Safety Net Proviso 33:22 Evaluation

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About IFS

The University of South Carolina (USC) Institute for Families in Society (IFS) is a non-partisan, non-governmental institute established in 1992 to conduct research focused on the health and well-being of families and communities. The Division of Integrated Health and Policy Research (IHPR) within IFS conducted the background research and analysis to prepare this report. IHPR is an interdisciplinary team with expertise in maternal and child health, health services and policy research, information technology, Geographical Information Science (GIS), statistics, data science, and web and graphic design. As the fourth oldest University-Medicaid partnership in the nation, a large aspect of IHPR work is our technical assistance and research partnership with the state's Medicaid agency (SCDHHS). Our work also involves extensive GIS and visualizations to help inform data-driven decisions in collaboration with several state and federal agencies, organizations, and private foundations. IFS has extensive experience in public health research and evaluation with both qualitative and quantitative approaches. Specifically, IFS has years of experience and staff expertise collecting meaningful data from patients and providers and working with South Carolina's complex Medicaid datasets and other relevant public health and health care datasets.

Research Approach

IFS's research approach enhances policy and decision-making through data-driven reports. IFS emphasizes the link between community residence and health outcomes. As independent researchers, our publications reflect our own methodologies, analyses, and results, not necessarily the views of our clients or sponsors.

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Executive Summary

In 2019, the South Carolina Legislature initiated a mechanism to support and monitor the state's safety net as part of **Proviso 33.22**.[1] This report reflects the calendar year (C.Y.) 2023 findings of services available or provided to the safety net population, which includes the uninsured, those living in poverty, individuals with disabilities, and Medicaid beneficiaries through Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Free Medical Clinics (FMCs) as of December 2023. Due to the lag in population data from the American Community Survey (ACS), all demographic comparisons between the 2023 and 2022 safety net reports are based on data from the prior calendar year. These comparisons reflect the most recent available data for assessing changes in access across the state's Rural, Micropolitan, and Metropolitan counties, including:

Changes in the Number of Safety Net Facilities

In 2023, the number of FMCs fell by 25.7% across the state, from 74 to 55 clinics. Metropolitan counties experienced the greatest reduction in FMCs, falling from 58 to 45 clinics. There was a 2.8% statewide increase in FQHCs, from 179 to 184 facilities, and a 16.3% increase in RHCs, from 92 to 107 facilities. Rural counties were the only areas in the state that lost RHCs (-1 facility) and FMCs (-4 facilities) between 2022 and 2023.

Rural Safety Net Socioeconomic Changes

Over the past five years, the state's Rural counties have seen consistent increases in uninsured rates and poverty, culminating in 2023. According to the latest ACS data, Rural counties experienced a steady increase in uninsured rates since 2019, growing from 13.7% to 15.1% of all persons ages 0 to 64 years as of 2022. The rural uninsured rate was 14.7% in 2021.

Safety Net Population Access to Providers

In 2023, there was a 14.7% statewide increase in the percentage of persons living in poverty who resided beyond 20 minutes to the nearest safety net provider (all types). Compared to the previous year, an additional 5,329 Rural residents lived more than 20 minutes from the nearest RHC, and 2,578 rural residents lived beyond 20 minutes from an FMC. Rural counties were the only areas in the state to lose access to RHCs and FMCs in 2022 and 2023. Approximately 90% of the safety net population lives within 20 minutes of the nearest FQHC.

Medicaid Access to Safety Net Providers

During calendar year (C.Y.) 2023, 32,178 Medicaid beneficiaries (ages 0 to 64) utilized FQHCs and RHCs for their healthcare services. These providers represent a 7.0% decline in service utilization compared to the previous year. In rural counties, beneficiaries utilizing these providers decreased by 17.7%, from 6,174 to 5,079 members. In Micropolitan counties, there was an 18.1% decrease in safety net utilization among Medicaid members, falling from 7,124 to 5,835 persons.

Background

In 2019, the South Carolina Legislature initiated a mechanism to support and monitor the state's safety net as part of **Proviso 33.22**.[1] This report analyzes the safety net proviso for the calendar year (CY) 2023 using a geospatial framework to explore the change in needs of medically underserved communities throughout the state and the need for safety net services. The report findings are reflective of the FY2023-24 proviso language related to the "evaluation of the state's safety-net providers that include, at a minimum, Federally Qualified Health Centers, Rural Health Clinics, and to the extent applicable to funding received by the state, free clinics."[2] Safety-net practices, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Free Medical Clinics (FMCs), organize and deliver a significant level of health care and other needed services to uninsured, Medicaid, and other vulnerable patients.[3] Note: This report does not address critical access hospitals, another safety net facility important to serving the state's underserved and rural population.

South Carolina's Safety Net

The safety net health care system is critical to South Carolina's healthcare landscape, providing essential services to uninsured, underinsured, and low-income populations. Safety net providers, including FQHCs, RHCs, FMCs, public hospitals, and community health centers, serve as the backbone of this system. FQHCs are community-based health centers that provide medically necessary primary health, behavioral health, mental health, and preventive services to all patients regardless of their ability to pay or their health insurance status.[4] RHCs are intended to provide access to primary care services for residents in rural communities that have either been designated as a Medically Underserved Area (**Appendix B Figure B1**), a Geographic- or Population-based Health Professional Shortage Area (**Appendix B Figures B2-B4**), or a Governor-Designated Secretary-Certified Shortage Area.[5] FMCs can provide general medical, prescription, and specialty services, including dental, lab testing, health education, and referrals.[6] As a safety-net provider, FMCs use a volunteer/staff model to provide healthcare services to uninsured, low- and no-income patients.

As a state, South Carolina has 70 Medically Underserved Areas (MUA) with more than 65% of the general population living in a Primary Care Health Professional Shortage Area (HPSA).[7] Of the state's approximately 3 million persons ages 18 to 64 years, about 446,920 (roughly 15%) were uninsured as of 2022.[8] The state also provided Medicaid insurance to approximately 1,209,326 million enrollees (December 2023 enrollment counts).[9] Of those enrolled in Medicaid, over half of all members lived in a MUA and nearly 70% resided in a Primary Care HPSA (SC MMIS as of December 2023).

This report highlights population and provider trends for FQHCs, RHCs, and FMCs using three key demographic measures:

1. The percentage of the uninsured population
2. The percentage of the population living below the federal poverty level
3. The percentage of the population living with a disability

The Agency for Healthcare Research and Quality (AHRQ) identifies these metrics as indicators of the most vulnerable populations likely to face significant barriers to accessing healthcare.[10] This report updates the measures of this population group's demand and access to the state's safety net services, fulfilling the monitoring goals outlined in the proviso's Rural Health Initiative. Additionally, the report includes details about South Carolina's Medicaid population and utilization of safety net providers during CY2023. All demographic estimates for the safety net population are based on the 2022 American Community Survey (ACS) 5-year data cycle questionnaires, which provide the most up-to-date population statistics for 2023. Readers are advised to interpret population counts cautiously, as an individual can be uninsured, living in poverty, and living with a disability simultaneously. The U.S. Census Bureau only provides cross-tabulated data for some of the three categories.

