Accountability Report Transmittal Form

Agency Name ___Department of Health and Human Services_____

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I. EXECUTIVE SUMMARY

Vision & Values

The mission of the South Carolina Department of Health and Humans Services (DHHS) is to manage the state's Medicaid program to provide the best healthcare value for South Carolinians.

South Carolina's Medicaid program provides basic healthcare services for approximately one million individuals annually who are either very poor, elderly, or disabled through a network of approximately 30,000 healthcare professionals. Overall, the Department of Health and Human Services processes about $4.5 billion in Medicaid claims each year with almost $1.5 billion of those claims coming through other state agencies.

A top priority of DHHS is to provide a healthcare delivery system that supports evidence-based care options for the Medicaid population. However, providing quality services is not enough – as stewards of a large proportion of state General Fund money and federal matching funds, DHHS must prioritize how it spends both time and money. An efficient and effective Medicaid program must deliver the highest healthcare value for each dollar to all stakeholders – recipients, providers and taxpayers.

To this end, DHHS has established the following key strategic goals:

- To provide a benefit plan that improves member health, is evidence-based, and is market-driven.
- To provide a credible and continually improving eligibility process that is accurate and efficient.
- To provide administrative support at the best possible value to ensure programs operate effectively.

Pursuing these goals with an attitude of servant leadership is also a priority for DHHS. Therefore, all DHHS employees are dedicated to doing their jobs in a manner that provides current and potential customers with service that is excellent, responsive, and brings value to everyone involved.

SFY 2005 Major Accomplishments

Recurring Funding Strengthened: A substantial portion of non-recurring revenue was appropriated with recurring funds, ensuring availability of and providing stability for the state's Medicaid services.

Fraud/Abuse: Program Integrity recoupments increased 75% for provider recoveries, over the previous state fiscal year. In addition, there was a 171% increase for recipient recoveries and a 10% increase in global settlements from the prior fiscal year.

Prescription Abuse Task Force: DHHS worked with the Attorney General's Office, SLED, and DHEC in creating a task force to pursue fraud and abuse in the Medicaid pharmacy program.

Alternative Sanctions for ICFs/MR: The agency instituted a "progressive discipline" policy for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). These alternative sanctions encourage such providers to correct deficiencies that don't pose immediate jeopardy to clients, without the agency resorting to the only options available previously – denying payments or terminating contracts.

Eligibility Audits: The agency continued statewide audits of eligibility workers' case files to verify accuracy and identify potential fraud, abuse, or errors.

Managing Psychotropic Drugs: Using private grant funds, DHHS contracted for a vendor to identify best practices in prescribing psychotropic drugs. By submitting pharmaceutical claims to the vendor, the prescribing patterns of such drugs can be analyzed and patterns of excessive or inappropriate prescribing can be identified.

Pharmacy and Therapeutics Committee: The Medicaid Pharmacy and Therapeutics Committee completed the review of all drug classes to help the agency establish a Medicaid preferred drug list and pursue supplemental rebate collections.

Medical Home Networks: Three local primary care case management networks (also called Medical Home Networks) began operating during the fiscal year. Medical Home Networks match primary care providers to Medicaid recipients and utilize preventive care and incentive reimbursement to better manage health outcomes and expenditures.

Decision Support System: DHHS contracted with a vendor that will provide vital management data to executive staff to support value-based decisions. This system will provide high-level financial key indicators, as well as information on service utilization dynamics and potential fraud and abuse cases.

Electronic Claims Verification: The agency developed an online claims status system for Medicaid providers, allowing them to examine claims in real time, and access other vital information around the clock.

Automated Cost of Living Increases: DHHS improved the process that calculates cost of living increases for persons receiving Social Security Administration (SSA) and Supplemental Security Income (SSI) benefits, providing payments faster.

Partnerships Streamline Eligibility: DHHS and DSS signed an agreement to share data on Medicaid, Food Stamp, Child Support and Temporary Assistance to Needy Families (TANF) populations, to facilitate processing for Medicaid applicants.

Reducing Disability Determination Backlogs: DHHS contracted with the Vocational Rehabilitation Department to perform disability determinations for all eligibility categories, reducing a backlog the agency received when the Medicaid eligibility function was transferred from the Department of Social Services (DSS) to DHHS. Reducing such backlogs in applications and redeterminations is allowing the agency to be more responsive to clients and accountable to taxpayers.

SILVERxCARD changes/Medicare Modernization Act: As legislatively directed, DHHS began designing a program to convert former SILVERxCARD state funds and use them in coordination with the forthcoming Medicare prescription drug coverage, for eligible recipients.

Smoking Cessation Coverage: The agency began covering certain smoking cessation pharmaceutical products like patches, tablets, and gums. Some products like lozenges, sprays and inhalers are also now covered, with a prescriber's prior authorization.

Kidney Disease Management: The National Kidney Foundation of SC partnered with the agency to offer informal trainings to primary care providers in a two-county area, designed to encourage the use of three simple tests that can detect possible chronic kidney disease. Chronic kidney disease is a widespread, debilitating and expensive disease among Medicaid recipients. This project was funded by private sources.

Limited Expansion of Doctor Office Visits: The agency implemented a limited expansion of the standard 12 annual doctor visits for certain restricted recipient groups. Extra visits require physician prior authorization based on stringent medical criteria, and are essentially available to individuals with multiple chronic conditions.

Expanded Options for Long Term Care: The agency broadened guidelines regarding which family caregivers can be paid for certain home and community-based services, to provide more flexibility for recipients and their families.

Long Term Care Efforts Featured as National Best Practice: The Centers for Medicare and Medicaid Services (CMS) named DHHS' Long Term Care program as a national model, citing its emphasis on consumer choice, quality services, consumer input and feedback, and adequate support structure.

Medicaid Reform Proposal: The agency submitted a concept paper to the federal government outlining the concepts of a Medicaid reform proposal. The proposal is designed to provide consumer choice in the Medicaid program and stabilize expenses for the state.

Management/Customer Service Training: For the second year, the agency required management employees to participate in intensive leadership training, while all employees participated in a customer service training series. Both trainings were conducted by State Budget and Control Boards' Office of Human Resources.

Agency Wins Two Health Awards: DHHS earned two Prevention Partners Awards from the Budget and Control Board. The agency was recognized with The Outstanding Administrator Award and The Award for Excellence.

Agency Restructuring: The Aging unit was transferred to the Lieutenant Governors Office, as part of the State Fiscal Year 2005 budget bill. Aging oversees services provided by Older Americans Act funds.

Opportunities and Barriers for FY 2005-2006

Opportunities

- DHHS is operating with a solid, yet conservative, budget in SFY 2006.
- DHHS is developing a plan to encourage consumer choice and encourage competition within the Medicaid program through the Medicaid reform Waiver, called "South Carolina Healthy Connections."
- The three operating Medical Homes Local Networks will encourage responsible and preventive use of Medicaid services, rewarding providers for coordinated care and strong health and financial outcomes.
- The agency is developing pay for performance standards for local Eligibility workers.

Barriers

- Increased utilization of costlier services is contributing to an unsustainable Medicaid growth rate.
- Legislative restrictions on pharmaceutical dispensing fees and the use of prior authorizations curtail administrative flexibility and potential cost-reducing efforts.
- DHHS' lack of control over other state agencies' use of Medicaid hinders managerial oversight.
- The full effect of the Medicare Modernization Act has yet to be determined.

Use of Accountability Report to Improve Organizational Performance

Executive Staff review the elements of this report, committing to the goals and performance measures relevant to their work. Periodic review of this report throughout the year will help DHHS prioritize work in relation to the mission and provide a check on progress toward the agency goals.

II. BUSINESS OVERVIEW

DHHS administers Title XIX of the Social Security Act (SSA). This is the state's Medicaid program, including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long Term Care System. In addition, the agency administers Title XXI of the SSA, the state's Children's Health Insurance Program (CHIP), and the Optional State Supplement program. DHHS also manages SilverCard, which provides prescription drug assistance to low-income seniors, and is transitioning this program to a State Pharmacy Assistance Program to exist in coordination with the new Medicare Part D drug coverage.

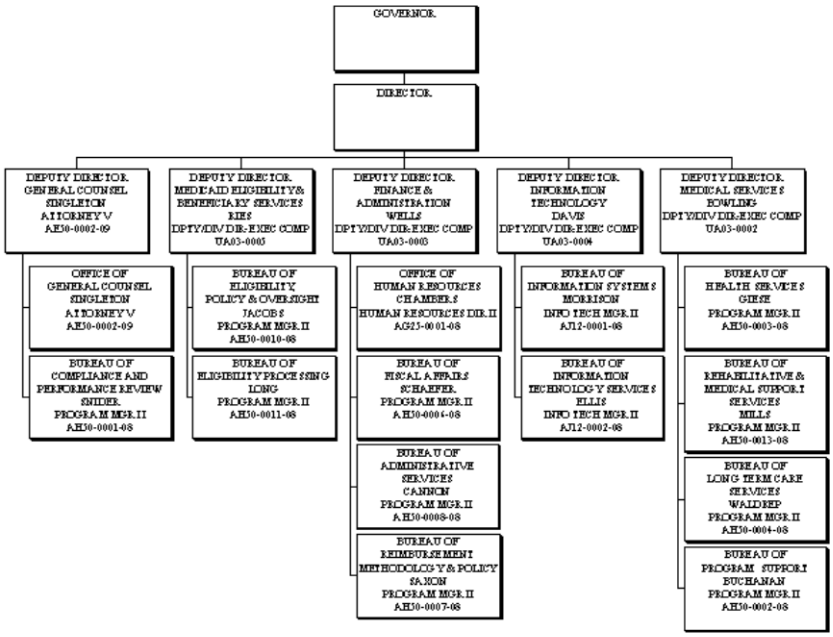
Working with the Governor and Legislature, DHHS leadership led the agency through great changes during SFY 2005, streamlining the organization and designing programs that meet the needs of qualified South Carolinians. Adhering to its mission to provide value in the state's Medicaid program, DHHS is applying a progressive, business-like approach to providing quality health care coverage to low-income families and the state's aged, blind, and disabled.

