2003-2004 Accountability Report
Transmittal Form

Agency Name: Department of Health and Human Services

Date of Submission: September 15, 2004

Agency Director: Robert M. Kerr

Agency Contact: Bryan Kost
Phone: 803-898-2865
Email: kostbr@dhhs.state.sc.us

I. EXECUTIVE SUMMARY

Mission & Values

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

South Carolina's Medicaid program provides basic healthcare services for approximately 840,000 individuals who are either very poor, elderly, or disabled through a network of approximately 30,000 healthcare professionals. Overall, the Department of Health and Human Services processes more than $4 billion in Medicaid claims each year with almost $1.5 billion of those claims coming through other state agencies.

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

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

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

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

SFY 2004 Major Accomplishments

Balanced Budget: Ended SFY 2004 without a deficit for the first time since the state's budget crisis began thanks to aggressive cost-containment measures implemented through SFY 2003 and 2004.

Fraud/Abuse: Initiated several fraud and abuse enhancements, resulting in an 86% increase in total recoupments of Medicaid dollars compared to SFY 2003.

Pharmacy and Therapeutics Committee: Successfully initiated its Medicaid Pharmacy and Therapeutics Committee to clinically evaluate and establish a Medicaid preferred drug list.

Medicaid Beneficiary Co-Pays: Implemented co-pays for certain health care services to encourage responsible use of Medicaid services and help control costs.

Pharmacy Point of Sale: Competitively procured a new Pharmacy Point-of-Sale contract that is a significant improvement over the prior contract in that it uses a flat fee, rather then volume-based, pricing structure; expands services while maintaining the same cost; and improves accountability through use of performance guarantees. Additionally, DHHS was successful in negotiating a reduction in the winning vendor's bid price saving several million dollars over the course of the contract.

Primary Care Case Management: Further developed the PCCM model, with local physicians working in a cooperative to manage Medicaid care in their area, helping coordinate services by joining Medicaid recipients with doctors who serve as their "medical home."

Managed Care Expansion: Established infrastructure to support expansion of private managed care options by contracting with a second Medicaid Managed Care Organization, called Better Health Plans of SC.

Consumer-Directed Care: Expanded SC Choice, a consumer-directed long term care initiative, empowering Medicaid recipients who receive community long term care services to participate in developing their care plans and selecting their care providers. Community long-term care costs about 40% less than institutional care.

Annual Eligibility Redetermination: Revised policy to require people receiving Transitional Medicaid benefits to provide verification that their qualified earnings are at or below 185% of the federal poverty level, in order to continue receiving Transitional Medicaid for the last six (6) months of the Transitional period.

Online Eligibility Verification: Developed a web-based eligibility verification service was developed to provide care providers real-time information on the Medicaid eligibility status of the clients they serve**.**

Medically Fragile Children Program Expansion: Expanded in the Upstate this managed care model that provides vital services to children with complex healthcare needs.

Behavioral Health Service Monitoring: Contracted with Carolina Medical Review to provide quality oversight for Children's Behavioral Health Services out-of-home placement. CMR will provide a comprehensive review process to ensure efficiency and effectiveness of this service.

Healthy Start/Grow Smart: Developed this health education effort for new mothers and infants providing information and support to women and their babies in the critical first year of life.

Nursing Home Transition Grants: Developed programs to support nursing home residents who want to return to their communities, using federal grants that provide for living needs and health care education for the individuals and families. This program expanded to 11 more counties in SFY 2004.

Disproportionate Share: Protected many Medicaid hospital and state agency providers by working with federal officials to allow appropriate provider matching mechanisms to draw down federal money for Disproportionate Share (DSH) reimbursement.

Management/Customer Service Training: Required management employees to participate in intensive leadership training and all employees to participate in a customer service training series – both of which were conducted by State Budget and Control Boards' Office of Human Resources.

HIPAA Compliance: Successfully met the federal deadline for implementing standardized transactions and code sets as required by the HIPAA. In addition, DHHS followed the Centers for Medicare and Medicaid Services' (CMS) example in the Medicare program by implementing a contingency plan which allowed non-compliant providers to continue to submit claims for payment.

Beneficiary Newsletter: Began issuing a newsletter to Medicaid recipients in SFY 2004, offering information on Medicaid issues and education on health management.

Eligibility System Task Force: Established team of front-line eligibility workers to make recommendations to improve the current Medicaid Eligibility Determination System (MEDS).

Eligibility Efficiency Review: Contracted with USC to provide a process/time management and efficiency review of the Medicaid eligibility system.

Eligibility Audits: Established a statewide investigative unit to perform unannounced audits of eligibility workers' case files to verify accuracy and identify potential fraud, abuse, or errors.

Agency Restructuring: Three non-core Medicaid functions have been transferred to other state entities:

- **Office on Aging** – which provides funding for services benefiting those age 60 and older such as Meals on Wheels, transportation, and personal care services;
- **Child Care Development Fund (CCDF)** – which provides financial child-care assistance for parents who are transitioning off welfare and for low-income parents who are working, furthering their education or are disabled; and
- **Social Services Block Grant (SSBG) –** which provides financial assistance to critical services in areas like child and adult protection, child-care and home-based alternatives to institutional care of children and adults.

Opportunities and Barriers for FY 2004-2005

Opportunities

- DHHS is operating with a solid, yet conservative, budget in SFY 2005.
- DHHS is applying business principles to Medicaid through efforts like managed care, consumer-directed care, the Pharmacy and Therapeutics Committee, and Care Call, among others.
- The Medical Homes Local Network pilot will offer more medical homes and managed care options for South Carolina's Medicaid recipients.
- The agency is pursuing a regional transportation broker system to provide this service in the state.
- Non-Medicaid services have been moved from DHHS, tightening the agency's focus.
- The President has authorized about $1.75 billion for programs that support consumer-driven care. Federal officials are encouraging states to pursue these types of initiatives.

Barriers

- Legislative restrictions on pharmaceutical dispensing fees and the use of prior authorizations curtail administrative flexibility.
- The complex system of eligibility categories and lengthy application procedures can confuse the public and hinder the agency's accuracy and speed of determinations.
- DHHS' lack of control over other state agencies' use of Medicaid hinders managerial oversight and some potential cost-savings efforts.

Use of Accountability Report to Improve Organizational Performance

Elements of the Accountability Report were developed at management's leadership training, as agency issues and programmatic goals were discussed. Integrating this discussion into this report empowers staff to commit to the goals and performance measures relevant to their work. Periodic review of this report throughout the year will help DHHS prioritize work in relation to the mission and provide a check on progress toward the agency goals.

II. BUSINESS OVERVIEW

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

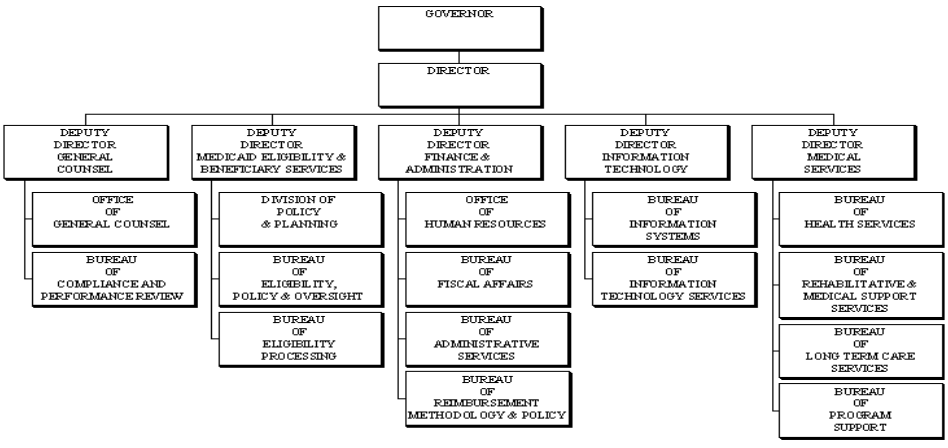
Working with the Governor and Legislature, DHHS leadership led the agency through great changes during SFY 2004, streamlining the organization and designing programs that meet the needs of qualified South Carolinians. From Executive and Legislative-led restructuring to consumer-directed care, the transformation of DHHS was marked by a progressive, business-like approach to providing quality health care coverage to low-income families and the state's aged, blind, and disabled.

