Act 60 Health Analysis

Final Report

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Boston Consulting Group
April 1, 2024

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1 Introduction and executive summary

Introduction and executive summary

South Carolina has the opportunity to improve its health and human services. By making services easier to use and improving coordination, State government can make the constituents of the State healthier, improve the efficiency of the health delivery system, and get the best value for its constituents.

South Carolina has the most fragmented health and human services structure in the nation.

Section 13 of Act 60 charged the Department of Administration with retaining independent, third-party experts, consultants, or advisors to analyze the missions and delivery models of all state agencies concerned with South Carolina's overall public health, as well as certain specific populations including, but not limited to, children and adolescents, newborns, pregnant women, the elderly, disabled, mentally ill, special needs individuals, those with chemical dependencies, the chronically ill, the economically disadvantaged, and Veterans. This report is a result of that effort.

Following a competitive solicitation, the Department of Administration engaged Boston Consulting Group (BCG) to "… prepare a written account setting forth … findings regarding the missions, delivery models and organizational structures of the various state agencies performing public health services and the effectiveness of such in addressing the overall public health of the State." Act 60 requires the written account to be delivered to the Legislature and Governor on or before April 1, 2024, in the form of a final report, with interim reports submitted by October 1, 2023, and January 1, 2024.

BCG's approach was thoughtfully designed to encompass a wide array of South Carolinian perspectives, actively seeking input from stakeholders such as service users, caregivers, agency leaders, frontline staff, advocacy groups, and the general public. More than 4,000 South Carolinians provided input through interviews,[1] surveys, site visits, town halls, and a public comment box (see Exhibit 1).[2] The findings from these stakeholders were then validated with a comprehensive review of relevant literature,[3] agency documents,[4] and

[1] Interviews with constituents, state executives, legislators, state health agency staff, and external partners

[2] Surveys covering more than 630 constituents across all counties and more than 3,800 staff of core state health agencies

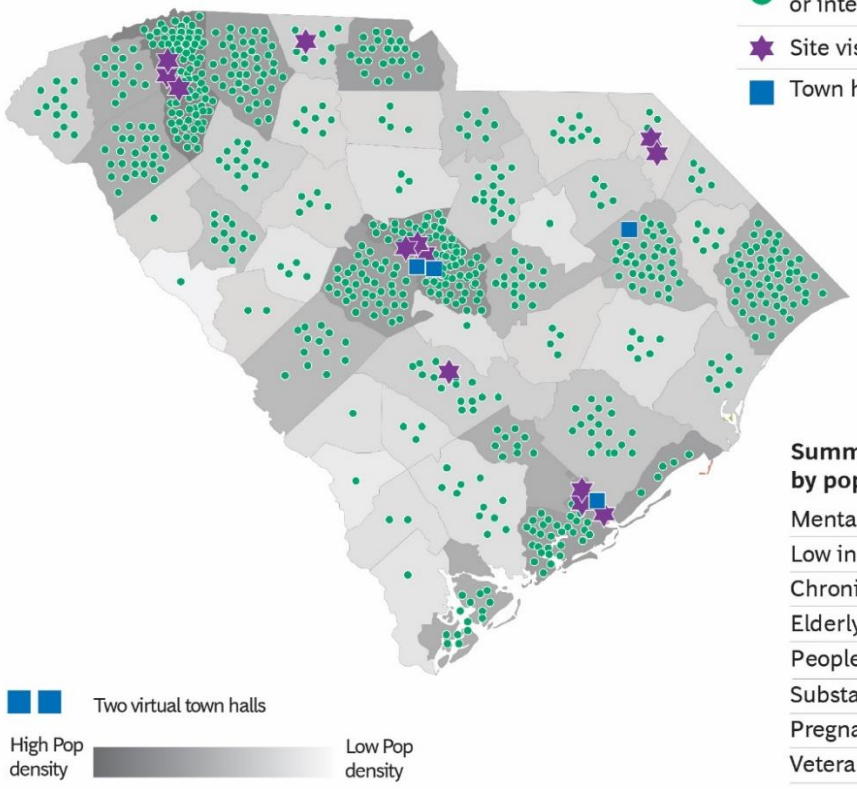
[3] Reports including but not limited to Legislative Audit Council (LAC) reports, and South Carolina Enterprise Information System (SCEIS) human resources and organizational data, including position descriptions of agency leadership

[4] Review of relevant statutes, agency mission and strategy documents, program overviews and financial data for each agency from 2019-2023

benchmarking of other U.S. states (with a focus on peer states in the Southeast[5]).[6] The recommendations that followed from that work aim to improve the health of South Carolinians, improve the efficiency of the health delivery system, and obtain the best value in health spending for its residents.

Exhibit 1: Map of stakeholder outreach as of December 15, 2023

More than 630 constituents have provided input across all counties, in addition to 13 completed site visits and 6 town halls



1. One respondent did not indicate the county in which s/he resides.
Note: Direct constituent input also collected via the complete response set from DRSC Community Survey 2023, and interview notes from Sage Squirrel 2023 constituent interviews across the state. Indirect constituent perspective also collected via advocacy group interviews, and other agency interviews (e.g., Dept of Child Advocacy, S.C. Developmental Disabilities Council, DOC)

[5] Peer states include Alabama, Georgia, North Carolina, Tennessee, Virginia, which represent other Southeastern states with similar demographics to South Carolina.

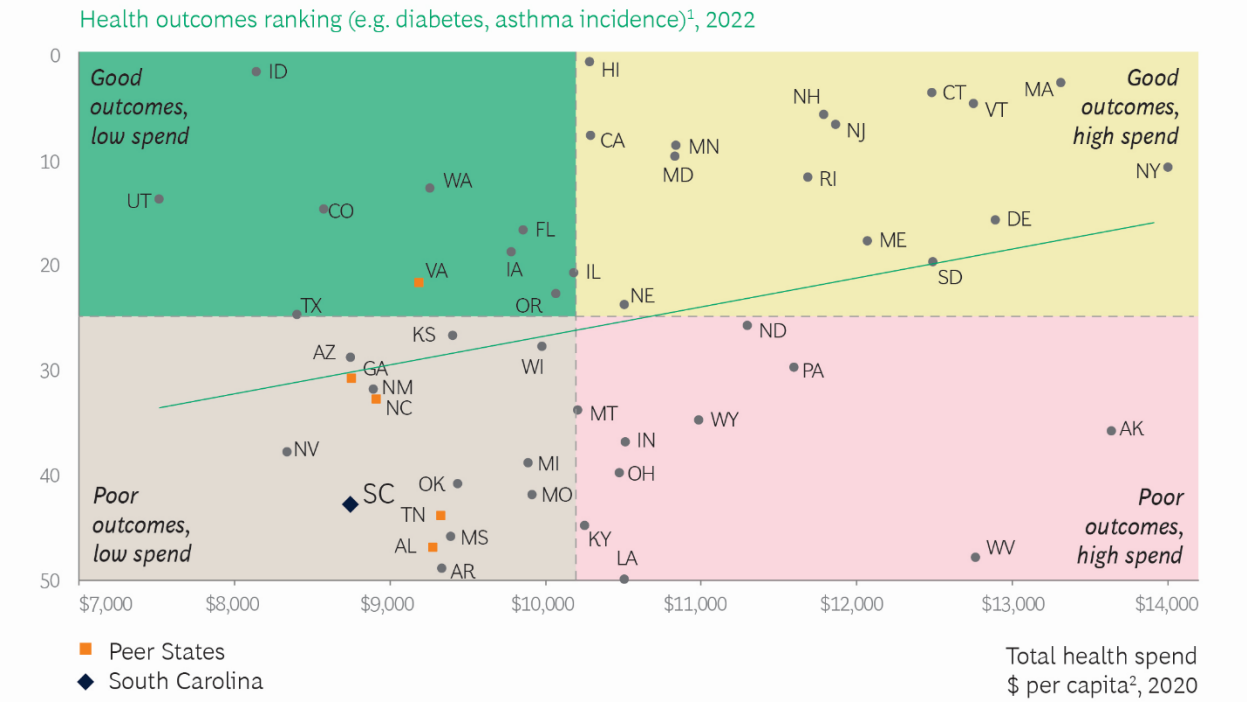
[6] Data from the Center for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), U.S. Census, Department of Housing and Urban Development (HUD), Agency for Healthcare Research and Quality (AHRQ), American Hospital Association (AHA), and the Kaiser Family Foundation (KFF).

Key challenges

South Carolina has significant room for improvement in health outcomes. In data compiled by America's Health Rankings, South Carolina ranked 43rd of all states in health outcomes and 4th out of 6th among peer states (see **Exhibit 2**).[7] South Carolina lags on physical and mental health metrics. Further, South Carolina's health outcomes are worse than expected when considering the State's level of spending, indicating that South Carolina sees a low return on investment (ROI) on its health and human services spend. This means that South Carolina has an opportunity to improve its health outcomes by more effectively using its current level of spending.

Exhibit 2: Health outcomes vs. overall health spending for U.S. states

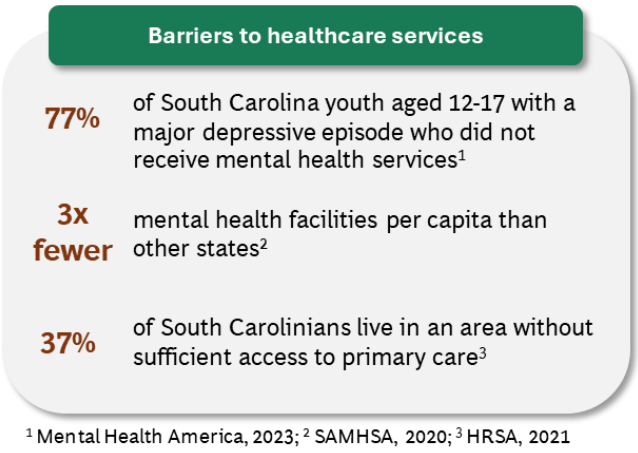
South Carolina lags U.S. in health outcomes with low ROI on overall health spending; potential signs of underinvestment



1. Composite health outcome ranking based on measures related to behavioral health, physical health, mortality, and risk factors between 2018-2022 2. 2020 Health spending per capita includes spending for all privately and publicly funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) By state of residence (aggregate spending divided by population). Hospital spending is included and reflects the total net. revenue (gross charges less contractual adjustments, bad debts, and charity care) Note: Health outcomes data is based on data from 2019-2022; Source: America's Health Rankings, Outcomes Composite 2022, Kaiser Family Foundation analysis of CMS Office of the Actuary, National Health Statistics Group. 2020 National Health Expenditure Data: Health Expenditures by State of Residence

[7] Peer states include Alabama, Georgia, North Carolina, Tennessee, Virginia, which represent other Southern states with similar demographics to South Carolina.

Constituents face barriers at each step of their journey to receive healthcare services. South Carolinians experience challenges finding and accessing benefits and services. A shortage of available services, especially for mental health, substance use, and disabilities, makes it difficult for constituents to receive the care they need. Today's services are also too focused on acute care (such as in a hospital) rather than on preventative care, which addresses peoples' health needs before they become more serious and expensive. When constituents do receive care, the quality is inconsistent across different types of service and regions of the State. Some South Carolinians receive world-class treatment and have positive experiences, but too many do not. Finally, challenges coordinating care, particularly for those who have complex needs and use multiple services, mean patients may be confused about the next steps in their care plan or experience disruptions in their treatment.



[1] Mental Health America, 2023; [2] SAMHSA, 2020; [3] HRSA, 2021

This uneven and unsatisfactory experience is partially caused by the way state government agencies operate today. These challenges start with structure – South Carolina has the most fragmented health and human services agency structure in the nation, with eight independent agencies. This has hindered the creation of a shared plan for health across the state, led to a lack of holistic accountability for the populations the agencies serve, and made it more difficult to work in a collaborative fashion across agencies. This has also led to slower innovation in health policies and programs, and inconsistency in the State's approach to drive quality. The limited infrastructure to support these areas – from lack of data sharing to limited codified practices across agencies – means South Carolina relies heavily on ad-hoc coordination and knowledge of individuals at each agency. High turnover and difficulty recruiting needed talent in the State workforce significantly exacerbate these issues.

Despite these challenges, the State has demonstrated some strengths it can build on – for example, expanding school-based mental health services, building online portals to help the elderly and early childhood populations navigate to services, and increasing psychiatric telehealth access – all supported by a dedicated set of state employees and front-line workers. These strengths provide momentum for the path forward.

Recommendations

There are seven recommendations, detailed below, to address the challenges discussed. Taken together, these recommendations would improve South Carolina's health and human services system and address the issues noted above. The recommendations are:

Recommendation	Description
Recommendation #1 Streamline state agency structure and roles *Page 23*	• Establish a central organization to provide leadership, drive accountability, and improve collaboration across health and human services agencies • Combine agencies with similar missions under the central organization • Evaluate and redesign organization structure within each agency to improve efficiency and effectiveness of operations
Recommendation #2 Build strategic plan and operating approach for health and human services *Page 32*	• Build a comprehensive plan for health and human services across the State • Strengthen accountability and coordination across agencies • Improve complex case coordination across state agencies • Increase data sharing across agencies to improve policy making and operations
Recommendation #3 Increase capacity for mental health, substance use, and disabilities services *Page 36*	• Strengthen existing public access capacity to better serve the most vulnerable South Carolinians • Increase private capacity to improve access to care for a broader array of constituents • Grow and better use the professional workforce
Recommendation #4 Improve quality of services in the State *Page 48*	• Improve state oversight and support for county-controlled healthcare providers • Strengthen operations within State-run healthcare facilities • Improve partnerships with Medicaid managed care organizations (MCOs) • Increase innovation in care models to better care for complex populations
Recommendation #5 Improve preventative care *Page 56*	• Boost supports for social factors that influence health • Bolster awareness of and access to preventative healthcare services • Increase access to primary care across the State
Recommendation #6 Help constituents navigate to benefits and services *Page 64*	• Make it easier for constituents to find benefits and services • Simplify the process to access benefits and services • Build supporting data and technology infrastructure for navigation
Recommendation #7 Strengthen state health and human services workforce *Page 72*	• Bolster state recruitment and better manage hiring process • Better retain and develop talent • Make it easier for staff to productively deliver quality services

Recommendation #1: Streamline state agency structure and roles

The structure of South Carolina's health and human services agencies – eight independent agencies – makes it the most fragmented of any state in the United States. Addressing this fragmentation would make it easier for constituents to find services, and lead to more efficient and effective service delivery. Therefore, the State should:

- Create a central entity responsible for coordinating health and human services agencies that reports directly to the Governor. Given the overlaps in populations and activities, South Carolina would achieve the most benefit from having all health and human services agencies under one entity, although creating an entity over all the health-related agencies, including those focusing on Medicaid (DHHS), Public Health (DPH), Mental Health (DMH), Substance Use (DAODAS), Disabilities (DDSN) and Aging (DOA), would be a meaningful step in the right direction.[8]
- Change the current DMH and DDSN Commission structures to create consistent governance across agencies. Agency directors would be directly appointed by the leader of the new entity.
- Merge DMH and DAODAS – into one department under the central organization – to deliver more integrated behavioral health services for constituents, lower administrative costs, and unlock new funding opportunities.
- Evaluate and redesign the organizational structures of each agency under the central organization to improve effectiveness and drive efficiencies.

Recommendation #2: Build a strategic plan and operating approach for health and human services

Developing and maintaining strong coordination among agencies is critical to efficiently deliver high-quality services for constituents. To achieve this, South Carolina should:

- Build a comprehensive plan for health and human services across the State to set cross-agency priorities, goals, and action steps.
- Strengthen accountability and coordination across agencies to achieve shared plan, establishing clear ways to track progress on goals and forums to work together on policy priorities and case management.

[8] South Carolina health agencies include: Department of Health and Human Services (DHHS), Department of Health and Environmental Control (DHEC), Department of Mental Health (DMH), Department of Alcohol and Other Drug Abuse Services (DAODAS), Department of Disabilities and Special Needs (DDSN), and Department of Aging (DOA). Act 60 requires the separation of public health activities from DHEC into a separate agency – these public health activities are the primary focus of this report, and not the Environmental Control activities.

- Increase data sharing across agencies to improve policy-making and operations, tapping into a wealth of health and demographic data to evaluate how to serve constituents better.

The ability to accomplish these recommendations is reliant upon the creation of a central organization contemplated in recommendation #1 above, providing one common entity with the authority to bring agencies together and hold them accountable for progress.

Recommendation #3: Increase capacity for mental health, substance use, and disabilities services

There is not enough healthcare capacity across South Carolina today. This most acutely impacts those with behavioral health conditions and disabilities, and leads to conditions going untreated. This, in turn, means patients get care in more expensive acute-care settings such as emergency departments. The system has more publicly operated or controlled capacity as a percentage of total capacity with limited private capacity – these public access facilities are often the only option for Medicaid and uninsured populations to receive care. To address this, the State should:

- Ensure that public access providers remain able to serve these populations by increasing state funding to match the level of other states.
- Streamline funding, particularly for substance use public access providers. South Carolina should direct these funds more strategically toward the highest-need services and geographies, and potentially leverage federal match dollars through Medicaid.
- Increase private capacity, which the State can facilitate by reducing the administrative frictions and start-up costs for providers, and ensuring competitive rates and coverage schemes for services provided.
- Build and effectively leverage the care professional workforce by strengthening local talent pipelines (e.g., growing scholarships and grants for aspiring professionals, increasing the number of slots in education and training programs), and better adapting to new care models (e.g., telehealth).

Recommendation #4: Improve quality of services in the State

As discussed above, there is an inconsistent quality of care across South Carolina. This means that outcomes, constituent experience, and physical settings vary across service types and geographies. To influence the quality of the health system, the State should:

- Strengthen its oversight of county-controlled Section 301 substance use healthcare providers, disability and special needs (DSN) boards, and facilities it oversees by strengthening standards, monitoring, and enforcement for non-compliance.

- Improve quality through its Medicaid managed care program by strengthening contract requirements (e.g., patient quality and provider network standards) and partnering more closely with MCOs to advance South Carolina's health goals.
- Increase innovation in care models to better support complex populations by more regularly participating in federal innovation programs and partnering with private and non-profit entities to broaden the reach of the State.

Recommendation #5: Improve preventative care

South Carolina has an opportunity to reorient its focus toward prevention, which can help support constituents' health before their needs become more serious. This, as a result, improves health outcomes and costs less than acute care. The State should:

- Target supports for social needs that impact health, such as nutrition, housing, and transportation, to those with complex conditions by prioritizing several targeted interventions in coordination across State agencies and community organizations (e.g., better directing existing housing funds to support those on path to substance use recovery).
- Bolster awareness of and access to preventative healthcare services to ensure that constituents pursue healthy behaviors and engage in adequate health screenings.
- Increase access to primary care across the State by growing the primary care workforce, particularly in rural and other underserved areas.

Recommendation #6: Help constituents navigate to benefits and services

South Carolinians face challenges in finding and accessing healthcare services and benefits, navigating a wide set of offerings provided by a fragmented set of organizations. This means that constituents may not receive the resources they need to improve their health, driving higher costs to the system from less preventative care. To address this, South Carolina should:

- Make it easier for constituents to find benefits and services by making information more available and easier to understand across different channels (e.g., online, phone, in-person), empowering "navigators" to guide constituents (e.g., agency staff, community organizations, providers, care managers), and increasing broader constituent awareness of these resources through promotional campaigns.
- Simplify the process to access benefits and services by lowering barriers to getting care (e.g., tighter referral pathways and co-location of services) and streamlining the benefits application process (e.g., simpler application language, reducing unnecessary process steps, and improving the online user experience).
- Build a stronger supporting data and technology infrastructure over time, considering ways to unify electronic health records (EHRs) across providers,

investing in unified population health and case management platforms that can help navigators make specific and tailored recommendations for where constituents should go to get their needs met, and building more integrated eligibility systems to make the benefits application process more efficient and seamless for constituents.

Recommendation #7: Strengthen state health and human services workforce

South Carolina faces significant challenges in recruiting and retaining staff, with an average turnover rate of ~19% and a vacancy rate of ~17% for health and human services agencies. Only ~42% of staff within these agencies consider their organization an attractive employer. These challenges lead to a recurring cycle of high turnover and staff capacity constraints, negatively impacting service planning and delivery and placing added pressure on remaining staff. To address these issues, the State should:

- Improve how it attracts and hires talent by taking a more proactive recruitment approach (e.g., broader recruiting pools, more active outreach efforts).
- Bolster efforts to retain top talent by bolstering recognition programs, strengthening career pathways, and improving working models, such as through flexible schedules. While salary increases for state workers in 2023 were positive steps, South Carolina should continue to consider increases to compensation over time to ensure the State is competitive with the market.
- Better support its talent to deliver high-quality services to constituents by improving employee training on day-to-day responsibilities, identifying opportunities where operational processes can be made more effective and efficient (e.g., via automated tools), and more rigorous evaluation of staff performance against job objectives.

Looking ahead

These recommendations represent significant changes to the health and human services system in South Carolina, and would help improve health outcomes, drive better efficiency of the health delivery system, and increase value for the overall dollars spent. However, there are potential risks to state stakeholders of failing to manage the change appropriately, including constituent confusion, provider turnover, and inefficient allocation of taxpayer resources.

To implement these recommendations, South Carolina requires a well-coordinated and appropriately resourced implementation approach. The State will need to prioritize the most critical initiatives based on scale of impact and cost, effectively coordinate implementation timelines, and diligently execute with a focus on the detail. The goal of these efforts is to be cost-neutral in the long-term, although short-term investments will be needed to implement these recommendations, which can be sourced from existing budgets, cost savings, revenue enhancements, and – if needed – state appropriations.

2 Assessment of South Carolina's healthcare system

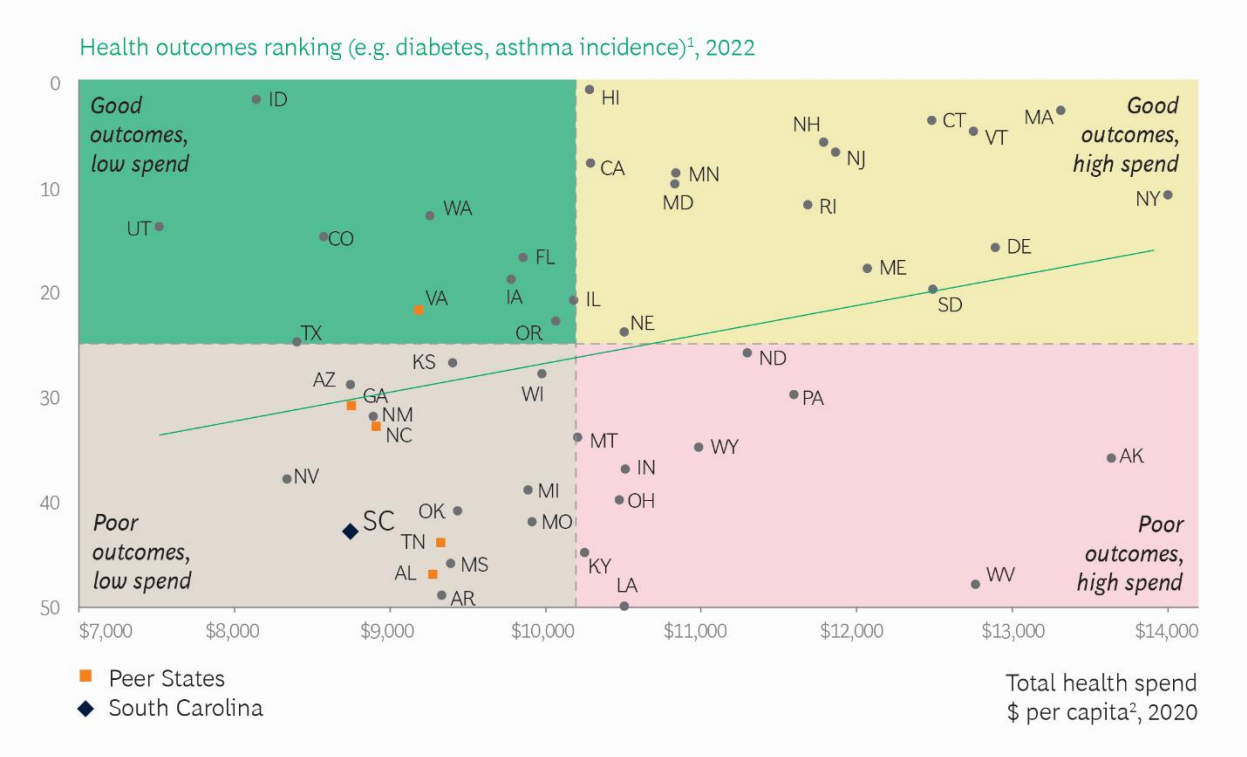
Assessment of South Carolina's healthcare system

South Carolina faces poor health outcomes for its level of spending

To understand the state of health in South Carolina today, BCG completed a benchmarking of the State's health outcomes and spending relative to other U.S. states. The benchmarking included a set of five peer states[9] with similar geographic and demographic characteristics.

Exhibit 3: Health outcomes vs. overall health spending for U.S. states

South Carolina lags U.S. in health outcomes with low ROI on overall health spending; potential signs of underinvestment

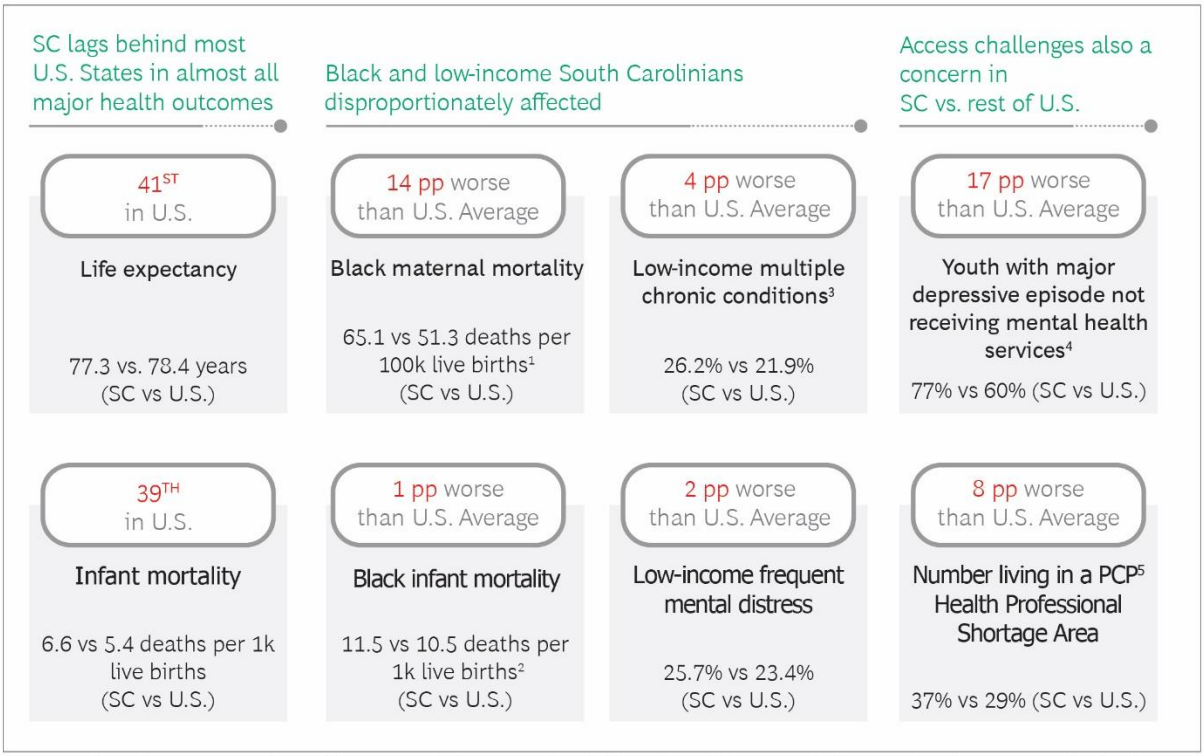


1. Composite health outcome ranking based on measures related to behavioral health, physical health, mortality, and risk factors between 2018-2022 2. 2020 Health spending per capita includes spending for all privately and publicly funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) By state of residence (aggregate spending divided by population). Hospital spending is included and reflects the total net revenue (gross charges less contractual adjustments, bad debts, and charity care)
Note: Health outcomes data is based on data from 2019-2022
Source: America's Health Ranking, Outcomes Composite 2022, Kaiser Family Foundation analysis of CMS Office of the Actuary, National Health Statistics Group. 2020 National Health Expenditure Data: Health Expenditures by State of Residence

[9] Peer states include Alabama, Georgia, North Carolina, Tennessee, Virginia, which represent other Southern states with similar demographics to South Carolina.

Overall, based on data compiled by America's Health Rankings, South Carolina ranked 43rd in terms of health outcomes and 4th out of 6th among peer states (see **Exhibit 3**).[10] In particular, South Carolina performs below average on several key metrics[11] across physical and mental health (see **Exhibit 4**).

Exhibit 4: SC performance vs. peers on health outcomes



1. 25 states have data on maternal mortality by race 2. Only 40 states have information on infant mortality by race 3. Low income=annual salary less than $25,000 4. Youth = ages 12-17 5. Primary Care Provider. Note pp = percentage points

South Carolina's health outcomes are lower than expected, considering the State's level of spending.[12] This may indicate that South Carolina sees a low ROI on its health spend. This is likely driven by more spend on high cost, acute care settings relative to prevention (e.g., early screenings), focus on healthy behaviors, and other actions that reduce the need for costly care of conditions down the road.

[10] America's Health Ranking, Outcomes Composite 2022

[11] The Commonwealth Fund 2020 scorecard on state health system performance, CDC national vital statistics system (NVSS): restricted use mortality microdata, federally available data, maternal and child health bureau, HRSA (2021), CDC national vital statistics system (NVSS): WONDER, CDC, BRFSS (2021), national center for injury prevention and control, CDC, Kaiser Family Foundation (2022-2023), HRSA (2021)

[12] 2020 National Health Expenditure Data: Health Expenditures by State of Residence, August 2022

Satisfaction lowest among those with behavioral health and disabilities conditions, uninsured, youth, and rural populations

To understand opportunities to improve upon the state of health and human services in South Carolina, BCG completed a survey of more than 600 English and Spanish-speaking South Carolina constituents. The survey assessed constituents' level of satisfaction with health services in the State today, using a scale of 1-5 to report satisfaction levels, with 5 being most satisfied and 1 being most dissatisfied.

