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State of South Carolina

Department of Health and Human Services

James H. Hodges
Governor

J. Samuel Griswold, PH.D.
Director

October 19, 1999

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Budget & Control Board
OFFICE OF STATE BUDGET

Mr. R. Lester Boles, Jr.
Director
Office of State Budget
1122 Lady Street, 12th Floor
Columbia, South Carolina 29201

Dear Mr. Boles:

Enclosed is the FY 1998-99 Accountability Report for the Department of Health and Human Services. It has been prepared in accordance with guidelines and instructions provided in your letter of August 13, 1999.

The process used to prepare the FY 1998-99 Accountability Report involved staff at all levels. A committee of key agency staff was convened to disseminate the information to all program areas. The components for updating and renewal of the Accountability Report were submitted by committee members from each area. The report is a compilation of the work of all program and administrative areas within the agency.

The Leadership System describes how the Agency's senior leaders guide the agency in setting directions and in developing effective leadership throughout the organization. Customer Focus and Satisfaction addresses how the Agency determines requirements, expectations, and preferences of its customers. Programs are listed in an order that will give the reader the ability to distinguish the critical programs, functions, and services in relation to the Agency's Mission Statement.

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Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2504 • Fax (803) 898-4515

If you have any questions regarding the report, please contact Roy Payton, at 898-2512 or by email at Payton@dhhs.state.sc.us.

Sincerely,

Sam Griswold

J. Samuel Griswold, Ph.D.
Director

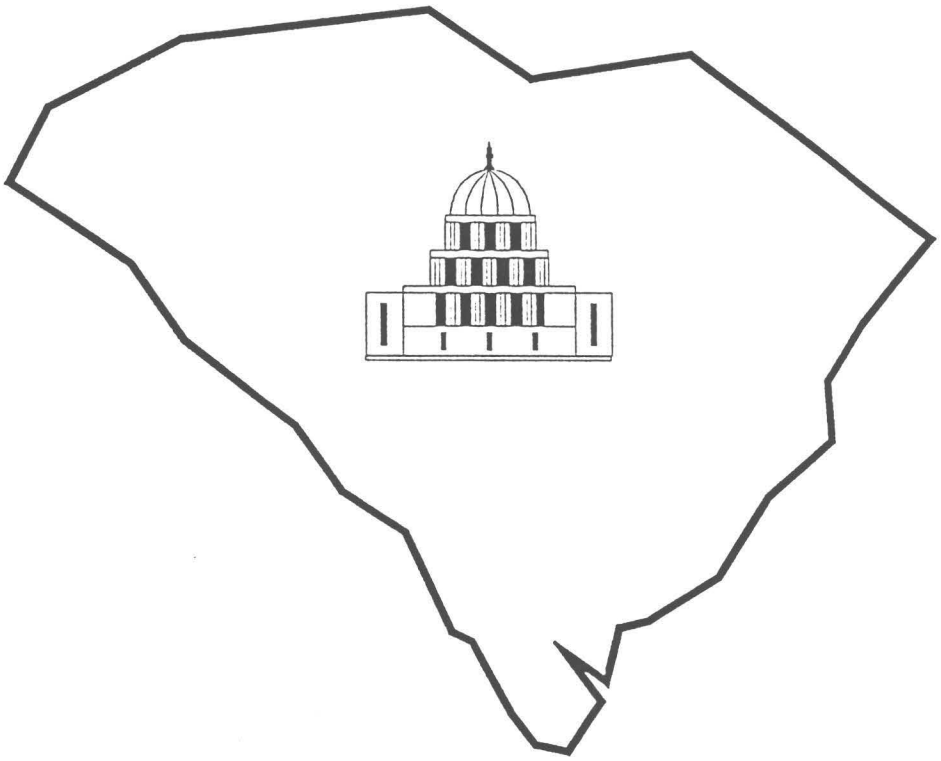
JSG/bpnp

Enclosures

STATE OF SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FY 1998-1999 ACCOUNTABILITY REPORT



James H. Hodges, Governor

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I. EXECUTIVE SUMMARY

The FY 1998-99 Accountability Report for the Department of Health and Human Services (DHHS) is divided into five sections: Executive Summary; Mission Statement; Leadership System; Customer Focus and Satisfaction; and the Description of Programs. The Description of Programs section is broken down into five parts, and contains by program area, rank, cost, goals, objectives and key indicators. Each part deals with one of the five programs administered by the Department of Health and Human Services: Part 1 discusses the Medicaid program; Part 2 discusses the Child Care and Development Program; Part 3 discusses the Social Services Block Grant program; Part 4 discusses Senior and Long Term Care Services; and Part 5 discusses the Optional State Supplementation Program.

Part 1 describes the health activities within the Medicaid program. During FY 1998-99, 648,581 South Carolinians received health services provided by South Carolina's medical community. The elderly made up 28.04% of these clients and utilized Medicaid health services valued at $1,431,709,047 or 70.43% of Medicaid expenditures for a unit cost of $6,438. Of the remaining Medicaid clients 71.96% were women and children, who received health care valued at $601,002,955. That was 29.57% of Medicaid expenditures, with women and children recording a unit cost of $1,053.

Payments to providers for services fell into several major categories. The largest recipient was the category of state agencies, which received 27.98% of payments, followed by the hospital industry (20.88%), nursing homes (14.60%), pharmaceutical (10.08%), physicians (6.73%), and Community Long Term Care (3.30%). See Schedule A for increase of Physician, Pharmacy and Hospital costs for FY 1995-96 thru FY 1999-2000 (estimated).

In 1997, South Carolina expanded its Medicaid program to include children through the age of 18 who were living in families earning 150% of the federal poverty level (FPL). This expansion was made possible through the Child Health Insurance Program (CHIP) that was created by the Balanced Budget Act of 1997 under Title XXI of the Social Security Act. South Carolina began covering children under CHIP on October 1, 1997, through its new Partners for Healthy Children (PHC) Program. During FY 1998-99, 44,627 children were served through CHIP. See Schedule B for increase in eligible children and recipients for FY 1995-96 thru FY 1998-99.

Part 2 describes South Carolina's public child care and development program funded by the Child Care and Development Fund and the Social Services Block Grant. The program provides child care and development services to 16,767 children who are in low-income working families and 24,958 children whose parents are participating in the Family Independence program, for a total of 41,725 children.

I. EXECUTIVE SUMMARY

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Part 3 describes the Social Services Block Grant services which are provided to approximately 61,412 South Carolinians annually. These services assist families in maintaining or restoring a level of physical, social, and economic well-being and enables them to function at the maximum level of their capabilities. Of the $29 million SSBG expenditures, the Department of Social Services (DSS) received $17 million to support the childrens and adult Social Services Program administered by DSS.

