South Carolina Legislative Audit Council

LAC

Report to the General Assembly

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A Sunset Review of the Department of Health and Environmental Control's Health Services

Legislative Audit Council

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Executive Summary

The sunset law (§1-20-10 *et seq.* of the South Carolina Code of Laws) requires that the State Reorganization Commission determine annually which agencies or agencies' programs are scheduled for review by the Legislative Audit Council. The commission selected health services provided by the Department of Health and Environmental Control (DHEC) for sunset review in FY 95-96. Pursuant to the sunset law, we reviewed the performance of DHEC's health services programs and assessed the effect of terminating certain programs. Our review targeted specific program, financial, and administrative issues.

DHEC provides an array of needed services. Overall, we found that DHEC needs to improve some financial and administrative management practices. DHEC should give greater attention to identifying and collecting available revenue and to ensuring that clients are eligible for service. Although DHEC has taken steps to improve efficiency, more progress is needed.

Program Issues

Some issues we reviewed relate to DHEC's health services programs. Our findings are summarized below.

- If DHEC were to reduce or end its provision of home health services or to no longer limit entry into the home health industry, there would be potential for higher medicare and medicaid costs. However, these changes would result in increased business opportunities for non-DHEC providers (see p. 7).

- DHEC provides home health services in every county, but its market share decreased from 76% in 1984 to 39% in 1994. DHEC's costs per visit and visits per patient are often lower than those of other providers (see p. 9).

- DHEC has regularly measured the efficiency and effectiveness of its health services programs. However, DHEC needs to improve its reporting process. The performance measures we reviewed were sometimes incomplete, based on dated or inappropriate information, or inadequately explained (see p. 14).

- DHEC does not require applicants for the women, infants, and children (WIC) program or the children's rehabilitative services (CRS) program to provide proof of income when applying for services. Eligibility for these programs is based on income. Since documentation is not required, it may be easy for ineligible applicants to obtain services (see pp. 17, 20).

- DHEC has not thoroughly investigated complaints about WIC participants who are reported to be ineligible or to be selling WIC vouchers (see p. 19).

- DHEC does not have an agencywide written policy outlining how complaints against food service establishments should be handled. Local offices have differing procedures for investigating consumer complaints (see p. 21).

- We found no material problems with DHEC's controls to ensure that septic tank permits are issued in compliance with state laws and regulations (see p. 22).

Financial Issues

We identified several areas where DHEC could improve its financial management. Improved procedures could increase agency revenue and allow DHEC to maximize its use of resources.

- DHEC does not have an adequate system for billing, tracking, and collecting health services accounts receivable. Health services does not know how much is owed or how much remains uncollected from private pay patients. This may result in inconsistent treatment of client debt and also result in lost revenue (see p. 23).

- DHEC needs to improve its system for identifying and billing private insurance companies for patients not covered by medicaid. DHEC may be paying for services that are covered by private insurance (see p. 26).

- DHEC does not consistently allocate program funds based on the relative needs of each health district. As a result, there is reduced assurance that services are provided consistently across districts (see p. 27).

- DHEC has not implemented a sliding fee scale for babynet services as required by state law. Also, the department uses 13 different fiscal agents to pay bills and maintain financial records for the program. This is not an efficient use of program resources (see pp. 29, 30).

Administrative Issues

We reviewed several areas where improved administrative operations could result in savings and greater efficiency. These areas are summarized below.

- Health services has multiple computer information systems that are not connected, and DHEC's process for managing information systems has not met health services' needs. The lack of integrated client and billing information results in inefficiency throughout health services (see p. 33).

- DHEC's health services network is comprised of 13 health districts and 46 county health departments. Analysis conducted by DHEC indicates that efficiency could be improved by reducing the number of health districts (see p. 37).

- Health services' oversight of health district activities is fragmented. A DHEC committee found duplication and inconsistency in management review of district activities (see p. 39).

- In FY 95-96, DHEC significantly reduced the number of permanent staff in its health services central office. Officials projected that central office expenditures for permanent staff would be approximately $1.7 million lower in FY 95-96 than in FY 94-95 (see p. 40).

- We reviewed DHEC's use of per visit employees in the bureau of home health and long term care and found no material problems (see p. 40).

Introduction

Background and History

The General Assembly created the Department of Health and Environmental Control (DHEC) in 1973 by reuniting the State Board of Health (created in 1878) and the Pollution Control Authority. The department is supervised by the South Carolina Board of Health and Environmental Control. The board has seven members who are appointed by the Governor with the advice and consent of the Senate for four-year terms. There is one member from each of the state's six Congressional districts and one at large. The at-large member is the board chairman.

According to §44-1-110 of the South Carolina Code of Laws, DHEC ". . . is the sole advisor of the state in all questions involving the protection of the public health . . . ." The board is empowered to make, adopt, promulgate, and enforce reasonable rules and regulations for the promotion of the public health and the abatement, control, and prevention of pollution. The department is headed by a commissioner and is divided into five deputy areas: health services, health regulation, environmental quality control, administration, and ocean and coastal resources.

Health Services

Health services is the largest part of DHEC's operations. In FY 94-95 health services comprised 76% of the department's expenditures and 73% of its employees (FTEs) (see p. 44). Health services oversees personal health programs that serve the citizens of South Carolina. Some programs focus on preventive health and attempt to stop the spread of communicable diseases, including tuberculosis and sexually transmitted diseases. Other programs focus on maternal and child health, such as the women, infants, and children (WIC) and family planning programs. DHEC also provides home health medical services. Environmental health programs oversee environmental conditions, for example, by performing restaurant inspections and issuing septic tank permits.

South Carolina has centralized administration of public health. DHEC health services has a central program and administrative unit in Columbia, 13 health district offices, and health departments in each of the state's 46 counties. District and local health department staff are state employees.

Plans for the Future

In 1994, the General Assembly established an advisory committee on the future of public health in South Carolina. The committee was to study what appropriate changes should be made in the public health responsibilities, functions, and resources of all state agencies involved in public health.

DHEC's commissioner served on the committee and identified the following agenda for public health agencies:

- ❑ Adjust to the changing health care environment.
- ❑ Continue and expand the focus on prevention.
- ❑ Participate in partnerships between the public and private sectors.
- ❑ Plan for transitioning health care functions now performed by public health to the private sector without stripping the public health sector of necessary funds.

DHEC's 1995 strategic plan states that the department will remain positioned to accomplish the core public health functions of assessment, policy development, and assurance. This may result in changing services and reallocating resources based on the needs of communities and the agency's customers.

Audit Objectives

The objectives for sunset audits are set in statute (§1-20-10). The statutory objectives and our responses to them are presented in Chapter 5 (see p. 43). Based on the need to target our use of audit resources, we consulted with members of the reorganization commission and identified specific fieldwork objectives to guide our review:

- Determine the economic, fiscal, and other impacts that would occur if DHEC terminated its provision of home health services (see p. 7).
- Review how DHEC measures the efficiency and effectiveness of its health services programs (see p. 14).
- Review DHEC's health services eligibility screening for efficiency and compliance with standards (see p. 17).
- Determine the efficiency with which DHEC processes complaints about food service establishments (see p. 21).
- Determine the extent to which DHEC issues septic tank permits in compliance with state law and regulation (see p. 22).
- Determine whether DHEC has adequate procedures for collecting health services accounts receivable (see p. 23).
- Determine whether DHEC has an adequate system for identifying and collecting third-party payments for health services (see p. 26).
- Determine the consistency with which DHEC allocates funding and personnel to the 13 DHEC health districts (see p. 27).
- Review the efficiency and effectiveness of DHEC's management of health services information resources (see p. 33).
- Determine whether the central (Columbia) office and district offices of health services could be made more efficient (see pp. 37, 39, 40).
- Determine the costs and benefits of DHEC's use of employees other than permanent FTEs for health services (see p. 40).

Scope and Methodology

Our review of DHEC's health services targeted specific objectives that we developed in response to the overall sunset objectives. Limited audit resources, in conjunction with the statutory publication date, did not permit a comprehensive review of health services managed by the department. We excluded review of other parts of DHEC (health regulation, environmental quality control, ocean and coastal resources, and administration), except as they related to our audit objectives and the programs under review.

We focused our review on FY 94-95, with consideration of earlier years for some areas. In all areas we noted current developments and agency plans. The primary criteria we used to measure performance were state and federal laws and regulations governing the provision and funding of health services. We also considered our 1986 audit of DHEC, other state laws and regulations, reports and standards from individual researchers and other audit and professional organizations, and general principles of financial and program management.

We reviewed DHEC's management controls to ensure client eligibility, recoupment of third-party payments, and collection of accounts receivable. We also reviewed controls in environmental health programs dealing with food service complaints and septic tank permits.

Our primary sources of evidence included:

- DHEC administrative, program, and client records.
- DHEC publications, policies and procedures.
- Interviews with officials from DHEC, other SC agencies, and other state and federal agencies.
- Reports and publications from other states and organizations.
- Studies about health care costs and other public health issues.

We visited 8 of the 13 health districts to conduct fieldwork and conducted limited sampling of client files from health services programs, as well as restaurant complaint and septic tank permit files. We did not conduct a comprehensive review of the reliability of computer-generated data provided by DHEC. In most cases we did not rely on computer-generated data to meet our audit objectives. Also, when DHEC's computer-generated data was viewed in context with other available evidence, we believe the opinions, conclusions, and recommendations in this report are valid.

This audit was conducted in accordance with generally accepted government auditing standards.

Program Issues

In this chapter we discuss issues that focus on DHEC's health services programs. We describe the effect if DHEC were to terminate its provision of home health services. We suggest improvements in DHEC's process for measuring program performance. We also address specific issues in the women, infants, and children (WIC), children's rehabilitative services (CRS), and environmental health services programs.

Home Health

If DHEC were to reduce or end its provision of home health services or to no longer limit entry into the home health industry, there would be potential for higher medicare and medicaid costs under current payment systems. However, these changes would result in increased business opportunities for non-DHEC providers.

Background

Home health agencies provide medical services to patients in their homes. Prescribed by physicians, these services include skilled nursing, physical therapy, dietary counseling, and medical social services. In South Carolina home health care is available from providers such as DHEC, hospitals, and other organizations.

Nationwide, the home health industry receives about 75% of its income from medicare and medicaid. In 1993, South Carolina providers received approximately $115.7 million from medicare and $6.5 million from medicaid.

Medicare is 100% funded by the federal government. Medicare payment rules are established by the federal government. Medicaid in South Carolina is 71% funded by the federal government and 29% by state government. Medicaid rules are established by state governments within federal guidelines.

Table 2.1 shows that 1993 medicare payments for home health services in Kentucky, North Carolina, and South Carolina were significantly lower than payments in the other southeastern states.

