



**Center for the
Study of
Social Policy**
Ideas into Action

Michelle H., et al. v. McMaster Progress Report: South Carolina Department of Social Services

October 1, 2025 – March 31, 2026

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I. Introduction

This report assesses the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA) in *Michelle H., et al. v. McMaster and Catone*, for the period of October 1, 2025 through March 31, 2026. The report has been prepared by court-appointed independent Monitor, Judith Meltzer, with the assistance of Monitor staff and is presented to the Honorable Richard M. Gergel, U.S. District Court Judge, the Parties to the lawsuit, and the public.

A. Summary of Litigation and Settlement Agreement

The *Michelle H. v. McMaster and Catone* lawsuit was filed in the United States District Court for South Carolina in January 2015 on behalf of a Class of children in foster care against the Governor of South Carolina and the State's Department of Social Services (DSS).¹ The suit alleged DSS failed to maintain an adequate number of foster homes and other appropriate living placements for children; failed to maintain connections between children and their families and communities; did not provide basic monitoring of children's safety due to excessive case manager caseloads and an unstable foster care workforce; and failed to provide basic health care services to children in foster care. The Parties negotiated a Final Settlement Agreement (FSA) that was approved by the Court on October 4, 2016.^{2,3}

The FSA outlines South Carolina's obligations to significantly improve the experiences of, and outcomes for, Class Members who include "all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS now or in the future" and reflects an agreement by the State to address long-standing problems in the operation of its child welfare system (FSA II.A.). State leaders and Plaintiffs crafted the FSA to guide a multi-year reform effort to address:

- Appropriate placements for children in foster care
- Workloads of case managers and team leaders
- Case manager contacts with children
- Investigations of allegations of abuse and/or neglect of children in the State's custody by a caregiver
- Family connections – visits between children and their parent(s), the placement of children with their siblings, and visits between siblings who are not placed together
- Access to timely physical and mental health care

¹ *Michelle H., et al. v. McMaster and Catone*, 2:15-cv-00134, (D.S.C.) (originally filed as *Michelle H., et al. v. Haley and Alford*).

² Final Settlement Agreement (October 4, 2016, Dkt. 32-1).

³ The FSA incorporates provisions ordered in a September 2015 Consent Immediate Interim Relief Order (September 28, 2015, Dkt. 29).

Since the development of the FSA, implementation plans for key bodies of work – which are also tracked by the Monitor – have been approved and ordered by the Court.⁴

B. Role of the Monitor and Methodology

The Final Settlement Agreement appointed Judith Meltzer and Paul Vincent as independent and equal Co-Monitors.⁵ Mr. Vincent sadly passed away on July 27, 2025. Since that time, Ms. Meltzer has continued to act as an impartial Monitor, responsible for conducting the factual investigation and verification of data and documentation necessary to compile and issue semi-annual public reports on the State's progress and performance in meeting the terms of the FSA (FSA III.).⁶

To determine the State's performance on the FSA requirements, the Monitor and Monitor staff utilized a range of sources and activities to collect information and to inform the overall assessment of the State's progress.⁷ These include, among others, analysis of quantitative data provided by DSS including data extracted from DSS's Child and Adult Protective Services System (CAPSS) and other sources; review of children's case records in CAPSS; analysis and validation of qualitative data collected by DSS and Monitor staff through structured reviews; observations and discussions from county office site visits; information provided through focus groups; data and information provided in DSS's reports to the Court; discussions with case managers, other DSS staff, private providers, and community members; meetings with leaders from DSS and other state agencies; and discussions with Plaintiffs' counsel.⁸

Additionally, this report draws on information provided through the Monitor's engagement with efforts to address high rates of placement instability in Richland County.⁹ That work was advanced through the Richland County Child Welfare Improvement Task Force (referred to hereinafter as the Richland County Task Force) which was created at the direction of the Court in October 2024 and charged with the development and implementation of an improvement plan to urgently address the placement instability crisis experienced by children in Richland County as well as problems related to the physical condition of the Richland County DSS office.^{10,11} The Task Force disbanded

⁴ To view Implementation Plans and Addendums for the *Michelle H.* FSA, see: <https://dss.sc.gov/child-welfare-transformation/>.

⁵ Judith Meltzer is former President and now Senior Fellow of the Center for the Study of Social Policy (CSSP) and is supported by Monitor staff including Molly Dunn, Lisa Mishraky-Javier, Shira Davidson, and Alyssa Liehr. More information about CSSP can be found at <https://cssp.org/>.

⁶ Hereinafter, Ms. Meltzer is referred to as the Monitor.

⁷ Appendix B. includes a list of specific activities the Monitor and her team used to assess DSS's performance during this period.

⁸ CAPSS is DSS's State Automated Child Welfare Information System.

⁹ The Monitor's engagement included review of improvement plans and participation in Richland County Task Force workgroup meetings and continues to include review of monthly reports produced by DSS to the Court and ongoing discussion with DSS leadership and others.

¹⁰ Order directing the prompt creation of a task force to prepare and implement a plan to address issues relating to overnight stays in the Richland County DSS office (October 18, 2024, Dkt. 331).

¹¹ Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).

on March 27, 2026, and its work is now being carried forward by the Richland County Child Welfare Improvement Team. Efforts undertaken in Richland County to address placement instability and to scale promising interventions to other parts of the state continue to be a primary area of focus for DSS and are discussed within this report.¹²

In acknowledgement of the ongoing work in Richland County, efforts to scale that work to other counties, and an increasing emphasis on placing children in their home counties, county-level data are presented throughout this report, with a focus on counties with the highest values for key data points.¹³ For example, county-level data is provided for counties with the highest rates of entry to foster care, the highest percentage of children placed out of county, and the most overnight stays, among other data points. Complete data for all 46 counties is included in Appendix D.

Data Limitations

Data presented in this report are based on information provided by DSS. During the course of producing this report, data limitations were identified that may affect certain measures.

First, a DSS data linkage issue resulted in approximately 80 children being omitted from the file containing records of all placements during the monitoring period, which is used to derive the number of children who were in foster care at any point during the monitoring period and is also used for measures related to placement moves and emergency placements. Records were most often omitted for children who entered and exited care very quickly. DSS has worked to correct this issue, and the data for the current monitoring period reflect the corrected process. Data for Monitoring Period 18 were also corrected. However, data from prior monitoring periods presented in this report may still be affected by a small number of missing records (approximately 1-2% of children).¹⁴

Second, the availability and reliability of kinship licensure data has been affected by DSS's use of a software platform, Binti, to manage the foster care licensing process; consequently, kinship licensure data are not included in this report in the same manner as in previous reports.¹⁵ Specifically, in late July to early August of 2025, DSS began using Binti to manage the foster care

¹² For more information see: Letter from the Monitor Providing Updates and Findings Regarding Efforts to Address Placement Instability in Richland County, submitted to the Court on April 7, 2026.

¹³ See: Official Transcript of Status Conference held on October 14, 2025, before Judge Richard M. Gergel (February 9, 2026, Dkt. 393) during which the Court noted placing children far from their homes contributes to, and exacerbates the problems that stem from, placement instability: "It creates so many problems for the kids and for the caseworkers in terms of working with them. And it just taxes the whole system." See also: Official Transcript of Status Conference held on April 17, 2026, before Judge Richard M. Gergel (June 24, 2026, Dkt. 414).

¹⁴ DSS has informed the Monitor that it has reviewed prior monitoring periods, and it does not believe missing records impacted performance for placement-related measures. The Monitor will work with DSS to confirm that prior performance assessments do not require revision.

¹⁵ For more information, see: <https://binti.com/>.

licensing process, and due to ongoing data integration issues between Binti and CAPSS since that time, DSS has been unable to provide kinship licensure data.¹⁶

Additionally, with regard to county-level data, it is important to note that case management responsibility may change over the course of a child's time in foster care. County-level data included in this report reflect the office responsible for a child's case management at the time of a given outcome. As a result, a child may appear in the data for more than one office of case management during the monitoring period if responsibility for the child changes. In some instances, an outcome may be attributed to only one office even when the events contributing to that outcome occurred under more than one office. For example, some data points reflect the child's circumstances as of the end of the monitoring period, but that office may not have been responsible for the child throughout the entire period.

C. Report Structure

This report assesses the State of South Carolina's progress toward meeting the requirements of the *Michelle H.* Final Settlement Agreement between October 1, 2025 and March 31, 2026 (Monitoring Period 19 or MP19).¹⁷ This report is presented in four sections:

- Section I outlines the *Michelle H.* FSA and describes the role of the Monitor and the methodology used to assess performance.
- Section II summarizes the State's progress toward meeting the FSA requirements during the monitoring period ending March 31, 2026, identifying areas of improvement and areas of challenge.
- Section III provides an overview of the child welfare system in South Carolina and a description of the State's fiscal resources supporting child welfare activities. It also includes demographic information about children in the State's foster care system between October 1, 2025 and March 31, 2026 (MP19).
- Section IV details the State's performance toward meeting each FSA requirement between October 1, 2025 and March 31, 2026 (MP19).

¹⁶ Note: data integration issues are not uncommon with the implementation of a new software platform such as Binti and could affect data for many months. DSS has informed the Monitor that it is coordinating with Binti staff to be able to produce reliable kinship licensing data.

¹⁷ This report refers to monitoring periods by date range (e.g., October 2025 – March 2026) and number (e.g., MP19). Guideposts to time frames and monitoring periods are provided throughout this report and a table listing the date range of each monitoring period is provided in Appendix A.

II. Areas of Improvement and Challenge

During the six-month monitoring period from October 1, 2025 through March 31, 2026 (MP19), DSS's performance in meeting the *Michelle H.* FSA requirements was maintained at target levels in many areas. DSS continued to meet or exceed FSA targets for all measures for which Maintenance of Effort designation has been granted by the Court, including requirements regarding the placement of children outside of congregate care settings, Out of Home Abuse and Neglect (OHAN) investigations, and visitation between children in foster care and their siblings. DSS also continued to meet the FSA target for initial dental examinations within 60 days of a child's entry to foster care, and this requirement may be eligible for Maintenance of Effort designation.

In other areas, though still below FSA required levels, performance improved. For the first time, team leaders across all areas—OHAN, foster care, and permanency—had caseloads that were within the workload standard. DSS made significant progress in ensuring children received timely, initial comprehensive medical assessments. DSS's performance in ensuring children visited with their parents improved, rising from 52 percent in MP18 to 64 percent in MP19; while performance remains significantly below the FSA target of 85 percent, this is the first meaningful improvement in performance in many monitoring periods.

Performance of case manager contacts with children was assessed during this monitoring period for the first time since MP10 (April – September 2021).¹⁸ Although performance improved, substantial work remains to ensure that monthly case manager and child contacts consistently meet all required DSS policy elements. For the first time since the inception of the lawsuit, DSS and the Monitor implemented a process for assessing DSS's performance in meeting children's needs for therapeutic placements and/or services in least-restrictive, family-like settings. Although data from the review this period are provided in the report, performance on the *Michelle H.* requirement will be reported annually based on a review of 50 cases and will be included in the next monitoring report. DSS and the Monitor staff put significant effort into planning for and conducting these performance reviews and will continue to revise and refine processes and protocols in future monitoring periods.

¹⁸ DSS's performance in meeting FSA requirements for case manager contacts with children has not been measured since MP10 when, by agreement of the Parties, measurement toward performance was suspended after years of consistently low performance. The suspension was intended to provide DSS with an opportunity to implement strategies to strengthen practice and improve documentation. The Parties agreed to resume FSA measurement in MP19.

Placement instability was not formally measured during Monitoring Period 19.¹⁹ However, other indicators suggest that placement instability continued to be unacceptably high but with signs of progress. Performance improved across several indicators of placement instability: fewer children experienced a placement move; children spent fewer nights in emergency placements; the number of children who experienced an overnight stay and the total number of nights children spent in DSS offices fell dramatically, and overall, children experienced significantly fewer nights in unplanned, short-term placements (emergency placements and overnight stays combined). However, since the end of MP19, there has been a sharp increase in the number of overnight stays such that this overall downward trend in indicators of placement instability must be viewed with caution.

Other challenges also remain. The majority of children (65%) continue to be placed outside of their counties of origin, less than half are placed with all of their siblings, and after making steady progress improving the percent of case managers within applicable caseload limits, performance for foster care and permanency case managers caseloads declined in Monitoring Period 19. Significant work remains to fully implement the revised Health Care Improvement Plan (HCIP) and establish the data and processes necessary to consistently measure performance across health care requirements.

Finally, DSS's ability to address these challenges and make continued progress toward meeting the *Michelle H.* FSA requirements will likely be hampered by the lack of additional financial investments from the state legislature. Although DSS requested \$48.6 million in additional recurring state general funds to support continued child welfare reforms and promote compliance with the terms of the *Michelle H.* settlement, the 2026-2027 Appropriations Act allocated \$4.2 million in new state recurring funds.^{20,21} The allocated funds did not include any of the \$20.7 million DSS requested for placement stabilization, which would have largely been directed toward scaling initiatives developed in Richland County to other parts of the state. Nor did the allocated funds include any of the requested \$13.7 million to support salaries, staffing, and training. DSS reports that it is assessing how it can move forward with some of the initiatives without the requested funding.

¹⁹ Pursuant to Section IV.F.1. of the FSA, the placement instability rate is calculated and reported annually and shall be less than or equal to 3.37. For the period of October 1, 2024 – September 30, 2025, the placement instability rate was 7.90.

²⁰ To view DSS's SFY 2026-2027 Agency Budget Plan, see: <https://www.admin.sc.gov/sites/admin/files/Documents/Budget/FY27%20L040%20-%20Department%20of%20Social%20Services.pdf>.

²¹ To view the South Carolina SFY 2026-2027 Appropriations Act, see: https://www.scstatehouse.gov/sess126_2025-2026/appropriations2026/ta26ndx.php. Note: on June 30, 2026, South Carolina ended SFY 2025-2026 without passing a budget for SFY 2026-2027, which began on July 1, 2026. Between July 1, 2026 and August 11, 2026, when the final approved SFY 2026-2027 Appropriations Act was passed, the state operated under a continuing resolution which maintained 2025-2026 spending levels for recurring expenditures.

A. Areas of Improvement

Since the start of implementation of the Final Settlement Agreement (FSA) and continuing through Monitoring Period 19 (October 1, 2025 – March 31, 2026), the Department has demonstrated progress in key areas:

- *Sustained Placement of Children in Family-Based Settings:* In MP19, the State met—as it has done for the past 10 monitoring periods—the FSA requirement that 86 percent of children be placed in family-based settings (FSA IV.E.2.). Maintenance of Effort designation of this FSA requirement was granted on June 18, 2026.²²
- *Continued Placement of Children with Kin and Increased Support of Kin Placements:* Recognizing the improved outcomes for children successfully placed with relatives, over the last five years, the Department has more than tripled the percentage of children placed with kin, and during the monitoring period, sustained kin placements at the previous level. As of the last day of the monitoring period (March 31, 2026), 31 percent of children were placed with kin compared to nine percent as of September 30, 2019.

DSS's efforts to move toward a kin-first culture took a major step forward when, on February 27, 2026, Governor McMaster signed Senate Bill 415 into law.²³ The passage of SB 415 was the final step of a multiple-year effort by DSS to put into place separate, streamlined licensing and approval standards for kin placements enabling the agency to receive Title IV-E federal reimbursement for foster care board payments on behalf of otherwise eligible children who are placed in those homes.²⁴ Kin caregivers across South Carolina who are licensed or approved using kin-specific standards receive board payments equal to those received by non-relative foster parents. DSS reports that its regional Foster Family and Licensing Support offices are working in conjunction with county DSS offices to conduct outreach to families regarding the kin-specific standards and the benefits of being licensed.

- *Significant Reduction in Overnight Stays:* During Monitoring Period 19 (October 1, 2025 – March 31, 2026), there was a dramatic decline in both the number of children who experienced an overnight stay in a DSS office and in the total number of nights children spent in offices. Throughout the monitoring period, 52 children experienced a total of 67 overnight stays at DSS offices, a 73 percent decrease in the number of children and an 89 percent decrease in the number of overnight stays since the prior monitoring period. This notable achievement, however, is tempered by the sharp increase in overnight stays since the end of the monitoring period. In the four-month period between April 1, 2026 and

²² Order on Motion for Miscellaneous Relief (June 18, 2026, Dkt. 412).

²³ See 415, 126th Gen. Assemb., 1st Reg. Sess. (S.C. 2025), https://www.scstatehouse.gov/sess126_2025-2026/bills/415.htm and S. 598, 126th Gen. Assemb., 1st Reg. Sess. (S.C. 2025), https://www.scstatehouse.gov/sess126_2025-2026/prever/598_20250423a.htm.

²⁴ For information on separate licensing/approval standards for relative or kin family foster homes, see: <https://www.federalregister.gov/documents/2023/09/28/2023-21081/separate-licensing-or-approval-standards-for-relative-or-kinship-foster-family-homes>.

July 31, 2026, there were a total of 291 overnight stays—more than four times greater than the number of overnight stays during all six-months of Monitoring Period 19. While the state was able to significantly reduce the use of overnight stays during Monitoring Period 19, it did not meet the FSA requirement prohibiting the placement of any child in a DSS office, and the increase in overnight stays since the end of the monitoring period is concerning (FSA IV.D.3.).

- *Reduction in the Number of Nights Children Spent in Emergency Placements:* The percentage of children who experienced an emergency placement during Monitoring Period 19 decreased, and the total number of nights children spent in emergency placements decreased significantly. Overall, 12 percent of children (557 of 4,571) who were in foster care at any point during MP19 (October 2025 – March 2026) had an emergency placement. In total, these 557 children had 1,346 emergency placements and spent 6,701 nights in those placements. Compared to the prior monitoring period (MP18), this is a 13 percent decline in the total number of nights spent in emergency placements. Moreover, the combined use of emergency placements and overnight stays as unplanned, short-term placements for children decreased by 18 percent during the October 1, 2025 – March 31, 2026, monitoring period.
- *Implementation of a New Process to Measure Timely Access to Therapeutic Placements and/or Services:* This was the first monitoring period in which DSS and the Monitor implemented the process for assessing DSS's performance in meeting Class Members' needs for therapeutic placements and/or services in the least-restrictive, family-like setting that preserves family and communications (FSA IV.I.). Performance will be reported annually based on a review of 50 cases and will be included in the next monitoring report. Insights and lessons learned from the review of the first 17 cases are included in this report. Insights from the initial review identified opportunities to strengthen the connection between assessment, CFTM decision-making, and case planning, as well as to address barriers such as placement instability, provider availability, and waitlists. These early insights will inform continued implementation and improvement.
- *Improvement in Team Leaders' Workloads:* For the first time, at least 90 percent of team leaders across all areas—OHAN, foster care, and permanency—were within the workload standard (FSA IV.A.2.(b)). While the State has not yet reached the target for this FSA measure, its ongoing attention to and continued improvements in meeting caseload/workload measures is an important result of the *Michelle H.* Settlement Agreement.
- *Improvement in Investigations of Allegations of Abuse or Neglect of Children in Foster Care:* The Department now more thoroughly investigates reports of allegations of abuse or neglect of children in foster care and in Monitoring Period 19 met all four remaining FSA targets related to Out of Home Abuse and Neglect (OHAN), all of which were granted

Maintenance of Effort designation by the Court.^{25,26} Markedly, during this monitoring period, the State's performance was 100 percent for each FSA target.

- *Improved Performance in Parent-Child Visits and Sustained Performance in Visits Between Siblings:* Though still falling far short of the FSA target (85%), DSS's performance in ensuring children visited with their parents improved substantially, reaching the highest point since reporting on this FSA measure resumed in 2023 (FSA IV.J.3.). In Monitoring Period 19, 64 percent of children had the required number of monthly visits with their parents, compared to 52 percent during MP18. DSS also maintained performance above the FSA target for the percentage of children visiting with their siblings, which was granted Maintenance of Effort designation on June 18, 2026 (FSA IV.J.2.).²⁷
- *Improved Performance in Timely Initial Comprehensive Medical Assessments and Sustained Performance for Initial Dental Assessments within 60 Days:* Though still below the FSA targets, DSS made significant progress in ensuring children received timely, initial comprehensive medical assessments. This improvement is attributable in part to incorporating case review findings that identified completed assessments that were not reflected in Medicaid claims data (FSA IV.K.5.). DSS also met the FSA target for children receiving initial dental examinations within 60 days of entering foster care for the fourth consecutive monitoring period, and this FSA requirement may be eligible for Maintenance of Effort designation. Overall, these findings demonstrate progress in identifying and documenting children's receipt of needed health care.

²⁵ Order on Motion for Miscellaneous Relief granting Maintenance of Effort Designation for the following OHAN FSA requirements: (1) timely initiation of investigations (FSA IV.C.4.(a)), (2) timely face-to-face contact with alleged child victims (FSA IV.C.4.(b)), and (3) appropriate investigatory findings and decision making (FSA IV.C.3.) (December 17, 2025, Dkt. 387); and Order on Motion for Miscellaneous Relief granting Maintenance of Effort Designation for OHAN FSA requirement: (4) contacts with core witnesses (FSA IV.C.4.(c)) (June 18, 2026, Dkt. 412).

²⁶ In October 2024, the Court terminated jurisdiction over the following FSA OHAN provisions: (1) Intake – Decision Not to Investigate (FSA IV.C.2.); (2) Timely Completion of Investigation Within Forty-five (45) Days of Initiation (FSA IV.C.4.(d)); (3) Timely Completion of Investigation Within Sixty (60) Days of Initiation (FSA IV.C.4.(e)); and (4) Timely Completion of Investigation Within Ninety (90) Days of Initiation (FSA IV.C.4.(f)) Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt. 329).

²⁷ Order on Motion for Miscellaneous Relief (June 18, 2026, Dkt. 412).

B. Areas of Challenge

The areas of success are significant and provide optimism for continuing improvements, but key challenges remain:

- *Very High Rates of Placement Instability:* Children in foster care in South Carolina continue to experience very high rates of placement instability. As stated in Monitoring Period 18 report, the 2024-2025 annual placement instability rate climbed to 7.90, meaning Class Members were moved an average of 7.90 times per 1,000 days in care (FSA IV.F.1.). This is both the highest instability rate and the largest one-year increase since the inception of the lawsuit. While the annual instability rate is not newly reported during Monitoring Period 19, it is noteworthy that during MP19, performance improved across indicators of placement instability, including the percentage of children with one or more placement moves, both the number of children experiencing overnight stays and the total number of overnight stays, the number of nights spent in emergency placements, and the combined use of overnight stays and emergency placements. However, despite the improvement, each of these indicators of placement instability continues to be unacceptably high, and the overall downward trend must be viewed cautiously in light of the steep increase in the use of overnight stays since the end of the monitoring period, from April through August 2026.
- *Many Children are Placed Outside of Their Counties of Origin:* As the Court noted during status conferences held on October 14, 2025, and April 17, 2026, placing children far from their homes contributes to, and exacerbates the problems that stem from, placement instability: “It creates so many problems for the kids and for the caseworkers in terms of working with them. And it just taxes the whole system...”²⁸ Overall, as of March 31, 2026, 35 percent of children were in placement settings located within their counties of origin, and 65 percent of children in foster care were in out-of-county placements. These numbers are virtually unchanged from the prior monitoring period when, as of September 30, 2025, 34 percent of children were in placement settings located within their counties of origin, and 66 percent were in out-of-county placements. Between June 1, 2025 and April 20, 2026, in compliance with the Court’s order, DSS placed a five-day moratorium on making Richland County foster care placements available to out-of-county children with a goal of addressing the severe shortage of appropriate placements for Richland County children.²⁹ With the order lifted and the moratorium no longer in place, it will be

²⁸ Official Transcript of Status Conference held on October 14, 2025, before Judge Richard M. Gergel (February 9, 2026, Dkt. 393). ²⁸ See also: Official Transcript of Status Conference held on April 17, 2026, before Judge Richard M. Gergel (June 24, 2026, Dkt. 414).

²⁹ Order Directing DSS Operations in Richland County (January 17, 2025, Dkt. 348) and Order following April 17, 2026 status conference (April 20, 2026, Dkt. 404).

important for DSS to develop and implement other strategies to ensure children are placed in their counties of origin to the extent possible.³⁰

- *Fewer Children Placed with Siblings:* During the monitoring period, performance declined and remained below the FSA target for the placement of children with their siblings; specifically, placement of children with *all* of their siblings was unacceptably below the target (48% of the 80% target) (FSA IV.G.2.&3.).
- *Case Manager Caseloads above the Standard:* After making steady progress improving the percent of case managers within the applicable limits, performance for foster care and permanency case managers declined in Monitoring Period 19. Supporting case managers across all areas to meaningfully engage and support children and families must remain a priority for DSS as it works to reach this FSA requirement (FSA IV.A.2.(b)).
- *Continued Challenges in the Quality of Case Manager Contacts with Children:* The FSA requires, at minimum, that 90 percent of children have monthly face-to-face contacts with their case managers (FSA IV.B.2.) and that 50 percent of those contacts occur in the child's residence (FSA IV.B.3.). Measurement of these FSA requirements was suspended after MP10 (April – September 2021) due to consistently low performance. Measurement resumed this monitoring period, assessing the quality of in-person case manager and child contacts that occurred. Although performance improved from 34 percent in MP10 to 42 percent in MP19, substantial work remains to ensure that monthly case manager and child contacts consistently meet all required DSS policy elements for a quality contact. Documentation limitations continued to make it difficult to determine whether required practice occurred. While 69 percent of contacts occurred in the child's residence, exceeding the 50 percent FSA requirement, continued improvement will require sustained attention to the quality and documentation of contacts, as well as to manageable caseloads and to placements closer to children's home counties to facilitate meaningful contact.
- *Challenges in Implementing the Health Care Improvement Plan (HCIP):* Significant work remains to fully implement the revised HCIP, submitted to the court on April 3, 2026, and to establish the data and processes necessary to measure performance across health care requirements. This includes ensuring implementation of initial medical screenings, assessing provider network adequacy, strengthening integrated data systems and information sharing, and assessing impact of initiatives such as Intensive Case Management (ICM) on health care outcomes for children in foster care. Continued attention is needed to assess whether HCIP strategies are being effectively implemented, address barriers, clarify roles and responsibilities among partners, and determine whether these efforts are improving health care outcomes for children.

³⁰ DSS reports that once the Binti placement module launches, which is expected to occur in November 2026, it will provide access to real-time data about licensed families and their vacancies, preferences, and locations that will assist in prioritizing in-county placements for children.

