -----
Earnings of dependent children	NC	NC		
Earnings of students	NC	NC		
Earnings from job placement programs	NC	NC		
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	NC	NC		
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NC		
Education Related Income Income from college work-study programs	NC	NC		
Assistance from programs administered by the Department of Education	NC	NC		
Education loans and awards	NC	NC		
Other Income Earned income tax credit (EITC)	NC	NC		
Alimony payments received	C	C		
Child support payments received *	C	C		
Roomer/boarder income	C	C		
Income from individual development accounts	NC	NC		
Gifts < \$ 100 per quarter	NC	NC		
In-kind income	NC	NC		

Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHP Expansion	Title XXI State-designed SCHP Program	Other SCHP Program*
Program Benefits	NC	NC		
Welfare cash benefits (TANF)				
Supplemental Security Income (SSI) cash benefits	NC	NC		
Social Security cash benefits	C	C		
Housing subsidies	NC	NC		
Foster care cash benefits	NC	NC		
Adoption assistance cash benefits	NC	NC		
Veterans benefits	C	C		
Emergency or disaster relief benefits	NC	NC		
Low income energy assistance payments	NC	NC		
Native American tribal benefits	NC	NC		
Other Types of Income (specify)				

*Except the first \$50.

*Make a separate column for each Aother@ program identified in Section 2.11.

*To add a column to a table, right click on the mouse, select Ainsert@ and choose Acolumn@

3.1.1.5 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 N/A. @

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 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHP Expansion	Title XXI State-designed SCHP Program	Other SCHP Program*
Earnings	\$ 100/working parent/month	\$ 100/working parent/month	\$	\$
Self-employment expenses **	\$ varies	\$ varies	\$	\$
Alimony payments Received	\$ NA	\$ NA	\$	\$
Paid	\$ NA	\$ NA	\$	\$
Child support payments Received	\$ 50/month	\$ 50/month	\$	\$
Paid	\$ amount paid	\$ amount paid	\$	\$
Child care expenses	\$200/month/ Child<12 years	\$200/month/ Child<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.

*Make a separate column for each Aother@ program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select Ainsert@ and choose Acolumn@.

3.1.1.6 For each program do you use an asset or resource test?

Title XIX Poverty-related Groups No Yes
(complete column A in 3.1.1.7)

Title XXI SCHIP Expansion program No Yes
(complete column B in 3.1.1.7)

Title XXI State-Designed SCHIP program No Yes
(complete column C in 3.1.1.7)

Other SCHIP program: _____ No Yes
(complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter ANA.

Table 3.1.1.7			
Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XXI designed S Progra (C)
Countable or allowable level of asset/resource test	\$ NA	\$ NA	\$
Treatment of vehicles: Are one or more vehicles disregarded? Yes or No	NA	NA	
What is the value of the disregard for vehicles?	\$ NA	\$ NA	\$
When the value exceeds the limit, is the child ineligible(AI) or is the excess applied (AA) to the threshold allowable amount for other assets? (Enter I or A)	NA	NA	

*Make a separate column for each Aother program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select Ainsert and choose Acolumn.

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999?

Yes No

3.1.2 How often is eligibility redetermined?

Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Monthly			
Every six months			
Every twelve months	X		
Other (specify)			

*Make a separate column for each Aother@program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select Ainsert@ and choose Acolumn@.

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

Yes ^o Which program(s)? Medicaid SCHIP Expansion
 For how long? 12 months

No

3.1.4 Does the CHIP program provide retroactive eligibility?

Yes ^o Which program(s)? Medicaid SCHIP Expansion
 How many months look-back? 3 months

No

3.1.5 Does the CHIP program have presumptive eligibility?

Yes ^o Which program(s)?
 Which populations?
 Who determines?

No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

Yes ^o Is the joint application used to determine eligibility for other State programs? If yes, specify: No

No

3.1.7 Evaluate the strengths and weaknesses of your eligibility determination process in increasing creditable health coverage among targeted low-income children.

The eligibility process was redesigned to make it simple, accessible and quick. The goal was to eliminate the eligibility determination process as a barrier to health care for children.

This was achieved by:

- A. Designing a short, simple and friendly application form. Instead of the traditional bureaucratic language, South Carolina's application uses sentences like "Tell us who you are and where you live." The application is one page, front and back. It is in fairly large type.
- B. Changing the application process so that the application can be mailed in. No face-to-face interview is required.
- C. Putting the applications where the potential applicants are: schools, doctors' offices, pharmacies, other health care providers, unemployment offices, day care centers, the departments of health and social services, churches and community organizations.

Documentation has been reduced to proof of income which can be copies of pay stubs for the last four weeks, a letter from the employer, or if self employed, the most recent federal income tax form. The application provides guidance regarding how other proof may also be accepted.

A toll free number is provided to give assistance with this or any other sections of the application. The application is easy to use and any lay person can provide assistance if needed. Applicants may also go to any County Department of Social Services for help if they prefer. Assistance may be obtained from many health providers and the local health departments. Eligibility is usually determined within a week of receipt. Eligibility begins at the first of the following calendar month.

The new process was extremely effective. South Carolina enrolled children at twice the rate anticipated and exceeded its goal. The established goal was to enroll 75,000 children. In September 1999, over 113,000 children have been added to Medicaid rolls and new children continue to be enrolled at an average of over 1,500 children per month. Of the 113,000 children that have been added to the rolls, about 57% are eligible under Title XIX and about 43% under Title XXI.

3.1.8 Evaluate the strengths and weaknesses of your eligibility redetermination process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

The state is still in the process of refining the final redetermination process. Again the goal is to make the process simple, quick and family friendly. The process sends a computer notice - or a series of computer notices - to families. Cases are reviewed according to a staggered review schedule. Those most likely to have significant changes are targeted for more frequent review. Examples are families with income near the limit and families with no income.

