1999-2000 Accountability Report

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I. EXECUTIVE SUMMARY

The FY 1999-2000 Accountability Report for the Department of Health and Human Services (DHHS) is divided into six sections: Executive Summary, Mission Statement, Leadership System, Customer Focus and Satisfaction, Other Performance Excellence Criteria and the Description of Programs. The Description of Programs section is broken down into five parts, and contains by program area, rank, cost, goals, objectives and key indicators. Each part deals with one of the five programs administered by the Department of Health and Human Services: Part 1 discusses the Medicaid Program, Part 2 discusses the Child Care and Development Program, Part 3 discusses the Social Services Block Grant Program, Part 4 discusses Senior and Long Term Care Services, and Part 5 discusses the Optional State Supplementation Program.

Part 1 describes the health activities within the Medicaid Program. During FY 1999-2000, 693,778 South Carolinians received health services provided by South Carolina's medical community. The elderly made up 26.07% of these clients and utilized Medicaid health services valued at $1,605,530795 or 69.28% of Medicaid expenditures for an average unit cost of $7,190. The remaining Medicaid clients 73.93% were children, or recipients who qualified due to eligible children in the family. These children received health care valued at $711,708,552 which was 30.72% of Medicaid expenditures, incurring an average unit cost of $1,124.

Payments to providers for services fell into several major categories. The largest recipient was the category of state agencies, which received 26.22% of payments, followed by the hospital industry (21.79%), Nursing Homes (13.85%), Pharmaceutical (11.13%), Physicians (6.52%), and Community Long Term Care (3.86%). The remaining services received 16.63% of the payments for a total of $2,339,099,527. See Schedule A for increase of Physician, Pharmacy and Hospital state costs from FY 1995-96 through FY 1999-2000.

In 1997, South Carolina expanded its Medicaid Program to include children through the age of 18 who were living in families earning 150% of the Federal Poverty Level (FPL). This expansion was made possible through the State Child Health Insurance Program (SCHIP) that was created by the Balanced Budget Act of 1997 under Title XXI of the Social Security Act. South Carolina began covering children under SCHIP on October 1, 1997, through its new Partners for Healthy Children (PHC) Program. During FY 1999-2000, 55,637 children were served through SCHIP. See Schedule B for the increase in eligible children and recipients up through age 20 from FY 1995-96 through FY 1999-2000.

In 1999, funds were appropriated to increase dental fees to the 75th percentile of Usual and Customary Reimbursement (UCR). This was done in order to address poor participation in the Medicaid Program by dental providers and to hopefully increase utilization of dental services by Medicaid eligible children. Enrollment of dentists increased from 619 in July 1999 to 824 in June of 2000. Recipient utilization for children under the age of 21 increased by 10,946 over the previous year. A Medical Management code was implemented to reimburse dentists for the additional time it may take to treat children with special health care needs.

Part 2 describes South Carolina's Public Child Care and Development Program funded by the Child Care and Development Fund (CCDF)and the Social Services Block Grant (SSBG). During FY 1999-2000, the program provided child care and development services to 12,483 children who were in low-income working families and 23,876 children whose parents participated in the Family Independence Program, for a total of 36,359 children.

Part 3 describes the Social Services Block Grant (SSBG) Services that were provided to more than 53,000 South Carolinians in FY 1999-2000. These services assisted families in maintaining or restoring a level of physical, social, and economic well-being and enabled them to function at the maximum level of their capabilities. Approximately 46% of SSBG funding during FY 1999-2000 directly or indirectly supported the provision of legally mandated services, such as child and adult protective services and foster care.

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

Part 5 describes the Optional State Supplementation (OSS) Program which has served 5,582 recipients in FY 1999-2000. This program supplements the income of individuals who reside in licensed residential care facilities that have enrolled with DHHS and have agreed to provide residential care services to eligible participants. South Carolina currently provides an OSS payment to persons who meet the state's net income requirement; meet the SSI categorical requirements (aged, blind, disabled) and reside in a Community Residential Care Facility (CRCF) that is licensed by the Department of Health and Environmental Control and enrolled with DHHS for purposes of the OSS payment process.

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

II. MISSION STATEMENT

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

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

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

III. LEADERSHIP SYSTEM

The Department of Health and Human Services is devoted to a comprehensive leadership system that mirrors the Baldrige criteria with an internal and external focus. The concept of leadership consists of an organizational focus (internal) and public responsibility focus (external).

1. Organizational Leadership

    A. Environment, Supportive Work Culture

    Dr. Griswold has created an environment that allows decision-making at the lowest possible level and allows employees to accept and execute responsibilities with confidence. The agency continues to use cross-functional teams to review work processes. Recent improvements in work processes have streamlined internal budget processes and external applicant processing.