Medicaid in South Carolina

- Provides for 20% of the state's population
- Pays for 50% of all births
- Covers more than 40% of all children
- Covers 33% of all seniors
- Pays for 75% of all nursing home beds
- Total budget of more than $4.2 billion
- Accounts for 10% of General Fund budget
- More than 30 million annual claims

DHHS employs 1,132 full-time employees and 194 temporary grant employees for a total of 1,326 employees working in the Columbia and throughout the state under the following organizational structure:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SEPTEMBER 2, 2004



Base Budget Expenditures and Appropriations

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

	02-03 Actual Expenditures		03-04 Actual Expenditures		04-05 Appropriations Act	
Major Budget Categories	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**
Personal Service	$38,993,611	$13,725,289	$39,906,088	$14,245,552	$39,599,450	$13,767,454
Other Operating	$171,082,554	$27,661,578	$149,486,631	$17,222,187	$138,930,574	$17,787,885
Special Items	$1,212,780	$1,050,623	$1,218,159	$1,072,814	$0	$0
Permanent Improvements	$0	$0	$1,250,000	$0	$0	$0
Case Services	$3,344,132,563	$479,426,109	$3,703,406,881	$519,839,023	$3,984,119,039	$686,441,953
Distributions to Subdivisions	$3,026,611	$0	$434,801	$0	$	$
Fringe Benefits	$11,554,351	$4,008,097	$11,469,478	$4,052,834	$11,620,489	$4,165,855
Non-recurring	$481,052,013	$3,113,963	$443,310,220	$1,001,637	$105,142,238	$
Total	**$4,051,054,483**	**$528,985,659**	**$4,350,482,258**	**$557,434,047**	**$4,279,411,790**	**$722,163,147**

Other Expenditures

Sources of Funds	02-03 Actual Expenditures	03-04 Actual Expenditures
Supplemental Bills	$0	$0
Capital Reserve Funds	$0	$0
Bonds	$0	$1,250,000

Interim Budget Reductions

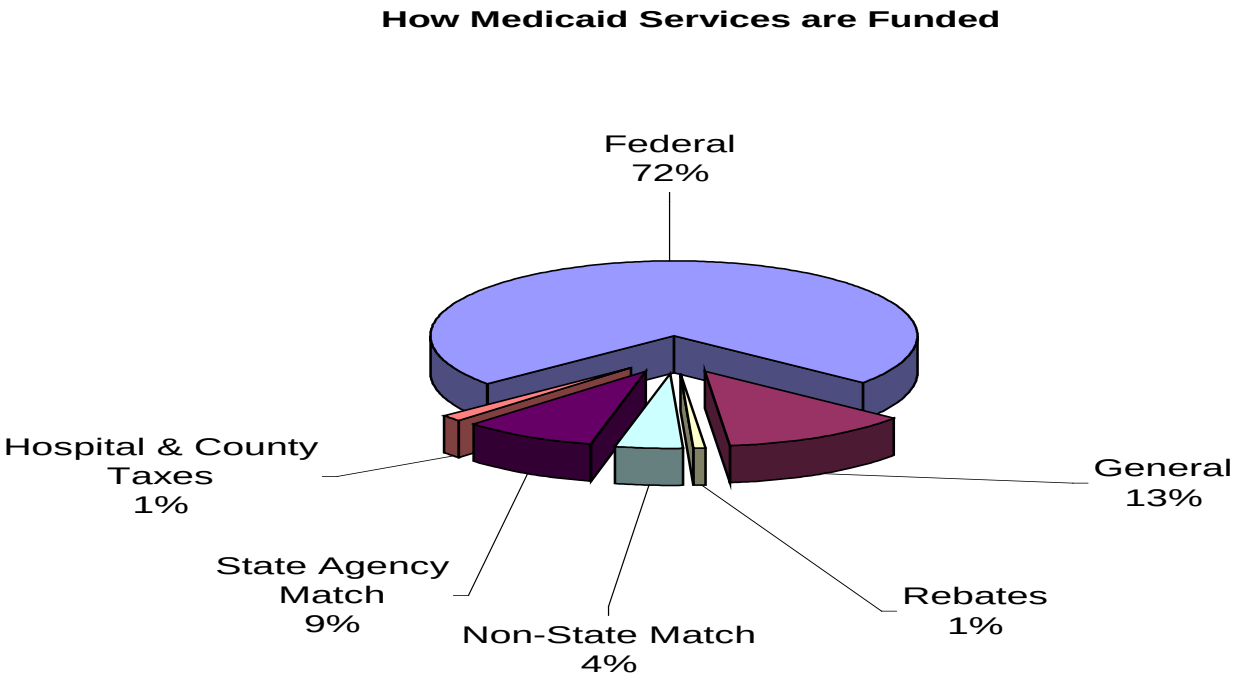
Total 02-03 Interim Budget Reduction	Total 03-04 Interim Budget Reduction
$49,473,466	$5,627,122

Key Customer Segments, Products/ Services, Stakeholders and Suppliers

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

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

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



III. MALCOLM BALDRIGE CRITERIA

Category 1 – Leadership

1.1 How do senior leaders set, deploy and ensure two-way communication for:
a) short and long term direction?
Executive Staff work with the Bureau Chiefs (managers of programmatic areas) to identify key needs the agency can address. Following a series of management training retreats for agency leadership, the Executive Staff developed a mission statement and three agency goals reflecting the current state of the agency and the Medicaid program in South Carolina. These have been communicated via leadership staff meetings, and through the agency's newsletter.

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

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

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

c) organizational values?
For the second year, the agency's organizational values have been formally adopted and shared at the beginning of the fiscal year. These values, developed by leadership staff incorporating the employee feedback, have been published in the agency's internal newsletter and incorporated into the DHHS Mission Statement and Goals document. The five values of Service, Excellence, Responsive(ness), Value, and Everyone are designed for all to support.

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

e) organizational and employee learning?
Executive Staff recognize the need for appropriate organizational and employee learning to reinforce the knowledge and skills of employees, thereby improving delivery of services. State-sponsored training opportunities, like the Certified Public Managers' Program, are identified and encouraged. In the past fiscal year, the agency has established mandatory training of supervisory skills for management staff; program-specific training for designated staff; and customer service and HIPAA compliance training for all staff.
These training opportunities were designed in response to employee feedback. Employees were encouraged to provide feedback following the trainings, too, for leadership to determine what training is helpful and what other training may be needed.

f) ethical behavior?
Ethical behavior is encouraged primarily through the following value of the agency:
E*veryone: We are a team; every employee is involved in our success; we believe in servant leadership and empowering employees to solve customer problems; as a team we will encourage and hold each other accountable.*

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

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

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

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

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

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

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

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

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

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

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

Category 2 – Strategic Planning

NOTE: The Strategic Planning Chart is included, in Excel format.

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

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

The Strategic Planning process begins with feedback from employees and service partners like providers, legislators, and recipients. Combining such feedback with ideas from staff and agency leadership leads to the cultivation of ideas. All ideas, from any source, can be brought to agency staff, and through Bureau Chiefs go to the Deputy Directors. Each year, the Deputy Directors examine the agency's mission, goals, and success indicators. All these people are key participants as are families of recipients (who often have important feedback that helps the Strategic Planning process) and advisory groups like the MCAC. Then the GO sheet system drives the implementation and tracking of the initiatives that transform the strategic plan into action.

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

2.2 What are your key strategic objectives?

DHHS key strategic objectives are represented by the projects outlined in the Strategic Planning Chart. The three goals the agency is focusing on now are listed in the Executive Summary, Section 3.

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

The GO (Goal Outline) tracking system, described in 1.1, is the agency's plan to develop and track plans supporting the strategic objectives. This tracking system requires a detailed cost analysis by fund on any agency initiative and must be approved by the chief financial officer. Therefore any project is allocated necessary resources to ensure accomplishment.

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

2.5 How do you communicate and deploy your strategic objectives, action plans and performance measures?

The GO sheet project priority/tracking system, outlined in 1.1, is the key communication and deployment tool.