To sustain the progress that has been made through the hard work of DSS leaders, staff, and partners as well as through the support from the legislature over the last 10 years and to continue to move forward to resolve the significant challenges that remain in assuring that every child in the system is given the opportunities to achieve required outcomes, DSS will need to do more to address some of the root causes of the problems that remain. Though the Monitor acknowledges it may be difficult for DSS to make significant progress in some areas without the additional funding requested but not appropriated by the state legislature for State Fiscal Year 2026 - 2027, actions should include:

- *Intensifying Focus on Front-Line Practice:* There needs to be an intensified focus on front-line practice by DSS staff and its private provider partners to ensure that practice is aligned with and carries out South Carolina's Guiding Principles and Standards (GPS) Case Practice Model, including its emphasis on teaming with families and open communication and collaboration among public and private partners.
- *Accelerating Expansion of Community-Based Services:* Although there has been incremental improvement, the work with DMH, DDSN, and DHS to expand access to community-based services through stronger partnerships with Medicaid, the behavioral health system, and private providers must accelerate. South Carolina needs to move toward developing a robust children's mental health system that serves all of its children and families, especially and including children in DSS custody.
- *Increasing and Strengthening Continuous Quality Improvement Capacity:* DSS must increase and strengthen its continuous quality improvement (CQI) capacity so that it can consistently assess what is working and what is not and modify strategies accordingly. In particular, DSS's CQI processes should combine quantitative performance data with qualitative information, incorporating the voices of children and families. This is important to assess not only whether FSA requirements are being met but also the quality and consistency of the underlying practice and the systemic factors affecting performance in areas such as placement stability, therapeutic placement and services, case manager contacts with children, and implementation of the revised HCIP.
- *Expanding Specialized Placement Resources and Services:* Although the legislature has supported the improvement efforts of DSS by providing needed resources over the last several years, budget gaps to expand specialized placement resources and services remain. Those gaps are unlikely to be filled and may grow in light of the legislature's decision not to allocate any additional funding to support these efforts in State Fiscal Year 2026-2027.
- *Engaging in Targeted Efforts to Support Local Improvement Plans:* With its improved data capacity, DSS can now identify those counties that are achieving successful outcomes and those where progress was stagnant or worsened. Targeted efforts to support local improvement plans should occur. Findings from CQI can: provide important insight into how practice and systemic factors interact to affect outcomes for children and families in the counties where children and families live; identify county barriers and opportunities for improvement; and identify where focused changes in leadership, practice, policy, improved community collaboration with partners, or additional resources may be needed.

III. South Carolina's Foster Care System and the Children it Serves

A. Overview of the State Child Welfare System

South Carolina's Department of Social Services (DSS) is a cabinet-level agency, led by State Director Tony Catone who reports to Governor Henry Dargan McMaster. DSS is responsible for the temporary custody and care of children who have been involuntarily separated from their parent(s) or guardian(s) due to a finding of abuse or neglect. While children are in foster care, DSS is responsible for meeting their needs, including ensuring they: are safe; have a stable place to live with caring adults, preferably family members; have their health care needs monitored and addressed; and are supported in maintaining connections with their communities and families. This includes DSS's obligation to engage with and support parents and guardians so children can return home safely and quickly. If reunification of a child with their parent(s) or guardian(s) is determined not to be possible, DSS must pursue another permanent, long-term plan, such as guardianship or adoption.

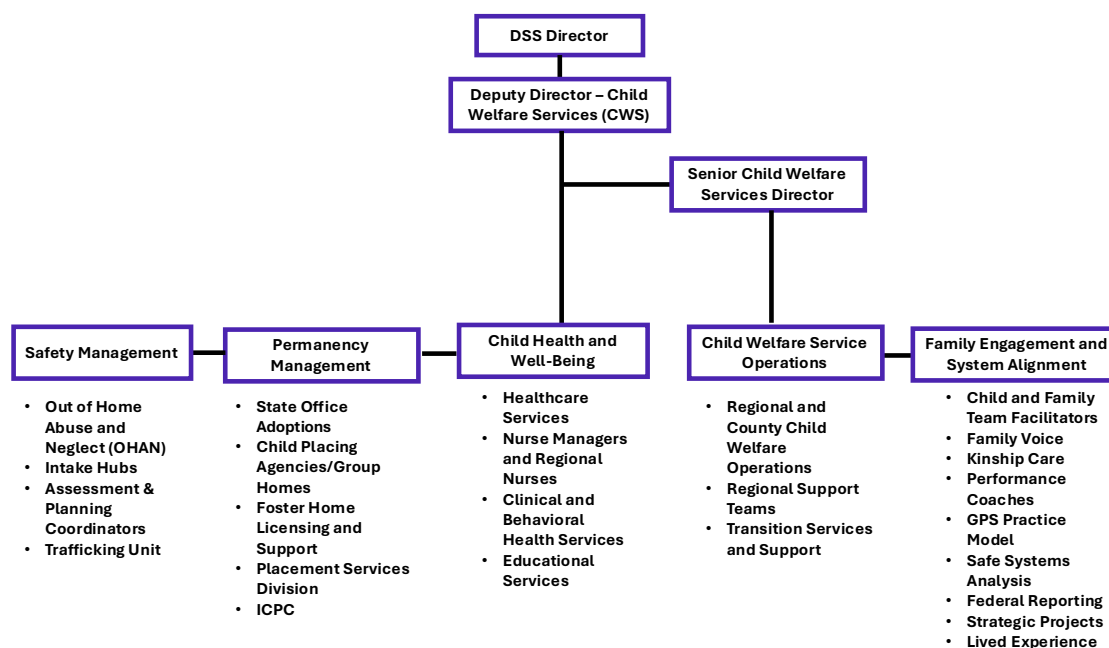
South Carolina's child welfare system is administered at the state level by DSS's Child Welfare Services Division, which is organized into five primary areas: Safety Management, Permanency Management, Child Health and Well-Being, Child Welfare Service Operations, and Family Engagement and System Alignment ([Figure 1](#)). Services are delivered to children and families through county DSS offices. The State's 46 counties are organized into four regions – Lowcountry, Midlands, Pee Dee, and Upstate – and some DSS functions are delivered regionally, including permanency, child health and well-being, foster care placement, and transition services and supports for older youth who are transitioning from foster care to adulthood.³¹

³¹ In September 2025, DSS changed the internal titles of adoptions staff to "permanency specialist" and the offices to "regional permanency offices". This change aligns with the agency's pursuit of all paths to permanency for legally free children, with adoption being one path.

Figure 1. DSS Child Welfare Services Division Organizational Chart

September 16, 2026

Source: DSS



Fiscal Resources and Budget

South Carolina's child welfare system is financed through a blend of federal and state funding streams.³² At the federal level, the Children's Bureau, part of the Administration for Children and Families, distributes funds to states for defined child welfare functions and services through mandatory spending programs. The largest of these programs – the Foster Care, Prevention, and Permanency Program – is authorized under Title IV-E of the Social Security Act and entitles states to federal reimbursement for part of the cost of providing foster care to children.³³ The program operates as an "uncapped" source of matched funding, meaning states are entitled to receive reimbursement for a portion of every dollar spent on a defined service on behalf of an "eligible"

³² Additionally, per state law, each county in South Carolina "shall provide office space and facility service, including janitorial, utility and telephone services, and related supplies, for its county Department of Social Services" (SC Code § 43-3-65 (2024)).

³³ The Title IV-E program was established by HR. 3434 Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272). Under Title IV-E, states may seek federal reimbursement for a portion of "foster care maintenance payments," defined as "payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, reasonable travel to the child's home for visitation, and reasonable travel for a child to remain in the school in which the child is enrolled at the time of placement" (42 USC § 675(4)).

child.³⁴ The child's eligibility depends on a number of factors, including the income level of the parents(s) from whose custody the child was removed.³⁵ To meet the Title IV-E income test, the income of the home of removal must be within eligibility guidelines, *as they were in effect on July 16, 1996*, for a former federal-state cash assistance program known as Aid to Families with Dependent Children (AFDC).³⁶ In South Carolina, this means the State can claim federal reimbursement if the child in foster care meets all other non-income eligibility requirements and the annual income of the home the child was removed from is not more than \$6,288 for a family of three or \$7,572 for a family of four.³⁷ Because Title IV-E eligibility is linked to 1996 income limits, generally fewer children are determined to be federally eligible each year, resulting in lower amounts of federal reimbursement to states. As of the writing of this report, 45.3 percent of children in foster care in South Carolina meet the Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).

Additionally, the federal Family First Prevention Services Act (FFPSA), passed in 2018, has financial implications for South Carolina's support of children in foster care.³⁸ Most relevant to *Michelle H.*, the FFPSA aligns with the FSA by creating financial disincentives for the placement of children in congregate care.³⁹ The FFPSA prevents federal reimbursement for most congregate placements beyond 14 days unless the child is placed in a specified child-care institution.⁴⁰ The FFPSA also incentivizes the provision of prevention services in the community to reduce the need for out-of-home placement by allowing states to use federal Title IV-E funding for evidence-based prevention

³⁴ Federal reimbursement is made at a state's Federal Medical Assistance Percentage (FMAP) rate. South Carolina's FMAP rate for Federal Fiscal Year 2026 (October 1, 2025 – September 30, 2026) is 69.53%. See: Kaiser Family Foundation. State Health Facts. Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=1&selectedRows=%7B%22states%22:%7B%22south-carolina%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³⁵ Emilie Stoltzfus. (2019). *The Title IV-E Income Test Included in the "Lookback."* (Congressional Research Service Memorandum). https://www.cwla.org/wp-content/uploads/2019/09/CD_lookback_4_2019.pdf.

³⁶ Ibid. Note: AFDC was repealed by Congress in 1996 (P.L. 104-193) when it was replaced by the Temporary Assistance to Needy Families block grant. However, eligibility for the Title-IV-E program remains linked to certain AFDC provisions. This linkage is often referred to as the "look back" because in determining income eligibility, states are required to *look back* to eligibility provisions from the prior AFDC law as they were in effect on July 16, 1996.

³⁷ Ibid.

³⁸ Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017).

³⁹ Ibid.

⁴⁰ Federal reimbursement is available after 14 days for placement of a child in one of the following settings: qualified residential treatment programs (QRTPs); settings specializing in providing prenatal, post-partum, or parenting supports for youth; settings providing high-quality residential care and supportive services to children who have been found to be, or are at risk of, becoming sex trafficking victims; and supervised settings in which the youth is living independently if the child has attained 18 years of age (Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017)).

services.⁴¹ In South Carolina, prevention services in its FFPSA Plan include motivational interviewing, in-home parenting skills, mental health prevention, and concrete economic assistance.

Medicaid is another essential source of federal revenue for state child welfare systems. Nearly all children in foster care are eligible for health insurance through Medicaid. States authorizing payment for Medicaid services included in their federally approved state plans and waiver programs receive federal matching funds for state expenditures at the state's Federal Medical Assistance Percentage (FMAP) rate—the same reimbursement rate used for Title IV-E foster care maintenance payments. In South Carolina, the FMAP rate for Federal Fiscal Year 2026 (October 1, 2025 – September 30, 2026) is 69.53 percent.⁴² This means that for each dollar South Carolina spends on a Medicaid-reimbursable service for a child or eligible family member, the federal government reimburses the State almost 70 cents. Because Medicaid reimbursement is applicable to nearly all children in foster care (as opposed Title IV-E reimbursement which applies to a fraction of children in foster care —e.g., 45.3 percent in South Carolina), states that have responsibly maximized the use of federal Medicaid matching dollars have been able to increase – sometimes vastly – funding available for the support of children in foster care.⁴³ Additionally, Medicaid's coverage requirements are broad. Its Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions require that children be provided with *all* necessary medical treatment and services, and Medicaid can be used to cover non-direct medical care expenses such as transportation to medical appointments and necessary home modifications. In South Carolina, most children in foster care are enrolled in Select Health, the State's contracted managed care organization (MCO) responsible for the provision of their medical and behavioral health services.

⁴¹ In February 2022, the Children's Bureau approved South Carolina's 5-year Family First Prevention Services plan. DSS began making Title IV-E claims under the FFPSA for all allowable prevention services during the third quarter of 2025. Previously, DSS had been using 100% federal funding received through the Family First Transition Act grant to support prevention services. Those funds expired on September 30, 2025. See: https://acf.gov/sites/default/files/documents/acyfcb_93556_families_first_transition_act_supplemental_terms_and_0.pdf. To view South Carolina's Family First Prevention Services plan, see: <https://dss.sc.gov/media/e0vle5k4/south-carolina-dss-title-iv-e-prevention-plan.pdf>.

⁴² *Supra* note 34.

⁴³ For example, two community-based programs, for which children and families involved in the foster care system are eligible and which would have otherwise required Title IV-E funding, became covered under Medicaid in July 2024: (1) Homebuilders — serving children at imminent risk of foster care entry or close to reunification to support family stability and improve overall function; and (2) Multi-Systemic Therapy (MST) — serving youth between the ages of 12 and 17 to address delinquent and/or maladaptive behaviors to prevent out-of-home placement and juvenile justice involvement. While the availability of these Medicaid funded services is an important advancement for South Carolina, it bears noting that data show that utilization of these services by foster children and their families remains extremely limited.

At the state level, funding obligations specific to the *Michelle H.* lawsuit are appropriated by South Carolina's General Assembly as part of the state budget process. For State Fiscal Year (SFY) 2026-2027 which began July 1, 2026, DSS requested \$48.6 million in additional recurring state general funds for child welfare services which, with \$8.9 million in federal and other fund estimates, would have generated a total of \$57.5 million in additional state, federal, and other funds for DSS's budget priority, "Enhancing the Future of South Carolina Children and Families."^{44,45} The request for this budget priority included funding to address the following areas: (1) placement stabilization, (2) board and care rates, and (3) salaries and staffing. The final approved SFY 2026-2027 Appropriations Act, passed on August 11, 2026, allocated \$4.2 million in new state recurring funds and authorized the use of \$1.5 million in federal funds for continued child welfare reform efforts and promotion of compliance with the terms of the *Michelle H.* settlement.⁴⁶ The 2026-2027 Appropriations Act did not include any requested funding to support placement stabilization or salaries and staffing; it provided partial funding for requests related to board and care rates. [Table 1](#) shows the specific agency budget requests related to *Michelle H.* settlement activities and the amounts included in the final Appropriations Act.

Table 1. DSS 2026 Budget Request and Final Appropriation

Source: DSS's SFY 2026-2027 Agency Budget Plan and South Carolina SFY 2026-2027 Appropriations Act

Item	Requested State General Funds	Appropriated Funds
Placement Stabilization	\$20.7M	\$0
Small Group Home Model	\$9.2M	
Transition Youth Day Services Program	\$4.3M	
Welcome and Assessment Center	\$2.7M	
Professional Foster Parent Model	\$2.7M	
Community Based Preservation and Stabilization	\$1.7M	
Individualized Stabilization Services	\$0.1M	

⁴⁴ South Carolina's State Fiscal Year runs from July 1st to June 30th.

⁴⁵ To view DSS's SFY 2026-2027 Agency Budget Plan, see: <https://www.admin.sc.gov/sites/admin/files/Documents/Budget/FY27%20L040%20-%20Department%20of%20Social%20Services.pdf>.

⁴⁶ To view the South Carolina SFY 2026-2027 Appropriations Act, see: https://www.scstatehouse.gov/sess126_2025-2026/appropriations2026/ta26ndx.php. Note: on June 30, 2026, South Carolina ended SFY 2025-2026 without passing a budget for SFY 2026-2027, which began on July 1, 2026. Between July 1, 2026 and August 11, 2026 when the final approved SFY 2026-2027 Appropriations Act was passed, the state operated under a continuing resolution which maintained 2025-2026 spending levels for recurring expenditures.

Item	Requested State General Funds	Appropriated Funds
Foster Care Board Rates, Cost of Care Adjustments, and Support Network Expansion	\$14.1M	\$4.2M⁴⁷
Group Home Cost of Care Adjustment	\$8.5M	
Child Placing Agency Foster Family Support	\$2.5M	\$2.5M
Foster Family Board Rate Increase	\$1.7M	\$1.7M
Therapeutic and Medical Therapeutic Foster Care	\$1.2M	
Foster Family Support Network Expansion	\$0.24M	
Salaries, Staffing, and Training	\$13.7M	\$0
Child Welfare Salary Plan Administration Maintenance of Effort	\$9.7	
Placement and Foster Family Licensing Staffing	\$1.5M	
Family Search & Engagement Staffing	\$1.5M	
Child and Family Teaming Staffing	\$0.91M	
Other Staffing Requests	\$0.12M	
Total	\$48.6M	\$4.2M

⁴⁷ Additionally, the Appropriations Act authorized the use of a total of \$1.5M in federal funds: \$790k for Child Placing Agency Family Support and \$700k for the Foster Family Board Rate Increase.

B. Population of Children in Foster Care

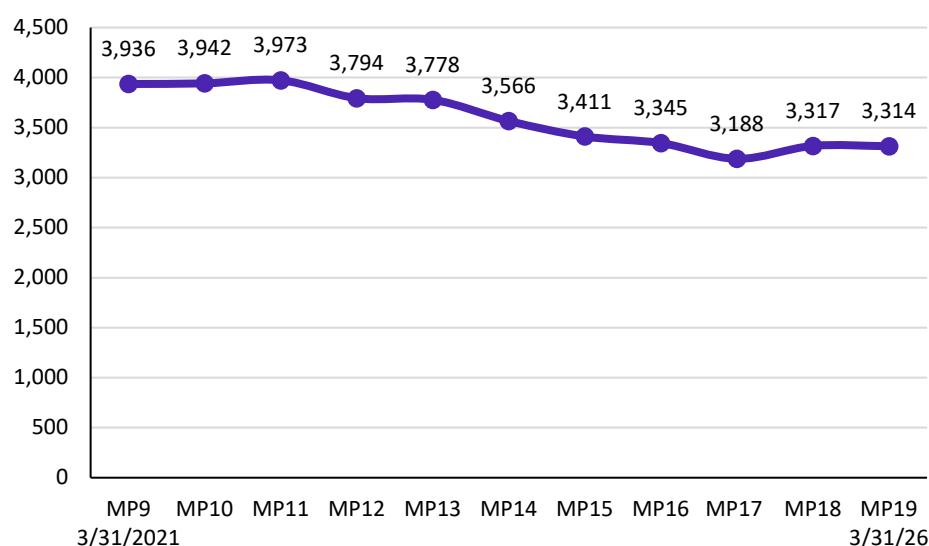
Number of Children in Foster Care

On March 31, 2026 (the last day of Monitoring Period 19), there were 3,314 children in foster care statewide. This is virtually the same number of children in care on the last day of the prior monitoring period (September 30, 2025). Overall, the number of children in foster care has decreased by 16 percent since March 31, 2021 ([Figure 2](#)).

Figure 2. Number of Children in Foster Care

Children in foster care, MP9 – 19 (March 31, 2021 – March 31, 2026)

Source: CAPSS data provided by DSS



On March 31, 2026, the rate of children in foster care per 1,000 in South Carolina's child population was 2.9, meaning that for every 1,000 children in the state, nearly three were in foster care. The map provided in [Figure 3](#) shows the number of children in foster care on March 31, 2026, by county of origin. The number and rate of children in foster care per 1,000 for each county is provided in [Table 4](#) of Appendix D.⁴⁸

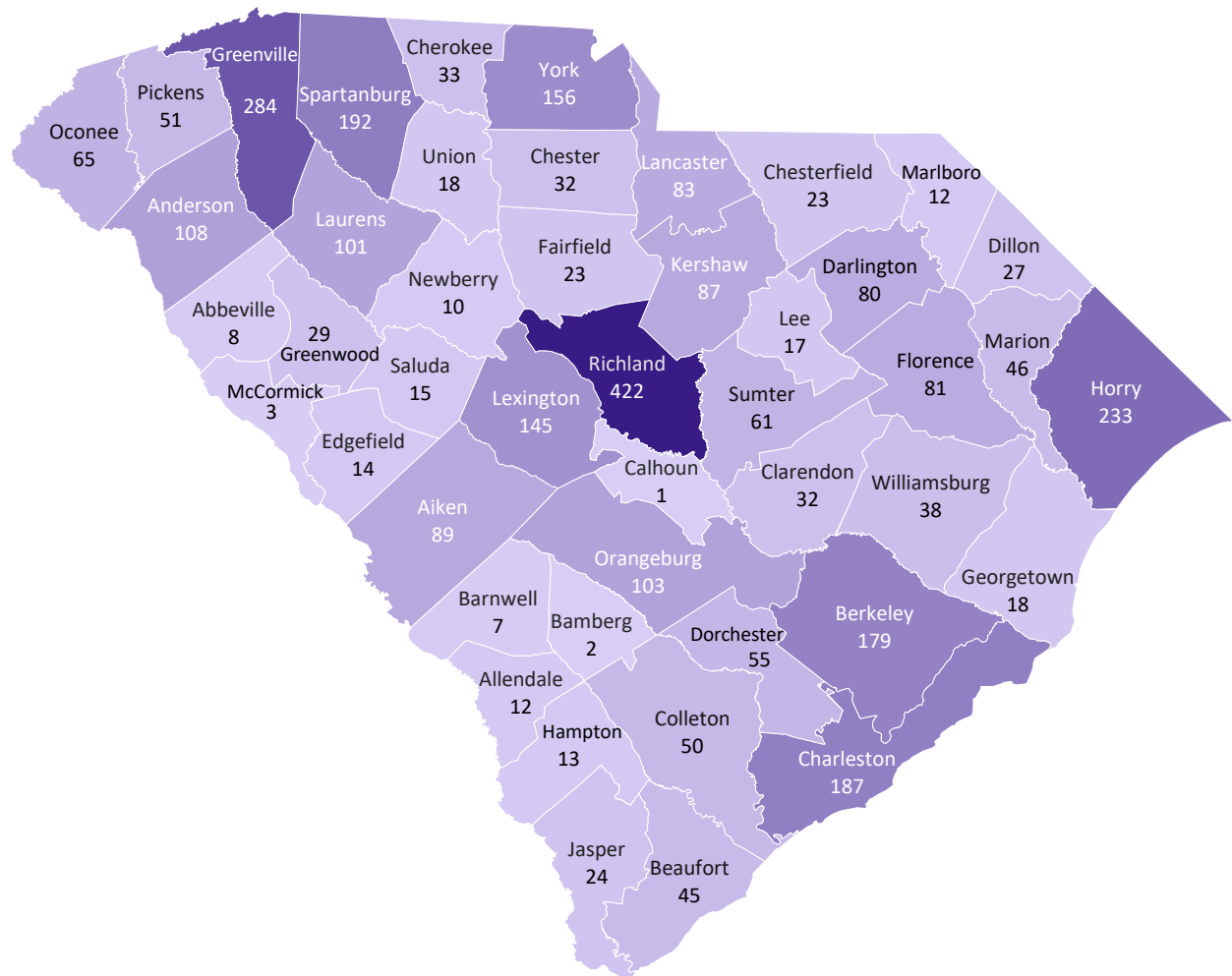
Throughout this report, county-level data are presented as relevant, for the 10 DSS county offices with the highest values for a given data point. The counties included therefore vary by data point and are selected based on the data point-specific number or rate. Complete data for all 46 South Carolina counties are included in Appendix D.

⁴⁸ [Table 5](#) of Appendix D lists the number of children in foster care served by each DSS office of Case Management.

Figure 3. Number of Children in Foster Care, by County of Origin⁴⁹

March 31, 2026

Source: CAPSS data provided by DSS



Powered by Bing
© GeoNames, TomTom

⁴⁹ DSS publishes real-time data on children in foster care on its public website. To view this map with current data, see: <https://reports.dss.sc.gov/ReportServer/Pages/ReportViewer.aspx?/Foster+Care>. Data from DSS's data dashboard include children in foster care who do not fall within the definition of *Michelle H.* Class Members under the FSA.

Demographics of Children in Foster Care

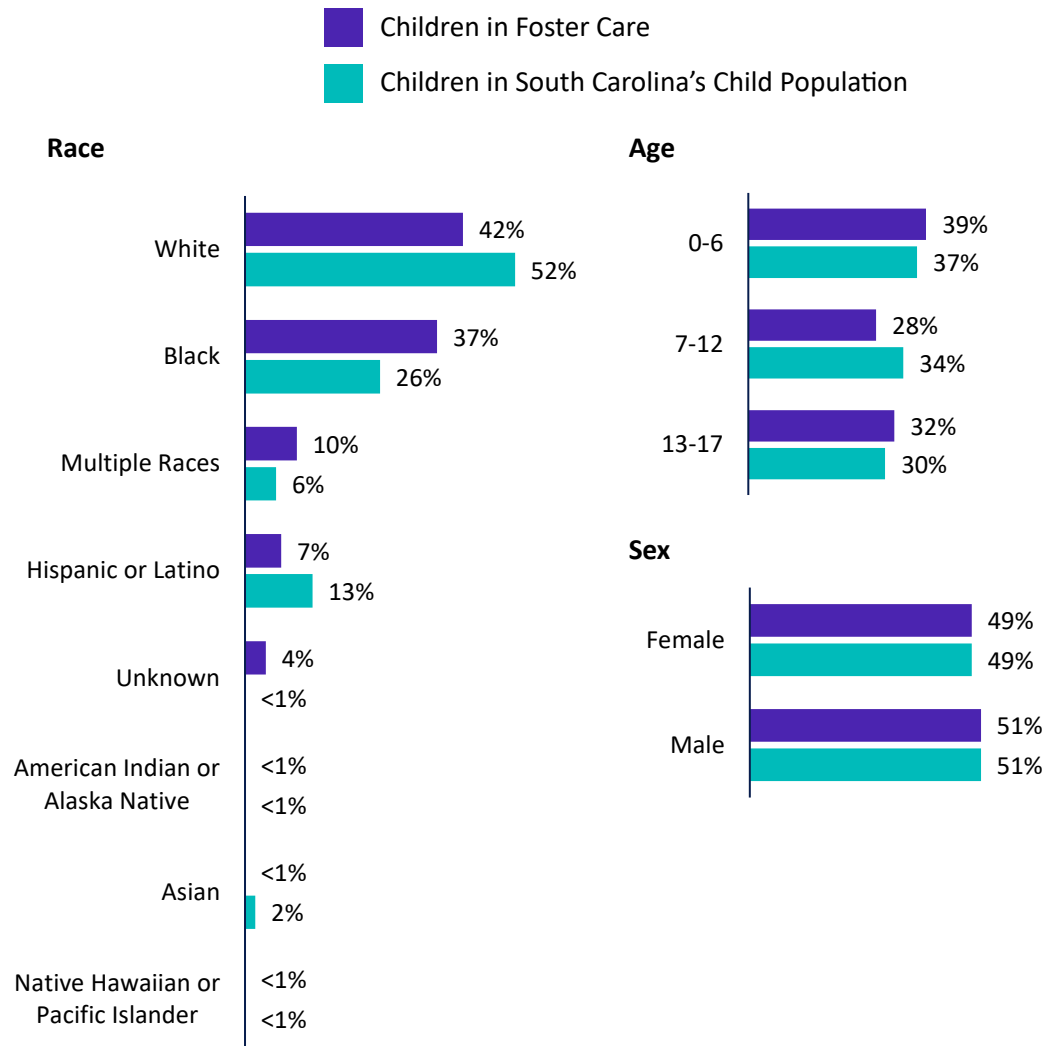
Of the children in foster care on March 31, 2026, the last day of Monitoring Period 19 (MP19), 42 percent were identified as White, 37 percent as Black, and 10 percent as children of multiple races ([Figure 4](#)). White children accounted for 42 percent of children in foster care compared to 52 percent of the state child population. Hispanic children represented seven percent of children in foster care compared to 13 percent of the state child population.⁵⁰ Comparatively, Black children represented 37 percent of children in foster care but 26 percent of the state child population.

