LEGISLATIVE AUDIT COUNCIL

Report to the General Assembly

January 2003

South Carolina Health and Human Services Agencies

A Review of Non-Medicaid Issues

- Organizational Structure
- Client Revenue Collection
- Client Eligibility
- Outcome Measures

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South Carolina Health and Human Services Agencies
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Synopsis

Members of the General Assembly asked the Legislative Audit Council to conduct an audit of the eight agencies assigned to the health, human services, and Medicaid budget subcommittee of the House Ways and Means committee. These agencies' budgets for FY 02-03 totaled $5.7 billion, comprising nearly 38% of the state's budget. The audit requesters asked us to make recommendations for reorganization of these agencies to eliminate duplication and improve services. They were also concerned about funding, controls over client eligibility, and the agencies' outcome measures. While many of the programs we reviewed are funded by Medicaid, we did not review administration of the Medicaid program in this report, as it is covered in a concurrent LAC audit, *Options for Medicaid Cost Containment* (January 2003).

We reviewed the organizational structure of South Carolina's health and human service agencies and found that similar services are often provided by multiple agencies. This structure can have several effects:

- It can be more difficult for clients to determine where to apply for help.
- Agencies may spend extra resources on interagency referrals and service coordination.
- Administrative costs in areas such as finance, personnel, and information technology are increased.
- Planning and budgeting are conducted in a fragmented manner.

We recommend consolidation in four areas where similar services are provided by more than one state agency:

- Senior and long term care programs.
- Addiction treatment programs.
- Programs for emotionally disturbed children.
- Rehabilitation programs.

Also, five of the eight health and human services agencies we reviewed are not part of the Governor's cabinet. There is no central point of accountability for their performance. No executive branch entity has the authority to ensure comprehensive planning and budgeting or that services are provided efficiently.

If programs with similar services were consolidated into fewer agencies, under the authority of a single cabinet secretary, the need for different agencies to make referrals to each other and to coordinate their similar services would be reduced. Administrative costs, in most cases, could be reduced, while planning and budgeting could be unified.

Additional Findings

- There is an opportunity to reduce the number of area agencies on aging (AAAs) administered by the Department of Health and Human Services. Currently 10 area agencies distribute funds from the state office to providers of services for seniors. The administrative savings from consolidation could be used to expand client services. Also, the AAAs do not use competitive procurements to ensure that providers are cost-effective and/or high quality.
- The Department of Mental Health (DMH) could increase revenues from patients, particularly at the community mental health centers. The centers collected an average of just 10% of the amount billed to clients and 15% of the amount billed to insurance. For every 10% increase in self pay collections, DMH would obtain approximately $840,000 in additional revenue.
- The Department of Health and Environmental Control (DHEC) has not been aggressive in collecting funds owed from clients for health services. DHEC does not have adequate policies for billing, tracking, and collecting accounts receivable. If DHEC made greater efforts to collect from those who are required to pay, it could provide more services.
- The Department of Social Services (DSS) has not verified client assets such as personal property and bank accounts for the family independence program. As a result, ineligible persons may be receiving services.
- DSS's internal controls to ensure that clients are eligible for the food stamp program are adequate. For the past several years, South Carolina has received enhanced funding from the U.S. Department of Agriculture due to its low error rate for the food stamp program.
- Performance measures we reviewed in the four health and human services agencies that provide direct client services were generally based on national benchmarks. However, in three of the agencies, performance data that the state offices require from their county or district offices was not always consistent or reliable.
  - The Department of Mental Health does not have reliable cost information for treatment programs provided at the community mental health centers.
  - Performance data collected by the Department of Health and Environmental Control from the 13 health districts is not consistent and does not provide a clear picture of progress or the need for improvement in the districts.
  - There is no consistency in the data on child welfare collected by four Department of Social Services county offices. Also, the controls over data verification are inadequate.

Introduction and Background

Audit Objectives

Members of the General Assembly requested the Legislative Audit Council to conduct an audit of the eight agencies assigned to the health, human services, and Medicaid budget subcommittee of the House Ways and Means Committee.

HEALTH AND HUMAN SERVICES AGENCIES REVIEWED

Department of Alcohol and Other Drug Abuse Services (DAODAS)
Commission for the Blind (SCCB)
Department of Disabilities and Special Needs (DDSN)
Department of Health and Environmental Control (DHEC)
Department of Health and Human Services (DHHS)
Department of Mental Health (DMH)
Department of Social Services (DSS)
Vocational Rehabilitation Department (VR)

The audit requesters were interested in program funding and the agencies' outcome measures. They were also concerned about whether the agencies have adequate controls over client eligibility. In addition, they asked us to make recommendations for reorganization of these agencies to eliminate duplication and improve services. Our objectives are listed below.

- Determine whether there are ways to reduce costs or improve services by changing the organizational structure of South Carolina's health and human service agencies.
- Determine whether agencies are maximizing insurance and client payments for their services.
- Determine whether DHEC and DSS have adequate controls to determine eligibility for programs where eligibility is determined by client income and/or assets.
- Determine whether the agencies have adequate outcome measures of the cost and effectiveness of their programs.

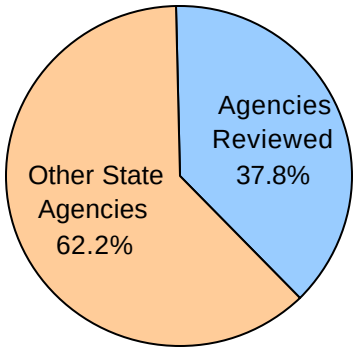
For further discussion of the audit's scope and methodology, see Appendix A.

Background

The agencies that we reviewed furnish services to South Carolinians which are based on economic and/or medical needs. These services include health care, food, and vocational training. The Department of Health and Human Services (DHHS) administers and determines eligibility for the Medicaid program, a joint state-federal program which funds health care for eligible persons.

The agencies' combined budgets for FY 02-03 comprise nearly 38% of the state's budget (see Chart 1.1). Their individual budgets range from $10.6 million to $3.4 billion (see Table 1.2). State funds make up an average of 20% of the agencies' budgets; many of these state funds provide a match to federal Medicaid funding. Employees of the eight agencies comprise approximately 30% of all state employees. See Appendix B for information about changes in the agencies' budgets over the past four years.

Chart 1.1: FY 02-03 State Government Budget



Source: Budget and Control Board

Table 1.2: Appropriations for Eight Health and Human Services Agencies FY 02-03

Agency	FY 02-03		
	Total Funds	State General Funds	Employees*
Health and Human Services	$3,447,616,123	$578,436,587	1,100
Social Services	806,131,461	107,920,067	4,210
Health and Environmental Control	495,680,199	114,152,333	4,694
Disabilities and Special Needs	429,232,394	146,182,062	2,617
Mental Health	344,935,818	178,412,977	5,232
Vocational Rehabilitation	105,082,614	14,268,114	1,059
Alcohol and Other Drug Abuse Services	47,801,947	10,080,429	56
Blind	10,551,669	3,482,578	127
TOTAL	$5,687,032,225	$1,152,935,147	19,095

*Full-time equivalent positions filled as of December 2002. This number was on average 15% less than the number of positions authorized by the General Assembly.
Source: Budget and Control Board

The organizational structure and lines of accountability of the eight agencies fit two general patterns.

- Three agencies — DAODAS, DSS, and DHHS — are in the Governor's cabinet. Their directors are appointed by and serve at the pleasure of the Governor.

- Five agencies are governed by boards of seven members, one from each Congressional district and one from the state at large. Board members' terms range in length from four to seven years. Board members are appointed by the Governor with the advice and consent of the Senate. The directors of four of these agencies — DMH, VR, SCCB, and DDSN — are appointed by the agency's governing body and serve at the board's pleasure. DHEC's director has a four-year term and is appointed by the board with the approval of the Governor and the advice and consent of the Senate. DHEC's board can remove its director only with the Governor's approval.

Organizational Structure

We reviewed the organizational structure of South Carolina's health and human services agencies and found that similar services are often provided by multiple agencies. This structure can have several effects:

- It can be more difficult for clients to determine where to apply for help.
- Agencies may need to spend extra resources on interagency referrals and service coordination.
- There are duplicative administrative costs in areas such as finance, personnel, and information technology.
- Planning and budgeting are conducted in a fragmented manner.

Most of the agencies we reviewed are not part of the Governor's cabinet. There is therefore no central point of accountability for their performance.

Similar Services Provided by Multiple Agencies

We identified four areas in which similar services are provided by more than one health and human services agency:

- Senior and long term care programs.
- Addiction treatment programs.
- Programs for emotionally disturbed children.
- Rehabilitation services.

There are opportunities to consolidate programs in each of these areas. By consolidating programs, complexity can be reduced, the need for interagency referrals can become less frequent, and planning and budgeting can be done more comprehensively. In most cases, administrative costs can be lowered. By citing these programs, we do not intend to preclude consolidation of other programs when there are potential net benefits.

Senior and Long Term Care Programs

All of the health and human services agencies we reviewed provide services for which seniors are eligible. Some of these agencies provide long term care services. Below we describe senior and long term care programs with similar services and/or clients at four agencies.

DEPARTMENT OF HEALTH AND HUMAN SERVICES — DHHS administers funding for multiple senior and long term care services. We focused on two programs in which services are funded or delivered through a network of regional or local offices.

DHHS operates a state office on aging which funds meals, transportation, nonmedical home care (bathing assistance, light housekeeping, cooking, etc.), and other services for senior citizens. This office also investigates allegations of abuse of persons who are in institutions, such as nursing homes. The state office on aging distributes funds through a network of 10 area agencies on aging (AAAs) and 60 local organizations. In FY 00-01, DHHS funded aging network services for approximately 37,000 clients at a cost of $17.6 million.

DHHS also operates a community long term care (CLTC) program which provides Medicaid funding for primarily nonmedical care to persons living at home who are eligible for institutional care. This program is operated through a network of 13 offices that oversee case management services. The CLTC program funds services such as “personal care” (bathing assistance, light housekeeping, cooking, etc.) and adult day care. In FY 01-02, DHHS funded these services for approximately 16,460 clients at a cost of $81 million.

DEPARTMENT OF SOCIAL SERVICES — DSS has an adult protective services unit that investigates the abuse and neglect of adults who are not in institutions. The department also provides “homemaker services” to frail, chronically ill, and disabled adults, including bathing assistance, light housekeeping, and cooking. In FY 01-02, DSS provided adult protective services to approximately 6,890 clients at a cost of $9.4 million . DSS provided homemaker services to about 3,710 clients at a cost of $5.1 million. Approximately 63% of the clients receiving homemaker services were adults.

DEPARTMENT OF MENTAL HEALTH — DMH owns two nursing homes that provide institutional long term care. One home, in Anderson, provided care to 300 military veterans in FY 01-02. The other DMH nursing home, in Columbia, provided care to 114 veterans and 479 non-veterans in FY 01-02. Most of the non-veterans received mental health services from other DMH institutions prior to entering the Columbia nursing home. The combined cost of serving the residents of both homes in FY 01-02 was approximately $40.2 million.

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL — DHEC provides home health services to homebound persons needing medical care, such as nursing and physical therapy. In FY 01-02, DHEC provided home health services to approximately 20,480 clients at a cost of $30.7 million.

Consolidation of Senior and Long Term Care Programs

The senior and long term care programs discussed above can be consolidated. We have not included DHEC's home health program in these options, because home health is already consolidated with other public health programs within DHEC.

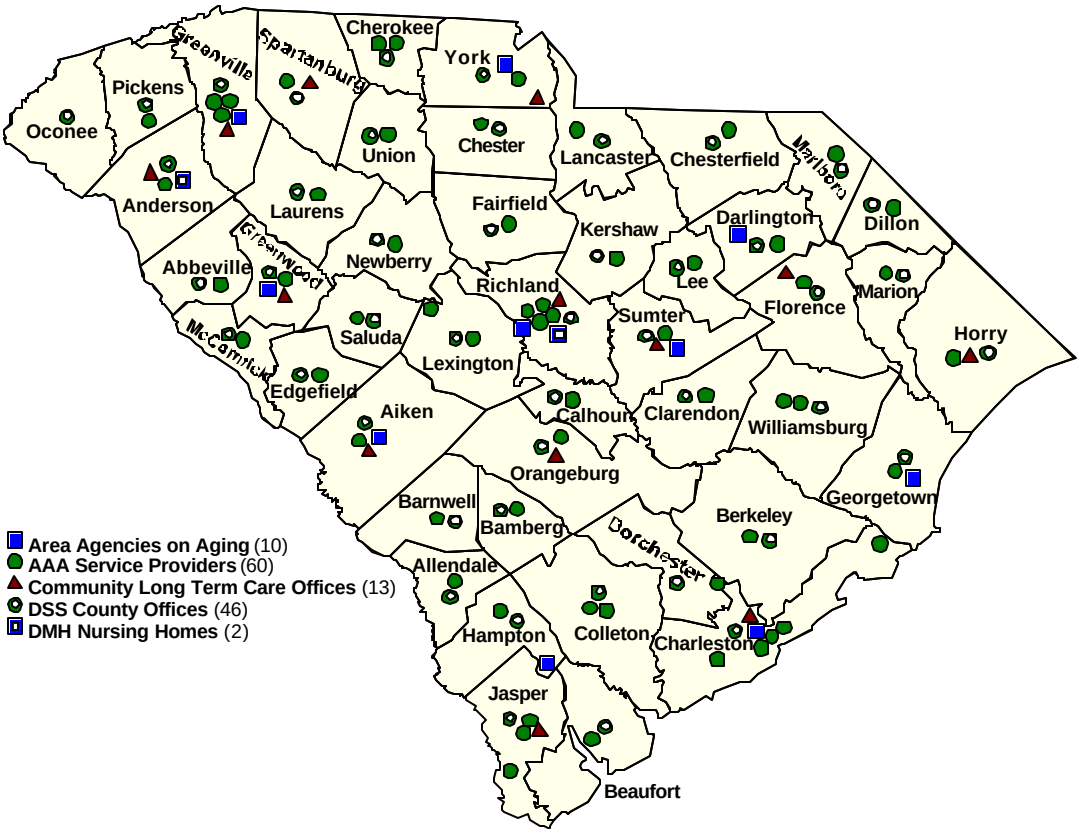
One option would be for senior and long term care services to be provided by a newly created, freestanding agency specializing in senior and long term care. This option would make it clear where clients can seek help and would reduce the need for interagency referrals and coordination. Caseloads for agencies that serve the elderly are projected to grow. The U.S. Census Bureau has projected a population increase of more than 100% for South Carolinians aged 60 and over between 2000 and 2025.

