Accountability Report Transmittal Form

Agency Name Department of Health and Human Services

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Agency Director William A. Prince

Agency Contact Person Roy Payton

Agency Contact's Telephone Number 803-898-2500

SECTION I. EXECUTIVE SUMMARY

The Department of Health and Human Services (DHHS) is the single state agency designated for administration of four major health and human services programs. These are: Medicaid which provides health insurance for low-income families, and the aged, blind and disabled; the Older Americans Act which provides essential support services such as congregate meals, transportation, personal care services, and meals on wheels for individuals over age 60; the Child Care Development Fund which provides financial assistance for child care services for children whose parents are transitioning off welfare and for low income families where the parents or guardians are working, in school or in training, or disabled; and, the Social Services Block Grant which is a flexible funding program used to fund such critical services as child protective services, adult protective services, child care, and home based services which prevent more costly institutionalization of adults and children.

These programs provide essential supports for over 800,000 recipients, involve services delivered by over 30,000 service providers, and encompass a budget of approximately $3.7 billion. As the primary steward of the public funds for these programs, DHHS is committed to maximizing and effectively managing its resources by working with its stakeholders and partnering with providers to contain costs, avoid duplication, and leverage other available sources of funds to address the needs of beneficiaries. DHHS is involved in streamlining eligibility and reporting processes, maintaining a strong network of service providers, providing a strong information and referral network, and reaching out to individuals and families to provide information regarding programs and services. DHHS actively works toward improvements in the quality of care by establishing service outcomes, incentivizing quality improvements, and offering professional development for caregivers.

1.1 Mission and Values

Through the FY 2001-02 strategic planning process, the mission and values were developed for the agency and adopted by agency staff and managers. For more discussion of the strategic planning process, visit the agency's website at www.dhhs.state.sc.us.

The agency's **mission** is 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 policies, pursuing resources, developing programs, building partnerships, providing program oversight, and ensuring fiscal accountability to promote an accessible system of quality health and human services. The agency's **values** are quality, integrity, customer service, teamwork, professionalism, accountability, communication, knowledge, stewardship and innovation.

1.2 Key Strategic Goals for Present and Future Years

The agency developed, and is committed to carrying out, eight key goals (also referred to as key results) for present and future years. Numerous strategies were set out for the accomplishment of each key goal or result. These goals and initiatives link to the agency's mission and details regarding the strategic initiatives for the goals can be found on the agency's website. The eight

goals are: 1) Maximize and effectively manage resources; 2) Promote quality improvement; 3) Promote and assure accountability to stakeholders; 4) Promote customer service; 5) Promote effective communication; 6) Promote appropriate care; 7) Promote access to services; and 8) Strengthen organizational infrastructure.

1.3 Opportunities and Barriers That May Affect the Agency's Success in Fulfilling Its Mission and Achieving Its Strategic Goals (This establishes the basis for the agency's budget request.)

Barriers

Downturn in the state economy and resulting state budget cuts: Because Medicaid is a program for low-income families and individuals, an economic downturn and loss of employment results in a burgeoning Medicaid eligible population and an increasing demand for services. To compensate for the downturn in the state's economy, the agency took steps through its strategic planning process to commit staff to an ambitious agenda for achieving its selected key results. A number of the key results were advanced within existing resources; however, some of the identified strategies to bring about major changes in the service delivery system, improve access to care, promote appropriate care, improve customer service, and strengthen organizational infrastructure will likely be delayed until funds are available.

Opportunities

Medicaid Eligibility Merger: With the transfer of the Medicaid eligibility function from the Department of Social Services (DSS) to DHHS, all aspects of the Medicaid program are now the responsibility of DHHS. The merger of the eligibility determination and service provision functions provides an opportunity to manage the program in a more efficient and effective manner. The skills and expertise brought by the DSS staff provides opportunity for the agency to enhance its strategic goal to promote customer service as it responds to and promotes good health for all beneficiaries. DHHS is committed to meeting the health care needs of beneficiaries in a caring and professional manner. Further details regarding this merger are discussed in Section 7.

Technology Support for Medicaid Eligibility Merger: Related to the DSS merger, there were significant opportunities and challenges for technology support. One of the agency's long-range strategic initiatives for technology is to give every employee in the agency the ability to be mobile workers, thus allowing employees to serve clients at any location. A plan for connecting the eligibility offices will support this initiative. Other opportunities include expanding the agency's intranet to include forms used in the eligibility function; network security, including new user ids and passwords, to facilitate mobile web users; and other web-based functions such as faxes and administrative applications, e.g., leave requests. Further details regarding this activity are discussed in Section 7.

Alternative Reimbursement Methodologies (ARM): DHHS is examining all options for managing the care of persons who receive Medicaid benefits to determine which approaches or models could be implemented that would have the following outcomes: the health outcomes for those in need are improved; the health status of targeted populations is improved; the ability of

patients to manage their condition by patient education, monitoring and communication is improved; the ability to predict cost and expenditures is improved; ways to address health disparities among various demographic groups are identified; and, resources invested in prevention and wellness are increased. Early planning efforts include an examination of alternative reimbursement methodologies to accomplish these outcomes.

1.4 Major Achievements From Past Year

Eligibility System Improvements: During FY 01-02, the management of the Medicaid program was consolidated in the agency with the transfer of the Medicaid eligibility determination function and staff from DSS. DHHS established the infrastructure to carry out this function and oversee the local and central eligibility determination process. Additionally, the agency converted the monthly paper Medicaid cards to plastic cards. An interactive voice response system (IVRS) was implemented for providers to verify Medicaid eligibility and to access the provider's most recent payment information. A toll free call center was established for recipients to call with questions regarding enrollment or covered services. A Medicaid Eligibility Determination System (MEDS) was developed that automated the functions of the eligibility workers that had been primarily a paper process. See Business Improvements, page 4, regarding MEDS. Also see Section 7 for further discussion regarding these initiatives.

Maximization of Federal Revenue: Pursuant to Proviso 8.52 in the FY 01-02 Appropriations Act, the agency continued its focus of maximizing federal revenues by working with other state agencies to determine if state funded programs and initiatives could be funded with Medicaid. In FY 01-02, these efforts generated $95 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 a human services consulting firm to assist in efforts to maximize federal funding. DHHS is the oversight agency responsible for this contract. The firm has been involved with many of the large health and human services agencies and the school districts. See Section 7 for further discussion.

Implementation of a Point of Sale (POS) and prospective drug utilization review (Pro-DUR) system: The implementation and operation of a pharmacy POS/Pro-DUR system has brought benefits to the state, DHHS, the Medicaid pharmacy program, the pharmacy providers, and the beneficiaries. In conjunction with the POS/Pro-DUR system, the pharmacy program has better capabilities with which to contain costs. Since many drugs require prior authorization (PA), significant costs have been avoided through the implementation of these processes. PAs are processed electronically, precluding issuance of a prescription and thereby avoiding costs. Clinicians review the PAs that require intervention for potential health problems or contraindications. With this POS/Pro-DUR system, there are improved health outcomes for beneficiaries and potential drug therapy problems are avoided. See Section 7 for further discussion of POS/Pro-DUR.

Designation as the Lead Agency for Child Care: DHHS administers the federal Child Care and Development Fund (CCDF) to increase the availability, affordability, and quality of child

care services. On September 23, 2001, Governor James H. Hodges signed Executive Order 2001-23 creating a coordinated child care system by establishing linkages that maximize resources and promote more effective planning to assist families in accessing affordable quality child care when they need it. DHHS is the lead agency for child care to: coordinate all current state child care expenditures and programs; administer all new funding sources of child care funds and programs to leverage the state's financial and programmatic resources for maximum efficiency and impact; establish and administer the South Carolina Child Care Coordinating Council; develop a statewide system for monitoring and providing technical assistance to child care providers that makes optimal use of the state's resources to improve the quality of child care; and, develop a statewide child care strategic plan.

The following are some areas where the agency has been successful in minimizing the cost for services while having the maximum benefit and coordination: First Steps; 4-year old kindergarten pilot; partnership with the United Way to engage business in child care activities; system infrastructure for professional development for the early care and education workforce; participation in the national Cost of Quality study for early care and education; Center for Excellence initiative; and child care licensing.

Business Improvements: DHHS reviewed existing workflow processes and instituted process improvements to improve processing time, improve information flow, reduce errors and enhance productivity. A key business process improvement is the Medicaid Eligibility Determination System (MEDS). In 1997, the agency established the MEDS project team to develop and implement a system that would replace the twenty-eight year old batch eligibility system operated by DSS, with a real-time system operated on the same mainframe as the agency's information system. The functions carried out by eligibility workers had been primarily paper processes and these are now being automated by MEDS. The benefits of this project are to: increase eligibility worker efficiency by reducing worker time per case; enhance system support by reducing the time to implement system software changes; improve the accuracy of eligibility determinations by maintaining or reducing the error rate; improve service to Medicaid applicants and recipients by lowering the average time to make decisions, providing timely notices, and providing notices with consistent language and manual citations; and improve service to providers by reducing the percent of claims suspended for correction of eligibility records. With eligibility workers handling 800 to 1,000 cases each, it is anticipated that this new system will provide for greater worker efficiency. A MEDS pilot was implemented in May 2002 with statewide implementation planned for Fall 2002. DSS and DHHS trained over 600 MEDS users. The agency is establishing baselines and will report on improved efficiencies in subsequent years.

SECTION II. BUSINESS OVERVIEW

2.1 Number of Employees: DHHS has 1230 FTE positions and 197 temporary grant positions for a total of 1427 employees.

2.2 Operation Locations

DHHS has a central office in Columbia and fourteen regional offices located in the Community Long Term Care (CLTC) offices. Eight regional Medicaid eligibility administrators' offices are located within the CLTC offices in Greenville, Greenwood, Spartanburg, Columbia, Orangeburg, Florence, Conway, and Charleston. The agency also has a child care program monitoring office located at Greenville Technical College.

2.3 Expenditures/Appropriations Chart:

Base Budget Expenditures and Appropriations

	00-01 Actual Expenditures		01-02 Actual Expenditures		02-03 Appropriations Act*	
Major Budget Categories	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**
Personal Service	$22,784,362	$7,513,913	$25,121,016	$8,233,809	$39,059,681	$13,025,313
Other Operating	136,616,305	17,675,322	157,856,083	17,032,952	145,316,867	15,771,055
Special Items**	1,030,297	919,334	1,841,702	1,059,950	10,582,915	4,177,215
Permanent Improvements	375,000	$0	525,000	$0	$0	$0
Case Services	2,604,147,256	403,916,639	3,068,988,879	450,918,452	3,224,925,165	538,876,735
Distributions to Subdivisions	2,051,342	268,000	1,943,425	150,000	8,050,000	
Fringe Benefits	5,964,723	1,939,408	6,936,144	2,263,511	9,434,825	3,472,306
Non-recurring	489,320,802	24,498,229	493,212,460	8,466,386	481,052,013	3,113,963
Total	**$3,262,290,087**	**$456,730,845**	**$3,756,424,709**	**$488,125,060**	**$3,918,421,466**	**$578,436,587**

* Net of Governor's Veto, also includes funds authorized by Part 1B proviso, which do not appear in Part 1A of the Act.

** State Budget Office methodology assigns non-recurring appropriations to object code 6100 (Special Items). The agency moves these appropriations to appropriate line items for expenditures.

Other Expenditures

Sources of Funds	00-01 Actual Expenditures	01-02 Actual Expenditures
Supplemental Bills	12,172,230	$0
Capital Reserve Funds	$0	$0
Bonds	$375,000	$525,000

2.4 Key Customers

The agency's key customers are its beneficiaries, providers of services, employees, other agencies, policy makers, and external organizations and associations.

2.5 Key Suppliers

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 CLTC services providers. One HMO is currently enrolled in the program. For the Child Care Development Fund (CCDF), key suppliers include various types of child care services providers (suppliers) e.g., family and group day care homes, centers, religious/faith-sponsored programs, and self-arranged care by relatives or friends. These child care service providers include, as of 6/30/02, the ABC Child Care Program's network of 4,443 child care providers. Through the Social Services Block Grant (SSBG), DHHS contracts with approximately 60 public and private providers to provide fifteen services through 62 contracts, grants, and agreements. The Older Americans Act (OAA) funds allow DHHS to contract with ten Area Agencies on Aging (AAA's) who, in turn, contract with one or more local service providers in each of the 46 counties.

