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))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

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: **Robert M. Kerr** Position/Title: **Director, Department of Health and Human Services**
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. **X** Providing expanded benefits under the State's Medicaid plan **(Title XIX); OR**

1.1.3. ☐ A combination of both of the above.

1.2 **X** **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 **X** **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):**

Effective date: 10/01/97

Implementation date: 10/1/97

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%.

Among children in families with income below 200% of poverty, those counted as non-white are 297,464 and constitute the majority or 58.63%. There are 209,894 White, accounting for 41.37%.

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% live in metropolitan statistical areas (MSAs). Only 194,470 of the total 507,358 reside outside MSAs.

The age distribution of children in families with income below 200% of poverty is concentrated somewhat more toward the older groups. Infants constitute only 4% of the total. Those ages 1 thru 5 years are 28.47%, with those 6-14 accounting for 45.75% and those ages 15 through 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, produce the estimates below for children under 200% of poverty:

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	Private Coverage	Public Coverage	Uninsured
Infants	6,362	13,891	5,178

<1yr			
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 that 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. The only public creditable coverage available is Medicaid.

In 1996, the South Carolina Medicaid program covered 300,858 children under 18 years of age. Eligibility levels stepped down with increasing age, starting with infants at 185% of poverty, children 1 - 5 at 133%, children 6 – 13 at 100% and children age 14 – 18 at 48%.

The traditional information systems and reports that support the Medicaid program did not enable the state to describe the income and/or poverty level of children who are enrolled in the program. The Medicaid Eligibility Determination System (MEDS) was implemented in October 2002 and allows the state to produce this type of information.

The age group with the largest number of eligibles was 6-14 years, constituting 37.8% of the total. The 1-5 age cohort, at 35.1% was the next largest, followed by infants under age one at 14.3% and the 15-18 age group consisting of just 12.8%.

Almost 64% of children covered by Medicaid were Black. White Children comprise about 35%, while Hispanic, Asian/Pacific Islander and American Indian children accounted for less than 1% together.

In terms of location, the majority of children covered by Medicaid lived in Metropolitan Statistical Areas. Only 38% lived outside an MSA.

In 2002, the South Carolina regular Medicaid program covered 430,303 children under 19 years of age. Eligibility levels stepped down with increasing age, starting with infants at 185% of poverty, children 1-5 at 133% of poverty, and children 6-18 at 100% of poverty.

Current eligibility levels for Title XXI are at 150% for children 1-18.

Uninsured Children

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

The Southern Institute on Children and Families November 1996 report on *Uninsured Children in the South* used 1994 Current Population Survey data and found:

- 154,700, or 15%, of those ages 18 and younger were uninsured in S.C. in 1993.
- The age distribution of uninsured children was 24% (36,600) ages birth thru 5; 31% (48,300) ages 6 thru 12; and 45% (69,800) ages 13 through 18.
- The income distribution was 35% in families with income at or less than 100% of the 1993 poverty level; 30% between 101 and 200%; and 35% over 200%.
- Of the uninsured at or under the poverty level, 29% were ages 0-5; 32% were ages 6-12; and 41% were ages 13-18.

Information is not available regarding the racial/ethnic or geographic distribution of uninsured children in S.C.

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))

Current State Efforts to Provide or Obtain Creditable Health Insurance

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):

Steps by Medicaid to Identify and Enroll Eligible Children

The South Carolina Medicaid program has a number of outreach initiatives, but they tend to focus more on increasing early and continuous access to care, thereby increasing the likelihood of compliance with treatment and achieving healthy outcomes, rather than identifying and enrolling eligible children. Some of the efforts, however, accomplish eligibility outreach in the process as well. Much of the outreach occurs through out-stationed eligibility workers.

- Outreach under Medicaid Enhanced Maternal Services assists potentially eligible women and their families experiencing barriers in the eligibility process.

- There are Medicaid sponsored community based outreach efforts within the state's 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.

- A contract with a public housing authority requires an aggressive Medicaid outreach program in Richland County using data to identify potential eligibles, holding community workshops and health fairs, and providing Medicaid eligibility information to prospective public housing applicants.