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

www.dhhs.state.sc.us

Category 3 – Customer Focus

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

State personnel professionals led the DHHS leadership through discussion, group exercises, and study focusing on providing excellent customer service, identifying and measuring goals, leading and motivating teammates, communicating within and across departmental boundaries, and applying business principles to DHHS operations.

The major role of DHHS is to pay for health services provided by qualified providers with services delivered to eligible beneficiaries. Primary customers, therefore, are those who get paid (medical professionals) and those they serve (Medicaid recipients). Determining the requirements of customers happens through agency correspondence and surveys, focus group studies, review of letters/feedback to the agency, and constant communication with these customers. For applicants and recipients, primary interaction is through eligibility offices, Medicaid recipient bulletins, the agency's toll-free number, the beneficiary newsletter, and Web site. Provider representatives can meet regularly with DHHS leadership and give feedback through the Medical Care Advisory Committee (MCAC) and through interactions on task forces and in professional working groups like provider association meetings.

In addition to these mechanisms, the agency currently has an internal task force examining the ways we work with customers.

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

The Internet has been the area of most change in regard to listening and learning. In addition to the website and public e-mail address, the agency is doing more business and receiving more feedback through online billing and issue resolution tools. Also, to help providers, DHHS has made available Medicaid business-related forms and lists. In the future, the state health agencies will learn more about the recipient populations through the data warehouse and client management tools.

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

Finally, the agency has identified the issue of customer service as a project to pursue in the coming fiscal year. A team is being created to examine the agency's customer service support systems and determine reorganization or increased collaboration can enhance DHHS' response to all customer needs.

3.3 How do you use information from customers/stakeholders to keep services or programs relevant and provide for continuous improvement?

DHHS tries to meet customers proactively to learn of their needs and provide adequate services. For example, the agency worked to create a medical homes local provider network in response to physicians' feedback on how to develop medical homes and empower providers to help manage Medicaid in their areas. The result in this case is a medical homes cooperative that will offer a structure that rewards local physicians for good health and fiscal outcomes – as they requested.

And as always, to be accessible to customers on issues of importance, DHHS has representation and/or communicates regularly with organizations like the following:

- Healthcare-related state agencies
- Medicaid Fraud Control Unit in the SC Attorney General's Office
- The Alliance for South Carolina's Children
- The Center for Hospice and End of Life Care
- Carolina Medical Review, Inc.
- The South Carolina Health Care Association
- The South Carolina Nursing Home Association
- The South Carolina Association of Non-Profit Homes for the Aging
- The South Carolina OB Task Force
- South Carolina Medical Association Maternal, Infants, and Child Health Committee
- South Carolina Health Care Association
- South Carolina Hospital Association
- South Carolina Reentry Interagency Collaborative Team
- South Carolina Interagency Council on Homelessness

Information gathered through such groups is used to continuously evaluate and improve program operation.

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

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

The Director and Executive Staff are committed to an open-door policy for recipients, providers and other interested parties. Executive Staff regularly meet with customers and stakeholders to discuss concerns by meeting with these parties regularly and availing themselves as speakers and participants in these constituencies' programs. The presence of DHHS employees on a variety of task forces, boards, and community groups is another way the agency builds relationships with customers and stakeholders.

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

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

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

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

The agency is committed to supporting employees to build and maintain effective customer relationships. Indeed this concept was the focus of agency-wide training this past fiscal year, that gave front-line and management employees the tools to identify and meet the needs of the various customers of DHHS. In addition, the agency is creating an internal customer service award with money or food prizes included that recognizes outstanding customer service by agency employees.

Category 4 – Measurement, Analysis, and Knowledge Management

4.1 How do you decide which operations, processes, and systems to measure for tracking financial and operational performance?

DHHS leadership tracks the operations, processes, and systems that show whether the agency is meeting goals and operating an efficient and effective program. Executive Staff recognize the need for these measurements and seek them by tracking major initiatives and their Outcome Measures as defined in the GO sheet system. Therefore, each time a working group plans a major project, the group identifies the outcome measures that will be collected. For example, in cases when the agency is working on a new approach to managing some healthcare program, the financial outcome can be measured by the increased efficiency of the new approach, while the operational outcome is measured by the potential gains made in health outcomes for the affected population.

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

DHHS leadership regularly reviews the financial and operational data of program lines and assesses year-to-date status to identify potential issues and make adjustments as needed.

4.2 What are your key measures?

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

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

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

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

- Establish a customer satisfaction survey baseline;
- Average Processing Time – compliance with federal processing guidelines;

- Percent accurately processed within federal requirements; and
- Establish average cost per application baseline.

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

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

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

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

Specifically, agency leaders created an Executive Staff-level position overseeing Information Systems. Among other things, this senior staff member and his team create necessary reports that support decision-making, and manage the timeliness, accuracy, and security of needed information.

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

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

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

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

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

4.4 How do you use data/information analysis to provide effective support for decision-making?
Quality data is the foundation of all decision-making at DHHS. The Deputy Director of Information Technology is facilitating access to the myriad of reports and statistics requested during decision-making processes. Executive staff has access to such reports directly from software installed on their computers. The agency is placing a priority focus on fiscal forecasting in programmatic planning.

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

4.5 How do you select and use comparative data and information?
The selection and use of comparative data is determined by the nature of any given situation. DHHS frequently uses regional and national data to compare South Carolina with other states. DHHS also uses fiscal quarter and year comparative data to identify utilization and expenditure trends for policy planning. The specific variables of service type or price, usage rates, or eligibles' demographic information define the type of report/chart/graph that is created and used. The key to effective use of comparative data is the agency's ability to create the measurement tools to quantify the needed information. The agency is committed to supporting the infrastructure to provide these management tools.

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

Specific tools used to capture and transmit agency knowledge include this Accountability Report, which is available to all employees on the agency's internal Intranet site, the Communique newsletter which shares agency knowledge and best practices monthly (soon to be bi-weekly), and the Support Staff Guidebook, an Intranet-based tool that serves as a manual on how to do business at DHHS. The Support Staff Guidebook contains sample agency correspondence, systems guidelines, regulations, and other tools of the trade that help staff do their work based on the knowledge of their seasoned colleagues.

In addition, DHHS uses available state and agency training extensively to share knowledge and capture best ideas. From initial job-specific training to agency-wide ongoing training to refresh all DHHS teammates in best

practice concepts, leadership strives to stress the importance of training in regard to creating a seamless work environment that ensures all staff know all they can to perform their jobs effectively.

One final note on sharing best practices: the agency's quarterly employee recognition program, and various department-level monthly or quarterly employee recognition efforts, are designed to identify best practices and share lessons that are learned among the DHHS team.

Category 5 - Human Resources

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

Formal tools used to motivate and encourage employees include regularly scheduled meetings with peers and supervisors, and a variety of agency training programs that are offered on an ongoing basis, as well as external programs such as the Certified Public Managers' Program that develop professional skills enhance potential. In addition, recognition is given through stories in the monthly newsletter, the *Communiqué*, and our Employee of the Month Award. An informal form of motivation was made this past fiscal year as the agency upgraded the employee identification tags, to enlarge workers' names so teammates can better read their colleagues names in the elevators and hallways. This was an effort to encourage people to get to know their DHHS team.

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

As mentioned in 1.1 (e) and 4.6, the agency uses development and training programs as a key tool to ensuring a knowledgeable workforce for the state's Medicaid program. Two primary sources define the type of training available at DHHS. The first is the observation of managers and their feedback to Human Resources. Managers can recommend high-achieving employees for programs such as the Certified Public Managers' Program and the Executive Institute. And, when managers identify areas for improvement, training can be either acquired or created to respond. Secondly, a training menu offered by the State Budget and Control Board is offered to agencies. DHHS Human Resources staff can use employees' feedback and managers' input to select desired training from the menu. All new employees go through new employee orientation and are then trained at their job location by the hiring supervisor and staff.

DHHS just completed its most aggressive training year ever, with all supervisors and managers going through a mandatory management-training program that focused on several important issues including:

- Managing Employee Performance: The EPMS and Progressive Discipline
- Valuing Diversity: Strategies to Combat Sexual Harassment and Discrimination
- The Impact and Role of HIPAA at DHHS
- Conflict Management and Violence Prevention in the Workplace
- Improving Workplace Communication

Additionally, each and every employee in the agency was required to complete Customer Service Excellence training.