Medicaid in South Carolina

- Provides for 20% of the state's population
- Pays for more than 50% of all births
- Covers more than 40% of all children
- Covers 33% of all seniors
- Pays for 75% of all nursing home beds
- Total budget of more than $4.2 billion
- Accounts for 19% of General Fund budget
- More than 30 million annual claims

DHHS employs about 1,130 full-time positions, 229 temporary grant positions, and 15 state temporaries for an estimated total of 1,374 positions in the Columbia and throughout the state under the following organizational structure: (next page)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SEPTEMBER 6, 2005



Base Budget Expenditures and Appropriations – graph on next page

Base Budget Expenditures and Appropriations

Note: The Excel Spreadsheet, "Major Program Areas" is included with this submission.

	03-04 Actual Expenditures		04-05 Actual Expenditures		05-06 Appropriations Act	
Major Budget Categories	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**
Personal Service	$39,906,088	$14,245,552	$ 38,413,555	$ 14,095,802	$ 42,249,725	$ 13,834,530
Other Operating	$149,486,631	$17,222,187	$ 102,015,355	$ 16,271,034	$ 144,211,652	$ 16,308,887
Special Items	$1,218,159	$1,072,814	$	$	$	$
Permanent Improvements	$1,250,000	$0	$	$	$	$
Case Services	$3,703,406,881	$519,839,023	$ 4,303,425,597	$ 687,211,502	$ 4,509,609,960	$ 754,152,929
Distributions to Subdivisions	$434,801	$0	$	$	$	$
Fringe Benefits	$11,469,478	$4,052,834	$ 10,905,961	$ 3,958,550	$ 12,414,881	$ 4,219,822
Non-recurring	$443,310,220	$1,001,637	$ 105,142,238	$	$ 91,661,519	$
Total	**$4,350,482,258**	**$557,434,047**	**$ 4,559,902,706**	**$ 721,536,888**	**$ 4,800,147,737**	**$ 788,516,168**

Key Customer Segments, Products/ Services, Stakeholders and Suppliers

DHHS Key Customer Segments are the Medicaid health providers, including other state agencies, and the people who use the services of those providers. The "products" DHHS provides is management of the funding and structure of the state's Medicaid program. This means efficient provision of enrollment and utilization services for both providers and Medicaid recipients. The other side of the service provision is the agency's work to ensure proper use of Medicaid in the state, therefore both providers and recipients are also subject to the agency's pursuit of fraud and abuse, when necessary.

The key stakeholders beyond these customers are the taxpayers and state leaders who fund and oversee the Medicaid program. Due to the size of the agency's reach and the amount of public money involved, in addition to the number of lives and businesses affected, the work of DHHS is subject to the input of many voices. Whether it's the elimination of a service, reduction in reimbursement, or an increase in rate and expansion of a care option, market forces and lives feel the affects of agency decisions. Therefore, each and every agency employee acknowledges a significant stewardship responsibility to the taxpayers for the funds this agency administers and to the Governor and the General Assembly for the responsibilities entrusted to this agency.

The suppliers that support the design and implementation of Medicaid-sponsored care include research entities, health care associations and brokerage companies, administrative support firms, and many other businesses and organizations that assist the agency in everything from identifying a healthcare need to designing software to track expenditures.

III. MALCOLM BALDRIGE CRITERIA

Category 1 – Leadership

1.1 How do senior leaders set, deploy and ensure two-way communication for:

a) short and long term direction?

Executive Staff work with the Bureau Chiefs (managers of programmatic areas) to identify key agency needs. Executive Staff developed a mission statement and three agency goals reflecting the current state of the agency and the Medicaid program. These have been framed and hung by the elevators on each floor in the central office, and have been communicated via leadership staff meetings, and through the agency's newsletter.

To deploy staff and resources toward the goals, the Executive Staff then began to hone in on the projects the agency should be pursuing – identifying what work is essential for DHHS. In determining what projects to undertake, the primary issue is the value of a project – what project accomplishment will mean for the state, and how the project supports the agency's goals. Prioritizing the list of needs and determining what resources the agency can employ are other major factors. Throughout this process, agency employees were consulted.

Once projects are identified, the team is deployed and communication is facilitated by the agency's GO (Goal Outcome) system. This management tool helps agency staff and leadership staff tracks the status of projects. Every major project gets a "GO" sheet. All projects, short or long term, are managed along the way through staff meetings and the GO sheet system. All staff has access to the GO system summary sheet, which lists all agency projects.

b) performance expectations?

As the mission and goals were developed, Executive Staff used feedback from teammates to identify the Success Indicators that will measure the progress of projects. Performance expectations of employees are tied to these success indicators, and each EPMS will be managed with an eye toward the overall goals, and how the employee performs in relation to the goals. Through staff meetings and day-to-day management, Executive Staff communicate, reward and enforce expectations.

c) organizational values?

As mentioned, the agency's organizational values have been formally adopted and shared by leadership staff in formats from department meetings to framed pieces hanging at each elevator. The five values of Service, Excellence, Responsive(ness), Value, and Everyone are designed for all to support.

d) empowerment and innovation?

Involving bureau staff in developing and continuously monitoring the GO system projects (projects feeding into the agency's overall goals) ensures that each employee feels ownership in the agency's mission and is empowered to suggest modifications. The GO sheet system is by design empowering in that it puts a self-reporting mechanism in the hands of those who are working agency projects. Additionally, recognizing project accomplishments along the way in Bureau Chief meetings and the agency's monthly newsletter will enhance individual empowerment.

e) organizational and employee learning?

Executive Staff recognize the need for appropriate organizational and employee learning to reinforce the knowledge and skills of employees, thereby improving delivery of services. State-sponsored training

opportunities, like the Certified Public Managers' Program, are identified and encouraged. For the second year, the agency participated in training of supervisory skills for management staff; program-specific training for designated staff; and customer service and HIPAA compliance training for all staff. These training opportunities were designed in response to employee feedback. Employees were encouraged to provide feedback following the trainings, too, for leadership to determine what training is helpful and what other training may be needed.

f) ethical behavior?

Ethical behavior is encouraged primarily through the following value of the agency:

E*veryone: We are a team; every employee is involved in our success; we believe in servant leadership and empowering employees to solve customer problems; as a team we will encourage and hold each other accountable.*

To encourage accountability, the agency took steps to strengthen supervisory oversight in areas that could be more open to fraud and abuse. For example, increased supervisory audits continue by management of eligibility offices statewide. Also, eligibility rules were changed last year to prevent workers from handling cases involving family members. These types of efforts reflect the agency's increased awareness of potential unethical behavior and proactive efforts to create a climate of integrity.

1.2 How do senior leaders establish and promote a focus on customers and other stakeholders?

The agency values, as articulated in the Executive Summary, establish and promote a focus on customers and other stakeholders. A major example of the administrations' focus on customers is the revamping of the constituent "log letter" process. Log letters are used to answer questions from the public, including Medicaid recipients, legislators, applicants, and provider organizations. Recognizing the importance of these Medicaid partners and the potential to support relations with these teammates, the agency has re-designed the process that ensures all questions get an answer. The result is a thorough and responsive correspondence and e-mail system that helps people get the answers they need. The agency's toll-free numbers and Web site also promote a focus on customers by providing access to agency staff and information.

As mentioned in question 1 (e) above, mandatory customer service training was offered again this past year for all agency staff. DHHS worked with human service personnel from the Budget and Control Board to design and deliver this training, which focused on the skills necessary to support employees in their public service. Also, the agency is creating a customer service team to study the ways the agency works with all partners and potentially reorganize the various components within a customer service unit. Also, a new internal customer service award was developed this year, with cash and food prizes to recognize employees who make extra efforts in helping DHHS customers. In addition, the agency developed an award for employees who find more efficient ways to perform agency tasks.

1.3 How do senior leaders maintain fiscal, legal, and regulatory accountability?

The agency has placed General Counsel as a Deputy Director- highlighting the importance of this function within the agency. Senior leaders require all proposed changes to programming or reimbursement to conform to state and federal guidelines before implementation. Proposals must identify which legal steps must occur before any change is pursued. In addition, the Medical Care Advisory Council (MCAC), a group of statewide healthcare advocates, advises the agency on Medicaid

issues. Finally, the agency is proactive in working with legislators and the Governor's office on all issues involving fiscal, legal, or regulatory considerations.

1.4 What key performance measures are regularly reviewed by your senior leaders?
Executive Staff continually examine the GO sheets, which identify the major agency projects (and how they tie to agency goals), as well as the status of these projects. The GO sheets indicate the budgetary impact of any project – the costs or potential savings involved. Also, fiscal staff regularly reports to senior leaders, so the leaders are aware of the financial performance of their areas of the organization. These regular reports include the following:

- *Operational Performance* - utilization rates/trends, accuracy measures, eligibility accuracy reports, program integrity audits;
- *Customer Performance* - customer response/efficiency reports, claims data, provider reimbursements information, eligibility efficiency reports;
- *Financial Performance* - fiscal charts, budget-to-actual reports; and
- *Mission and Program* - strategic plan review, program specific outcome measures.

1.5 How do senior leaders use organizational performance review findings and employee feedback to improve their own leadership effectiveness and the effectiveness of management throughout the organization?
Using the information provided from the measures in 1.4 above, agency leaders get a sense of what they're employees are managing, and what their challenges are. If a project is behind schedule or over budget, senior leaders know to improve their management of their teammates. By staying accessible to their employees, and by using input from Bureau Chiefs, Executive Staff can assess the leadership strength and needs throughout the agency. Also, the Employee Performance Management System (EPMS) process offers a tool for Executive Staff to assess management strengths and challenges.