Consolidation would make it clear where clients can seek help and would reduce the need for interagency referrals and coordination.

Another option would be for these senior and long term care services to be provided either by the Department of Social Services or by the Department of Health and Human Services. This option would provide the service consolidation benefits of the first option and would not require extra administrative costs. It would, however, significantly expand and make more complex the mission of DSS. The consolidation of senior and long term care services within DHHS would require a change in state law. S.C. Code §44-6-30(4) prohibits DHHS from providing services.

Although central administrative costs could increase with a new agency, they could be partially offset through consolidation of some regional senior and long term care offices. As shown on Map 2.1, there are more than 100 offices that provide senior and long term care services.

Map 2.1: Senior and Long Term Care Offices



Consolidation of Area Agencies on Aging

Wherever the state aging network (currently at DHHS) is placed, there is an opportunity to reduce the number of its area agencies on aging. In a 1993 LAC audit, we reported that fewer AAAs would permit the aging network to operate more efficiently and/or with more staff expertise.

DHHS allocates federal and state funds to 10 AAAs, including seven councils of government and three private organizations. The AAAs perform planning and oversight functions and transfer most of their allocation from DHHS to 60 service providers throughout the state.

Two studies have reported that savings could be realized by reducing the number of AAAs. In 1985, a state office on aging study concluded that approximately $400,000 per year could be saved if four AAAs were operated

instead of 10. Also in 1985, a private consulting firm estimated that four versus ten AAAs could yield annual savings of $900,000. Because current administrative costs are higher than in 1985, the potential savings from fewer AAAs could be greater. South Carolina has the authority to reduce the number of its AAAs by following a process established in federal law.

Neighboring states have a wide range in the number of citizens aged 60 and over per AAA. Table 2.2 shows a list of states and their AAAs as of 1999. South Carolina has fewer seniors per AAA than most of these states.

Table 2.2: Seniors per Area Agency on Aging, 1999

State	Number of AAAs	Seniors Per AAA
Florida	11	312,000
Tennessee	9	101,000
Georgia	12	86,000
North Carolina	17	75,000
South Carolina	10	63,000
Virginia	25	41,000

The administrative savings from AAA consolidation could be used to expand client services and/or increase the number of personnel and degree of specialization within the fewer and larger areas. One area in need of increased attention is the awarding of contracts by area agencies to local service providers. The AAAs do not use a competitive procurement system for most services to ensure that providers are of higher quality and/or lower cost than other potential providers. Rather, the AAAs use a “sole source” method of selection. It is likely that additional service-providing organizations would submit bids and/or proposals if given the opportunity.

Addiction Treatment Programs

Three agencies operate addiction treatment and related programs that could be consolidated.

Department of Alcohol and Other Drug Abuse Services — DAODAS contracts with 34 local agencies throughout the state that provide community-based addiction treatment services. In addition, DAODAS provides addiction treatment services for the Department of Juvenile Justice and the Department of Labor, Licensing, and Regulation. In FY 01-02, DAODAS funded addiction recovery services for approximately 52,700 clients at a cost of $41.8 million.

DEPARTMENT OF MENTAL HEALTH — DMH provides inpatient addiction recovery services at two institutions in Columbia, one for adults and one for youth. The department's community mental health centers treat clients for addictions in conjunction with treatment for other mental illnesses. In FY 01-02, DMH provided addiction treatment services to approximately 5,870 clients at a cost of $17.2 million.

VOCATIONAL REHABILITATION DEPARTMENT — VR provides inpatient addiction treatment services in Florence and Greenville. In FY 01-02, VR provided addiction treatment services to approximately 1,035 clients at a cost of $2.5 million.

Consolidation of Addiction Treatment Programs

Three agencies provide addiction treatment and related services that could be consolidated.

Addiction treatment programs can be consolidated. One option would be for all addiction treatment services to be provided by an addictions unit within DMH, because addiction is often treated by mental health professionals. This option could make it clear where clients can seek help for addictions and could reduce the need for interagency referral and coordination. It could also reduce administrative costs because DAODAS would no longer exist as an independent agency. VR officials reported that federal law requires their clients' services to be coordinated by a VR counselor. Federal law, however, does not prohibit VR from purchasing services from another state agency, such as DMH.

A second option would be for all addiction treatment services to be provided through DAODAS. This option, however, would not reduce administrative costs and would continue the practice of providing mental health services through multiple agencies.

Neighboring states have varying organizational structures for addiction treatment services. Florida, Georgia, North Carolina, and Virginia have single divisions or departments whose services include both addiction treatment and general mental health care. In Tennessee, addiction treatment is provided by one agency, while general mental health care is provided by another agency. DAODAS officials reported that there are only three states other than South Carolina with "stand alone" agencies providing addiction treatment and related services.

Programs for Emotionally Disturbed Children

There is a parallel system of three agencies involved in determining the treatment needs of different groups of emotionally disturbed children. This system results in duplication and inefficiency in administration and may also direct resources away from early intervention and toward more expensive services.

DEPARTMENT OF MENTAL HEALTH — DMH is the primary agency that provides mental health services to children. One DMH institution treats children who require inpatient services, including substance abuse treatment. DMH also provides other services to children including individual, group, and family therapy, and "wraparound" services such as behavior managers and transportation. The department also offers school-based services in more than 400 schools. In FY 01-02, DMH provided services to approximately 33,100 children at a cost of $66.5 million. In addition to DMH, two other agencies provide case management services for subgroups of emotionally disturbed children.

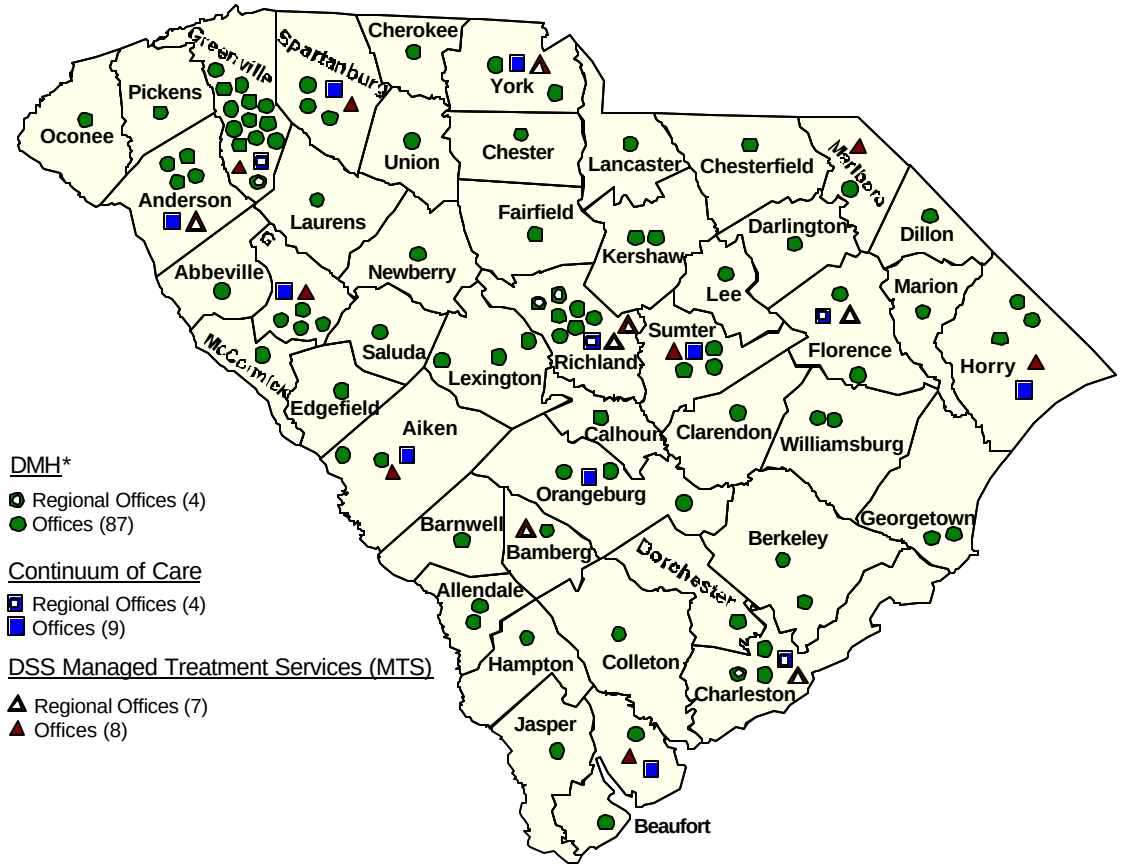
DEPARTMENT OF SOCIAL SERVICES — DSS provides case management services for children in the custody of the state who have emotional problems so severe that they cannot adjust in regular foster care. The DSS unit called managed treatment services (MTS) refers and places these children in homes that offer therapeutic foster care or in institutions such as group homes. DSS also acts as the legal guardian of these children. DSS served 1,915 children in FY 01-02 at a cost of approximately $69.3 million.

CONTINUUM OF CARE FOR EMOTIONALLY DISTURBED CHILDREN — The Continuum, in the Governor's office, provides case management services for children who are *not* in the custody of the state, but who are severely emotionally disturbed and whose needs have not been adequately met by existing services and programs. The Continuum served approximately 380 children in FY 01-02 at a cost of $11.6 million. The Continuum limits the number of clients it can serve, determining with assessments those who have the most severe needs. As of October 2002, approximately 100 children were on the Continuum's waiting list.

The three agencies have duplicated administrative structures. The Department of Mental Health, the DSS MTS unit, and the Continuum all have systems of regional offices that serve their clients (see Map 2.3). DMH has 4 regional coordinators housed at existing mental health sites. The DSS MTS unit has 7 regions and 15 offices around the state that are not a part of the DSS county offices. The Continuum has 4 regional offices and 9 "outpost" offices. The existence of multiple agencies serving emotionally disturbed children also results in duplicative information gathering and

inconsistent assessments. For example, the Continuum requires a lengthy application and performs its own assessments, which may differ from the assessments used by DSS or DMH.

Map 2.3: Services for Emotionally Disturbed Children



* DMH does not have separate regional offices; its regional coordinators are housed in existing offices. DMH offices include all clinics and other specialized facilities such as group homes, but do not include schools where DMH offers services.

Consolidation of Programs for Emotionally Disturbed Children

All mental health services for children could be combined in the Department of Mental Health. This option would make it clear where families with emotionally disturbed children can seek help and would reduce the need for interagency referral and coordination. It would also reduce some administrative costs because the Continuum would no longer need its own administrative services. There would be potential administrative savings in eliminating the overlapping systems of regional offices. An agency official stated that if the offices serving emotionally disturbed children were spread more evenly over the state, case managers could spend less time traveling and could handle more cases. For example, while case managers at DSS and the Continuum now handle 10 – 12 cases, this load could be increased to 15 – 20. Consolidation could eliminate the duplication of assessments performed by different agencies.

An advantage of service consolidation would be the possibility of unified planning of services for all emotionally disturbed children.

Because the Department of Social Services would retain its responsibility as the guardian of children in the custody of the state, its internal costs would increase if many of its case managers were moved to DMH. However, these costs could be partially offset by the savings discussed above. Also, most of the children now served by DSS and the Continuum are also currently served by DMH. DMH staff participate in teams making treatment decisions for the children. These resources could be redistributed in the system.

Another advantage of service consolidation would be the possibility of unified planning of services for all emotionally disturbed children. Officials estimate that not nearly all the emotionally disturbed children in the state are being served by any agency. Based on a federal formula, estimates of the number of seriously emotionally disturbed children with substantial functional impairment range from 56,000 to 67,000 children. As many as 40 – 50% of these children may not have been served at all by the current system. An increased emphasis on early intervention could lessen the need for the “high-end” expensive placements now needed by children served by DSS and the Continuum. Finally, children served by DSS and the Continuum “age out” of eligibility for services usually by age 18 or 21. The Department of Mental Health provides services that could continue into adulthood if needed.

The state of North Carolina formerly had a program similar to the Continuum which provided a system of services to a specific group of severely emotionally disturbed children who had not been adequately served by existing agencies and programs. After 1998 this program was more fully integrated into North Carolina’s mental health agency. Partially by using

administrative savings, the services formerly available just to a small group with severe needs may now be provided to more children with a variety of mental health needs.

Interagency Structure for Case Management

S.C. Code §20-7-5710, passed in 1994, provides for an Interagency System for Caring for Emotionally Disturbed Children (ISCEDC). A number of agencies were to be involved in determining the proper services and placement for each emotionally disturbed child. Both DSS and the Continuum use multi-agency teams to appropriately plan for children under the current systems. Officials agree that all agencies involved with the child, including the schools, should be included in the effort to serve children effectively. If services were consolidated in the Department of Mental Health, the interagency structure could be continued, with appropriate amendments reflecting the new structure.

Simplification of payment structure should be a feature of a consolidated system of care.

Under the current system, the agencies serving severely emotionally disturbed children often share the costs of their placement. According to officials, this system results in unnecessary and time consuming transfers of funds between agencies. Simplification of payment structure should be a feature of any new consolidated system of care. This could be accomplished, for example, by having the Department of Health and Human Services serve as the manager of funds to pay for services purchased for emotionally disturbed children served by more than one agency.

Rehabilitative Services

In a July 2002 LAC audit, we reported that the South Carolina Commission for the Blind and the Vocational Rehabilitation Department both provide rehabilitative services such as disability determination and rehabilitation. In FY 01-02, the Commission for the Blind served approximately 4,800 clients at a cost of $9.6 million. VR served approximately 37,700 clients at a cost of $67.4 million. We recommended that the General Assembly consider various options for merging the Commission for the Blind with the Vocational Rehabilitation Department. A merger would reduce the number of agencies providing rehabilitation services. It could also reduce administrative costs, because the Commission for the Blind would no longer exist as an independent agency.

Governor's Cabinet

As shown in Chart 2.4, most of the health and human services agencies we were asked to review are not part of the Governor's cabinet. There is therefore no central point of accountability for the performance of these agencies. No executive branch entity has the authority to ensure comprehensive planning and budgeting or that services are provided efficiently.