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

Our Employee Performance Management System (EPMS) engages both the employee and supervisor to actively define, refine, and rate job performance. The process is designed to keep channels of communication open and, by documenting optional "objectives," allow for flexibility to adjust the report to accurately reflect the actual work. Beyond adjusting "objectives" as they arise, managers are encouraged to re-write position descriptions when major changes are made to an employees job duties. The EPMS is developed keeping daily job duties in focus, thereby giving the employee and supervisor goals which can be easily identified and measured. The process measures basic job functions, but also encourages employees through the rating of "performance characteristics." The evaluation and planning stages require the manager and employee to sit down and discuss the job and the goals of the job. All these elements of the process encourage high performance. As a result of the recent agency-wide managerial training, DHHS is more strongly encouraging all managers to ensure that the EPMS process is managed in a timely fashion for each employee.

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

DHHS encourages open lines of communication among employees, supervisors and Executive Staff. All agency units are encouraged to celebrate events together. Much of this is organized agency-wide by the employee activity committee, called CHAMPS (Community, Health, Activity, Morale, Programs, and Service), which plans events like ice cream socials and holiday parties for all employees. Feedback at such functions is a key mechanism for morale measurement. In addition, an employee suggestion box is located at the main entrance to the administration building.

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

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

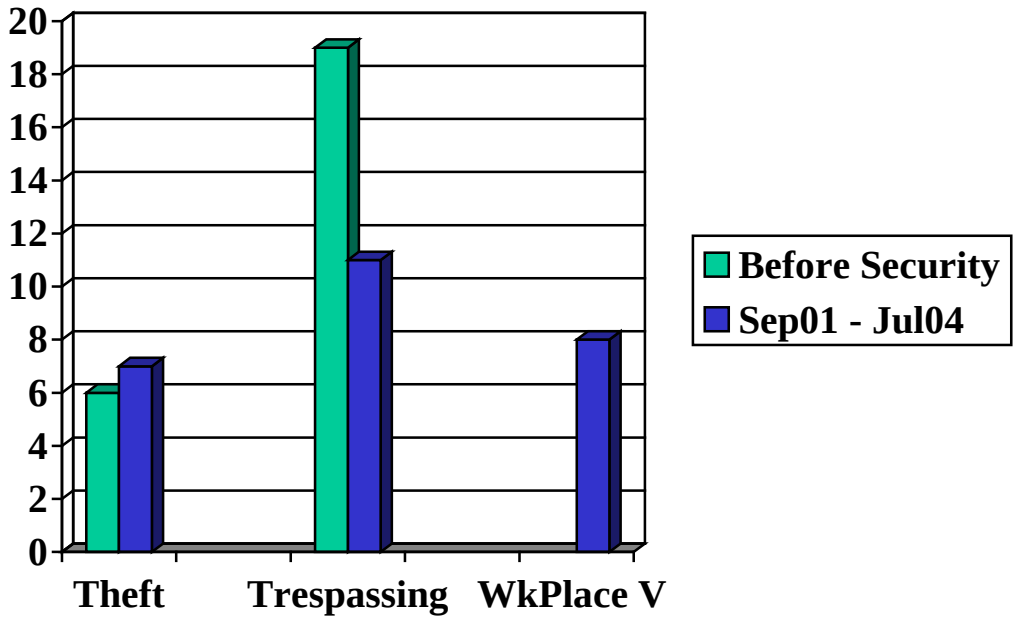
In addition, DHHS has an active CHAMPS Team that helps bring various classes and screenings to the agency to encourage employees to monitor and promote healthy living. Activities like aerobics and yoga are available on-site during lunch hours. The Employee Wellness Committee also promotes various charitable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

The security division has increasingly employed measurements and tracking systems to ensure a safe work environment. DHHS security has made improvements such as magnetized card access, security cameras, and a guard service at the main entrance to increase safety.

The agency has paid particular attention to its role in the statewide network of responders and emergency personnel staff, and uses regular e-mail updates during times of natural disasters.

The graph below, provided by the agency's security manager, identifies some of the security measurements (theft, trespassing, workplace violence) that are being tracked at DHHS:

Security Incident Chart



5.6 What activities are employees involved with that make a positive contribution to the community?
The agency has a solid presence in many statewide health and advocacy groups. For example, several agency employees are serving in leadership roles within in the State Public Health Association. Program staff also participates as members of a variety of study groups and commissions that examine issues and make recommendations to agencies and public policy leaders in a broad range of topics. Some of these professional partnerships are listed in 3.3. In addition, DHHS offers flexible scheduling for employees to volunteer at schools or serve on various local boards. DHHS employees are encouraged to participate in community events like bake sales, blood drives, awareness walks, and other fundraising efforts and bring these opportunities to the attention of their colleagues, as appropriate. Each year, the agency is a major state agency contributor to the state's United Way Campaign. Finally, program and executive staff are encouraged to participate in forums, and even serve as keynote speakers, when appropriate.

Category 6 – Process Management

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

DHHS pays providers to deliver services to eligible beneficiaries. Therefore, DHHS "products" include the support of medical providers, the management of the rates they are paid, and the qualification and support of the people they serve.

Key design and delivery processes include:

- MEDS (Medicaid Eligibility Determination System) – a program to ascertain eligibility of applicants;
- MMIS (Medicaid Management Information System) – the database of beneficiary demographics and usage information;
- Provider contracts and enrollment agreements – the arrangements bringing providers into the system;
- GAFRS – the system that manages payments to providers;
- The use of external actuaries to set managed-care reimbursement rates;
- PEP (Physician Enhanced Program), HMOs (Health Maintenance Organizations), HOP (Health Options Program) – various health care delivery options designed to address the various needs of beneficiaries;
- Private managed care and "medical homes" – other options of care delivery for beneficiaries designed to organize all aspects of their care under one provider's management; and
- Disease management – the concept of proactive care initiatives to prevent adverse health issues before they arise.

When new technology can simplify or speed processes, it is incorporated when possible. A recent example of this is the addition of online claims processing and monitoring for health care providers. Also, effective use of the Internet is allowing providers direct access to important forms and information that makes doing business easier for them. The Internet also serves many potential and current Medicaid enrollees, particularly serving them through the online e-mail Q&A service.

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

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

In regard to existing and on-going agency work, the incorporation of such factors in process design and delivery is ensured through constant assessment of workflow processes and outcomes. Such assessment is encouraged at the Bureau Chief level, where these leaders are frequently examining their program

areas' outcomes and procedures. All employees are encouraged to utilize organization knowledge, new technology and cost control elements in their work. Changing customer and mission-related requirements are incorporated whenever such changes are identified.

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

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

Executive Staff try to meet a few times a week to keep all processes working together on agency goals. Executive Staff are constantly reviewing the processes and outcomes of the bureaus they oversee. Their meetings allow for rapid response to intercept potential problematic issues or merge processes when cooperation will lead to better outcomes. It's at the Executive Staff (Deputy Director) level that the GO sheet tracking tool is constantly examined and how the agency's work ties in to the overall mission. When projects in the GO system change from a "green" status to either yellow or red, the Executive Staff manage Bureau Chiefs and working teams to ensure attention to the issue.

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

Due to the complexity and scope of services provided by DHHS, there are a multitude of support processes. For providers, health service units support the process of recruiting health care professionals to contract with the state, follow policies, set up payment mechanisms, pursue grievances, and the like. For beneficiaries, eligibility offices ascertain the services applicants may qualify for, assist in enrolling them and may even offer counsel on health planning and healthy living.

There are processes designed to provide research support for new program development, existing program management, and state and federal legislative developments. Agency-wide, there are fiscal support services that plan and budget, reimbursement systems that ensure accurate payments, contracting and procurement divisions to support DHHS partnerships and purchasing. Other support processes include technology development and maintenance, general counsel, internal audits and external fraud investigation, and public information activity. At the agency-wide level, it should be noted that DHHS's management of Medicaid by definition sets up the agency as a support unit for many other state agencies. Therefore, much of the internal support elements also serve the work of other Medicaid-related agencies.

