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I. EXECUTIVE SUMMARY

Fiscal Year 2000-2001 was a year of transition for the Department of Health and Human Services. In October 2000, major leadership changes occurred in the agency including the Governor's appointment of a new agency director, Bill Prince, replacement of the Deputy for Administration and the Deputy for Fiscal Affairs, and appointment of a Chief of Staff for the agency. The transition resulted in many positive changes for the agency and significant accomplishments were achieved in many program areas.

Major agency achievements for the previous year:

Establishment of a positive work environment and stabilization of the agency's workforce:
Prior to the change in leadership, the agency was experiencing serious morale problems, which were documented in an Employee Satisfaction Survey, completed in August, 2000 and were resulting in significant staff turnover. Mr. Prince immediately took steps to address the morale issues and stabilize the workforce of the agency. Employee concerns and desired changes were identified through a series of meetings with a broad range of staff from across the agency and from the Employee Satisfaction Survey. The following changes were implemented and have resulted in heightened employee morale and stabilization of the workforce:

- A telecommuting pilot is underway.
- An Employee Recognition and Award policy was developed and implemented.
- An Alternate Work Schedule Policy was developed and implemented.
- The daily dress code policy was revised to institute a casual work environment.
- The process for approval and posting of vacancies was streamlined.
- Administrative areas of need were identified, prioritized and funded.
- A school volunteer program was re-activated.
- A job-shadowing program was implemented.
- A major training initiative was reactivated on the Medicaid Management Information System, a primary job tool for many staff.
- A mentoring program is under development.
- A major strategic planning initiative was launched.

Improved management practices and establishment of mission and vision statements for the agency:
DHHS launched the first strategic planning initiative for the agency since 1988. This process, described in greater detail under strategic planning in Section III of this report, created new processes for agency planning, decision making, budgeting, and prioritization of issues as well as a new mission, vision, and values statements for the agency.

Maximization of Federal Revenue:
The Department of Health and Human Services continued its primary focus of maximizing federal revenues by working with other state agencies to determine if state funded programs and initiatives could be funded with Medicaid. These efforts materialized $110 million that, in the face of a significant state revenue shortfall, was used to continue the previous year's level of funding of the Medicaid program. These efforts included using prior year cost settlements and

increasing rates to state agencies as well as new Medicaid initiatives with the school districts. The state also contracted with MAXIMUS to assist in efforts to maximize federal funding. DHHS is the oversight agency responsible for this contract. MAXIMUS has been involved with many of the large health and human services agencies and the school districts. Their initiatives have produced $11m to date in new state revenue. Initiatives in this area continue.

Implementation of a Point of Sale (POS) and prospective drug utilization review (Pro-DUR) system: A pharmacy Point of Sale/Prospective Drug Utilization Review (POS/ProDUR) system was implemented November 1, 2000. Pharmacy claims are now submitted via POS for adjudication in an on-line, real-time environment. DHHS projects cost savings/cost avoidance of up to 3% in Pharmacy Services program costs during the first full year's operation.

Increased the net enrollment of new children in Medicaid by more than 35,000: DHHS provided aggressive outreach to find and enroll Medicaid eligible children into the Medicaid program. As a result, approximately 35,000 new children were added.

Worked with other public agencies to coordinate services regarding child care/early childhood education: DHHS administers the federal Child Care and Development Fund (CCDF) of approximately $75 million to increase the availability, affordability and quality of child care services statewide in S.C. The need for child care funds exceeds our state's resources. To maximize the impact of these limited resources, DHHS promoted coordination among federal, state and local (public and non-governmental) child care and early childhood development programs to produce maximum results by preventing duplicative efforts, streamlining current activities and assuring that available resources are deployed to address the state's priorities. Coordination was accomplished by working cooperatively with other agencies, organizations and child care providers to expand the resources for families served by these child care programs. As a participant in the development of the State Health Improvement Plan, DHHS championed the need for coordination and long term planning. DHHS is working with the Governor's Office, Division of Children's Services, to explore the concept of designating a single state agency to coordinate all child care funding and programs. The following are some areas where the agency worked towards minimizing the cost for services while having the maximum benefit.

- **First Steps:** As the lead agency for child care, DHHS actively supported the First Steps initiative from the initial planning phases to date with technical assistance, resources and materials for the Office of First Steps and First Steps County Partnerships. The following are a summary of DHHS's contribution to the First Steps initiative:
    - Reviewed all Level Two implementation grant applications to ensure that expenditures at the county level did not duplicate existing child care programs.
    - Contracted with First Steps to consolidate and expand child care teacher training efforts to improve the quality of child care services.
    - Prevented duplication by using existing DHHS personnel to conduct evaluations of child care facilities seeking funds from First Steps to ensure compliance with the First Steps enabling legislation.
    - Worked closely with the Office of First Steps to develop policies and

recommendations that maximize the impact and quality of local child care initiatives.
    - Made data available to county First Steps' programs for planning purposes.

- **Child Care Licensing and Technical Assistance Activities:** DHHS began the necessary dialogue with other state agencies involved in child care licensing and technical assistance to ensure maximum impact in child care quality improvements in S.C. Efforts will continue until the work is completed. DHHS coordination activities included the following:
    - Supported the Health Child Care SC initiative facilitated by the SC Department of Health and Environmental Control (DHEC) through participation in collaborative planning among public, private and non-profit organizations for improvements in the availability, affordability and quality of child care in SC.
    - Actively worked with the Governor's Office, Division of Children's Services, through the Legislative Agenda Committee to develop a vision and strategies for improving the coordination of child care activities, especially in the areas of licensing and technical assistance to providers.
    - Took the lead role in developing a state plan to improve the quality of family day care by utilizing existing resources and expertise available within the state.

Progress toward development of a statewide "Senior Access Program" as a single point of entry into services for long term care services for elderly individuals and their families: The "Senior Access Program" is currently operational in nine counties. This program provides simplified client intake, a nursing assessment, coordinated case management, and reduced duplication of services. Prevention elements of the program include identification and early intervention of those at risk to delay the necessity of nursing home care. DHHS had planned to expand the program during the current fiscal year but no additional resources were made available. However, a number of steps were taken to address the objectives of the Senior Access Program and prepare for the implementation statewide when funding is available. A team from DHHS worked with each Council on Aging and regional CLTC office that operate as "Senior Access" to develop communications tools and reports and build information and referral capacity in order to better serve clients and develop systems for future replication. Existing funds were reallocated and designated as "Focal Point Funding" within Areas Agencies on Aging (AAA) and Council's on Aging to support services such as information and assistance, outreach, marketing or promotional costs, educational materials used for community education efforts and associated staff cost. DHHS staff participated in the development of the State Health Improvement Plan (SHIP), which includes the single point of entry into services for seniors. DHHS conducted planning meetings with clients and providers of long term care services to study the most effective methods of building capacity for caregivers with $1.4 million in Family Care Giver Funding which recently became available under Title III E of the Older Americans Act. Funding under the act may be used for information to caregivers about available services; assistance to caregivers in gaining access to services; individual counseling, organization of support groups, and caregiver education and training; respite care; and supplemental services to complement the care provided by the caregiver. DHHS staff also worked with the Aging network, AARP and the Silver Haired Legislature to provide education to legislators on the importance of funding home and community based services to delay institutionalization.

Provided a forum or focal point for discussions of senior issues that include senior concerns, preventive services, long term care services, advocacy, protection, senior employment, home health care, nursing homes care, consumer choice and end of life issues: DHHS sponsored, provided leadership for, facilitated, staffed and/ or participated in multiple forums in FY 2000 –2001 to promote the discussion of senior issues and develop recommendations for the ongoing development of Senior and long term care services and provide training for professionals and family caregivers. Events sponsored and coordinated included:

- The Eden Alternative Conference
- The Alzheimer's Conference
- The South Carolina Conference on Aging – Senior Day
- Meetings and the legislative session of the Silver Haired Legislature
- Monthly meetings with the Senior Legislative Group
- The Certified Nursing Assistants Conference
- Forums by the Adult Protection Coordinating Council

DHHS also staffed and coordinated the Annual Hearing of the Joint Legislative Committee on Aging, which addressed senior concerns. Needs identified through these forums included:

- Accessible housing and transportation
- Assistance in buying prescription drugs
- Increased funding for all home and community based services including home delivered meals, personal care and homemaker services
- Assistance with home repairs and yard maintenance
- Increase in the Homestead exemption
- Ease in accessing Medicaid eligibility forms and determination
- Help in accessing information
- Ease in completing assessment information
- Continued building and improvement of senior centers
- Protection from fraud and abuse
- Legislation preventing telemarketing
- Consumer direction in home and community based services
- Funding for de-institutionalization of disabled persons who can live in the community if housing, services and a system of accessible transportation are available.

DHHS incorporated these needs into its portion of the State's Plan for compliance with the Olmstead decision and conducted meetings and focus groups with a number of providers, advocates, recipients and caregivers on aging issues and concerns for direct service nursing home staff.

Compliance with the Health Insurance Portability and Accountability Act (HIPAA): The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 required the health insurance industry to adopt standards for communicating and maintaining health related data. We began the process of gaining HIPAA compliance by drafting an Advanced Planning Document (APD) to our federal oversight agency in January of 2001 to secure 90% federal funding to assist with our compliance efforts. In March

2001, we developed a Request for Proposal (RFP) for all state health-related agencies to utilize. We currently have an active RFP in process for an assessment of the Transaction and Code Sets rule of HIPAA. We continue to move forward in our HIPAA compliance efforts to add the Privacy rules to our intended assessments.

Business Process Improvements:
DHHS reviewed existing work flow processes and instituted process improvements to improve processing time, improve information flow, reduce errors, and enhance productivity. Key process improvements are highlighted below:

- **Development of an Automated Procurement System**

The Department of Health and Human Services uses a Purchase Requisition Form (192) to request the purchase of goods and services. The requisition/purchase process has been a manual paper-based system. During the past year, the agency automated this process. The requisition is completed online and, through workflow automation, is transferred to the appropriate parties. The transaction is traced through the entire process and the status is available online. This automation has improved the process and reduced the amount of time and effort involved in tracking requisitions resulting in productivity increases.