- A contract with a major hospital system for Maternal Outreach Services includes Medicaid and other program application coordination and follow-up on application procedures for pregnant and postpartum women and their infants.

- Department of Health and Environmental Control Family Planning outreach workers provide eligibility counseling about other programs for which women losing family planning eligibility and their families may be eligible, including Medicaid.

- There is a Memorandum of Agreement between the Medicaid and WIC agencies ensuring that, through cooperation, WIC services are available to Medicaid eligibles and Medicaid eligibility information is available to WIC recipients.

- 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 57 sites with 177 eligibility workers, plus some FQHCs utilize their own personnel to take applications.

- Some schools work through our local eligibility contractor to contract for an eligibility/outreach worker in their school facilities.

- Transportation services are provided when needed to access scheduled medical treatment.

- Information and applications continue to be provided upon request.

- Activities to educate beneficiaries regarding how to access and appropriately use medically necessary services.

- Efforts to link beneficiaries with primary care providers that promote prevention, and early detection, intervention and treatment.

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.

Efforts to Enroll Children in Public/Private Partnership Insurance Programs

South Carolina currently has no public/private partnership health insurance programs which 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 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 SCHIP eligible, but were enrolled under Title XIX because they had insurance coverage. The state generates a report that separates children who have third party coverage from those who do not. Children without coverage go into SCHIP, while children with coverage are put into regular Medicaid, so that appropriate match is drawn.

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 SCHIP 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

Outreach regarding availability and enrollment has been accomplished through two avenues. The first will consist of an extension of current Medicaid outreach activities described in Section 2.2.1 to the newly eligible population. The second involves the total re-design of the application process to make both the application and the process "user-friendly" and to cut the perceptual link with welfare programs and their associated stigma. The expansion initiative is called "Partners for Healthy Children" and has its own logo of five smiling children's faces.

The Governor spearheaded this effort by holding news conferences about the new program designed to help working families. He wrote a cover letter for the application, as well as letters to public school superintendents, state agency directors, and health service providers urging them to make the applications available to potential eligibles through their facilities. Packages of applications and re-order cards accompanied the Governor's letters.

The entire application process has been was revamped to make it more accessible, easier to understand, and less stigmatizing. The information and application package is printed on bright yellow paper with a "Partners for Healthy Children" logo and consists of two pages folded together. The first page is a cover letter from the Governor explaining the program in plain English, with the income guidelines on the back. The second page, front and back, is the simplified application. If family income falls within the guidelines, parents are instructed to fill out the application, attach proof of income, and mail it to Partners for Healthy Children. If they need help, there is a toll free number to call. If income is a little above the guidelines, parents are told their children may still be eligible and are encouraged to contact the appropriate Department of Social Services Office. The number for each county office is listed on the page with the income guidelines.

Eligibility workers at the Department of Social Services and those out-stationed at provider facilities will assist with enrollment for potential eligibles who have income above the published guidelines. County Offices of the Department of Disabilities and Special Needs and Entitlement Specialists in the Department of Mental Health's community mental health centers will assist clients who may be eligible in completing and submitting forms. Out-stationed eligibility workers and other staff in FQHCs and

public health clinics will also assist their clients, if needed.

The application packages are being were distributed across the state through:

- public schools;
- local offices of six health and human service related public agencies;
- hospitals (including disproportionate share and traditional safety net providers);
- health clinics (including FQHCs and public health);
- pediatricians' and other primary care physicians' offices; and
- pharmacies.
- State Legislators' offices

In 1997, over half a million applications were delivered to distribution sites and another half million have been printed and delivery is underway. Schools have received over 300,000 applications to send home with their students. Since the program's inception, 4,340,000 applications have been distributed. Schools have received over 1.1 million applications.

Press packets were distributed around each of the Governor's press conferences. Numerous articles appeared in daily and weekly newspapers across the state. There are plans for the application forms to be printed and included as inserts in the major newspapers of the state.

The agency continues coordinating with representatives of the Catawba Indian Nation to identify potentially eligible Catawba children. Each family with a child or children who may be eligible is sent an application form.