Notably, constituents with intellectual and related disabilities, mental health conditions, and substance use disorder expressed the highest levels of dissatisfaction with services in South Carolina. The uninsured population was particularly dissatisfied, with a 0.38 point lower satisfaction compared to the average across all constituents. The uninsured is a group that heavily intersects with those with behavioral health and disabilities conditions. Constituents in more rural areas and youth populations reported higher dissatisfaction with services as well. (See **Exhibit 5** for more detail.)

Exhibit 5: Constituent satisfaction lowest with mental health, disabilities, and substance use disorder services; uninsured, youth, rural populations least satisfied

Relative satisfaction rate vs. average for South Carolina constituents

1. Survey respondents were disproportionally low income and utilized State services based on search criteria, and therefore may not be representative of full SC population with private insurance; 2. Does not include Medicaid; Source: SC Constituent Survey; N = 575

In light of these findings, as the State contemplates recommendations moving forward, it should give consideration to constituents with intellectual and related disabilities, mental health challenges, and substance use disorder. The State should also consider the impact of any strategies on rural, low-income, uninsured, and youth populations.

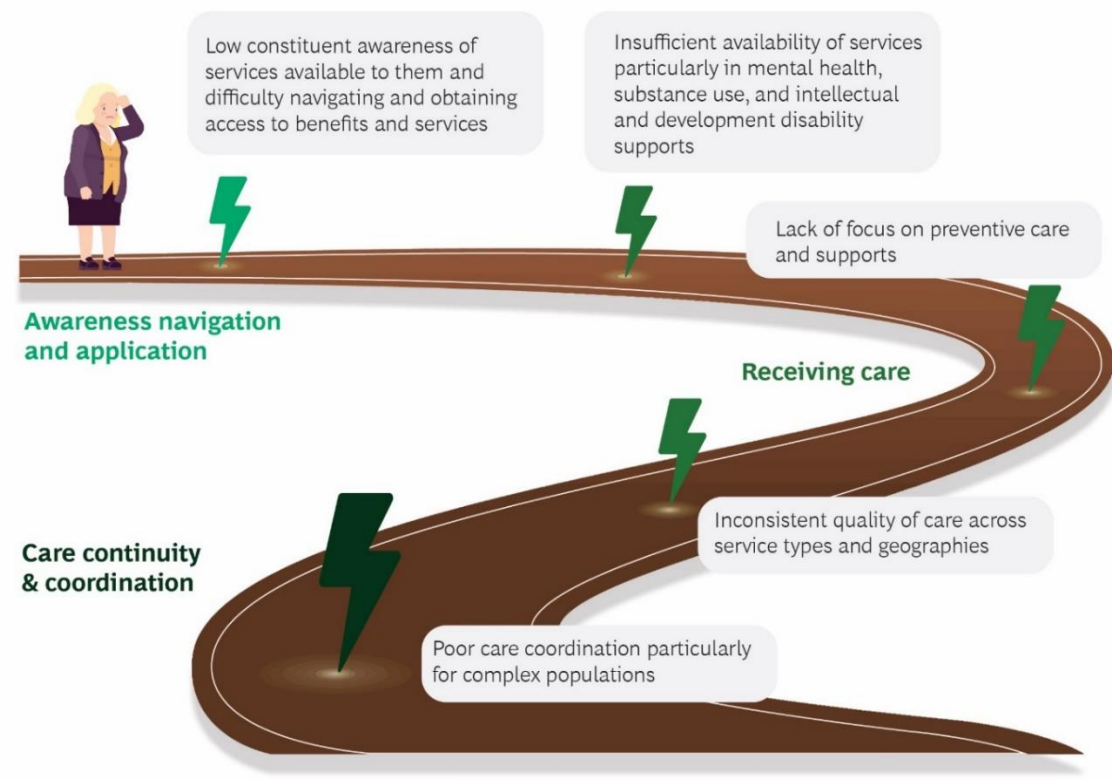
Constituents face challenges across the entire journey to access services

A review of the typical steps a constituent takes on their health journey provides insight into potential areas of challenge. This assessment evaluated four overall steps:

1) Awareness: Constituents discover symptoms or recognize a need and identify next steps/options.
2) Navigation and application: First point of entry where constituents understand eligibility, complete applications, and find the right provider.
3) Receiving care/services: Constituents wait for services, schedule and coordinate services, access a provider, and receive treatment.
4) Care continuity and coordination: Constituents receive post-service transitionary care and long-term care plan management.

Exhibit 6: Constituent navigation journey and challenges

Five critical challenges in the constituent journey



Constituents face barriers at each step of this journey, as shown in **Exhibit 6** above, with five primary challenges identified:

1) **Low constituent awareness of services** available to them and **difficulty navigating and obtaining access to benefits and services**: Constituents often do not know their condition, the necessity of potential treatment, and the benefits or services for which they are eligible. Once patients are aware of the impact and existence of services available to them, they often do not know how to apply for services. Patients find the applications complex with complicated requirements.

> "I just didn't even know where to start. No one place or person will tell you everything that could help your [autistic] child…you have to google and research and call to try to piece together all of the options and pros/cons."
>
> *~ Caregiver of a patient with autism*

2) **Insufficient availability of services,** particularly in mental health, substance use, and disability supports**:** South Carolina is under-capacity across many mental health, substance use disorder, and disability care settings, with the deepest gaps in residential and step-down settings (e.g., SC ranks in the bottom 25% vs. other states in behavioral health residential capacity per capita).[13] These shortages also constrain capacity in more acute settings (e.g., hospital inpatient) by limiting discharge options. In addition, care available to Medicaid or uninsured patients is often even more limited than top-line capacity gaps. This would suggest that Medicaid patients in South Carolina have a ~3.3-fold lower likelihood of scheduling a specialty appointment than those with private insurance.[14] Finally, workforce shortages contribute to capacity gaps across the continuum. South Carolina has ~20% fewer psychiatrists and ~50% fewer psychologists per capita vs. the national average.[15]

3) **Limited focus on preventative care and supports:** Opportunities exist for South Carolina to strengthen constituents' understanding of healthy behaviors and access to routine preventative care (e.g., screenings, immunizations) and health-related social need supports (e.g., transportation, healthy food, housing). These measures are critical to help people live healthier lives and to reduce avoidable clinical spending by preventing health concerns before they escalate.

> "We need to reach people earlier, with more resources. We need to support people before the crisis, or we're going to keep ending up in situations that are hugely painful for the patient and everyone around them."
>
> *~ Agency staff member*

[13] N-SSATS 2020, N-MHSS 2020

[14] PubMed; Medicaid Patients have Difficulty Scheduling Health Care Appointments Compared with Private Insurance Patients: A Meta-Analysis, 2019

[15] HRSA Area Health Resource Files, 2021

Currently, South Carolina underperforms on several critical social factors that impact health (e.g., 14th highest rates of housing insecurity, 11th highest rates of food insecurity).[16] Preventative care investment also lags compared to other states. For example, spending per capita on local health departments, a critical preventative setting, is in the bottom third nationally.[17] Additionally, the primary care workforce capacity is not sufficient to meet demand (38th in primary care physicians per capita).[18]

> "My son is on multiple waiting lists, and his positions on the lists are in the 10,000s and 12,000s. He's been on the list for years."
>
> *~ Caregiver of a patient with intellectual disability and related disabilities*

4) Inconsistent quality of care across service types and geographies: Service quality varies across counties and service delivery type, with varied treatment outcomes and patient experience, an uneven composition of services across the State, and facilities that range from outdated to state-of-the-art. For example, all six state-run nursing homes are below the 30th percentile nationwide in overall ratings from the Centers for Medicare and Medicaid Services (CMS). Two homes are below the 15th percentile, including the general nursing home.[19]

5) Limited care coordination particularly for complex populations: Constituents with complex and co-morbid conditions (e.g., intellectual and related disabilities, foster care, acute behavioral health) experience poor care coordination across services, with frictions in accessing appropriate care. In addition, transitions between different care types are often dropped. Many constituents reported a lack of "warm handoffs" between settings upon discharge (e.g., referrals, support for making appointments). Furthermore, provider turnover leads to interruptions in care.

   A real-life example highlights how these challenges manifest for constituents: Ethan (identity masked to protect privacy) is a male in his early 20s. He experimented with drugs in high school and became addicted to opioids. His journey (Exhibit 7) demonstrates the complexity of navigating and maintaining the required treatment, given navigation and access barriers.

> "I completed the number of visits covered by insurance, and then my therapist said I was being released. She didn't tell me about any community support groups or other resources, she just gave me a crisis phone number and told me to try journaling or meditation. I hope I don't regress—I don't want to have to go into crisis to get help."
>
> *~ Patient with serious mental illness*

[16] Center for Economic and Policy Research, "Housing Insecurity by Race and Place During the Pandemic," 2021.

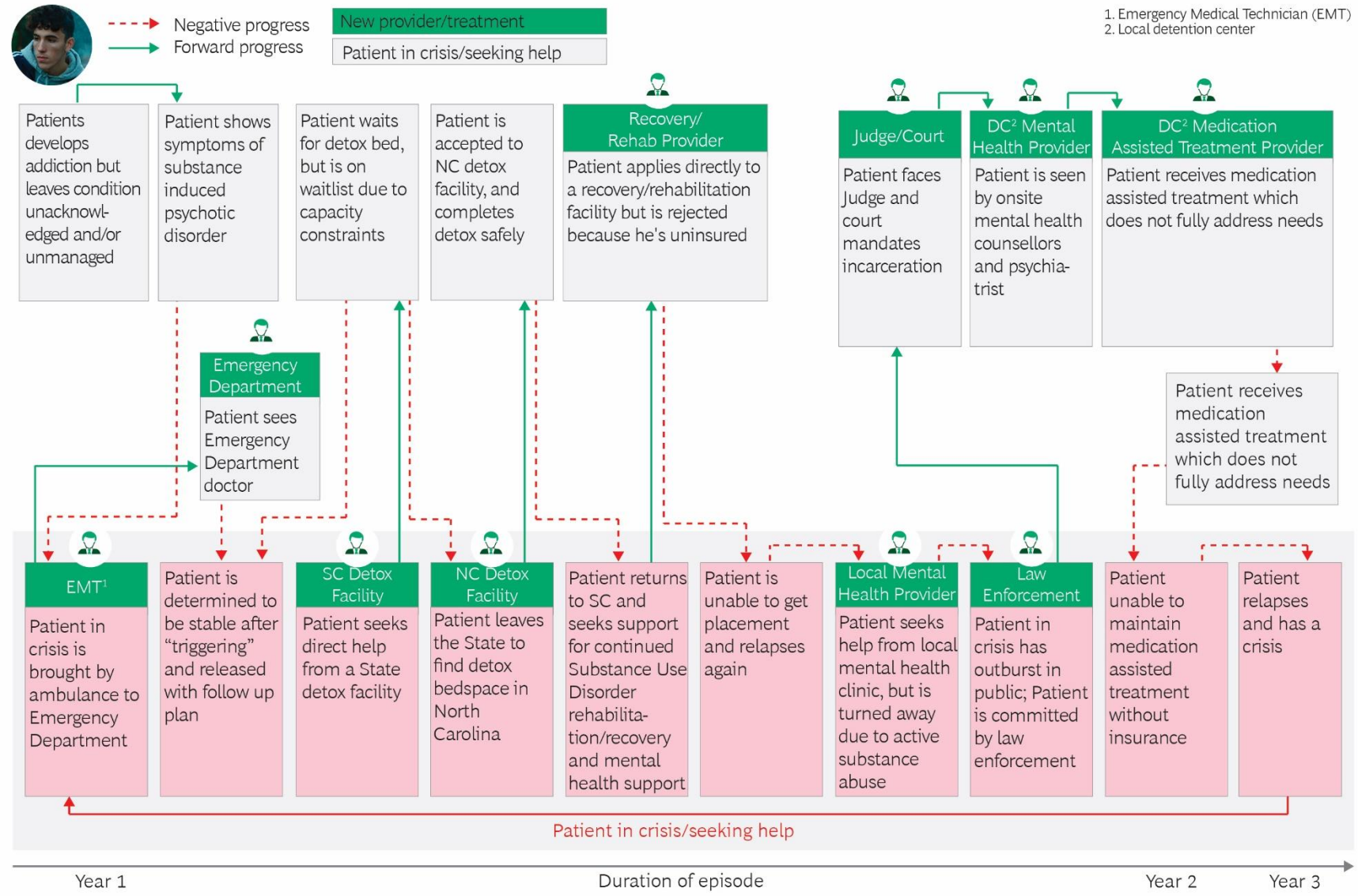
[17] NACCHO, 2019 National Profile of Local Health Departments

[18] HRSA Area Health Resource Files, 2021

[19] CMS Nursing Home Care Compare, 2023; Note: CMS rating comprised of staffing, health inspections, and patient outcome measures

Exhibit 7: Ethan's story

This demonstrates the complexities of navigating treatment for both substance use disorder and mental illness



Sub-par constituent experience driven by challenges with state agencies

Given this complex environment, there are a set of challenges regarding how these agencies operate that directly affect the challenges seen in the constituent experience:

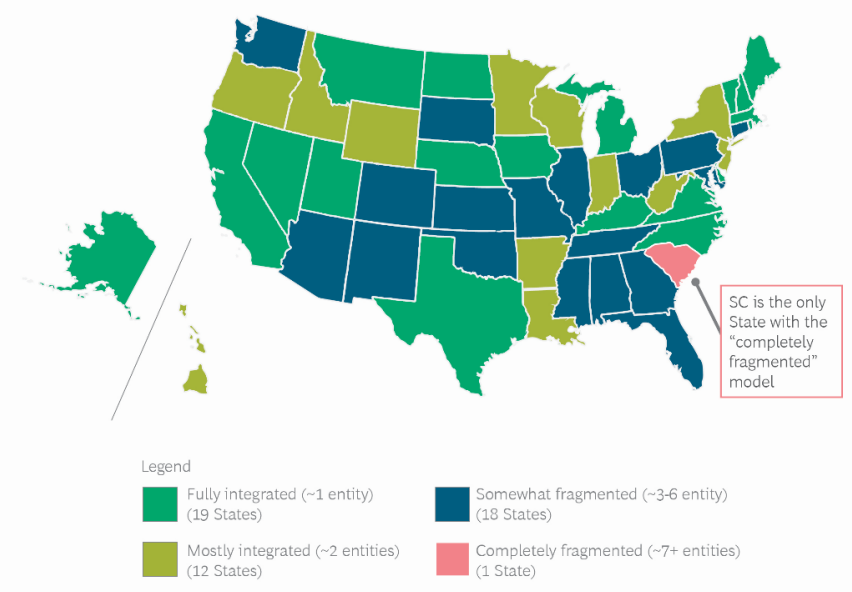
> "A lot of patients are relying on more than one service, and it gets confusing fast…we [staff from different agencies] have to sit side by side to figure out who is going to do what."
>
> *~ Agency staff member*

Fragmented agency structure and coordination approach

South Carolina has the most fragmented health and human services agency structure when compared to other states (see Exhibit 8). It is the only state in which all health and human services-related departments are independent of one another and does not have common oversight below the Governor. This fragmentation results in a lack of cohesive statewide strategy, care gaps, and navigation challenges for constituents. To successfully address complex, cross-cutting issues such as behavioral health, youth mental health, and constituent navigation, the State must take a more coordinated approach. However, at present there is limited coordination across key functions such as strategic planning, case management, data sharing, and policy development due to fragmentation and misaligned charters. In fact, ~50% of agency staff believe their agency does not collaborate well with other agencies.[20]

Exhibit 8: South Carolina has the most fragmented health and human services structure in the U.S.

Models for how states structure health & human services agencies by state



[20] Act 60 Agency Survey

Lack of innovation and inconsistent oversight of state and local-operated service delivery

South Carolina's lack of integrated strategy and forward-planning has also led to insufficient innovation and improvements in policies and programs that influence health outcomes. For example, South Carolina receives, on average, ~30% less discretionary grant funding per capita than other U.S. states over the last 5 years – dollars that other states frequently use for innovation.[21] Better partnerships between the State and its health care partners—including providers, community-based organizations, and MCOs—will help South Carolina progress in key areas (e.g., health-related social needs, maternal and infant health). Although South Carolina was an early adopter of school-based services, the State has been slower to adopt other evidence-based models of care (e.g., Certified Community Behavioral Health Clinics) that could help better integrate care between mental health and substance use disorder.

> "We are behind as a state [in innovating] …we have spent years operating like we are still in the 80s…we need to embrace innovation."
>
> *~ State agency leader*

Additionally, there are different roles and governance models across service lines today. For example, DMH runs the largest State-owned system in the country, vs. DAODAS and DDSN, which rely on county-controlled entities. This creates a fragmented delivery model that potentially contributes to inconsistent quality across the State.

To highlight the point, the proportion of patients who completed treatment across 301 substance use clinics varied from 33% to 75%.[22] In addition, South Carolina lacks sufficient mental healthcare capacity overall, with more than triple the number of constituents to mental health facilities than the U.S., and the State's mental health capacity is heavily skewed toward public facilities—nearly 65% of SC mental health treatment facilities are run directly by the State mental health agency compared to an average of 3% nationally. This reflects potential underweight private capacity[23] (see Exhibit 9).

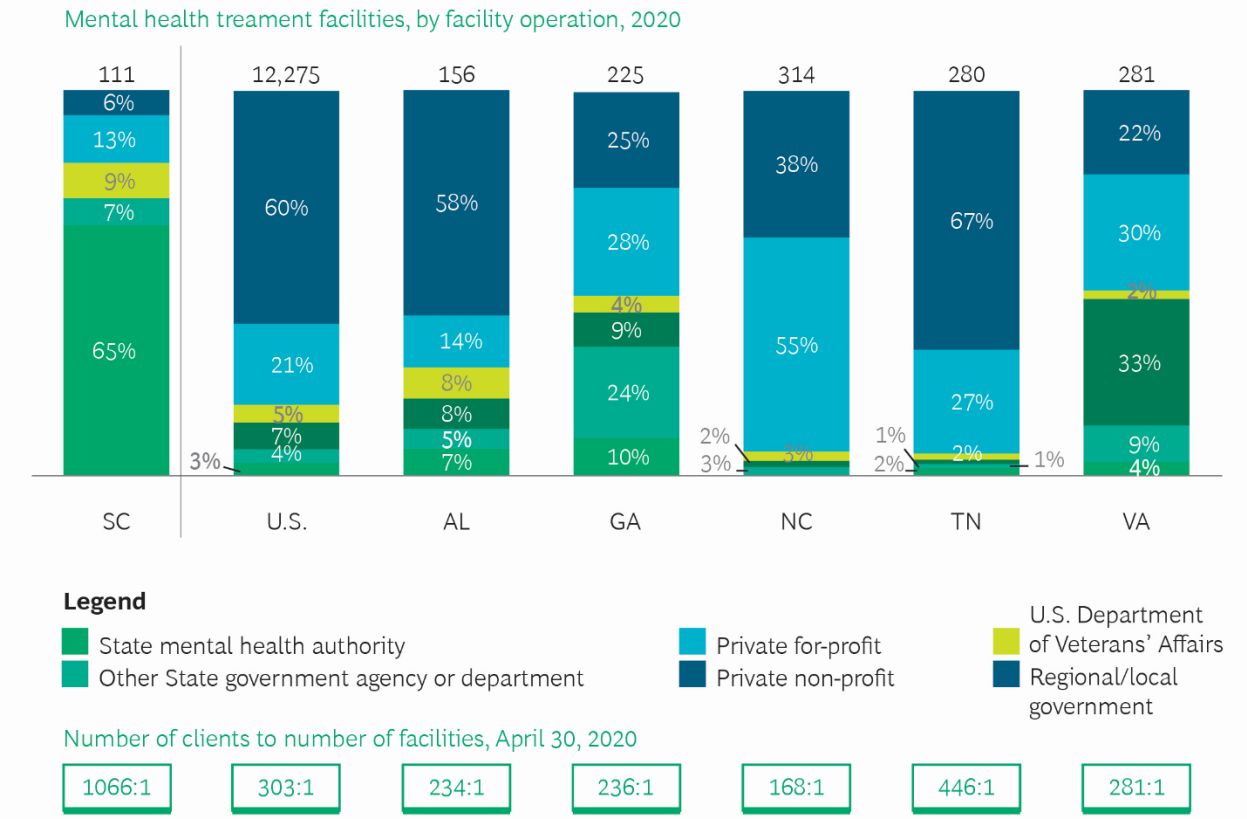
[21] Average yearly discretionary grant funding received from the respective federal agencies from 2019-2023. CMS; HHS (TAGGS); U.S. Census

[22] DAODAS FY2022 discharges and outcomes report

[23] SAMHSA data.

Exhibit 9: Ownership of South Carolina's mental health treatment facilities

SC is only the state among peers where majority of mental health treatment facilities are operated by the state



Note: Data taken on April 30, 2020. Only includes facilities that responded to the SAMHSA survey. South Carolina had a 93% response rate; Source: Center for Behavioral health statistics and quality, SAMHSA, national mental health services survey (N-MHSS), 2020.

Gaps in data infrastructure and high agency vacancies and turnover

Gaps in data collection and sharing among agencies limit the understanding of any individual's interactions across the system, measurement of outcomes, and how the State can improve its care. There is also an opportunity to more effectively use technology to engage better with constituents and help them navigate the healthcare system.

> "Such turnover in state government…[a] huge wave of retirement….new people not accustomed to [the] state system. [They] don't know what they don't know."
>
> *~ State agency leader*

High agency turnover also exacerbates challenges facing state agencies. In FY23, state agencies experienced ~19% average staff turnover, with only ~42%[24] of staff reporting that they believe their agency is an attractive employer that recruits and retains good talent. These challenges hinder agencies' ability to consistently serve constituents effectively.

[24] Note: data from FY23; Source: Act 60 Agency Survey, peer surveys, agency HR data, S399 Agency, and Position data - 8/14/2023, S399 Agency FY 2019-2023 separation data

3 | Recommendations

Recommendations

The following sections provide specific recommendations for the issues identified above. While these recommendations are independent of one another, they are intended to work in concert. As detailed below, it is important that the State adopt a broader, more holistic approach to improving its health care delivery.

By implementing these recommendations, South Carolina would improve health outcomes, drive better efficiency of the health delivery system, and increase value for the overall dollars spent. The table below highlights each recommendation and its benefits.

Recommendation		Benefits for South Carolina
#1	Streamline state agency structure and roles *Page 23*	• Make it easier for constituents to navigate to healthcare services, apply for benefits, and receive coordinated care • Reinvest administrative cost savings (e.g., via reduced duplication in administrative services) • Support more effective and consistent internal agency operations
#2	Build strategic plan and operating approach for health and human services *Page 32*	• Better allocate State resources to the highest need programs, services, and geographies • Use collective data, expertise, and resources to make greater progress on health issues than any agency could do on its own • Drive better accountability of service delivery for constituents
#3	Increase healthcare capacity *Page 36*	• Improve health outcomes by ensuring that constituents get the right care appropriate to their needs, especially for the most vulnerable • Reduce the use of costly acute care settings, such as EDs, by serving people in more appropriate, lower-cost settings
#4	Improve quality of services in the State *Page 48*	• Improve health outcomes by ensuring that constituents receive strong, evidence-based care, informed by the most up-to-date practices • Drive greater efficiency and effectiveness in spending on managed care through better partnerships with MCOs (e.g., reduced acute care spending, increased MCO investment in State priorities) • Increase flow of federal dollars into the State through participation in federal innovation programs
#5	Improve preventative care *Page 55*	• Support people's health needs before they become more serious • Limit more expensive future treatment costs • Alleviate burden on acute and treatment capacity over time due to improved population health status

Recommendation		Benefits for South Carolina
#6	Help constituents navigate to benefits and services *Page 64*	• Improve health outcomes by ensuring that constituents receive needed benefits and services • Lower future healthcare costs by ensuring early use of supportive services and benefits • Increase flow of federal dollars into the State through increased use of benefits and services
#7	Strengthen state health and human services workforce *Page 72*	• Improve service delivery to constituents via reduced vacancies, stronger staff skills and training, and more automated processes • Reduce recruiting and training costs associated with high turnover

Recommendation #1: Streamline state agency structure and roles

South Carolina's health and human services agencies provide a range of services to constituents, often with overlapping programs (e.g., nutrition support) or serving complementary populations (e.g., services for individuals with autism). South Carolina's model—with eight independent agencies—makes it the most fragmented of any state in the United States (see **Exhibit 10** for agencies considered).[25]

Exhibit 10: Eight South Carolina health and human services agencies considered in assessment

This fragmentation results in numerous challenges for constituents looking to access services, from identifying where to go for services to receiving those services in an integrated fashion. For example, for individuals with both intellectual disabilities and mental health conditions, Medicaid covers medical expenses; day services are provided by DDSN; and mental health services are provided by DMH. However, there is minimal shared care management and system of referrals across these agencies to ensure a holistic, integrated experience.

In addition to the constituent-facing challenges, internal operations to deliver services are made less efficient and less effective because of the current structure. Multiple agencies

[25] While other agencies, such as the SC Vocational Rehabilitation Department and the Continuum of Care program within the Department of Children's Advocacy, play a role in the health and human services delivery in the state, these agencies were not explicitly part of the scope of this assessment.

often have dedicated staff deployed to similar work without a coordinating infrastructure (e.g., shared processes, common technology) to facilitate complementary or overlapping work. The statewide move toward shared services has started to alleviate the internal operations challenges, but further opportunity remains.

The opportunities to streamline State agency structures and roles are to:

- Establish a central organization to provide leadership, drive accountability, and improve collaboration across health and human services
- Merge agencies with similar missions within the central organization
- Evaluate and redesign organizational structure within each agency

As South Carolina contemplates changes to structures and roles, it is critical to balance the benefits of increased integration with maintaining the distinct role each agency plays in responding to the needs of the population they serve. Therefore, in the forthcoming section, the recommendations include ways to ensure that the expertise and experience of the agencies remain intact in the event structural changes are made.

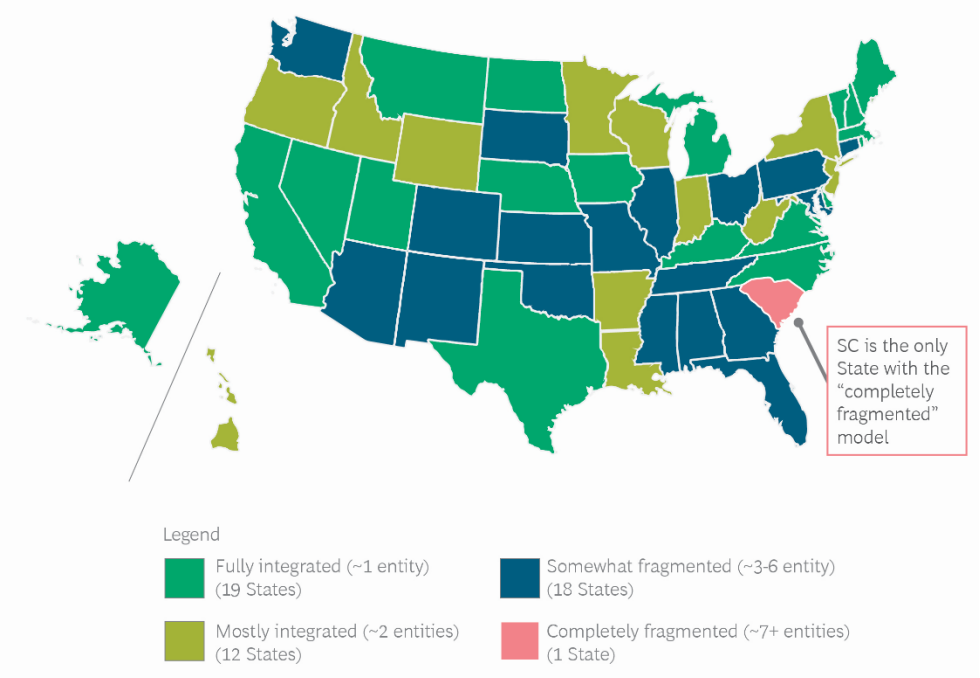
Establish a central organization to provide leadership, drive accountability and improve collaboration across health and human services

South Carolina's health and human services landscape is complex, with numerous agencies and non-governmental stakeholders working to deliver services to constituents. Additionally, as previously mentioned, South Carolina has the most fragmented agency structure across the United States; most other states have some form of "umbrella" organization or role that oversees health and human services activities (see Exhibit 11).

Meeting the needs of South Carolinians—particularly those most vulnerable, like pregnant women, the elderly, and those with disabilities—requires significant coordination across the health and human services ecosystem, both in strategy-setting (e.g., developing a comprehensive approach to maternal health across Medicaid and public health) and in day-to-day operations (e.g., braiding funds across agencies, developing data-sharing approaches to gain a holistic view of constituents). To ensure that deep level of coordination, South Carolina should consider making structural changes to the oversight of health and human services.

Exhibit 11: South Carolina has the most fragmented health and human services structure in the U.S.