- **Enhancement of Nursing Home Automated Cost Reporting**

The Provider Automated Cost Report System (PACERS) is a Disk Operating System (DOS) used by Nursing Home providers to report costs related to Medicaid and non-Medicaid clients. The provider cost information is used to calculate Nursing Home reimbursement rates. During the past year, the PACERS application has been rewritten to a Windows-based application with additional functionality. Web-based transfer of data from the providers to the agency is planned for the coming fiscal year. This automation has improved the reporting process and the reliability of the data.

- **Development of a new fraud case management and tracking system**

During the past year, DHHS automated this process of tracking fraud cases by developing the Fraud Case Management Tracking system. Once a fraud case has been established it can be tracked through the entire process in an automated fashion. This automation has improved the reporting and tracking process by reducing the time involved in manually tracking a case as well as improved the reliability of the information.

- **Automation of TANF reinstatement**

With the implementation of the Temporary Assistance to Needy Families (TANF), the Department of Social Services removed TANF clients from Medicaid eligibility. The federal Department of Health and Human Services mandated to all state Medicaid Directors to review and reinstate these clients as appropriate. The agency automated functions to do the client review, tracking, address validation and statistics related to this reinstatement. This automation has improved the reporting and tracking process by reducing the time involved in manually evaluating each Medicaid client and tracking clients that need to be reinstated. This project could not have been done in a timely manner without automation.

•**Develop automated Fax system for CLTC CMS**

The Community Long Term Care (CLTC) Client Management System (CMS) authorizes provider services, among other things, for the CLTC client. In the past, authorizations has been mailed or manually faxed to the providers. The expanded functionality will allow the CLTC worker to approve and fax the service authorization to the provider directly from the CMS system. The date and time of the fax is stored in the CMS database. This expanded functionality will improve reliability, reduce time, and in some cases expedite services.

2. Agency Mission, Vision, Values:

Through the FY 2001-02 strategic planning process, the following mission, vision and values were developed for the agency and adopted by agency staff and managers:

Mission

To provide statewide leadership to effectively utilize resources to promote the health and well being of South Carolinians.

The agency fulfills its mission by planning, setting policy, pursuing resources, developing programs, building partnerships, providing program oversight, and ensuring fiscal accountability to promote an accessible system of quality health and human services.

Vision

Accessible quality health and human services for all South Carolinians.

Values

Quality: We are committed to excellence in all that we do.

Integrity: We maintain credibility by being truthful and adhering to the highest standards of ethical and professional conduct.

Customer Service: We are committed to listening to, understanding and addressing the needs of our customers in a prompt, respectful, and responsive manner.

Teamwork: As a team, we are committed to work together effectively, reinforcing the strengths of one another by valuing input from and providing feedback to one another.

Professionalism: We adhere to standards of work and conduct that reflect positively on the agency.

Accountability: Our work demonstrates responsibility to our stakeholders.

Communication: We are committed to listening to customer needs and responding timely, accurately and reliably. We promote the open exchange of information and ideas throughout our workplace.

Knowledge: We value professional competency and promote on-going learning.

Stewardship: As guardians of public funds and resources, we exercise competent and judicious management.

Innovation: We are visionary, creative, and responsive to change.

3. Key Results (Goals) for present and future years and broad strategies for addressing them are outlined below:

I. Maximize and Effectively Manage Resources

A. In coordination with state agencies and/or stakeholders, work to contain costs, avoid duplication, target and maximize use of existing resources, and/or draw down additional federal matching and grant dollars.

B. Implement and monitor accomplishment of the strategic plan, operational plans, work plans, and work schedules to prioritize and assure effective use of all agency resources.

C. Develop and implement an inclusive and comprehensive budget development process to prioritize allocation of resources, leverage existing resources to maximize funding, and incorporate a cost benefit approach to resource allocation.

D. Enhance, expand, and/or network existing computerized processes and/or automate or enhance current manual processes to expedite work flow and more effectively use agency resources.

E. Enhance security to protect the agency's staff, property, data, and system resources.

F. Train staff in work processes which maximize the use of their time in completion of work responsibilities.

G. Provide training for customers/stakeholders in specified areas where they can assist the state in maximizing and/or effectively using resources.

II. Promote Quality Improvement

A. Review select work flow processes and institute process improvements such as automation and/or methodology changes to improve processing time, reduce errors, improve information flow, and/or improve the quality of work products.

B. Train staff in new computer applications or processes to support internal agency process improvement efforts.

C. Develop, implement, and evaluate approaches and incentives to improve the quality of care delivered to our beneficiaries.

D. Research, develop, implement, and evaluate outcome measures, standards, and best practice guidelines for select services.

E. Promote professional development of caregivers for select services.

III. Promote and Assure Accountability to our Stakeholders

A. Monitor changes in state and federal law, regulations, standards, policies and procedures, and reporting requirements and comply on a timely basis.

B. Implement, maintain, enhance, or expand selected tracking, monitoring, data collection and management processes in order to provide for accurate and timely accounting with regard to compliance with state and federal laws, regulations, and policies; appropriate allocation and use of resources; service outcomes, and stakeholder expectations.

IV. Promote Customer Service

A. Seek and incorporate, to the extent feasible, customer needs and preferences into service delivery systems and management processes.

B. Implement processes or process services improvements which enhance responsiveness to customer requirements for services, information, technical assistance, input, or timely payment.

C. Assure availability of trained staff and provide staff training in areas which facilitate accurate and appropriate response to customer requirements.

D. Automate manual processes or enhance computerized processes to ease customer paperwork requirements, reduce error potential, and/or make processing more efficient.

V. Promote Effective Communication

A. Expand and promote use of internet/intranet applications in order to provide quick, on-line access to essential information.

B. Screen and revise beneficiary publications to assure appropriate literacy level and translate for high incidence, non-English speaking populations.

C. Provide internal and external avenues for communication (e.g. surveys, focus groups, forums, training sessions) in order to promote customer/stakeholder input and information exchange on select topics such as needs identification, resource maximization and allocation, priority setting, quality improvement, policies and procedures, etc.

D. Streamline, enhance, or computerize select work processes and data collection systems to provide for efficient, timely and accurate production and dissemination of information.

E. Provide staff training on high volume inquiry topics in order to promote accurate communication.

VI. Promote Appropriate Care

A. Research, develop, implement, incentivize, monitor and/or evaluate service delivery standards or best practice guidelines for select agency services.

B. Research, develop, promote and/or implement service delivery models and management processes which coordinate or manage service delivery and access to services based on individualized beneficiary assessment.

C. Provide system supports such as caregiver training, respite care, etc. which promote care suitable to the needs of the beneficiary.

VII. Promote Access to Services

A. Streamline, enhance, and/or automate existing eligibility determination and reporting processes to expedite timeliness of eligibility determinations and improve provider access to eligibility information.

B. Pursue timely and appropriate payments to providers of service in order to recruit and retain an adequate network of service providers.

C. Coordinate/collaborate with stakeholders and other service delivery entities to avoid duplication, to optimally use existing resources, and to leverage matching funds to draw down federal funds for delivery of new services or expansion of existing services.

D. Review existing service delivery rules and models, identify barriers to access, and explore additions or modifications to make services more accessible to recipients.

E. Provide information and referral, outreach activities, and materials tailored to eligible service populations to make them aware of agency services and how to access them.

F. Pursue funding to maintain or expand service availability.

VIII. Strengthen Organizational Infrastructure

A. Adopt technological applications and systems improvements to maintain or increase organizational capacity to process work and produce timely and accurate information for reporting.

B. Recruit, develop and retain a knowledgeable work force.

C. Develop, maintain, or enhance the agency's research, data collection, and analysis, and planning activities and functions to provide sound information for decision-making.

4. **Opportunities and barriers that may affect the agency's success in fulfilling its mission and achieving its strategic goals:**

Barriers:

Downturn in the state economy and resulting state budget cuts: Through its strategic planning process, DHHS has developed an ambitious agenda for achieving its selected key results. A number of the key results can be advanced within existing resources; however, strategies to bring about major changes in the service delivery system to improve access to care, promote appropriate care, improve customer service, and strengthen organizational infrastructure cannot be accomplished without additional funds. Because Medicaid is a program for low income families and individuals, a State economic downturn and loss of employment will result in a burgeoning Medicaid eligible population and an increasing demand for services. Without additional resources to address growing demand, the agency will be forced to cut services and place some innovations on hold.

Opportunities:

Application of state of the art computer technology: Technological advances in computerization and software offer the potential to replace numerous manual processes in DHHS, streamline workflow, and improve customer service. With the growth in agency programs and claims volume, these applications are essential to maintain effective operations.

Telecommuting: Telecommuting has the potential to generate continuing savings for the agency. Efficiencies achieved through telecommuting will help the agency maintain its operations and continue to administer agency programs.

Management Improvements: Consolidation and streamlining of certain services and administrative processes that are currently fragmented and better management of administrative processes that improve value and efficiency offer potential for improved management effectiveness.

II. BUSINESS OVERVIEW

Department of Health and Human Service

Accountability Report Appropriations/Expenditures Chart

	99-00 Actual Expenditures		00-01 Actual Expenditures		01-02 Appropriations Act	
Major Budget Categories	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**
Personal Service	$20,909,815	$7,124,511	$22,793,257	$7,513,913	$25,432,284	$8,302,996
Other Operating	$143,442,262	$19,705,479	$136,711,463	$17,653,404	$158,680,954	$20,171,368
Special Items	$0	$0	$1,030,297	$919,334	$26,246,852	$9,483,358
Permanent Improvements	$0	$0	$0	$0	$0	$0
Case Services	$2,533,491,244	$387,146,245	$2,604,311,798	$403,916,638	$2,685,231,982	$472,948,503
Distributions to Subdivisions	$2,526,580	$175,000	$2,072,129	$288,787	$8,050,000	$0
Fringe Benefits	$5,163,342	$1,742,642	$5,964,724	$1,939,409	$6,026,697	$1,997,872
Non-recurring	$231,554,502	$69,651,594	$489,320,802	$24,498,229	$460,306,899	$8,466,386
Total	**$2,937,087,745**	**$485,545,471**	**$3,262,204,470**	**$456,731,976**	**$3,369,975,668**	**$521,370,483**

Other Expenditures

Sources of Funds	99-00 Actual Expenditures	00-01 Actual Expenditures
Supplemental Bills	$13,129,978	$12,172,230
Capital Reserve Funds	$300,0000	$0
Bonds	$0	$0

Key Suppliers:

Medicaid
Medicaid is a grant-in-aid program in which the federal and state governments share the cost of medical care for needy persons who have low income. Medicaid is a federally authorized program that provides financial assistance to states for the payment of providers of medical assistance. The program was authorized by Title XIX of the Social Security Act which was signed into law in 1965. South Carolina began participation in the Medicaid Program in July 1968. The State Department of Health and Human Services (DHHS) is responsible for administering the Medicaid program through contractual arrangements with public and private entities. Key suppliers for the Medicaid program are nearly 30,000 health care providers including hospitals, nursing homes, physicians, pharmacies, clinics, dentists, hospice, home health, transportation, durable medical equipment and Community Long Term Care services. One HMO is currently enrolled in the program.