2.6 Description of Major Products and Services

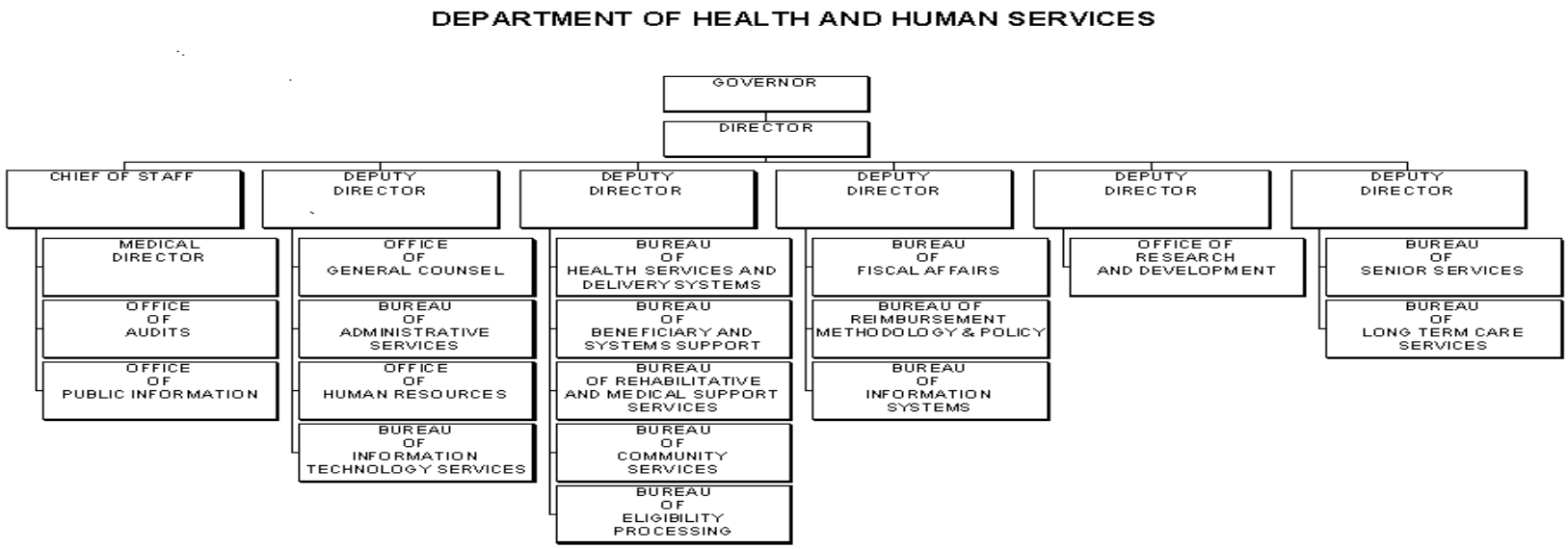
Medicaid: Medicaid pays for a variety of medically necessary services. Refer to Appendix A for a list of services and service descriptions. Medicaid is now referred to as the Partners for Health program. It is a grant-in-aid program in which the federal and state governments share the cost of providing medical care for needy persons who have low income. The program was authorized by Title XIX of the Social Security Act that was signed into law by the President on July 30, 1965. Congress has continuously changed the Medicaid Program since the legislation creating it was enacted. South Carolina began participation in the Medicaid Program in July 1968. Because the cost of the Partners for Health (Medicaid) Program is shared by the state and federal governments, states are given some flexibility in providing coverage to their needy citizens. For this reason, the rules for Medicaid coverage vary from state to state. An individual who is eligible in South Carolina is not necessarily eligible in another state.

Child Care Development Fund (CCDF): The primary CCDF service is financial assistance for child care services received by children whose parents are transitioning off welfare and by children whose families are income-eligible and parent(s)/guardian(s) are working, in school or training, or disabled. DHHS has entered into agreements with several state agencies (Department of Social Services, Department of Education, 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.

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 independent functioning within their capabilities. SSBG funds 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.

Older Americans Act (OAA): DHHS is the state agency designated by the Governor to receive and administer federal Older Americans Act (OAA) funds. These funds provide a range of programs and services for persons age 60 and over, especially those at risk of losing their independence. The Act directs that priority be given to serving those with the greatest economic and social need with particular attention to low-income minority older persons. These services include preventive home and community-based services such as meals, transportation and home care. The OAA is the major source of funding for the aging network to provide these services. The aging network is comprised of ten planning agencies or Area Agencies on Aging (AAA) and local service providers most of which are known as Councils on Aging. In addition to services, local senior centers offer many activities for seniors. The AAAs also house the Long Term Care Ombudsman program that investigates complaints against long-term care facilities in their respective regions.

2.7 Organizational Structure



SECTION III. ELEMENTS OF MALCOLM BALDRIGE AWARD CRITERIA

Category 1 – Leadership

1.1 How do senior leaders set, deploy, and communicate: a) short and long term direction, b) performance expectations, c) organizational values, d) empowerment and innovation, e) organizational and employee learning, and f) ethical behavior?

a) Short and long term direction: DHHS is a cabinet agency and its leadership is appointed by the Governor. The overall direction of the agency 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 directions, as well as performance expectations, are defined through the development of operational plans in support of the strategic plan. Operational plans describe 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. 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.

Federal law mandates a Medical Care Advisory Committee (MCAC) to advise the agency director about health and medical care services. Members appointed by the director must be physicians or other representatives of the health profession familiar with the medical needs of low-income populations and resources available and required for their care; members of consumers' groups and organizations; and, the director of DSS or Department of Health and Environmental Control (DHEC) (both serve on the MCAC for DHHS). The MCAC meets monthly and meetings are announced pursuant to the provisions of the Freedom of Information Act (FOIA). The agenda includes a report from the agency director. The MCAC makes formal recommendations to the agency.

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 agency's key results as well as broad based strategies, operational plans, and priorities are developed with reference to the identified values. Articles are published in the agency's newsletter, *Communique*, featuring one of the agency's values. These articles provide on-going communication with staff regarding the importance of these values.

d) Empowerment and innovation: The strategic planning process serves as a primary vehicle for staff empowerment and innovation. Staff are challenged and positively reinforced to develop innovative strategies to address key results. The strategic planning process itself provides empowerment by involving a broad range of staff representing 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 via the strategic planning process. The agency has adopted a number of broad strategies for developing and maintaining employee knowledge and learning. Among these are development of a mentoring program and a biennial training needs assessment with broad based input from agency staff and from which a training plan is developed. 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 interactions 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 meetings 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, setting the context in which the agency achieves its mission. At the forefront in DHHS' policy development, planning, and priority setting are customer needs/satisfaction, whether providers, beneficiaries, state/federal policymakers, or other stakeholders. Senior management promotes customer focus through a continuous process of interaction with agency customers through convening or participating in focus groups, forums, conferences, and meetings of advocacy organizations and provider groups and associations. In these settings, information regarding agency activities and initiatives is provided and customer input and feedback is obtained. Additionally, the agency maintains established standards for timely response to customer inquiries and complaints. As

part of its focus on customer service, the agency designated a licensed social worker to coordinate its constituent services and serve as liaison internally and externally to resolve or respond to constituent inquiries and complaints. A database of constituent referrals and inquiries is maintained and a monthly analysis is conducted.

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

Performance indicators are established in all operational plans developed in support of the strategic plan. As part of the operational planning process for the FY 01-03 strategic plan, baseline indicators were established. These performance indicators will be reviewed annually. Financial reports are trended and evaluated monthly by senior leaders. 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, federal audits, USC School of Public Health, MUSC, etc.) 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.

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 that invite input and feedback which are 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, federal audits, USC, Clemson University, MUSC) 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 convenes and/or participates in numerous inter-agency committees, provider and professional association meetings, and discussion forums with advocates and beneficiaries to identify needs, desires, and concerns. These 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 coordinates 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 Eden Alternative Conference and SC Conference on Aging.

Category 2 – Strategic Planning

2.1 What is your Strategic Planning process, including participants, and how 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' strategic planning process was completed in 2001 with a combination of executive and mid-level managers and a diagonal cross-section of staff. Over 250 of the agency's employees participated. The strategic planning process involved identification of agency customers and stakeholders and their expectations of the agency; an assessment of how well the agency was 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 01-03, and development of broad strategies for achieving key results. Because of the growth in the size, diversity, and complexity of agency programs, development of a strategic plan was essential to insure the most efficient use of agency resources and to provide focus on

agency priorities. An operational plan was developed that encompassed initiatives, process improvements, and enhancements in every area of the agency. Implementation began in July 2001 and continued throughout 2002.

2.2 How do you develop and track action plans that address your key strategic objectives? (Note: Include how you allocate resources to ensure accomplishment of your action plans.)

Initiatives to advance key results are identified and prioritized. Operational plans for strategic initiatives to advance the key results are developed and reviewed. 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 are 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. Accomplishments are tracked on a quarterly basis via detailed status reports. All action plans require an indication of whether an initiative can be completed within existing resources or whether it requires new resources. If new resources are required, a request is incorporated into the agency's annual budget development process.

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 is intimately involved in development of the objectives as well as operational plans, action plans, and performance measures. As a result, there is on-going communication and ownership concerning each of these components. Deployment is carried out by the staff within the organizational units which developed the strategies and operational plans. Progress toward objective completion is monitored quarterly. Additionally, once the strategic plan is complete, a strategic plan document is produced which communicates the mission, vision, values and key results as well as the broad strategic objectives of the agency. A summary form of this document is shared with customers and stakeholders through the many forums and committees with which DHHS maintains on-going and continuous contact. An operational plan is also produced to provide an agency overview of all on-going initiatives. The *Communique* articles referenced in Section III, 1.1c provide reinforcement with staff in deployment of the agency's values.

Category 3 – Customer Focus

3.1 Identify key customers and stakeholders.

The agency's internal stakeholders are the 1427 employees who carry out the day-to-day operation of the agency. The external customers include over 30,000 health, child care, and aging service providers with whom the agency contracts for service delivery and over 800,000 low-income service beneficiaries. The external stakeholders include policymakers such as the Governor and the legislature, the federal government from whom the agency receives funding,

and state agencies with whom the agency partners to develop policy and programs and provide services. Additional external stakeholders include advocates, provider associations, other health insurers and the general public.

Increasingly Medicaid is being recognized as a publicly funded health insurance program for low-income working people and their families. The DHHS service network extends into every county and clients range from the unborn to centenarians. While at one time the majority of clients were directly connected to the state's welfare system, today less than 10 percent receive monetary assistance. The contribution of the agency's 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. See the DHHS website for the Economic Impact of Medicaid study conducted for the agency in 2002 by the Moore School of Business, USC.

3.2 How do you determine who your customers are and what their key requirements are?

Federal law and regulations concerning DHHS programs stipulate to a large extent the eligible population served (beneficiaries) and the range of services provided (providers with whom the agency contracts). Beyond federal law and regulation, the state has limited discretion to add optional eligibility groups (beneficiaries) and optional services. The agency assesses key requirements of 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. The agency assesses 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. The agency also issues public notices and convenes 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 3.2 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 strategic planning process also reassesses how well the agency is responding to customer needs.

3.4 How do you use information from customers/stakeholders to improve services or 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. DHHS is committed to providing positive customer service to its employees, beneficiaries, and service providers. A strategy of continuous process improvement has been

developed and is directed toward enhancing communication capacity, improving efficiency, and reducing the paperwork burden for all its customers. Customer/stakeholder input from focus groups, provider and provider association contacts, meetings, etc. has been incorporated into initiatives such as the development of a statewide child care plan, the interactive voice response system, DSS eligibility merger, the Medicaid plastic card, and others. See Section 7 for discussion regarding initiatives to improve services or programs with customer/stakeholder information.

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. The agency builds positive relationships with its customers by keeping them informed of what the agency is doing or plans to do and by giving them an opportunity to be heard and to give input. Formal and informal mechanisms are maintained for handling and tabulating information on customer/stakeholder complaints. A toll free line for beneficiaries is provided. See Section 7.1 for further discussion.

3.6 How do you build positive relationships with customers and stakeholders? Indicate any key distinctions between different customer groups.

