From: Linguard, Christie
Subject: Meeting Notice - The Commission of the SCDDSN - Commission Meeting - February 15, 2024
Date: Tuesday, February 13, 2024 2:13:22 PM
Attachments: Commission Packet for February 2024.pdf

Good Afternoon,

The South Carolina Commission on Disabilities and Special Needs will hold its regularly scheduled meeting in-person on Thursday, February 15, 2024, at 10:00 a.m. in conference room 251 at the SC Department of Disabilities and Special Needs, Central Administrative Office, 3440 Harden Street Extension, Columbia, SC. To access the live audio stream for the 10:00 a.m. meeting, please visit https://ddsn.sc.gov**.**

Attached is the Commission Packet for the meeting.

For further information or assistance, contact (803) 898-9769 or (803) 898-9600.

Thank you.

SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

A G E N D A

South Carolina Department of Disabilities and Special Needs
3440 Harden Street Extension
Conference Room 251 (TEAMS)
Columbia, South Carolina

February 15, 2024 **10:00 A.M.**

1. Call to Order *Chairman Ed Miller*
2. Notice of Meeting Statement *Commissioner Gary Kocher, MD*
3. Welcome
4. Adoption of Agenda **Pages 1 & 2**
5. Invocation *Chairman Ed Miller*
6. Approval of Commission Meeting Minutes from November 16, 2023 **Pages 3-6**
7. Commissioners' Update *Commissioners*
8. Public Input
9. Programs and Services

   Limitless Purpose **Pages 7-19** *Padgett & Lila Mozingo*
10. Commission Committee Business

    Finance & Audit Committee *Committee Chair Michelle Woodhead*

    1. Financial Approval and Threshold Report **Page 20**
       a. Linen Contract for Coastal, Pee Dee and Saleeby Regional Centers
       b. Regional Center Shift Differentials
       c. Coastal Retherm Equipment Replacement

    2. 800-07-CP: South Carolina Commission on Disabilities and Special Needs Needs Committee Procedures Attachment A – Finance and Audit Committee Procedures **Pages 21-25**

11. Old Business

    1. Quarterly Incident Reports **Pages 26-27** *Ms. Ann Dalton*
    2. Internal Audit Update *Ms. Jamie Heyward*
    3. Legislative Update **Pages 28-94** *Ms. Courtney Crosby*
    Mr. Robert McBurney

12. New Business

    1. New Building/Agency Move — *Ms. Constance Holloway*
    2. FY24 YTD Spending Plan Budget vs. Actual Expenditures — *Mr. Quincy Swygert*

13. Director's Update — *Ms. Constance Holloway*

14. Executive Session

    - Contractual Matter – Lutheran Services Carolina

15. Rise Out of Executive Session

16. Action on Item(s) Discussed in Executive Session, if needed

17. Next Regular Meeting – March 21, 2024

18. Adjournment

SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

MINUTES

November 16, 2023

The South Carolina Commission on Disabilities and Special Needs met on Thursday, November 16, 2023, at 10:00 a.m., at the Department of Disabilities and Special Needs Central Office, 3440 Harden Street Extension, Columbia, South Carolina.

The following were in attendance:

COMMISSION
Present In-Person
Eddie Miller - Chairman
Michelle Woodhead – Vice Chairman
Gary Kocher, MD - Secretary
Barry Malphrus

Microsoft Teams
David Thomas

DDSN Administrative Staff

Constance Holloway, State Director/General Counsel; Quincy Swygert, Chief Financial Officer; Lori Manos, Associate State Director of Policy; Courtney Crosby, Internal Audit Director; Harley Davis, Ph.D., Chief Administrative Officer; Carolyn Benzon, Deputy General Counsel; Mark Kaminer and Chanel Cooper, Information Technology Division; and Christie Linguard, Executive Assistant.

Notice of Meeting Statement

Chairman Miller called the meeting to order, and Secretary Kocher read a statement of announcement about the meeting that was distributed to the appropriate media, interested persons, and posted at the Central Office and on the website in accordance with the Freedom of Information Act.

Welcome

Chairman Miller welcomed everyone to the meeting.

Adoption of the Agenda

On a motion by Commissioner Kocher, seconded by Commissioner Malphrus, the meeting agenda was unanimously approved as written by the Commission. (Attachment A)

Invocation

Commissioner Kocher gave the invocation.

Approval of Commission Meeting Minutes from September 21, 2023

Commissioner Woodhead made a motion to approve the Commission meeting minutes from the September 21, 2023, meeting. This motion was seconded by Commissioner Malphrus and unanimously approved by the full Commission. (Attachment B)

Programs and Services

Dr. Robert L. Bank, Acting State Director for the SC Department of Mental Health (DMH), spoke about the timeliness of his attendance and speaking at this meeting since it appears that both agencies are going to be housed in the same building. He went on to introduce himself and talk a little about how he became a resident of South Carolina and ultimately, the acting state director. Dr. Bank then briefed the Commission on his PowerPoint entitled, A True System of Care. He stated that DMH Nursing Homes will be moved under the Department of Veteran's Affairs; however, the clinical portion will be handled elsewhere. Currently DMH houses 800 nursing home patients, 400 inpatient mental health patients, and 200 inpatient sexually violent predators. They have 16 mental health centers throughout the state and a clinic in every county. Dr. Bank concluded with his final thoughts on Senate Bill 399 and collocating with four agencies in a building in West Columbia. He proposes that these agencies get together soon to discuss some issues. Director Holloway agrees that all agencies need to carve out time to meet to discuss the collocation. She went on to personally thank Dr. Bank for his wisdom and continued guidance. (Attachment C)

Commissions' Updates

Commissioner Malphrus requested that the Policy Committee place on their January agenda to review a policy for emergency consumer transport from the regional centers. Also, he would like the Commission to have a discussion in January regarding ongoing DDSN projects.

Commissioner Kocher stated that all the Meet and Greets for the Disability and Special Needs Boards in the Regional Centers were great.

Commissioner Woodhead stated that her employer held disability employment awareness month during the month of October. She had the opportunity to sit on a panel and was able to tell her story of raising a child with a disability. After this meeting, she is headed to Georgia for the wheelchair tennis championships.

Public Input

There was no public input.

Programs and Services

Mr. Shawn Keith, Executive Director of the South Carolina Autism Society, spoke briefly about the Autism Society and the Aging and Disability Vaccination Collaborative (Initiative). The Vaccine Education Initiative (VEI) was launched to address systemic barriers to care and promote vaccine education, confidence, and access. (Attachment D)

Commission Committee Business

Policy Committee

Commissioner Kocher stated that a meeting took place this past Tuesday and noted the approval of the policies listed below:

800-07-CP: South Carolina Commission on Disabilities and Special Needs Committee Procedures – Coming out of the Committee as a motion and second, the full Commission approved the directive as written. (Attachment E)

800-07-CP: Attachment D (Policy Committee Procedures) – Commissioner Malphrus asked if one change could be made on Page 1 to include "including all recommended changes" in section B. The Commission unanimously approved the directive with the aforementioned change. (Attachment F)

100-01-DD: DDSN Directives/Standards Electronic Communications System - Coming out of the Committee as a motion and second, the full Commission approved the directive as written. (Attachment G)

Old Business

High Management Solicitation Update

Vice Chairman Woodhead read the following statement from Chairman Miller:

Commissioners, at the September 21st Commission meeting you may recall there was a motion to table the vote of the *High Maintenance Solicitation* that Ms. Janet Priest presented. However, after the meeting, I spoke to several Agency executive team members and was informed that due to the importance and timeliness of submissions, approval should be considered immediately. Therefore, I made the decision to approve submission of this *Solicitation*. The minutes need to reflect that this *Solicitation* was approved for submission by me after the meeting in September.

Head and Spinal Cord Injury (HASCI) Drop-In Centers Update

Ms. Manos briefed the Commission on the background of the HASCI Drop-In Centers. These Centers will need state funding for at least one more year. Commissioner Woodhead made a motion to fund the HASCI Drop-In Centers at $112,000 per quarter for all four Centers. This motion was seconded by Commissioner Malphrus and unanimously approved by the full Commission.

Chairman Miller asked if Director Holloway can move up on the agenda to give her Director's Update because she has to leave to take care of her sick child.

Director's Update

Director Constance Holloway gave her Director's Update on the Agency. (Attachment H)

New Business

FY24 YTD Spending Plan Budget vs. Actual Expenditures

Mr. Swygert gave the YTD Spending Plan through October 31, 2023, which denotes under budget spending by .01%. He denoted that through October 31, 2023, the agency has sent out a legislative pass thru funding of $6,885,00.

Next Regular Meeting

January 18, 2024, at 10:00 AM. (No meeting is scheduled in December).

Adjournment

On a motion by Commissioner Thomas, seconded by Commissioner Kocher and approved by the full Commission, the meeting was adjourned at 11:16 A.M.

Submitted by:

Christie D. Linguard
Executive Assistant

Approved by:

Commissioner Gary Kocher, M.D.
Secretary

Limitless Purpose Family Celebration

Celebrate the abilities of *all* children at this free event, featuring music, games, refreshments, a resource fair and the opportunity to connect with other parents and caregivers.

10:30 a.m. - 2 p.m., Saturday, March 16

The Meech House at Mungo Park, 2121 Lake Murray Blvd, Columbia.

This year's event features even more resources for families:

-10:30 a.m. - 12:30 p.m.	**Resource Fair** featuring companies that serve families and children **Limitless Potential Showcase:** Discover just a few of the shining stars across South Carolina who are excelling despite looking or learning a little differently. Several individuals will have items for purchase.
-12 p.m.-12:30 p.m.	Lunch and special presentations
-12:30 p.m. - 2 p.m.	Featured Speaker, Roundtable Discussions for parents and caregivers. Activities and games provided by the counselors of the Irmo Chapin Recreation Commission's Therapeutic Rec Program from 12-2 p.m.

FREE but registration required at http://tinyurl.com/Family-Celebration or
Questions? Contact Padgett Mozingo at (803) 476-7124.

Limitless Purpose
LimitlessPurpose.org

Beyond the Limits

Padgett and Lila Mozingo

Lila Mozingo

- Homeschooled 12 year old
- Has a successful small business – Lila's Sweet Treats
- Pet sitter extraordinaire
- Loves animals, music, making friends and being included
- Will attend three camps this summer: Camp Heart to Heart, Farm Camp at Bowers Farm in Pomaria, Cole's Kids Service Camp At Camp Cole
- Chief Inspiration Officer for Limitless Purpose

Padgett Mozingo

- Communications Consultant, Community Engager, Teacher, Baker

- Avid reader who knows the impact reading has on everyone's lives

- Mother of two equally amazing children: Lila and her brother Garrett who is on scholarship studying engineering at Clemson Honors College

- Firm believer that *all* children can be limitless

- Cofounder and volunteer President for Limitless Purpose

Lila's Sweet Treats

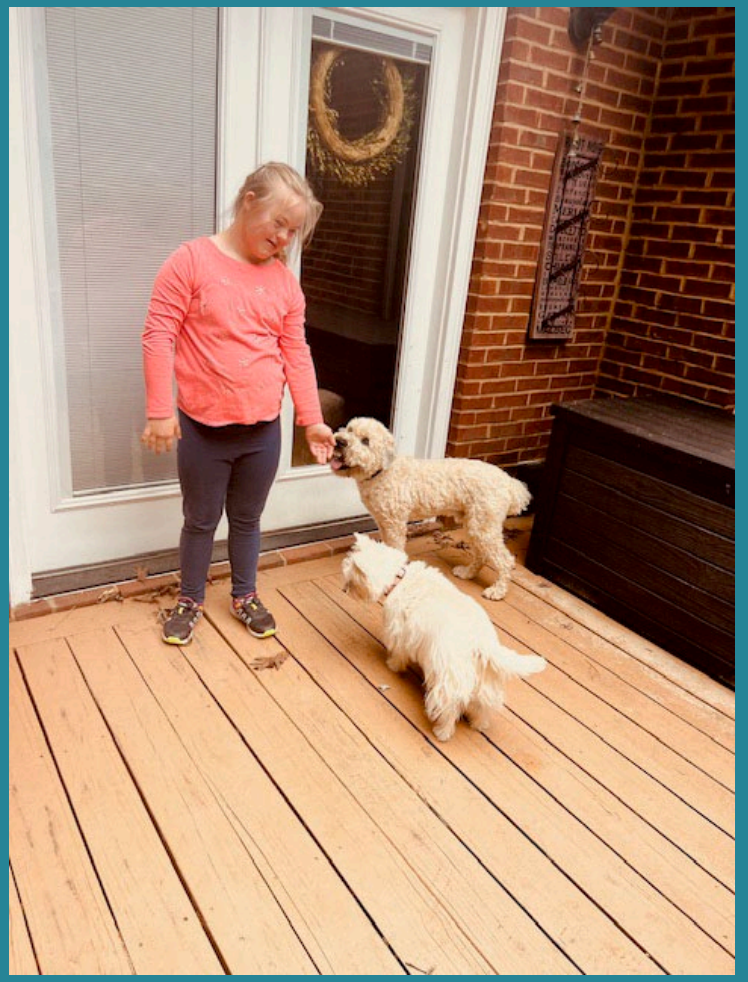
- Home based bakery, door deliveries before Covid made them cool
- Teaching valuable life skills – Processes, Math, People Skills
- Over 1,000 Facebook followers
- Over 250 regular customers
- Products to 7 states and Germany
- Positioned for future employment of her choice


THIS GIRL WILL
CHANGE THE WORLD


Lila's
Sweet trea
Sweet Treats. Sweeter Purpose.
www.limitlesslil


Made fresh for
#Limitless Lila
Dispelling myths about Down syndrome
LimitlessLila.com
SC
Partnership
of Disability
Organizations


POLICE



Limitless Purpose

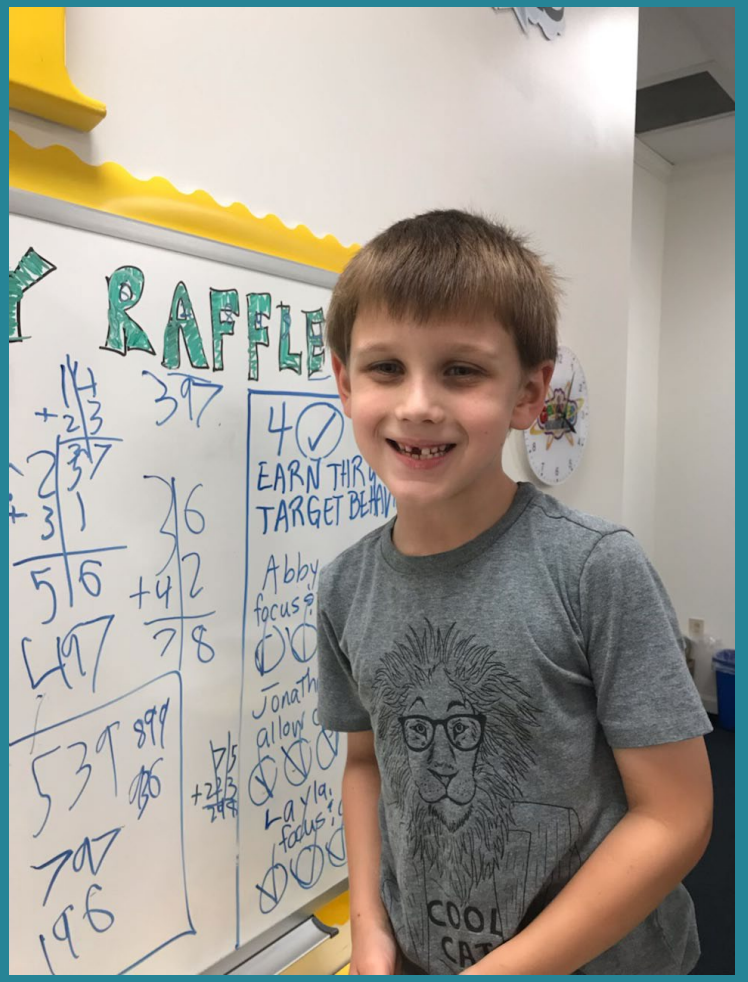
- Statewide Nonprofit officially founded in September 2019

- Held an **annual free event** for families since 2022

- **Limitless Library** - Received and distributed **more than 22,000 books**

- **Limitless Learner Summer Incentive Awards** – Awarded **nearly $55,000** to **more than 200 children and teens** with disabilities for summer camps, swim lessons, horseback riding, tutors and much more

- **Provide hope** and reassurance by **bringing together children and parents**


RAFFLE
COOL CAT


I am Limitless


Kids


IRMO
FIRE


Miracle

Limitless Lila . . .

Limitless Purpose . . .

Limitless Potential . . .

Limitless Possibilities

Monthly DDSN Staff Report - Financial Approval & Threshold Reporting for February 2024

The purpose of this monthly report is to ensure staff comprehensively reports on all Executive Limitation Policy (800-CP-03) financial transactions for approval and financial threshold reporting requirements. The Finance and Audit Committee will decide which items require presentation to the Commission for a formal vote, as well as which items need only be reported via this monthly report to the Commission to ensure transparent reporting. After the Finance and Audit Committee's decisions, this report will highlight item wording in red to notify Commission this will not need a formal vote and highlight items in yellow indicating item will require a formal Commission vote to approve.

I. **New Non-Service Contracts $200,000 or Greater**:

II. **Existing Service Contracts Increasing $200,000 or Greater (simple list if based on indiv. choice; detail summary if not)**:

Linen Contract for Coastal, Pee Dee and Saleeby is up for renewal and 5-year solicitation has been advertised.

$1.5M - $300K annually for Coastal ($150K increase over prior year spending plan level)
$2M - $400K annually for Pee Dee & Saleeby ($150K increase over prior year spending plan level)

Current Spending Plan approval levels are currently $935K for all four regional centers.

III. **$200,000 or Greater Increase in Personnel Positions for a Program or Division**:

Regional Center Shift Differentials:

Shift Code	Shift Code Text	Hours	Rate	Total Paid	Proposed Rate	Proposed Comparison	Estimated Increase
1212	Weekday (2nd)	173,402.04	$0.50	$ 86,701.02	$ 2.00	$ 346,804.08	$ 260,103.06
1213	Weekday (3rd)	227,311.60	$0.50	$113,655.80	$ 2.00	$ 454,623.20	$ 340,967.40
1214	Weekend (1st)	70,287.62	$0.50	$ 35,143.81	$ 2.00	$ 140,575.24	$ 105,431.43
1222	Weekend (2nd)	44,161.98	$0.50	$ 22,080.99	$ 3.50	$ 154,566.93	$ 132,485.94
1221	Weekend (3rd)	74,372.88	$0.50	$ 37,186.44	$ 3.50	$ 260,305.08	$ 223,118.64
Totals				**$ 294,768.06**		**$ 1,356,874.53**	**$ 1,062,106.47**

IV. **New CPIP or Re-Scoping of an Existing CPIP**:

1) **Coastal Retherm Equipment Replacement –** The scope of this project is to order New Retherm Equipment (Brand Specific to match other regional centers equipment). See attached quote of $760K. Also, the new equipment will require electrical panel modifications. An electrical engineer (Southern Energy Resources LLC) was hired to assess modifications required to accommodate the new equipment. Results from the assessment identified twelve existing buildings would require modifications. See below estimate of the retherm project:

Equipment - $760,226.92 (Aladin Temp Rite)
AE Fees - $29,600 (Southern Energy Resources LLC)
Installation: Electrical Modifications – approx. $175,000
Installation: Mechanical – approx. $65,000
DHEC Fees - $2,000
Special Inspections – approx. $5,000

Total – approx. 1,036,826.92
Contingency 10% - 103,682.69
ESTIMATED PROJECT TOTAL – 1,140,509.61

V. **New Consulting Contract**:

VI. **New Federal Grant**:

(NOTE: In July of each year, a report of all prior FY non-service expenditures by vendor over $200,000 will be presented as a "post-payment" review. This will add visibility for expenditures from contracts originated in prior FYs and vendors with separate purchases aggregating over $200,000 in current FY.)

DSN Commission Finance and Audit Committee Procedures
Commission Approved ~~August 18, 2022~~XXXX, 2024

This document sets forth the procedure to be used by the Finance and Audit Committee (the Committee) of the South Carolina Commission on Disabilities and Special Needs (the Commission).