Table 2.1: 1993 Medicare Home Health Payments

	Payments Per Home Health Patient	Payments Per Medicare Enrollee[a]
Alabama	$4,517	$486
Florida	$4,016	$390
Georgia	$4,930	$491
Kentucky	$2,961	$239
Mississippi	$4,548	$602
North Carolina	$3,037	$234
South Carolina	$3,284	$239
Tennessee	$5,911	$752
United States	$3,412	$272

a Total medicare home health expenditures divided by total medicare enrollees, including enrollees who did not receive home health care.

Source: U.S. Department of Health and Human Services.

Home Health Care Provided by DHEC

Section 44-1-200 of the South Carolina Code of Laws states that DHEC ". . . may provide home health services to those persons living in areas of the State in which adequate home health services are not available . . . ."

DHEC provides home health care in every South Carolina county. There are also non-DHEC providers in every county. Of the five counties where DHEC's market share was highest in 1994, all had below-average per capita income and population density in 1993. Of the five counties where DHEC's market share was lowest, four had above-average per capita income and three had above-average population density.

Table 2.2 summarizes the FY 94-95 revenues and expenditures reported by DHEC for its home health program. We did not determine whether the program is self-supporting. It is not clear what portion of the overhead expenditures would continue to be incurred if the program were terminated.

Table 2.2: DHEC's Home Health Program — FY 94-95 Revenues and Expenditures

Cash Revenues	
Medicare	$54,795,210
Medicaid	$4,734,046
Private Pay	$5,032,629
State Appropriations	$318,753
Total	**$64,880,638**
Cash Expenditures	
Direct Expenditures	$63,576,220
Overhead Expenditures	$6,757,889
Total	**$70,334,109**

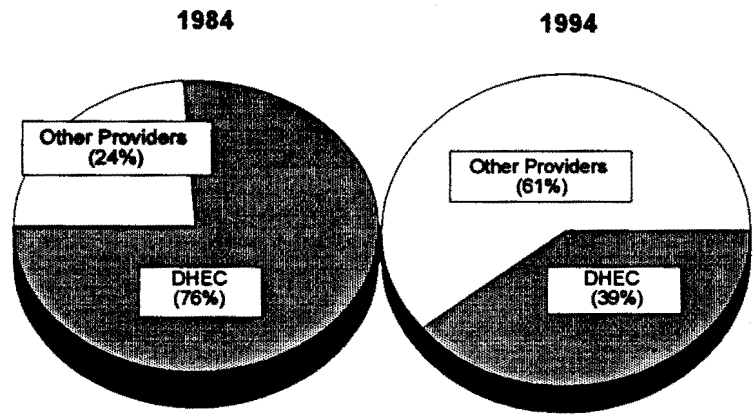
DHEC's Decreasing Market Share

From 1984 through 1994, the number of home health patients served by DHEC increased 26% while the number served by non-DHEC providers increased 531%. As a result, DHEC's market share decreased from 76% to 39% (see Figure 2.1).

The General Assembly amended §44-69-30 in 1995, authorizing DHEC to enter home health partnerships with other providers and to sell or otherwise transfer its home health licenses.

In 1995, DHEC signed contracts under which two non-DHEC providers would be paid a fee to serve DHEC's patients. DHEC did not transfer ownership of its home health licenses. The areas served under the new contracts include Chester, Lancaster, and York counties, and Beaufort, Colleton, Hampton, and Jasper counties. Both contracts include a requirement that services be available to indigent patients. DHEC officials stated that they plan to enter into similar agreements with other non-DHEC providers.

Figure 2.1: Home Health Services — DHEC's Market Share — 1984 and 1994



Guidelines For Providing Services Through Other Organizations

In 1996, DHEC developed guidelines for determining whether to provide home health services, currently provided by DHEC, through other organizations. The department's objectives are to:

> . . . continue to assure the provision of high quality patient care, continued provision of services to indigent patients, employment of [DHEC] home health staff, provision of home care services adequate to meet the needs of the state, and a contribution to the overall improvement of public health benefits to the community.

DHEC's guidelines do not require that the effect on medicare and medicaid costs be considered.

DHEC's guidelines, however, do not require that the effect on medicare and medicaid costs be estimated or considered before the department reduces the quantity of services it provides or enters into agreements with other organizations.

The Effect of DHEC's Market Share on Medicare and Medicaid Costs

Transferring DHEC's home health services to other providers can affect medicare and medicaid costs. The specific effect depends on how much DHEC's payment rate and number of visits per patient differ from those of other providers.

Medicare and medicaid rates in South Carolina are based on factors including individual home health agency costs per visit and the number of visits. In 1996, DHEC's interim medicare payment rate per home health visit was approximately $55 while the median rate for all South Carolina providers was $61.

In 1995, DHEC provided 58.9 visits per patient while the median among all South Carolina providers was 58.2. Among DHEC's 13 health districts, average visits per patient ranged from 44.3 to 77.1.

If DHEC were to no longer provide home health services, there would be increased business opportunities for non-DHEC providers. However, there would also be potential for higher medicare and medicaid costs.

Certificates of Need

Sections 44-69-30 and 44-69-75 of the South Carolina Code of Laws require that each home health agency obtain a certificate of need (CON) and a license from DHEC before providing services. In addition to South Carolina, 19 other states require home health CONs of various forms.

On a county-by-county basis, DHEC limits the number of home health agencies to which it issues CONs. Each home health agency may provide an unlimited quantity of services in the counties where it has legal authority to conduct business. From 1984 to 1994, the total of non-DHEC home health agencies increased from 67 to 180.

DHEC's Process for Issuing CONs

Section 44-7-120 states that the purpose of the CON and licensure requirements is to:

> . . . promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities . . . .

The 1995 state health plan permits an additional CON to be issued in each county that is below the state average in home health patients served or visits made per thousand population. However, since there will always be counties with below average quantities of home health care provided, this formula can always be used to justify an increase in the number of home health agencies.

Section 44-69-75 does not require agencies that provide only one type of home health service, such as skilled nursing alone or physical therapy alone, to obtain CONs. Agencies whose mix of services does not include skilled nursing are not required to obtain CONs. As a result, similar organizations are not regulated in a similar manner.

The Effect of CONs on Medicare and Medicaid Costs

It is uncertain whether South Carolina's CON process has helped limit home health costs.

We found no academic research on the effect of CON requirements on overall home health costs. There are studies indicating that CONs can sometimes increase home health costs per visit; however, we found none that measured the effect of CONs on the quantity of home health services provided. The number of visits provided and the number of patients served can sometimes affect overall costs more than cost per visit. The studies also did not account for variation in the way different states administer CON programs.

Without a CON process, there would be additional providers. However, the increased competition might not result in lower costs. Medicare and medicaid give little incentive for providers to limit their costs or the number of visits they make. Both pay a specific rate per visit. Providers with higher costs per visit and providers that make more visits receive greater payment up to predetermined maximums.

Proposed Changes in Medicare

Congress is considering legislation that would base medicare home health payments on predetermined rates, independent of the number of visits per patient. If this method of payment were implemented, there would be increased incentive to limit costs and visits per patient. DHEC's market share would have little or no effect on medicare costs. In addition, there would be little justification for using the CON process to control costs.

DHEC's Dual Role In Providing and Regulating Home Health Care

Because DHEC operates its own home health agency while also limiting the number of non-DHEC home health providers, there is an organizational conflict of interest.

This conflict of interest could be reduced, but not eliminated, by transferring the responsibility of issuing CONs to another organization in state government. However, a transfer would not be necessary if the medicare and medicaid payment systems were changed so that the CON process is no longer needed.

Conclusion

If DHEC were to reduce or end its provision of home health services or no longer limit entry into the home health industry, non-DHEC providers would have increased business opportunities.

Medicare and medicaid payments, however, are based on provider costs per home health visit and the number of visits provided. DHEC's costs per visit and visits per patient are often lower than those of other providers. As a result, when DHEC reduces or ends its services, medicare and medicaid payments may sometimes increase. Eliminating the CON requirement also has the potential to result in higher medicare and medicaid payments under current payment systems.

Until the medicare and medicaid payment systems are changed to predetermined rates, independent of the number of visits per patient, a conservative interim approach would be to reduce or end DHEC-provided home health services on a case-by-case basis while increasing CONs on a case-by case basis.

Recommendations

1. DHEC should amend its guidelines to require that department staff estimate and consider the potential effect on medicare and medicaid costs before changing the quantity of home health services provided by DHEC or entering into agreements with other organizations.
2. If the medicare program is changed so that home health payments are based on predetermined rates, independent of the number of visits per patient, the General Assembly may wish to consider amending the South Carolina Code of Laws so that home health agencies are not required to obtain certificates of need. In addition, the General Assembly may wish to consider amending state law so that the basis for medicaid home health payments remains similar to the basis for medicare home health payments.

Measuring the Performance of Health Services Programs

DHEC has regularly measured the efficiency and effectiveness of its health services programs. Our review confirmed that the department has generally selected appropriate performance measures. However, DHEC needs to improve its reporting process to give the General Assembly and the public the information necessary to understand and assess its performance.

We reviewed the performance measures reported in DHEC's annual report for FY 93-94 and the measures for FY 94-95 as reported to the Governor (annual report information for FY 94-95 was not yet available). We concentrated our review on measures for the following programs:

- Family planning.
- Sexually transmitted diseases (STD)/HIV.
- Immunization.
- Women, infants, and children (WIC).

Performance measures should be easily understood by those not well acquainted with the program.

Performance measures provide information to legislators and to the public. Since FY 93-94, agencies have been required by law to make an annual accountability report which contains the agency's "mission, objectives to accomplish the mission, and performance measures that show the degree to which objectives are being met."[1] For performance measures to provide an effective snapshot of programs, they must be easily understood by those not well acquainted with the program. Our review focused on whether the measures DHEC used were appropriate, as well as whether the information provided was accurate, complete, reliable, and useful.

The majority of performance measures used by the programs we reviewed were appropriate. We found many of DHEC's measures in model standards published by the American Public Health Association, Department of Health and Human Services Centers for Disease Control, and the Governmental Accounting Standards Board. For example, DHEC measures the percent of 2-year-old children with completed immunizations, the incidence rate of STDs, the percent of women receiving prenatal care in the first trimester, and the number of persons receiving family planning services. All of these measures can be found in model standards. Although the measures were generally appropriate, we found the following problems which indicate a need for improvement.

1. In 1995 this requirement (formerly in appropriation act provisos) was codified in §§1-1-810 and 820 of the South Carolina Code of Laws.