Part 4 describes the activities of Senior and Long Term Care Services which provides a comprehensive list of services to over 70,000 seniors and other vulnerable populations including prevention, early intervention, home delivered services, home health and community long term care (for those eligible for nursing home care). It also provides reimbursement on oversight for long term care facilities and oversees the provision of home health and hospice services to those eligible recipients. Senior and Long Term Care Services is also responsible for elder rights and the investigation and resolution of complaints received regarding long term care facilities.

Part 5 describes the Optional State Supplementation (OSS) program which has served 5,528 recipients in FY 1998-99. This program supplements the income of individuals who reside in those licensed residential care facilities that have enrolled with DHHS and have agreed to provide residential care services to eligible participants. South Carolina currently provides an OSS payment to persons who meet the state's net income requirement; meet the SSI categorical requirements (aged, blind, disabled); and reside in a Community Residential Care Facility (CRCF) that is licensed by the Department of Health and Environmental Control and enrolled with DHHS for purposes of the OSS payment process.

OSS payment covers the cost of room and board in a licensed CRCF. OSS recipients are permitted to keep a portion of their income for personal needs. The personal needs allowance, the state income limit, and the OSS payment level are all mandated and adjusted annually through the South Carolina legislative process. The OSS program is funded with 100% state dollars.

II. MISSION STATEMENT

The mission of the Department of Health and Human Services is to enhance the viability of South Carolina by improving the health and social status of South Carolinians.

This effort links private businesses, local governments and school districts, non-profit organizations, state agencies, and thousands of credentialed health-care professionals into a network that reaches into every community within South Carolina. It is largely funded by drawing down federal dollars that are matched by formula to appropriations of the General Assembly.

The Department of Health and Human Services accomplishes its mission through contractual arrangements with the private, public, and non-profit sectors. These agreements bind the agency with most of the state's doctors, pharmacists, hospitals, home-health agencies, and nursing homes, as well as dozens of state agencies.

III. LEADERSHIP SYSTEM

Leadership

Leadership is defined as the capacity or the ability to guide or direct. Our Agency is committed to guiding our employees to their utmost potential. We are devoted to: 1) Expanded Span of Control 2) Efficiency 3) Continuous Improvement of Processes 4) Communication 5) Strategic Planning and 6) Employee Development.

Expanded Span of Control

The Agency Director began to break down the traditional hierarchy span of control soon after assuming the directorship. He believes in empowerment of employees and that the lowest level employee is a strong contributor to the mission of the Agency. Each employee, in turn, feels that he has a strong voice in the success of the Agency.

Efficiency

The Agency Director continues to guide the agency in a most cost-effective use of its resources. Representatives from all levels in the organization assist the Agency Director in brainstorming solutions to the most prudent approach for providing quality health care to South Carolina citizens.

Continuous Improvement of Processes

We are continually reviewing our administrative processes to be sure that we are using technology to full capacity. We are in the process of developing an Intranet system that will allow us to provide a user friendly method for employees to access policies, complete training request forms, and request leave.

Communication

The internal monthly newsletter was updated and revised to provide the most thorough information to our employees. Information regarding promotions, new hires, new initiatives and policies that affect Agency employees are included in the newsletter. The Agency also has monthly Bureau Chief meetings that disseminate information to employees. Bureau Chief meetings represent the executive leadership and minutes from these meetings are available to all employees.

Strategic Planning

The Agency will embark on an extensive Strategic Planning process in early FY 1999-2000.

Employee Development

In the fall of 1999, the Agency management team, comprised of Bureau Chiefs and Deputy Directors will undertake a needs analysis in order to design a comprehensive training program for staff. We foresee that the training program will be devoted toward strengthening managerial skills and team development. We have developed a state of the art training facility devoted to providing in-house training for technology and managerial skills. We are committed to designing a training curriculum and providing an environment that has as its emphasis the development of the Agency's human resources.

Summary

The Agency Director's support of this leadership philosophy has fostered an environment that supports creativity and has increased employee morale. The Agency, as a result, is providing a more efficient delivery of health services to the citizens of South Carolina.

IV. CUSTOMER FOCUS AND SATISFACTION

Medicaid

Medicaid is a federally authorized program under Social Security Act, Title XIX, that provides financial assistance to states for the payment of providers of medical assistance on behalf of cash assistance recipients, children, pregnant women, and the disabled and elderly who meet income and resource requirements, as well as their categorically eligible groups.

Transportation and School Health Services monitors customer focus and satisfaction through a combination of program monitoring and technical assistance visits; customer satisfaction surveys; and feedback from providers and recipients.

Early Intervention and Preventive Services monitors customer focus and satisfaction through program monitoring, provider record reviews, and technical assistance visits. Complaints from providers and recipients are followed up on as quickly as possible for appropriate resolution or referral. The Medically Fragile Children's Program has a parental satisfaction survey component, as well.

The Child Health Insurance Program (CHIP) is reaching families who do not have health coverage through an outreach program. A variety of brochures, posters and promotional materials in both English and Spanish are used. The State also establishes partnerships with community organizations, other state agencies and faith-based organizations to insure that the State's population of uninsured children is targeted for enrollment. South Carolina also developed a simplified application in both English and Spanish and a mail in process that makes it easier for families to enroll their children.

Child Care And Development Program

Families who may be eligible to receive child care assistance include participants in job or educational placements through the South Carolina Family Independence Program, as well as low-income working families who have gross income that is at or below 125% of poverty based on family size. A family may continue to be income eligible until their income exceeds 175% of poverty. In addition to meeting the income standards, both parents must be working or attending school or training to be eligible for child care assistance.

Parents receiving child care assistance are offered the widest possible choices in child care options. They have the option of choosing the provider who will care for their child, whether it be a center, family or group day care home, church, synagogue, school, employer, or self-arranged care by relatives or friends. Parents are given a list of all providers in the state which meet standards higher than licensing requirements, a checklist, video and other resources to assist them in making an informed choice when choosing a child care provider.

The agency operates a toll-free client line and a toll-free complaint line to address customer concerns. The agency is piloting a customer satisfaction project through which parents are interviewed regarding their satisfaction with the services of the agency and with their child care provider. This survey also allows the agency to verify the parent's continued eligibility and solicit their comments and recommendations for improving services.

Through monitoring visits, training and technical assistance to providers, as well as toll-free provider lines, the agency identifies and addresses providers' qualifications, problems and concerns, and the providers' level of satisfaction with the agency's child care program.

Social Services Block Grant (SSBG)

The Social Services Block Grant (SSBG) program in South Carolina supports services for a diverse population of children, adults and families. Persons receiving services funded through SSBG must be members of one of five target groups which meet the federal goals for SSBG. Also, they must meet income eligibility guidelines, and demonstrate a need for the specific services. Applicants for services other than child care must have a total family gross income at or below 175% of the poverty guidelines, or need services, such as child or adult protective services, which are provided without regard to income. The poverty guidelines income limit for a family of three is $1,991 per month.