Models for how states structure health & human services agencies by state



Note: Health and human services activities include: Public Health, Medicaid, Mental Health, Substance Use, Development Disabilities, Seniors, and Social Services (e,g., Child Care, TANF, SNAP). Other than RI, responsibility for Veterans is independent from other health related responsibilities
Source: BCG Analysis, State Agency Websites

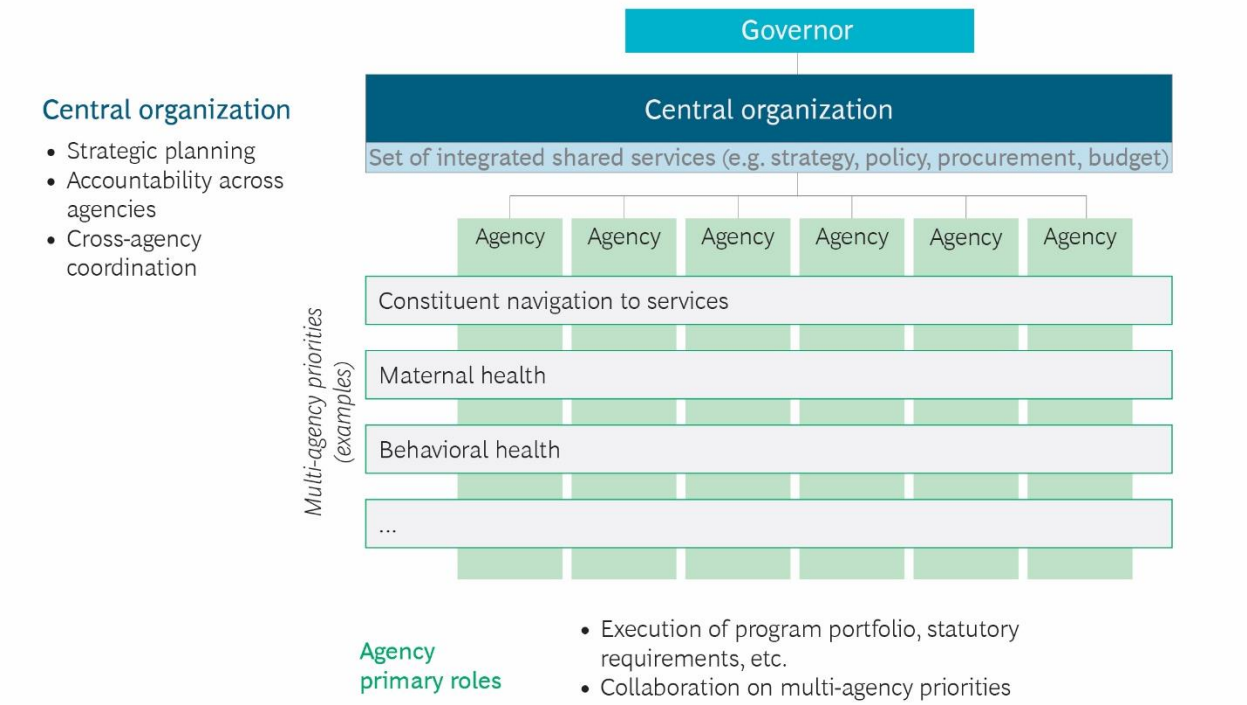
There are multiple approaches to achieve this coordination, from adjusting agency missions to take on this coordination explicitly, to building an entirely new organization to take on the role. Because South Carolina does not currently have an agency or other government organization (e.g., a centralized strategy office) with a broad enough purview, the most effective path would be to create a new entity.

This new entity—often a Cabinet-level organization reporting directly to the Governor in other states—would be responsible for:

- Developing a statewide strategic plan for health and human services.
- Driving accountability for overall and agency-specific outcomes.
- Coordinating cross-agency activity.
- Facilitating communication both internally and with external stakeholders.

In this model, agencies continue to lead execution on their program portfolio and in line with their statutory requirements. (See **Exhibit 12** for detail.)

Exhibit 12: A central organization would improve cross-agency coordination



Building this new entity requires a thoughtful approach to achieve the expected benefits of increased coordination of policy-setting, improved resource deployment, higher-quality service delivery, and greater accountability through streamlined reporting to the Governor.

There are several considerations South Carolina should consider when designing the new entity:

First, the State should consider which agencies to include within the new entity. The majority of states (19) that have an umbrella organization have oversight across all of health and human services agencies. However, a few states[26] (3) have focused on the health-related agencies—most frequently including Medicaid, Public Health, Mental Health, Substance Use, Disabilities, and Aging—and maintained a peer human services agency, considering the breadth and size of the human services footprint.

Given the overlaps in populations and activities, South Carolina would achieve the most benefit from having all health and human services agencies under a single entity, although creating an entity over just the health-related agencies would still be a meaningful step in the right direction on its own.

Second, the State will need to align the governance model of the in-scope agencies to the new entity. This shift will require moving away from the current DMH and DDSN

[26] Louisiana, Wisconsin, Wyoming

Commission structures to have agency directors directly appointed by the leader of the new entity. This move would put South Carolina in line with most other states, as only Missouri and Mississippi[27] have Commissions today. Given the important role the Commissions play in advocating for the populations their agencies serve and providing expertise on policy and operational matters, the State should maintain the Commissions as advisory boards.

Third, the role of the central organization can vary widely, from higher-level policy direction (e.g., maternal health, behavioral health strategy) to deep operational engagement (e.g., budget development, procurement oversight). Regardless of the direction, all successful models have the authority of the organization clearly defined in statute to ensure alignment across parties.

Finally, in developing the new entity, South Carolina should conduct a detailed review of activities at each relevant agency and if/how those activities might shift to the new entity, in addition to any "net new" activities. This exercise will likely result in opportunities to consolidate similar types of work across agencies—for example, in "shared services" functions like procurement and information technology—and reallocate that work to the new entity. The review will also ensure that the new entity has a commensurate level of resourcing to execute on its role, including newly added activities such as strategic planning and data and analytics. In addition, South Carolina should consider the right operational and structural separations, including being housed in distinct parts of the organization and staffed with different resources between activities, to mitigate potential conflicts of interest.

While the development of a new entity would be a significant change for South Carolina, it would greatly increase the chance of success for many of the other recommendations in this report.

Integrate agencies with similar missions within the central organization

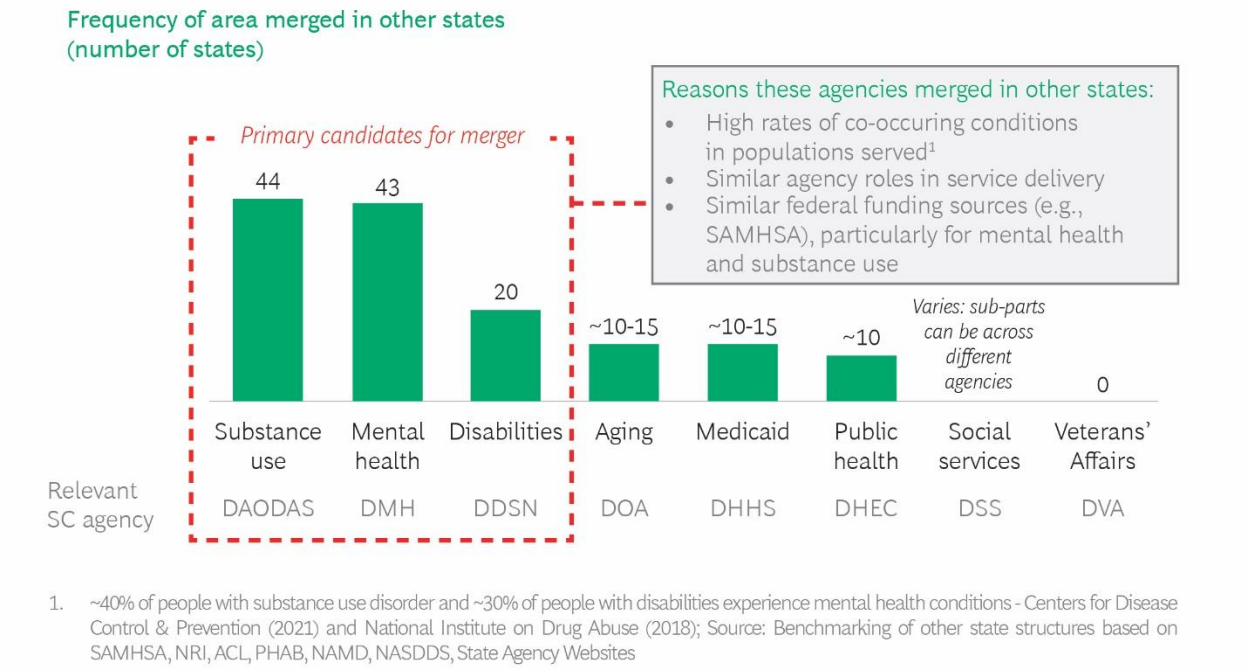
For agencies within the central umbrella organization, many states have also merged the operations of agencies with complementary areas of focus or populations served to improve the constituent experience and enable greater efficiency in delivery.

An analysis of the health and human services-related agency structures across the United States indicated that mental health and substance use agencies were most often merged with another agency; mental health stands alone in only seven states, while substance use does in six. Disabilities services was mixed across states, with about half independent and half as part of larger agency. Other agencies in scope—Medicaid, Aging, Public Health, and Human Services—were less likely to be operationally merged in other states.[28] (See Exhibit 13 for details.)

[27] NRI, 2020; State Agency Websites

[28] BCG Analysis, State Agency Websites, NAMD, 2023; PHAB, 2023; ACL, 2023; SAMHSA, 2023; NRI, 2023

Exhibit 13: Primary candidates for merger consideration



1. ~40% of people with substance use disorder and ~30% of people with disabilities experience mental health conditions - Centers for Disease Control & Prevention (2021) and National Institute on Drug Abuse (2018); Source: Benchmarking of other state structures based on SAMHSA, NRI, ACL, PHAB, NAMD, NASDDS, State Agency Websites

The combination of mental health and substance use agencies is often the result of similar federal funding sources (e.g., the Substance Abuse and Mental Health Services Administration, [SAMHSA], for mental health and substance use), agency roles (e.g., in service delivery or procurement), or to better support populations with high levels of co-occurring conditions.[29] States that have integrated mental health and substance use agencies have seen benefits in delivering more integrated services for constituents, lowering administrative inefficiencies, and unlocking new funding opportunities. To achieve these benefits, South Carolina should consider merging agency operations for DMH and DAODAS.

[29] 40% of people with substance use disorder and 30% of people with disabilities experience mental health conditions – Center for Disease Control, 2021; National Institute on Drug Abuse, 2018

Exhibit 14: Mental health and substance use is consolidated at both reporting line and agency-levels for majority of states

Note: Substance Use Disorder (SUD); Mental Health (MH); Development Disabilities (DD); Reporting Line consolidation means agencies report to a common leader or organization and is based on SAMHSA's funding report and validated through the state agency websites. Agency-level consolidation means agencies are operationally integrated and is based on SAMHSA's funding report and validated based on NASMHPD Research Institute, Inc (NRI) SMHA state profiles and state agency websites. Excluding when mental health, substance use disorder, and disability services are merged with at least one of each other, substance use services are consolidated at the agency level with public health services in 2 states and disabilities services are consolidated at the agency level with public health, Medicaid, or senior services in 5 states.
Source: BCG Analysis, State Agency Websites, NRI's 2020 State Profiles, SAMHSA 2015 Report on Single State Agencies for Substance Abuse Services and State Mental Health Agencies

Combining DMH and DAODAS would bring South Carolina in line with most other states and the agencies' primary federal partner, SAMHSA. It would also offer significant constituent benefits, particularly in serving those who have both mental health and substance use disorders and who face significant challenges today in South Carolina. For example, the State ranks in the bottom 25% of all states in behavioral health residential and inpatient treatment capacity per capita, and 77% of South Carolina youth aged 12-17

with a major depressive episode did not receive mental health services.[30] By merging the agencies operationally, they would have:

- Enhanced coordination through shared decision-making on policy priorities.
- Improved integrated care for constituents through co-location of mental health and substance use services.
- More comprehensive and holistic data on the population they serve.
- Increased opportunity to participate in SAMHSA demonstration programs (e.g., Certified Community Behavioral Health Clinics [CCBHCs]).

While there are potential benefits to coordination by bringing DDSN into a merged agency with DMH and DAODAS as well, there is less of a case to doing so in the near term. Most other states do not consolidate disability services due to the different population needs, program administration required, and provider types involved, vs. mental health and substance use care and supports. Since the primary benefit is the merger of DMH and DAODAS, we recommend pursuing that combination only in the near term.

To benefit from a DMH and DAODAS merger, South Carolina must consider several aspects in the design of the combined agency:

First, the State should consider the unique agency attributes of DMH and DAODAS that need to be addressed in merging. DMH and DAODAS have different service delivery models today, with DMH services run primarily by State employees vs. DAODAS services, which are run by a combination of county and non-profit entities. The integrated agency will need to be set up to manage the varied portfolio. Additionally, the current governance structure of DMH and DAODAS also differs: DMH is run by a Commission, while DAODAS is a Cabinet agency. As discussed above, aligning these governance models will be critical to achieving a successful integration.

Second, when designing the combined entity, the State should ensure it maintains right level of expertise and specific population-focus for both mental health and substance use. This can be done by aligning where it is appropriate to integrate activities and roles vs. not. The combined entity will also have to consider the right technological integration (e.g., systems, data permissioning) across the mental health and substance use programs.

Third, the State must ensure the right level of communication and support for stakeholders impacted, given the potential impact this integration will have on constituents, providers, and others in the ecosystem.

While the integration of DMH and DAODAS would address some of the most acute pain points felt by the populations they serve today, a merger alone will not solve the problem. The development of a central organization to align the strategy and activities of the newly

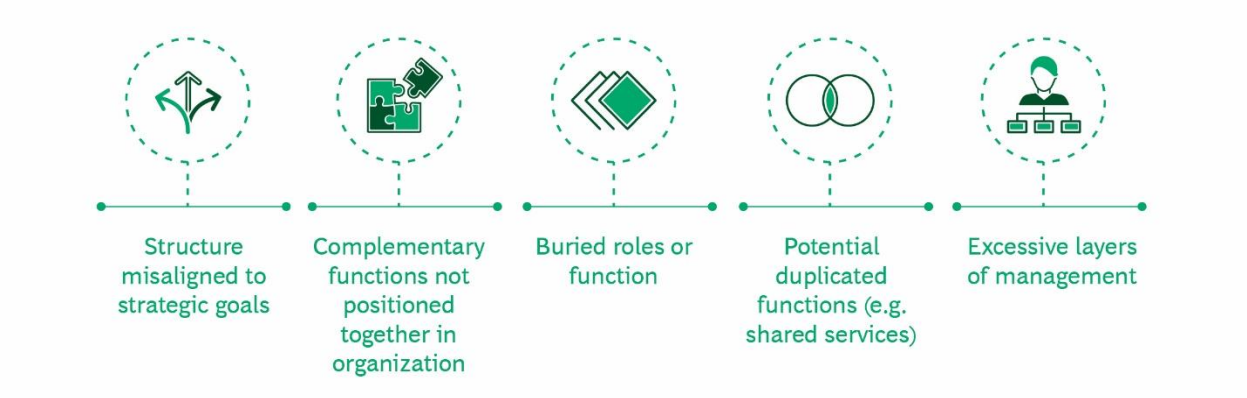
[30] Mental Health America, 2023

integrated DMH and DAODAS with the other health and human services agencies remains critical.

Evaluate and redesign organization structure within each agency

Alongside top-level agency structure changes, ensuring a strong organization structure for each agency is crucial to delivering effective and efficient operations. Examples of well-designed organization structures include maintaining an appropriate organizational depth (i.e., distance from agency leader to front-line staff), positioning complementary activity within the same units, ensuring the organization has all required functions to execute the strategy, and elevating functions closer to leadership with the highest strategic importance. These elements support stronger communication across teams, better accountability, and more efficient use of resources.

Exhibit 15: Improvement opportunities in agency organizational design identified



Currently, organizational structures across South Carolina's health and human services agencies have several gaps (see Exhibit 15 above). First, some agencies have particularly deep organizations, which may hinder communication between leaders and front-line staff. For example, four agencies have an average organizational depth of greater than seven layers. Contributing to this depth, agencies have an average of four to five direct reports per manager, lower than the target of eight or more direct reports per manager on average that other states have set (North Carolina, Texas, Iowa, Oregon).[31] This contributes to operational silos, hindering communication and shared decision-making across teams.

These issues are likely compounded by missing roles and functions within agencies—for example, data and planning roles—that limit collaboration among complementary roles and impact ability for cohesive strategic planning. Furthermore, some agencies have "buried" functions deeper in the organization than optimal when considering the function's strategic importance. Finally, as discussed earlier in recommendation #1, there

[31] NC DHHS Final Report to the Joint Legislative Program Evaluation Oversight Committee, 2016, Texas Government Code, Chapter 651; Iowa General Assembly House File 2454, Iowa General Assembly Senate File 2088; Oregon General Assembly, HB2020, 2011; NC OBSM Report

is likely duplication across administrative services within each agency, such as human resources, information technology, procurement, and other functions.

To address these challenges, the State should conduct a review of each agency's organizational structures to identify opportunities to design a future-state organization that would improve agency-level operations and communication across teams. As part of this review, South Carolina could consider whether agencies have the correct overall resourcing, role definition, and reporting structure to allow them to achieve their priorities. The central organization should lead this review in partnership with each agency, using a consistent approach across agencies.

Recommendation #2: Build strategic plan and operating approach for health and human services

Building and maintaining strong coordination among health and human services agencies is important to efficiently deliver high quality services for constituents. However, today there are several challenges, including no shared plan across health and human services in South Carolina, poor coordination and accountability across agencies, limited coordination on complex case management, and limited data sharing across agencies. These challenges are driven in large part due to the lack of common oversight across health and human services agencies.

The ability to build and maintain strong coordination among state agencies relies on the creation of a central organization, as described in recommendation #1 above, with one common leader with the power to bring agencies together. This organization would drive the following recommendations:

- Build a comprehensive plan for health and human services across the State.
- Strengthen accountability and coordination across agencies.
- Improve complex case coordination across South Carolina state agencies.
- Increase data sharing across agencies to improve policy making and operations.

Build a comprehensive plan for health and human services across the State

Many states ground cross-agency coordination in a shared plan that sets unified priorities, goals, and action plans with assigned owners for the coming years. A shared plan ensures that South Carolina stakeholders are heading in the same direction and lays the groundwork for agencies to work together more deeply on shared priorities.

While there has been movement in this direction in South Carolina, there is no shared plan for health and human services across agencies in the State. DHEC's State Health Improvement Plan (SHIP) has brought together community and agency stakeholders to align on public health priorities in South Carolina. However, progress toward achieving goals has been mixed, since no one agency has authority over all of the SHIP's recommendations, leading to a limited set of action plans for implementing the recommendations. As such, there is an opportunity to build on the State's current efforts, broadening the focus across all the health and human services agencies, and establishing more action-oriented implementation plans.

> "The State Health Improvement Plan is a good start. But we need to figure out how to get these things done. We need clearer goals and then we need to get people together on these goals and create a plan."
>
> *~ Industry association*

South Carolina should establish a planning process to develop cross-agency priorities, goals, and action plans. While agencies should continue to develop dedicated strategic plans on issues directly within their purview, a comprehensive plan for health and human services is critical to provide direction on cross-agency priorities that require collective action. The State should ensure that the planning process includes broad-based participation across all agencies and gathers input from relevant external stakeholders. In Texas, for example, agencies use a bottom-up approach to identify their key priorities, which the Health and Human Services organization consolidates into an annual plan, establishing clear initiatives, goals, and cross-cutting areas of focus.

Nesting within the larger planning process, interagency task forces can also help to define goals and detailed solutions on particularly complex issues that require deeper engagement. The State has facilitated some of these efforts to date. For example, DHHS convened a summit to discuss care challenges for foster youth, bringing together agencies, advocacy groups, and the MCO that covers all foster youth in the State.

Moving forward, there is an opportunity to continue these efforts and broaden to other areas – for example, improving constituent navigation to services. Iowa, for example, created a Mental Health Planning and Advisory Council, which brings together members from across State agencies and community stakeholders to support statewide planning.

Strengthen accountability and coordination across agencies

Acting on cross-agency priorities requires regular communication on policy goals and discipline to meeting commitments made in shared plans. Other states support this through formal bodies or mechanisms to facilitate interagency coordination. However, in South Carolina today, there are limited coordination and accountability systems across health and human services agencies.

> "State-serving agencies should be making sure access is available, and they don't seem to be working in an intentional way. There is no unified effort."
>
> *~ Advocacy group*

Moving forward, South Carolina should build and maintain tracking dashboards for leaders to monitor progress towards cross-agency goals on a regular basis. In addition, cross-

agency leadership should have regular meetings to discuss key issues, track progress based on the dashboard, and address any issues that arise.

For example, Texas leverages both data-driven monitoring and consistent check-ins to support planning and accountability. The central health and human services policy team maintains a progress dashboard in collaboration with agencies, and cross-agency leadership discusses the dashboard at bi-weekly meetings. In addition, the Executive Commissioner has regular one-on-one check-ins with agency directors to support accountability towards goals and tackle roadblocks.

Improve complex case coordination across state agencies

Constituents with complex and co-occurring conditions (e.g., intellectual and related disabilities, acute behavioral health) experience poor care coordination across services, with frictions in accessing the right care. In addition, transitions between different care types are often dropped – many constituents report a lack of "warm handoffs" between settings upon discharge (e.g., referrals for community treatment, support for making appointments). Provider turnover also leads to interruptions in care.

> "The focus can become 'who is responsible' instead of 'how can we come together and help this person."
>
> *~ Agency employee*

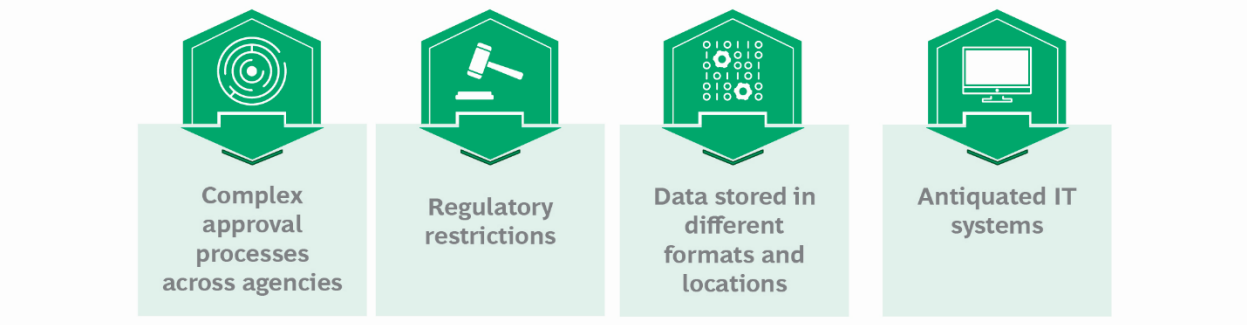
To address these challenges, agencies should formalize and strengthen cross-agency case management mechanisms to ensure patients with complex needs get the care they need when they need it. Although some coordination mechanisms are in place today – for example, representatives from agencies like DDSN, DMH, and DAODAS meet on a regular basis to address overlapping cases – many measures tend to be ad hoc. Other states have expanded cross-agency case management groups for the most complex, hard-to-support individuals. In Illinois, the chief officer for children's behavioral health leads a weekly inter-agency crisis staffing call to find placements for complex youth, for example those in foster system or with complex intellectual disabilities. The State should also consider involving MCOs more deeply in case management, building on a single managed care organization model for foster youth, and developing tracking tools for complex cases to monitor progress and next steps. In addition, South Carolina can improve care transitions by designing "warm handoffs" at key points of friction for patients with complex needs with clear referral pathways and communication to patients.

Increase data sharing across agencies to improve policy making and operations

Today, agencies have access to a wealth of health and demographic information on South Carolina constituents, both on an individual and aggregate basis. This data could be used to improve policy formulation, strengthen agency decision-making, and bolster care coordination for constituents.

However, the potential of this shared data to serve constituents is largely untapped. South Carolina's data is stored in different formats across many different, often antiquated information systems and controlled by different agencies. In addition, regulatory limits and complex approval processes make data sharing difficult.[32] (See Exhibit 16.)

Exhibit 16: Barriers to data sharing in South Carolina



The State should create a data-sharing plan across health and human services agencies, led by the new central entity (discussed in recommendation #1) in partnership with the Department of Administration's Office of Technology and Information Services, that articulates:

- The priority ways to use shared data
- Which data points need to be shared
- Data exchange frequency
- Agency owners

> "We have enormous amounts of data that we aren't using…data sharing is difficult and there is no forward-thinking vision. We need to build a stronger infrastructure."
>
> *~ Agency employee*

Stronger long-term data sharing agreements between agencies and harmonized data governance standards (e.g., privacy, security) can also help to make it easier to share data with faster approval processes. To enable these activities, South Carolina should further modernize agency data systems and create flexible data linkages between these systems. Statutory changes may also help support data sharing to address potential legal limitations to sharing.

Data sharing is challenging across many states – but some are expanding their efforts. For example, Tennessee's Data Analytics for Transparency and Accountability (TN DATA) initiative works to centralize data sharing and coordinate analytics partnerships across 11 state agencies and nonprofit organizations.[33] These partnerships enable improved cross-agency data reporting and analysis while complying with privacy and other data standards.

[32] For example, many types of inter-agency data sharing require approval from the Revenue and Fiscal Affairs Office, and there are often strict limits on what types of data can be shared with federal agencies and state stakeholders.

[33] TN DATA website

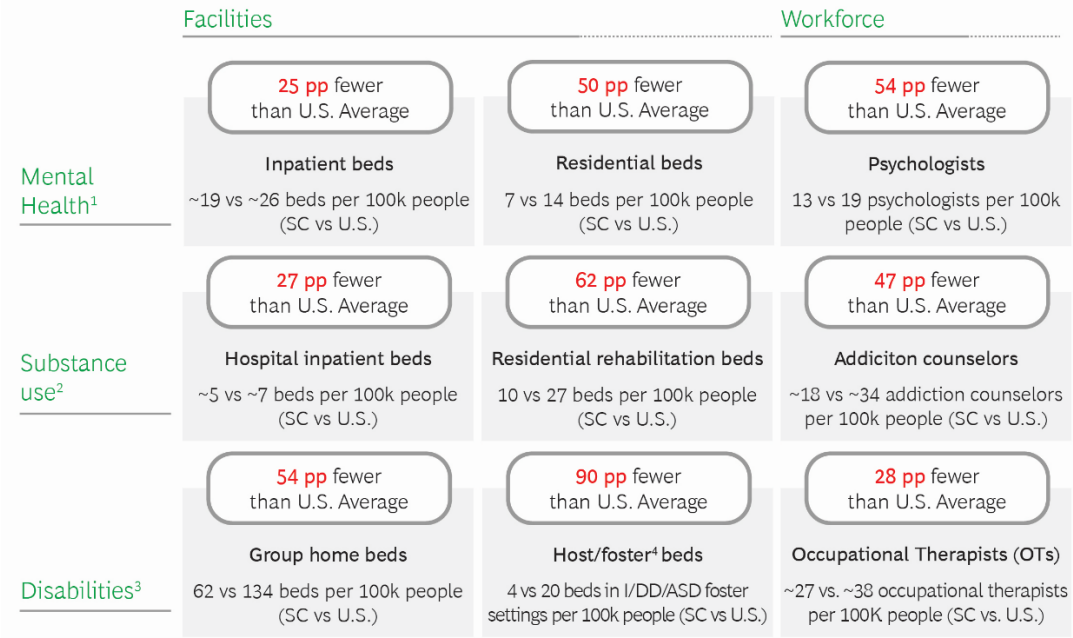
Recommendation #3: Increase healthcare capacity for mental health, substance use, and disabilities services

Capacity across the healthcare system in South Carolina is constrained. In particular, mental health, substance use, and disability services face the largest gaps in capacity compared to other states (vs. physical health services, although these services also face capacity gaps, particularly in rural areas). As a result, the following section focuses primarily on addressing capacity gaps in mental health, substance use, and disabilities.

Having sufficient capacity across the care continuum is critical to addressing the mix of constituent care needs in the right place at the right time. By contrast, gaps in capacity across this continuum can lead to people getting care in the wrong settings (e.g., substance use detox within EDs) or going untreated. This harms constituent health outcomes and is costly for the system (e.g., ED boarding following a mental health event, institutional care for those with intellectual and related disabilities).

Today, there is limited capacity for behavioral health and disabilities services across many parts of the care continuum in South Carolina when considering total public and private capacity. Exhibit 17 details selected examples of capacity gaps across mental health, substance use, and disabilities.

Exhibit 17: South Carolina has gaps in total public and private capacity across mental health, substance use and disabilities – selected statistics



1. N-MHSS (2020); DMH; HRSA (2021); DHEC licensing; CMS: provider interviews; HRSA psychologists figure only includes psychologists that have obtained a doctorate degree; Mental health residential beds are those that provide residential (i.e., 24 hour) mental health care but are not licensed as psychiatric hospitals; 2. N-SUMHSS 2022; HRSA (2021); U.S. Census; 3. University of Minnesota Residential Information Systems Project (RISP) tracks IDD long-term supports/services paid for or provided by public sources (Medicaid, state, and local); DDSN; Group homes refer to residential facilities with <7 beds, including but not limited to, CTH-II and SLL-II settings; 4. Includes therapeutic host/foster specifically geared at IDD population (e.g., SC's Community Training Home-I program)

For behavioral health, there is limited capacity available for treatment and recovery – in fact, the State has approximately 40% fewer mental health and 50% fewer substance use treatment facilities per capita relative to the national average.[34] While data challenges make it difficult to see where capacity is most limited, it appears there are capacity challenges across all care types, with the deepest capacity gaps in residential and step-down (IOP, PHP). For example, South Carolina has a gap vs. the U.S. of ~360 mental health residential beds and ~870 substance use residential beds.

These shortages in treatment and recovery capacity put pressure on crisis and acute care settings. Untreated behavioral health conditions make it more likely a crisis situation will arise. Crisis situations often involve law enforcement and EMS, who frequently are not equipped with the right tools or expertise to address behavioral health challenges. To stabilize patients in crisis, the ED is often the only option given the lack of more appropriate treatment settings; however, EDs are expensive, often have limited behavioral health stabilization capabilities, and upon discharge may have few options to refer patients to more appropriate services. In fact, South Carolina sees a 6% higher per capita rate of ED admissions for behavioral health conditions compared with other states, which already have high ED admission rates, with a national average of 69.1 admissions per 1K (up ~4% over past 5 years from 66.7).[35] To address these challenges, state agencies have recently focused on growing capacity to divert constituents to crisis stabilization units (CSUs) instead of EDs, established mobile crisis services to support crisis responders, and created partnerships with law enforcement with embedded mental health professionals. Many stakeholders engaged through this process indicated an opportunity to further scale these efforts.