On March 31, 2026, 39 percent of children in foster care were aged six and under, 28 percent were aged seven through 12, and about one-third (32%) were aged 13 through 17 ([Figure 4](#)). Both young children (six and under) and youth (13 through 17) were slightly overrepresented in foster care when compared to their proportion of the state child population; children aged six and under made up 39 percent of the foster care population and 37 percent of the state child population, while youth (aged 13 through 17) represented 32 percent of the foster care population and 30 percent of the state child population. About half (49%) of the children in foster care on the last day of MP19, were reported to be female. These demographics have remained consistent for multiple monitoring periods.

⁵⁰ In [Figure 4](#) and throughout this report, children identified as being of Hispanic origin are counted as Hispanic and are not included in any other racial or ethnic categories.

Figure 4. Children in Foster Care, by Race,⁵¹ Age,⁵² and Sex⁵³*March 31, 2026; compared to the child population of South Carolina (2025)*

Sources: CAPSS data provided by DSS; Kids Count Data Center from the Annie E. Casey Foundation



⁵¹ Child population by race and ethnicity | KIDS COUNT Data Center. (2026, July). KIDS COUNT Data Center. <https://datacenter.aecf.org/data/tables/103-child-population-by-race-and-ethnicity?loc=42&loct=2#detailed/2/42/false/575/72,66,67,8367,69,70,71,12/423,424>.

⁵² Child population by single age | KIDS COUNT Data Center. (2026, July). KIDS COUNT Data Center. <https://datacenter.aecf.org/data/tables/100-child-population-by-single-age?loc=42&loct=2#detailed/2/42/false/575/42,43,44,45,46,47,48,49,50,51,52,53,54,55,56,57,58,59,60,8454/418>.

⁵³ Child Population by Gender Statistics. (2026, July). KIDS COUNT Data Center. <https://datacenter.aecf.org/data/tables/102-child-population-by-gender?loc=42&loct=2#detailed/2/42/false/575/14,15,65/421,422>.

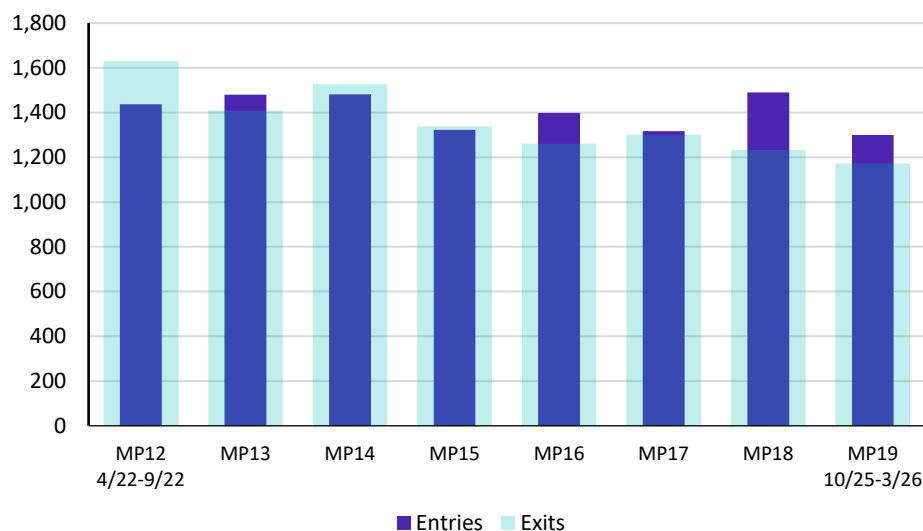
Entries into Foster Care

Between October 1, 2025 and March 31, 2026 (MP19), there were 1,300 entries of children to foster care and 1,173 exits ([Figure 5](#)).⁵⁴ The statewide rate of new entries to foster care during the six-month monitoring period was 1.1 children per 1,000 in the state child population. Richland County had the highest number of entries to foster care (166), followed by Horry County (107) ([Figure 6](#)). Marion County had the highest rate of entry, 4.7 per 1,000 children in the county child population, followed closely by Fairfield County with a rate of 4.6. The rate of entry in these two counties was significantly above the statewide rate and the rates of other counties ([Figure 7](#)).⁵⁵

Figure 5. Foster Care Entries and Exits

MP12– 19 (April 2022 – March 2026)

Source: CAPSS data provided by DSS

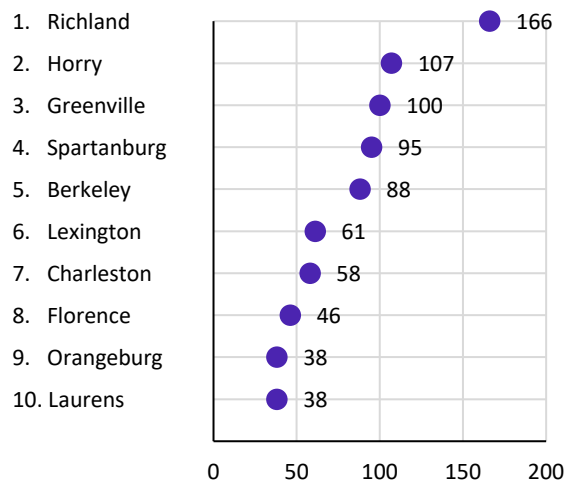
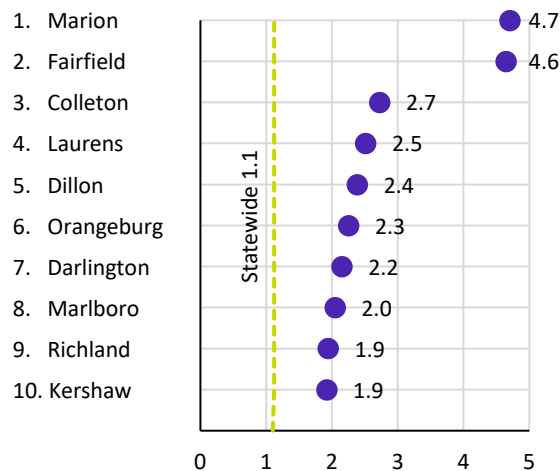


⁵⁴ These 1,300 entries include 13 entries by children who were voluntarily placed in foster care and, therefore, are not *Michelle H.* Class Members. During MP19, 16 children entered foster care twice, accounting for 32 of the total 1,300 entries, and 8 children exited foster care twice, accounting for 16 of the total 1,173 exits. This includes 1 child who both entered and exited foster care twice during the monitoring period.

⁵⁵ See [Table 6](#) in Appendix D showing these data for all South Carolina counties.

Figure 6. Counties with the Highest Numbers of Entries to Foster Care*MP19 (October 2025 – March 2026)*

Source: CAPSS data provided by DSS

**Figure 7. Counties with the Highest Rates of Entry to Foster Care per 1,000 Children in the County Child Population⁵⁶***MP19 (October 2025 – March 2026)*Source: CAPSS data provided by DSS; U.S. Census Bureau⁵⁷

⁵⁶ Counties with fewer than 10 entries to foster care between October 1, 2025 and March 31, 2026 have been excluded.

⁵⁷ U.S. Census Bureau. (2025). *Annual county and Puerto Rico municipio resident population estimates by selected age groups and sex: April 1, 2020 to July 1, 2025 (CC-EST2025-AGESEX-45)* — South Carolina.

Most children who enter foster care in South Carolina enter through law enforcement action placing them in emergency protective custody (EPC). State statute authorizes law enforcement officers to unilaterally remove children from their homes and place them in EPC in certain circumstances.^{58,59} Between October 1, 2025 and March 31, 2026 (MP19), 67 percent of all foster care entries (873 of 1,300) were through EPC actions by law enforcement. This is a decrease from the prior monitoring period when 72 percent of children entered foster care due to an EPC. In MP19, the rate of EPC entry per 1,000 children in South Carolina's child population was 0.8. Richland County had the highest number of children (128) enter foster care via an EPC, followed by Greenville County (65) ([Figure 8](#)). Fairfield County had the highest rate of EPC entry, with 4.6 per 1,000 children in the county population entering foster care via an EPC, followed by Marion County with a rate of 3.7 ([Figure 9](#)).⁶⁰ The rate of EPC entry in these two counties was significantly above the statewide rate and the rates of other counties.

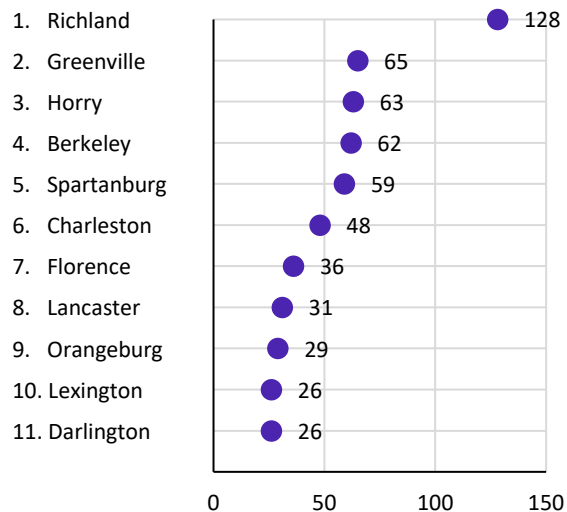
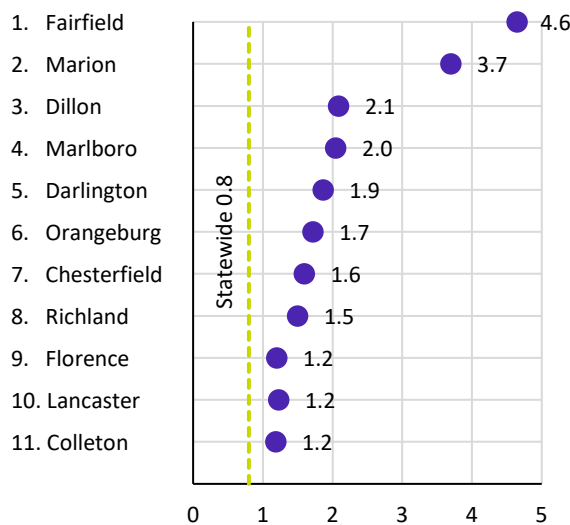
⁵⁸ See: SC Code § 63-7-620 (2024), authorizing law enforcement to use an EPC when, among other circumstances: (1) the officer has probable cause to believe that by reason of abuse or neglect the child is in substantial and imminent danger if not taken into emergency protective custody, and there is not time for a court order; (2) the child's parent(s) or guardian(s) has been arrested and as a result, the child's welfare is threatened due to loss of adult protection and supervision, and the parent(s) or guardian(s) does not consent to another person assuming physical custody of the child; or (3) a child has become lost accidentally, and a search by law enforcement has not located the parent(s) or guardian(s).

⁵⁹ Note: SC Code § 63-7-740 (2024) allows family court judges to order ex parte that a child be taken into emergency protective custody without the consent of parents, guardians, or others, exercising temporary or permanent control over the child if: (1) the family court judge determines there is probable cause to believe that by reason of abuse or neglect there exists an imminent and substantial danger to the child's life, health, or physical safety; and (2) parents, guardians, or others exercising temporary or permanent control over the child are unavailable or do not consent to the child's removal from their custody. During MP19, 23% of children (299 of 1,300) who entered foster care entered due to an ex parte order by a family court judge. This is an increase from MP18 when that percentage was 19%. Combined with entries pursuant to EPC actions by law enforcement, 91% percent of children who entered foster care during this monitoring period entered via an emergency action. This is the same combined total as in MP18.

⁶⁰ See [Table 6](#) in Appendix D showing these data for all South Carolina counties.

Figure 8. Counties with the Highest Numbers of Entry via EPC*MP19 (October 2025 – March 2026)*

Source: CAPSS data provided by DSS

**Figure 9. Counties with the Highest Rates of Foster Care Entry via EPC per 1,000 Children in the County Child Population⁶¹***MP19 (October 2025 – March 2026)*Source: CAPSS data provided by DSS; U.S. Census Bureau⁶²

⁶¹ Counties with fewer than 10 EPC entries to foster care between October 1, 2025 and March 31, 2026 have been excluded.

⁶² U.S. Census Bureau. (2025). *Annual county and Puerto Rico municipio resident population estimates by selected age groups and sex: April 1, 2020 to July 1, 2025 (CC-EST2025-AGESEX-45)* — South Carolina.

Placement Settings for Children in Foster Care

On March 31, 2026, 3,280 Class Members were in out-of-home foster care placements with 86 percent (2,812) residing in family-like settings (Figure 10).⁶³ Family-like settings include non-kin foster homes where 1,019 children resided, kin homes where 1,002 children resided, and therapeutic foster homes where 791 children resided. Fourteen percent of children (468) resided in congregate care placements, including 415 children placed in group homes and 53 children placed in residential treatment facilities.

When children are placed far from their communities of origin, they may lose contact with their schools, friends, siblings, relatives, places of worship, and communities.⁶⁴ Federal law prioritizes the placement of children in foster care in their communities of origin by requiring, to the extent possible, that children are placed in the least-restrictive setting near to their parents' home and their school of origin.⁶⁵ Overall, as of March 31, 2026, 35 percent of children were in placement settings located within their counties of origin and 65 percent of children in foster care were in out-of-county placements (Figure 11).^{66,67}

DSS tracks the number of children who are placed within their regions and counties of origin by placement type. On March 31, 2026, the last day of the monitoring period, children being cared for by kin were placed within their counties of origin at a higher rate than children placed in other placement settings: specifically, 61 percent of children placed with kin resided within their counties of origin. Children placed in group homes and residential treatment facilities had the highest rates of out-of-county placement, 88 percent and 85 percent, respectively (Figure 11). Greenwood County had the highest percentage of out-of-county placements at 90 percent, followed by Clarendon County where 84 percent of children were in out-of-county placements on the last day of the monitoring period (Figure 12).⁶⁸ Williamsburg and Beaufort counties had the lowest percentages of out-of-county placements at 42 percent and 44 percent, respectively (Figure 13).⁶⁹

⁶³ This number excludes 34 children who resided in other institutional settings. On March 31, 2026, 17 children were hospitalized for 30 days or more, and 17 children were in a Department of Juvenile Justice (DJJ) or other correctional facility.

⁶⁴ Font, S. A., Sattler, K. M., & Gershoff, E. T. (2018). Measurement and correlates of foster care placement moves. *Children and Youth Services Review*, 91, 248–258. <https://doi.org/10.1016/j.childyouth.2018.06.019>.

⁶⁵ 42 U.S.C. §675(5) and §675(1)(G)(i).

⁶⁶ *Supra* note 63.

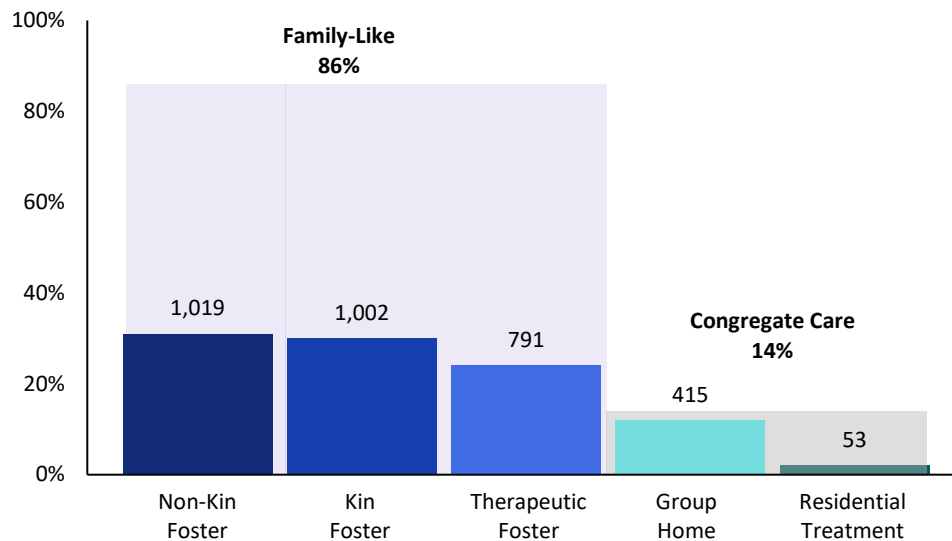
⁶⁷ Note: there is no specific FSA requirement or performance metric about the placement of children in their counties of origin.

⁶⁸ See Table 7 in Appendix D showing these data for all South Carolina counties.

⁶⁹ *Ibid*.

Figure 10. Placement Settings of Children in Foster Care*March 31, 2026*

Source: CAPSS data provided by DSS

**Figure 11. In- and Out-of-County Placements, by Placement Setting***March 31, 2026*

Source: CAPSS data provided by DSS

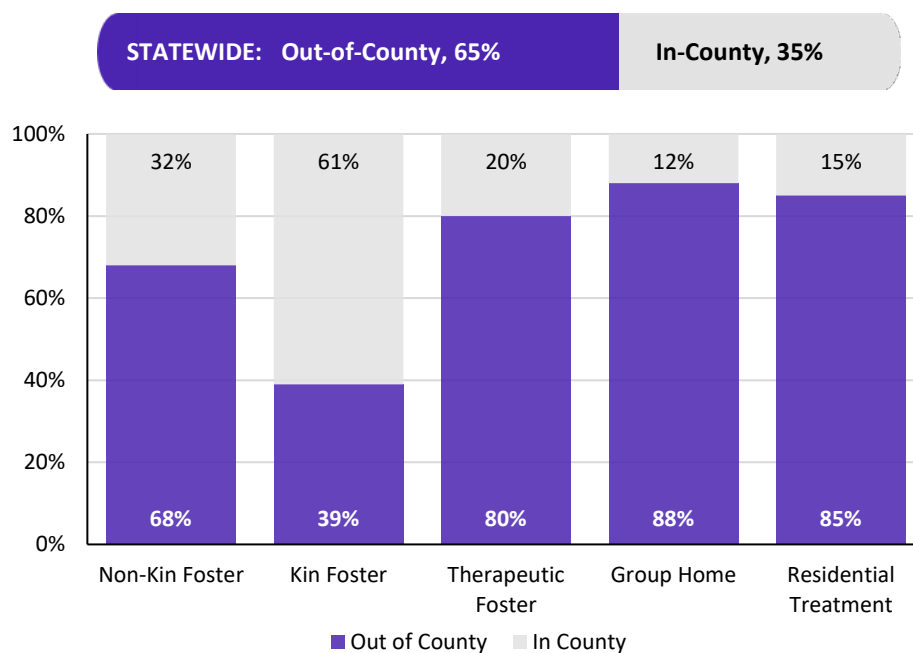
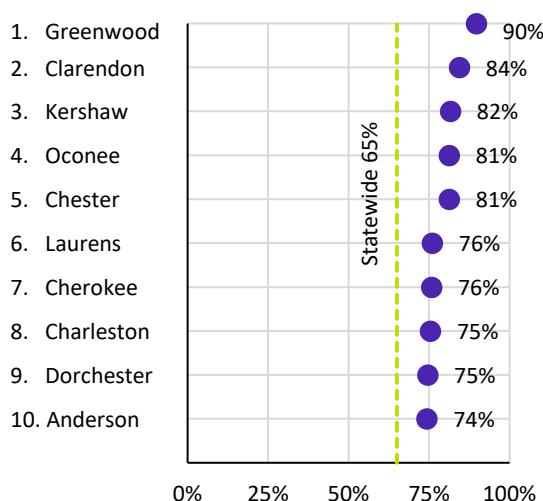
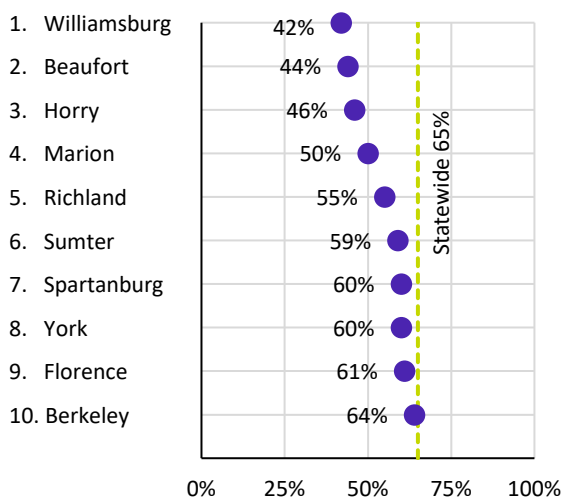


Figure 12. Counties with the Highest Percentages of Out-of-County Placements⁷⁰*March 31, 2026*

Source: CAPSS data provided by DSS

**Figure 13. Counties with the Lowest Percentages of Out-of-County Placements⁷¹***March 31, 2026*

Source: CAPSS data provided by DSS



Placement setting data were also disaggregated by age and race. Older children were placed in congregate settings at exponentially higher rates than younger children ([Figure 14](#)). Less than one percent of children (7 of 1,294) aged six and under were placed in congregate care, while five percent of children (45 of 937) aged seven through 12, and 40 percent of children (416 of 1,049)

⁷⁰ Counties with fewer than 25 children in foster care as of March 31, 2026, have been excluded.

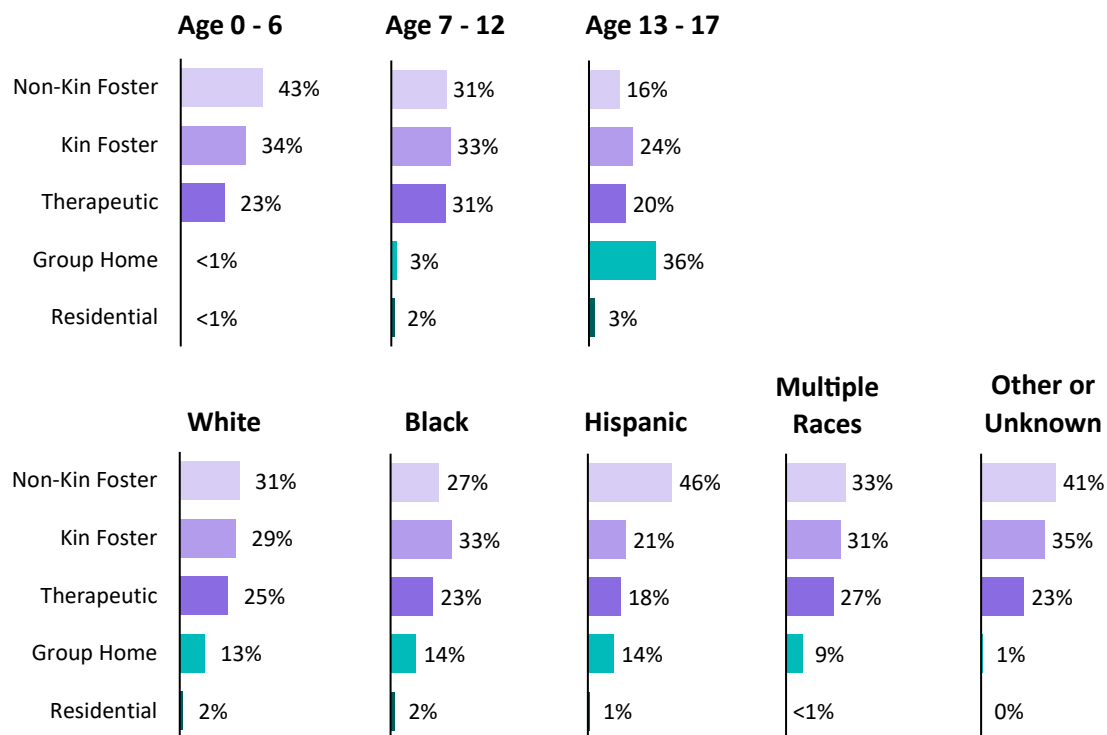
⁷¹ Ibid.

aged 13 through 17 were placed in a group home or residential treatment facility.⁷² Hispanic children were placed in non-kin foster homes at a higher rate than children of other races, while Black children were placed in non-kin foster homes at a lower rate than children of other races.

Figure 14. Placement Settings, by Age and Race⁷³

March 31, 2026

Source: CAPSS data provided by DSS



⁷² Note: combined congregate care totals (Group Home + Residential Treatment) differ from what is shown in [Figure 14](#) due to rounding.

⁷³ "Other or Unknown" includes children identified as Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, or an unknown race.

Length of Stay and Exits from Foster Care

During Monitoring Period 19 (MP19, October 2025 – March 2026), 1,173 children under the age of 18 exited foster care, with lengths of stays in foster care ranging from one to 3,977 days (or nearly 11 years). The median length of stay among children exiting during MP19 was 245 days.

Focusing on children who experience foster care for shorter periods of time can help child welfare agencies better identify when the trauma of separating children from their families could have been avoided through improved cross-agency collaboration and the provision of in-home and community-based services. When successful, it prevents the lasting harm that children and families experience when separated by removals to foster care – even for very short periods of time.⁷⁴ Accordingly, DSS's Office of Accountability, Data, and Research (ADR) analyzes the amount of time children spend in foster care, with an emphasis on children who remain in foster care for less than six months. The Monitor focused the following analysis on “short stays” (60 days or fewer) and “very short stays” in foster care (7 days or fewer) experienced by children during MP19.⁷⁵

Among all exits from foster care occurring between October 1, 2025 and March 31, 2026, 75 percent (884 of 1,173) occurred after a stay of 61 days or more, while 25 percent (289 of 1,173) occurred after a short stay of 60 days or less. This is a decrease from the prior monitoring period when 29 percent of exits from foster care followed a short stay. Among children who exited foster care within 60 days of entry, 68 percent (197 of 289) returned to the custody of their parent(s) or guardian(s), 28 percent (80 of 289) exited to live with other relatives, and four percent (12 of 289) exited to other living arrangements ([Figure 15](#)). In Greenwood County, 73 percent of all exits from foster care occurred within 60 days of entry ([Figure 16](#)).⁷⁶ This was the highest percentage of short stays in the state. In Monitoring Period 19, 13 percent of exits (151 of 1,173) were within seven days of entry. These “very short stays” occurred in 31 counties, five of which had more than 10 children exit foster care within seven days or fewer: Horry, Greenville, Richland, Berkeley, and Spartanburg counties.