DHHS develops service activities and service standards for the majority of the services funded through the SSBG. These standards are developed based upon best practice in the service field, input from providers of the service, research, and state and federal regulations and laws and are incorporated in contracts and grant agreements with service providers. Additionally, on an annual basis, service providers receive program reviews during which provider concerns and issues regarding SSBG standards and contract requirements are identified.

Customers are involved in the development of their needs-assessment and service plan. During the service application process, customers receive a statement of their rights and responsibilities which provide avenues for input and grievances. Customer input regarding the quality of the services they are receiving is obtained during program reviews.

Senior And Long Term Care Services

Senior and Long Term Care Services conducts numerous client assessments and quality reviews to ensure clients are receiving appropriate and effective services. This is especially true for Medicaid clients and those in long term care facilities. Customer satisfaction is a key element of the implementation of the Long Term Care Proviso, which was established in four counties in FY 1998-99 and will continue expanding in FY 1999-00. In addition, each county Council on Aging has a governing board which has a basic charge of developing services requested and needed by clients. During FY 1999-00 Senior Services in conjunction with the Governor's Office, held 13 public forums throughout the state to better respond to the needs of seniors.

Twenty five nursing facilities are currently implementing a new paradigm in care called the Eden Alternative as an approach to improve the quality of life of nursing home residents. Grants to fund these initiatives were provided by DHHS from civil monetary penalty money collected from sanctioned nursing facilities. The Eden Alternative seeks to address loneliness, helplessness and boredom of nursing facility residents. Edenizing homes place more emphasis on companionship, variety, and spontaneity in daily life, staff improvement and community involovement.

Optional State Supplementation Program

The program serves individuals who have income under a certain level and reside in residential care facilities. Almost 75% of these individuals receive an SSI payment as well as an optional supplement payment.

Senior Care has participated in revising regulations which govern the licensure of community residential care facilities which will focus on enhancing quality of care for these residents.

V. DESCRIPTION OF PROGRAMS

Part 1.

Program Title: **MEDICAID**

Program Rank: 1

A. Hospital Services

Program Costs:

State:	$109,468,807*
Federal:	$295,603,248
Earmarked:	$ 17,931,245
Total:	$423,003,300*

*Includes surplus to cover shortfall expenditures.

Program Goals: To provide inpatient, outpatient, and hospital based physician services to Medicaid recipients.

Program Objectives:

1) To administer the hospital program by developing and coordinating policies and procedures and communicating changes in policy in a timely manner to Medicaid providers and provider associations through Medicaid bulletins and manual updates.

2) To assure reasonable and adequate provider reimbursement by monitoring current expenditures, projecting future expenditures, and making appropriate recommendations with regard to state appropriations.

3) To expedite claims processing to assure timely provider reimbursement by monitoring claims resolution, streamlining paperwork requirements, maintaining open communication with MMIS staff, and making appropriate recommendations for system changes and reference file updates.

4) To insure quality of care by executing and managing an annual contract with the Peer Review Organization (PRO) for quality assessment and review; developing outcome measure studies to address identified problems and needs, and monitoring quality assurance activities performed by the PRO.

5) To provide technical assistance and training to providers on policies and procedures by conducting liaison activities, making on-site visits to provider offices, providing assistance with policy interpretation and billing procedures, and conducting basic billing and policy workshops.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of DHHS FTEs assigned to program	9	10
Number of Enrolled Service Providers	117	117
Outputs:		
Number of transactions processed:		
Inpatient Services	319,017	304,804
Outpatient Services	670,723	763,846
Hospital Based Physician Services	423,353	447,526
Total - Hospital Services	1,413,093	1,516,176
Efficiency:		
Average transactions per recipient:		
Inpatient Services	2.3	2.2
Outpatient Services	2.9	3.0
Hospital Based Physician Services	2.6	2.7
All Hospital Services	4.5	4.5
Average expenditure per recipient:		
Inpatient Services	$2489	$2620
Outpatient Services	$228	$236
Hospital Based Physician Services	$62	$65
All Hospital Services	$1,313	$1287
Average provider to staff ratio	13:1	12:1
Transaction to staff ratio	157,010:1	151,617:1
Outcomes:		
Number of unduplicated recipients receiving services:		
Inpatient Services	139,772	138,653
Outpatient Services	229,303	255,232
Hospital Based Physician Services	162,082	165,614
All Hospital Services	312,455	337,266
Quality:		
Number of quality of care studies completed	3	3
Number of quality reviews completed	3,683	6,344

B. Pharmaceutical Services

Program Cost:

State:	$ 55,857,503
Federal:	$142,484,743
Earmarked:	$ 5,800,000
Total:	$204,142,246

Program Goals: The goal of the Medicaid Pharmacy Services program is to provide needed pharmaceuticals for the purpose of saving lives in an emergency or a short term illness, for sustaining life in chronic or long term illness, or for limiting the need for hospitalization.

Program Objectives:

1) Improve the health and well-being of Medicaid recipients by providing reimbursement to enrolled pharmacy providers who have dispensed necessary pharmaceuticals.

2) Provide coverage of needed pharmaceuticals for the purpose of saving lives in an emergency or a short term illness, for sustaining life in chronic or long term illness, or for limiting the need for hospitalization.

3) Promote efficient and cost-effective pharmaceutical therapies through the Drug Utilization Review (DUR) programs.

4) Access rebate monies through the effective management of the pharmaceutical services initiatives.

5) Enhance provider liaison activities and provider participation.

6) Revise and update program policy and procedural directives.

7) Expedite the approval process of provider submission of claim and adjustment requests for reimbursement.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of recipients utilizing pharmacy services	385,469	427,929
Number of enrolled pharmacy providers	1,032	1,100

Outputs:		
Number of prescriptions reimbursed by Pharmaceutical Services	3,889,428	4,542,217
Average prescription utilization per recipient per month	2.20	2.38
Efficiency:		
Average cost per recipient	$438.54	$477.05
Average reimbursement per prescription	$43.46	$44.94
Pharmaceutical Rebate Program	$38,760,293	$49,460,426

C. Physician & Clinic Services

Program Costs:

State:	$ 49,382,448
Federal:	$126,824,879
Earmarked:	$ 5,126,500
Total	$181,333,827

Program Goals: To improve access to primary and preventive care for Medicaid recipients, and to foster appropriate use of the health care delivery system.

Program Objectives:

1) To administer Medicaid services provided by rural health clinics, federally qualified health centers, physicians, podiatrists, nurse practitioners, and other medical professionals by developing and coordinating policy and procedures and communicating changes in policy in a timely manner to Medicaid providers and provider associations through Medicaid bulletins and manual updates.

2) To assure reasonable and adequate provider reimbursement by monitoring current expenditures, projecting future expenditures, and making appropriate recommendations with regard to state appropriations.