DHHS builds positive relationships with stakeholders by responding to their requests, complaints, and inquiries and by meeting with them regularly to listen to their concerns and mutually solve problems. The agency strives to be partners with its customers and stakeholders through its advocacy efforts and forthrightness on difficult issues. The agency also meets with numerous consumer groups on a regular basis and provides speakers for community meetings. A primary 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 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?

DHHS contracts with outside consultants to test data. Having supervisors review work products against primary source data, ensures quality and completeness. Data is reviewed for comparability between funding years. The agency works with providers to assure that criteria for data are the same. DHHS makes comparisons with similar programs nationally. Formatted data reports the agency submits to funding streams that provide federal matching dollars for

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 develop 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. Financial data is used for decision-making in fiscal and program areas to include funding cuts, program changes, rate changes, eligibility changes, contractual issues, operating costs, etc.

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

DHHS uses 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 child care data to national and general population health and child care 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 policy changes or adjustments need to be made.

Category 5 - Human Resources

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

Managers and supervisors make every effort to encourage and motivate employees by taking a management approach that utilizes positive feedback and open lines of communication among staff. Additionally, staff is encouraged to participate in many of the DHHS benefits, including flexible work schedules and business casual dress attire, which help promote a positive work environment. Employees are also encouraged to utilize the many training opportunities so that they can work more efficiently and 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?

Through its training department, the agency makes available a wide variety of training to all employees. Training classes include but are not limited to orientation training, managerial training, computer training, customer service training, and diversity training. These training classes are offered in-house in a state-of-the-art training room, as well as through contracted outside vendors based on periodic needs assessments. DHHS also uses employee surveys to identify specific training needs of staff.

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

DHHS has been and remains totally committed in support of the merit pay program, when available, to reward high performing employees. The agency has in place an Employee Recognition and Award program, which shows all employees the agency's commitment to recognize hard-working and dedicated employees. All managers and supervisors are encouraged to provide continuous feedback to employees. This constant feedback, combined with the goals set forth in the EPMS, provide for an effective means of fostering ongoing high performance.

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 fiscal year 2000. Plans are to conduct surveys on a periodic basis. Routinely scheduled meetings of supervisors, managers, and directors also help determine useful methods and measures for well-being, satisfaction, and motivation. Among the many programs that have evolved out of the assessment methods are the agency's business casual dress every day, Employee of the Month program, an alternative work schedule, and the telecommuting program.

5.5 How do you maintain a safe and healthy work environment?

DHHS has a workplace violence policy and a sexual harassment policy. The agency also uses secure ID badges for all employees that limit access based on clearance level. Additionally, the main office uses single door access, making the management of all incoming and outgoing employees, visitors, and clients much easier and safer. The agency has been very proactive in addressing the ergonomic concerns of employees, including ergonomic reviews of employee workspace to help eliminate medical problems. Security is discussed in more detail in Section 7.

5.6 What is the extent of your involvement in the community?

Agency employees actively participate in a vast array of community and professional endeavors that aide in the health and well-being of all South Carolinians. DHHS supports a Meals-on-Wheels route, supports the Salvation Army during the holiday season by staffing a kettle, and participates in the First Ladies Walk for Life to help in the battle against cancer.

Category 6 – Process Management

6.1 What are your key design and delivery processes for products/services, and how do you incorporate new technology, changing customer and mission-related requirements, into these design and delivery processes and systems?

The agency's 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 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 child care provider, and the agency's accounting system (GAFRS). DHHS continuously solicits customer input and assesses ways to streamline and upgrade its processes to make them more efficient and customer friendly, particularly with regard to application of technological process improvements. DHHS incorporates 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 example of enlisting technology to focus on new customer needs, product and service delivery, and partnering to improve a service is the statewide Point of Sale (POS) computerized system for the pharmacy program. It is a real-time system that replaces a cumbersome paper process. POS enables pharmacists to view a Medicaid patient's total pharmaceutical benefit and to actively intervene to thwart potential medication counteractions. 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 requirements?

DHHS maintains current data and numerous tracking systems to assess how well key performance indicators are met. Within available resources, the agency is 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 operation of the agency's 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 your key support processes, and how do you improve and update these processes to achieve better performance?

Program staff provides technical assistance to providers. The agency also provides information and assistance to family caregivers, to businesses, to other agencies, to legislators. The agency improves its processes in response to information received from customers. DHHS is deeply committed to helping improve services. Technical teams are sent 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, the contractors and enrolled service providers are the agency's primary suppliers. DHHS interacts with them monthly through its Medical Care Advisory Committee meetings and maintains continuous interaction with provider associations to obtain input and feedback. The agency is very proactive in providing technical assistance and data, as well as training and training updates, and resource materials.

Category 7 – Business Results

Following discussion of the questions below, business results will be reported for each of the agency's eight key results (broad goals). Strategic initiatives that link to these goals will be discussed. Many of the initiatives are new and therefore trend data and national benchmarking is not available this year.

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

Customer satisfaction is measured through surveys, focus groups, service utilization, number of complaints and customer participation. For example, external and internal customer input was obtained and incorporated in the redesign of the automated nursing home cost report. The agency works closely with institutional provider associations in setting rates. There is a continual relationship with institutional providers with on-going interaction and discussion. Additionally, focus groups were held with recipients regarding the Medicaid plastic card prior to its implementation. In April 2002, 250 participants randomly selected from the ABC Voucher System, received surveys for the purpose of determining their level of satisfaction with the child care services their child is receiving. Of those who responded, 85% indicated they were very satisfied with the ABC Voucher Program and were very satisfied with the services provided by their child care provider. DHHS is preparing to survey a second group of randomly selected participants in the coming year. As a part of the Universal Financing Approaches for America's Children Project, DHHS contracted for a state random digit household survey to gather information on parental decisions about types, amounts, costs and preferences related to child care used, maternal employment, and other related information. This information which addresses demand for child care will be used in tandem with financing mechanisms in the design of a long-range child care infrastructure plan. The Universal Financing project is further discussed in Section 7, Goal VII.

Pursuant to a contract with DHHS, the University of South Carolina, Institute for Families in Society, initiated a survey of Physician Enhanced Program (PEP) providers during this fiscal year. The survey addressed access to care for PEP patients, preventative, age appropriate and primary care services for PEP patients, hospital privileges for PEP providers, referrals to specialists, coordination of medical care for PEP patients, and satisfaction with the PEP program. Additionally, the survey identified factors that influenced satisfaction. The results of this survey will be analyzed and recommendations will be made regarding programmatic revisions.

The Medicaid Contractual Transportation Program uses a Customer Survey as part of the annual compliance review performed on each provider. Prior to the on-site visit, DHHS mails the survey to the provider. The provider is asked to distribute to customers (beneficiaries and other human service agencies utilizing the provider's transportation services). After DHHS receives the surveys back from consumers, results are reviewed. If needed, technical assistance is provided addressing any areas identified in the surveys and/or during the on-site visit. Additionally, information from surveys is used to improve the overall functioning of the Contractual Transportation Program.

Participants in the High Risk Channeling Project were surveyed in calendar year 2000 to determine their experiences while participating in the Project. Additionally, physicians were surveyed in order to get their feedback on the Project's efficiency and effectiveness. This feedback was used to develop best practice guidelines. During the fall of 2001 a mail/telephone survey was conducted with enrollees, participants, and potential participants in the Family Planning Waiver (FPW) to determine use of family planning services, non-use of family planning services, reasons for using, and reasons for not using family planning services. Responses were used by the independent evaluator in the development of suggestions to improve performance of the FPW.

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

DHHS' mission is to provide statewide leadership to effectively utilize resources to promote the health and well being of South Carolinians. During the current year, the agency maximized resources in its Medicaid, child care and aging programs through building partnerships to maximize federal revenue and by pursuing grant resources. The agency also undertook steps to effectively manage resources. See Goals I and II, pages 23 and 28.

7.3 What are your performance levels and trends for the key measures of employee satisfaction, involvement and development?

Performance levels remain high. Based on feedback received through surveys, and employee group and one-on-one meetings, employee satisfaction continues to remain high. Employees are encouraged to become involved in many agency processes. Employees attend training on an on-going basis that helps them in their professional development.

7.4 What are your performance levels and trends for the key measures of supplier/contractor/partner performance?

Providers of services are not only customers but are key suppliers for the agency. The agency enrolls or enters into contracts with it suppliers in accordance with the requirements for the particular provider type. The agency interacts with providers monthly through its MCAC meetings and maintains continuous interaction with provider associations to obtain input and feedback. Program staff provides technical assistance. 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.

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

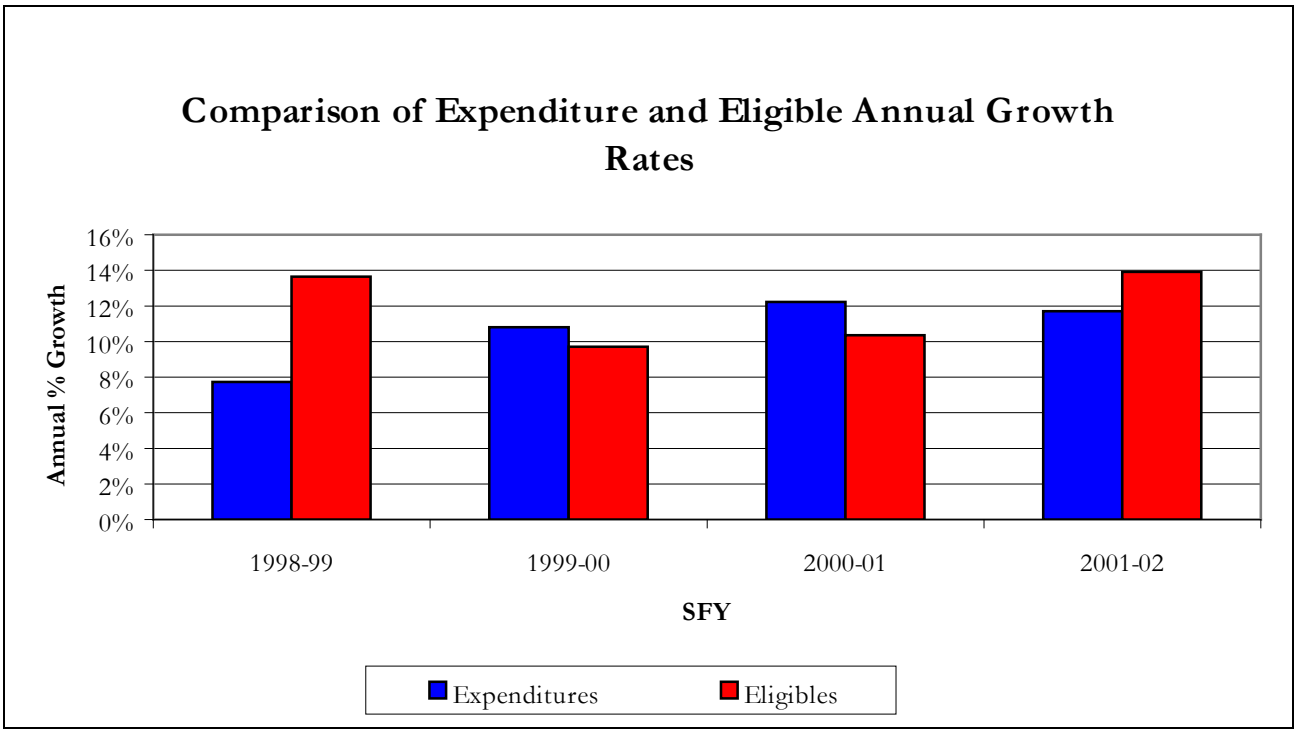
The Office of General Counsel represents the agency in state and federal courts and administrative hearings; and advises the director and staff on legal matters pertaining to the agency. DHHS complies with state and federal regulations regarding the operation of the grants that the agency administers. Currently, there are no federal deferrals or disallowances related to

grant compliance issues and the active litigation is mostly state litigation regarding interpretations of the manualized or state regulatory rules governing the operations of the grant programs. The number of legal challenges to the operation of the agency's grant programs is expected to remain relatively low. Developments in the law, such as the HIPAA privacy and standardization federal regulations and the *Olmstead* decision relating to the Americans with Disabilities Act, which could have precipitated such challenges, have been anticipated and actively met through the agency's history of engaging the affected stakeholders (sub-grantees and grant beneficiaries) in dialogue and implementing whatever operating adjustments have been needed. DHHS continues its policy (supported by federal law) of keeping service providers and recipients well informed of expected changes.