The system is effective and efficient. The intent is to prevent children from losing health care coverage by streamlining a complicated paper work process.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost-sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose **Aselect@Atable.@** Once the table is highlighted, copy it by selecting **Acopy@** in the Edit menu and then **Apaste@** it under the first table.

Table 3.2.1 CHIP Program Type Medicaid Expansion - the SC Chip program provides all of the services that the Title XIX program provides. All services provided must be medically necessary.

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	X	none	
Emergency hospital services	X	none	
Outpatient hospital services	X	none	
Physician services	X	none	
Clinic services	X	none	
Prescription drugs	X	none	
Over-the-counter medications			
Outpatient laboratory and radiology services	X	none	
Prenatal care	X	none	
Family planning services	X	none	
Inpatient mental health services	X	none	
Outpatient mental health services	X	none	
Inpatient substance abuse treatment services	X	none	
Residential substance abuse treatment services	X	none	

Table 3.2.1 CHIP Program Type Medicaid Expansion - the SC Chip program provides all of the services that the Title XIX program provides. All services provided must be medically necessary.

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Outpatient substance abuse treatment services	X	none	
Durable medical equipment	X	none	
Disposable medical supplies	X	none	
Preventive dental services	X	none	
Restorative dental services	X	none	
Hearing screening	X	none	
Hearing aids	X	none	
Vision screening	X	none	
Corrective lenses (including eyeglasses)	X	none	
Developmental assessment	X	none	
Immunizations	X	none	
Well-baby visits	X	none	
Well-child visits	X	none	
Physical therapy	X	none	

Table 3.2.1 CHIP Program Type Medicaid Expansion - the SC Chip program provides all of the services that the Title XIX program provides. All services provided must be medically necessary.

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Speech therapy	X	none	
Occupational therapy	X	none	
Physical rehabilitation services	X	none	
Pediatric services	X	none	
Chiropractic services	X	none	
Medical transportation	X	none	
Home health services	X	none	
Nursing facility	X	none	
ICF/MR	X	none	
Hospice care	X	none	
Private duty nursing	X	none	
Personal care services	X	none	
Habilitative services			
Case management/Care coordination	X	none	

Table 3.2.1 CHIP Program Type Medicaid Expansion - the SC Chip program provides all of the services that the Title XIX program provides All services provided must be medically necessary.

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
coordination			
Non-emergency transportation	X	none	
Interpreter services			
Other (Specify): <u>Family Support</u>	X	none	
Other (Specify)			
Other (Specify)			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose **Aselect@Atable.@** Once the table is highlighted, copy it by selecting **Acopy@** in the Edit menu and then **Apaste@** it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

The full range of Medicaid services is provided to children under the SCHIP program. Many of the services are designed to meet the particular needs of children to assure proper development. The EPSDT program with all its related services is available. Vision, hearing and dental services are especially important for children, as are immunizations and well child check-ups, which are provided.

South Carolina provides many targeted case management programs for children with special needs, including: mental retardation and related disabilities; severely emotionally disturbed; alcohol and drug abuse; sensory impairments; chronic mental illness; head and spinal cord injuries and related disabilities; and sickle cell disease. Evaluation, counseling and education are available for those with diabetes, developmental issues, and genetic problems.

Several home and community based waivers are in place. These provide special services for children with problems like mental retardation, developmental disabilities, and head and spinal cord injuries.

Family support services are available for those with various medical and/or psychosocial factors which place individuals at serious risk for poor health outcomes. These include such services as assessment/reassessment, reinforcement, counseling, and guidance relative to nutritional, medical informational and psychosocial needs that impact their health. Non-emergency transportation is facilitated.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
A. Comprehensive risk managed care organizations (MCOs)	X		
Statewide?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mandatory enrollment?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of MCOs	One		
B. Primary care case management (PCCM) program			
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)			
D. Indemnity/fee-for-service (specify services that are carved	X		

Table 3.2.3

out to FFS, if applicable)			
E. Other (specify)	The Healthy Options Program and the Physicians Enhanced Program (see section 2.2.3)		
F. Other (specify)			
G. Other (specify)			

*Make a separate column for each other program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select insert and choose a column.

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)

No, skip to section 3.4

Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid	State-designed	Other CHIP
----------------------	----------	----------------	------------

	CHIP Expansion Program	CHIP Program	Program*
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

* Make a separate column for each Aother@ program identified in section 2.1.1. To add a column to a table, right click on the mouse, select Ainsert@ and choose Acolumn@.

** See Table 3.2.1 for detailed information.

3.3.2 If premiums are charged: What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 If premiums are charged: Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

- Employer
- Family
- Absent parent
- Private donations/sponsorship
- Other (specify): _____

- 3.3.4 If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?
- 3.3.5 If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?
- 3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?**
- 3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income?** Check all that apply below and include a narrative providing further details on the approach.
- _____ Shoe-box method (families save records documenting cumulative level of cost sharing)
- _____ Health plan administration (health plans track cumulative level of cost sharing)
- _____ Audit and reconciliation (State performs audit of utilization and cost sharing)
- _____ Other (specify):
- 3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented?** (If more than one CHIP program with cost sharing, specify for each program.)
- 3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?**

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

The primary outreach and education approach SC has used is making the application very simple and friendly, putting the applications where the potential recipients are, and allowing the applications to be mailed in. A toll free telephone number is featured prominently and assistance, including translation services, is available via this number.

For applications that are mailed-in with information missing, staff in the processing unit make several attempts to reach the applicant by phone to obtain what is missing. The applications of those who cannot be reached this way are referred to the local Department of Health and Environmental Control (DHEC) for follow-up.