Incomplete Performance Measures

In DHEC's FY 93-94 annual report, the WIC program reported exactly the same information as it had for the prior year. A change in databases had prevented the acquisition of current data; however, DHEC's report did not explain why WIC reported the same numbers for the second year in a row. The STD/HIV program listed measures showing how it reached members of specific target groups. However, the program excluded mention of a major target group (homosexual and bisexual males) from its performance measures. In the FY 93-94 annual report, maternal and child health identified outcome measures such as mortality rate and rate of low birth weight babies, but neglected to report any data for these measures.

Measures With Dated or Inappropriate Information

The family planning program reports the percent of population in need of services who are being served. However, the program reports an "apples and oranges" measure. The reported measure inappropriately compares the total number of clients served (which includes all income levels) to the number "in need." The number "in need" is defined as all teenagers at risk of unintended pregnancy plus all women below 150% of poverty at risk of unintended pregnancy. Also, the program's "in need" information is based in part on 1987 data, which is compared to the number served in FY 94-95. The WIC program reported cost data (cost per participant) derived from projected number of clients served, when reported performance data should be based on actual experience, not projections.

Inadequate Explanation of Measures

We found instances where the connection between measures used and program goals and objectives was not obvious in DHEC's reports. For example, the family planning program reports the percent of under-15-year-old clients continuing in family planning. When we asked why this measure was used, we were informed that teenage mothers' babies have higher rates of low birth weight and infant mortality. Since these conditions are major concerns of maternal and child health, the under-15-year-old continuation rate is related to outcome goals. However, the annual report did not provide adequate explanation. Also, for several years the HIV program measured progress toward a goal of 3% positive HIV tests. The annual report did not explain the purpose of this goal and its relation to overall HIV/AIDS goals and objectives.

Documentation and Accuracy of Information

Some programs could not furnish evidence of the source of the measures reported.

The General Assembly requires that agencies be accountable for their performance. However, DHEC does not keep copies of printouts and other sources of performance data. Some programs could not furnish any evidence of the source of the numbers reported for some measures. For example, the STD program provided no documentation for half of the measures reported in FY 93-94.

DHEC also needs to improve controls over the accuracy of its information. Although we found no inaccuracies which would change conclusions, DHEC reported some incorrect information. We found inaccuracies in information provided by the immunization, WIC, family planning, and STD programs. For example, DHEC inaccurately reported the number of K-12 school children with completed immunizations for the 93-94 and 94-95 school years.

Immunization Progress

According to staff, DHEC, as well as the Governor's office targeted childhood immunizations as an important public health goal beginning in 1992. As a result of their efforts, South Carolina is now among the top states in childhood immunizations. The percentage of 2-year-olds with completed immunizations has risen from 62% in 1992 to 90% in 1995. We reviewed the methodology that DHEC used to determine the percentage of 2-year-olds with completed immunizations and found no problems.

Recommendations

3. DHEC should ensure that its annual accountability reports to the Governor and the General Assembly contain performance data that is accurate, complete, and reliable. Reports should provide sufficient explanatory and background information and indicate any problems with the data used.

4. DHEC program areas should retain records that document the source of information provided in performance measures.

Participant Eligibility

Many of DHEC's health services are available to citizens who meet medical or categorical (age, sex, etc.) eligibility requirements regardless of income. In some programs, those with incomes above a certain level are asked to pay a portion of the cost. Other DHEC programs have income eligibility limits. Individuals who earn more than a certain income cannot receive services. We reviewed two programs that have income eligibility limits: the women, infants, and children (WIC) program and the children's rehabilitative services (CRS) program.

WIC Program

DHEC does not require that applicants for the WIC program submit proof of income when applying for services. Since documentation is not required, it may be easy for ineligible applicants to obtain WIC services.

The WIC program provides vouchers for supplemental foods, such as milk, cereal, and baby formula. In FY 94-95, approximately $56.5 million was spent to purchase food for WIC participants in South Carolina. The program also provides nutritional education to pregnant, postpartum, and breast-feeding women, infants, and children up to age five. The income eligibility level for WIC is at or below 185% of poverty. For example, as of April 1, 1995, a family of four could make up to $28,028 and still be eligible for WIC services. The average monthly benefit per participant in federal FY 94-95 was approximately $42.

DHEC does not require the applicant to provide documentation and does not perform verification of income.

When applying for WIC services, applicants are allowed to self-declare their income. DHEC does not require the applicant to provide documentation, such as a pay stub, and does not perform any independent verification of income. However, a significant percentage of WIC applicants do have their income verified prior to receiving services. Under federal regulations [7 C.F.R. §246.7(d)(2)(vi)], applicants for the WIC program who are currently on medicaid or who are receiving aid to families with dependent children (AFDC) or food stamps are automatically income eligible for WIC. In order to receive medicaid, AFDC and food stamps, applicants must provide proof of income which is independently verified by the Department of Social Services. DHEC estimates that approximately 40% of WIC participants are covered by medicaid.

A 1985 GAO report recommended that the United States Department of Agriculture (USDA), which administers the WIC program, promulgate regulations requiring documentation of applicant income. USDA's current regulations do not require that applicants provide proof of income but do allow states the option of requiring participants to document their income. A 1992 biennial report on WIC participants found that 25 (50%) states required income documentation.

An alternative to requiring all applicants to provide proof of income when they apply for services would be to audit a sample of participants annually and document their income to ensure their eligibility. Such a process is used in the national school lunch program. Each year a sample of no more than 3% of the families receiving free or reduced price lunches is reviewed. These families are requested to provide written documentation of current income.

In FY 94-95, if 5.8% of WIC benefits went to ineligible participants, it would have amounted to over $3.2 million.

DHEC staff cited several concerns about requiring WIC applicants to provide income documentation. For example, some eligible applicants may be denied services if they cannot provide adequate documentation of income. Also, staff stated it is unlikely that income verification would reduce the number of ineligible WIC participants, and it would definitely increase administrative costs. Further, due to the low average monthly benefit, the amount of funds lost per individual client is not great. None of the other seven states in USDA's southeast region requires statewide income verification.

A national study conducted in 1988 estimated that approximately 5.8% of WIC benefits went to ineligible participants. If South Carolina is average and 5.8% of the $56.5 million spent to purchase food in FY 94-95 went to ineligible participants, it would amount to over $3.2 million. Requiring documentation of income, either at the time of application, or through an annual audit process, could decrease the number of ineligible applicants receiving services and allow more eligible participants to be served. Further, requiring income verification could help deter individuals from attempting to falsely obtain WIC benefits by misstating their income.

Recommendation

5. DHEC should implement an ongoing system of verifying income for a sample of WIC participants whose income has not been verified by other programs.

WIC Complaints

DHEC needs to improve its process for investigating complaints of abuse of the WIC program. When DHEC receives complaints concerning participants who are ineligible or who may be selling WIC vouchers, it does not thoroughly investigate these complaints.

South Carolina's WIC FY 94- 95 state plan states, "Verification of income for WIC participation is *not* allowed unless the clinic has a completed WIC Complaint Form . . . ." Once the form has been completed, DHEC can request that the subject of the complaint provide proof of income. Federal regulation (7 C.F.R. §246.23) allows DHEC to recover the cost of the benefits from the participant, unless the recovery would not be cost effective. South Carolina's WIC FY 94-95 state plan allows participants to be discharged from the WIC program for three months if they abuse the program.

We reviewed a judgmental sample of 17 complaints received in 1994 and 1995 concerning WIC participants who were alleged to be either income ineligible or selling or exchanging their WIC vouchers for cash. In one case we reviewed, a complainant alleged that a WIC participant's income was above WIC's income eligibility limit. DHEC staff requested documentation by phone and by letter but never received it. The WIC participant continued to receive WIC vouchers after the requests for documentation had been made. In another case of alleged income ineligibility, DHEC's investigation consisted of re-screening the applicant. Since WIC income is declaratory, the participant was simply asked again what her income was but was not required to provide any documentation.

No WIC participants were discharged from the program in 1995 due to abuse.

We also found two cases where WIC participants were alleged to be selling infant formula purchased with WIC vouchers through the classified section of the newspaper. In both cases, DHEC told the participant that selling the formula was against program rules but took no further action. According to DHEC staff, no participants were discharged from the WIC program in 1995 due to abuse.

Requiring participants to provide proof of income when income ineligibility is alleged could decrease the number of ineligible applicants receiving services. In addition, it could serve as a deterrent to other individuals who might attempt to obtain WIC vouchers by falsely stating their incomes.

Recommendations

6. When a complaint alleging income eligibility is made, DHEC should require that WIC participants provide documentation of income and should discontinue services if documentation is not provided.

7. If a WIC participant is found to have abused the program, DHEC should discharge the participant from the program and take action to recover the cost of the benefits if it is cost effective.

Children's Rehabilitative Services (CRS) Program

DHEC does not require applicants for the CRS program to submit proof of income when applying for services. Since no documentation is required, it may be easy for applicants to obtain CRS services for which they are not eligible.

The CRS program was created to help provide medical services to children with special health care needs. Some of the medical conditions covered are sickle cell anemia, cystic fibrosis, and heart disease. The income eligibility level for CRS is at or below 200% of poverty. For example, as of March 1, 1995, a family of four could make up to $30,300 and still be eligible for CRS services. The average cost per patient for the approximately 12,000 children enrolled in the CRS program in FY 94-95 was $945. However, costs can be much higher. For example, in FY 93-94, CRS spent more than $10,000 per child for 26 children.

When applying for CRS services, applicants are allowed to self-declare their income. DHEC does not require the applicant to provide documentation. CRS periodically updates the income of its clients. However, the financial updates are either obtained when the child visits a clinic or mailed to the home to be filled out and returned by the parents. In both cases, DHEC does not require documentation and does not verify the amount reported.

While DHEC does not require income documentation or verify income, a significant percentage of CRS clients do have their income verified. Approximately 67% of CRS clients receive medicaid services, and in order to qualify for medicaid, these clients must provide proof of income which is then verified by DSS.

CRS staff expressed concern that verifying income of applicants could result in delays in children obtaining needed services and would require additional staff to implement. CRS currently obtains financial updates every six months for non-medicaid CRS clients while medicaid clients are updated yearly.

An income verification policy could result in more medicaid-eligible clients being identified.

Section 30.5 of the FY 95-96 Appropriation Act requires that CRS make use of all other available funds, including medicaid, prior to using its funds. CRS received over $4 million in state appropriations in FY 95-96. The CRS application contains a statement allowing DHEC to verify income information. Prior to a recent change limiting its program to medicaid recipients, North Carolina required CRS clients to provide income documentation only prior to inpatient hospitalization. Georgia requires all applicants to provide proof of income. One benefit of this policy, according to a Georgia official, is that it clearly documents which clients are eligible for medicaid.

Requiring documentation of income, particularly at the time of application, could help prevent ineligible applicants from receiving services and allow more eligible participants to be served. Further, requiring income verification could help deter individuals from attempting to falsely obtain CRS benefits by misstating their income. It could also result in identification of more medicaid-eligible clients.