For disabilities services, there is also a shortage of capacity. While South Carolina is at or above national averages for larger institutional settings with greater than 7 beds, there are significant gaps with smaller residential settings, such as group homes (with a gap of ~3,700 beds vs. the U.S.) and IDD/ASD-specific host/foster beds (with a gap of ~870 placements vs. the U.S.).[36] There are also significant gaps in the disability workforce. For example, the State ranks 42nd in the U.S. for occupational therapists (OTs) per capita[37]. These gaps in capacity lead to a lack of appropriate care for those with disabilities and added burdens on their caretakers.

The system also has more publicly run or controlled facilities as a percentage of total facilities, with limited private capacity. Not only are 31% of South Carolina's Substance Use Disorder treatment facilities operated by state or local governments, it is the only state where the majority of mental health treatment facilities —72%—are operated by state and local governments (65% by the State), compared to national averages of 7% and

[34] N-MHSS 2020, N-SSATS 2020

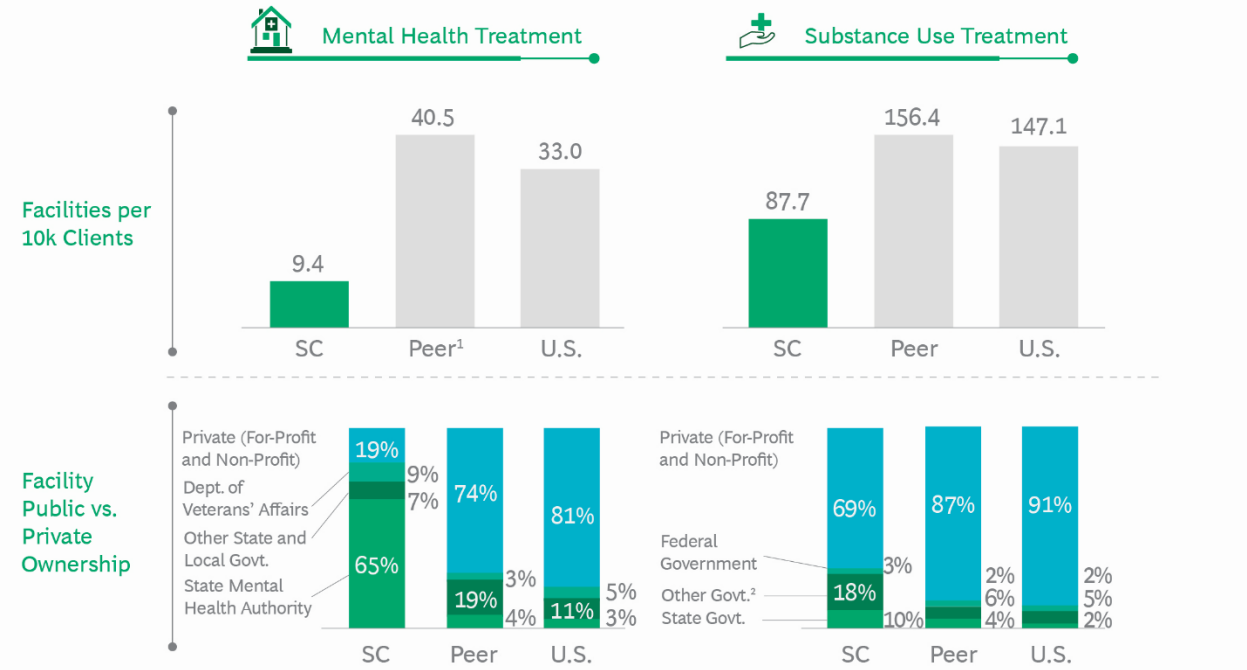
[35] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Trends in the Utilization of Emergency Department Services, 2009-2018. 2021

[36] University of Minnesota Residential Information Systems Project (RISP)

[37] South Carolina has 27 OTs per 100K people vs. 38 OTs per 100K in the U.S. (2021). U.S. Census.

14% respectively (see **Exhibit 18**).[38] Community Mental Health Centers (CMHCs) serve double the share of Medicaid and uninsured patients vs. SC's total population payer mix, and ~60%[39] of the patients served by 301s are Medicaid beneficiaries or are uninsured. Moreover, 72% of residential disabilities services are provided by DSN boards, county-controlled disability providers[40] who are critical to access for rural, Medicaid, and uninsured populations. Often, they are the only options available to these populations.

Exhibit 18: South Carolina lags behind U.S. average and peer states in total behavioral health capacity and has more public ownership of these facilities



Note: Mental health data taken on April 30th 2020 and substance use data taken on March 31st, 2020. Only includes facilities that responded to the SAMHSA survey. South Carolina had a 93% response rate for mental health facilities and 97% for substance use facilities. 1.Average of Peers (AL, GA, NC, TN, VA) 2. Includes local and tribal governments
Source: Center for Behavioral health statistics and quality, SAMHSA, national mental health services survey (N-MHSS), 2020

Beyond this safety net capacity, increasing private capacity in South Carolina is critical to filling these overall capacity gaps. In general, private providers can deliver services more flexibly than the public sector, likely a result of more streamlined administrative, funding, and decision-making processes. In addition, private entities can be quicker to leverage innovative practices, potentially given greater market competition and access to best practices across the country, particularly for those entities with national footprints. Lastly, in contrast with the private sector, the public sector has many different areas of focus; by

[38] N-MHSS 2020, N-SSATS 2020

[39] DAODAS data – "Clients served by payer type," average from years 2018-2023

[40] DDSN data; Figure excludes DDSN Regional Centers. DSN boards are privately operated but market under DDSN brand and participate in state benefits

ensuring that the State's service delivery role remains limited primarily to delivering safety net capacity, it can better direct its focus on the statewide planning needed to improve capacity and service mix for the populations it serves.

Considering these opportunities, South Carolina should pursue three objectives to build and maintain a comprehensive set of mental health, substance use, and disability services:

- Strengthen existing public access capacity to better serve the most vulnerable South Carolinians
- Increase private capacity to improve access to care for a broader array of constituents
- Grow the professional workforce and use it more effectively

These recommendations support one another. For example, driving private capacity helps provide opportunities for the workforce, and a stronger workforce can alleviate turnover and vacancies at public access facilities. At the same time, executing on these out of sync could create disruption. For example, raising incentives for private capacity creation could siphon talent away from safety net providers, working against the goal of preserving public access capacity. As such, they should be planned together to the greatest extent possible.

While these recommendations focus on the lack of capacity for behavioral health and disabilities conditions (since they face the largest capacity gaps) there are also capacity gaps within physical health and rural settings. For example, rural communities see a concerning lack of acute care capacity—as of October 2023, 26% of all rural hospitals in South Carolina were at immediate risk of closure.[41] Many of the recommendations discussed below also apply to addressing capacity gaps in physical health and rural settings.

Strengthen existing public access capacity to better serve the most vulnerable South Carolinians

As discussed above, there are limited options for the most vulnerable groups (e.g., uninsured, Medicaid, rural constituents) to receive care in the State outside the public access facilities (e.g., 301s, DSN boards, CMHCs, and other State-owned facilities). These providers play a critical role as safety net providers, providing access to a consistent set of core services within every county for those with behavioral health conditions and disabilities. As such, it is important to ensure these providers remain strong to serve this population.

However, these public access providers, particularly the 301s, DSN boards, and CMHCs, may not always provide a consistent service mix across South Carolina. This means that while some patients may have access to a full set of services, many do not. For example, individualized counseling is not provided at all 301s, only 13% of 301s provide office-based

[41] "Rural Hospitals At Risk Of Closing" (October 22, 2023), The Center for Healthcare Quality and Payment Reform

opioid treatment,[42] and close to a third of DSN boards do not offer a full service array.[43,44] Service mix issues could also lead to mismatches with patient demand. For example, some 301 sites are reported to have long waitlists, while others have significant spare capacity.

Several challenges contribute to these issues. First, there is limited planning for the right service mix at each location, both within each county and across South Carolina more broadly, despite statutory responsibilities at both the county and state levels to do so. Beyond gaps in planning, 301s, DSN boards, and CMHCs have, at times, declined to offer certain services or serve more complex populations (e.g., evidence of "cherry-picking" less acute patients, limited focus on needed services such as Medication-Assisted Treatment).[45]

Gaps and fragmentation of funding also contribute to service mix issues. South Carolina spends less in state funding per capita than other states in mental health, substance use, and disabilities, with the most significant underspending in substance use (see **Exhibit 19**).[46] This limited level of spending limits the breadth and availability of services that can be offered across South Carolina. In addition, funding sources for substance use, in particular, are also highly fragmented today across DAODAS (primarily through the Substance Use Prevention, Treatment, and Recovery Services Block Grant [SUBG]), DHHS (both Medicaid dollars and the Healthy Opportunities proviso), liquor tax revenue, other federal and state grants, and patient revenues. This fragmentation in funding sources for substance use limits the ability to more strategically guide how these funds are used statewide and maximize the opportunities from federal matching. Finally, while the State has begun to move from a per capita to a fee-for-service based approach to allocating the SUBG, the allocation methodology still caps 301s at a maximum per capita allocation.

[42] SC DAODAS 301 Commission Types and Services, 2023

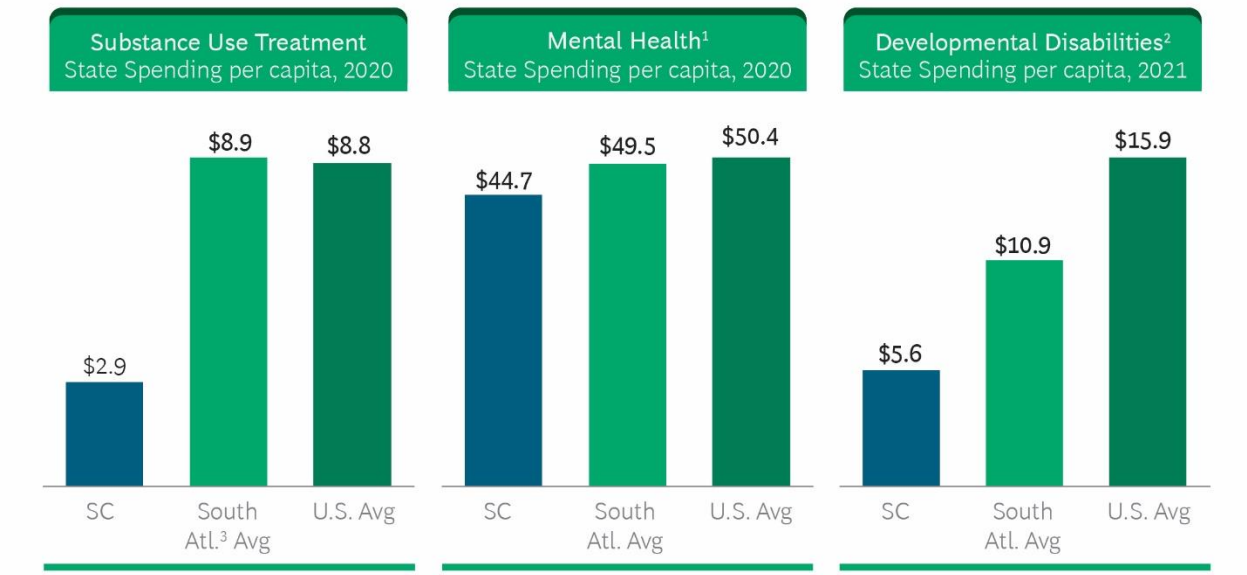
[43] Figure excludes case management services, which are required to be conflict free and may not be present at every DSN Board location.

[44] SC DDSN Dashboard for Provider Performance, 2023

[45] Discussion with DDSN

[46] South Atlantic states include DE, FL, GA, MD, NC, SC, VA, WV. South Carolina Substance Use Disorder Treatment Policy Brief – October 2021

Exhibit 19: South Carolina spends less state funding on behavioral health and disabilities



Note: State spending excludes State Medicaid Spending
1. Data for 47 states, missing NY, MI, MN 2. Data for 46 states, missing MA, VT, WA, WY 3. South Atlantic States (DE, FL, GA, MD, NC, VA, WV) included in data set
SUD Source: University of South Carolina Substance Use Disorder treatment policy brief
MH Source: SAMHSA Web-Based Grant Application 2020; SAMHSA URS; United States Census Bureau 2020
DD Source: The State of the States in Intellectual and Developmental Disabilities, Kansas University Center on Developmental Disabilities, The University of Kansas; United States Census Bureau 2020

To address these issues and ensure sufficient patient access to these services, the State should first establish a statewide plan for service mix, particularly for the 301s, DSN boards, and CMHCs – for example, the baseline set of services across the State vs. expanded services based on patient needs in certain areas. 301s and DSN boards should coordinate their county-specific plans, required by statute, with this statewide plan. To support this desired service mix, South Carolina should consider ways to increase total state funding for substance use, mental health, and disability services, bringing it in line with other states, targeting the highest need populations, services, and geographies (e.g., populations with both ID/RD and behavioral health issues). In addition, South Carolina should consider pooling funds for substance use and improving the allocation methodology (e.g., continuing to shift the SUBG allocation methodology from per capita to FFS allocations) to better direct these dollars toward the highest need services and geographies. In addition, by streamlining the funding, the State might also be able to draw down additional federal match dollars through Medicaid.

To ensure follow through on this and ensure right quality of services for funding, South Carolina should also strengthen its oversight of these providers (discussed in recommendation #4 on improving quality of services).

Increase private capacity to improve access to care for a broader array of constituents

As discussed above, to increase access to mental health, substance use disorder, and disability services, it is critical to build private capacity in the State to grow beyond the safety net services that public access facilities provide.

> "Medicaid reimbursement is top of the list for us when we think about where to expand…we have issues with things like staffing and licensing across states, but if the reimbursement is there, that allows us to invest more time and resources into working through those challenges."
>
> *~ Private substance use provider*

First, as part of the statewide strategic plan for health, South Carolina should establish an approach for building private capacity, mapping the current capacity today and the most priority gaps to fill based on service type and geography. Today, responsibility for this data is scattered across different state agencies, including DHEC, DAODAS, DDSN, and DHHS. As such, these agencies should work collaboratively to develop this capacity map and identify priority gaps.

To execute on this plan, South Carolina should use a variety of levers tailored to each care setting. Other states have incentivized private capacity growth through a combination of financial incentives via Medicaid and public grants, regulatory relief through easing provider administration, and commercial payer accountability (see Exhibit 20).

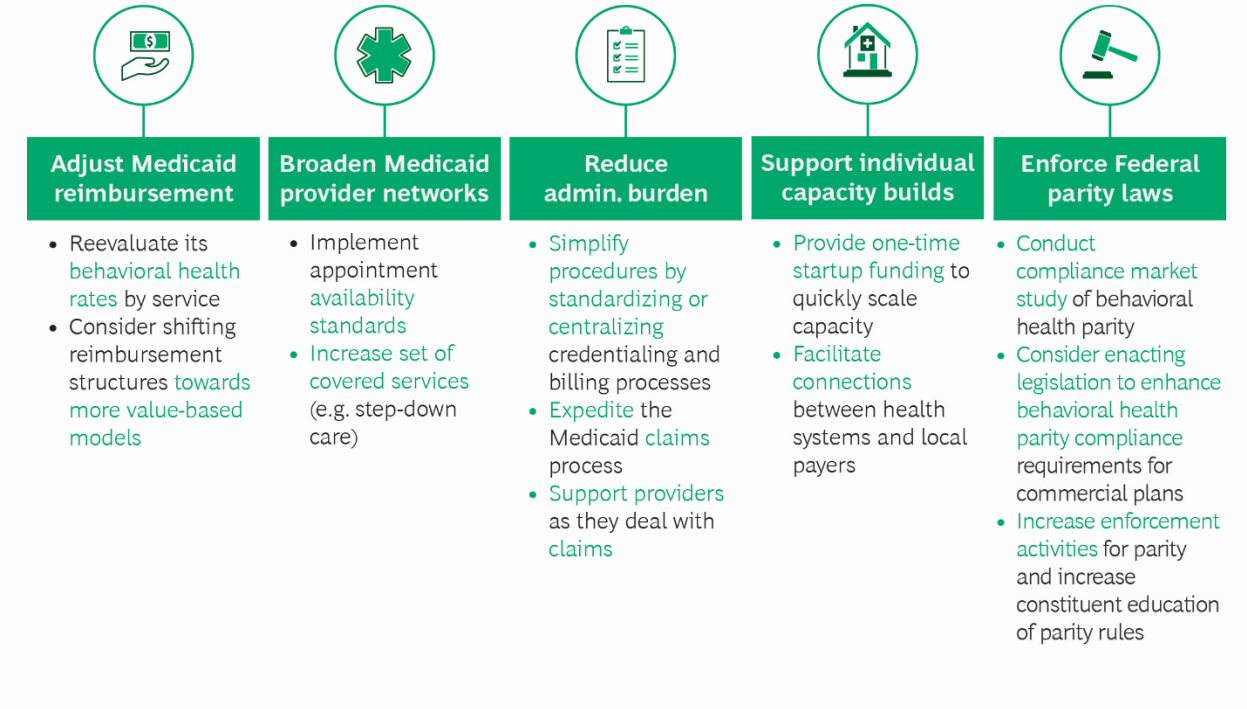
First, Medicaid reimbursement rates have a significant impact on private providers' decisions to build behavioral health and disabilities services capacity since they are the largest payer of these services across the Nation. The level of rates is especially important for providers that serve Medicaid patients since these rates typically lag the rates from commercial insurers,[47] leading to particularly challenging economics for providers. However, Medicaid rates in South Carolina today tend to be even lower than those in other peer states. The State's Medicaid reimbursement rates for mental health services fall in the bottom quartile nationally and are approximately 10% – 50% lower than neighboring states like North Carolina, Virginia, and Georgia.[48] While the reimbursement rates for substance use treatment are more aligned with the national average, there is still considerable variability across different services—for example, rates for office-based opioid treatment programs lag substantially behind other states.[49]

[47] The Commonwealth Fund, 2022. Physician and inpatient payments for Medicaid lag Commercial insurance by ~40-60%.

[48] Medicaid Reimbursement for Psychiatric Services: Comparisons Across States And With Medicare, 2023, Jane M. Zhu et al.

[49] Provider interviews

Exhibit 20: Primary levers to increase capacity in South Carolina



To address these challenges, the State should adjust Medicaid rates and reimbursement models to ensure that they are competitive with the market to attract more private providers and increase service availability for Medicaid patients. South Carolina should reevaluate its behavioral health rates by service and determine where increases in rates or the implementation of other supplemental payments are necessary to enhance service capacity and availability. For example, in 2023, New Mexico approved a ~$400M Medicaid rate increase for most types of health care providers, bringing rates up to as high as 120% of Medicare rates.[50] Over time, South Carolina should consider shifting reimbursement structures towards more value-based models that reward and attract providers who deliver strong outcomes as another way to improve the economics for private providers of serving Medicaid patients. In another example, New Hampshire MCOs are required to submit value-based payment implementation plans that articulate how payment models advance State priorities, including reducing ED utilization for behavioral health and improving access to substance use disorder treatment.

South Carolina should also consider broadening Medicaid provider networks and covered services; for example by implementing appointment availability standards (in place in 74% of states) and strengthening network adequacy standards to reduce maximum travel times

[50] New Mexico Human Services Department

for services.[51] Working with MCOs to drive these changes could help make healthcare services more accessible over time, especially for those in rural areas.[52] Furthermore, South Carolina should consider broadening its plan to include key services that are currently not covered. For example, step-down care is not a Medicaid-covered service in the State, although there are plans to include it by July 2024. By including these services, South Carolina can provide more comprehensive care and address a critical gap in the current healthcare system.

Provider administrative burden, such as paperwork to enroll providers in Medicaid or achieving licensure to operate facilities, may also dampen private capacity creation by creating high startup costs.[53] While SB164 eliminated most certificate of needs requirements,[54] providers continue to face administrative burdens that the State could address. South Carolina can simplify procedures by standardizing or centralizing credentialing and billing administrative processes following states like Mississippi, North Carolina, and Ohio, which have all moved in the past 5 years to centralized credentialing to simplify the process for providers.[55] Additionally, South Carolina could help expedite the Medicaid claims process, similar to Ohio's model where 90% of behavioral health provider claims are reimbursed within 15 days,[56] which could shorten providers' cash cycles and reduce their need for short-term financing.

Furthermore, offering support to providers as they deal with claims, prior authorizations, and credentialing can help providers more quickly navigate the billing process. An example is Nebraska's approach, where MCOs are required to assist providers with these tasks through various channels, including training sessions, online resources, and call centers. Considering the complexity of changes to regulatory and administrative processes, these efforts will take time, but they will continue to help South Carolina create a more provider-friendly environment to attract additional private capacity.

Beyond systemic change, other states also actively support individual private capacity development to encourage innovation in constrained areas, like substance use residential capacity or mental health crisis care (e.g., crisis stabilization units, EmPATH units[57]). Providing one-time startup funding can quickly scale capacity, especially for more capital-intensive projects. The State has already demonstrated its capability and commitment in this arena. For example, DHHS funded the $100M behavioral health hub in Florence, to be

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[51] *Variation in Network Adequacy Standards in Medicaid Managed Care*, 2022, Jane M. Zhu et al. For instance, North Carolina's Medicaid program aligns network adequacy standards for outpatient BH services with those for primary care, ensuring equitable access to both types of services.

[52] Variation in Network Adequacy Standards in Medicaid Managed Care, 2022, Jane M. Zhu et al.

[53] The Physicians Foundation, "2022 Survey of America's Physicians", 2022

[54] ASC Focus, "South Carolina Enacts Major Reforms to Certificate Need Law", 2023

[55] Mississippi Division of Medicaid, "Medicaid to implement centralized credentialing process for Medicaid managed care providers in July", 2022; Ohio Academy of Family Physicians, "Ohio Medicaid Introduces Centralized Credentialing – Ohio Academy of Family Physicians", 2021; NCDHHS, "Provider Data Management / Credentialing Verification Organization Solution Coming in 2024", 2023

[56] Select Health of SC, "Health Care Professional and Provider Manual", 2023

[57] EmPATH units are hospital-based crisis stabilization units. SCDHEC, "Hospital-Based Crisis Stabilization Units"

jointly governed by MUSC, McLeod Health, and HopeHealth.[58] DDSN offered one-time capital funding to private providers as an incentive to build capacity in South Carolina, and DHHS created a grant opportunity for providers to develop crisis stabilization units.

In addition, South Carolina can develop support for private-sector providers by facilitating connections between health systems and local payers, and fostering partnerships between existing in-state providers and those who have yet to establish a presence in the State.

> **"We're able to stabilize patients, but then there's nothing else we can do for them…we struggle to get patients into longer term therapy programs, either inpatient or outpatient."**
>
> *~ South Carolina Emergency Department Provider*

On the commercial insurance side, South Carolina should examine ways to strengthen enforcement of federal parity laws, which require that most health insurance plans should not impose more restrictive coverage for behavioral health needs compared to physical health needs. Despite this requirement, enforcement has proved difficult across the country, and disparities remain between behavioral and physical health coverage with out-of-network utilization rates higher and in-network reimbursement rates lower for behavioral health compared to physical health care.[59] Since 2017, more states have begun investigating and levying fines against health plans violating parity requirements—today, at least 17 other states have enacted legislation to enhance compliance among insurance providers, although South Carolina has not enacted this legislation.[60]

In the near-term, South Carolina should conduct a compliance market study to identify where specific commercial payers may be out of compliance with federal parity laws. In addition, the State should consider where there may be opportunities to use existing oversight powers to strengthen enforcement (e.g., reporting requirements) and how it can increase consumer education of parity laws (e.g., to better use existing Department of Insurance complaint process). Over the longer-term, South Carolina should consider statutory changes to provide the State with greater oversight powers to enforce parity laws. For example, Arizona passed a law requiring insurers to compile and submit parity compliance reports to the State every 3 years.[61] By following a similar path, South Carolina can significantly improve the enforcement of parity laws to ensure that individuals receive adequate coverage for their behavioral health needs.

[58] SCDHHS, "New Florence Behavioral Health Initiative Represents First-of-its-kind Collaboration", 2023

[59] Milliman Research Report, "Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement."

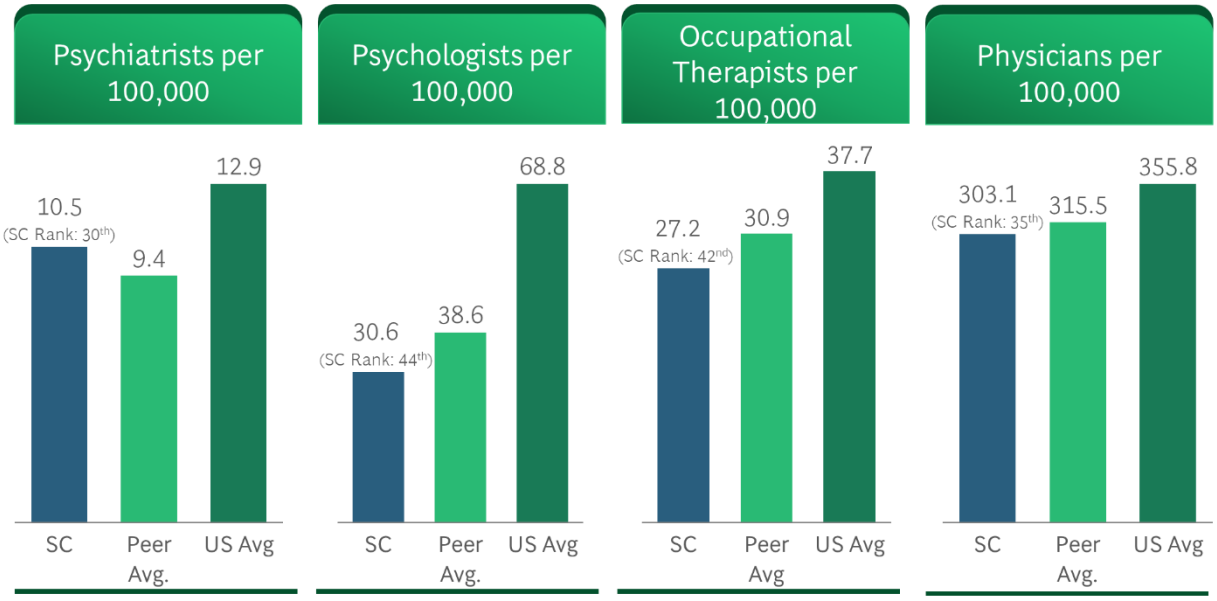
[60] ParityTrack, "Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report," 2018

[61] Arizona Department of Insurance and Financial Institutions, "Mental Health Parity Reporting"

Grow and better use the professional workforce

Currently, South Carolina grapples with significant shortages of behavioral health and disabilities professionals (see **Exhibit 21**). For example, in behavioral health, South Carolina has ~50% fewer psychologists per capita and ~20% fewer psychiatrists per capita vs. national average.[62] For the disabilities workforce, for example, there is ~28% fewer occupational therapists per capita vs. the national average. These shortages constrain the available capacity to treat those with behavioral health and disabilities conditions, and especially for Medicaid and uninsured populations.

Exhibit 21: South Carolina has smaller behavioral health and disabilities healthcare workforce per capita than other states – selected statistics



Note: Peers are AL, GA, NC, TN, VA. Data is from 2021
Source: HRSA (2021), U.S. Census

To address this, South Carolina can embark on a series of initiatives aimed at building talent pipelines. These initiatives could include supporting grants for training, scholarships, and professional development opportunities. Increasing residency program slots is another vital step,[63] as is the implementation of loan repayment or forgiveness programs. Upstream educational and credentialing programs can also help to create more early supply of professionals – there are several examples of this in South Carolina today. For example, DHHS has existing partnerships with USC and Clemson to sponsor courses

[62] HRSA, Area Health Resource File, 2021

[63] South Carolina ranks 29th in total residency spots per capita and 30th in percent of residents staying in state to practice medicine after graduation. South Carolina also ranks 33rd nursing programs per capita (AAMC, 2023; U.S. Census Bureau; AACN)

for people interested in becoming Board Certified Behavior Analysts.[64] Across all of these elements, a workforce task force could help guide these efforts and provide strategic direction to ensure a comprehensive approach.

There are many examples of these efforts in other states. A compelling one is in Nebraska, which established the Behavioral Health Education Center of Nebraska (BHECN) in 2009. With an annual state funding of approximately $5M, supplemented by federal grants, BHECN has made notable achievements—including a 30% increase in psychiatric prescribers and a 40% increase in psychologists and therapists over a 10-year period between 2010 and 2020. In addition, the Missouri Talent Pathways program has addressed the lack of Direct Support Professionals (DSPs), who provide disability care,[65] by pairing a credentialing and education program with apprenticeships with local disabilities providers. This program led to a 26% higher retention rate of DSPs with 18% cost savings for employer partners from lower recruiting and training costs.[66]

South Carolina can better adapt to new care models by leveraging its current workforce to maximize existing capacity. The State should begin by continuing to enhance its telehealth capabilities[67]—for example, for faster behavioral health crisis response and ED follow-ups—by leveraging providers in other parts of South Carolina with excess capacity as well as out-of-state providers. The State should also help grow the paraprofessional workforce (e.g., peer support professionals, community health workers) by ensuring appropriate reimbursement rates for paraprofessional providers, investing in recruitment and education programs for paraprofessional roles, and supporting the integration of paraprofessionals into clinical teams. A noteworthy example of this approach is Missouri State University's community behavioral health support Associate's degree program that partners with a junior college to hire graduates for support specialist roles typically reserved for those with Bachelor's degrees. South Carolina can also consider revising its scope of practice laws to be less restrictive to better enable non-physician professionals, like nurse practitioners (NPs) and physician associates (PAs), to provide a broader scope of

[64] DHHS, "Become a Board Certified Behavior Analyst"

[65] Direct Support Professionals play a pivotal role in guiding individuals with disabilities towards more independent and engaged lives, offering support in work settings, daily activities, and community involvement. Dept. of Labor, Direct Support Professionals (DSPs)

[66] Missouri's program was a partnership between the U.S. Department of Labor, the Missouri Department of Mental Health – Missouri DMH Division of Developmental Disabilities, other state agencies, and community organizations.