⁷⁴ Sankaran, V., Church, C., & Mitchell, M. (2019). A Cure Worse than the Disease? The Impact of Removal on Children and their Families. University of Michigan Law School Scholarship Repository, 102(4). and Getz Z., Simmel C., Zhang L., Greenfield B. (2022). “Short-stayers” in child welfare: Characteristics and system experiences. *Children and Youth Services Review*, 138, 106531.

⁷⁵ Note: children may have had more than one stay during the monitoring period.

⁷⁶ See [Table 8](#) in Appendix D showing these data for all South Carolina counties.

Figure 15. Length of Stay and Exit Reason for Stays of 60 Days or Less in Foster Care

Among children who exited foster care during MP19 (October 2025 – March 2026)

Source: CAPSS data provided by DSS

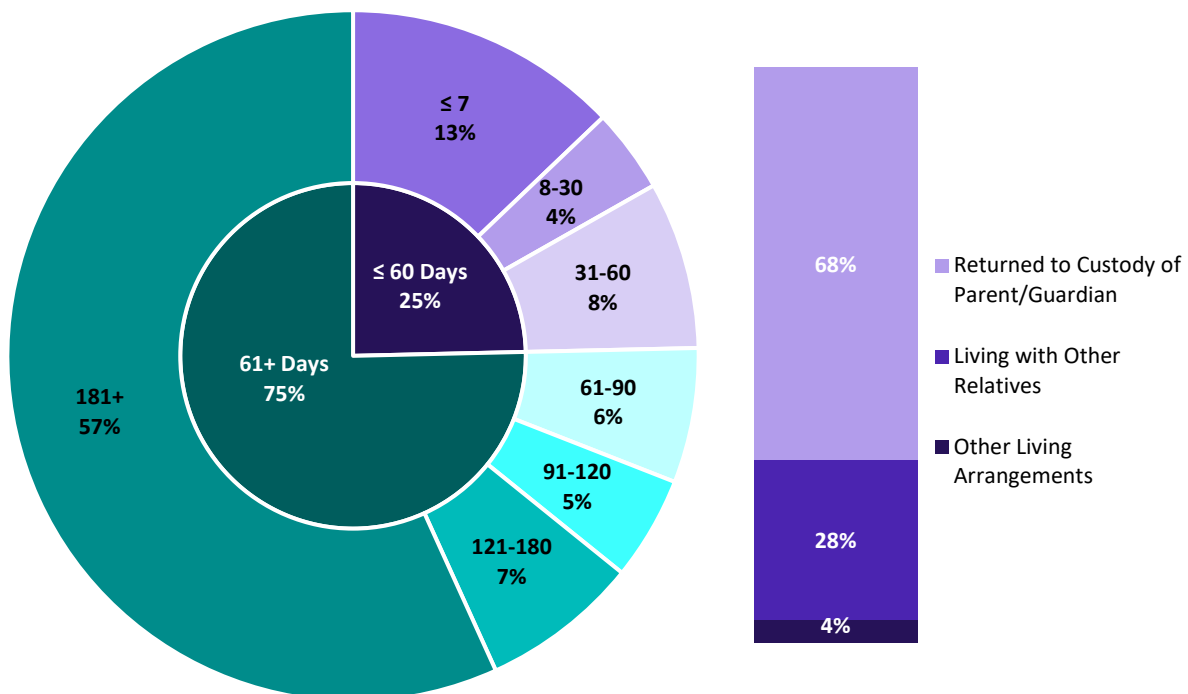
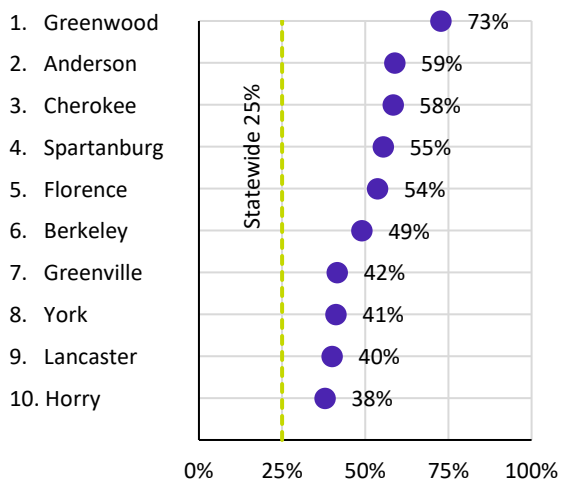


Figure 16. Counties with the Highest Percentage of Exits from Foster Care within 60 Days of Entry⁷⁷

Among children who exited during MP19 (October 2025 – March 2026)

Source: CAPSS data provided by DSS



⁷⁷ Counties with fewer than 10 exits from foster care between October 1, 2025 and March 31, 2026 have been excluded.

Among children who exited foster care during MP19, entry circumstances differed when comparing children with short stays to those with longer stays. Although entry through EPC by law enforcement was common among both short and longer stay exits, it accounted for a substantially larger proportion of short stay exits during the monitoring period (October 2025 – March 2026). Of children who exited after a short stay of 60 days or less, 85 percent (246 of 289) had entered foster care due to law enforcement action placing them in emergency protective custody ([Figure 17](#)). This is a lower percentage than the prior monitoring period when 91 percent of children who exited after a short stay had entered due to an EPC. In contrast, among children who exited during MP19 following a stay of more than 60 days in foster care, 64 percent (570 of 884) entered due to emergency protective custody. This percentage was unchanged from MP18.

Figure 17. Comparison of Children with Short Stays (≤ 60 Days) and Longer Stays (61+ Days)

By entrance via EPC from law enforcement among children who exited during MP19 (October 2025 – March 2026)

Source: CAPSS data provided by DSS



IV. Performance

A. Placements

Children who are separated from their parent(s) and guardian(s) and placed into foster care need to be cared for in settings where they are safe, stable, and supported. This means ensuring that children are in family-like environments, with kin and siblings, and within their communities. This policy and practice expectation requires that child welfare systems identify and support kin and family-based caregivers and provide flexible, accessible, individualized interventions to address children's safety, health, and well-being.

This expectation is embedded within FSA requirements related to placement stability, placement of children in family-like settings, placement of children with their siblings, and placement of children in the least-restrictive settings that can appropriately meet their therapeutic needs. The FSA includes a specific requirement relating to the placement of children who are also involved with the juvenile justice system.

Ensuring the availability of appropriate, stable placements for children throughout South Carolina has been a significant challenge for DSS for many years. That challenge became acute in Richland County, and in October 2024, the Court ordered DSS to address high rates of placement instability through the creation of the Richland County Child Welfare Task Force and the development of an Improvement Plan.⁷⁸ As of August 2026, nearly all of the strategies included in the Improvement Plan are being implemented in Richland County and the state is beginning to deploy those strategies showing promise to other parts of the state.

⁷⁸ Order directing the prompt creation of a task force to prepare and implement a plan to address issues relating to overnight stays in the Richland County DSS office (October 18, 2024, Dkt. 331).

1. Placement Instability

Placement Moves

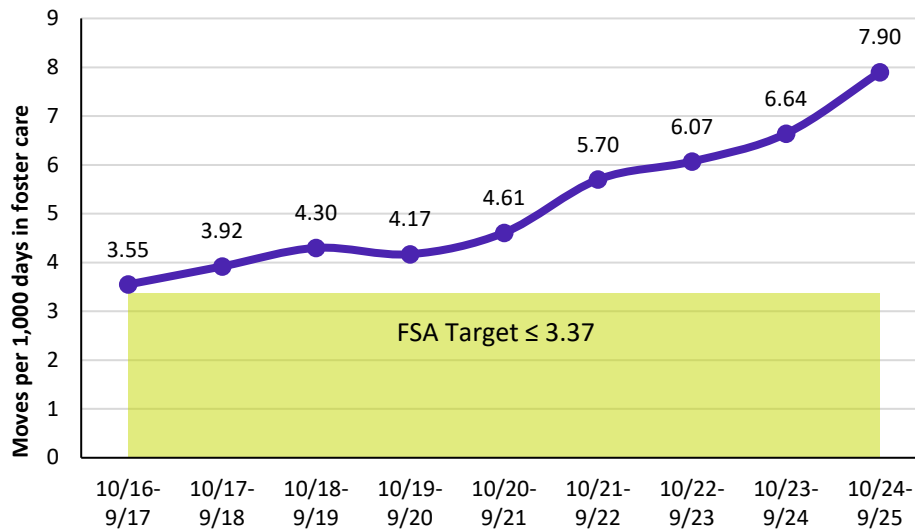
FSA Requirement	<i>For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37 (FSA IV.F.1.).</i>
Performance Assessment	FSA Requirement Not Met: The annual 2024 – 2025 placement instability rate was 7.90 .

Section IV.F.1. of the FSA requires that the placement instability rate for all Class Members in foster care for eight days or more during the 12-month period be less than or equal to 3.37.⁷⁹ Performance on this provision is reported annually for the period between October 1st and September 30th and was previously included in the report for Monitoring Period 18 and will be assessed in the next report (Monitoring Period 20). The 2024-2025 placement instability rate was 7.90, meaning Class Members were moved an average of 7.90 times per 1,000 days in foster care ([Figure 18](#)). This was the largest increase in placement instability since the inception of the lawsuit and more than double the FSA target.

⁷⁹ Placement instability is defined as the rate of placement moves per 1,000 days of foster care (FSA II.O.). Placement moves are changes in foster care placements, excluding the removal to foster care, temporary absences from an ongoing placement (such as trial home visits), and moves occurring after a Class Member’s 18th birthday (FSA II.N.). Additionally, the re-designation of an emergency placement, that is not a congregate care placement, within 30 days as a long-term foster or therapeutic foster home when the child does not physically move is not considered a placement move (FSA IV.E.4&5.).

Figure 18. Placement Instability Rate*October 2024 – September 2025*

CAPSS data provided by DSS



In addition to the annual placement instability rate, DSS reports the number of placement moves children experience during each monitoring period. Among children who were in foster care at any point between October 1, 2025 and March 31, 2026 (MP19), 57 percent of children (2,593 of 4,571) remained stable in their placement with no placement move ([Figure 19](#)). This is an improvement from MP18 when 53 percent of children were stable in their placements.

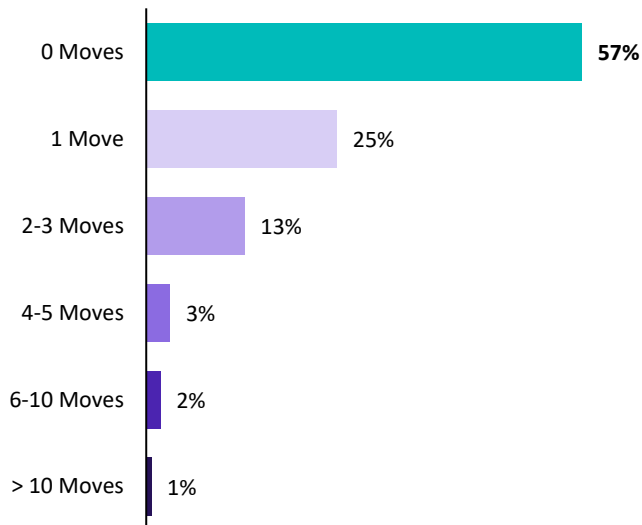
In Monitoring Period 19, 43 percent of children (1,978 of 4,571) experienced at least one placement move, meaning they had least two placements during the six-month period. These children moved between one and 38 times during the monitoring period with a combined total of 4,232 placement moves. Thirty children moved more than 10 times ([Figure 20](#)). These 30 children made up two percent (30 of 1,978) of those experiencing placement instability but accounted for 12 percent of the total number of placement moves (504 of 4,232). Children aged 13 through 17 were most likely to experience at least one placement move (39%) followed by children aged six and under (34%), while children aged seven through 12 were least likely to have placement instability (27%) ([Figure 21](#)). Colleton County had the highest percentage of children experiencing at least one placement move (58%) followed by Kershaw County (56%) ([Figure 22](#)).⁸⁰ Lancaster County had the lowest percentage of children with at least one placement move (27%) ([Figure 23](#)).⁸¹

⁸⁰ See [Table 9](#) in Appendix D showing these data for all South Carolina counties.

⁸¹ Ibid.

Figure 19. Percentage of Children Experiencing Placement Moves, by Number of Moves*MP19 (October 2025 – March 2026)*

Source: CAPSS data provided by DSS

**Figure 20. Distribution of Placement Moves Experienced by Children***MP19 (October 2025 – March 2026)*

Source: CAPSS data provided by DSS

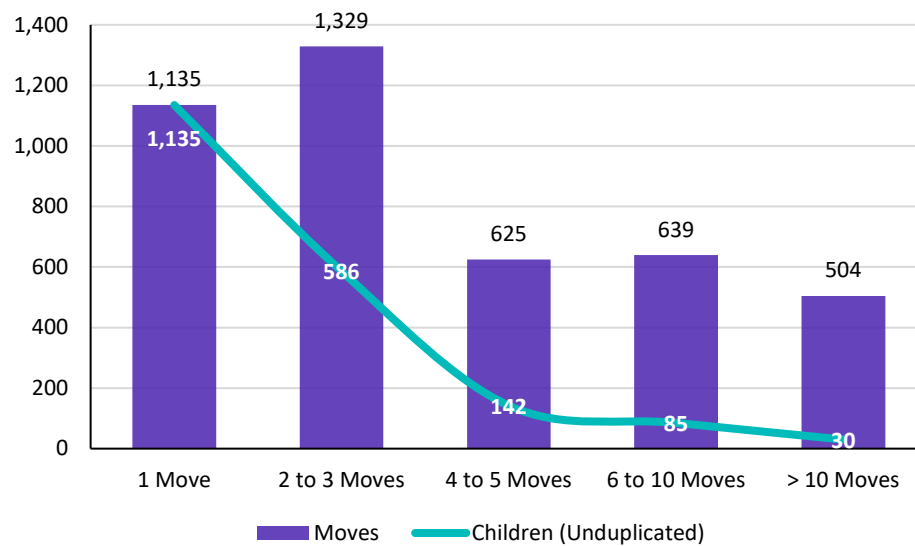
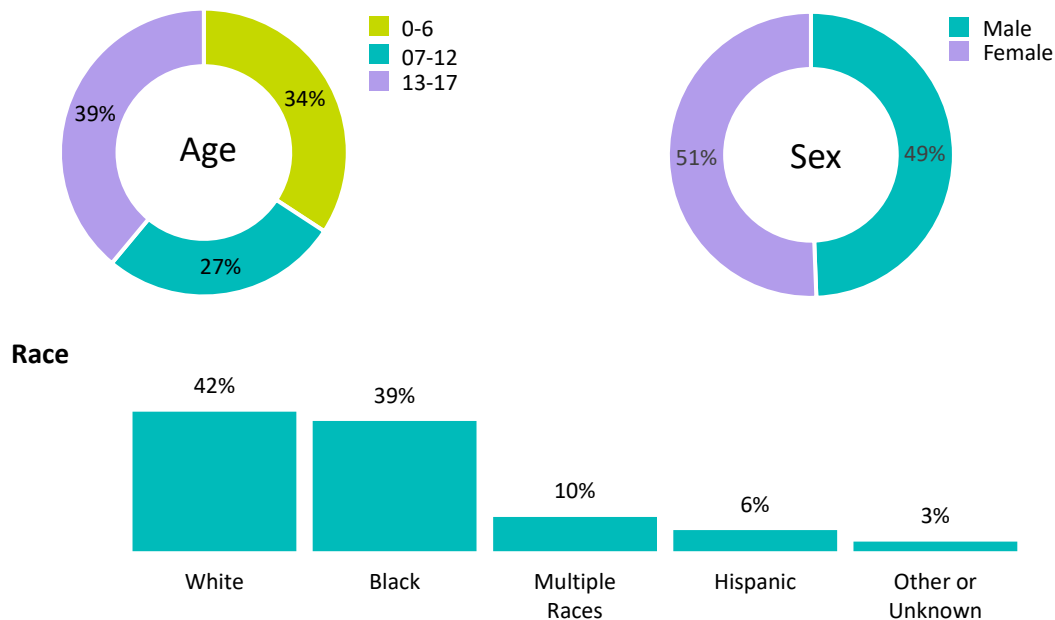


Figure 21. Children with One or More Placement Move, by Age, Sex, and Race⁸²

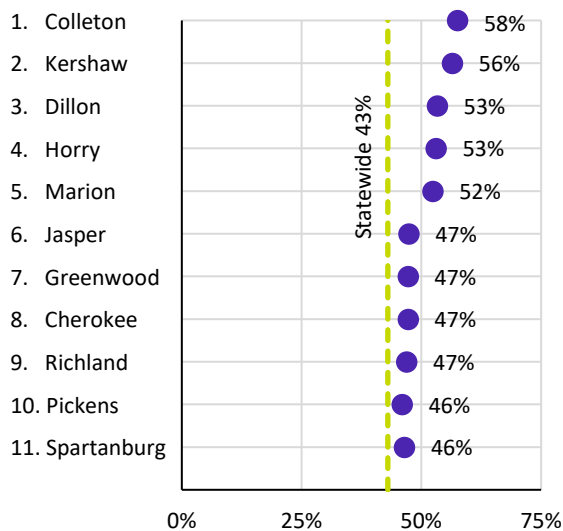
MP19 (October 2025 – March 2026)

Source: CAPSS data provided by DSS

**Figure 22. Counties with the Highest Percentages of Children with One or More Placement Move⁸³**

MP19 (October 2025 – March 2026)

Source: CAPSS data provided by DSS



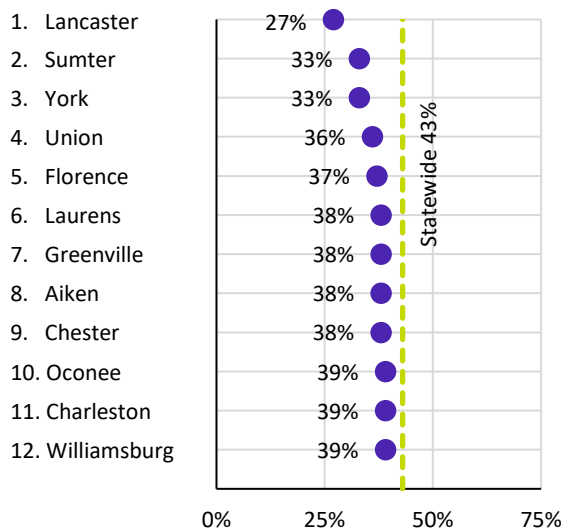
⁸² "Other or Unknown" includes children identified as Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, or an unknown race.

⁸³ Counties with fewer than 25 children in foster care at any point between October 1, 2025 and March 31, 2026, have been excluded.

Figure 23. Counties with the Lowest Percentages of Children with One or More Placement Move⁸⁴

MP19 (October 2025 – March 2026)

Source: CAPSS data provided by DSS



⁸⁴ Ibid.

Overnight Stays in DSS Offices and Hotels

FSA Requirement	<i>DSS shall cease using DSS offices as an overnight placement for Class Members and shall cease placing or housing any Class Members in hotels, motels and other commercial non-foster care establishments. For any Class Members moved out of such DSS Offices or Hotels, DSS shall provide for their appropriate placement. In the extraordinary event that a child stays overnight in a DSS office, Defendants shall immediately notify the Co-Monitors, who shall provide a report to Parties as appropriate, including whether or not, in their view, the incident should be reported to the Court as a violation which would preclude Defendants' ability to achieve compliance on this provision (FSA IV.D.3.).</i>
Performance Assessment	FSA Requirement Not Met: 52 children spent a total of 67 nights in a DSS office, hotel, motel, or other commercial non-foster care placement.

The FSA requires DSS to cease using DSS offices as overnight placements for children. An “overnight stay” is defined as a minimum four-hour period in a DSS office, hotel, motel, or other commercial non-foster care establishment between the hours of 10:00 p.m. and 6:00 a.m.⁸⁵ Each night a child spends in a DSS office is counted as an overnight stay (e.g., if a child spends two consecutive nights in a DSS office, that is counted as two overnight stays.) DSS provides daily notification of any overnight stay to the Monitor and tracks overnight stays weekly, monthly, and by monitoring period.

Between October 1, 2025 and March 31, 2026 (MP19), 52 children had a total of 67 overnight stays in a DSS office or hotel, motel, or other commercial non-foster care establishment ([Figure 24](#)). This is a 73 percent decrease in the number of children and an 89 percent decrease in the number of overnight stays compared to the prior monitoring period when 190 children experienced 622 overnight stays. Overnight stays began to decline in August and September 2025—when unlicensed cottages used for overnight placements were officially licensed by DSS—and remained low through March 2026 when inexplicably, overnight stays again began to rise sharply ([Figure 25](#)).^{86,87} While the state was able to significantly reduce the use of overnight stays

⁸⁵ Note: this currently operative definition of “overnight stay” is included in the Short-Term Plan to Address Overnight Stays, which was approved by the Court on March 23, 2022. See Joint Motion for Approval of Overnight Stay Plan (March 4, 2022, Dkt. 236) at pg. 3 and Order Approving Overnight Stay Plan (March 23, 2022, Dkt. 238).

⁸⁶ To become licensed, facilities must meet the following requirements, among others: establishment of formal policies and procedures, qualifications for staff employment, additional training, and guidelines for fire, sanitation, nutrition, and medication management.

⁸⁷ As noted in the Supplemental Richland County DSS Improvement Plan, when a child spends one night in an unlicensed cottage, it is considered an “overnight stay”; once these emergency, small capacity facilities become licensed as group homes, a child’s placement at the facility is considered an “emergency placement” rather than an overnight stay. See: Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).

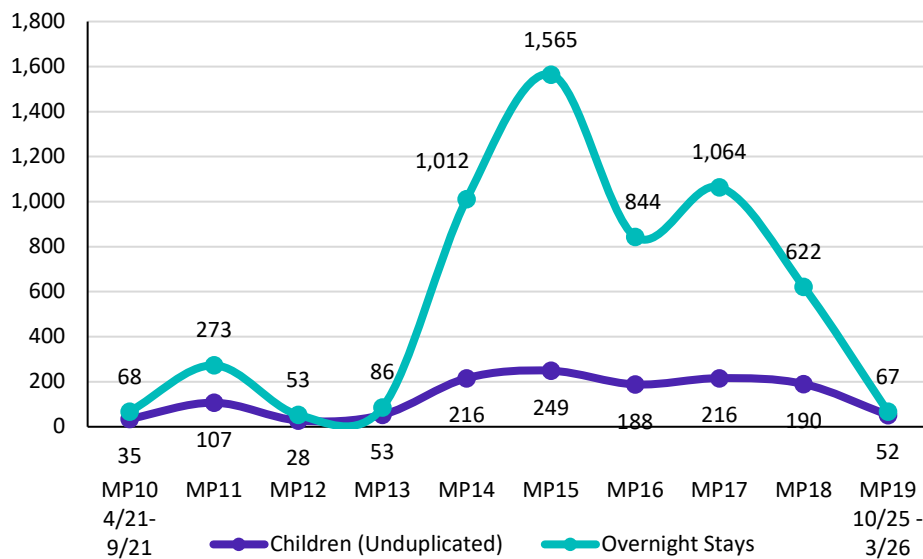
during Monitoring Period 19, it did not meet the FSA requirement prohibiting the placement of any child in a DSS office, and the increase in overnight stays since the end of the monitoring period is concerning.

During MP19, Horry County had 13 overnight stays, the most of any county but a decrease from MP18 when it had 41. Richland County had two overnight stays in MP19, compared to 189 during MP18 when it had the highest number of overnight stays statewide ([Figure 26](#)).⁸⁸ In the months following the end of MP19 (April – August 2026), there have been a total of 406 overnight stays; Beaufort County has had the most with 39 ([Figure 27](#)).

Figure 24. Overnight Stays

Number of unduplicated children who experienced an overnight stay and total number of overnight stays, MP10 – 19 (April 2021 – March 2026)

Source: Data provided by DSS

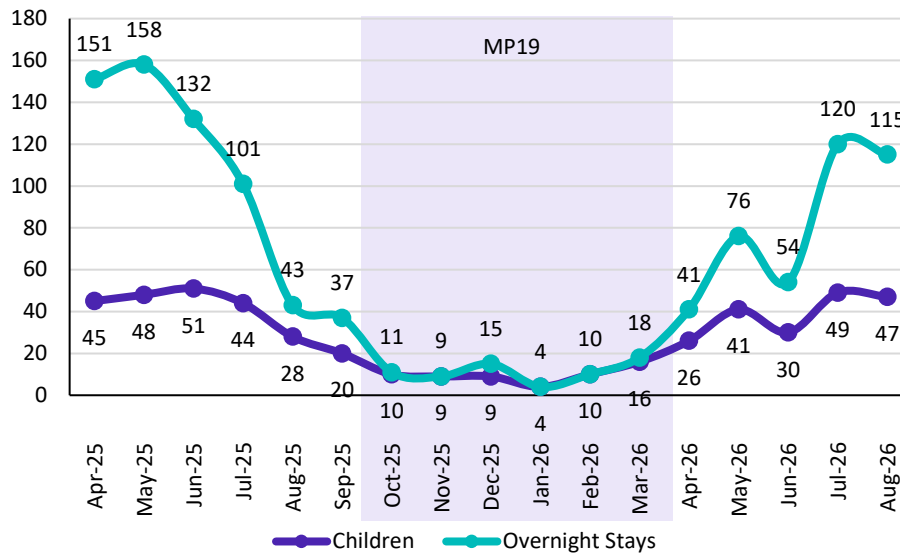


⁸⁸ See [Table 10](#) in Appendix D showing these data for all South Carolina counties.