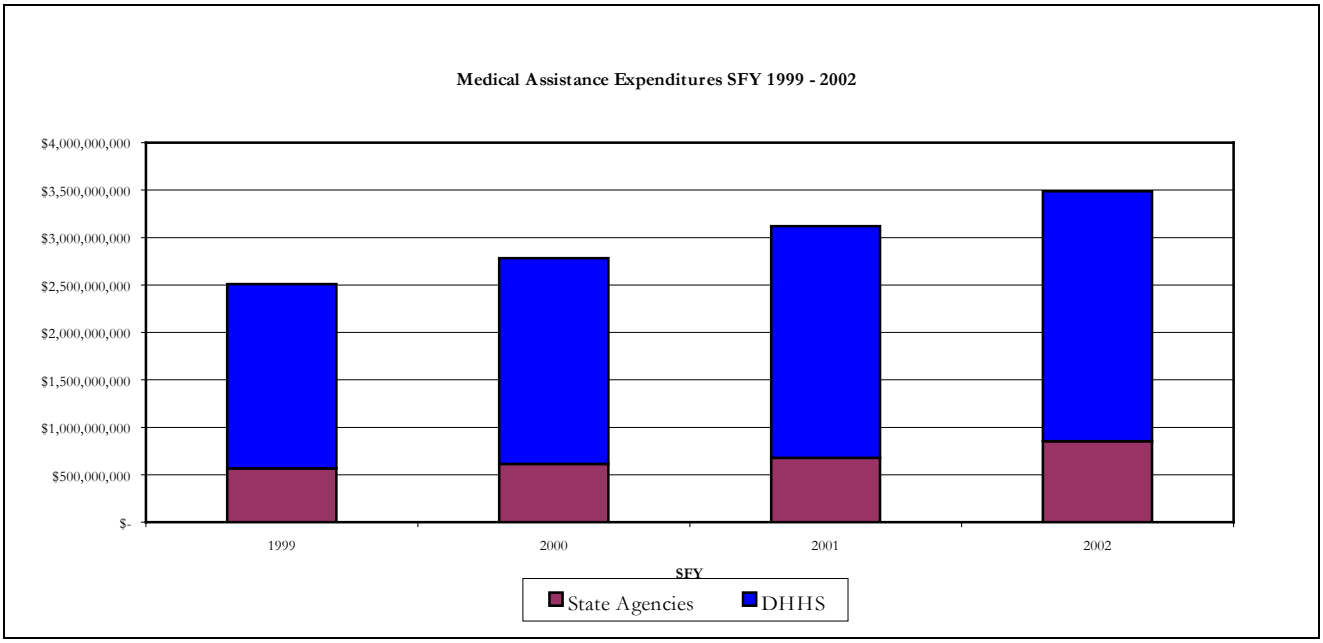
The Budget and Control Board conducted an audit in February 2002 regarding Medicaid eligibility errors. The error rate was found not significantly different from zero. During 2001, the Budget and Control Board also conducted an analysis of the economic benefits and costs of the Medicaid program.

7.6 What are your current levels and trends of financial performance?

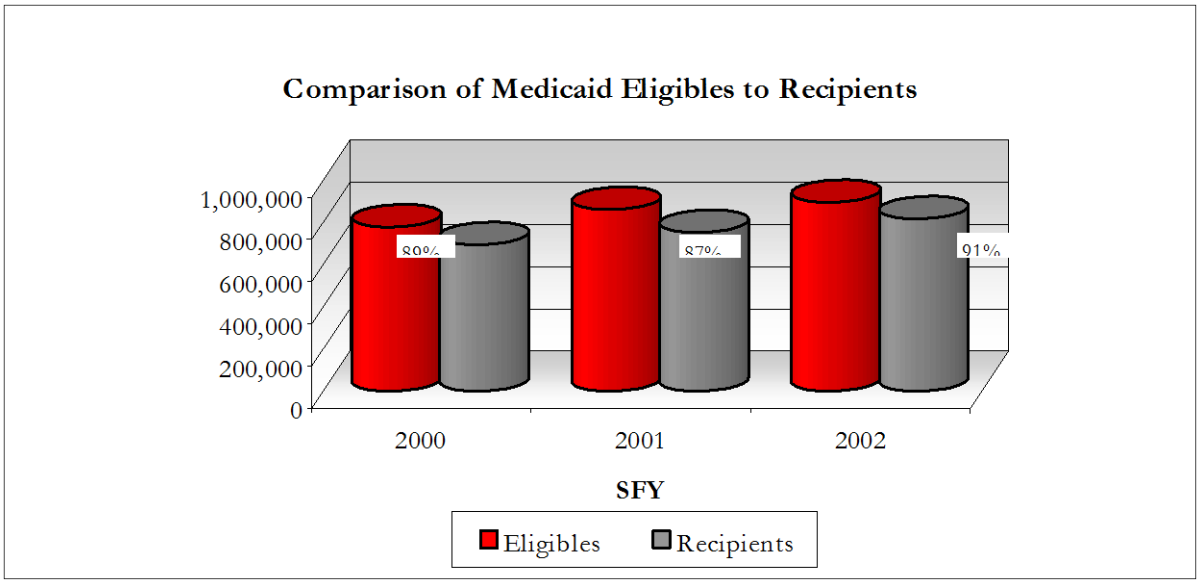
Medicaid expenditure growth has remained fairly constant at 10-12% within the last several years. Many of the factors behind this level of growth underlie more general trends in health care costs such as double digit increases in drug prices. Additional specific growth factors for Medicaid have been significant increases in enrollment of children and low-income families. The agency has implemented certain cost saving measures that it anticipates will help maintain the growth level for SFY '03 to 9% or less.



The following graph depicts medical assistance expenditures from baseline SFY 1999 to 2002, showing expenditures for state agencies as well as for DHHS.



The following graph depicts the ratio of Medicaid eligible individuals to Medicaid recipients for SFY 2000 to 2002. An eligible individual is a person who has been found to meet all of the categorical, income and asset requirements. A Medicaid recipient is a person who is Medicaid eligible and has actually received a Medicaid sponsored service that was reimbursed during the fiscal year.



As noted above, the agency's eight strategic goals or key results and initiatives for those goals are discussed below.

Goal I. Maximize and Effectively Manage Resources

Maximization of Federal Revenue

DHHS is responsible for oversight and management of a 3-year contract with a human services consulting firm, entered into on September 1, 2000 to maximize federal revenue in the state. Department of Health and Human Services, Department of Social Services, Department of Juvenile Justice, Department of Mental Health, Department of Disabilities and Special Needs, Department of Health and Environmental Control, School for Deaf and Blind, Department of Education, Department of Alcohol and Other Drug Abuse Services, Commission for the Blind, Department of Vocational Rehabilitation, and Employment Security Commission are parties to the contract. Claims filed as of June 2002 as a result of this initiative include more than $27.7 million for the initiatives implemented at DSS for Title IV-E Foster Care Services; approximately $3.3 million for Section 1931/CHIP expenditures at DHHS; $5.5 million for the Community Mental Health Medicaid Rate Enhancement; $1.6 for the Targeted Case Management Rate Enhancement at the Department of Juvenile Justice; and, approximately $4.6 million for Medicaid Administrative Claiming at the Department of Education.

Additionally, the agency was directed by a proviso to maximize federal revenue. A total of $95 million in revenues was realized from the project and properly posted in the agency's accounting system. All project revenue was utilized to support Medicaid program expenditures.

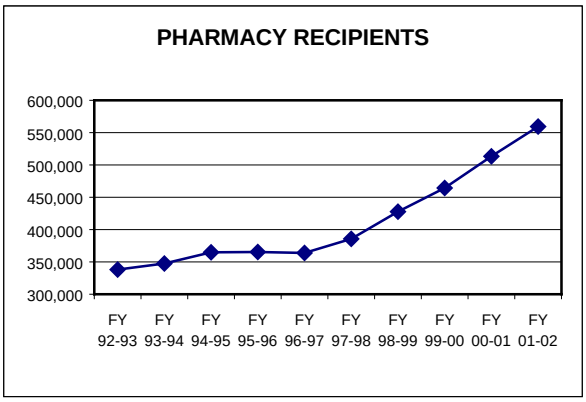
Pharmacy Point of Sale

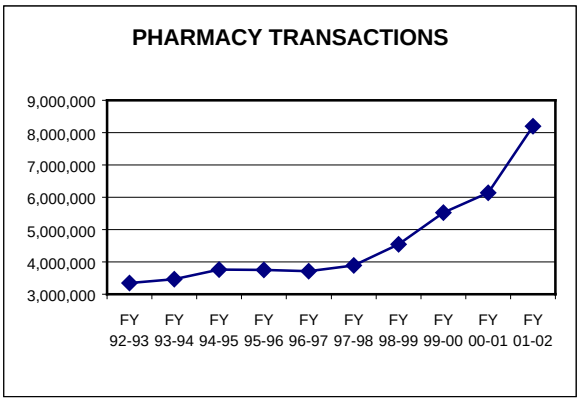
A pharmacy Point of Sale/Prospective Drug Utilization Review (POS/Pro-DUR) system was implemented November 1, 2000. Pharmacy claims are now submitted via POS for adjudication in an on-line, real-time environment. The POS system captures, edits, and adjudicates pharmacy claims at the point of sale. Providers receive immediate, on-line information regarding eligibility, prescription coverage, and Medicaid reimbursement amount.

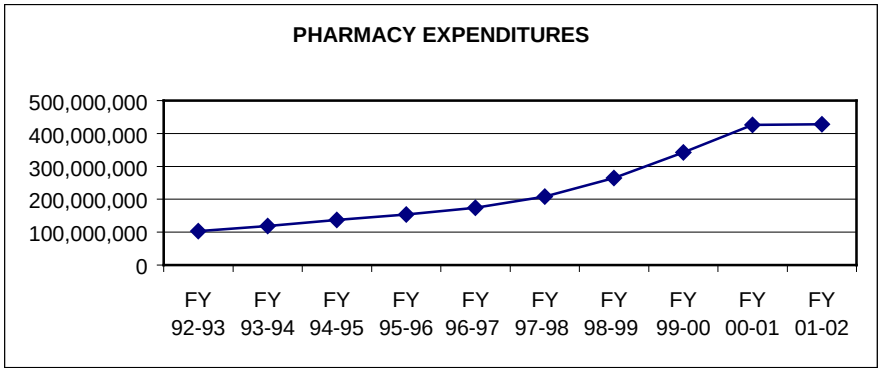
Additionally, the on-line, real-time Pro-DUR, electronically reviews claims at the point of sale for potential drug therapy problems. Pro-DUR results in improved quality of Medicaid-reimbursed health care services, improved quality of health outcomes, and cost avoidance by precluding issuance of a prescription, which may result in health problems and/or have to be discarded because of contraindication. Prior to POS, all pharmacy prior authorizations (PAs) were submitted to the program area for manual evaluation and pricing. This entirely manual process greatly limited DHHS' abilities to expand the PA program.

In the current POS environment, many PAs are processed electronically through the POS system while the POS contractor's clinicians review those PAs requiring intervention. With these processes in place, DHHS expanded its PAs to include a number of other high cost drugs. Prior to implementation of the POS program and consequent expansion of prior authorization, expenditures in the pharmacy program had consistently grown by approximately 20% per year.

The charts below illustrate the growth in pharmacy recipients, transactions, and expenditures from FY 93-FY 02. While recipients and transactions have continued to climb, cost savings measures produced a leveling of expenditures between FY 01 and FY 02.







Changes in Medicare Crossover Payment Policy for Dual Eligibles

The Medicaid program experienced significant growth in the early months of FY02, indicating need for the agency to contain costs through policy and program changes in order to remain within budget. Effective October 20, 2001, DHHS implemented a change in its payment of Medicare crossover claims for physicians and other non-institutional service providers. The projected savings from this change for the current fiscal year (2002) was approximately $11.6 million total dollars. Projected annual savings are expected to be $19.3 million. Had the agency not taken steps to control expenditures through this mechanism, the agency would have run a deficit by year-end.

Medicaid Eligibility

Consolidation of the Management of Medicaid Eligibility in One Agency - Prior to establishment of DHHS (formerly the Health and Human Services Finance Commission) in 1983, the Department of Social Services (DSS) was the state Medicaid agency. When DHHS was established and designated as the state Medicaid agency, eligibility determination was retained at DSS under a contract between the two agencies because most Medicaid recipients at that time were eligible by virtue of being welfare recipients.