In addition, the agency continues to respond to requests for applications. Individuals who hear about the program are calling the tool free number to request copies of the application. The state Department of Insurance and a number of predominantly Black churches have requested applications to distribute.

After the new application process is well established, the state will examine the need for additional outreach and promotional activities. These activities were designed to inform and to increase enrollment, and if necessary, will target particular age groups or geographic locations with low response rates. An initial action utilized information outreach brochures developed by Southern Institute on Children and Families and customized for our state and printed by the Children's Hospital Collaborative. Public

Services Announcements were developed, as well.

Outreach Refocused

In late 2001, the outreach focus shifted from outreaching eligibles to connecting current eligible children with a medical home. However information and applications continue to be provided upon request. Newly directed outreach activities educate current Medicaid 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.

Coordination

The 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.

In addition, the state has a Human Services Coordinating Council consisting of over 20 agencies concerned with health and human services. This Council meets quarterly, but operates through a committee structure to ensure the coordination and smooth functioning of closely related programs across agencies. The Council provides a forum in which problems can be raised and resolved and multi-agency programs coordinated so that they appear "seamless" to clients.

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 the Medicaid 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, 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 the new Medicaid 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 serve on many of those committees.

In addition to coordination through the MICH Council, Medicaid 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.

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.

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 (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)**

- ☐ **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))**
- ☐ **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))**
- ☐ **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))

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

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))

Objective 1:

Reducing the Number and Proportion of Uninsured Children in the State.

Performance Goal: Enroll targeted low-income children in Partners for Healthy Children.

Performance Measure: Percent of targeted low-income children in Partners for Healthy Children.

Data Sources: MMIS, CPS and Census, CMS 64.21E and 64. EC at quarter ended 09-30-03

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

- Numerator: Net additional number of children in Medicaid/PHC: 215,903 September 2003

  Regular Medicaid = 165,529
  SCHIP Medicaid = 50,374

- Denominator: Baseline number of uninsured children below eligibility standard: Initial target was 75,000; revised to 85,000 then 162,500.

Progress Summary**:** 215,903/162,500 = 132.9% (September)

Note: Not all retroactive cases have been included in enrollment as of report date, December 16, 2003. The new three-year average for low income (under 200% FPL) uninsured children in our state for 2000, 2001, 2002 is down to 52,000 (standard error 15,000), which is less than

10% of the total population under 19.

Objective 2:

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

Performance Goal:
Establish medical homes* for children under the Medicaid/PHC programs by recruiting and orienting physicians for participation in HMO, HOP, and PEP programs.

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

Data Sources: Internal program reports.

Methodology: Compare number of Medicaid enrolled practices and primary care physicians participating in medical home programs at 1997 baseline and 2003. Compare number of Medicaid/PHC children enrolled in the HMO and PEP programs and number of children receiving services through a HOP physician practice for baseline 1997 year and 2003.

Progress Summary**:**

Physicians Participating in Medical Home Programs

- HMOs: (787-291)/291 = 170.4%
- PEP: (49-3)/3 = 1533.3%
- HOP: (608-40)/40 = 1420%

Between FFY 2002 and FFY 2003 there was a 47% increase in the number of physicians participating in the HMO program from 537 in 2002 to 787 in 2003. This change is due to the fact that two more counties were added to our HMO, Select Health in 2003. Between FFY2002 to FFY 2003 there was a 4% increase in the number of enrolled PEP providers, from 47 in 2002 to 49 on 2003. The number of HOP enrolled physicians increased by 10% between FFYs 2002 and 2003, from 551 to 608. Since FFY 2001, children enrolled in HMO and PEP programs increased by 20%, from 68,886 to 83,055 and children enrolled in the HOP increased by 8%, from 69,512 to 74,862.

Medicaid PHC Children in Formal Medical Homes

- HMOs and PEP: (83,055-4,076)/4,076 = 1938%
- HOP: (74,862-528)/528 = 14,078%

Objective 3:

Use of Preventative Care (Immunizations, Well Child Care) - Increase access to preventive care for PHC children.