1.6 How does the organization address the current and potential impact on the public of its products, programs, services, facilities and operations, including associated risks?
The GO sheet system, which requires program staff to identify impact to beneficiaries and providers, plus positives and negatives, ensures agency staff considers the results of the programs and operations of DHHS. Executive Staff, particularly the legal and fiscal staff, as well as the MCAC, provide further risk assessment. Also, by working with key constituencies like providers, legislators, and recipients, agency staff can identify the impact and risks of proposed action.

1.7 How does the senior leadership set and communicate key organizational priorities for improvement?
(See 1.1 – particularly the use of the GO sheet system as a prioritization tool)

1.8 How does senior leadership and the agency actively support and strengthen the community? Include how you identify and determine areas of emphasis.
Executive Staff and the entire DHHS team are encouraged to participate in community organizations and task forces, and their causes – like the United Way, the Red Cross, the Public Health Association, and other efforts. Any employee with an idea for an area of emphasis can go to the agency's employee activity committee, called CHAMPS (Community, Health, Activity, Morale, Program and Service), which will work with senior leadership to select and publicize which community causes/events the agency will support. Issues related to personal and community health are often focused upon.

Category 2 – Strategic Planning

2.1 What is your Strategic Planning process, including KEY participants, and how does it account for:

a. customer needs and expectations;
b. financial, regulatory, societal and other potential risks;
c. human resource capabilities and needs;
d. operational capabilities and needs; and
e. supplier/contractor/partner capabilities and needs?

The Strategic Planning process begins with feedback from employees and service partners like providers, legislators, and recipients. Combining such feedback with ideas from staff and agency leadership leads to the cultivation of ideas. All ideas, from any source, can be brought to agency staff, and through Bureau Chiefs go to the Deputy Directors. All these people are key participants as are families of recipients (who often have important feedback that helps the Strategic Planning process) and advisory groups like the MCAC.

The process employs communication tools like a toll free number, beneficiary notices, and a beneficiary newsletter to account for customer needs and expectations (a). Financial, regulatory, societal and other potential risks (b) were addressed in 1.6 above. Human resource capabilities and needs (c) are identified during the GO sheet procedure, as team members, a team leader, and required financial resources must be identified. By having Deputy Directors (senior leadership) share one GO tracking system, any operational capabilities and needs (d) are addressed because these top managers can ensure adequate resources are available. The same principle of sharing a project tracking system means that supplier/contractor/partner capabilities and needs (e) are also considered during the Strategic Planning process.

2.2 What are your key strategic objectives? (Outlined in Strategic Planning Chart)
DHHS key strategic objectives are represented by the projects outlined in the Strategic Planning Chart.

2.3 What are your key action plans/initiatives? (Outlined in Strategic Planning Chart)

2.4 How do you develop and track action plans that address your key strategic objectives?
The GO (Goal Outline) tracking system, described in 1.1, is the agency's plan to develop and track plans supporting the strategic objectives. The GO system ensures that resources are deployed for strategic objectives.

2.5 How do you communicate and deploy your strategic objectives, action plans and performance measures?
The GO sheet project priority/tracking system, outlined in 1.1, is the key communication and deployment tool.

2.6 If the agency's strategic plan is available to the public through the agency's Internet homepage, please provide an address for that plan on the website.
N/A

Category 3 – Customer Focus

3.1 How do you determine who your customers are and what their key requirements are?
For the second year, state personnel professionals led the DHHS leadership through discussion, group exercises, and study focusing on providing excellent customer service, identifying and measuring goals, leading and motivating teammates, communicating within and across departmental boundaries, and applying business principles to DHHS operations.

The major role of DHHS is to manage the state Medicaid program by paying for health services provided by qualified providers to eligible beneficiaries. Primary customers, therefore, are those who get paid (medical professionals) and those they serve (Medicaid recipients). Determining the requirements of customers happens through agency correspondence and surveys, focus group studies, review of letters/feedback to the agency, and constant communication with these customers.

For applicants and recipients, primary interaction is through eligibility offices, Medicaid recipient bulletins, the agency's toll-free number, the beneficiary newsletter, and website. The toll free number answers tens of thousands of calls each month, and uses each customer service call as an opportunity to gain insight of the needs Medicaid recipients have.

Provider representatives can meet regularly with DHHS leadership and give feedback through the Medical Care Advisory Committee (MCAC) and through interactions on task forces and in professional working groups like provider association meetings. In addition, a new physicians advisory group was created to guide the agency in healthcare-related business decisions.

3.2 How do you keep your listening and learning methods current with changing customer/business needs?
The Internet has been the area of most change in regard to listening and learning. In addition to the website and public e-mail address, the agency is doing more business and receiving more feedback through online billing and issue resolution tools. In the future, the state health agencies will learn more about the recipient populations through the data warehouse and client management tools.

In addition, the customer support services available to specific provider groups (Durable Medical Equipment providers, specialty care providers, etc.) use feedback they receive from phone conversations and business transactions as a major means of learning what our customers need.

For recipients, the major source of information comes from the local Eligibility Offices. In addition, a yearly Medicaid beneficiary newsletter also goes out to all recipients, delivering content based on feedback from recipients. Finally, in the past year, the agency has created a working Customer Service Team that meets quarterly, to share ideas and improve customer service across all departments.

3.3 How do you use information from customers/stakeholders to keep services or programs relevant and provide for continuous improvement?
DHHS tries to meet customers proactively to learn of their needs and provide adequate services. For example, the agency worked to create a medical homes local provider network in response to physicians' feedback on how to develop medical homes and empower providers to help manage Medicaid in their areas. The result in this case is a medical homes cooperative that will offer a structure that rewards local physicians for good health and fiscal outcomes – as they requested.

And as always, to be accessible to customers on issues of importance, DHHS has representation and/or communicates regularly with dozens of provider and advocacy-related organizations. Information gathered through such groups is used to continuously evaluate and improve program operation.

3.4 How do you measure customer/stakeholder satisfaction?
DHHS uses surveys, focus groups, consumer forums and service utilization analysis, in addition to public feedback, to evaluate the satisfaction of customers and stakeholders.

3.5 How do you build positive relationships with customers and stakeholders? Indicate any key distinctions between different customer groups.
The agency's effort to build positive relationships is embodied in the SERVE value guidelines, as indicated in the Executive Summary.

The Director and Executive Staff are committed to an open-door policy for recipients, providers and other interested parties. Executive Staff regularly meet with customers and stakeholders to discuss concerns by meeting with these parties regularly and availing themselves as speakers and participants in these constituencies' programs.

Since the open flow of information and productive communication are essential to any positive relationship, the Director has streamlined the agency's procedures for responding to letters and e-mails, ensuring more timely responses to the public, legislators and the media.

To help Medicaid recipients with issues facing them, the agency continues sending a beneficiary newsletter. Regular reporting to providers and beneficiaries through bulletins and notices helps build positive relationships.

Regarding the general public, the agency uses outreach efforts like press releases when necessary to offer information to help people understand Medicaid programs and when relevant, make proper choices regarding their own care.

Since legislators need to know about the programs and funding of the agency, DHHS staff work to keep key political leaders and their staff apprised of the agency operations, striving to remain accessible and offer timely responses.

With all these audiences, the agency website is increasingly becoming a vital communications tool. The agency revamped the website during SFY 2005. Now applicants can view income guidelines online, and find all forms necessary to apply for Medicaid in most cases. Providers can sign up to participate in Medicaid, view fee schedules, and read bulletins and manuals online.

To build and maintain effective customer relationships, the agency again embarked on agency-wide customer service training. In addition, the agency has created an internal customer service award with prizes included that recognizes outstanding customer service by agency employees.

<u>Category 4 – Measurement, Analysis, and Knowledge Management</u>
4.1 How do you decide which operations, processes, and systems to measure for tracking financial and operational performance?

DHHS leadership tracks the operations, processes, and systems that show whether the agency is meeting goals and operating an efficient and effective program. Executive Staff recognize the need for these measurements and seek them by tracking major initiatives and their Outcome Measures as defined in the GO sheet system. Therefore, each time a working group plans a major project, the group identifies the outcome measures that will be collected.

In addition, state/federal laws require that certain aspects of programs be evaluated and program data be reported, including outcomes and profiles of processes or populations. Still other measurements may be assessed in response to special inquiries from the public, media, the Governor, General Assembly, or other interested parties.

DHHS leadership regularly reviews the financial and operational data of program lines and assesses year-to-date status to identify potential issues and make adjustments as needed. One tool that will help with this effort is a decision support system the agency has just contracted obtained. This vital management data will be available to executive staff to support value-based decisions. This system will provide high-level financial key indicators, as well as information on service utilization dynamics and potential fraud and abuse cases.

4.2 What are your key measures?

In addition to the standard measurements identified above for individual components, the agency's broader measures have been identified that will indicate progress toward the overall goals.

For the first goal of providing a benefit plan that improves member health, is evidence based, and market driven, the key measures are:

- To establish a baseline index of general health for Medicaid members relative to the general population;
- To increase the number of consumer-driven, incentive-based medical homes; and
- To maintain the average Medicaid expenditures per person below the growth rate of healthcare costs nationally.

For the second agency goal of providing a credible and continually improving eligibility process that is accurate and efficient, the key measures are:

- Establish a customer satisfaction survey baseline;
- Average Processing Time – compliance with federal processing guidelines;
- Percent accurately processed within federal requirements; and
- Establish average cost per application baseline.

For the third agency goal of providing administrative support at the best possible value to ensure programs operate effectively, the key measures are:

- To realign the workforce to maximize savings while maintaining the percentage of administrative cost to program cost at less than 3%;
- To establish an internal customer satisfaction survey baseline;
- To provide at least ten examples of substantial savings and/or process improvements as a result of leveraging technology; and
- To enhance savings by 10% by expanding the number of fraud and abuse reviews, and audit compliance reviews.