Due to welfare reform, the de-linking of Medicaid eligibility from welfare assistance and implementation of the Children's Health Insurance Program (CHIP), the composition of the Medicaid population has changed from predominantly welfare recipients to low income, working families. Recognizing that nearly two thirds of the Medicaid population no longer had a direct link to DSS and the need to contain costs in the program, DHHS, DSS, and the Governor took steps to consolidate the management of the Medicaid program in one agency. State DSS Medicaid workers transferred to DHHS earlier this year. County DSS Medicaid workers transferred to DHHS effective July 1, 2002.

The agency infrastructure was established with a Bureau of Eligibility Processing to oversee the local and central eligibility determination functions. Staff transfer was initiated with the move of DSS State office staff to DHHS earlier this year. The eligibility staff from the county DSS offices was transferred in June 2002. County positions were reallocated to establish eight regional administrators who will be co-located in CLTC regional offices. Their primary function is to supervise and manage Medicaid eligibility functions in these regions.

Implementation Plastic Medicaid Cards - DSS, under contract with DHHS, formerly issued and mailed approximately 400,000 paper Medicaid cards per month at an annual cost of $1.6 million. The initial one-time production and distribution cost for the plastic cards and a new client Medicaid handbook was $572,000. The on-going cost of issuing plastic cards and handbooks to new eligibles is estimated at $25,000 per month. The net annual savings beyond the first year is estimated at $1.3 million. Not only did the plastic card save money, it also makes it possible to provide accurate, up-to-date information to service providers regarding eligibility and service limits; thereby avoiding inappropriate Medicaid billing.

The plastic Medicaid cards were implemented December 2001. Initially, those eligible for Medicaid in December 2001 received both a plastic card and the paper Medicaid card. Beginning January 2002, no paper Medicaid cards were issued. Approximately 752,000 plastic Medicaid cards were sent in the initial release.

<u>Provision of Integrated Personal Care (IPC) in Community Residential Care Facilities (CRCF)</u>

The IPC program was developed to maximize existing state funding appropriated for the Optional State Supplementation (OSS) program. Approximately 4,400 elderly and/or disabled South Carolinians who reside in licensed CRCFs have their income subsidized with OSS funds. Many of these residents currently meet or are approaching nursing home level care, due to functional deficits. The IPC program uses a portion of funds appropriated for the OSS to pay participating CRCFs for the provision of IPC services, i.e., personal care aide services, by trained aides. The provision of IPC services to residents who require additional assistance with bathing, dressing, maintaining continence, etc., is intended to prevent or delay institutionalization. By maximizing Medicaid funding in this manner, the state obtains $268 in federal funds per IPC participant per month.

Implement Telecommuting Throughout DHHS on a Phased-In Basis

DHHS implemented a telecommuting program during the current fiscal year to increase employee productivity, reduce office space lease cost, and reduce turnover and sick leave among employees. The program is also anticipated to benefit the community by reducing traffic, reducing pollution, and saving on fuel consumption. All anticipated outcomes are being carefully monitored as telecommuting is being phased in throughout the agency. The agency has already avoided cost by freeing up office space to accommodate the transfer of state level DSS Medicaid eligibility workers to DHHS without additional lease costs. Without the downsizing of office space relative to telecommuting, the additional office space required to accommodate these employees would have cost the agency approximately $112,500.

Moving Toward Regionalization

The agency took steps over the past year to regionalize some program area functions and increase the efficiency and effectiveness of these program operations. The area offices of the Community Long Term Care (CLTC) program were utilized for these regional offices. The co-location of staff in existing offices was a cost-effective means to regionalize these program functions and to better serve beneficiaries and providers.

An informal review and reconsideration process was developed for the ABC Child Care program. An informal review step in the appellate process serves as a mechanism to resolve issues that do not rise to the level of a formal appeal and thereby alleviates the need for a formal evidentiary hearing. The ABC Child Care program staff can informally handle many of the appeals requests and save time for the Appeals Division staff. It is anticipated that this process will relieve the Appeals Division of approximately 60 (90%) of the ABC Child Care appeals per year and will expedite the processing of ABC Child Care reconsideration requests (67 ABC Child Care appeal requests were received in calendar year 2001).

The number of appeals requests from Medicaid applicants/recipients increased by 31% in calendar year 2001 while the number of hearings officers remained the same. To reduce travel time and expense for staff to conduct appeals hearings, arrangements were made for the hearings to be held at the regional offices. It is anticipated that the move to regionalized hearings will permit the reallocation of 270 man-hours. Less travel will allow for more efficient use of time to conduct appeals and will save at least $1,300 in travel costs.

The Medicaid eligibility function and resources were divided into eight regions within the state. There will no longer be forty-six county directors to manage Medicaid eligibility. Instead workers and supervisors will be under the direct supervision of eight regional administrators. The eight Regional administrators will regionalize county staff and resources and manage eligibility functions outside of the traditional county boundaries. Eligibility staff (workers and supervisors) will be moved as appropriate within the counties of each region to assist other staff as needed. The eight regional administrators will be co-located in eight of the fourteen CLTC regional offices.

Fraud and Abuse Detection and Investigation

The agency initiated efforts to enhance fraud and abuse detection and investigation by educating providers and the procurement of fraud detection software. Staff has participated in meetings with various organizations representing dentists, pharmacies, medical equipment providers, state agencies, and the Attorney General's Medicaid Fraud Control Unit to provide education and awareness regarding fraudulent activities. Additionally, during FY 01, DHHS acquired and installed new fraud detection software to enhance fraud detection efforts. In contrast to the $431,000 collected in FY 01, the agency collected $6.7 million in FY 02.

Future Revenue Maximization

Develop and Implement an Electronic Monitoring and Automated Billing System for CLTC In-Home Services - DHHS is implementing electronic monitoring and automated billing for in-home services providers under the Community Long Term Care program, referred to as *Care Call*. DHHS is responsible for authorizing and overseeing the provision of in-home services for elderly and disabled individuals. An on-going concern has been ensuring that recipients receive the services that are authorized and billed.

The electronic monitoring system will require in-home workers to dial in upon arrival and departure to validate their services delivery in line with the authorization. The system will also act as a billing mechanism so that claims will be paid based on recorded time in the home. The system will also act to verify eligibility. The system should eliminate fraud and abuse in billing for services not rendered, prevent service delivery to ineligible recipients, and assure that recipients receive the services required. DHHS will be monitoring and assessing the cost avoidance generated by this system.

Step Down Program for Medically Fragile – The Medically Fragile Children's Program (MFCP) is a managed care medical program for children with special needs provided at Palmetto Richland Memorial Hospital. Services include access to a pediatrician 24 hours a day, 7 days a week; unlimited occupational, physical and speech therapy; all necessary medications, both prescription and over the counter; supplies; durable medical equipment; transportation to and from medical appointments; and education and respite for parents. An outside evaluation of the program demonstrated improved health outcomes and cost reduction for children served by the program. However, children who left the program due to improved health, quickly regressed and health care costs rose. DHHS implemented a step down program to maintain the health of the children and control costs. A bundle of services was created that children with less medically complex special needs utilized most frequently. These services include primary and emergency medical care; well child care; laboratory; durable medical equipment; speech, occupational and physical therapies; pharmacy; training; and medical care coordination. The initial site for the step down program is Richland County with services available to children within a 30 to 45 mile radius.

Goal II. Promote Quality Improvement

Implement Selected High Utilizer Initiatives

Environmental Health Program – During the current fiscal year, DHHS conducted planning for implementation of an Environmental Health Program. The children's environmental health program is a pilot program intended to address environmental factors that negatively impact children's health. Proposed target areas are asthma/asthma triggers, second hand smoke, lead exposure/poisoning, and unsafe drinking water/unsanitary sewage disposal. The purpose of the project is to improve prevention and management of chronic disease, to improve health outcomes and contain costs. The project will be piloted in Aiken, Allendale, Bamberg, Barnwell, Calhoun, Orangeburg and Richland counties beginning with Bamberg and Richland counties. Rather than traditional fee-for-service reimbursement, an alternative reimbursement methodology will be utilized to compensate providers for services rendered under the project. Program components include completion of a screening form by a primary care provider or public health staff at the request of the primary care provider and for children who have no medical home; an in-home environmental assessment by the Department of Health and Environmental Control (DHEC) with any applicable education and counseling that might be indicated by the assessment by DHEC or the primary care provider; blood lead level testing and follow-up services that might be indicated; services applicable to the individual target areas; and linkage to a medical home and feedback to the primary care provider.

Step Down Program for Medically Fragile – The Medically Fragile Children's Program (MFCP) is a managed care medical program for children with special needs provided at Palmetto Richland Memorial Hospital. Services include access to a pediatrician 24 hours a day, 7 days a week; unlimited occupational, physical and speech therapy; all necessary medications, both prescription and over the counter; supplies; durable medical equipment; transportation to and from medical appointments; and education and respite for parents. An outside evaluation of the program demonstrated improved health outcomes and cost reduction for children served by the program. However, children who left the program due to improved health, quickly regressed and health care costs rose. DHHS implemented a step down program to maintain the health of the children and control costs. A bundle of services was created that children with less medically complex special needs utilized most frequently. These services include primary and emergency medical care; well child care; laboratory; durable medical equipment; speech, occupational and physical therapies; pharmacy; training; and medical care coordination. The initial site for the step down program is Richland County with services available to children within a 30 to 45 mile radius.

Implementation Plastic Medicaid Cards

As discussed under Goal I, the agency converted from paper to plastic Medicaid cards in December 2001. Not only did the plastic card save money, it made it possible to provide accurate, up-to-date information to service providers regarding eligibility and service limits. With current information, providers can bill Medicaid appropriately and avoid payment delays.

Reinstatement of Medicaid Recipients Who Inappropriately Lost Eligibility

This federally mandated initiative ensured that any Medicaid beneficiary, who was inappropriately closed since October 1996, received an opportunity for reinstatement for 90 days of coverage and an opportunity to apply for continuing benefits. In April 2001, 27,719 families/44,434 individuals were reinstated for May, June, and July 2001. As of February 2002, 15,709 of all reinstated individuals had been continued on Medicaid beyond the reinstatement period. To prevent future improper denials and terminations, a process involving the manual review of each case prior to final action was implemented March 2001. Policy was updated and computer systems were adjusted effective December 1, 2001 to de-link TANF and Medicaid altogether.

Future Directions for Eligibility

Information Services Support for DSS Merger Connectivity - A DSS county office survey will be conducted and used to determine the appropriate connectivity for each office and the number of terminals that will need to be replaced by computer workstations. This survey will also determine the current number of outstationed workers, their locations and their connectivity needs. One of the agency's long-range strategic initiatives for technology is to give every employee in the agency the ability to be mobile workers, thus allowing employees to serve clients at any location. The plan for connecting the eligibility offices will support this initiative. The agency's intranet has been expanded to include forms used in the eligibility function. Network security, including new user ids and passwords, will facilitate mobile web users. Other administrative services such as faxing, will become network-based functions and will be available thru the Internet. Administrative applications such as leave will also become web-based.

Mail-In Application for Low Income Families (LIF) - To alleviate the workload of county eligibility staff, DHHS and DSS collaborated on the design and development of a mail-in application for low-income families (LIF). Staff training has been conducted and the mail-in application has been expanded to include other eligibility groups.

Expansion of Outstationed Eligibility Workers - Since 1986, the Medicaid program has maintained a cost sharing arrangement to provide for outstationed eligibility workers. Under this arrangement, public and private Medicaid providers, mostly hospitals, DHEC and health centers have paid half of the costs for Medicaid eligibility workers, supplies and equipment while the federal government pays the other half. These eligibility workers are out stationed exclusively in provider facilities and perform the Medicaid eligibility determination function for beneficiaries, applicants and clients accessing medical services, primarily at the provider sites. This arrangement benefits the provider by allowing on site eligibility determinations and verifications. It benefits DHHS by allowing us to expand our workforce and to give potential beneficiaries more access to the eligibility determination process. Efforts to expand contracts to sponsor eligibility workers have been initiated. Current contractors were contacted and 56 planned to continue with this program. There has been an increase of five new workers. Outstationing of non-sponsored Medicaid eligibility staff is under review and consideration. Potential outstation sites are being researched. The non-sponsored eligibility workers are being considered for

location at community sites and in facilities that cannot afford to pay half of the funding for a worker but substantial numbers of Medicaid beneficiaries frequent the sites for medical and other social services.