    B. Employee Development

    The agency continues to improve on developing a comprehensive development program for all of its employees. Dr. Griswold has strongly encouraged supervisors at all levels to attain the Associate Public Manager (APM) certificate and to pursue the Certified Public Manager (CPM) Certificate. Integral courses with this curriculum are leadership courses, specifically "Four Roles of Leadership" and "Fourth Generation Management". Our goal is to develop leaders throughout the ranks of the agency, not just at the Senior Management level. At the Senior Management level, we continue to support the Executive Institute and to send at least one employee per year through this comprehensive leadership program. Currently, ten employees have attended the Executive Institute.

2. Public Responsibility/Citizenship

    The agency has taken the lead role in promoting and providing a comprehensive health care program for all SC citizens. Over the next few months, the agency will survey all stakeholders to identify how we can be even more responsive to the needs of South Carolinians.

    We continue to staff and give administrative support to advocacy groups, children, and elder citizens of the state. These groups include the Governor's initiatives with First Steps and the Silver Haired Legislature.

IV. CUSTOMER FOCUS AND SATISFACTION

Medicaid

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

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

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

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

Child Care And Development Program

Families who may be eligible to receive child care assistance include participants in job or educational placements through the South Carolina Family Independence Program, as well as low-income working families who are income-eligible. On May 15, 2000, the gross income level for entrance into the child care program was changed from 125% of poverty to 150% of poverty based on family size. A family may continue to be eligible until their income exceeds 175% of poverty. In addition to meeting the income standards, both parents must be working, attending school or training, or be disabled to be eligible for child care assistance.

Parents receiving child care assistance are offered the widest possible choices in child care options. They have the option of choosing a provider who will care for their child, whether it be a center, family or group day care home, church, synagogue, school, employer, or self-arranged care by relatives or friends. Parents are given a list of all providers in the state that meet standards higher than licensing requirements, a checklist, video and other resources to assist them in making an informed choice when selecting a child care provider. In order to simplify the application process for parents, DHHS makes applications available in the community without requiring a face-to-face interview. Applications may be mailed or dropped off at the DHHS office.

The agency operates a toll-free client line and a toll-free complaint line to address customer concerns. The agency piloted a customer satisfaction project. Parents were interviewed regarding their satisfaction with the services of the agency and with their child care provider. This survey also allowed the agency to verify the parents' continued eligibility and solicit their comments and recommendations for improving services. Ninety-eight (98) percent of clients surveyed expressed excellent customer service satisfaction with the ABC Voucher Program.

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

Social Services Block Grant

The Social Services Block Grant (SSBG) Program in South Carolina supports services for a diverse population of children, adults and families. Persons receiving services funded through SSBG must be members of one of five target groups that meet the federal goals for SSBG. Also, they must meet income eligibility guidelines, and demonstrate a need for the specific services. Applicants for services other than child care must have a total family gross income at or below 175% of the poverty guidelines, or need services, such as, child or adult protective services, which are provided without regard to income. The income limit for a family of four for FFY 2000 is $2,435 per month.

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

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

Senior And Long Term Care Services

Senior and Long Term Care Services conducts numerous client assessments and quality reviews to ensure clients are receiving appropriate and effective services. This is especially true for Medicaid clients and those in long term care facilities. Customer satisfaction is a key element of the implementation of the Long Term Care Proviso, which was established in four counties in FY 1998-99 and continued expanding in FY 1999-2000. In addition, each county Council on Aging has a governing board which has a basic charge of developing services requested and needed by clients. During FY 1999-2000 Senior Services in conjunction with the Governor's Office, held 13 public forums throughout the state to better respond to the needs of seniors.

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

Optional State Supplementation Program

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

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

V. OTHER PERFORMANCE EXCELLENCE CRITERIA

Employee Satisfaction Survey
In the 1999-2000 fiscal year, the Department of Health and Human Services embarked on the first stage of its effort to introduce the Malcolm Baldrige National Quality Award criteria to its business practices. The agency began this effort by undertaking a strategic planning process. The initial step in this process was to survey employees in order to measure satisfaction with the agency and to gather comments and recommendations for improvement. DHHS is committed to effectively serving its customers and partners and realizes the important relationship between the satisfaction of its employees and the quality of its services. The data from the survey has been collected and is in the process of analysis. Results are expected to be forwarded to DHHS in mid-October.

Customer Satisfaction Survey
To further enhance understanding of the agency's perception among customers, planning has begun on a second survey, which will gauge customer and partner needs, expectations, and satisfaction. Distribution for this survey is targeted for late October. Upon receipt and analysis of data from this survey, DHHS will have gained insight into its strengths and areas for improvement.

Focus Groups and Vision Discussions
As a follow up to the surveys, focus groups and vision discussions are planned which will include employees from all levels of the agency as well as a cross section of the agency's customers. Discussions center on problem solving will result in suggestions and recommendations for improvement.

Process Reviews
Based on the information gathered from customer and employee surveys and discussions, agency processes will be targeted for review and development. Performance requirements will be developed with effectiveness, efficiency, and productivity as the goal.

Strategic Plan
As a result of these efforts, DHHS will have sufficient information to begin the development of performance goals, benchmarks, and objectives for the strategic plan. These facets of the strategic plan will provide direction and a means of evaluating progress and quality. The strategic plan itself will be developed to reflect the values and mission of the agency and the agency's dedication to the service of its customers and partners.

