MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements, as they exist in current regulations, found at 42 CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: South Carolina
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

July 23, 2009

(Signature of Governor, or designee, of State/Territory, Date Signed) **Ms. Emma Forkner was designated by the Governor to review and approve all State Plans**

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: **Ms. Emma Forkner**	Position/Title: **Director, South Carolina Department of Health and Human Services (SCDHHS)**
Name:	Position/Title:
Name:	Position/Title:

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 **The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):**

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103); OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX); OR**

1.1.3. ☒ A combination of both of the above.

1.2 ☒ **Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))**

Expenditures for child health assistance will not be claimed prior to the time that South Carolina has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☒ **Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR 457.130)**

South Carolina complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

1.4 ☐ **Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65)**:

Original State Plan:
Submitted: 12/8/1997
Approved: 2/18/1998

Initially submitted to establish SCHIP coverage through an expansion of the Medicaid program to provided coverage to children who are under age 19 with family income at or below 150% of the FPL

Amendment # 1:
Submitted: June 8, 2004
Approved: August 18, 2004

Added to update the state's plan to bring it into compliance with the final SCIP regulations.

Amendment # 2
Submitted: 10/04/2007
Approved: October 1, 2007

Added to expand the states coverage to include children under age 19 with family income greater than 150% and below 200% of poverty through the addition of a separate children's health insurance component. The state desires to change its plan from a Medicaid Expansion to a Combination plan effective October 1, 2007.

Amendment # 3
Submitted: 12/18/2008
Approved: Withdrawn 02/10/09

SCHIP's Revises Child/incapacitated adult care deduction

Amendment # 4
Submitted: 07/23/2009
Approved: 09/24/09

Correctly indicates that psychiatric residential treatment and dental services for the separate children's insurance population are provided on a fee for service basis and are not included in the benefit package provided by the health plans. This is not a change in policy.

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1 Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

Children below 200% of poverty

In 1997, the estimate of South Carolina children aged 18 and younger below 200% of poverty was 507,358. Of that total, 374,639 were under 150% of poverty, 330,193 were under 133% and 243,029 were under 100%. A 2006 estimate pegs the number of children under 18 in South Carolina in households below 200% of poverty at 474,812.

In 1997, among children in families with income below 200% of poverty, those counted as non-white comprised the majority (58.63%) of children below 200 % of poverty. White children accounted for 41.37% of the total.

In 2002, the estimate of South Carolina children aged 18 and younger below 200% of poverty was 507,358. Of that total, 374,639 were under 150% of poverty, 330,193 were under 133% and 243,029 were under 100%.

The majority of children below 200% of poverty, 61.67% lived in metropolitan statistical areas (MSAs). Only 194,470 of the total 507,358 resided outside MSAs.

In 2002 the age distribution of children in families with income below 200% of poverty was concentrated somewhat more toward the older groups. Infants comprised only 4% of the total. Those ages 1 thru 5 years were 28.47%, with those 6 thru 14 accounted for 45.75% and those ages 15 thru 18 being the remaining 21.11%.

The Employee Benefit Research Institute (EBRI) November 1996 analysis of the March 1996 Current Population Survey found 16% of South Carolina's total population uninsured, with 68.5% having private coverage and 22.5% public, compared to 17.4% uninsured nationally. They estimated the percent of U.S. population having private coverage, public coverage and uninsured by age and poverty level categories. These percentages, applied to South Carolina's estimated 1997 children's population, produced the estimates below for children under 200% of poverty:

	Private Coverage	**Public Coverage**	**Uninsured**
Infants <1yr	6,362	13,891	5,178
Ages 1 – 5	50,397	79,015	27,036
Ages 6 – 14	94,669	103,972	52,546
Ages 15 – 18	43,898	42,453	28,286
Total*	195,326	239,331	113,046

*Numbers for private, public, and uninsured add to more than the total population because individuals may get coverage from more than one source.

Creditable Coverage

Little is known about children with privately provided creditable coverage. There are no public-private partnerships providing insurance for children in the state. Medicaid and SCHIP offer the only public creditable coverage in South Carolina

Uninsured Children

Analysis by different entities of the limited data available about the uninsured yield different estimates of uninsured children in South Carolina and their characteristics. The estimates above, derived from the EBRI (1996), pegged the number of uninsured children under 200% of poverty at 113,046. This was, fairly close to the three-year average, "official" number used for Title XXI allocations, which was 110,000.

A study, "The State of Kids Coverage", August 2006 using data compiled by the State Health Access Data Center reported the following for all children 0 to 17 in South Carolina at all income levels.

Year	Private HI	Public HI	Uninsured
1997 - 1998	676,725	179,281	156,601
2003 - 2004	618,382	325,683	85,688

These numbers clearly indicate that the number of uninsured children is being addressed by the availability of public health insurance.

Updating the Numbers

In August of 2002, the South Carolina Department of Insurance received a state-planning grant from the Health Resources and Services Administration (HRSA) a division of the US Department of Health and Human Services. The funding ($1.3 million) was awarded to study the medically uninsured in South Carolina. In addition, supplemental funds were awarded in September of 2003 for the purpose of communicating the results and recommendations to the general Assembly, employers and citizens of South Carolina. The project reported the following in 2004.

The Income Distribution for Households with Uninsured Children

Income range	% of All Uninsured Children
Less that $10,000	5.07%
$10,000 to 24,999	16.22%
$25,000 to $49,999	40.56%
$50,000 or more	23.65%
Unreported	13.53%

Education Distribution of Households with Uninsured Children

Education Attainment	% Of Households with Uninsured Children
Less than a high school diploma	14.86%
High School diploma/GED	44.57 %
Some College	28.11%
More than 4 years of college	10.8 %
Unreported	1.61%

Age Distribution of Uninsured Children

Age	% Of All Uninsured Children
Under 5 years of age	17.57 %
5 to 9 years old	25.34%
10 to 14 years old	35.14%
15 to 17 years old	21.96%

Racial Distribution of Uninsured Children

Race	% Of All Uninsured Children
White	69.59%
African-American	21.28%
Other	9.13%

A recent study funded by the Robert Wood Johnson Foundation concluded, "In South Carolina, out of a total population of 4,152,108 people, 16% do not have health insurance coverage. 9.3 percent of South Carolina's children are uninsured. The study estimated that about 99,442 children were uninsured.

2.2 Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42 CFR 457.80(b))

2.2.1 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

The South Carolina Medicaid program has a number of outreach initiatives that tend to focus on increasing early and continuous access to care, thereby increasing the likelihood of compliance with treatment and achieving healthy outcomes. These efforts accomplish eligibility outreach in the process as well.

DHHS has established contracted partnerships with several entities, both public and private, in an effort to educate our population on accessing and maintaining medical coverage and managing their coverage to ensure quality health care. These efforts additionally identify potential eligibles, or eligibles who have lost coverage, and assist them in obtaining medical coverage. A few of these initiatives are as follows.

- Maximus - DHHS has contracted with Maximus to serve as the state's managed care Enrollment Counselor Service. The Outreach and Education component will develop and implement an overall outreach strategy. Already established efforts to link beneficiaries with primary care providers that promote prevention and early detection, intervention and treatment are enhanced. Challenges and barriers facing the public will be identified and addressed to encourage the uninsured to apply for, obtain and maintain medical coverage. Collaborative efforts and community partnerships will provide valuable insight to reaching the uninsured and helping eligibles to maintain coverage.

  The Maximus outreach strategy is a community-based approach providing education and awareness to all uninsured potentially eligible populations in the

state including all children potentially eligible for Medicaid or SCHIP. South Carolina is in the process of redefining its agreement with Maximus to provide enrollment activities, education and public awareness activities for the new separate children's health insurance group. The current marketing plan will continue to focus on informing the uninsured of the medical coverage options. There focus will include informing the public of the separate children's health insurance program.

- Palmetto Project – This partnership connects DHHS with Palmetto Project's community and faith based health promotion activities to promote the prevention, early detection and treatment of chronic diseases and stress the importance of having and using a medical home. One of 3 goals is to increase the provision of Medicaid/SCHIP medical assistance to eligibles in the state.

- Sharedcare, Inc. – The intent of Health Care Outreach Services is to enhance health care access to medical assistance for the uninsured and under-insured through facilitation of the eligibility process for available community health care coverage. The purpose of the partnership is to ensure that the uninsured receive information about community health care programs, to include information on the Medicaid/SCHIP eligibility process.

- Commun-i-care – The intent of this partnership is to enhance the eligible population's access to medical assistance through facilitation of the eligibility process. The contractor will provide information on eligibility programs particularly about the availability of benefits for low-income children.

- Family Connections – This contractor renders outreach services to the parents of children with special needs, publicizing medical assistance eligibility programs and navigates these parents through the application and redetermination processes as necessary. This entity often agrees to serve on eligibility workgroups in streamlining efforts of eligibility processes, forms, etc. DHHS participates in their annual conference.

- DHEC – This initiative strives to maintain and enhance outreach activities to access and promote appropriate use of medical coverage by eligibles and promote linkage to a medical home. Additionally, the activities inform families who have been determined eligible, or who are potentially eligible or have lost coverage, of the concept of a medical home and medical/rehabilitative services, with a focus on children whose eligibility was discontinued due to lack of response to renewal efforts.

DHECs contacts with children for immunizations, maternal and child health issues and other children's health issues, provides them with a perfect opportunity to educate uninsured children and their families. Our relationship with them allows us to request their assistance in educating the families of uninsured children accessing their programs about the separate children's health insurance program.

- Department of Education - Partnerships with school districts to coordinate assistance with parents of low income children in obtaining medical coverage and their options for medical homes. DOE staff often confers with DHHS staff for awareness of eligibility initiatives, coordination of first-of-the-school-year activities and appropriate referrals in assisting eligibles and potential eligibles with the application and re-determination processes. Some schools work through our local eligibility contractor to contract for an eligibility/outreach worker in their school facilities. Applications and brochures are provided upon request to schools or district staff.

- There are Medicaid sponsored community based outreach efforts within the states alcohol and other drug abuse treatment programs, with an emphasis on getting high-risk and at-risk women and their families referred to appropriate treatment services and medical assistance programs if uninsured or under-insured.

- The S.C. Medicaid program utilizes out-stationed eligibility workers in hospitals and clinics, including traditional safety net providers, to enroll eligibles when they seek medical services. Currently there are 86 sites with 199 eligibility workers, plus some FQHCs utilize their own personnel to take applications.

- Information and applications continue to be provided upon request for providers, schools, health fairs, advocacy information forums, etc.

2.2.2 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership.

South Carolina currently has no public/private partnership health insurance programs that enroll children.

2.3. **Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits**

coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. ***(Previously 4.4.5)***
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42 CFR 457.80(c))

If an income eligible family with income at or below 150% of FPL has health insurance at the time the application is submitted, the children are eligible under Title XIX rather than Title XXI. Even if there is health insurance, the benefit structure is usually inferior to Medicaid in providing such things as well child care and screenings for vision, hearing, and developmental progress. South Carolina does not want to encourage families to drop existing coverage in order to be eligible for more comprehensive services and prefers to provide wrap around coverage to supplement existing benefits.