Child Care Development Fund (CCDF)
Federal regulations for the Child Care and Development Fund (CCDF) give the designated lead agency in each state flexibility within specified parameters to determine how child care services are provided to families who are receiving, transitioning off, or at risk of dependence on public welfare assistance, as well as to other low income families. As the designated lead agency for the CCDF, the South Carolina Department of Health and Human Services (DHHS) administers the Advocates for Better Care (ABC) Child Care Program. The ABC Child Care Program enrolls various types of child care service providers (suppliers) to give parents receiving ABC child care assistance the widest possible choices in child care options. These child care service providers include family and group day care homes, centers, religious/faith-sponsored programs, and self-arranged care by relatives or friends. As of 6/30/01, the ABC Child Care Program's network included 4,271 child care providers.

Social Services Block Grant (SSBG)
DHHS is the designated agency to administer the SSBG program. DHHS contracts with approximately 56 public and private providers to provide sixteen services through 65 contracts, grants, and agreements.

Senior Services
DHHS contracts with 10 Area Agencies on Aging (AAA's) who, in turn, contract with one or more local service providers in each of the 46 counties.

Description of Major Products and Services:

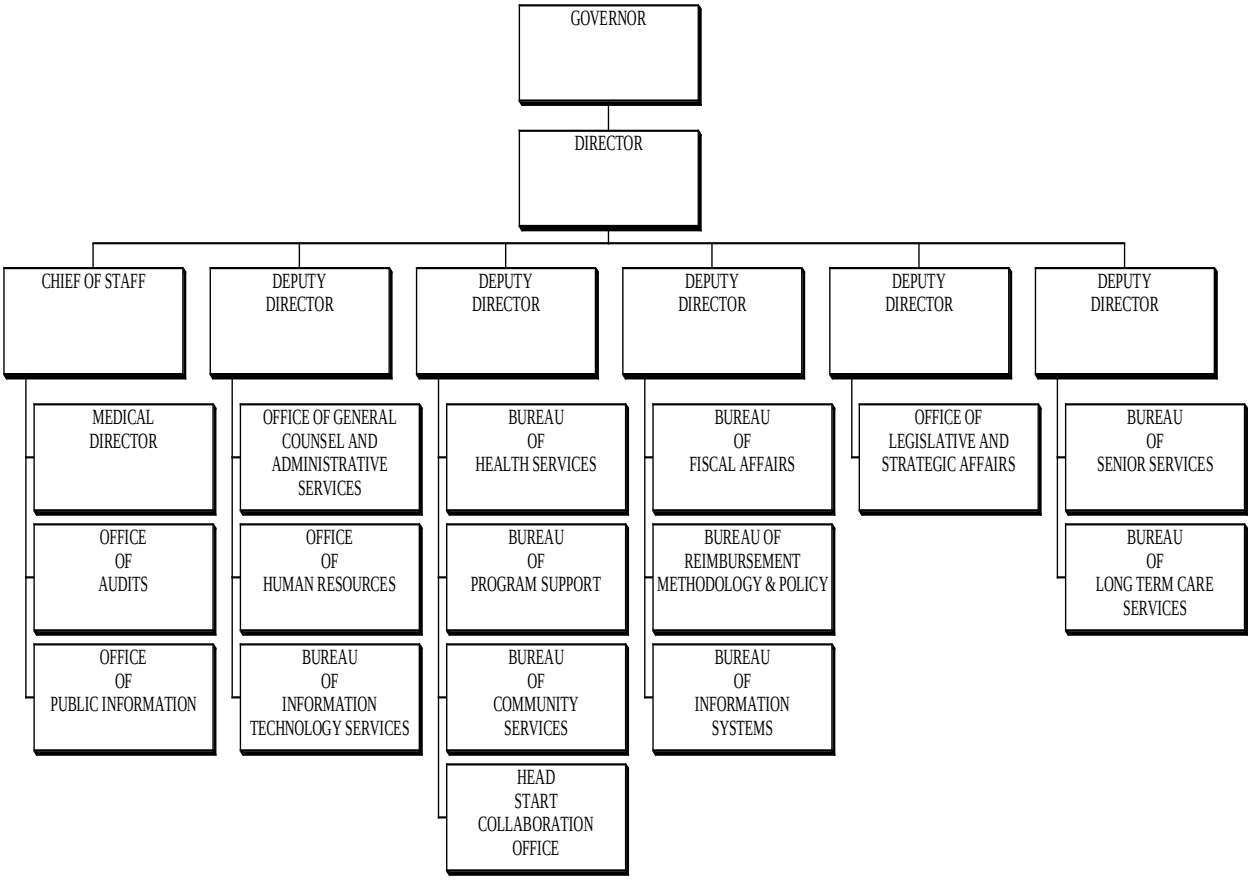
Medicaid
Medicaid pays for a variety of services, which are medically necessary. Please refer to Appendix A for a complete list of services and service descriptions.

Child Care Development Fund (CCDF)
The primary service funded under CCDF is financial assistance for child care services received by children whose parents are transitioning off of welfare and by children whose families are income-eligible and parent(s)/guardian(s) are working, in school or training, or disabled. DHHS also has entered into agreements with several state agencies (SC Department of Social Services, State Department of Education, SC Department of Disabilities and Special Needs, Clemson University, Head Start, SC First Steps to School Readiness, SC Center for Child Care Career Development) and others (child care resource and referral organizations, and providers) for the purpose of improving the quality, affordability and availability of child care services in SC. These agreements were developed to provide financial and programmatic incentives to improve the quality of child care services; to periodically conduct market rate surveys of child care providers throughout SC to develop child care service reimbursement rates for providers enrolled with the ABC Child Care Program; and to facilitate access to child care services by special populations (such as families leaving welfare, families with children who have disabilities, and children needing before/after school care in low-income areas where there is an inadequate supply of child care providers to meet the need).

Social Services Block Grant (SSBG)
The Title XX Social Services Block Grant (SSBG) is a flexible funding source that allows states to plan programs and spend funds within broad national goals. The primary goal of SSBG is to assist the state's citizens in restoring or maintaining a level of physical, social, and economic well being that allows them to function as independently as possible within their capabilities. States are given substantial discretion in the use of SSBG funds and may determine what services will be provided, who is eligible, and how the funds are distributed among services. South Carolina utilizes SSBG to fund a wide range of critical services at the community level, such as Child Protective Services, Adult Protective Services, Child Care, and Home Based Services that prevent or delay more costly institutionalization of adults and children. With the exception of protective services and foster care, persons receiving services funded through SSBG must be members of one of the five target groups that meet federal goals for SSBG, have a total family gross income at or below 175% of poverty, and demonstrate a need for specific services. For FY 2001, the income guidelines for a family of four are $2,846 per month.

Senior and Long Term Services
The majority of funding for the Aging Network is provided through the Older Americans Act. Medicaid primarily funds nursing home, hospice, adult daycare, and home health funding. Residential care facilities are funded by state appropriations. The services provided form a total continuum of care for the elderly and disabled. The aging network provides preventive home and community-based services such as meals, transportation and home care. In addition, many activities are housed in senior centers. Area Agencies on Aging house the Long Term Care Ombudsman program, which investigates complaints against long term care facilities. Nursing homes and residential care facilities provide 24 hour care to the frail elderly and disabled. Hospice services are care services for the terminally ill. Home health provides medical and support services to persons in their home in order to improve their quality of life. The CLTC program provides a variety of in-home services to persons who are qualified for nursing home placement but wish to remain in the home and community. Both Aging Network services and CLTC have extensive waiting lists. All persons age 60 and above are eligible for aging services while CLTC, nursing homes and the other major services have strict eligibility criteria.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AUGUST 8, 2001



III. ELEMENTS OF MALCOLM BALDRIGE AWARD CRITERIA

Category 1 - Leadership

1.1 How do senior leaders set, deploy, and communicate short and long term direction, performance expectations, organizational values, empowerment and innovation, organizational and employee learning, and ethical behavior?

a) Short and long term direction
The overall direction of DHHS is set and communicated via the strategic planning process and the resulting strategic plan. The plan, developed with broad based input from agency employees, provides a statement of the mission, vision, values and key results (goals) of the organization as well as a summary of the broad strategies the agency plans to pursue to achieve key results. Short and long term direction as well as performance expectations are defined through the development of operational plans in support of the strategic plan. Operational plans specify specific initiatives to be undertaken, action plans for accomplishment, project operation and management, primary objectives, resources required, timeframes for completion, internal and external partners to be involved, and measurable indicators of project success. The specific initiatives to support broad strategies are identified jointly by managers and staff, submitted to executive management for consideration, prioritized by the executive management team, fully defined through development of operational plans, and deployed by staff upon executive management approval.