The most effective place we have used for outreach is the public school system. Each year about a million applications have been sent to schools so that an application can be sent home by the school with each child. Principals are made aware that the local Departments of Health and Environmental Control (DHEC) are available to come into their schools to assist in special events, make presentations, or help in whatever way is desired to distribute applications and get them completed.

South Carolina has not conducted major media campaigns, but 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 some assist in completing the application.

The following is a summary of outreach initiatives grouped by type:

Outreach

Faith-Based Outreach

Leaders of the largest predominately black denomination, the *Baptist Educational and Missionary Convention* and the *African Methodist Episcopal Church*, are working to inform members of Partners for Healthy Children (PHC). They are sharing information during Sunday announcements and are asking lay persons to distribute applications to members as they leave the service. The Department of Health and Human Services (DHHS) is invited to share information at state-wide conferences and youth related events as well. Other denominations sharing PHC information include *Lutheran, Baptist, United Methodist, and Presbyterian*.

Schools

PHC applications are distributed by every school in the state. Each child enrolled receives an application to take home. Some of the schools include the application with their *AVIP®* (very important papers) folders, which require the parents to sign a statement indicating they have reviewed the materials. Other schools are incorporating the application into the curriculum. Adolescent students were given the assignment to fill out the application. In turn, they were given an extra-credit grade for doing so. Still other school districts have offered cash incentives to students and parents for completing the application.

Professional Associations Affiliated with Schools

- *School Nurses Association* - Articles regarding PHC have appeared in the School Nurses Association's newsletter and information has been shared during their annual meeting.

- C *Athletic Director's Association* - A letter from the director of the association endorsing PHC was sent along with a packet of applications to every Athletic Director in the state.

Pharmacies

The *Pharmacy Association* works closely with DHHS to inform the public about PHC. Articles about PHC are featured in the Association's journal and newsletters. Several locally owned pharmacies, as well as chain pharmacies display information and applications about PHC. The *South Carolina Association of Chain Drug Stores* is also a major partner. The largest participating chain pharmacies include:

Walmart
Eckerd

Kmart
Kroger

CVS

Physicians/Dentists

Applications have been provided to every primary care physician/dentist participating in Medicaid. As new physicians/dentists begin participating, DHHS staff offers training to their staff on PHC. Physicians/Dentists display information in offices and distribute applications to patients.

- C *Dr. Bostick* (dentist in Jasper county)- Includes applications in his billings.

To further promote the Partners for Healthy Children program, several of the professional affiliations have partnered with DHHS. These include:

- C *The American Academy of Family Physicians* - The Academy invited DHHS to share information about PHC with its members at the annual conference.
- C *The American Academy of Pediatrics* - Applications have been distributed to active members during their annual conference.

Government Agencies

DHHS has joined forces with other state agencies to take advantage of a similar audience. These agencies include:

- C *Employment Security Commission (ESC)* - Applications are distributed at all ESC sites in the state.
- C *Department of Alcohol and Other Drug Abuse Substances (DAODAS)* - Presentations are made to the BRIDGE program, which is geared toward adolescents involved with the juvenile justice system who have challenges with alcohol and/or drugs.
- C *South Carolina Council Against Violence and Sexual Assault (SCCAVSA)* - Applications are distributed at domestic violence centers throughout the state.
- C *South Carolina Legal Services* - Applications are shared with clients at all legal offices in the state.
- C *Department of Parks, Recreation, and Tourism (PRT)* - PRT distributes applications to all of the community parks and community centers in South Carolina. Applications are

- shared with families who frequent the parks and centers.
- C *Division on Aging* - Staff carry applications with them during home visits and share with families with small children.

 - C *Community Long Term Care (CLTC)* - Workers carry applications with them when they visit clients.
 - C *Department of Disability and Special Needs (DDSN)* - Applications are shared during home visits.
 - C *Department of Health and Environmental Control (DHEC)* - DHEC actively supports the PHC initiative. Health Districts throughout the state are working with DHHS to reach potentially eligible children. DHEC distributes applications at Health Departments, health fairs, schools, child care facilities, and faith-based activities, other community events. Staff also distribute information at other unconventional locations such as Laundromats, grocery stores, and nail and hair salons.
 - C *Caring for Tomorrow's Children (CFTC)* - CFTC distributes applications with monthly mailings.
 - C *Careline* - An initiative of DHEC, distributes applications with the My Baby Keepsake Book. Applications are also mailed to callers.
 - C *Department of Social Services (DSS)* - Partners for Healthy Children information is shared with families seeking information about various programs, including WIC, TANF, et al. Outstationed workers work in health departments and

clinics across the state and assist families with the application.

Non-Profit/Community Organizations

- C *Family Connection* - The organization has partnered with DHHS to outreach to families in the Greenville area. Volunteers share applications with businesses, child care facilities, grocery stores, etc.
- C *Growing into Life* - This healthy community organization works with families in the Aiken county area and shares information about PHC.
- C *Hope for Kids* - This organization has incorporated PHC into their existing outreach throughout the state.
- C *March of Dimes* - Lowcountry March of Dimes shares PHC information with the migrant population as well as during health fairs and other community events.
- C *Commun-I-Care* - Includes applications in monthly mailings to clients.
- C *Adult Literacy Council*- Literacy centers throughout the state share applications with clients.
- C *Food Pantries* - Applications are available at all food pantries in the state.
- C *Habitat for Humanity*- Applications are given to families who apply to participate in the habitat program.

- C *Cumbee Center to Assist Abused Persons-* Display posters with the toll-free number.
- C *Salvation Army-* Posters are displayed and applications are available.
- C *The Sickle Cell Foundation-* Applications are shared with families affiliated with their organization.
- C *South Carolina Fair Share-* The organization shares applications during door-to-door campaigns across the state.
- C *Interfaith Community-* Applications were included in packets of information sent to potentially eligible families.
- C *Anderson Sunshine House-* Volunteers share applications with homeless families in Anderson county.
- C *Anderson Interfaith Ministries-* Volunteers and staff are integrating PHC into existing outreach.
- C *Boys & Girls Clubs of York County-* Share applications with families.
- C *South Carolina Appleseed Legal Justice Center-* Applications are shared with their clients.