Children in households with income greater than 150% of the FPL without creditable coverage will be directed to the separate children's health insurance program. If household income is greater than 200% of the FPL or if there is creditable coverage available and the household income is greater than 150% of poverty, there is no publicly financed potential for coverage for children between 1 and 19.

The application asks for information about any health insurance coverage the family already has and verifies that information with the employers and record matches under regular Medicaid TPL procedures. The state also looks at the number of recipient children who would have been SCHIP eligible, but were enrolled under Title XIX because they had insurance coverage. Children without coverage go into SCHIP, while children with coverage are put into regular Medicaid, so that appropriate match is drawn.

Coverage under the Medicaid program, the SCHIP Medicaid expansion or the SCHIP separate children's health insurance groups will be differentiated in the system through assigned identification codes based upon income level and availability of health insurance. The system will be programmed to set the identification codes.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

____ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. **Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations.**
(Section 2102)(a)(4) (42CFR 457.490(a))

South Carolina provides SCHIP coverage through an expansion of children's Medicaid, covering children to age 19 up to 150% FPL. These children receive Medicaid State Plan services through fee for service providers and through Managed Care Organizations.

Under a separate child health program for children with income between 150% and 200% FPL, medical services, are provided through managed care organizations (MCO). Psychiatric residential treatment and dental services for the separate children's insurance population will be provided on a fee for service basis and will not be included in the benefit package provided by the MCO. South Carolina identified the State Health Plan (SHP) benefit package for state employees and their dependents as the medical benefits package for children in the separate child health program. An all-inclusive member-per-month rate (PMPM) will reimburse an insurance (MCO) plan approved to provide this benefit package, with identified additions and exceptions.

For the expansion and the separate child health insurance program, eligibility will be guaranteed for 12 months unless the child moves out of the state, becomes age 19 or dies. Eligibility for individuals in the Medicaid expansion group begins the first day of the month that an application is filed provided all financial and non-financial criteria are met. Eligibility for the separate program will be effective the month after enrollment in a plan. A child's eligibility is marked in the Medicaid Eligibility Determination System (MEDS) as eligible for regular Medicaid funding match or SCHIP funding, for the 12-month period. Any reported changes in income, third party coverage, or resources, are maintained and addressed at annual review. Beneficiaries are required only to report a change of address.

3.2. **Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan.** **(Section 2102)(a)(4) (42CFR 457.490(b))**

The SCHIP program requires that the contracting MCO shall possess the expertise and resources to ensure the delivery of quality health care services to SCHIP MCO Program members in accordance with the program standards and the prevailing medical community standards. The Contractor shall adopt practice guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- Consider the needs of the members.
- Are adopted in consultation with contracting health care professionals;
- Are reviewed and updated periodically as appropriate.

The MCO shall disseminate the guidelines to all affected providers and, upon request, to members and potential members. Decisions for utilization management, member education, coverage of services and other areas to which guidelines apply are consistent with the guidelines.

1. MCOs will have written policies and procedures in place to monitor, no less than quarterly, the under and over utilization of services by members.
    a. MCOs will submit a report to SCDHHS, at least quarterly, the utilization of the members.
    b. MCOs will evaluate the entire Utilization Management Program, at least annually, and submit to SCDHHS by December 15th, the Utilization Management Program.
2. SCDHHS will meet with the MCO, at least annually, to review the utilization monitoring and program.

Core benefits shall be available to each Medicaid MCO Program member within the Contractor's service area and the Contractor shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under the state's state employee benefit plan. The Contractor:

- Shall ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
- May not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member.
- May place appropriate limits on a service (a) on the basis of certain criteria, such as medical necessity; or (b) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

Services shall be furnished up to the limits as specified in the minimum service requirements outlined in section 6.2 of the SCHIP State plan.

An entity that agrees to provide the benefit services to a child in the separate children's health insurance group for the PMPM will be required to contract with the State. The State is responsible for monitoring a plan's performance to assure contract compliance.

- The State will monitor the operation of the plan for compliance with the provisions of the contract and applicable federal and state laws and regulations. SCDHHS does perform monthly monitoring of current plans on many different topics. Selected HEDIS measures and other state-identified performance measures are monitored on a monthly or quarterly basis. DHHS also performs an extensive evaluation/review of each managed care entity related to consumer satisfaction, provider satisfaction, and cost comparison as well as having an external quality review done by the Carolina Centers for Medical Excellence.
- The Contractor is required to conduct quality of care outcome studies, which include

quality measures for HEDIS, childhood immunizations, asthma, ER utilization and EPSDT/Well Care services. The SCHIP Policy and Procedures Guide, Quality Measures lists the SCDHHS quality measures. SCDHHS may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

- The contractor is required to conduct quality of care studies, reporting quarterly.
- The State will perform annual medical audits through contractual arrangements with an External Quality Review Organization (EQRO), to ensure quality and accessible health care is provided. The Contractor will be required to submit a plan of corrective action. SCDHHS will mandate the timeline for completion of a corrective action.The State will monitor the contractor's quality assurance activities and corrective actions. MCNs generally have 30 calendar days to submit any required plan of corrective action. DHHS and the MCN will negotiate the timeline for completion of a corrective action. The State will monitor enrollment and termination practices and ensure proper implementation of grievance procedures.
- The State will have access to all information related to complaints and grievances filed by members and will make provisions for prompt response to any detected deficiencies or contract violation and for the development of corrective action. The Contractor will report all complaints to SCDHHS monthly. A written report of complaints and grievances will be provided monthly. The report will include the member's name and identification number; summary of grievances and appeals; date of filing; current status; date of resolutions and resulting corrective actions.

If performance is not acceptable based on contractual requirements, the State may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

Section 4. Eligibility Standards and Methodology (Section 2102(b))

_____ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☒ **Geographic area served by the Plan:** Entire State
4.1.2. ☒ **Age:** Depending on income, newborn to age 19
4.1.3. ☒ **Income:** Medicaid Expansion covers children in households with

countable income at or below 150% of FPL. Separate Child Health Group includes children in households with income above 150% through 200 % of the FPL. Title XIX income exclusions and disregards will be applied to both the Medicaid expansion and the separate child health insurance groups to arrive at countable income. The disregards are limited to:

- For each employed budget group member, disregard $100.00 of gross monthly-earned income.
- Allow a deduction of child/incapacitated adult care expense pr month per child/adult less the amount paid by the ABC voucher program for each child receiving child care. The monthly deduction is not to exceed:
  - $200 pr child under age 2
  - $175 perchild age 2 and up to age 12
  - $175 per incapacitated adult
- Disregard $50.00 per month of child support received for children in the Budget Group. The $50.00 is given once for all child support received in the home.

4.1.4. ☒ **Resources (including any standards relating to spend downs and disposition of resources):** Title XIX AFDC related resource rules are used for both groups. Value of countable resources must be less than $30,000. Examples of excluded resources include the home, household items and personal effects and up to $20,000 in equity for one vehicle per licensed driver in the household, cash value of life insurance (Face value must be < $10,000, certain bona fide burial arrangements and qualified retirement plans.

4.1.5. ☒ **Residency (so long as residency requirement is not based on length of time in state):** Covered child must reside in the state of SC with the intent to remain indefinitely.

4.1.6. ☐ **Disability Status (so long as any standard relating to disability status does not restrict eligibility):**

4.1.7. ☒ **Access to or coverage under other health coverage:** The child must not have other creditable coverage or cannot be the dependent of an employee of the state of SC. Comprehensive health coverage is defined as coverage with at minimum, hospitalization, doctor visits, x ray and lab coverage. The parent or guardian must not have voluntarily dropped creditable coverage within the three-month period prior to filing an application for SCHIP.

4.1.8. ☒ **Duration of eligibility:** Continuous coverage for up to 1 year. Coverage can be terminated if the child moves out of state, reaches age 19 or dies. Continuous coverage for individuals in the separate child health insurance program begins the month following the month it is determined that the individual meets all financial and non-financial eligibility criteria and has been enrolled into a managed care plan. The 12-month coverage period ends the last day of the 12th month of coverage.

Continuous coverage for individuals in the Medicaid expansion group begins the first day of the month that an application is filed provided all financial and non-financial criteria are met. The continuous period for individuals in the expansion ends the last day of the 12th month following the month of application.

Example: An application for services is received in February 2008. All categorical and financial requirements are met and a decision is rendered in February 2008. If enrollment occurs prior to the February 2008 cutoff, coverage for children in the separate children's health insurance program would be available for the period beginning March 1, 2008 through the last day of February 2009. Coverage for children in the expansion would be available as early as the month of application and would be available through the last day of the 12th month. For example, application is filed in February and it is determined eligible in February, health coverage will be continuously available beginning the first day of February 2008 through the last day of January 2009.

4.1.9. ☒ **Other standards (identify and describe):**

- Ineligible for the separate children's health program if an inmate of or in the custody of a public institution or public agency (including children who are receiving psychiatric residential treatment at the time of initial application or redetermination).
- Each applicant is required to provide a social security number or must provide proof of application for a social security number prior to establishment of eligibility.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

The programs covering children under age 19 in South Carolina include coverage under

mandatory and optional Title XIX groups, and coverage under the state's Title XXI Medicaid expansion as well as the separate children's health insurance group, called Healthy Connections Kids..

All administrative procedures for SCHIP and Medicaid for infants and children are designed to be seamless. There is one application form and one renewal form for households (infants and children) applying for services under either the Title XIX or the Title XXI program. Individual circumstances dictate the assigned coverage.

The SC Department of Health and Human Services administers both programs and all staff performing the eligibility and renewal functions are employed by the SC Department of Health and Human Services.

Children eligible for coverage under the state's Title XIX state plan are not eligible for coverage under the SCHIP plan. Screening to determine whether coverage under Title XIX or SCHIP is appropriate is embedded within the determination or renewal process and is based on the household's available income, whether other health insurance is carried or is available and whether the age of the child falls within the established limits for either of the Title XXI coverage groups (the Medicaid expansion or the separate child health insurance coverage group) or for coverage under Title XIX. Applications can be completed at any of the state's local eligibility offices or can be mailed in. No face-to-face interview is required.

Individuals determined eligible for services under Title XIX or under the SCHIP Medicaid expansion (income at or below 150% of the FPL) will be offered the option of services through managed care options, or on a fee for service basis and access to services may be available as early as the first day of the month the application was filed. Retroactive coverage is also available.

Individuals qualifying under the separate child health insurance group will be limited to coverage provided by a separate contracted carrier serving the county in which the child resides. Access to services will begin no earlier than the month following the month in which the child is determined eligible and enrolled in an available plan. Retroactive coverage is not available to children in the separate children's health insurance program.