Recommendation

8. DHEC should consider amending its procedure to require applicants for the CRS program who are not on medicaid to provide proof of income, particularly at the time of the initial application.

Complaints Against Food Service Establishments

DHEC does not have an agencywide written policy outlining how complaints against food service establishments should be handled. As a result, DHEC's district offices and county health departments have differing procedures for investigating consumer complaints.

Neither district offices nor county health departments are required to maintain complaint logs, use standardized complaint forms, investigate complaints within a certain time period, or notify complainants of resolutions. We found that some districts and counties, however, have implemented some policies and procedures. For example, two of three counties we visited maintained a complaint log. Also, one county has a written policy requiring inspectors to investigate complaints within a specified number of days. An agencywide written policy would help ensure that complaints are handled thoroughly and consistently throughout the state.

Recommendation

9. DHEC should implement an agencywide written policy outlining how complaints against food service establishments should be handled.

Septic Tank Permitting Program

We did not find any material problems with DHEC's controls to ensure that onsite sewage treatment and disposal system (septic tank) permits are issued in compliance with state laws and regulations. DHEC has uniform policies and procedures for issuing permits to construct, approving systems for installation, and handling permit denials and appeals. DHEC's state officials also conduct regular reviews of district performance in issuing permits.

In our 1986 audit, we found that the state office was not ensuring that deficiencies they identified in the reviews were being corrected. We recommended that district officials be required to provide a corrective action plan outlining methods to correct deficiencies. We reviewed all program and system surveys completed by the state office in 1995 through April 1996. The districts are now required to address any deficiencies and outline their plans for corrective action. This process provides increased control over permit approvals.

We conducted a limited review of permit files in three counties and found documentation that the permitting process was generally conducted in accordance with state laws, regulations and DHEC policy.

Financial Issues

In this chapter we discuss areas where DHEC could improve its financial management. We identified issues regarding accounts receivable, identifying clients' insurance coverage, program funding allocations, and fees and accounting services in the babynet program.

Collection of Accounts Receivable

DHEC does not have an adequate system for billing, tracking, and collecting accounts receivable. Health services does not know how much is owed or how much remains uncollected from private pay patients. There is no agencywide policy for the billing and collection of money due. Instead, each health services program and district establishes its own policies. This may result in the inconsistent treatment of clients and also result in lost revenue.

Section 44-1-180 of the South Carolina Code of Laws allows DHEC to establish charges for its services. The charges must be based on the cost of providing the service. Federal law requires that the family planning program develop a patient pay system for charging patients whose income is above a certain level.

While DHEC has established charges for services in certain programs, it has not developed adequate policies for billing and collecting accounts receivable. DHEC's central bureau of finance does not track private pay receivables. DHEC's third- party administration manual does not address the billing and collection of outstanding accounts receivable. The bureau of finance's internal procedures manual also does not address billing and collection of private pay accounts receivable.

Family planning and the DHEC laboratory are two major programs that bill individuals and companies for the services they provide. Both have inadequate policies for billing and collecting accounts receivable.

Family Planning

The family planning program does not have a written billing and collection policy. Billing and collection practices vary from district to district. We requested information from the 13 health districts on the amount of private pay accounts receivable outstanding as of March 31, 1996. Not all districts were able to provide the information. However, nine districts reported over $374,000 in outstanding accounts receivable.

The family planning program provides services to any woman of childbearing age. These services include the provision of birth control, HIV testing, education, counseling, and nutritional assessment, and are provided free to women whose income is below 100% of the federal poverty guidelines and to teenagers. Patients above the poverty level are charged on a sliding fee scale. Patients with incomes above 250% of poverty are supposed to pay 100% of the cost of the services. In FY 94-95, approximately 18,000 of the 80,000 patients seen in the program were charged for some portion of the cost of services.

Health districts' efforts to collect amounts due from patients varied significantly.

A survey of districts found that efforts to collect the amounts due from private pay patients varied significantly. Most districts reported reminding patients of any outstanding balances when they came in for subsequent family planning visits. Some districts reported billing patients quarterly, while others stated they did not bill patients. One district reported sending out delinquent account letters yearly. One district reported billing patients whose outstanding balance was more than $50, while another reported billing patients with an outstanding balance over $2.

Bureau of Laboratories

The bureau of laboratories does not have written policies for the collection of accounts receivable or for writing off bad debts. The bureau provides laboratory testing in support of DHEC's programs and to private providers, such as hospitals and physicians.

In FY 94-95, the bureau earned more than $1,489,000 from the provision of laboratory services to private providers. However, as of April 1, 1996, the bureau had over $114,000 in accounts receivable that were more than 90 days old. There were 338 individual invoices that were more than a year old.

According to a laboratory official, they do not regularly bill for any outstanding balances. In addition, since 1992 the bureau has only rarely written off any debt.

Agency Perspective

According to DHEC officials, collection of outstanding accounts receivable for health services programs is complicated. DHEC officials stated that a vigorous collection effort might discourage patients from obtaining needed services. The agency believes that the long-term effect of discouraging treatment could be that more costly treatment would be needed in the future.

DHEC staff have been aware of the need for an improved system for billing, tracking, and collecting accounts receivable. In 1990, it was proposed that DHEC establish an internal collection unit to assist in the collection of accounts receivable. No such unit has been created. In October 1995, DHEC officials considered contracting with a collection agency for the collection of unpaid fees but officials in health services felt that use of a collection agency was not feasible at that time.

Conclusion

An important part of any payment system is the billing and collection of outstanding accounts receivable. Variations in collection policies can result in inconsistent treatment of clients. In addition, districts or programs with inadequate collection policies may not be collecting as much revenue as they could.

Recommendation

10. DHEC should establish a comprehensive system for billing and collecting accounts receivable for all health services programs. The system should identify:

    - Who is responsible for billing and collecting accounts receivable.
    - What procedures are to be followed to collect outstanding accounts, including sending bills at specified intervals to patients or other providers.

    When reasonable efforts to collect have been exhausted, DHEC should ensure that accounts are written off.

Identifying Third-Party Payers

DHEC can improve its system for identifying and billing private insurance for patients not covered by medicaid. DHEC's current method for identifying private insurance is to ask patients if they have private insurance coverage. If patients say they do not have insurance, DHEC takes no further action. Also, each program collects insurance information independently. As a result, insurance may pay for services in one program while another program has no knowledge of the client's insurance coverage (see p. 35). DHEC may be paying for services that are covered by private insurance.

The medicaid program, administered by the South Carolina Department of Health and Human Services (HHS), makes a greater effort to identify insurance coverage. Medicaid is designed to be the payer of last resort for medical services. In order to ensure that the program is payer of last resort, the federal government mandates that states take reasonable measures to discover any other third-party payer. In part to satisfy this requirement, HHS has contracted with a private company to pursue and verify insurance leads on medicaid clients.

If patients report they have no insurance, DHEC takes no further action.

According to an HHS official, between 10% and 15% of medicaid clients have private insurance. The official estimated that HHS was able to recover approximately $14 million from private insurance companies in 1995. HHS identifies patient insurance from a variety of sources. Approximately 55% of the insurance information comes from medicaid applicants. However, 45% of the coverage is identified from other sources, such as insurance companies, attorneys, and a match with Employment Security Commission data.

DHEC officials stated that searching for insurance coverage for non-medicaid clients could increase the agency's administrative workload. In addition, it is questionable whether private insurance would cover many services that DHEC provides. However, it is possible that DHEC could increase revenue by more actively pursuing clients' insurance coverage.

Recommendation

11. DHEC should more actively pursue private insurance reimbursement for services provided to non-medicaid clients. A contract with a private company similar to that used by the Department of Health and Human Services is one option that should be considered.

Allocation of Health District Funding

DHEC does not have adequate procedures for allocating funds to its 13 health districts. Program funds are not consistently allocated to health districts based on the relative needs of each district. As a result, there is reduced assurance that services are provided consistently across districts.

In FY 94-95, funding per population at or below 185% of the poverty level ranged from $116 per person in one district to $230 in another. This degree of variation indicates that funding allocations may not be directly related to a district's need for services.

There are many factors which could affect a district's need for services. Among these factors are the availability of other providers, ability to attract staff, poverty, size of a district, population density of a district, and health of the district population. A district's need for services may not be directly related to the amount of service provided in previous years. For example, two districts that provided the same amount of services in a prior year may have significantly different numbers of clients in need of services.

We reviewed the allocation of funds to four areas: environmental health services, family planning, the women, infants, and children (WIC) program, and the maternal and child health (MCH) block grant. We also spoke to several district officials. We found:

- DHEC allocates environmental health services funds based on the number of staff in each district. The department adjusts staffing levels when vacancies occur or additional funds are received, based on a formula that partially takes into account relative district need. For example, the formula includes a factor based on the number of restaurants, assuming five inspections per year. However, the factor for septic tank site inspections is based on the number of "activities" conducted in the previous year. This factor may not be directly correlated with need. We found evidence that DHEC has shifted positions to relatively understaffed districts and that the disparity in staffing among districts has decreased.

- DHEC allocates family planning funds based on the previous year's allocation and number of clients served. DHEC does not take into account the relative needs of districts for family planning services.

- DHEC allocates WIC administrative funds based on target caseloads derived from each district's prior year caseload. This method does not take into account the relative needs of districts for WIC services.

- MCH block grant and state matching funds are allocated on the basis of direct services provided in the previous year. This method does not take into account the district's relative need for services.

DHEC has developed a new allocation method for MCH block grant funds that officials project will be implemented in FY 96-97. The new method is described in written procedures and includes a need factor based on poverty and the overall health of a district's population. If implemented, the method will result in increased funding for some districts and decreased funding for others.

Because DHEC does not consistently allocate funds to health districts based on the relative needs of each district, there is decreased assurance that the clients of each district will receive services of comparable quality and quantity.

Recommendation

12. DHEC should allocate funds to districts according to a written methodology which takes into account the relative needs of each district.

Sliding Fee Scale for Babynet Services

DHEC has not implemented a sliding fee scale for babynet services as required by state law. South Carolina's babynet program was created in response to 1986 amendments to the federal Education of the Handicapped Act (now known as the Education of Individuals with Disabilities Act). The amendments (20 U.S.C. §1471 *et seq.*) provide funding to states to establish programs to provide early intervention services to children from birth to three years of age who suffer from developmental disabilities.

To implement the federal law, South Carolina passed the Infants and Toddlers with Disabilities Act in 1989. Section 44-7-2570(A) of the state act states: "The department shall develop a schedule of sliding fees for families with incomes above the federal poverty level." DHEC developed a fee schedule in August 1993 but has not implemented it.