Rural Health

- C *Healthy Start (Lowcountry, Pee Dee, Richland) -* Staff members share information with clients and physicians on site and through community activities

Spanish Speaking Outreach

- C *Lowcountry March of Dimes-* Shares information about PHC with migrant

workers and their families. Assists in completing applications.

C *Migrant Task Forces*- Located throughout the state, these organizations share applications with migrant workers.

C *Greenwood United Ministries*- Volunteers Physicians and staff share applications with families at the Thursday night clinics.

C *Hispanic Festival* hosted by St. Francis by the Sea Catholic Church- Applications were distributed.

C Applications are available in several Mexican restaurants in the state.

C Contact has been made with the Latino newspaper and an article is being prepared.

Korean Outreach

C *Family Service Center*- In the process of publishing a newsletter for the Korean population and plan to include information about PHC. Assists Korean applicants with completing the application. Working with DHHS to translate marketing materials into Korean.

Child Care

C Applications have been mailed to all licensed child care facilities in the state. Posters and applications are

displayed at each center.

- C Applications have been mailed to all persons participating in the ABC Voucher System.

Hospitals

- C A public-private partnership was established at the inception of PHC between the Governor's office and the *South Carolina Children's Hospital Collaboration*.
- C Applications are displayed and distributed in emergency rooms and by personnel at the hospitals in the state.

Housing Authorities

- C Applications are distributed by volunteers and staff at public housing sites in the state.
- C Posters and on site informational sessions are held at participating sites.

Health Clinics

- C *Free Health Clinics* - Applications are distributed to patients seeking services.
- C *South Carolina Primary Care Association* - Federally Qualified Health Centers (FQHC) distribute applications to clients. The toll-free number is posted for clients to see.
- C *Family Health Centers, Inc - Orangeburg* - Applications were direct mailed to families with children under 19 who did not have health insurance and sought health care at the Orangeburg site in 1997.

Miscellaneous

- C *Black Family Summit*- DHHS maintained a booth and shared information with participants. PHC information was also included in registration packets.
- C *Select Health*- PHC applications are available during health fairs and other community events of this Medicaid HMO.
- C *Back to School Bash*- A booth was maintained and applications were distributed. A commercial also ran on television to promote PHC.
- C Applications are available in less conventional locations such as *beauty salons, Laundromats, gas stations, grocery stores, restaurants, convenience stores, libraries, and financial loan offices.*
- C *Parish Nurses*- Share applications during visits.
- C *State Fair*- A booth was maintained and applications were distributed. Personnel was available to assist applicants with completing the application.
- C *Emergency Medical Services*- EMS units have applications available in the Lowcountry area and include them with their billing.
- C *Youth Net*- Information and applications were distributed.
- C *The Healthy Communities group in*

Jasper County- Developing a Help Book, which will be mailed to every resident in the county. A copy of the application and an informational sheet will be included in the book.

- C *Relay for Life- Applications* were distributed in Ridgeland and Hardeeville.

Private Employers

- C *Family Connection volunteers* share information with employers in the Greenville area.
- C *Chamber of Commerce- Contact* is being made with the Chamber to inform businesses about PHC.

Media Coverage

- C *WIS TV -Ran a commercial* for 3 months (August - October).
- C *WHBP -Radio station* featured staff to discuss PHC.
- C *Gullah Sentinel - An article* is planned for future publications.

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Billboards						
Brochures/flyers	The simplicity of the application and wide distribution has served the dual purpose of brochure and application	5				
Direct mail by State/enrollment broker/administrative contractor	X Applications were mailed to clients of some Federally Qualified	2				

	Health Centers and ABC child care voucher recipients					
Education sessions						
Home visits by State/enrollment broker/administrative contractor	X	5				
Hotline	X	4				
Incentives for education/outreach staff						
Incentives for enrollees	X Some school districts have provided a financial incentive for each child who returns a completed application	3 This was very effective where it was used, but only a few school districts did this				
Incentives for insurance agents						

State/broker initiated phone calls						
Other (specify): <u>School based mass mailing</u>	X	5				
Other (specify): <u>DHEC follow-up on incomplete applications</u>	X	5				

*Make a separate column for each other program identified in section 2.1.1. To add a column to a table, right click on the mouse, select Insert and choose a column.

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (T=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events	X	3				
Beneficiary's home	X	4				
Day care centers	X	2				
Faith communities	X	3				
Fast food restaurants	X	3				
Grocery stores	X	3				
Homeless shelters						
Job training centers	X	3				
Laundromats	X	3				
Libraries	X	3				
Local/community health centers	X	3				
Point of service/provider locations	X	4				

Table 3.4.2						
Public meetings/health fairs	X	3				
Public housing	X	2				
Refugee resettlement programs						
Schools/adult education sites	X/ NA	5				
Senior centers						
Social service agency	X	4				
Workplace						
Other (specify) <u>Public health agency</u>	X	4				
Other (specify)						

*Make a separate column for each other program identified in section 2.1.1. To add a column to a table, right click on the mouse, select Insert and choose Column.

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Currently, the application form asks where the applicant got the form. Previously color coded applications were used to identify the target distribution of the form, but as the number of efforts increased, this became too cumbersome. At the central processing (or mail-in) unit, applications are tracked according to the outreach code in question 8. Periodically, an analysis report is printed to show the number of applications generated from various outreach activities. A copy of this report is attached. [Exhibit 1]

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

DHHS has continued to utilize the philosophy of ~~A~~meeting families where they live[@]. In general, when trying to reach ethnic populations, the agency has sought out existing organizations that were established in specific areas of the state and who were trusted by the ethnic residents. However, all outreach activities conducted by DHHS were designed to reach all potentially eligible children, regardless of ethnicity or race.