Operation of Pharmacy Point Of Sale (POS)

As referenced under Goal I, the agency promotes quality improvement through its pharmacy new Point of Sale/Prospective Drug Utilization Review (POS/Pro-DUR) system implemented November 1, 2000. Pharmacy claims are submitted via POS for adjudication in an on-line, real-time environment. The POS system captures, edits, and adjudicates pharmacy claims at the point of sale. Providers receive immediate, on-line information regarding: eligibility, prescription coverage, and Medicaid reimbursement amount. See page 23.

Development, Implementation and Evaluation of Quality of Care and Quality of Life for Long Term Care Clients

Nursing Home Quality Improvement Initiative – An operational plan was developed for civil monetary penalty funds to improve quality of care. During the current year, grants were awarded to 40 nursing facilities for Eden, Eden Expansion or Quality Initiatives. Eden is a new paradigm for nursing homes and is a tool to improve the quality of life of residents in facilities. Conventional nursing homes are transformed into human habitats with gardens, animals, birds and children. These are combined to enrich the lives of residents, as well as staff and visitors. Regional Certified Nurse Aide (CNA) workshops will also be held this year. An International Eden conference will be held in November 2002. Focus group information collected by the University of South Carolina School of Public Health will be used for planning purposes and potential interventions.

Nurse Aide Training/Testing – The Nursing Home Reform Act (OBRA ’87) included requirements for nurse aide training and testing programs and a certified nurse aide registry. These programs provide the mechanism by which individuals are certified as competent to provide direct care services in nursing facilities. The nurse aide registry is a means of maintaining and communicating information regarding competency and any history or abuse, neglect or misappropriation of property. The agency will secure a new contractor for on-site scoring and testing of nurse aides at the training site and for operation of a web-based nurse aide registry effective January 1, 2003. In June 2002, DHHS assumed responsibility of conducting the approval and on-going compliance for nurse aide training programs. This function was originally performed at DHEC and moved to DHHS for continuity of service. Nursing facilities will manage the funds for training, testing and certification starting October 1, 2002 to maintain cost effectiveness. This effort will ensure that DHHS is only paying the Medicaid portion for the training and testing of aides. The training curriculum has been revised to better align with the survey process. A major policy change will occur on October 1, 2002 when training at a state approved program will become a prerequisite prior to testing. This is an effort to make sure aides are better prepared to work in nursing homes. Training for facilities and training programs on all these new requirements was held in July 2002.

Provision of Integrated Personal Care (IPC) in Community Residential Care Facilities (CRCF) - The IPC program was developed to maximize existing state funding appropriated for the Optional State Supplementation (OSS) program. Approximately 4,400 elderly and/or disabled South Carolinians who reside in licensed CRCFs have their income subsidized with OSS funds. Many of these residents currently meet or are approaching nursing home level care, due to functional deficits. The provision of IPC services to residents who require additional assistance with bathing, dressing, maintaining continence, etc., is intended to prevent or delay more costly institutionalization. Participating facilities employ or contract with registered nurse(s) to develop the service care plans, train personal care aides and monitor the care and services provided. The quality of care and thus, quality of life for these residents will be enhanced through the provision of IPC services and through the oversight and involvement of nurses in the delivery of care. Implementation is scheduled for September 1, 2002.

Public Awareness/End of Life Issues – DHHS continues work with Carolina Center for Hospice and End of Life Care and MUSC on education of physicians and the general public regarding end of life care issues. These issues include advance care planning, end of life care options and pain management. End of Life Coalitions have been developed across the state. Information has been shared with Medicaid recipients as well as the general public on the importance of discussing with family members, medical care teams and one's own religious leaders their wishes for care if they should become seriously ill. Recipients are provided necessary documents to complete along with guidelines and reference material on how to start conversations with family members regarding end of life care. In conjunction with the End of Life Coalition, DHHS staff conducted the study of pain management as a fifth vital sign in nursing homes. The results of this study were the basis of a Duke Endowment Grant application by the Coalition to expand educational efforts on providing effective pain management. If funded, this grant will allow for further study, in-depth education and monitoring efforts for the state's nursing home population.

Nursing Home Health Promotion Awards – In order to promote quality care in nursing facilities, DHHS developed an awards program to recognize excellence in facilities meeting national Medicaid certification requirements. This program was implemented October 1, 2001 and as of June 30, 2002, twelve facilities had been recognized for being deficiency free. Prior to implementation of the awards program, there were seven deficiency free facilities from October 2000 through June 2001.

Goal III. Assure/Promote Accountability

Implementation of Requirements for the Health Insurance Portability and Accountability Act (HIPAA)

The Administrative Simplification provisions of the HIPAA of 1996 required the health insurance industry to adopt standards for communicating and maintaining health related data. The agency was granted an extension for implementation of the Transaction and Code Sets rule of HIPAA until October 2003. An assessment of the Transaction and Code Sets was completed and an advanced planning document (APD) was submitted to CMS and was approved. The agency has completed an assessment of the privacy rule. The privacy rules must be implemented by April 2003.

HIPAA has the largest impact on coding. Local codes are often used by Medicaid plans to define health care services that are not recognized through national coding. The impact that HIPAA will have on local coding issues is one area that the state has been researching in depth. The state is participating in several national workgroups to attempt to establish the effect of the impact on claims processing. The state is also taking steps to evaluate the codes currently being used and is attempting to create a method to systematically replace local codes with analogous nationalized coding.

Development and Implementation of an Electronic Monitoring and Automated Billing System for CLTC In-Home Services

As discussed in Goal I, page 27, DHHS is committed to promoting accountability with the electronic monitoring and automated billing system for in-home services providers under the Community Long Term Care program, referred to as *Care Call*. The system should eliminate fraud and abuse in billing for services not rendered, prevent service delivery to ineligible recipients, and assure that recipients receive the services required.

Development and Implementation of a Strategic Plan

In 2001, DHHS completed its first strategic plan since 1988. Because of the growth in the size, diversity, and complexity of agency programs, development of a strategic plan was essential to insure the most efficient use of agency resources and to provide focus on agency priorities. An operational plan was developed that encompassed initiatives, process improvements, and enhancements in every area of the agency. Implementation began in July 2001 and progress toward objective accomplishment is measured quarterly. There are over 100 initiatives outlined in the plan. The strategic plan and the operational plan enabled the agency to set and communicate goals and objectives, measure its effectiveness in meeting them and report on accomplishments.

Design and Implementation of a Provider Self-Audit Policy

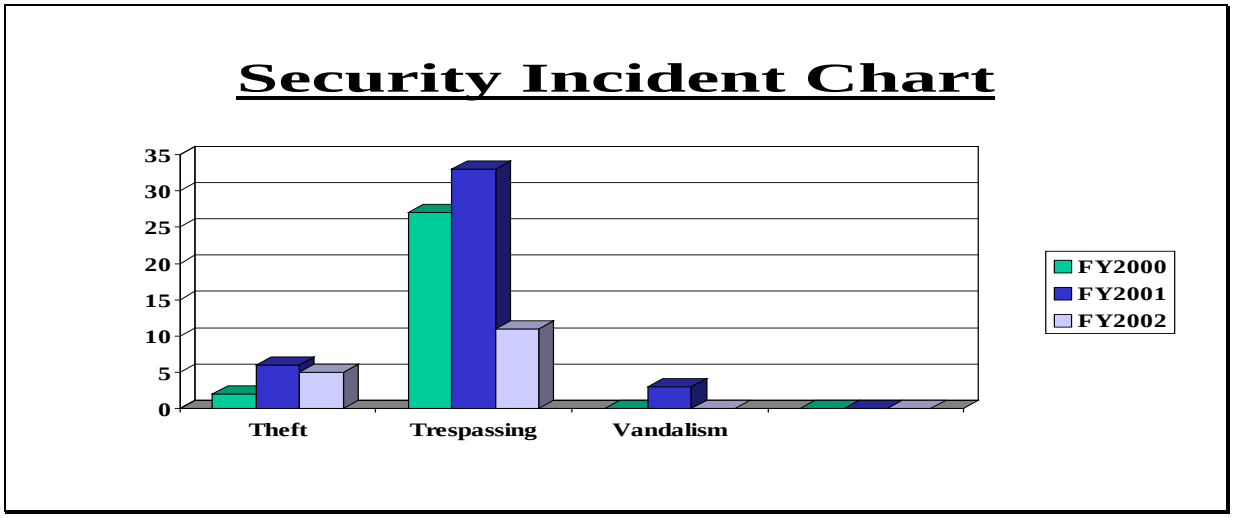
DHHS implemented a provider self-audit policy during the current fiscal year. Under this policy, identified discrepancies are submitted to the provider for self-audit and re-payment. This procedure enables DHHS to increase collections while maintaining the same level of agency manpower devoted to this task. DHHS has processed 30 cases in this fiscal year to date, collecting over $125,000 with minimal administrative costs.

Goal IV. Promote Customer Service

Security

DHHS' employees are its customers, and their safety and welfare is of the utmost importance. The agency has taken a proactive approach to security through the use of an updated access control system, video surveillance, and security officers. In October 2001, security officers began regulating and directing traffic entering the building, ensuring identification badge compliance, and providing periodic patrols of the area. A multi-task card system for access to

the parking garage and the building was developed and implemented. The cards are programmed with the proper access levels for each individual employee. A video surveillance system was installed and nine surveillance cameras are currently operational. Utilizing a computer located at the security desk, all cameras are monitored by security officers. The chart below outlines the reduction in incidents of vandalism, theft, and trespassing. Trespassing includes reports of unauthorized persons in the building and area. All incidents of theft and vandalism are reported to law enforcement.



Implementation of an Interactive Voice Response System for Verification of Eligibility by Providers

In October 2001, DHHS implemented a Medicaid Interactive Voice Response System (IVRS) to enable providers to use a touch-tone phone to verify Medicaid eligibility. The toll free number is located on the back of recipients plastic Medicaid card. To access the IVRS, providers must use their Medicaid Provider ID and may obtain ten verification transactions per call. Providers may also use the IVRS to access their most recent Medicaid payment information. This mechanism has diverted calls previously directed to staff, allowing for reallocation of staff time to addressing provider billing issues. With the tremendous growth in the program and no additional FTEs to absorb the growth, implementation of this mechanism has made it possible to accommodate growing demand from providers with the same number of staff. Approximately 8,000 to 9,000 calls per day are received through the IVRS. These are calls that the agency's provider representatives would have to answer if not for the IVRS so there is a cost avoidance benefit to the system.

Implementation Plastic Medicaid Cards

As discussed under Goal I, paper Medicaid cards were replaced with plastic cards effective December 2001. Not only did the plastic card save money, it made it possible to provide accurate, up-to-date information to service providers regarding eligibility and service limits, thereby avoiding inappropriate Medicaid billing. The agency included a toll free number for

beneficiaries to call with any questions about enrollment or covered services. A call center at DHHS responds to beneficiary inquiries. Prior to implementation, focus groups were held with recipients who now feel they have an insurance card like everyone else.

Goal V. Promote Effective Communication

Expansion and Enhancement of the Agency's Website to Promote Increased Intranet and Internet Utilization

The agency has focused on promoting internet/intranet communication, where feasible, to reduce the cost of copying, printing, and postage, to maximize effective communications and to share information in a timely manner. With access on the website to longer reports and documents, more information can be shared than with a paper process. A major focus of this initiative was to communicate via the Internet with committees and organizations with which the agency has on-going, regularly scheduled meetings including the agency's MCAC. Meeting notices and agenda packages are disseminated through this mechanism. DHHS also initiated web-based distribution of provider manuals with re-issuance of a new 430-page hospital services manual on the web. Rather than sending three copies per provider, only one copy was provided each hospital along with encouraged use of the web-based manual. DHHS avoided $27,900 in printing and postage based on $13 per manual for printing and $18 per manual for postage charges. The agency plans to expand this web-based application.

Instead of faxing or mailing materials in response to news media requests, the Office of Public Information has been able to discuss these materials with reporters in a real-time, on-line basis. During March and April of 2002, the Office of Public Information fielded an average of 12 media calls daily. Had the materials discussed with reporters been faxed or mailed to them, rather than being available on the DHHS website, the cost could have been several hundred dollars.