4.3 How do you ensure data integrity, timeliness, accuracy, security and availability for decision making?

Due to the broad scope of services managed by DHHS, the number of provider partners involved, the amount of money from various funding streams, and the diversity of populations being served, DHHS stands as a source of nearly limitless data measurement possibilities. The Deputy Director for Information Technology and the Deputy Director of Finance and Administration, both executive staff members, have a vital role in ensuring data integrity, timeliness, accuracy, security, and availability to support staff, legislative, and other state leaders' needs.

First, the agency's acquisition of a decision support system will go a long way toward providing timely and accurate information for decision. Such high-level data will guide the agency in first identifying areas to improve, and then finding appropriate solutions to better provide value in the Medicaid program.

In addition to this developing system, the Division of Research and Analysis and the Division of Budgets are responsible for capturing, analyzing, and presenting the data necessary to monitor program and fiscal trends to ensure the availability of necessary data to help agency and elected leaders make decisions.

In addition, the Office of Compliance and Performance Review is working to ensure the integrity and accuracy of the processes and services behind the data. Other strategies to protect data quality and ensure accessibility include reviews of comparative data and investigations of variances; access for providers to the data system via the Web; internal audits; and federal audits.

To ensure timeliness the agency has designed many reports that measure month-to-date outcomes for continuous analysis and timely availability of major program lines. Availability is assured by the agency's compliance with all appropriate requests for data, and the timely submission of state and federally required measurement reports. Many of these data sources are available online for public use.

Regarding security, the agency is committed to keeping Medicaid information confidential, especially information that can lead to identification of individuals, as required by law. DHHS has met the major HIPAA deadlines and has made extensive outreach during the past year to help providers and other agencies meet HIPAA guidelines. Regular updates from HIPAA staff and annual HIPAA training help all staff remain cognizant of privacy and security issues.

This focus on managing and improving information systems allows DHHS to provide and respond to the Governor, General Assembly, advocacy groups, the general public, and the media with adequate and accurate data for decision-making.

4.4 How do you use data/information analysis to provide effective support for decision-making?

Quality data is the foundation of all decision-making at DHHS. The Deputy Director of Information Technology is facilitating access to the myriad reports and statistics requested during decision-making processes. Executive staff has access to such reports directly from software installed on their computers. The agency is placing a priority focus on fiscal forecasting in programmatic planning. Again, the presence of the decision support system will help with this function.

Beyond standard agency reports, the availability of more specific demographic, fiscal, and programmatic-type reports is helping planners make data-driven decisions. Though most of the data is generated within the agency, occasionally the gathering of data is beyond the agency's ability, and DHHS will contract to obtain the information needed. DHHS has been a key partner in the development of the statewide data warehouse and client management system, in hopes of coordinating what health agencies know and what these agencies do in regard to the people who are served in South Carolina. The agency sees these efforts as a vital component to increased data-based decisions in providing health services.

To provide data and analysis available for public consumption, and to support state leaders' decision-making, DHHS created an Annual Report during SFY 2005. This report provided a one-stop tool highlighting the dynamics and challenges of the state's Medicaid program, with dozens of pages of graphs and charts examining the programs and services, as well as the populations and providers, involved in Medicaid.

4.5 How do you select and use comparative data and information?

The selection and use of comparative data is determined by the nature of any given situation. DHHS frequently uses regional and national data to compare South Carolina with other states. DHHS also uses fiscal quarter and year comparative data to identify utilization and expenditure trends for policy planning. Often, data comparing year-to-date utilization and expenditures is used to chart progress through the budgetary year. The specific variables of service type or price, usage rates, or eligibles' demographic information define the type of report/chart/graph that is created and used. The key to effective use of comparative data is the agency's ability to create the measurement tools to quantify the needed information. The agency is committed to supporting the infrastructure to provide these management tools, as evidenced by the purchase of a decision support system.

4.6 How do you manage organizational knowledge to accomplish the collection and transfer and maintenance of accumulated employee knowledge, and identification and sharing of best practices?

The collection and transfer of accumulated employee knowledge is managed in two arenas. First, at the program level, the Division and Department level, workers are providing on-the-job training and sharing of knowledge and ideas to perform agency tasks and ensure a pipeline of qualified workers for DHHS. In addition, program-level knowledge and job skills are then shared at the Bureau Chief and Deputy Director level, where agency-wide projects and strategic planning may require cross-department cooperation. At this executive staff level, the transfer of ideas is vital to ensuring efficient operations, eliminate duplicative efforts, and set the standard for future performance on similar efforts.

Specific tools used to capture and transmit agency knowledge include this Accountability Report, which is available to all employees on the agency's internal Intranet site, the Communique newsletter which shares agency knowledge and best practices monthly, and the Support Staff Guidebook.

In addition, DHHS uses available state and agency training extensively to share knowledge and capture best ideas. From initial job-specific training to agency-wide ongoing training to refresh all DHHS teammates in best practice concepts, leadership strives to stress the importance of training in regard to

creating a seamless work environment that ensures all staff know all they can to perform their jobs effectively.

Some final notes on sharing best practices: the agency's quarterly employee recognition program, and various department-level monthly or quarterly employee recognition efforts, are designed to identify best practices and share lessons that are learned among the DHHS team. Also, the agency began an award program during SFY 2005 that recognizes employees who think up better ways to do business.

Category 5 - Human Resources

5.1 How do you and your managers/supervisors encourage and motivate employees (formally and/or informally) to develop and utilize their full potential?

Formal tools used to motivate and encourage employees include regularly scheduled meetings with peers and supervisors, and a variety of agency training programs that are offered on an ongoing basis, as well as external programs such as the Certified Public Managers' Program and the Executive Institute that develop professional skills and enhance potential. Employees with specialized degrees or certifications (like CPAs, RNs, etc.) are strongly encouraged to keep up their certification and qualification levels. In addition, recognition is given through stories in the monthly newsletter, the *Communiqué*, and our Employee of the Month Award.

5.2 How do you identify and address key developmental and training needs, including job skills training, performance excellence training, diversity training, management/leadership development, new employee orientation and safety training?

As mentioned in 1.1 (e) and 4.6, the agency uses development and training programs as a key tool to ensuring a knowledgeable workforce for the state's Medicaid program. Two primary sources define the type of training available at DHHS. The first is the observation of managers and their feedback to Human Resources. Managers can recommend high-achieving employees for programs such as the Certified Public Managers' Program and the Executive Institute. Secondly, a training menu offered by the State Budget and Control Board is offered to agencies.

DHHS just completed a second year of aggressive training, with all supervisors and managers going through a mandatory management-training program that focused on the qualities of effective leadership. Additionally, each and every employee in the agency was required to complete Customer Service Excellence training.

5.3 How does your employee performance management system, including feedback to and from employees, support high performance?

Our Employee Performance Management System (EPMS) engages both the employee and supervisor to actively define, refine, and rate job performance. The process is designed to keep channels of communication open and, by documenting optional "objectives," allow for flexibility to adjust the report to accurately reflect the actual work. Beyond adjusting "objectives" as they arise, managers are encouraged to re-write position descriptions when major changes are made to an employees job duties. The EPMS is developed keeping daily job duties in focus, thereby giving the employee and supervisor goals which can be easily measured. As stressed at the agency-wide managerial training, DHHS is strongly encouraging all managers to ensure that the EPMS process is managed in a timely fashion.

5.4 What formal and/or informal assessment methods and measures do you use to determine employee well being, satisfaction, and motivation?

DHHS encourages open lines of communication among employees, supervisors and Executive Staff. All agency units are encouraged to celebrate events together. Much of this is organized agency-wide by the employee activity committee, called CHAMPS (Community, Health, Activity, Morale, Programs, and Service), which plans events like ice cream socials and holiday parties for all employees. In addition, an employee suggestion box is located at the main entrance to the administration building. A new development, used not so much to measure motivation as encourage it, is a digital display message board that greets employees at the main office. This message board features quotes of inspiration and messages of congratulation, along with other agency-related information.

5.5 How do you maintain a safe, secure and healthy work environment? (Include your workplace preparedness for emergencies and disasters.)

Executive Staff work to ensure a safe place for employees. Attention to the work environment is the proactive way to avoid incidences. In addition, proper handling of workers compensation claims and other reports of incidents help identify future potential issues. Leadership is regularly informed of reports and trends on safety and health issues.

In addition, DHHS has an active CHAMPS Team that helps bring various classes and screenings to the agency to encourage employees to monitor and promote healthy living. Activities like aerobics and yoga are available on-site during lunch hours. The Employee Wellness Committee also promotes various charitable walks throughout the Midlands to help the community and get workers involved.

The security division has increasingly employed measurements and tracking systems to ensure a safe work environment. DHHS security has made improvements such as magnetized card access, security cameras, and a guard service at the main entrance to increase safety. The agency has paid particular attention to its role in the statewide network of responders and emergency personnel staff, and uses regular e-mail updates during times of natural disasters.

5.6 What activities are employees involved with that make a positive contribution to the community?

The agency has a solid presence in many statewide health and advocacy groups. For example, several agency employees are serving in leadership roles within in the State Public Health Association. Program staff also participates as members of a variety of study groups and commissions that examine issues and make recommendations to agencies and public policy leaders in a broad range of topics. In addition, DHHS offers flexible scheduling for employees to volunteer at schools or serve on various local boards. DHHS employees are encouraged to participate in community events like bake sales, blood drives, awareness walks, and other fundraising efforts and bring these opportunities to the attention of their colleagues, as appropriate. Each year, the agency is a major state agency contributor to the state's United Way Campaign. Finally, program and executive staff are encouraged to participate in forums, and even serve as keynote speakers, when appropriate.