3) To expedite claims processing to assure timely provider reimbursement by monitoring claims resolution, streamlining paperwork requirements, maintaining an open communication line with MMIS staff, and making appropriate recommendations for system changes and reference file updates.

4) To monitor access to quality health care by targeting counties with low physician participation levels for on-site visits to encourage increased physician participation and by compiling access to care data and monitoring access for each fiscal year.

5) To provide technical assistance and training to providers on policies and procedures by conducting liaison activities, making on-site visits to provider offices, providing assistance with policy interpretation and billing procedures, and conducting basic billing and policy workshops.

6) To improve and expand access to quality, coordinated health care by providing medical homes for Medicaid recipients through such initiatives as the Physician Enhanced Program (PEP) and The Healthy Options Program (HOP).

7) To insure quality of care by developing and reviewing outcomes based on established indicators.

8) To improve the health status and well being of Medicaid recipients under the age of 21 by promoting regular well child screening and treatment services through the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT).

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of DHHS FTEs assigned to program	16	16
Number of enrolled service providers	6,564	6,872
Outputs:		
Number of transactions processed:		
Physician Services	4,046,572	4,583,508
Clinic Services	481,571	557,018
EPSDT (well child screening & immunizations)	173,999	178,564
Efficiency:		
Average transactions per recipient:		
Physician Services	10.7	11.0
Clinic Services	3.9	4.2
EPSDT Services	1.7	1.7
Average expenditure per recipient:		
Physician Services	$336	$343
Clinic Services	$313	$334
EPSDT Services	$ 74	$ 74
Average provider to staff ratio	410:1	430:1
Average transaction to staff ratio	293,884:1	332,443:1

Outcomes:

Number of unduplicated recipients receiving services:		
Physician services	377,220	416,784
Clinic Services	123,555	133,762
EPSDT services	105,147	106,972

Quality:

Number of physician/clinic medical home contracts	302	401
Number of recipients linked to physician/ clinic medical home	27,446	44,851

D. Dental Services

Program Cost:

State:	$ 3,964,302
Federal:	$10,966,681
Earmarked:	$ 750,000
Total:	$15,680,983

Program Goals: To provide quality accessible dental services to Medicaid eligible children. To provide quality accessible emergency dental services to Medicaid eligible adults.

Program Objectives:

1) Improve the health status and well-being of Medicaid recipients through the provision of quality dental care.

2) Improve access to services by increasing dental provider participation in the Medicaid program.

3) Review, evaluate and revise dental program policies and procedures to ensure access to services for recipients, timely payments to providers, and accountability for services rendered.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of licensed dentists statewide	1,533	1,719
Number of Medicaid enrolled dentists	575	722
Outputs:		
Number of children served	103,594	115,304
Number of adults served	22,564	22,686
Efficiency:		
Average cost per recipient	$139.02	$135.02
Average cost per child served	$139.75	$133.02
Average cost per adult served	$136.34	$140.10

Outcomes:

Number of Children Receiving Screening and Services	103,594	115,304
Number of Adults Receiving Emergency Services	22,564	22,686

E. Vision Services

Program Cost:

State:	$1,334,803
Federal:	$3,105,659
Earmarked:	
Total:	$4,440,462

Program Goals: To provide quality accessible vision services to Medicaid eligible recipients.

Program Objectives:

1) Improve the health status and well-being of Medicaid recipients through the provision of quality vision care.

2) Improve access to services by increasing vision provider participation in the Medicaid program.

3) Review, evaluate and revise vision program policies and procedures to ensure access to services for recipients, timely payments to providers, and accountability for services rendered.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of licensed vision providers statewide	558	569
Number of Medicaid-enrolled vision providers	535	545
Outputs:		
Number of examinations provided to children	33,359	36,609
Number of glasses prescribed for children	27,151	33,809
Number of examinations provided to adults	14,024	15,519
Number of glasses prescribed for adults	608	719

Efficiency:

Average cost per recipient	$42.34	$43.16
Average cost per adult served	$38.16	$38.17
Average cost per child served	$44.65	$45.60

F. Chiropractic Services

Program Costs:

State:	$27,342
Federal:	$63,616
Earmarked:	
Total:	$90,958

Program Goals: To provide quality accessible chiropractic services to Medicaid eligible recipients.

Program Objectives:

1) Improve the health status and well-being of Medicaid recipients through the provision of quality chiropractic care.

2) Review, evaluate and revise chiropractic program policies and procedures to ensure access to services for recipients, timely payments to providers, and accountability for services rendered.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of licensed chiropractors statewide	N/A	810
Number of Medicaid-enrolled chiropractors	N/A	252
Outputs:	N/A	
Number of children served		317
Number of adults served	N/A	420
Efficiency:		
Cost per recipient	N/A	$123.41
Outcomes:		
Number of children receiving Chiropractic Services	N/A	317
Number of adults receiving Chiropractic Services	N/A	420

F. Chiropractic Services

Program Costs:

State:	$27,342
Federal:	$63,616
Earmarked:	
Total:	$90,958

Program Goals: To provide quality accessible chiropractic services to Medicaid eligible recipients.

Program Objectives:

1) Improve the health status and well-being of Medicaid recipients through the provision of quality chiropractic care.

2) Review, evaluate and revise chiropractic program policies and procedures to ensure access to services for recipients, timely payments to providers, and accountability for services rendered.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of licensed chiropractors statewide	N/A	810
Number of Medicaid-enrolled chiropractors	N/A	252
Outputs:	N/A	
Number of children served		317
Number of adults served	N/A	420
Efficiency:		
Cost per recipient	N/A	$123.41
Outcomes:		
Number of children receiving Chiropractic Services	N/A	317
Number of adults receiving Chiropractic Services	N/A	420

G. Transportation

Program Costs:

State:	$ 9,666,303
Federal:	$23,537,402
Earmarked:	$ 450,000
Total:	$33,653,705

Program Goals: To provide quality accessible transportation services to Medicaid eligible recipients.

Program Objectives:

1) Improve the health status and well-being of Medicaid recipients through the provision of contractual, individual and ambulance transportation services.

2) Review, evaluate and revise all transportation policies and procedures to ensure the efficient and cost-effective use of resources to meet the needs of the state's Medicaid population.

3) Develop policy and procedure regarding the use of mass transit systems for non-emergency transportation where available.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of licensed ambulance services statewide	204	204
Number of DHHS FTEs	4	4
Number of contractual providers	25	25
Number of fleet vehicles	535	567
Number of enrolled ITP providers	1,065	1,066
Outputs:		
Number of Medicaid-enrolled ambulance providers	128	130
Number of recipients served	49,635	52,463
Number of non-emergency trips	793,308	1,412,254

Efficiency:		
Cost per recipient served	$483	$641
Outcomes:		
Number of Medicaid appointments kept by recipient	799,200	1,418,218
Quality:		
Number of technical assistance visits	41	42
Number of Human Service Community Surveys on providers performed	N/A	75
Number of provider related complaints	7	8

H. Rehabilitative Therapy Services - (Other Medical Services)

Program Costs:

State:	$ 320,257
Federal:	$ 745,134
Earmarked:	
Total:	$1,065,391

Program Goals: The goal of the Rehabilitative Therapy Services Program is to ensure the availability of high quality, accessible physical therapy, occupational therapy, speech-language pathology, and audiology services to eligible South Carolinians.