I. SCOPE:

The Committee provides assistance to the Commission in fulfilling its oversight responsibilities relating to budgeting, accounting and financial reporting processes, and the performance of the internal audit function. The Committee will oversee South Carolina Department of Disabilities and Special Needs (DDSN) management processes and activities relating to:

a. Maintaining the reliability and integrity of DDSN's accounting policies, financial reporting practices, and internal controls;

b. Review significant accounting and reporting developments and issues;

c. The performance and work plan of the internal audit function in accordance with DDSN Directive 275-05-DD: General Duties of the DDSN Internal Audit Division;

d. Compliance with applicable laws, regulations, and DDSN directives;

e. Review and approval of the annual operating and capital budgets, as well as any amendments;

f. Analyzing financings and capital transactions being considered by DDSN and the adequacy of its capital structure; and

~~g. Review of DDSN fiscal related directives; and~~

~~h.~~g. Review of DDSN fiscal regulatory and oversight reports.

The Committee also provides an open avenue of communication between DDSN management, Internal Audit, and the Commission.

Consistent with the annual audit plan, the Committee has the authority to ~~conduct or~~ authorize investigations into any matters within its scope of responsibility. Inquiry and briefings on all significant financial matters along with related presentations and motions for full Commission approval originate from the Committee.

II. COMMITTEE MEMBERSHIP:

The Chair of the Commission will appoint members to the Committee. The Committee will consist of at least three (3) members of the Commission. Members will be sought that have relevant experience and/or fiscal expertise, but this is not a limiting factor related to Committee Membership. The members of the Committee will be appointed and may be removed by the Chair.

III. MEETING FREQUENCY:

The Committee will meet ~~monthly~~ quarterly or as determined by the Committee Chairperson based on the workflow of DDSN. Meetings of the Committee may be called by or at the request of the Commission, any member of the Committee, or the Chair of the Commission. Meetings will be held at the time and place designated in the meeting notice. The Chief Financial Officer, in coordination with other members of Executive Management, will prepare a suggested committee meeting agenda and share with the Committee Chair at least five days in advance of the scheduled meeting. Notice of the time, place, and agenda of the meetings will be posted as prescribed by the By-Laws and the South Carolina Freedom of Information Act. A majority of the appointed Committee members will represent a quorum and the actions of a quorum of the Committee shall be the act of the Committee. The Committee will retain minutes of each meeting.

IV. PROCEDURE:

A. Financial Reports/Budgets/Spending Plans

The Committee will consult with management concerning annual spending plans and budget processes, review budgets, projections of future financial performance, analysis of the financial effect of proposed transactions, borrowings, and capital structure. The Committee will review financial information with management in most cases before the information is presented to the Commission. The Committee will assist the Commission in analyzing financial information that is presented to them for review. The Committee will advise the Commission of finance matters that it believes require Commission attention.

Routine Committee business includes review and approval of staff prepared budgets, projects, and financial plans for general reasonableness of the underlying assumptions. The Committee will provide recommendations of approval or modification to the Commission.

~~B. Directives~~

~~The Committee shall receive fiscal-related directives for review and revision as referred by the DSN Commission Policy Committee or as referred by the Commission Chairman. Review and approval of directives follows Section III. A. of the Policy Committee Procedures: Committee Undertakes a Review of a Directive or Standards, listed below as adapted to conform to the Finance and Audit Committee.~~

~~"The Directive/Standard is reviewed by staff who will make revision recommendations regarding the document. A draft version, including staff recommendations, will be posted to the website and the public will have 10 business days to review and submit comments (see Directive 100-01-DD: Electronic Communications System)."~~

~~It is DDSN's intent to solicit feedback/input from all entities affected by the directives/standards; however, in rare cases the 10 business day period may not occur due to extenuating circumstances.~~

~~Committee members will be given a copy of the suggested staff changes prior to posting for public comment. This effort will provide the Committee members a chance to give their input prior to the Directive being posted so that changes can be made prior to posting for public comment.~~

~~After the 10 business day public review period, staff will consider and respond to each comment; make additional changes to the Directive or Standards; and present the Directive or Standards to the Finance and Audit Committee at a scheduled meeting. The Committee members may request additional changes and will determine which changes will be accepted based on the comments as well as staff recommendations.~~

~~When a consensus is reached by the Finance and Audit Committee, a version representing this consensus will be created for presentation to the DSN Commission for approval. Following approval, the document will be posted on the DDSN website under "Current DDSN Directives" or "Current DDSN Standards."~~

DSN Commission Finance and Audit Committee Procedures
Commission Approved XXXX, 2024

This document sets forth the procedure to be used by the Finance and Audit Committee (the Committee) of the South Carolina Commission on Disabilities and Special Needs (the Commission).

I. SCOPE:

The Committee provides assistance to the Commission in fulfilling its oversight responsibilities relating to budgeting, accounting and financial reporting processes, and the performance of the internal audit function. The Committee will oversee South Carolina Department of Disabilities and Special Needs (DDSN) management processes and activities relating to:

a. Maintaining the reliability and integrity of DDSN's accounting policies, financial reporting practices, and internal controls;

b. Review significant accounting and reporting developments and issues;

c. The performance and work plan of the internal audit function in accordance with DDSN Directive 275-05-DD: General Duties of the DDSN Internal Audit Division;

d. Compliance with applicable laws, regulations, and DDSN directives;

e. Review and approval of the annual operating and capital budgets, as well as any amendments;

f. Analyzing financings and capital transactions being considered by DDSN and the adequacy of its capital structure; and

g. Review of DDSN fiscal regulatory and oversight reports.

The Committee also provides an open avenue of communication between DDSN management, Internal Audit, and the Commission.

Consistent with the annual audit plan, the Committee has the authority to authorize investigations into any matters within its scope of responsibility. Inquiry and briefings on all significant financial matters along with related presentations and motions for full Commission approval originate from the Committee.

II. COMMITTEE MEMBERSHIP:

The Chair of the Commission will appoint members to the Committee. The Committee will consist of at least three (3) members of the Commission. Members will be sought that have relevant experience and/or fiscal expertise, but this is not a limiting factor related to Committee Membership. The members of the Committee will be appointed and may be removed by the Chair.

III. MEETING FREQUENCY:

The Committee will meet quarterly or as determined by the Committee Chairperson based on the workflow of DDSN. Meetings of the Committee may be called by or at the request of the Commission, any member of the Committee, or the Chair of the Commission. Meetings will be held at the time and place designated in the meeting notice. The Chief Financial Officer, in coordination with other members of Executive Management, will prepare a suggested committee meeting agenda and share with the Committee Chair at least five days in advance of the scheduled meeting. Notice of the time, place, and agenda of the meetings will be posted as prescribed by the By-Laws and the South Carolina Freedom of Information Act. A majority of the appointed Committee members will represent a quorum and the actions of a quorum of the Committee shall be the act of the Committee. The Committee will retain minutes of each meeting.

IV. PROCEDURE:

A. Financial Reports/Budgets/Spending Plans

The Committee will consult with management concerning annual spending plans and budget processes, review budgets, projections of future financial performance, analysis of the financial effect of proposed transactions, borrowings, and capital structure. The Committee will review financial information with management in most cases before the information is presented to the Commission. The Committee will assist the Commission in analyzing financial information that is presented to them for review. The Committee will advise the Commission of finance matters that it believes require Commission attention.

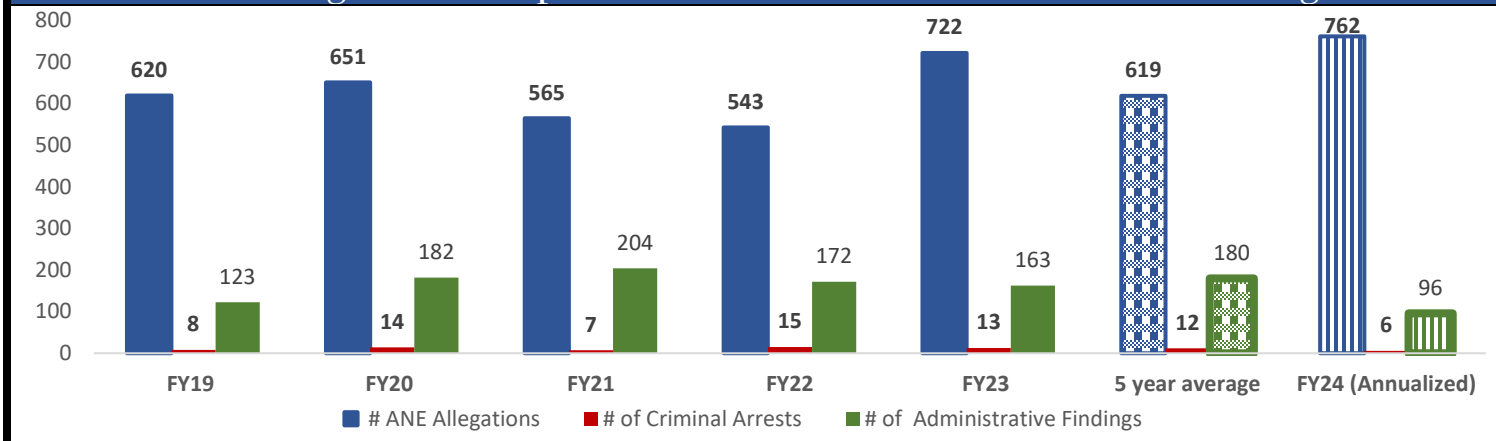
Routine Committee business includes review and approval of staff prepared budgets, projects, and financial plans for general reasonableness of the underlying assumptions. The Committee will provide recommendations of approval or modification to the Commission.

SCDDSN Incident Management Report 5-year trend data

for Community-Based Services *(Includes Residential & Day Service Settings) Thru 12/31/2023*

Allegations of Abuse, Neglect, Exploitation	FY19	FY20	FY21	FY22	FY23	5 YEAR Average	FY24 Annualized (Thru Q2)
# of Individual ANE Allegations	620	651	565	543	722	**619**	762 (381)
# of ANE Incident Reports (One report may involve multiple allegations)	415	436	388	389	511	**430**	530 (265)
Rate per 100	9.6	11.8	10.9	9.3	12.1	**10.8**	11.3
# ANE Allegations resulting in Criminal Arrest	8	14	7	15	13	**12**	6 (3)
# ANE Allegations with Administrative Findings from DSS or State Long-Term Care Ombudsman	123	182	204	172	163	**169**	96 (48)

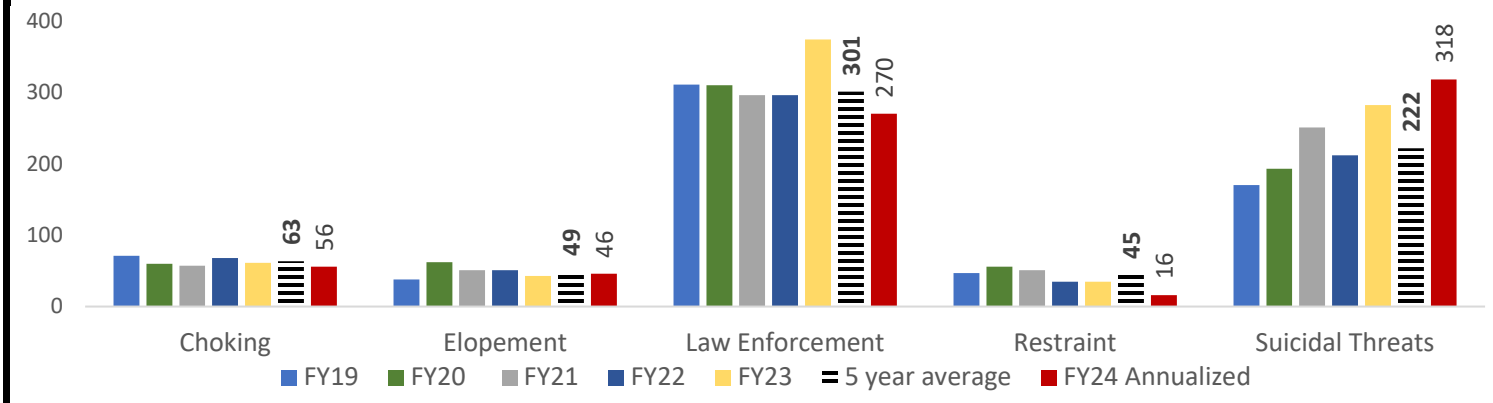
ANE Allegations: Comparison to Arrest Data & Administrative Findings



There was 1 ANE Report for FY24Q2 involving a child under the age of 18 in a Community Setting. All other reports were for adults.

Critical Incident Reporting	FY19	FY20	FY21	FY22	FY23	5 YEAR Average	FY24 Annualized (Thru Q2)
# Critical Incidents	916	982	974	1245	1265	**1076**	1270 (635)
Rate per 100	9.6	11.8	10.9	15.4	13.2	**12.2**	13.5
# Choking Events	71	65	57	68	61	**64**	56 (28)
# Law Enforcement Calls	311	310	296	296	292	**301**	270 (135)
# Suicidal Threats	170	193	251	212	282	**222**	318 (159)
# Emergency Restraints or Restraints w/ Injury	47	56	51	35	35	**45**	16 (8)

5 Year Critical Incident Trend Report- Community Settings



7 Critical Incident Reports involving a child under the age of 18 have been reported in FY24 in a Community Setting.

Death Reporting	FY19	FY20	FY21	FY22	FY23	5 YEAR Average	FY24 Annualized (Thru Q2)
# of Deaths Reported- Community Residential Settings	78	86	130	102	95	**98**	112 (56)
Rate per 100	1.6	1.9	2.8	2.2	2.0	**2.1**	2.2
# of Deaths reported for Waiver Participants living at home							360 (180)

Report Date: 2/5/2024

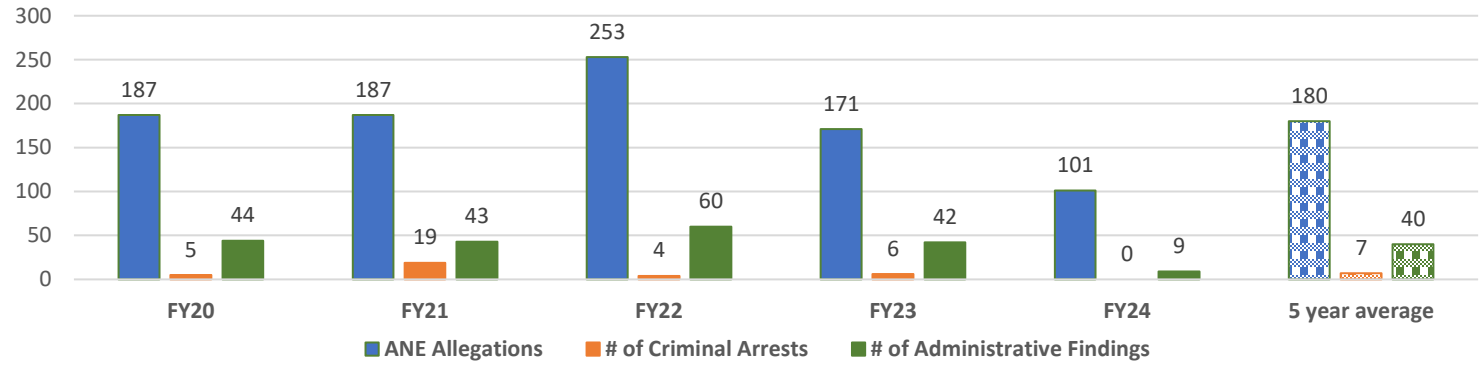
SCDDSN Incident Management Report 5-year trend data

Draft

for Regional Centers *Thru 1/31/2024*

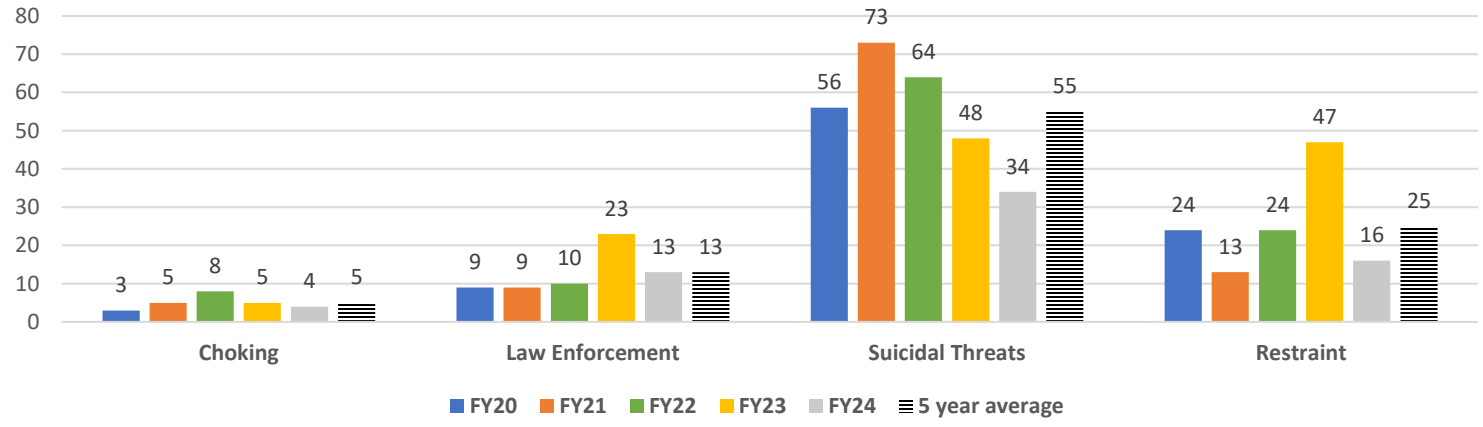
Allegations of Abuse, Neglect, & Exploitation	FY20	FY21	FY22	FY23	FY24	5 YEAR Average
# of Individual ANE Allegations	187	187	253	171	101	180
# of ANE Incident Reports (One report may involve multiple allegations)	136	138	167	138	79	132
Rate per 100	28.9	27.9	38.0	31.7	14.1	28.1
# ANE Allegations resulting in Criminal Arrest	5	19	4	6	0	7
# ANE Allegations with Administrative Findings from DSS or State Long-Term Care Ombudsman	44	43	60	42	9	40

ANE Allegations: Comparison to Arrest Data & Administrative Findings



There were 2 ANE reports for FY24 involving a minor.

Critical Incident Reporting	FY20	FY21	FY22	FY23	FY24	5 YEAR Average
# Critical Incidents	135	124	160	171	89	**136**
Rate per 100	20.8	19.1	24.2	24.8	15.8	**20.9**
# Choking Events	3	5	8	5	4	**5**
# Law Enforcement Calls	9	9	10	23	13	**13**
# Suicidal Threats	56	73	64	48	34	**55**
# Emergency Restraints or Restraints w/ Injury	24	13	24	47	16	**25**



There were 0 Critical Incident Reports for FY24 involving minors. All reports were for adults.

Death Reporting	FY20	FY21	FY22	FY23	FY24	5 YEAR Average
# of Deaths Reported - Regional Centers	22	48	36	21	11	**28**
Rate per 100	3.4	7.0	5.4	4.0	2.0	**4.4**

Summary of Amendments to S 915 and H 4927

Both **S 915 and H 4927** seek to implement changes to health agencies requested during the past legislative session as a part of **S. 399/Act 60. Act 60** mandated that the Dept of Administration hire a company, BCG, to study the SC Health system structure. These bills are a result of that study. The bills create an Executive Office of Health Policy which serves as a member of the Governor's cabinet. The Secretary would oversee the current agencies, Dept of Public Health, Health and Human Services, Dept of Aging, the Dept of Mental Health, the Dept of Alcohol and Other Drug Abuse Services (DAODAS) and DDSN.

The bills eliminate the current commission governance for all agencies, in place of the Health Secretary, and would be replaced in favor of advisory panels appointed by the Health Secretary.

They also direct a merger of the Department of Mental Health and DAODAS. The bills also change the names of the agencies and make those statutory adjustments.

Specifically, DDSN's name is changed to the **Department of Intellectual and Related Disabilities (DIRD).**

Amendments

The amendments proposed by BCG/Admin for the most part complete the administrative breakup of the DHEC into the Dept of Public Health and the Dept of Environmental Services.

In addition, to those changes, the Baby Net (0-3 early Intervention Program) has been transferred to DIRD.

There have also been some adjustments to the DDSN/DIRD statutes to give the agency enhanced contractual regulatory authority when dealing with providers.

Most other changes in the amendment are ministerial and technically administrative in nature.