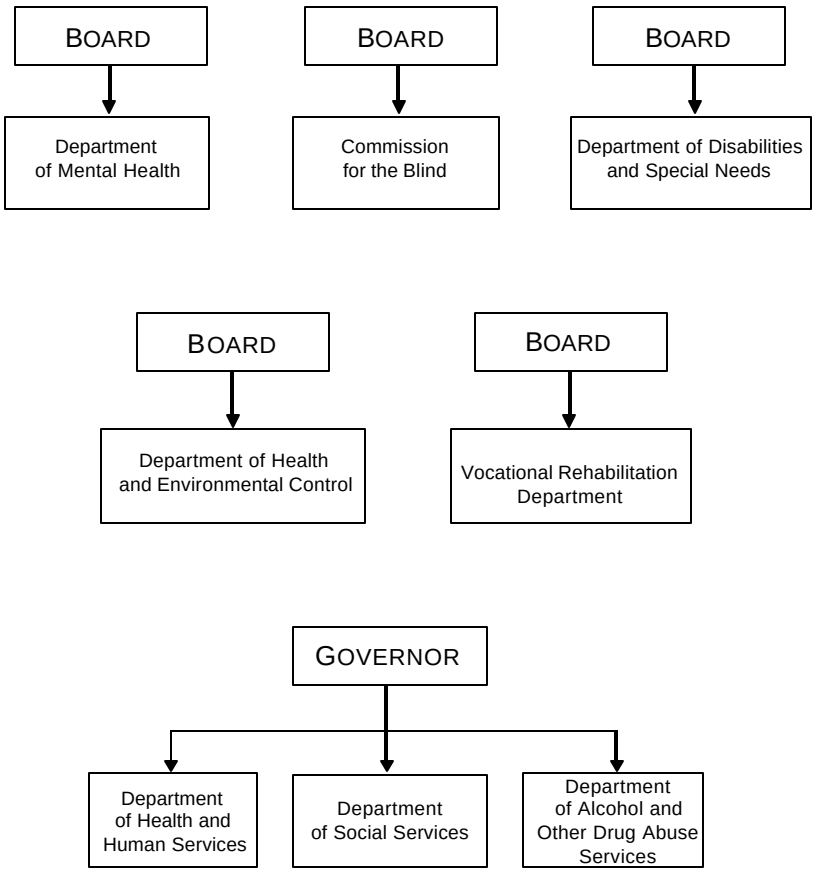
For each cabinet agency, the Governor has the authority to appoint and supervise a cabinet secretary. Because the Governor is elected every four years, the public can hold him accountable for a cabinet agency's performance. By contrast, non-cabinet agencies are overseen by multi-member boards and commissions (appointed by the Governor) who appoint agency directors.

There is no central point of accountability for the performance of these agencies.

The directors of non-cabinet agencies are insulated from accountability, because their boards and commissions are not elected by the general public. The Governor has no mechanism for hiring or terminating non-cabinet agency directors other than the indirect and time-consuming process of appointing board or commission members. Without direct oversight authority over agency directors, it is less likely that the Governor will be held accountable for the performance of a non-cabinet agency.

There can be other negative effects from including just a few agencies in the cabinet. The Governor has no authority to coordinate service delivery among all of the health and human services agencies. The Governor also has limited authority to resolve differing points of view among agencies before they submit funding requests to the General Assembly.

Chart 2.4: Oversight Structure of Health and Human Services Agencies Reviewed



Consolidation of Agencies Within the Cabinet

There is more than one potential structure for consolidating all health and human services agencies within the Governor's cabinet. Under one structure, state law could be amended so that each health and human services agency is headed by a separate cabinet secretary appointed by the Governor. A disadvantage of this structure is the lack of a cabinet-level official with the authority to oversee the entire health and human service system.

Alternatively, state law could be amended to authorize a single cabinet secretary, appointed by the Governor, to oversee all health and human services agencies. The cabinet secretary would be responsible for supervising a separate director for each health and human service agency. With a

single-secretary structure, one official would have authority for planning, budgeting, and delivering services throughout the health and human services system. The process of consolidating and managing programs with similar services would be easier. This cabinet secretary could also better ensure integration and consolidation of the agencies' information technology (see p. 19).

In general, the Governors in neighboring states have greater authority to appoint department heads than South Carolina's Governor.

In general, the Governors in neighboring states have greater authority to appoint department heads than South Carolina's Governor. In North Carolina and Virginia, health and human service agencies are headed by a single secretary appointed by the Governor. Georgia has a unified health and human service agency with separate divisions, headed by a commissioner and a board appointed by the Governor. Neither Florida nor Tennessee has a unified health and human service agency. They have multiple health and human service agencies with separate agency heads appointed by the Governor.

Officials at the S.C. Department of Disabilities and Special Needs and the S.C. Vocational Rehabilitation Department have stated that their clients would have diminished input into agency decisions under a cabinet system of governance. In our view, however, a cabinet system could increase accountability and responsiveness to client concerns by directly linking the performance of agencies with a single statewide elected official who is authorized to implement changes. This is particularly important when an agency's programs or its leadership develop problems that need to be addressed urgently.

The authority and accountability of the Governor in South Carolina would be increased if each health and human service agency were part of the cabinet, under the authority of a single cabinet secretary.

It is important to note that South Carolina state government has health and human service agencies and programs in addition to those we reviewed in this audit. For example, the Governor's office operates the Children's Foster Care Review Board, while the Department of Education operates programs to prevent drug abuse and teen pregnancy. Also, one of the agencies we reviewed, the Vocational Rehabilitation Department, does not view itself as a health or human service agency. Officials with the department stated:

> … [A]s a cabinet agency the Vocational Rehabilitation Department might operate more effectively if grouped with other employment-oriented programs. Among the eight agencies in this review, SCVRD is the only mandated partner with the Workforce Investment Act administered by the U.S. Department of Labor.

Conclusion

If programs with similar services were consolidated into fewer agencies, under the authority of a single cabinet secretary, obtaining help from state government could be made less complex. The need for different agencies to make referrals to each other could be reduced, while planning and budgeting could be done more comprehensively. In most cases, administrative costs could be lower.

We have not provided figures for the potential savings from fewer agencies under a single cabinet secretary. Savings estimates would be subject to error, because they would depend on a number of variables, including but not limited to the following:

- The specific consolidation measures selected.
- The managerial decisions of those implementing the consolidation.
- The adequacy of current funding and staffing levels.
- The success of implementing long-term improvement in areas such as information technology.

It is not likely that there is a "best way" to consolidate South Carolina's health and human service programs. Nonetheless, changes in organizational structure can be successful if they are designed to improve services and lower costs.

Recommendations

The General Assembly should consider amending state law to consolidate the state's health and human service programs. The objectives of this consolidation should include reduced complexity for clients, less frequent need for interagency referrals, more comprehensive planning and budgeting, and, where feasible, lower administrative costs. In developing this legislation, the General Assembly should consider the following specific recommendations.

1. Create a freestanding agency for senior and long term care services, comprised of:
   - The community long term care program of the Department of Health and Human Services.
   - The state office on aging of the Department of Health and Human Services.
   - The adult protective services program and the homemaker services program (for adults) of the Department of Social Services.
   - The nursing homes operated by the Department of Mental Health.

2. Require the state office on aging, currently within DHHS, to reduce the number of area agencies on aging.

3. Require area agencies on aging to use a competitive procurement method when awarding contracts to local service providers.

4. Consolidate the Department of Alcohol and Other Drug Abuse Services and the inpatient addiction treatment services of the Vocational Rehabilitation Department within the Department of Mental Health.

5. Consolidate the Continuum of Care for Emotionally Disturbed Children and the Department of Social Services' program for emotionally disturbed children within the Department of Mental Health.

6. Consolidate the Commission for the Blind within the Vocational Rehabilitation Department.

7. Establish a single cabinet secretary to oversee all health and human services agencies.

Information Technology (IT) Issues

The fragmentation of information systems at the health and human service agencies has been a longstanding problem. In South Carolina, agencies are not able to efficiently track clients who obtain services from more than one program or agency, and clients must supply the same information multiple times. Efforts to determine the feasibility of creating a unified or "enterprise" information system have been slowed (see p. 21). Previous inter-agency efforts to collaborate and improve this situation have not been successful.

We did not review information technology in depth because of ongoing projects that plan to address these issues. We provide information on two ongoing projects that are related to efforts to consolidate the agencies' information systems and create standards that would be beneficial for interagency communication and coordination. We also identified one area (compliance with the 1996 federal HIPAA law) where the effects of fragmented management of IT are evident.

HIPAA Compliance

The state has not taken a unified approach to ensure that agencies comply with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, public and private entities that administer health plans (such as Medicaid or state employee plans), health care providers (such as DHEC or DMH), and health information clearinghouses must take the following steps:

- Ensure that individually identifiable health care information remains confidential and secure.
- Standardize how administrative and financial health care information is exchanged electronically.

The law provides deadlines for implementation with stringent penalties for noncompliance. The original deadline for the standards for health care information processing was October 2002; however, agencies have received an extension until October 2003. The deadline for implementing the privacy rules is April 2003. Through standardizing electronic claims processing, HIPAA is expected to result in cost savings in the future, particularly for entities in the private sector. South Carolina officials do not predict that the state will realize financial benefits in the near term, although improved consistency in the information used by agencies would be beneficial.

The Budget and Control Board has appointed a HIPAA coordinator, but his role is informal, primarily limited to helping agencies identify and share relevant information. As of October 2002, he did not have information on exactly which agencies are required to comply with HIPAA or an estimate of the state's total cost. In December 2002 the board furnished information that 14 state agencies (including DAODAS, DDSN, DHEC, DHHS, DMH, and DSS) are covered by HIPAA.

According to the HIPAA coordinator, the General Assembly has not appropriated additional funds for HIPAA compliance, and agencies may be unable to comply. State Medicaid agencies may obtain federal funds to aid in HIPAA compliance. According to an official with the Department of Health and Human Services, that agency's costs to comply with HIPAA are currently estimated at approximately $31 or $32 million, but federal funds may pay $25 or $26 million. Some agencies, such as DHEC, have developed cost estimates, but may not have funds to complete the work. Other agencies, such as DDSN and DSS, do not have comprehensive estimates of what it will cost to comply.

Other states have approached the issue with a unified planning effort. For example, the North Carolina Department of Health and Human Services completed a high-level, statewide HIPAA impact assessment and compliance plan. This document estimated that the statewide cost for HIPAA compliance in North Carolina would be $119.3 million. A statewide approach to HIPAA planning would benefit South Carolina agencies that must comply with the law.

Feasibility Study for a Consolidated Information System

One way to eliminate duplication in information systems would be to develop a new information system for all client-related data across agencies. Proviso 72.90 in the FY 02-03 Appropriations Act required the Budget and Control Board to contract for a feasibility study for the development of a comprehensive ("Enterprise") information system for the eight agencies we reviewed. According to the proviso, the goal of the system would be "to add operational efficiencies, reduce redundant IT costs, and to enable state health agencies to deliver client services in a more focused, efficient, and cost-effective manner." A priority area for the new system would be eligibility determination and coordination.

Although the proviso required that the study be completed by January 2003, as of November 2002, the board had not yet contracted for the study. Lack of funding was a major cause of the delay. The proviso authorized the Budget and Control Board to charge the agencies for all costs associated with the study, and some agencies were seeking federal funds.

Enterprise Architecture Project

Another way to improve coordination and the ease of sharing information would be for the state to adopt statewide standards for information technology. Our 1997 audit, *Improving South Carolina's Management and Use of Information Technology*, recommended that the state adopt standards for hardware and software, which could result in cost savings and improved efficiency. While various state entities have adopted guidelines for some areas of information technology, statewide standards have not been put in place. The Budget and Control Board has contracted for a plan to develop a statewide information architecture (a set of standards) that would help in the standardization of security and other IT policies across state agencies.

The contractor is working with 19 agencies, including 6 health and human services agencies (DHHS, DSS, DHEC, DMH, DDSN, and DAODAS), to develop a recommended architecture and implementation plan. As of November 2002, this project was still in the first of three phases, developing

a plan. According to officials, this phase may be completed by early 2003. The cost for the first phase of the project is $343,600. A second phase would adapt the architecture to the needs of five high priority business areas for the state (to be determined at that time), and a third phase would design the structure by which the state would govern and manage the standards on an ongoing basis. A key challenge in implementing standards is enforcing them once they are in place.

Summary

It is clear that efforts to meet the information technology needs of the health and human services agencies, as well as those of other agencies, will require substantial resources. A unified effort in planning and implementation of information technology advances would help ensure success. A single cabinet department for all health and human services agencies could contribute to this goal (see p. 15).

Collections from Clients and Eligibility Issues

We found that the Department of Mental Health (DMH) and the Department of Health and Environmental Control (DHEC) have not maximized client and insurance payments for their services. In addition, the Department of Alcohol and Other Drug Abuse Services (DAODAS) could do more to ensure that its providers recover payments from clients. We did not assess Medicaid collections in this review.

DMH, DHEC, and DAODAS all offer services for which clients are required to pay. In each case, the agencies cannot deny service to clients with insufficient resources. But for clients who can pay, we could not determine any reason that the agencies should not take action to collect. Increased collections could result in increased services for clients who need them. The Department of Revenue offers programs that can assist agencies in collecting funds due the state.

Department of Mental Health Collections

There is potential for increases in patient account revenues at the Department of Mental Health. In FY 01-02, DMH collected $6,219,553 in inpatient facilities and $2,196,676 in community mental health centers in private insurance and client payments (see Table 3.1). In FY 01-02, the community mental health centers (CMHCs) collected only 10% of self pay and 15% of private insurance billed, resulting in high receivables balances. The agency was owed in excess of $3 million (as of December 2001) for inpatient services and $21 million (as of June 2002) for community mental health center services. These balances do not include amounts written off as uncollectible.

Table 3.1: Department of Mental Health Collections FY 00-01 Through FY 01-02

	FY 00-01		FY 01-02	
	Private Insurance	Self Pay	Private Insurance	Self Pay
Inpatient Facilities	$1,194,764	$6,284,337	$636,352	$5,583,201
Community Mental Health Centers	1,488,347	860,272	1,323,002	873,674
TOTAL	$2,683,111	$7,144,609	$1,959,354	$6,456,875

Source: Department of Mental Health

The Department of Mental Health provides services to clients regardless of their ability to pay and cannot refuse services to anyone based on an inability to pay. Most DMH outpatient clients qualify for fee reductions based on their income. As of November 2002, 69% of DMH's self-pay clients receiving services from a community mental health center received a fee reduction based on income. Of those with a reduction, 90% had a reduction of 90% or greater. Clients with these reductions are generally charged $2 for each service. However, according to agency officials, the community mental health centers are not collecting the $2.