Program Objectives:

1) Accommodate the need of school districts and other state agencies to provide rehabilitative therapy services to children and adults with special needs; to maximize the use of federal funds and reduce the expenditure of state dollars in the provision of these services.

2) Improve access to private therapy services through removal of the prior authorization process for school districts and the pooling of state agency funds to support payment to private therapy providers statewide.

3) Ensure the coordination of service delivery, reduce duplication of services, and monitor the impact of the removal of prior authorization through close and regular review of utilization and expenditures.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of enrolled service providers	1,074	1,175
Number of DHHS FTEs	4	4
Outputs:		
Number of recipients served	2,712	3,328
Efficiency:		
Average expenditure per recipient	$177	$224
Outcomes:		
Number of state agencies accessing therapy Services for clients	4	4
Quality:		
Number of provider technical assistance visits	111	40

I. Diabetes Education Services

Program Cost:

State	$ 6 ,472
Federal	$15,057
Earmarked:	
Total:	$21,529

Program Goals: The goal of Diabetes Education Services is to provide educational and counseling programs on disease self management skills and behavioral lifestyle changes to Medicaid recipients with a diagnosis of diabetes.

Program Objectives:

1) Ensure the coordination and accessibility of Diabetes Education Services through provider contacts and technical assistance visits.

2) Accommodate the needs of providers through closely monitored provider response efforts.

3) Increase the number of providers in the Diabetes Education Services program.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Providers of Diabetes Education Services	4	9
Outputs:		
Individuals receiving Diabetes Education Services	260	409
Efficiency:		
Average expenditure per recipient	$45	$53

J. Postpartum Infant Home Visit

Program Cost:

State:	$ 400,799
Federal:	$ 932,532
Earmarked:	
Total:	$1,333,331

Program Goals: To assess environmental, social, and medical needs of the infant and mother.

Program Objectives:

1) To provide the opportunity for a Postpartum/Infant home visit to every Medicaid sponsored newborn.

2) To identify methods to enhance the ability of providers to make appropriate referrals to necessary services.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of recipients receiving Postpartum/ Infant Home Visits	22,601	20,174
Outputs:		
Number of providers of the Postpartum/Infant Home Visits	12	14
Efficiency:		
Average Cost Per Patient	$61.98	$66.09
Average Cost Per Transaction	$57.20	$60.78
Outcomes:		
Percent of recipients receiving Home Visits	82%	73%
Quality:		
Number of Technical Assistance and/or Compliance Visits	3	3

K. Family Planning

Program Cost:

State	$ 1,083,618
Federal:	$10,076,221
Earmarked:	$ 36,000
Total:	$11,195,839

Program Goals: To reinforce the importance of family planning services and to reduce the numbers of unintended and unwanted pregnancies.

Program Objectives:

1) To increase the number of reproductive age women receiving planning services after pregnancy.

2) To reduce the number of unintended and unwanted pregnancies among women eligible for Medicaid.

3) To reduce the number of inadequately spaced pregnancies among mothers eligible for maternity services under the expanded eligibility provisions of Medicaid.

4) To estimate the overall savings in Medicaid spending attributable to providing family planning services to women for two years postpartum.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of Family Planning clients served	76,480	87,470
Total number of transactions	222,628	271,822
Outputs:		
Number of providers participating in the program	8,397	8,766
Efficiency:		
Average cost per transaction	$45	$41
Average number of transaction per recipients	2.91	3.11
Average cost per recipients	$131	$128

Outcomes:

Increase in the use of contraceptives	89.1%	89.3%
Decrease in the number of unintended pregnancies	50.1%	N/A
Increase in the number of women receiving publicly supported family planning services	13,778	N/A

L. Managed Care Program

Program Cost:

State:	$2,133,545
Federal:	$5,242,260
Earmarked:	$ 119,562
Total:	$7,495,367

Program Goals: To improve and expand access to quality coordinated health care through providing a medical home for Medicaid recipients.

Program Objectives:

1) To expand access to medical home through the Health Maintenance Organization (HMO) Program.

2) To enhance coordination of medical care through linkage of primary care providers and specialized services.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of enrolled recipients	4,972	7,174
Output:		
Number of enrolled HMO contractors	3	1
Number of Primary Care Physicians's (PCP's)	464	500
Efficiency:		
Average cost per transaction	$91.86	$90.28
HMO expenditures	$3,843,249	$7,323,773
Outcomes:		
Number of Recipients linked to Primary Care Physician's (PCP's)	4,972	7,174
Quality:		
Average number of dis-enrollments per month	72	142
Average number of complaints received per month	2	5

M. Durable Medical Equipment (DME)

Program Cost:

State:	$ 8,853,941
Federal:	$22,139,073
Earmarked:	$ 661,365
Total:	$31,654,379

Program Goals: The goal of the Medicaid Durable Medical Equipment Program is to provide high quality accessible medical care and medically related social services for Medicaid eligible South Carolinians.

Program Objectives:

1) To improve the health and well-being of Medicaid recipients by providing reimbursement to DME providers who have dispensed necessary medical equipment and supplies.

2) To provide equipment and supplies that are necessary for the treatment of an illness or injury or to improve the function of a malformed body member.

Performance Measures :	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of enrolled providers	1,450	1,414
Outputs:		
Total transactions for DME	491,038	538,504
Number of unduplicated recipients	51,721	58,947
Efficiency:		
Average cost per recipient	$645	$588
Average cost per transaction	$68	$64

N. Child Health Insurance Program/Title XXI (CHIP)

Program Cost:

State:	$ 2,000,000
Federal:	$21,733,479
Earmarked:	$ 3,796,330
Total:	$27,529,809

Program Goals: Reduce the number of uninsured children in the State of South Carolina.

Program Objectives:

1) Reduce the number of uninsured and under-insured children in the State of South Carolina through outreach initiatives and enrollment of children under the Child Health Insurance Program (CHIP).

   a) Market CHIP through the Partners For Healthy Children (PHC) Program
   b) Enroll targeted low income children

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of PHC applications distributed	1,379,524	1,062,504
Number of targeted outreach initiatives	51	51
Outcomes:		
Number of PHC applications received	25,486	37,142
Number of new CHIP enrollees	30,934	19,697
Number of CHIP clients served	24,463	44,627
Efficiency:		
Average annual cost per client served	$430	$552

Part 2.