All of these support functions are set up as working units that will support the major initiatives of the broader bureaus. As such, the employees working in these areas use public feedback as well as internal data to provide more effective or efficient service. Bureau Chiefs and Executive Staff are empowered to restructure the personnel or funding to better align staff, make purchases, etc., to improve performance. Frequently, the improved use of technology is found to be a tool to achieve better performance. An

example of this is online question/answer capabilities made available for statewide eligibility workers, or the "e-leave" electronic employee leave system.

6.5 How do you manage and support your key supplier/contractor/partner interactions and processes to improve performance?
DHHS suppliers/contractors/partners primarily include medical and allied professionals and the people receiving the care. Many of the support processes above are designed to meet specific needs of each of these partners in their delivery or pursuit of care. Specific work units of the agency are dedicated to specific provider types and beneficiaries to help them get paid, get answers, get advice, get services, or whatever they may need. The agency has toll-free numbers for these partners and often assigns individuals to monitor the relationships.

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

In addition, DHHS employees educate and reach out to strategic partners through educational programs and materials, various trainings, presentations and conferences. These trainings and resources support key suppliers and contractors and help DHHS work with them to improve performance and strengthen partnerships. This is a key way for DHHS to manage the myriad of partners involved in providing health care for South Carolinians.

Category 7 – Business Results

7.1 What are your performance levels and trends for the key measures of customer satisfaction?
DHHS' major customers are the beneficiaries who receive Medicaid services and the providers who deliver the care. In the past fiscal year, strides have been made to improve the services provided to beneficiaries by increasing web-based and postal communication, reducing the time necessary to apply for Medicaid, ensuring accurate phone and mail responses, and working to solve issues regarding coverage or benefits. The agency is currently studying the customer service dynamics and delivery, with the goal of maximizing employee alignment and possibly restructuring the customer service elements within the agency to further ensure streamlined and coordinated response and resolution. All these factors, combined with anecdotal evidence (letters to legislators, calls to eligibility offices) would indicate an increase in customer satisfaction in dealing with DHHS and understanding recipients' roles and benefits within the complex Medicaid environment. The agency plans to employ customer service measures to more accurately capture this information in the future.

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

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

As mentioned in Category 4.2, the agency's three goals each have several Success Indicators that will define the progress the agency makes toward the goals. For many of these, the measurement tools are being developed to capture the information for the Success Indicators criteria. The following represent the trends within the Success Indicators – trends that DHHS aims to improve so the agency meets its mission "To manage the Medicaid program to provide the best healthcare value for South Carolinians." In all cases, levels have been identified as perhaps improving but not yet satisfactory- thus their appearance within the major agency goals.

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

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

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

7.3 What are your performance levels for the key measures of financial performance?

During the past fiscal year, DHHS, aggressively focused on cost containment and programmatic controls to keep Medicaid program growth in check, with no loss in services available to recipients. In SFY 2004, DHHS expenditure growth was 5.8%, lower than several national benchmarks (figure 7.3-1)

representing the lowest annual change since SFY 1998. DHHS program growth was flatter when pharmaceuticals are separated (figures 7.3-2, 7.3-3). DHHS growth without including pharmacy costs was only 2.5%. The agencies pharmacy growth rate closely mirrored national trends. For a look at other state agencies' Medicaid expenditures, see figures 7.3-4 and 7.3-5. Figure 7.3-6 shows the DHHS expenditures, by program.

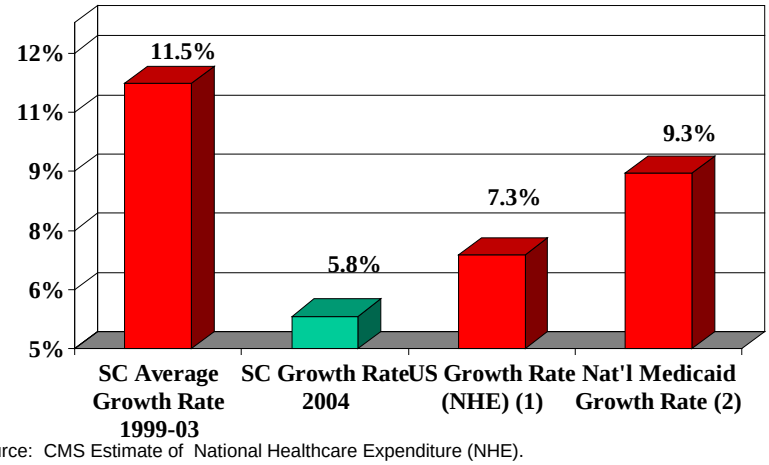
In addition to focusing on costs, the agency also focused on tightening and enforcing existing eligibility criteria. This was accomplished through increasing reviews to ensure that Medicaid services are available to South Carolinians meeting established criteria. With eligibility oversight tightened, the number of monthly South Carolinians eligible for Medicaid trended downward in recent history (figure 7.3-7), while the actual number of recipients utilizing Medicaid services increased marginally at 1.2%.

Another key development is the funding package provided in the SFY 2005 state budget, which increased the proportion of the DHHS budget that is funded from recurring general funds and reduced the amount of non-recurring funding. Thanks to efforts by the Governor and General Assembly, as well as advocates and other stakeholders, the increased proportion of recurring funds will provide South Carolina with a more stable revenue stream in the years to come (figure 7.3-8). However, the agency still faces significant challenges in the years to come to contain costs and growth. These challenges are not solely based on economic or demographic factors in the state but increasingly from rising pharmaceutical costs and health related inflationary factors. DHHS will continue to aggressively contain costs internally, while providing a benefit plan that improves member health, is evidence based and is market driven.

Graphs begin on next page.

Comparison of Health Care Growth Rates

State Fiscal Year 2004

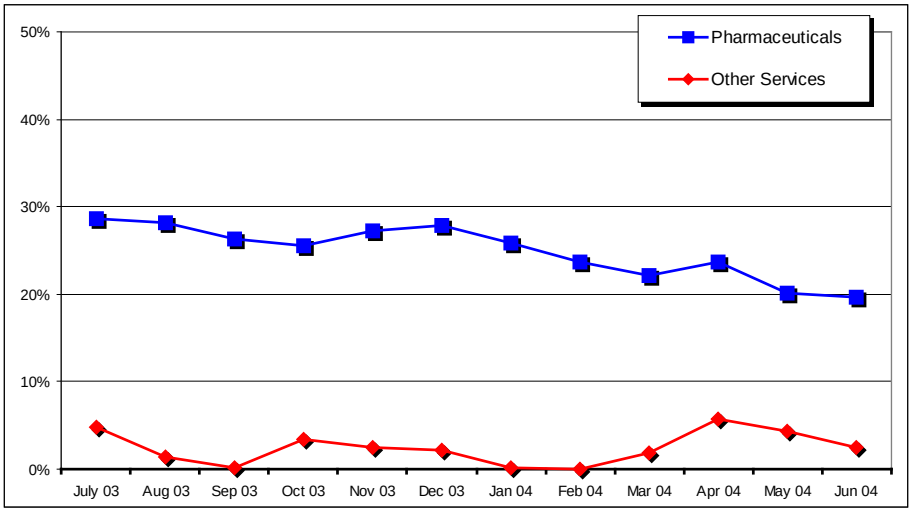


(1) Source: CMS Estimate of National Healthcare Expenditure (NHE).
(2) Source: Kaiser State Fiscal Conditions and Medicaid, Release November 2003.
* Does not include disproportionate share payments