DHEC officials cited several concerns about implementing a sliding fee scale. Administrative costs of collection could exceed any revenue generated by fees. The state could lose federal chapter 1 funds,[1] which are used to supplement early intervention services for handicapped infants and toddlers. A state's chapter 1 allocation is based on the number of children receiving these services at no cost to the parents. Children whose parents were charged under the babynet program could not be counted towards the state's allocation of chapter 1 funds. In addition, according to a DHEC official, babynet program officials concluded that the state law required only the development, not the actual implementation, of the fee scale.

By not implementing the babynet fee scale, DHEC has not fulfilled the intent of the law, which is to require families above the poverty level to pay a portion of the cost of services. In addition, the program may be losing revenue that could be used to provide additional services. The babynet program does not require

1. Chapter 1 of Title 1 of the Elementary and Secondary Education Act of 1965, as amended.

its clients to provide income information. However, 651 (28%) of the approximately 2,300 clients served by the program are not on medicaid and may be above the federal poverty level. It is possible that some of these clients could be charged for services.

Recommendations

13. The General Assembly may wish to consider amending §44-7-2570 of the South Carolina Code of Laws to delete the requirement for a sliding fee scale for the babynet program.

14. If the General Assembly chooses not to amend the law, then DHEC should implement a sliding fee scale and charge those families above the federal poverty level a portion of the cost of babynet services.

Use of Fiscal Agents

DHEC contracts with 13 different fiscal agents to pay bills and maintain financial records for the babynet program. This is not an efficient use of program resources. Each health district uses a fiscal agent to provide various services to children with developmental disabilities. In most cases, the fiscal agent is the county disabilities and special needs board. For FY 95-96, these contracts total approximately $675,000. Approximately $118,000 (18%) of the total is used for administrative costs associated with paying bills and maintaining financial records for the program.

According to a DHEC finance official, DHEC can do the billing and maintain fiscal records for the babynet program. DHEC handles the billing and record keeping for other health services programs.

According to a babynet official, they decided to use local entities as fiscal agents to encourage local participation in the program. In addition, nine different state agencies are involved in the treatment of babynet children and DHEC did not want to appear as if it were trying to dominate the program by assuming responsibility for all the program's administrative functions.

By contracting with fiscal agents instead of performing the services itself, DHEC may be spending more than necessary for administration. DHEC could use any savings achieved by performing babynet administrative functions to fund additional services for children.

Recommendation

15. DHEC should discontinue contracting with fiscal agents to pay bills and maintain records for the babynet program.

Administrative Issues

In this chapter we discuss ways that DHEC health services can increase the efficiency of its administration. Improved management of computer information systems, reduction in the number of health districts, consolidation of health district oversight functions, and central office staff reductions may result in increased efficiency. DHEC has recognized the potential for improvement in these areas.

Health Services Information Resource Management

From FY 90-91 through FY 94-95, DHEC spent approximately $26.5 million for health services computer systems and related salaries. However, many of these expenditures have been to manage, develop, and/or maintain a diverse collection of single-purpose systems. Improvements are needed for more efficient service delivery and use of resources.

Health services has multiple information systems that are not connected. DHEC has implemented a patient automated tracking system (PATS) that provides client demographic information for some programs and schedules clinic appointments. However, each program maintains its own separate information:

- More than 20 computer systems are used in health services.
- Most computer systems serve only one program.
- DHEC maintains at least four major billing systems for health services.
- Clients have different records for different programs.

Many health services information systems are out-of-date, and tasks which could be easily automated are performed manually:

- Some programs have computer systems that require staff to manually fill out opscan ("bubble") sheets that are mailed to Columbia for processing.
- Home health nurses fill out by hand lengthy patient admissions and physician's order forms; other staff input these data into the computer.
- Some programs do not have the capability for network transmission and contain data for a single site only.

- Staff in some programs can only obtain management reports by compiling them manually from several sources.

DHEC's Management of Information Systems

DHEC's process for managing agencywide systems has been unable to meet health services' needs. DHEC has been slow to implement change, has relied too much on in-house system development, and has not unified management or funding for automation.

Prior to 1994, DHEC had a central administrative staff that was responsible for managing information systems. Although the agency recognized that it had computer problems, management did not address these problems in a timely manner. For example, in 1986 the DHEC commissioner established a project to create a unified patient information system as "high priority," but ten years later it has not been completed. Also, according to district staff, in 1992 they were told that an automated billing system would soon be available. The districts purchased an inexpensive billing system to use in the interim, and they are still using the "interim" system in 1996.

DHEC management has not addressed information system problems in a timely manner.

Some systems that DHEC developed in-house have had many problems, and when staff leave there has been inadequate support for the systems they designed. For example, DHEC computer staff were responsible for the development of the health services laboratory information system. Our 1986 audit of DHEC stated that development of the lab system was poorly planned. In June 1985 DHEC had spent approximately $430,000 on the system and it was not complete. Since that time, from July 1985 through June 1995, the lab spent an additional $2.3 million to design and operate a system that has not been satisfactory. According to staff, the system has no documentation (written instructions describing how the system operates), and only one DHEC employee has any ability to correct system problems. Staff has prepared a request for proposal (RFP) to totally replace the system. Children's rehabilitative services (CRS) program staff stated they contract with an ex-DHEC employee to make system changes because current employees do not know the CRS system, which has no documentation.

In 1994 DHEC decentralized its management of information systems and created a health services information system (HSIS) unit. However, the HSIS unit has not managed or maintained many of the health services systems, including the home health, long term care, and CRS systems. These programs have either hired their own systems people or contracted for support.

DHEC's funding for information systems has been separate for each program. According to staff, some programs have rules that limit funding for

administrative expenditures to those directly for that program. Others, such as home health, can recoup the costs of developing information systems, but only over a period of years (which makes "up front" funding a problem). The funding and management structures have contributed to the continued existence of separate systems.

Systems Affect Agency Efficiency

DHEC's fragmented information systems have resulted in inefficiency for staff throughout health services. Staff spend too much time in record keeping. Staff in one local office stated that they have to record a child's immunization in three different automated records and two manual systems. The record-keeping requirements make training new employees difficult.

The lack of integrated financial information may result in lost revenue.

The lack of integrated financial information may result in lost revenue. DHEC's programs independently determine client eligibility and obtain financial information necessary to determine whether DHEC can obtain reimbursements for its services. We noted one case where a child participates in the babynet and CRS programs. CRS knew that the child had private insurance to pay treatment costs, but babynet was not aware of this funding source.

The current health services information systems do not provide adequate management information. For example, a manager in the CRS program stated they could improve planning and management if they had information to track expenditures by child or by diagnosis. The home health system cannot provide the current program cost information needed to negotiate rates with managed care programs. The laboratory system cannot produce statistical reports other than those placed in the system when it was designed.

DHEC's Plans

DHEC has recognized that its information systems need improvement. In 1995, the commissioner requested that an internal task force evaluate all of DHEC's information systems and recommend a future course for the agency. All proposed changes to information systems were put "on hold" until the evaluation was completed. As of June 1996, this process was ongoing. DHEC is developing agency standards for hardware and software that will allow the agency to have integrated information systems. There may be further organizational changes in information systems staff. Health services is planning to acquire and implement a unified information system, based on a system that has been piloted in one district.

Conclusion

Health services needs a unified information system. Removing barriers to shared information is of increasing concern at all levels of government. In March 1996 the Governor established the Information Resources Council of South Carolina, a public-private entity that is to encourage policy that will result in agencies sharing and having access to information resources on a statewide basis.

Impending changes in government structure and funding may give states more responsibility for managing health services programs, but fewer resources in staff and budgets. Improved use of information technology offers DHEC health services the potential for improving or maintaining services at lower cost.

As of June 1996, it was unclear whether DHEC's current plans will have greater success than previous attempts to improve agency information management. Unified management and funding of health services information systems would likely result in improvements.

Recommendations

16. DHEC should develop health services information systems that consolidate and unify client and billing information.

17. DHEC should unify the management and funding of health services information systems.

Number of Health Districts

DHEC's health service network is comprised of 13 health districts (see Figure 4.1) and 46 county health departments. Analysis conducted by DHEC staff indicates that efficiency could be improved by reducing the number of health districts.

Figure 4.1: DHEC Health Districts, 1996

In 1970, DHEC created 12 health districts. By 1981, however, DHEC had 15 health districts. Lower Savannah had been split into Lower Savannah and Edisto, Midlands had been split into East and West Midlands, and Pee Dee had been split into Pee Dee I and II.

In 1991, a DHEC committee cited potential cost savings from recombining the three districts that had been split. In addition, it cited potential savings from combining DHEC's only two-county districts, Appalachia I and II. In 1991, DHEC recombined East and West Midlands to form the Palmetto district, and Pee Dee I and II, resulting in 13 health districts. The department did not recombine Lower Savannah and Edisto nor did it combine Appalachia I and II.

DHEC's health districts have a range in characteristics. For example:

- Appalachian I and II health districts have two counties each, while Pee Dee and Upper Savannah health districts have six counties each.
- Appalachia II health district has 1,309 square miles, while Pee Dee health district has 3,562 square miles.
- In 1994, Edisto health district had a population of 117,700, while Palmetto health district had a population of 530,400.
- In 1990, Appalachia I health district had a poverty rate of 10% while Edisto health district had a poverty rate of 24%.

District consolidation may result in lower long-term administrative costs.

Positive effects of district consolidation may include lower long-term administrative costs relative to the cost of direct services. DHEC's policy is to realize savings through staff attrition. Fewer districts can also make it easier to recruit staff in rural areas and provide services in a consistent manner.

Negative effects of consolidation include increased travel time and costs as well as the increased complexity that comes from the management of a larger district. Contributing to the increased complexity are more staff and clients plus more private health service providers and local governments with which the district must interact.

Recommendation

18. DHEC should reduce the number of its health districts where it can be demonstrated that there will be long-term net benefits.

Oversight of Health Districts

DHEC's officials have been reviewing ways to streamline oversight of the department's 13 health districts. Oversight of district activities is fragmented, resulting in unnecessary complexity and reduced efficiency.

DHEC's Columbia-based program staff regularly conduct reviews of the districts. *Separate* reviews are conducted of programs including maternity, family planning, immunization, environmental health services, children's rehabilitative services, home health, long term care, tuberculosis, and sexually transmitted disease. Some reviews focus on the districts' compliance with program standards and the performance of DHEC's health professionals. Other reviews focus on third-party payments to DHEC.

Separate from its health programs, DHEC has an office of professional services. This office oversees adherence to professional standards by employees such as registered nurses, licensed pharmacists, licensed social workers, and dieticians. Periodically, the office of professional services sends staff from Columbia to each health district to evaluate the performance of DHEC's health professionals.