Program Title: **CHILD CARE AND DEVELOPMENT PROGRAM**

Program Rank: 2

Program Cost:

State:	$10,037,587
Federal:	$52,456,365
Earmarked:	
Total:	$62,493,952

Program Goals: South Carolina's public child care and development program is funded by the Child Care and Development Fund (CCDF) and some Social Service Block Grant (SSBG) funds. The program goal is to increase the availability, affordability and quality of child care services in order to (1) provide low-income families with the financial resources to find and afford quality child care for their children; (2) enhance the quality and increase the supply of child care for all families; (3) provide parents with a broad range of options in addressing their child care needs; (4) strengthen the role of the family; (5) improve the quality of, and coordination among, child care programs and early childhood development programs; and (6) increase the availability of early childhood development and before- and after-school care services. A minimum of 4% of the total child care funds must be used to improve quality, increase the availability of child care and educate consumers about quality child care.

Program Objectives:

To provide a seamless system of eligibility and funding for child care services. First priority is to Welfare Reform (Family Independence) clients; however, the program also funds child care subsidies for low-income working families based upon the availability of funding. The child care program emphasizes parental choice of providers and access to quality services.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Output:		
Total children receiving services	42,109	41,725
Number of provider visits to improve quality	1,363	1,759
Number of low-income working poor children served	16,764	16,767

Number of Family Independence children served	25,345	24,958
Quality:		
Number of care givers/directors trained.	14,073	14,757
Number of providers meeting standards above state licensing requirements	1,246	1,319
Number of technical assistance visits to self-arranged care providers (non-regulated)	N/A	274
Efficiency:		
Percentage of total CCDF dollars for administrative costs	3%	4%
Average monthly cost per child served	$240	$240

Part 3.

Program Title: SOCIAL SERVICES BLOCK GRANT (SSBG)

Program Rank: 3

Program Cost:

State:	$
Federal:	$29,038,026
Earmarked:	$
Total:	$29,038,026

Program Goals: The goal of the SSBG program is to render services that assist citizens of the state in restoring or maintaining a level of physical, social, and economic well-being that allows them to function at the maximum level of their capabilities. Within broad federal guidelines, South Carolina is given flexibility to develop social services programs to meet these goals. Services are provided through contracts, grants, or agreements with public and private providers. SSBG funding has been cut by the Federal Government in recent years, resulting in some service reduction.

Program Objectives:

1) Provide a continuum of services to protect children and adults who cannot protect themselves from abuse, neglect and exploitation and to strengthen and preserve families with children or, whenever possible, to promote early reunification.

2) Provide community-based services to adults and their family care givers in order to prevent and reduce inappropriate institutional care as much as possible or to arrange for appropriate services when this is in the person's best interest.

3) Develop special projects that enhance, support, and/or demonstrate effective, innovative approaches to service delivery.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Outputs:		
SSBG child welfare dollars redirected to strengthen and preserve families	$5,037,361	$5,354,647
Total clients receiving SSBG services	72,578	61,412
Total children receiving SSBG services	53,966	42,800

Total investigations of alleged child abuse and neglect reports	18,555	18,184
Total adults receiving SSBG services	18,612	18,612
Total adults receiving home delivered meals	2,517	2,467
Efficiency:		
Percentage of SSBG dollars for administrative costs	6%	4%
Average annual cost per client served	$428	$505
Average annual cost per child client served	$417	$529
Average annual cost per adult client served	$336	$343
Outcomes:		
Number of families preserved or reunified	6,122	6,250
Number of children protected from abuse and/or neglect	8,403	8,235
Number of adults protected from abuse, neglect or exploitation	8,066	7,900
Number of adults receiving community-based services to prevent institutionalization	5,203	5,100

Part 4.

Program Title: SENIOR AND LONG TERM CARE SERVICES

Program Rank: 4

A. Senior Services

Program Cost:

State:	$ 1,768,699
Federal:	$12,243,403
Earmarked:	$ 3,658,983
Total:	$17,671,085

Program Goals: The goal of Senior and Long Term Care Services is to provide a high quality, seamless continuum of care to the elderly citizens of South Carolina including prevention, early intervention, community and institutional long term care. The purpose of these services is to support the highest quality of life possible and delay or avoid institutionalization of the elderly. When long term care services are necessary, the goal is to provide them in the least restrictive setting possible. Senior and Long Term Care Services also serves as a vehicle to mediate and resolve complaints on behalf of residents of long term care facilities. Also provided is a wide range of information, referral and training to enable older South Carolinians, their families, and professionals to make choices which support, independence and dignity. This is achieved through a statewide network of 10 regional Area Agencies on Aging, 10 Community Long Term Care regional offices, 58 local service providers and other contractors and grantees.

Program Objectives:

1) To be the state's focal point in providing information about how to access services for the elderly such as transportation, outreach, case management, information and referral to other agencies to enable older South Carolinians efficient and uncomplicated access to appropriate services.

2) To provide technical assistance, financial support and quality assurance oversight for the provision of home and community based services at the local level focusing on older persons who are in greatest economic and social need, who are not eligible for other programs due to income or medical eligibility criteria.

3) To assist in the planning, financing, construction and renovation of community senior centers and ensure these centers provide wellness and preventive services such as meals, fitness activities, education, health screening and social support programs in order to support the physical, mental and social needs of the elderly.

4) To provide education and training about Alzheimer's Disease for professionals and family care givers and to develop information and referral services and respite services for care givers.

5) To provide job training and placement for older workers through the Senior Community Services Employment program.

6) To develop opportunities and programs using the skills, talent and interests of older adults in programs and settings for children and youth.

7) To gather, maintain and analyze information and statistics essential in planning for the present and future needs of the older population of South Carolina.

8) Through the Long Term Care Ombudsman Program, identify, investigate and resolve or mediate complaints made by, or on behalf of residents of long term care facilities relating to action, inaction or decisions which adversely affect the health, safety, welfare or rights of residents.

9) To provide health insurance counseling, assistance and referral to older residents of the state and their families using a system reliant on volunteers.

10) To provide information and aid in completion of advance directives, living wills, health care power of attorney and other legal planning documents which enable the recipient's last wishes to be accurately carried out.

11) Maintenance of a comprehensive system of data and information, collected at the local level, on all persons making contact or receiving services from the aging network.

12) To provide state-of-the-art professional training for professionals and volunteers to enhance their skills in service provision, administration, research and support of individuals and families.