Figure 25. Overnight Stays, by Month⁸⁹

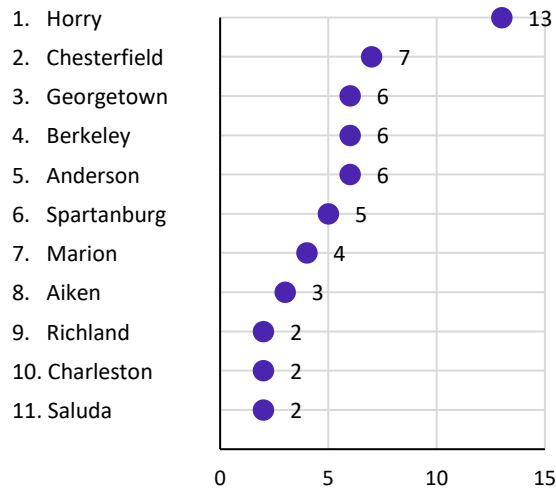
Number of children who experienced an overnight stay and total number of overnight stays,
October 2025 – August 2026

Source: Data provided by DSS

**Figure 26. Counties with the Most Overnight Stays, MP19**

(October 2025 – March 2026)

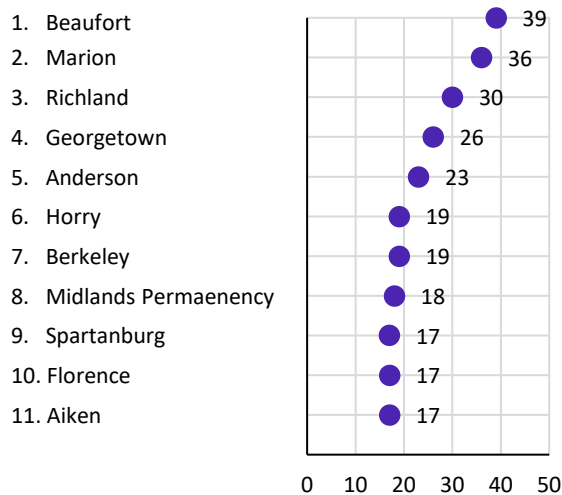
Source: Data provided by DSS



⁸⁹ Children are only counted once for each month in which they had an overnight even if they experienced multiple overnights in the month. Children who had overnight stays in multiple months will be counted once in each month.

Figure 27. Counties with the Most Overnight Stays Since MP19*(April – August 2026)*

Source: Data provided by DSS



Among the 52 children who experienced overnight stays during MP19, 87 percent (45) had one overnight stay, and no child had more than 10 overnight stays ([Figure 28](#)). This distribution differs from MP18 when 42 percent of children had one overnight stay, and nine children experienced more than 10 overnight stays. The age distribution of children who experienced overnight stays also differed from the prior monitoring period. In MP19, 13 percent of children who had an overnight stay were aged six and under compared to three percent in MP18 ([Figure 29](#)).

Figure 28. Distribution of Overnight Stays Experienced by Children*MP19 (October 2025 – March 2026)*

Source: Data provided by DSS

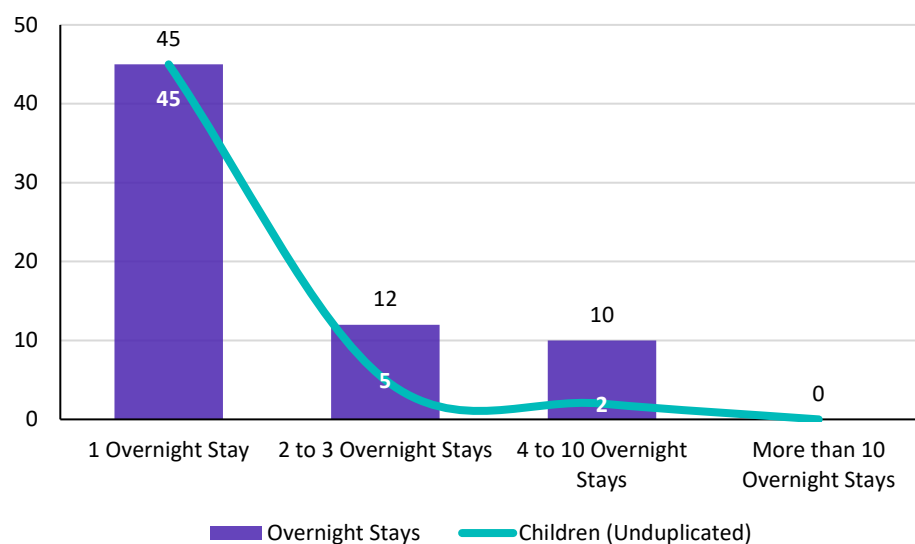
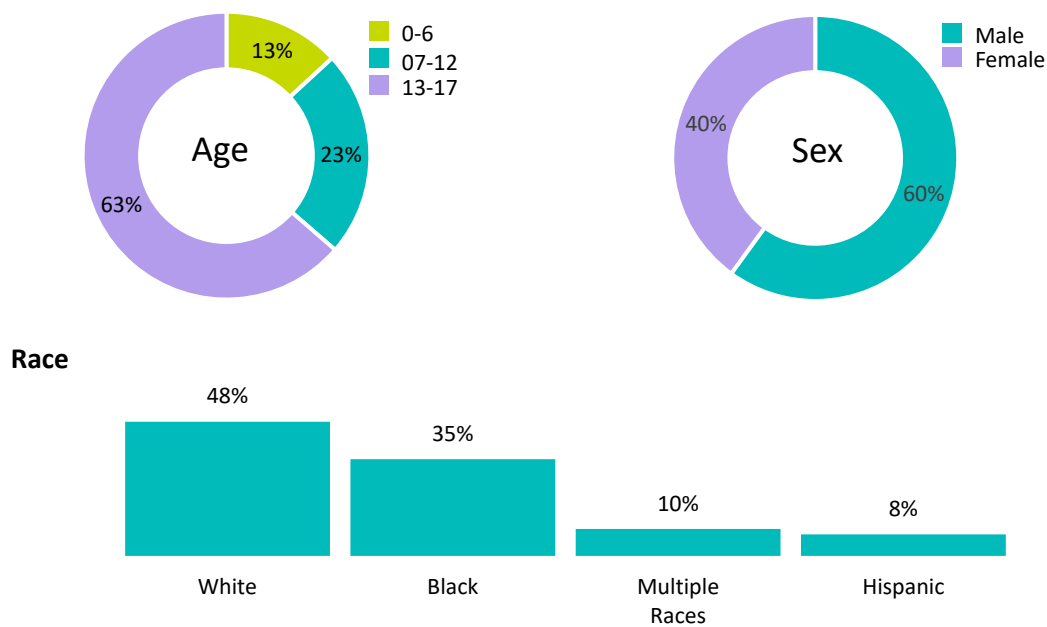


Figure 29. Children Who Experienced Overnight Stays, by Age, Sex, and Race*MP19 (October 2025 – March 2026) compared to MP18 (April 2025 – September 2025)*

Source: Data provided by DSS



Emergency Placements

FSA Requirements	<i>Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days (FSA IV.E.4.) [and] Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days (FSA IV.E.5.).</i>
Performance Assessment	FSA Requirements Not Met: 8 children experienced an initial emergency placement lasting more than 30 days, and 132 children experienced subsequent emergency placements within 12 months lasting more than seven days.

An emergency placement is any licensed foster care placement used as a short-term placement for a child when all efforts to identify a permanent, long-term placement have been unsuccessful.⁹⁰ The FSA places time limits on the use of emergency placements, including limiting initial emergency placements to 30 days or less and subsequent emergency placements to seven days or less.⁹¹

Overall, 12 percent of children (557 of 4,571) who were in foster care at any point during MP19 (October 2025 – March 2026) had an emergency placement that began during the monitoring period. In total, these 557 children had 1,346 emergency placements and spent 6,701 nights in those placements (Figure 30). Compared to the prior monitoring period (MP18), this is a decrease in both the percentage of children who experienced an emergency placement and a significant 13 percent decline in the total number of nights spent in emergency placements. In MP18, 13 percent of children (606 of 4,616) experienced an emergency placement and spent a total of 7,677 nights in those placements.

With regard to the specific FSA requirements, of the 557 children who experienced an emergency placement in MP19, eight had initial emergency placements lasting longer than 30 days, an increase from MP18 when six children had initial emergency placements lasting more than 30

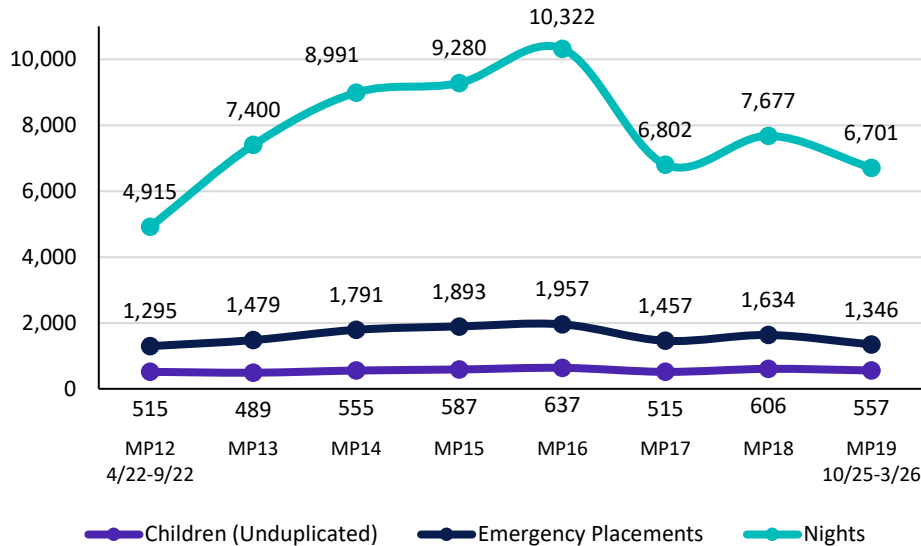
⁹⁰ DSS's policy defines an emergency placement as a short-term placement that is only utilized after all efforts have been made to identify a permanent long-term placement and those efforts were unsuccessful. This currently operative definition differs from the definition provided in Section II.H. of the FSA, which is "an emergency shelter or other placement used as an emergency or temporary facility to house children as described by Human Services Policy and Procedure Manual § 817." The current definition is included in Chapter 5: Foster Care, Policy 510.2.4: Non-Kin Family Foster Home Placement of DSS's Child Welfare Services Manual and is referenced in DSS's court filings related to the Richland County DSS Improvement Plan. See: Letter from J. Michael Montgomery with Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (December 23, 2024, Dkt. 339) at pg. 4; see also: Letter from J. Michael Montgomery with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365) at pg. 7.

⁹¹ For the purposes of this measure, emergency placements that are re-designated within 30 days as a long-term foster home or therapeutic foster home are excluded (FSA IV.E.4.&5.).

days. Among the 557 children who had an emergency placement during MP19, 132 children had more than one emergency placement within the preceding 12 months that lasted more than seven days, a decrease from MP18 when the number was 149 children. The State did not meet either FSA target related to emergency placements in MP19.

Figure 30. Emergency Placements

Number of children who experienced an emergency placement, number of emergency placements, and total number of nights spent in emergency placements, MP12 – 19 (April 2022 – March 2026)
Source: CAPSS data provided by DSS



Children spent between one and 112 nights in emergency placements during MP19. Eight children experienced more than 60 nights in emergency placements, with a combined total of 651 nights. These eight children made up one percent of those who were in emergency placements but accounted for 10 percent of the total number of nights spent in emergency placements during the monitoring period ([Figure 31](#)). The majority of children who experienced an emergency placement during the monitoring period were aged 13 through 17 (66%), and Black children made up the greatest proportion of children with emergency placements (42%) ([Figure 32](#)). Spartanburg County had the highest percentage of children, 27 percent, who had one or more emergency placements during the six-month monitoring period ([Figure 33](#)).⁹² Williamsburg County did not have any children who experienced an emergency placement, and in York and Dillon Counties three percent of children experienced an emergency placement ([Figure 34](#)).⁹³

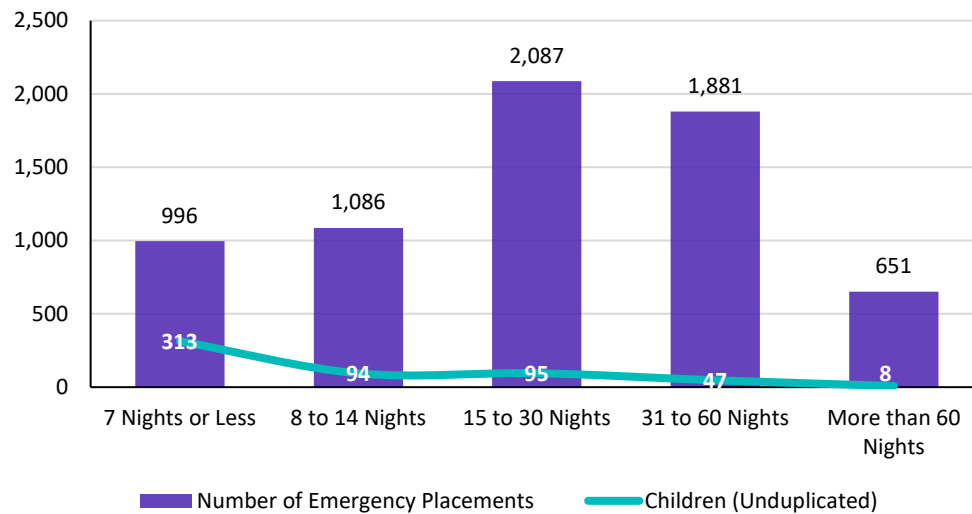
⁹² See [Table 11](#) in Appendix D showing these data for all South Carolina Counties.

⁹³ Ibid.

Figure 31. Distribution of Nights Children Spent in Emergency Placements

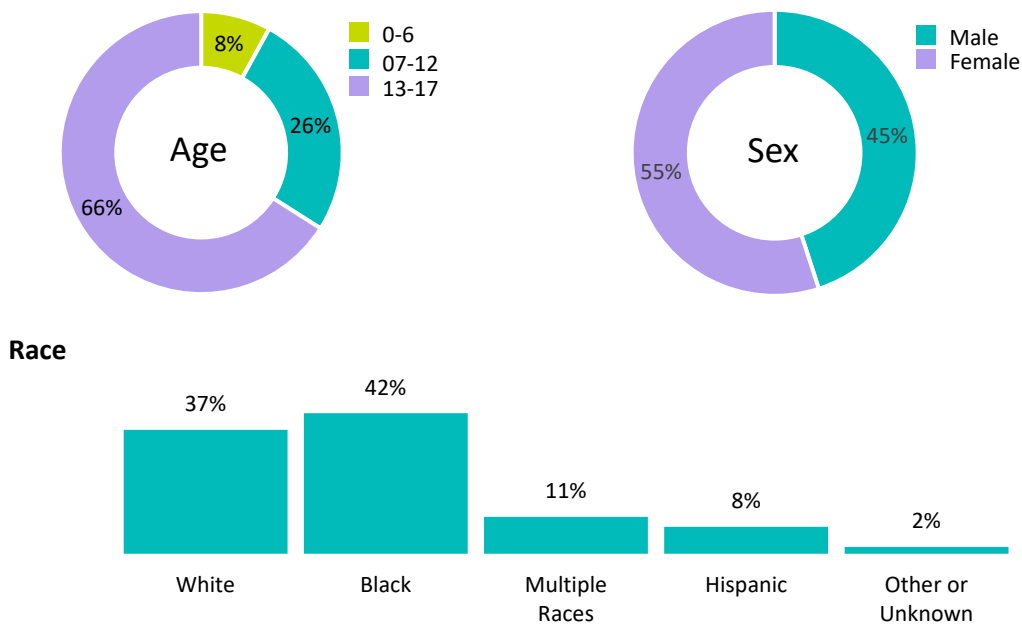
MP19 (October 2025 – March 2026)

Source: CAPSS data provided by DSS

**Figure 32. Children Who Experienced Emergency Placements, by Age, Sex, and Race⁹⁴**

MP19 (October 2025 – March 2026)

Source: CAPSS data provided by DSS



⁹⁴ "Other or Unknown" includes children identified as Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, or an unknown race.

Figure 33. Counties with the Highest Percentages of Children with One or More Emergency Placement⁹⁵

MP19 (October 2025 - March 2026)

Source: CAPSS data provided by DSS

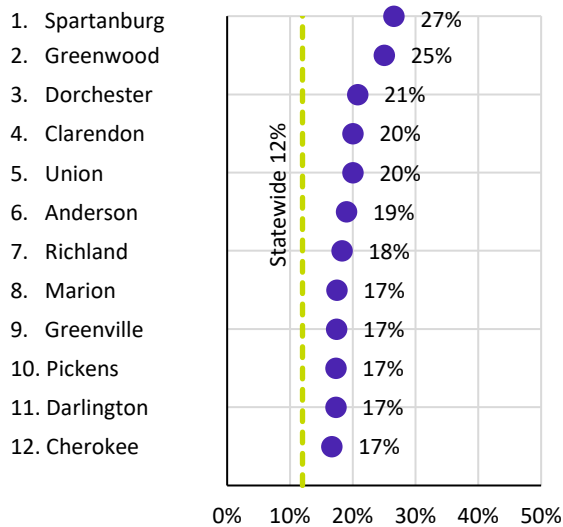
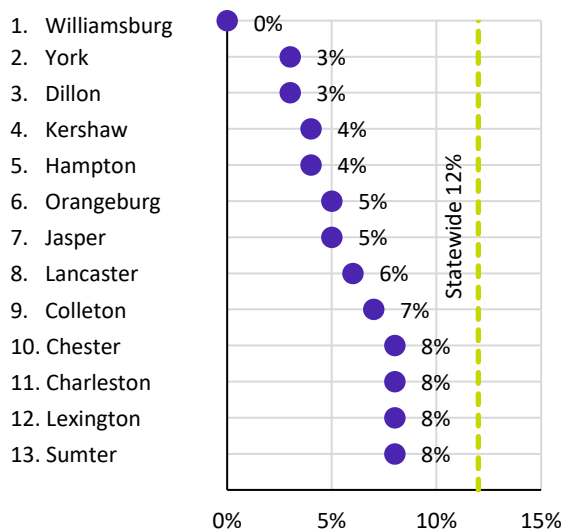


Figure 34. Counties with the Percentages of Children with One or More Emergency Placement⁹⁶

MP19 (October 2025 - March 2026)

Source: CAPSS data provided by DSS



⁹⁵ Counties with fewer than 25 children in foster care at any point between October 1, 2025 and March 31, 2026, have been excluded.

⁹⁶ Ibid.

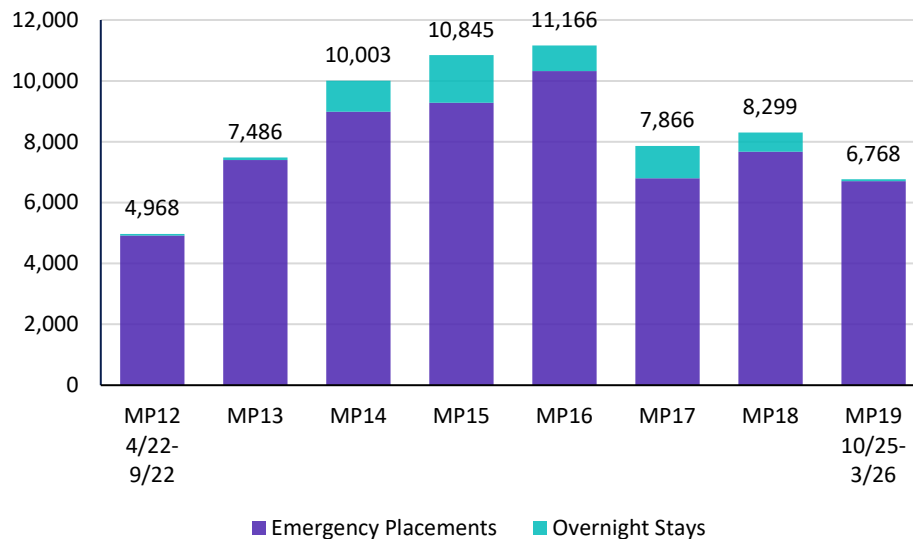
Short-Term Placements

The FSA has distinct requirements regarding overnight stays and emergency placements; however, in practice, children often experience these “short-term placements” interchangeably and/or successively. For example, a child may move from a DSS office to an emergency placement or between a series of emergency placements while staff search for, and children await, appropriate and stable placements. Data regarding the combined use of overnight stays and emergency placements as unplanned, short-term placements for children were also analyzed. In MP19 (October 2025 – March 2026), the total number of nights children spent in a short-term placement decreased by 18 percent, dropping from 8,299 total nights in MP18 (April – September 2025) to 6,768 nights in MP19 (Figure 35). This number is considerably lower than in MP16 (April 2024 – September 2024) when children spent 11,166 nights in short-term placements. However, DSS’s overall use of short-term placements remains unacceptably high.

Figure 35. Number of Nights Children Spent in Short-Term Placements

Combined overnight stays and emergency placement nights, MP12 - 19 (April 2022 – October 2026)

Source: CAPSS data provided by DSS



Discussion

While placement instability continued at unacceptably high rates throughout South Carolina during the six-month monitoring period (October 2026 – March 2026), there was a decline across indicators of placement instability:

- Fewer children experienced a placement move (43% in MP19 compared to 47% in MP18);
- Far fewer children experienced an overnight stay (52 in MP19 compared to 190 in MP18, a 73% decrease) and the total number of nights children spent in DSS offices declined dramatically (67 in MP19 compared to 622 in MP18, an 89% decrease);
- Children spent fewer nights in emergency placements (6,701 total nights in MP19 compared to 7,677 in MP18, a 13% decline); and
- Overall, children spent fewer nights in unplanned, short-term placements (6,768 combined overnights stays and nights in emergency placements in MP19 compared to 8,299 in MP18, an 18% decrease).

This downward trend is notable but tempered by the sharp increase in overnight stays since the end of Monitoring Period 19. It is vital that DSS works in real time to understand the drivers of this increase and take swift action to address and ameliorate problems as they arise. Continual monitoring and diligence will be needed to sustain and improve upon the progress that has been made.

As acknowledged in the State's Supplemental Richland County DSS Improvement Plan, addressing placement instability in Richland County and throughout the state necessarily requires a multi-pronged approach.⁹⁷ The Plan relies on shorter-term strategies to slow the revolving door of inappropriate, short-term placements that are detrimental to children and untenably taxing on DSS staff, private providers, and the system as a whole. These strategies include ending the use of emergency placements of 12-hours or less; making Rapid Response interventions available 24/7 to children experiencing behavioral crises; prioritizing counseling and diagnostic assessments for children who are experiencing placement instability or those who do not have established mental health services; holding child and family team meetings to identify needed support services to help stabilize placements that are at risk of disruption; creating Welcome and Assessment Centers to provide short-term, structured 24-hour care to up to six children experiencing placement instability to help them stabilize and transition to longer-term placements; and licensing small capacity group homes to provide longer-term care to up to three children who have specialized care needs, with the goal of stabilizing the child so they can then be successful in a less restrictive placement setting.⁹⁸

⁹⁷ Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).

⁹⁸ Letter from J. Michael Montgomery Providing Information Required by October 15, 2025 Order (Dkt. 381) prior to April 17, 2026 Status Conference (April 10, 2026, Dkt. 401).

Though these are important measures that needed to be implemented quickly, several of these strategies provide short-term fixes and on their own will not eliminate the placement instability. Equally important are the state's longer-term strategies to prevent children from entering foster care unnecessarily and, for those children who must enter foster care, ensuring the availability of a robust array of well-supported kin and non-kin placements, including therapeutic foster homes, that can meet children's needs in the least-restrictive and most family-like setting. Strategies under way in Richland County include use of a collaborative process between DSS and law enforcement agencies to prevent unnecessary entries into foster care that includes the availability of a DSS law enforcement liaison to provide consultation to law enforcement officers in the field, quickly deploy staff when needed, support the convening of a Removal Prevention Child and Family Team Meeting (CFTM), and utilize Family Search and Engagement staff to identify kin who may be able to provide care and support to children, helping to prevent children's entry into foster care.⁹⁹ Strategies to increase the placement array include collaboration with a CPA to pilot a "professional foster parent model" and, in partnership with CPAs, the use of targeted plans to recruit more foster families in Richland County.¹⁰⁰

Many strategies included in the Richland County Plan have been in place in Richland County for nearly a year. DSS reports that it is engaging in continuous quality improvement efforts to assess the success of the new initiatives and has begun deploying those strategies showing promise to other parts of the state. Strategies that are being offered, or that DSS plans to offer, in additional counties include: rapid response services, which became available in Lexington, Fairfield, and Kershaw counties on March 13, 2026; counseling and diagnostic services for youth experiencing placement instability, which DSS is working to expand to Greenville, Charleston, and Horry counties, tentatively by the end of the year; and the use of Removal Prevention CFTMs, as part of a collaborative process with local law enforcement, to prevent unnecessary removals to foster care, which is expected to begin implementation in Horry and Charleston counties on October 5, 2026 and eventually be implemented statewide.¹⁰¹

Because the \$20.7 million in additional funds DSS requested to support placement stabilization activities were not included in the 2026 – 2027 Appropriations Act, DSS will need to be strategic and creative to maintain progress and scale successful initiatives. As DSS is able to deploy initiatives to other parts of the state, it will be important for DSS to actively engage in continuous quality improvement efforts to determine which strategies are proving effective, why they are effective, what inputs and conditions support their success, and how the strategies can be adapted with partners in other communities. The Monitor is engaged with DSS in assessing the rollout of these strategies. Additional progress on the full implementation of the GPS Case Practice Model will also be essential to longer-term achievement of results. Finally, continued and in some instances, more effective partnership with private providers throughout the state and with the Medicaid and behavioral health system to expand the availability of community-based services for children and families remains vital.

⁹⁹ Ibid.

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

2. Placement of Children in Family-Like Settings

FSA Requirement	<i>At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period (FSA IV.E.2.).</i>
Performance Assessment	FSA Requirement Met: 86% of children resided in family-like placements.

The FSA requires that 86 percent of Class Members be placed outside of congregate care placements on the last day of the monitoring period. The State has consistently met this FSA target since Monitoring Period 10 (April – September 2021), and on June 18, 2026, the Court granted the Parties' Joint Motion for Maintenance of Effort designation of this FSA requirement.^{102,103} DSS continued to meet the FSA target in MP19. On March 31, 2026, the last day of the monitoring period, 86 percent of Class Members (2,818 of 3,280) were placed in family-like settings and outside of congregate care ([Figure 36](#)).¹⁰⁴

While the FSA does not include targets for the placement of children aged 13 through 17 outside of congregate care settings, data have consistently shown that children in this age range are far more likely than younger children to be placed in congregate settings and at high rates. On March 31, 2026, 40 percent of children aged 13 to 17 (416 of 1,049) resided in a congregate care facility. This number is an increase over prior monitoring periods, and the highest percentage since September 30, 2021 (MP10) ([Figure 37](#)).