Changing to an electronic communication pattern has been so successful and so accepted that DHHS has suspended the printing of its internal newspaper and is now distributing it electronically. This will save $540 through the remainder of FY 2001-02.

The agency is committed to promoting effective communication. Medicaid Bulletins are used to communicate program initiatives, changes, etc., to providers. The agency also communicates with external partners and stakeholders through convening or participating in focus groups, forums, committees, conferences, and meetings of provider and advocacy organizations. Internally, the *Communique* is widely used to communicate with staff. As discussed in Section III, 1.1c, articles featuring the agency's values have been published in the *Communique*. These articles provide on-going communication with staff regarding the importance of these values. Communication with staff also occurs through staff meetings, issues meetings, and budget meetings at all levels of the agency.

Goal VI. Promote Appropriate Care

Develop and Implement an Electronic Monitoring and Automated Billing System for CLTC In-Home Services

As discussed under Goal I, DHHS is implementing electronic monitoring and automated billing for in-home services providers under the Community Long Term Care program, referred to as *Care Call*. The electronic monitoring system will require in-home workers to dial in upon arrival and departure to validate their services delivery in line with the services authorization. The system should assure that recipients receive the services required and prevent service delivery to ineligible recipients. This system will build on the ongoing CLTC compliance activity to assure appropriate care by providing on line, real time information concerning the provision of in-home care. CLTC provider compliance reviews are an ongoing function and are discussed further under Goal VI.

CLTC Provider Compliance Reviews

Pursuant to assurances provided in the approved Medicaid home and community-based waivers to assure health, safety and welfare of waiver recipients, CLTC performs several compliance activities. Prior to entering into a contract for the provision of care, potential providers must meet certain specific requirements. For providers of "hands on" care, this includes an on-site survey performed by a registered nurse. Upon authorization of the first client for CLTC services, a survey nurse again reviews these providers for compliance with the service provision and administrative requirements of the contract. At least yearly, or more frequently if indicated, surveys are also performed. All provider surveys are unannounced. At each survey, a report is issued listing any deficiencies identified and corrective action is required. Should numerous, repeated or critical deficiencies be identified, action may be taken to suspend a provider, remove existing clients or terminate the contract as appropriate. Suspended providers must not only provide evidence of corrective action, but also stand another unannounced survey before they can be reinstated. In addition to any action CLTC may take, CLTC operates in close coordination with DHEC licensing to address issues of licensed providers.

In addition, CLTC field staff has a direct link to state office compliance staff through telephone or special email ID. Frequently issues of concern regarding provider compliance and recipient health and safety are raised through these avenues and providers are required to respond to such reports and/or stand another special unannounced survey which reflects correction of the matter.

Design, Implementation and Monitoring of an Outcomes-Based Service Delivery System for Therapeutic Residential Services for Children

DHHS implemented initiatives to develop an outcomes-based service delivery system for services provided to emotionally disturbed children in therapeutic residential treatment facilities. This initiative is an effort to validate costs, enhance quality improvement, and foster a collaborative relationship between public agencies and private providers. Outcomes were identified as safety, improved functioning, stability/permanency, and stakeholder satisfaction. A Memorandum of Agreement (MOA) was implemented with the University of South Carolina

(USC), Institute of Public Affairs to conduct a pilot study that will involve data collection and evaluation from a representative sample of private providers. USC will collect admission, discharge, and critical incident data; enter the pilot data; and complete an evaluation of the pilot by analyzing the data and reporting final results of the pilot. In addition, USC staff routinely renders technical assistance to residential providers and provides updates to state agencies every other month. The pilot is scheduled to end 6/30/03. Memoranda of Agreement were implemented with the five state placing agencies to participate with the study.

Child Care Provider Compliance Reviews

An ongoing function of the agency is to ensure appropriate care through compliance reviews of childcare providers. DHHS assures the quality and accessibility of child care services funded by the ABC Child Care Program through voluntary program standards that address key indicators of program quality beyond state child care regulatory requirements. This function is accomplished through the Divisions of Program Monitoring and Out-stationed Program Monitoring. Program monitors conduct on-site unannounced assessments at regularly scheduled intervals to enhanced providers enrolled in the ABC Program to determine compliance with quality program standards as well as with reporting requirements. Reimbursement to programs is based on the level of quality provided. Approximately 1,350 of childcare providers statewide have agreed to meet the voluntary ABC childcare quality standards. The Divisions manage a program of technical assistance and training, as well as grants and other incentives, to enhance the quality of care for all children served by the ABC program.

Future Direction for Promoting Appropriate Care

Nursing Home Transition Grant: "South Carolina Home Again"- DHHS was awarded funding for *South Carolina Home Again,* a Nursing Home Transition Grant sponsored by the Center for Medicare and Medicaid Services (CMS, formerly HCFA). This project, directed by Community Long Term Care (CLTC), partners with the Department of Mental Health (DMH) and the Department of Disabilities and Special Needs (DDSN). The grant's primary objective is to identify and transition nursing home clients who want to return to the community, and to test and implement infrastructure system changes needed for this purpose. The target population includes the elderly, individuals with disabilities, and clients with mental health conditions. Another goal of this grant is to develop and test new services including Community Transition Nursing and a bundled mental health package. Aside from the benefit of transitioning individuals back into the community, this project should eventually realize cost-savings to the Medicaid program since community care provided through the CLTC waivers costs only 42% of the cost for Medicaid-sponsored nursing home care. CMS is expected to begin funding this $600,000, 3-year grant effective September 30, 2002. Implementation will begin after the award is made.

Goal VII. Promote Access to Services

Design and Implementation of Strategies to Promote Coordination Within the Child Care System

The Governor designated DHHS to be the lead agency for child care. The agency established and will provide on-going administrative support for the new Child Care Coordinating Council. The

Council identified child care priorities and developed a strategic plan, and will exchange ideas, share information and coordinate strategies that will improve the quality of child care. A statewide system for quality assurance and monitoring will be developed. Opportunities to coordinate and collaborate to maximize resources will be explored with county First Steps programs. Other initiatives include:

Implementation of Center for Excellence – DHHS facilitated a partnership between USC, USC Foundations, Gateway Academy, SCETV and DHHS to construct and equip a child care center for 200 children that will serve as a model of a private-public partnership to provide NAEYC accredited early care and education. The second level of the facility will serve as a Research Center for university researchers and will provide state-of-the-art facilities to meet the education and training needs of the early care and education community. Opening date is projected to be late spring 2003.

Implementation of 4K Pilot Project - DHHS provided funding to the Office of First Steps (OFS) to implement a public-private four year-old kindergarten (4-K) pilot with ten private child care providers in five regions of the state during the 2002-2003 school year. This pilot will maximize the existing resources of private providers, and expand quality 4-K programs that are necessary for future school success. In addition, 4-K programs provided in private child care settings will accommodate the needs of working parents of four-year old children who need full day care and will promote collaboration between public 4-K programs and the private child care community. An additional benefit of this partnership is the sustainability of a quality private child care market. Private providers balance the higher costs of serving infants and toddlers through the revenue for four year-old children. Loss of the revenue from the four year olds to the public 4-K program could result in higher charges to families needing care for infants and toddlers, may drive families to seek poorer quality or unregulated care for their children, or may result in the loss of supply of quality child care for infants and toddlers because providers can not afford to stay in business. This could cause a child care crisis in this state.

Participation in National Universal Financing for Early Care and Education for America's Children Project - DHHS is partnering with a team of Columbia University and University of Washington researchers on an 18 month initiative to conduct a cost analysis of the infrastructure for the early care and education (child care) system designed specifically to SC costs and specifications. A SC task force of 53 public and private stakeholders is working intensively with the national partners on their pilot protocol to provide the SC specifications for the system. Those specifications, coupled with results of a statewide household survey and other SC data, will provide the basis for the cost analysis to aid policymakers and stakeholders in establishing long-range priorities and considering tradeoffs among different policy options. This partnership will provide long-range direction for a quality early care and education system to positively benefit children and families in SC. Initial specifications, the household survey, and data collection have been completed. (See Section 7.1)

Maintaining Viability of Small Rural Public Hospitals

In collaboration with the SC Rural Hospital Association, DHHS explored options for maintaining the financial viability of small rural public hospitals. South Carolina has eleven

hospitals in this classification that provide critical services to recipients in rural areas. These eleven hospitals served 39,089 unduplicated Medicaid recipients either inpatient and/or outpatient services during SFY 2002. In addition to the regular claims payments for inpatient and outpatient services (plus disproportionate share payments for the qualifying hospitals), these facilities received $2.5 million in Hospital Special Fund Grants from the DHHS during SFY 2002. Additionally, the Center for Medicare and Medicaid Services (CMS) approved inpatient and outpatient cost settlements for Medicaid un-reimbursed costs for the small rural public hospitals. For FY 2001-02, these payments will be $7.9 million. Also, the small rural public hospitals receive quarterly payment adjustments called "Small Hospital Access Payments." The access payment amount paid to the small rural public hospitals for FY 2001-02 was $1.8 million.

SC Access: Establishment of a Single Statewide Data Base System Accessible Via the Internet Listing Available Resources

DHHS is implementing *SC Access*, a database of comprehensive information, assistance, and referral services for children and adults of any age with a disability, long-term illness, or need. The system was initiated in response to information from consumers during the Olmstead planning process concerning the need for access to resource information. The system will provide current information on opportunities and services available in the home communities of the users. It will be available through the Internet to consumers, local, regional, and state agencies, and organizations serving persons with disabilities. Highly trained, multi-cultural, and cross-disability counselors from the various agencies will help people find and access essential health and human services/resources. The development of the information and referral database is being accomplished with a grant from the Centers for Medicare and Medicaid Services (CMS). The system is under development and full implementation is expected January 2004.

Expansion of the Scope of the Family Planning Waiver to Include Promotion of Medical Homes

The Family Planning Waiver (FPW) is an 1115 (a) demonstration project providing family planning services (only) to women at or below 185% of the federal poverty level. The waiver was renewed effective February 1, 2002 for a three-year period. As a component of the renewal process, promotion of medical homes was incorporated into the goals and objectives of the waiver. The women enrolled in the waiver have been provided information promoting primary care and the geographic location of community health centers. Quality assurance reviews of the waiver are planned for September 2002 in five counties. Independent evaluations have consistently found the waiver to be cost effective due to its role in averting and/or delaying unintended or unwanted pregnancies.

Incorporation Medicaid Eligibility Processing for the Breast and Cervical Cancer Program (BCCP) into the Central Eligibility Processing Division

The Breast and Cervical Cancer Program provides full Medicaid coverage for otherwise uninsured women from ages 47 to 64 who are identified through Best Chance Network (BCN) and are in need of treatment for breast or cervical cancer including pre-cancerous conditions and early stage cancer. DHHS incorporated Medicaid eligibility determination for the BCCP program into its Central Eligibility Processing Division to expedite Medicaid eligibility

determinations for these women in order to improve their health outcomes and to reduce morbidity and mortality from breast and cervical cancers. DHHS collaborated with DHEC staff for implementation and on-going evaluation. Internal processes were developed and training has been provided for staff to make the eligibility determinations.

Goal VIII. Strengthen Organizational Infrastructure

Computerization of the Agency's Manual, Paper Driven, Mission Critical Processes

DHHS initiated an assessment and developed a plan to automate a number of the agency's manual, paper driven processes during FY 2002. The objectives of this initiative were to improve efficiency by reducing redundant and labor-intensive manual processes, to enable more accurate and timely production of data for reporting, and to reduce paper and printing costs.

Electronic Monitoring and Billing for In-Home Services: DHHS is implementing electronic monitoring and automated billing for in-home service providers under the Community Long Term Care program, referred to as *Care Call*. DHHS is responsible for authorizing and overseeing the provision of in-home services for elderly and disabled individuals. An on-going concern has been ensuring that recipients receive the services that are authorized and billed. The electronic monitoring system will require in-home workers to dial in upon arrival and departure to validate their services delivery in line with the authorization. The system will also act as a billing mechanism so that claims will be paid based on recorded time in the home. The system will additionally verify eligibility. The system should eliminate fraud and abuse in billing for services not rendered, prevent service delivery to ineligible recipients, and assure that recipients receive the services required. DHHS will be monitoring and assessing the cost avoidance generated by this system.