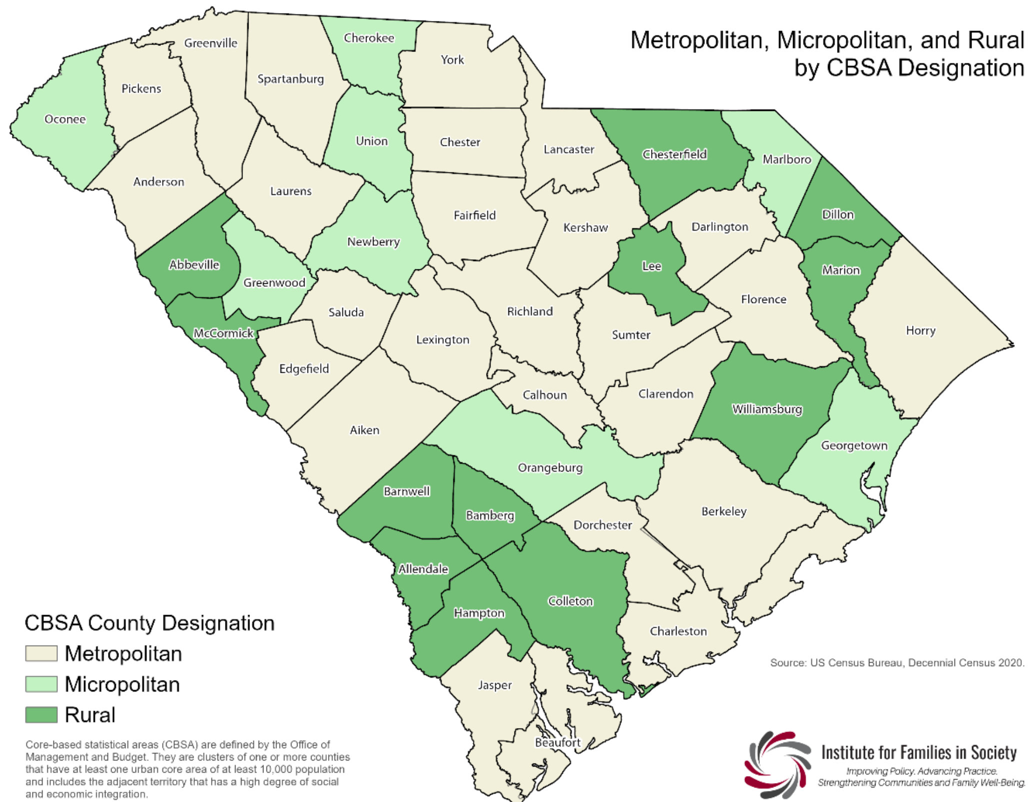
South Carolina's safety net population includes the uninsured population, persons living in poverty, and persons living with a disability.[10]

Safety Net Attributes: Rurality

This report uses the Core Based Statistical Areas (CBSAs) defined by the United States Office of Management and Budget (OMB) to measure South Carolina's rural and urban safety net characteristics at the county level.[11] CBSA provides a federal standard to define and analyze rural counties based on population density and economic integration (see **Figure 1**). CBSAs include Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas (µSA), defined based on an area's economic, transportation, and institutional connections to urban cores. The OMB definition defines rural counties as non-metropolitan (non-metro) areas. A metropolitan area is an urban cluster of at least 10,000 people but less than 50,000 people, while a Metropolitan county is an urban cluster of at least 50,000 people. A county qualifies as an outlying county of a CBSA if at least 25% of the population living in the county work in the central county or counties of the CBSA or if at least 25% of the employment in the county is accounted for by workers who reside in the central county or counties of the CBSA.[12] Under the 2020 CBSA classification system, just under half (20) of South Carolina's 46 counties are designated as either Micropolitan (8) or Rural (12), accounting for approximately 14.1% of the state's population as of 2022.

Considering the multidimensionality of rurality and with the focus of this report on the underserved, IFS also examined geographic distances to providers using population data from ZIP Code Tabulated Areas (ZCTAs). All estimates were then aggregated into the census county, using the U.S. Census Bureau's crosswalk for assigning ZCTAs to county boundaries. **Figure 5** shows the 20-minute service catchments for FMCs, RHCs, and FQHCs. The change in 20-minute access to each facility type is shown in **Tables 9** and **10.**

Figure 1 Core Based Statistical Areas in South Carolina



Safety Net Attributes: Facilities

Tables 1 through 3 detail the number of safety net providers (FQHCs, RHCs, FMCs) within Rural, Micropolitan, and Metropolitan counties between 2020 and 2024 in two-year intervals. Changes in state totals are repeated in each table for ease of interpretation. Statewide, FQHCs increased from 174 facilities in 2020 to 184 in 2024. In rural counties, FQHCs increased from 30 to 31 facilities. Statewide, RHCs increased from 82 in 2020 to 107 in 2024. Rural counties were the only areas in the state that experienced a loss of RHCs in 2020 (-12.0%) and 2022 (-4.3%).

Since 2022, the number of the state's FMCs has decreased in rural and metropolitan counties. However, the state's Metropolitan counties have seen the most significant closures, falling from 58 to 45 clinics between 2022 and 2024 (see **Table 3**).

Table 1 Change in safety net facilities within Rural counties, 2020 - 2024

	2020		2022		2024		% Change (Δ) 2022-2024	
	Rural	SC	Rural	SC	Rural	SC	Rural	SC
Federally Qualified Health Center (FQHC)	30	174	31	179	31	184	0.0%	+2.8%
Rural Health Clinic (RHC)	25	82	23	92	22	107	-4.3%	+16.3%
Free Medical Clinic (FMC)	5	74	6	74	2	55	-66.7%	-25.7%

- As shown in above **(Table 1)**, there are now only two FMCs in the state's 12 most rural counties, reflecting a decrease compared to 2022. In contrast, FQHCs have seen little change in growth in rural counties, maintaining a stable presence with 31 centers.

Table 2 Change in safety net facilities within Micropolitan (µSA) counties, 2020 – 2024

	2020		2022		2024		% Change (Δ) 2022-2024	
	µSA	SC	µSA	SC	µSA	SC	µSA	SC
Federally Qualified Health Center (FQHC)	27	174	27	179	28	184	+3.7%	+2.8%
Rural Health Clinic (RHC)	22	82	31	92	38	107	+22.6%	+16.3%
Free Medical Clinic (FMC)	11	74	10	74	8	55	-20.0%	-25.7%

- As shown above (**Table 2**), the number of RHCs in Micropolitan counties increased by 22.6% since 2022, rising from 31 to 38. This is a continuation in growth in RHCs since 2022.

Table 3 Change in safety net facilities within Metropolitan (MSA) counties, 2020 – 2024

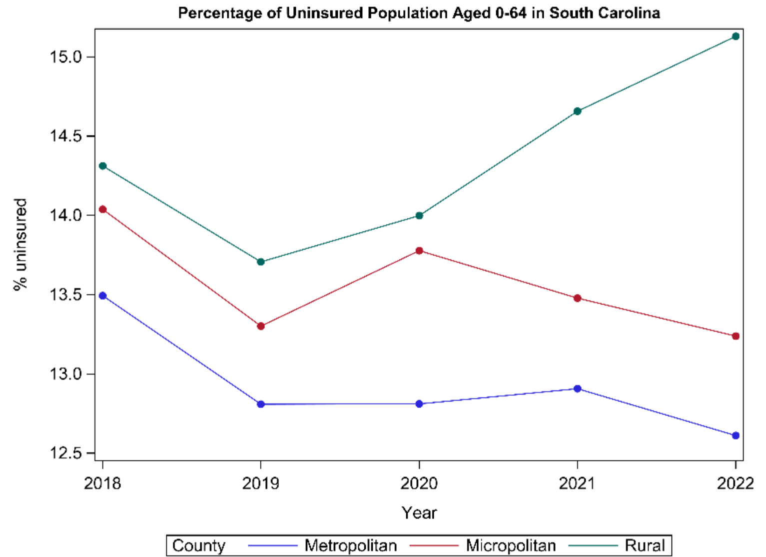
	2020		2022		2024		% Change (Δ) 2022-2024	
	MSA	SC	MSA	SC	MSA	SC	MSA	SC
Federally Qualified Health Center (FQHC)	117	174	121	179	125	184	+3.3%	+2.8%
Rural Health Clinic (RHC)	35	82	38	92	47	107	+23.7%	+16.3%
Free Medical Clinic (FMC)	58	74	58	74	45	55	-22.4%	-25.7%

- As shown above (**Table 3**), FMCs in MSAs decreased by 22.4% since 2022, dropping from 58 to 45 clinics. This decline is part of a statewide reduction in FMCs since 2022.

Safety Net Population Trends, 2018 to 2022

Based on 2022 ACS estimates, approximately 13.4% of all South Carolinian's ages 0–64 (n = 508,945) reported being uninsured when asked if they had health insurance coverage.[8] This represents a 3.1% decrease in the state's overall uninsured rate since 2018. There was a 2.9% percentage point decrease in the state's uninsured rate between 2021 and 2022 (see **Table 4**).