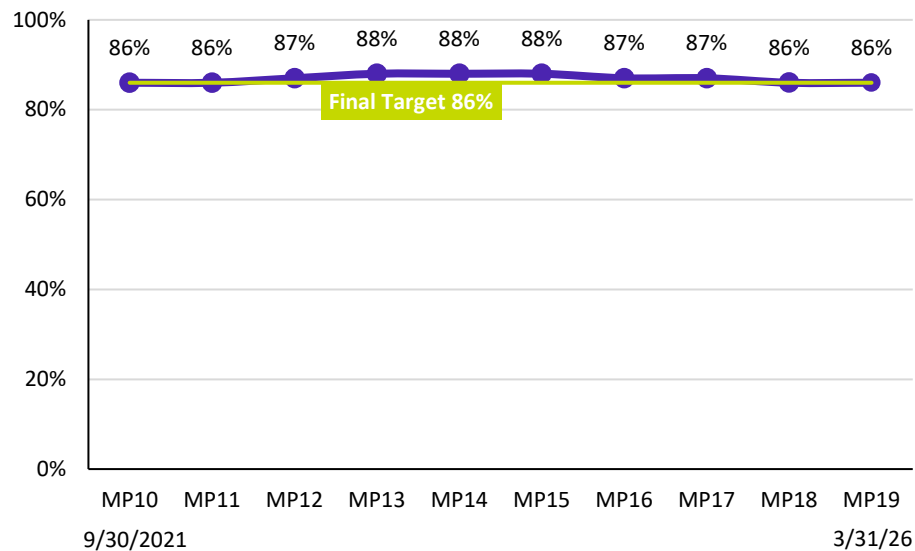
¹⁰² Order on Motion for Miscellaneous Relief (June 18, 2026, Dkt. 412).

¹⁰³ On December 17, 2025, the Court granted the Parties' Joint Motion for Termination and Exit from Court Supervision for 2 other FSA requirements related to the placement of children in foster care in family-like settings: (1) FSA IV.E.3. requiring that 98% of children aged 12 and under reside in family-based placements and (2) FSA IV.D.2., requiring that no child aged six or under reside in a non-family group placement without a valid exception. See: Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 388).

¹⁰⁴ Children residing in other institutional settings on the last day of the monitoring period are excluded from the universe. On the last day of MP19, 34 children resided in other institutional settings; 17 were in DJJ or other correctional facilities, and 17 were in non-temporary (30-days or more) hospital settings. Children experiencing an overnight stay in a DSS office, hotel, motel, or other commercial non-foster care establishment are categorized as residing in congregate care.

Figure 36. Placement of Children in Family-Based Settings*MP10 – 19 (September 30, 2021 – March 31, 2026)*

Source: CAPSS data provided by DSS

**Figure 37. Children Aged 13 – 17 Placed in Congregate Care Settings***MP10 – 19 (September 30, 2021 – March 31, 2026)*

Source: CAPSS data provided by DSS

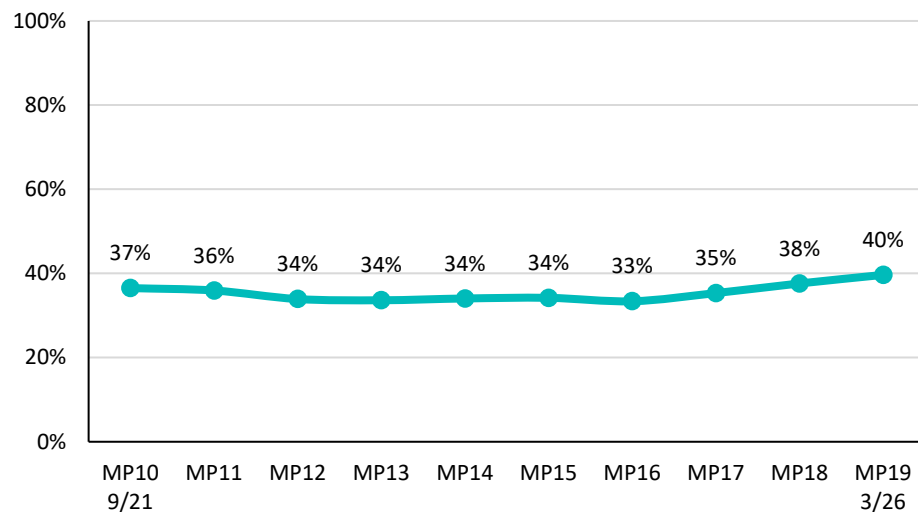


Figure 38 shows the demographics of children placed in family-like settings and the demographics of children placed in congregate care. Eighty-nine percent of children in congregate care are aged 13 through 17 while that age group makes up 46 percent of children in family-like settings. Black children make up 43 percent of children in congregate care and 36 percent of children in family-like settings.

Figure 38. Children in Family-Like Settings and Children in Congregate Care, by Age, Sex, and Race

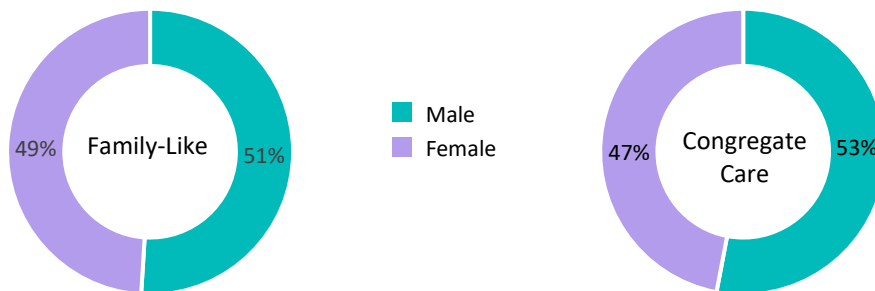
March 31, 2026

Source: CAPSS data provided by DSS

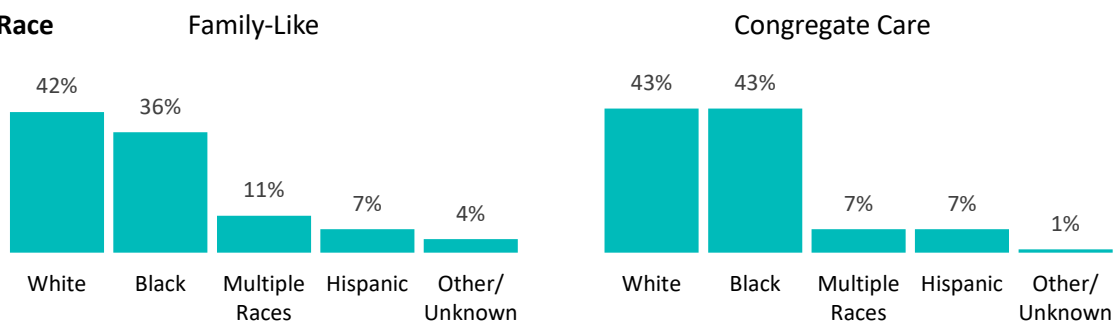
Age



Sex



Race



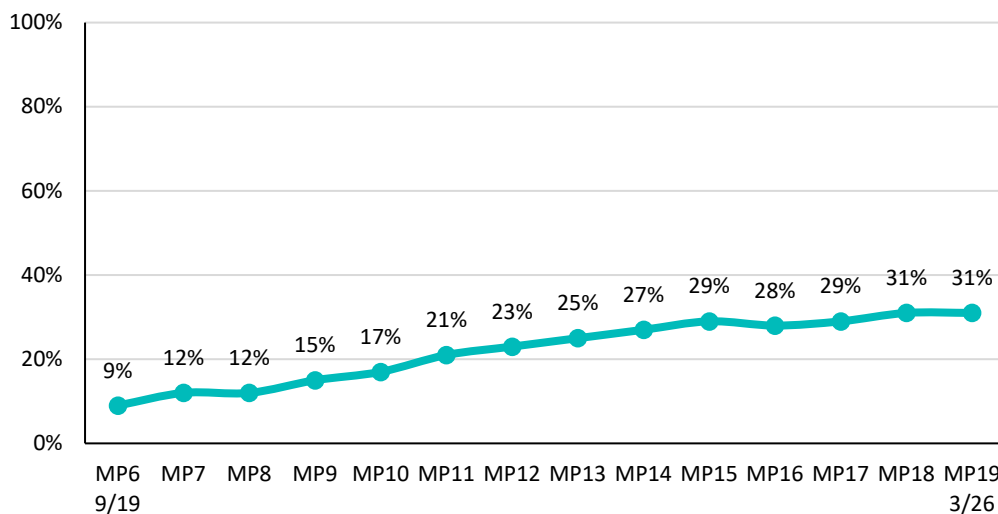
Placement with Kin

DSS has recognized that placing children with kin and increasing financial and other supports provided to children and their kin caregivers is an important strategy to improve children's stability and well-being and to reduce the use of congregate care placements. Kin placements have, for the most part, incrementally increased each monitoring period and remained steady in Monitoring Period 19 (October 2025 – March 2026). On March 31, 2026 (the last day of the monitoring period), 31 percent of children in foster care (1,002 of 3,280) were placed with kin ([Figure 39](#)). Though the rate of kin placement has hovered around 30 percent for the past several monitoring periods, placement of children with kin has increased dramatically since September 30, 2019, when only nine percent of children were placed with kin.

Figure 39. Percentage of Children Placed with Kin

MP6 – 19 (September 2019 – March 2026)

Source: CAPSS data provided by DSS



Discussion

In Monitoring Period 19 (October 2025 – March 2026), DSS continued to meet the FSA requirement that 86 percent of children aged 17 and under be placed outside of congregate care settings, which was granted Maintenance of Effort Status on June 18, 2026 (FSA IV.E.2.).¹⁰⁵ DSS has continued to prioritize its kinship foster care program, recognizing that kin foster care placements often keep children in and/or connected to their communities of origin ([Figure 11](#)), help to reduce the trauma associated with removal, provide greater placement stability, and increase the likelihood of siblings being placed together. These kin placements also lead to fewer instances of institutional abuse and repeat maltreatment and improve mental and behavioral health and educational stability for children.

¹⁰⁵ Order on Motion for Miscellaneous Relief (June 18, 2026, Dkt. 412).

During the monitoring period, DSS's efforts to move toward a kin-first culture took a major step forward when Governor McMaster signed Senate Bill 415 into law.¹⁰⁶ SB 415 streamlined licensing and approval standards for kin caregivers and was the final step of a multiple-year effort by DSS to take advantage of a September 2023 change in federal regulations allowing state child welfare agencies to use separate licensing and approval standards for kin placements and to receive Title IV-E federal reimbursement for foster care board payments on behalf of otherwise eligible children who are placed in those homes.¹⁰⁷ Previously, state child welfare agencies could only claim Title IV-E reimbursement for foster care board payments if the agency applied the same licensing or approval standards to kin and non-relative foster homes. With the passage of SB 415, kin caregivers across South Carolina who are licensed or approved using kin-specific standards receive board payments equal to those received by non-relative foster parents.

DSS reports that its regional Foster Family and Licensing Support offices are working in conjunction with county DSS offices to conduct outreach to families regarding the kin-specific standards and the benefits of being licensed. Families who are interested are referred for provisional licensure while they complete the process.¹⁰⁸ DSS also reports that it is working in partnership with the American Bar Association's Center on Children and the Law to develop training designed to strengthen staff capacity to support kinship caregivers. It includes a family-centered curriculum that reflects the complexities kin face, including policy, licensing, financial responsibilities, and multigenerational dynamics. It emphasizes dignity-first, kin first principles, and uses consistent, interactive learning methods to prepare staff for both foundational concepts and technical aspects of family finding, engagement, placement, and permanency. DSS anticipates conducting a pilot of the training in November 2026 with full implementation occurring in 2027. Further, DSS is in the process of updating policies related to investigations, family preservation, and kinship to align with and reinforce the kin-first concepts included in the training. The hope is that the State's efforts to promote and support a kin-first culture will lead to an ever increasing number of children being placed with kin.

As the State continues to grapple with high rates of placement instability, it is important that it has measures in place to guard against moving back towards overreliance on congregate care for children of all ages. As noted, the FSA does not include specific targets for the placement of children aged 13 through 17 outside of congregate care settings. However, children in this age range are placed in congregate care at unacceptably high rates, with nearly 90 percent of these placements located outside of the child's county of origin as of March 31, 2026 ([Figure 11](#)).

¹⁰⁶ See 415, 126th Gen. Assemb., 1st Reg. Sess. (S.C. 2025), https://www.scstatehouse.gov/sess126_2025-2026/bills/415.htm and S. 598, 126th Gen. Assemb., 1st Reg. Sess. (S.C. 2025), https://www.scstatehouse.gov/sess126_2025-2026/prever/598_20250423a.htm.

¹⁰⁷ For information on separate licensing/approval standards for relative or kin family foster homes, see: <https://www.federalregister.gov/documents/2023/09/28/2023-21081/separate-licensing-or-approval-standards-for-relative-or-kinship-foster-family-homes>.

¹⁰⁸ Data on licensing status of kinship families is not currently available as DSS has transitioned to its new licensing system with Binti and while the technical connection is active, system integration beginning in June 2025 has produced inconsistencies, missing fields, and workflow-related data gaps that DSS is working to resolve.

Children aged 13 through 17 are also more likely to experience placement instability than younger children. Further, though the FSA does not require specific targets for placement of children aged 13 through 17 outside of congregate care settings, it does require—through provisions related to therapeutic foster care placement and services—that placement recommendations for children of all ages who have been identified as needing therapeutic placement and/or services be “*driven by the least restrictive, most normalized care philosophy suitable to a child’s individual needs and shall recommend placement of a child in the least restrictive family-like setting that preserves family and community connections*” (FSA IV.I.2.).¹⁰⁹

To increase the number of foster homes and therapeutic foster homes for youth aged 13 through 17, DSS reported that it is expanding targeted recruitment efforts beyond Richland County to Greenville, Charleston and Horry counties. These efforts will use a multi-faceted recruitment approach that incorporates social media outreach, community engagement, and data-driven targeting, and it will emphasize supporting current foster families and kinship caregivers. The 2026 year-end goal across the three counties is to recruit and license a total of 10 new foster families and 20 new therapeutic foster families who are willing to accept teens or sibling groups. Beginning in March 2026, DSS launched bi-monthly meetings with CPAs serving the three counties to discuss targeted recruitment strategies and establish internal goals for the calendar year.

¹⁰⁹ See: *Section IV.A.4. Therapeutic Placements* of this report for further discussion.

3. Juvenile Justice Placements

FSA Requirement	<i>When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or Department of Juvenile Justice that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement (FSA IV.H.1.).</i>
Performance Assessment	Not Reported: Performance data are not available.

The FSA prevents DSS from recommending to the family court or Department of Juvenile Justice (DJJ) that a Class Member remain in juvenile justice detention or another juvenile justice placement without pending charges or beyond the term of the Class Member's plea or adjudicated sentence because DSS does not have a foster care placement for the Class Member. The FSA further requires DSS to take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea and provide for the Class Member's appropriate placement.

Due to the lack of tracking data regarding these requirements, the Monitor has historically had to rely on reports from community members and limited information from DSS about practice and performance related to this FSA requirement.¹¹⁰ Because of the lack of data, the Monitor is again unable to assess DSS's performance on this FSA requirement for Monitoring Period 19 (October 2025 – March 2026) although anecdotal reports suggest that there are instances where children remain in DJJ custody because of the lack of an appropriate DSS placement

During this monitoring period, Monitor staff had a preliminary conversation with DSS about advancing collaboration with DJJ to obtain data necessary for assessing performance on this requirement. As an initial step, DSS reported that in early 2026, it worked with DJJ to create an overlap analysis of youth who were dually involved with the DSS foster care system and with DJJ. That analysis found that over a six-year period from 2020 through 2025, six percent of children served by DSS were also involved with DJJ. During the next monitoring period (MP20), the Monitor and DSS will discuss these data, their implications, and identify next steps to acquire the data

¹¹⁰ In November 2022, the Co-Monitors and DSS, with the South Carolina DJJ's permission and collaboration, published a report of findings from their joint comprehensive review of the experiences of children involved with both DSS and DJJ. To view the report, including key findings and recommendations, see: <https://cssp.org/wp-content/uploads/2025/03/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf>.

needed for measurement of performance on this FSA requirement and the development of efforts to more appropriately serve children.

Discussion

As part of its Teaming for Teens work in Greenville, Anderson, and Spartanburg counties, DSS holds Removal Prevention CFTMs to reduce the number of unnecessary entries of DJJ-involved youth aged 13 through 17 into foster care, which can include entries due to EPCs by law enforcement and the DJJ court.¹¹¹ DSS reported that during Monitoring Period 19 (October 1, 2025 – March 31, 2026), these three counties held Removal Prevention CFTMs for 32 youth, and of those, 19 (59%) did not enter foster care during the 30-day period following the CFTM.¹¹² DSS also reported that it is collaborating with the Department of Children's Advocacy (DCA) and DJJ on a plan for DCA staff to assume responsibility for facilitating Removal Prevention CFTMs for when the DJJ-referred youth is not involved with DSS.¹¹³ DSS has informed the Monitor that implementation is expected in November 2026.

¹¹¹ Note: through Teaming for Teens, Removal Prevention CFTMs, are held for youth aged 13-17 who are DJJ-involved. In Richland County, Removal Prevention CFTMs are used more broadly to prevent entries to foster care of children of all ages and who may or may not be involved with DJJ. See: *Section IV.A.1. Placement Instability* of this report discussing the use of Removal Prevention CFTMs in Richland County.

¹¹² CAPSS data provided by DSS.

¹¹³ Letter from J. Michael Montgomery Providing Information Required by October 15, 2025 Order (Dkt. 381) prior to April 17, 2026 Status Conference (April 10, 2026, Dkt. 401).

4. Therapeutic Placements

The FSA requires DSS to promptly and appropriately identify and address Class Members' needs for therapeutic placements and/or services in the least-restrictive, family-like setting that preserves family and community connections. The Parties successfully negotiated a joint motion to modify FSA Section IV.I., Therapeutic Foster Care Placements and Services, and the Court approved the modified requirements on November 1, 2024. The modified requirements are intended to ensure that children identified as needing therapeutic placements and/or services are referred to and receive appropriate services in a timely manner and receive updated assessments at least annually, following a placement disruption, or following a material change in their needs. The modified FSA further requires that recommendations for therapeutic placements and/or services *"be driven by the least restrictive, most normalized care philosophy suitable to the child's individual needs and shall recommend placement of a child in the least-restrictive family-like setting that preserves family and community connections"* (FSA IV.I.2.).

The modified FSA also required DSS, in collaboration with the Monitor, to develop and implement a quality service review process to establish baseline data on DSS's assessment and provision of therapeutic placements and/or services to children in foster care. These baseline data were used to establish interim performance benchmarks, inform the final objective target measure, and outline the timeframe for achieving FSA requirement IV.I.6.

During MP18 (April - September 2025), DSS and the Monitor developed and implemented the quality service review process. The baseline review found that 47 percent of children in the sample were determined to have received therapeutic placements and/or services in the least-restrictive setting consistent with their needs.¹¹⁴ This baseline informed the development of interim performance benchmarks for the first and second successive 12-month review periods, as discussed in the MP18 report.

¹¹⁴ The baseline was established using 66 children with a final Child and Adolescent Needs and Strengths tool (CANS) completed in September 2024 recommending therapeutic placement and a subsequent CFTM. Seventeen children (26%) were placed in the CANS-recommended level within 60 days. A qualitative review of 23 of the remaining 49 children found that 14 received placements and/or services consistent with their needs in the least-restrictive setting. Combined quantitative and qualitative findings established a baseline DSS performance of 47% (31 of 66 children).

FSA Requirement	<i>At least 95% of Class Members that are both identified through an approved CANS (with fidelity to the CANS model) as needing therapeutic placement and/or services and recommended for specific therapeutic placement and/or services during a Child and Family Team Meeting (CFTM) (with fidelity to the CFTM model) will be referred for such recommended placement and/or services within 30 days of the date of the CFTM. The recommendation(s) may include but are not limited to diagnostic assessment; community support services; rehabilitative behavioral health services; therapeutic foster care; moderate, enhanced, or Q RTP levels of group care; and placement in a psychiatric residential treatment facility. If a non-family-based placement is recommended, it shall identify why the youth's needs cannot be met in a family setting. The placement recommendation shall be driven by the least restrictive, most normalized care philosophy suitable to the child's individual needs and shall recommend placement of a child in the least restrictive family-like setting that preserves family and community connections. If a Class Member is placed in congregate care because a less restrictive, family-like setting to meet their individual needs is unavailable, then that placement shall be considered inconsistent with the child's needs under this Section (FSA IV.1.2.).</i>
Performance Assessment	FSA Requirement Not Reported: Performance data will be reported annually beginning with MP20.
FSA Requirement	<i>At least 95% of Class Members identified through an approved CANS and a Child and Family Team Meeting as needing therapeutic placement and/or services shall receive an updated assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs. The updated assessment will re-invoke the processes in 1.2, consistent with DSS policies case planning and assessment (FSA IV.1.3.).</i>
Performance Assessment	FSA Requirement Not Reported: Performance data will be reported annually beginning with MP20.
FSA Requirement	<i>At least 90% of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS' case and service plan within sixty (60) days following the date of the CFTM during which the recommendations were made (FSA IV.1.6.).</i>

	<u>Interim Benchmarks for the First Successive 12-Month Period of Review:</u> • 60 percent of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS's case and service plan within 60 days following the date of the CFTM during which the recommendations were made. • 70 percent of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS's case and service plan within 90 days following the date of the CFTM during which the recommendations were made.
Performance Assessment	FSA Interim Benchmarks Not Reported: Performance data will be reported annually starting in MP20.

During Monitoring Period, the Monitor and DSS modified the qualitative review methodology based on lessons learned from the baseline review and implemented the revised methodology to measure DSS's performance on the first successive 12-month interim benchmarks. The revised methodology includes enhancements to the sampling plan to improve the representativeness of the review sample and the addition of virtual interviews with caregivers, children (when age and developmentally appropriate), Guardians ad Litem (GALs), and service providers. A total of 50 cases will be reviewed over the 12-month period, with 25 cases reviewed during each monitoring period beginning with MP19. These enhancements are intended to strengthen the quality, depth, and reliability of the information collected through the review process. Insights and lessons learned from the review of the first 17 cases are included below. Performance will be reported based on the review of all 50 cases in the next monitoring report.

The review examined whether children identified through the Child and Adolescent Needs and Strengths tool (CANS) and CFTM as needing therapeutic placements and/or services:

- Were referred to appropriate therapeutic placements and/or services within 30 days of the CFTM;
- Received the recommended therapeutic placements and/or services within 60 days of the CFTM;
- Received updated assessments at least annually, following a placement disruption, or following a material change in their needs; and
- Received placements and services that appropriately addressed their therapeutic needs in the least-restrictive, family-like setting that preserved family and community connections.

The review universe was developed using CAPSS data from DSS. Of the 255 children who entered foster care during October 2025, eligibility criteria were applied to identify children who: (1) remained in care for at least 90 days; (2) had a finalized CANS recommending a therapeutic placement; (3) had a CFTM; and (4) remained in foster care as of June 1, 2026. These criteria resulted in a universe of 49 eligible Class Members.

From this universe, a sample of 25 children was selected using a stratified random sampling approach. Sampling categories were designed to ensure representation across key demographic and geographic characteristics, including the state's four geographic regions; county classification (urban, medium, and rural); race and ethnicity, gender; and age groups (0-2, 3-6, 7-12, and 13-17).

The review was conducted by a team of two reviewers using case record reviews and remote interviews conducted by videoconference or telephone. Reviewers examined relevant case documentation, including CANS, CFTMs, placement information, service referrals, and case plans, among other relevant documentation. Virtual interviews were conducted with case managers and team leaders, caregivers, children (when age and developmentally appropriate), GALs, and therapeutic service providers to obtain additional information regarding the child's therapeutic needs, experiences with placement and services, and progress toward meeting identified therapeutic needs.

Of the 25 children included in the sample, 17 children's cases were reviewed. The remaining eight cases could not be completed due to challenges obtaining participation from prospective interviewees, including limited responses to interview requests.¹¹⁵ Opportunities to replace unavailable cases were limited due to the small size of the universe. Additionally, the revised quality service review methodology was implemented within a condensed timeframe, which presented challenges related to scheduling interviews, completing case reviews, and establishing reviewer familiarity with the revised process. As this was the first implementation of the revised methodology, DSS and the Monitor identified areas for continued refinement of the methodology, strengthening of reviewer capacity, clarification of review procedures, and improvement of processes to support timely completion and consistency in future reviews. The insights and lessons learned below are based on the 17 cases reviewed.

Demographic Overview of Children Included in the Sample

The 17 children whose cases were reviewed entered care in October 2025 and represented a range of demographic characteristics ([Figure 40](#)) and placement experiences.

Placement instability was evident across all cases reviewed. All 17 children (100%) experienced two or more placements within the six-month period between October 1, 2025 and March 31, 2026, and more than half of the children whose cases were reviewed (10 of 17, 59%) experienced four or more placement moves during that same period ([Figure 41](#)).

¹¹⁵ Note: 33 cases will be included in the next review to ensure the full 50 case sample is completed for performance measurement and reporting in the next monitoring period.