Copier Management Plan: A copier management plan was developed and implemented to upgrade technology with the phase out of existing copier leases as the leases expire. Existing copiers are being replaced with copiers that have fax and network printing capabilities. DHHS was spending approximately $50,000 per year on toner cartridges for laser printers plus another $24,000 per year on maintenance, parts, and labor for laser printers. The new copier arrangement not only permits printing, copying, and faxing from the same machine but also is based on a per-copy cost which includes all maintenance. A business assessment has been made of copier utilization and placement in the agency. As new copiers are installed and old copiers are phased out, new copiers will be allocated and placed to maximize efficiency in use. This initiative will also allow for reallocation of existing laser printers to areas where they are needed, phase out costly ($1,800 each) laser printers as they break, and is anticipated to avoid approximately $100,000 per year in administrative costs when fully implemented.

Eligibility Process Improvements: Eligibility process improvements were identified and implemented for the Partners for Health program. The Partners for Health tracking system was converted from a DOS-based to Windows-based system. The new automated tracking system will be time saving for staff, provide greater technology for case processing and allow for quicker and more accurate reports.

Implementation of Imaging Technology: Imaging is a process in which paper files are converted to computer files that can be stored in the computer instead of a file cabinet. The imaged files can also be shared electronically. During FY 02, DHHS undertook imaging to accommodate the transfer of 40,000 Medicaid eligibility case files for disabled clients that were transferred to DHHS as part of the merger of the eligibility function from DSS. The agency plans to expand the process to other agency files such as the eligibility files from the DSS county offices and the Partners for Health files.

Automated Processes: The agency's volunteer leave system was automated. Automation of hospital cost reporting and 114 personnel forms have been initiated. Savings are anticipated in paper reduction and increased staff efficiency.

Development and Implementation of a Medicaid Eligibility Determination System (MEDS)

In 1997, the agency established the MEDS project team to develop and implement a system that would replace the twenty-eight year old batch eligibility system operated by DSS, with a real-time system operated on the same mainframe as the agency's information system. The benefits of this project are to: increase eligibility worker efficiency by reducing worker time per case; enhance system support by reducing the time to implement system software changes; improve the accuracy of eligibility determinations by maintaining or reducing the error rate; improve service to Medicaid applicants and recipients by lowering the average time to decision, providing timely notices, and providing notices with consistent language and manual citations; and improve service to providers by reducing the percent of claims suspended for correction of eligibility records. With eligibility workers handling 800 to1000 cases each, it is anticipated that this new system will provide for greater worker efficiency. Piloting of the MEDS system is in progress. Full implementation will occur in the fall of 2002.

Development, Planning and Implementation of a Comprehensive MMIS Training Program

DHHS customer service staff use the Medicaid Management Information System (MMIS) to research claims, answer provider inquiries, and resolve billing errors. Recognizing the need for staff to be proficient in use of the system in order to provide good customer service, DHHS developed and implemented a comprehensive MMIS training program during the past year. Training materials were developed to include pre- and post-tests for the training modules. Training teams were identified and training sites arranged. The initial phase of training began in September 2001. To date 73 individuals have been trained and certified. MMIS Certification is awarded to individuals who completed at least the eight core modules of the eleven available topics (three of which were deemed elective courses). Pre- and post-testing revealed participants' overall knowledge of the subject matter increased by 18.3% after attending training.

Other training sessions were held in June 2002 and others are scheduled for September 2002. The MMIS Training Project is ongoing, with plans to offer training on a quarterly basis.

Establishment of an Office of Research and Development

Prior to the current year, research and development activities were carried out by agency managers in addition to their on-going responsibilities which have grown significantly as they have absorbed significant agency growth in programs, services, and recipients with no additional staff. This former arrangement impaired the ability of the agency to look outward and forward in researching alternative approaches and pursuing alternative sources of funding for implementation. The Office of Research and Development (ORD) was established in November 2001 via the reallocation of existing FTEs. The purpose of the office was to enable the agency to vigorously research initiatives in other states with possible replication in South Carolina, to develop and pursue waivers and grants to enhance and support new and existing programs, and to support agency program areas in analysis of existing data to evaluate the current status of programs. The ORD has also assumed responsibility for the agency's on-going strategic planning process and preparation of the agency's accountability report.

APPENDIX A

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, 2001- June 30, 2002).

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 HOSPITAL 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.

CLINIC SERVICES

Clinic services are outpatient services and are limited to procedures performed by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. For Rural Health Clinic (RHC) services, the services are covered when furnished to patients at RHCs, skilled nursing facilities, or the patient's residence. For Federal Qualified Health Center (FQHC) services, the services are covered when furnished to patients at FQHCs.

Current Service Limitations: Maximum twelve (12) visits per year for patients age 21 or older; unlimited for pregnant women and children under 21 years of age.

NURSING FACILITY SERVICES

Medicaid nursing facility services are health related services to individuals who do not require acute hospital care, but whose mental or physical condition requires services that are above the level of room and board and can be made available through licensed, certified and contracted institutional facilities. These services may be intermediate, skilled (including Institutions for Mental Disease or IMDs) or sub-acute levels of care. There are no limits on the number of days that an individual can receive nursing facility services, so long as the individual meets the Medicaid medical and financial criteria.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

EPSDT are well-child, comprehensive and preventive health care 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.

FAMILY PLANNING

Family planning services are available, on a voluntary basis, to individuals sponsored by the Medicaid program. They include an array of services to help prevent unintended or unplanned pregnancies. Covered services include traditional contraceptive drugs and supplies, preventive contraceptive methods, and abstinence-based programs for at-risk recipients between the ages of 8-19, otherwise known as Medicaid Adolescent Pregnancy Prevention Services (MAPPS). Examples of services are: 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. Additionally, the Family Planning Waiver provides coverage of family planning services for all women at or below 185% of poverty (who would otherwise not have been eligible for Medicaid.)

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 Service Limitations: Twelve (12) visits per year for adults, unlimited for children under the age of 21.

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.

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.

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 twelve 12 visits within a calendar year. Chiropractic visits are counted separately from the ambulatory visit limit. Children under age 21 have unlimited visits.

DENTAL SERVICES

Routine dental services are available to recipients from birth through the month of their 21st birthday 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 and are limited to certain major surgical procedures consistent with good medical practice.

THERAPIES

Covered services include physical therapy, occupational therapy, and speech/language and audiological services. Licensed or certified practitioners provide the services.

PHARMACY SERVICES

Pharmacy services include the provision of needed pharmaceutical products (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: Covered pharmacy services include most rebated pharmaceutical products that are authorized by prescription. Medicaid sponsors reimbursement for unlimited prescriptions or refills for eligibles through the month of their 21st birthday. Eligibles age 21 and above (adults) are limited to four Medicaid-covered prescriptions or refills per month. However, certain products and product categories are exempt from the monthly prescription limitation. Additionally, for adult eligibles needing more than four prescriptions within a given month, a prescription limit override process is available for those prescriptions that meet the prescription limit override criteria.

Non-controlled substance prescriptions: 1) limited to a maximum 34 days' supply per prescription/refill and 2) at least 75% of the current prescription must be used (as directed on the prescription) before Medicaid pays for a refill of the prescription. Controlled substance prescriptions: 1) state and federal regulations determine the allowed dispensed quantities and 2) state and federal regulations determine the allowed timeline for dispensing any authorized refills.

Certain products require prior authorization, meaning that coverage is determined through the pharmacy services prior authorization process. Approval for Medicaid coverage of products requiring prior authorization is patient-specific and is determined according to certain criteria and conditions. Medicaid pays for most generic products; most brand name products for which generics are available require prior authorization.

PREVENTIVE AND REHABILITATIVE SERVICES FOR PRIMARY CARE ENHANCEMENT

Preventative and Rehabilitative Services for Primary Care Enhancement (P/RSPCE) are interventions that address medical risk factors that interfere with a patient's ability to maintain an optimal state of health. P/RSPCE support primary medical care. The services are directed

toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The service goals include: linking patients with a primary care (medical) home; supporting appropriate use of the health care system; reinforcing compliance with primary medical care; enhancing the patient's optimal state of health; and assisting the patient to attain the highest possible level of independent functioning relative to his/her health.

Risk factors deemed medically necessary must be identified to qualify for services. Once a risk factor is identified, the patient, physician, and P/RSPCE staff develops a case plan of care. Individual and/or group visits consists of services such as dental education, appointment follow-up**,** referrals to community resources, identifying resources to transition patients into an appropriate system of care, and other health related resources.

INTEGRATED PERSONAL CARE SERVICE

Integrated Personal Care (IPC) are personal care services provided to residents in licensed Community Residential Care Facilities (CRCF) who are identified through an initial medical assessment to have a minimum of two functional dependencies or one functional dependency and cognitive impairment. The services are provided based on the individual's needs and are set forth in a care plan developed by a licensed practitioner.

ICF/MR

Intermediate Care Services for the Mentally Retarded (ICF/MR) provides, in a protective residential setting, active treatment, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help individuals with mental retardation or related conditions function at their greatest ability. There are no limits on the number of days that an individual can receive ICF/MR services, so long as the individual meets the Medicaid eligibility criteria.

HOSPICE SERVICES

Hospice services provide palliative care (relief of pain and uncomfortable symptoms), as opposed to curative care, to terminally ill individuals. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient as well as the psychosocial needs of the patient's family and caregiver.

Hospice services are available to Medicaid recipients who choose to elect the benefit and who have been certified to be terminally ill with a life expectance of six months or less by their attending physician and/or Medical Director of the hospice agency. Hospice services are provided according to a plan of care that has been developed by an interdisciplinary staff of the hospice agency. Covered services include nursing care, medical social services, physician services, dietary and bereavement counseling, medical appliances and supplies, drugs which are used for the relief of pain and symptom control related to the terminal illness, biological, short term inpatient care, home health aide services, homemaker services, physical therapy, occupational therapy, and speech therapy. Because the hospice benefit provides an all-encompassing plan of care and services, the Medicaid recipient must waive all rights to other

Medicaid benefits for services related to the treatment of the terminal condition for the duration of the election of hospice care.

CASE MANAGEMENT

Case management services are those services necessary to coordinate an optimum life style for a targeted patient population through a coordinated effort of monitoring the patient's needs with a systematic referral process for services and documented follow-up. Targeted populations include non-institutionalized patients with mental retardation and related disabilities; severely emotionally disturbed children as defined by the Continuum of Care; chronically mentally ill adults; seriously emotionally disturbed children as defined by the Department of Mental Health; at risk pregnant women and their infants up to one year after delivery; substance abusers; persons with sickle cell disease; physically handicapped children as determined by DHEC's Children's Rehabilitative Services program; foster children; individuals with head and spinal cord injuries and related disabilities; individuals with sensory impairment; Juvenile Justice children; and, vulnerable adults in need of adult protective services;

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 should be completed and reported for pregnant members and newborns. All pregnant members and their infants should receive risk appropriate medical and referral services.

Additionally, Postpartum/Infant Home Visits are offered to assess environmental, social, and medical needs of the infant and mother. The visits include appraisals of the mother and infant health status and referrals to appropriate needed services. All Medicaid sponsored postpartum mothers and newborns are eligible for this visit. For infants who have been in the Neonatal Intensive Care Unit and had a significant problem prior to discharge, Pre-Discharge Visits are offered. A referral must be made for these services, which is provided by a physician or registered nurse.

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.

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.

HOME HEALTH SERVICES

Home Health Services provide intermittent skilled nursing services, physical therapy, speech therapy, occupational therapy, home health aide and medical supplies to eligible recipients as a part of the Medicaid State Plan. Services must be ordered by a physician, rendered in accordance with a written plan of care, and must be delivered in the patient's place of residence, which cannot be a nursing facility or institution. Eligible individuals must meet certain medical criteria to be eligible for the service. Home health agencies must meet the Medicare certification standards and be licensed by South Carolina Department of Health and Environmental Control (DHEC).

Current Service Limitations: Home health visits are limited to 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 include inpatient psychiatric hospitalizations, residential treatment facility services for children under age 21, and community-based and residential behavioral health services for children. Outpatient services include outpatient hospital, community mental health, substance abuse treatment, targeted and ancillary case management, and injectable medication administration related to mental health treatment. Private practice psychiatric services are also included.

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.