[67] For example, DMH currently does ~40% of its CMHC psychiatry visits by telemedicine. Discussion with DMH staff.

care. Today, South Carolina is one of just 11 states classified as having a "restricted" practice environment by the American Association of Nurse Practitioners.[68] [69] [70]

Relaxing these scope of practice laws in targeted areas where other clinicians could provide similar care quality could significantly increase the range of services that qualified providers can offer and attract more providers to the state who value the ability to practice at the top of their license.

Recommendation #4: Improve quality of services in the State

Today, there is an inconsistent quality of care across different service types and geographical areas, with varied treatment outcomes and patient experience, and facilities that range from outdated to state-of-the-art. The significant variation in service quality contributes to South Carolina's poor health outcomes (ranked 43rd overall in the nation).[71]

Other states have considered improving healthcare quality by improving oversight of county- and state-run providers, increasing accountability of their Medicaid MCOs, and encouraging innovation in care models to better care for complex populations. As such, states take a portfolio approach to addressing quality—not just focusing on their State-owned assets, but also influencing local government, private sector, and nonprofit organizations to improve outcomes for populations.

There are four recommendations to improve the quality of services in South Carolina:

- Improve State oversight and support for county-controlled healthcare providers
- Strengthen operations within State-run healthcare facilities
- Improve partnerships with Medicaid MCOs
- Increase innovation in care models to better care for complex populations

While this assessment focuses on where the most critical gaps were identified and where the State has disproportionate influence, South Carolina has a critical role to play in the quality of delivery at private providers, primarily through licensure but also through distribution of state funding. It is important to ensure strong oversight of these entities, especially given the focus on increasing the set of private providers, as discussed in recommendation #3. Some of the tools discussed in the below recommendations to

[68] AANP Restricted Practice – "State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation of team management by another health provider in order for the NP to provide patient care"

[69] American Association of Nurse Practitioners (AANP) State Practice Environment, 2023

[70] AANP Restricted Practice – "State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation of team management by another health provider in order for the NP to provide patient care"

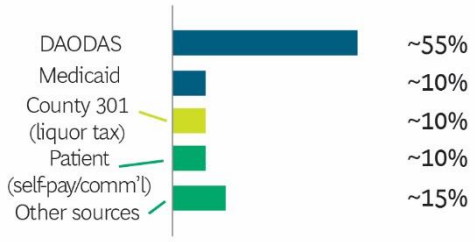
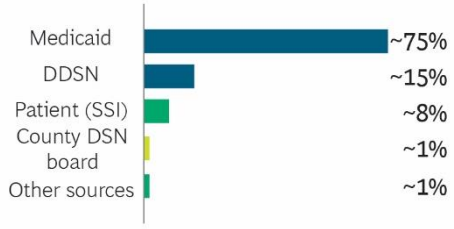
[71] America's Health Rankings, 2023; Note: Overall healthcare ranking includes social/economic factors (30% weight), physical environment (10%), clinical care (15%), behaviors (20%), health outcomes (25%).

improve quality for county-controlled and state-operated providers are available for private provider oversight as well. Since several state agencies have oversight powers here (primarily DHEC, DDSN, DAODAS), it is important to establish clear roles for overseeing these providers and use their authorities in a complementary way.

Improve state oversight and support for county-controlled healthcare providers

In South Carolina, 301 substance use providers, and DSN board disability providers are county-controlled "public access" providers, predominantly serving the most vulnerable populations (see Exhibit 22 for key details).

Exhibit 22: Key facts for 301s and DSN Boards

	301 substance use providers	DSN board disability providers
No. of providers	• 31 providers	• 37 providers
Operated by	• Primarily private, (nonprofits) although 3 facilities are county-operated[72]	• Primarily private, nonprofits
State oversight[73]	• DAODAS oversees service delivery (contracts with 301s for SAMHSA, other grants; approves county plans for liquor tax distribution) • DHEC licenses facilities	• DDSN oversees service delivery • DDSN licenses group homes (e.g., residential, respite settings) • DHEC licenses health care facilities (ICF/IID, CCFs)
County oversight	• County 301 boards appoint provider leadership and direct liquor tax	• County DSN boards appoint provider leadership
Funding sources (average)[74]		

[72] County-operated sites in Beaufort, Charleston, and Union counties

[73] Excludes clinician licensure; service delivery oversight related primarily to ensuring compliance and/or quality assurance for payment (e.g., state appropriated funds, Medicaid, other federal funds)

[74] SC DAODAS historical funding data per county, average of counties between 2018-2022; SC DDSN internal interviews and SC DDSN's DSN Board financial statement, 2023; Other sources may include federal grants, self-pay / commercial, and other miscellaneous funds

As discussed in recommendation #3 on strengthening public access capacity, these providers provide critical access to their communities. South Carolina not only has less overall capacity per capita than other states (e.g., ~50% fewer disabilities group home beds vs. U.S. average – leading to a total gap of ~3,700 beds), but also these providers make up a disproportionate share of that capacity. In fact, 31% of substance use providers are public vs. 9% in U.S. and 72% of residential disability services in South Carolina are provided by DSN boards.[75]

However, today 301s and DSN boards struggle to provide consistent, high-quality services across the State for these vulnerable populations. As discussed in recommendation #3, depending on where you live you could have access to a full service array, but many do not. There may also be an inconsistent quality of services provided, with varying patient outcomes across locations. Individualized counseling is not provided at all 301s, and treatment completion rates at 301s ranged from 33% to 75% across different sites.[76]

Limited state oversight for these providers contributes to these challenges. First, there is an opportunity for stronger standards and monitoring across 301s and DSN boards – for example, there are limited patient outcome standards for DSN boards with less frequent reporting (primarily annual). Further, across 301s and DSN boards, some new or struggling providers may lack the skills to operate their facilities effectively – there is no comprehensive system for training, technical support, and knowledge capture. This also exacerbates the administrative burden some providers may face in complying with state reporting and billing requirements. Despite concerns with provider performance, state agencies have infrequently pursued enforcement actions to promptly correct the underperformance, potentially driven by the lack of alternative providers for constituents if underperforming facilities are closed.

South Carolina can improve its oversight for 301s and DSN boards in several ways:

- First, it should set more comprehensive standards for substance use and disability service providers – for example, moving from primarily compliance-oriented standards to stronger treatment outcome standards for disability providers (e.g., improved quality of life measures).
- Second, it should re-evaluate its monitoring requirements to ensure they are frequent enough to evaluate performance appropriately, balanced against the provider effort required to report the information.
- Third, it should enforce non-compliance more rigorously and set transparent processes for how and when enforcement actions will be used, supported by robust communication with community leaders.

[75] SAMHSA, 2020; DDSN data; DMH data

[76] SC DAODAS 2022 Outcome and Discharge Report

Improving state oversight on its own without additional support will likely not fully improve the quality of these services. As discussed in recommendation #3 on preserving public access capacity, the State spends 60% - 70% less in state funding on substance use treatment and disability services vs. the U.S. average. This limited level of spending limits the breadth and quality of services that can be offered across the State. As such, in addition to stronger oversight, South Carolina can also increase its support for 301s and DSN boards. It should consider ways to increase total funding for substance use disorder and disability services in targeted ways to support improved quality. The State can also better support new or struggling providers through greater technical assistance and leadership training to empower and improve their capabilities.

South Carolina spends 60% - 70% less in state funding on substance use treatment and disability services than the U.S. average.

While the State likely already has the power to improve oversight, a lack of explicit statutory authority has made it more difficult for the agencies to fully use their oversight powers. DAODAS's and DDSN's enabling statutes do not provide explicit authority to set a statewide strategy for service mix or minimum standards through regulation, nor take a robust set of enforcement actions in case of non-compliance.[77] The lack of an explicit statutory basis for state oversight actions may invite challenges and create confusion for communities on how the State will use its potential authorities.

Virginia recently used statutory changes to improve its oversight over its county-run network of substance use, disability, and mental health providers, setting forth in statute clear state responsibility for setting performance standards for providers, monitoring their compliance with standards, and enforcing in cases of non-compliance. Similarly, South Carolina should amend the DAODAS and DDSN enabling statutes to include explicit authorities to set a statewide strategy for service mix (in line with the statewide plan for health and human services contemplated in recommendation #2), establish standards and monitoring processes, and set clearly defined steps for addressing provider non-compliance with pre-defined triggers for enforcement actions.

As discussed above, multiple state agencies play roles in the oversight process – DHEC as licenser, DAODAS and DDSN as overseers of service delivery. As such, it is important that they work collaboratively to use their oversight tools in a way that enhances quality and limits duplication of effort.

As South Carolina considers changes to its oversight, it should consider how any actions will impact patient disruption and provider staff turnover, and engage the relevant community leaders and providers closely.

[77] DDSN, DAODAS enabling statutes

Strengthen operations within state-run healthcare facilities

Today, South Carolina operates several types of healthcare facilities, primarily focused on mental health, substance use, and long-term care (see **Exhibit 23**).[78] These facilities complement the county-controlled providers as important safety net providers for some of South Carolina's most vulnerable constituents.

Exhibit 23: Selected healthcare facilities operated directly by the State

Facility Type	Facilities	Operating Agency
Inpatient	Psychiatric Hospitals - 2 general inpatient psychiatric hospitals - 1 substance use treatment hospital - 1 sexually violent criminal treatment program - 1 "not guilty by reasons of insanity" treatment program	Dept. of Mental Health
Outpatient	Community Mental Health Centers (CMHCs) - 16 centers overseeing 60+ facilities	Dept. of Mental Health
Long-term care	Nursing Homes - 5 veteran nursing homes - 1 general nursing home Intermediate Care Facilities (ICFs) - 5 regional facilities for people with ID/RD	Dept. of Mental Health (Nursing homes transitioning to Dept. of Veterans' Affairs effective 7/2024) Dept. of Disabilities and Special Needs

However, there is an opportunity to improve the quality of services across these state-operated facilities. While patient outcomes and experience are not consistently measured across providers, there is evidence of significant lags in state performance. For example, all six state-run nursing homes are below the 30th percentile nationwide, in overall CMS ratings, and two homes are below the 15th percentile, including the general nursing home.[79] In addition, there are insufficient staffing levels across facilities with high vacancies and turnover. CMHCs, for example, saw 25% turnover of its staff in 2023 (although recent pay increases have contributed to reduced CMHC turnover to ~8.5% in FY2024[80]). For DDSN's regional center intermediate care facilities (ICFs), only 13% of staff agreed that staffing levels were adequate,[81] although there have been efforts within the past 2 years to improve staffing.[82]

[78] Local health department operations considered in recommendation #5 on improving preventative care.

[79] CMS Nursing Home Care Compare, 2023; Note: CMS rating comprised of staffing, health inspections, and patient outcome measures

[80] Discussion with DMH staff

[81] DDSN LAC report (2023)

[82] DDSN staff noted that they have improved career ladders, added leadership positions, and improved staff compensation.

In addition, evidence-based clinical practices and other state policies may not be followed consistently. For example, for disability facilities, a legislative audit of DDSN-owned facilities found significant gaps in oversight (e.g., time to investigate allegations, lack of necessary recording), and CMHCs may turn away those with substance use disorder despite a DMH policy not to do so.[83] Constituents interviewed also reported that many facilities are outdated and poorly laid out; these perspectives were also reflected within the 2023 DDSN Legislative Audit Committee (LAC) report.

To address these challenges, South Carolina should improve these facilities' operations in several ways:

First, the State should strengthen standards for these facilities, including patient outcomes and experience, evidence-based clinical practices, and facility layout and condition to ensure a comprehensive set of measures and sufficient target levels.

Second, while the State has internal tools for evaluating the performance of its facilities (e.g., DMH's CMHC Audit tool), it should continue to improve its monitoring and reporting for these providers by adopting enhanced compliance checks—for example, more frequent or unannounced inspections—and increasing public reporting of the quality of its providers in an easy-to-understand way for constituents.[84]

> "We had to move to a smaller location that wasn't designed for child care and now our nursing station limits our field of view. If something happens out of our direct view, we may not know or be able to promptly de-escalate situations."
>
> *~ Front line employee*

Third, the State can improve the staffing of the facilities by better filling needed staff vacancies (also discussed in recommendation #7 on state workforce) and increasing training for both facility leadership and staff using best clinical and operating practices to serve constituents.[85]

Fourth, South Carolina should develop clearer internal processes and expectations for keeping facility leadership accountable for quality standards, and rigorously enforce those expectations. These changes will take time to implement and should be done in a phased approach to ensure they are most likely to be successful.

Improving operations at state-run providers should be done in coordination with organizational changes, such as those contemplated in recommendation #1, to ensure a seamless transition and limited interruptions for patients. For example, South Carolina required that Veteran nursing homes shift from DMH to the Department of Veterans' Affairs (DVA) effective July 1, 2024. This change requires a comprehensive update to

[83] Legislative Audit Council Report of SC DDSN, 2023

[84] For example, some CMHCs do not publish a consistent set of measures on treatment outcomes.

[85] For example, these trainings could cover protocols for abuse reporting and strategies at long-term care facilities, expectations for accepting patients with substance use disorder at CMHCs.

vendor contracts, efficient coordination of resources (including personnel), and the implementation of any necessary operational adjustments.

Improve partnerships with Medicaid managed care organizations

In South Carolina, ~81% of Medicaid beneficiaries[86] are covered through MCOs, making the State's managed care program a strong and broad-based lever for South Carolina to use in improving care quality.[87] States frequently use contract standards aligned to State policy goals and tight partnerships with MCOs to help them prioritize the right improvements to their provider networks and member engagement practices.

First, the State should strengthen MCO contract requirements in line with South Carolina's health goals. While the State has recently moved to improve some standards (e.g., Hospital Quality Achievement Program), it lags behind peer states such as Georgia, North Carolina, Virginia, and Tennessee in quality and network adequacy requirements. For example, while South Carolina withholds 1.5% of its capitations for quality performance,[88] Georgia, Tennessee, and Missouri withhold greater than 2.5% of capitations from MCOs,[89,90,91] and South Carolina only requires that routine visits be scheduled within 4 – 6 weeks of a request, while Tennessee requires that appointments are not to exceed 3 weeks from the date of request.[92] In the near-term, South Carolina can start with bolstering basic standards like quality and network adequacy. Over time, it can evolve towards more ambitious program elements, such as standards focused on value-based payments or social factors impacting health.[93]

In addition to strengthening MCO contract requirements, South Carolina has an opportunity to improve how it partners with MCOs. Historically, the State engaged with MCOs in a more passive way, with less focus on achieving state health goals. Recently, DHHS has started to build a new centralized function to engage with MCOs. Building on these efforts, the State should continue to strengthen its central MCO engagement team with the right skills, training, and access to agency leadership. This central MCO team should take a collaborative and data-driven approach to engaging with MCOs to provide objective, real-time feedback on performance and share government data with MCOs where possible to better empower MCOs to adapt care delivery.

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[86] Share of Medicaid populations covered under different delivery systems, 2022 Kaiser Family Foundation

[87] Currently, constituents can select from five contracted MCOs to receive coverage: Absolute Total Care, BlueChoice (Healthy Blue), Humana Healthy Horizons, Molina, and Select Health (First Choice).

[88] SCDHHS, "State FYI 2023 Medicaid Managed Care Capitation Rate Certification", 2022-23

[89] State of Georgia, "Georgia Families Contract"

[90] Tenncare MCO Statewide Contract, 2024

[91] Missouri DSS MoHealth Net, Managed Care Performance Withhold Technical Specifications, 2023

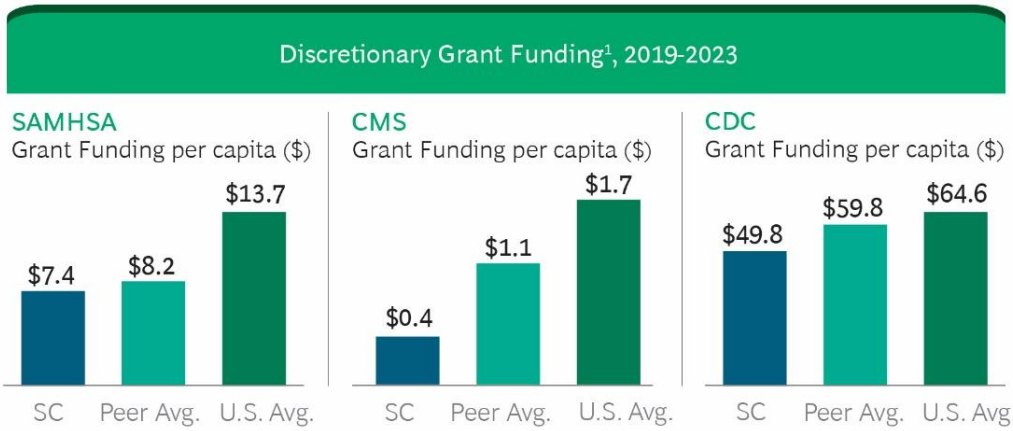
[92] Commonwealth Fund, Medicaid Managed Care Database, 2019

[93] For example, unlike ~90% other managed care states, South Carolina has not yet established clear social factor requirements for their MCOs, per KFF.

Increase innovation in care models to better care for complex populations

Innovation in healthcare is advancing rapidly, with various states enthusiastically exploring new models for delivering care. The Federal Government is actively involved, sponsoring frequent demonstration programs to foster this growth. States also regularly promote innovation in the private sector through partnerships with private and nonprofit entities, offering grants and other incentives to facilitate investments in new care models.

Exhibit 24: South Carolina has limited participation in federal innovation



Note: Peers are AL, GA, NC, TN, VA
1. Average yearly discretionary grant funding received from the respective federal agencies from 2019-2023
Source: CMS; HHS – TAGGS; U.S. Census

South Carolina has implemented several innovations in care delivery that have helped constituents, such as school-based mental health services, telehealth to support behavioral health, and mobile clinics for mental health crisis services. However, the State continues to lag in participating in the broader set of innovations that other states have engaged in. For example, South Carolina receives on average ~30% less discretionary grant funding per capita than other U.S. states over the last 5 years (see Exhibit 24 above) and has no approved CMS innovation 1115 waivers. This means that South Carolina is leaving federal money "on the table" that could support innovation in the state. In addition, building on past successes with public-private partnerships (e.g., DMH partnership with The Duke Endowment to support telemedicine and school mental health programs), the State has an opportunity to further foster innovation with private partners.

To increase innovation toward improved care models, South Carolina should explore boosting participation in federal innovation grants and demonstration programs and fostering more innovation in partnership with the private sector.

First, there are many federal innovation programs that South Carolina should explore. For example, two potential options are Certified Community Behavioral Health Clinics (CCBHCs) and the Innovation in Behavioral Health (IBH) model. The SAMHSA-sponsored CCBHC model, adopted by 47 states (excluding South Carolina,[94] North Dakota and South Dakota), aims to improve care coordination for behavioral health by providing 24/7 comprehensive coordinated mental health and substance use services to all community members, all within one facility. This model has shown significant improvements in access to services[95] and improved quality outcomes.[96] The IBH model, released by CMS in January 2024, focuses on integrating behavioral, physical, and social support systems, forming interprofessional care teams, and promoting health information technology capacity building; up to 8 states will be selected to participate in the model in 2024.[97]

Second, South Carolina should consider facilitating additional partnerships with private and non-profit entities to capitalize in the significant innovation occurring in the private healthcare sector. For example, in 2024, Illinois Dept. of Human Services partnered with Google to launch a centralized portal for children's mental health care aimed at centralizing and simplifying the process of accessing services.[98]

Select examples of innovation in other states

Federal programs

- **Certified Community Behavioral Health Clinics (CCBHC):** SAMHSA-sponsored model to combine behavioral health, primary care, and other wraparound supports all within one setting.
- **Innovation in Behavioral Health (IBH):** CMS-sponsored model to integrate behavioral, physical, and social support systems. Uses unified health information technology as a basis for collaboration across these systems.

Public-private partnerships

- **Illinois partnership with Google:** The IL Department of Human Services partnered with Google to launch a centralized portal for children's mental health care to centralize information on services.

Recommendation #5: Improve preventative care

Over the past decades, healthcare systems have increasingly re-oriented their focus toward prevention rather than acute care. Focusing on prevention helps to support a person's health before their needs become more serious. Doing so improves health outcomes while reducing costs compared to acute care, such as a trip to an emergency department (ED), which is expensive for both patients and the State. To accomplish this, states have addressed the wide range of factors that impact population health,

South Carolina's mental health and substance use disorder emergency department visits is 72.96 per 1,000, ranking 21st out of 35 surveyed states

[94] Over the past few years, South Carolina has set up 2 smaller-scale "look alike" CCBHC pilots; there is an opportunity to greatly accelerate South Carolina's participation in this innovative new model for behavioral health care.

[95] For example, Missouri saw a 122% increase in individuals receiving Medication Assisted Treatment (MAT).

[96] For example, New York saw a 46% reduction in ED utilization and 26% reduction in monthly costs.

[97] CMS, Innovation in Behavioral Health (IBH) Model (January 18, 2024)

[98] CapitolNews Illinois, State Partners with Google to launch new portal for children's mental health resources, 2024

including providing non-medical social services (e.g., improving food and housing security); providing basic immunization, screening services, and routine checkups; supporting access to primary care; and planning for public health emergencies.

However, the State sees a higher mix of acute care over prevention today. For example, the State's mental health and substance use disorder emergency department visit rate is 72.96 per 1,000, ranking South Carolina 21st out of 35 surveyed states.[99] Several challenges have contributed to the State's lack of focus on prevention; these include a fragmented focus on social factors that impact health, lagging investment in screening and public awareness efforts vs. other states, and gaps in primary care capacity, particularly in rural areas.

To address these challenges, there are three ways the State can reorient toward greater focus on preventative care and supports:

- Boost supports for social factors that influence health
- Bolster awareness of and access to preventative healthcare services
- Increase access to primary care across the State

Boost supports for social factors that influence health

Social factors that impact health are responsible for driving approximately 80% of health outcomes.[100] South Carolina has an opportunity to better focus on these social factors to improve the health of the State's constituents. Existing benefits may be underutilized or insufficient to support people's health-related social needs appropriately. For example, only 41% of eligible individuals are enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) compared to the national average of 52%.[101]

[99] Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), State Emergency Department Databases (SEDD), and State Inpatient Databases (SID), 2019-2018 and the Census Bureau. Includes D.C.

[100] HealthPartner Institute, University of Minnesota, 2017

[101] USDA, WIC Eligibility Data

Exhibit 25: Example programs for how the State could address social factors

Selected Social Factors	Example programs from other states
Access to Quality Housing	**Massachusetts Department of Mental Health Rental Subsidy Program (DMH RSP)** Partnership between Department of Housing and Community Development (DHCD) and Department of Mental Health (DMH), providing a rental subsidy alongside residential services/ case management to support tenancy, health, and recovery for those who are low-income and struggling with mental illness. (Funded to provide support for >280 participants in 2022).
Availability of nutritious food	**North Carolina NCCARE360 platform** Statewide electronic network, connecting healthcare and human services organizations. Platform allows providers to identify patients - within a healthcare system - with unmet social needs and connect them to community-based organizations (CBOs). (More than 24,000 people were referred for food assistance in 2022, with 81% of cases closed and resolved)
Transportation availability	**Connecticut Department of Mental Health and Addiction Services (DMHAS) partnership with Wheeler (community health organization) to offer Access Line** Telephone line with a service offering transportation from home, hospital, treatment program, or other community location to Withdrawal Management (WM) or Substance Use Residential Treatment Programs. (Wheeler supported 31,000 participants in 2023, through direct care, telephone, and outreach activities).
Access to employment support	**Ohio Mental Health and Addiction Services Supported Employment Project** Program offering employment guidance and individual placement to young adults struggling with mental illness and/or substance abuse. Delivered at 2 youth social service centers: Daybreak, which is an emergency & enrichment shelter for homeless youth, and Firelands, which is a counseling and recovery facility. (Service goal of providing employment to 50 participants each year).

Today, responsibility for supporting these social factors is fragmented across state agencies. For example, while DHEC operates the WIC program, DSS operates the Supplemental Nutrition Assistance Program (SNAP) program - both nutrition programs for overlapping populations. While it is typical for this responsibility to be split across agencies, other states have made greater efforts than South Carolina to create a shared plan for addressing social needs impacting health and coordinate their approaches, particularly with external partners, such as MCOs and community-based organizations (CBOs). These challenges also contribute to fragmentation in the population health data platforms across the State, which makes it difficult to get a full view of a constituent's needs. The creation of a central organization (as contemplated in recommendation #1) will address some of these fragmentation issues, but there remain partners outside of the central organization (e.g., other state agencies, community organizations) that will need to be engaged outside of the umbrella.

> "A lot of people are scared to seek help, or they don't know that there are doctors or medicines that could help them not feel that way anymore…My sister needed help, but we found out after it was too late."
>
> *~ South Carolina Constituent*

To address this, South Carolina must first increase its access to screening data on constituents' social needs. For example, other states have done this by increasing screening requirements through Medicaid (e.g., Z-codes) and working with providers to incorporate screening into their standard exams (e.g., primary care well-visits). Based on this data, the State should prioritize a targeted set of interventions to address the most impactful social needs that contribute to health challenges (see **Exhibit 25** above for

examples). To plan for these interventions, health and human services agencies should engage a broader group of stakeholders, including other state agencies, MCOs, providers, and CBOs, to help develop a plan to implement these actions. For example, a state partnership between DMH, DAODAS, and the Housing Authority could lead to the growth in supportive housing for populations struggling with substance use disorder or mental health issues by guiding on locations for new developments. Since there can be significant operational complexity associated with these kinds of interventions more generally, the State should focus its initial interventions on a tightly defined population and geographic area. In addition, South Carolina can help build a coordinated infrastructure, including both technology and dedicated staff, to identify population needs and monitor interventions. The opportunity for a unified population health system is discussed further in recommendation #6 on improving constituent navigation. Furthermore, South Carolina should consider additional ways to increase Medicaid coverage for social supports, for example, through adding requirements for MCOs to provide social supports or incorporating non-medical social supports as Medicaid covered services.

Bolster awareness of and access to preventative healthcare services

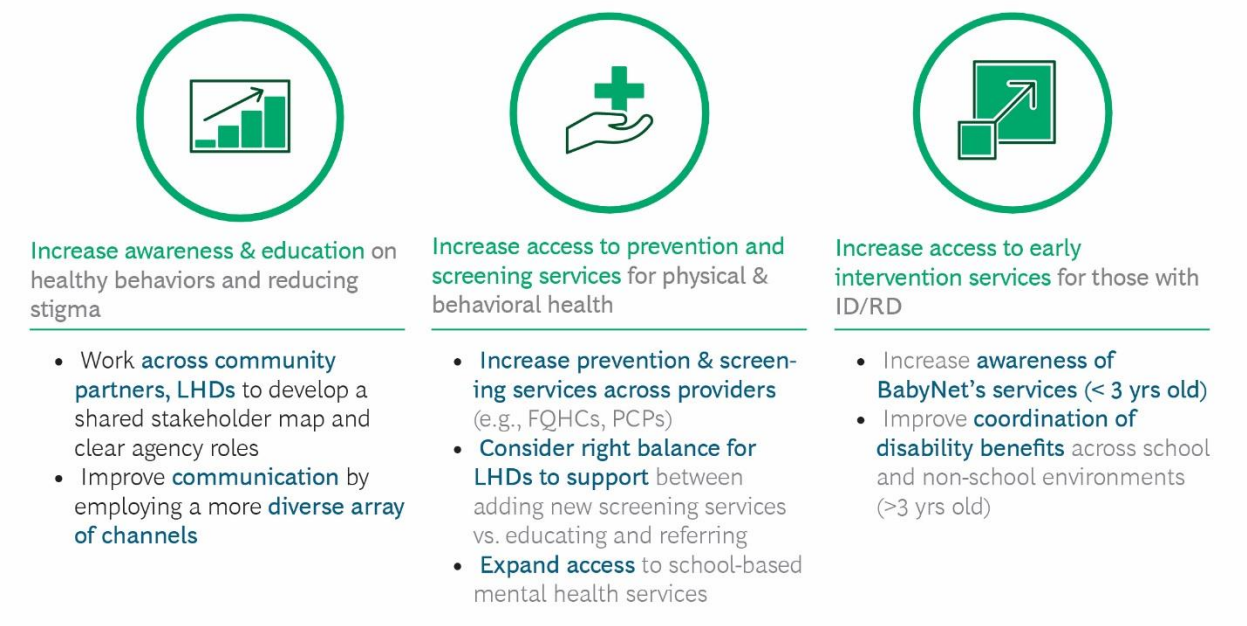
Beyond supporting social needs, the State plays a crucial role in promoting healthy behaviors, in part through providing access to the right screening and education. However, today, like many states, South Carolina constituents may not always be fully aware of available preventative care services (e.g., well-visits, mammograms); know which ones to access, or when; or may face stigma in getting treatment, especially those with mental health and substance use conditions. Furthermore, there is an opportunity to grow the availability of affordable screening and prevention services across the State, particularly for vulnerable populations.[102] Federally Qualified Health Centers (FQHCs) and local health departments (LHDs), which play a critical role in providing screening services and engaging with local community organizations, often find themselves constrained by limited resources. In fact, the State's public health funding per capita ranks 35th nationally at $163 in South Carolina vs. $183 in the nation.[103] While South Carolina has built a solid foundation for behavioral health preventative and early intervention services in some areas, there remain opportunities to improve.