Performance Measures:	Actual FY 97-98	Actual FY 98-99
Input:		
Total people served	29,401	31,200
People receiving congregate meals	12,297	13,982
People receiving home delivered meals	11,503	11,482
People receiving home care	4,306	4,895
People receiving transportation	6,374	6,452
People receiving adult day care	248	142
People receiving care management	5,157	2,561
Families of persons with Alzheimer's Disease (AD) receiving information through the Alzheimer's Help Line	312	436
Families of persons with AD receiving in-home social work assessments	250	70
Families receiving AD care management	200	100
Families receiving AD group respite or adult day care	85	166
Families receiving AD in-home respite care	151	130
People enrolled in Senior Community Service Employment Program	209	215
Number of complaints received by the Long Term Care Ombudsman	3,155	3,376
Living Will witness trainings	4	4
Advance Directive presentations	4	5
Output:		
Home delivered meals provided	1,561,658	1,577,658
Congregate meals provided	1,167,734	1,071,886

Hours of home care provided	208,407	206,998
Miles of transportation provided	10,526,784	10,988,157
Hours of adult day care provided	110,856	62,521
Hours of care management provided	21,586	9,250
Senior Centers completed	9	7
Number of senior volunteers for the LINC Intergenerational Program	533	746
Long Term Care Ombudsman complaints substantiated	2,060	2,358
Living Wills witnessed by Ombudsman living will witnesses for persons in institutions	450	390

Outcome:

Professionals, para-professionals, volunteers and others receiving training	1,375	2,657

Quality:

Dollar savings to public through insurance counseling and training	$98,964	$268,000

B. Community Long Term Care Services

Program Cost:

State:	$15,947,485
Federal:	$46,760,379
Earmarked:	$ 850,000
Total:	$55,869,597

Program Objectives:

1) Provide case management and home care services at no more than 75% of the cost of nursing facility placement for elderly and disabled clients requiring home care to avoid institutionalization.

2) Reduce the HIV and AIDS client inpatient acute care expenditures to no more than 70% of the cost of acute care services through the utilization of home- and community-based waiver services and other Medicaid covered services.

3) Provide home and community-based services for mechanical ventilator dependent clients who meet nursing facility level of care at no more than the cost of sub-acute nursing facility placement to avoid institutionalization.

4) Provide personal care aide services to children age 21 or under who meet the medical necessity criteria.

Performance Measures: Elderly/Disabled Waiver	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of referrals each year	10,686	15,008
Outputs:		
Total clients served each year	9,771	13,717
Efficiency:		
Cost per day, per client, for CLTC services	$18	$21
Cost per day, per client, for nursing home placement	$83	$87
Percentage of daily nursing home rate expended for CLTC services	22%	24%

Outcomes:

Savings to Medicaid Program per day, per client	$65	$66

Performance Measures: Ventilator Dependent Waiver	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of referrals each year	15	16
Outputs:		
Total clients served each year	29	28
Efficiency:		
Cost per day, per client, for CLTC services	$58	$67
Cost per day, per client, for nursing home placement	$180	$180
Percentage of daily nursing home rate expended for CLTC services	32%	37%
Outcomes:		
Savings to Medicaid Program per day, per client	$121.60	$113.00

Performance Measures: Children's Personal Care Aide Program	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of referrals each year	350	368
Outputs:		
Total clients served each year	429	408

C. Nursing Home (NH), Hospice and Home Health Services

Program Cost:

State:	$ 92,289,034
Federal:	$219,251,598
Earmarked:	$ 1,935,350
Total:	$313,475,982

Program Objectives:

1) Maintain an adequate supply of trained nurse aides available for employment in Medicaid certified nursing facilities, who have demonstrated competency based upon standardized testing.

2) Assure equal access to nursing facility services for Medicaid covered individuals in need of these services.

3) Enforce standards for the quality of care and quality of life for residents of Medicaid certified nursing facilities.

4) Provide appropriate and quality home health services to the Medicaid eligible homebound population.

5) Provide quality hospice services to terminally ill Medicaid eligible individuals who wish to receive palliative care.

6) Provide guidance, in accordance with Medicaid regulations, in the oversight of long term care facilities (including nursing homes) and assurance of their compliance with health and safety standards.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of NH recipients	15,915	16,898
Number of Medicaid contracted NH	142	147
Number of individuals who participated in the Nurse Aide Training Program	1,798	2,234
Number of competency tests provided	1,450	1,996
Number of Medicaid-sponsored nursing facility bed days	4,058,629	4,200,156

Outputs:		
Number of individuals added to the nurse aide registry	4,135	4,050
Number of certification renewals	N/A	8,158
Number of Medicaid recipients who received home health services	3,937	4,172
Units of home health services provided	304,633	311,606
Efficiency:		
Cost per nurse aide for training	$325	$325
Cost per nurse aide for testing	$86	$86
Cost per renewal	N/A	$25
Average gross Medicaid rate/day to nursing facilities (without recurring income)	$83	$87
Average net Medicaid rate/day paid to nursing facilities (with recurring income)	$67	$71
Outcomes:		
Number of facilities notified of potential sanctions	23	42
Number of facilities sanctioned	10	11

Part 5.

Program Title: **OPTIONAL STATE SUPPLEMENTATION PROGRAM**

Program Rank: 5

Program Cost:

State:	$14,484,489
Federal:	
Earmarked:	
Total:	$14,484,489

Program Goals: To provide a source of supplemental payment for those individuals who meet the eligibility criteria set forth by the state and reside in a licensed community residential care facility.

Program Objectives:

1) Establish the maximum number of Optional State Supplement recipients that can be funded per year.