In October 1995, a "workgroup" comprised of DHEC staff from different functional and geographic areas found duplication of oversight activities as well as inconsistencies. This workgroup stated that:

> By consolidating existing program reviews, discipline and program audits, contract compliance, and third party reviews into one process, Central Office staff participation will be reduced by over 50%.

The workgroup recommended that DHEC eliminate its multiple reviews, reducing them to one consolidated review per year per district. The workgroup also recommended integrating this effort with self-studies conducted by the districts as well as DHEC's agencywide internal audit and quality assessment units.

A department official reported that DHEC has no written time line for implementation of these changes. Department officials have stated that the first consolidated review will be conducted in FY 96-97.

Recommendation

19. DHEC should establish and follow a time line for consolidating its health district oversight process.

Central Office Staff Reductions

In FY 95-96, DHEC significantly reduced the number of staff in its health services central office.

Between June 30, 1995, and March 31, 1996, DHEC reduced the number of permanent staff in its health services central office from 412 to 357. At the time of our review, FY 95-96 was not completed. However, DHEC officials projected that central office expenditures on permanent staff would be approximately $1.7 million lower in FY 95-96 than in FY 94-95.

As part of its effort to increase efficiency, DHEC transferred 24 full-time staff positions to a newly-formed central administrative unit to serve the Columbia-based health programs. This unit performs many administrative functions that previously were conducted by individual programs. Department officials reported that some administrative functions have not yet been transferred to the central administrative unit, which has been in operation less than a year. Budgeting is the primary function which has not been transferred fully.

Per Visit Employees

DHEC health services spent over $33 million in FY 94-95 for personnel other than full-time employees (FTEs). The majority of these employees were per visit employees who work in the bureau of home health services and long term care. These employees, primarily nurses, community health aides, and physical therapists, are paid a flat rate for each visit to a patient's home and receive a mileage reimbursement. They do not receive state benefits such as health and dental insurance, but may participate in the state retirement plan. Although DHEC has used per visit employees since 1987, their status was first authorized by the General Assembly in the FY 95-96 appropriation act.

We did not find any material problems with DHEC's use of per visit employees.

We did not find any material problems with DHEC's use of per visit employees. DHEC is not obligated to employ per visit employees unless they are needed to work. Employing persons in a per visit status allows DHEC flexibility in staffing and scheduling. This flexibility may become more important if DHEC phases out its provision of home health services in some areas. We found that 81 per visit employees were paid more than $50,000 each (not including travel reimbursements) in FY 94-95. However, DHEC has appropriate internal controls to ensure that visits are being made and services are provided. Also, we found that DHEC's per visit rates are comparable to home health per visit compensation in the private sector.

Fair Labor Standards Act

DHEC does not pay overtime to per visit nurses and therapists although some may work over 40 hours per week. DHEC considers these employees exempt from the provisions of the Federal Fair Labor Standards Act (FLSA), which governs overtime pay; however, it is not clear whether these employees meet the criteria for exemption. According to a DHEC official, DHEC's legal staff has not evaluated this issue.

Recommendation

20. DHEC should analyze the status of the per visit employees in relation to the Fair Labor Standards Act.

Sunset Issues

Issue (1) Effects of Regulation

Determine the amount of the increase or reduction of costs of goods and services caused by the regulations promulgated by and the administering of the programs or functions of the agency under review.

DHEC's bureau of environmental health services performs traditional regulatory functions for food service establishments and septic tanks. Fees charged to obtain restaurant permits may be passed on to consumers, and consumers who want to install septic tanks must pay fees that increase their costs. However, it is unlikely that these fees significantly impact the total costs of these goods and services.

DHEC's regulatory process may limit the number of food service establishments. Land owners' use of their property may be restricted if it is not approved for a septic tank. These restrictions may result in higher costs to consumers. However, the increase in costs due to regulation may be less than the costs which could result from the spread of disease from unsafe food or harmful environmental conditions.

We also reviewed the impact of DHEC's provision of home health services and found that DHEC's presence in the home health market may lower costs for consumers. DHEC's home health costs are below the median for all South Carolina providers (see p. 11).

Issue (2) Impacts of Deregulation

Determine the economic, fiscal, and other impacts that would occur in the absence of the regulations promulgated by and the administering of the programs or functions of the agency under review.

If restaurants were not required to obtain permits or pass inspections, there would be increased potential for harm to consumers from unsafe food. Harm to humans and the environment could also result from septic tanks placed in inappropriate locations or that were not designed or functioning properly. We recommend that the regulatory functions performed by the bureau of environmental health services continue.

We reviewed the impact on medicare and medicaid costs of DHEC's provision of home health services and its regulation of the home health industry through the certificate of need (CON) process. If DHEC terminated its provision of home health services or no longer limited entry into the home health industry by requiring CONs, there would be potential for higher medicare and medicaid costs under the current payment systems. However, these changes would also result in increased business opportunities for non-DHEC providers (see p. 7).

Issue (3) Administrative Costs

Determine the overall cost, including manpower, of the agency under review.

For FY 94-95, health services comprised 76% of DHEC's expenditures and 73% of its employees (FTEs). Table 5.1 shows health services expenditures by program and by type of funds for FY 92-93 through FY 95-96. State funds account for about 22% of budgeted expenditures for FY 95-96 and have shown the smallest increase (7.5%) over the period. Major federal funding sources include U.S. Department of Agriculture funds for the WIC program and the maternal and child health block grant. Reimbursements from medicare and medicaid make up the majority of other funds received by health services.

As of March 1996, health services had 4,181 FTEs. This reflects a reduction in FTEs from FY 94-95 (see p. 40). Chart 5.1 provides information about the distribution of FTEs. Approximately 9% of health services FTEs are based in the central office in Columbia; the rest are located in the health district and county

offices. In FY 94-95, personal services expenditures were approximately $167.9 million, 58% of health services expenditures. DHEC health services spent more than $33 million on employees other than FTEs in FY 94-95. We reviewed the use of non-FTE employees in the bureau of home health and long term care and found no material problems (see p. 40).

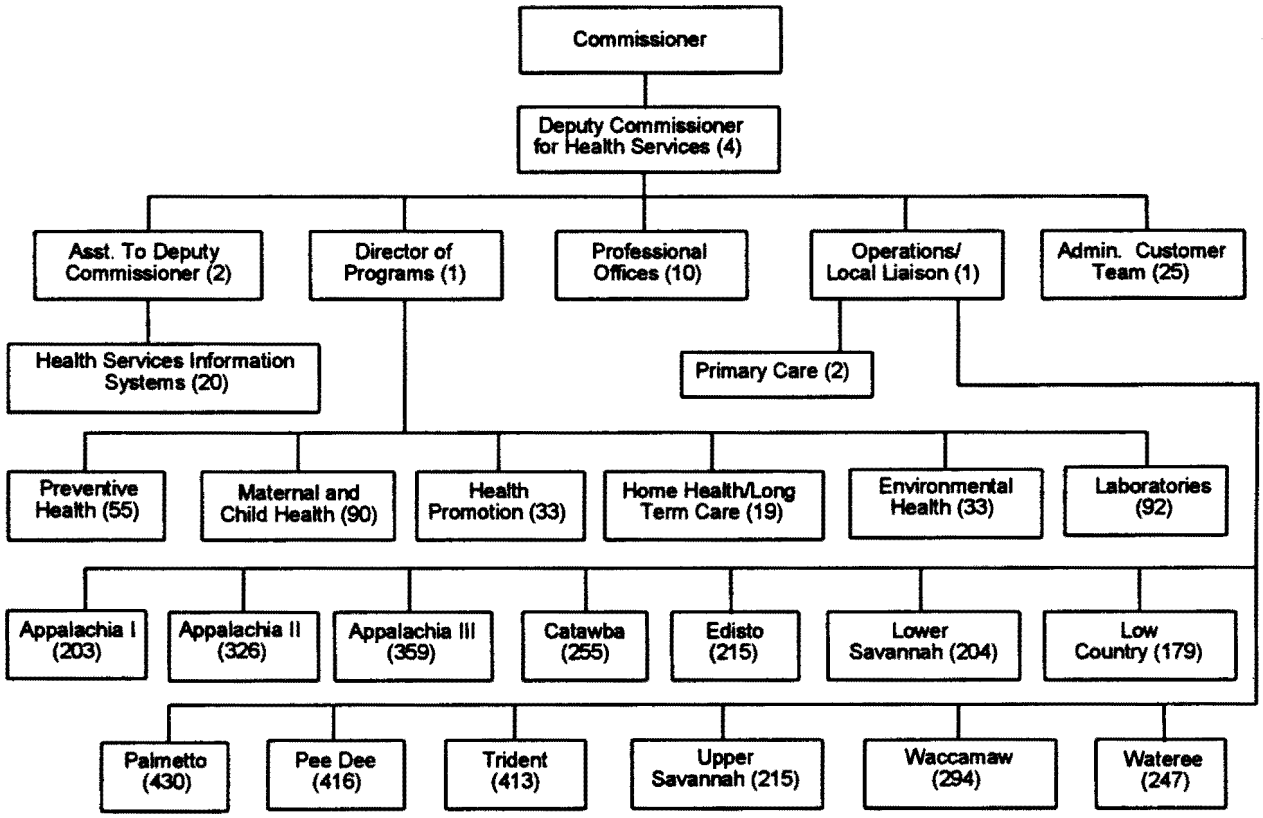
Table 5.1: DHEC Health Services[a] Expenditures by Program and Source of Funds — FY 92-93 through FY 95-96

	FY 92-93	FY 93-94	FY 94-95	FY 95-96[b]	Four-Year Increase
EXPENDITURES BY PROGRAM					
Management	$2,591,942	$2,678,004	$4,550,919	$5,901,074	127.7%
Health Promotion	$5,315,727	$6,198,962	$7,068,926	$9,819,192	84.7%
Primary Care	$1,050,734	$1,181,917	$1,029,430	$1,088,717	3.6%
Home Health/Long Term Care	$58,480,037	$69,271,016	$76,003,179	$74,143,130	26.8%
Preventive Health	$17,774,932	$19,908,700	$24,752,760	$31,087,637	74.9%
Maternal and Child Health	$104,044,651	$121,394,052	$121,976,295	$152,830,313	46.9%
Public Health Districts[c]	$34,736,979	$36,515,965	$36,631,125	$36,672,918	5.6%
Laboratories	$6,778,322	$7,230,351	$7,679,808	$8,058,055	18.9%
Environmental Health	$5,444,872	$5,684,038	$5,784,238	$5,885,504	8.1%
Vital Records[d]	$2,046,631	$1,998,883	$2,076,590		
Permanent Improvements	$100,000	$150,000			
Total Health Services	$238,364,825	$272,211,888	$287,553,270	$325,486,539	36.5%
EXPENDITURES BY SOURCE OF FUNDS					
State	$65,252,931	$65,985,817	$67,566,050	$70,127,345	7.5%
Federal	$85,699,020	$104,256,370	$105,112,812	$137,538,942	60.5%
Other	$87,412,874	$101,969,701	$114,874,408	$117,820,252	34.8%
Total Health Services	$238,364,825	$272,211,888	$287,553,270	$325,486,539	36.5%
FTEs	4,126	4,239	4,322	4,181	

a Does not include expenditures for support of health services by DHEC's central administrative services or commissioner's office.
b Budgeted.
c Primarily direct state appropriations to the districts. The districts also receive program funds.
d Vital records was relocated to the office of the commissioner for FY 95-96.