South Carolina can improve constituents' awareness and access for preventative health services in three main ways (see Exhibit 26).

[102] DHEC, State Health Assessment. South Carolina Community Health Needs Assessment Survey, 2022

[103] America's Health Rankings (2021-2022); reflects state dollars dedicated to public health and federal grants directed to states from the CDC and HRSA

Exhibit 26: South Carolina should bolster awareness and access for preventative healthcare services



First, South Carolina can increase overall awareness and education on healthy behaviors and destigmatize getting help. Today, like many states, South Carolina is dealing with limited education and awareness, and prevailing stigma around getting treatment, especially around mental illness and substance use. State agencies should work more closely across their network of community partners (e.g., religious organizations, schools, local providers, other CBOs) by developing a shared stakeholder map and ensuring clear agency roles in engaging partners. To ensure that LHDs can support this effort, the State can better equip them with set of common tools and resources to help communicate around key health priorities and facilitate best-practice sharing across LHDs. South Carolina can also improve statewide public health communication by employing a more diverse array of channels—from websites and social media to traditional media outlets—to reach wider audiences. Examples include DAODAS's campaigns to elevate awareness, educate the public, and combat the stigma surrounding substance use.

Second, the State should continue to increase access to prevention and screening services for physical and behavioral health. Today, there are opportunities for better screening in South Carolina. For example, the immunization rate is below the 25th percentile[104] and the rate for child well-visits is at the ~65th percentile.[105] Furthermore, constituents interviewed observed that there is a significant gap in mental health screenings across the State, similar to the national trend in which only ~9% of Primary Care Physicians (PCPs)

[104] Percentage of adults who received the flu shot in the past year and a pneumonia vaccine if >65, 2020; BRFSS

[105] Percentage of children with age-appropriate medical and dental preventative care visits in the past year, 2020; NSCH

screened for depression in 2019.[106] To address this, the State should continue to increase services at providers across South Carolina, including at FQHCs, PCPs, specialists, and other community-based settings. The State should also consider the right role for LHDs to play in increasing access to services. Depending on the needs in each county, LHDs could provide additional screening services that are not provided today (e.g., body mass index, diabetes screenings) and/or educate and refer constituents to the right sets of services in the broader community. In addition, the State should continue to increase access to school-based mental health services to prevent more acute mental health issues later on and consider integration with adjacent health topics, such as substance use prevention. South Carolina has made significant progress in increasing school-based mental health, with services available in ~80% of South Carolina's schools and the ratio of students to mental health counselors dropping by half from January 2022 to September 2023.[107] To further build on this progress, the State could leverage the Medicaid/CHIP federal match to improve funding for school-based mental health services.

Third, the State can increase access to supports for youth with intellectual and related disabilities. Since 2017, South Carolina's BabyNet program has shown remarkable effectiveness by increasing annual referrals to the program by ~77% and improving the percentage of families supported by early intervention services by ~34%.[108] However, when children leave the BabyNet program at 3 years old, many have limited options for continued treatment, given the lack of preschool and school-based special education programs. To address this, South Carolina should strengthen the continuum of support that evolves with the growing needs of children with ID/RD. For children under 3, the State should continue to increase awareness of BabyNet's services to ensure that more children are referred to the program while they are still eligible. This should be balanced with the resources available for the program. For children 3 and older, South Carolina should improve the coordination of disability benefits and services across both school and non-school environments when youth leave the BabyNet program.

Increase access to primary care across the State

Primary care plays a crucial role in maintaining overall population health and reducing the need for costly specialists and emergency services by helping constituents to navigate to specialists and other health resources – in fact, US adults who see a primary care physician have shown 33% lower health care cost and 19% lower odds of premature death than those who only see a specialist.[109] [110] However, today, South Carolina's primary care workforce is smaller than in other states – for example, the State has 6% - 23% fewer

[106] National Ambulatory Medical Care Survey (NAMCS); CDC, 2019

[107] DHHS, "Gov. McMaster, SCDHHS Announce Number of School-based Mental Health Counselors Doubles in South Carolina" (January 25, 2024); DMH data

[108] Report on BabyNet Federal Compliance Efforts, DHHS, 2023

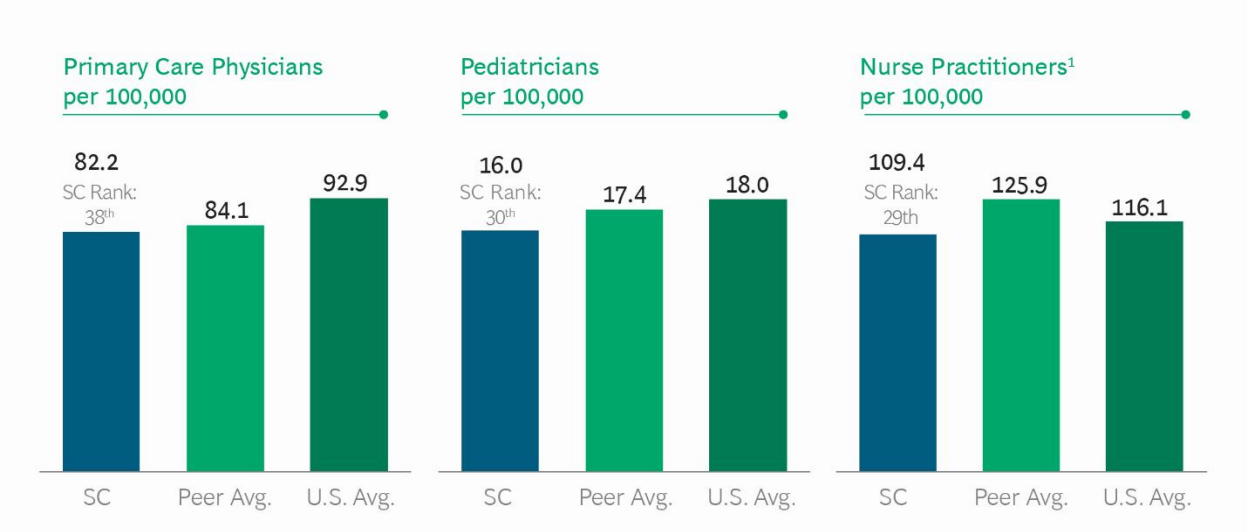
[109] Shi L. The impact of primary care: a focused review. Scientifica (Cairo). 2012; 2012:432892. doi: 10.6064/2012/432892. Epub 2012 Dec 31. PMID: 24278694; PMCID: PMC3820521.

[110] Commonwealth Fund, Primary Care: Our First Line of Defense; PMC, The Impact of Primary Care: A Focused Review (nih.gov)

PCPs, pediatricians, dentists, and nurse practitioners per capita compared to the national average, ranking between 29th to 45th in the United States (see **Exhibit 27**).[111]

Compounding this statewide gap, there is a significant lack of care in rural and other underserved areas in the State. In fact, 37% of South Carolinians reside in areas that are designated having a shortage of primary care services (HPSA) in contrast to a national average of 29% (see **Exhibit 28**). Further, in 14 of South Carolina's 46 counties, there is no practicing obstetrician-gynecologist (OB/GYN) physician, and in 5 other rural counties there is just 1 practicing OB/GYN.[112]

Exhibit 27: South Carolina has a smaller primary care workforce vs. other states–selected statistics



Note: Peers are AL, GA, NC, TN, VA
1.Nurse Practitioners with a National Provider Identifier (NPI)
Source: HRSA (2021), NIH

To address these challenges, South Carolina should start by strengthening the primary care workforce in the State across a breadth of roles; for example, including PCPs, OB/GYNs, pediatricians, nurses, substance use prevention counselors, and community health workers. South Carolina could offer more scholarship grants and loan repayment and forgiveness programs, particularly for those practicing in rural areas, to address the financial cost of medical degrees. An example is the Physician Education Loan Repayment Program in Texas, which offers repayment assistance to PCPs, particularly favoring those who commit to serving in HPSAs for a minimum of 4 years. In addition, over time, the State should consider increasing residency and educational slots for primary care physicians, nurses, and other professionals, addressing the insufficient amount of

[111] HRSA, Area Health Resource Files, 2021

[112] "Graphic: South Carolina's shortage of OB-GYNs," Post and Courier, August 21, 2022

residency slots today (the State was ranked 29th in physician residency spots per capita[113] and 33rd in nursing programs per capita based on constituents completing medical programs from 2013 - 2022).[114]

As discussed in recommendation #3, targeted increases to the scope of practice for NPs and PAs may also help grow primary care capacity in the State. Additionally, South Carolina can help promote retention and reduce burnout among both nurses and physicians - today, the State ranks 30th in percent of constituents staying in the state to practice medicine[115] - by increasing support for South Carolina's physician health program (PHP),[116] boosting wellness supports such as peer counseling programs, and implementing measures to ensure provider safety.[117] Lastly, PCPs are increasingly being seen as first stops for screening for behavioral health conditions – 70% of primary care visits nationally are driven at least in part by psychological challenges[118] – but PCPs are often not sufficiently trained to navigate the fragmented behavioral health service delivery system. As such, the State should consider increasing training for primary care providers to screen and refer for substance use conditions using the SBIRT[119] approach and for mild or moderate mental health conditions.[120]

South Carolina should also continue to increase primary care at safety net settings in underserved areas, like Federally Qualified Health Centers (FQHCs) and Person-Centered Medical Home (PCMH) programs. The State should continue to incentivize the growth of these providers through grants, Medicaid rate enhancements, or other financial supports. For example, Texas's FQHC Incubator Program provided grant funding to FQHCs, including seed funding for new clinics, and led to a 65% increase in patients served by FQHCs between 2003 - 2006.[121] In addition, the State can support technical assistance and practice supports for FQHCs by engaging more deeply with the State's Health Center Controlled Network (HCCN) of FQHCs, which provides technical assistance today across South Carolina's FQHCs.

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[113] AAMC "Table C6. Physician Retention in State of Residency Training, by State", 2022-2023

[114] American Association of Colleges of Nursing Member Programs; U.S. Census Bureau estimates of the Resident Population for the United States: April 1, 2020 to July 1, 2023

[115] AAMC "Table C6. Physician Retention in State of Residency Training, by State", 2022-2023

[116] PHPs provide important confidential peer to peer services to in need of support for their health and well-being; Federation of State Physician Health Programs, "State Programs", 2023

[117] The importance of these measures is highlighted by the fact that nine states require employers to maintain violence prevention programs[117] to protect healthcare workers. NASHP, "State Strategies to Support the Future of the Primary Care Physician and Nursing Workforce", 2022

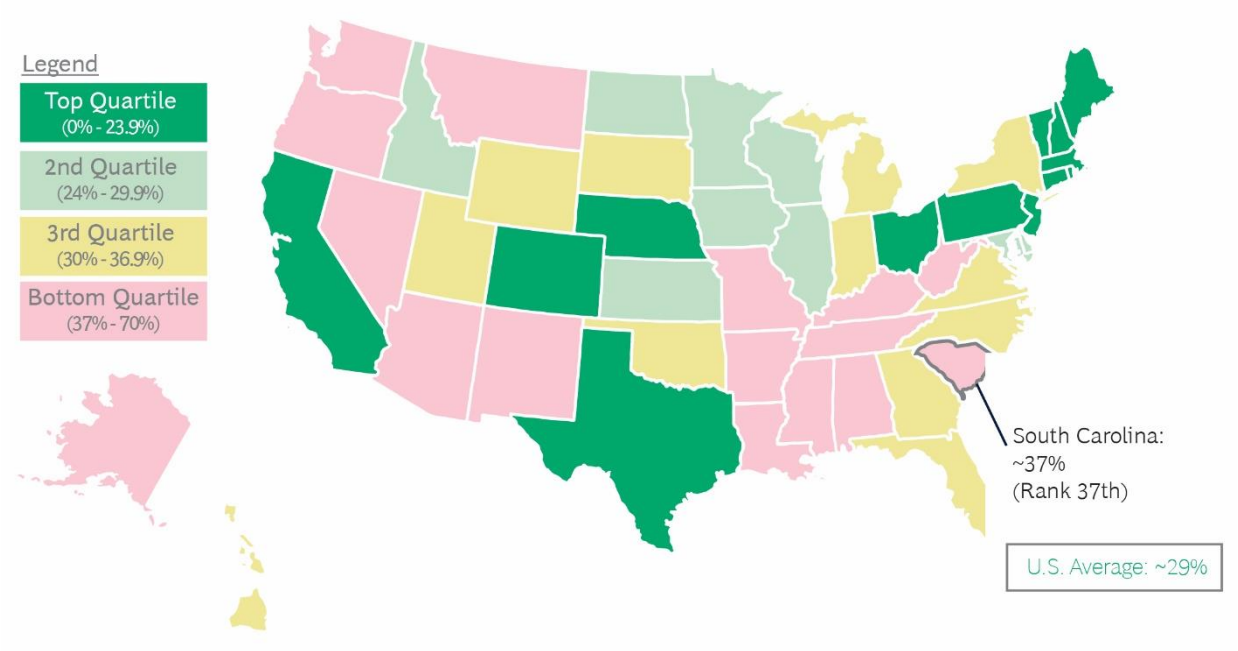
[118] American Psychiatric Association, "Role of Psychiatry in Primary Care", 2014

[119] Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. SAMHSA

[120] For example, Virginia's Mental Health Access Program (VMAP), focused on pediatric mental health needs, offers a range of educational resources for PCPs as well as in-the-moment phone consultations with psychiatrists and other mental health and early childhood specialists.

[121] Texas Association of Community Health Centers, "Expand Access to Care Through Grants to FQHCs"

Exhibit 28: South Carolina has more people per capita living in PCP shortage areas than U.S.



Note: Washington DC and U.S. territories excluded
Source: KFF, HRSA (2021), U.S. Census 2023

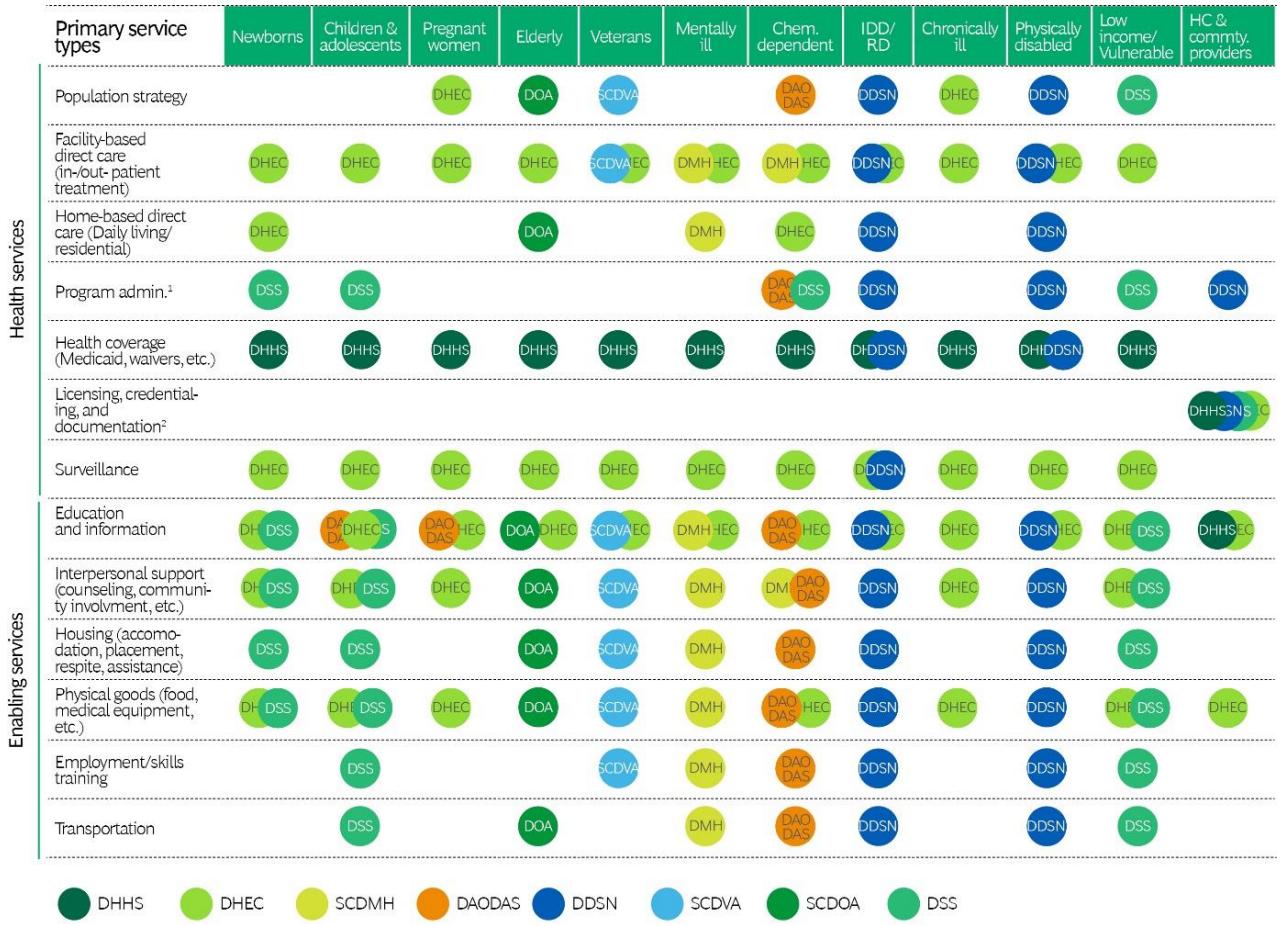
Recommendation #6: Help constituents navigate to benefits and services

Like all other states in the nation, a wide variety of benefits (e.g., Medicaid, nutrition, cash assistance programs) and services (e.g., mental health, substance use, disability healthcare) are available to constituents in South Carolina. Constituents, especially those part of vulnerable populations, rely on these offerings to support their health and well-being.

These benefits and services are provided by a fragmented set of organizations—including state agencies, counties, providers, and community partners—which often overlap in the populations and services they focus on. This is especially true for state agencies (see Exhibit 29). These organizations often have different ways of communicating their offerings, different application processes, and inconsistent supports for constituents as they try to access services—all with limited coordination on how they can work together.

This complexity results in confused and frustrated constituents who face significant challenges in navigating to these critical benefits and services. There is a low awareness of what benefits and services they are eligible for or should be using; it is difficult to find the information or guidance needed, either online or with live support; and the process to access healthcare services and apply for benefits is not designed with the constituent's needs in mind.

Exhibit 29: Fragmentation across benefits & services provided by State agencies today



1. DSS coverage of chemically dependent populations is through family support service funds available for TANF recipients 2. DSS (childcare centers, adoption agencies, Kinship, Foster, and Adoptive homes); DDSN (Res. and Facility-Based Day Programs); DHEC (health care providers) 3. Individuals who may, sometimes by virtue of other need states (E.g., elderly, IDD/RDD), be eligible for APS
Note: Service types are not mutually exclusive; "primary" population is defined here as an identity that serves as an entry point for service eligibility

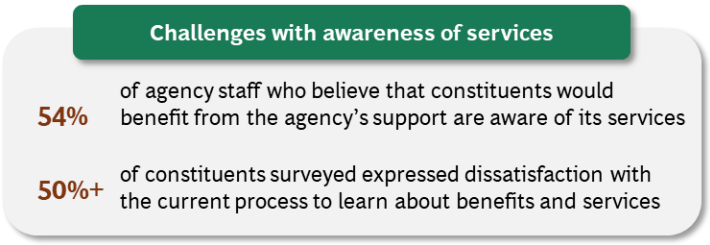
When constituents have trouble navigating to these offerings, they are less likely to use benefits and services. As a result, constituents may not receive the services they need to improve their health. As discussed in recommendation #5, pursuing healthy behaviors, receiving timely screenings and preventative care, and accessing support for social needs are all critical to supporting people's health before their needs become acute and more expensive. Furthermore, since many of these benefits and services are in part funded by the Federal Government, underutilization may leave available federal funding left untapped. To improve how constituents navigate to health and human services, South Carolina should:

- Make it easier for constituents to find benefits and services
- Simplify the process to access benefits and services
- Build supporting data and technology infrastructure for navigation

The central organization contemplated in recommendation #1 will help provide crucial coordination support to address the fragmentation across constituent navigation.

Make it easier for constituents to find benefits and services

As discussed above, it is hard for constituents to find benefits and services in South Carolina today. Constituents are often unaware of benefits and services available to them; for instance, only 54% of agency staff[122] on average believe constituents who would benefit from the agency's support are aware of their services. Constituents also face a complex set of ways to get access to information on these offerings today - online, in-person, via phone – but many of these channels are fragmented, poorly organized and have confusing language. While there is a wide set of "navigators" present throughout the State who help constituents find services – agency staff, community partners, providers, care managers – the State has an opportunity to better empower them to help constituents. Given these compounding factors, constituents are forced to navigate a complex web of information, often on their own; out of frustration, many quit looking for the benefits and services they know they need but cannot find. In fact, of the constituents surveyed through this review, over 50% of constituents expressed dissatisfaction with the current process of learning about available services and benefits.[123]



To address these challenges, the State should make it easier for constituents to find benefits and services by making information more available across different channels,

[122] Act 60 Agency Survey

[123] Act 60 Constituent Survey

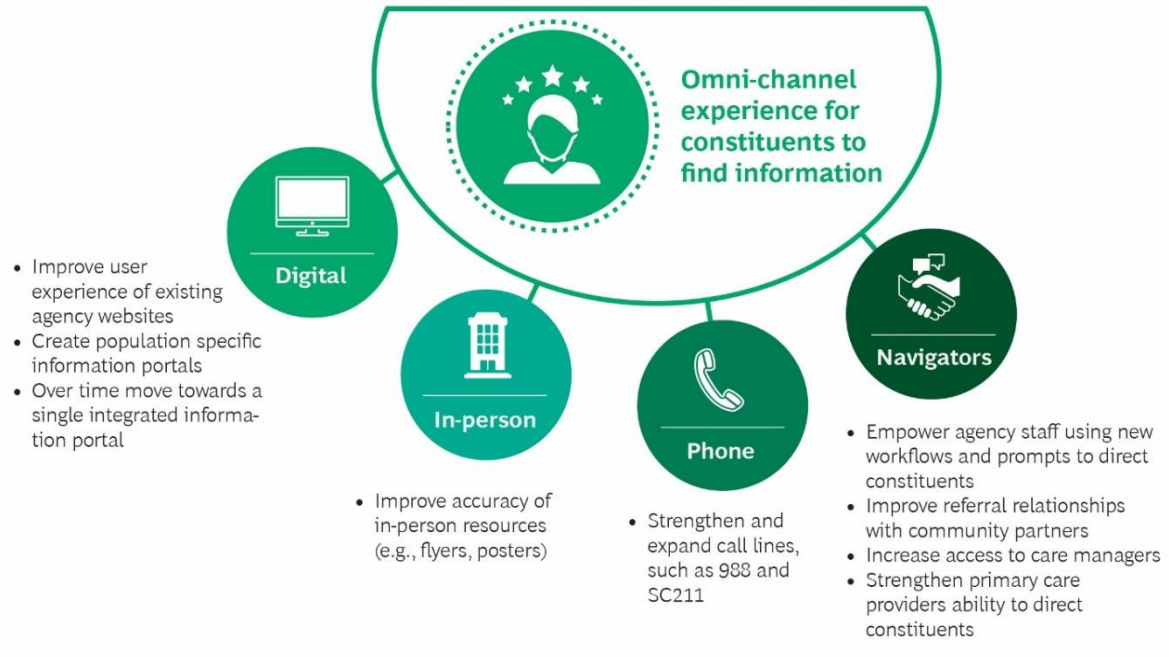
empowering navigators to guide constituents, and promoting these resources across the State.

> "The information websites about available services are confusing and use words and terms I don't understand. The system is a maze not meant for typical people to navigate."
>
> ~ *Constituent*

First, the State should **make information more available and easier to understand** across different channels (see **Exhibit 30**). South Carolina should start by improving existing digital resources by improving the user experience (e.g., simplifying website language and design), keeping web pages up-to-date, and adding new features to further support constituents (e.g., "Find a Provider" tools to compare providers, AI assistants).[124] Over time, the State should continue to develop integrated information portals for specific populations, such as First5SC (for early childhood) and GetCareSC (for seniors, caregivers, and adults with disabilities), to consolidate data scattered across state agencies.

Eventually, the State could offer one fully integrated portal with information on health benefits and services. Future integrated portals could include easy-to-use pre-screening tools to allow individuals to determine their own eligibility for various services, and comprehensive, easy-to-access lists of contact information for when questions arise.

Exhibit 30: Omni-channel experience for constituents to find information



[124] Many states, and even the Federal Government, have revamped their websites to better address the public's needs. 2022 Report to OMB and the Public on Modernizing Agency Websites, US DHHS, 2022. Trends in state health and human services website design, Mostly Medicaid, 2024

The State could also work with a private partner to develop these portals. For example, as discussed in recommendation #4, Illinois announced a partnership with Google to build a centralized portal for information on children's mental health care services across the state. In addition, the State can improve the accuracy of in-person resources, such as flyers posted on walls of local sites, ensuring they are up-to-date. Further, the State should strengthen and expand call lines, such as 988 and SC211,[125] to help navigate constituents better to information on health and human services in the state, and consider opportunities for an integrated contact center to consolidate efforts.

Second, South Carolina should better empower its "navigators" who provide constituents additional support in finding the right benefits and services. These individuals are typically State agency staff, community organizations, care managers, and providers. State agency staff in local offices are a first touchpoint for many in the system. Constituents can learn about offerings when they engage directly with agency staff at local sites or on the phone, particularly adjacent services that they might benefit from but were not originally seeking at the start of the encounter. However, agency staff may not always be aware of all the resources available in other agencies or community organizations; trained on the right process to refer constituents; or empowered to help. To address this, the State should consider building a new workflow for agency staff; building in prompts to suggest benefits and services the constituent might qualify for; and then referring that person to a dedicated onsite staff member who can provide guidance on the specific resources and next steps for that person.

> "I don't know what options are available to my patient to even tell them what they should do, or who they should call. Right now, we just have no visibility to direct patients."
>
> *~ County Staff Member*

There are opportunities to empower navigators beyond State agency staff. South Carolina should create tighter referral relationships with community partners (e.g., Area Agencies on Aging [AAAs]), to create two-way referrals between State healthcare services and benefits and offerings from these partners (e.g., supports for social needs). Dedicated care managers can also serve as powerful navigators for people with complex conditions—such as individuals trying to bridge the physical and behavioral health systems—and work with Medicaid MCOs to increase access to care management for these populations. In addition, primary care providers serve as important navigators to their patients to access appropriate follow-up services, from benefits to specialist services. As part of this and as discussed in recommendation #5, South Carolina should increase the amount of primary care providers in the State, particularly in underserved areas. Further, responders to behavioral health crises, such as EMS and law enforcement, represent another group that is critical in helping navigate a constituent to the right care options – as such, the State

[125] SC211 is a statewide call line to help direct constituents to information, services, and providers across the state. Today, SC211 is not used significantly for healthcare services – 45% of the calls were for Electricity and Rent Assistance; as such, there is an opportunity to increase utilization of this call line for health and human services needs. United Way's 211, "2020 Housing Report"

should continue to deepen SLED partnerships to better inform and train these responders on the relevant healthcare resources available (e.g., crisis stabilization units, embedded mental health resources within law enforcement, etc.).

To promote all these resources, South Carolina can use a variety of channels. The State can promote using broad-based channels like social media, advertisements, and flyers to elevate the key portals with consolidated information on the available resources and organizations. In addition, the State can use in-person events, pulling together different agencies and community organizations.

Simplify the process to access benefits and services

Even if constituents find the benefits and services that are right for them, it can often be hard for them to access these offerings. There are often many barriers to receiving healthcare services, including challenges of getting appointments in advance, a lack of transportation or other non-medical issue presenting challenges getting to services, and a lack of "warm handoffs" for referrals between different providers. In addition, when constituents apply for benefits, the process can be burdensome – for example, some benefit applications can take constituents more than 30 minutes to complete[126] – with complex application language, clunky application systems, gaps in online or mobile friendly options,[127] and tedious or duplicative steps.[128]

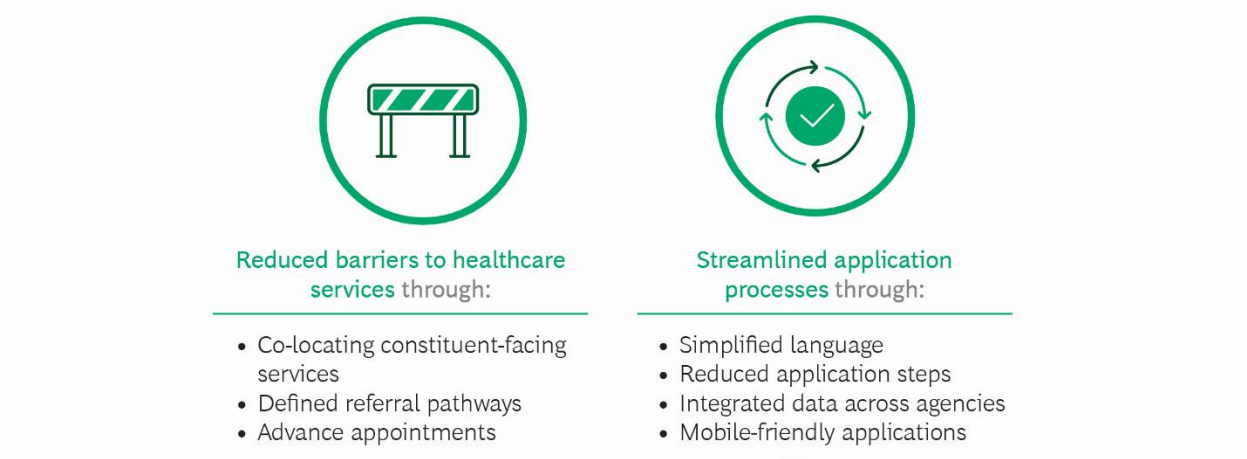
Overall, the State should simplify the process to access benefits and services across the State (see Exhibit 31).