Performance Goal 3.1:
Immunize two-year-old children enrolled in PHC at the same rate as two-year-old children in the general population

Performance Measure: Immunization rates for Medicaid/PHC children.

Data Sources: South Carolina Department of Health and Environmental Control's (SCDHEC) "Two-Year-Old Immunization Coverage of SC Children 2002"*

Methodology: Compare complete 4313 series immunization rates for Medicaid/PHC children to those for the general population of two-year-olds in sample.

Performance Goal 3.2:
Deliver EPSDT services to children enrolled in PHC/SCHIP at the same rate as children enrolled in regular Medicaid.

Performance Measure: Percent of PHC/SCHIP children age 6-20 receiving recommended screenings.

Data Sources: CMS 416 Reports—4313 series = 4 DTP, 3 Polio, 1 MMR, 3 Hib

Methodology: Compare the percent of PHC/SCHIP children to the percent of regular Medicaid children age 6-20 receiving recommended screenings.

Progress Summary**:** In SFY 1998, the screening ratio for regular Medicaid dropped below the 1997 baseline. The SCHIP screening ratio of 43%, however, was slightly above Medicaid's 1997 level. There were changes in how South Carolina's EPSDT program was administered and billed in 1999. In addition, the reporting criteria for the CMS 416 changed. The 1999 and 2000 screening ratios were less than earlier years, although the SCHIP ratio of 0.34 for 1999 and 0.24 for 2000 were higher than regular Medicaid at 0.27 for 1999 and 0.21 for 2000. There was no change for SCHIP, 0.24, in FY 2001 but there was a decrease for regular Medicaid, 0.20. For FY 2002 there was a decrease in SCHIP to 0.21 while regular Medicaid remained at 0.20. EPSDT ratios for 2003 will not be available until spring 2004.

Objective 4:

Improve access for children to medical care delivered in the most appropriate setting.

Performance Goal 4.1:

Decrease the overall percent of Medicaid/PHC children's emergency room visits for non-emergent conditions.

Performance Measure: Percentage of non-emergent ER visits.

Data Sources: MMIS

Methodology: Compare % of non-emergent ER visits for 1997 baseline and 2003.

Progress Summary: In SFY 1997 the percent of Medicaid children's emergency room visits for non-emergent conditions was 13.4%. In 1998 it decreased to 4.4% and remained the same in SFY 1999. Unfortunately in 2000 the percent was slightly higher at 4.9%. In 2001, 2002, and 2003 there were percent decreases to 4.5%, 4.4%, and 4.2%, respectively. This 4.2% for 2003 reflects an overall decrease of 69% since the beginning of the PHC program.

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

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 2003.

Progress Summary: In SFY 1998, the percent of children's inpatient admissions without insurance as the expected pay source, dropped to 4.5%, a decrease of almost 20%. In SFY 1999, the percent dropped to 3.5%, another 20% decrease. In SFY 2000, however there was an increase to 4.0%, up 15% over the previous year. In SFY 2001, there was an increase to 5% from last years 4%, a 20% difference. In SFY 2002, there was a 12% yearly decrease from 5% to 4.4%, when compared to SFY 2001. For SFY 2003, there was a 16% increase from 4.4% to 5.1%. Thus led to an overall decrease from the baseline of 7%.

Note: Data provided is a preliminary count. Updated data will be provided once it is received.

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

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 2003.

Progress Summary: In SFY 1998, the percent of children's emergency room visits without insurance was 18.8%, representing almost a 9% decrease. In SFY 1999, it had dropped to 15%, a decrease of about 20%. In SFY 2000 it dropped another 15% to 12.7%. In SFY 2001 it also dropped 1.5% to 12.5%. In SFY 2002 it dropped 16% to 10.5%. For SFY 2003 the decreasing trend showed a 13% decrease to 9.1%. Overall, the percent of uncompensated care for children's visits to the emergency room has decreased by 55% from the baseline.

Note: Data provided is a preliminary count. Updated data will be provided once it is received.

Improve management of chronic conditions among PHC enrolled children.