The community mental health centers collected as little as 2.2% of the amount billed to patients.

DMH policy requires that clients' income be re-verified on an annual basis. DMH internal audit reports since February 2000 showed that all eight of the centers audited did not properly verify or re-verify the income of clients with fee reductions. These reports also showed other problems including:

- Not investigating insurance coverage.
- Inadequate staffing in billing and accounts receivables.
- Not using the outstanding claims report to follow-up on old claims.
- Lack of management oversight of billing operations.

The community mental health centers collected as little as 2.2% of the amount billed to patients and as little as 9.8% of the amount billed to insurance. In FY 01-02, collection percentages for private pay varied from 2.2% to 29.2% of the amount billed and private insurance from 9.8% to 21.9% (see Table 3.2). In addition, we found that different centers have varying office collection procedures. In some centers, staff inform patients of charges prior to their appointments, and after services are rendered, they take patients to a check-out area where payment is requested. In other centers, clients simply leave after their appointments. DMH officials agree that collections vary based on the aggressiveness of collection efforts.

Staff cited lack of billing staff and the computer system as reasons why they have not been aggressive. According to staff, the system is over 30 years old and does not have capabilities that a medical office needs. For example, the system is not set up to calculate deductibles or co-pays for private insurance. Staff must contact the insurance companies manually, adding to the workload.

Table 3.2: Collection Percentages by Community Mental Health Center, FY 01-02*

	Insurance			Self Pay		
Center	Billings	Collections	Collections as % of Billings	Billings	Collections	Collections as % of Billings
Aiken	$440,035	$60,825	13.8%	$635,299	$53,139	8.4%
Anderson	379,787	81,652	21.5%	442,652	114,630	25.9%
Beckman	514,501	81,455	15.8%	195,136	48,730	25.0%
Berkeley	488,344	70,582	14.5%	380,916	53,969	14.2%
Catawba	942,154	153,975	16.3%	848,789	85,116	10.0%
Charleston	391,158	80,427	20.6%	516,136	40,614	7.9%
Coastal	330,001	51,915	15.7%	206,330	60,336	29.2%
Columbia	514,399	76,114	14.8%	720,335	46,944	6.5%
Greenville	381,842	83,560	21.9%	480,413	44,940	9.4%
Lexington	522,090	75,617	14.5%	543,800	46,912	8.6%
Orangeburg	431,114	47,809	11.1%	476,746	26,136	5.5%
Pee Dee	567,847	55,443	9.8%	626,456	23,258	3.7%
Piedmont	516,363	93,805	18.2%	306,195	88,288	28.8%
Santee	526,729	85,469	16.2%	828,297	60,585	7.3%
Spartanburg	718,841	87,442	12.2%	502,988	47,313	9.4%
Tri-County	344,801	51,949	15.1%	503,743	11,041	2.2%
Waccamaw	791,637	84,963	10.7%	183,877	21,723	11.8%
TOTAL	$8,801,643	$1,323,002	15.0%	$8,398,108	$873,674	10.4%

*The billings for insurance and self pay are not mutually exclusive; insurance billings that are rejected may be then billed to patients.
Source: Department of Mental Health

Department of Revenue (DOR) Programs

The Department of Revenue has two programs that can increase recoveries for state and other governmental agencies. These agencies include health and human services agencies, such as the Lexington/Richland Alcohol and Drug Abuse Council (see p. 33).

The Setoff Debt program withholds amounts owed to S.C. governmental entities from individual taxpayers' refunds. The Governmental Enterprise Accounts Receivable (GEAR) program is an enhancement to the Setoff Debt program which functions as a collection agent and has the authority to garnish wages, seize bank accounts, sell real or personal property, and revoke any licenses. The taxpayer is charged a flat fee of $25 for each Setoff Debt collection. The GEAR program assesses a 28.5% fee for the collection. The Department of Revenue has increased collections in the Setoff Debt program over the last three years to over $56 million in 2002 (see Table 3.3).

According to the Department of Revenue, S.C. Governmental entities have an estimated $1.4 billion in unpaid accounts. This forces taxpayers to make up the balance. In addition, clients may have less incentive to comply when they perceive collection efforts to be weak.

Table 3.3: Department of Revenue Setoff Debt Collections for all Entities

	Tax Refunds Affected	Amount
Calendar Year 2000	190,609	$46,306,794
Calendar Year 2001	207,363	$49,553,523
January 1, 2002 – August 31, 2002	221,299	$56,923,119

Ways to Increase Collections

The greatest potential for increasing collections at the Department of Mental Health would be in the community mental health centers. The DMH central office is using the Department of Revenue's Setoff Debt program for inpatient services, and also uses liens against the estates of clients for collection of inpatient accounts. However, the community mental health centers have not used these collection methods.

In FY 00-01, DMH began using the Setoff Debt program to collect inpatient accounts and in calendar year 2001 collected $222,355 from 776 individuals. DMH uses this program only for debts less than three years old, as allowed by state law. In 2002, the central office started a pilot project with the Columbia area mental health center to determine if this program would be beneficial in collecting amounts owed to the centers. According to DMH officials, some funds have been collected but the number of debts submitted was too few to calculate the effects. They plan to continue the project for 2003.

Officials at the community mental health centers were receptive to using the Setoff Debt program. Funds that are collected by the community mental health centers stay at the centers and could result in more services for clients. Also, with the Department of Revenue programs, once the agency turns the debt amounts over to the DOR, it does not have to further pursue these collections.

Liens

DMH also collects delinquent accounts by placing liens or claims against the estates of clients who are deceased. In 2001 the department collected $732,927 through liens. The liens placed by the department are for inpatient charges only and do not include charges by the CMHCs. This process places a lien on property while a client is living, but no payment is required until the client is deceased.

For every 10% increase in self pay collections, DMH would obtain approximately $840,000 in additional revenue.

Officials at DMH were not aware of any reasons why the community mental health centers could not process liens or claims against estates. Alternatively, the central office could include the centers' charges in its lien filings. As long as the records of charges are available, the liens can easily be processed. Community centers are also able to submit bills to an open estate; however, this requires that they know the client is deceased.

Notice of Death

The central office has an agreement with DHEC to receive an electronic report of deaths in S.C. which can be run against the client database to determine if clients or former clients were deceased. This report is run against the inpatient system and not the outpatient system. According to a DMH official, with little adaptation they could also cross check the clients who are served through the outpatient system. This report allows liens or claims against an estate to be filed in a timely manner. Although many inpatient clients also receive outpatient services, the death report is not forwarded to the community mental health centers.

Conclusion

The benefits from increased collections would be substantial. For every 10% increase in self pay collections, DMH would obtain approximately $840,000 in additional revenue.

Funds Transferred from DMH to the General Fund and Private Entities

Annual provisos in the appropriations acts required DMH to contribute funds from the patient fee account to private entities. Since 1983, private non-profit entities have been allocated over $4.7 million from the patient fee account. These funds were previously designated for capital improvements. In addition, since 1984, provisos have required the department to place $3.8 million in the General Fund annually from this account. It is unclear whether transferring these funds is the most appropriate use of funds from the patient fee account.

Table 3.4: Patient Fee Account Funds Transferred from DMH

Recipient of Funds	FY 01-02 Amount*	Transferred Since	Total Transferred
General Fund	$3,800,000	1981	$88,083,000
Palmetto Pathways	$50,000	1983	1,040,000
S.H.A.R.E.	$250,000	1992	2,896,000
Alliance for the Mentally Ill	$50,000	1992	300,000
New Day Clubhouse	$50,000	1995	450,000
TOTAL			$92,769,000

* Amounts have varied in some years.
Source: Department of Mental Health

Recommendations

8. The Department of Mental Health should follow its policies regarding verifying income for reduced fee clients.

9. The Department of Mental Health should continue to use the Setoff Debt program for inpatient accounts and, where appropriate, implement the GEAR program.

10. The Department of Mental Health should implement the Setoff Debt program in the community mental health centers and, where appropriate, the GEAR program.

11. The Department of Mental Health should include charges to community mental health centers in the existing lien process or implement a lien process in the community mental health centers.

12. The Department of Mental Health should provide information to the community mental health centers concerning deceased patients as received from the Department of Health and Environmental Control.

13. The General Assembly should consider allowing the Department of Mental Health to retain funds collected from patients.

Department of Health and Environment Control Collections

The Department of Health and Environmental Control (DHEC) has not made an adequate effort to collect funds owed by clients for health services. In our 1996 audit of DHEC's health services, we found that DHEC did not have an adequate system for billing, tracking, and collecting accounts receivable. Although the department has improved its information system so that it has the capability to support a better collection effort, DHEC still does not make a consistent effort to bill and collect amounts due. The department has several health service programs which require that a client pay a portion of or the total fee for a service. Many of these services are also billed through Medicaid, Medicare, or private insurance.

Billing

Although several programs require clients to pay if they can afford to pay, DHEC only bills a small percentage of its clients. For example, federal regulations require that in the family planning program, DHEC determine charges based on income. According to a DHEC official, DHEC staff determine who is eligible for reduced fees by asking for a client's income and family size; no documentation of income or family size is required. In FY 01-02, the family planning program served 114,546 clients. Of those served, 67,134 were Medicaid clients. Of those not Medicaid-eligible, 71% received a 100% fee reduction requiring them to pay nothing. Only 9% of total clients were billed for services.

Proof of income is not required to qualify for reduced fees.

The children's rehabilitative services (CRS) program serves clients below 225% of the federal poverty level. The program manual refers to a patient fee schedule for charging clients; however, staff stated that they never bill CRS clients for services. DHEC may bill clients for the insurance reimbursement if it is sent to the client instead of DHEC. According to staff, clients respond to these billings about 50% of the time and reimburse the funds. DHEC can remove clients from this program if they don't provide financial or insurance information, and staff stated they have done so on rare occasions.

The DHEC home health program also bills clients who are not Medicare or Medicaid eligible. Clients may qualify for reduced fees based on their income; however, proof of income is not required. In FY 01-02, the home health program collected 69% of charges billed, and 22% of the amount billed was written off.

When there are significant public health interests, DHEC provides services free of charge to clients. For example, several sexually transmitted diseases and HIV services do not have private pay charges. Also, many immunizations are given free of charge to persons without insurance or to those who are underinsured.

Collections

DHEC reports on average it has collected about 68% of the amounts billed to clients for private pay and private insurance. However, that amount does not include amounts not charged to clients for services. The health districts reported a total of $1.8 million in accounts receivable. DHEC does not use any aggressive measures to collect funds from clients. According to DHEC officials, a vigorous collection effort might discourage patients from obtaining needed services.

Table 3.5: Collections by DHEC Health District, FY 01-02

	Private Pay	Private Insurance	Total Collections*
Appalachia I	$459,478	$3,825	$463,303
Appalachia II	797,151	23,216	820,367
Appalachia III	644,648	970	645,618
Upper Savannah	361,966	4,480	366,446
Wateree	412,826	16,885	429,711
Palmetto	729,622	21,470	751,092
Catawba	372,873	1,964	374,837
Lower Savannah	301,425	30	301,455
Edisto	311,674	8,505	320,179
Pee Dee	792,420	78,914	871,334
Wacammaw	451,757	16,938	468,695
Trident	483,501	24,266	507,767
Low Country	323,290	713	324,003
TOTAL	$6,442,631	$202,176	$6,644,807

* Does not include Medicaid or Medicare payments.
Source: Department of Health and Environmental Control

Lack of Policies

DHEC does not have consistent policies for collecting or tracking amounts owed. The health districts track receivables to some extent, but this information is not reported to the central office. The districts also do not track amounts owed by program.

Although DHEC policy requires that districts record billing and collection information in applicable systems, this does not lead to uniform processes in the health districts. For example, the McBee system (a private pay recording system) has a billing form built in and the ability to generate delinquent letters; however, there is no written policy requiring that delinquent letters be sent. The information system may have the capability of supporting an adequate collection system, but if its features are not used then the system has little effect.

According to a policy in DHEC's central administrative policy manual, accounts receivable balances may be written off if two delinquent notices are sent or 120 days have elapsed. This policy also states that "it is the ultimate responsibility of each organizational area who provides the service/good to determine collection attempts and document specific detailed write-off procedures." We found that only two health districts have billing, collection, or write-off policies as required. The lack of policies may result in inconsistent treatment of clients and a loss of revenue. The home health and children's rehabilitative services programs have central billing policies for their programs. However, children's rehabilitative services staff do not bill clients, and this policy allows the write-off of charges if there is no response from an insurance company after three billings.

Ways to Increase Revenue

The Department of Health and Environmental Control could increase collections from clients by developing and implementing uniform billing and collection procedures applicable to all health districts. The department could also strengthen the requirements for an account to be written off. DHEC could also participate in the Department of Revenue's setoff debt or GEAR programs (see p. 25) to collect debts for health services. DHEC does participate in the GEAR program for the collection of debts owed for environmental services.

Federal regulations for the family planning program require that fees be established. By establishing a fee schedule, but not verifying income to qualify for fee reductions, DHEC does not have adequate controls over these reductions to ensure they are appropriate. One way to improve controls would be for DHEC's internal audit staff to review collection practices.

DHEC's Perspective

Numerous staff stated that DHEC is not aggressive in the collection of funds because it does not want to deter clients from obtaining services. However, by making greater efforts to collect funds owed, DHEC would be able to serve more clients or enhance services.

Recommendations

14. The Department of Health and Environmental Control should require verification of income before fee reductions are given.

15. The Department of Health and Environmental Control should implement a uniform billing and collection policy for the health districts.

16. The Department of Health and Environmental Control should participate in the Department of Revenue's programs for debt collection in health service programs.

17. The Department of Health and Environmental Control's internal audit division should review the agency's collection efforts.

Client Payments for Addiction Treatment Services

The Department of Alcohol and Other Drug Abuse Services (DAODAS) could do more to ensure that its providers receive payment from clients. DAODAS contracts with 34 private and local government providers who offer services to clients, and it does not have direct control over client payments. However, DAODAS requires that the providers have "…an operational fee policy that includes uniform and consistent billing and collection procedures that are indiscriminately applied to all services provided …to clients." The policy also requires that the providers follow DAODAS policy for assessing clients' resources and determining their ability to pay. However, the department does not ensure that the providers follow these policies. The providers keep the funds they collect, and the amount they collect does not affect their funding from the state. Also, although DAODAS completes an annual review of provider performance, the review does not include compliance with collection policies.