South Carolina General Assembly
125th Session, 2023-2024

S. 915

STATUS INFORMATION

General Bill
Sponsors: Senators Peeler, Alexander, Setzler, Verdin, Davis, Hutto, Kimbrell, Young and Senn
Companion/Similar bill(s): 4927
Document Path: SR-0530KM24.docx

Introduced in the Senate on January 9, 2024
Currently residing in the Senate Committee on **Medical Affairs**

Summary: Executive Office of Health Policy

HISTORY OF LEGISLATIVE ACTIONS

Date	Body	Action Description with journal page number
1/9/2024	Senate	Introduced and read first time (Senate Journal-page 88)
1/9/2024	Senate	Referred to Committee on **Medical Affairs** (Senate Journal-page 88)

View the latest legislative information at the website

VERSIONS OF THIS BILL

01/09/2024

A BILL

TO AMEND THE SOUTH CAROLINA CODE OF LAWS SO AS TO CREATE THE EXECUTIVE OFFICE OF HEALTH AND POLICY AND PROVIDE FOR THE DUTIES OF THE SECRETARY OF THE AGENCY; BY AMENDING SECTION 1-30-10, RELATING TO DEPARTMENTS OF STATE GOVERNMENT, SO AS TO DISSOLVE SEVERAL DEPARTMENTS AND CREATE THE STATE OFFICE OF THE SECRETARY OF PUBLIC HEALTH AND POLICY; BY AMENDING SECTION 8-17-370, RELATING TO THE MEDIATION OF GRIEVANCES BY THE STATE HUMAN RESOURCES DIRECTOR SO AS TO ADD THE SECRETARY OF HEALTH AND POLICY, THE DIRECTORS OF THE COMPONENT DEPARTMENTS OF THE EXECUTIVE OFFICE OF HEALTH AND POLICY, AND ALL DIRECT REPORTS TO THE SECRETARY AND TO DIRECTORS OF THE COMPONENT DEPARTMENTS; BY AMENDING SECTION 43-21-70, RELATING TO THE EMPLOYMENT OF THE DIRECTOR OF THE DEPARTMENT AND ADVISORY COUNCIL ON AGING, SO AS TO PROVIDE THAT THE SECRETARY OF HEALTH AND POLICY SHALL APPOINT A DIRECTOR TO BE THE ADMINISTRATIVE OFFICER OF THE DEPARTMENT ON AGING; AND TO REPEAL TITLE 44, CHAPTER 9 RELATING TO THE STATE DEPARTMENT OF MENTAL HEALTH.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Title 44 of the S.C. Code is amended by adding:

CHAPTER 12

Executive Office of Health and Policy

Section 44-12-10. There is created within the executive branch of the state government an agency to be known as the Executive Office of Health and Policy with the organization, duties, functions, and powers defined in this Chapter and other applicable provisions of law.

Section 44-12-20. The Secretary of Health and Policy shall be the head and governing authority of the office. The secretary must be appointed by the Governor with the advice and consent of the Senate, subject to removal from office by the Governor pursuant to provisions of Section 1-3-240(B).

Section 44-12-30. As used in this chapter:

(1) “Secretary” means the Secretary of Health and Policy.

(2) “Office” means the Executive Office of Health and Policy.

(3) “Department” or “departments” mean any one or more of the component departments housed within the office.

(4) “State Health Plan” means the cohesive, coordinated, and comprehensive State Plan for public health services developed by the Secretary.

Section 44-12-40. In performing his duties as authorized by this chapter, the secretary:

(1) shall develop a cohesive, coordinated, and comprehensive State Health Plan for public health services provided by the component departments housed within the office so that there is a maximum level of coordination among the component departments. The plan should serve as a blueprint for the State to assess and improve the quality of care that South Carolinians receive. The plan should be continually updated and must include, at a minimum, an inventory, projections, and standards for health services, facilities, equipment, and workforce which have the potential to substantially impact delivery of care, costs, and accessibility within the State. The plan should also address how to improve health services delivery in the State, recognize operational efficiencies, and maximize resource utilization. The secretary shall establish and appoint members to a health planning advisory committee to provide advice in the development of the plan. Members of the advisory committee should include health care providers, consumers, payers, and public health professionals. Members of the advisory committee are allowed the usual mileage and subsistence as provided for members of boards, committees, and commissions;

(2) shall review and approve or disapprove all regulations promulgated by the component departments prior to their submission to the General Assembly;

(3) shall be the sole advisor of the State concerning all questions involving the protection of public health within its limits;

(4) shall have the authority to determine the appropriate course of treatment for patients with complex or co-occurring diagnoses necessitating involvement of two or more component departments;

(5) shall, subject to applicable federal law, require data sharing to the fullest extent possible among the component departments when necessary to accomplish the goals of the plan;

(6) shall, to the extent practicable, consolidate administrative services among the component departments. Consolidated administrative services include, but are not limited to:

(a) financial and accounting support, such as accounts payable and receivable processing, procurement processing, journal entry processing, and financial reporting assistance;

(b) human resources administrative support, such as transaction processing and reporting, payroll processing, and human resources training;

(c) budget support, such as budget transaction processing and budget reporting assistance; and

(d) information technology;

(7) shall, with regard to information technology, ensure that the office and the component departments comply with all plans, policies, and directives of the Department of Administration;

(8) may employ such persons as he determines are necessary to carry out the office's duties; and

(9) may enter into contracts with public agencies, institutions of higher education, and private organizations or individuals for the purpose of carrying out the office's duties.

Section 44-12-50. (A) The Executive Office of Health and Policy shall consist of the following component departments:

(1) the Department of Health Financing;

(2) the Department of Public Health;

(3) the Department on Aging;

(4) the Department of Intellectual and Related Disabilities; and

(5) the Department of Behavioral Health and Substance Abuse Services.

(B)(1) The component departments shall be headed by a department director appointed by the secretary with the advice and consent of the Senate. Department directors shall serve at the will and pleasure of the secretary. In the case of a vacancy in a department director's position prior to the appointment and confirmation of a successor, the secretary may assign an employee of the department or the office to perform the duties required of the vacant position on an interim basis.

(2) The secretary shall develop the budget for the office with each component department constituting a separate program area. The secretary shall consult with each component department director in developing the priorities and funding request for his component department.

(3) The secretary may, to the extent authorized through the annual appropriations act or relevant permanent law, organize the administration of the office, including the assignment of personnel to the office and among its component departments, as is necessary to carry out the office's duties.

Section 44-12-60. The component departments shall carry out their duties, functions, and powers as provided in their respective enabling statutes and as otherwise provided by laws subject to the management decisions, policy development, and standards established of and by the secretary as provided in this chapter.

SECTION 2. Section 1-30-10(A) of the S.C. Code is amended to read:

(A) There are hereby created, within the executive branch of the state government, the following departments:

1. Department of Administration

2. Department of Agriculture

~~3. Department of Alcohol and Other Drug Abuse Services~~

~~4.~~3. Department of Commerce

~~5.~~4. Department of Corrections

~~6. Department of Disabilities and Special Needs~~

~~7.~~5. Department of Education

~~8. Department of Public Health~~

~~9. Department of Health and Human Services~~

~~10.~~6. Department of Insurance

~~11.~~7. Department of Juvenile Justice

~~12.~~8. Department of Labor, Licensing and Regulation

~~13. Department of Mental Health~~

~~14.~~9. Department of Motor Vehicles

~~15.~~10. Department of Natural Resources

~~16.~~11. Department of Parks, Recreation and Tourism

~~17.~~12. Department of Probation, Parole and Pardon Services

~~18.~~13. Department of Public Safety

~~19.~~14. Department of Revenue

~~20.~~15. Department of Social Services

~~21.~~16. Department of Transportation

~~22.~~17. Department of Employment and Workforce

~~23. Department on Aging~~

~~24.~~18. Department of Veterans' Affairs.

~~25.~~19 Department of Environmental Services

20. State Office of the Secretary of Public Health and Policy

SECTION 3. Section 8-17-370 of the S.C. Code is amended by adding:

(21) The Secretary of Health and Policy, the directors of the component departments of the Executive Office of Health and Policy, and all direct reports to the Secretary and to directors of the component departments.

SECTION 4. Section 43-21-70 of the S.C. Code is amended to read:

Section 43-21-70. The ~~Governor~~ Secretary of Health and Policy shall appoint with the advice and consent of the Senate a director to be the administrative officer of the Department on Aging who shall serve at the Governor's pleasure and who is subject to removal pursuant to the provisions of Section 1-3-240.

SECTION 5. The Code Commissioner is directed to change the following headings in the S.C. Code:

(1) Article 1, Chapter 6, Title 44 shall be styled as "State Department of Health and Human Services";

(2) Chapter 1, Title 44 shall be styled as "Department of Public Health";

(3) Chapter 20, Title 44 shall be styled as "Department of Disabilities and Special Needs"; and

(4) Chapter 9, Title 44 shall be styled as "Department of Mental Health".

SECTION 6. Chapter 9, Title 44 of the S.C. Code is repealed.

SECTION 7. (A) Upon the effective date of this Act, the Directors of the Departments of Public Health and Aging shall serve as the interim department directors of their respective departments within the Executive Office of Health and Policy, unless otherwise removed by the Secretary of Health and Policy, until such time as a successor is appointed and assumes the position following confirmation by the Senate. The Director of the Department of Health and Human Services shall serve as the interim Director of the Department of Health Financing, unless otherwise removed by the Secretary of Health and Policy, until such time as a successor is appointed and assumes the position following confirmation by the Senate. The Director of the Department of Disabilities and Special Needs shall serve as the interim Director of the Department of Intellectual and Related Disabilities, unless otherwise removed by the Secretary of Health and Policy, until such time as a successor is appointed and assumes the position following confirmation by the Senate. In the case of a vacancy in the director's position in one or more of the departments on or after the effective date of this act and prior to the appointment and confirmation of a successor, the Secretary of Health and Policy may assign an employee of the department or the Executive Office of Health and Policy to perform the duties required of the vacant position in the interim.

(B) Upon the effective date of this Act, the Director of the Department of Mental Health shall serve as the interim director of the Department of Behavioral Health and Substance Abuse Services, unless otherwise removed by the Secretary of Health and Policy, until such time as a successor is appointed and assumes his or her duties. In the case of a vacancy in the director's position at the Department of Behavioral Health and Substance Abuse Services on or after the effective date of this act and prior to the appointment and confirmation of a successor, the Secretary of Health and Policy may assign an employee of the department or the Executive Office of Health and Policy to perform the duties required of the vacant position in the interim.

(C) Upon the effective date of this act, the Director of the Department of Alcohol and Other Drug Abuse Services shall serve as the interim director of the Division on Alcohol and Drug Addiction of the Department of Behavioral Health and Substance Abuse Services until such time as a replacement

is appointed by the director of the Department of Behavioral Health and Substance Abuse Services. Prior to the appointment and confirmation of the director of the Department of Behavioral Health and Substance Abuse Services, the Secretary of Health and Policy has the discretion to remove the division director. In the case of a vacancy in the director's position at the Department of Alcohol and Drug Addiction or the Division on Alcohol and Drug Addiction on or after the effective date of this act and prior to the appointment of a successor by the director of the Department of Behavioral Health and Substance Abuse Services, the Secretary of Health and Policy may assign an employee of the department or the Executive Office of Health and Policy to perform the duties required of the vacant position in the interim.

(D) Nothing in this act prevents the Secretary of Health and Policy from reappointing the directors of their respective departments serving in those roles as of the effective date of this act.

(E) The Governor's initial appointee as Secretary of Health and Policy shall serve in an interim capacity with the powers and duties assigned to the Secretary through this act until such time as the Senate provides advise and consent regarding the appointment. Should the Senate not advise and consent to the initial appointee prior to sine die adjournment of the 2025 regular session, the office shall be vacant, and the interim appointee shall not serve in hold over status.

SECTION 8. (A) Except for personnel and funds transferred pursuant to subsection (B) of this Section, the Departments of Health Financing, Public Health, Aging, and Intellectual and Related Disabilities shall operate as component departments of the Executive Office of Health and Policy in the 2024-25 fiscal year using the authority and funds appropriated to the Departments of Health and Human Services, Public Health, Aging, and Disabilities and Special Needs as standalone agencies in the appropriations act of 2024. Except for personnel and funds transferred pursuant to subsection (B) of this Section, the Department of Behavioral Health and Substance Abuse Services shall operate as a component department of the Executive Office of Health and Policy in the 2024-25 fiscal year using the authority and funds appropriated to the Departments of Mental Health and Alcohol and Other Drug Abuse Services as standalone agencies in the appropriations act of 2024.

(B) Upon appointment and confirmation, the Secretary of Health and Policy may cause the transfer to the Executive Office of Health and Policy such: (1) personnel and attendant funding included in the administrative areas of the 2024 appropriations act and (2) operating expenses included in the administrative areas of the 2024 appropriations act of one or more of the component departments of the Office as, in the determination of the Secretary, is necessary to carry out the duties of the Office. The Department of Administration shall cause all necessary actions to be taken to accomplish any such transfer and shall in consultation with the Secretary prescribe the manner in which the transfer provided for in this section shall be accomplished. The Department of Administration's action in facilitating the provisions of this section are ministerial in nature and shall not be construed as an approval process

over any of the transfers.

(C) Except for those positions transferred pursuant to this section or otherwise specifically referenced in this act, employees of the Departments of Health and Human Services, Public Health, Aging, Disabilities and Special Needs, Mental Health, or Alcohol and Other Drug Abuse Services shall maintain their same status with the appropriate component department of the Executive Office of Health and Policy. Employees of the Departments of Public Health and Aging shall become employees of their respective departments within the Executive Office of Health and Policy. Employees of the Department of Health and Human Services shall become employees of the Department of Health Financing within the Executive Office of Health and Policy. Employees of the Departments of Mental Health and Alcohol and Other Drug Abuse Services shall become employees of the Department of Behavioral Health and Substance Abuse Services within the Executive Office of Health and Policy.

(D) Nothing in this act affects bonded indebtedness, if applicable, real and personal property, assets, liabilities, contracts, regulations, or policies of the Departments of Health and Human Services, Public Health, Aging, Disabilities and Special Needs, Mental Health, or Alcohol and Other Drug Abuse Services existing on the effective date. All applicable bonded indebtedness, real and personal property, assets, liabilities, contracts, regulations, or policies shall continue in effect in the name of the Executive Office of Health and Policy or the appropriate component division.

SECTION 9. This act takes effect upon approval by the Governor.

----XX----

South Carolina General Assembly
125th Session, 2023-2024

H. 4927

STATUS INFORMATION

General Bill
Sponsors: Reps. Herbkersman, W. Newton and G.M. Smith
Companion/Similar bill(s): 915
Document Path: LC-0370VR24.docx

Introduced in the House on January 24, 2024
Currently residing in the House Committee on **Judiciary**

Summary: Executive Office of Health Policy

HISTORY OF LEGISLATIVE ACTIONS

Date	Body	Action Description with journal page number
1/24/2024	House	Introduced and read first time (House Journal-page 16)
1/24/2024	House	Referred to Committee on **Judiciary** (House Journal-page 16)

View the latest legislative information at the website

VERSIONS OF THIS BILL

01/24/2024

A BILL

TO AMEND THE SOUTH CAROLINA CODE OF LAWS BY ADDING CHAPTER 12 TO TITLE 44 SO AS TO CREATE THE "EXECUTIVE OFFICE OF HEALTH AND POLICY", TO PROVIDE FOR THE DUTIES OF THE SECRETARY OF THE OFFICE, AND TO PROVIDE FOR THE RESTRUCTURING OF CERTAIN DEPARTMENTS OF STATE GOVERNMENT TO BECOME COMPONENT DEPARTMENTS OF THE OFFICE; BY AMENDING SECTION 1-30-10, RELATING TO DEPARTMENTS OF STATE GOVERNMENT, SO AS TO MAKE CONFORMING CHANGES; BY AMENDING SECTION 8-17-370, RELATING TO THE MEDIATION OF GRIEVANCES BY THE STATE HUMAN RESOURCES DIRECTOR, SO AS TO ADD THE SECRETARY OF HEALTH AND POLICY, THE OFFICE'S COMPONENT DEPARTMENT DIRECTORS, AND OTHERS TO THE LIST OF EXEMPTED PUBLIC EMPLOYEES; BY AMENDING SECTION 43-21-70, RELATING TO THE EMPLOYMENT OF THE DIRECTOR OF THE DEPARTMENT ON AGING, SO AS TO MAKE CONFORMING CHANGES, AND FOR OTHER PURPOSES; AND BY REPEALING CHAPTER 9 OF TITLE 44 RELATING TO THE STATE DEPARTMENT OF MENTAL HEALTH.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Title 44 of the S.C. Code is amended by adding:

CHAPTER 12

Executive Office of Health and Policy

Section 44-12-10. There is created within the executive branch of the state government an agency to be known as the Executive Office of Health and Policy with the organization, duties, functions, and powers defined in this chapter and other applicable provisions of law.

Section 44-12-20. The Secretary of Health and Policy shall be the head and governing authority of the office. The secretary must be appointed by the Governor with the advice and consent of the Senate, subject to removal from office by the Governor pursuant to the provisions of Section 1-3-240(B).

Section 44-12-30. As used in this chapter:

(1) "Secretary" means the Secretary of Health and Policy.

(2) "Office" means the Executive Office of Health and Policy.

(3) “Department” or “departments” means any one or more of the component departments housed within the office.

(4) “State Health Plan” means the cohesive, coordinated, and comprehensive state plan for public health services developed by the secretary.

Section 44-12-40. In performing his duties as authorized by this chapter, the secretary:

(1) shall develop a cohesive, coordinated, and comprehensive State Health Plan for public health services provided by the component departments housed within the office so that there is a maximum level of coordination among the component departments. The plan should serve as a blueprint for the State to assess and improve the quality of care that South Carolinians receive. The plan should be continually updated and must include, at a minimum, an inventory, projections, and standards for health services, facilities, equipment, and workforce which have the potential to substantially impact delivery of care, costs, and accessibility within the State. The plan should also address how to improve health services delivery in the State, recognize operational efficiencies, and maximize resource utilization. The secretary shall establish and appoint members to a health planning advisory committee to provide advice in the development of the plan. Members of the advisory committee should include health care providers, consumers, payers, and public health professionals. Members of the advisory committee are allowed the usual mileage and subsistence as provided for members of boards, committees, and commissions;

(2) shall review and approve or disapprove all regulations promulgated by the component departments prior to their submission to the General Assembly;

(3) shall be the sole advisor of the State concerning all questions involving the protection of public health within its limits;

(4) shall have the authority to determine the appropriate course of treatment for patients with complex or co-occurring diagnoses necessitating involvement of two or more component departments;

(5) shall, subject to applicable federal law, require data sharing to the fullest extent possible among the component departments when necessary to accomplish the goals of the plan;

(6) shall, to the extent practicable, consolidate administrative services among the component departments. Consolidated administrative services include, but are not limited to:

(a) financial and accounting support, such as accounts payable and receivable processing, procurement processing, journal entry processing, and financial reporting assistance;

(b) human resources administrative support, such as transaction processing and reporting, payroll processing, and human resources training;

(c) budget support, such as budget transaction processing and budget reporting assistance; and

(d) information technology;

(7) shall, with regard to information technology, ensure that the office and the component

departments comply with all plans, policies, and directives of the Department of Administration;

(8) may employ such persons as he determines are necessary to carry out the office's duties; and

(9) may enter into contracts with public agencies, institutions of higher education, and private organizations or individuals for the purpose of carrying out the office's duties.

Section 44-12-50. (A) The Executive Office of Health and Policy shall consist of the following component departments:

(1) the Department of Health Financing;

(2) the Department of Public Health;

(3) the Department on Aging;

(4) the Department of Intellectual and Related Disabilities; and

(5) the Department of Behavioral Health and Substance Abuse Services.

(B)(1) The component departments shall be headed by a department director appointed by the secretary. Department directors shall serve at the will and pleasure of the secretary. In the case of a vacancy in a department director's position prior to the appointment of a successor, the secretary may assign an employee of the department or the office to perform the duties required of the vacant position on an interim basis.

(2) The secretary shall develop the budget for the office with each component department constituting a separate program area. The secretary shall consult with each component department director in developing the priorities and funding request for his component department.

(3) The secretary may, to the extent authorized through the annual appropriations act or relevant permanent law, organize the administration of the office, including the assignment of personnel to the office and among its component departments, as is necessary to carry out the office's duties.

Section 44-12-60. The component departments shall carry out their duties, functions, and powers as provided in their respective enabling statutes and as otherwise provided by laws subject to the management decisions, policy development, and standards established of and by the secretary as provided in this chapter.