Summary
DHHS believes that the strategic planning effort will result in the alignment of work processes with the agency's strategic directions, thereby ensuring that improvement and learning reinforce organizational priorities. The agency's focus on customer-driven quality and operational performance excellence are key strategic issues, which are integral parts of successful organizational planning. DHHS believes the strategic planning effort will enhance its productivity and quality of service to the citizens of South Carolina.

V. DESCRIPTION OF PROGRAMS

Part 1.

Program Title: **MEDICAID**

Program Rank: 1

A. Hospital Services

Program Costs:

State:	$127,717,827
Federal:	$356,377,666
Earmarked:	$ 25,531,384
Total:	$509,626,877

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

Program Objectives:

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

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

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

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of DHHS FTEs assigned to program	9	10	13
Number of Enrolled Service Providers	117	117	117
Outputs:			
Number of transactions processed:			
Inpatient Services	319,017	304,804	317,702
Outpatient Services	670,723	763,746	881,211
Hospital Based Physician Services	423,353	447,526	484,959
Total - Hospital Services	1,413,093	1,516,176	1,683,872
Efficiency:			
Average transactions per recipient:			
Inpatient Services	2.3	2.2	2.2
Outpatient Services	2.9	3.0	3.1
Hospital Based Physician Services	2.6	2.7	2.7
All Hospital Services	4.5	4.5	4.6
Average expenditure per recipient:			
Inpatient Services	$2,489	$2,620	$2,965
Outpatient Services	$228	$236	$237
Hospital Based Physician Services	$62	$65	$69
All Hospital Services	$1,313	$1,287	$1,441
Average provider to staff ratio	13:1	12:1	9:1
Transaction to staff ratio	157,010:1	151,617:1	129,529:1
Outcomes:			
Number of unduplicated recipients receiving services:			
Inpatient Services	139,772	138,653	147,738
Outpatient Services	229,303	255,232	286,368
Hospital Based Physician Services	162,082	165,614	176,639
All Hospital Services	312,455	337,266	365,556
Quality:			
Number of quality of care studies completed	3	3	3
Number of quality reviews completed	3,683	6,344	7,214

B. Pharmaceutical Services

Program Cost:

State:	$ 57,133,923
Federal:	$181,544,604
Earmarked:	$ 21,600,000
Total:	$260,278,527

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

Program Objectives:

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

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

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

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

5) Enhance provider liaison activities and provider participation.

6) Revise and update program policy and procedural directives.

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of recipients utilizing pharmacy services	385,469	427,929	464,331
Number of enrolled pharmacy providers	1,032	1,100	1,052

	Actual FY 97-98	**Actual FY 98-99**	**Actual FY 99-00**

Outputs:			
Number of prescriptions reimbursed by Pharmaceutical Services	3,889,428	4,542,217	5,521,859
Average prescription utilization per recipient per month	2.20	2.38	2.57
Efficiency:			
Average cost per recipient	$438.54	$477.05	$560.55
Average reimbursement per prescription	$43.46	$44.94	$47.14
Pharmaceutical Rebate Program	$38,760,293	$49,460,426	$67,003,557

C. Physician & Clinic Services

Program Costs:

State:	$ 49,164,471
Federal:	$141,527,591
Earmarked:	$ 11,699,318
Total	$202,391,380

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

Program Objectives:

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

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

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

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

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

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

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

8) To improve the health status and well being of Medicaid recipients under the

age of 21 by promoting regular well child screening and treatment services through the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT).

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of DHHS FTEs assigned to program	16	16	16
Number of enrolled service providers	6,564	6,872	10,744
Outputs:			
Number of transactions processed:			
Physician Services	4,046,572	4,583,508	5,137,232
Clinic Services	481,571	557,018	618,763
EPSDT (well child screening & immunizations)	173,999	178,564	186,982
Efficiency:			
Average transactions per recipient:			
Physician Services	10.7	11.0	11.3
Clinic Services	3.9	4.2	4.1
EPSDT Services	1.7	1.7	1.8
Average expenditure per recipient:			
Physician Services	$336	$343	$353
Clinic Services	$313	$333	$333
EPSDT Services	$74	$74	$78
Average provider to staff ratio	410:1	430:1	672:1
Average transaction to staff ratio	293,884:1	332,443:1	368,671:1
Outcomes:			
Number of unduplicated recipients receiving services:			
Physician services	377,220	416,784	454,477
Clinic Services	123,555	133,762	147,950
EPSDT services	105,147	106,972	104,031

	Actual FY 97-98	Actual FY 98-99	Actual FY 99-00
Quality:			
Number of physician/clinic medical home contracts	302	401	455
Number of recipients linked to physician/clinic medical home	27,446	44,851	59,628

D. Dental Services

Program Cost:

State:	$ 8,393,053
Federal:	$21,850,056
Earmarked:	$ 1,000,000
Total:	$31,243,109

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

Program Objectives:

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

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

3) Review, evaluate and revise Dental Program policies and procedures to ensure access to services for recipients, timely payments to providers, and accountability for services rendered. Monitor impact of dental fee increases effective January 1, 2000.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of licensed dentists statewide	1,533	1,719	1,713
Number of Medicaid enrolled dentists	575	619	824
Outputs:			
Number of children served	103,594	115,304	126,340
Number of adults served	22,564	22,686	26,354
Efficiency:			
Average cost per recipient	$139	$135	$242
Average cost per child served	$140	$133	$250
Average cost per adult served	$136	$140	$202

	Actual FY 97-98	Actual FY 98-99	Actual FY 99-00
Outcomes:			
Number of children receiving screening and services	103,594	115,304	126,340
Number of adults receiving emergency services	22,564	22,686	26,354

E. Vision Services

Program Cost:

State:	$1,543,118
Federal:	$3,586,927
Earmarked:	
Total:	$5,130,045

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

Program Objectives:

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

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of licensed vision providers statewide	558	569	660
Number of Medicaid-enrolled vision providers	535	545	560
Outputs:			
Number of examinations provided to children	33,359	36,609	41,462
Number of glasses prescribed for children	27,151	33,809	36,625
Number of examinations provided to adults	14,024	15,519	13,382
Number of glasses prescribed for adults	608	719	931
Efficiency:			
Average cost per recipient	$42	$43	$44
Average cost per adult served	$38	$38	$35
Average cost per child served	$45	$46	$47

F. Chiropractic Services

Program Costs:

State:	$122,931
Federal:	$285,748
Earmarked:	
Total:	$408,679

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

Program Objectives:

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

2) Review, evaluate and revise Chiropractic Program policies and procedures to ensure access to services for recipients, timely payments to providers, and accountability for services rendered within allocated funding.

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of licensed chiropractors statewide	N/A	810	800
Number of Medicaid-enrolled chiropractors	N/A	252	272
Outputs:			
Number of children served	N/A	317	1,319
Number of adults served	N/A	420	2,582
Efficiency:			
Cost per recipient	N/A	$123	$105

G. Transportation

Program Costs:

State:	$ 9,146,075
Federal:	$24,322,247
Earmarked:	$ 1,315,065
Total:	$34,783,387

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

Program Objectives:

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

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of licensed ambulance services statewide	204	204	210
Number of DHHS FTEs	4	4	6
Number of contractual providers	25	25	25
Number of fleet vehicles	535	567	567
Number of enrolled ITP providers	1,065	1,066	797
Outputs:			
Number of Medicaid-enrolled ambulance providers	128	130	139
Number of recipients served	49,635	52,463	152,453

	Actual FY 97-98	Actual FY 98-99	Actual FY 99-00
Number of non-emergency trips	793,308	1,412,254	1,582,916
Efficiency:			
Cost per recipient served	$483	$641	$228
Outcomes:			
Number of Medicaid appointments kept by recipient	799,200	1,418,218	747,756
Quality:			
Number of technical assistance visits	41	42	47
Number of Human Service Community Surveys on providers performed	N/A	75	93
Number of provider related complaints	7	8	122

H. Rehabilitative Therapy Services - (Other Medical Services)

Program Costs:

State:	$ 974,919
Federal:	$2,266,168
Earmarked:	
Total:	$3,241,087

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

Program Objectives:

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

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of enrolled service providers	1,074	1,175	1,861
Number of DHHS FTEs	4	4	4
Outputs:			
Number of recipients served	2,712	3,328	9,268
Efficiency:			
Average expenditure per recipient	$177	$224	$350

	Actual FY 97-98	Actual FY 98-99	Actual FY 99-00
Outcomes:			
Number of state agencies accessing therapy Services for clients	4	4	4
Quality:			
Number of provider technical assistance visits	111	40	27

I. Diabetes Education Services

Program Cost:

State	$ 8,028
Federal	$18,662
Earmarked:	
Total:	$26,690

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

Program Objectives:

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

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Providers of Diabetes Education Services	4	9	18
Outputs:			
Individuals receiving Diabetes Education Services	260	409	493
Efficiency:			
Average expenditure per recipient	$45	$53	$54

J. Postpartum Infant Home Visit

Program Cost:

State:	$ 413,971
Federal:	$ 962,264
Earmarked:	
Total:	$1,376,235

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

Program Objectives:

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of recipients receiving Postpartum/Infant Home Visits	22,601	20,174	20,425
Outputs:			
Number of providers of the Postpartum/Infant Home Visits	12	14	12
Efficiency:			
Average Cost Per Patient	$62	$66	$67
Average Cost Per Transaction	$57	$61	$61
Outcomes:			
Percent of recipients receiving Home Visits	82%	73%	77%
Quality:			
Number of Technical Assistance and/or Compliance Visits	3	3	0

K. Family Planning

Program Cost:

State	$ 1,217,403
Federal:	$11,405,543
Earmarked:	$ 50,000
Total:	$12,672,946

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

Program Objectives:

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

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of Family Planning clients served	76,480	87,470	93,415
Total number of transactions	222,628	271,822	305,097
Outputs:			
Number of unduplicated medical providers participating	N/A	929	1,020
Efficiency:			
Average cost per transaction	$45	$41	$41
Average number of transaction per recipient	2.91	3.11	3
Average cost per recipient	$131	$128	$136

	Actual FY 97-98	Actual FY 98-99	Actual FY 99-00
Outcomes:			
Increase in the number of women receiving publicly supported family planning services	13,778	4,692	5,945
Total number of transactions for prescription contraceptives	64,180	84,331	101,720
Total number of units for contraceptives (using the HIC forms)	484,557	535,353	553,726

L. Managed Care Program

Program Cost:

State:	$ 2,704,248
Federal:	$ 7,441,452
Earmarked:	$ 494,778
Total:	$10,640,478

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

Program Objectives:

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of recipients enrolled in the Primary Care Physician's Program (PCP's)	4,972	7,174	23,284
Outputs:			
Number of enrolled HMO contractors	3	1	1
Number of Primary Care Physicians's (PCP's)	464	500	461
Efficiency:			
Average cost per transaction	$92	$90	$80
HMO expenditures	$3,843,249	$7,323,773	$11,030,526
Quality:			
Average number of dis-enrollments per month	72	142	439
Average number of complaints received per month	2	5	2

M. Durable Medical Equipment (DME)

Program Cost:

State:	$10,367,550
Federal:	$25,351,501
Earmarked:	$ 534,865
Total:	$36,253,916

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

Program Objectives:

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of enrolled providers	1,450	1,414	1,371
Outputs:			
Total transactions for DME	491,038	538,504	617,635
Number of unduplicated recipients	51,721	58,947	64,134
Efficiency:			
Average cost per recipient	$645	$588	$596
Average cost per transaction	$68	$64	$64

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

Program Cost:

State:	$ 7,531,047
Federal:	$28,905,312
Earmarked:	$ 177,379
Total:	$36,613,738

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

Program Objectives:

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

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

2) Enroll targeted low income children

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of PHC applications distributed	1,379,524	1,062,504	1,467,500
Number of targeted outreach initiatives	51	51	50
Outcomes:			
Number of new SCHIP enrollees	30,934	19,697	45,874
Number of SCHIP clients served	21,463	44,627	55,637
Efficiency:			
Average annual cost per clients served	$430	$552	$654

Part 2.

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

Program Rank: 2

Program Cost:

State:	$11,680,517
Federal:	$45,192,760
Earmarked:	
Total:	$56,873,277

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

Program Objectives:

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Outputs:			
Total children receiving services	42,109	41,725	36,359
Number of provider visits to improve quality	1,363	1,759	1,934
Number of low-income working poor children served	16,764	16,767	12,483

	Actual FY 97-98	**Actual FY 98-99**	**Actual FY 99-00**
Number of Family Independence children served	25,345	24,958	23,876
Quality:			
Number of care givers/directors trained.	14,073	14,757	14,271
Number of providers meeting standards above state licensing requirements	1,246	1,319	1,229
Number of technical assistance visits to self-arranged care providers (non-regulated)	N/A	274	384
Efficiency:			
Percentage of total CCDF dollars for administrative costs	3%	4%	4.4%
Average monthly cost per child served	$240	$240	$241

Part 3.

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

Program Rank: 3

Program Cost:

State:	
Federal:	$29,368,895
Earmarked:	
Total:	$29,368,895

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

Program Objectives:

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

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Outputs:			
SSBG child welfare dollars redirected to strengthen and preserve families	$5,037,361	$5,354,647	$5,510,936

	Actual FY 97-98	**Actual FY 98-99**	**Actual FY 99-00**
Total clients receiving SSBG services	72,578	61,412	53,030
Total children receiving SSBG services	53,966	42,800	31,812
Total investigations of alleged child abuse and neglect reports	18,555	18,184	18,415
Total adults receiving SSBG services	18,612	18,612	21,218
Total adults receiving home delivered meals	2,517	2,467	2,576
Efficiency:			
Percentage of SSBG dollars for administrative costs	6%	4%	4%
Average annual cost per client served	$428	$505	$610
Average annual cost per child client served	$417	$529	$747
Average annual cost per adult client served	$336	$343	$345
Outcomes:			
Number of families preserved or reunified	6,122	6,250	5,887
Number of children protected from abuse and/or neglect	8,403	8,235	8,781
Number of adults protected from abuse, neglect or exploitation	8,066	7,900	7,293
Number of adults receiving community-based services to prevent institutionalization	5,203	5,100	5,025

Part 4.