Category 6 – Process Management

6.1 What are your key processes that produce, create or add value for your customers and your organization, and how do they contribute to success?

DHHS pays providers to deliver services to eligible beneficiaries. Therefore, DHHS "processes" include supporting medical providers, managing the rates they are paid, and qualifying and supporting the people they serve. In the future, the processes could involve measuring and rewarding quality outcomes, too.

Key design and delivery processes include:

- MEDS (Medicaid Eligibility Determination System) – a program to ascertain eligibility of applicants;
- MMIS (Medicaid Management Information System) – the database of beneficiary demographics and usage information;
- Provider contracts and enrollment agreements – the arrangements bringing providers into the system;
- GAFRS – the system that manages payments to providers;
- The use of external actuaries to set managed-care reimbursement rates;
- PEP (Physician Enhanced Program), HMOs (Health Maintenance Organizations), HOP (Health Options Program) – various health care delivery options designed to address the various needs of beneficiaries;
- Private managed care and Medical Home Networks – other options of care delivery for beneficiaries designed to organize all aspects of their care under one provider's management (a "medical home"); and
- The toll free beneficiary call line, as well as the provider service lines. These services, in addition to an internal letter response system, ensure timely and accurate answers to the public, legislators, media, our provider partners, and the people who rely on Medicaid for their health care needs.

6.2 How do you incorporate organizational knowledge, new technology, changing customer and mission-related requirements, cost controls, and other efficiency and effectiveness factors into process design and delivery?

By driving the agency's new projects through the thought process of the GO sheet tracking system, which requires project managers to examine the benefits and outcomes of pursuing initiatives, the agency is supporting the consideration of factors like technology, customer requirements, cost controls, etc. into the planning and design of agency pursuits. By looking at factors like "potential savings," "impact on beneficiaries," and "positives/negatives/and other relevant information," employees must pursue existing organization knowledge as well as consider cost controls, new technology or changing customer requirements in process design and delivery.

In regard to existing and on-going agency work, the incorporation of such factors in process design and delivery is ensured through constant assessment of workflow processes and outcomes. Such assessment is encouraged at the Bureau Chief level, where these leaders are frequently examining their program areas' outcomes and procedures. All employees are encouraged to utilize organization knowledge, new technology and cost control elements in their work. Changing customer and mission-related requirements are incorporated whenever such changes are identified.

6.3 How does your day-to-day operation of these processes ensure meeting key performance requirements?

The design/delivery processes are all monitored at various levels. Bureau Chiefs, who work at a level that empowers them to set major initiatives yet remain close to the process, are often the staff keeping an eye on how the processes are meeting requirements. Therefore, Bureau Chiefs meet frequently with their supervisors, the Executive Staff. In addition, Bureau Chiefs meet frequently as a group to discuss progress toward major initiatives and necessary adjustments to processes.

Executive Staff meet a few times a week to keep all processes working together on agency goals. Executive Staff are constantly reviewing the processes and outcomes of the bureaus they oversee. Their meetings allow for rapid response to intercept potential problematic issues or merge processes when cooperation will lead to better outcomes.

6.4 What are your key support processes, and how do you improve and update these processes to achieve better performance?

Due to the complexity and scope of services provided by DHHS, there are a multitude of support processes. There are health service units that support providers, and customer service employees to support beneficiaries. There are processes designed to provide research support for new program development, existing program management, and state and federal legislative developments. Agency-wide, there are fiscal support services that plan and budget, reimbursement systems that ensure accurate payments, contracting and procurement divisions to support DHHS partnerships and purchasing. Other support processes include technology development and maintenance, general counsel, internal audits and external fraud investigation, and public information activity.

The employees working in these areas use customer feedback as well as internal data to provide more effective or efficient service. Bureau Chiefs and Executive Staff are empowered to restructure the personnel or funding to better align staff, make purchases, etc., to improve performance. Frequently, the improved use of technology is found to be a tool to achieve better performance.

6.5 How do you manage and support your key supplier/contractor/partner interactions and processes to improve performance?

DHHS suppliers/contractors/partners primarily include medical and allied professionals and the people receiving the care. Specific work units of the agency are dedicated to specific provider types and beneficiaries to help them get paid, get answers, get advice, get services, or whatever they may need.

A service provider may have a representative to deal with, just as a beneficiary may have a case manager. Feedback from these partners is constantly sought through electronic and paper communications. Satisfaction surveys are used, and the agency tries to communicate clearly to the partners as changes are considered and implemented. Partners have formal grievance processes they can pursue when they contest a payment amount, or eligibility decision, and the like.

In addition, DHHS employees educate and reach out to strategic partners through educational programs and materials, or trainings and conferences, to improve performance and strengthen partnerships.

Category 7 – Business Results

7.1 What are your performance levels and trends for the key measures of customer satisfaction?

DHHS' major customers are the beneficiaries who receive Medicaid services and the providers who deliver the care. In the past fiscal year, strides have been made to improve the services provided to beneficiaries by increasing web-based and communication, reducing the time necessary to apply for Medicaid, ensuring accurate phone and mail responses, and working to solve issues regarding coverage or benefits. The agency has formed a Customer Service Team that meets quarterly to work on issues that lead to improved customer satisfaction levels. All these factors, combined with anecdotal evidence (letters to legislators, calls to eligibility offices) would indicate an increase in customer satisfaction in dealing with DHHS and understanding recipients' roles and benefits within the complex Medicaid environment.

In regard to the healthcare providers, DHHS has made progress in utilizing the web for claims submission and resolution, provider notice transmission, and overall general information dissemination. The provider services components of the agency have improved the processes involved in answering provider's questions, and the infrastructure is being strengthened to contract with vendors and construct a provider support network that addresses all aspects of doing business with Medicaid. These accomplishments point to increased provider satisfaction.

7.2 What are your performance levels and trends for the key measures of mission accomplishment and organizational effectiveness?

As mentioned in Category 4.2, the agency's three goals each have several Success Indicators that will define the progress the agency makes toward the goals. For many of these, the measurement tools are being refined to capture the information for the Success Indicators criteria. The establishment of the Medicaid decision support system and the statewide Client Management System will help the agency measure these indicators.

Goal: Provide a benefit plan that improves member health, is evidence based, and is market driven.
Success Indicators: Establish a baseline index of general health for Medicaid members relative to the general population; increase the number of consumer-driven, incentive-based medical homes; maintain average Medicaid expenditures per person below the growth rate of healthcare costs nationally.
Trend: DHHS has moved the concepts of managed care, disease management, and medical homes front and center in the Medicaid environment in South Carolina. In addition, by emncouraging market-oriented mechanisms like incentive reimbursement and consumer-driven care, the agency is contributing to the trend of pursuing better health outcomes by using a business mindset in Medicaid design and delivery.

Goal: Provide a credible and continually improving eligibility process that is accurate and efficient.
Success Indicators: Establish a customer satisfaction survey baseline; average processing time-compliance with federal processing guidelines; percent accurately processed within federal requirements; establish average cost per application baseline.
Trend: The agency has instituted internal controls, managerial oversight, and investigative expansion to reduce and discourage inaccuracies, fraud and abuse within the eligibility determination system and ensure the integrity of the roles. Also, by focusing on the structure and processes of the eligibility function, with particular attention to the worker and the applicant, the agency is streamlining the process of determining who is properly eligible for Medicaid coverage.

Goal: Provide administrative support at the best possible value to ensure programs operate effectively.

Success Indicators: realign the workforce to maximize savings while maintaining the percentage of administrative cost to program cost at less than 3%; establish an internal customer satisfaction survey baseline; provide at least ten examples of substantial savings and/or process improvements as a result of leveraging technology; enhance savings by 10% by expanding the number of fraud and abuse reviews, audit and compliance reviews.
Trend: By encouraging accountability in delivering the Medicaid program, DHHS is strengthening a culture of efficiency among the employees and other partners who form the Medicaid infrastructure. Marked increases in fraud and abuse investigations and punitive actions/collections against those misusing the system has sent the signal that the agency, legislators, the Governor and the public are committed to an efficient and effective Medicaid program in South Carolina.

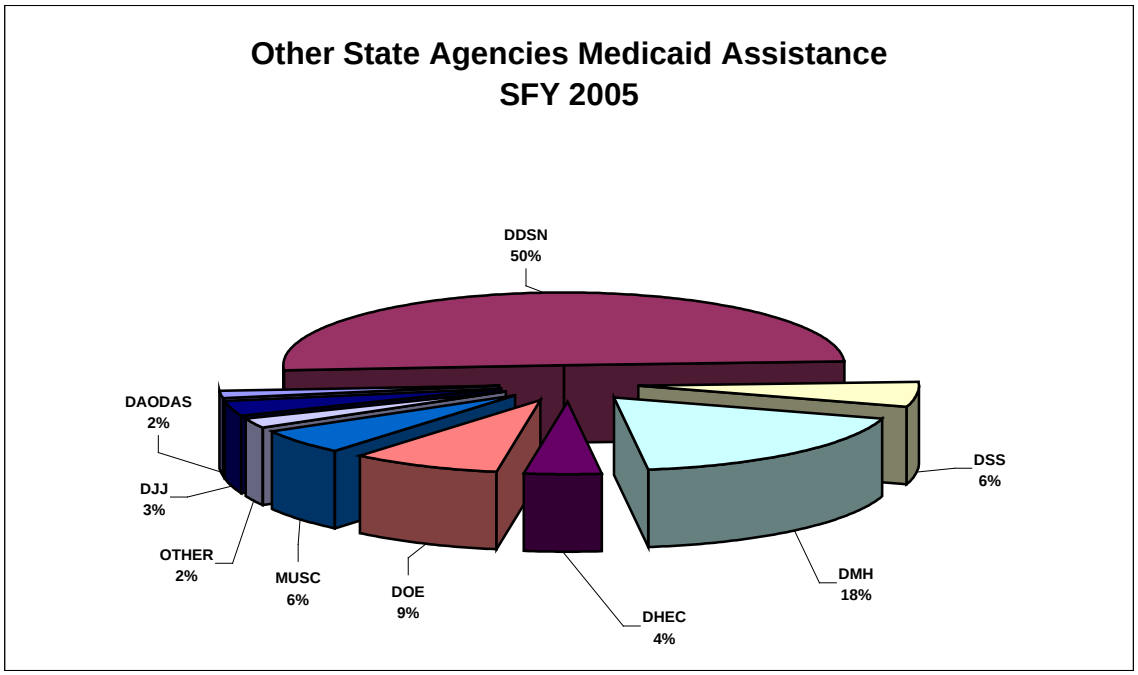
In addition to these indicators and trends, the agency has been measuring trends across all service lines, and has published recent trends in the Annual Report, to show how expenditures and recipients are changing among the Medicaid services. The Annual Report contains information explaining the dynamics behind the trends.