Performance Goal 4.3:
Decrease the incidence of children hospitalized for asthma among Medicaid/PHC enrolled children by 2%.

Performance Measure: Incidence rates for State fiscal year.

Data Sources: Office of Research and Statistics

Methodology: Compare incidence rates for State fiscal year (SFY) 96/97 and 97/98, 97/98 and 98/99, 98/99 and 99/00, 99/00 and 00/01, and 96/97 and 00/01.

Progress Summary: From SFY 96/97 and 97/98, the rate decreased 7%; from SFY 97/98 and 98/99, the rate decreased 20%; from SFY 98/99 and 99/00, the rate increased 7%; from SFY 99/00 and 00/01, the rate decreased 9%; from SFY 00/01 and SFY 01/02 the rate decreased 3%; and from SFY 01/02 and SFY 02/03 the rate increased 3%. The overall rate from SFY 96/97 and 02/03 decreased 28%.

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

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

9.3.2. X The reduction in the percentage of uninsured children.

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

9.3.4. X 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.** X **Immunizations**
- **9.3.7.2.** X **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. X **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. X **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 Division of Eligibility Policy and Oversight is responsible for completing the Annual SCHIP Report. The division 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 division staff analyzes the collected data and creates a draft. The draft is circulated and checked, by necessary entities, for validity, accuracy and completeness. Once divisional 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. X **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. X **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. X **Section 1902(a)(4)(C) (relating to conflict of interest standards)**

9.8.2. X **Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)**

9.8.3. X **Section 1903(w) (relating to limitations on provider donations and taxes)**

9.8.4. X **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 PHC. In short, wherever information appears about South Carolina Medicaid, information is also provided about PHC. Information about the programs appear in tandem.

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 programs are available. The agency is working now to enhance our website for improved usability.

Information is provided to Medicaid enrolled providers on a regular basis to assist in informing their patients of our programs. This is done in an effort to educate current eligibles and provide referral to those seeking health care. The benefit package available under PHC is identical to that offered to Medicaid recipients.

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 program 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*. Member hospitals include the Children's Hospital of Greenville Hospital System, McLeod Children's Hospital, Children's Hospital of the Medical University of South Carolina, and the Children's Hospital of 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.

Medical Care Advisory Committee

The State's Medical Care Advisory Committee (MCAC) also provides input to *Partners for Healthy Children.* 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 monthly, providing regular 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))

Interaction With Indian Tribes

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.

We will continue to hold meetings with tribal leaders to discuss health care related issues. We continue to use these meetings to solicit input and provide information to the tribes on PHC.

Agency staff attend meetings with the Indian Health Service and the Health Clinic of the Catawba Indian Nation to discuss various aspects of PHC and how they may impact tribal members.

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).

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

	2003	2004	2005
Benefit Costs	**Reporting Period**	**Next Fiscal Year**	**Following Fiscal Year**
Insurance payments	1,871,932	2,576,184	2,576,184
Managed Care	0	0	0
Per member/Per month rate @ # of eligibles	0	0	0
Fee for Service	50,402,721	69,183,816	69,183,816
Total Benefit Costs	52,274,653	71,760,000	71,760,000
(Offsetting beneficiary cost sharing payments)	0	0	0
Net Benefit Costs	52,274,653	71,760,000	71,760,000
Administration Costs			
Personnel	0	0	0
General Administration	4,647,136	5,380,000	5,380,000
Contractors/Brokers (e.g., enrollment contractors)	0	0	0
Claims Processing	0	0	0
Outreach/Marketing costs	0	0	0
Other	0	0	0
Total Administration Costs	4,647,136	5,380,000	5,380,000

10% Administrative Cap (net benefit costs ÷ 9)	5,808,295	7,973,333	7,973,333

Federal Title XXI Share	44,894,215	60,863,460	60,878,888
State Share	12,027,574	16,276,540	16,261,112

TOTAL COSTS OF APPROVED SCHIP PLAN	56,921,789	77,140,000	77,140,000

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: 75,000

Per member/per month rate: $85.71 average cost per enrollee per month

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

10.3. X 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.