In addition to the annual strategic planning process, new initiatives are identified, developed, and presented to executive management on an on-going basis via Weekly Issues Meetings. Initiatives selected for implementation are further refined via development of operational plans and deployed by the appropriate organizational unit upon executive approval and allocation of necessary resources.

b) Performance Expectations
Performance expectations are set and communicated by position descriptions, EPMS documents, and assigned responsibility for action steps in the operational plans developed in support of the strategic plan. Progress in meeting performance expectations is assessed quarterly through monitoring and providing feedback on action plan accomplishment as well as annually through the EPMS review process. Performance expectations are also communicated through individual supervisory sessions and staff meetings.

c) Organizational values
Organizational values were established via the strategic planning process with broad based input from staff and are communicated through the strategic plan. The key results of the agency as well as broad based strategies, operational plans, and agency priorities are developed with reference to the identified values. Management will annually assess how well the agency is operationalizing its established values.

d) Empowerment and innovation
The strategic planning process during the current year has served as a primary vehicle for staff empowerment and innovation. Staff were challenged and positively reinforced to develop innovative strategies to address key results. The strategic planning process itself provided

empowerment by involving a broad range of staff representing over 40% of the agency's workforce. Additionally, empowerment and innovation are promoted on an on-going basis by providing a continuous forum (Weekly Issues Meetings) for organizational units to present new strategies and proposals for addressing agency challenges and identified needs. Staff input and recommendations are sought on a continuous basis in problem solving, policy development, and program planning.

e) Organizational and employee learning

Knowledge was identified as a key value of the agency and the agency has adopted a number of broad strategies for developing and maintaining employee knowledge and learning. Among these are development and implementation of an annual training plan with broad based input from agency staff and development of a mentoring program. In addition to this formal mechanism for insuring employee learning, agency management promotes an atmosphere in which mistakes are treated as a learning experience rather than as the basis for punishment.

Organizational learning is accomplished by an on-going process of internal and external interaction in which input, feedback, and information is obtained and incorporated into developing policy, priorities, planning, and resource allocation. Internal interaction occurs through staff meetings, issues meetings, and budget meetings. External interaction occurs through convening or participating in focus groups, forums, committees, conferences, and meeting of provider and advocacy organizations.

f) Ethical behavior

Integrity is an established and communicated value of the agency. Executive and management staff seeks to model ethical behavior in the conduct of their day to day responsibilities. Unethical behavior, when identified, is addressed.

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

Customer service is an established and communicated value of the agency, establishing the context in which the agency achieves its mission. Customer needs/satisfaction, whether providers, beneficiaries, state/federal policymakers, or other stakeholders are at the forefront in DHHS' policy development, planning, and priority setting.

Senior management promotes customer focus through a continuous process of interaction with our customers through convening or participating in focus groups, forums, conferences, and meetings of advocacy organizations and provider groups and associations. These settings are used to obtain input and feedback and to advise them of agency activities and initiatives. Additionally, the agency maintains established standards for timely response to customer inquiries and complaints.

1.3 What key performance measures are regularly reviewed by your senior leaders?

Beginning with FY 2001-02, performance indicators were established in all operational plans developed in support of the strategic plan. These performance indicators will be reviewed annually. Additionally, DHHS utilizes multiple client and financial data reports to monitor and analyze key performance measures including service utilization and related expenditures. Quality assurance reviews are completed to determine the level of provider compliance with program standards and policies. Contract compliance reviews are implemented to ensure that administrative and service contract deliverables are achieved. External evaluations are

performed by appropriate entities (e.g. Carolina Medical Review, USC School of Public Health,) to assess the level to which program and service outcomes are achieved. Grant reviews are conducted to assure compliance with grant provisions.

1.4 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?

Performance review findings are used as the basis for a continuous program and process improvement. Areas of deficiency are addressed through changes in policies and programs and action plans which incorporate steps for improvement. Employee feedback and organizational performance review findings are used as the basis for making organizational and policy change to improve overall effectiveness of the organization. As an example, in FY 2000-01, DHHS implemented a formal employee survey regarding agency operations, management, policies, and procedures. Many of the survey recommendations, such as enhanced flextime policies, were implemented as agency policy.

1.5 How does the organization address the current and potential impact on the public of its products, programs, services, facilities, and operations, including associated risks?

As noted previously, DHHS maintains aggressive, on-going interaction with its stakeholders through convening or participating in focus groups, forums, and committees. Developments and changes in DHHS programs are routinely reported in these forums well in advance of implementation for the sole purpose of obtaining input and feedback. Many changes in agency programs are preceded by public notices and hearings which invite input and feedback which is taken into consideration in finalizing policy and programs. Additionally, DHHS utilizes multiple client and financial data reports to monitor and analyze key performance measures including service utilization and related expenditures in order to assess the impact of its programs. Quality assurance reviews are also completed to determine the level of provider compliance with program standards and policies. Contract compliance reviews are implemented to ensure that administrative and service contract deliverables are achieved. External evaluations are performed by appropriate entities (e.g. Carolina Medical Review, USC, Clemson University) to assess the level to which program and service outcomes are achieved.

1.6 How does senior leadership set and communicate key organizational priorities for improvement?

Organizational priorities for improvement are identified, prioritized, and communicated through the annual strategic planning process and the resulting plan; on a continuous basis by monitoring and providing feedback on performance in relation to operational plans, work plans, and indicators, and in response to complaints and concerns raised by customers and stakeholders. Organizational priorities for improvement are also communicated via informal mechanisms including staff meetings, supervisory sessions, and E-mail. Deputy directors meet regularly with their Bureau Chiefs, Division Directors, and staff to discuss priorities. DHHS addresses major issues, such as discussions about how to implement budget reductions, in a team fashion, bringing in staff from all levels and areas of the agency.

1.7 How does senior leadership and the agency actively support and strengthen the community? Include how you identify and determine areas of emphasis?

DHHS staff convene and/or participate in numerous inter-agency committees, provider and professional association meetings, and discussion forums with advocates and beneficiaries to

identify needs, desires, and concerns which are incorporated, as feasible, into developing plans, programs, policies and resource allocation decisions.

DHHS actively participates in the United Way campaign, has an award-winning Meals-on-Wheels program, annually participates in the Salvation Army kettle program, and promotes volunteerism by encouraging employee participation on boards of local service organizations and by permitting employees to take limited time off to volunteer in local school settings.

DHHS staffs committees that bring together providers, advocates, payers, and regulators on issues of state and community concern. DHHS also sponsors conferences designed to actively support and strengthen the community such as the Certified Nurse Assistant Conference, Eden Alternative Conference, and SC Conference on Aging.

Category 2 – Strategic Planning

2.1 What is your strategic planning process, including participants, and does it account for customer needs and expectations, financial, societal and other risks, human resource capabilities and needs, operational capabilities and needs, and supplier/contractor/partner capabilities and needs.

DHHS's strategic planning process was aggressively completed in a four-month period (May-August, 2001) with excellent participation by agency managers and staff. The process was conducted using two levels: Level I involved participation by a combination of executive and mid-level managers in three sessions. These managers in turn facilitated similar sessions with a broader group of managers and line staff at Level II. A diagonal cross-section of staff was used, enabling representative staff at every level to participate, and over 250 of the agency's 600 employees (42% of the workforce) actively participated in development of the strategic plan and operational plans for implementation.

The strategic planning process involved identification of agency customers and stakeholders and their expectations of the agency; an assessment of how well the agency is doing in meeting those expectations, and development of strategies to address key stakeholder expectations. The process also involved identification of external trends (societal and financial risks) which may create opportunities or threats to accomplishment of agency objectives; establishment of a mission, vision, and values for the agency; identification of desired key results for FY 2001-02, and development of broad strategies for achieving key results. The agency's plan will be completed August 31, 2001.

2.2 How do you develop and track action plans that address your strategic objectives?

Initiatives to advance key results were identified and prioritized. Draft operational plans for strategic initiatives to advance the key results have been developed, are currently under review, and should be completed by September 15, 2001. Operational plans include a definition of each strategic initiative, the primary objectives of the initiative, a rationale for implementation, an explanation of the how the project will be managed and the resource requirements for accomplishment, identification of internal and external partners, identification of the key agency results (goals) that will be addressed and how they will be advanced by the initiative, measurable indicators of success, and an action plan. Operational plans have been developed to address human resource needs such as training, succession planning, operational needs such as

technological process improvements; and customer needs such as improving access and promoting customer services. We will track action plan accomplishment on a quarterly basis via status reports on action plan accomplishment.

2.3 How do you communicate and deploy your strategic objectives, action plans and performance measures?
Staff responsible for carrying out initiatives to address strategic objectives was intimately involved in development of the objectives as well as operational plans, action plans, and performance measures. As a result there was on-going communication and ownership concerning each of these components from the inception. Deployment will be carried out by the staff within the organizational units, which developed the strategies and operational plans. Additionally, once the strategic plan is complete, a strategic plan document will be produced which will communicate the mission, vision, values and key results as well as the broad strategic objectives of the agency. A summary form of this document will be shared with customers and stakeholders through the many forums and committees with which DHHS maintains on-going and continuous contact.

Category 3 – Customer Focus

3.1 Identify customers and stakeholders.
Our internal stakeholders are the 600 employees who carry out the day-to-day operation of the agency.

Our external customers include over 30,000 health, child care, and aging service providers with whom we contract for service delivery and over 700,000 low income service beneficiaries. Our external stakeholders include state policy makers such as the Governor and the legislature, the federal government from whom the agency receives funding, other state agencies with whom we partner to develop policy and programs and provide services, advocates, interest groups, provider associations, other health insurers and the general public.

Our service network extends into every South Carolina county. Our clients range from the unborn to centenarians. While at one time the majority of our clients were directly connected to the state's welfare system, today less than 10 percent receive monetary assistance. Increasingly Medicaid is being recognized as a publicly funded health insurance program for low-income working people and their families. The contribution of our programs to the state's economy is also acknowledged because health care has passed manufacturing as the state's largest employment category. Health care is a $10 billion annual business in South Carolina, and Medicaid represents one-third of that market.

3.2 How do you determine who your customers are and what are their key requirements?
Federal law and regulations concerning our programs stipulate to a large extent the eligible population that we serve (beneficiaries) and the range of services we provide (providers with whom we contract). Beyond federal law and regulation, the state has limited discretion to add optional eligibility groups (beneficiaries) and optional services (providers). We assess key requirements of our beneficiaries through focus groups, surveys, complaints, continuous contact with advocacy and provider organizations, by monitoring service utilization and outcome data, and by convening or participating in forums where information on beneficiary needs are

gathered. We assess key requirements of our service providers through focus groups, surveys, complaints, continuous contact with provider associations, and by convening or participating in meetings,committees, and task forces where provider issues are discussed. We also issue public notices and convene public hearings to obtain input concerning changes in service delivery.

3.3 How do you keep your listening and learning methods current with changing customer/business needs?

The process described in #2 above is an on-going, continuous process, which facilitates current input and feedback relative to changing customer needs. Advances in technology such as the internet and intranet are incorporated into listening and learning methods as they become available. The annual strategic planning process also reassesses how well we are responding to customer needs.