Source: Department of Health and Environmental Control and state budget documents.

Chart 5.1: Organization Chart and FTEs — DHEC Health Services, March 1996



Total FTEs = 4,181. Chart does not show 39 unallocated FTEs.

Source: Department of Health and Environmental Control.

Issue (4) Efficiency of Administration

Evaluate the efficiency and effectiveness of the administration of the programs or functions of the agency under review.

Many of the health services areas we reviewed are related to questions of efficiency and effectiveness. Our primary findings are:

- DHEC has regularly measured the efficiency and effectiveness of its health services programs. However, improvements are needed in the reporting process (see p. 14).
- DHEC's health services computer information systems are not adequate to meet the department's needs. The lack of integrated information results in inefficiency throughout health services (see p. 33).
- DHEC does not have an adequate system for billing, tracking, and collecting accounts receivable for health services programs. This may result in revenue loss and inconsistent treatment of clients (see p. 23).
- Health services needs to improve its system for identifying insurance coverage for non-medicaid clients. DHEC may be paying for services that are covered by private insurance (see p. 26).
- DHEC does not consistently allocate program funds to the health districts based on the relative needs of each district. This can hamper program effectiveness (see p. 27).
- DHEC might improve efficiency by reducing the number of health districts (see p. 37).
- DHEC's oversight of health district activities is fragmented, resulting in reduced efficiency (see p. 39).
- In an effort to improve efficiency, DHEC significantly reduced the number of staff in its health services central office (see p. 40).
- DHEC's use of 13 different fiscal agents to pay bills and maintain financial records for the babynet program is not an efficient use of program resources (see p. 30).

Issue (5) Public Participation

Determine the extent to which the agency under review has encouraged the participation of the public and, if applicable, the industry it regulates.

DHEC encourages public participation in its health services programs. We noted several examples where health services programs requested public input. County health departments regularly survey their customers about the services provided. DHEC surveyed WIC program participants about food preferences. Also, the home health program surveys its clients about the services received. We did not review the methodology or results of these or other efforts that we observed.

Issue (6) Duplication of Services

Determine the extent to which the agency duplicates the services, functions and programs administered by any other state, federal, or other agency or entity.

We did not perform a detailed review to determine the extent to which duplication exists between DHEC and other agencies. However, according to §44-1-110, DHEC is the sole advisor of the state in all questions involving the protection of the public health. South Carolina has centralized responsibility for public health programs, and DHEC is responsible for public health at the state and county level. Local hospitals have some programs that DHEC also has, such as home health and preventive health services.

Other state agencies, such as the Department of Mental Health, the Department of Disabilities and Special Needs, and the Department of Alcohol and Other Drug Abuse Services, also perform some public health functions and provide public health services.

Issue (7) Handling of Complaints

Evaluate the efficiency with which formal public complaints filed with the agency concerning persons or industries subject to the regulation and administration of the agency under review have been processed.

We reviewed DHEC's process for investigating complaints against food service establishments and found that DHEC does not have an agencywide written policy for handling these complaints. There is inconsistency in how different local offices investigate food services complaints (see p. 21).

We also noted that DHEC does not adequately investigate complaints about participants in the women, infants, and children (WIC) program (see p. 19).

Issue (8) Compliance With the Law

Determine the extent to which the agency under review has complied with all applicable state, federal, and local statutes and regulations.

DHEC's provision of health services is governed by state and federal laws. We did not perform a comprehensive review of DHEC's compliance with laws relating to health services. We reviewed relevant federal and state laws and regulations for programs targeted in our fieldwork objectives (see p. 3), and we focused on reviewing controls DHEC has in place to ensure compliance with these laws. We found:

- There were no material problems with DHEC's controls to ensure that septic tank permits are issued in compliance with state laws and regulations (see p. 22).
- For some programs, DHEC does not always have adequate controls to ensure that clients are eligible for the services they receive (see p. 17).
- DHEC has not implemented a sliding fee scale for babynet services as required by state law (see p. 29).
- DHEC considers its per visit employees exempt from the provisions of the federal Fair Labor Standards Act; however, it is not clear whether these employees meet the criteria for exemption (see p. 40).

Agency Comments

South Carolina
DHEC
Department of Health and Environmental Control
2600 Bull Street, Columbia, SC 29201-1708

July 1, 1996

Mr. George L. Schroeder, Director
Legislative Audit Council
400 Gervais Street
Columbia, SC 29201

Dear Mr. Schroeder:

I have attached our responses to recommendations and also additional comments that I would like included in the "Agency Comments" section of "A Sunset Review of the Department of Health and Environmental Control's Health Services."

Your staff was very thorough and objective in their work. They demonstrated a high degree of professionalism and a willingness to listen to other points of view. Please thank them on behalf of our agency staff.

If I can provide additional information, feel free to call on me at any time.

Sincerely,

Douglas E. Bryant
Commissioner

DEB:dbl

Attachments

South Carolina Department of Health and Environmental Control
Response to 1996 Sunset Review Recommendations

I. Program Issues

Home Health Services

> ***Page 13, Recommendation 1:*** *DHEC should amend its guidelines to require that department staff estimate and consider the potential effect on Medicare and Medicaid costs before changing the quantity of home health services provided by DHEC or entering into agreements with other organizations.*

We concur with the recommendation and will take action to amend the guidelines. While the guidelines do not currently state it, DHEC does estimate the cost effects of partnerships in detail. This audit report leaves the impression that the new arrangements will be more costly for Medicare and Medicaid. However, the Department's intent is that these new arrangements and partnerships should save Medicare and Medicaid money. A complete financial analysis is done prior to entering any arrangement. Limiting Federal Medicare and State and Federal Medicaid expenditures is an increasingly important issue for taxpayers, providers, and consumers.

> ***Page 13, Recommendation 2:*** *If the Medicare program is changed so that home health payments are based on predetermined rates, independent of the number of visits per patient, the General Assembly may wish to consider amending the South Carolina Code of Laws so that home health agencies are not required to obtain certificates of need. In addition, the General Assembly may wish to consider amending state law so that the basis for Medicaid home health payments remains similar to the basis for Medicare home health payments.*

For consideration by the General Assembly. Linking payment systems to the Certificate Of Need process should be done cautiously. Studies thus far are inconclusive (Health Care Financing Review, Fall 1994, Vol. 16 #1) as to whether the prospective payment system would negatively or positively impact the quality and cost of services provided. There have been none, which we know of, that make a direct link between the Medicare prospective payment system and the need for Certificate Of Need. One study has shown increased cost of services provided in demonstration projects for prospective payment systems. (Health Care Finance Review, pp. 109-130).

Measuring the Performance of Health Services Programs

> ***Page 16, Recommendation 3:*** *DHEC should ensure that its annual accountability reports to the Governor and the General Assembly contain performance data that is accurate, complete, and reliable. Reports should provide sufficient explanatory and back ground information and indicate any problems with the data used.*

We concur with this recommendation and will take further action to assure future reports are accurate, complete, and reliable.

> ***Page 16, Recommendation 4:*** *DHEC program areas should retain records that document the source of information provided in performance measures.*

We concur with this recommendation and will take action to correct any deficiencies.

> ***Page 18, Recommendation 5:*** *DHEC should implement an ongoing system of verifying income for a sample of WIC participants whose income has not been verified by other programs.*

We concur with this recommendation and will implement a system of verifying income for a sample of WIC participants without a current Medicaid card. Most of our clients are Medicaid recipients and this is the method of income verification we have used in the past. We have not done verifications on those without a current Medicaid card due to strict federal administrative costs limits and the GAO report referenced in this document. This report showed that when across program comparisons were made, Women, Infants and Children (WIC) program eligibility error rates are very low. For example, the National School Lunch Program has an eligibility error rate of 11.1 percent. The Food Stamp, Aid to Families with Dependent Children (AFDC) and Medicaid programs all have error rates of over 7 percent of benefits paid. The same study further states that the Food Stamp, AFDC and Medicaid programs have administrative procedures with high associated costs. Administrative costs for Food Stamps averaged $21.42 per month per recipient in 1986. A high percentage of the costs were associated with maintaining the income-eligibility standard. Administrative costs are even higher for AFDC and Medicaid, which averaged $44.00 and $94.31, respectively, in 1986. In conclusion, this same study states: "The findings show that WIC has been able to achieve a much lower income-eligibility error rate than several other major social welfare programs while relying on only simple income determination procedures." Income verification will increase administrative costs of delivering WIC. This will not result in an increase of eligible participants and may actually result in a decrease of participants because administrative funds will be diverted to income verification instead of funding staff to certify participants.

Participant Eligibility

> ***Page 20, Recommendation 6:*** *When a complaint alleging income eligibility is made, DHEC should require that WIC participants provide documentation of income and should discontinue services if documentation is not provided.*

We concur with this recommendation. We intend to follow-up on all complaints regarding income eligibility. We will also follow program policy related to discharge if documentation is not provided. We have not done this in the past because of the GAO report discussed previously.

> ***Page 20, Recommendations 7:*** *If a WIC participant is found to have abused the program, DHEC should discharge the participant from the program and take action to recover the cost of the benefits if it is cost effective.*

We concur with this recommendation. We intend to follow program policy which may include discharge from the program and recovering the cost of benefits if it is cost effective. In the two cases in which participants were selling their formula, the participants were counseled by the district staff regarding program guidelines and instructed not to sell their infant formula. The program is revising its system of follow-up on all complaints received to assure that the methods of deterring abuse used by staff indeed produce the desired outcomes. This means that when counseling is the method used to deter abuse, there must be follow-up to assure that program abuse has ceased.

> ***Page 21, Recommendation 8:*** *DHEC should consider amending its procedure to require applicants for the CRS program who are not on Medicaid to provide proof of income, particularly at the time of the initial application.*

We concur with this recommendation and will explore the cost benefit ratio of requiring proof of income for non-Medicaid applicants. It should be noted, however, that a national study which examined error rates in income eligibility across public assistance programs found that programs such as Medicaid and AFDC which have high cost administrative procedures for determining income eligibility actually had higher error rates than programs which relied only on simple income determination procedures. Diverting funds from services to administrative cost could have more of a negative effect on the health status of children than any potential benefit derived.