SECTION 2. Section 1-30-10(A) of the S.C. Code is amended to read:

(A) There are hereby created, within the executive branch of the state government, the following departments:

1. Department of Administration

2. Department of Agriculture

~~3. Department of Alcohol and Other Drug Abuse Services~~

~~4.~~3. Department of Commerce

~~5.~~4. Department of Corrections

~~6. Department of Disabilities and Special Needs~~

~~7.~~5. Department of Education

~~8. Department of Public Health~~

~~9. Department of Health and Human Services~~

~~10.~~6. Department of Insurance

~~11.~~7. Department of Juvenile Justice

~~12.~~8. Department of Labor, Licensing and Regulation

~~13. Department of Mental Health~~

~~14.~~9. Department of Motor Vehicles

~~15.~~10. Department of Natural Resources

~~16.~~11. Department of Parks, Recreation and Tourism

~~17.~~12. Department of Probation, Parole and Pardon Services

~~18.~~13. Department of Public Safety

~~19.~~14. Department of Revenue

~~20.~~15. Department of Social Services

~~21.~~16. Department of Transportation

~~22.~~17. Department of Employment and Workforce

~~23. Department on Aging~~

~~24.~~18. Department of Veterans' Affairs.

~~25.~~19. Department of Environmental Services

20. Executive Office of Health and Policy

SECTION 3. Section 8-17-370 of the S.C. Code is amended by adding:

(21) The Secretary of Health and Policy, the directors of the component departments of the Executive Office of Health and Policy, and all direct reports to the Secretary and to directors of the component departments.

SECTION 4. Section 43-21-70 of the S.C. Code is amended to read:

Section 43-21-70. The ~~Governor~~ Secretary of Health and Policy shall appoint with the advice and consent of the Senate a director to be the administrative officer of the Department on Aging who shall serve at the Governor's pleasure and who is subject to removal pursuant to the provisions of Section 1-3-240.

SECTION 5. The Code Commissioner is directed to change the following headings in the S.C. Code:

(1) Article 1, Chapter 6, Title 44 shall be entitled "State Department of Health and Human Services";

(2) Chapter 1, Title 44 shall be entitled "Department of Public Health";

(3) Chapter 20, Title 44 shall be entitled "Department of Intellectual and Related Disabilities"; and

(4) Chapter 9, Title 44 shall be entitled "Department of Mental Health".

SECTION 6. Chapter 9, Title 44 of the S.C. Code is repealed.

SECTION 7. (A) Upon the effective date of this act, the Directors of the Departments of Public Health and Aging shall serve as the interim department directors of their respective departments within the Executive Office of Health and Policy, unless otherwise removed by the Secretary of Health and Policy, until such time as a successor is appointed by the secretary and assumes the position. The Director of the Department of Health and Human Services shall serve as the interim Director of the Department of Health Financing, unless otherwise removed by the Secretary of Health and Policy, until such time as a successor is appointed by the secretary and assumes the position. The Director of the Department of Disabilities and Special Needs shall serve as the interim Director of the Department of Intellectual and Related Disabilities, unless otherwise removed by the Secretary of Health and Policy, until such time as a successor is appointed by the secretary and assumes the position. In the case of a vacancy in the director's position in one or more of the departments on or after the effective date of this act and prior to the appointment of a successor, the Secretary of Health and Policy may assign an employee of the department or the Executive Office of Health and Policy to perform the duties required of the vacant position in the interim.

(B) Upon the effective date of this act, the Director of the Department of Mental Health shall serve as the interim Director of the Department of Behavioral Health and Substance Abuse Services, unless otherwise removed by the Secretary of Health and Policy, until such time as a successor is appointed by the secretary and assumes the position. In the case of a vacancy in the director's position at the Department of Behavioral Health and Substance Abuse Services on or after the effective date of this act and prior to the appointment of a successor, the Secretary of Health and Policy may assign an employee of the department or the Executive Office of Health and Policy to perform the duties required of the vacant position in the interim.

(C) Upon the effective date of this act, the Director of the Department of Alcohol and Other Drug Abuse Services shall serve as the interim Director of the Division on Alcohol and Drug Addiction of the Department of Behavioral Health and Substance Abuse Services until such time as a replacement is appointed by the Director of the Department of Behavioral Health and Substance Abuse Services. Prior to the appointment of the Director of the Department of Behavioral Health and Substance Abuse Services, the Secretary of Health and Policy has the discretion to remove the division director. In the

case of a vacancy in the director's position at the Department of Alcohol and Other Drug Abuse Services or the Division on Alcohol and Drug Addiction on or after the effective date of this act and prior to the appointment of a successor by the Director of the Department of Behavioral Health and Substance Abuse Services, the Secretary of Health and Policy may assign an employee of the department or the Executive Office of Health and Policy to perform the duties required of the vacant position in the interim.

(D) Nothing in this act prevents the Secretary of Health and Policy from reappointing the directors of their respective departments serving in those roles as of the effective date of this act.

(E) The Governor's initial appointee as Secretary of Health and Policy shall serve in an interim capacity with the powers and duties assigned to the Secretary through this act until such time as the Senate provides advise and consent regarding the appointment. Should the Senate not advise and consent to the initial appointee prior to sine die adjournment of the 2025 regular session, the office shall be vacant, and the interim appointee shall not serve in hold over status.

SECTION 8. (A) Except for personnel and funds transferred pursuant to subsection (B) of this Section, the Departments of Health Financing, Public Health, Aging, and Intellectual and Related Disabilities shall operate as component departments of the Executive Office of Health and Policy in the 2024-2025 Fiscal Year using the authority and funds appropriated to the Departments of Health and Human Services, Public Health, Aging, and Disabilities and Special Needs as standalone agencies in the appropriations act of 2024. Except for personnel and funds transferred pursuant to subsection (B) of this Section, the Department of Behavioral Health and Substance Abuse Services shall operate as a component department of the Executive Office of Health and Policy in the 2024-2025 Fiscal Year using the authority and funds appropriated to the Departments of Mental Health and Alcohol and Other Drug Abuse Services as standalone agencies in the appropriations act of 2024.

(B) Upon appointment and confirmation, the Secretary of Health and Policy may cause the transfer to the Executive Office of Health and Policy such: (1) personnel and attendant funding included in the administrative areas of the 2024 appropriations act and (2) operating expenses included in the administrative areas of the 2024 appropriations act of one or more of the component departments of the Office as, in the determination of the Secretary, is necessary to carry out the duties of the Office. The Department of Administration shall cause all necessary actions to be taken to accomplish any such transfer and shall in consultation with the Secretary prescribe the manner in which the transfer provided for in this section shall be accomplished. The Department of Administration's actions in facilitating the provisions of this section are ministerial in nature and shall not be construed as an approval process over any of the transfers.

(C) Except for those positions transferred pursuant to this section or otherwise specifically referenced in this act, employees of the Departments of Health and Human Services, Public Health, Aging,

Disabilities and Special Needs, Mental Health, or Alcohol and Other Drug Abuse Services shall maintain their same status with the appropriate component department of the Executive Office of Health and Policy. Employees of the Departments of Public Health and Aging shall become employees of their respective departments within the Executive Office of Health and Policy. Employees of the Department of Health and Human Services shall become employees of the Department of Health Financing within the Executive Office of Health and Policy. Employees of the Departments of Mental Health and Alcohol and Other Drug Abuse Services shall become employees of the Department of Behavioral Health and Substance Abuse Services within the Executive Office of Health and Policy. Employees of the Department of Disabilities and Special Needs shall become employees of the Department of Intellectual and Related Disabilities.

(D) Nothing in this act affects bonded indebtedness, if applicable, real and personal property, assets, liabilities, contracts, regulations, or policies of the Departments of Health and Human Services, Public Health, Aging, Disabilities and Special Needs, Mental Health, or Alcohol and Other Drug Abuse Services existing on the effective date. All applicable bonded indebtedness, real and personal property, assets, liabilities, contracts, regulations, or policies shall continue in effect in the name of the Executive Office of Health and Policy or the appropriate component division.

SECTION 9. This act takes effect upon approval by the Governor.

----XX----

Act 60 Health Analysis
Addendum to Interim Report

January 9, 2024

Submitted by Boston Consulting Group

Introduction and executive summary

In advance of the final report which will contain the complete recommendations, rationale, and key implications that will be shared with the designated State leaders on or before April 1, 2024, Boston Consulting Group (BCG) has provided the following targeted addendum to the interim report provided January 1, 2024 to address a selection of recommendations that may require statutory change in the 2024 legislative session.

As outlined in the interim report, there are seven emerging recommendation areas for consideration (see Exhibit A).

Exhibit A: Emerging recommendations

This addendum addresses the following recommendations and sub-set of opportunities:

Recommendation #1: Streamline state agency structure and roles. As discussed in the interim report, South Carolina's model – of 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 navigate to services and support more efficient and effective service delivery across agencies.

- Strengthen coordination of health and human service operations via a central organization. The State should create a central entity responsible for coordinating health and/or human services agencies across the State 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 that focus on Medicaid, Public Health, Mental Health, Substance Use, Disabilities and Aging, would be a meaningful step in the right direction on its own. In addition, to align the governance models across the in-scope

agencies, the State should move away from the current DMH and DDSN Commission structures to have agency directors directly appointed by the leader of the new entity. However, to preserve the Commissions' expertise and local understanding, the Commissions should be maintained as advisory boards. Lastly, in designing the central organization, the State should consider the organization's role in policy development and operations, and the level of integration of activities between the central organization and in-scope agencies.

- Integrate agencies with similar missions within the central organization. After detailed review of the roles of the current state health agencies and benchmarking against other states, there are two agencies that are strong candidates for operational integration under the central organization. South Carolina should consider merging agency operations for DMH and DAODAS to deliver more integrated behavioral health services for constituents, lower administrative inefficiencies, and unlock new funding opportunities. While there are potentially coordination benefits 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 given the different population needs and program administration required compared with mental health and substance use care & supports.

Recommendation #2: Build 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. The ability to do this is reliant upon the creation of a central organization contemplated in the recommendation above, providing one common leader with the power to bring agencies together to deliver on the following recommendations.

- Build a comprehensive plan for health & human services across the State: To lay the groundwork for interagency coordination, the State should establish a central planning process to develop cross-agency priorities, goals, and action plans, including broad-based participation across all agencies and input from relevant external stakeholders.
- Strengthen accountability & coordination across agencies: The State should build and maintain tracking dashboards for leaders to regularly monitor progress towards cross-agency goals. In addition, cross-agency leadership should have meetings on a regular basis to discuss key issues, track progress, and address any issues that arise.
- Improve complex case coordination across state agencies: 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. In addition, the State should evaluate ways to 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 & operations: Agencies have access to a wealth of health and demographic information on South Carolina residents; however, today the potential of this data to serve constituents is largely untapped. To take advantage of this data, the State should create a data sharing plan across health & human services agencies, led by the new central entity 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,

exchange frequency, and agency owners. The State should also implement stronger long-term data sharing agreements between agencies and develop harmonized data governance standards (e.g., privacy, security) to make it easier to share data with faster approval processes. To enable these activities, the State should further modernize agency data systems and create flexible data linkages between these systems.

Recommendation #3: Improve quality of services in the State. As discussed in the interim report, there is an inconsistent quality of care across service types and geographies in the State today. Other states have considered improving healthcare quality through improvements to oversight over county-run and state-run providers, accountability of their Medicaid managed care organizations (MCOs), and innovation in care models to better care for complex populations. While the final report will address each of these opportunities in further detail, this addendum focuses on the opportunity to improve the quality of county-run providers focused on substance use and disabilities (301s, DSN boards).

- Improve state oversight over county-run healthcare providers: To address the inconsistent quality and service mix across 301s and DSN boards today, the State should establish a statewide strategy for ensuring sufficient patient quality and access, set more comprehensive standards, re-evaluate its monitoring requirements, better support new or struggling providers, and enforce non-compliance more rigorously through transparent processes for how and when enforcement actions will be used. To enable the above, the State will have to amend the DAODAS and DDSN enabling statutes to provide these agencies explicit authority to carry out these functions.
- Increase & streamline funding for substance use disorder services: The State spends approximately 70% less per capita in state funding on substance use treatment than both other South Atlantic states and all U.S. states.[1] As such, the State should consider ways to increase total funding for substance use disorder services through increasing state appropriated funding, shifting a greater proportion of the state liquor tax to substance use activities, and better using Medicaid's federal match on state dollars spent on substance use for Medicaid members. In addition, the State should consider reducing the fragmentation of funding for substance use by pooling the administration of the state liquor tax with other state funds for substance use to direct these funds more effectively.

Note that the above recommendations and the additional recommendations not contemplated in this addendum are to be further detailed and are subject to change based on additional review and consultation with relevant stakeholders. The final report will have the comprehensive set of recommendations for consideration and will be provided on or before April 1, 2024.

[1] South Atlantic states include DE, FL, GA, MD, NC, SC, VA, WV. South Carolina Substance Use Disorder Treatment Policy Brief – October 2021. Data as of 2020.

Recommendation #1: Streamline state agency structure & 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 – of eight independent agencies – makes it the most fragmented of any state in the United States.

The fragmented nature of the agency structure 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 disabilities and mental health conditions, Medicaid covers medical expenses, day services are provided by DDSN, and mental health services are provided by DMH, but there is minimal shared care management across to ensure a holistic, integrated experience.

In addition to the constituent-facing challenges, the internal operations to deliver these services are less efficient and effective than they could be given the current structure. Agencies often have dedicated staff deployed to similar work without a coordinating infrastructure (e.g., shared processes, common technology) to work across agencies. The statewide move toward shared services has started to alleviate the internal operations challenges, but further opportunity remains.

The opportunities to streamline state agency structure and roles are to:

- Strengthen coordination of health and human service operations via a central organization
- Integrate agencies with similar missions within the central organization

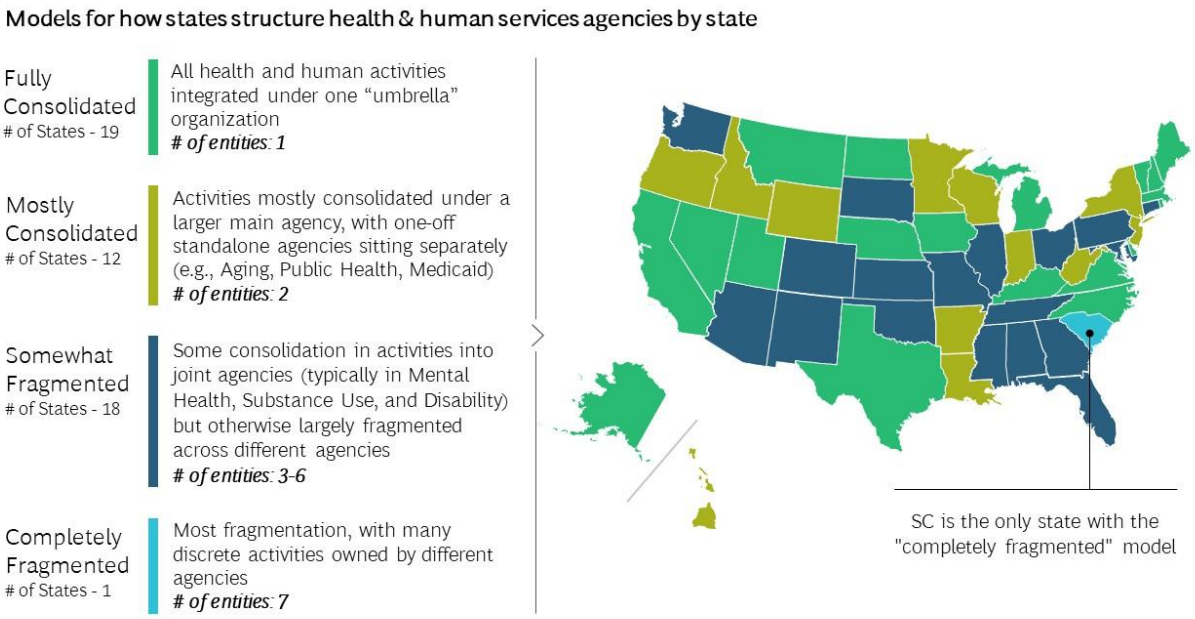
As the State contemplates changes to structure and roles, it is critical to balance the benefits of increased integration with maintaining the distinct role each agency plays in responding to the needs of the population they serve. Therefore, in the forthcoming section, the recommendations include ways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

Strengthen coordination of health and human service operations via a central organization

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 B).

Exhibit B: South Carolina's fragmented health and human services structure vs. other U.S. states

South Carolina has the most fragmented health and human services agency structure vs. all other states



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

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 & human services ecosystem, both in strategy setting (e.g., developing 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 approach to gain 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.

There are multiple approaches to achieve this coordination – from adjusting agency mandates to take on this coordination explicitly to building a new organization to take on this role. Given South Carolina does not have an agency or other government organization (e.g., a centralized strategy office) today that has 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, and 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 mandates.

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 the State should take into account when designing the new entity:

First, the State should consider which agencies to include within the new entity. The majority of states (19) who have an umbrella organization have oversight across all of health and human services agencies. However, there are a handful of states[2] (3) that 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 given 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 one entity, although creating an entity over all the health-related agencies would be a meaningful step in the right direction on its own.

Second, the State will have 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 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 – only Missouri and Mississippi[3] have Commissions today. Given the important role the Commissions play today 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.

Lastly, in developing the new entity, the State must conduct a detailed review of activity at each relevant agency and if / how that activity 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 this new entity. The review will also ensure the commensurate level of resourcing exists within the new entity to execute on their role, including newly added activities like strategic planning and data & analytics.

While development of a new entity will be a significant change for the State, it will enable increased chance of success for many of the other recommendations offered in this report.

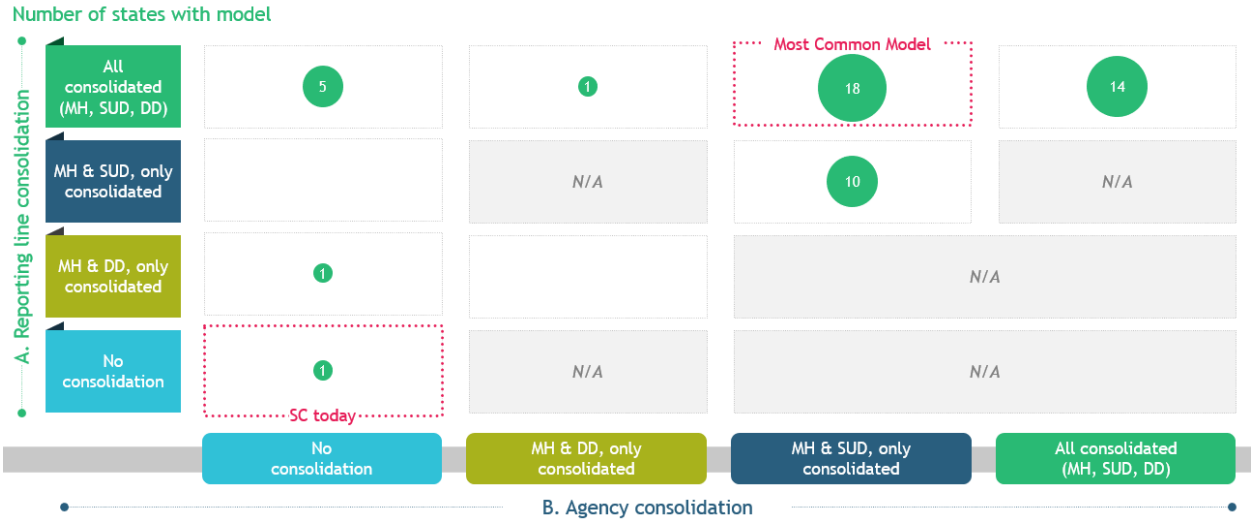
Integrate agencies with similar missions within the central organization

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

[2] Louisiana, Wisconsin, Wyoming
[3] NRI, 2020; State Agency Websites

An analysis of the health and human services-related agency structures across the United States indicated mental health and substance use agencies were most often merged with another agency; mental health only stands alone in 7 states while substance use does in 6 states. 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 together in other states.[4]

Exhibit C: Mental health and substance use is consolidated at both reporting line & 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 NRI's 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

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.[5] States that have integrated mental health and substance use agencies have seen benefit 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.

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 benefit, particularly in serving those who have both mental health and substance use disorders who face

[4] BCG Analysis, State Agency Websites, NAMD, 2023; PHAB, 2023; ACL, 2023; SAMHSA, 2023; NRI, 2023
[5] 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

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. 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 & substance use services, more comprehensive and holistic data on the population they serve, and increased opportunity to participate in SAMHSA demonstration programs (e.g., Certified Community Behavioral Health Clinics (CCBHCs)).