3.4 How do you use information from customers/stakeholders to improve services and programs?

Information from customers/stakeholders is reviewed and assessed and to the extent feasible is incorporated into developing plans, policies, resource allocation decisions, and program development.

3.5 How do you measure customer/stakeholder satisfaction?

Customer satisfaction is measured through surveys, focus groups, service utilization, number of complaints, and customer participation. We build positive relationships with our customers by keeping them informed of what we are doing or what we plan to do and by giving them an opportunity to be heard and to give input. We maintain formal and informal mechanisms for handling and tabulating information on customer/stakeholder complaints. We provide a toll free line for beneficiaries to reach us.

3.6 How do you build positive relationships with customers and stakeholders?

We build positive relationships with our stakeholders by being responsive to their requests, complaints, and inquiries and by meeting with them regularly to listen to their concerns and mutually solve problems. We strive to be partners with our customers and stakeholders by being an advocate and being forthright on difficult issues. We also meet with numerous consumer groups on a regular basis and we provide speakers for community meetings. A prime goal is to provide information as requested in a timely and friendly manner.

Category 4 – Information and Analysis

4.1 How do you decide which operations, processes, and systems to measure?

Operations, processes and systems are selected for measurement through the annual strategic planning process. Federal law and regulations also dictate aspects of service delivery and outcomes, which must be evaluated and measured. Additionally, operations, processes, and systems may be selected for measurement in response to requests or concerns of our stakeholders or as part of the management processes of individual program areas.

4.2 How do you ensure data quality, reliability, completeness, and availability for decision making?

We contract with outside consultants to test data. Quality and completeness is ensured by having supervisors review work products against primary source data. Data is reviewed for

comparability between funding years. We work with providers to assure that criteria for data are the same. We make comparisons with similar programs nationally. Formatted data reports we submit to funding streams that provide federal matching dollars for our health, social, childcare, and aging programs are routinely audited for completeness and accuracy.

4.3 How do you use data/information analysis to provide effective support for decision-making?
Data is used to establish trends and projections, identify gaps in service delivery, and attainment of service delivery targets. This information is used for planning, priority setting, and policy and budget development

4.4 How do you select and use comparative data and information?
We use data to do comparative studies to evaluate the services provided by the agency. Historical data, similar projects, similar funding availability, and national and statewide trends form the basis for selecting and comparing data and information. Program staff compares SC Medicaid and childcare data to national and general population health and childcare data and trends. The results of these activities are used to set program priorities and strategies. This data helps agency staff determine which areas and programs the agency needs to monitor more closely or where we need to make policy changes or adjustments.

Category 5 - Human Resource Focus

5.1 How do you and your managers/supervisors encourage and motivate employees (formally and/or informally) to develop and utilize their full potential?
Managers and supervisors motivate employees and assist them in developing their full potential by providing positive feedback, flexible work schedules, a comfortable work environment (business casual dress attire everyday), training opportunities, mentoring opportunities, recognition programs, and appropriate resources so that they can work effectively.

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?
Various types of training including orientation training, managerial training, computer training, customer service training, and diversity training are provided by the agency or through contracts with training vendors based on periodic needs assessments. The training needs assessments are formally conducted in two year intervals and take into account feedback from agency employees and the agency's training advisory committee. Data is gathered through interviews, surveys, and review of existing records. In the future, training will become a part of an employee's EPMS that will assist in further assessing training needs and identifying areas for employee growth. As a result, training plans can be specifically developed by the supervisor, employee, and training staff to address performance gaps.

5.3 How does your employee performance management system, including feedback to and from employees, support high performance?
In our support of rewarding our high performers, we have committed to support the Merit Pay program and have implemented an on-going Employee Recognition and Award Program.

During orientation employees are trained on the EPMS system, and all new supervisors must complete a mandatory one hour supervisory training that trains on the EPMS process. All supervisors are encouraged to provide continuous feedback to employees. In addition the agency has scheduled classes for Coaching Skills to be given on two occasions during the fiscal year.

5.4 What formal and/or informal assessment methods and measures do you use to determine employee well being, satisfaction, and motivation?
DHHS adopted an employee survey process in FY 2000 which will be repeated on a periodic basis. Mr. Prince also conducted agency "fire-side chats" with each division of the agency and asked for employee feedback and suggestions. As a result of the survey and these meetings, the agency implemented business casual dress every day, an Employee of the Month program, an Employee Mentoring program, an Alternative Work Schedule, and a number of management changes.

5.5 How do you maintain a safe and healthy work environment?
The agency has a Workplace Violence Policy and Sexual Harassment Policy and provides an avenue for employees to report violent incidents or incidents of Sexual Harassment. We are soliciting bids to procure a safety plan for the agency that will include single door access and employee sign in. We have been proactive in addressing ergonomic concerns and have an avenue for employees to request an ergonomic review of their work space if they are experiencing medical problems.

5.6 What is the extent of your involvement in the community?
Our employees participate in a broad range of community and professional activities that contribute to our mission of promoting the health and well-being of all South Carolinians. We have implemented a program that allows employees to devote 4 hours a month to participation in school activities. We continue to support a Meals on Wheels route and support a Salvation Army Kettle during the Christmas season. We provide assistance to our CLTC clients through an employee auction.

Category 6 – Process Management

6.1 What are your key designs and delivery processes for products/services, and how you incorporate new technology, changing customer and mission-related requirements, into these design and delivery processes and systems?
Our primary delivery process is contractual/enrollment agreements with over 30,000 providers to deliver services; monitoring and technical assistance processes to provide feedback and assistance to the provider network in resolving claims payment problems and to recipients in accessing services; and claims payment systems such as the Medicaid Management Information System which tracks $3.2 billion in payments to 30,000 providers for over 30 million claims, our ABC voucher System that enables parents of 42,000 children to make their own decisions about their childcare provider, and our accounting system (GAFRS). We continuously solicit customer input and assess ways to streamline and upgrade our processes to make them more efficient and customer friendly, particularly with regard to application of technological process improvements. We incorporate new technology and customer requirements by focusing on being efficient in making timely payments, making it easier to submit claims for payment, and keeping processing time to a minimum. An excellent example of enlisting technology to focus on new

customer needs, product and service delivery, and partnering to improve a service is our new statewide Point of Sale (POS) computerized system for our pharmaceutical program. It is a real-time system that replaces a cumbersome paper process. POS enables pharmacists throughout South Carolina to view a Medicaid patient's total pharmaceutical benefit and to actively intervene to thwart potential contraventions of medications. This same system permits DHHS to emphasize generic substitutions for more costly brand names, require prior authorization for some products, and deny refills until 75 percent of the original prescription has been used.

6.2 How does your day-to-day operation of key production/delivery processes ensure meeting key performance indicators?

DHHS maintains current data and numerous tracking systems to assess how well we are meeting key performance indicators. Within available resources, we are seeking to automate as many of these tracking mechanisms as feasible to allow for more timely feedback on measures of performance. The day-to-day operations of our systems is monitored continually for improvements and streamlining of the processes by all agency staff. Feedback from customers/providers/vendors are integrated into process improvements.

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

We have program staff who provide technical assistance to providers. We also provide information and assistance to family caregivers, to businesses, to other agencies, to legislators. We improve our processes in response to information we receive from our customers. We are deeply committed to helping improve the services we finance. We send technical teams into "the field" when requested by providers or recipients to help negotiate positive results.

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

In addition to being primary customers, our contracted and enrolled service providers are our primary suppliers. We interact with them monthly through our Medical Care Advisory Committee meetings and maintain continuous interaction with provider associations to obtain input and feedback. We are very proactive in providing technical assistance and data, as well as training and training updates, and resource materials. We delegate management on a regional basis through the Area Agencies on Aging and the Community Long Term Care Area Offices to insure support and to receive feedback on a localized basis.

Category 7 - Business Results

Program Title: **MEDICAID**

A. Hospital Services

Program Costs:

State:	$107,744,537
Federal:	$370,813,848
Earmarked:	$ 48,737,572
Total:	$527,295,957

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of DHHS FTEs assigned to program	10	13	12

Performance Measures:	**Actual FY 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Number of contracted in state Service Providers	117	117	130
Outputs:			
Number of transactions processed:			
Inpatient Services	304,804	317,702	371,337
Outpatient Services	763,746	881,211	915,405
Hospital Based Physician Services	447,526	484,959	507,523
Total - Hospital Services	1,516,176	1,683,872	1,794,265
Efficiency:			
Average transactions per recipient:			
Inpatient Services	2.2	2.2	2.4
Outpatient Services	3.0	3.1	3.0
Hospital Based Physician Services	2.7	2.7	2.7
All Hospital Services	4.5	4.6	5.0
Average expenditure per recipient:			
Inpatient Services	$2,620	$2,965	$3,101
Outpatient Services	$236	$237	$263
Hospital Based Physician Services	$65	$69	$72
All Hospital Services	$1,287	$1,441	$1,484
Average provider to staff ratio	12:1	9:1	11:1
Transaction to staff ratio	151,617:1	129,529:1	149,522:1
Outcomes:			
Number of unduplicated recipients receiving services:			
Inpatient Services	138,653	147,738	156,856
Outpatient Services	255,232	286,368	306,564
Hospital Based Physician Services	165,614	176,639	188,985
All Hospital Services	337,266	365,556	391,126
Quality:			
Number of quality of care studies completed	3	3	3
Number of quality reviews completed	6,344	7,214	7,333

B. Pharmaceutical Services

Program Cost:

State:	$ 60,431,967
Federal:	$224,327,824
Earmarked:	$ 34,966,737
Total:	$319,726,528

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of recipients utilizing pharmacy services	427,929	464,331	513,514
Number of enrolled pharmacy providers	1,100	1,052	1,080

	Actual FY 98-99	**Actual FY 99-00**	**Actual FY 00-01**
Outputs:			
Number of prescriptions reimbursed by Pharmaceutical Services	4,542,217	5,521,859	6,134,390
Average prescription utilization per recipient per month	2.38	2.57	2.58
Efficiency:			
Average cost per recipient	$477.05	$560.55	$622.62
Average reimbursement per prescription	$44.94	$47.14	$52.12
Pharmaceutical Rebate Program	$49,460,426	$67,003,557	$85,532,327