Coverage for all children, once established will continue for one year unless the child moves out of state, reaches age 19 or dies. The state will limit change reporting to address changes only. No other change reporting during the coverage year will be required or requested. SC through its TPL processes will continue to locate and where appropriate pursue third party reimbursement for individuals eligible through the Medicaid program. However, creditable coverage established and identified for SCHIP beneficiaries during the coverage year will not affect SCHIP eligibility. Third party information identified during the eligibility period will be provided to eligibility staff for use in the renewal process.

Eligibility is redetermined prior to the end of each twelve-month period. Written notice is

provided to each household prior to the end of the period. The household is directed to complete and return the renewal form either in person or through the mail. The renewal form will undergo the same screening process required of a new application.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☐ **Check here if this section does not apply to your state.**

South Carolina will establish an enrollment cap for the separate children's health insurance group only. No cap will be applicable to children in households with income at or below 150 % of the FPL or for infants (under age 1) in households with income at or below 185% of the FPL. The state will create a reporting mechanism to monitor ongoing expenditures. Program expenditures will be reviewed on a monthly basis and projected to year's end. If the projection indicates the possibility of a deficit or a need to initiate the cap, notice will be provided to CMS and to the general public that enrollment is to be curtailed. The determination will be based on anticipated Title XXI expenditures for both Medicaid Expansion and separate child health insurance program enrollees.

No additional children will be enrolled in the separate health insurance group at the point that it appears that funding will not support added enrollees or continued program growth. Applications will continue to be available and local offices will continue to accept applications and determine potential eligibility. Eligibility will continue to be established, but enrollment into a health plan will be suspended pending the release of the cap.

Families determined to be ineligible for coverage because they do not meet one or more eligibility criteria will be notified immediately. Appeal options will be provided. Families determined to meet program requirements will be placed on the waiting list in the order that their applications were filed. Applicants are notified in writing if their children are eligible and placed on the waiting list. Spaces become available at the end of each month when enrollment ends for currently enrolled children who:

- Turned 19 years of age;
- Became eligible for Medicaid or the SCHIP expansion;
- Obtained creditable coverage;
- Moved out of state; or
- Failed to reapply; or
- Reapplied but were determined ineligible.

When space becomes available, children are removed from the waiting list and enrolled in SCHIP until all spaces are filled. Children on the waiting list are notified in writing that space is available, and will be provided information regarding enrollment with a SCHIP plan. Families so notified will be given thirty days to enroll in a participating plan. If a family's application has been on file for

more than 90 days the family will also be required to update the original application before being allowed to enroll in a plan. Families with more than one child on the waiting list will have all children enrolled at the same time and have the same enrollment date for all children in the household.

The cap will not limit families who timely file renewal applications. Siblings or children born to a currently eligible child entering a currently covered household will not be subject to the waiting list restrictions. The newly eligible child is enrolled the first of the month after the eligibility is established. The renewal date for the newly eligible child will be the same as for the currently enrolled sibling or minor parent.

If an enrollment cap is needed or if the state begins using a waiting list, the state will make available to potential applicants and provide applicants and enrollees in a timely manner a description of the procedures relating to the cap including the process for deciding which children will be given priority for enrollment, how children will be informed of their status on the waiting list and the circumstances under which enrollment will reopen. We will provide radio notice, include the information on the agency's website and post written notices in all locations where a Medicaid or SCHIP application can be initiated. We will also provide individual notices to all families applying for the program or inquiring about the potential for coverage.

The state will formally notify CMS of any intention to implement a cap at least 30 days prior to implementation of the enrollment cap. Letter from the state's Title XXI agency Director will provide formal notice. If the state anticipates that the need for the cap will exceed 60 days, a state plan amendment will be submitted to CMS before the end of the 60 day period.

4.4 Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3)).**

As noted in section 4.3, the eligibility process is designed to be seamless and consider the availability of health insurance to any child applying for coverage. Applicants are asked to provide current health insurance information as part of the eligibility process and will be asked to provide indication of any potential for coverage under any public group plan.

Prior to implementation of the separate children's health insurance group, the

application and the renewal form will be revised to add questions that identify prior coverage as well as state government employment and probe further into the availability of creditable coverage for individual children residing in the household. The questions will change the focus from the availability and/or potential for coverage at the household level to the availability or potential for coverage at the individual level.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

Children applying for services will be first evaluated and directed to the Medicaid program prior to being considered for enrollment in the SCHIP program. All children between 1 and 19 will be identified in the eligibility system under a single coverage identifier. Coverage under the Medicaid program, the SCHIP Medicaid expansion or the SCHIP separate children's health insurance groups will be differentiated in the system through assigned identification codes based upon income level and availability of health insurance. The system will be programmed to set the identification codes.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

See section 4.3. All children will simultaneously undergo evaluation for Medicaid and SCHIP eligibility.

4.4.4 **The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

A child will be ineligible for SCHIP if he or she has creditable coverage under an individual or group health plan or had creditable coverage in the three month period prior to application.

The application form and the renewal form will explore the existence of current or recent health insurance coverage. The application form requires that the applicant family state whether or not current health insurance coverage exists and whether health insurance coverage existed within the

past 3 months. Children with currently existing coverage will be denied SCHIP coverage. Children whose insurance was voluntarily dropped during the 3-month period prior to application are not eligible for coverage until the 3-month waiting period expires.

Eligibility staff through the state's automated system has access to the applicant's employment data as part of the application process in MEDS (Medicaid Eligibility Determination System). This data will be used as lead information when exploring the possibility of continuing and recent health insurance coverage. Eligibility staff will verify with current and past employers whether coverage currently exists or whether there was coverage during the three-month period prior to application if there is reason to question the applicant's statement

Children of employees of the state of South Carolina with access to health insurance are not eligible for coverage through the SCHIP program. Eligibility staff will confirm that all alleged state employees actually have access to coverage before making a decision to deny or discontinue services. Exceptions: If a parent who was providing the coverage is laid off, fired, can no longer work because of disability, has a lapse in insurance coverage because he or she obtains new employment, the employer no longer offers coverage or no longer offers dependent coverage, or the parent dies, the three month waiting period will not apply.

4.4.4.2. ☐ **Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.**

4.4.4.3. ☐ **Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.**

4.4.4.4. ☐ **If the state provides coverage under a premium assistance program, describe:**

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

☒ 4.4.5 **Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Child Health insurance coverage is available to any targeted low-income children in the state who are American Indian or are Alaskan natives**.**

The Catawba Indians are the only federally recognized Indian tribe in South Carolina. Health Services for the tribe are coordinated through the Catawba Service Unit. The Catawba Service Unit is a unit of the Indian Health Service Agency. (IHS). The unit is responsible for providing federal health services to American Indians and Alaska natives.

The unit has agreed to work with the State Department of Health and Human Services to provide information and referral services about Medicaid and SCHIP availability to tribal members. They have also agreed to assist in providing outreach services. The unit has agreed to meet with state agency staff at least quarterly to address tribal eligibility and utilization issues. We will provide the tribal health center staff and the unit's Medicaid coordinator with an ongoing supply of applications and Healthy Connection's Kids' brochures. The brochures address both Medicaid and SCHIP criteria.

The Catawba Service Unit publishes a periodic newsletter and allows SCDHHS to provide articles and general information about Medicaid and SCHIP eligibility, Medicaid and SCHIP service offerings. We will also ask that the Service unit continuously publish the toll free number of the agency's Resource Center. The Resource Center is designed to provide information to any SC resident seeking information about programs offered by the Department of Health and Human Services.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42 CFR 457.90)

Outreach

The Outreach and Education component of the Maximus contract (see 2.2.1) will develop and implement an overall outreach strategy, particularly with regard to education and enrollment by using community partnerships to connect current and potential members throughout the state with medical coverage and quality health care. Efforts will target specific, hard to reach consumer groups that may not have access to traditional means of obtaining information (e.g. television, radio, Internet, phone). The primary focus of this relationship is to conduct educational activities, events and workshops throughout the state

that promote awareness as well as to assist members with enrolling into the SC Healthy Connections Choices program.

The current relationship with a private marketing firm will provide direction for an outreach campaign focusing on informing the uninsured and under-insured of the separate children's health program.

The entire application process has been revamped to make it more accessible, easier to understand, and less stigmatizing. If applicants need help with the application or beneficiaries need help with an annual review form, there is a toll free number to call.

The eligibility worker screens an application for medical assistance for Medicaid and SCHIP. This is transparent to the applicant. The applicant is notified of the eligibility determination and which benefit package their eligibility provides.

The agency continues coordinating with representatives of the Catawba Indian Nation to identify potentially eligible Catawba children.

The agency continues to respond to requests for applications or brochures. Individuals can call the toll free number to make a request.

Outreach Refocused

In late 2001, the outreach focus shifted from outreaching eligibles to connecting current eligible children with a medical home. However, while many initiatives tend to focus on access to care, eligibility outreach is accomplished in the process. Newly directed outreach activities educate current Medicaid and SCHIP beneficiaries regarding how to access and appropriately use medically necessary services. Outreach shall also be directed toward linking current Medicaid beneficiaries to primary care providers that promote prevention, and early detection, intervention and treatment. Upon implementation, children qualifying for the separate program will be linked with a medical home with the same objectives. These efforts identify potential eligibles or eligibles who have lost coverage, and assist them in obtaining medical coverage.

Coordination

A primary mechanism for coordination in South Carolina is the Governor's Cabinet. It meets regularly, with participation by directors of state agencies having responsibility for programs related to Medicaid, as well as the separate children's program, to discuss issues that cut across agencies.

The Maternal, Infant and Children's Health (MICH) Council provides a formal mechanism for coordination among public agencies and private providers for programs serving children. This council is staffed by the Governor's Office of Executive Policy and Programs, Division of Health and Human Services, but agency staff traditionally has played a major role supporting and serving on the council and its committees. The membership includes state agencies administering programs serving mothers and children as well as

private providers. The Council coordinates policies and plans for programs such as Family Planning, WIC, Maternal and Child Health, Medicaid/SCHIP, Special Education, Disabilities and Special Needs, Alcohol and Drug Abuse, and Mental Health with private providers of services to expectant mothers, infants, and children. Currently, two of their areas of emphasis include fostering public/private partnerships as a basis for our new emphasis on medical homes for its children and on regionalization of risk appropriate care for pregnant women and infants. The Council uses an active committee structure to accomplish its work and DHHS staff serves on many of those committees.

In addition to coordination through the MICH Council, the state coordinates services through the Title V agency and will continue to do so. That agency is the Department of Health and Environmental Control and their programs provide preventive and rehabilitative services for primary care enhancement. These services include assessments of health status, needs and knowledge; identification of relevant risk factors which justify medical necessity; development of a goal-oriented plan of care; counseling; and monitoring. These services are provided in support of the primary care physician's efforts to provide a medical home to families with an identified risk or medical problem. This involves extensive coordination with other public and private agencies, as well as interagency staffings around individual client and family problem resolution. DHHS staff actively serves on the OB and Pediatric task force committees chaired by DHEC.