While there are potentially coordination benefits 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 because of the different population needs and program administration required vs. mental health and substance use care & supports. Additionally, combining three agencies would require significant investment in integration and change management. Since the primary benefit is the merger of DMH and DAODAS, we recommend pursuing that combination only in the near-term.

To ensure the benefits of a DMH and DAODAS merger, the State 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 run by a combination of county and non-profit entities. The integrated agency will have 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 the right level of expertise and specific population-focus remains for both mental health and substance use. This can be done by aligning early on 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, given the potential impact this integration has on constituents, providers and others in the ecosystem, the State must ensure the right level of communication and support for stakeholders impacted.

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

Recommendation #2: Build strategic plan & operating approach for health & 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 & human services in the State, poor coordination & 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 & human services agencies today.

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

- Build a comprehensive plan for health & 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 & operations

Build a comprehensive plan for health & 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 stakeholders in the State 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 & 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 the State, although progress to 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 current efforts in the State, broadening the focus across all of the health & 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

The State should establish a central 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 & 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 & Human Services organization consolidates into an annual plan, establishing clear initiatives, goals, and cross-cutting focuses.

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. DHHS, for example, convened a summit to discuss care challenges for foster youth, bringing together agencies, advocacy groups, and the managed care organization (MCO) which covers all foster youth in the State. Moving forward, there is an opportunity to continue these efforts and expand to other areas – for example, improving constituent navigation to services. Iowa, for example, created a Mental Health Planning & Advisory council which brings together members from across state agencies and community stakeholders to support statewide planning.

Strengthen accountability and coordination across agencies

Taking action 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, today in South Carolina, there are limited coordination and accountability systems across health & 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 regularly monitor progress towards cross-agency goals. In addition, cross-agency leadership should have meetings on a regular basis 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 & 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

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

Constituents with complex and co-occuring conditions (e.g., intellectual and developmental 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.

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 – e.g., 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 managed care organizations (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, the State 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 residents both on an individual basis and on an aggregate basis. This data could be used to improve policy formulation, strengthen agency decision-making, and bolster care coordination for constituents.

However, today the potential of this data to serve constituents is largely untapped**.** The State'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.[6]

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

> "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

The State should create a data sharing plan across health & human services agencies, potentially 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, exchange frequency, and agency owners. 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, the State 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.

Although data sharing is challenging across many states, other states are expanding these 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.[7] These partnerships allow for improved cross-agency data reporting and analysis, while maintaining compliance with privacy and other data standards.

Recommendation #3: Improve quality of services in the State

Service quality – including outcomes, patient experience, and physical setting - varies across counties and service delivery type. In addition, the quality of treatment environments can vary widely – from outdated and overcrowded facilities in violation of regulations to state-of-the-art new facilities built with the latest clinical guidance. The significant variation in service quality may contribute to the State's poor health outcomes (ranked 43rd overall).[8]

Other states have considered improving healthcare quality through improvements to oversight over county-run and state-run providers, accountability of their Medicaid managed care organizations (MCOs), and innovation in care models to better care for complex populations.

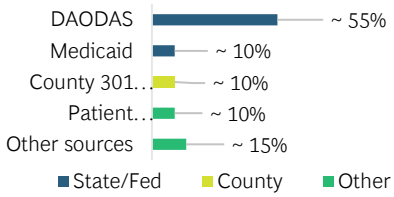
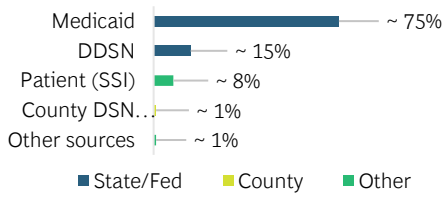
While the final report will address each of these opportunities in further detail, the following section focuses on the opportunity to improve the quality of county-run providers focused on substance use and disabilities.

Improve state oversight & support for county-run healthcare providers

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

[7] TN DATA website
[8] 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%).

Exhibit D: 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, (non profits) although 3 facilities are county operated[9]	Private non-profits
State oversight[10]	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 DHEC licenses facilities
County oversight	County 301 boards appoint provider leadership and direct liquor tax	County DSN boards appoint provider leadership
Funding sources (average)[11]		

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 I/DD group home beds vs. US average), these providers make up a disproportionate share of that capacity with 31% of substance use providers being public vs. 9% in US and 56% of disability services in South Carolina being provided by DSN boards.[12]

However, today 301s and DSN boards struggle to provide consistent, high quality services across the State for these vulnerable populations. Some sites may have limited services - for example, individualized counseling is not provided at all 301s, only 13% of 301s provide office-based opioid treatment,[13] and less than 60% of DSN boards offer a full service array.[14] 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. There may also be an inconsistent quality of services provided, with varying patient outcomes across locations. For example, treatment completion rates at 301s ranged from 33-75% across different sites, and continued substance or alcohol use post-discharge varied from 0-30%.[15]

Limited state oversight and support for these providers may contribute to these challenges. First, the State lacks a statewide strategy for service offerings based on varying patient needs in different

[9] County-operated sites in Beaufort, Charleston, and Union counties
[10] 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)
[11] 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
[12] SAMHSA, 2020; DDSN data; DMH data
[13] SC DAODAS 301 Commission Types and Services, 2023
[14] SC DDSN Dashboard for Provider Performance, 2023
[15] SC DAODAS 2022 Outcome and Discharge Report

parts of the State. In addition, there may be inconsistent standards and monitoring across 301s and DSN boards – for example, there are limited quality standards for DSN boards with primarily annual reporting. 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.

The State can improve its oversight and support for 301s and DSN boards in several ways. First, the State should establish a statewide strategy for ensuring sufficient patient quality and access – for example, the baseline set of services across the State vs. expanded services based on patient needs in that area. Second, the State should set more comprehensive standards for substance use and disability service providers – for example, stronger quality standards for disability providers. Third, the State 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. Fourth, the State can better support new or struggling providers through greater technical assistance and leadership training to empower and improve their capabilities. Last, the State 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.

While the State likely has the power today to improve oversight, a lack of explicit statutory authority may have chilled agencies' willingness to fully use their oversight powers. DAODAS's and DDSN's enabling statutes do not provide explicit authority to set a statewide strategy, set minimum standards through regulation, or take a robust set of enforcement actions in case of non-compliance.[16] The lack of an explicit statutory basis for state oversight actions may invite challenges to state oversight actions and create confusion for communities on how the State will use its potential authorities.

Virginia recently used statutory changes to improve the State's 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, establish standards & monitoring processes, and set clearly defined steps for addressing provider non-compliance with pre-defined triggers for enforcement actions.

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.

[16] DDSN, DAODAS enabling statutes

Increase and streamline funding for substance use disorder services

Improving state oversight on its own will not improve the quality of these services, particularly for substance use. As of 2020, South Carolina spends approximately 70% less in state dollars on substance use treatment compared with other South Atlantic states and other U.S. states, with $2.8 state funding per capita vs. with $8.9 state funding per capita for regional peers and $8.8 state funding per capita in the U.S.[17] This limited level of spending limits the breadth and availability of services that can be offered across the State. In addition, public funding sources for substance use are also highly fragmented today across DAODAS, DHHS (both Medicaid dollars and the Healthy Opportunities proviso), liquor tax revenue, other federal and state grants, and patient revenues. In particular, only 11% of the liquor tax is dedicated for substance use activities and is based only on certain types of liquor sales; these funds do not receive a federal match through Medicaid today. This fragmentation in public 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.

The State should consider ways to increase total funding for substance use disorder services. Several options may include increasing state appropriated funding, shifting a greater proportion of the state liquor tax to substance use activities, and better using Medicaid's federal match on state dollars spent on substance use for Medicaid members. In addition, the State should consider reducing the fragmentation of funding for substance use; one potential option is by pooling the administration of the state liquor tax with other state funds for substance use (e.g., DAODAS's SAMHSA Substance Use Block Grant, Medicaid funding for individuals with substance use disorder) to more effectively direct these funds across the State.

Next steps

The final report which will contain the complete recommendations, rationale, and key implications will be shared with the designated State leaders on or before April 1, 2024.

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

Act 60 Health Analysis
Interim Report

Due by January 1, 2024

Submitted by Boston Consulting Group

BCG BOSTON CONSULTING GROUP

I. Overview of approach and progress to-date

In Section 13 of Act 60, the Department of Administration has been charged with retaining independent, third-party experts, consultants, or advisors to analyze the missions and delivery models of all state agencies concerned with the overall public health of the State 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. From the analysis, the independent, third-party experts, consultants, or advisors will make appropriate recommendations and explain the benefits of each recommendation.

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 by April 1, 2024, in the form of a final report, with interim reports submitted by October 1, 2023, and January 1, 2024. Having submitted the initial interim report, this second interim report reflects a high-level summary of BCG's current state assessment findings. Additional detail including recommendations will be incorporated in the final report.

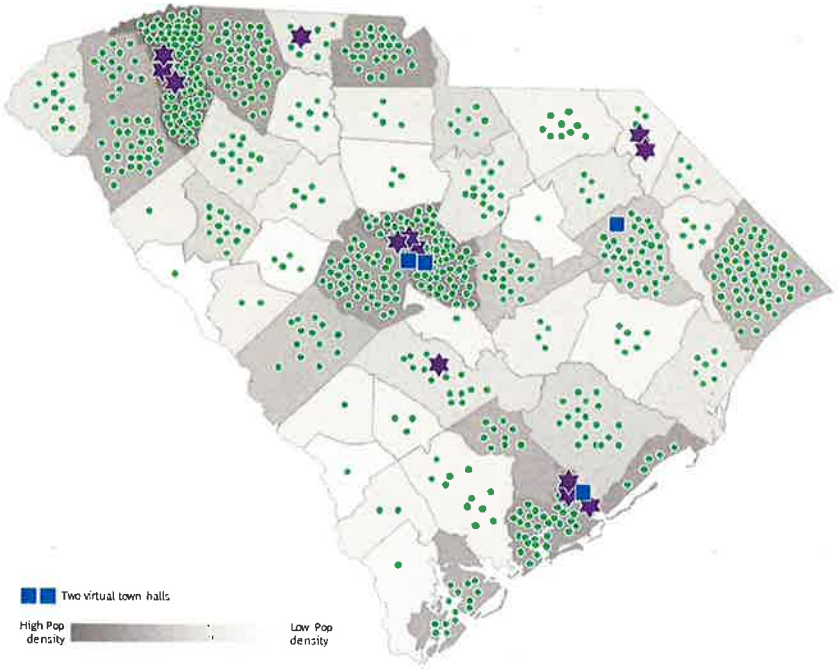
BCG has engaged in several key activities to understand the current state of health and human service delivery in South Carolina. Since beginning its work in July 2023, a current state assessment has been conducted based on a robust set of inputs across three categories:

- **Stakeholder engagement:** Completed more than 230 interviews with constituents, state executives, legislators, state health agency staff, and external partners. Additionally, there have been 13 site visits and six town halls, as well as two surveys covering more than 630 constituents across all counties and more than 3,800 staff of core state health agencies (see Exhibit A). Lastly, a public comment box was posted on SC.gov and shared directly with constituents to collect further public feedback.
- **Agency data review:** Examined agency accountability 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. Completed a review of relevant statutes, agency mandate and strategy documents, program overviews and financial data for each agency from 2019-2023.
- **External benchmarking:** Assessed the State's outcomes, structure and activities versus other states using publicly available data from the Center for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), US 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).

BOSTON CONSULTING GROUP

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

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



Legend	Total # of inputs
Constituents surveyed or interviewed	635[1]
Site visits	13
Town halls	6

Summary statistics by population type	
Mental/behavioral health	484
Low income (<50k)	442
Chronically ill	203
Elderly (>=65)	121
People with disability	90
Substance use reported	83
Pregnant women	64
Veterans	63

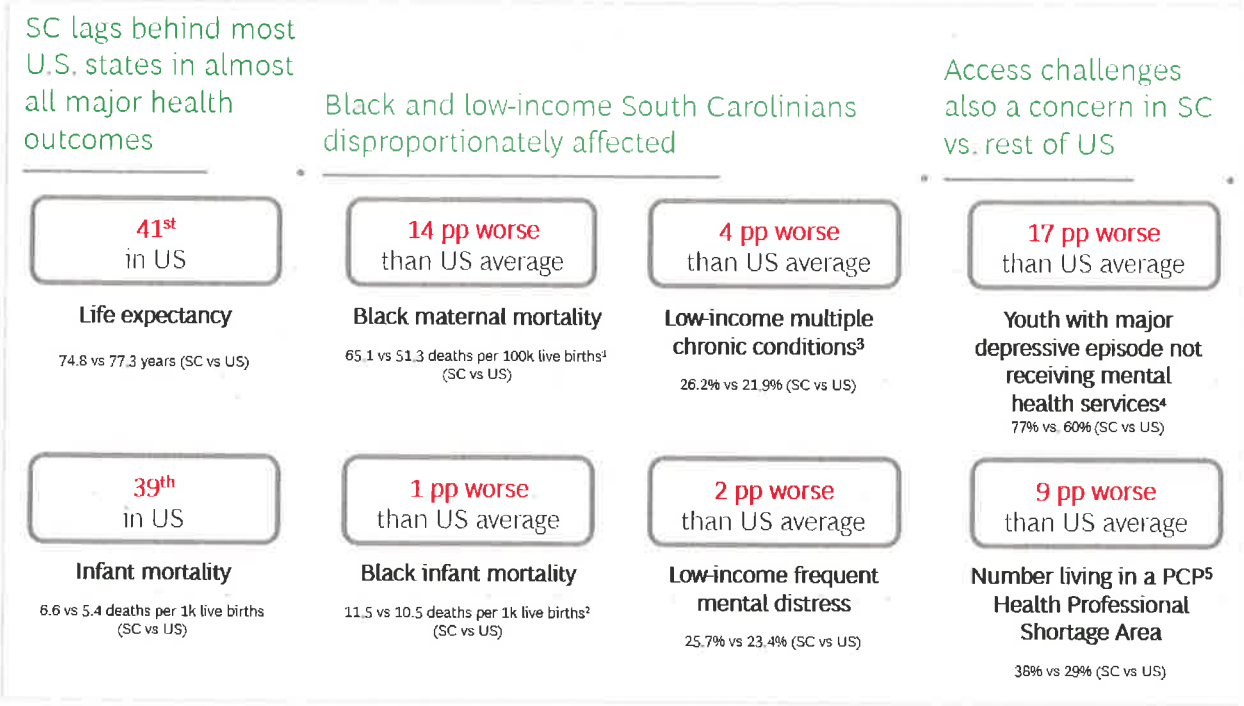
1. One respondent did not indicate the county in which s/he resides.
Note: Direct constituent input also collected via the complete response set from DRSC Community Survey 2023, and interview notes from Sage Squirrel 2023 constituent interviews across the state. Indirect constituent perspective also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

II. Review of health outcomes and spending

To understand the state of health in South Carolina today, a benchmarking was completed of the State's health outcomes and spending relative to other U.S. states, including a set of five peer states with similar geographic and demographic characteristics (see Exhibit C).

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[1]. In particular, South Carolina performs below average on several key metrics[2] across physical and mental health including:

Exhibit B: SC performance vs. peers on health outcomes



1. Only 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 when considering the State's level of spending[3]. This may indicate that South Carolina sees a low return on investment on its health spend, likely driven by more spend on high cost, acute care settings relative to prevention, such as early screenings, focus on healthy behaviors, and other actions that reduce the need for costly care of conditions down the road.

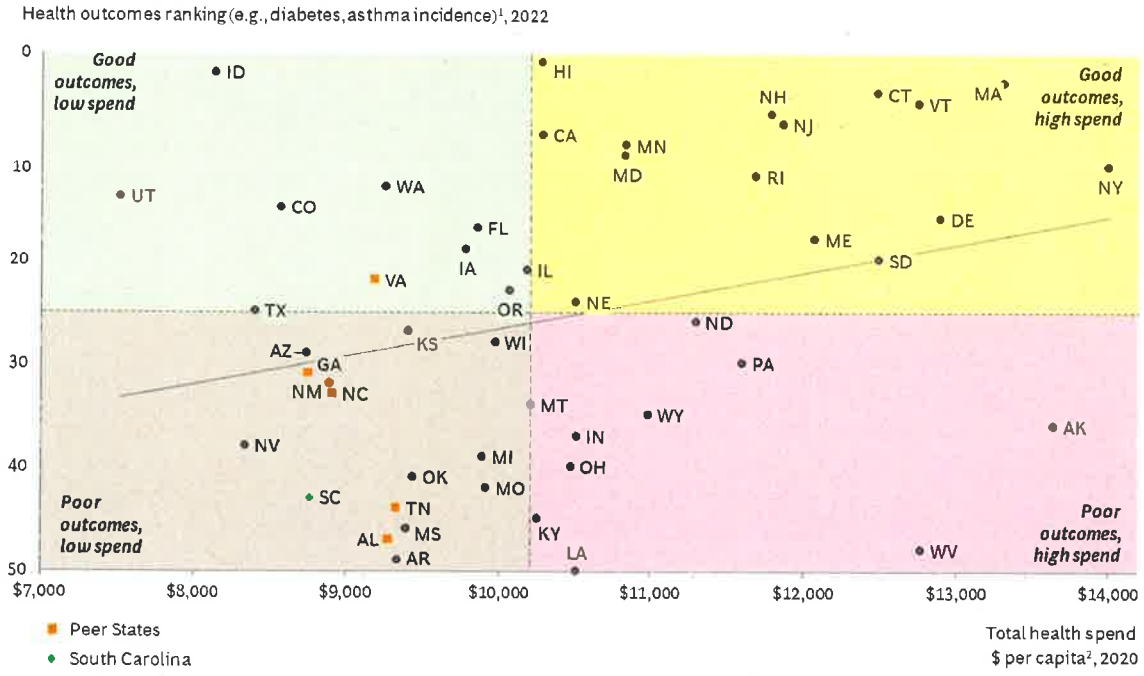
[1] America's Health Ranking, Outcomes Composite 2022

[2] 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, health resources and services administration, CDC national vital statistics system (NVSS): WONDER, CDC, behavioral risk factor surveillance system, 2021, national center for injury prevention and control, CDC, Kaiser Family Foundation (2022-2023), Health Resources and Services Administration (2022-2023)

[3] 2020 National Health Expenditure Data: Health Expenditures by State of Residence, August 2022

Exhibit C: Health outcomes vs. overall health spending for US states

South Carolina lags US 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

III. Assessment of South Carolina's healthcare system

Analysis of resident satisfaction survey

To understand opportunities to improve upon the state of health and human services in South Carolina, a survey of 600+ English and Spanish-speaking South Carolina residents was completed, asking for residents' level of satisfaction with health services in the State today. The survey used a scale of 1-5 to report satisfaction levels, with 5 being most satisfied and 1 being most dissatisfied.

There were several key takeaways from the survey (see Exhibit D):

- **Services and conditions:** Residents with intellectual and related disabilities, mental health challenges, and substance use disorder were the most dissatisfied. Compared to the average satisfaction across all residents receiving services, there is a 0.30 point lower satisfaction with intellectual and related disabilities, a 0.25 point lower satisfaction with

mental health and behavioral health, and a 0.22 point lower satisfaction with substance use services.

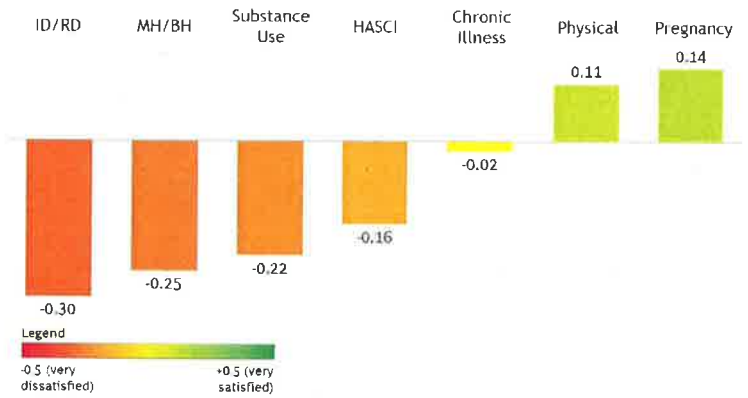
- **Geography:** Residents living in rural areas were somewhat more dissatisfied. Compared to the average across all residents receiving services, Pee Dee has a 0.07 point lower satisfaction and Upstate has a 0.06 point lower satisfaction.
- **Coverage type:** Residents who are uninsured were the most dissatisfied. Uninsured residents had a 0.38 point lower satisfaction compared to the average across all residents receiving services.
- **Age:** Younger residents were more dissatisfied. Residents between 18-25 years old had a 0.28 point lower satisfaction compared to the average across all residents receiving services.