C. Physician & Clinic Services

Program Costs:

State:	$ 43,857,483
Federal:	$166,280,226
Earmarked:	$ 26,285,187
Total	$236,422,896

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of DHHS FTEs assigned to program	16	16	16
Number of enrolled service providers	6,872	10,744	11,374
Outputs:			
Number of transactions processed:			
Physician Services	4,583,508	5,137,232	5,520,341
Clinic Services	557,018	618,763	644,366
EPSDT (well child screening & immunizations)	178,564	186,982	192,365
Efficiency:			
Average transactions per recipient:			
Physician Services	11.0	11.3	11.3
Clinic Services	4.2	4.1	4.4
EPSDT Services	1.7	1.8	2.0
Average expenditure per recipient:			
Physician Services	$343	$353	$381
Clinic Services	$333	$333	$373
EPSDT Services	$74	$78	$89
Average provider to staff ratio	430:1	672:1	710:1
Average transaction to staff ratio	332,443:1	371,436:1	397,317:1
Outcomes:			
Number of unduplicated recipients receiving services:			
Physician services	416,784	454,477	488,613
Clinic Services	133,762	147,950	144,986
EPSDT services	106,972	104,031	94,416
Quality:			
Number of physician/clinic medical home contracts	401	455	562

Performance Measures:	Actual FY 98-99	Actual FY 99-00	Actual FY 00-01
Number of recipients linked to physician/clinic medical home	44,851	59,628	72,616

D. Dental Services

Program Cost: State: $ 7,365,257
Federal: $42,858,009
Earmarked: $10,712,863
Total: $60,936,129

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.

3) 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. Monitor impact of dental fee increases effective January 1, 2000.

Performance Measures:	**Actual FY 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of licensed dentists statewide	1,719	1,713	1,615
Number of Medicaid enrolled dentists	619	824	886
Outputs:			
Number of children served	115,304	126,340	156,752
Number of adults served	22,686	26,354	32,100
Efficiency:			
Average cost per recipient	$135	$242	$377
Average cost per child served	$133	$250	$393
Average cost per adult served	$140	$202	$298
Outcomes:			
Number of children receiving screening and services	115,304	126,340	156,752
Number of adults receiving emergency services	22,686	26,354	32,100

E. Vision Services

Program Cost:

State:	$ 1,834,898
Federal:	$ 4,347,373
Earmarked:	
Total:	$ 6,182,271

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of licensed vision providers statewide	569	660	674
Number of Medicaid-enrolled vision providers	545	560	575
Outputs:			
Number of examinations provided to children	36,609	41,462	40,672
Number of glasses prescribed for children	33,809	36,625	41,677
Number of examinations provided to adults	15,519	13,382	12,214
Number of glasses prescribed for adults	719	931	1,114
Efficiency:			
Average cost per recipient	$43	$44	$47
Average cost per adult served	$38	$35	$41
Average cost per child served	$46	$47	$49

F. Chiropractic Services

Program Costs:

State:	$
Federal:	$
Earmarked:	
Total:	$539,582 (Medicare/Medicaid $61,879)

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 within allocated funding.

Performance Measures:	**Actual FY 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of licensed chiropractors statewide	810	800	711
Number of Medicaid-enrolled chiropractors	252	272	356
Outputs:			
Number of children served	317	1,319	1,815
Number of adults served	420	2,582	3,558
Efficiency:			
Cost per recipient	$123	$105	$111

G. Transportation

Program Costs:

State:	$ 6,982,540
Federal:	$24,206,176
Earmarked:	$ 3,430,862
Total:	$34,619,578

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, monitor and evaluate the non-emergency transportation infrastructure to ensure the accessibility and availability of transportation resources for Medicaid eligible recipients.

Performance Measures:	**Actual FY 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of licensed ambulance services statewide	204	210	228
Number of DHHS FTEs	4	6	6
Number of contractual providers	25	25	29
Number of fleet vehicles	567	567	642
Number of enrolled ITP providers	1,066	797	1,072
Outputs:			
Number of Medicaid-enrolled ambulance providers	130	139	146
Number of recipients served	52,463	152,453	136,239
Number of non-emergency trips	793,308	1,412,254	1,611,833
Efficiency:			
Cost per recipient served	$200	$237	$260

	Actual FY 98-99	Actual FY 99-00	Actual FY 00-01
Outcomes:			
Number of Medicaid recipients (duplicated) transported	799,200	1,418,218	1,672,524
Quality:			
Number of technical assistance visits	41	42	43
Number of Human Service Community Surveys on providers performed	N/A	75	97
Number of provider related complaints	7	8	86

H. Rehabilitative Therapy Services

Program Costs:

State:	$1,240,117
Federal:	$2,938,175
Earmarked:	
Total:	$4,178,292

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of enrolled service providers	1,175	1,861	*****1180
Number of DHHS FTEs	4	4	4
Outputs:			
Number of recipients served	3,328	9,268	10,893
Efficiency:			
Average expenditure per recipient	$224	$350	$384

*****File maintenance deleted 600 inactive providers from Medicaid enrollment.

	Actual FY 98-99	Actual FY 99-00	Actual FY 00-01
Outcomes:			
Number of state agencies accessing therapy Services for clients	4	4	4
Quality:			
Number of provider technical assistance visits	40	27	19

I. Diabetes Education Services

Program Cost:

State	$12,365
Federal	$29,297
Earmarked:	
Total:	$41,662

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Providers of Diabetes Education Services	9	18	40
Outputs:			
Individuals receiving Diabetes Education Services	409	493	649
Efficiency:			
Average expenditure per recipient	$53	$54	$64

J. Postpartum Infant Home Visit

Program Cost:

State:	$ 377,992
Federal:	$ 895,566
Earmarked:	$
Total:	$1,273,558

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of recipients receiving Postpartum/Infant Home Visits	20,174	20,425	19,780
Outputs:			
Number of providers of the Postpartum/Infant Home Visits	14	12	12
Efficiency:			
Average Cost Per Patient	$66	$67	$68
Average Cost Per Transaction	$61	$61	$60
Outcomes:			
Percent of recipients receiving Home Visits	73%	77%	77%
Quality:			
Number of Technical Assistance and/or Compliance Visits	3	0	0

K. Family Planning

Program Cost:

State	$ 1,019,890
Federal:	$11,845,840
Earmarked:	$ 296,469
Total:	$13,162,199

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 inadequately spaced pregnancies among mothers eligible for maternity services under the expanded eligibility provisions of Medicaid.

3) To estimate the overall savings in Medicaid spending attributable to providing family planning services to women with incomes less than 185% of the federal poverty level.

Performance Measures:	**Actual FY 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of Family Planning clients served	87,470	93,415	97,604
Total number of transactions	271,822	305,097	319,043
Outputs:			
Number of unduplicated medical providers participating	929	1,020	1,078
Efficiency:			
Average cost per transaction	$41	$41	$41
Average number of transaction per recipient	3	3	2
Average cost per recipient	$128	$136	$136
Outcomes:			
Increase in the number of women receiving publicly supported family planning services	4,692	5,945	4,189

	Actual FY 98-99	**Actual FY 99-00**	**Actual FY 00-01**
Total number of transactions for prescription contraceptives	84,331	101,720	103,826
Total number of units for contraceptives (using the HIC forms)	535,353	553,726	628,423

L. Managed Care Program

Program Cost:

State :	$ 5,165,885
Federal:	$14,667,879
Earmarked:	$ 1,121,566
Total:	$20,955,330

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of recipients enrolled in the Primary Care Physician's Program (PCP's)	7,174	23,284	27,696
Outputs:			
Number of enrolled HMO contractors	1	1	1
Number of Primary Care Physician's (PCP's)	500	461	482
Efficiency:			
Average cost per transaction	$90	$80	$77
HMO expenditures	$7,323,773	$11,030,526	$21,944,832
Quality:			
Average number of new enrollments per month	NA	NA	1520
Average percent of dis-enrollments per month	NA	NA	5%
Average number of complaints received per month	5	2	2

M. Durable Medical Equipment (DME)

Program Cost:

State:	$10,915,304
Federal:	$28,970,543
Earmarked:	$ 1,310,040
Total:	$41,195,887

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of enrolled providers	1,414	1,371	1,605
Outputs:			
Total transactions for DME	538,504	617,635	668,270
Number of unduplicated recipients	58,947	64,134	72,390
Efficiency:			
Average cost per recipient	$588	$596	$569
Average cost per transaction	$64	$64	$62

N. State Child Health Insurance Program/Title XXI (SCHIP)

Program Cost:

State:	$ 2,319,635
Federal:	$34,155,137
Earmarked:	$ 6,637,444
Total:	$43,112,216

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 State Child Health Insurance Program (SCHIP).

   a) Market SCHIP through the Partners For Healthy Children (PHC) Program

2) Enroll targeted low income children

Performance Measures:	**Actual FY 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of PHC applications distributed	1,062,504	1,467,500	866,000
Number of targeted outreach initiatives	51	50	80
Outcomes:			
Number of new SCHIP enrollees	19,697	45,874	45,573
Number of SCHIP clients served	44,627	55,637	54,918
Efficiency:			
Average annual cost per clients served	$552	$654	$796

Part 2.

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

Program Cost:

State:	$ 6,407,962
Federal:	$56,274,452
Earmarked:	$ 3,050,916
Total:	$65,733,330

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, in addition to specific quality set-aside 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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Outputs:			
Total children receiving services	41,725	36,359	41,525
Number of provider visits to improve quality	1,759	1,934	1,651
Number of low-income working poor children served	16,767	12,483	17,272
Number of Family Independence children served	24,958	23,876	24,253

	Actual FY 98-99	Actual FY 99-00	Actual FY 00-01
Quality:			
Number of care givers/directors trained.	14,757	14,271	14,609
Number of providers meeting standards above state licensing requirements	1,319	1,229	1,302
Number of technical assistance visits to self-arranged care providers (non-regulated)	274	384	0
Efficiency:			
Percentage of total CCDF dollars for administrative costs	4%	4.4%	4%
Average monthly cost per child served	$240	$241	$250

Part 3.

Program Title: **SOCIAL SERVICES BLOCK GRANT (SSBG)**

Program Cost:

State:	$ 288,787
Federal:	$17,736,249
Earmarked:	$ 164,543
Total:	$18,189,579

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. The federal government cut SSBG funding in recent years, resulting in some reduction of services.