Figure 40. Children Included in the Therapeutic Placements and/or Services Review, by Age, Sex, Region, and Race

MP19 (October 2025 - March 2026)

Source: CAPSS data provided by DSS

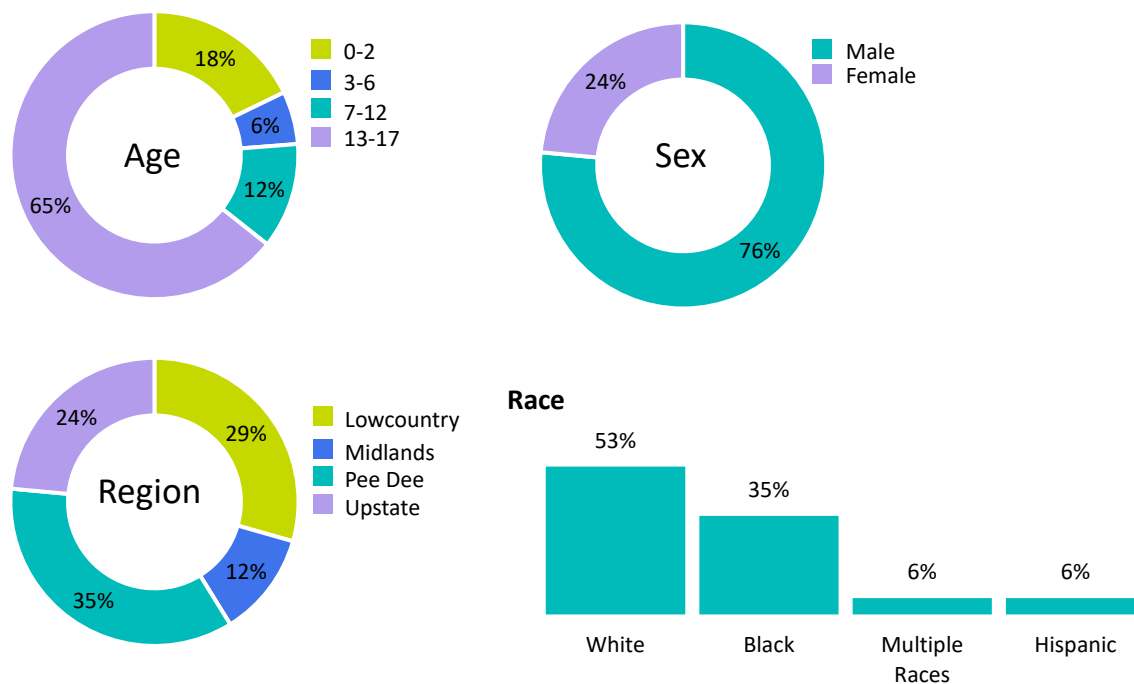
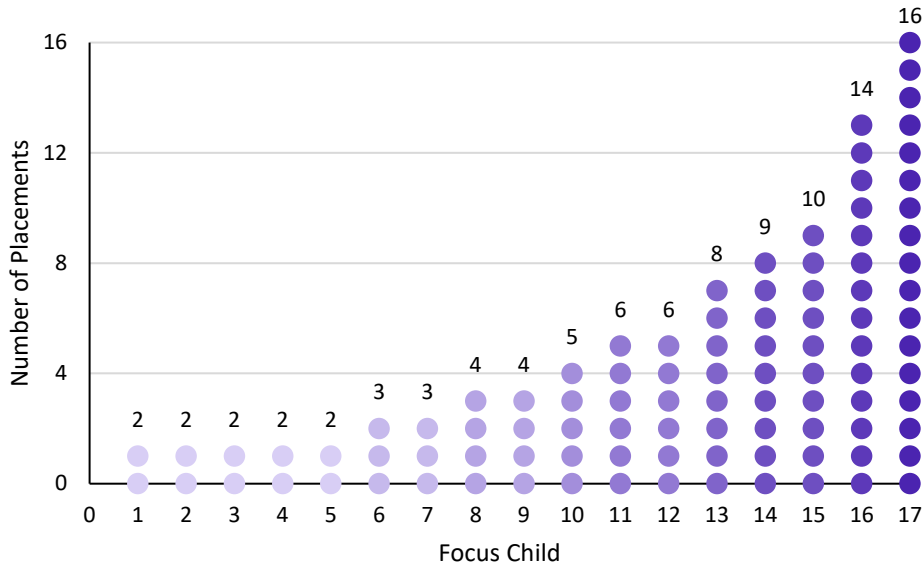


Figure 41. Children Included in the Therapeutic Placements and/or Services Review, by Number of Placements

MP19 (October 2025 - March 2026)

Source: CAPSS data provided by DSS



Assessment and Reassessment of Therapeutic Needs

Of the 17 children whose cases were reviewed, 14 (82%) had finalized initial CANS assessments completed within the required 30 days from entry into foster care that recommended therapeutic placement. The review examined whether children received updated assessments when required, including following a placement disruption and following a material change in their needs. Because all 17 children entered foster care in October 2025, none had reached the 12-month annual reassessment timeframe at the time of the review. Therefore, the annual reassessment component of the requirement could not be assessed. However, nine of the 17 children (53%) had a documented CANS reassessment following a material change in either placement or their needs at the time of review.

The review also examined the CFTM process used to identify and address children's therapeutic needs, including whether the CFTMs were conducted with fidelity to DSS policy, the type of CFTM conducted, and whether recommendations for therapeutic placement and/or services were documented. Of the 17 children whose cases were reviewed, 12 (71%) were determined to be conducted with fidelity to DSS policy. The review found variations in the type of CFTM conducted, including initial, 25-day, 90-day, and placement CFTMs. Fifteen of 17 CFTMs were facilitator led. Recommendations for therapeutic placement and/or services were documented in 12 of the 17 cases reviewed (71%).

Children's identified therapeutic needs varied. The most frequently identified needs included occupational therapy, speech therapy, physical therapy, individual counseling, trauma-focused

therapy, medication management, and behavioral modification. Other identified needs included anger management, group therapy, Multisystemic Therapy (MST), neurology services, and specialized medical services and equipment for medically fragile children with limited mobility.

Timeliness of Referrals for Therapeutic Placements and/or Services

The review examined whether children with documented recommendations for therapeutic placements and/or services from the CFTM were referred to the recommended placement and/or service within 30 days of the CFTM. Of the 12 children with documented recommendations within the CFTM, 10 (83%) received referrals within the required 30-day timeframe.

Timeliness of Receipt of Therapeutic Placements and/or Services

The review examined whether children with documented recommendations for therapeutic placements and/or services in the CFTM received the recommended placement and/or services within 60 and 90 days of the CFTM. Of the 12 children with documented recommendations within the CFTM, nine (75%) received the recommended placement and/or service within 60 days from the CFTM in which the recommendations were made. The same nine children (75%) met the 90-day benchmark with no additional children receiving the recommended placements and/or services within 60 or 90 days after the CFTM in which the recommendations were made.

The review identified several barriers that affected timely access to recommended therapeutic placements and/or services. The most frequent was placement instability and continuity of services and limited availability of services, including provider waitlists and delays in securing appointments. Other barriers included difficulties obtaining vital records, medical records, and assessments; travel distance and limited availability of providers within reasonable proximity to the child's placement; scheduling challenges; caregiver engagement; authorization and financial barriers; providers declining placements based on information documented in the Universal Application; limited availability of providers accepting Medicaid; provider staffing and availability, including staff absences due to illness; and challenges related to cultural responsiveness of services.¹¹⁶

Placement in the Least-Restrictive, Family-Like Setting Aligned with Therapeutic Needs

The review examined whether children received needed therapeutic placements and services in the least-restrictive, most normalized, family-based setting that preserved family and community connections and whether children were placed in congregate care because a less-restrictive, family-like setting was unavailable to meet their therapeutic needs. Of the eight cases with documented placement recommendations in the CFTM, upon which performance for this benchmark is based, all eight (100%) were determined to have received the needed therapeutic

¹¹⁶ The Universal Application is a form used by DSS that provides information about a child's strengths, needs, history, placement considerations, and other relevant characteristics to inform placement decisions and assist providers in determining whether a placement is appropriate.

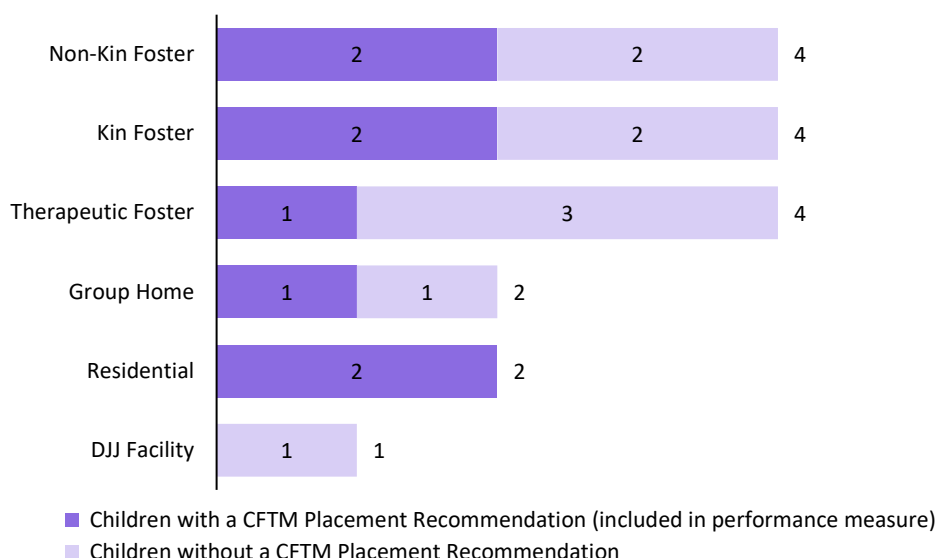
placement and services in the least-restrictive setting that aligned with their needs. None of the eight children were placed in congregate care during the review period because a less-restrictive, family-like setting was unavailable to meet their therapeutic needs.

Among all 17 children whose cases were reviewed, regardless of whether a specific placement recommendation was documented in the CFTM, 12 (71%) were placed in a family-like setting aligned with their identified therapeutic needs within 60 days of the CFTM ([Figure 42](#)).

Figure 42. Children Included in the Therapeutic Placements and/or Services Review, by Placement Type 60 Days from the CFTM

MP19 (October 2025 - March 2026)

Source: CAPSS data provided by DSS



Children's Voices

Of the 17 children whose cases were reviewed, 10 children were interviewed based on age and developmental appropriateness. Of the 10 children interviewed, eight (80%) reported feeling safe and well-cared for, and seven (70%) reported that their needs were being met where they were placed at the time of the review. Children generally described the CFTM process as helpful, noting that it provided them with an opportunity to share their perspective and inform decisions affecting them. Children also identified challenges related to maintaining connections to family, friends, and their communities in addition to challenges related to continuity of education. Only two (20%) children reported that their placement at the time of the review was near community, family, and friends, and seven (70%) reported experiencing school disruptions or changes because of their placement. Seven of the 10 (70%) children interviewed reported that the therapeutic services they received had been helpful, while others described challenges related to insurance coverage and communication among providers. Children's comments included:

“Therapy has been difficult. I don’t want to talk about things but know I should.”

“Things I didn’t understand, they broke...down, and that helped me understand. The CFTM meeting kept me in the know. I felt heard; no one talked when I was talking. They listened to me. They did not respond sarcastically. It made me feel good—it was the only time I felt my voice was heard.”

“I really like my placement. The people are amazing, and it is really fun.”

Caregivers’ Experiences

Of the 17 caregivers interviewed, 11 (65%) reported that the child’s therapeutic needs were clearly explained to them. Most of the caregivers, (88%, 15) reported positive communication with both therapeutic service providers and DSS staff. Caregivers described communication, collaboration, and follow-through among members of the child’s team as important contributors to effective service delivery and their ability to meet children’s therapeutic needs. Caregivers also identified challenges when agreed-upon supports or services were delayed or when information about the child’s needs was not available at the time of placement. Caregivers’ comments included:

“I didn’t have any paperwork on the child when he was dropped off — no emergency information and no information about his needs. All information we got came from the CPA.”

“Best DSS worker ever— so helpful. She comes by every month and will email to ask how everyone is doing. There is a store close to the DSS office, and she offers to pick up walkers, etc. The DSS worker has even helped with other children in my care.”

“It’s been great. In-person communication weekly with the therapist —both before and after the session.”

“The CFTM process can be helpful when all participants communicate honestly, work collaboratively, and follow through with agreed-upon actions. Without consistent accountability and implementation, however, the effectiveness of the meetings is significantly reduced.”

Discussion

The review identified areas of strength as well as opportunities to bolster systems and practices supporting the therapeutic needs of children in foster care. Children interviewed generally reported feeling heard and supported in addressing their therapeutic needs. Caregivers generally described positive relationships and communication with DSS staff and service providers. These experiences suggest that consistent communication, coordination, and support can promote engagement in case planning and help caregivers meet children’s therapeutic needs and maintain placement stability. The use of family-like placements, including kinship placements when appropriate, was also identified as a strength, consistent with findings from the baseline review.

Several key insights and opportunities for improvement emerged from the review:

- *Strengthening the connection between assessment, CFTM decision-making, and case planning.* The review identified an opportunity to strengthen how information from the CANS and ongoing formal and informal assessments are incorporated into CFTMs and case plans. Practice guidance, documentation, and supervision could more clearly support teams in linking identified therapeutic needs to specific recommendations, responsible parties, and follow-up actions.
- *Improving therapeutic service network adequacy and access.* Barriers identified through the review, including provider availability, waitlists, authorization requirements, geographic distance, scheduling, and limited specialized services, highlight the need to assess the adequacy and accessibility of the therapeutic service network and address gaps.
- *Strengthening placement matching, stability, and continuity of care.* Placement instability was a factor in all 17 cases reviewed. Opportunities for improvement include examining: placement matching processes, the availability of therapeutic family-based placements, and information and support provided to prospective caregivers following placement. Given the potential impact of placement instability on children's relationships, education, and therapeutic progress, DSS should consider strategies to improve placement stability and continuity of care.
- *Strengthening teaming and shared accountability.* Effective coordination among DSS staff, children and families, caregivers, service providers, CPAs, GALs, and other Child and Family Team members is essential to ensuring shared understanding of children's needs and recommended therapeutic placements and/or services. Opportunities for improvement include strengthening expectations for communication and participation and establishing clear accountability for follow-through on recommendations and agreed-upon actions.

DSS's ongoing implementation of the GPS Case Practice Model provides an opportunity to address these areas through practice guidance, supervision, workforce development, service network planning, and strengthened coordination with caregivers, CPAs, and therapeutic service providers. DSS is incorporating these strategies into forthcoming revisions to its Placement Implementation Plan.

B. Case Manager Caseloads and Contacts with Children

A sufficient, qualified, and trained workforce with manageable caseloads is foundational to a well-functioning child welfare system. Case managers must have the resources and support that allow them to conduct meaningful contacts with children and families, assess children's safety and risk of harm, support regular family visits, and monitor progress towards individualized case goals, among many other important tasks. Child welfare agencies must ensure that the appropriate number and types of positions — including case managers, team leaders, and support staff — are allocated within each region and county office so that caseloads are manageable, staff feel supported, and vacancies are quickly filled with as little disruption as possible to children, families, and co-workers.

1. Caseloads and Workloads

Caseload and Workload Limits for Out of Home Abuse and Neglect (OHAN), Permanency Specialist, and Foster Care Case Managers

FSA Requirement	<i>At least 90% of Workers and Worker supervisors shall have a workload within the applicable Workload Limit (FSA IV.A.2.(b)).</i>
Performance Assessment	FSA Requirement Partially Met: - OHAN: 100% of case managers and 100% of team leaders met the standard. - Foster care: 83% of case managers and 90% of team leaders met the standard. - Permanency: 70% of case managers and 90% of team leaders met the standard.

The FSA requires that at least 90 percent of case managers have caseloads and 90 percent of team leaders have workloads within the standard.¹¹⁷ For the purpose of communicating performance on workload-related FSA measures, “caseload” is used throughout this report to refer to the work of case-carrying staff with at least one Class Member on their caseload, while “workload” is used to refer to the work of team leaders supervising case-carrying staff with at least one Class Member on their caseload. The Workload Implementation Plan, approved by the Co-Monitors and the Court, set the final targets for caseloads and workloads.¹¹⁸ Approved standards differ between case managers and team leaders, by worker type (foster care, permanency, or Out of Home Abuse and Neglect (OHAN)), and by length of time employed ([Table 2](#)).

¹¹⁷ The FSA uses the term “supervisor” to refer to DSS staff who oversee case-carrying staff. As part of its GPS Case Practice Model development and work to define enhanced job expectations, DSS, as of May 2023, uses the term “team leader” for this role.

¹¹⁸ To view the Workload Implementation Plan, see: <https://dss.sc.gov/media/i3qlwxka/dss-workload-implementation-plan.pdf>.

To assess compliance, DSS's ADR selected a random day in each month of Monitoring Period 19, in addition to the final day of the monitoring period (March 31, 2026), to measure case manager caseloads and team leader workloads. While ADR and the Monitor assessed performance monthly, only performance data for March 31, 2026, are reported in this report.¹¹⁹

Table 2. Caseload and Workload Standards, by Worker Type

Source: Approved DSS Workload Implementation Plan (February 2019)

Worker Type	Standard	Standard for New Case Managers ¹²⁰	More than 125% of Standard
Case Manager Caseloads			
Foster Care ¹²¹ (ratio of case manager to children)	1:15	1:8	> 18 children
Permanency (ratio of case manager to children)	1:15	1:8	> 18 children
OHAN (ratio of case manager to investigations)	1:8	1:4	> 10 investigations
Team Leader Workloads			
Foster Care (ratio of team leader to case managers)	1:5	N/A	> 6 case managers
Permanency (ratio of team leader to case managers)	1:5	N/A	> 6 case managers
OHAN ¹²² (ratio of team leader to case managers)	1:6	N/A	> 7 case managers

¹¹⁹ The random dates that caseloads were validated this monitoring period were October 27, 2025; November 18, 2025; December 12, 2025; January 5, 2026; and February 13, 2026. Although only March 31, 2026, data are reported, the Monitor reviewed performance data for each month during the monitoring period; performance for any given team fluctuated a maximum of 6 percentage points across the monitoring period.

¹²⁰ "New case managers" refers to those case managers who have been employed less than 6 months since completing Child Welfare Pre-Service Certification training.

¹²¹ DSS has many staff with "mixed" caseloads that include different types of cases involving both Class and Non-Class Members. On December 21, 2017, the Co-Monitors provisionally approved DSS's proposal to calculate caseloads for foster care case managers with mixed caseloads by adding the total number of children in foster care (Class Members) they serve to the total number of families (cases) of Non-Class Members also served. The following types of cases are currently counted by family (case): CPS investigations; family preservation; other child welfare services; and those involving a child subject to the Interstate Compact on the Placement of Children. This methodology is only applied to foster care case managers with mixed caseloads and is not applied to permanency specialist or OHAN case managers.

¹²² The Co-Monitors approved a higher workload standard for OHAN team leaders in recognition of the fact that the OHAN case managers they supervise have lower caseload standards than other direct service case managers.

On the last day of the monitoring period (March 31, 2026), 83 percent of foster care case managers (264 of 320), 70 percent of permanency specialist case managers (58 of 83), and 100 percent of OHAN case managers (32 of 32) had caseloads within the applicable limit ([Figure 43](#)). With the exception of OHAN case managers that maintained performance at 100 percent, caseload compliance of all other case managers decreased in MP19 compared to the prior monitoring period. However, Monitoring Period 19 (October 2025 – March 2026) notably marked the first time in which all team leaders met the FSA requirement ([Figure 44](#)). Overall, the State has demonstrated progress and has partially met this FSA requirement.

Figure 43. Caseloads within the Required Limits, by Case Manager Type

MP16 – 19 (September 2024 – March 2026)

Source: CAPSS data provided by DSS

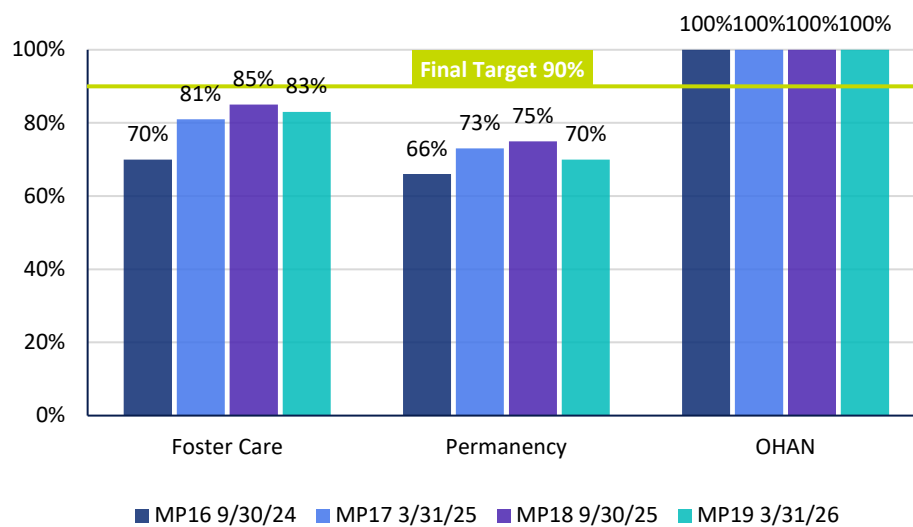
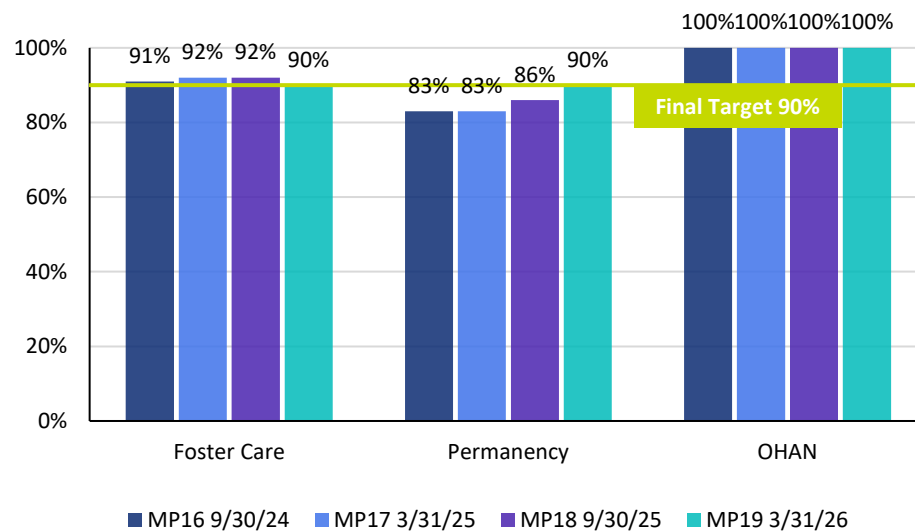


Figure 44. Workloads within the Required Limits, by Team Leader Type*MP16 – 19 (September 2024 – March 2026)*

Source: CAPSS data provided by DSS



It is important to note that overall performance for foster care case managers is based on two different standards – one for new case managers, who are within six months of having completed the required Child Welfare Pre-Service Certification training, and one for those who have been employed for six months or longer since completing the training. These graduated caseload standards are important quality of practice and staff retention strategies, allowing new staff the time to develop their skills and learn how to practice in accordance with the GPS Case Practice Model before acquiring a full caseload.¹²³ Data regarding caseload compliance for both sets of case managers were analyzed.

On March 31, 2026, there were 39 new foster care case managers; 79 percent (31 of 39) had caseloads within the standard, a decrease from 84 percent (43 of 51) on the last day of MP18. In MP19, among the 281 foster care case managers who had completed Child Welfare Pre-Service Certification training more than six months prior, 233 (83%) had caseloads within the standard, a slight decrease from MP18. As of the last day of Monitoring Period 19, of the 3,314 total Class Members, there were 737 Class Members who were served by case managers with caseloads above the required standard; this represents just over one in four children.

As of the last day of Monitoring Period 19, 14 counties performed below the FSA target for caseload compliance among foster care case managers. Caseloads among the 10 counties with the lowest rates of compliance ranged widely; in Berkeley County 100 percent of foster care case

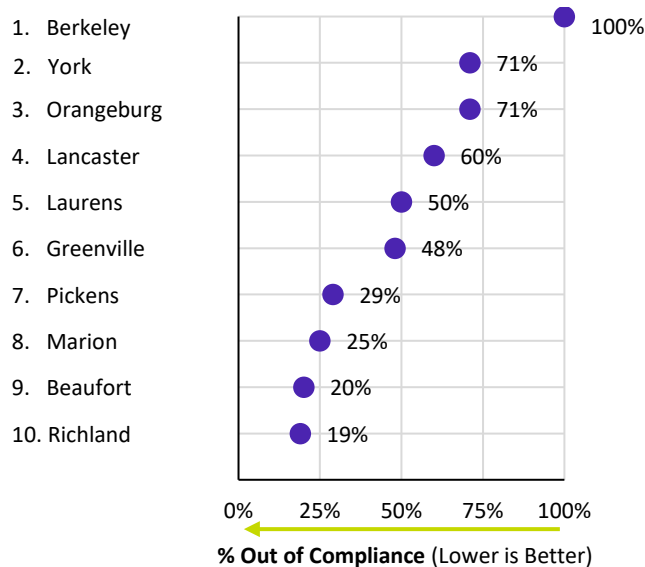
¹²³ To view the GPS case practice model, see: <https://dss.sc.gov/media/hnegmcwl/gps-practice-model-final-may-2023.pdf>.

managers were *not* in compliance with the caseload standard, while in Richland County 19 percent of foster care case managers were out of compliance with the caseload standard ([Figure 45](#)).¹²⁴

Figure 45. Counties with the Highest Percentage of Foster Care Case Managers Out of Compliance with Caseload Standards

March 31, 2026

Source: CAPSS data provided by DSS



¹²⁴ See [Table 12](#) in Appendix D showing these data for all South Carolina counties.

FSA Requirement	<i>No Worker or Worker's supervisor shall have more than 125% of the applicable Workload Limit (FSA IV.A.2.(c)).</i>
Performance Assessment	FSA Requirement Partially Met: • OHAN: 0 (of 32) case managers and 0 (of 6) team leaders were above 125% of the standard. • Foster care: 20 (of 320) case managers and 1 (of 123) team leaders were above 125% of the standard. • Permanency: 13 (of 83) case managers and 0 (of 21) team leaders were above 125% of the standard.

The FSA requires that case managers and team leaders do not carry caseloads or workloads over 125 percent of the applicable caseload limit. On March 31, 2026, no OHAN case manager had a caseload over 125 percent of the applicable caseload limit. Six percent of foster care case managers (20 of 320) had caseloads over 125 percent of the limit and 16 percent of permanency specialist case managers (13 of 83) had caseloads over 125 percent of the limit ([Figure 46](#)). On March 31, 2026, there were no OHAN team leaders or permanency specialist team leaders with a workload over 125 percent of the applicable limit, and there was only one foster care team leader (of 123, or 1%) over 125 percent of the limit ([Figure 46](#)). Overall, the State made slight progress towards meeting this FSA requirement in comparison to the prior period.