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

Program Rank: 4

A. Senior Services

Program Cost:

State:	$ 2,130,583
Federal:	$12,283,612
Earmarked:	$ 2,943,543
Total:	$17,357,738

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

Program Objectives:

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

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

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

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

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

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

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

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

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

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

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Total people served	29,401	31,200	29,783
People receiving congregate meals	12,297	13,982	12,799

	Actual FY 97-98	Actual FY 98-99	Actual FY 99-00
People receiving home delivered meals	11,503	11,482	13,705
People receiving home care	4,306	4,895	3,783
People receiving transportation	6,374	6,452	6,476
People receiving adult day care	248	142	317
People receiving care management	5,157	2,561	6,829
Families of persons with Alzheimer's Disease (AD) receiving information through the Alzheimer's Help Line	312	436	304
Families of persons with AD receiving in-home social work assessments	250	70	93
Families receiving AD care management	200	100	93
Families receiving AD group respite or adult day care	85	166	202
Families receiving AD in-home respite care	151	130	124
People enrolled in Senior Community Service Employment Program	209	215	193
Types of Long Term Care Ombudsman complaints:			
Residents rights (including abuse, neglect and exploitation)	1,388	1,564	1,688
Residents care (including improper care, failure to follow Medical Doctor orders, personal hygiene)	897	1,107	1,152
Quality of life (including cleanliness of quarters, diet and nutrition, availability of activities)	258	306	373

	Actual FY 97-98	Actual FY 98-99	Actual FY 99-00
Administration (including adequate staffing, training, record-keeping)	183	191	256
Not against the facility (problems with outside agencies, systems or persons)	211	218	185
Number of complaints received by the Long Term Care Ombudsman	3,155	3,376	3,655
Living Will witness trainings	4	4	3
Advance Directive presentations	4	5	9
Number of I-Care volunteers	428	463	493
Outputs:			
Home delivered meals provided	1,561,658	1,577,658	1,905,173
Congregate meals provided	1,167,734	1,071,886	1,126,224
Hours of home care provided	208,407	206,998	221,091
Miles of transportation provided	10,526,784	10,988,157	9,016,290
Hours of adult day care provided	110,856	62,521	91,278
Hours of care management provided	21,586	9,250	28,871
Senior Centers completed	9	7	4
Number of senior volunteers for the Intergenerational Program	533	746	1,274
Long Term Care Ombudsman cases opened in nursing homes and residential care facilities	2,427	2,517	2,930
Long Term Care Ombudsman cases closed in nursing homes and residential care facilities	2,060	2,419	2,984

	Actual FY 97-98	Actual FY 98-99	Actual FY 99-00
Long Term Care Ombudsman complaints verified in nursing homes and residential care facilities	1,126	1,291	1,587
Long Term Care Ombudsman complaints from DDSN and DMH facilities	410	369	520
Living Wills witnessed by Ombudsman for persons in institutions	450	390	388
Number of persons receiving Medicare insurance counseling	3,421	10,974,	4,732
Outcome:			
Professionals, para-professionals, volunteers and others receiving training	1,375	2,657	4,627
Quality:			
Dollar savings to public through insurance counseling and training	$98,964	$268,000	$150,539
Efficiency:			
Total cost per client (state & federal dollars)	$309	$304	$320
Cost per client (state dollars)	$52	$55	$55
Number of persons on waiting lists for services	4,535	4,664	4,794

B. Community Long Term Care Services (CLTC)

Program Cost:

State:	$22,551,109
Federal:	$54,418,903
Earmarked:	$ 850,000
Total:	$77,820,012

Program Objectives:

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

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

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

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

Performance Measures: Elderly/Disabled Waiver	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of referrals each year	10,686	15,008	12,625
Outputs:			
Total clients served each year	9,771	13,717	14,397
Number of persons on waiting list for services	3,697	1,470	3,615
Efficiency:			
Cost per day, per client, for CLTC services	$18	$21	$23
Cost per day, per client, for nursing home placement	$83	$87	$94
Percentage of daily nursing home rate expended for CLTC services	22%	24%	24%
Outcomes:			
Savings to Medicaid Program per day, per client	$65	$66	$71

Performance Measures: Ventilator Dependent Waiver	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of referrals each year	15	16	19
Outputs:			
Total clients served each year	29	28	35
Efficiency:			
Cost per day, per client, for CLTC services	$58	$67	$69
Cost per day, per client, for nursing home placement	$180	$180	$180
Percentage of daily nursing home rate expended for CLTC services	32%	37%	62%
Outcomes:			
Savings to Medicaid Program per day, per client	$122	$113	$111
Performance Measures: Children's Personal Care Aide Program			
Inputs:			
Number of referrals each year	350	368	324
Outputs:			
Total clients served each year	429	408	432
Performance Measures: HIV/AIDS Waiver			
Inputs:			
Number of referrals each year	661	694	579
Outputs:			
Total clients served each year	920	1,073	1,143
Efficiency:			
Cost per day, per client, for CLTC services	$2,370	$2,115	$2,410

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

Program Cost:

State:	$100,238,561
Federal:	$239,502,665
Earmarked:	$ 2,770,407
Total:	$342,511,633

Program Objectives:

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

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

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

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

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of NH recipients	15,915	16,898	17,131
Number of Medicaid contracted NH	142	147	150
Number of individuals who participated in the Nurse Aide Training Program	1,798	2,234	2,498
Number of competency tests provided	1,450	1,996	2,615