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Outputs:			
SSBG child welfare dollars redirected to strengthen and preserve families	$5,354,647	$5,510,936	$5,135,939
Total clients receiving SSBG services	61,412	53,030	58,402
Total children receiving SSBG services	42,800	31,812	37,279
Total investigations of alleged child abuse and neglect reports	18,184	18,415	18,736

	Actual FY 98-99	**Actual FY 99-00**	**Actual FY 00-01**
Total adults receiving SSBG services	18,612	21,218	21,163
Total adults receiving home delivered meals	2,467	2,576	2,641
Efficiency: Percentage of SSBG dollars for administrative costs	4%	4%	3.3%
Average annual cost per client served	$505	$610	$383
Average annual cost per child client served	$529	$747	$384
Average annual cost per adult client served	$343	$345	$381
Outcomes: Number of families preserved or reunified	6,250	5,887	5,844
Number of children protected from abuse and/or neglect	8,235	8,781	8,884
Number of adults protected from abuse, neglect or exploitation	7,900	7,293	5,041
Number of adults receiving community-based services to prevent institutionalization	5,100	5,025	5,624

Part 4.

Program Title: **SENIOR AND LONG TERM CARE SERVICES**

A. Senior Services

Program Cost:

State:	$ 2,234,309
Federal:	$12,824,940
Earmarked:	$ 3,598,667
Total:	$18,657,916

Program Goals: The goal of Senior Services is to provide high quality home and community–based services to older adults and their caregivers, as well as to provide information and assistance about benefits and resources available in their communities. The programs and services provided through Senior Services are focused upon maintaining the maximum independence possible and assisting individuals in remaining active and involved in their communities. Many of the programs are focused on prevention and early intervention to promote healthy aging and prevent unnecessary or premature decline and institutionalization. Other activities are directed toward providing support for caregivers and responding to complaints and concerns expressed by or on behalf of residents of South Carolina's long term care facilities. Senior Services operates through a statewide network of 10 regional Area Agencies on Aging and 58 local service providers.

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 (AD) 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) 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.

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

9) 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.

9) 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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Total people served	31,200	29,783	29,733
People receiving congregate meals	13,982	12,799	13,107
People receiving home delivered meals	11,482	13,705	14,821
People receiving home care	4,895	3,783	3,786
People receiving transportation	6,452	6,476	5,997
People receiving adult day care	142	317	326
People receiving care management	2,561	6,829	5,798
Families of persons with Alzheimer's Disease (AD) receiving information.	436	304	2,056

	Actual FY 98-99	Actual FY 99-00	Actual FY 00-01
Families of persons with AD receiving assessments	70	93	285
Families receiving AD respite	296	326	762
People enrolled in Senior Community Service Employment Program	215	193	219
Types of Long Term Care Ombudsman complaints:			
Residents rights (including abuse, neglect and exploitation)	1,564	1,688	1,575
Residents care (including improper care, failure to follow Medical Doctor orders, personal hygiene)	1,107	1,152	1,058
Quality of life (including cleanliness of quarters, diet and nutrition, availability of activities)	306	373	299
Administration (including adequate staffing, training, record-keeping)	191	256	218
Not against the facility (problems with outside agencies, systems or persons)	218	185	145
Dept. of Disability & Special Needs and Dept. Of Mental Health complaints	369	520	391
Total number of complaints received by the Long Term Care Ombudsman	3,376	3,655	3,686
Living Will witness trainings	4	3	3
Advance Directive presentations	5	9	3
Number of I-Care volunteers	463	493	510
Outputs:			
Home delivered meals provided	1,601,276	1,694,962	1,832,976
Congregate meals provided	943,409	957,728	980,778
Hours of home care provided	156,157	176,575	176,732
Miles of transportation provided	9,075,504	8,987,360	8,155,170

	Actual FY 98-99	Actual FY 99-00	Actual FY 00-01
Hours of care management provided	14,778	16,962	14,401
Senior Centers completed	7	4	4
Long Term Care Ombudsman cases opened in nursing homes and residential care facilities	2,517	2,930	3,344
Long Term Care Ombudsman cases closed in nursing homes and residential care facilities	2,419	2,984	2,742
Long Term Care Ombudsman complaints verified in nursing homes and residential care facilities	1,291	1,587	1,906
Long Term Care Ombudsman complaints from DDSN and DMH facilities	369	520	391
Living Wills witnessed by Ombudsman for persons in institutions	390	388	305
Number of persons receiving Medicare insurance counseling	10,974,	4,732	8,798
Outcome:			
Professionals, para-professionals, volunteers and others receiving training	2,657	4,627	3,692
Quality:			
Dollar savings to public through insurance counseling and training	$268,000	$150,539	$152,784
Efficiency:			
Total cost per client (state & federal dollars)	$304	$320	$449
Cost per client (state dollars)	$55	$55	$53
Number of persons on waiting lists for services	4,664	4,794	5,223

Note: The number of persons served and outputs under the Older Americans Act have in most cases been changed for all three years to reflect the new AIM reporting system figures.

B. Community Long Term Care Services (CLTC)

Program Cost:

State:	$20,116,239
Federal:	$55,542,377
Earmarked:	$ 3,322,336
Total:	$78,980,952

Program Goals:

The goal of the Community Long Term Care program is to provide in home services as a cost effective alternative to nursing home placement. This is achieved through a network of 14 area offices and enrolled providers.

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.

4) 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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of referrals each year	15,008	12,625	10,324
Outputs:			
Total clients served each year	13,717	14,397	14,487
Number of persons on waiting list for services	1,470	3,615	3,354
Efficiency:			
Cost per day, per client, for CLTC services	$21	$23	$19
Cost per day, per client, for nursing home placement	$87	$94	$94
Percentage of daily nursing home rate expended for CLTC services	24%	24%	20%

	Actual FY 98-99	Actual FY 99-00	Actual FY 00-01
Outcomes:			
Savings to Medicaid Program per day, per client	$66	$71	$75
Performance Measures: Ventilator Dependent Waiver			
Inputs:			
Number of referrals each year	16	19	11
Outputs:			
Total clients served each year	28	35	32
Efficiency:			
Cost per day, per client, for CLTC services	$67	$69	$69
Cost per day, per client, for nursing home placement	$180	$180	$180
Percentage of daily nursing home rate expended for CLTC services	37%	62%	38%
Outcomes:			
Savings to Medicaid Program per day, per client	$113	$111	$111
Performance Measures: Children's Personal Care Aide Program			
Inputs:			
Number of referrals each year	368	324	282
Outputs:			
Total clients served each year	408	432	456
Performance Measures: HIV/AIDS Waiver			
Inputs:			
Number of referrals each year	694	579	497
Outputs:			
Total clients served each year	1,073	1,143	1,114
Efficiency:			
Cost per day, per client, for CLTC services	$10	$9	$8

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

Program Cost:

State:	$ 89,881,629
Federal:	$252,777,382
Earmarked:	$ 16,901,408
Total:	$359,560,419

Program Objectives:

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

2) Assure equal access to nursing home 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 homes.

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of NH recipients	16,898	17,131	17,760
Number of Medicaid contracted NH	147	150	154
Number of individuals who participated in the Nurse Aide Training Program	2,234	2,498	3,194
Number of competency tests provided	1,996	2,615	2,408

	Actual FY 98-99	Actual FY 99-00	Actual FY 00-01
Number of Medicaid-sponsored nursing home bed days	4,200,156	4,337,639	4,416,766
Outputs:			
Number of individuals added to the nurse aide registry	4,050	2,623	1,305
Number of certification renewals	8,158	2,944	4,726
Number of Medicaid recipients who received home health services	4,172	10,004	8,825
Units of home health services provided	311,606	331,392	304,562
Number of Medicaid–only recipients who received hospice services	115	111	119
Units of hospice services provided	26,695	25,967	29,073
Efficiency:			
Cost per nurse aide for training	$325	$308	$295
Cost per nurse aide for testing	$86	$86	$86
Cost per renewal	$25	$25	$25
Average gross Medicaid rate/day to nursing homes (without recurring income)	$87	$92	$96
Average net Medicaid rate/day paid to nursing homes (with recurring income)	$71	$75	$78
Number of persons on waiting lists for nursing home services	399	312	225
Outcomes:			
Number of nursing homes notified of potential sanctions	42	38	30
Number of nursing homes sanctioned	11	15	16

Part 5.

Program Title: **OPTIONAL STATE SUPPLEMENTATION (OSS) PROGRAM**

Program Cost:

State:	$16,143,117
Federal:	
Earmarked:	
Total:	$16,143,117

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 (CRCF).

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 98-99**	**Actual FY 99-00**	**Actual FY 00-01**
Inputs:			
Number of CRCFs that have enrolled as providers	402	352	405
Outputs:			
Average monthly recipient count	4,417	4,257	4,390
Efficiency:			
Average monthly amount paid	$1,207,041	$1,287,555	$1,345,260

SOUTH CAROLINA MEDICAID COVERED SERVICES

The following list of services and benefits are consistent with the outline and definition of covered services in the Title XIX SC State Medicaid Plan. Unless otherwise specified, service limitations are based on the State Fiscal Year (July 1, 2000- June 30, 2001).

INPATIENT HOSPITAL SERVICES

Inpatient hospital services are those items and services, provided under the direction of a physician, furnished to a patient who is admitted to a general acute care medical facility for institutional and professional services on a continuous basis that is expected to last for a period greater than 24 hours. An admission occurs when the Severity of Illness/Intensity of Services criteria set forth by the review contractor and approved by DHHS is met. Among other services, inpatient hospital services encompass a full range of necessary diagnostic, therapeutic care including surgical, medical, general nursing, radiological and rehabilitative services in emergency or non-emergency conditions. Additional inpatient hospital services would include room and board, miscellaneous hospital services, medical supplies, and equipment.