In FY 01-02, the 34 providers collected a total of $9.6 million in insurance and client payments (excluding Medicaid). Some providers take more steps to collect from clients than others. For example, the Lexington/Richland Alcohol and Drug Abuse Council (LRADAC) has used the Department of

Revenue's Setoff Debt and GEAR collection programs to greatly increase its collections (see p. 25). For FY 01-02, LRADAC collected $428,285 as a result of these programs (25% of its total collections). As of August 2002, LRADAC and 21 other DAODAS providers (65%) had used the DOR programs.

DAODAS's funding allocations to the providers have been based primarily on historical funding. According to an agency official, the agency is planning to base future funding more on benchmarks for client outcomes. DAODAS could consider standards for revenue collection as part of the new funding formulas. At a minimum, it could review providers' collection policies and results as part of its annual review of providers. Maximizing revenues from clients who have adequate resources can result in more funds being available to provide needed services.

Recommendation

18. The Department of Alcohol and Other Drug Abuse Services should ensure that its service providers comply with policies for determination and collection of client fees.

Client Eligibility

One of our audit objectives was to determine whether the Department of Health and Environmental Control (DHEC) and the Department of Social Services (DSS) have adequate controls to determine eligibility for programs which are primarily based on client income and/or assets. The family independence (FI) program and food stamp program are administered by DSS, and the women, infants, and children (WIC) program is administered by DHEC.

DSS has not consistently verified client assets.

We reviewed family independence cases approved from July 2001 to December 2001 in two DSS county offices. While we found no material problems with the verification of client income or the recertification of cases, our review indicated that DSS has not consistently verified client assets.

We concluded that the internal controls for the food stamp program are adequate. The program is reviewed at various levels for client eligibility. For the WIC program, federal requirements for documentation of client income are very general, and there are no requirements relating to client assets.

Family Independence Program Eligibility Requirements

The family independence program replaced the previous welfare system and requires able-bodied adults to work or to participate in training activities to receive benefits. For the period of our review, DSS policy required FI applicants who were employed to provide documentation of earned income for eight consecutive weeks. As evidence of income, the agency accepted paycheck stubs or employer wage forms. This requirement did not apply to persons who were unemployed at the time of application. In these cases, DSS uses sources such as the income eligibility verification system which provides data on wages, unearned income, and unemployment compensation.

For assets such as real property and bank accounts, DSS policy lists various types of verification sources including court records, current bank statements, and tax receipts. State law does not require DSS to verify assets unless there is a reason to believe that the applicant has falsified, misrepresented, or omitted material facts relating to eligibility. However, according to DSS staff in the two counties that we reviewed, a property check should be conducted through the county courthouse records in the county where the person is applying for services. If the applicant indicated that he/she did not own any property, this property check is the agency's primary method of verification. Officials in these counties verify information on bank accounts by obtaining bank statements or documentation such as a receipt from an automated teller machine from the applicant.

In addition, §43-5-65(d) of the South Carolina Code of Laws requires recertification of on-going FI cases at least every 12 months. DSS policy requires the caseworker to re-verify all eligibility requirements, including income and asset documentation.

Family Independence Case Reviews

We selected a limited sample of family independence cases approved from July 1 through December 31, 2001, in Richland and Georgetown counties. In 15 (23%) of the 65 cases that we reviewed, DSS did not verify ownership of real property. In addition, in 5 (28%) of the 18 cases where verification of a bank account was required, the agency did not obtain verification.

Agencies administering programs which are based primarily on client income and assets must ensure that only eligible applicants are receiving benefits. When client income and assets are not verified, the number of ineligible applicants receiving services is likely to increase.

Food Stamp Program

The food stamp program, funded by the U.S. Department of Agriculture (USDA), provides assistance to help families buy food. We determined that the internal controls for the food stamp program are adequate. There are various levels of review conducted on food stamp cases. DSS's quality control division randomly selects food stamp cases throughout the state. One aspect of the division's review is to determine whether a client was eligible to participate in the program. Then, to validate the state's quality control system, USDA staff review some of the cases already reviewed by DSS staff. From FFY 93-94 to FFY 00-01, South Carolina received a total of $11.8 million in enhanced funding from the USDA for maintaining a low error rate for the food stamp program. For the last two years, South Carolina's food stamp error rate averaged 4.55%.

WIC Program

The Department of Health and Environmental Control's WIC program is also funded by the USDA. The program provides vouchers for supplemental foods, such as milk, cereal, and baby formula.

Federal requirements for the WIC program regarding documentation of client income are very general, and there are no requirements for verification of client assets. In our 1996 report, *A Sunset Review of the Department of Health and Environmental Control's Health Services,* we found that DHEC did not require proof of income from persons applying for WIC services. In February 2000, federal regulations were amended to require proof of family income. According to a DHEC official, the agency employee who processes the WIC application must indicate that the applicant provided proof such as pay stubs; however, they do not maintain documentation in the files. A similar practice is used in Florida.

Every two years, the USDA requires states to conduct a management evaluation review of WIC case files to check, in part, for client proof of eligibility. Areas of improvement are noted and the county and/or district provides corrective action plans to the state office. The state office then conducts follow-up. In addition, every three years, USDA performs a financial and a programmatic review of South Carolina's WIC program. Income eligibility issues are addressed in the programmatic review. In South Carolina's 2001 review, USDA auditors observed actual interviews between DHEC staff and WIC applicants and made recommendations related to interview techniques and training.

Other Southeastern States

Overall, we found that controls in other southeastern states are similar to those in South Carolina. We contacted officials in five states (Alabama, Florida, Georgia, Mississippi, and North Carolina) concerning their family independence, food stamp, and WIC programs. With the exception of the WIC program, most states require proof of both client income and assets such as bank accounts. Federal regulations for the WIC program do not address client assets.

Recommendation

19. The General Assembly should consider amending §43-5-70 of the South Carolina Code of Laws to require the verification of assets, including bank accounts and real property, such as vehicles and homes, for all applicants at the time they apply for the family independence program.

Performance Measures

Sections 1-1-810 and 1-1-820 of the South Carolina Code of Laws require state agencies to submit an annual accountability report to the Governor and the General Assembly. The accountability reports must contain the agency's mission, objectives to accomplish the mission, and performance measures that show the extent to which objectives are met.

We reviewed performance measures related to program effectiveness or costs for four of the health and human service agencies which provide direct client services:

- Department of Mental Health (DMH)
- Department of Health and Environmental Control (DHEC)
- Department of Social Services (DSS)
- Department of Disabilities and Special Needs (DDSN)

All of the agencies that we reviewed have revised their performance measurement systems in the past two years. Three of the four agencies — DMH, DHEC, and DSS — have implemented systems which require county or district reporting on measures.

We focused on the appropriateness of agency measures and whether the information provided by the agencies was complete, reliable, and useful. Our general period of review was FY 00-01. We found that agency measures were generally based on national benchmarks. However, we concluded that measurement systems can be improved, particularly information on overall program results and costs reported by counties or districts. Our findings by agency are discussed below.

Department of Mental Health

The Department of Mental Health does not have reliable cost information for programs provided at the community mental health centers. Many of the measures used by the department are based on standards established by the Joint Commission on Accreditation of Healthcare Organizations and the U.S. Department of Health and Human Services (DHHS). For example, the commission has established measures for mental health inpatient facilities which include readmissions rates and the number of client seclusions. For community mental health facilities, DHHS has developed measures for client satisfaction, service appropriateness, and access to service.

In addition, DMH participated in a 16-state study, an effort of the National Association of State Mental Health Program Directors, to compare mental health data state to state. According to an association official, it is difficult to

compare mental health data among states due to differing state mandates. This official stated that the best approach may be to collect data and establish trends within a state rather than among states.

One of the primary goals of the Department of Mental Health is to treat clients in the community rather than in inpatient facilities. Based on this goal, we reviewed the agency's FY 01-02 report on program outcomes and costs for community programs. The costs of community treatment programs totaled approximately $139 million.

We found extreme variations in client program costs from center to center.

We found extreme variations in client program costs from center to center. For example, the costs for Adult Homeshare, a program which allows mentally ill persons to live in the least restrictive environment, ranged from $96 per hour of service in one center to $721 per hour of service in another. In a second instance, costs for adult continuing treatment and support ranged from $91 to $222 per hour.

When we asked agency officials why there were major differences in costs among the community centers for the same programs, they stated that the cost data was inaccurate and that community program costs have not always been a priority. DMH officials stated that these costs are determined according to the time spent by the clinicians who provided the services. DMH central office staff has provided some training to center staff regarding program costs. However, additional training on identifying and recording costs is needed to ensure consistency and accuracy among the centers.

Considering the department's emphasis on the treatment of mentally ill persons in the community rather than inpatient facilities, it is important to obtain an accurate accounting of community treatment costs. The department's internal auditors could help in this effort by reviewing community treatment costs for accuracy. Reliable cost data in conjunction with client outcomes could help the department to determine which community programs were most cost-effective and should be prioritized.

Recommendations

20. To ensure that community treatment programs are properly identified and coded for costs, the Department of Mental Health should provide training in identifying costs to employees who treat clients in the community.

21. The Department of Mental Health's internal audit division should review community treatment program costs to ensure consistency and accuracy among the community centers.

Department of Health and Environmental Control

Performance data collected by DHEC is not consistent.

We found that performance data collected by the Department of Health and Environmental Control from the 13 health districts is not consistent and does not provide a clear picture on progress or the need for improvement within a district. Many of DHEC's measures are based on data developed by the U.S. Department of Health and Human Services in collaboration with national and regional health professionals. Similar to recommendations in the federal publication *Healthy People 2010*, DHEC performance measures address physical activity, tobacco use, immunizations, and access to health care.

In FY 01-02, DHEC implemented an operational plan which requires each health district to provide a yearly report on strategies and activities for each of the agency's measures. The department uses an intranet system which allows district personnel to enter data and to review activities in other districts.

In its operational plan manual, DHEC provides a general example, including questions that should be addressed by the districts in their assessments. However, this information does not provide a specific format for the presentation of data. As a result, district assessments for the same outcome are presented in an inconsistent manner, and the information may not be useful.

We focused on the agency's long-term outcome measure to reduce the state's infant mortality rate. This measure is considered a good gauge of the state's overall health status for the infant population and also is a predictor of the next generation's health status.

We found that the district assessments for this measure varied widely. Our review indicated the following:

- Districts did not provide statistics for the same years.
- Some districts provided specific information on the mortality rate by county while others did not. One district provided its rate but no information on the rate within any county in the district.
- Some districts detailed specific efforts to reduce the mortality rate while others provided little or no information in this area.

Program directors at the central office review data and provide comments on the 13 district assessments for a given outcome. The director commenting on the outcome to reduce the infant mortality rate stated, "In general, the reports on progress made in implementing activities and strategies for this LTO (long term outcome) were very limited and insufficient to gauge progress."

We talked with DHEC staff about the inconsistency of district assessments. Officials stated that after only one year it is too soon for the assessments to gauge progress in the state. However, they acknowledged the need for central office staff to work with district personnel who are responsible for the assessments to help ensure consistency in information reported by the districts.

We also attended a DHEC focus meeting in which managers from 5 of the 13 health districts participated. District staff commented on the need for the central office to standardize data and to provide more direction to the districts on what to include in their assessments. One district official noted that assessment data would then be more useful.

Recommendation

22. The Department of Health and Environmental Control should ensure that performance measurement data is consistent among the health districts.

Department of Social Services

We found that there is no consistency in the data on child welfare collected by four Department of Social Services county offices. Also, the controls over data verification are inadequate. The department's performance measures are generally based on standards developed by the Child Welfare League (a national non-profit organization) or are based on program mandates. Both the Child Welfare League and DSS measures address family foster care, adoptions, and child abuse and neglect. In addition, DSS has developed measures based on program requirements such as those related to eligibility determination for food stamp participants.

We focused on DSS's child welfare program outcome measures and looked at how four counties — Georgetown, Florence, Orangeburg, and Spartanburg — collected performance data. Some data for the child welfare program is collected on the agency's information system, Child and Adult Protective Services System (CAPSS). However, at least 27 of the 43 measures for the program are not available through CAPSS. For these measures, DSS county offices collect data internally. We found that the county offices are collecting data differently. For example, for foster care information, one county enters information on a hand-written log, a second county uses one database to enter information, and a third county uses yet another database. These internal county systems have not been externally verified for accuracy. Further, at least three of the four counties have used

data from their internal systems to establish baseline data to assess their future performance.

There is no consistency in the data on child welfare collected by four DSS county offices.

We also concluded that the child welfare program outcome, "Improve Child Well-Being," which requires data on school performance and stability, is vague and that it is difficult to collect meaningful data or to determine progress within or among counties. An official in one county stated that this outcome is considered differently by all schools served by the DSS county office. According to this employee, the agency should not use different systems in each of the 46 counties to collect data. An official from a second county stated that this outcome may be interpreted differently by personnel within a county as well as among counties.

Central office staff who work with county staff on performance measures have not ensured that data on measures is collected in a consistent manner. Districts have been permitted to use internal data systems with no regard to comparing data among districts or to the accuracy of data. In addition, because county staff has used this information to establish baseline data, future assessments may not be comparable or may be based on inaccurate data. The development of standard forms to collect performance data, and consistent data systems for measures that are not available on the agency's computer system, would help to ensure accuracy.

Performance measures should be used as a basis for management decisions. When data is collected inconsistently among the reporting entities, the information may result in an "apples to oranges" comparison and may not be useful. In addition, agency management cannot effectively use measures to determine best practices among the counties or the need for improvement by county.

Recommendations

23. The Department of Social Services should develop standard forms and specify methods to collect performance data that is not collected on the agency's computer system. The department should periodically verify data for accuracy.

24. The Department of Social Services should regularly review performance outcome measures to ensure that they are specific and clearly defined.

Department of Disabilities and Special Needs

We found no material problems with the appropriateness of DDSN's outcome measures. We reviewed one of the department's measures in detail and found that DDSN maintains adequate documentation on reports of client abuse and neglect.

DDSN uses personal outcome measures developed from client surveys which address issues such as client safety and fair treatment. These measures require survey responses from clients or their families which provide a gauge on their satisfaction with services. We talked with developmental disabilities officials in Georgia and North Carolina who use similar measures. In addition, in July 2002, DDSN began using performance measures which will allow comparison of its data to information from 23 other states. These measures address issues such as client employment and abuse and neglect.

Audit Scope and Methodology

This audit was a review of the eight agencies assigned to the health and human services and Medicaid budget subcommittee of the House Ways and Means committee.