Our Targeted Case Management services assure coordination with and appropriate referrals among related programs like children's rehabilitative services, WIC, Babynet, mental health, alcohol and drug abuse treatment and special needs. In order to be reimbursed for targeted case management services, the providers workers must have completed training in the Case Management Institute operated by the University of South Carolina, which teaches case management concepts and procedures in a multi-agency collaborative environment, encouraging staff from related agencies in the same geographic area to become familiar with each other and with the other agencies' programs.

The Medical Care Advisory Committee (MCAC) of the South Carolina Department of Health and Human Services advises the Department of Health and Human Services about health and medical care services and provides consultation to the agency regarding marketing policies required of Medicaid Managed Care Organizations and SCHIP Providers.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☒ Coverage the same as Medicaid State plan

For SCHIP children covered under the state's Medicaid expansion, the state will provide coverage that is the same as that approved and provided under the state's Medicaid plan.

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☒ Coverage that includes benchmark coverage plus additional coverage

South Carolina provides SCHIP coverage for the separate children's health program, covering uninsured children with income above 150% through 200% FPL, and identified

the State Health Plan (SHP) benefit package for state employees and their dependents as the benefit package for these eligible children. The benefit plan description is as follows:

- Physician
- Well child visits and immunizations
- Inpatient and outpatient hospital
- Prescription drugs
- Blood transfusions
- Home nursing care charges
- Durable Medical Equipment
- Medical supplies
- Ambulance
- Dental services
- Vision services
- Occupational, speech and physical therapy
- Treatment of behavioral health disorders
- Major organ transplants
- Diagnostic X-Ray, Lab and Pathology
- Limited care in a Skilled Nursing Facility
- Home Health Care
- Hospice care
- Rehabilitation care

The following exceptions apply. SCHIP coverage will:

- Add pre-natal care
- Apply no waiting periods
- Apply no co-pay, coinsurance or deductible,
- Apply no pre-existing condition limitation,
- Ensure minimal dental and visual benefits are provided, to include:
    - Annual eye exam and one pair of glasses.
    - Preventative, restorative and surgical dental services.

The Medicaid service package and service options will be available to any child qualifying under the previously existing SCHIP expansion (see section 6.1.4).

6.1.4.5. ☐ **Coverage that is the same as defined by existing comprehensive state-based coverage**

6.1.4.6. ☐ **Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit-by-benefit comparison (Please provide a sample of how the comparison will be done)**

6.1.4.7. ☐ **Other (Describe)**

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

Separate Child Health Program Covered Services

6.2.1. ☒ **Inpatient services (Section 2110(a)(1))** Inpatient hospital services are those items and services, provided under the direction of a physician, furnished to a patient who is admitted to a general acute care medical facility for facility and professional services on a continuous basis that is expected to last for a period greater than 24 hours. Inpatient hospital services encompass a full range of necessary diagnostic, therapeutic care including surgical, medical, general, nursing, radiological and rehabilitative services in emergency or non-emergency conditions. Inpatient hospital services would include room and board, miscellaneous hospital services, medical supplies, and equipment.

6.2.2. ☒ **Outpatient services (Section 2110(a)(2))** Out patient services are defined as those preventive, diagnostic, therapeutic, rehabilitative, surgical, and emergency services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding 24 hours. Outpatient/ambulatory care facilities include Hospital Outpatient Departments, Diagnostic/Treatment Centers, Ambulatory Surgical centers, Emergency Rooms, End Stage Renal Disease Clinics (ESRD) and Outpatient Pediatric AIDS Clinic (OPAC). Included in these services are assessments for mental health and substance abuse and treatment of renal disease. Outpatient services would include emergency services for treatment of a medical emergency or accidental injury. Comprehensive neurodevelopmental and/or psychological developmental assessment and testing services shall be provided to eligible children under the age of 21 who have, or are suspected to have, a developmental disability, significant developmental delay, behavioral or learning disorder or other disabling condition. Such medically necessary diagnostic services, treatment and other measures, are for the purpose of correcting or ameliorating physical and/or mental illnesses and conditions which left untreated, world negatively impact the health and quality of life of the child. Therapeutic and rehabilitative services include, but are not limited to, physical therapy, occupational therapy, and speech therapy rendered in an outpatient hospital setting. Services performed in an outpatient hospital setting are considered to be Family Planning services when the primary diagnosis is "Family Planning" and are not payable.

6.2.3. ☒ **Physician services (Section 2110(a)(3))** Physician services include the full range of preventive care services, primary care medical services and physician specialty services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care and treatment of the specific condition. Physician services are performed at physician's offices, patients' homes, clinics, skilled nursing facilities. Technical services performed in a physician's office are considered part of the professional services delivered in a n ambulatory setting unless designated as separate service.

The benefits for services rendered by a chiropractor are for the detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body, for the removal of nerve interference where such interference is the result of, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition. Spinal axis aches, sprains, nerve pains, and functional disabilities of the spine are considered to provide therapeutic grounds for chiropractic treatment. Most other non-spinal diseases and pathological disorders do not provide therapeutic grounds for chiropractic treatment. Examples of these types of diseases and disorders are rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia, and emphysema.

The benefits for services of a podiatrist, acting within the scope of his license, are payable only to the extent that benefits under this plan will not exceed benefits that would have been paid to an M.D. or D.O. for treatment of the given condition, except that no payment is provided when the services consist of, either in whole or in part, the removal of corns, callosities, hypertrophy or hyperplasia of the skin or any subcutaneous tissues; or the cutting, trimming, or other partial removal of toenails;

6.2.4. ☒ **Surgical services (Section 2110(a)(4))** See inpatient and out patient services. Surgical benefits include coverage of certain organ transplants to include liver, heart, lung, heart and lung, pancreas and bone marrow. Prior approval must be secured from the agency for all transplant procedures. Experimental or investigational surgery is not covered under the plan.

6.2.5. ☒ **Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))** See Physician's Services and outpatient services.

6.2.6. ☒ **Prescription drugs (Section 2110(a)(6))** Drugs and medicines are payable when required to bear the legend "Caution: Federal law prohibits dispensing without prescription," insulin, or drugs and medicines licensed or accepted for a specific diagnosis covered prescription drug expenses. Up to a 90 day supply is allowed. The basic objective 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.

Pharmacy services include the dispensing of most generic legend (i.e., products that require a prescription in order to be dispensed) and most generic non-legend pharmaceuticals to eligible children. For each pharmaceutical dispensed, a valid prescription authorized by a licensed practitioner (physician, dentist, optometrist, podiatrist, or other health care provider authorized by law to diagnose and prescribe drugs and devices) must be on file.

6.2.7 ☐ **Over-the-counter medications (Section 2110(a)(7))**

6.2.8. ☒ **Laboratory and radiological services (Section 2110(a)(8))** The plan will pay for outpatient diagnostic services when such service is performed or ordered by a Physician. This includes diagnostic X-ray, laboratory and pathological services for the diagnosis of an illness or injury and clinical laboratory and tissue diagnostic examinations and medical diagnostic procedures for the diagnosis of an illness or injury, provided, however, that the physician charges for any machine generated tests are not a covered medical expense.

6.2.9. ☒ **Pre-natal care and pre-pregnancy family services and supplies (Section 2110(a)(9)) Pre-natal services are available.** All medically necessary services as determined by the treating physician are covered. Family planning services are not covered.

6.2.10. ☒ **Inpatient mental health services, other than services described in 6.2.18. but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))** Covered to the same extent as

inpatient hospital services as long as services are provided by a licensed psychiatrist, psychologist, or other professional working within the scope of his or her professional license.

6.2.11. ☒ **Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)** Covered to the same extent as outpatient hospital services as long as provided by a licensed psychiatrist or psychologist or other professional practicing within the scope of his/her license. Psychological testing to determine job, occupational, or school placement or for educational purposes, milieu therapy or to determine learning disability is not covered.

6.2.12. ☒ **Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (**Section 2110(a)(12)) Durable Medical Equipment are payable when required for therapeutic use for a specific condition when such equipment is used under the direction of a physician. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved. Equipment, including Durable Medical Equipment, which has a non-therapeutic use, purchased or requested with or without a prescription including but not limited to home and vehicle modifications, an air conditioner, air filter or air filtration system, wigs, hairpiece, or any other artificial device or procedure to replace scalp hair, dehumidifier, home whirlpool, exercise equipment, ace bandages, tennis shoe supports, knee braces, bandages and gauze and similar equipment, are not covered.

Medical supplies are limited to the syringes, and related supplies for conditions such as diabetes, dressings, for conditions such as cancer or burns, catheters, colostomy bags and related supplies, test tape, necessary supplies for renal dialysis equipment or machines, and surgical trays.

Prosthetic Appliances are payable when necessary for the correction of conditions caused by trauma or disease and that restore a function to the body. The plan will benefits provide for the replacement of those prosthetic appliances that assist the body to function when the replacement is medically necessary and required by wear to the appliance, or growth of the covered person.

Also covered is oxygen and rental of equipment for its administration outside a hospital, with rental payments not to exceed the equipment's purchase price, orthopedic braces, crutches, lifts attached to braces, and orthopedic shoes (limited to one pair per six month period) which are medically necessary and required by a specific diagnosis. Charges for supplies or shoes that have non-therapeutic uses are not a covered medical expense.

6.2.13. ☐ **Disposable medical supplies (Section 2110(a)(13))**

6.2.14. ☒ **Home and community-based health care services (See instructions) (Section 2110(a)(14))** The plan will provide benefits for the following medically necessary services and supplies provided a child at home:

A. Covered Medical Expenses for purposes of this section shall be limited to:

1. Part-time or intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis, not to exceed eight hours per day, for temporary and definitely fixed periods of time of up to 21 days, with allowances for extensions and exceptional circumstances where the need for care in excess of 21 days is finite and

predictable) nursing care by a registered nurse (R.N.), or by a licensed practical nurse (L.P.N.) where appropriate;

2. Part-time or intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis, not to exceed eight hours per day, for temporary and definitely fixed periods of time of up to 21 days, with allowances for extensions and exceptional circumstances where the need for care in excess of 21 days is finite and predictable) home health aide services which consist primarily of caring for the individual; and

3. Physical, occupational or speech therapy provided by the home health care agency;

4. Medical drugs, supplies and medicines prescribed by a physician and required for the care rendered by the nurse or physical, occupational or speech therapist, but only to the extent that the medical drugs, supplies, durable medical equipment and medicines are otherwise covered.

B. The payment of benefits for Home Health Care is subject to the following additional requirements:

1. That the Home Health Care benefits, if provided, would permit the child to remain in a less intensive care facility, or at home, than would otherwise be required without these benefits;

2. The annual maximum benefit for professional services only is 100 visits. A visit shall consist of up to four hours, whether consecutive or non-consecutive, within any 24-hour period, incurred by a registered nurse or a licensed practical nurse to provide nursing care, by a therapist to provide physical, occupational or speech therapy, or by a home health care aide to provide services within the scope of the license; and

3. Covered Medical Expenses under this section shall not include:

- Any service or supply rendered by a person who ordinarily resides in the home of the covered person or is a member of the family, or
- any transportation service.