OUTPATIENT SERVICES

Outpatient services are defined as those preventive, diagnostic, therapeutic, rehabilitative, surgical, and emergency services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding 24 hours. Outpatient/ambulatory care facilities include Hospital Outpatient Departments, Diagnostic/Treatment Centers, Ambulatory Surgical Centers, Emergency Rooms, End Stage Renal Disease Clinics (ESRD) and Outpatient Pediatric AIDS Clinic (OPAC). Included in these services are assessments for mental health and substance abuse and treatment of renal disease. Additional outpatient services would include emergency services for treatment of a medical emergency or accidental injury. Comprehensive neurodevelopmental and/or psychological developmental assessment and testing services shall be provided to eligible children under the age of 21 who have, or are suspected to have, a developmental disability, significant developmental delay, behavioral or learning disorder or other disabling condition. Such medically necessary diagnostic services, treatment and other measures, are for the purpose of correcting or ameliorating physical and/or mental illnesses and conditions which left untreated, would negatively impact the health and quality of life of the child.

PHYSICIAN SERVICES

Physician services include the full range of preventive care services, primary care medical services and physician specialty services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis as needed for the prevention, diagnostic, therapeutic care and treatment of the specific condition. Physician services are performed at

physician's offices, patient's homes, clinics, and skilled nursing facilities. Technical services performed in a physician's office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service.

Current Medicaid Service Limitations:

12 visits per member per state fiscal year for adults, unlimited for children under the age of (21).

Early and Preventive Periodic Screening, Diagnosis and Treatment (EPSDT)/Well Child - Preventive health care such as the EPSDT program provides comprehensive and preventive health services to children through the month of their 21st birthday through periodic medical screenings. The basic screening package includes a comprehensive health and developmental history, assessment of physical and mental development, a comprehensive unclothed physical examination, age-appropriate immunizations, appropriate laboratory tests and health education. Screenings should be provided according to the schedule recommended by the American Academy of Pediatrics (AAP) Guidelines for Health Supervision (Pre-1995 recommendations) and the required standards established by HCFA (42 CFR 441.50 - 441.62). The provider is responsible for assuring that children through the month of their 21st birthday are screened according to this schedule and that the diagnostic and treatment services found medically necessary as a part of EPSDT, yet not covered by the Title XIX SC State Medicaid Plan, are provided.

MATERNITY SERVICES

Maternity services include high levels of quality care for pregnant members. Maternity care service benefits include prenatal, delivery, postpartum services and nursery charges for a normal pregnancy or complications related to the pregnancy. Risk assessment form 204 is to be made and reported for pregnant members, newborns, and for infants up to one year after birth. All pregnant members and their infants must receive risk appropriate medical and referral services.

INDEPENDENT LABORATORY AND X-RAY SERVICES

Benefits cover laboratory and x-ray services ordered by a physician and provided by independent laboratories and portable x-ray facilities. An independent laboratory and x-ray facility is defined as a facility licensed by the appropriate State authority and not part of a hospital, clinic, or physician's office.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment includes medical products, surgical supplies, equipment such as wheelchairs, prosthetic and orthotic devices, and hearing aide services when ordered by a physician as medically necessary in the treatment of a specific medical condition. The attending physician has the responsibility of determining the type or model of equipment needed and length of time the equipment is needed through a written necessity statement. Luxury and

deluxe models are restricted if standard models would be appropriate. Repairs to medical equipment are covered if reasonable.

PRESCRIPTION DRUGS

Pharmaceutical services include providing eligible recipients with needed pharmaceuticals including **psychotropic** medications as ordered by valid prescriptions from licensed prescribers for the purpose of saving lives in emergency situations or during short term illness, sustaining life in chronic or long term illness, or limiting the need for hospitalization.

Current Service Limitations:

Routinely covered pharmaceutical services include most rebated legend (prescription) and most non-legend over-the-counter or OTC products. Medicaid sponsors reimbursement for unlimited prescriptions or refills for eligibles through the month of their 21st birthday. Eligibles age 21 and above are allowed up to four (4) Medicaid-covered prescriptions or refills per month. However, certain items are exempt from the monthly prescription limit. The exemptions to the monthly prescription limit are the following: insulin syringes used in the administration of home injectable therapies; home-administered injectables (excluding insulin); aerosolized pentamidine; clozapine therapy; and family planning pharmaceuticals. For pharmaceuticals that are not exempted from the prescription limit, an override process allows the monthly prescription limit to be exceeded upon prescriber request and prescriber certification that the patient has a life-threatening illness or is in the terminal stage of an illness. Medicaid pays for a maximum 34-day supply of medication per prescription or refill. At least 75% of the current prescription must be used (as directed on the prescription) before Medicaid pays for a refill of the prescription. Medicaid pays for most generic products; most brand name products for which generics are available require prior authorization. Prior authorization is also required for certain other products. Approval for Medicaid coverage of products requiring prior authorization is patient-specific and is determined according to certain criteria and conditions.

PODIATRY SERVICES

Podiatry services are those services responsible and necessary for the diagnosis and treatment of foot conditions. Services are limited to specialized care of the foot as outlined under the laws of the State of South Carolina. Services include podiatric surgical procedures and routine foot care. Podiatry care can be rendered to patients in nursing or rest home facilities, provided that the service is medically necessary. Routine foot care includes the cutting or removal of corns, calluses, trimming of nails, or other hygienic and preventive maintenance care. Additional services are considered routine when they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections.

TRANSPORTATION (Non-emergency, emergency)

It may be necessary for a Medicaid recipient to require non-emergency transportation to receive medical services from a provider located in-county, or in a county other than the member's county of residence. Prior approval for non-emergency transportation is required by DSS. DSS workers will follow their and DHHS guidelines for providing non-emergency transportation to recipients.

If the provider authorizes out-of-state referral services and the referral service is available in-state as determined by Department of Health and Human Services (DHHS), the provider is responsible for all Medicaid covered services related to the referral, including transportation and lodging. The exception would be when the services are provided at one of the pre-approved out of state hospitals (Emory, Henrietta Eggleston-Atlanta, Duke, UNC, Bowman Gray- NC and Pinehurst - NC). Under these circumstances, the in-state guidelines will apply. If the provider authorizes out-of-state services and the service is not available in-state the provider will only be responsible for the cost of referral services and any ambulance or medivac transportation or other services provided in core benefits.

Ambulance transportation services for individuals to receive necessary medical care services are available. Medical necessity for ambulance transport is established when the recipient's condition warrants the use of ambulance transportation and the use of any other method is not appropriate. Types of services include ambulance, non-emergency medical vehicles, and air ambulances.

HOME HEALTH SERVICES

Home Health services are health care services delivered in a person's place of residence, excluding nursing homes and institutions, and include intermittent skilled nursing, home health aide, physical, occupational and speech therapy services, and physician ordered supplies.

Current Medicaid Service Limitations:

75 visits per member, per state fiscal year

MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE TREATMENT SERVICES

Mental Health, Alcohol and Other Drug Treatment services will be reimbursed by Medicaid fee-for-service. Mental Health and Alcohol/Other Drug Treatment Services include:

- Outpatient Mental Health and Alcohol/Other Drug Treatment Services (Including: Outpatient Hospital, Community Mental Health Services, Alcohol/Other Drug Treatment Services, Targeted Case Management, Ancillary Case Management Services, and Injectable Medication Administration related to mental health treatment);

- Inpatient psychiatric hospitalizations. (Including psychiatric admission to a medical/surgical hospital or a psychiatric hospital);

- Private practice psychiatrist's services.

VISION CARE

Recipients under the age of 21 receive one comprehensive eye exam every 365 days. Additional exams are covered if medically necessary. Eyeglasses for recipients under the age of 21 and adults enrolled in the Mental Retardation/Related Disabilities waiver are limited to one pair and one replacement if medically necessary (prescription must change by at least one half diopter) during a 12-month period. Eyeglasses for recipients 21 and over are covered only following cataract or detached retina surgery. If medically necessary, a replacement pair of eyeglasses will be provided every two years thereafter.

DENTAL SERVICES

Routine dental services are available to recipients under the age of 21 and adults enrolled in the Mental Retardation/Related Disabilities (MR/RD) waiver. Routine dental services include any diagnostic, rehabilitative, or corrective procedure, supplies and preventive care furnished or administered under the supervision of a dentist.

Emergency dental services are available to all recipients. These are services necessary to repair traumatic injury, to relieve acute severe pain, to control acute infectious processes, and emergency services necessary due to a catastrophic medical condition. Oral surgery services are covered as a part of emergency dental services. Non-covered procedures are those that do not restore a bodily function, are frequently performed without adequate diagnosis, are not proven effective, or are experimental in nature. Services of an assistant surgeon that actively assists an operating surgeon are covered. Coverage is limited to certain major surgical procedures consistent with good medical practice.

CHIROPRACTIC SERVICES

Chiropractic services are available to all recipients. Chiropractic services are limited to manual manipulation of the spine to correct a subluxation. Medicaid recipients are limited to a maximum of one visit per day and up to 12 visits within a calendar year. Chiropractic visits are counted separately from the ambulatory visit limit. Children under age 21 have unlimited visits.

THERAPIES FOR CHILDREN WITH CHRONIC/COMPLEX HEALTH CARE NEEDS

The Title XIX SC State Medicaid Plan provides for a wide range or therapeutic services available to individuals under the age of twenty-one (21) who have sensory impairments, mental retardation, physical disabilities, and/or developmental disabilities or delays, as well as to

individuals of any age who are in the Mental Retardation/Related Disabilities Waiver or the Head and Spinal Cord Injury Waiver programs

Rehabilitative therapy services include: speech-language pathology, audiology, physical and occupational therapies, and Nursing Services for Children under 21 years of age.

HOME AND COMMUNITY BASED WAIVER SERVICES

Home and community-based waiver services target persons with long term care needs and provide recipients access to services that enable them to remain at home rather than in an institutional setting. An array of home and community based services provides enhanced coordination in the delivery of medical care for long term care populations. Waivers currently exist for the following special needs populations: 1) persons with HIV/AIDS, 2) persons who are elderly or disabled, 3) persons with mental retardation or related disabilities, 4) persons who are dependent upon mechanical ventilation; and 5) persons who are head or spinal cord injured. Home and community-based waiver recipients must meet all medical and financial eligibility requirements for the program in which they are enrolled. A plan of care is developed by a case manager for all enrolled waiver recipients and the services to be provided.

FAMILY PLANNING

An array of family planning services is available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments, diagnostic procedures, health education and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics, and pharmacies. Covered services include traditional contraceptive drugs and supplies and preventive contraceptive methods. Family planning services are also available through special teen pregnancy prevention programs.