HEALTH AND HUMAN SERVICES AGENCIES

Department of Alcohol and Other Drug Abuse Services (DAODAS)
Commission for the Blind (SCCB)
Department of Disabilities and Special Needs (DDSN)
Department of Health and Environmental Control (DHEC)
Department of Health and Human Services (DHHS)
Department of Mental Health (DMH)
Department of Social Services (DSS)
Vocational Rehabilitation Department (VR)

Due to resource constraints, we did not review each of the four audit objectives at each agency. Although all of the agencies reviewed are involved in the Medicaid program, we did not review Medicaid program administration in this audit because it was the topic of a concurrent LAC report, *Options for Medicaid Cost Containment* (January 2003).

This audit focused on the organizational structure of health and human services as a whole; all eight agencies were included in the examination of ways to cut costs or improve services by changing organizational structure. We also included the Governor's Office Continuum of Care for Emotionally Disturbed Children in our review of this objective. Based on charges agencies make to clients and their insurance companies (non-Medicaid), we selected the Department of Mental Health, the Department of Health and Environmental Control, and the Department of Alcohol and Other Drug Abuse Services for our review of client revenues. Client eligibility was reviewed at the Department of Social Services and the Department of Health and Environmental Control; these were the primary agencies with programs other than Medicaid where eligibility is determined by client income and/or assets.

We reviewed agency outcome measures at the Department of Health and Environmental Control, the Department of Social Services, the Department of Mental Health, and the Department of Disabilities and Special Needs, the client-serving agencies with the largest budgets. The budgets of three of the four agencies whose measures we did not review (the Department of Alcohol and Other Drug Abuse Services, the Commission for the Blind, and the Vocational Rehabilitation Department) made up only 3% of the total budgets

of the eight agencies. The audit did not review programs or administrative functions other than those specified in the audit report.

The audit focused on recent events; although the period of review varied with different audit objectives, we did not conduct analysis of periods prior to the past three fiscal years, FY 98-99 through FY 01-02. We conducted interviews with South Carolina officials and officials in other states. We consulted a variety of sources of information including the following:

- Financial and accounting records.
- Accountability reports and outcome measures.
- Internal audits.
- Contracts.
- Policies and procedures and planning documents.
- Reports from consultants and other external sources.
- Previous studies of the organization of SC state agencies.
- Client files.
- Reports and other information from other states.

We measured performance against state and federal laws and regulations and also used criteria for the establishment of appropriate internal controls. We considered the experience of other states as criteria where relevant. We performed limited nonstatistical sampling in the area of client eligibility. We identified areas where management controls could be improved, specifically over collections from clients, agency performance data, and client eligibility. We used information that we did not verify, but this information was not central to our audit objectives. When this information was viewed in context with other available evidence, we believe that opinions, conclusions, and recommendations in this report are valid.

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

Changes in Agencies' Funding

Over the past four years, the eight agencies' total budgets have increased by 18.4%, while their state appropriations have increased 18.5%. In the past two years the agencies' overall budget growth was 8.4%, while state appropriations increased only 2.3%.

Health and human services appropriations have generally grown at the same rate as the whole of state government. In FY 98-99 the eight agencies comprised 37.4% of the state's budget, while in FY 02-03 this percentage was largely unchanged at 37.8%.

Table B.1: Agency Appropriations* FY 98-99 and FY 02-03

	Total Appropriations			State Appropriations		
Agency	FY 98-99	FY 02-03	%Change	FY 98-99	FY 02-03	%Change
Health and Human Services	$2,682,697,946	$3,447,616,123	28.5%	390,652,391	578,436,587	48.1%
Social Services	767,979,261	806,131,461	5.0%	109,849,001	107,920,067	-1.8%
Health and Environmental Control	485,719,506	495,680,199	2.1%	110,634,700	114,152,333	3.2%
Disabilities and Special Needs	339,678,739	429,232,394	26.4%	127,873,835	146,182,062	14.3%
Mental Health	338,425,553	344,935,818	1.9%	177,704,653	178,412,977	0.4%
Vocational Rehabilitation	98,456,990	105,082,614	6.7%	16,285,311	14,268,114	-12.4%
Alcohol and Other Drug Abuse Services	36,463,207	47,801,947	31.1%	10,146,675	10,080,429	-0.7%
Blind	9,147,169	10,551,669	15.4%	3,795,869	3,482,578	-8.3%
TOTAL — 8 Agencies	$4,758,568,371	$5,687,032,225	19.5%	$946,942,435	$1,152,935,147	21.8%
TOTAL — State Government	$12,717,495,150	$15,060,995,600	18.4%	$4,588,671,682	$5,437,436,227	18.5%

*FY 02-03 appropriations do not reflect subsequent budget cuts.
Source: Budget and Control Board

Appendix B
Changes in Agencies' Funding

Agency Comments

AGENCIES RESPONDING

Continuum of Care for Emotionally Disturbed Children reviewed pp. 11 – 14, but did not submit comments.

Appendix C
Agency Comments

South Carolina Department of Alcohol and Other Drug Abuse Services

MARK SANFORD
Governor

WENDELL PRICE
Interim Director

January 21, 2003

Mr. George L. Schroeder
Director
Legislative Audit Council
1331 Elmwood Avenue, Suite 315
Columbia, SC 29201

Dear Mr. Schroeder:

Thank you for the opportunity to review the Legislative Audit Council final draft report, *South Carolina Health and Human Services Agencies: A Review of Non-Medicaid Issues*, and the invitation to provide written comments for publication with the report.

Enclosed are comments related to sections addressing addictions services and the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS).

We appreciate the work done by you and your staff. Please let me know if I can be of further assistance.

Sincerely,

Wendell Price
Interim Director

WP/jh3/
Encl.

DAODAS

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South Carolina Health and Human Services Agencies:
A Review of Non-Medicaid Issues
Response from the South Carolina Department of Alcohol
and Other Drug Abuse Services (DAODAS)

The Legislative Audit Council's report suggests that addiction services be consolidated, with treatment services provided by an addictions unit within the Department of Mental Health.

This structure would threaten the delivery of alcohol and other drug abuse services by: eliminating the current continuum of care, losing focus on accountability and outcomes, and diluting the effectiveness of services.

Elimination of Continuum of Care
In addition to DAODAS' inpatient treatment programs (which include adolescent and women's residential programs), the system provides social and medical detoxification, intervention services to include ADSAP (SC DUI offenders), an array of outpatient services ranging from individual counseling to intensive outpatient and therapeutic day treatment plus evidence-based prevention programming for youth and adults.

DAODAS' Utilization Review (UR) function is a cost-saving service that screens all Medicaid clients for appropriateness and level of care in a manner that ensures the least restrictive treatment setting at the most efficient cost not only for DAODAS providers but also for public hospital inpatient providers through the state. The goal of UR, since its inception in FY98, is to decrease the number of clients utilizing hospital services and to direct these clients to a more appropriate level of care. Using FY98 as the baseline, the gross savings for services only realized through the UR process is approximately $6.03 million.

The risk of consolidating addiction treatment programs is the loss of a full continuum of comprehensive programming, from primary prevention through treatment, now present in Act 301 providers, but not located within the Mental Health system nor at Vocational Rehabilitation alcohol and drug abuse centers (Homesview / Palmetto Center).

Accountability and Outcomes
The Planning and Quality Management and Information Technology departments at DAODAS track and monitor key performance outcomes for the 301 system. Although it was omitted from the LAC's report, these outcomes are key measures of performance and mission accomplishment and hold each commission responsible for any dollars (federal and state) they receive.

Specific client outcome data include: 1) the percentage of former clients using alcohol in the past 30 days; 2) the percentage of former clients using alcohol to intoxication in the past 30 days; 3) the percentage of clients using illegal drugs in the past 30 days; 4) the percentage of former clients using tobacco in the past 30 days; 5) the percentage of former clients using outpatient health care in the past 30 days; 6) the percentage of former clients unemployed or not employed in the past 30 days; 7) the percentage of former clients with dependent living arrangements or who are homeless; 8) the percentage of former clients using emergency room care in the past 30

days; 9) the percentage of former clients using outpatient health care for medical or emotional problems in the past 30 days; 10) the percentage of former clients using emergency room care for medical, emotional or AOD problems in the past 30 days; 11) the percentage of former clients arrested on any charge in the past 30 days; and 12) the percentage of student clients who were suspended, expelled or in detention in the past 30 days.

Specific client-retention data include: 1) assessment provided within three days of intake; 2) clinical service provided within seven days of assessment; 3) ADSAP provided within 30 days of assessment; 4) clinical follow-up service provided one day after detoxification care; 5) clinical follow-up services on provided between one and six days after residential care; and 6) clinical completion of treatment services.

If local commissions fall below state mandated levels of performance, the County Assistance Plan (CAP) is employed to bring them up to standard. If they continue to fail to perform, their contract will be reviewed and could be terminated.

Effectiveness/ Efficiency of System

Through the analysis of outcomes, DAODAS gauges the effectiveness and efficiency of the service delivery system and compare it to other structures and other states. The report mentions that four of five neighboring states have single divisions or departments whose services include both addiction treatment and general mental health care.

Once structure is examined, however, it's apparent that administrative costs are not lower with a combined agency. In addition, data suggests that not only do costs increase, but services decrease both in quantity and quality.

True administrative cost at DAODAS would total approximately $1.56 million, and would include only 25 employees. The majority of DAODAS staff either provide direct services, or are inextricably tied to the provision of direct services, and could not be eliminated without significant and adverse impact on local services and local service providers. Additionally, the federal agency over the federal block grant has determined that all DAODAS expenditures are direct costs.

True administrative cost at DAODAS, in percentage terms, is approximately 3.7%. If the definition of administrative costs were liberalized, it would only approach 8.5 - 9%.

The consolidation of treatment services within a department at Mental Health would risk the loss of the continuum of comprehensive programming that only DAODAS provides. This would also eliminate the only true community-based system of care in the state and risk the loss of millions of local dollars that are invested in the local systems. Changes in organizational structure can be successful only *if they are designed to improve services and lower costs*. The solution is providing costs at the local level, as currently done, rather than increasing a large beaurocratic agency and restructuring a public/private partnership into a state agency.

South Carolina Commission for the Blind

P.O. BOX 79 • COLUMBIA, SOUTH CAROLINA 29202-0079 • PHONE 898-8822 • FAX 898-8845

January 13, 2003

George L. Schroeder, Director
Legislative Audit Council
1331 Elmwood Avenue, Suite #315
Columbia, SC 29201

Dear Mr. Schroeder:

Please find attached the response of the South Carolina Commission for the Blind to the audit report, South Carolina Health and Human Services Agencies: A Review of Non-Medical Issues.

If there are questions about our response, please telephone me at: 898-8822.

Sincerely,

Dr. Nell C. Carney
Commissioner

SOUTH CAROLINA COMMISSION FOR THE BLIND

RESPONSE TO

LAC REPORT

SOUTH CAROLINA HEALTH AND HUMAN SERVICES AGENCIES: A REVIEW OF NON-MEDICAL ISSUES

We disagree with recommendation number 6 to consolidate the Commission for the Blind with the Vocational Rehabilitation Department as recommended by the LAC Audit Report published in July, 2002. We disagree with the findings of the earlier report because it is our opinion that the LAC failed to demonstrate cost savings could result from the consolidation of the two agencies. Further, it is our opinion that the earlier report failed to demonstrate that the high quality of services now provided to the blind citizens of the state would continue with the Vocational Rehabilitation Department.

It is our opinion that conclusions drawn from national studies and information from merged agencies in other states were in error due to misinterpretation of the information presented. The conclusions that can be drawn from comparing the statistics of the Commission for the Blind with those of the Vocational Rehabilitation Department are also in error. The Commission for the Blind focuses on one small disability group while VRD serves many disability populations.

Should the South Carolina General Assembly create a mega Health and Human Services Department with a Cabinet Secretary, it is our conclusion that the blind citizens of the state would be best served by giving the Commission for the Blind the same autonomy as other health and human services agencies.

Stanley J. Butkus, Ph.D.
State Director
Robert W. Barfield
Deputy State Director
Administration
Ronald G. Dozier
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
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AND
Special Needs

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January 21, 2003

Mr. George L. Schroeder
Director
Legislative Audit Council
1331 Elmwood Ave., Suite 315
Columbia, South Carolina 29201

Dear Mr. Schroeder:

Thank you for the opportunity to respond to the final draft report of South Carolina Health and Human Services Agencies: A Review of Non-Medicaid Issues. I think your staff did an excellent job in describing operations reviewed at the Department of Disabilities and Special Needs.

We are pleased that the report notes no problems with DDSN's outcome measures initiatives and most important, notes the adequacy of documentation on reports of client abuse and neglect. DDSN has restructured to become more efficient by centralizing eligibility and licensure thereby strengthening consistency and productivity in those areas.

As you learned, there is very little overlap between the unique population served by DDSN and those persons served by other human service sector agencies. Where overlap does occur we have interagency memoranda of agreement in place that detail the coordination process.

In addition to ensuring agency accountability it is important to note that the members of the SC Commission on Disabilities and Special Needs serve at the will of the Governor and may be removed without cause at any time. This was stated in a previous response to

you which noted that DDSN was created by the 1993 legislation restructuring state government and that the commission members' appointments were changed to an "at will" status. The practical impact of this is that the Commission and executive staff pay extremely close attention to follow the Governor's direction. The final draft report opinion that the hiring and termination of non-cabinet agency directors would be a time-consuming process through appointments is inconsistent with current law that states commission members serve at will and the Governor can make a change overnight if he so chooses.

We are concerned that the final draft report suggests we are against restructuring. We are not against restructuring and stated in our previous response to you " We know that the executive and legislative branches will make the final decisions and we are prepared to carry out any and all responsibilities assigned to us." Our previous comments concerned the creation of a huge umbrella agency whose top priorities would be broad policy issues such as education or health, and due to its size could not be focused on the special needs population.

We did note that DDSN was originally separated out some 30 years ago because families and policy makers made the case that persons with the most severe lifelong disabilities who cannot take care of themselves need a significant voice speaking for them. Experience here in South Carolina and in other states shows that the special population whose severe disabilities are from birth to death get lost in the mix of an agency with wide generic responsibilities. DDSN is not against the cabinet system of governance at all but does advocate for representation at the highest level of state government for people with severe lifelong disabilities.

Thank you for the opportunity to give you our comments based on our experiences and understanding of DDSN' s unique population and services provided. We are prepared to follow the decisions and directions of the Governor and the General Assembly as we have always done in the past.