[126] Benefit Enrollment Field Guide, CodeforAmerica, 2024

[127] Constituents must rely on traditional methods such as the telephone or "snail mail" to track the status of certain applications, such as DDSN waivers, instead of leveraging more modern methods.

[128] Although the COVID-19 pandemic drove increased investment in online resources, with about 75% of SNAP/TANF applications now conducted online, offline alternatives and assistance resources remain indispensable for vulnerable populations with limited online access.

Exhibit 31: The State should simplify the process to access benefits and services



First, the State can **lower barriers to accessing healthcare services**. One way to make it easier to access services is through co-locating constituent-facing services, such as mental health, substance use, employment services, and preventative screenings, all under one roof. Today, the State's constituent-facing services in local areas are primarily fragmented in different locations – any given county might have a separate LHD, CMHC, 301 provider all in different places – but many constituents may need some or all of these services on a regular basis; co-locating these services could simplify constituents' ability to get to services. The central organization contemplated in recommendation #1 could facilitate the co-location process. In addition, the State can improve referral pathways across agencies and other providers; for example, building stronger referral linkages between DDSN regional ICF facilities and DMH CMHCs would enable more access to mental health services for people in these ICFs. Offering more advance appointment scheduling through a variety of channels (online, phone, and in-person) could also help constituents access services and providers to refer to these services. For example, today patients report challenges in securing appointments in advance at CMHCs – as such, other state agencies and private providers may be hesitant to refer patients to these services.

Second, South Carolina can **streamline the benefits application process** to reduce the time it takes constituents to access benefits and make the process less burdensome. The State should start by simplifying application language, more clearly defining technical terms, providing illustrative examples, and offering the application in a range of languages. While the Federal Government sets much of the standard language for applications, there is still an opportunity to simplify its presentation. For example, on average, South Carolina constituents need a 9th grade reading level to understand the Medicaid application vs. Texas and other states need only a 5th grade reading level or lower.[129] In addition, the State should reduce unnecessary application process steps, such as filling in duplicative

[129] Benefit Enrollment Field Guide, CodeforAmerica, 2024

information on demographic information or requiring submission of paper forms. The State could also better integrate data across agencies together into applications through data sharing across the central organization (as discussed in recommendation #1). Further, it should consider making improvements to the online user experience for benefits applications by making online applications mobile-friendly, including features such as guest enrollment, pre-fill capabilities, real-time online assistance resources, modernizing the document upload process, and adding self-service tools, such as the ability to easily track the status of applications. These improved features will require underlying technology investments to be implemented.

Build supporting data and technology infrastructure for navigation

For the above recommendations to be effective, the State will need a more comprehensive data and technology infrastructure. Today, much of the information on services and constituents is scattered across many different organizations' systems that do not talk to each other. This makes it hard for navigators to help constituents: for example, different providers within a mental health vs. a substance use facility are limited in understanding a person's care needs from prior visits. This also leads to a disjointed process for constituents – they are often responsible for communicating that complex medical information on their own to different providers and must constantly input the same demographic and medical information in every place they go.

To address these issues, the State should build a stronger and more unified data and technology infrastructure to provide the "backbone" in helping constituents navigate the system. Consolidating technology systems to support constituent navigation could also generate cost savings for the State.

First, the State should consider solutions to unify electronic health records (EHRs) to make moving across different providers more seamless for constituents. Today, many State agencies have their own EHRs for the services they provide; for example, DHEC, DMH, and DAODAS each have their own different solutions. Further, these EHRs do not communicate with records held by broader providers and community organizations. To address this, the State should prioritize the provider types that would benefit most from unifying patient records, consider the right way to unify data (e.g., shifting to one platform, creating flexible links between different systems), and build or partner to create the right system. To ensure the right people and data sharing standards are in place for this effort, the central organization could help set up the overall workstream with clarity on data sharing agreements with right security and privacy standards (as contemplated in recommendations #1 and #2).

Second, the State should consider launching unified population health and case management platforms based on existing constituent data on health and social needs and a database of available programs and supports, with a recommendation engine that can help match constituent needs with the right interventions. As discussed above, many navigators may face challenges in recommending the appropriate benefits and services for constituents because they may not know enough about the person's needs or they are unaware of all the possible offerings that might be a good fit. This platform could help

address this gap and ensure a consistent approach across agencies. As such, the State should understand what exists across agencies today, review options for potential platforms, determine whether to build or partner, and work to integrate the platform with the workflows of navigators across the system.

Third, over time, the State should explore implementing an Integrated Eligibility System (IES), a unified system where constituents can apply and manage multiple benefits in one location. While the applications for SNAP, Temporary Assistance for Needy Families (TANF), Refugee Cash Assistance (RCA) are integrated together, others like Medicaid, WIC and Child Care Scholarship (CCS) are separate, necessitating that constituents submit the same information repeatedly, which leads to a frustrating and time-consuming process. Other states (e.g., Kentucky) that have adopted an IES have reported several benefits, including a reduction in duplicative systems and administrative costs; faster determination processes; lowered workloads for employees; and easier enrollment processes for constituents seeking benefits. However, implementing an IES is complex and requires dedicated stakeholders committed to the project; strong coordination between different agencies; standardized training and business practices to ensure consistency and efficiency; and the development of a functional and user-friendly system.

As the State evaluates these potential technology system changes, it should consider the existing set of technology systems as well as ongoing technology development projects.

Recommendation #7: Strengthen the State's health and human services workforce

Nearly 17,000 employees work across eight health and human services agencies across both clinical (e.g., medical assistants, dietitians, clinical instructors) as well as administrative roles (e.g., program managers, research analysts). Across these employees, South Carolina health and human services agencies have had trouble recruiting and retaining staff with an average turnover rate of approximately 19% in South Carolina[130] (vs. ~9% for all U.S.[131]), and an average less than 24-month vacancy rate of approximately 17% in South Carolina (vs. ~5% for all U.S. state and local governments (excl. education).[132] (see Exhibit 32).[133] Only 42% of agency staff believe their agency is an attractive employer for recruitment and retention.[134] Overall, agency staff feel they are asked to do difficult work

[130] Agency HR data, S399 Agency and Position data - 8/14/2023, S399 Agency FY 2019-2023 separation data, includes both classified and unclassified FTEs

[131] 46% of all employees in state and local public health agencies left their jobs during the five-year study period (2017-2021); ~9% reflects a 5 year annualized figure. "U.S. governmental public health workforce shrank by half in five years" Harvard T.H. Chan School of Public Health.

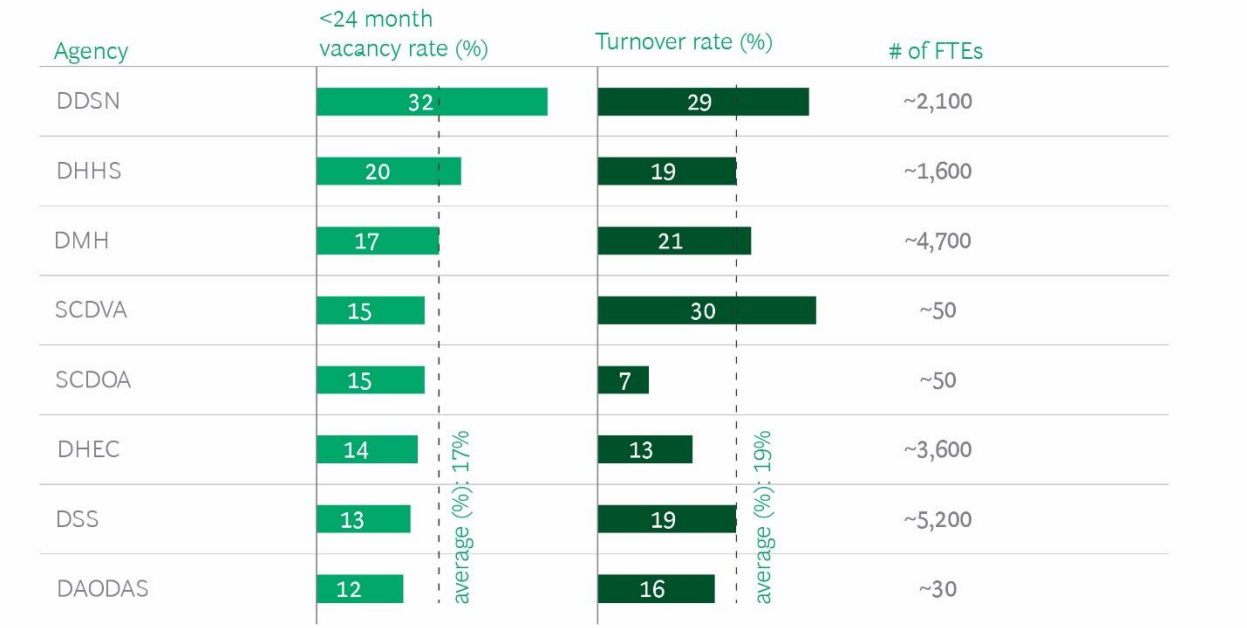
[132] Vacancy rate for all positions in state and local governments, excluding education, in September 2023. Bureau of Labor Statistics, "Table 1. Job openings levels and rates by industry and region, seasonally adjusted"

[133] Department of Administration HR data as of 1/4/2024, includes both classified and unclassified FTEs

[134] Act 60 Agency Survey, peer surveys

for little recognition or rewards, and sometimes feel stymied in the delivery of the mission they signed up for due to insufficient training or poor operational processes.[135]

Exhibit 32: Variation in turnover and vacancy rate across agencies



Note: calculations include both classified and unclassified FTEs in calculation
Source: Agency HR data, S399 Agency and Position data - 8/14/2023, S399 Agency FY 2019-2023 separation data

The current challenges in recruitment and retention lead to cyclical concerns for these agencies. As employees leave agencies, there is a higher turnover and vacancy rate, which constrains staff capacity. This reduced capacity lowers the ability to plan and support constituents at the existing level. As a result of this reduced staff capacity, there is added pressure on existing workers to perform at a higher level, which might cause them to leave, restarting the cycle.

> "We have lost talented applicants due to the time it takes to process applications. Most applicants can not afford to wait a month to be notified if they have a job offer, then wait another 2-3 weeks to start and then work a month before receiving their first paycheck."
>
> *~ Agency employee*

South Carolina should focus its future approach across each part of the talent lifecycle—how the State attracts talented staff, retains them, and ensures they are well equipped to be productive (see Exhibit 33).

[135] Act 60 Agency Survey

Exhibit 33: Several factors that impact SC's ability to attract, retain, and nurture its staff

The State has three main opportunities to improve its workforce:

- Bolster state recruitment
- Better retain and develop talent
- Make it easier for staff to productively deliver quality services

Because talent management most frequently occurs at the individual agency level, the State will have to consider what solutions can be centrally vs. de-centrally directed. The State should also consider if any of these solutions are better handled centrally as it will dictate future HR functions that sit within the central organization (as contemplated in recommendation #1).

Bolster state recruitment

To quickly find the right people for the right roles, the health and human services agencies need strong recruitment and hiring capabilities. Strong approaches in other states include developing deep recruiting channels and branding to attract the right candidates, and using active hiring approach to get skilled candidates in the door quickly. While health and human services agencies have made progress in these areas, there remains an opportunity to further improve as discussed below.

The State's overall time to hire (posting to offer) is faster than other states – 77 days in South Carolina (see **Exhibit 34**)[136] vs. 96 days for other states (according to Neogov).[137] However, there remain opportunities to improve the process as many of these roles can

[136] S.C. Department of Administration, 2023 Time to hire data, Health and human services agencies. Excludes all positions which began advertising an opening after the successful applicant had already submitted their application due to concerns with data reporting and accuracy.

[137] Neogov, "Time to Hire Report", 2020

take significantly longer than average to fill and the time to hire remains ~2x the private sector (36 days to hire[138]). The majority of the time to hire in South Carolina is taken up during the marketing (49 days) and interviewing and evaluation stages (42 days).[139]

Exhibit 34: Average time to hire across South Carolina's health and human services agencies (2023)

Note: Excludes all positions which began advertising an opening after the successful applicant had already submitted their application due to concerns with data reporting and accuracy
Source: 2023 Time to Hire Data from the Department of Administration

Passive recruitment practices across health and human services agencies contribute to lags at these stages of the process. First, agencies have an opportunity to improve recruiting outreach and channels for identifying quality talent early, rather than just posting jobs and waiting for responses in some cases. Although there have been recent examples of this across agencies (e.g., DDSN's High School DSP Training Program), they have produced mixed results to-date.[140] In addition, the interviewing and evaluation stage gets prolonged due to hiring managers taking significant time to set up interviews and make a hiring decision, partially driven by lower candidate quality from challenges in recruiting. Underlying all of this, it is difficult to adopt more active recruiting tactics for decentralized agency HR teams since they are relatively lean. High turnover has only increased the burdens on this staff. These issues slow candidates from application to orientation and make finding the strongest candidates more difficult.

South Carolina should start with a clear identification of the highest-priority roles to fill based on the criticality of the role and available talent supply. Based on this, South

[138] Neogov, "Time to Hire Report", 2020

[139] Average time from application to offer. S.C. Department of Administration, 2023 Time to hire data, Health and human services agencies

[140] Discussion with DDSN staff

Carolina should take a more active recruiting approach, building on past efforts to improve the recruiting process. To better attract the right candidates, the State should increase investment in specialized recruitment through job fairs, structured internship and apprentice programs, and partnerships with academic institutions, vocational schools, or community organizations that have relevant talent. The State could pair these recruiting events with a brand ambassador program, where selected employees share positive experiences of working with the agency. To support recruitment efforts, the State should invest in personnel with a background in active recruitment. In addition, increasing the use of recruitment dashboards within each agency that offer real-time updates on application statutes could help recruiters act more quickly on priority positions when candidates move through the process slowly. Recent changes to the hiring technology system can help make these dashboards easier to develop.

Better retain and develop talent

To retain and develop talent, organizations use a mix of financial incentives, such as compensation, and non-financial incentives, such as recognition, working models, and career pathing.

> "I have lost many great co-workers who were with the agency 6 plus years because they never received a raise in pay or enough recognition from the agency which is why it has been difficult retaining good help."
>
> *~ Agency employee*

However, as discussed above, State agencies have struggled with retaining its staff, particularly in mission-critical roles such as clinicians.[141] Many challenges underlie this poor employee retention and growth. While salary increases for state workers in 2023 were positive steps,[142] the State has seen a reduced level of competitiveness in recent years on compensation and benefits[143] compared with other options employees have, such as positions in the private sector. Additionally, agency staff report dissatisfaction with not being recognized by their managers or broader teams for the work they do.[144] Staff also cite frustration with their current working models, particularly with an eye toward a more flexible work schedule. [145] Compounding this, state agencies do not consistently have clearly defined promotion ladders, which limits employee upward mobility.[146]

South Carolina can boost retention and reduce turnover in several ways. First, the State can improve staff recognition through better manager training regarding supporting their

[141] Agency HR data, S399 Agency and Position data - 8/14/2023, S399 Agency FY 2019-2023 separation data, includes both classified and unclassified FTEs

[142] In 2023, the State offered a general increase in compensation to all State employees and also funded a compensation plan for all nursing occupations.

[143] Benefits include elements such as sick and vacation days, health, and retirement plan.

[144] Act 60 Agency Survey

[145] Act 60 Agency Survey, Quid, BCG analysis, BCG Center for Growth and Innovation Analytics

[146] Act 60 Agency Survey

teams, launching annual awards ceremonies for each agency, and hosting employee spotlights regularly featuring top performers in state newsletters. Another option to consider is increasing flexible working models for applicable roles, including work-from-home options,[147] 4-day workweeks, flextime, or part-time options to accommodate different employee needs, balanced against the business needs of the agency and the nature of the position. In addition, the upcoming move of health and human services agencies to a new combined location provides opportunities to improve the physical working environment for staff—for example, layout, amenities—to boost employee satisfaction at work, potentially considering employee feedback on areas for improvement. In addition, clearly defined career ladders can help to improve retention, upward mobility, and development for priority roles. For example, DDSN's creation of career ladders for Direct Service Professionals (DSPs) offer a defined path to compensation increases over time and has led to better retention of these professionals.[148] Over time, the State should regularly review and adjust salary to remain competitive with similar roles in the market and considering cost of living and inflation.

Make it easier for staff to productively deliver quality services

After recruiting and retaining talent, South Carolina should focus on ways to deploy staff to better serve constituents. However, today, numerous staff reported in interviews through this study that they do not have the right level of training to execute their day-to-day responsibilities, and must navigate onerous process steps that hinder their work.[149] There is also an opportunity to better hold staff accountable for delivering on their responsibilities. Ultimately, many workers who join state health and human services organizations do so to serve a public mission and support constituents. [150]

> "We need trainings that best fit our patients/clients and current needs. We don't need to train people in areas that are not relevant for either their job or the population they serve."
>
> *~ Agency employee*

As such, the State should better support its talent to deliver high-quality services to constituents, not only to improve the constituent experience, but also to allow staff to be true to the mission they signed up for.

First, the State should improve the efficiency and effectiveness for a priority set of processes by using automated tools and reducing unnecessary process steps (e.g., improving the internal Medicaid eligibility workflows to process applications more quickly

[147] State law requires that remote work only be used where the state agency can demonstrate both efficiencies and cost savings from doing so.

[148] Discussion with DDSN staff

[149] Act 60 Agency Survey, Peer Survey

[150] 40% of public health workers cite organizational pride as a main reason for staying in their position; de Beaumont Foundation and Association of State and Territorial Health Officials, *Public Health Workforce Interests and Needs Survey: 2021 Dashboard*. www.phwins.org/national. July 31, 2023

with lower error rates). Improving processes would also help staff morale and retention by making their jobs easier to accomplish.

Second, the State should improve training and skilling at all levels – at the leadership level, for example, through offering peer programs such as statewide executive training by roles (e.g., all agency CFOs), and providing structured opportunities to learn from other states through industry associations. In addition, the State could increase the skills and training of broader staff by expanding structured mentorship programs, pairing junior staff with experienced mentors for personalized career development, and access to online learning platforms, offering a range of courses for continuous skill development.

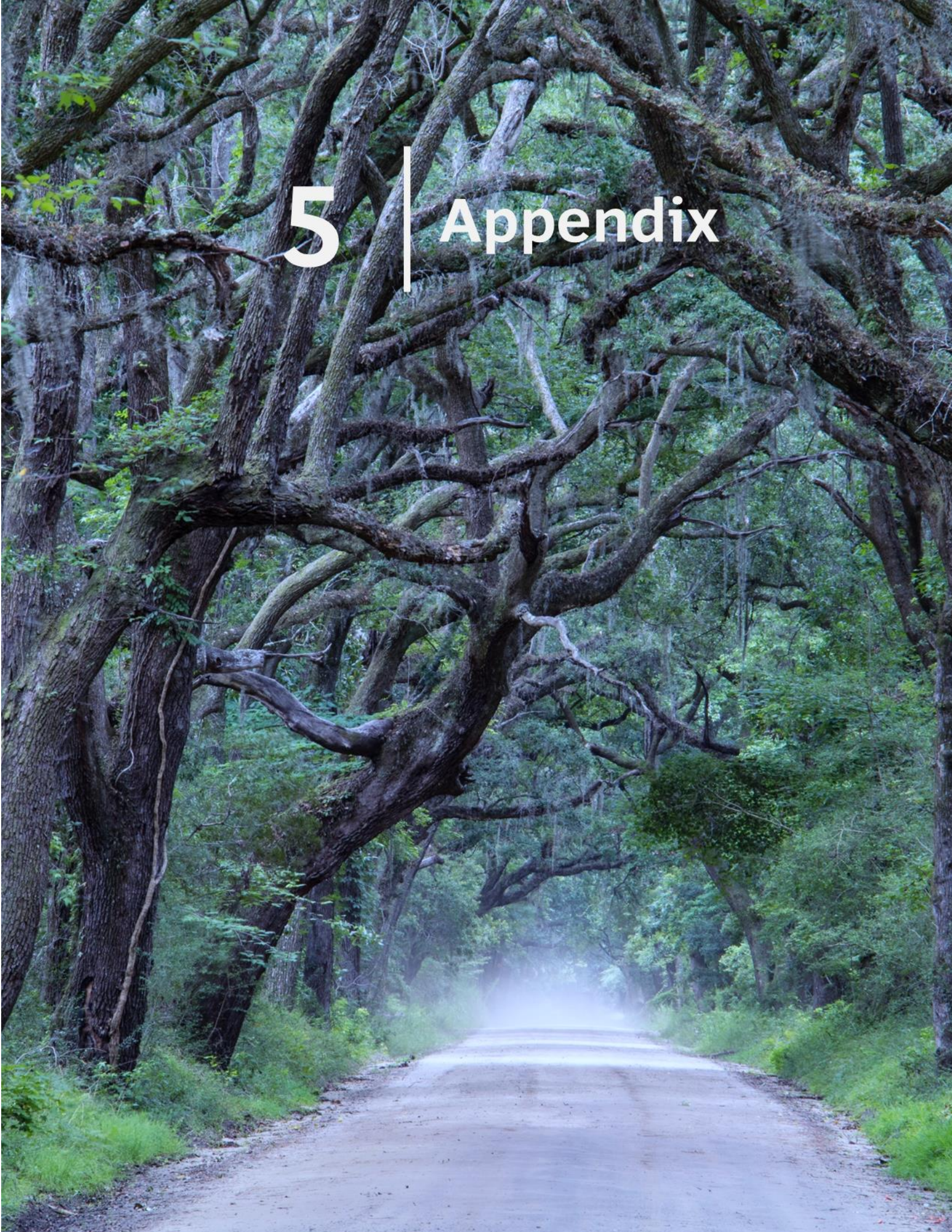
Third, the State should improve accountability through more rigorous evaluation of staff performance against job objectives and more holistically track individual and team outcomes.

4 | Looking ahead

Looking ahead

These recommendations represent significant changes to the health and human services system in South Carolina. If adopted, these changes can help improve health outcomes for the State, drive better efficiency of government, and increase the value for the overall dollars spent. However, there are potential risks to stakeholders of failing to manage the change appropriately, including constituent confusion, provider turnover, and inefficient allocation of taxpayer resources.

To implement recommendations effectively, South Carolina requires a well-coordinated and appropriately resourced implementation approach. The State will need to prioritize the most critical initiatives based on scale of impact and cost, effectively coordinate implementation timelines, and diligently execute with a focus on the detail. The goal of these efforts is to be cost-neutral in the long-term, although short-term investments will be needed to implement these recommendations, which can be sourced from existing budgets, cost savings, revenue enhancements, and – if needed – state appropriations.



5 Appendix

Appendix

a. List of acronyms and abbreviations

Term	Definition
ACM	Active Contract Management
AFP	Academy for Family Physicians
APS	Adult Protective Services
BACB	Behavior Analyst Certification Board
BCG	Boston Consulting Group
BHECN	Behavioral Health Education Center of Nebraska
CBO	Community-Based Organization
CCBHCs	Certified Community Behavioral Health Clinics (comprehensive mental health clinics)
CCS	Child Care Scholarship
CHIP	Children's Health Insurance Plan
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CPS	Child Protective Services
CQI	Continuous Quality Improvement
DAODAS	S.C. Department of Alcohol and Drug Abuse Services
DD	Development Disabilities
DDSN	S.C. Department of Disabilities and Special Needs
DHEC	S.C. Department of Health and Environmental Control
DHHS	S.C. Department of Health and Human Services
DMH	S.C. Department of Mental Health
DOA	S.C. Department of Aging
DSN Board	Disabilities and Special Needs Board
DSS	S.C. Department of Social Services
DVA	S.C. Department of Veterans Affairs
ED	Emergency Department
EHR	Electronic Health Record
FQHC	Federally Qualified Health Center (healthcare providers for underserved populations)
FTE	Full-Time Equivalent
HASCI	Head and Spinal Cord Injury
HPSA	Health Professional Shortage Area

Term	Definition
HRSA	Health Resources and Services Administration
IBH	Innovation in Behavioral Health
ICF	Intermediate Care Facility
IES	Integrated Eligibility System
LHD	Local Health Department
MCOs	Managed Care Organizations (managed state healthcare insurance and services)
MH	Mental Health
MMIS	Medicaid Management Information System (Medicaid's data/claims processing)
MUSC	Medical University of South Carolina
N-MHSS	National Mental Health Services Survey (SAMHSA project)
N-SSATS	National Survey of Substance Abuse Treatment Services (SAMHSA project)
PCP	Primary Care Physician
Peer states	Alabama (AL), Georgia (GA), North Carolina (NC), Tennessee (TN), and Virginia (VA)
RCA	Refugee Cash Assistance
SAMHSA	Substance Abuse and Mental Health Services Administration
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

b. List of stakeholders interviewed - state agencies and external stakeholders

We thank the stakeholders who contributed their valuable insights to this report through interviews. These collaborations were instrumental in shaping our findings.

State agencies	
DHEC	
• Edward Simmer, Director • Karla Buru, Chief of Staff • Brannon Traxler, Director of Public Health	• Darbi MacPhail, Finance • Marcus Robinson, HR
DVA	
• Todd B. McCaffrey, Secretary of VA • Tim Frambes, Director of Veteran Services	• Joseph McLamb, Chief of Staff • Fanta Coleman, Finance
DDSN	
• Constance Holloway, Interim Director / General Counsel • Janet Priest, Assoc. State Director, Operations • Lori Manos, Assoc. State Director, Policy • Dr. Harley Davis, Chief Administrative Officer	• Robert McBurney, Program Manager (Emergency Operations and Special Projects) • Quincy Swygert, CFO • Elizabeth Lemmond, Director of HR
DOA	
• Connie Munn, Director • Thomas Williams, Community Resources Division Director • Dale Watson, State Long Term Care	• Rhonda Walker, Finance • Cheryl Washington, HR
DAODAS	
• Sara Goldsby, Director • Michelle Nienhius, Division Manager, Prevention and Intervention	• Hannah Bonsu, Division Manager, Treatment and Recovery Angela Outing, HR • Lee Dutton, Chief of Staff
DMH	
• Robert Bank, Acting State Director • Deborah Blalock, Deputy Director, Community Mental Health Services • Versie Bellamy, Deputy Director, Division of Inpatient Services • Ralph Pollock, Medical Director • Dr. Kimberly Rudd, Chief Medical Officer for IP Services and LTC, Assistant Deputy Director for LTC	• Mark Binkley, Director of Special Projects (former Interim Director, General Counsel) • George McConnell, Director, Morris Village • John Magill, Former Director • Gregory Pearce/Elliot Levy, DMH Commissioners • Debbie Calcote, Deputy Director of Administrative Services • Lee Bodie, Finance

State agencies	
DSS	
• Michael Leach, Director • Connelly-Anne Ragley, Director of Communications and External Affairs • Kelly Cordell, Director, Adult Advocacy • Suzanne Sutphin, Director, Agency QA and CQI • Garry James, Director, Professional Development and Innovation	• Steven Ferrufino, Chief Transformation Officer • Tim Mose, Director, Child Support Services • Emily Medere, Deputy Director, Child Welfare Services • Amber Gillum, Deputy Director, Economic Services • Glenise Elmore, HR
DHHS	
• Robert Kerr, Director • Eunice Medina, Chief of Staff; Deputy Director, Programs • Nicole Mitchell Threatt, Deputy Director, Eligibility Enrollment and Member Services • Brad Livingston, CFO • Rhonda Morrison, CIO and Deputy Director	• Deirdra T. Singleton, Deputy Director for Administration and Chief Compliance Officer • Melanie Hendricks, Deputy Director, Community Treatment Services • Heather Kirby, Director, Office of Research and Data Analysis • Boyd Shealy, HR • Chrissy Jackson, Finance
Admin	
• Marcia Adams, Executive Director • Paul Koch, Chief of Staff • David Avant, Chief Legal Counsel	• Mike Shealy, Finance • Karen Wingo, HR • Kevin Paul, HR
Comptroller General	
• Brian Gaines, Comptroller General	

External stakeholders	
Payers (MCOs)	
• Dietrick Williams, Vice President and Regional Medicaid President for SC, Humana • Taffney Hooks, Member Services Manager, Humana • John McClellan, President and CEO, Absolute Total Care	• Tim Vaughn, President and CEO, BlueChoice HealthPlan • Courtnay Thompson, Market President, Select Health • Sean Popson, Director of Plan Operations and Administration, Select Health
Other Agencies	
• Amanda Whittle, Dept of Child Advocacy • Valerie Bishop, Disability Council • Eden Hendrick, Department of Juvenile Justice • Richard Hutto, Housing Authority	• Bryan Stirling, Department of Corrections • Mark Keel, Chief, SLED • Felicia Johnson, Vocational Rehabilitation • Chief Prock, Chief of Police, Myrtle Beach
Advocacy Groups	
• Beth Franco, Executive Director, Disability Rights South Carolina • Bill Lindsey, Executive Director, NAMI - South Carolina • Kimberly Tissot, President and CEO, ABLE SC • Sue Williams, CEO, Children's Trust of South Carolina • Kim Beaudoin, CEO, Palmetto Association for Children and Families	• Sue Berkowitz, Esq., Director, Appleseed Legal Justice Center • Mary Brown, Executive Director, SC Foster Parent Association • Graham Adams, PhD, CEO, South Carolina Rural Health Association • Amy Hornsby, Governor Ombudsman • Henry Lewis, EMS Association • Kerrie Schnake, Infant Mental Health Association
Service Providers	
• Donna Isget, President and CEO, McLeod Health • Sarah Hearn, Government Affairs Manager, MUSC • Dr. Patrick Cawley, Executive Director and CEO, MUSC • Quenton Tomkins, Government Affairs Manager, MUSC • Mark O'Halla, President and CEO, Prisma Health	• Dr. Morsal Tahouni, Medical Director, MUSC Emergency Department • Dr. Keia Hewitt, Director of Emergency Services, MUSC Catawba • Dr. Scott Russell, Division Director, MUSC Pediatric Emergency Medicine • Alaura Marion, Rebound Behavioral Health • Shannon Marcus, CEO, Three Rivers Behavioral Health
Associations	
• Maggie Cash, South Carolina Children's Hospital Collaborative • Dr. Keith Shealy, President, South Carolina AFP • Richele Taylor, CEO and CLO, South Carolina Medical Association (SCMA) • Laura Aldinger, Director, SC Behavioral Health Services Association	• Thornton Kirby, President and CEO, South Carolina Hospital Association • Edward Bender, General Counsel, South Carolina Hospital Association (former) • Anne Summers, Consultant, UHS

c. Agency profiles

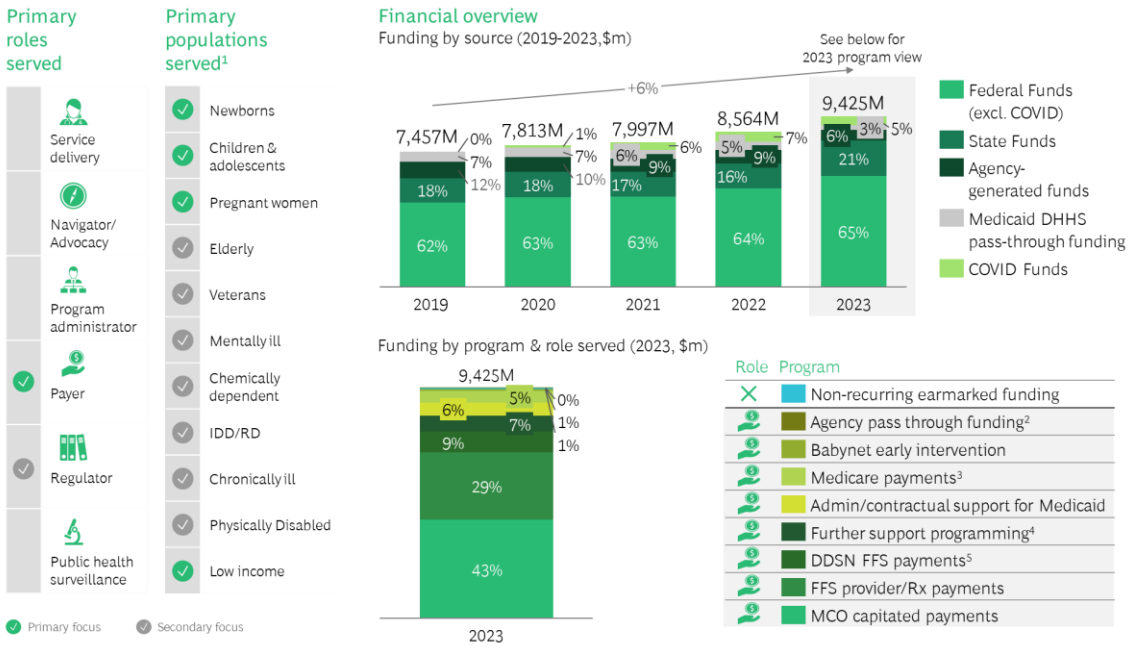
Department of Health and Human Services (DHHS)

Mission and statute: DHHS's mission **is to be boldly innovative in improving the health and quality of life for South Carolinians.** To accomplish this mission, DHHS is statutorily authorized to administer Medicaid, operate the Cooperative Health Statistics Program, and refrain from engaging in the delivery of services. The agency prepares and approves interagency program plans prior to submission and "continuously reviews" programs against objectives and informs the General Assembly. DHHS also maintains an inter-agency info system with client and fiscal data, contracts with other agencies for eligibility determination or any other operational programs, and monitors and evaluates all contractual services for performance.