4. The Plan will provide benefits for Medical Social Worker Services.

6.2.15. ☒ **Nursing care services (See instructions)** (**Section 2110(a)(15))** Nursing care charges are payable for services provided in the home by a licensed registered nurse (R.N.) if medically necessary, or by licensed practical nurses, if appropriate, provided in the home by a home health agency certified by the State of South Carolina.

6.2.16. ☒ **Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)** Abortions only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

6.2.17. ☒ **Dental services (Section 2110(a)(17)) Provides dental screenings every six months beginning at age 3. Includes medically necessary preventive, restorative and surgical dental services.** Routine dental services include any diagnostic, rehabilitative, or corrective procedure, supplies and preventive care furnished or administered under the supervision of a dentist.

Emergency dental services are available. When necessary to repair traumatic injury, to relieve

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

6.2.18. ☒ **Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18)) Only covered for services meeting criteria for medical necessity, rendered by a mental health professional and by a participating provider.** Covers behavioral health disorders treated inpatient for alcoholism and drug abuse at those facilities designated by the South Carolina Commission on Alcohol and Drug Abuse are payable.

6.2.19. ☒ **Outpatient substance abuse treatment services (Section 2110(a)(19)) Only covered for services meeting criteria for medical necessity, rendered by a mental health professional and by a participating provider.** Behavioral health disorders treated in the outpatient department of a Hospital or outside of a Hospital, and outpatient treatment for alcoholism and drug abuse at those facilities designated by the South Carolina Commission on Alcohol and Drug Abuse are payable.

6.2.20. ☐ **Case management services (Section 2110(a)(20))**

6.2.21. ☒ **Care coordination services (Section 2110(a)(21))** As defined as a part of the MCO or MCN contracts between the MCO (or MCN) and the State Department of Health and Human Services with that allowed under section 2110 (a)(21). Care coordination is the manner or practice of planning directing and coordinating health care needs and services of SCHIP MCO plan members. Care coordination is covered for all MCO members.

6.2.22. ☒ **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))** Services are payable when provided by a therapist licensed in the appropriate professional discipline.

6.2.23. ☒ **Hospice care (Section 2110(a)(23))** Hospice expenses are covered for persons who are diagnosed as having a terminal illness with a life expectancy of six months or less. Covered services must be provided by a Hospice care agency or by others who are not its employees but who are supervised or coordinated by the Hospice care agency and provided pursuant to a written treatment plan approved by a physician and reviewed by the physician at least once a month. Services include part-time or intermittent nursing or home health care and medical social serviced provided under the direction of a physician.

Hospice benefits are not payable for Assessment of the covered person's home and family situation and that person's social, emotional and medical needs, identification of community resources available to the covered person, assisting the covered person to obtain community resources to meet the covered person's needs, psychological and dietary counseling, consultation and case management services by a physician, Physical or occupational therapy or Medical supplies, drugs, medicines prescribed by a physician.

6.2.24. ☒ **Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24)):** . One comprehensive eye examination every 365 days is payable. Eye glasses are limited to one pair per year. Replacements due to breakage or loss of eyewear are not authorized. However, if the prescription changes at least one half diopter during a 12 month

period, the lenses can be changed to the original frame. If the patient has lost or broken the frame, the patient is financially responsible for the frame; the plan will supply the lenses.

6.2.25. ☐ **Premiums for private health care insurance coverage (Section 2110(a)(25))**

6.2.26. ☒ **Medical transportation (Section 2110(a)(26):** Ambulance and emergency transportation only. Emergency transportation is payable when defined as transportation related to an emergency or acute care situation where normal transportation would potentially endanger the life of the patient. Medical necessity for ambulance transportation is established when the recipient's condition warrants the use of ambulance transportation and the use of any other method is not appropriate. Types of services include ambulance, non-emergency medical vehicles, and air ambulances. The plan will consider a transfer for social reasons (e.g., so patient can be closer to family support system, etc.) provided the medical records justify the need for the transfer and the patient still requires acute hospital care.

6.2.27. ☐ **Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))**

6.2.28. ☒ **Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))** Well Child Care: The plan will provide the following benefits for routine well care visits. For children under age 1 – five annual visits. For children between 1 and 2 years of age – 3 annual visits. Children two through 18 will be entitled to an annual visit for well child care.

Immunizations – The plan will pay for routine immunizations based upon an age appropriate schedule. If the child has delayed or missed receiving immunizations at recommended times, the plan will pay for catch up immunizations through age 18. Covered immunizations include Hepatitis B, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus, Pneumococcal Conjugate, Measles, Mumps, Rubella, Chickenpox, Influenza, Meningococcal.

Rehabilitation Care - The plan will provide benefits for physical rehabilitation designed to restore bodily function that has been lost because of trauma or disease process. The rehabilitation care may consist of physical therapy, speech therapy, occupational therapy, and therapy to teach ambulation, transfer technique, bed mobility, dressing, feeding technique, bowel and bladder training and other activities of daily living. For the purposes of this provision the following terms are defined as follows:

Acute Rehabilitation Phase shall refer to therapy beginning soon after the onset of illness or injury. In many cases, acute phase rehabilitation is appropriately done in an outpatient setting. In complex cases, the appropriate setting may be an acute care facility and then a sub-acute rehabilitation facility or a full service rehabilitation unit. Acute rehabilitation may last days, weeks or several months depending on the severity of illness or injury beginning soon after onset of illness or injury.

Long Term Rehabilitation shall refer to the point where further functional improvement is theoretically possible but the gains are slow and the cause/effect relationship with formal treatment is unclear.

The following terms and conditions must be established:

- Pre-certification is required for any inpatient rehabilitation care, regardless of the reason for the admission, and is required for any outpatient rehabilitation therapy that occurs subsequent to an inpatient admission for rehabilitation therapy;
- The rehabilitation therapy must be performed in the most cost-effective setting as required by the condition;
- The Provider must submit a treatment plan with the proposed treatment, the expected result and the length of the treatment required to reach that result;
- There must be reasonable expectation that sufficient function can be restored for the patient to live outside the institutional setting;
- Continued rehabilitation therapy is dependent upon documentation that progress is continuing to be made, and only so long as there is a significant improvement in the capabilities of the patient;
- An inpatient admission must be to a rehabilitation facility under the same licensure as a short term general hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH), or if to a freestanding rehabilitation facility, one accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF);
- Rehabilitation benefits are not payable for vocational rehabilitation intended to teach a patient how to be gainfully employed; or pulmonary rehabilitation, except in conjunction with a covered and approved lung transplant; or behavior therapy, including speech therapy associated with behavior; or long term rehabilitation after the acute phase, including cognitive retraining and community re-entry programs.

Pap Smear – The plan will cover one pap smear per female 18 years of age when determined medically necessary by a physician.

Note: Where there are no comments the state does not limit the amount, duration or scope of a service.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*

6.4 Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following:

(Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ **Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):**

6.4.1.1. **Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. **The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. **The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. **Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family**

coverage relative to the coverage for the low income children.) **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

The state's overall monitoring plan for the SCHIP program seeks to measure member access and satisfaction, maximize program efficiency, effectiveness and responsiveness, and reduce operational and service costs with an emphasis on encouraging preventive care and a healthy lifestyle. Each participating plan will be required to emphasize well baby and well child care and immunization based upon the schedule recommended by the American Academy of Pediatrics (AAP).

Monitoring efforts will consist of internal monitoring by the participating plans, oversight by the State and evaluation by an independent external review organization. These efforts are currently in place for MCOs contracting with the agency for Medicaid and will be delineated in a Policy and Procedures Guide for SCHIP Provider Plans. Title XXI beneficiaries establishing eligibility under the separate children's health insurance program will be limited to enrollment with contracted SCHIP MCOs that will be subject to the same quality standards and utilization review requirements of currently participating Medicaid MCOs.

The QA internal monitoring plan for each contracting MCO (provider) shall be written and include an assurance that the objective of the plan is to monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. The QA effort is health outcome oriented and relies upon data generated by the plans as well as data developed by outside sources. SCDHHS will, where available, provide the participating plan any historical medical data available to assist in the establishment of a well child or adolescent child care treatment plan.

Results and activities shall be reported in writing at least quarterly.

Plans will report the status and results of each QA project. Each project must be completed in a reasonable time period so as to generally allow information to be useful in the agency's annual evaluation of the provider. The State will evaluate each plan's compliance with program policies/procedures, identify problem areas and monitor corrective action.

Participating plans are required to submit reports as outlined by their contract. Reports include but are not limited to:

- A monthly report of all network providers and subcontractors enrolled in the Contractor's plan, including but not limited to, primary care providers, hospitals, home health agencies, pharmacies, medical vendors, specialty or referral providers and any other providers which may be enrolled for purposes of providing health care services to MCO program members under this Contract;
- A monthly report of all enrollees including the ID number assigned each enrollee;
- A monthly report of all persons enrolled in any other health plan, in a standardized & prescribed format;
- Furnish monthly, individual encounter /claims data.
- A monthly grievance and appeals log;
- The Contractor shall notify SCDHHS or its designee when a MCO program member requires institutionalization in a long-term care facility/nursing home and again at the time the 30th day of placement is completed.

Monthly and upon request, the Contractor shall submit a Medicaid Enrollment by county report.

If the Contractor does not provide required reports based on contractual directives, the State may impose sanctions as outlined in the agency's standard Medicaid or SCHIP contract.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

The contractor shall measure and report its performance using standard measures and submit specific data that enables evaluation.

7.1.2. ☒ Performance measurement

Plans will conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical care and non clinical care areas that are expected to have favorable effect on health outcomes and enrollee satisfaction

7.1.3. ☐ Information strategies

7.1.4. ☒ Quality improvement strategies

Plans must have an ongoing quality improvement and ongoing assessment and performance improvement program for services it furnishes to members. At minimum, plans will have in effect mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to enrollees.

Each contracting provider is required to draft a continuous quality improvement plan (CQI). The MCO will establish and implement a system of Quality Assessment and Performance Improvement (QAPI) and a Utilization Management (UM) plan The MCO will have an ongoing Continuous Quality Improvement (CQI) program for the services furnished to its members that meets the requirements of 42CFR 438.200. The Contractors Medical Director will be responsible for managing the CQI program The Contractor will submit, annually by February 15, its QAPI Work plan, UM Work plan and Integrity Plan to SCDHHS for review and approval. Any subsequent changes or revisions must be submitted to SCDHHS for approval prior to implementation.

The Contractor will agree to External Quality Review, review of QAPI / CQI / UM meeting minutes and annual medical audits to ensure that it provides quality and accessible health care to Medicaid MCO program members, in accordance with standards under the terms of its contract. Such audits shall allow SCDHHS or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to survey and other information concerning the use of services and the reasons for disenrollment.