Historically the Spanish-speaking population has not had a large presence in South Carolina until recently, but estimates indicate that the growth of this population will be six times that of other populations in the next several years. A Spanish version of the application form has been developed and distributed. DHHS has worked with task force groups across the state and shared information about PHC. These groups have then disseminated applications and some have even assisted in completion of the forms. One of the Covering Kids sites is focusing specifically on the Spanish speaking population and this population is one of several being targeted at another Covering Kids site.

Applications and assistance were provided directly to South Carolina's only Native American community - the Catawba reservation. The Family Service Center at United Way worked with us to translate materials into Korean and do outreach to this small population in Columbia. They also assist families in completing the application forms.

The faith community has been used effectively to reach the African-American population. Various predominantly African-American denominations are working with the agency to distribute information about PHC. Outreach activities have included speaking to women's groups and ministerial associations, distribution of applications after services, health fairs, and display booths.

The toll free phone line has some staff bilingual in Spanish. For other languages, there are interpreters available, through a service of the phone company, for non-English speaking callers.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

See 3.4.1 and 3.4.2. The school system has been universally effective in reaching all populations. An organization called Family Connection has been particularly effective in reaching families of children with special needs.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

The Medicaid program coordinates with and provides referrals for such programs as the WIC program. Department of Health and Environmental Control (DHEC) family planning workers carry applications with them to distribute to their clients. The Free and Reduced School Lunch Program in many schools chose to help get the word out about PHC in 1999. DSS, the agency administering Food Stamps also identified children on Food Stamps but not enrolled in Medicaid and sent PHC applications to those households. Coordination with Family Connection assists children with special needs. All health or human services state agencies have a supply of applications and have received orientation training in the CHIP program.

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5					
Type of Coordination	*** School Lunch	Maternal and child health	Family Connections**	Other (specify) Food Stamps	WIC
Administration		X DHHS provides funding for outreach and special services through a contractual arrangement		X DSS identified Food Stamp households with children not enrolled in Medicaid and mailed PHC applications to over 15,000.	X There is an MOA to make certain WIC clients are referred for Medicaid Eligibility
Outreach	X ***	X	X **	X	X
Eligibility determination				X DSS is adding questions to Family Independence and Food Stamp applications to allow Medicaid determinations.	
Service delivery		X DHEC clinics are enrolled Medicaid providers			
Procurement					
Contracting					
Data collection					
Quality assurance					
Other (specify)					
Other (specify)					

***In 1998, the school lunch programs in many districts included permission to share information with SCHIP sections on their applications, or included a section where parents could request information about SCHIP. DHHS screened the names submitted by the school lunch programs for existing Medicaid enrollment and mailed over 3,800 applications to those who indicated interest and were not enrolled. A little over sixty of those applications had been mailed to the central processing unit by March 2000.

**Family Connections is a program that provides support to families with children with special needs. There is a Medicaid Outreach contract with Family Connections and the Department of Health and Environmental Control.

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

Eligibility determination process:

Waiting period without health insurance (specify):

Information on current or previous health insurance gathered on application (specify):

The application asks for information on any health insurance the family already has.

Information verified with employer (specify):

Regular medicaid third party liability (tpl) procedures apply.

Records match (specify):

Regular Medicaid third party liability (tpl) procedures apply.

Other (specify): All regular Medicaid tpl procedures apply.

Other (specify):

Benefit package design:

_____ Benefit limits (specify):

_____ Cost-sharing (specify):

_____ Other (specify):

_____ Other (specify):

_____ Other policies intended to avoid crowd out (e.g., insurance reform):

_____ Other (specify):

_____ Other (specify):

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

If a family has any health insurance at the time of application, the children are eligible under Title XIX, not Title XXI. South Carolina does not want to encourage families to drop any existing coverage as a requirement to be eligible for the more comprehensive services available under Medicaid. As of the end of FFY 1999 - 4,845 children who would have been SCHIP eligible but had insurance were in the category of expansion children-regular match. (Source: internal calculations)

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table, go to Edit menu and chose **Aselect**,

Atable. Once the table is highlighted, copy it by selecting **Acopy** in the Edit menu then **Apaste** it under the first table.

Characteristics	Number of Children Ever Enrolled		Average Number of Months of Enrollment		Number of Disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	43,074	56,819	8	9	2,062	4,886
Age						
Under 1	0	0	0	0	0	0
1-5	3,397	4,630	8	9	189	730
6-12	14,510	19,628	9	10	785	1,663

Table 4.1.1 CHIP Program Type Medicaid Expansion

Characteristics	Number of Children Ever Enrolled		Average Number of Months of Enrollment		Number of Disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
13-18	25,167	32,561	8	9	1,088	2,493
Countable Income Level*						
At or below 150% FPL	43,074	56,819	8	9	2,062	4,886
Above 150% FPL	0	0	0	0	0	0
Age and Income						
Under 1	0	0	0	0	0	0
At or below 150% FPL	0	0	0	0	0	0
Above 150% FPL	0	0	0	0	0	0
1-5	3,397	4,630	8	9	189	730
At or below 150% FPL	3,397	4,630	8	9	189	730
Above 150% FPL	0	0	0	0	0	0
6-12	14,510	19,628	9	10	785	1,663
At or below 150% FPL	14,510	19,628	9	10	785	1,663

