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 and support for 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

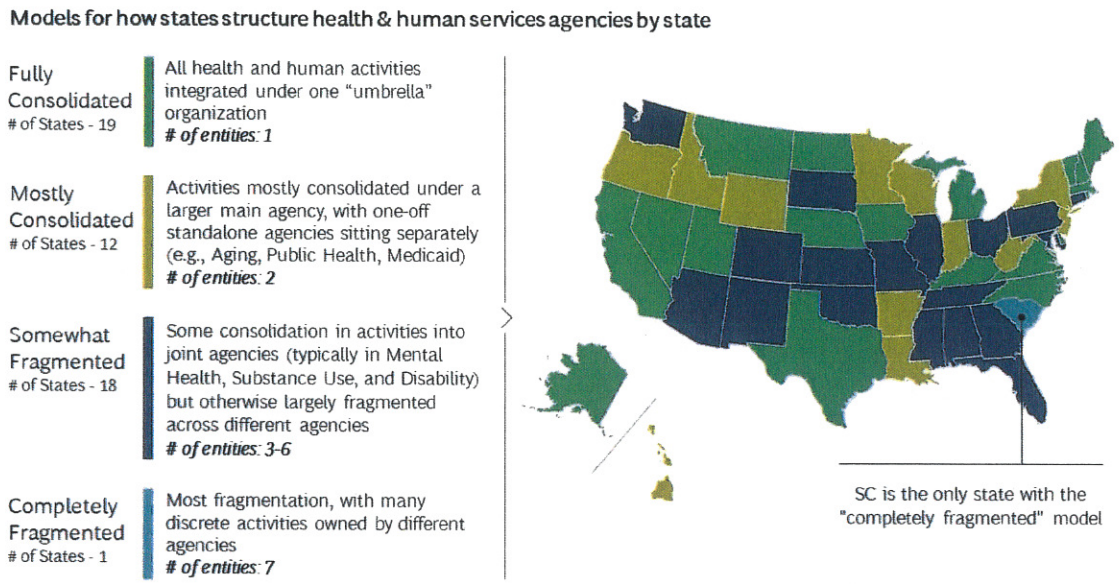
As the State contemplates changes to structure and roles, it is critical to balance the benefits of increased integration with maintaining the distinct role each agency plays in responding to the needs of the population they serve. Therefore, in the forthcoming section, the recommendations include ways 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.

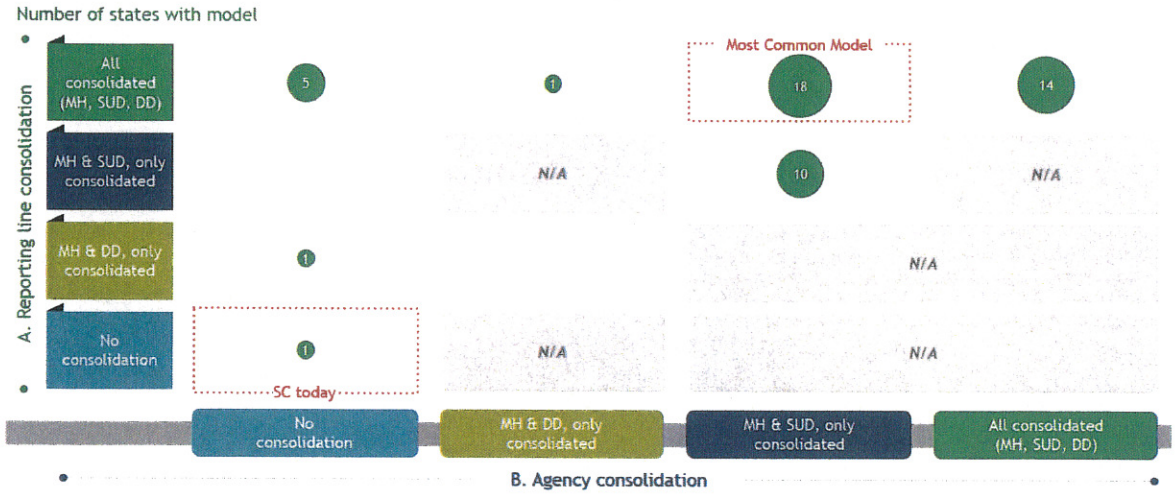
Integrate agencies with similar missions within the central organization

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).

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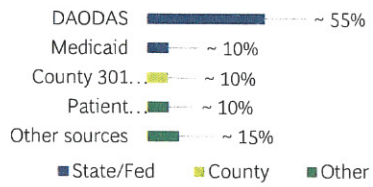
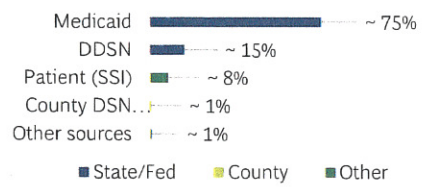
[7] TN DATA website

[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