Figure 2 self-reported uninsured population in South Carolina, 2018 - 2022



The uninsured rate in South Carolina's Rural counties increased 5.6% between 2018 – 2022, from 14.3% to 15.1%.

From 2018 to 2022, the Rural uninsured rate grew from 14.3% to 15.1%, for a +5.6% increase over the period and a +2.7% increase from 2021 to 2022 (see **Figure 1**). In Micropolitan counties, the uninsured rate fell from 14.0% in 2018 to 13.2% in 2022, for a -5.7% decrease over the period and a -2.2% decrease between 2021 and 2022. Metropolitan counties saw a -6.7 % decrease in the uninsured rate from 13.5% in 2018 to 12.6% in 2022 and a --2.3 % decrease from 2021 to 2022.

South Carolina's rural counties are consistently the only areas in the state to see an increase in uninsured rate on an annual basis.

Table 4: Change in uninsured status among persons ages 0 - 64, 2018 – 2022 (∆ = change in %)

Region Type	2018	2019	2020	2021	2022	∆ 2018 - 2022	∆ 2021 - 2022
Rural	14.3%	13.7%	14.0%	14.7%	15.1%	+ 5.6%	+ 2.7%
Micropolitan	14.0%	13.3%	13.8%	13.5%	13.2%	- 5.7%	- 2.2%
Metropolitan	13.5%	12.8%	12.8%	12.9%	12.6%	- 6.7%	- 2.3%
State	13.8%	13.1%	13.3%	13.5%	13.4%	- 2.9%	-0.7%

Statewide, persons living below the federal poverty level (FPL) fell by 10% between 2018 – 2022, from 21.3% in 2018 to 19.2% in 2022. There was no change from 2021 to 2022. All estimates are based on ACS individual poverty data [13] (see **Table 5**). Declines occurred throughout Rural (-8.9%), Micropolitan (-9.4%), and Metropolitan (-11.0%) counties. Poverty declines were the highest within Metropolitan counties, decreasing from 18.2% in 2018 to 16.2% in 2022, an 11.0%

reduction. From 2018 to 2022, the Rural county poverty rate decreased from 26.7% to 24.3%, reflecting a 9.0% reduction. However, there was a 2.5% increase in rural poverty between 2021 and 2022.

South Carolina's rural counties were the only areas in the state that saw an increase in poverty between 2021 and 2022.

The poverty rate in South Carolina's Rural counties increased 2.5% between 2021 – 2022, from 23.7% to 24.3%.

Figure 3 population living in poverty in South Carolina, 2018 - 2022

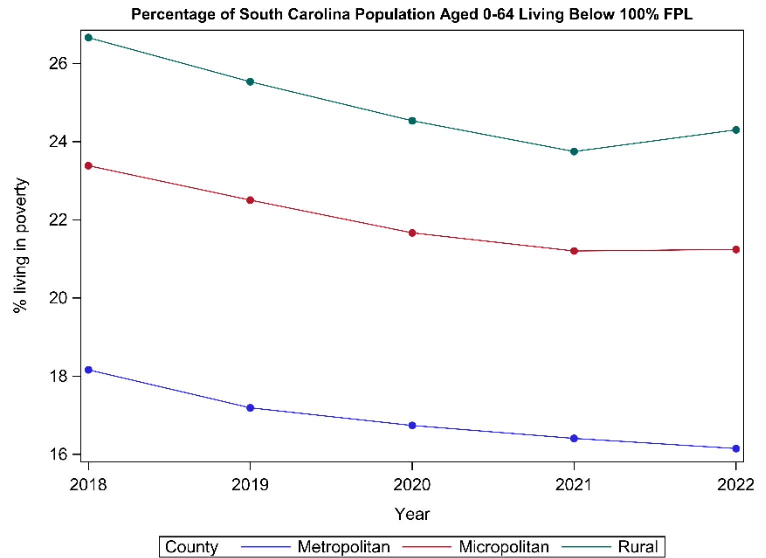


Table 5 Change in population living in poverty among ages 0 - 64, 2018 – 2022 (Δ = change in %)

Region Type	2018	2019	2020	2021	2022	Δ 2018 - 2022	Δ 2021 - 2022
Rural	26.7%	25.5%	24.5%	23.7%	24.3%	-9.0%	+2.5%
Micropolitan	23.4%	22.5%	21.7%	21.2%	21.2%	-9.4%	0.0%
Metropolitan	18.2%	17.2%	16.7%	16.4%	16.2%	-11.0%	-1.2%
State	21.3%	20.3%	19.6%	19.2%	19.2%	-10.0%	0.0%

Statewide, the percentage of persons reporting living with a disability, including hearing, vision, cognitive, ambulatory, self-care, and independent living difficulties, fell by 6.5% between 2018 and 2022, dropping from 12.3% to 11.5% of the state's population (see **Table 6**).[14] From 2018 to 2022, the percentage of persons living with a disability in Rural counties decreased from 14.2% to 13.4%, reflecting a 5.6% reduction over the period and a 2.2% decrease from 2021 to 2022 (see **Figure 4**). In Micropolitan counties, the percentage decreased from 12.8% in 2018 to 12.2% in 2022, marking a 4.7% reduction overall and a 1.6% decrease from 2021 to 2022. Metropolitan areas saw an 8.0% reduction in persons living with a disability, falling from 11.3% in 2018 to 10.4% in 2022 and by 1.0% between 2021 and 2022.

Since 2018, the percentage of persons reporting living with a disability across Rural (-5.6%), Micropolitan (-4.7%), and Metropolitan (-8.0%) counties has declined statewide.

The percentage of persons living with a disability fell by 5.6% in Rural counties between 2018 – 2022, from 14.2% to 13.4%.

Figure 4 disability characteristics in South Carolina, 2018 - 2022

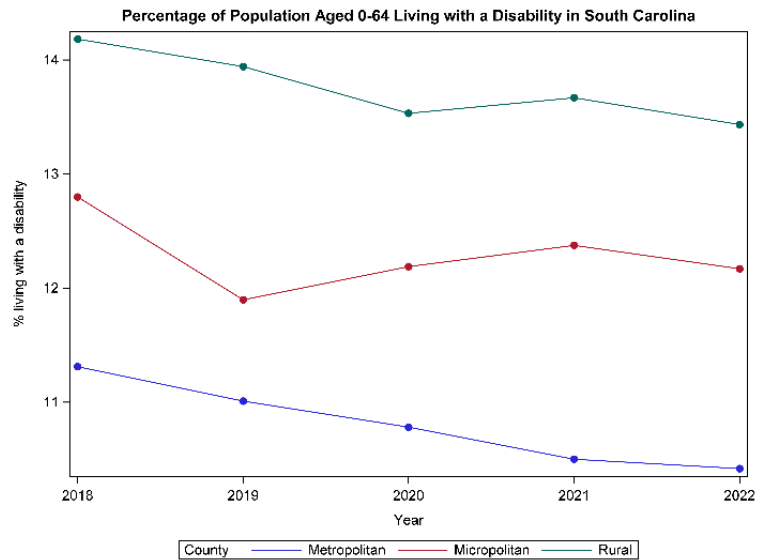


Table 6 Change in disability characteristics among children and adults, 2018 – 2022 (Δ = change in %)

Region Type	2018	2019	2020	2021	2022	Δ 2018 - 2022	Δ 2021 - 2022
Rural	14.2%	13.9%	13.5%	13.7%	13.4%	-5.6%	-2.2%
Micropolitan	12.8%	11.9%	12.2%	12.4%	12.2%	-4.7%	-1.6%
Metropolitan	11.3%	11.0%	10.8%	10.5%	10.4%	-8.0%	-1.0%
State	12.3%	11.9%	11.7%	11.7%	11.5%	-6.5%	-1.2%