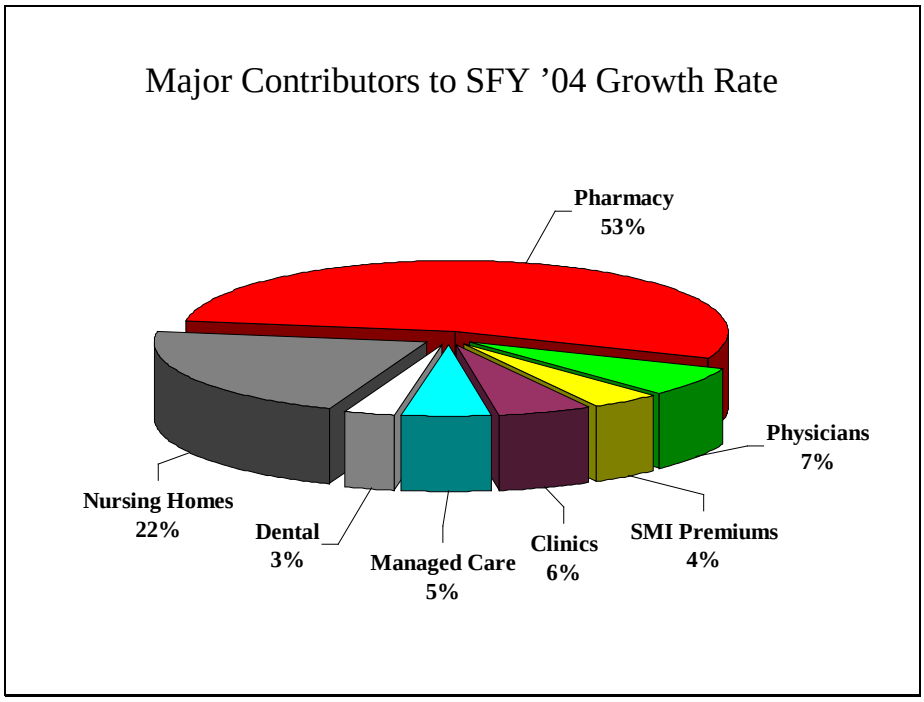
Graph 7.3-1

Total DHHS Medicaid Assistance Comparison of Pharmaceutical Services and All Other Services

Year to Date Ending June 2004



Graph 7.3-2

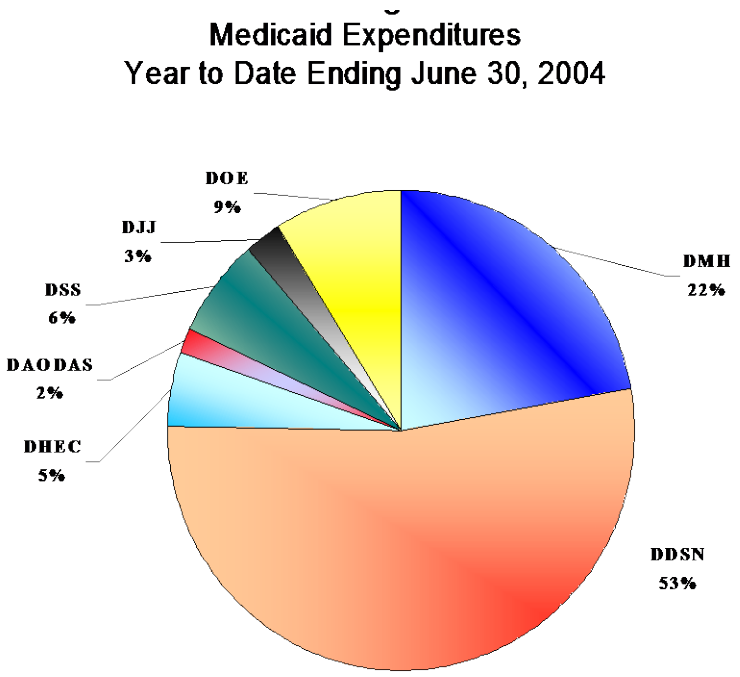


Graph 7.3-3

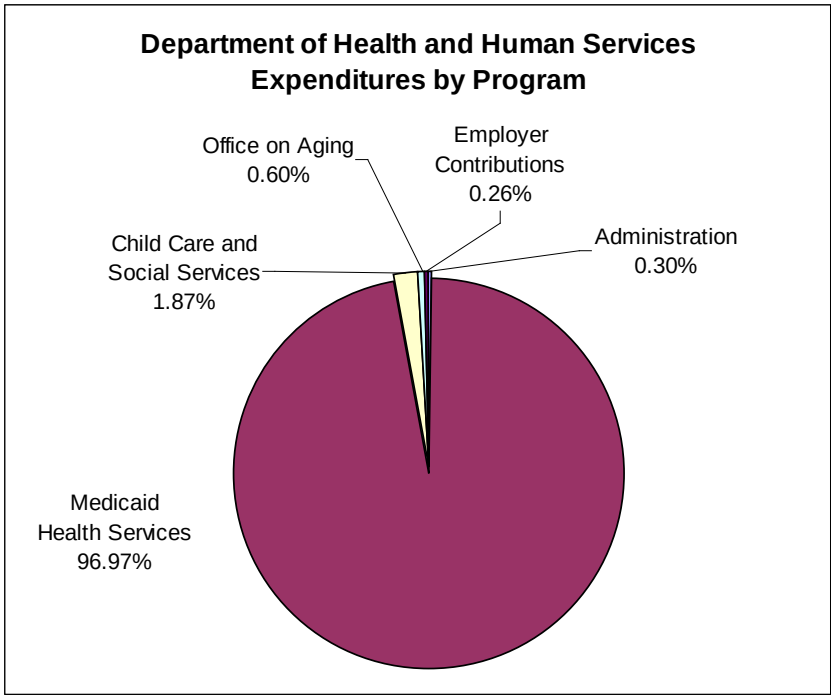
OTHER STATE AGENCY MEDICAID ASSISTANCE

	2001	2002	% Change	2003	% Change	2004	% Change
Department of Mental Health	$154,771,202	$176,915,739	14.3%	$195,109,098	10.3%	$171,365,310	-12.2%
DDSN	$361,844,091	$447,672,251	23.7%	$412,816,446	-7.8%	$412,987,890	0.0%
DHEC	$37,912,332	$33,915,283	-10.5%	$38,725,914	14.2%	$37,298,961	-3.7%
Medical University of South Carolina	$10,338,737	$14,538,468	40.6%	$27,829,341	91.4%	$41,939,631	50.7%
University of South Carolina	$2,370,369	$2,833,498	19.5%	$5,612,272	98.1%	$5,690,602	1.4%
DAODAS	$8,788,887	$15,857,149	80.4%	$11,839,390	-25.3%	$13,879,179	17.2%
Continuum of Care	$6,371,356	$8,529,603	33.9%	$10,328,196	21.1%	$8,898,251	-13.8%
School of the Deaf and Blind	$1,325,643	$1,391,696	5.0%	$2,048,508	47.2%	$3,437,980	67.8%
Department of Social Services	$58,176,304	$60,534,139	4.1%	$52,182,875	-13.8%	$50,324,531	-3.6%
Department of Juvenile Justice	$16,316,642	$17,786,139	9.0%	$23,598,126	32.7%	$20,449,250	-13.3%
Department of Education	$18,611,003	$74,306,918	299.3%	$69,965,732	-5.8%	$68,705,945	-1.8%
Commission for the Blind	$29,672	$22,299	-24.8%	$25,449	14.1%	$8,876	-65.1%
Total Other Agency Medicaid Assistance	$676,856,238	$854,303,182	26.2%	$850,081,347	-0.5%	$834,986,406	-1.8%