Exhibit D: Key takeaways from constituent satisfaction survey

Mental / Behavioral Health & Intellectual / related disability support have lowest relative satisfaction

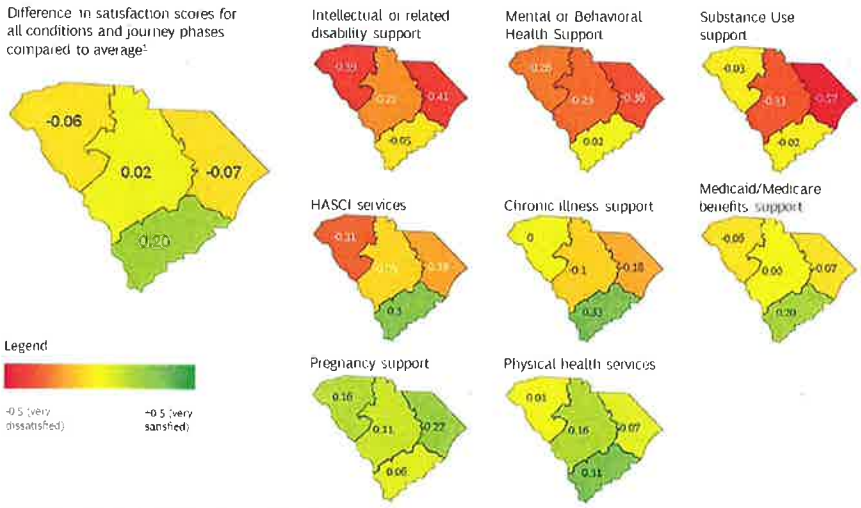
Services and conditions

Relative satisfaction compared to average across all residents receiving services



Source: SC Constituent Survey; N = 575

In addition, significant regional differences exist across services particularly acute in Chronic Illness and Substance Use

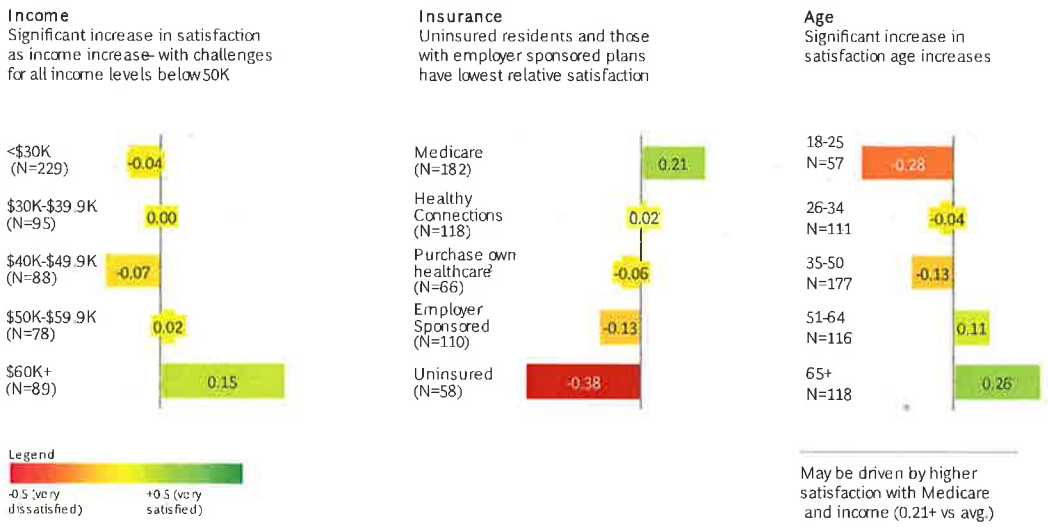


1. Average for all individuals requesting services

Note: N count for key regions - Low Country: 100, Midlands: 126, Pee Dee: 146, Upstate: 223

Source: SC Constituent Survey; N=575

Lower satisfaction among low income residents, younger residents, as well as those and those who are uninsured[1]



1. As a note, 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

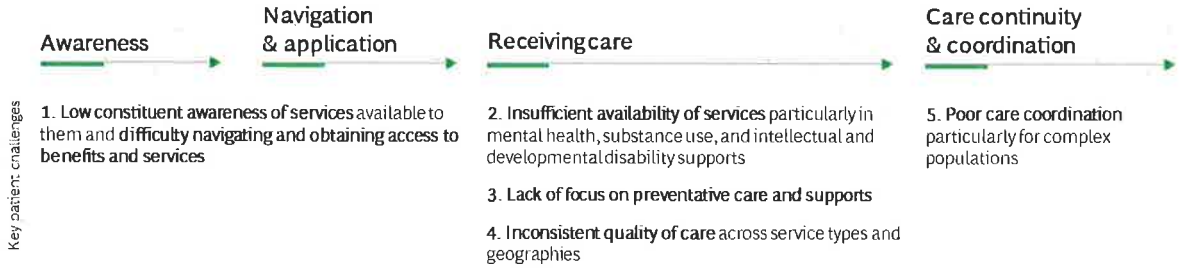
Given these findings, as the State considers recommendations moving forward, they should be done keeping these populations in mind: constituents with intellectual and related disabilities, mental health challenges, and substance use disorder. Additionally, the State should especially consider the impact of any strategies on rural, low-income, uninsured, and youth populations.

Challenges identified across constituent journey

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 and complete applications, 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:** Post-service transitionary care and long-term care plan management

Exhibit E: Constituent navigation journey and challenges



Constituents face barriers at each step of this journey (see Exhibit E) - 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 they are eligible for. Once patients are aware of the impact and existence of the available services, they often don't know how to apply for services, and 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

> "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"
>
> – Patient with an intellectual disability or related disability

2) **Insufficient availability of services** particularly in mental health, substance use, and intellectual and developmental disability supports: South Carolina is under capacity across many mental health, substance use disorder, and intellectual or developmental 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).[4] 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 would suggest. Finally, workforce shortages contribute to capacity gaps

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

across the continuum; SC has ~20% fewer psychiatrists and ~50% fewer psychologists per capita vs. the national average.[5]

> 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

> My daughter is authorized for 60 hours of personal care assistance per week, but we only receive 10-12 hours because there aren't enough people to do the work. We live in the Charleston area. I can't imagine how hard it is to find care in rural communities
>
> – Caregiver of a patient with intellectual disability and related disabilities

3) **Lack of focus on preventative care and supports:** Opportunities exist for South Carolina to strengthen constituent 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 spend by preventing health concerns before they escalate.

Currently, SC underperforms on several critical social determinants of health (e.g., 14th highest rates of housing insecurity, 11th highest rates of food insecurity).[6] Preventative care investment also lags other states (e.g., spending per capita on local health departments, a critical preventative setting, is in the bottom third nationally).[7] Primary care workforce capacity is also not sufficient to meet demand (38th in primary care physicians per capita).[8]

> 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

> We had a patient who was coming to us for outpatient services that would walk 10 miles there and back to come get treatment
>
> – Front line staff member

[5] HRSA Area Health Resource Files

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

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

[8] HRSA Area Health Resource Files

4) **Inconsistent quality of care** across service types and geographies: Service quality - including outcomes, patient experience, and physical setting - varies across counties and service delivery type. In addition, the quality of treatment environments can vary widely – from outdated and overcrowded facilities in violation of regulations to state-of-the-art new facilities built with latest clinical guidance.

> "I called a [county Substance Use provider] on a Friday and said I'm worried my son is going to overdose. I was told that the facility didn't accept anyone after 4pm on Friday, so I'd have to call back on Monday
>
> – Caregiver of a child facing substance use disorder crisis

> "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

5) **Poor care coordination particularly for complex populations:** Constituents with complex and co-morbid conditions (e.g., intellectual and developmental disabilities, foster care, acute behavioral health) experience poor care coordination across services, with frictions in accessing right care. In addition, transitions between different care types are often dropped - many constituents report lack of 'warm handoffs' between settings upon discharge (e.g., referrals, support for making appointments). Provider turnover also leads to interruptions in care.

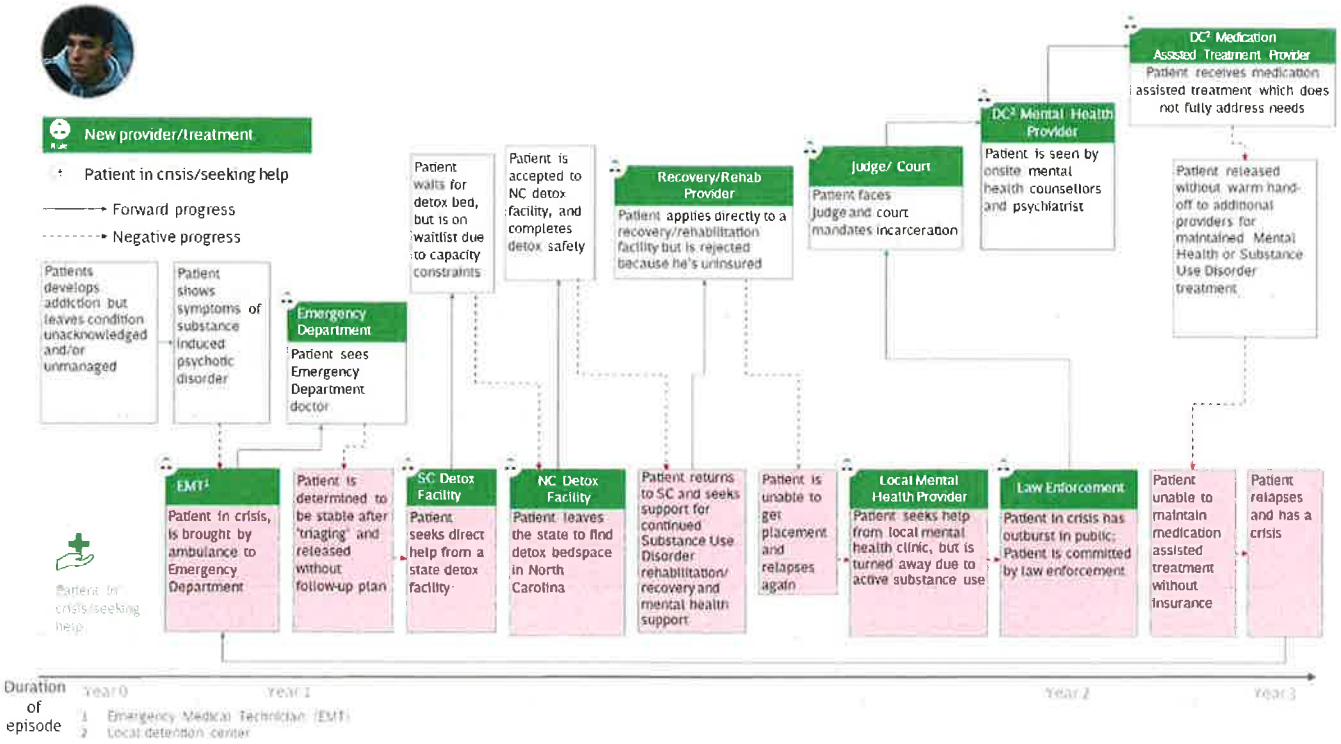
> "With some of these complex patients who come to the emergency room, I don't know [what agency] to call first...no one is taking ownership over managing their care...there's definitely a lot of "passing the buck" going on
>
> – Hospital provider

> "I do not think that the agencies communicate well amongst themselves. There is no centralized referral services or coordination of services that is easily accessible to staff ... it would be prudent to consider a centralized referral line ... If it is this difficult for us, consider how difficult it is for patients/clients!
>
> – Agency staff member

A real-life example, masked to protect the individual's privacy, highlights how these challenges manifest for residents: Ethan is a male aged 15-30 who experimented with drugs in high school and became addicted to opioids. His story demonstrates the complexity of navigating and maintaining the required treatment given navigation and access barriers. (See Exhibit F for Ethan's journey).

Exhibit F: Illustrative story explaining the difficulty navigating care with multiple conditions (substance use disorder and mental illness)

Ethan | Complexities of navigating both substance use disorder and mental illness means that constituents continue to find themselves in crisis



BCG BOSTON CONSULTING GROUP

IV. Assessment of state agencies and delivery system

Overview of state agencies

To understand opportunities to address these challenges in the healthcare system, it is critical to evaluate the activities of South Carolina's health and human services state agencies. Today, South Carolina has eight state agencies focused on health and human services[9]:

Exhibit G: Overview of eight South Carolina Health and Human Services agencies

Agency	Size[10]	Existing Statutory Mandate
Department of Health and Human Services (DHHS)	Budget: $9,425M FTEs: ~1,600	**Administer Medicaid, operate Cooperative Health Statistics Program**, refrain from engaging in the delivery of services; prepare and approve interagency program plans prior to submission, **"continuously review" programs against objectives and inform General Assembly**; maintain **inter-agency** info system with client/fiscal data, contract with other agencies for eligibility determination or any other operational programs, and **monitor and evaluate all contractual services for performance**
Department of Social Services (DSS)	Budget: $3,352M FTEs: ~5,200	**Study various social problems in the state,** inquire into causes, and make **policy recommendations**, make rules/regulations and administrative guidance for county DSS depts, audit quality of county office CPS/foster care and adoption programs and investigate issues, administer CPS, SSS block grants, treatment standards for perpetrators of domestic violence, etc.
Department of Disabilities and Special Needs (DDSN)	Budget: $890M FTEs: ~2,100	Authority for all of the **state's disabilities and special needs services and programs**, including planning and coordinating full range of services across stakeholders
Department of Health and Environmental Control (DHEC)	Budget: $686M FTEs: ~3,600[11]	**Investigate reported causes of disease, enforce preventative measures** (e.g., quarantines, sanitation rules for places used by public) to protect citizens, notify safety authorities and **inform the public** as necessary to prevent a public health emergency

[9] Of South Carolina's ~$11.6 billion general appropriations budget in FY2023, ~3 billion (~26%) is allocated towards these eight agencies, which comprises ~20% of the agencies' total budgets. Federal funding provides another ~63% of the agencies' total budgets, with the remaining ~17% coming via other funding sources.

[10] FTE count includes classified, unclassified FTEs and vacant FTE positions. Excludes temporary, temporary grant and time limited positions. Based on 2023 funding, including federal, state and other sources.

[11] Includes Public Health and all other DHEC components

Agency	Size[10]	Existing Statutory Mandate
Department of Mental Health (DMH)	Budget: $622M FTEs: ~4,700	Jurisdiction over **all inpatient and outpatient MH services**; forensic patients and sexually violent predators must be served in DMH-operated facilities. DMH is also mandated to contain a "Division on Alcohol and Drug Addiction which shall have a primary responsibility in the State for treatment of alcohol and drug addicts", with this mandate not extending to policymaking for these populations.
Department of Alcohol and Other Drug Abuse Services (DAODAS)	Budget: $85M FTEs: ~30	Full authority for **formulating, coordinating and administering the state plans for controlling narcotics** and controlled substances and alcohol abuse. Responsible for **evaluating county-level service delivery plans**, providing oversight, and administering block grants
Department of Aging (SCDOA)	Budget: $62M FTEs: ~45	**Implement and administer all programs of the federal government related to aging**, and study, investigate, plan, promote and execute programs to meet the present and future needs of aging citizens
Department of Veterans' Affairs (SCDVA)	Budget: $23M FTEs: ~51	**Assist former, present and future members of the armed forces** in securing their entitled benefits

Key challenges for state agencies

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

1) **Fragmented agency structure:** South Carolina has the most fragmented health and human services agency structure when compared with other states (see Exhibit H). It is the only state where all health and human services-related departments are independent of one another without common oversight below the Governor. This has led to a lack of cohesive statewide strategy for populations, gaps in available care, and challenges for constituents to navigate the system.

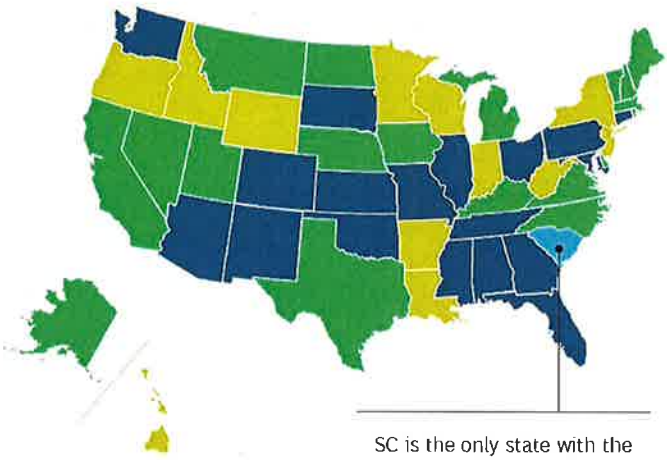
> "If someone has more than one diagnosis agencies often refuse them treatment, saying another agency is responsible. There is no transparency. . . Often we are left to navigate it ourselves."
>
> – South Carolina resident

Exhibit H: South Carolina's fragmented health and human services structure vs. other U.S. states

South Carolina has the most fragmented health and human services agency structure vs. all other states

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

Fully Consolidated # of States - 19	All health and human activities integrated under one "umbrella" organization ***# of entities: 1***
Mostly Consolidated # of States - 12	Activities mostly consolidated under a larger main agency, with one-off standalone agencies sitting separately (e.g., Aging, Public Health, Medicaid) ***# of entities: 2***
Somewhat Fragmented # of States - 18	Some consolidation in activities into joint agencies (typically in Mental Health, Substance Use, and Disability) but otherwise largely fragmented across different agencies ***# of entities: 3-6***
Completely Fragmented # of States - 1	Most fragmentation, with many discrete activities owned by different agencies ***# of entities: 7***



SC is the only state with the "completely fragmented" model

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

2) **Gaps in agency mandates and unclear ownership for end-to end strategy for key populations:** Agency charters include several gaps and overlaps, including no explicit responsibility for end-to-end health strategies (e.g., mental health) and missing services for certain populations. There are also overlaps in substance use oversight and responsibility for disability services across agency charters.

> "We are a service provider first [versus a funder or strategy setter for the population] …we provide services for the most vulnerable. That is where our resources go
>
> - State agency leader

3) **Limited planning, coordination, and accountability across state agencies:** To successfully address complex, cross-cutting issues, such as behavioral health, youth mental health, and constituent navigation, the state must take a coordinated approach. However, today, there is limited coordination across key functions such as strategic planning, complex case management, data sharing, and policy development. In fact, close to half of staff think their agency doesn't collaborate well with other agencies.

> 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

4) **Lack of innovation in policies and programs:** South Carolina has seen insufficient innovation and improvement in policies and programs to influence statewide health outcomes, driven by the lack of integrated strategy and forward-planning. Better partnerships between and the State and their health care partners – including providers, community based organizations, and Managed Care Organizations (MCOs) - will help progress on key areas where the state is lagging (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

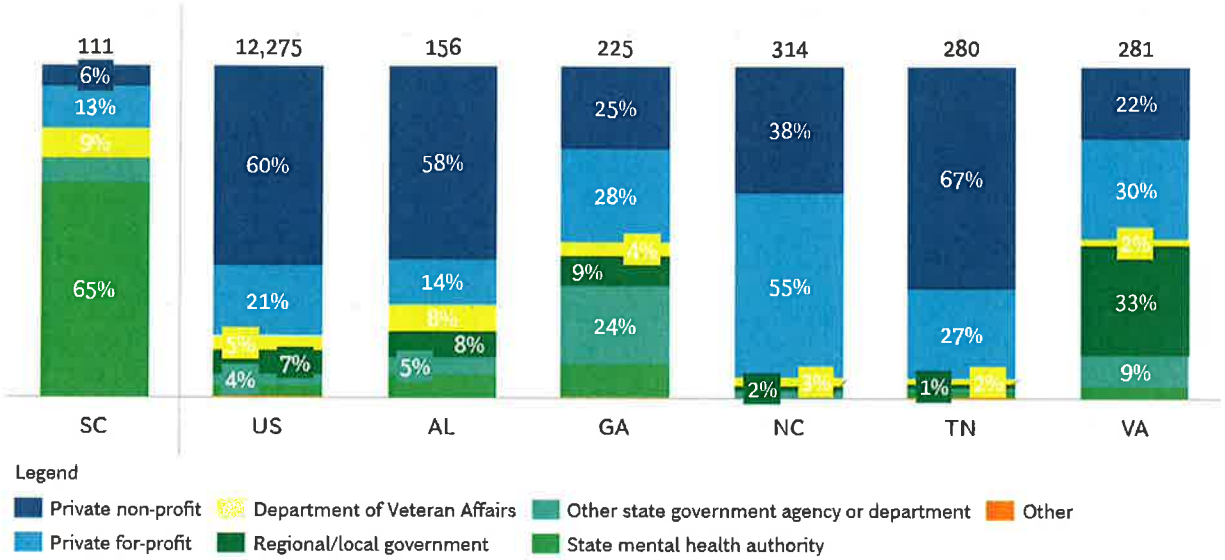
5) **Inconsistent oversight and accountability of state and local owned service delivery:** Different roles and governance models across service lines (e.g., DMH runs largest state-owned system in country vs. DAODAS and DDSN reliant on county-run entities), creates a fragmented delivery model. The structure of how local provider assets are controlled may contribute to inconsistent quality across the state. For example, the proportion of patients that completed treatment across 301 substance use clinics varied from 33% to 75%.[12] In addition, not only does South Carolina lack sufficient mental healthcare capacity overall with over triple the number of residents to mental health facilities than the US, but also 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

> "The county [disability] providers operate independently from the state…we have little to no influence.
>
> – State agency leader

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

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

Mental health treatment facilities, by facility operation, 2020



Number of clients to number facilities, April 30, 2020

1066:1	303:1	234:1	236:1	168:1	446:1	281:1

Note: Data taken on April 30th 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, substance abuse and mental health services administration, national mental health services survey (N-MHSS), 2020.