Geographic Access to All Safety Net Facilities

Figure 5 shows all areas in the state within 20 driving minutes of any safety net provider (FMC, RHC, FQHC). From 2022 to 2023, the percentage of the safety net population living within 20 minutes of these providers decreased by 2.4% to 14.7%, depending on the population group. Within rural counties, the percentage of persons living beyond 20 minutes from any facility in poverty doubled, rising from 3.1% to 6.8% of all persons (see **Table 7**). **Rural counties were the only regions in the state that saw a loss in access to all safety net providers between 2022 and 2023.**

Figure 5 Service area catchments for all safety net facilities (FMC, RHC, FQHC)

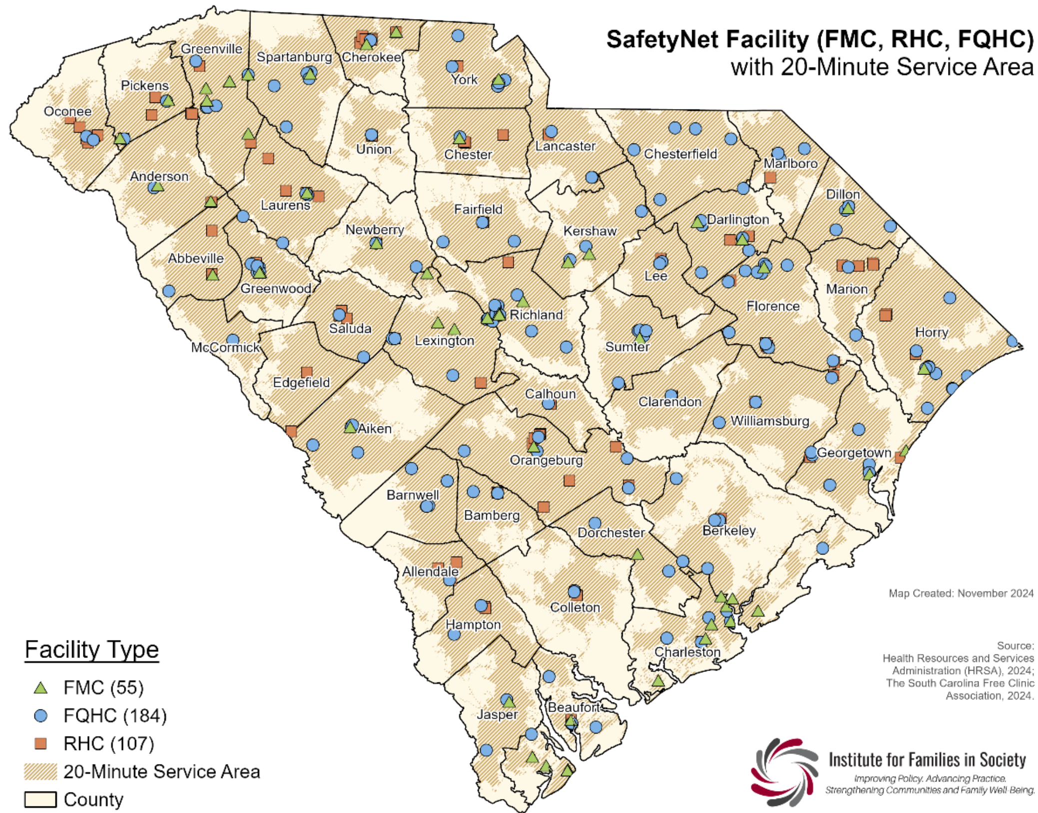


Table 8 Percentage of the safety net population living beyond 20 minutes to any safety net facility by year

	2022			2023			Change (Δ) in access		
	Uninsured	Poverty	Disability	Uninsured	Poverty	Disability	Uninsured	Poverty	Disability
Rural	5.0%	3.1%	7.3%	5.6%	6.8%	7.9%	12.0%	119.4%	8.2%
µSA	6.4%	5.1%	9.5%	6.8%	4.7%	8.9%	6.3%	-7.8%	-6.3%
MSA	3.6%	5.9%	3.6%	3.6%	3.7%	3.7%	0.0%	-37.3%	2.8%
State	3.8%	3.4%	4.2%	3.9%	3.9%	4.3%	2.6%	14.7%	2.4%

Geographic Access to Safety Net Facilities by Facility Type

Between 90.1% and 96.9% of the state's safety net population resides within 20 minutes of the nearest FQHC, RHC, or FMC. **Table 8** shows changes in the percentage of persons that lived from 20 minutes to a safety net facility between 2022 and 2023. The rural safety net population lost access to providers in 2023, with the percentage of persons living in poverty living beyond 20 minutes from the nearest provider doubling from 3.1% to 6.8%. Statewide, there was a 2.4% to 14.7% decrease in access to safety net providers between 2022 and 2023. **Table 9** shows the

change in the 20-minute catchments to each safety net provider type between 2022 and 2023.

Table 9 Change in safety net population residing beyond 20 minutes to the nearest facility, 2022 to 2023

	2022			2023			gain (+) or loss (-) in access		
	Uninsured	Poverty	Disability	Uninsured	Poverty	Disability	Uninsured	Poverty	Disability
FQHC									
Rural	8.9%	8.5%	10.8	8.2%	8.5%	10.3%	+7.9%	0.0%	+4.6%
µSA	10.2%	8.5%	13.6	10.8%	8.4%	13.0%	-5.9%	+1.2%	+4.4%
MSA	9.4%	7.9%	10.0	9.0%	8.0%	9.7%	+4.3%	-1.3%	+3.0%
State	**9.3%**	**7.8%**	**10.2%**	**8.9%**	**7.9%**	**9.8%**	**+4.3%**	**-1.3%**	**+3.9%**
RHC									
Rural	13.4%	18.5%	19.5%	20.2%	25.2%	25.3%	-50.7%	-36.2%	-29.7%
µSA	21.3%	21.0%	23.8%	11.1%	8.2%	14.6%	+47.9%	+61.0%	+38.7%
MSA	54.9%	51.0%	52.0%	51.9%	49.1%	50.0%	+5.5%	+3.7%	+3.8%
State	**50.3%**	**45.9%**	**48.0%**	**47.1%**	**43.4%**	**45.9%**	**+6.4%**	**+5.4%**	**+4.4%**
FMC									
Rural	70.5%	70.7%	74.2%	74.4%	72.9%	78.4%	-5.5%	-3.1%	-5.7%
µSA	39.8%	37.9%	48.1%	41.1%	38.0%	46.3%	-3.3%	-0.3%	+3.7%
MSA	24.5%	23.7%	25.6%	27.9%	26.8%	28.8%	-13.9%	-13.1%	-12.5%
State	**29.1%**	**29.8%**	**31.6%**	**32.5%**	**32.6%**	**34.3%**	**-11.7%**	**-9.4%**	**-8.5%**

Table 10 shows the total number of persons residing within 20 minutes of the nearest FQHC, RHC, and FMC by safety net classification group. Among all facility types, FQHCs were the most accessible to the state's safety net population in 2023, with 87.0% to 91.8% living within 20 minutes of the nearest facility. In Rural counties, 74.7% to 79.8% of the population was within 20 minutes of the nearest RHC, and 21.6% to 27.2% were within 20 minutes of the nearest FMC.

Table 7 Count (%) of the 2023 Safety Net population living within 20 minutes to the nearest facility.