7.3 What are your performance levels for the key measures of financial performance?
During the past fiscal year, DHHS, aggressively focused on cost containment and programmatic controls to keep Medicaid program growth in check, with no loss in services available to recipients. In SFY 2005, DHHS expenditure growth was about 9%, higher than the previous year, but still below the national Medicaid average.

In addition to focusing on costs, the agency also focused on tightening and enforcing existing eligibility criteria. This was accomplished through increasing reviews to ensure that Medicaid services are available to South Carolinians meeting established criteria. With eligibility oversight tightened, the number of monthly South Carolinians eligible for Medicaid has held steady.

Another key development is the funding package provided in the SFY 2006 state budget, which increased the proportion of the DHHS budget that is funded from recurring general funds and reduced the amount of non-recurring funding. Thanks to efforts by the Governor and General Assembly, as well as advocates and other stakeholders, the increased proportion of recurring funds will provide South Carolina with a more stable revenue stream in the years to come. However, the agency still faces significant challenges in the years to come to contain costs and growth. These challenges are not solely based on economic or demographic factors in the state but increasingly from increased utilization of services, rising pharmaceutical costs and health related inflationary factors. DHHS will continue to aggressively contain costs internally, while providing a benefit plan that improves member health, is evidence based and is market driven.

Graphs begin on next page.

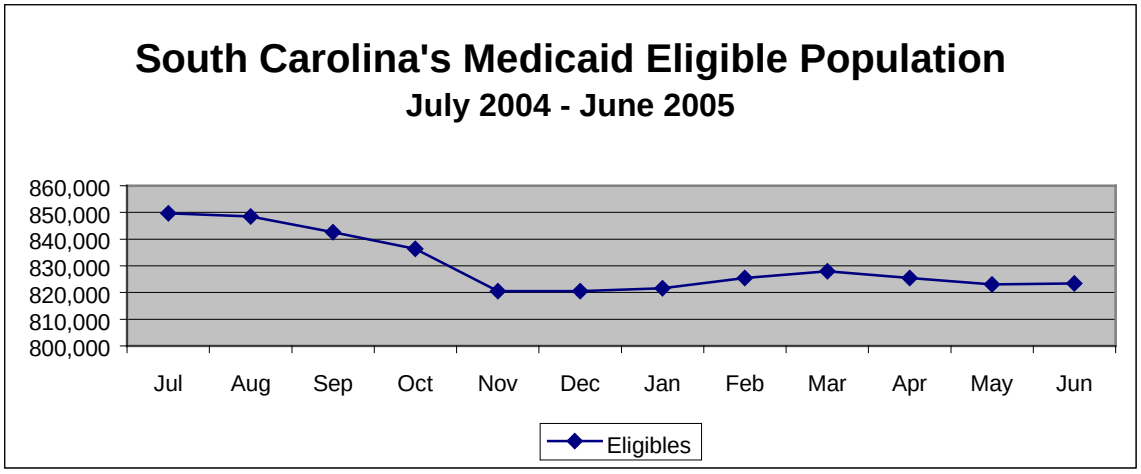


Graph 7.3-1

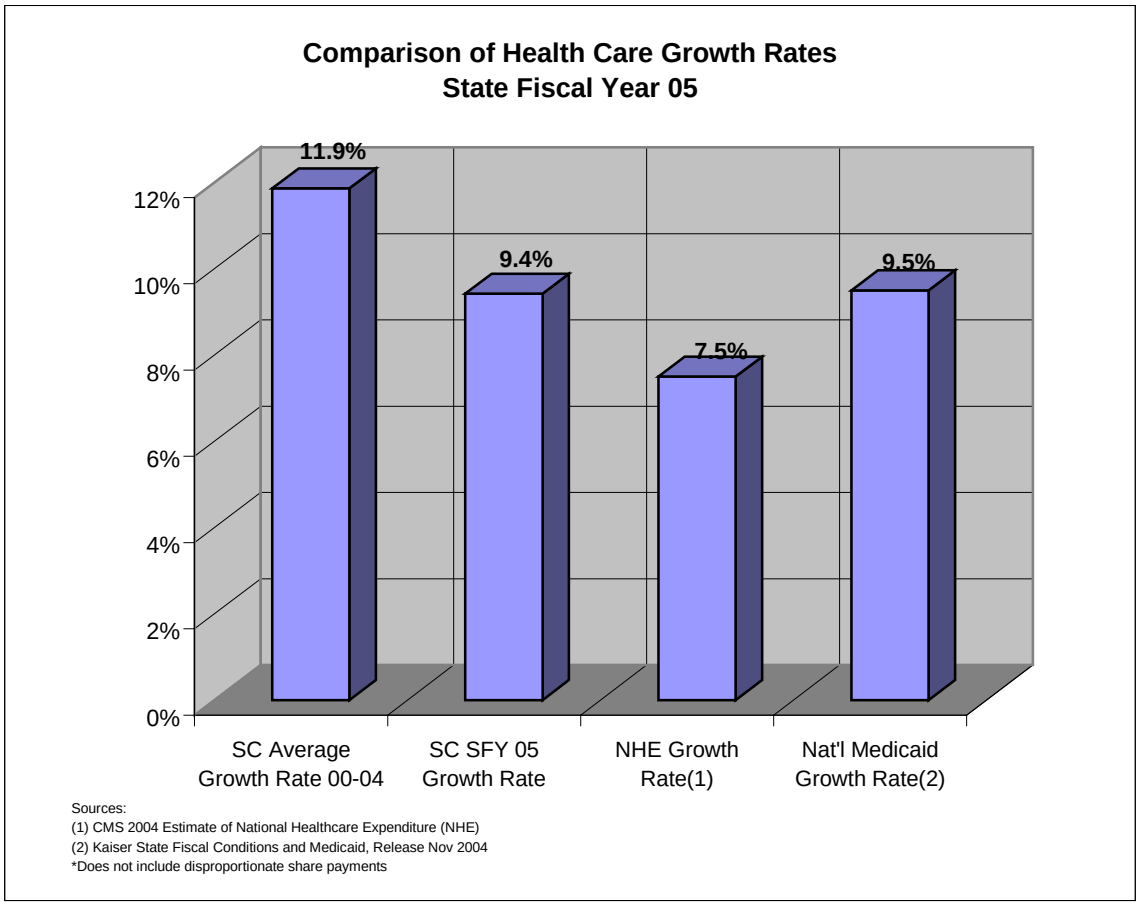
Other State Agencies Medicaid Assistance

	2002	2003		2004		2005	
Department of Mental Health	$176,915,739	$195,109,098	10.3%	$171,365,310	-12.2%	$155,403,328	-9.3%
Department of Disabilities & Special Needs	$447,672,251	$412,816,446	-7.8%	$412,987,890	0.0%	$430,634,503	4.3%
Department of Health & Environmental Control	$33,915,283	$38,725,914	14.2%	$37,298,961	-3.7%	$37,575,748	0.7%
Medical University of South Carolina	$14,538,468	$27,829,341	91.4%	$41,939,631	50.7%	$48,496,689	15.6%
University of South Carolina	$2,833,498	$5,612,272	98.1%	$5,690,602	1.4%	$7,982,304	40.3%
Department of Alcohol & Other Drug Abuse Services	$15,857,149	$11,839,390	-25.3%	$13,879,179	17.2%	$13,087,351	-5.7%
Continuum of Care	$8,529,603	$10,328,196	21.1%	$8,898,251	-13.8%	$8,606,575	-3.3%
School for the Deaf & Blind	$1,391,696	$2,048,508	47.2%	$3,437,980	67.8%	$3,559,479	3.5%
Department of Social Services	$60,534,139	$52,182,875	-13.8%	$50,324,531	-3.6%	$49,360,351	-1.9%
Department of Juvenile Justice	$17,786,139	$23,598,126	32.7%	$20,449,250	-13.3%	$27,540,540	34.7%
Department of Education	$74,306,918	$69,965,732	-5.8%	$68,705,945	-1.8%	$73,504,294	7.0%
Commission for the Blind	$22,299	$25,449	14.1%	$8,876	-65.1%	$6,666	-24.9%
Department of Corrections	$0	$0	0.0%	$0	0.0%	$11,058	100.0%
Wil Lou Gray Opportunity School	$0	$0	0.0%	$0	0.0%	$9,322	100.0%
Total Other Agency Medicaid Assistance	$854,303,182	$850,081,347	-0.5%	$834,986,406	-1.8%	$855,778,208	2.5%