The standards by which the Contractor will be surveyed and evaluated will be at the sole discretion and approval of SCDHHS. If deficiencies are identified, the Contractor must formulate a Plan of Correction (POC) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. SCDHHS must prior approve the POC and will monitor the Contractor's progress in correcting the deficiencies.

The Contractor must attain accreditation by a nationally recognized organization such as the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC) within a reasonable time period, not to exceed four years from the initial county network approval date. SCDHHS will consider other nationally recognized organizations, but prior approval from the SCDHHS must be obtained prior to survey application.

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

While the benefit package for the separate children's health insurance group does not require EPSDT services as the package for the Expansion does, well baby/child/adolescent care and immunizations are an important component of available services. Plans will have procedures for notification; tracking and follow up to ensure these services are available to all members. Immunization data and provision of well care will be required, evaluated and reported at least quarterly to the agency.

Review methods used will include record reviews by DHHS or its designees, evaluation of contractually required reports and analysis of the recipient encounter data and the monthly provider network reports.

SCDHHS will through a private contractor (the University of South Carolina):

- Collect data from the paid claims system on all MCOs
- Collect data from the Agency Register / Immunizations on all MCOs
- Analyze data from based on HEDIS measures definitions:
    1. First 15 months
    2. Child Well Visits: ages 3 - 6
    3. Adolescent Well Visits: ages 12yrs – 18 yrs.
    4. Ambulatory Visits for Children and Adolescents
        - Preventive Medicine / Immunizations
        - ER Visits
        - Ages 0 - 18

The MCO will complete, at a minimum, one clinical and one non-clinical Performance Improvement Project (PIP). These projects will be reported to SCDHHS, quarterly with an annual evaluation to SCDHHS, no later than April.

- The quality of care studies and the PIPs will be part of the annual evaluation by the EQRO.

The MCO will, at the discretion of SCDHHS, complete a PIP on any HEDIS measure ranking below the 70^{th} percentile.

- The PIP will be reported to SCDHHS quarterly, with an annual evaluation, due no later than April.

SCDHHS will review all quality of care issues and studies with the MCO, at least annually. SCDHHS may review more frequently as the need exists.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Members will have access to emergency care without the requirement of prior authorization. Emergency care will be available 24 hours a day. Plans will be required to submit emergency services definitions, protocols and criteria or authorization/denial of emergency services for in and out of service area. The protocol must specify the circumstances under which the plan will cover emergency services rendered by a provider with whom the plan does not have a contractual or referral arrangement. Any modifications must be submitted to SCDHHS for approval at least 30 days prior to the modification.

The Contractor shall maintain appropriate levels, as determined by SCDHHS, of organizational components, including, but not limited to primary care providers, specialty providers and other providers necessary for the provision of the services under this Contract. The Contractor shall establish and maintain provider networks and in-area referral providers in sufficient numbers, as determined by SCDHHS, to ensure that all contracted services are available and accessible in a timely manner within the Contractor's service area. The Contractor shall make available and accessible, as determined by SCDHHS, hospitals, facilities, and professional personnel sufficient to provide the required core benefits.

The locations of facilities, primary care providers, and network providers must be sufficient in terms of geographic convenience to low-income and rural areas.

Review methods used will include record reviews by DHHS or its designees, evaluation of contractually required reports and analysis of the recipient encounter data and the monthly provider network reports.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

Plans will implement mechanisms to assess each member for special health care needs in order to identify any ongoing special condition of the member that requires a course of treatment or regular care monitoring. Plans will allow members to directly access a specialist as appropriate for the member's condition and identified needs (for example, through the standard referral or an approved number of visits).

Plans will determine the need for any enhanced services that may be necessary for these populations to maintain their health and well-being. Expenditures for the health care services of the special populations as previously described have been factored into the reimbursement rate.

Children and infants with chronic/complex health care needs are identified as individuals that may require additional health care services that should be incorporated into a health management plan that guarantees that the most appropriate level of care is provided for these individuals

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

In establishing and maintaining the service delivery network, plans will consider anticipated enrollment; the expected utilization of services, taking into consideration the characteristics and health care needs of the population represented; the number of network providers who are not accepting new patients; the geographic location of providers and members, considering distance travel time and whether the location provides physical access for members with disabilities.

Plans will maintain appropriate levels of organizational components, including, but not limited to primary care providers, specialty providers and other providers necessary for the provision of the services. Plans will establish and maintain provider networks and in-area referral providers in sufficient numbers to ensure that all services are available and accessible in a timely manner. The plan may provide these services directly or may enter into subcontracts with providers who will provide services to the members in exchange for payment by the plan for services rendered.

Section 8. Cost Sharing and Payment (Section 2103(e))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. ☐ **YES**
8.1.2. ☒ **NO, skip to question 8.8.**

8.2. Describe the amount of cost sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:
8.2.2. Deductibles:
8.2.3. Coinsurance or copayments:
8.2.4. Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(B)) (42CFR 457.505(b))

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☐ **Cost sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☐ **No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☐ **No additional cost sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☐ **State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.** **(42CFR 457.570(a))**

☐ **The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges.** **(42CFR 457.570(b))**

☐ **In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate.** **(42CFR 457.570(b))**

☐ **The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program.** **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ **No Federal funds will be used toward state matching requirements.** **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ **No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements.** **(Section 2105(c)(5) (42CFR 457.224)** ***(Previously 8.4.5)***

8.8.3. ☒ **No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.**
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ **Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997.** **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ **No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.** **(Section 2105)(c)(7)(B)) (42CFR 457.475**

8.8.6. ☒ **No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above).** **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

See summary at the end of this section.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

See summary at the end of this section.

9.3 Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B)) (42 CFR 457.710(d))

SUMMARY 9.1, 9.2, & 9.3

Objective 1:
Reducing the Number and Proportion of Uninsured Children in the State

Performance Goal: Increase the number of targeted low-income children in Medicaid and SCHIP.

Target: To meet the revised goal of enrolling 228, 500 additional children since base year 1997.

Performance Measure: Percent of targeted low-income children in Medicaid and SCHIP.

Data Sources: MMIS, CPS and Census, CMS 64.21E and 64.

Methodology: Reports of eligible children compared to enrollment baseline for July 1997. Difference = net addition.

Numerator: Net additional number of children in Medicaid/SCHIP since 1997.

Denominator: Baseline number of uninsured children below eligibility standard: Initial target was 75,000; revised to 85,000 then 162,500. Revised to 195,000 (2008) and 228.500 (2009) to include SCHIP expansion. (Ref.: Three year average of current population survey for 2003-2005 as reported by SARTS = 66,000 children under 200% of Poverty).

Objective 2:
Increasing Access to Care (Usual Source of Care, Unmet Need)

Performance Goal 2.1:
Provide medical homes for children under the Medicaid/SCHIP programs by recruiting and orienting physicians for participation in Primary Care Case Management (PCCM), HMO and Medical Home Networks.

Target: Maintain the number of Medical Homes.

Performance Measure: The number of Medicaid/SCHIP enrolled practices and primary care physicians participating in medical home programs.

Data Sources: Internal program reports.

Methodology: Compare number of Medicaid/SCHIP enrolled practices and primary care physicians participating in medical home programs at 1997 baseline and current year.

Performance Goal 2.2
Increase the number of Medicaid and SCHIP children enrolled in PCCM, HMOs and Medical Home Networks.

Target: To enroll 75% of all eligible children in a medical home by 2010.

Performance Measure: The number of Medicaid and SCHIP children enrolled in PCCM, HMO and Medical Home Networks.

Data Sources: Internal Program reports.

Methodology: Compare number of Medicaid and SCHIP children enrolled in PCCM, HMO and Medical Home Networks in 1997 and current year.

Objective 3:
Use of Preventative Care (Immunizations, Well Child Care) - Increase access to preventive care for Medicaid and SCHIP children.

Performance Goal 3.1:
Increase access to continuing care for Medicaid eligible children by delivering EPSDT services.

Target: Increase the number of EPSDT screenings to expected screenings by 1% each year for children ages 6 to 18.

Performance Measure: Compare the percent of Medicaid and SCHIP (Medicaid Expansion Program only) EPSDT screenings received to expected number of screenings on the CMS 416 Report (expected screening schedule is published in the *SCDHHS Physicians Provider Manual*).

Data Sources: CMS 416 Reports.

Methodology: Compare the percent of Medicaid and SCHIP (Medicaid Expansion Program only) children age 6-18 receiving screenings to expected screenings.

EPSDT Components: The MCO is responsible for assuring that children through the month of their 19th birthday are screened according to the American Academy of Pediatrics periodicity schedule:
(http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf).

The EPSDT/Well Child program consists of two mutually supportive operational components: (1) assuring the availability and accessibility of required health care services; and (2) helping SCHIP recipients and their parents and guardians effectively use these resources.

The MCO will assure that the EPSDT/Well Child program contains the following benefits:

- Comprehensive Health and Developmental History
- Comprehensive Unclothed Physical exam
- Laboratory Test
- Lead Toxicity Screening
- Health Education
- Vision Services
- Dental Services
- Hearing Services

The administration of immunizations is a required component of EPSDT/Well Child screening services. An assessment of the child's immunization status will be made at each screening and immunizations administered as appropriate. If a child is due for an immunization it must be administered at the time of the screening. If illness precludes the immunization, the reason for the delay will be documented in the child's record. An appointment will be given to return for administration of the immunization at a later date.

If a provider does not routinely administer immunizations as a part of his/her practice, he/she will refer the child to the county health department and maintain a record of the child's immunization status.

Performance Goal 3.2:
Increase access to continuing care for SCHIP eligible children under age 5 by delivering well child visits.

Target: Provide wellness checkups in the Separate children's insurance (SCHIP) program at a rate equal to EPSDT rates in the Medicaid and Medicaid expansion programs.

Performance Measure: Increasing the number of children receiving well child visits.

Data Sources: SCHIP provider data.

Methodology: Compare the rate of SCHIP (separate program only) well child visits to expected number of well child visits (as stated in the benefits package) to Medicaid and SCHIP (expansion program only) EPSDT rates per the CMS 416 Report. Note: EPSDT expected screening schedule is in accordance with the American Academy of Pediatrics: (http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf).

Since FFY2008 is the initial enrollment year and will be baseline data collection year; reporting will begin FFY 2009.

Objective 4:
Provide access for children to medical care delivered in the most appropriate setting.
Performance Goal 4.1:
Decrease the overall percent of Medicaid/SCHIP children's emergency room visits for non-emergent conditions.

Target: Less than 4%

Performance Measure: Percentage of non-emergent ER visits.

Data Sources: MMIS

Methodology: Compare % of non-emergent ER visits for 1997 baseline and current year.

Performance Goal 4.2a:
Decrease uncompensated care delivered to children in hospital settings.

Target: 4% or less

Performance Measure: Percentage of inpatient admissions.

Data Sources: Office of Research and Statistics, Hospital Discharge Data Set.

Methodology: Compare % of children's inpatient admissions without insurance as pay source for 1997 baseline and current year for all children.