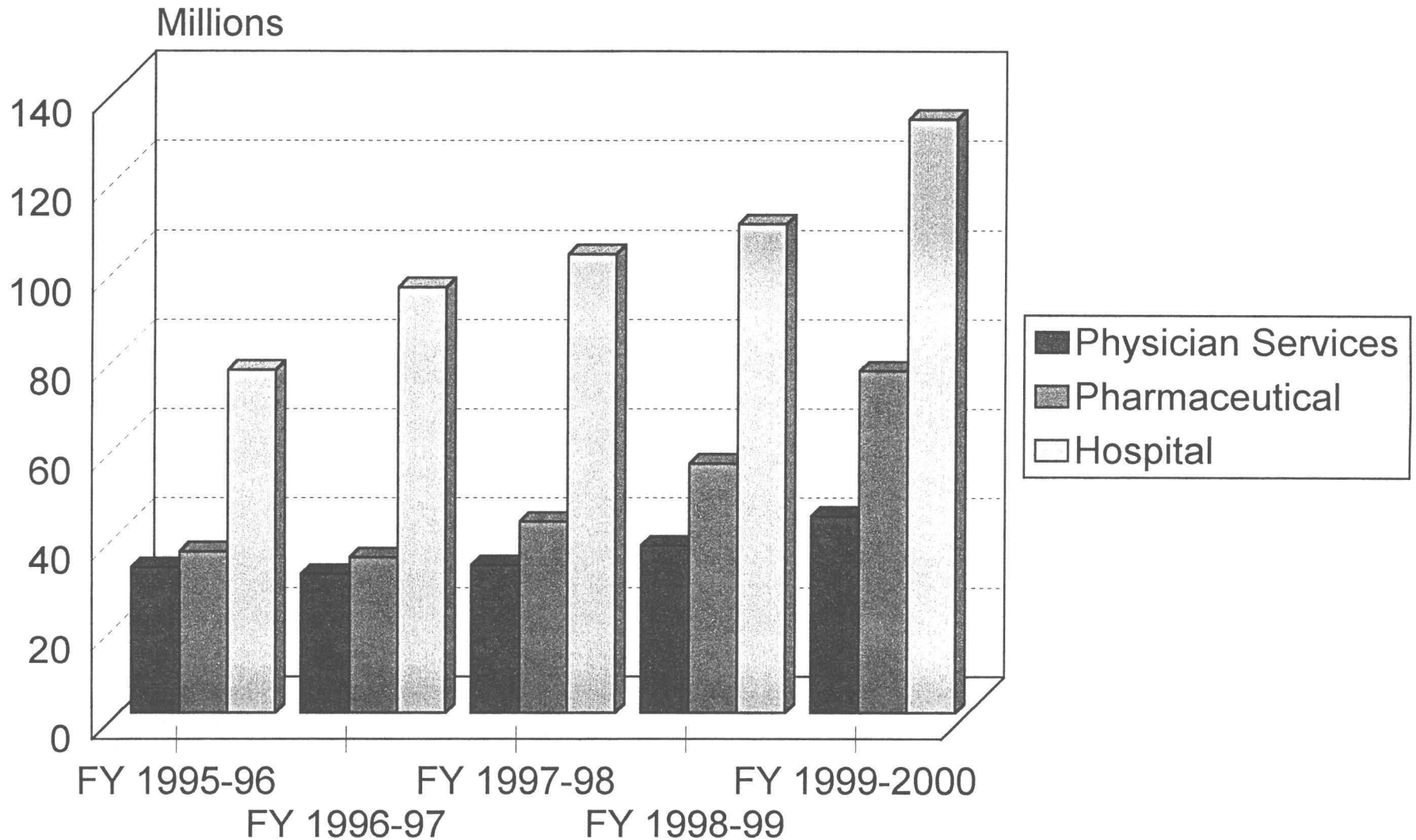
2) Maintain an accountable billing and payment system for the OSS program.

3) Provide assistance and educate enrolled facilities on policies and procedures.

4) Maintain a procedure in conjunction with the Community Long Term Care program for implementing a statewide waiting list as necessary to assure fiscal management of the OSS program.

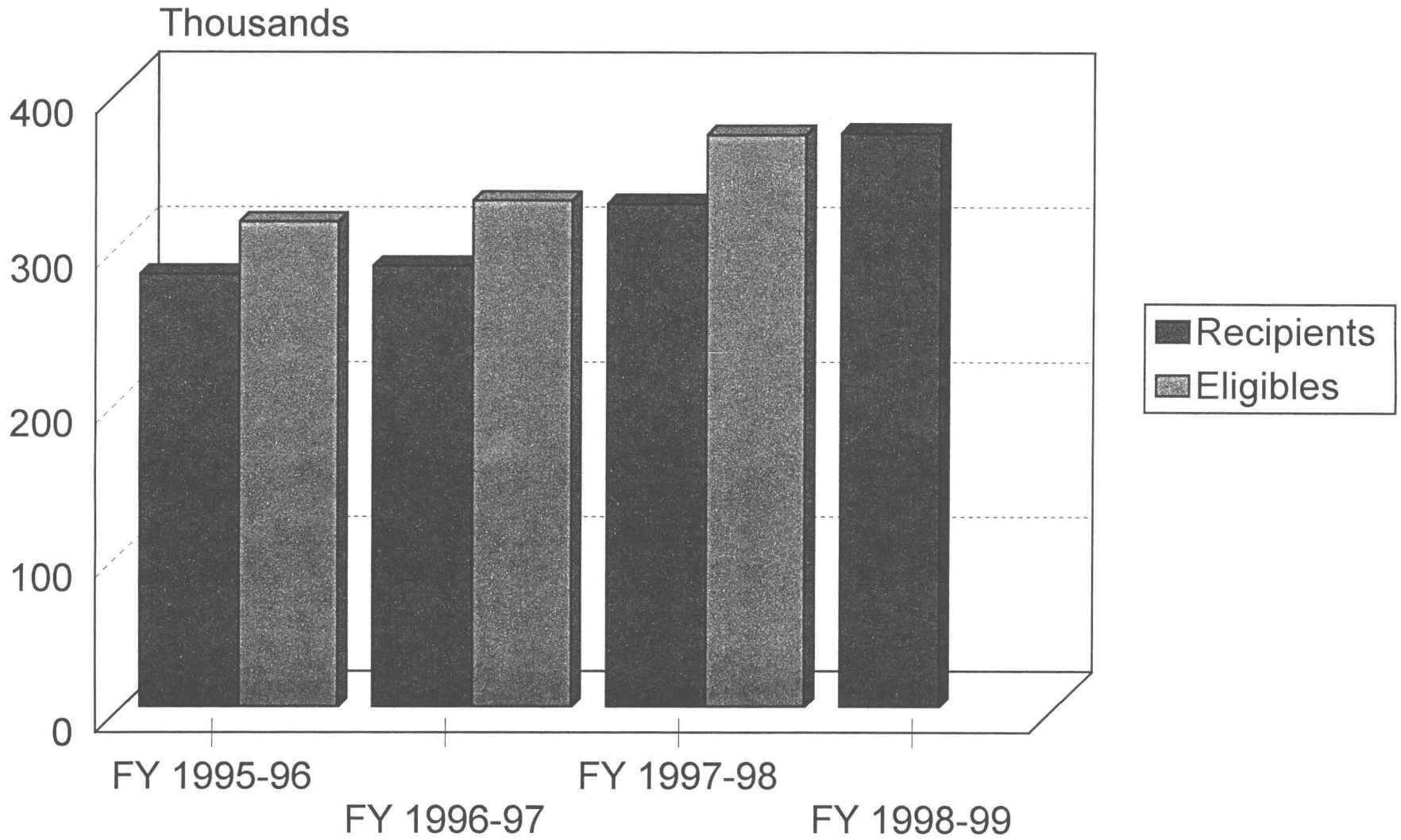
Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**
Inputs:		
Number of CRCFs that have enrolled as providers	359	402
Outputs:		
Average monthly recipient count	4,236	4,417
Efficiency:		
Average monthly amount paid	$1,180,849	$1,207,041

Department of Health and Human Services
Physicians, Pharmaceutical, and Hospital Costs
(State Dollars)



(FY 1999-2000 Estimated)

Department of Health and Human Services
Eligible and Recipient Children in Medicaid



Eligibles for FY 1998-99 Not Available