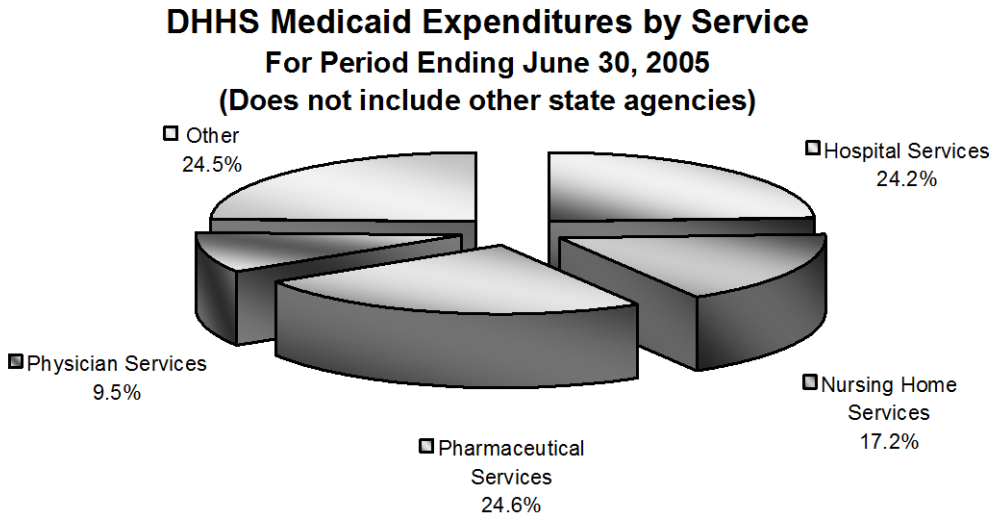
Graph 7.3-2



Graph 7.3-3

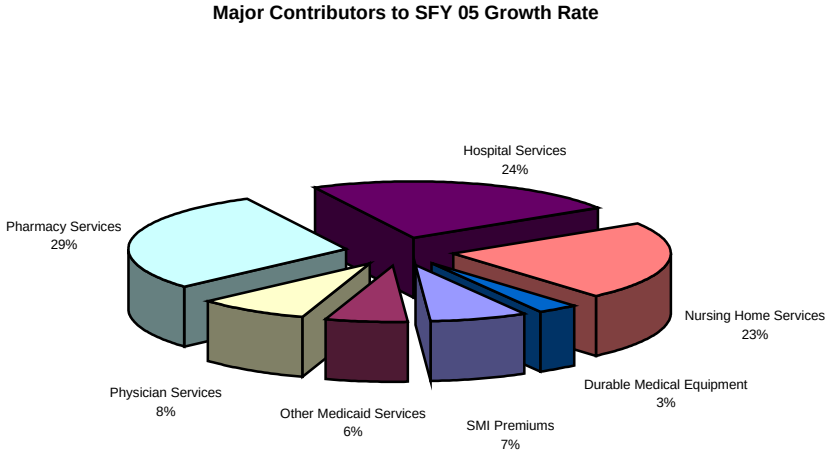


Graph 7.3-4



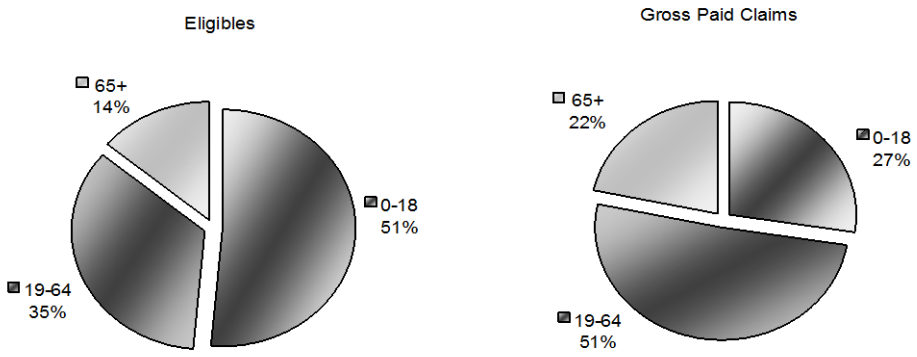
Note: Hospital expenditures do not include disproportionate share payments. Pharmacy expenditures include SILVERXCARD.

Graph 7.3-5



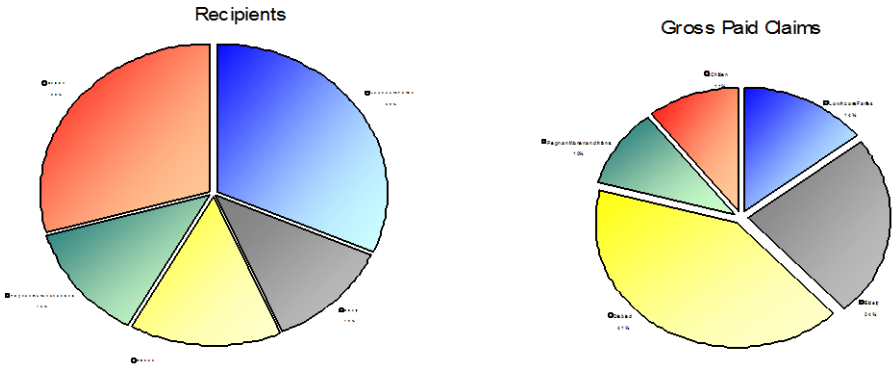
Graph 7.3-6

Eligibles to Gross Paid Claims by Age
State Fiscal Year 2005

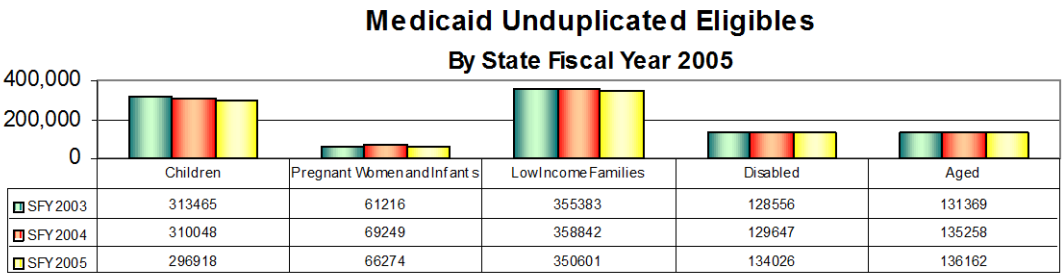


Graph 7.3-7

Recipients to Gross Paid Claims by Major Category
State Fiscal Year 2005



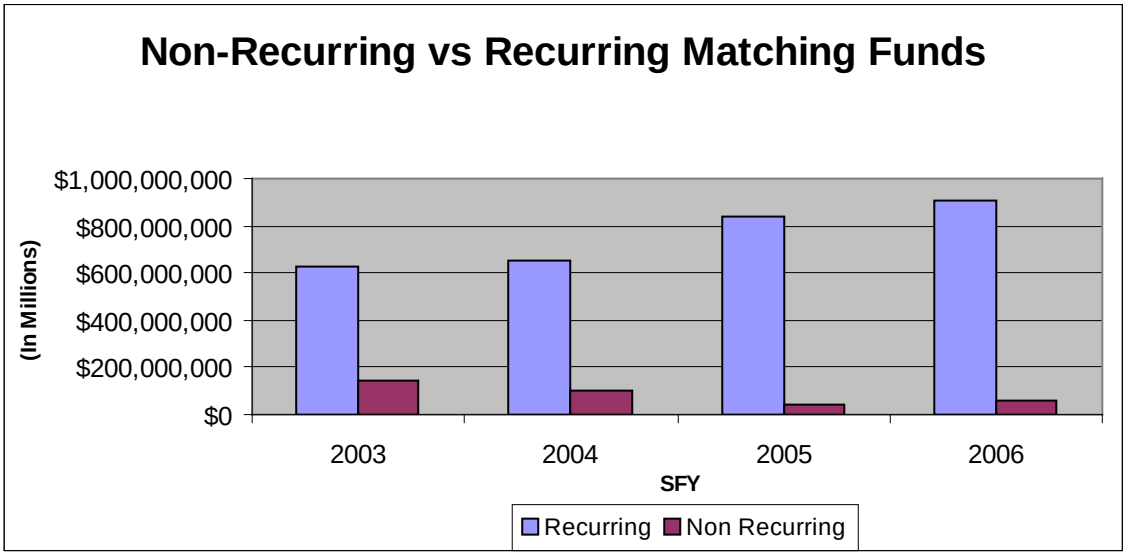
Graph 7.3-8



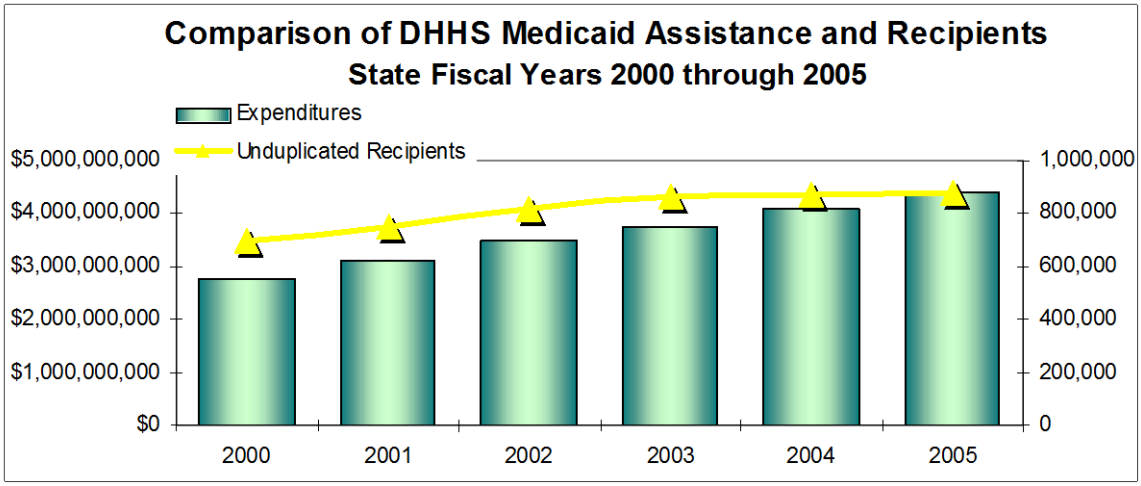
	Children	Pregnant Women and Infants	Low Income Families	Disabled	Aged
SFY 2003	313465	61216	355383	128556	131369
SFY 2004	310048	69249	358842	129647	135258
SFY 2005	296918	66274	350601	134026	136162