Performance Goal 4.2b:
Decrease uncompensated care delivered to children in hospital settings.

Target: Less than 11%.

Performance Measure: Percentage of emergency room visits.

Data Sources: Office of Research and Statistics, Emergency Department Data Set.

Methodology: Compare % of children's inpatient admissions without insurance as pay source for 1997 baseline and current year for all children.

Objective 5:
Objectives Related to SCHIP Enrollment

Performance Goal: Increase SCHIP Enrollment.

Target: Enroll 78,000 additional children by December 2009 (SCHIP separate program only). Maintain continuing enrollment of at least 66,000 children.

Performance Measure: Number of children enrolled in SCHIP separate children's insurance program.

Data Sources: MMIS

Methodology: Percent/number of new children enrolled in SCHIP since base year 2007.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. ☒ **The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.**

9.3.2. ☒ **The reduction in the percentage of uninsured children.**

9.3.3. ☒ **The increase in the percentage of children with a usual source of care.**

9.3.4. ☒ **The extent to which outcome measures show progress on one or more of the health problems identified by the state.**

9.3.5. ☐ **HEDIS Measurement Set relevant to children and adolescents younger than 19.**

9.3.6. ☐ **Other child appropriate measurement set. List or describe the set used.**

9.3.7. ☐ **If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:**

- **9.3.7.1.** ☒ **Immunizations**
- **9.3.7.2.** ☒ **Well-child care**
- **9.3.7.3.** ☐ **Adolescent well visits**
- **9.3.7.4.** ☐ **Satisfaction with care**
- **9.3.7.5.** ☐ **Mental health**
- **9.3.7.6.** ☐ **Dental care**
- **9.3.7.7.** ☐ **Other, please list:**

9.3.8. ☐ **Performance measures for special targeted populations.**

9.4. ☒ **The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires.** **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ **The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports.** **(Section 2107(b)(2)) (42CFR 457.750)**

The Bureau of Eligibility Policy and Oversight is responsible for completing the Annual SCHIP Report. The Bureau generally starts gathering, analyzing, and reporting data annually in September. The data needed to complete the report is gathered from several entities throughout the agency and state. Then the staff analyzes the collected data and creates a draft. The draft is circulated and checked, by necessary entities, for validity, accuracy and completeness. Once Bureau staff receives the circulated drafts with necessary corrections and/or suggestions, all corrections and/or suggestions are taken under consideration and incorporated, as appropriate, into the final draft that is submitted.

9.6. ☒ **The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit.** **(Section**

2107(b)(3)) (42CFR 457.720)

9.7. ☒ **The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.** **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☒ **Section 1902(a)(4)(C) (relating to conflict of interest standards)**
9.8.2. ☒ **Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)**
9.8.3. ☒ **Section 1903(w) (relating to limitations on provider donations and taxes)**
9.8.4. ☒ **Section 1132 (relating to periods within which claims must be filed)**

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42 CFR 457.120(a) and (b))**

Public Involvement

When the PHC program – the predecessor to the Healthy Connections Kids program - was in the start-up phase, steps were taken to bring the new program to the attention of the public. Now that it is an established program, ongoing efforts to inform South Carolina residents of the availability of assistance with their health care needs include information about health care options for children. In short, wherever information appears about South Carolina Medicaid, information is also provided about Healthy Connections Kids. Information about the programs appears in tandem and the state has gone to great lengths to make sure that the public is aware that children's health issues are of primary importance to the state's leadership. The change from PHC to Healthy Connections Choices and Healthy Connections Kids is designed to emphasize the fact that the state is taking another step towards preventive care and towards the concept of the medical home for all low-income SC residents.

Information for Medicaid recipients is provided to those seeking assistance through paper copy of information brochures as well as documents, which are available through the Agency web site. Applications as well as overviews regarding all Medicaid and Healthy Connections Choices options are available. The agency is working now to enhance the website for improved usability.

Information is provided to enrolled providers on a regular basis to assist in informing their patients of our programs. Providers are encouraged to share program information with and refer individuals who are uninsured and may be eligible for coverage through the Healthy Connections Kids program. This is done in an effort to educate current and potential beneficiaries and provide referral to those in need of health insurance.

The benefit package available under the expansion is identical to that offered to Medicaid recipients. The benefit package offered to children under the separate children's health insurance group is equivalent to that offered to employees of the state of South Carolina with some add-ons. Both efforts are designed to point parents toward routine preventive care of their children, choosing and maintaining a medical home and maintaining health coverage.

Public Hearings

Key members of the State's General Assembly annually sponsor a series of public hearings, one for advocacy organizations and clients, one for providers and one for State agencies. One of the primary purposes is to elicit suggestions for changes in the Medicaid and SCHIP programs to make it more responsive to needs of its customers. The major themes expressed at the hearings center around broadening coverage for children, working with providers to create a usual source of care (or medical home) for Medicaid children, and making the application process simpler. All these themes have been incorporated in the Medicaid expansion. The separate children's health insurance group will be added to the dialog with the theme being the development of a medical home for every enrolled child.

Community-Based Providers

The South Carolina Children's Hospital Collaborative played a key role in development of *Partners for Healthy Children.* We plan to maintain that involvement as we move toward the establishment of the Healthy Connections Choices logo and concepts. Member hospitals include the Children's Hospital of the Greenville Hospital System, McLeod Children's Hospital, Children's Hospital of the Medical University of South Carolina, and the Children's Hospital of Palmetto Richland Memorial Hospital. They utilized an advisory committee of private health providers, advocacy groups and representatives of state agencies responsible for services to children. The group advocated strongly for increasing the Medicaid eligibility level for children ages six through eighteen to 133% of poverty, as well as for continuous eligibility. They also assisted in securing funds for the initial expansion and supported the agency in its pursuit of expansion to the 200% level.

Medical Care Advisory Committee

The State's Medical Care Advisory Committee (MCAC) also provides input to the agency's response to the health needs of children. They have been intimately involved in the development of the Healthy Connections Choices concept. Members, who are appointed by the director on a rotating and continuous basis, fall into three broad categories: Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; members of consumers' groups, including Medicaid recipients, and consumer organizations and the director of the public welfare department (Department of Social Services) or the public health department (Department of Health and Environmental Control), whichever does not head the Medicaid agency. This committee meets regularly, providing input in program development and revision.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42 CFR 457.120(c))

The agency has had long experience in working closely with Native Americans in developing and implementing State health programs. The agency continues to coordinate with representatives of the Catawba Indian Nation to identify potentially eligible Catawba children.

Health Services for the tribe are coordinated through the Catawba Service Unit. The Catawba Service Unit is a unit of the Indian Health Services Agency (IHS). The unit is responsible for providing federal health services to American Indians and Alaska natives and providing referrals to those not eligible for their service package. Local coordination between the unit and local eligibility staff is ongoing.

Staff from the State Department of Health and Human Services met with officials from the Health services office to discuss coordination of Medicaid and SCHIP services and implementation of the separate health . We have tentatively agreed to the following actions:

- Provide a Medicaid/SCHIP fact sheet for the information and referral staff currently working with the nation;
- Assist in the development of posters and handouts for display in the IHS health center and the newly developing dental clinic;
- Coordinate a series of articles for the Catawba Service Unit's newsletter about SCHIP and Medicaid services. The newsletter is routinely distributed to the Catawba population; and

- Provide the nation with access to agency staff for speaking engagements if desired.

We have offered to hold meetings with tribal leaders and plan to continue to work directly with the staff of the Catawba Health Services unit to discuss health care related issues. These meetings will be used to solicit input and provide information to the tribes about Medicaid and SCHIP.

The unit has agreed to work cooperatively with the State Department of Health and Human Services to provide information and referral services about Medicaid and SCHIP availability to tribal members. They have also agreed to assist in providing outreach and referral services to others that they come in contact with.

9.9.2 For an amendment related to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

Prior notice of the expansion of its SCHIP offering will be initiated prior to implementation of the increase in the coverage limits. The move to increase the income limit will not be advertised as an addition to the state's children's health coverage but will simply be incorporated into the present concept as an expansion of the already available Medical support options. The Healthy Connections Kids' piece is presented as a part of South Carolina's Healthy Connections Choices concept.

As noted in section 4.3, the Healthy Connections Kids program will be presented to the public as a single program with a single application, and a process that provides coverage under the Title XIX Medicaid program, the original SCHIP expansion (up to 150% 0f the FPL) and separate children's health insurance program (up to 200% of the FPL). The appropriate program assignment will simply be based upon household income and individual access to creditable coverage.

Public notice will be accomplished through the use of brochures, newsletters and other public information methods. This notice serves to publicize the expansion of the state's SCHIP effort, but is not required since the expansion does not restrict eligibility or benefits and does not implement or increase any cost sharing requirements for the program.

Required notice of any action that restricts eligibility or benefits or increases cost sharing will be provided through creation of a state plan amendment. Any such

state plan amendment will be forwarded to CMS as soon as practical but no later than 45 days after implantation of the action. Individual notices of such action will be provided to affected recipients by mail. Applicants will be provided with written notices explaining the restrictions as they make contact with the agency. The general public will be notified through radio ads, notices posted in local eligibility offices. The information will also be posted on the agency's website.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42 CFR 457.140)

See attached worksheet

Planned use of funds, including –

-Projected amount to be spent on health services;

-Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and

-Assumptions on which the budget is based, including cost per child and expected enrollment.

-Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

COST OF APPROVED SCHIP PLAN

South Carolina Title XXI Medicaid Expansion Budget

	2008	2009
Benefit Costs	**Reporting Period**	**Following Fiscal Year**
Insurance payments	0	0
Managed Care	6,036,950	6,036,950
Per member/Per month rate @ # of eligibles	0	0
Fee for Service	31,965,764	31,965,764
Total Benefit Costs	38,002,714	38,002,714
(Offsetting beneficiary cost sharing payments)	0	0

Net Benefit Costs	38,002,714	38,002,714

Administration Costs

Personnel	2,791,444	2.791,444
General Administration	764,201	764,201
Contractors/Brokers (e.g., enrollment contractors)	100,113	100,113
Claims Processing	460,528	460,528
Outreach/Marketing costs		
Other		
Total Administration Costs	4,116,286	4,116,286
10% Administrative Cap (net benefit costs ÷ 9)	4,222,523	4,222,523

Federal Title XXI Share	33,210,832	33,295,070
State Share	8,908,168	8,823,930

TOTAL COSTS OF APPROVED SCHIP PLAN	42,119,000	42,119,000

South Carolina Separate Children's Health Insurance Program Budget

	2008	2009
Benefit Costs	**Reporting Period**	**Following Fiscal Year**
Insurance payments	0	0
Managed Care	18,272,434	109,643,040
Per member/Per month rate @ # of eligibles	117.14 x 6 x 25,998	117.142 x 12 x 78,000

Fee for Service (Dental)	14.68 x 6 x 25,998 2,289,904	13,740,480
Total Benefit Costs	20,562, 338	123,383,352
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs	20,562,338	123,383,352

Administration Costs

Personnel	1,183,916	3,310,985
General Administration	- 661,152	2,265,457
Contractors/Brokers (e.g., enrollment contractors)	78,505	157,010
Claims Processing	361,131	722,262
Outreach/Marketing costs		
Other		
Total Administration Costs	2,284,704	6,455,714
10% Administrative Cap (net benefit costs ÷ 9)	2,284,704	13,709,280

Federal Title XXI Share	18,014,893	102,637,914
State Share	4,832,149	27,201,320

TOTAL COSTS OF APPROVED SCHIP PLAN	22,847,042	129,839, 234

South Carolina Total Budget – SCHIP

	2008	2009
Benefit Costs	**Reporting Period**	**Following Fiscal Year**
Insurance payments	**0**	**0**
Managed Care	24,309,384	115,679,990
Per member/Per month rate @ # of eligibles		
Fee for Service	34,255,668	44,706,544
Total Benefit Costs	58,565,052	161,386,234
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs	58,565,052	**161,386,234**
Administration Costs		
Personnel	3,975,360	6,102,429
General Administration	1,425,353	3,029,658
Contractors/Brokers (e.g., enrollment contractors)	178,618	257,123
Claims Processing	821,659	1,182,790
Outreach/Marketing costs		
Other		
Total Administration Costs	6,400,990	10,572,000
10% Administrative Cap (net benefit costs ÷ 9)	6,507,227	17,931,804
Federal Title XXI Share	51,225,725	135,932,984
State Share	13,740,317	36,025,250
TOTAL COSTS OF APPROVED SCHIP PLAN	64,966,042	171,958,234

The sources of non-Federal funding used for State match:

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations (such as United Way, sponsorship)
- ☐ Other (specify)

Number of estimated enrollment: 78,000 additional children is the maximum number of children projected to be added over the next two years as a result of the increase in the FPL and the creation of the separate children's health insurance program.

Per member/per month rate:
The average cost per enrollee per month in the expansion is $188.66
The State's PMPM rate for the separate children's health program is $131.82.

Assumptions used for this budget are:

$188.66	Average cost, Medicaid Expansion
$131.82	Average cost/month, separate child health program
66,893	Number of enrollees, Medicaid Expansion
25,998	Number of enrollees, separate child health program (FY 2008) FY 2009 budget assumes that we reach a total enrollment of 78,000

* Note: Outreach and marketing costs for both the expansion and the separate children's health insurance groups are included in the totals for contract costs.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ **The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and**

10.2. ☒ **The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))**

10.3. ☒ **The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.**

Section 11. Program Integrity (Section 2101(a))

_____**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 ☒ **The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound.** **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** ***The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)***

- **11.2.1.** ☒ **42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)**
- **11.2.2.** ☒ **Section 1124 (relating to disclosure of ownership and related information)**
- **11.2.3.** ☒ **Section 1126 (relating to disclosure of information about certain convicted individuals)**
- **11.2.4.** ☒ **Section 1128A (relating to civil monetary penalties)**
- **11.2.5.** ☒ **Section 1128B (relating to criminal penalties for certain additional charges)**
- **11.2.6.** ☐ **Section 1128E (relating to the National health care fraud and abuse data collection program)**

Section 12. Applicant and enrollee protections (Sections 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

South Carolina is using Medicaid fair hearing practices and procedures for review of eligibility and enrollment concerns. Procedures outlined in the state's approved Title XIX state plan will apply to the review of all eligibility and enrollment matters

Upon denial of eligibility, suspension of eligibility or reduction or termination of services, an applicant or beneficiary will be timely notified (generally within 10 calendar days) in writing of the reason for denial. All administrative review options provided to recipients under the states Title XIX state plan will be afforded beneficiaries of services under the XXI Medicaid expansion or the separate children's health insurance program. The timely notice will include statements explaining administrative review options. An applicant requesting review of an adverse action must notify the agency in writing within 30 days of the date of the adverse action. The notice will further explain that the individual has the right to continued benefits if the appeal is initiated within 10 calendar days of the notice of suspension, reduction or termination of benefits.

The state normally provides a complainant with 30 days prior notice of a hearing; however a recipient who desires an expedited decision may elect to waive the notice period. The recipient has the right to request that his hearing be held with a minimum notice of 10 days.

The first level of appeal is a conference with the eligibility worker and supervisor. This level may be skipped. The second level of appeal is with the Agency's Appeals and Hearings Division. Hearing Officers appointed by the agency director and administratively positioned outside of the eligibility determination hierarchy hear the issues and provide an unbiased review of issue. Section 126-150 of the South Carolina Code of regulations establishes the authority of the hearing officer. At the hearing an applicant or beneficiary may represent himself or may be represented by legal counsel or a representative of his choice. If a recipient requests a hearing within the timely notice period (10 days), enrollment (or eligibility) will not be suspended, reduced or discontinued until a decision is reached through the fair hearing process. The recipient must request continuation and acknowledge that he/she will be responsible for repayment

of any services received during the period between notification and a final administrative action if the agency's action is upheld.

The hearing officer will be an impartial official and may not have been previously involved with the matters raised at the hearing. The hearing officer is responsible for scheduling the hearing - must provide at least 30 days notice - and informing the claimant of the date and time of the hearing and of the hearing procedures and the right of the claimant to examine the record prior to the hearing All final administrative decisions must be rendered within 90 days of the date the initial request was received and will be in writing and in the case of an adverse decision, inform the claimant of any additional administrative appeal options that are available.

The third level of appeal moves outside of the agency to state appointed and sanctioned administrative hearing officers. Any party has the right to petition for further review of an Order of Final Administrative Decision, pursuant to the Administrative Procedures Act [SC Code Ann. Section 1-23-310, et seq. (1976, as amended)]. In accordance with the Rules of Procedure for the SC Administrative Law Judge Division, within 30 days of receipt of the Order/Decision from which the appeal is taken

The forth level of appeal is the state's circuit courts.

Health Services Matters

12.2 Please describe the review process for health services matters that comply with 42 CFR 457.1120.

South Carolina is using Medicaid fair hearing practices and procedures for review of health service matters.

Additionally, each provider will be required under the conditions of their provider contract to provide a means for impartial review of adverse actions.

Upon denial, reduction or termination of a health service or of disenrollment with a participating provider, the provider is required to timely notify the client or his authorized representative in writing of the right to file a complaint or grievance. The notice shall explain how to file a grievance with the provider, how to file a grievance with the state and the circumstances under which health services or a treatment regimen will be continued pending a hearing. The notice will also provide the circumstance under which an expedited hearing may occur. For expedited service authorization where a provider or the MCO contractor indicates, or determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain

maximum function, the provider, contractor or state must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) working days after receipt of the request for service. Service providers must provide the grievant due process rights. The grievant will be directed to file his request for review directly with the provider then with the state if the provider provides an adverse decision.

The SCHIP provider will notify the client of the complaint or grievance resolution or schedule a date for the grievance committee or hearing official to formally hear the issue. The hearing should take place within 30 days of the written request for a hearing. The written decision must be provided within 30 days of the completion of the hearing. A decision resulting from an expedited request must be provided within 3 days of the request. If the provider hearing results in an adverse decision, the grievant may request a review by the state agency. The State agency review is provided by the agency's Appeals and Hearings Division. State agency decisions may be reviewed by an administrative court outside of the Medicaid agency's hierarchy. The state agency decision must be rendered within 90 days of the date the original request was submitted to the MCO or health care provider. The state agency will have 3 working days from the date the medical and/or other records are provided to the state.

State agency procedures as outlined in section 12.1 and further defined in the state's Title XIX State Plan and the State's Code of Regulations will apply. The state's code of regulations, Chapter 126, Article 1, sub article 3 provides the following Medicaid appeals related information:

SUBARTICLE 3.

APPEALS AND HEARINGS

126-150. Definitions.

A. Agency--The Department of Health and Human Services and its employees.

B. Appeal--The formal process of review and adjudication of Agency determinations, which shall be afforded to any person possessing a right to appeal pursuant to statutory, regulatory and/or contractual law; Provided, that to the extent that an appellant's appellate rights are in any way limited by contract with the Agency or assigned to the Agency, said contractual provision shall control.

C. Hearing Officer--Any Agency employee appointed by the Director to make Decisions either affirming or reversing Agency program determinations by setting forth findings of fact and conclusions of law in appeals arising under this regulation.

D. Person--An individual, partnership, corporation, association, governmental

subdivision, or public or private agency or organization.

E. Provider--A person who provides services to individuals under programs administered by the Agency.

126-152. Appeal Procedure.

A. An appeal shall be initiated by the filing of a notice of appeal within thirty (30) days of written notice of the Agency action or decision which forms the basis of the appeal. The failure to file the requisite notice of appeal within the thirty (30) day period specified above shall render the Agency action or decision final; provided, that should the written notice specify some period to appeal other than thirty (30) days, that period shall apply; provided, that the requirement that written notice be given by the Agency shall not be applicable to situations where applicants for Medicaid benefits acquire the right to appeal when the Agency fails to act on the application within the time period specified by federal regulation.

B. The notice of appeal shall be in writing and shall be directed to Appeals and Hearings, Department of Health and Human Services, Post Office Box 8206, Columbia, South Carolina 29202-8206. In appeals by providers, the notice of appeal shall state with specificity the adjustment(s) or disallowance(s) in question, the nature of the Issue(s) in contest, the jurisdictional basis of the appeal and the legal authority upon which the appellant relies.

C. If a notice of appeal does not satisfy the requirements of paragraph (B) above, the Hearing Officer, upon his own motion or by motion by an adverse party, may require a more definite and certain statement.

126-154. Hearing Officer.

A Hearing Officer has the authority, among other things to: direct all procedures; issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or proposed findings of fact and conclusions of law; call witnesses and cross-examine any witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with requirements under this Subarticle.

126-156. Prehearing Conferences

The Hearing Officer, within his discretion, may direct the parties in any appeal to meet prior to a formal hearing for the purpose of narrowing the issues and exploring the possibilities of settlement of matters in contest.

126-158. Hearing Procedures

A. All parties to an appeal shall have the right to be represented by counsel, call witnesses, submit documentary evidence, cross-examine the witnesses of an adverse party, and make opening and closing statements.

B. Representation in Proceedings. A business entity, an agency, or an organization may elect to be represented by a non-attorney in an administrative hearing with the approval of the presiding hearing officer; non-lawyer persons including Certified Public Accountants, an officer of a corporation, or an owner of an interest in the business entity must present proof of unanimous consent of the owners or officers of the business entity before being allowed to proceed as representatives. Attorneys licensed in other jurisdictions must obtain a Limited Certificate of Admission, or such other leave as required by the South Carolina Supreme Court, before being allowed to proceed as representatives. This regulation in no way limits a person's right to self-representation, or to be represented by an attorney, or to be represented by a non-attorney of his or her own choosing, when such non-attorney representation is allowed by law. "

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.