Sincerely,

Stan Butkus, Ph.D
State Director

SB/sjd

D H E C
PROMOTE PROTECT PROSPER
2600 Bull Street
Columbia, SC 29201-1708

January 21, 2003

Mr. George L. Schroeder
Director, Legislative Audit Council
1331 Elmwood Avenue
Suite 315
Columbia, SC 29201

Dear Mr. Schroeder:

We have reviewed the draft report entitled, "South Carolina Health and Human Services Agencies-A Review of Non-Medicaid Issues." We have attached our response to the recommendations and content of the report.

We appreciate the professionalism displayed by the audit staff during their visit. If you have any questions, please do not hesitate to contact Mary Fuhrman at 896-0651.

Sincerely,

C. Earl Hunter

C. Earl Hunter
Commissioner

Attachments

cc: R. Douglas Calvert, Chief of Staff
Wanda C. Crotwell, Assistant to the Commissioner for External Affairs
Lisa F. Waddell, MD, MPH, Deputy Commissioner, Health Services
Sara W. Balcerek, MSN, Assistant Deputy Commissioner, Health Services
Benjamin R. Lee, Jr., Interim Director, Health Services Administration
Johnny B. Dotterer, Contract Officer, Chief of Staff Office
Mary I. Fuhrman, CPA, CIA, Director, Office of Internal Audits

SC DHEC Response to the LAC Draft Audit Report—South Carolina Health and Human Services Agencies-A Review of Non-Medicaid Issues

Pages 15-19

The agency has reviewed the recommendation that all health and human service agencies be combined under a single cabinet secretary. We certainly understand the desire for comprehensive planning and budgeting, as well as the coordinated provision of services, but would hope that a great deal of study be given to the issue before any hasty decisions are made. We would welcome the opportunity to work with members of the General Assembly and the Office of the Governor to explore the pros and cons of such a proposal.

Page 20

DHEC expects to meet all HIPAA deadlines for compliance. The HIPAA Task Force, appointed by the Commissioner in October 2001, has met twice a month for the past year and provided leadership to complete the following: an internal privacy assessment; gap analysis; preemption analysis of relevant state laws; development and delivery of awareness training to all DHEC employees; development and approval of 19 new policies and amendment of 4 policies; development of a physical plant security and privacy assessment tool; and review of all billing and transaction codes in cooperation with DHHS to convert to the required national standards. Information Systems' staff members have completed an assessment of the system changes necessary, are working on new and revised policies, and are in the process of system changes necessary to begin testing, as required, in April 2003.

DHEC has provided leadership nationally on public health issues related to HIPAA and to other state agencies. In the next three months, the agency will develop and deliver detailed training to all staff in covered entities within the agency, complete the physical plant assessment and associated corrective action plans, develop procedures for the privacy office, and complete system changes.

DHEC has received no additional resources to comply with HIPAA. Staff members have assumed additional responsibilities necessary to complete the assessment and compliance plan. The agency expended $30,000 for consultation to review the process and identify any gaps that required addressing. The major cost of HIPAA has been and will continue to be the additional staff time and resources required beyond their regular job duties to devote to HIPAA now and in the future. In addition, the cost of information systems changes will be a major expense. The agency has made every effort to budget these costs, but the additional budget cuts may limit the agency's ability to cover all the identified system changes.

Pages 29-32

The Office of Internal Audits conducted an audit of the Automated McBee System from June 17, 2002, to September 17, 2002, and issued the draft report on December 18, 2002. Internal Audits expects to issue the final report in February 2003. The primary objective of the audit was to review the adequacy of internal controls in place for the Automated McBee System. Additional objectives were to: 1) verify that internal controls were in place to ensure that cash receipts were adequately recorded, secured, and deposited in a timely manner; 2) verify that patients seen were tracked in the system; 3) confirm that appropriate billings were done for services rendered; and 4) ensure that adjustments to the system were properly explained, reviewed, and approved by management. The audit period was from July 1, 2001, through June 30, 2002.

Internal Audits looked at three areas—Health Services, Vital Records, and Environmental Health—at two county health departments. For Environmental Health and Vital Records, the clients must usually pay in full in advance to receive services. However, for Health Services clients are seen regardless of the ability to pay and balances are carried forward if not paid in full. Collections on outstanding balances are attempted

through both the delinquent letter process and by requesting payment the next time a client comes in for services. Typically, the individual balances by client are low. As a result, it may not be cost-effective for DHEC to participate in DOR's programs for debt collection for health services. In addition, the mission of public health is to promote and protect the health of the public and the environment. The agency's philosophy of service delivery is in concert with this mission. Our approach is to encourage rather than discourage patients, especially the underserved, to access public health prevention and treatment services. We attempt to minimize barriers to service such as aggressive billing methods in order to assure that clients receive the services necessary to prevent the spread of disease and protect the overall health of the public in South Carolina. However, DHEC will evaluate DOR's programs for their potential benefit.

The last time the offices sampled in the audit wrote off delinquent balances was just before they went on the Automated McBee System. The delinquent balances written off that were tested from that period of time showed that they were written off only after at least two years had passed which was required for Family Planning delinquent balances at that time, and complies with the agency policy.

As of May 2002, 75 out of 78 total sites (96%) were using the Automated McBee System. Only 3 small sites out of 78 total sites (4%) were still using the manual system. Since many of these sites have not been online with the new system for an extended period of time, many of the write-off procedures have not yet occurred. However, both health departments sampled were sending out delinquent payment letters quarterly to those clients that were carrying a balance. Because the system has not been up and running that long, it has not yet been determined if this process is cost-effective. The districts will need to evaluate whether the cost of the postage, paper, and employee's time to generate the letters is resulting in a positive gain of collections. Over the next year, DHEC should have the ability to determine whether the current agency process is cost-effective and what additional steps the agency may need to take to further define this process. As a part of this, the agency will also review the sliding fee schedule and determine whether a more formal income verification process is needed.

Pages 39-40

The background and recommendation addressing DHEC pertains to the Health Services Deputy area specifically. Other areas of the agency also have strategic plans and performance data.

The *Healthy People 2010* goals and objectives for the nation mentioned in the report is the premier performance standard for public health nationwide. It provides the overall framework and outcomes that public health is addressing. The goals and objectives were developed based on science and a broad priority setting process across the country. Many federal funding sources for public health rely on *Healthy People 2010* indicators to measure performance. By referencing and using *Healthy People 2010* objectives, Health Services is able to compare itself to the US average, as well as compare South Carolina's progress to other states in the region and nation.

Outcome measures in Health Services' operational plan address all of the major issues related to death, disease, disability and behaviors that all Health Service programs are working on, not just the few cited in the report. This is a strength of the operational plan and allows for all units and staff to know where their daily efforts contribute to our mission, as well as better determine which units should coordinate around shared objectives.

The operational plan is not just for districts but also for central office divisions, within Health Services. This framework allows for better planning across all program units, ensuring better communication and coordination. The plan allows for comparisons across units, on similar issues. For example, any staff in the state that have interest in breastfeeding can quickly generate a computer-based summary report that contains the strategies and activities from those units within Health Services that are implementing actions on

breastfeeding. This is an important quality improvement tool and encourages peer-to-peer experience and idea sharing.

Error of Fact: Data that districts and central office units use to assess their progress on the outcomes in the plan are provided in a standardized format over the agency's Intranet. Standardized data on 155 outcomes was made available to districts and central office units for evaluation and comparison. Examples of data related to infant mortality were attached to our previous response. This standardization was implemented last year to ensure that all units were using the same data to assess their progress on the outcomes in the plan.

The lack of standardization found in the LAC audit pertains not to data itself, but rather on how districts and central office units describe their progress on the outcomes in the plan. A strength of the plan is having districts and divisions report on progress on the outcomes to support and encourage data driven decision-making. The data are standardized when consistent data sources are available; assessment statements are qualitative by design and not meant to be standardized.

Health Services has made considerable progress in implementing a planning process that focuses on outcomes and performance improvement, as listed below:

- Prior to the implementation of the operational plan, Bureaus and Divisions, responsible for overseeing the implementation of the various programs, communicated directly with districts, the leadership in Health Services, and the funding stakeholders and community partners. There was no formal mechanism for inter-program coordination. This lack of coordination was more apparent at the district and county health department level. Programs also did not share a common language, and were not aware of what other programs were working on. While there was excellent work being done within each program, the collective impact of Health Services' efforts was not as strong as it could have been. With the implementation of the Health Services Operational Plan (HSOP) there are now formal mechanisms for program coordination and overall monitoring of Health Services' effort. All major outcomes that each program is working on are included in the plan, within the same framework and using the same terminology. Programs work together to jointly address strategies on common outcomes. Communication between central office programs and districts is better coordinated, and linkages have been improved across districts as well. Access to the plan is widespread and the plan database can generate many different type of reports for improved analysis and quality improvement. The HSOP serves as the forum for this coordination. Leadership within Health Services can better determine what effort is going on across the state on a given health outcome the agency is addressing, as well as better determine which areas need more focus. Data to measure progress is also provided in a standardized manner on the Intranet, resulting in greater consistency in measuring progress.

- Health Services continually works to improve quality and performance measurement. Our first priority was to develop health status outcome indicators that are currently reflected in the plan. Some outcome indicators may be influenced by factors outside of DHEC's direct control, but they are the best measure of whether or not we are doing the right things to improve the public's health. We are in the process of developing more specific quality indicators to augment our health status outcome indicators. Work has already begun within some program areas. These indicators will be measured and monitored in a standardized manner, across districts, allowing for Health Services' managers at all levels to better determine performance. The incorporation of these indicators directly addresses the recommendation cited in the LAC report.

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert C. Toomey
Director

January 21, 2003

Mr. George Schroeder
Director
Legislative Audit Council
1331 Elmwood Avenue – Suite 315
Columbia, South Carolina 29201

Dear Mr. Schroeder:

Thank you for the opportunity to comment on the Legislative Audit Council Report: *South Carolina Health and Human Services Agencies*. Enclosed are our comments. If you have any questions, please feel free to contact Robert Kerr at 898-2675.

Sincerely,

Robert C. Toomey
Director

RCT/kp

Enclosure

Office of the Director
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2500 Fax (803) 898-4515

South Carolina Department of Health and Human Services
Response to Legislative Audit Council Report:
South Carolina Health and Human Services Agencies

Page 18,

1. **Create a freestanding agency for senior and long term care services …**

With respect to the recommendation to create a freestanding agency for senior and long term care services, further study is needed to evaluate the costs and benefits.

DMH South Carolina Department of Mental Health

2414 Bull Street/P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

George P. Gintoli
State Director of Mental Health
(803) 898-8319

MISSION STATEMENT
To support the recovery of people with mental illness.

January 17, 2002

Mr. George Schroeder
Legislative Audit Council
1331 Elmwood Avenue, Suite 315
Columbia, South Carolina 29201

Dear Mr. Schroeder:

I commend the Council for their conscientious and thoughtful report on the Health and Human Services agencies and welcome the recommendations provided. I am especially grateful that the comments we submitted in our review of the draft report were seriously considered and, in many cases, altered the final report for DMH.

Many of the issues identified in the Report are, in fact, issues that DMH previously identified and which the agency continues to address. We have recently implemented Baldrige principles and are using the PDCA (Plan, Do, Check, Act) model of problem solving, applying this principle to various issues within the agency. Our Division of Education, Training and Research is currently developing a set of dashboard indicators for the agency's management in order to improve oversight of the overall mental health system. This effort includes benchmarking against national mental health data, an effort in which South Carolina has been a leader.

Client revenue collections remain a difficult issue at best due to the type of client we serve. We believe additional improvement in collections can, and will, occur as we investigate appropriate strategies to do so, despite the fiscal limitations resulting from recent budget cuts and the loss of administrative employees. It is unlikely that the amount of increased revenue will be significant due to the limited ability of our clients to pay for services.

DMH has recently implemented new technology systems including a new patient reimbursement/information system and a fully integrated accounting system. These systems (much overdue) will assist the agency to improve collections as well as comply with all state and federal financial regulations. As cited in the Report, DMH has initiated the Setoff Debt program through the Department of Revenue. This program has proven successful, generating approximately $230,000 during calendar year 2002.

I look forward to participating in the implementation of the Report's overall recommendations and believe the outcome will be a better service delivery system for the citizens of South Carolina.

Sincerely,

George P. Gintoli
Director

DSS
Serving Children and Families

KIM S. AYDLETTE, STATE DIRECTOR

January 21, 2003

Mr. George L. Schroeder, Director
SC Legislative Audit Council
1331 Elmwood Avenue
Columbia, SC 29201

Dear Mr. Schroeder:

Thank you for this opportunity to respond to the Legislative Audit Council audit, South Carolina Health and Human Services Agencies: A Review of Non-Medicaid Issues.

1. While this agency does not disagree with the recommendation that senior and long term care programs be consolidated, the Department of Social Services is mandated by law to provide investigation and case management services to adult victims of abuse and neglect who cannot protect themselves, regardless of age. Many clients served by the agency's Adult Protective Services Program are disabled young adults who are subject to abuse, neglect or exploitation but do not meet the definition of senior or elderly. Services to these vulnerable adults must continue at DSS or be absorbed by some other agency.

2. This agency disagrees with the recommendation that its' homemaker services should be moved. The audit's description of homemaker services failed to note that DSS uses homemakers in its work with Child Abuse and Neglect cases. Roughly 37% of the homemaker caseload is for children living with their families. If all the homemakers are removed from DSS, it would result in the loss of this service for Child Protective Service cases and would likely result in more children being taken into foster care due to lack of support services to help maintain them in their own homes.

3. This agency strongly disagrees with the recommendation that all mental health services for children be combined in the Department of Mental Health. The major reason that Managed Treatment Services (MTS) and the Continuum of Care (COC) were created is that a relatively small number of children (approximately 2,000) had severe, multi-dimensional (and multi-agency) problems that were not being addressed by DMH. At the time the Integrated System of Care for Emotionally Disturbed Children (ISCEDC) fund was created, DSS was serving over 1,250 children annually in DSS Medicaid-matched treatment programs. DSS was instrumental in working with DHHS/Medicaid to develop the service array that the current MTS and the COC use. DSS would support a decision to move the COC to another agency. In particular, placing the COC within DSS would improve efficiency. The services and operation of MTS and COC are very similar, having a common ancestry, service model and structure.

