MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT 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 Children's Health Insurance Program (CHIP). 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 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))**

//S// June 23, 2010

(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 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
Effective Date: 10/01/1997

Initially submitted to establish CHIP 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: 06/08/04/
Approved: 08/18/04
Effective Date: 06/07/04

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

Amendment # 2
Submitted: 10/04/07
Approved: 03/28/08
Effective Date: 10/01/07

Added to expand the states coverage to include children under age 19 with family income greater than 150% and at or 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: 12/18/08
Approved: Withdrawn 02/10/09

SCHIP's Revises Child/incapacitated adult care deduction

Amendment # 4
Submitted: 07/23/09
Approved: 09/24/09
Effective Date: 07/01/09

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.

Amendment #5
Submitted: 06/23/2009
Approved:
Effective Date: 10/01/10

The state desires to change its plan from a combination plan to a Medicaid Expansion to include children under age 19 with family income below at or below 200 % of poverty effective October 1, 2010.

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 at or 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 CHIP 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 CHIP. 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.

- 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/CHIP 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/CHIP 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 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 partners with Palmetto Project, Healthy Learners, and the Benefit Bank assisting in their efforts to identify and enroll uninsured children. The agency has provided basic Medicaid eligibility training and technical assistance for intake, including a Memorandum of Agreement for authorizing original citizenship and identity documents.

2.3. Describe the procedures the state uses to accomplish coordination of CHIP 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 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.

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 CHIP eligible, but were enrolled under Title XIX because they had insurance coverage. Children without coverage go into CHIP, while children with coverage are put into regular Medicaid, so that appropriate match is drawn. Coverage under Medicaid or CHIP Medicaid expansion will be differentiated in the system through assigned identification codes based upon income level, age and availability of health insurance. The system is programmed to set the identification codes.

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

__X__ **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))

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))

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

__X__ **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:**
4.1.2. ☐ **Age:**
4.1.3. ☐ **Income:**
4.1.4. ☐ **Resources (including any standards relating to spend downs and disposition of resources):**
4.1.5. ☐ **Residency (so long as residency requirement is not based on length of time in state):**
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:**
4.1.8. ☐ **Duration of eligibility:**
4.1.9. ☐ **Other standards (identify and describe):**

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)

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.**

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)).

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))

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

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.**

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))**

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 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 CHIP. This is transparent to the applicant. The applicant is notified of the eligibility

determination.

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 CHIP 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. 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 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, Department 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/CHIP, 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 providers.

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

__X__ **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**
- **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**
- **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 (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))**
- **6.2.2.** ☐ **Outpatient services (Section 2110(a)(2))**
- **6.2.3.** ☐ **Physician services (Section 2110(a)(3))**
- **6.2.4.** ☐ **Surgical services (Section 2110(a)(4))**
- **6.2.5.** ☐ **Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))**
- 6.2.6. ☐ Prescription drugs (Section 2110(a)(6))
- **6.2.7** ☐ **Over-the-counter medications (Section 2110(a)(7))**
- 6.2.8. ☐ **Laboratory and radiological services (Section 2110(a)(8))**
- **6.2.9.** ☐ **Pre-natal care and pre-pregnancy family services and supplies (Section 2110(a)(9)) Pre-natal services are available.**
- **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))

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)**

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))

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))**

6.2.15. ☐ **Nursing care services (See instructions)** (**Section 2110(a)(15))**

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)**

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.**

6.2.18. ☐ **Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))**

6.2.19. ☐ **Outpatient substance abuse treatment services (Section 2110(a)(19))**

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

6.2.21. ☐ **Care coordination services (Section 2110(a)(21))**

6.2.22. ☐ **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))**

6.2.23. ☐ **Hospice care (Section 2110(a)(23))**

6.2.24. ☐ **Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24)):**

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

6.2.26. ☐ **Medical transportation (Section 2110(a)(26):**

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))**

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

__X__ **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))

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**
- **7.1.2.** ☐ **Performance measurement**
- **7.1.3.** ☐ **Information strategies**
- **7.1.4.** ☐ **Quality improvement strategies**

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))

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))

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))

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))

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

__X__ **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 CHIP.

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 CHIP.

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/CHIP 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 CHIP 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/CHIP programs by recruiting and orienting physicians for participation.

Target: Maintain the number of Medical Homes.

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

Data Sources: Internal program reports.

Methodology: Compare number of Medicaid/CHIP 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 CHIP 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 CHIP children enrolled in PCCM, HMO and Medical Home Networks.

Data Sources: Internal Program reports.

Methodology: Compare number of Medicaid and CHIP 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 CHIP 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 CHIP 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 CHIP 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 CHIP 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
- Visison 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.

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/CHIP 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 CHIP Enrollment

Performance Goal: Increase CHIP Enrollment.

Target: Enroll additional children and maintain continuing enrollment.

Performance Measure: Number of children enrolled in CHIP.

Data Sources: MMIS

Methodology: Percent/number of new children enrolled in CHIP 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 Administration is responsible for completing the Annual CHIP 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 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. Healthy Connections Choices 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. This is done in an effort to educate current and potential beneficiaries and provide referral to those in need of health insurance.

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 CHIP 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.

Community-Based Providers

The South Carolina Children's Hospital Collaborative played a key role in development of *Partners for Healthy Children*. We maintain that involvement as we promote Healthy Connections Choices . 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. 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.

The plan to convert HCK to the Medicaid expansion was approved unanimously by MCAC.

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 CHIP services. We have tentatively agreed to the following actions:

- Provide a Medicaid/CHIP 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. 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 CHIP.

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 CHIP availability to tribal members. They have also agreed to assist in providing outreach and referral services to others that they come in contact with.

The Catawba Service Unit sits on our MCAC.

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 CHIP offering was initiated prior to implementation of the increase in the coverage limits. The move to increase the income limit was not advertised as an addition to the state's children's health coverage but simply incorporated into the present concept as an expansion of the already available Medical support options. Public notice was accomplished through the use of brochures, newsletters and other public information methods. The notice served to publicize the expansion of the state's CHIP effort, but was not required since the expansion did not restrict eligibility or benefits and did 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)

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

SCHIP Budget Plan Template

	Federal Fiscal Year First Year Costs
Enhanced FMAP rate for FFY 2011	**0.7903**
Benefit Costs	
Insurance payments	0
Managed care	
per member/per month rate @ # of eligibles	47,811,475
Fee for Service	62,036.525
Total Benefit Costs	**109,848,000**
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	109,848,000
Administration Costs	
Personnel	4,766,676
General administration	632,701
Contractors/Brokers (e.g., enrollment contractors)	510,743
Claims Processing	645,880
Outreach/marketing costs	0
Other	0
Total Administration Costs	6,556,000
10% Administrative Cost Ceiling	12,205,333
Federal Share (multiplied by enh-FMAP rate)	92,181,000
State Share	24,223,000
TOTAL PROGRAM COSTS	122,053,333

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

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:

Per member/per month rate:
The average cost per enrollee per month in the expansion is $188.66

Assumptions used for this budget are:

$188.66	Average cost, Medicaid Expansion
66,893	Number of enrollees

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))

__X__ **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))

__X__ 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.

Health Services Matters

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

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.