	Actual FY 97-98	Actual FY 98-99	Actual FY 99-00
Number of Medicaid-sponsored nursing home bed days	4,058,629	4,200,156	4,337,639
Outputs:			
Number of individuals added to the nurse aide registry	4,135	4,050	2,623
Number of certification renewals	N/A	8,158	2,944
Number of Medicaid recipients who received home health services	3,937	4,172	10,004
Units of home health services provided	304,633	311,606	331,392
Number of Medicaid–only recipients who received home health services	96	115	111
Units of hospice services provided	29,119	26,695	25,967
Efficiency:			
Cost per nurse aide for training	$325	$325	$308
Cost per nurse aide for testing	$86	$86	$86
Cost per renewal	N/A	$25	$25
Average gross Medicaid rate/day to nursing homes (without recurring income)	$83	$87	$92
Average net Medicaid rate/day paid to nursing homes (with recurring income)	$67	$71	$75
Number of persons on waiting lists for nursing home services	478	399	312
Outcomes:			
Number of nursing homes notified of potential sanctions	23	42	38
Number of nursing homes sanctioned	10	11	15

Part 5.

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

Program Rank: 5

Program Cost:

State:	$15,450,655
Federal:	
Earmarked:	
Total:	$15,450,655

Program Goals: To provide a source of supplemental payment for those individuals who meet the eligibility criteria set forth by the state and reside in a licensed Community Residential Care Facility (CRCF).

Program Objectives:

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

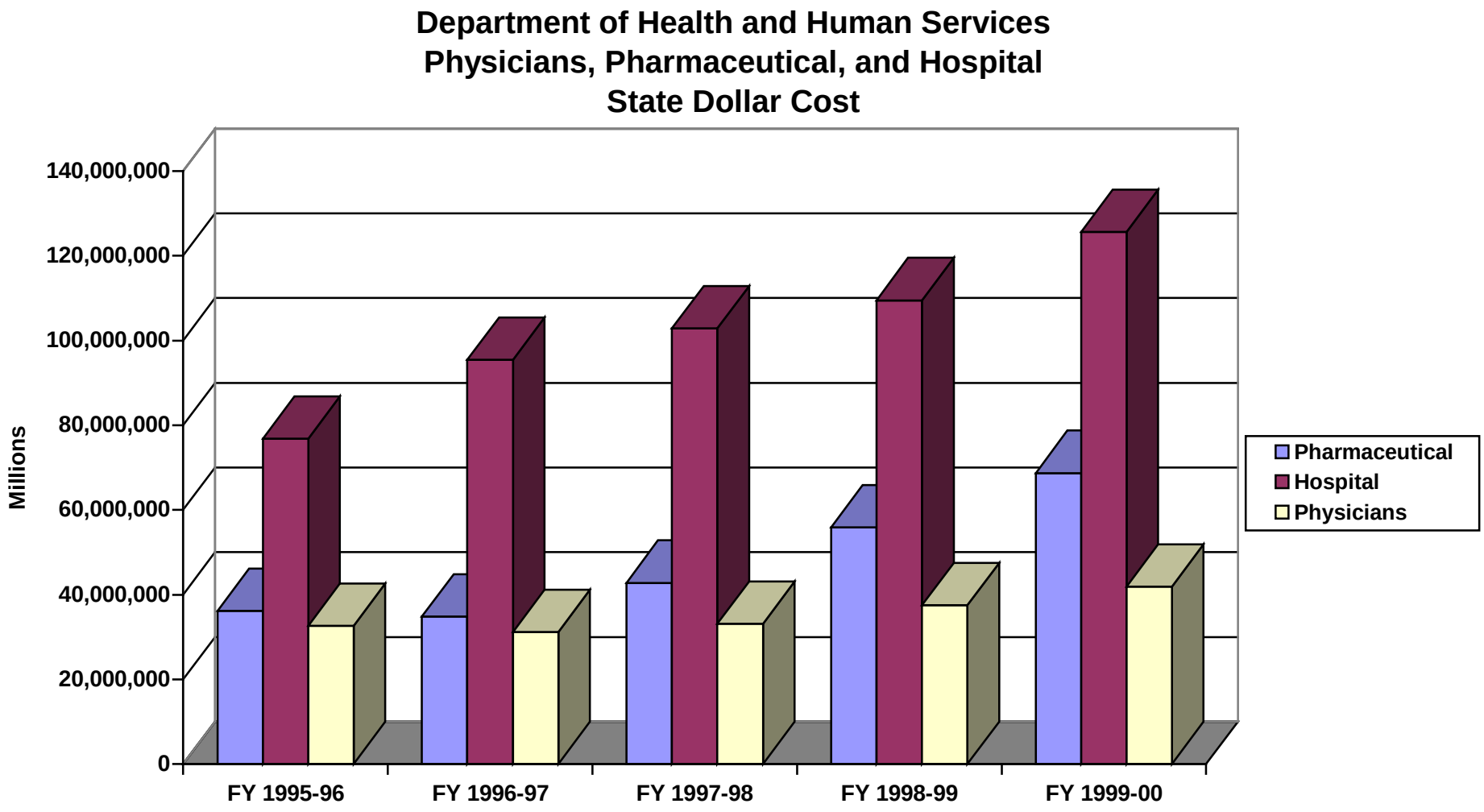
2) Maintain an accountable billing and payment system for the OSS Program.