	Count of Safety Net Population Residing within 20 miles to nearest facility (%), by County Type								
Safety Net Facility	Uninsured			Living in Poverty			Living with a Disability		
	Rural	µSA	MSA	Rural	µSA	MSA	Rural	µSA	MSA
FQHC	22,691 (91.8)	36,387 (89.2)	294,880 (91.0)	34,832 (91.6)	59,969 (91.6)	463,980 (92.0)	17,528 (89.7)	32,119 (87.0)	312,280 (90.3)
RHC	19,712 (79.8)	36,267 (88.9)	208,887 (48.1)	28,460 (74.8)	60,100 (91.8)	256,609 (50.9)	14,601 (74.7)	31,531 (85.4)	172,869 (50.0)
FMC	6,338 (25.7)	24,013 (58.9)	312,911 (72.1)	10,331 (27.2)	40,591 (62.0)	36,9114 (73.2)	4,224 (21.6)	19,847 (53.7)	246,059 (71.2)

Utilization of Safety Net Providers among Medicaid Members

All counts of Medicaid members that utilized a safety net provider were based on Healthcare Effectiveness Data and Information Set (HEDIS®) population counts during CY22 and CY23. During CY23, 32,178 Medicaid beneficiaries ages 0 to 64 years utilized an FQHC or an RHC to obtain all or a portion of their health care services. The number of members decreased by 2,425 from 2022, or a 7.0% decrease in members served. FMC encounters do not have dedicated billing identifiers in state Medicaid administrative records. As shown in **Table 11**, there was a 17.7% decrease in the number of beneficiaries in Rural counties who utilized an FQHC or RHC and an 18.1% decrease in the number of beneficiaries in Micropolitan counties using an FQHC or RHC. These changes should be interpreted cautiously, as they do not account for potential beneficiary movement between counties between calendar years.

Table 8 Change in safety net utilization (FQHC, RHC) among Medicaid beneficiaries 2022 – 2023

	2022			2023			Change (Δ) between 2022 and 2023		
Age Group	Events for Members With At Least 1 Safety Net Visit			Events for Members With At Least 1 Safety Net Visit					
	Rural	µSA	MSA	Rural	µSA	MSA	Rural	µSA	MSA
Total	6,174	7,124	21,305	5,079	5,835	21,264	-17.7%	-18.1%	-0.2%

Summary of Findings

In the last two years, South Carolina's Rural counties were the only areas in the state to see an increase in the uninsured population (+2.7%) and the percentage of persons living below the poverty line (+2.5%). Rural counties were also the only areas to see a decline in access (travel time) to both RHCs and FMCs. All areas in the state are experiencing a loss in access to FMCs, which have fallen from 74 to 55 clinics since 2020. Between CY22 and CY23, there was a 7.0% decrease in Medicaid members who utilized FQHCs or RHCs for their health care services. These declines were most significant in Rural (-17.7%) and Micropolitan (-18.1%) counties.

Glossary

American Community Survey (ACS) - an annual survey program of several population datasets and reports created by the U.S. Census Bureau.[15]

Census-Based Statistical Areas (CBSA) – federal regions defined by the Office of Management and Budget that include one or more counties anchored by an urban center of >= 10,000 people. Metropolitan Statistical Areas are CBSAs with an urbanized area of >= 50,000 people, while Micropolitan Statistical Areas have an urban cluster of 10,000 to 50,000 people. Rural Areas are regions outside the boundaries of metropolitan and micropolitan statistical areas, typically characterized by lower population densities and smaller settlements.[11]

Federally Qualified Health Centers (FQHCs) - community-based health centers that provide comprehensive primary health care and behavioral and mental health services to all patients regardless of their ability to pay or their health insurance status.[4]

Free Medical Clinics (FMC) - health care organizations that utilize a volunteer/staff model to provide a range of healthcare services which may include medical, dental, pharmacy, vision and/or behavioral health services to economically-disadvantaged individuals. Such clinics are 501(c)(3) tax-exempt organizations or operate as a program component or affiliate of a 501(c)(3) organization.[6]

Health Professional Shortage Area (HPSA) - geographic areas or populations that have a shortage of primary, dental, or mental health care providers.[16]

Medically Underserved Area (MUA) - a geographic area with a lack of access to primary care services. Designation is based on the Index of Medical Underservice (IMU) The IMU is calculated based on the population to provider ratio, the percent of the population below the Federal Poverty Level, the percent of the population over age 65, and the infant mortality rate. The IMU is scaled from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved. Areas with an IMU or 62 or less are designated as medically underserved.[17]

Population-weighted Centroid – an alternative to the geometric centroid, which represents the geometric center of an area (county, census tract, etc.), the population-weighted centroid factors in the population of a given area, representing the center of population density.

Rural Health Clinic (RHC) - clinics providing primary care services to residents in rural, underserved communities; located in either a Geographic- or Population-based HPSA, a MUA, or Governor-Designated Secretary-Certified Shortage Area.[5]

ZIP Code Tabulation Areas (ZCTA) - approximate area representations of U.S. Postal Service (USPS) five-digit ZIP Code service areas used by the Census Bureau to present statistical data from censuses and surveys.[18]

Methodology

To evaluate geographic access to South Carolina's network of safety-net facilities, IFS geo-located each facility based on the facility's available address using a Geographic Information System (GIS). Those facilities located in-state were used in the analysis.

While standards exist for drive time (45 minutes) and distance (30 miles) to primary care providers, most of the SC Medicaid population lives much closer than the standard. Data for the latest Managed Care Organization (MCO) network adequacy analysis were used to determine the maximum drive time (20 minutes) to the closest primary care provider for most of the Medicaid population. The 20-minute drive time was used as the threshold to measure access for safety-net facilities target populations, the rural and underserved. The rationale for this is that all patients, regardless of service arrangement (e.g., Fee-For-Service, Managed Care, uninsured, etc.), should have fair access to healthcare. Using road network distance, 20-minute service areas were drawn around each of the three safety-net provider locations for 2022 and 2023.

Data Sources & Caveats

The data framing the analysis of this report were pulled from many difference resources and varying time periods to provide a full picture of the residential makeup, geographic size, and critical medical care information for South Carolina. The US Census Bureau releases data from its decennial census as well as their annual surveys at many different geographic levels. The 2022 ACS was used to provide the most up-to-date information on residential demographics in the state for 2023. All comparisons to 2022 safety net demographics were based on 2021 ACS data. The Rand McNally Road Atlas for 2023 was used to establish the geographic size and scale of South Carolina. Information on the medically underserved areas of South Carolina and the specific HPSA data and maps come from Health Resources and Services Administration (HRSA). HRSA is also the organization that funds the FQHCs.

Safety-Net Providers

This evaluation is location specific. Service delivery sites are not equal in services offered. Safety-net providers may offer a variety of services at a given location.

FQHCs: Grantee and Look-Alike delivery sites were pulled from the HRSA data stores. Sites must have been listed as 'Active' for the given years.

RHCs: Locations were identified and pulled from the HRSA data stores.

FMCs: Locations were identified and pulled from The South Carolina Free Clinic Association.

Address data for each safety-net provider was standardized and then geo-located using ESRI's ArcPro utilizing ESRI's StreetMap Premium Routing Data.

The final provider datasets were then linked to a GIS road network for analysis.

Residents:
To determine if the residents of a particular community had access to a safety-net provider, the population-weighted centroid of each Zip Code Tabulation Area (ZCTA) was used.

Inclusions:
Only those safety-net providers that could be geo-located within the state and only those ZCTAs with a population were included for evaluation.

Exclusions:
The following elements were excluded from the evaluation for the provided reason(s): providers that could not be geo-located based on available address information or located within the state or could not be snapped to the analysis network for processing; ZCTAs without a measurable population (e.g., state parks, public lands, etc.).

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Appendix A. The Safety Net Proviso

Proviso 33.22 (DHHS: Rural Health Initiative) - 2023-2024 Appropriations Bill H.4300

33.22. (DHHS: Rural Health Initiative) From the funds appropriated to the Department of Health and Human Services for the Rural Health Initiative in the current fiscal year, the department shall partner with the following state agencies, institutions, and other key stakeholders to implement these components of a Rural Health Initiative to better meet the needs of medically underserved communities throughout the state. The department may leverage any and all available federal funds to implement this initiative. Recurring and non-recurring funding for the Rural Health Initiative may be carried forward by the department and expended for the same purpose.