Primary population and services: DHHS serves as the **single state Medicaid payer** across patient populations that qualify for Medicaid, with a primary focus on newborns, children, pregnant women, people with disabilities, and low-income populations. The agency plays a key role in managing Medicaid waivers—in particular, the three Home and Community-Based Services waivers. As part of its responsibilities to improve health outcomes across the State, it supports constituents through licensing and sharing education and information.

Organizational model and operations: DHHS operates through a **Cabinet** model, as DHHS **leadership is appointed directly by the Governor**. DHHS has approximately 1,600 full-time employees and $9.425B in 2023 funding.

Exhibit 35: Agency Fact Sheet | DHHS



As defined by Senate Bill 399 2. To DHEC and DMH; DADOAS pass through funding is not included 3. Dual eligibles and Medicare Part D clawback 4. Special population waivers, transportation, basic living needs support, Rural Health Initiative 5. Services administered by DDSN; DHHS in payer role; Source: SC Central Administration Expenditure Data (2019-2023); SCEIS Employment Data

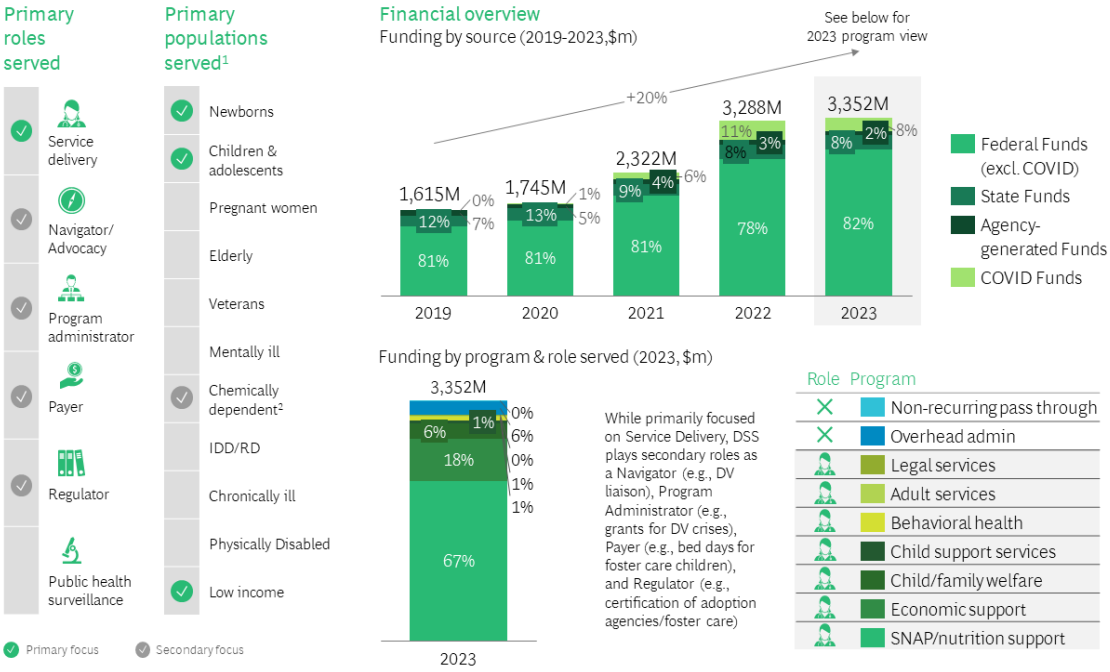
Department of Social Services (DSS)

Mission and statute: **DSS' mission** is to serve South Carolina by promoting the **safety, permanency, and well-being of children and vulnerable adults**, helping individuals achieve stability and strengthening families. DSS is **authorized** to achieve this mission by **studying various social problems** in the state, inquiring into causes, making **policy recommendations**, crafting rules and regulations and **administrative guidance** for county DSS departments. DSS also **audits the quality** of county office Child Protective Services (CPS) or foster care and adoption programs, investigates issues, administers CPS, State Social Services (SSS) block grants, and treatment standards for perpetrators of domestic violence.

Primary population and services: DSS primarily **delivers services for newborns, children and adolescents, and low-income populations**, through including but not limited to, sharing education and information, creating interpersonal support, finding stable housing, offering employment or skill training, and arranging transportation.

Organizational model and operations: DSS operates through a **Cabinet** model, as DSS leadership is appointed directly by the Governor. DSS has approximately **5,200 full-time employees** and **$3.352B** in **2023 funding**. The DSS State office **directly operates 46 county DSS sites**, which serve as an **entry point** for functions including constituent education, eligibility determination and enrollment, and service coordination.

Exhibit 36: Agency Fact Sheet | DSS



1. As defined by Senate Bill 399 2. DSS coverage of chemically dependent populations is through family support service funds available for TANF recipients; Source: SC Central Administration Expenditure Data (2019-2023); SCEIS Employment Data

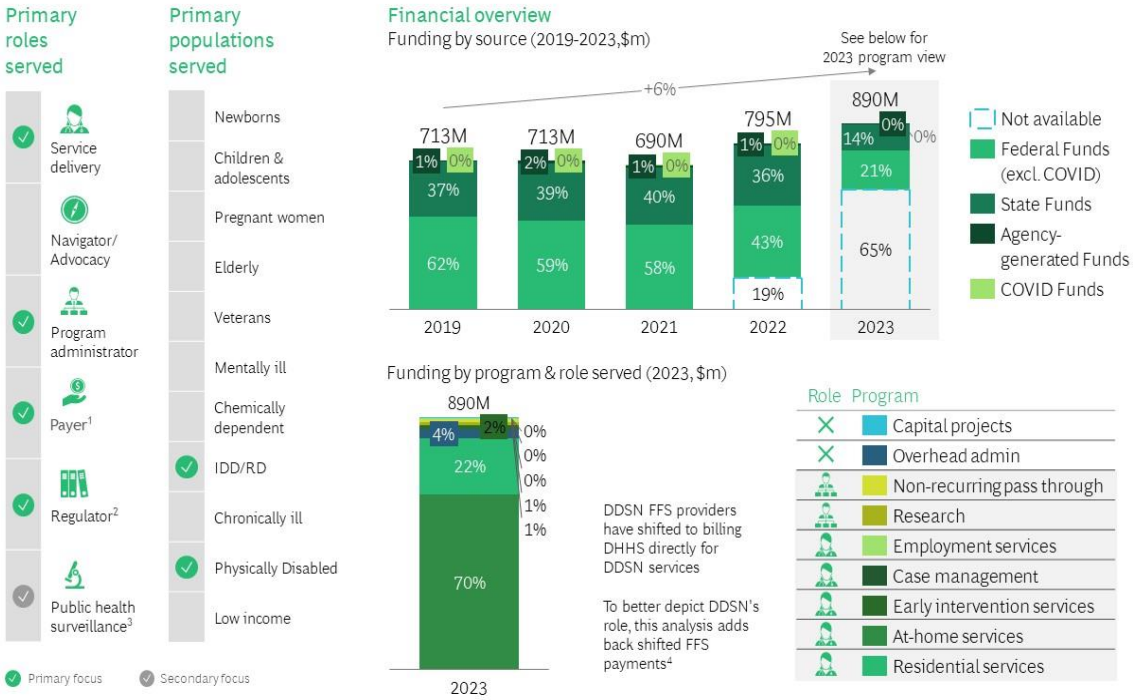
Department of Disabilities and Special Needs (DDSN)

Mission and statute: The vision of DDSN is to provide the very best services to all persons with disabilities and their families in South Carolina. DDSN has authority for all of the State's disabilities and special needs services and programs, including planning and coordinating full range of services across stakeholders.

Primary population and services: DDSN delivers services and administers programs primarily for populations with intellectual and related disabilities and physical disabilities. DDSN offers services to these patients through facility-based care, home-based care, and health coverage through waiver management. For these populations, DDSN also administers programs that increase education sharing, housing availability, employment/skills training, and transportation initiatives.

Organizational model and operations: DDSN operates through a Commission model, as DDSN leadership is appointed by a Commission. DDSN has approximately 2,100 full-time employees and $890M in 2023 funding. DDSN directly manages five residential centers. It administers three Medicaid waivers for intellectual disability and related disabilities, Community support, and Head and Spinal Cord Injury (HASCI).

Exhibit 37: Agency Fact Sheet | DDSN



1. Payor for State funded services to DDSN-eligible individuals 2. Regulator for Community Training Home I and II, Supervised Living Program I and II, and day programs 3. HASCI surveillance. 4. DDSN FFS payments shifted to DHHS over for 2022 and 2023 were for $151M and $574M, respectively; Source: SC Central Administration Expenditure Data (2019-2023); SCEIS Employment Data

Department of Health and Environmental Control (DHEC)

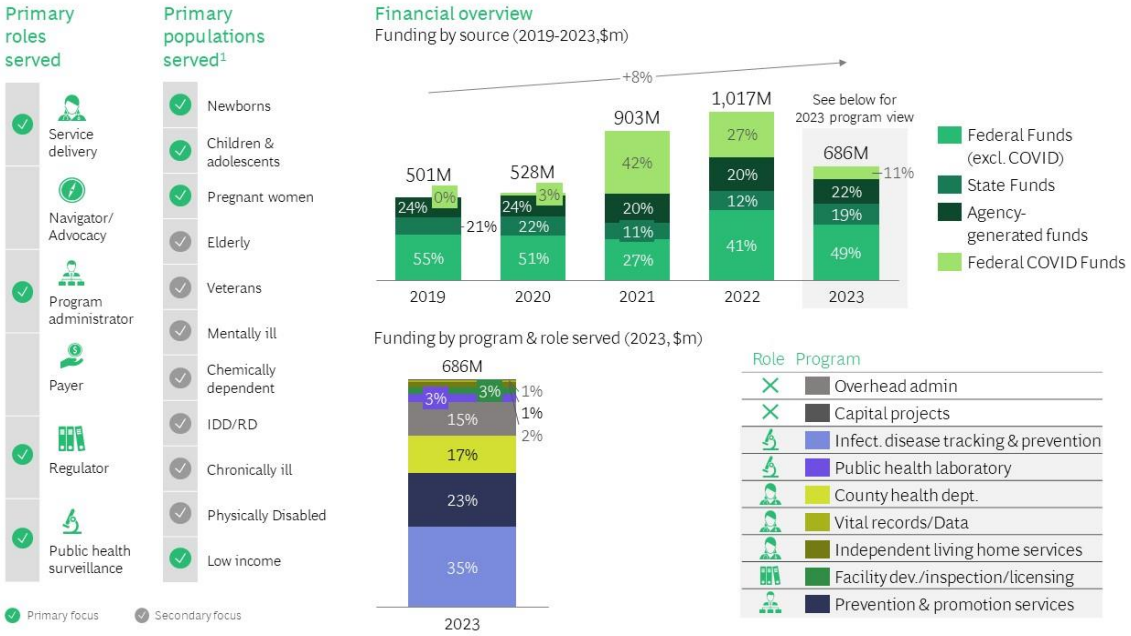
DHEC is **transitioning** (2023-2024) to become the **Department of Public Health**. When this change happens, existing oversight over food and environment will shift to other agencies.

Mission and statute: **DHEC's mission** is to improve the quality of life for all South Carolinians by protecting the **health of the public and the environment**. DHEC is authorized to achieve this mission through statutory requirements of **regulating** the standards of facilities through licensing, **investigating** reported causes of disease, **enforcing** preventative measures (e.g., quarantines, sanitation rules in public places) to protect constituents, **notifying** safety authorities, and **informing** the public as necessary to prevent a public health emergency.

Primary population and services: DHEC covers broad roles. **Primarily**, the agency **delivers services, administers programs, acts as a regulator**, **and conducts public health surveillance**. These roles are targeted towards **newborns, children and adolescents, pregnant women, and low-income groups**. To achieve its mission of protecting the public and the environment, DHEC works to deliver facility-based care through local health departments, administer programs that offer education and housing assistance, regulate providers through licensing, and conduct regular surveillance of the State's public health.

Organizational model and operations: DHEC operates through a **Commission** model, as its leadership is appointed by a Commission. DHEC has approximately **3,600 full-time employees** and **$686M in 2023 funding**. DHEC **directly manages local health** delivery through **46 local health departments**, run by state employees who administer services.

Exhibit 38: Agency Fact Sheet | DHEC



1. As defined by Senate Bill 399; Note: Analyses include only public health components of DHEC; soon-to-be-transitioned environmental and food activities are excluded; Source: SC Central Administration Expenditure Data (2019-2023); SCEIS Employment Data

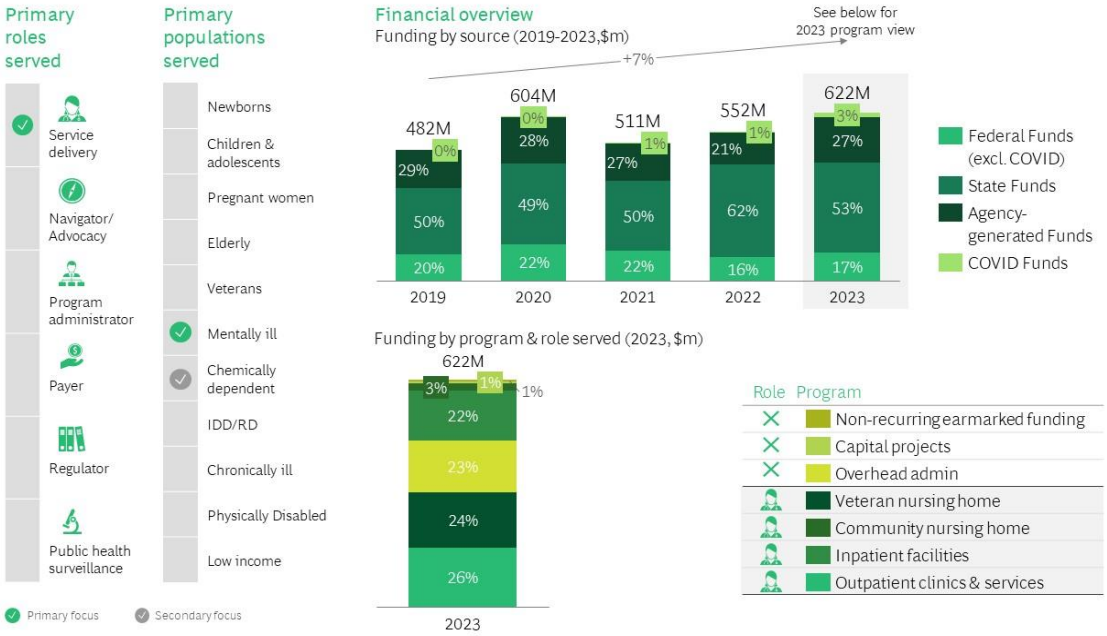
Department of Mental Health (DMH)

Mission and statute: DMH is tasked with supporting the recovery of people with mental illnesses. DMH has jurisdiction over all inpatient and outpatient mental health services, and "primary responsibility…for treatment of alcohol and drug addicts." Additionally, the DMH has a secondary role in serving chemically dependent populations. Their primary role for these populations is service delivery.

Primary population and services: DMH primarily delivers services to mentally ill populations, with a secondary focus on chemically dependent groups. DMH directly offers health services through facility-based and home-based care, supplementing this care with supporting services organized around sharing education and information, interpersonal support, offering employment and skill training, housing stabilization, and arranging transportation.

Organizational model and operations: DMH operates through a Commission model, as DMH leadership is appointed by a Commission. The DMH has approximately 4,700 employees and $622M in 2023 funding. In this model, the State directly manages 56 county outpatient clinics across 16 regional Community Mental Health Centers, three inpatient hospitals, an inpatient facility for sexually violent predators, and a general nursing care facility. DMH has contract relationships with ~13 additional inpatient facilities.

Exhibit 39: Agency Fact Sheet | DMH



Source: SC Central Administration Expenditure Data (2019-2023); SCEIS Employment Data; Agency Leadership Interviews; SC Code of Laws (Title 44)

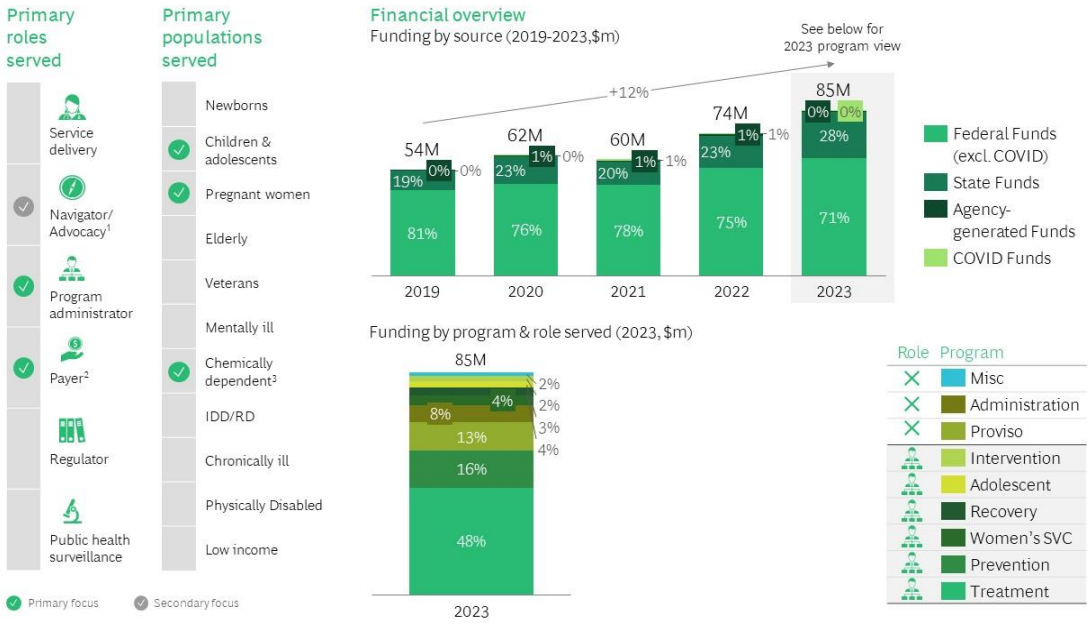
Department of Alcohol and Other Drug Abuse Services (DAODAS)

Mission and statute: DAODAS' **mission** is to ensure the **availability and quality** of a **continuum of substance use service**, thereby improving the health status, safety, and quality of life of individuals, families, and communities across South Carolina. To accomplish this mission, DAODAS is **statutorily authorized** for **formulating, coordinating, and administering the state plans** for controlling narcotics and controlled substances and alcohol abuse. DAODAS is responsible for **evaluating county-level service delivery** plans, providing oversight, and administering block grants.

Primary population and services: DAODAS serves as a **program administrator and payer** for **chemically dependent, children and adolescent, and pregnant women** populations, offering this patient population a **broad swathe of programs**. DAODAS administers **health programs** that offer facility-based direct care, home-based direct care, and health coverage through waiver management, supplementing this care with **supporting programs** that include sharing education and information, creating interpersonal support, finding stable housing, offering employment or skill training, and arranging transportation.

Organizational model and operations: DAODAS operates through a **Cabinet** model, as DAODAS leadership is appointed directly by the Governor. DAODAS has approximately **30 full-time employees** and **$85M in 2023 funding.** Within this organizational model, DAODAS administers grants and provides oversight to **32 county-based boards**, established under Act 301, that administer alcohol and drug addiction services.

Exhibit 40: Agency Fact Sheet | DAODAS



1. Two FTE work as Navigators connecting individuals leaving correctional settings to recovery resources as well as responding to Substance Use Disorder-related helpline calls 2.~30% (~$25M) of'23 spend is FFS claims-based reimbursement 3. Chemical dependence is a form of chronic illness; Source: SC Central Administration Expenditure Data (2019-2023); DAODAS financial data (2023); SCEIS Employment Data; Agency Leadership Interviews; SC Code of Laws (Title 44)

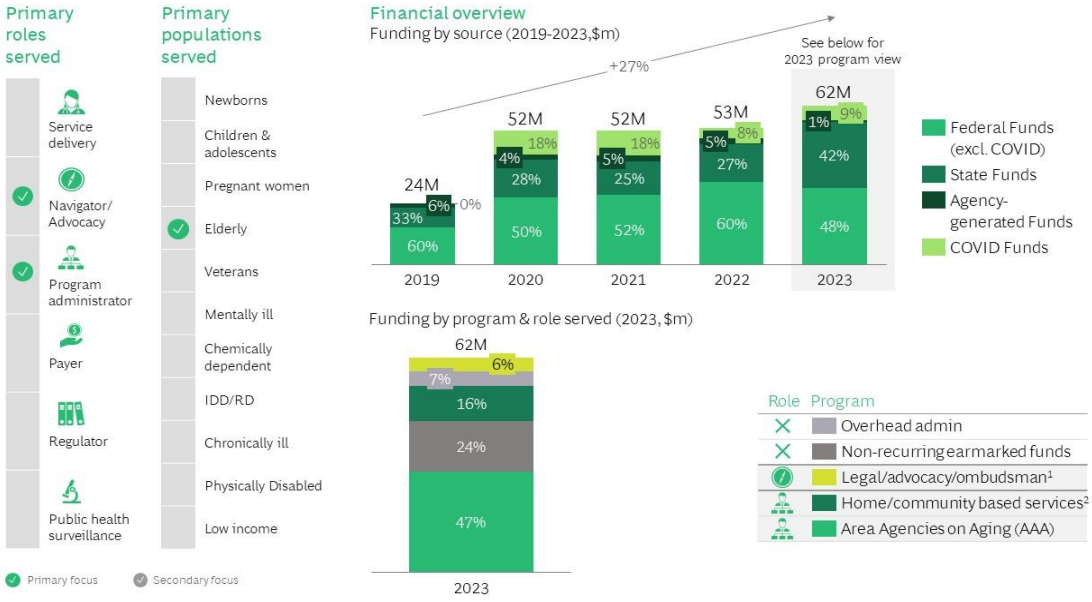
Department of Aging (DOA)

Mission and statute: DOA's mission is to enhance the quality of life for all of South Carolina's seniors and vulnerable adults by meeting their present and future needs. DOA is authorized to achieve this mission through statutory requirements to implement and administer all programs of the Federal Government related to aging. DOA is also authorized to study, investigate, plan, promote and execute programs to meet the present and future needs of aging constituents.

Primary population and services: DOA serves elderly populations, primarily offering navigation and advocacy initiatives and administering relevant programs. To achieve their mission of serving all seniors and vulnerable adults, DOA supports elderly populations in their navigation of eligible resources. DOA also administers health programs that offer home-based direct care and supporting programs that share education and information, create interpersonal support, find stable housing, and arrange transportation.

Organizational model and operations: The DOA operates through a Cabinet model, as DOA leadership is appointed directly by the Governor. DOA has approximately 45 full-time employees and $62M in 2023 funding. Under the requirements of the Older Americans Act (OAA), DOA works to meet the needs of the senior population by planning, advocacy, and providing state and federal resources to the 10 Area Agencies on Aging.

Exhibit 41: Agency Fact Sheet | DOA



1. LTC ombudsman, adult guardian ad litem, Silver Haired Legislature 2. Includes funds for seniors aging in place, caregivers, and Alzheimer's patients, as well as a geriatrician loan repayment program (~$35k annually); Source: SC Central Administration Expenditure Data (2019-2023); SCEIS Employment Data

Department of Veterans' Affairs (DVA)

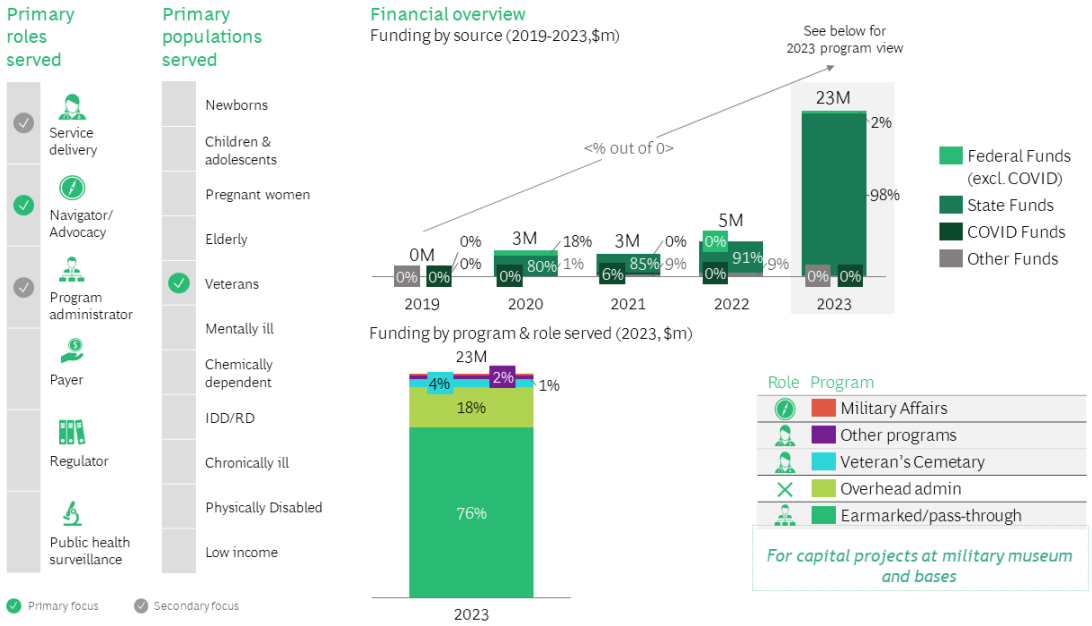
DVA will soon be taking over the operation of Veteran nursing homes from DMH. The 5 homes currently operated by contractors will be moved by 7/1/2024. The home currently operated by DMH will be transferred by 7/1/2025.

Mission and statute: S.C. DVA's mission is to lead and enable a statewide coalition of partners with an interest in Veterans to create and sustain an environment in which Veterans can thrive as valued and contributing members of the South Carolina community. To achieve this mission, DVA is statutorily required to assist former, present, and future members of the armed forces in securing their entitled benefits.

Primary population and services: DVA serves Veteran populations, primarily offering navigation and advocacy. To achieve their mission of serving all Veterans, DVA administers health programs that offer Veterans facility-based direct care and supporting programs that share education and information with veterans.

Organizational model and operations: The DVA operates through a Cabinet model, as DVA leadership is appointed directly by the Governor. DVA has approximately 51 full-time employees and $23M in 2023 funding.

Exhibit 42: Agency Fact Sheet | DVA



Source: SC Central Administration Expenditure Data (2019-2023); SCEIS Employment Data Source: SC Central Administration Expenditure Data (2019-2023); SCEIS Employment Data


BCG