[12] DAODAS FY2022 discharges and outcomes report

state mental health agency compared to an average of 3% nationally, reflecting potential underweight private capacity[13] (see Exhibit I) [14].

6) **Limited data sharing and poor data quality to measure and manage against health goals:** Gaps in data collection and sharing among agencies limit the understanding of any individual's interactions across the system, measurement of outcomes, and how state can improve their care. There is also an opportunity to expand use of technology to engage better with constituents and help them navigate the healthcare system.

> "We need to be able to share data [across agencies] to make effective decisions...even after many discussions, we still can't get up to date infant mortality data.
>
> – State agency leader

7) **High turnover and attrition within state agency workforce:** In FY23, state agencies experienced ~19% average staff turnover, with only ~42%[15] of staff reporting they believe their agency is an attractive employer that recruits and retains good talent. Such weaknesses in the state agency workforce hurts the agencies' ability to serve their constituents and can negatively impact frontline care quality and accessibility.

> "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

[13] SAMHSA data.

[14] DAODAS Quality data.

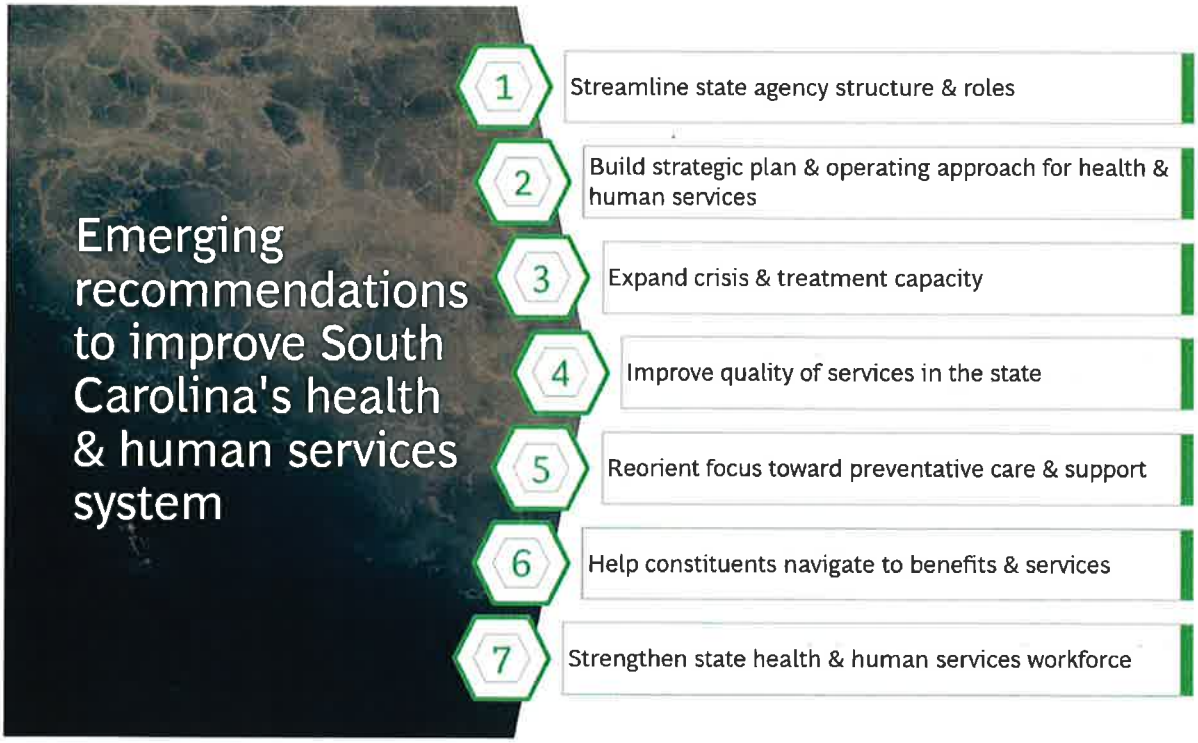
[15] Note: data from FY23; Source: Act 60 Agency Survey, peer surveys, agency HR data, S399 Agency and Position data - 8/14/2023, S399 Agency FY 2019-2023 separation data

BCG BOSTON CONSULTING GROUP

V. Emerging recommendations for further consideration

Based on these findings is a set of seven emerging recommendations for further consideration to address the challenges the state faces (see Exhibit J). These recommendations are to be further detailed and are subject to change based on additional review and consultation with relevant stakeholders. Ultimately, a combination of statutory, budgetary, and/or operating changes may be required to implement these recommendations.

Exhibit J: Emerging recommendations



Streamline state agency structure and roles to address fragmentation and duplication of activity, increase coordination amongst health-related agencies, and provide easier navigation to services for constituents. Potential opportunities for consideration include creating a central role or function across health & human services agencies, merging agencies with complementary areas of focus, and considering changes to the commission model for subset of health-related agencies. Additionally, within each health-related agency, there is an opportunity to evaluate organizational structure to increase efficiency and effectiveness of agency operations.

Build strategic plan and operating approach for health & human services that outlines the health-related outcomes South Carolina would like to achieve and defines roles for each health-related agency as well as external stakeholders (e.g., providers, community-based organizations, associations, MCOs) in achieving those outcomes. This recommendation includes development of the plan itself, governance of how plan will be developed, administered and monitored, and foundational enablers to support its operation, including data sharing. The scope of the topics to

be addressed in this recommendation include population-level focus areas such as behavioral health and maternal care as well as individual-level focus areas such as complex case management for individuals touched by multiple agencies.

Expand crisis and treatment capacity, especially for mental health, substance use disorder and disability populations to ensure adequate access to constituents in the state, with a focus on those most vulnerable. To do so, this recommendation evaluates preserving public access capacity for Medicaid and uninsured populations, most of which is delivered through the state-run mental health and county-run substance use and disabilities boards. In addition, there is an opportunity for the State to attract additional non-government capacity for underserved service lines. Lastly, this recommendation will consider how the State can grow and better use the clinical workforce in the State.

Improve the quality of services in the State to ensure that existing access provides quality treatment to those it serves. Potential opportunities to improve quality include improving the standards, monitoring and support of providers, enhancing partnerships with the State's Managed Care Organizations (MCOs) to incentivize quality services, and innovating the care delivery system to incorporate the latest evidence-based practices.

Re-orient toward preventative care and supports to address health needs before they become acute which can improve outcomes and reduce cost. This recommendation includes opportunities to strengthen prevention efforts – including education and awareness – for chronic disease and behavioral health and improve preparedness for public health emergencies. Additionally, this recommendation proposes expanded access to primary care services and supports for the social determinants of health, including housing, nutrition, and employment.

Help constituents navigate to benefits and services, overcoming the complexities driven by how the system is set up today. Recommendations include methods to boost constituent – and internal staff – awareness of available benefits and services, simplify constituent access to information both in-person and online, and make applying for benefits and services easier, eliminating process barriers to access.

Strengthen state health & human service workforce, maintaining a well-trained, dedicated workforce to deliver high-quality services to constituents. To do so, this recommendation considers how to improve the employee value proposition that attracts and retains talent and provide professional development and training to continually upskill the staff.

BOSTON CONSULTING GROUP

VI. Next steps

In January 2024, BCG will provide an addendum to this interim report containing additional detail on a selection of recommendations that may require statutory change in the 2024 legislative session.

The final report which will contain the complete recommendations, rationale, and key implications will be shared with the designated State leaders by April 1, 2024.

BCG BOSTON CONSULTING GROUP

VII. Appendix

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

State agencies (1/2)

Group	Name	Role
DHEC (5)	Edward Simmer	Director
	Karla Buru	Chief of Staff
	Brannon Traxler	Director of Public Health
	Darbi MacPhail	Finance
	Marcus Robinson	HR
Admin (7)	Marcia Adams	Executive Director
	Paul Koch	Chief of Staff
	David Avant	Chief Legal Counsel
	Brian Gaines	Finance
	Mike Shealy	Finance
	Kevin Paul	HR
	Karen Wingo	HR
SCDVA (4)	Todd B. McCaffrey	Secretary of VA
	Tim Frambes	Director of Veteran Services
	Joseph McLamb	Chief of Staff
	Fanta Coleman	Finance
DDSN (7)	Constance Holloway	Interim Director /Gen Counsel
	Janet Priest	Assoc. State Director, Ops
	Lori Manos	Assoc. State Director, Policy
	Dr. Harley Davis	Chief Administrative Officer
	Robert McBurney	Program Manager (Emergency Ops and Special Projects)
	Quincy Swygert	CFO
	Elizabeth Lemmond	Director of HR
SCDOA (5)	Connie Munn	Director
	Thomas Williams	Community Resources Division Director
	Dale Watson	State Long Term Care
	Rhonda Walker	Finance
	Cheryl Washington	HR

BOSTON CONSULTING GROUP

State agencies (2/2)

Group	Name	Role
DAODAS (5)	Sara Goldsby	Director
	Michelle Nienhius	Div. Mgr, Prev & Interv.
	Hannah Bonsu	Div. Mgr, Treatment & Rec.
	Angela Outing	HR
	Lee Dutton	Chief of Staff
DMH (11)	Robert Bank	Acting State Director
	Deborah Blalock	Dep. Dir., Comm. MH Svcs
	Versie Bellamy	Dep. Dir., Div. of Inpatient Svcs
	Ralph Pollock	Medical Director
	Dr. Kimberly Rudd	Chief Med. Officer for IP Services & LTC, Asst. Dep. Dir. for LTC
	Mark Binkley	Director of Special Projects (fmr. Interim Dir, General Counsel)
	George McConnell	Dir., Morris Village
	John Magill	Fmr. Director
	Gregory Pearce/Elliot Levy	DMH Commissioners
	Debbie Calcote	Dep. Dir. of Administrative Services
	Lee Bodie	Finance
DSS (10)	Michael Leach	Director
	Connelly-Anne Ragley	Dir. of Communications and Ext. Affairs
	Kelly Cordell	Director, Adult Advocacy
	Suzanne Sutphin	Director, Agency QA and CQI
	Garry James	Director, Prof. Dev. & Innovation
	Steven Ferrufino	Chief Transformation Officer
	Tim Mose	Director, Child Support Services
	Emily Medere	Deputy Dir., Child Welfare Svcs
	Amber Gillum	Deputy Dir., Economic Services
	Glenise Elmore	HR
DHHS (10)	Robert Kerr	Director
	Eunice Medina	Chief of Staff; Dep Dir, Programs
	Nicole Mitchell Threatt	Dep Dir, Eligibility Enrollment and Member Svcs
	Brad Livingston	CFO
	Rhonda Morrison	CIO & Dep. Director
	Deirdra T. Singleton	Dep. Dir. for Administration and Chief Compliance Officer
	Melanie Hendricks	Dep. Dir., Community Treatment Services
	Heather Kirby	Dir., Office of Research & Data Analysis
	Boyd Shealy	HR
	Chrissy Jackson	Finance

BCG BOSTON CONSULTING GROUP

External stakeholders (1/2)

Group	Name	Role
Payers (MCOs)	Dietrick Williams	VP & Regional Medicaid President for SC, Humana
	Taffney Hooks	Member Services Manager, Humana
	John McClellan	President & CEO, Absolute Total Care
	Tim Vaughn	President & CEO, BlueChoice HealthPlan
	Courtnay Thompson	Market President, Select Health
	Sean Popson	Director of Plan Operations & 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	Dept of Correct.
	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 & 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

External stakeholders (2/2)

Group	Name	Role
Service Providers & Associations	Donna Isget	President & CEO, McLeod Health
	Sarah Hearn	Government Affairs Manager, MUSC
	Dr. Patrick Cawley	Executive Director & CEO, MUSC
	Quenton Tomkins	Government Affairs Manager, MUSC
	Mark O'Halla	President & CEO, Prisma Health
	Laura Aldinger	Director, SC Behavioral Health Services Association
	Thornton Kirby	President & CEO, South Carolina Hospital Association
	Edward Bender	General Counsel, South Carolina Hospital Association (fmr.)
	Maggie Cash	South Carolina Children's Hospital Collaborative
	Dr. Keith Shealy	President, South Carolina AFP
	Richele Taylor	CEO & CLO, South Carolina Medical Association (SCMA)
	Dr. Morsal Tahouni	Medical Director, MUSC Emergency Dept.
	Dr. Keia Hewitt	Director of Emergency Services, MUSC Catawba
	Dr. Scott Russell	Division Director, MUSC Pediatric Emergency Medicine
	Anne Summers	Consultant, UHS
	Alaura Marion	Rebound Behavioral Health
	Shannon Marcus	CEO, Three Rivers Behavioral Health

b. Health outcomes and cost benchmarking data tables (America's Health Rankings and Kaiser Family Foundation)

Health outcomes rankings are calculated using a weighted z-score. The score for a state is found by calculating the z-score for each health outcome metric, which measures the distance the state's metric is from the US rate. Each metric's z-score is then multiplied by a value reflecting its impact on health outcomes, creating the weighted z-score. The weighted z-scores of each of the metrics are added together and the aggregate is compared to other states to get the ranking (1 Best to 50 Worst)

Health Outcome Metrics

Related Metric		Description
Behavioral Health	Drug Deaths	# of deaths due to drug injury per 100,000
	Excessive Drinking	% of adults who reported heavy/binge drinking
	Frequent Mental Distress	% of adults who reported their mental health was not good 14 or more days in the past 30 days
	Non-Medical Drug Use – Past Year	% of adults who reported using prescription non-medically or illicit drugs
	Suicide	# of deaths due to intentional self-harm per 100,000
Physical Health	Frequent Physical Distress	% of adults who reported their physical health was not good 14 or more days in the pas0 days
	High Health Status	% of adults who reported their health was very good
	Low Birth Weight	% of infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth
	Low Birth Weight Racial Disparity	Ratio of the low birth weight rate of the racial/ethnic group with the highest rate (varies by state) to the non-Hispanic white rate
	Multiple Chronic Conditions	% of adults who had three or more of the following chronic health conditions (listed below – Arthritis to Diabetes)
	Arthritis	% of adults who reported ever being told by a health professional that they had some form of arthritis
	Asthma	% of adults who reported ever being told by a health professional that they currently have asthma
	Cancer	% of adults who reported ever being told by a health professional that they had any form of cancer other than skin cancer
	Cardiovascular Diseases	% of adults who reported ever being told by a health professional that they had angina or coronary heart disease; a heart attack or myocardial infarction; or a stroke
	Chronic Kidney Disease	% of adults who reported ever being told by a health professional that they have kidney disease (excluding kidney stones, bladder infection or incontinence)
	Chronic Obstructive Pulmonary Disease	% of adults who reported ever being told by a health professional that they have chronic obstructive pulmonary disease, emphysema or chronic bronchitis
	Depression	% of adults who reported ever being told by a health professional that they have a depressive disorder, including depression, major depression, minor depression or dysthymia
	Diabetes	% of adults who reported ever being told by a health professional that they have diabetes
Risk Factors	High Blood Pressure	% of adults who reported being told by a health professional that they had high blood pressure
	High Cholesterol	% of adults who reported having their cholesterol checked and being told by a health professional that it was high
	Obesity	% of adults with a body mass index of 30.0 or higher based on reported height and weight
Mortality	Premature Death	Years of potential life lost before age 75 per 100,000 population
	Premature Death – Racial Disparity	Ratio of the premature death rate of the racial/ethnic group with the highest rate (varies by state) to the non-Hispanic white rate

BCG BOSTON CONSULTING GROUP

Health Outcome Ranks and Spend per Capita

Related Metric		SC	VA	GA	NC	TN	AL	US Average
Behavioral Health Outcomes Ranks	Drug Deaths	35	24	10	30	45	18	27.9
	Excessive Drinking	19	22	15	21	12	4	17.3%
	Frequent Mental Distress	40	25	27	14	46	47	14.7%
	Non-medical Drug Use - Past Year	39	26	34	18	36	40	15.5%
	Suicide	27	16	18	13	30	26	14
Physical Health Outcome Ranks	Frequent Physical Distress	41	17	28	30	46	43	53.2%
	High Health Status	34	23	37	19	39	47	8.5%
	Low Birthweight	46	27	47	43	36	48	2.1
	Low Birthweight Racial Disparity	37	26	26	26	20	26	9.6%
	Multiple Chronic Conditions	36	30	25	35	46	47	25.8%
	Arthritis	40	27	18	29	42	48	9.8%
	Asthma	15	24	16	6	30	29	7.5%
	Cancer	24	19	2	13	37	48	8.0%
	Cardiovascular Diseases	31	27	34	38	46	45	3%
	Chronic Kidney Disease	32	20	48	35	47	45	6.2%
	Chronic Obstructive Pulmonary Disease	35	26	29	36	47	45	20.5%
	Depression	20	19	12	29	46	31	10.9%
	Diabetes	44	31	37	40	46	47	10.9%
Risk Factor Ranks	High Blood Pressure	42	32	40	35	41	47	32.4%
	High Cholesterol	40	46	32	34	44	48	35.7%
	Obesity	36	27	23	34	31	47	33.9%
Mortality Ranks	Premature Death	42	19	37	34	44	47	8,659
	Premature Death Racial Disparity	11	11	6	25	11	6	1.6
Total Health Outcomes Ranking		43	22	31	33	44	47	
Total Spend per capita		$8.8k	$9.2k	$8.8k	$8.9k	$9.3k	$9.3k	$10.2k

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. The 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.

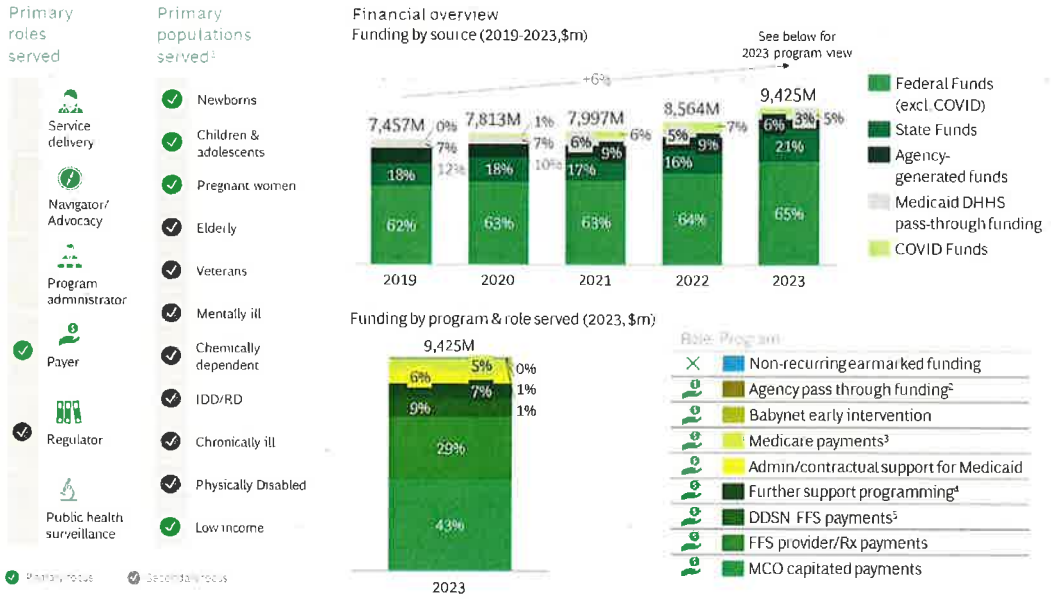
Primary population and services

DHHS serves as the **single state Medicaid payer** across all patient populations that qualify for Medicaid, with a **primary focus** on newborns, children, pregnant women, the disabled, and low-income populations. The agency plays a key role in managing **Medicaid waivers** - in particular the three Home and Community Based Services (HCBS) 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 & 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 **$9.425 billion in 2023 funding**.