(A) The Department of Health and Human Services shall incentivize the development of primary care access in rural and underserved areas, leverage Medicaid spending on Graduate Medical Education (GME) and continue to leverage the use of teaching hospitals to ensure rural physician coverage in counties with a demonstrated lack of adequate access and coverage through the following provisions:

(1) Rural and Underserved Area Provider Capacity - the department shall partner with the University of South Carolina School of Medicine to develop a statewide Rural Health Initiative to identify strategies for significantly improving health care access, supporting physicians, and reducing health inequities in rural communities. In addition, the department shall also contract with the MUSC Hospital Authority in the amount of $1,500,000, and the USC School of Medicine in the amount of $2,000,000 to further develop statewide teaching partnerships. The department shall also expend $5,000,000 in accordance with a graduate medical education plan developed cooperatively by the Presidents or their designees of the following institutions: the Medical University of South Carolina, the University of South Carolina, and Francis Marion University.

(2) Rural Healthcare Coverage and Education - The USC School of Medicine, in consultation with statewide rural health stakeholders and partners, shall continue to operate a Center of Excellence to support and develop rural medical education and delivery infrastructure with a statewide focus, through clinical practice, training, and research, as well as collaboration with other state agencies and institutions. The Center shall submit to the department an annual spending plan centered on efforts to improve access to care and expand healthcare provider capacity in rural communities. Upon approval of the annual spending plan, the department shall authorize at least $3,000,000 to support center staffing as well as the programs and collaborations delivering rural health research, the ICARED program, workforce development scholarships and recruitment, rural fellowships, health education development, and/or rural practice support and education. Funding released by the department pursuant to this section must not be used by the recipient(s) to supplant existing resources already used for the same or comparable purposes. No later than February first of the current fiscal year, the USC School of Medicine shall report to the Chairman of the House Ways and Means Committee, the Chairman of the Senate Finance Committee, and the Director of the Department of Health and Human Services on the specific uses of funds budgeted and/or expended pursuant to this provision.

(3) Rural Medicine Workforce Development - The department shall support the development of additional residency and/or fellowship slots or programs in rural medicine, family medicine, and any other appropriate primary care specialties that have been identified by the department as not being adequately served by existing Graduate Medical Education programs. New training sites and/or residency positions are subject to approval as specified by the Accreditation Council for Graduate Medical Education (ACGME). As funds are made available, the department may also accept proposals and award grants for programs designed to expose resident physicians to rural practice and enhance the opportunity to recruit these residents for long-term practice in these rural and/or underserved communities.

(4) Statewide Health Innovations - At least $2,500,000 must be expended by the department to contract with the USC School of Medicine and at least $1,000,000 to Clemson University to develop and continue innovative healthcare delivery and training opportunities through collaborative community engagement via ICARED, Clemson Rural Health Programming, and other innovative programs that provide clinical services, mental and behavioral health services, children's health, OB/GYN services, and/or chronic disease coverage gaps. In consultation with statewide rural health stakeholders and partners, the department must ensure collaborative efforts with the greatest potential for impact are prioritized.

(5) Rural Health Network Revitalization Project - For the purpose of establishing self-sustaining rural health networks that will improve care delivery in rural communities, funds appropriated for Rural Health Network Revitalization shall be expended, in consultation with the Director of Department of Health and Human Services, by the South Carolina Center for Rural and Primary Healthcare within the University of South Carolina School of Medicine to provide material support, facilitation, technical assistance, and other resources to rural communities seeking to create or renew their rural health networks. The Center shall submit to the department an annual spending plan. Upon approval of the annual spending plan, the Center shall:

(a) be authorized to provide funding to such communities for a time to establish and support the work,

(b) work with partners across the State to implement evidence-based models of community development and healthcare delivery,

(c) evaluate the implementation and impact of the network development work undertaken; and

(d) facilitate the development, implementation, and evaluation of alternative payment models with payors within the State.

No later than February first of the current fiscal year, the South Carolina Center for Rural and Primary Healthcare within the University of South Carolina School of Medicine shall report to the Chairman of the House Ways and Means Committee, the Chairman of the Senate Finance Committee, and the Director of the Department of Health and Human Services on the specific uses of funds budgeted and/or expended pursuant to this provision.

(B) The department shall continue to investigate the potential use of disproportionate share, directed payment, and/or any other source of funds in order to improve access to medical services in one or more rural communities identified by the department in which such access has been determined to be unstable or at-risk. As funds are available to the department, it may establish a grant program for providers to implement sustainable delivery models or capital improvements to enhance access to health care services. When the program is in force, the department shall publish grant criteria and guidelines and, at its discretion, may cap or limit the amount of available funds at any time. The department shall require written proposals and may include stipulations it deems necessary and prudent to ensure funds are used to improve the sustainability of access to services in rural or other underserved areas. The department shall also ensure that a facility has been properly sized to meet the needs of its service area. By October 1st of each year, the department shall report to the Chairman of the House Ways and Means Committee and the Chairman of the Senate Finance Committee on the status of outstanding grants.

(C) The Revenue and Fiscal Affairs Office and the Area Health Education Consortium's Office of Healthcare Workforce Analysis and Planning shall provide the department with any information required by the department in order to implement this proviso in accordance with state law and regulations. Not later than January 1, of the current fiscal year, the department shall submit to the President of the Senate and Speaker of the House of Representatives an evaluation of the state's safety-net providers that includes, at a minimum, Federally Qualified Health Centers, Rural Health Clinics, and to the extent applicable to funding received by the state, free clinics.

Appendix B: HPSA/MUA Designations and County Demographic Maps

Figure B1: South Carolina Medically Underserved Areas (MUAs), by type as of October 2024