Preliminary data as of July 1, 2005

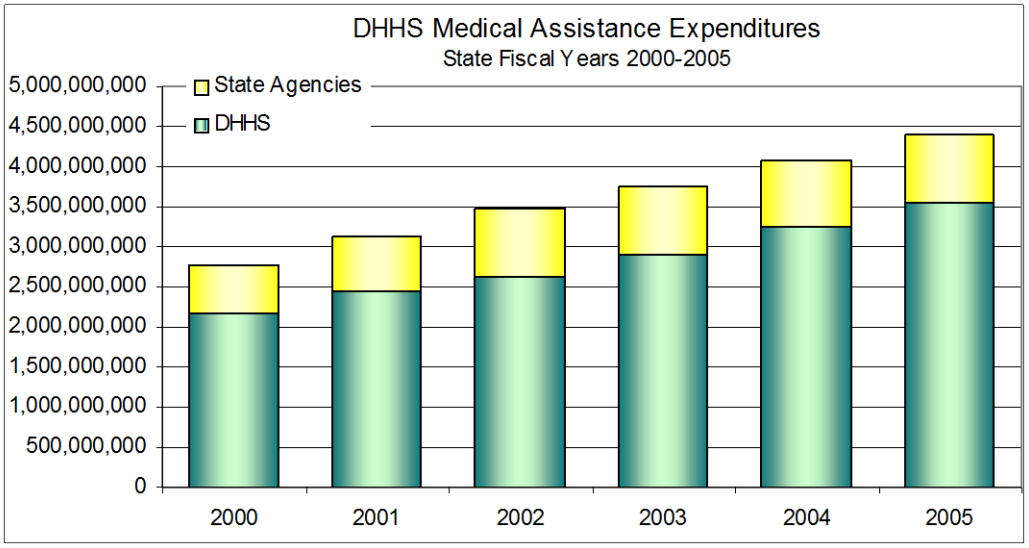
Graph 7.3-9



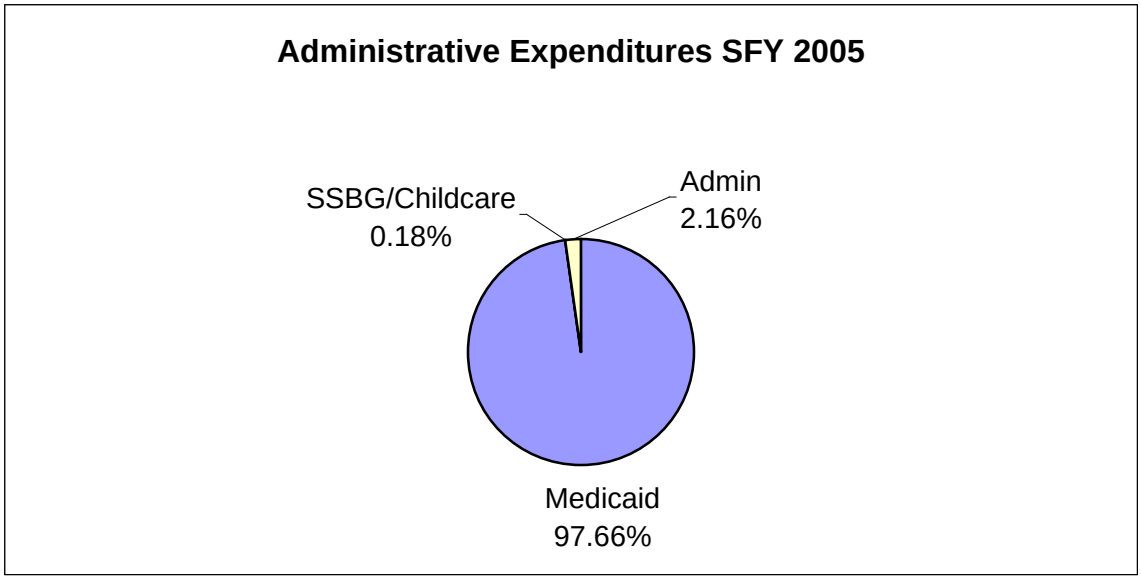
Graph 7.3-10



Graph 7.3-11



Graph 7.3-12



Graph 7.3-13

7.4 What are your performance levels and trends for the key measures of Human Resource Results (Includes: performance measurement, employee satisfaction, well-being learning and development, employee diversity and retention)

The following Human Resources initiatives are in place to help ensure employee satisfaction and provide a meaningful workplace within the Department of Health and Human Services:

- **Employee Morale** - The **C**ommunity, **H**ealth, **A**ctivity, **M**orale, **P**rogram and **S**ervice (CHAMPS) is a Steering Committee spearheaded by the Office of Human Resources to promote the orderly and efficient planning and management of various agency activities. Annual employee activities include: Red Cross Blood Drives, Special Customer Service Awards, Employee Recognition and State Service Pin Awards Ceremony, holiday and social events, Prevention Partners, Wellness Screenings, Charity Walks, United Way Campaign, etc.

- **Open Communication** – The Office of Human Resources staff members are trained in mediation and conflict resolution and utilize the techniques during employee/employer disputes. The agency actively uses the Budget and Control Board's Statewide Mediator Pool for non-grievable issues not resolved at a lower administrative level. In addition, all Human Resource personnel including benefits, employee relations and training & development, and recruitment maintain an open door policy for all employees and supervisors of the agency.

- **Training and Development** – The Office of Human Resources coordinates a comprehensive agency-wide training effort.
    - Personal Development of employees is promoted by offering agency wide training curriculum related to computer software, time management, and

customer services. Over 541 employees participated in approximately 40 classes costing an average of $119 per employee.
  - Over 250 supervisors attended a 4-day comprehensive supervisory training session contracted through the Budget and Control Board.
  - Implemented and coordinated the New Employee Orientation Program effective April 2, 2005. Since April 2005, 47 employees have attended.
  - The Affirmative Action Plan for DHHS has been established to maintain and further diversify the workforce and to comply with federal and state guidelines.
  - The Office of Human Resources designed and implemented an electronic training on Diversity and Harassment and will begin a comprehensive supervisory and agency-wide employee training initiative.
  - Implemented a two day strategic planning and leadership training session attended by over 63 Deputy Directors, Bureau Chiefs, and Division Directors.
  - Reimbursed nine (9) eligible employees approximately $3,000 through the Tuition Assistance Program to enhance employees' productivity and knowledge and to develop a better-educated workforce.

- **Team Building** - Executive staff promotes a team approach to organizational structure by encouraging succession planning and cross-training in specific divisions; the team approach is being used during the interview and selection process as well as during division and department goal planning. The Office of Human Resources acted as a partner to foster team building during the reorganization of at least seven different Bureaus to the team concept in 2004-2005. This included pay analyses, job analyses, and consultation. Further the team approach has been used consistently throughout the year when designed new approaches to the Department's work.

- **Employee Evaluation and Expectations** - Employee planning stage job functions and objectives are directly linked to the agency's mission and goals and communicated one on one, during staff meetings, through the agency wide newsletters, the agency intranet, and posted on the walls throughout the agency. The EPMS default rates are monitored monthly by Human Resources with the assistance of executive staff to ensure employees' performance is evaluated. In 2004-2005, the EPMS meets by default rate was reduced by an average of 14.58% since the beginning of the fiscal year. On average, the meets by default rate declined approximately 4% each quarter.

- **Recruiting for Diversity and Retention** - Began advertising positions through the Midlands Technical College website and the WIS television career link for televised presence of recruiting positions. The agency has served the following programs in providing internships for students: Masters in Public Health and Public Administration, from USC; Bachelor's programs in Health Services Management from Winthrop; Information Systems Technology from USC; Midlands Education Business Alliance; Midlands Technical College; Medical

University of South Carolina; North Carolina Agricultural and Technical College; Experience Works – organization for aging population; and the Columbia Urban League.

All these efforts positions the agency for increased levels of performance, employee satisfaction and well-being creates a more meaningful workplace which attracts a better workforce, learning and development fosters retention through more loyal employees, and employee diversity that emphasizes teamwork facilitates a better quality product for the department.

7.5 What are your performance levels and trends for the key measures of regulatory/legal compliance and community support?

The Office of General Counsel represents the agency in state and federal courts and administrative hearings; and advises the director and staff on legal matters pertaining to the agency. DHHS complies with state and federal laws and regulations regarding the operation of the Medicaid program. Currently, there are no federal deferrals or disallowances related to compliance issues. The active litigation is mostly state litigation regarding interpretations of manualized or state regulatory rules governing the operations of the Medicaid program. The number of legal challenges to the operation of the Program is expected to remain relatively low. Developments in the law, such as HIPAA privacy and standardization and security federal regulations, which could have precipitated such challenges, have been anticipated and actively met through the agency's history of engaging the affected stakeholders (sub-grantees and grant beneficiaries) in dialogue and implementing whatever operating adjustments have been needed. DHHS continues its policy (supported by federal law) of keeping service providers and beneficiaries well informed of expected changes.

We continue to audit parties that contract with this agency to ensure contract compliance and adherence to state and federal laws and regulations as required by the contract.

Regarding community support, the agency’s commitment to the new CHAMPS Team (Community, Health, Activity, Morale, Program, and Service) is evidence that the employees are interested in expanding the public opportunities and activities for the agency. The agency is currently focusing on expanding the role and activities of the CHAMPS Team.