Table 4.1.1 CHIP Program Type Medicaid Expansion

Characteristics	Number of Children Ever Enrolled		Average Number of Months of Enrollment		Number of Disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Above 150% FPL	0	0	0	0	0	0
13-18	25,167	32,561	8	9	1,088	2,493
At or below 150% FPL	25,167	32,561	8	9	1,088	2,493
Above 150% FPL	0	0	0	0	0	0
Type of plan						
Fee-for-service	41,804	54,758	8	9	2,021	4,689
Managed care	1,270	2,061	7	9	41	197
PCCM	0	0	0	0	0	0

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

****Due to South Carolina=s early start regarding enrollment and to retroactive eligibility, there were 15,327 children enrolled in September 1997. These children were not counted as new enrollees on the HCFA 64 because technically they were enrolled before the official SCHIP start date of October 1, 1997.**

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

In FFY 1998, there were 43,074 children ever enrolled in South Carolina=s SCHIP and 2,062 disenrollees for a net enrollment of 41,012. The next year there were 56,819 ever enrolled, 4,886 disenrollees and 51,933 net enrollments. During both years children from the oldest age group enrolled at the highest rate, perhaps because our regular Medicaid coverage for them was at a lower poverty level.

Since our eligibility level was set at 150% of poverty, all of our enrollees were at or below 150% of FPL. In FFY 1998, 97% of enrollees were in a fee-for-service plan. Enrollment in Managed Care Plans increased from 3% in 1998 to 4% in 1999.

The average number of months of enrollment was eight for most age and type of plan groups in 1998. Children aged six through twelve had an average of nine months and managed care enrollees averaged seven months in 1998. Average months of enrollment increased to nine for most groups in 1999 but ten for those aged six through twelve.

Disenrollments increased from 2,062 in 1998 to 4,886 in 1999. Rates hovered around 4 to 5% for most groups in 1998. In 1999, however, it increased to 7 or 8% for all but the children aged one through five, whose rate was about 15%.

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

There were no SCHIP enrollees who had health insurance coverage; any SCHIP eligible applicants with health insurance were enrolled in Title XIX at the regular Medicaid match rate. For September 1999, there were 4,845 children who would have been SCHIP eligible but had insurance and were in the category of expansion children-regular match.(Source: internal calculations)

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

There are no other public or private programs organized to increase availability of health insurance for children in South Carolina. The SCHA (South Carolina Health Alliance) has received an RWJ Covering Kids grant, but outreach really did not start until FFY 2000.

4.2 Who disenrolled from your CHIP program and why?

South Carolina has continuous eligibility for a twelve month period: therefore, disenrollment separate from not re-enrolling at renewal for either Medicaid or SCHIP is not a significant issue.

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss

disenrollment rates presented in Table 4.1.1 Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

South Carolina has continuous eligibility for a twelve month period, therefore, disenrollment separate from not re-enrolling at renewal for either Medicaid or SCHIP is not an issue. In FFY 1998 there were 2,062 disenrollees out of 43,074 children ever enrolled, a disenrollment rate of 4.8%. The disenrollment rate increased to 8.6% in FFY 1999 when 4,886 of the 56,819 children ever enrolled disenrolled. Regular Medicaid experienced disenrollment rates of 13.4% and 11.1% for FFYs 1998 and 1999 respectively.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

South Carolina has no data regarding whether children who did not re-enroll got other coverage.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

South Carolina does not have a system in place to track reasons for discontinuation of coverage. We plan to set up a system in July based on a combination of reports on case closures/disenrollments from DSS and surveys of client samples drawn from the DSS reports.

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	6,948	7%				
Access to commercial insurance						
Eligible for Medicaid						
Income too high						
Aged out of program						
Moved/died						
Nonpayment of premium	N/A	0				
Incomplete documentation						
Did not reply/unable to contact						
Other (specify)						
Other (specify)						

Don't know	6.948	7%				
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*Make a separate column for each Aother@program identified in section 2.1.1. To add a column to a table, right click on the mouse, select Ainsert@and choose Acolumn@.

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

When it was discovered that too many children were being dropped from eligibility when they turned one (1) year old, DHHS and DSS cooperated to change policy and communications with clients. DHHS also included follow-up for those not responding to DSS in the DHEC contract for outreach. DHHS, DSS and Covering Kids are working together to simplify and make the redetermination process more user friendly.®

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 33,193,232 (includes 1,346,470 under 10% cap)

FFY 1999 54,767,379 (includes 1,575,266 under 10% cap)

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type Medicaid Expansion

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	31,846,762	53,192,113	25,209,902	41,963,260
Premiums for private health insurance (net of cost-sharing offsets)*	120,855	230,162	95,670	181,574
Fee-for-service expenditures (subtotal)	31,725,907	52,962,951	25,114,232	41,781,686
Inpatient hospital services	4,238,507	6,850,869	3,355,202	5,404,651
Inpatient mental health facility services	5,367,907	7,085,756	4,249,235	5,589,954
Nursing care services	0	0	0	0
Physician and surgical services	3,398,729	6,760,460	2,690,435	5,333,326
Outpatient hospital services	1,847,950	3,417,170	1,462,837	2,695,806
Outpatient mental health facility services	516	0	408	0
Prescribed drugs	2,192,299	5,628,112	1,735,425	4,440,017
Dental services	2,251,893	2,951,950	1,782,599	2,328,793
Vision services	81,860	121,790	64,800	96,080
Other practitioners= services	444,374	707,952	351,767	558,504
Clinic services	3,225,816	5,974,234	2,553,556	4,713,074
Therapy and rehabilitation services	16,169	40,917	12,800	32,280
Laboratory and				

Table 4.3.1 CHIP Program Type Medicaid Expansion

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
radiological services	335,607	752,185	265,666	593,399
Durable and disposable medical equipment	182,537	313,950	144,496	247,676
Family planning	0	0	0	0
Abortions	0	0	0	0
Screening services	325,202	352,757	257,430	278,290
Home health	68,915	132,309	54,554	104,379
Home and community-based services	19,564	83,843	15,487	66,144
Hospice	0	0	0	0
Medical transportation	111,932	168,581	88,606	132,994
Case management	2,294,047	2,772,096	1,815,968	2,186,906
Other services	5,322,083	8,847,020	4,212,961	6,979,413

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Administrative support for the CHIP program. Expenditures included directly charged personnel costs and associated supply, travel and contractual expenses. SCDHHS indirect cost was charged as well.