Graph 7.3-4

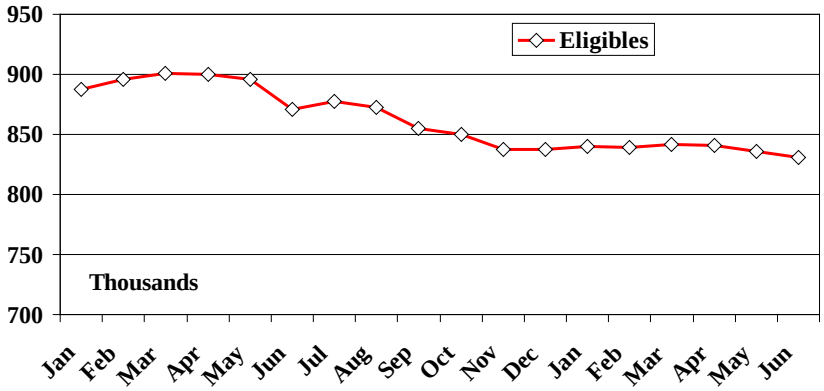


Graph 7.3-5



Graph 7.3-6

South Carolina's Medicaid Eligible Population January 2003- June 2004

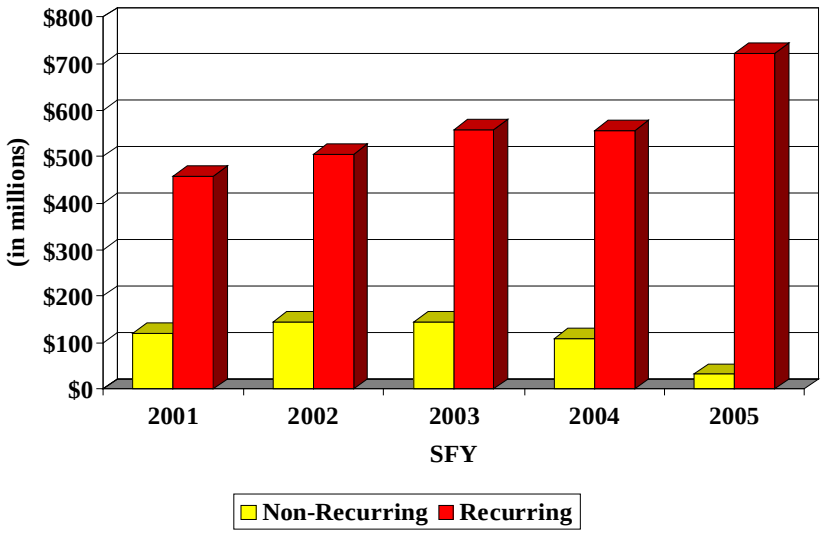


Source: RSS3850R01 August 2004

Graph 7.3-7

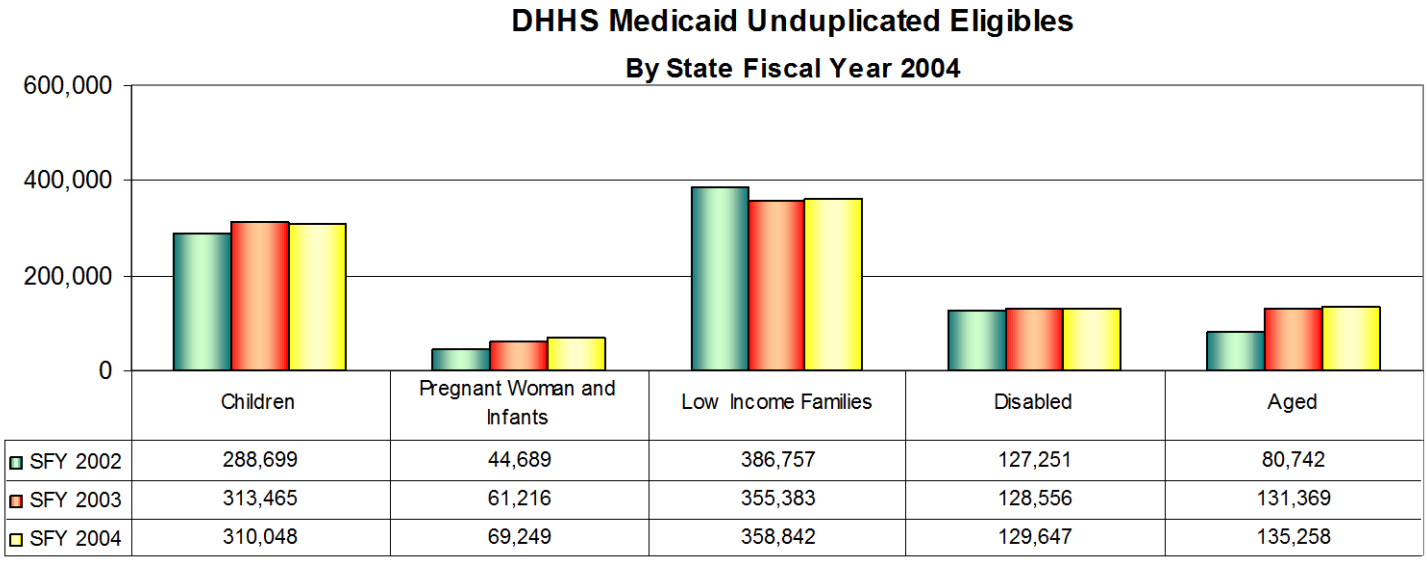
Non-Recurring vs Recurring Matching Funds

(DHHS Appropriated Funds Only)



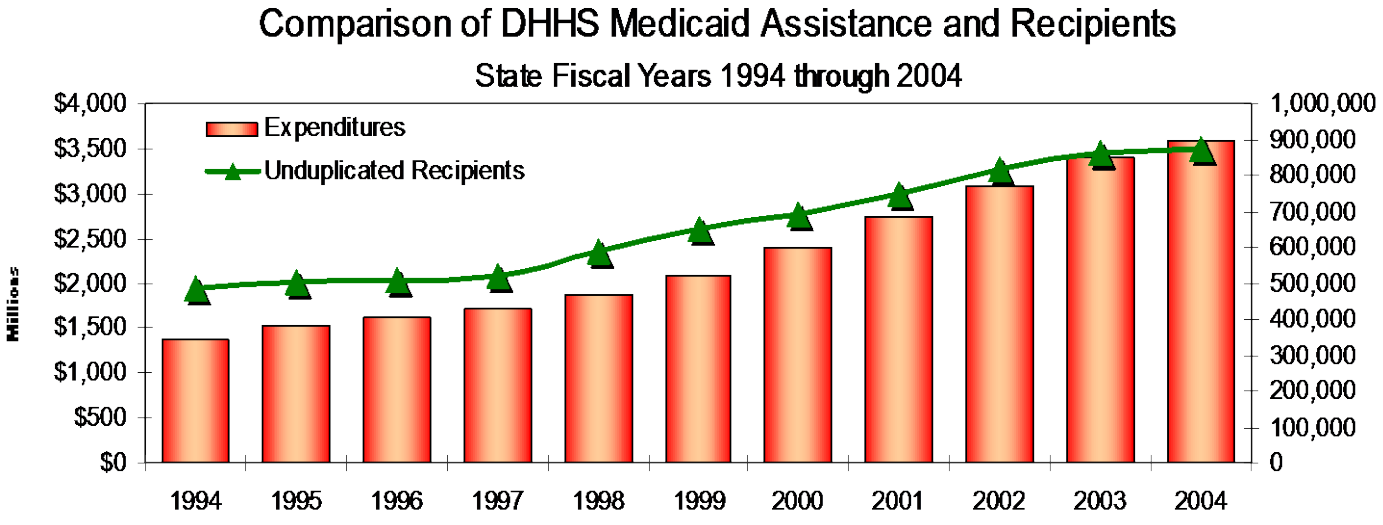
Graph 7.3-8

The following graphs measuring trends in DHHS services, costs, and eligibles/recipients reflect the agency's progress in managing the Medicaid program to provide the best healthcare value for South Carolinians:

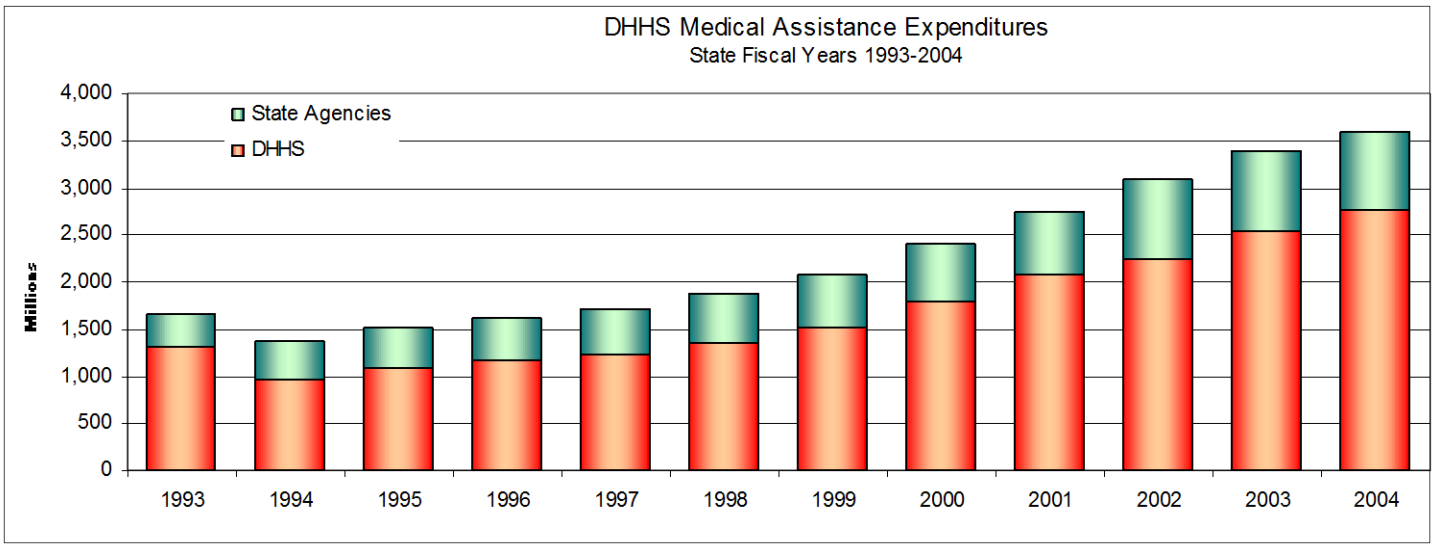


	Children	Pregnant Woman and Infants	Low Income Families	Disabled	Aged
SFY 2002	288,699	44,689	386,757	127,251	80,742
SFY 2003	313,465	61,216	355,383	128,556	131,369
SFY 2004	310,048	69,249	358,842	129,647	135,258

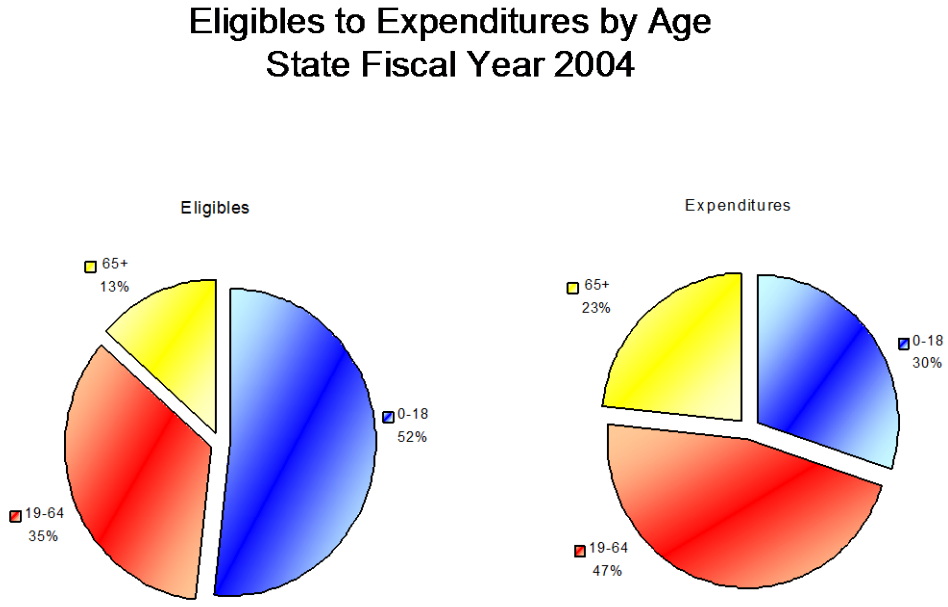
Graph 7.3-a



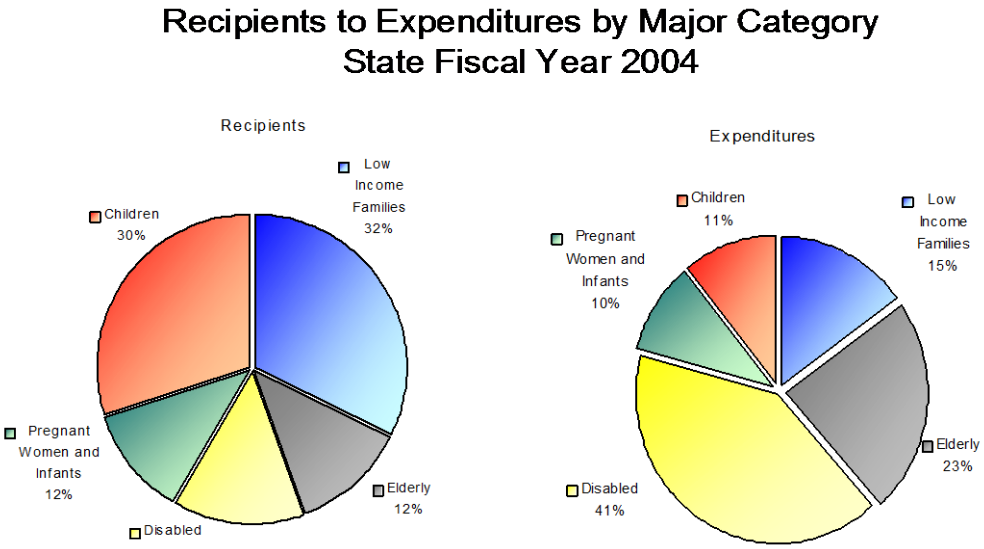
Graph 7.3-b



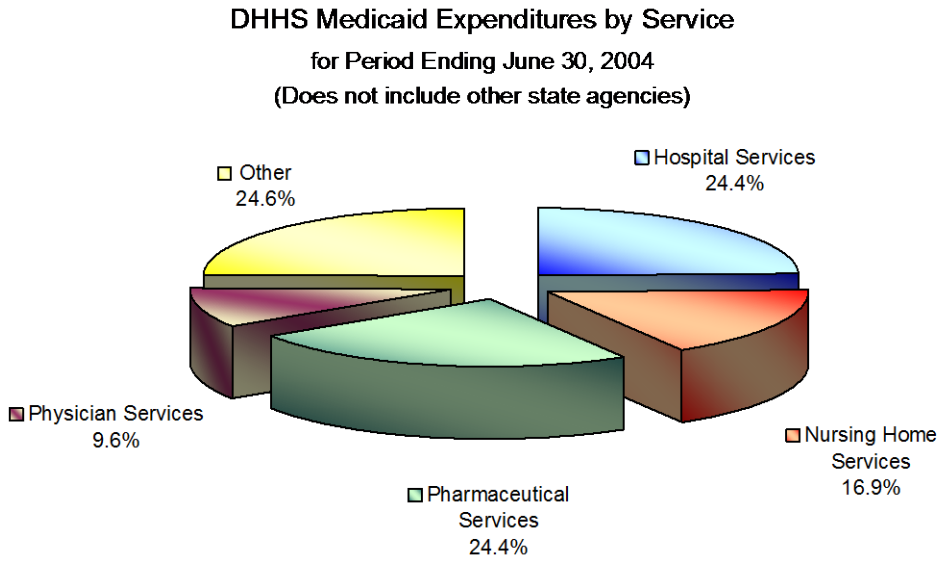
Graph 7.3-c



Graph 7.3-d



Graph 7.3-e



Graph 7.3-f

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

The following initiatives are in place to help ensure employee satisfaction is as follows:

- **Open Communication** - Open door policies of all executive level staff, human resources director, and employee relations manager; staff members are trained in mediation and conflict resolution to serve on the Statewide Mediator Pool; the agency readily refers non-grievable conflicts to the Statewide Mediator Pool;
- **Training and Development** - Personal Development of employees is promoted by offering agency wide training curriculum related to computer software, time management, customer services, and supervisory skills;
- **Flexibility** - Employees are offered quality of life personnel options such as flexible work hours, telecommuting, and business casual dress;
- **Agency Turnover Rates** - Are monitored as compared to other state agencies and statewide; members of staff also serve on special recruitment and retention teams to assess specific staffing shortages and needs;
- **Team Building** - Executive staff is piloting a team approach organizational structure to promote succession planning and cross-training in specific divisions; the team approach is also being used during the interview and selection process; and
- **Employee Evaluation and Expectations** - Employee planning stage job functions and objectives are directly linked to the agency's mission and goals and communicated at staff meetings and through the agency wide newsletter and intranet; default rates on the EPMS are monitored by executive staff to ensure employees are being evaluated.

All these efforts point to increased levels of performance measurement, employee satisfaction, well-being, learning and development, employee diversity and retention.

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

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

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

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