DMH provides a limited range and volume of services for a broad spectrum of clients. The children served by MTS and COC have highly specialized and intensive service needs that DMH has been unable to meet appropriately. Further, many of these problems are not improved with traditional mental health services. The children served by DSS/MTS have typically gotten lost in a system serving 40,000 children and many more thousands of adults each year. DSS has immediate parental responsibility for children placed in state custody by the Family Court. DSS is mandated by law to ensure their safety and cannot create a waiting list for clients or delay services until adequate resources or client slots become available to serve them. Furthermore, DSS has state and federal mandates to see that each foster child it serves is in a safe, nurturing and appropriate placement (including treatment placements if necessary).

MTS is part of a cabinet agency accountable to one person – the governor. The Department of Mental Health is not a cabinet agency at this time and until it is, moving MTS would be a step towards less accountability – not more. If the DSS ISCEDC funds were transferred to DMH, there is no guarantee that these funds will be used solely for foster children nor that they would be protected from state budget cuts as DSS has done. The funds could be spent on non-DSS children (or adults), while DSS children with special needs might be unable to access the funds.

The recommendation that all mental health services for children be combined in the Department of Mental Health also fails to adequately address the issue of custody. The audit notes that: "This option [consolidation] would make it clear where families with emotionally disturbed children can seek help and would reduce the need for interagency referral and coordination." Children receiving treatment through the Managed Treatment Services program at DSS are foster children in the custody of DSS and the agency is clear about where to seek treatment for the children.

Further, placing MTS within DMH would dramatically increase the need for interagency coordination and is likely to result in duplication of services. If MTS case management services were moved to DMH, DSS foster children with emotional disabilities would have two case managers: one at DMH, with the authority to authorize treatment services, including out-of-home treatment placements such as therapeutic foster care, but no "parental" responsibility for the child; and one at DSS with responsibility for a child's safe and appropriate placement but not necessarily the authority or funding to secure it.

A dual casemanager model was unsuccessful in the past. After the creation of ISCEDC in 1994, the children in foster care had two case managers, one at DSS and one at the Governor's Office COC, with Medicaid paying for both case management staffs. In 1996, the foster children were taken out of COC, and MTS was formed at DSS to provide more specialty care, to manage the ISCEDC fund and to **eliminate** the need for and cost of two case managers. Case mangers at DMH and DSS would increase the costs to the State and would be confusing for clients and providers. Each duplicated case manager will have need for supervision, support staff, physical space, office equipment and so on.

Any decision to transfer MTS to DMH must include careful consideration of what case management tasks will remain at DSS and what case management tasks will go to DMH. The likely structure would be for DMH to provide case management while DSS retains custody. DMH staff will have to learn and comply with federal requirements and DSS will have to monitor compliance, as the state's Title IV-E agency, in order to continue to claim federal funding for all foster children.

The DSS caseworker and DSS attorneys will prepare cases for court and will navigate the complex requirements associated with permanency for these children. However, the DMH case manager (just like the DSS regular case manager for the same child) will participate in staffing for decisions about permanency options, attend court hearings and testify in court, prepare for court, interact with the child's parents and their treatment worker, and interact with other entities such as the guardian ad litem for the child and the Children's Foster Care Review Board. This duplication of effort will be costly to the state and will be at odds with the audit's recommendation to avoid duplication of services.

Moving MTS to DMH will also negatively impact all other foster children at DSS. MTS staff are not just treatment case managers but are also an integral part of the child welfare system. They are charged with meeting requirements established by state statute, federal regulations and statutes, and family court judges for the clients they manage. DSS serves 5,000 foster children in regular foster care and MTS. If MTS staff are moved out of DSS, the duties associated with being the legal custodian would not go with them. DSS foster care staff would have to assume those responsibilities. Caseloads will rise by at least 25%, subjecting the system to an unacceptable risk of overload and dysfunction at a time when resources are at their most limited. MTS assistance to clients with mental retardation, autism, and other non-ISCEDC disabilities will be eliminated. In essence, DSS will be forced to establish a mechanism to provide services similar to what MTS does now for these non-ISEDC children.

Case management through the current ISCEDC collaboration is the mechanism to ensure that services, including those of DMH, are delivered efficiently without duplication or fragmentation. MTS serves clients in every county of the state, often co-located in DSS county offices. As space becomes available the agency plans to further streamline MTS and county operations.

4. The agency disagrees with the recommendation that the legislature consider amending Section 43-5-70 of the SC Code of Laws. This section states that there is no requirement to verify clients' statements that they do not own property or other assets unless "there is reason to believe that the applicant has falsified, misrepresented, or omitted any material facts…" In light of this state statute, Family Independence policy requires that assets be verified when a client reports ownership of assets. Policy does not require verification of assets when the client claims none.

When a client applies for benefits in the FI program, all aspects of eligibility are verified. If a client reports ownership of any asset, the value of the asset is verified. There is no requirement that workers verify assets when the client states that (s)he does not own any real property or have any bank accounts. Verification of bank accounts has not been deemed to be a cost effective endeavor unless the client reports ownership. In order to attempt to verify a negative allegation, it would be necessary to request a record search for every bank in the county, and even this would not verify that no account existed. Most banking institutions charge fees for completing any search of their records. Attempts to verify negative allegations could prove very costly to the agency.

Verification of a client's denial of property ownership is equally difficult. For example, an applicant can say he/she does not own any property, and a check in the Richland County courthouse can verify that the client does not own property in Richland County. It cannot verify the client does not own property in Greenville County or Beaufort County or New York City.

The maximum monthly benefit paid in the FI program for a family of three is $200 per month. In order to receive this benefit, all adults must participate in training or unpaid work experience for a minimum of 30 hours per week. It seems highly unlikely that individuals with resources sufficient to disqualify them for assistance would work the required 30 hours weekly for the sum of $200 monthly. The agency's policy correctly reflects the belief that case manager's efforts are much more cost effective working with clients to find employment.

In addition, the audit correctly states that the internal controls for the food stamp program are adequate. The program has consistently registered one of the lowest error rates in the nation and has received millions of dollars in enhanced funding because of its low error rate. Ninety percent of the clients receiving cash assistance in the Family Independence program also receive food stamps and are therefore subject to exactly the same quality control reviews at the federal and state level. This means that these FI cases have passed federal quality review standards and have been determined to be eligible. Adding an additional eligibility requirement is both costly and unnecessary.

Thank you for this opportunity to respond to this review.

Sincerely,

Kim Aydlette,
State Director Designee

SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT

SCVRD

Enabling eligible South Carolinians with disabilities to prepare for, achieve and maintain competitive employment

Larry C. Bryant, Commissioner

January 21, 2003

Mr. George L. Schroeder
Director
Legislative Audit Council
1331 Elmwood Avenue, Suite 315
Columbia, South Carolina 29201

Dear Mr. Schroeder:

Thank you for the opportunity to respond to the final draft report of *South Carolina Health and Human Services Agencies: A Review of Non-Medicaid Issues.*

I appreciate your audit team's professionalism and diligence in gaining an understanding of our program. I have reviewed the document with members of my staff and respectfully submit our reflections on the report's conclusions.

Please call me at 896-6504 if you have any questions.

Sincerely,

Larry C. Bryant
Commissioner

cc: Derle A. Lowder Sr., Chairman

1410 Boston Avenue • PO Box 15 • West Columbia, South Carolina 29171-0015

South Carolina Vocational Rehabilitation Department

Response to the Legislative Audit Council final draft report of
South Carolina Health and Human Services Agencies: A Review of Non-Medicaid Issues

The report's content affects our agency in three key proposals: (1) the establishment of a single cabinet secretary to oversee all health and human service agencies; (2) the reassignment of our alcohol and drug abuse treatment facilities to the Department of Mental Health; and (3) the consolidation of the Commission for the Blind within our agency. Our perspective on these issues follows.

Restructuring into cabinet

The placement of SCVRD into a cabinet agency of health and human service agencies is not viewed as being in the best interest of people with disabilities for a number of reasons.

Mission: Employment vs. Lifelong Services. Our mission is concise: to enable South Carolinians with disabilities to prepare for, achieve and maintain competitive employment.

We fear that our clients' access to an employment-focused, consumer-driven vocational rehabilitation agency might be compromised if the agency is made part of a much larger group of agencies for whom employment of clients is not the central issue. We do not focus on health care assistance or lifelong services; we are an employment agency for people with disabilities.

Most human service agency funding is tied into Medicaid. Our goal is to *remove* people from dependence on Medicaid by placing them into jobs that will provide them with health care benefits.

The importance of employment cannot be overemphasized, both in terms of fulfillment of quality of life goals for our clients and in the benefits to our state's economy. These benefits are gained through the conversion of people relying on government benefits into competitively employed, taxpaying citizens in our communities who repay the cost of their vocational rehabilitation in about six years.

Proven Accountability. SCVRD has operated as an independent agency for the past 45 years, consistently demonstrating its accountability. Among the nation's vocational rehabilitation agencies, *SCVRD has long been number one in the number of people served and rehabilitated per capita, and in cost effectiveness.*

Our key performance measures are based on business results that reflect accountability. The agency has actively embraced the Baldrige Criteria in its pursuit of performance excellence, continuous improvement and program integrity. In 2001 SCVRD was recognized for its accomplishments in this area by the South Carolina Quality Forum, which named the agency as a Governor's Quality Awards Silver Achiever.

Consumer-driven Commission. As an independent agency SCVRD currently operates under the direction of a commission whose makeup is dictated by federal vocational rehabilitation law. This law mandates that the commission must represent people with a broad range of disabilities. Therefore it is consumer-empowered to make decisions affecting the agency's services and to hire an agency director. Our commission is responsible for direct oversight. In a cabinet agency vocational rehabilitation consumers would not be empowered with as strong a voice in the agency's governing structure.

Employment Focus. Maintaining independent status is preferred, but as a cabinet agency the Vocational Rehabilitation Department would operate more effectively if grouped with other employment-oriented programs. Among the eight agencies in this review, SCVRD is the only mandated partner with the Workforce Investment Act administered by the U.S. Department of Labor.

Vocational rehabilitation agencies that are part of cabinets don't always fall into health and human service groupings. For example, the Georgia VR program is part of the Department of Labor, while the Kentucky VR program is part of the Cabinet for Workforce Development.

Structure vs. Results. The LAC report indicates that many of the Southeast's health and human service agencies are grouped under a cabinet secretary. The report did not indicate the resulting effectiveness of those groupings. For many years our independent agency has been first in the nation in key vocational rehabilitation performance and cost-efficiency measures.

Alcohol and drug abuse treatment facilities

As are all SCVRD services, the treatment programs at Holmesview Center in Greenville and Palmetto Center in Florence are employment-oriented. Admission to these centers is voluntary and based on the same eligibility requirements that all SCVRD clients must meet.

Comprehensive Services Beyond Treatment. The clients' treatment in these facilities is only part of their overall vocational rehabilitation plans. Federal law mandates that from start to finish, from eligibility through placement into employment, services must be coordinated by a vocational rehabilitation counselor. The department has on-site employment specialists who provide job-oriented services throughout the treatment process. When clients leave Palmetto Center or Holmesview Center, they go back to their local VR counselors, who coordinate a continuity of services that help reduce recidivism and keep the clients on track with their plans for employment. Once employed, clients continue to receive follow-up attention from their counselors to ensure that they and their employers are satisfied.

Funding Issues. Federal vocational rehabilitation funding can only be used for services to eligible vocational rehabilitation clients. The majority of the financial resources used to operate Holmesview Center and Palmetto Center come from federal vocational rehabilitation funding. In addition, the building that houses Holmesview Center is owned by the department and was paid for with federal VR funds.

The department uses these resources in efficient and effective ways. The LAC report shows that the two centers served 1,035 clients last fiscal year with a total budget of $2.5 million, or $2,415 per client, which compares favorably with other agencies providing treatment services. The rehabilitation rate of these centers is excellent. For example, of the clients treated in a six-month period about one year ago (July through December 2001) about 62 percent have been successfully rehabilitated into employment. Through their ability to work and pay taxes, they repay the cost of their rehabilitation.

Merger with the Commission for the Blind

Details of the proposed consolidation of SCVRD with the Commission for the Blind (SCCB) are not included in the report because these recommendations were made in a July 2002 LAC audit. SCVRD's concerns about such a merger continue to be:

- ***VR's agency board represents more than 130 disabilities.*** Any mandated appointment to the SCVRD agency board of a person representing the blind and visually impaired community or any other specific disability group would not be in accordance with federal regulations governing the makeup of a VR agency's commission. SCVRD is not a disability-specific agency. The law requires that the board represent people with a broad range of disabilities. Designating a seat to a particular disability group would appear to favor one disability type over the many others.
- ***The agencies' missions differ.*** The SCVRD focuses strictly on employment of people with disabilities and rehabilitated nearly 9,000 of them into employment last fiscal year. SCCB placed 230 clients into employment through its vocational rehabilitation component last year, but the report points out that 71 percent of the clients SCCB served received state-supported services that were not employment focused.
- We agree in principle that limited long term cost savings in some areas could be realized through a consolidation, but startup costs would be significant due to installation of computer hardware and software, conversion of offices to accommodate needs of blind clients and staff, and in some locations a lack of space to absorb new staff. Any savings from consolidation would be more than offset by startup costs during the initial stages, an especially difficult obstacle given current budget constraints.

STATE OF SOUTH CAROLINA

State Budget and Control Board

OFFICE OF EXECUTIVE DIRECTOR

P.O. Box 12444
COLUMBIA, SOUTH CAROLINA 29211
(803) 734-2320

January 17, 2003

George Schroeder
Legislative Audit Council
1331 Elmwood Ave, Suite 315
Columbia, S.C. 29211

Dear Mr. Schroeder:

Thank you for the opportunity to comment on portions of your report concerning South Carolina health and human service agencies.

The sections involving key, yet complex, technology issues surrounding the 1996 HIPPA law should provide the Legislature with helpful insight into these statewide matters. While not mandated to do so by law, the Budget and Control Board has provided advice and information for the many state agencies impacted by this legislation. Lawmakers may choose to take additional measures to ensure full compliance.

As also noted, the Board is taking action to conduct a feasibility study for a consolidated information system. In light of the state's current financial situation, we are endeavoring to receive the maximum amount of federal funding prior to issuing a contract for this analysis.

We also remain committed to adopting statewide standards for information technology. Work is underway right now to develop a statewide information architecture. Currently, 19 agencies are a part of this effort.

While new resources will be required to fully realize an integrated IT structure for South Carolina's health care agencies and other state bodies, the Budget and Control Board is not letting that need keep us from moving forward in this very crucial area.

Sincerely,

Frank W. Fusco

Frank W. Fusco