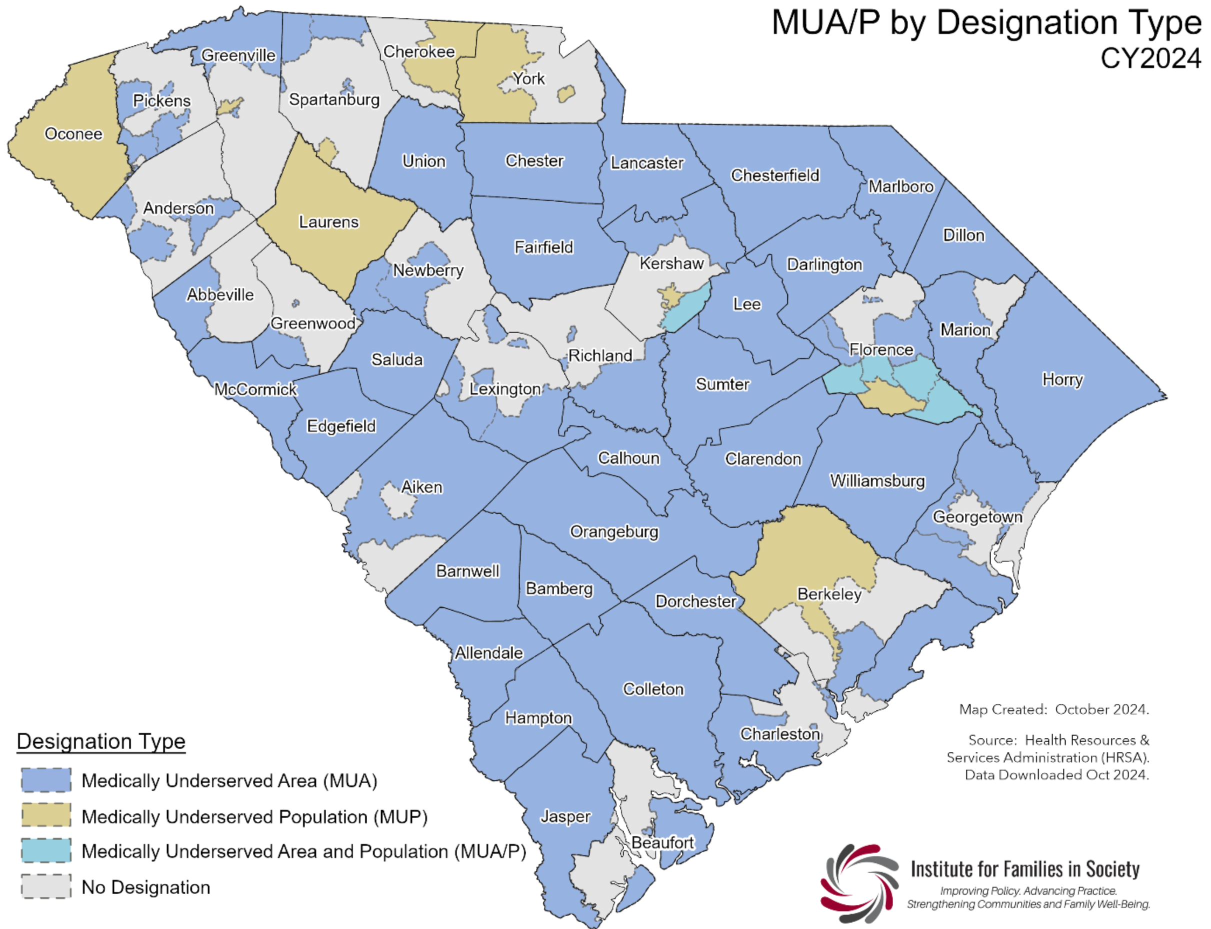


Figure B2: South Carolina's Primary Care HPSAs

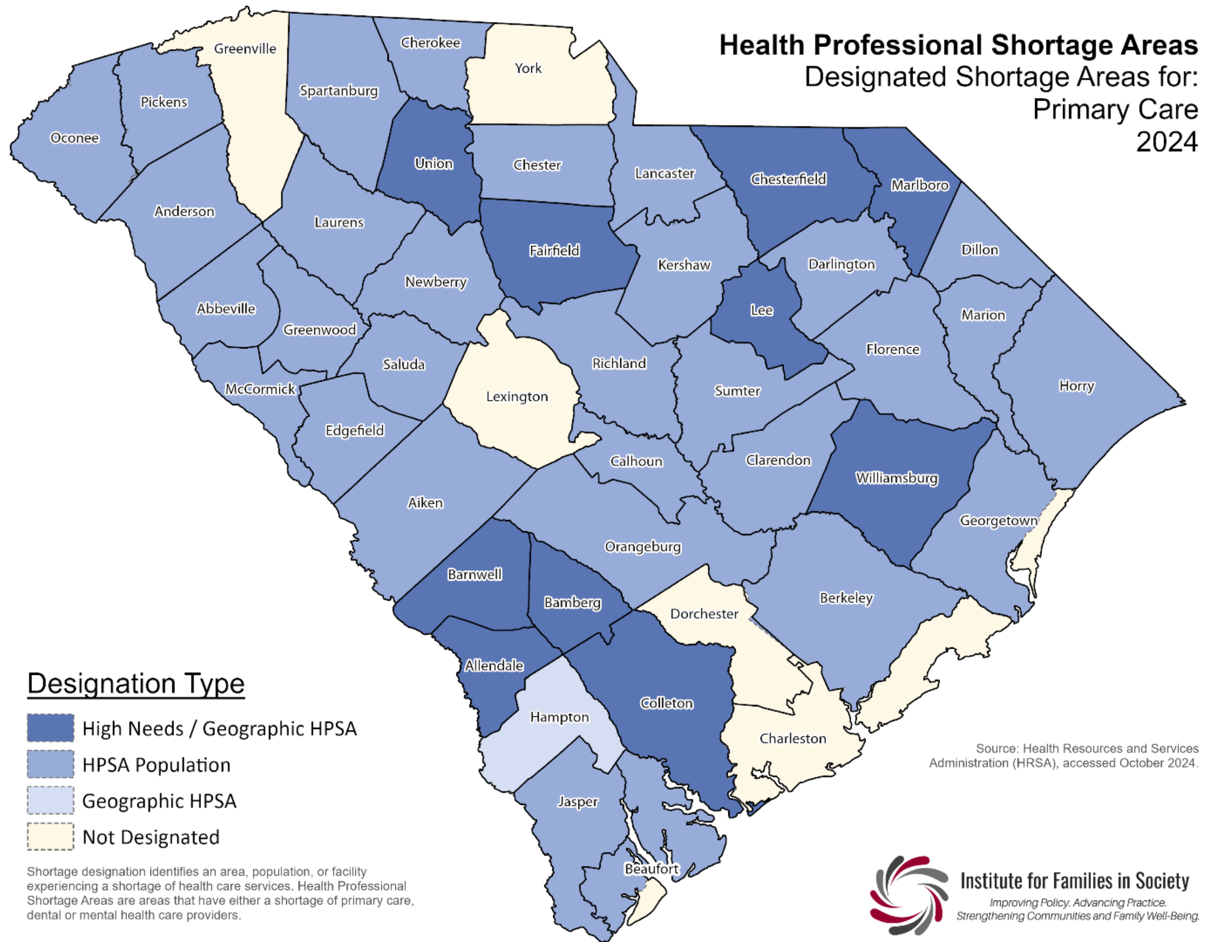


Figure B3: South Carolina Mental Health Designated HPSAs

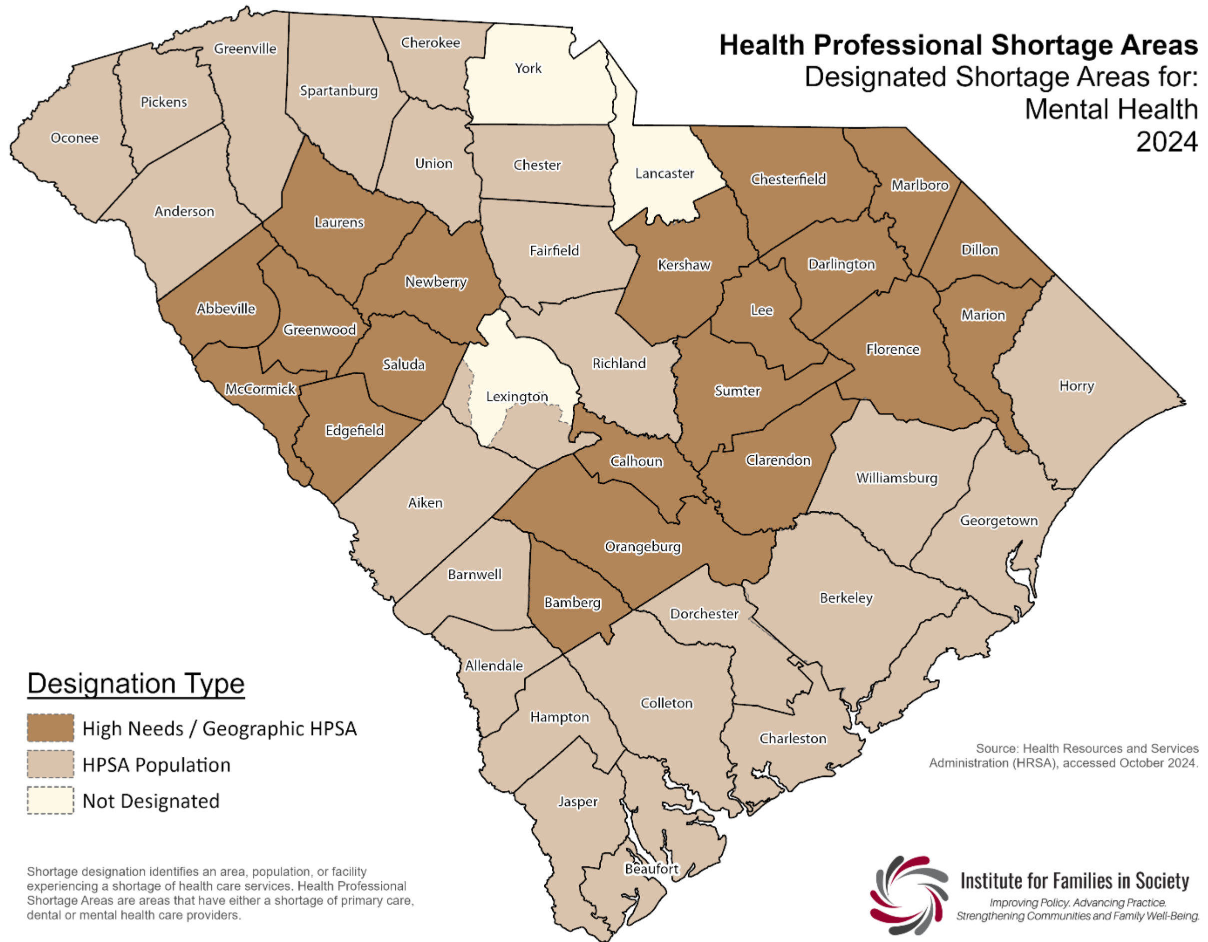