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

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

Performance Measures:	**Actual FY 97-98**	**Actual FY 98-99**	**Actual FY 99-00**
Inputs:			
Number of CRCFs that have enrolled as providers	359	402	352
Outputs:			
Average monthly recipient count	4,236	4,417	4,257
Efficiency:			
Average monthly amount paid	$1,180,849	$1,207,041	$1,287,555

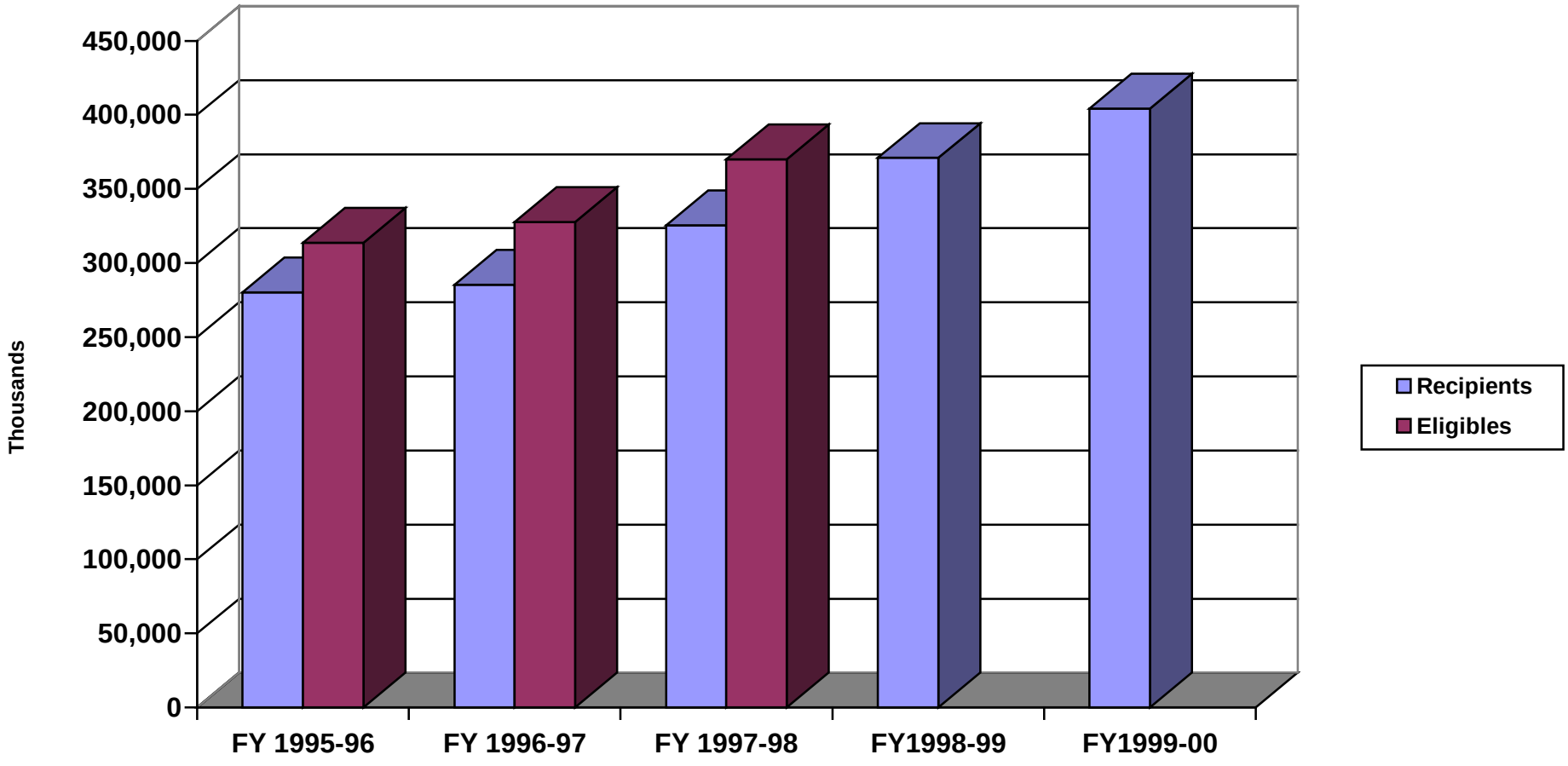
Schedule A



Source: GAFRS 9427

Schedule B

Department of Health and Human Services
Eligible and Recipient Children in Medicaid, Ages 0-20



Eligibles data for FY 1999 & 2000 not completed by HCFA/Source: HCFA 2082
Recipient data source: CCA 2900