What role did the 10 percent cap have in program design?

Insignificant, as a Medicaid expansion, many of the program support roles were already staffed or could be redirected.

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share	1,346,470	1,575,266				
Outreach	0	0				
Administration	1,346,470	1,575,266				
Other	0	0				
Federal share	1,065,866	1,241,783				
Outreach						
Administration	1,065,866	1,241,783				
Other						

*Make a separate column for each other program identified in section 2.1.1. To add a column to a table, right click on the mouse, select insert and choose column.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section (b)(1)(B)(vii))

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

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify >MCO.= If an approach is used in fee-for-service, specify >FFS.= If an approach is used in a Primary Care Case Management program, specify >PCCM.=

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Appointment audits			
PCP/enrollee ratios			
Time/distance standards			
Urgent/routine care access standards			
Network capacity reviews (rural providers, safety net providers, specialty mix)			
Complaint/grievance/disenrollment reviews			
Case file reviews			
Beneficiary surveys	X-- FFS: See discussion in section 4.3 below.		
Utilization analysis (emergency room use, preventive care use)	X-- FFS: See Strategic Objectives/Perf. Goals		
Other (specify) : Carolina Medical Review does annual review which includes all listed areas.	X--MCO		
Other (specify)			
Other (specify)			

*Make a separate column for each Aother@program identified in section 2.1.1. To add a column to a table, right click on the mouse, select Ainsert@ and choose Acolumn@.

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Requiring submission of raw encounter data by health plans	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requiring submission of aggregate HEDIS data by health plans	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Make a separate column for each Aother@program identified in section 2.1.1. To add a column to a table, right click on the mouse, select Ainsert@ and choose Acolumn@.

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Much of the information available on access comes from a 1999 survey of PHC enrollees and parents of students in schools, selected because of their high percentage of students eligible for free and reduced school lunch programs. This survey was conducted by the Partnership for Community and Organizational Services of the University Specialty Clinics-Social Work, within the University of South Carolina. Questions addressed barriers to enrollment in PHC, as well as barriers to accessing health services.

Enrollment Barriers: Stigma and perceived quality of care in Medicaid

When asked to respond to the statement that AMedicaid is only for the poor@, 20% of Medicaid recipients, 15% of privately insured, and 23% of the uninsured agreed. About half of Medicaid recipients and the uninsured agreed that AMedicaid clients receive the same quality of care as private pay clients.@, while only 44% of those privately insured agreed. Likewise, 76% of Medicaid clients and 73% of the uninsured agreed that AMedicaid clients are treated with respect.@ Among the privately insured, only 55% agreed. About one quarter of Medicaid clients felt that

there were constraints on their choices about their child's care in Medicaid. A higher portion of privately insured respondents perceived constraints (35%), while the uninsured fell in between, at 29%. Government interference through Medicaid was feared by about 20% of Medicaid clients, 34% of the uninsured and 49% of the privately insured. In spite of these perceived disincentives, over 90% of respondents said they would be willing to sign up to get Medicaid if they could not afford health care.

Access Barriers:

Fifteen percent of the privately insured reported some difficulty in accessing medical care for their children in the past year. Twenty-one percent of Medicaid clients and 44% of the uninsured also reported difficulty. Cost was a barrier to 27% of the uninsured. Those with Medicaid and private insurance reported similar cost barriers for prescription medicines (5%), and mental health care (2% and 0%). Medicaid clients, however, reported cost barriers to dental services less than the privately insured--8% versus 13%. Among Medicaid clients, 5% reported difficulty in getting an appointment soon enough, compared to 2% of the privately insured. Nine percent of Medicaid clients reported having to wait too long in the doctor's office, while only 2% of others reported that experience. Transportation was cited as a barrier by 7% of Medicaid clients, 8% of the uninsured and 4% of the privately insured. The most significant barrier reported was getting time off from work. More than 27% of the uninsured, 20% of Medicaid clients and 18% of the privately insured cited this as a barrier. Difficulty finding child care was reported by 17% of all three groups.

Medical Homes:

Ninety-seven percent of Medicaid clients reported their child had a regular place to go for sick care, compared to 96% of privately insured and 93% of the uninsured. Those with private insurance (81%) were more likely to use the doctor's office than Medicaid clients or the uninsured (both 62%). Nineteen percent of Medicaid clients said they used a clinic and 11% the emergency room. Ninety-six percent of both privately insured and Medicaid clients had a regular place to go for preventive care, but only 77% of the uninsured did. Among the privately insured, 75% used the doctor's office, while only 55% of Medicaid and the uninsured used this source. Twenty-five percent of Medicaid clients and 11% of privately insured said they used the health department for preventive care. Use of clinics by Medicaid and the uninsured was about the same, at 16-17%.