Complaints Against Food Service Establishments

> ***Page 22, Recommendation 9:*** *DHEC should implement an agency wide written policy outlining how complaints against food service establishments should be handled.*

We concur with this recommendation and will implement an agency-wide policy. The Division of Food Protection is currently working on an agency-wide written policy outlining how complaints against food service establishments should be handled.

II. Financial Issues

Collection of Accounts Receivable

> ***Page 25, Recommendation 10:*** *DHEC should establish a comprehensive system for billing and collecting accounts receivable for all health services programs. The system should identify:*
> - *Who is responsible for billing and collecting accounts receivable;*
> - *What procedures are to be followed to collect outstanding accounts, including sending bills at specified intervals to patients or other providers.*
>
> *When reasonable efforts to collect have been exhausted, DHEC should ensure that accounts are written off.*

We concur with this recommendation and are in the process of establishing a comprehensive system. The Department recognized several years ago the need to improve its administrative functions for billing, tracking and accounts receivable collections. Efforts have been underway to develop administrative policies and procedures to properly address this matter. A major roadblock has been the absence of modern information systems for billing and financial management. The Department is implementing the Administrative Information Management System (AIMS). Health Services expects to make significant improvement by implementing the Integrated Client Encounter System (ICES) which has a sophisticated billing module. We feel these new systems will appropriately address concerns.

Identifying Third Party Payers

> ***Page 26, Recommendation 11:*** *DHEC should more actively pursue private insurance reimbursement for services provided to non-Medicaid clients. A contract with a private company similar to that used by the Department of Health and Human Services is one option that should be considered.*

We concur with this recommendation. For example, over the past six years the CRS program has improved efficiency and third party collection techniques. This is evidenced by the increase in revenue from $478,547 in FY90 to $1,240,656 in FY95 (gross revenue prior to DHEC administrative assessment). Additionally CRS has begun conducting data matches with DHHS as a means of identifying and evaluating the possible existence of other third party information. DHEC will continue its commitment to explore other options and their cost/benefit ratios to further enhance funding resources.

Allocation of Health District Funding

> ***Page 28, Recommendation 12:*** *DHEC should allocate funds to districts according to a written methodology which takes into account the relative needs of each district.*

We have a different opinion. Allocation of funding based on need may achieve equality with respect to one or more need indicators, but such allocation does not assure quality. There is no direct correlation between allocation based on need and the delivery of quality services. While there may be some correlation between relative need and quantity of services, this has not always proven to be the case. In some instances, where the allocation was based on only relative need, Health Districts which were receiving the larger allocations were serving a lower proportion of the people in need than districts with smaller relative need. In most cases, relative need does play a role in how district allocations are determined, but when resources do not allow the program to meet all of the need, then there can be a case made for considering need met or patients served as a component of an allocation system. For example should a district with 20% of the relative need for Family Planning patients, serving only 10% of the patients Statewide, continue to receive the funds based only on the need figure, or should district which has 10% of the need, but is serving 20% of the State caseload receive additional funding. This is a difficult issue, and therefore it is important to maintain flexibility in how resources are allocated to allow not only a need component, but to consider other factors such as need met, cost of providing services, other local resources contributing to services, the health status of the area and other appropriate factors.

Sliding Fee Scale for BabyNet Services

> ***Page 30, Recommendation 13:*** *The General Assembly may wish to consider amending Section 44-7-2750 of the South Carolina Code of Laws to delete the*

requirement for a sliding fee scale for the baby net program.

For consideration by the General Assembly. Our preference would be that the General Assembly amend Section 44-7-2570. Implementation of a uniform sliding fee scale common to all nine agencies that provide BabyNet services has not been possible due to conflicting agencies' payment policies. For example, the Department of Disabilities and Special Needs does not have a sliding fee scale for their services, while the Department of Mental Health does charge fees.

Page 30, Recommendation 14: *If the General Assembly chooses not to amend the law, then DHEC should implement a sliding fee scale and charge those families above the federal poverty level a portion of the cost of babynet services.*

We concur with the recommendation and will implement a sliding fee scale if the law does not change.

Use of Fiscal Agents

Page 31, Recommendation 15: *DHEC should discontinue contracting with fiscal agents to pay bills and maintain records for the babynet program.*

We have a different opinion. The local private, non-profit boards of the Department of Disability and Special Needs are the fiscal agents for BabyNet. Over the past fiscal year, BabyNet staff has communicated extensively with the fiscal agents and has conducted site visits for evaluation purposes. Based on these evaluations and estimates provided by the fiscal agents of the time spent performing transactions, it was determined that 4.1 FTEs are required to perform these functions. This would cost DHEC approximately $121, 000 in personnel costs to perform the functions in-house, not including operational expenses. For state FY 1996-97, BabyNet has negotiated with all fiscal agents and has reduced this cost even further, from $118,000 to $110,000. From a fiscal perspective, it is less costly to contract for fiscal administration. Fiscal agents perform a number of non-routine administrative functions for BabyNet:

(1) The BabyNet program authorizes co-payments and deductibles. This is done via the authorization process and requires extensive involvement in interpreting insurance Explanation of Benefits and communicating with service coordinators, providers, and insurance companies to resolve payment issues and determine accurate payment.

(2) Fiscal agents are required to validate services that are provided prior to payment by receiving and matching service coordinator validation against provider invoices. Although this extra step is time consuming, it eliminates the potential for excessive or fraudulent billing.

(3) Fiscal Agents are required to make payment (cut checks) for family services for payment of emergency services usually related to safety and health. This vital

component of our program is endorsed by the state Interagency Coordinating Council principally because it fits the family-centered requirements of Federal law.

Placing BabyNet funds in locally based, private non-profit organizations makes this concept work. It is a public-private partnership that improves efficiency and service to families of developmentally disabled children. In this case, the non-profit organizations are local affiliates of the Department of Disabilities and Special Needs, thus BabyNet is utilizing a collaborative approach with another state agency and local non-profit organizations for efficiency's sake and the benefit of the families served.

III. Administrative Issues

Health Services Information Resource Management

Page 36, Recommendation 16: *DHEC should develop health services information systems that consolidate and unify client and billing information.*

We concur with this recommendation and are working to implement it. The goal and direction of Health Services Management and HSIS staff has been to replace the current systems with an integrated, client-centered system that will maximize efficiency of the front line staff while providing the necessary data for management and reporting purposes. Over the past three years a number of calculated steps in a process to achieve that goal have been accomplished. All data elements currently being captured on forms or in electronic systems were analyzed. They were compared for redundancy and justified as to the need for capture. Agreement was reached regarding definitions of terms and a data dictionary was created. Rather than automate inefficient processes, a committee involving district management and front line employees, staff from all programs including Home Health and CRS, billing staff and HSIS staff worked intensively for several months to assure that only necessary data would be collected, that no billing opportunities would be missed and that the system promoted an efficient work flow in the health department. The design specifications for ICES came from this group. The ICES system is scheduled for pilot testing in September 1996 and will replace all of the major systems in Health Services, except Home Health and CRS, which are scheduled to be added in January 1997. The business rules associated with each program were delineated and edits to insure those rules are followed incorporated into the design. Development and documentation standards were developed, as well as standards for the Information Resource Coordinators in the field. A Request for Proposals was developed for a laboratory system that will interface with ICES. According to the literature, these are some of the more difficult tasks in integrating and automating systems.

Page 36, Recommendation 17: *DHEC should unify the management and funding of health services information systems.*

We concur with the recommendation. Implementation has already begun.

Number of Health Districts

Page 38, Recommendation 18: *DHEC should reduce the number of its health districts where it can be demonstrated that there will be long-term net benefits.*

We concur with this recommendation and will continue to evaluate the organizational structure. The Department believes that there are many ways to improve efficiency of district operations. DHEC will continue to evaluate the District organization structure and make changes in management and administrative staffing patterns; share personnel and duties across district lines; consider regional administrative and management structures or merging and thus reducing the number of health districts, where it can be demonstrated that there will be long-term benefits.

Oversight of Health Districts

Page 40, Recommendation 19: *DHEC should establish and follow a time line for consolidating its health district oversight process.*

We concur with the recommendation and will establish a time line.

Per Visit Employees

Page 41, Recommendation 20: *DHEC should analyze the status of the per visit employees in relation to the Fair Labor Standards Act.*

We concur with the recommendation and have already begun the analysis.

IV. General Comments

Page 1*: "Health services oversees personal health programs that serve the citizens of South Carolina."*

This statement is true, but does not adequately describe Health Services' role in protecting the public health. Health Services' responsibilities go far beyond the provision of personal health services.

Health Services is responsible for epidemiology, including assessment, evaluation and monitoring health status; working with other agencies and the private sector to prevent disease and disability through regulation and disease control measures; promoting access to medical care; and promoting the social, economic and environmental conditions that support health.

Page 16: *"For example, DHEC inaccurately reported the number of K-12 school children with completed immunizations for the 93-94 and 94-95 school years."*

These numbers were slightly inaccurate due to an error in addition; however, the more important indicator of the percent of children with completed immunizations remained at 99% and 98% respectively. In 1994, South Carolina was the number 1 state in the nation regarding its immunization level of 2 year old children. We have an efficient and effective system. DHEC does its own immunization survey based on the birth registry which is much more timely and has a higher response rate than the Federal Centers for Disease Control and Prevention (CDC) survey. For example, DHEC already has accurate information for 1995. CDC's composite survey is two years behind ours.

Page 44: *"Issue (3) Administrative Costs"*

The figures provided in this section are accurate, but additional clarification is needed to define *"Administrative Costs."* The report mentions that 9% of Health Services FTEs are based in Central Office in Columbia. If the implication is that these are *administrative FTEs,* it should be acknowledged that many of the employees in Central Office perform functions that are essential public health services, not administrative duties. This is particularly true with the Laboratory, Environmental Health, Maternal and Child Health, Health Promotion, Home Health and Preventive Health program staff.

It should be noted that Table 5.1 used two different types of numbers. Comparing *actual expenditures* to *budgeted expenditures* reduces the intended precision of the comparison. It would be advisable to compare the same type of number. It would appear from Table 5.1 that there has been a significant increase in the "management" costs for Health Services. What the table fails to note is that there has been a consolidation and centralization of administrative functions at the Deputy level. The centralization has shifted expenses to the "management" category. This is an accounting practice rather than an actual increase in costs. A final comment concerning Table 5.1 is that the dollar amounts for the four fiscal years have not been adjusted for inflation. The analysis should recognize the reduction in buying power that is eroded by inflation. This is particularly important when looking at the funds provided by the State. When considering the effects of inflation, the increase of 7.5% in State funds was less than the rate of inflation.

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