Figure B4: South Carolina Dental Health Designated HPSAs

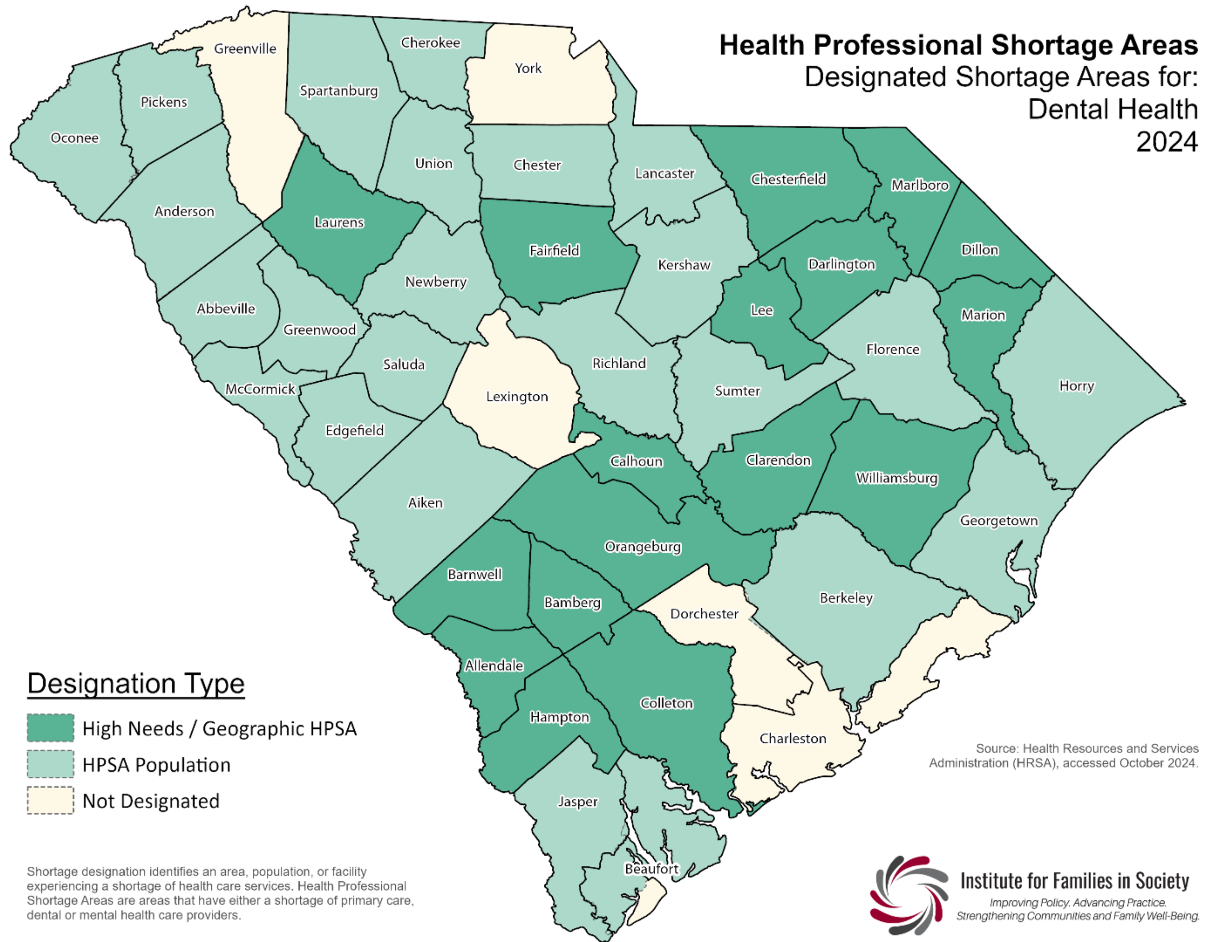
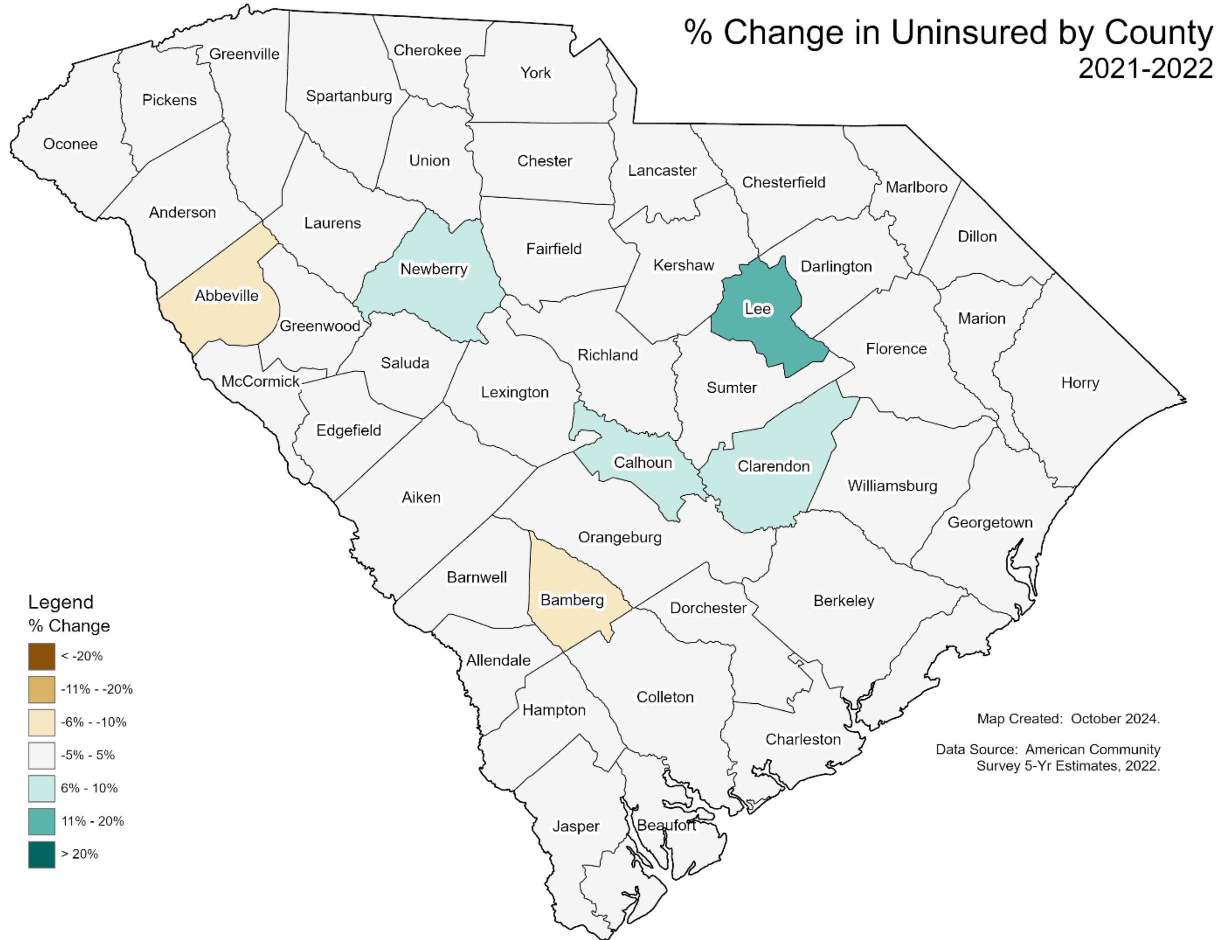


Figure B5: 1-Year Change (2021–2022) in South Carolina's uninsured rates, by County



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