Exhibit K: Agency Fact Sheet | Department of Health and Human Services (DHHS)



1. 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

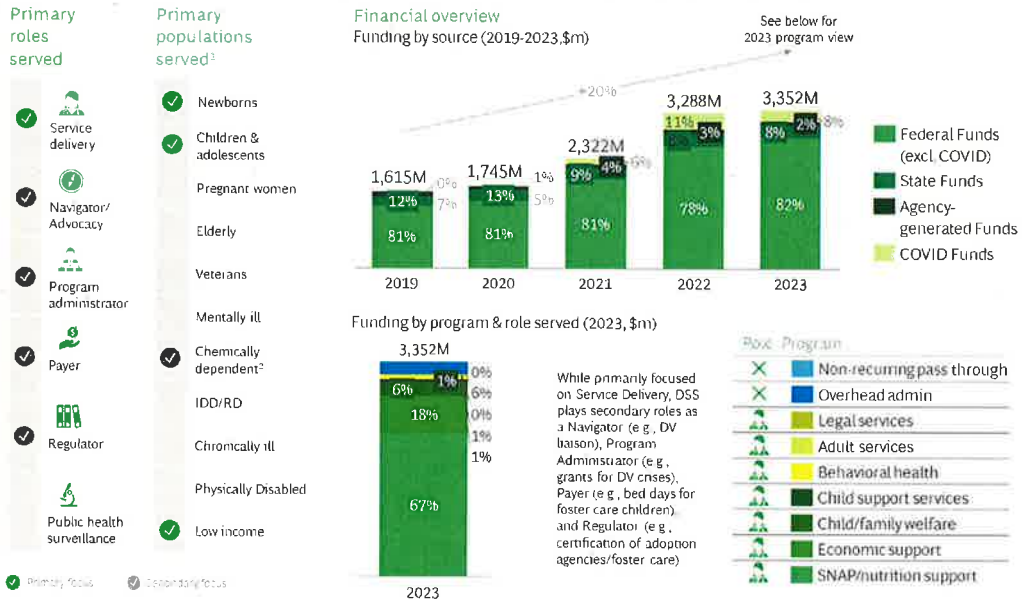
DSS primarily **delivers services for newborns, children and adolescents, and low-income populations**, through including but not limited to, sharing education and information, creating interpersonal support, finding stable housing, offering employment or skill training, and arranging transportation.

Organizational model & 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 **$3.352 billion** 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 L: Agency Fact Sheet | Department of Social Services (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

BOSTON CONSULTING GROUP

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.

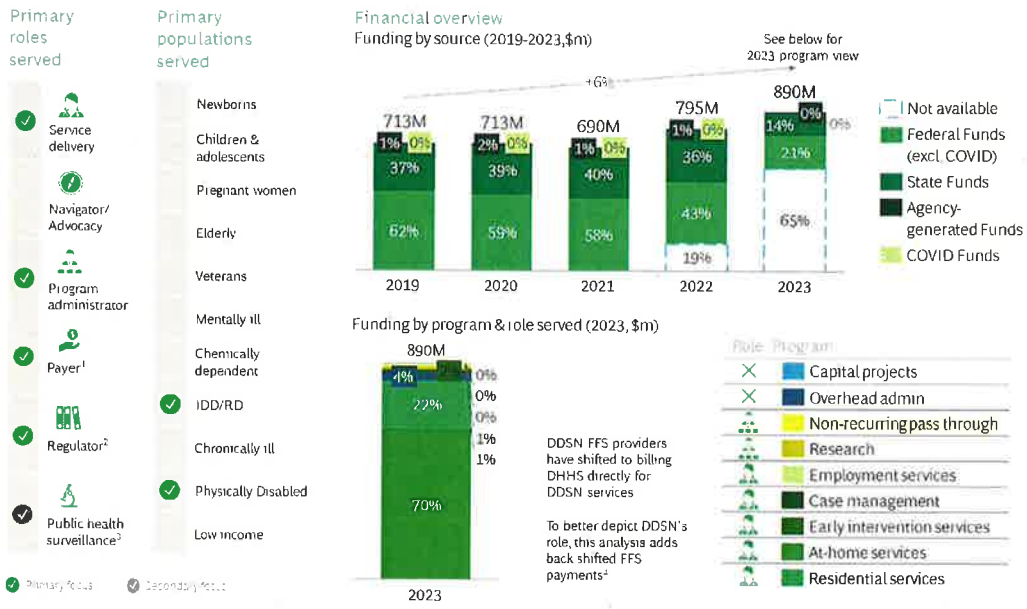
Primary population and services

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 & operations

DDSN operates through a **Commission** model, as DDSN leadership is appointed by a commission. DDSN has approximately **2,100 full-time employees** and **$890 million 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 M: Agency Fact Sheet | Department of Disabilities and Special Needs (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)

*Recently, DHEC is **transitioning** to become the **Department of Public Health** over 2023-24. When this change happens, existing oversight over food and environment will shift to other agencies.*

Mission and statute

The **mission of DHEC** 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 **investigating** reported causes of disease, **enforcing** preventative measures (e.g., quarantines, sanitation rules for places used by public) to protect citizens, **notifying** safety authorities, and **informing** the public as necessary to prevent a public health emergency.

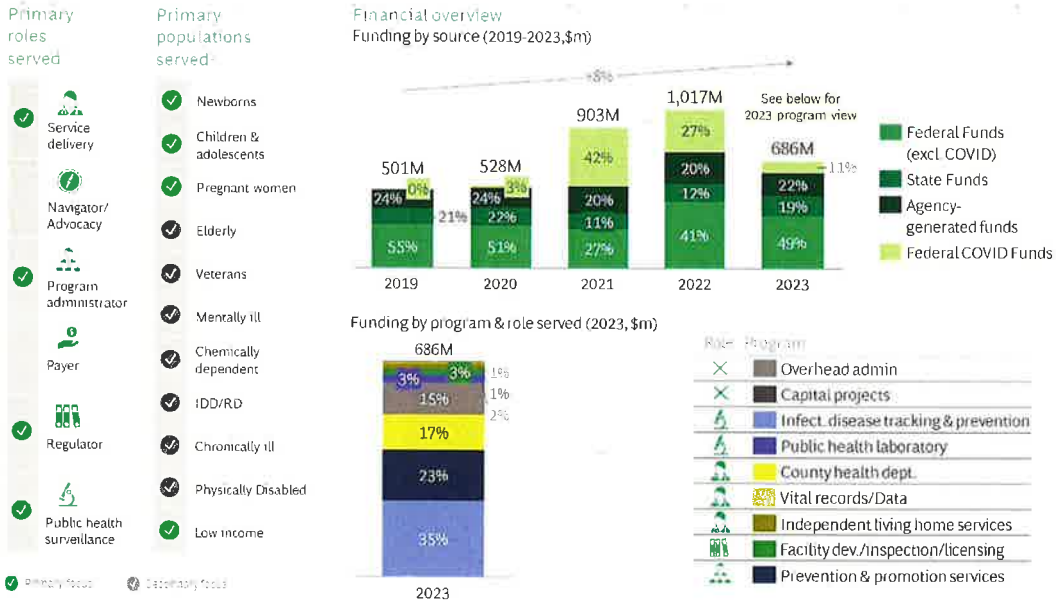
Primary population and services

DHEC covers a broad swathe of 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**. In order 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 & operations

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

Exhibit N: Agency Fact Sheet | Department of Health and Environmental Control (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 (SCDMH)

Mission and statute

The **South Carolina Department of Mental Health (SCDMH) is tasked with supporting the recovery of people with mental illnesses**. SCDMH has jurisdiction over all inpatient and outpatient mental health services, and "primary responsibility...for treatment of alcohol and drug addicts." Additionally, the SCDMH has a secondary role in serving **chemically dependent populations**. Their primary role for these populations is service delivery.

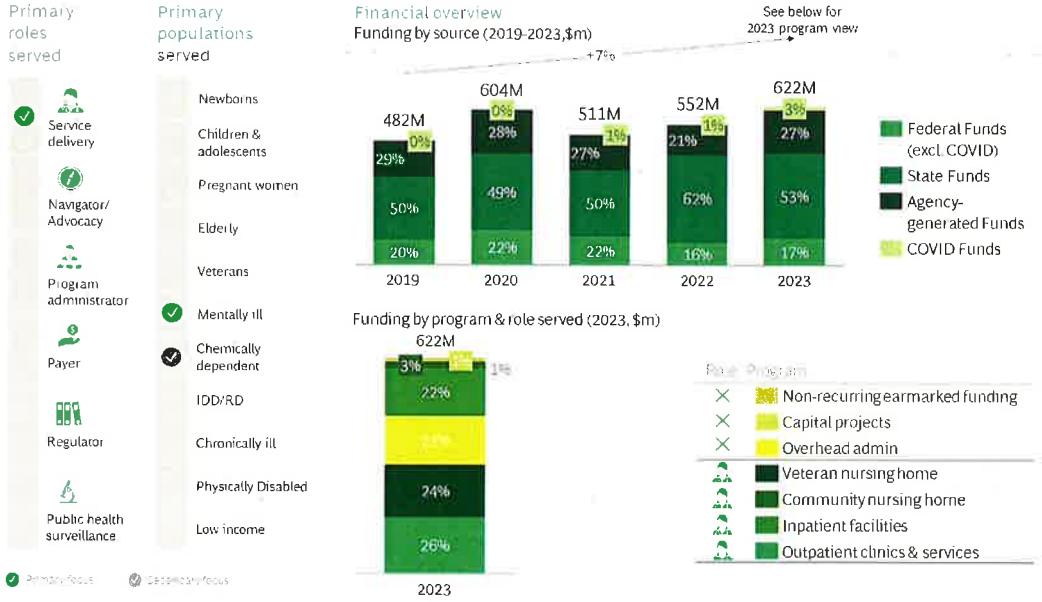
Primary population and services

SCDMH **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 & operations

SCDMH operates through a **Commission** model, as DMH leadership is appointed by a commission. The SCDMH has approximately **4,700 employees** and **$622 million 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 O: Agency Fact Sheet | Department of Mental Health (DMH)



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

BOSTON CONSULTING GROUP

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.

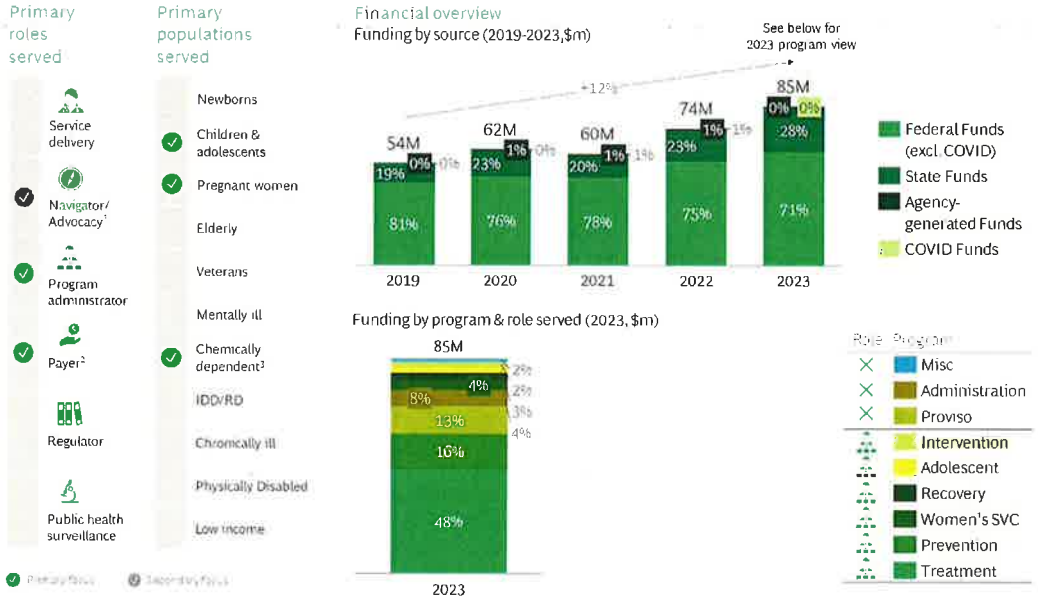
Primary population and services

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 & operations

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

Exhibit P: Agency Fact Sheet | Department of Alcohol & Drug Abuse Services (DAODAS)



1. Two FTE work as Navigators connecting individuals leaving correctional settings to recovery resources as well as responding to SUD-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 (SCDOA)

Mission and statute

SCDOA'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. SCDOA is authorized to achieve this mission through statutory requirements to **implement and administer** all programs of the **federal government** related to aging. SCODA is also authorized to study, investigate, plan, promote and execute programs to meet the **present and future needs of aging citizens.**

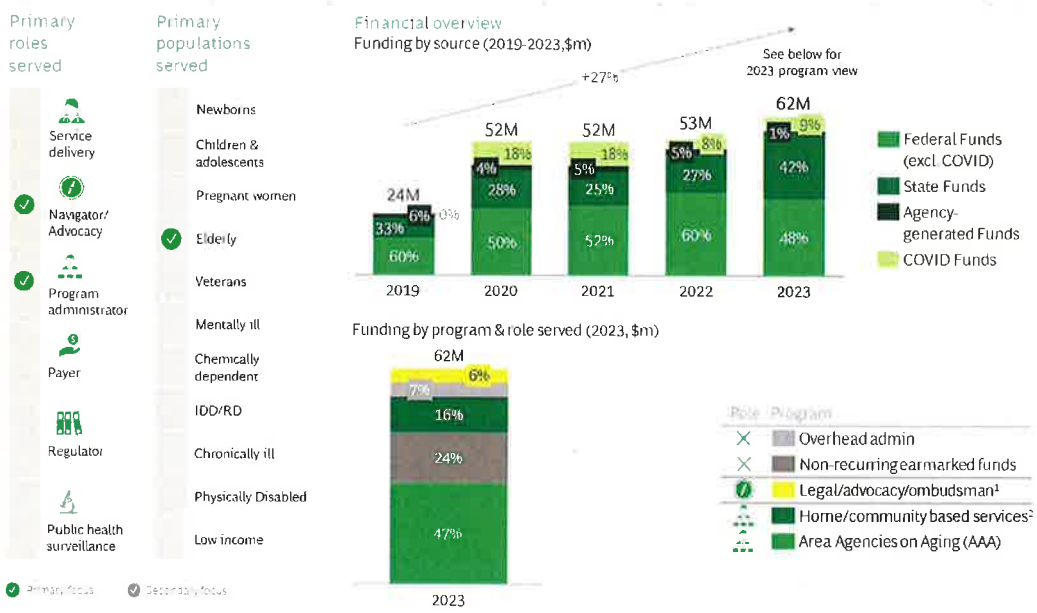
Primary population and services

SCDOA serves **elderly** populations, primarily offering **navigation and advocacy** initiatives and **administering relevant programs.** To achieve their mission of serving all seniors and vulnerable adults, SCDOA supports elderly populations in their **navigation of eligible resources.** SCDOA 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 & operations

The SCDOA operates through a **Cabinet** model, as SCDOA leadership is appointed directly by the Governor. SCDOA has approximately **45 full time employees** and **$62 million** in 2023 funding. Under the mandates of the Older American Act (OAA) the Department of Aging 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 Q: Agency Fact Sheet | Department on Aging (SCDOA)



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 (SCDVA)

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

Mission and statute

SCDVA's **mission** is to **lead and enable a state-wide 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, SCDVA is **statutorily required** to assist former, present and future members of the armed forces in **securing their entitled benefits.**

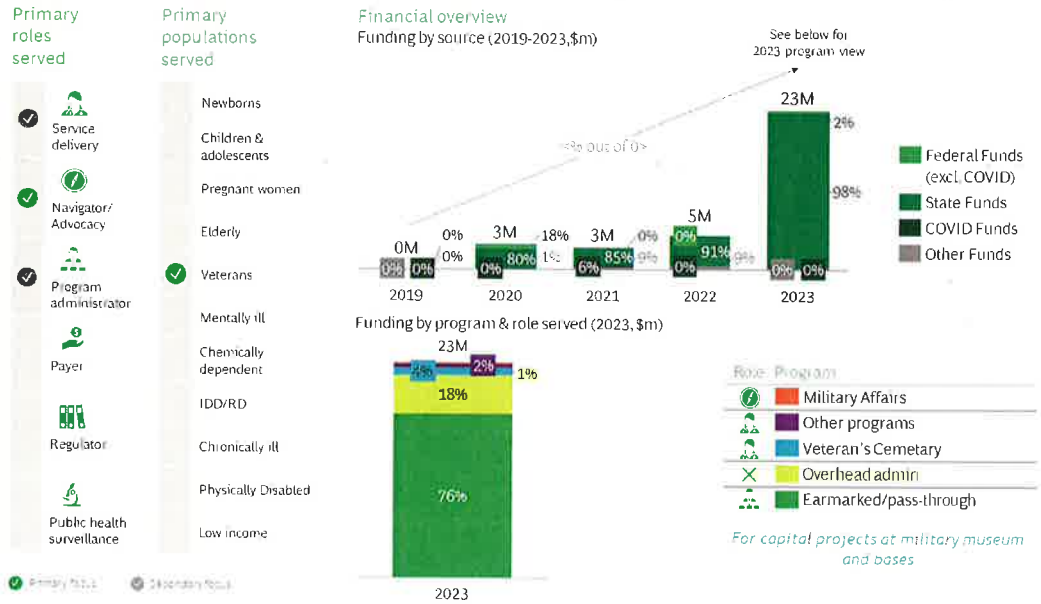
Primary population and services

SCDVA serves **veteran** populations, primarily offering **navigation and advocacy.** To achieve their mission of serving all veterans, SCDVA **administers health programs** that offer veterans facility-based direct care and **supporting programs** that share education and information with veterans.

Organizational model & operations

The SCDVA operates through a **Cabinet** model, as SCDVA leadership is appointed directly by the Governor. SCDVA has approximately **51 full time employees** and **$23 million** in 2023 funding.

Exhibit R: Agency Fact Sheet | South Carolina Department of Veteran Affairs (SCDVA)



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

FY24 SPENDING PLAN BUDGET - APPROVED	$ 327,752,128

YTD EXPENDITURES BY CATEGORY	EXPENDITURES THRU 1/31/2024
501000 - PERSONAL SERVICES - PAYROLL	$ 44,189,163
502000 - CONTRACTUAL SERVICES	$ 118,451,595
503000 - SUPPLIES AND MATERIALS	$ 3,873,052
504000 - FIXED CHARGES AND CONTRIBUTIONS (RENT/LEASE)	$ 2,652,361
505000 - TRAVEL	$ 239,334
506000 - FIXED ASSETS (CAPITALIZED)	$ 336,574
507000 - LAND & BUILDINGS	$ 1,839,275
511000 - PUBLIC ASSISTANCE	$ 4,431,973
513000 - EMPLOYER CONTRIBUTIONS - FRINGE BENEFITS	$ 19,701,212
515000 - UTILITIES	$ 1,082,622
517000 - ALLOCATIONS	$ -
518000 - AID TO SUBDIVISIONS (STATE AID)	$ -
520000 - FIXED ASSETS(NON-CAPITALIZED)	$ 20,495
TOTAL YTD EXPENDITURES	**$ 196,817,656**
% OF YTD EXPENDITURES	**60.05%**
% OF SPENDING PLAN REMAINING	**39.95%**
% OF FISCAL YEAR REMAINING	**41.67%**
% DIFFERENCE - OVER (UNDER) BUDGETED EXPENDITURES	**1.72%**

ITEMS NOT IN SPENDING PLAN (WILL NOT RECEIVE FUNDING UNTIL 9/30/2023)	
561000 - SPECIAL OPERATIONS (LEGISLATIVE PASS THRU)	$ 12,685,000

Methodology & Report Owner: DDSN Budget Division