Distance/ Visits/ Wait Time/ Referrals:

All Medicaid respondents reported a healthcare facility within 30 minutes of their home. Forty-six percent said their healthcare provider had weekend hours. Half reported it was not difficult and another 32% ~~A~~not too difficult@to contact their healthcare provider over the phone. Eighty-eight percent reported their child had gone to the doctor's office, clinic, or healthcare provider (other than the emergency room) during the year, with the median number of visits being three and the mean being five. The average wait time reported was 20 minutes. Over 60% reported their child had no need for a referral to a specialist during the year. Of those who thought their child did need a referral, 93% reported no problem in obtaining one.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

There are tentative plans for another sample survey of parents of PHC children in 2001.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify >MCO.= If an approach is used in fee-for-service, specify >FFS.= If an approach is used in primary care case management, specify >PCCM=

Table 4.5.1			
Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)			
Client satisfaction surveys	X FFS & MCO		
Complaint/grievance/disenrollment reviews	X FFS & MCO		
Sentinel event reviews			
Plan site visits	X MCO		
Case file reviews	X MCO		
Independent peer review	X MCO		
HEDIS performance measurement	X (MCO only)		
Other performance measurement (specify)			
Other (specify)			
Other (specify)			
Other (specify)			

*Make a separate column for each other program identified in section 2.1.1. To add a column to a table, right click on the mouse, select insert and choose a column.

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

AA 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, indicates 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 ten. 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 had 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. Please see the attached report for more details.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

There are tentative plans to conduct another survey of parents of recipients in 2001. The possibility of case file reviews for a sample population of children regarding immunizations is being explored.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program=s performance. Please list attachments here.

Attachment: A Utilization Focused Evaluation of the Childrens Health Insurance Program (CHIP) of the State of South Carolina Under Title XXI of the Social Security Act, Prepared for the South Carolina Department of Health and Human Services by Margaret D. Hopkins, BS, MSW, University Specialty Clinics - Social Work, Reginald Gladney, BA, MPA, Ph.D. Candidate, University Specialty Clinics - Social Work, William K Hallman, Ph.D, Department of Human Ecology, Rutgers University, and Betinna Friese, BA, University Specialty Clinics - Social Work, The Partnership for Community and Organizational Services of the University Specialty Clinics - Social Work, University of South Carolina College of Social Work, Frank B. Baymeon, III, DSW, Director, George W. Appenzeller, MSW, Administrator, 1300 Sumter Street, Columbia, SC 29201, September 1999.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your Abest practices? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter >NA= for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

The streamlined eligibility and enrollment process has been even more successful than we anticipated. South Carolina's use of a simplified FRIENDLY application form that can be mailed in is one of its best practices. The number of children enrolled (which far exceeds the original goal) and the low error rate (less than one percent) are strong indicators of the success of this effort. The redetermination process is still being refined. The children who lose eligibility at the time of redetermination will need to be examined. If children who can still qualify are lost because of the process, changes to this component will need to be made.

5.1.2 Outreach

South Carolina used a simple and cost effective approach to outreach. The simple mail-in application served as the key. Applications were made available through the public school system, health providers, churches, day care centers and community organizations. By far the most effective method was distribution of an application to every child in the public school system in a take home packet. This system was so successful, it really eliminated the need for more formal public information campaigns and for paid advertizing. Measures of effectiveness are the cost to the state per application received. This cost is little more than the cost of printing the application itself.

5.1.3 Benefit Structure

South Carolina's program is a Medicaid expansion. The advantage of this was using a structure already in place, and provision of the most comprehensive set of services. Indicators of the effectiveness of this approach are whether services the children need are covered and whether the children have access to a provider to obtain needed services.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap): N/A

5.1.5 Delivery System

South Carolina's Title XXI program is a Medicaid expansion. There were several advantages to this. The system was already in place; therefore, services were already defined, providers were already enrolled and familiar with the program, and a payment system was already functioning. Further, by using a Medicaid system, South Carolina could use the same outreach and enrollment measures to reach children who were eligible for Medicaid (Title XIX), but who were not enrolled. To date, South Carolina has actually enrolled more children under Title XIX than Title XXI through its eligibility and outreach efforts. Families do not need to know the difference in the eligibility rules and do not have to determine with which of two or more programs they should file an application .

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

South Carolina does not believe that children should be denied the comprehensive coverage offered by the Medicaid program because the family may have some private insurance. We also do not believe it is in the best interest of the state to create an incentive for families to drop existing coverage in order to qualify for Medicaid. If it is a requirement for families to have no private insurance for their children in order to qualify for support, we believe that most families will drop private coverage. South Carolina's approach has been to enroll any child with existing insurance under Title XIX rather than Title XXI and then to aggressively pursue TPL recoveries in these cases. We disagree that crowd out should be an issue. All families with the same income should have access to the same public support for health care for their children.

5.1.7 Evaluation and Monitoring (including data reporting)

One of the difficulties encountered is the constant state of change of the Medicaid program specifically and the health care field in general. This has always made it a special challenge to design an approach for evaluation and monitoring based on information that should be comparable over a period of time. The state of constant change makes comparisons across time periods less than pure, since changes reflected by data may be attributed to outside factors rather than the impact of the program being evaluated.

5.1.8 Other (specify):

5.2 What plans does your State have for improving the availability of health insurance health care for children? (Section 2108(b)(1)(F))

South Carolina would like to be able to raise the income limit for eligibility; however, the enhanced funding may be exhausted covering families up to 150% of poverty. South Carolina does not have the additional resources to provide a higher level of coverage without the availability of the enhanced match.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

We believe states should be able to earn enhanced match for all children covered up to 200% of poverty without the amount being capped. South Carolina would like to see the crowd out requirements removed. We believe such requirements have the reverse effect of that intended. Families drop existing coverage in order to be eligible for the Title XXI and third party resources are lost. We also believe that even if it worked the way it was intended, it is discriminatory against families that have struggled to provide health care coverage. These are the very families that should be rewarded. If a crowd out policy is required, it would make more sense for it to require that any family that has had other insurance within a period before applying for XXI coverage, must retain that coverage as long as it is available to them. Perhaps there could be no crowd out provision for families with incomes below 150% of poverty, and whatever combination of premiums, co-payments and deductibles could be waived if other insurance coverage is retained for those with higher incomes.