Figure 46. Case Managers and Team Leaders with More than 125% of the Caseload or Workload Limit

March 31, 2026

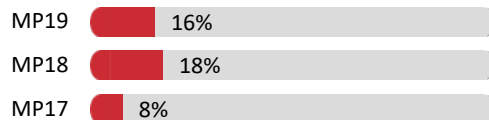
Source: CAPSS data provided by DSS

Case Managers Over 125% Caseload Limit

Foster Care



Permanency



OHAN



Team Leaders Over 125% Workload Limit

Foster Care



Permanency



OHAN



The Workload Implementation Plan states that team leaders should not be directly responsible for carrying cases, with certain exceptions.¹²⁵ Data were analyzed regarding the number of team leaders who were directly responsible for cases in addition to overseeing a team of case managers. As of March 31, 2026, there were 23 team leaders statewide carrying a total of 107 cases.¹²⁶ These team leaders worked across 14 of the 46 county offices and two of the Regional Permanency offices in the state and carried between one to 14 cases each. On average, cases were open for 123 days, while nine cases were open for longer than one year, including one case that was open for 882 days (or two and a half years).¹²⁷

Discussion

During Monitoring Period 19, DSS demonstrated mixed performance in meeting caseload and workload requirements. Team leaders met the target of having workloads within the standard for the first time since monitoring began. At the same time, the percentage of foster care and permanency specialist case managers with caseloads within the standard declined for the first time in four monitoring periods. Overall, fewer case managers had caseloads above 125 percent of the limit as of the last day of MP19. As compliance of foster care and permanency specialist case managers decreased in MP19, so did the total number of case managers employed by DSS. In MP18, there were 452 case managers employed across Permanency, Foster Care, and OHAN teams; in MP19, this total dropped to 435.

Despite the varied performance in caseload and workload compliance for Monitoring Period 19, the State has demonstrated considerable improvement over time. For example, in March 2022, only 37 percent of OHAN case managers, 42 percent of foster care case managers and 49 percent of permanency specialist case managers were within the standard. In its April 10, 2026 Data Submission to the Court, DSS attributed this progress toward hiring and training workers and

¹²⁵ Note: in accordance with the Workload Implementation Plan, team leaders are not intended to carry cases. There are limited exceptions in which DSS has identified situations where it may be necessary for team leaders to be directly responsible for cases for short periods of time. When a case manager is promoted to team leader, they may retain case management responsibilities for up to 45 days if a case is nearing closure, there are complexities regarding the case that need to be addressed, or an important legal event will occur within the timeframe. When cases are being transferred from one case manager, office, unit, or program area to another, the case may be temporarily assigned to the receiving team leader for up to 5 days until the team leader assigns the case to the receiving case manager. DSS has also identified that team leaders sometimes carry cases when a case manager leaves the agency and creates a vacancy that takes some time to fill or when case managers are on extended leave. While the team leader is directly managing, or “carrying” a case, they are responsible for all required case duties, including visits with the child; monitoring the child’s safety, placement, well-being, case plan, and service delivery; ensuring the child is visiting with their siblings and/or parent(s); and other activities as necessary. DSS requires Regional Director approval for team leaders to carry cases for more than 5 days and documentation of the case(s) the team leader will carry, the circumstances leading to the team leader carrying cases, and a specific plan and timeline be created to address the issue. This documentation must be shared with DSS’s ADR unit. At this time, DSS has provided documentation for a small fraction of team leaders carrying cases, and the Monitor cannot determine if exceptions apply.

¹²⁶ CAPSS data provided by DSS.

¹²⁷ The case opened for 882 days was a permanency case.

reducing worker turnover in part, to implementation of the court-ordered salary plan which has raised worker compensation.¹²⁸ Although for several years these efforts have been aided by additional financial resources for child welfare services provided by the state legislature, \$13.7 million in additional funding requested by DSS to support salaries, staffing, and training was not included in the 2026 – 2027 Appropriations Act. The lack of additional resources may hamper DSS's ability maintain the gains it has made and to address remaining challenges in creating and sustaining a skilled and stable workforce and in ensuring that all workers have caseloads that permit them to practice in accordance with DSS's GPS Case Practice Model. Case practice challenges include mentoring and training case managers to work as a team engaging children, families, and others who support them; and assessing the underlying needs of children and families so that interventions can be appropriately tailored and matched to meet those needs.

To address these challenges, DSS reported that it has invested in an array of activities aimed at supporting new and existing staff.¹²⁹ Efforts to recruit new staff included partnering with universities and targeting participation in career fairs in counties with the highest worker vacancy rates. In addition, 46 interns from 25 different colleges and universities were placed within DSS Child Welfare Services for the Fall 2025 semester, and 36 students interned for the Spring semester ending in May 2026. Efforts to support staff retention included making counseling services and trauma support available; compensating workers for engaging in peer support; expanding performance coaching to bolster the growth and development of new staff; and offering additional opportunities for leadership development and real-world application of skills. Further, DSS reported continuing to allocate funding to increase recruitment and retention through tuition assistance and reimbursement programs.

High rates of placement instability increase the demands on case managers who must handle the stress and workload involved with supporting children who do not have stable placements. These demands, which became acute in Richland County but persist throughout the state, include late-night hours requiring staff to respond to and transport children without placement, sometimes shuttling children to and from night-to-night emergency placements, creating an additional burden on staff and additional instability for children. To address the implications of these late-night work hours on staff wellness and address the goals as outlined in the Richland County Improvement Plan, RCDSS hired six case management staff in June 2025 specifically dedicated to working eight-hour second and third shifts in Richland County, some falling outside of normal business hours, to help reduce reliance on first-shift case managers for after-hours calls. DSS reported in their monthly Richland County update to the court that staff for all six positions completed certification training in October 2025.¹³⁰ In the months following, DSS reported an overall reduction in the total number of days each month in which staff were called in for after-hours and weekend duty, with no more than three staff members called in any month.

¹²⁸ Letter from J. Michael Montgomery Providing Information Required by October 15, 2025 Order (Dkt. 381) prior to April 17, 2026 Status Conference (April 10, 2026, Dkt. 401).

¹²⁹ Ibid.

¹³⁰ Letter from DSS Providing Update Pursuant to Order EFC 348 (July 15, 2026, Dkt. 413).

2. Case Manager Contacts with Children

FSA Requirement	<i>At least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place (FSA IV.B.2.).</i>
Performance Assessment	FSA Requirement Not Met: 42% of children (143 of 344) had the required number of contacts with their assigned case manager.
FSA Requirement	<i>At least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child (FSA IV.B.3.).</i>
Performance Assessment	FSA Requirement Met: Among children who had the required number of contacts with their assigned case manager, 69% (238 of 344) of contacts took place in the residence of the child.

The FSA requires that at least 90 percent of Class Members receive a minimum of one in-person contact each month with their assigned case manager and that at least 50 percent of these monthly contacts occur in the child's residence. Only contacts that include all the required elements established by DSS policy are counted toward compliance for this FSA commitment.^{131,132} According to DSS policy, monthly case manager contacts must include: (1) an interview with the child alone, away from both the caregiver and other children in the home, when age and developmentally appropriate; (2) an assessment of the child's safety, including the caregiver's ability to meet the child's needs; (3) an assessment of progress towards legal and relational permanency; (4) an assessment of the child's well-being, including the child's physical, emotional, behavioral, and educational status; and (5) an assessment of case planning and services including progress, challenges, effectiveness and appropriateness of services, needed adjustments to the case plan, and next steps.¹³³ Case managers are required to document these activities in CAPSS to demonstrate that the required elements of the contact occurred, including the location and circumstances of the contact, and a summary of the discussions and observations.

DSS's performance in meeting FSA requirements for case manager contacts with children has not been measured since MP10 when, by agreement of the Parties, measurement toward

¹³¹ SCDSS Policies and Procedures Manual: Child Welfare Services, Chapter 5: Foster Care, Policy 570: Case Manager Contact with a Child, Youth, or Young Adult (effective October 1, 2020).

¹³² To view the Visitation Implementation Plan, see: <https://dss.sc.gov/media/4evhcpy/3-28-2019-final-dss-visitation-implementation-plan.pdf>.

¹³³ SCDSS Policies and Procedures Manual: Child Welfare Services, Work Aid 5.5: Case Manager Contact with a Child, Youth, or Young Adult (effective May 1, 2021).

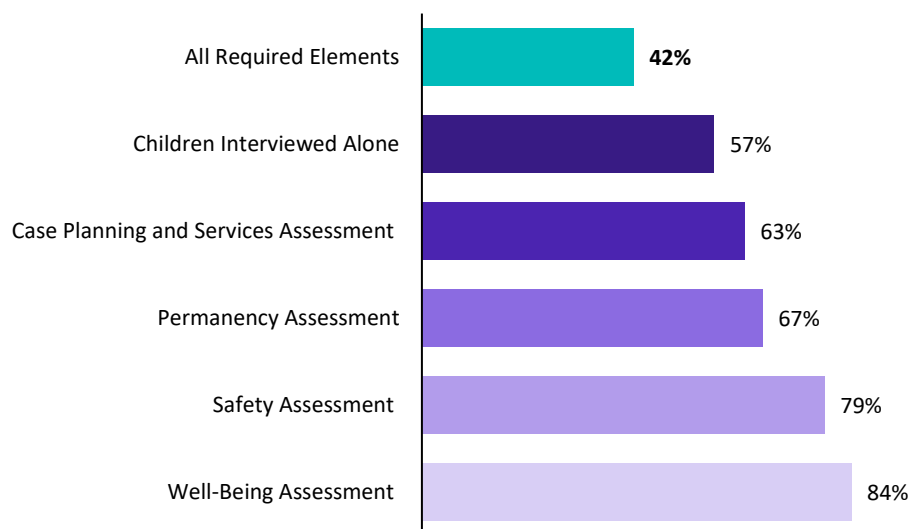
performance was suspended after years of consistently low performance. The suspension was intended to provide DSS with an opportunity to implement strategies to strengthen practice and improve documentation. The Parties agreed to resume FSA measurement in MP19.

Performance was assessed through a case record review of CAPSS documentation for the last month of the monitoring period (March 2026). During the month of March 2026, there were 3,582 children in foster care. CAPSS data indicated that 3,429 children (96%) had a documented in-person contact with their assigned case manager during the month. A sample of 344 children's cases was reviewed to determine whether the documented contacts included all required DSS policy elements and therefore counted toward FSA performance.¹³⁴ Results from the case record review found that 42 percent (143 of 344) of the documented contacts met all required DSS policy elements ([Figure 47](#)). This represents an improvement from MP10, when 34 percent of case manager contacts with children met all required elements. Although performance improved, it remains well below the FSA requirement that 90 percent of children receive a monthly in-person contact that meets all required policy elements. Among the 344 children cases reviewed, 238 (69%) occurred in the child's residence, exceeding the FSA requirement that at least 50 percent of monthly in-person contacts occur in the child's residence. This requirement may now be eligible for Maintenance of Effort designation.

Figure 47. Percentage of Case Manager and Child Contacts Containing All Required Elements and the Percentage Containing Each Individual Element¹³⁵

March 2026

Source: Case record reviews completed by DSS and Monitor staff



¹³⁴ Data are from a CAPSS record review conducted by Monitor and DSS staff of a statistically valid sample designed to produce results at a 95% confidence level with a +/- 5% margin of error.

¹³⁵ Note: data in this figure do not include documented follow-up contacts that occurred during March 2026.

Discussion

Findings from the Monitor's review of March 2026 performance show continued progress in some areas of practice while highlighting persistent challenges in the quality and documentation of monthly case manager contacts with children. Consistent with prior reviews, the quality of documentation directly affected reviewers' ability to determine whether required practice elements occurred. When documentation did not clearly describe required elements of a child contact such as assessments, observations, or discussions, reviewers were unable to conclude that the monthly contact met DSS policy and therefore counted toward FSA compliance. DSS's performance across required elements for child contacts was highest for assessing and documenting the child's safety and well-being. Improvements are needed in documenting other required elements of monthly in-person contacts, particularly interviewing children alone (when age and developmentally appropriate); assessing the child's progress towards permanency; assessing appropriateness and effectiveness of services; and discussions regarding progress toward case plans goals and any needed adjustments to services or case planning.

DSS reports that it continues to implement multiple strategies intended to improve the quality and documentation of monthly case manager contacts with children. These efforts include Quality Contact training for case managers and team leaders, enhanced documentation guidance and CAPSS reminders, team leader coaching and field observations, county and regional quality assurance reviews, leadership reviews of performance data, and regular feedback to cases managers regarding documentation and practice expectations. DSS is also placing a renewed emphasis on related practice areas within the GPS Case Practice Model—including Case Manager Contacts, Functional Assessments, Case Planning, and Documentation—to further embed the GPS Case Practice Model's foundational vision, values, and guiding principles into daily practice.

Continued improvement in performance is anticipated as DSS's practice improvement strategies are fully implemented and reinforced. Sustained improvement will also require manageable caseloads and having appropriate placements available for children within and/or closer to their home counties. The Monitor will continue to assess whether these efforts result in improvements in the quality of case manager contacts with children and DSS's performance in meeting the FSA requirements.

C. Intakes and Investigations of Alleged Abuse and Neglect in Out-of-Home Care

Ensuring the safety and well-being of children in foster care is a primary obligation of any child welfare system. This obligation is recognized by FSA requirements for the timely and appropriate screening and investigation of allegations of abuse and/or neglect of children in foster care. In South Carolina, DSS's Intake Hub screens all reports of abuse or neglect and assigns allegations against a caregiver of a child in foster care to the Out of Home Abuse and Neglect (OHAN) unit for investigation.¹³⁶

In October 2024, the Court found that DSS had made sufficient improvement to terminate its jurisdiction over four FSA provisions regarding allegations of institutional abuse and neglect; consequently, performance on those requirements is no longer monitored or reported.¹³⁷ Additionally, the Court has granted Maintenance of Effort designation for all four remaining OHAN FSA requirements; three entered Maintenance of Effort status in December 2025: (1) timely initiation of investigations (FSA IV.C.4.(a)); (2) timely face-to-face contact with alleged child victims (FSA IV.C.4.(b)); and (3) appropriate investigatory findings and decision making (FSA IV.C.3.).¹³⁸ In June 2026, the fourth FSA requirement entered Maintenance of Effort status: (4) contacts with core witnesses (FSA IV.C.4.(c)).¹³⁹ Performance on these FSA requirements continues to be assessed through twice-yearly case record reviews.

¹³⁶ SC Code § 63-7-1210 (2024); SCDSS Policies and Procedures Manual: Child Welfare Services, Chapter 13: Out of Home Abuse and Neglect (OHAN), Policy 1300: Out of Home Abuse and Neglect Investigations (effective September 18, 2024).

¹³⁷ See: Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt. 329), terminating jurisdiction over the following FSA OHAN provisions: (1) Intake – Decision Not to Investigate (FSA IV.C.2.); (2) Timely Completion of Investigation Within Forty-Five (45) Days of Initiation (FSA IV.C.4.(d)); (3) Timely Completion of Investigation Within Sixty (60) Days of Initiation (FSA IV.C.4.(e)); and (4) Timely Completion of Investigation Within Ninety (90) Days of Initiation (FSA IV.C.4.(f)).

¹³⁸ Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 387).

¹³⁹ Order on Motion for Miscellaneous Relief (June 18, 2026, Dkt. 412).

1. Timely Initiation of Investigation and Timely Face-to-Face Contact with the Alleged Victim

FSA Requirements	<i>The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations (FSA IV.C.4.(a)) [and] [t]he investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors (FSA IV.C.4.(b)).</i>
Performance Assessment	FSA Requirements Met: 100% of OHAN investigations were initiated in 24 hours of DSS's receipt of the report and included a face-to-face contact with the alleged victim child within 24 hours. ¹⁴⁰

The FSA requires that at least 95 percent of referrals of abuse or neglect of children in foster care are initiated within 24 hours (FSA IV.C.4.(a)), and that the investigation includes face-to-face contact with the alleged victim child within 24 hours, with approved exceptions for good-faith efforts, in at least 95 percent of investigations (FSA IV.C.4.(b)).¹⁴¹ The Monitor measures performance for both FSA requirements IV.C.4.(a) and (b) using the same methodology and timeframes, requiring face-to-face contact with the alleged child victim within 24 hours of receiving a report. The Monitor and DSS staff review case records of all investigations assigned to

¹⁴⁰ On September 24, 2024, the Co-Monitors and the Parties agreed that for the purposes of the review, OHAN case managers would have a maximum of two additional hours from the time of the receipt of the report to initiate the investigation, including making face-to-face contact with the alleged victim child(ren) (i.e., OHAN case managers would have up to 26 hours from the receipt of a report to initiate the investigation).

¹⁴¹ The Co-Monitors approved the following efforts as “good-faith efforts” for timely initiation which must be completed and documented, as applicable, to make contact with the alleged victim child(ren) within 24 hours: the case manager attempted to see the child(ren) at school or child care facility; the case manager attempted to see the child(ren) at doctor’s visit or hospital; the child(ren) moved to an out-of-state location in order to receive specialized treatment, and the case manager attempted to interview by virtual means; the case manager attempted to see the child(ren) at the police department; the case manager attempted to attend the forensic/Child Advocacy Center interview; the case manager attempted to see the child(ren) at therapist’s office; the case manager contacted the assigned foster care case manager(s) and/or team leader(s); the case manager attempted to contact the parent/guardian of the victim child(ren) if the child(ren) has returned home; and the case manager attempted to contact the child(ren) at all foster care placements where the child(ren) may temporarily be placed in the first 24 hours. Additionally, the following extraordinary circumstance exceptions to timely initiation were approved by the Co-Monitors: the child(ren) returned to their biological family prior to receiving the report and the family refuses contact; the child(ren) is (are) deceased; law enforcement prohibited contact with the child(ren); facility restrictions due to the child(ren)’s medical requirements; natural disaster; and the child(ren) is missing despite efforts to locate (efforts should include all applicable good-faith efforts).

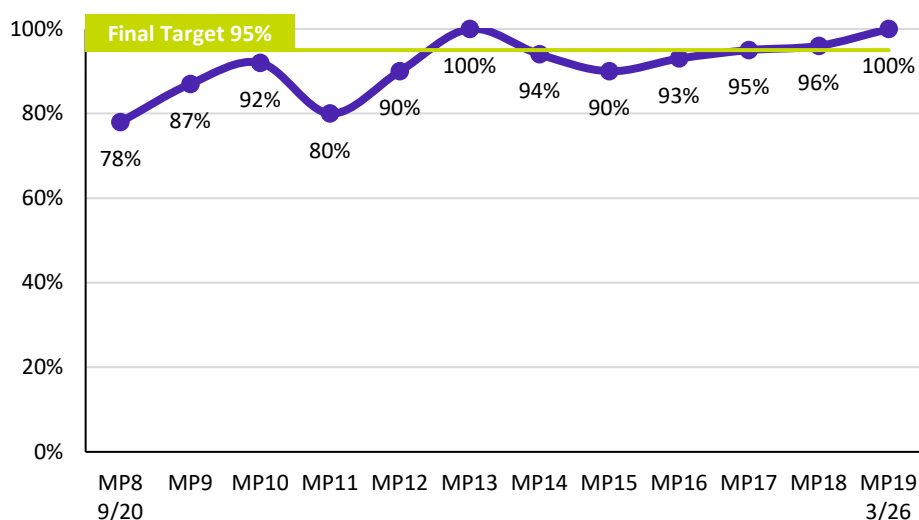
OHAN in the last month of the monitoring period (March 2026) to report on performance.

In March 2026, the OHAN unit conducted 38 investigations involving Class Members. Case managers met with all alleged victim children within 24 hours in 37 investigations, and in one additional investigation, all applicable good-faith efforts were made to contact each of the alleged victim children.¹⁴² Therefore, all (100%) investigations were initiated timely and included face-to-face contact with alleged victims ([Figure 48](#)). The State met the FSA requirement in MP19 and the two prior monitoring periods. The Court granted Maintenance of Effort status for these provisions on December 17, 2025.¹⁴³

Figure 48. OHAN Investigations with Timely Initiation and Face-to-Face Contact with Alleged Victim(s)

MP8 - 19 (September 2020 – March 2026)

Source: Case record reviews completed by University of South Carolina Center for Child and Family Studies (up to September 2021), DSS, and Monitor staff



¹⁴² In 2 of 38 (5%) investigations, the investigation was initiated, including making face-to-face contact, within 26 hours and still within the maximum period of time allowed per the September 24, 2024, agreement of the Co-Monitors and Parties. [Supra note 140](#).

¹⁴³ Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 387).

2. Contact with Core Witnesses

FSA Requirement	<i>Contact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors (FSA IV.C.4.(c)).</i>
Performance Assessment	FSA Requirement Met: Contact was made with all necessary core witnesses in 100% of investigations.

The FSA requires that DSS contact core witnesses in at least 90 percent of investigations of a referral of institutional abuse or neglect, with exceptions approved by the Monitor (FSA IV.C.4.(c)).¹⁴⁴ A core witness is defined as an individual who is pertinent to the investigation because they witnessed or have knowledge of the alleged actions and can shed light on the allegations and the actions of the alleged perpetrator(s).¹⁴⁵ Core witnesses may differ from investigation to investigation but in all cases must include: alleged child victim(s); reporter(s); alleged perpetrator(s); law enforcement, when involved; the child's DSS case manager; and other adult(s) and/or child(ren) in the home. If the allegations involve an institutional setting, all other adults and children relevant to the investigation are also considered core witnesses. Performance on this FSA requirement is determined by a case record review of all OHAN investigations involving Class Members that were initiated in the last month of the monitoring period.

Of the 38 investigations initiated in March 2026 and reviewed by Monitor and DSS staff, case records documented contact with all necessary core witnesses in 34 investigations, and in the other four investigations documented an applicable exception. Therefore, contact with all necessary core witnesses was made in all (100%) investigations ([Figure 49](#)). [Figure 50](#) shows the frequency of contact across all categories of core witnesses for investigations initiated in March 2026 compared to the prior review of investigations initiated in September 2025. The State continued to meet the required performance for this FSA target in MP19. The Court granted Maintenance of Effort status for this provision on June 18, 2026.¹⁴⁶

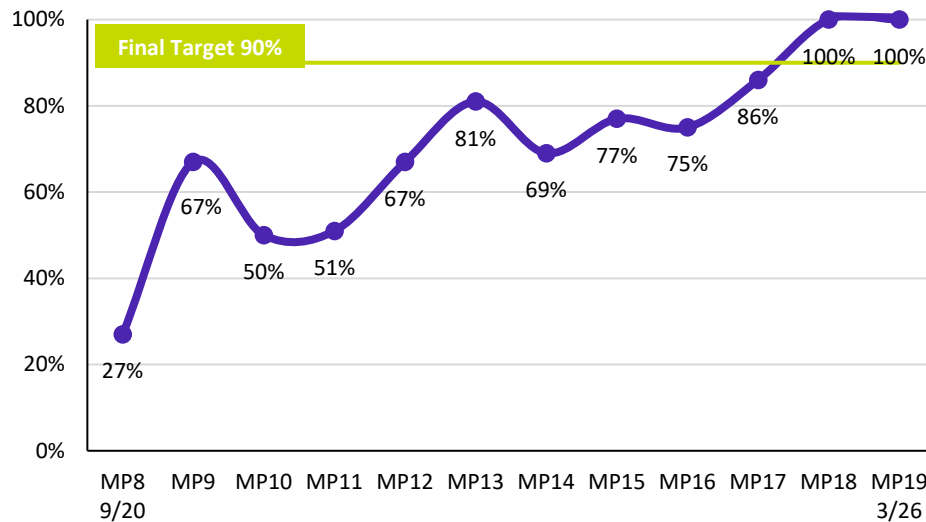
¹⁴⁴ The following exceptions were approved by the Co-Monitors to the requirement that the OHAN case manager contact a core witness during an investigation: witness refused to cooperate; witness advised by counsel or law enforcement that interview could not occur (e.g., due to pending charges, lawsuit); witness is deceased; unable to locate or identify witness; and medical conditions prevented witness from cooperating. In all instances, the exception must be supported by documentation of the exception and good-faith efforts to engage the witness.

¹⁴⁵ Out of Home Abuse and Neglect Implementation Plan, pg. 4; see: <https://dss.sc.gov/media/oagnwbjr/michelle-h-2017-approved-ohan-section-of-august-9-implementation-plan-su.pdf>.

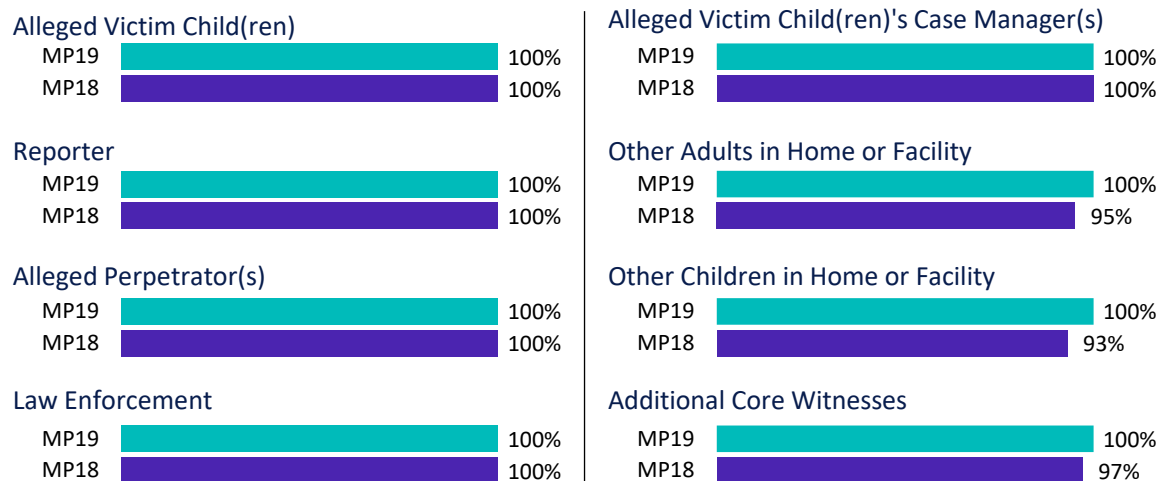
¹⁴⁶ Order on Motion for Miscellaneous Relief (June 18, 2026, Dkt. 412).

Figure 49. OHAN Investigations with Contact with All Necessary Core Witnesses*MP8 - 19 (September 2020 – March 2026)*

Source: Case record reviews completed by University of South Carolina Center for Child and Family Studies (up to September 2021), DSS, and Monitor staff

**Figure 50. Frequency of OHAN Investigation Contacts, by Witness Type¹⁴⁷***MP18 (September 2025) compared to MP19 (March 2026)*

Source: Case record reviews completed by DSS and Monitor staff



¹⁴⁷ Good-faith exceptions were applied to applicable core contact types and are as follows: reporter (2 of 36); alleged perpetrator(s) (2 of 38); other adults in the home or facility (3 of 28); other children in the home or facility (2 of 25); and additional core witnesses (4 of 30).

3. Investigation Decisions

FSA Requirement	<i>At least 95% of decisions to “unfound” investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected (FSA IV.C.3.).</i>
Performance Assessment	FSA Requirement Met: 100% of decisions to “unfound” investigations of referrals for institutional abuse or neglect were determined to be appropriate.

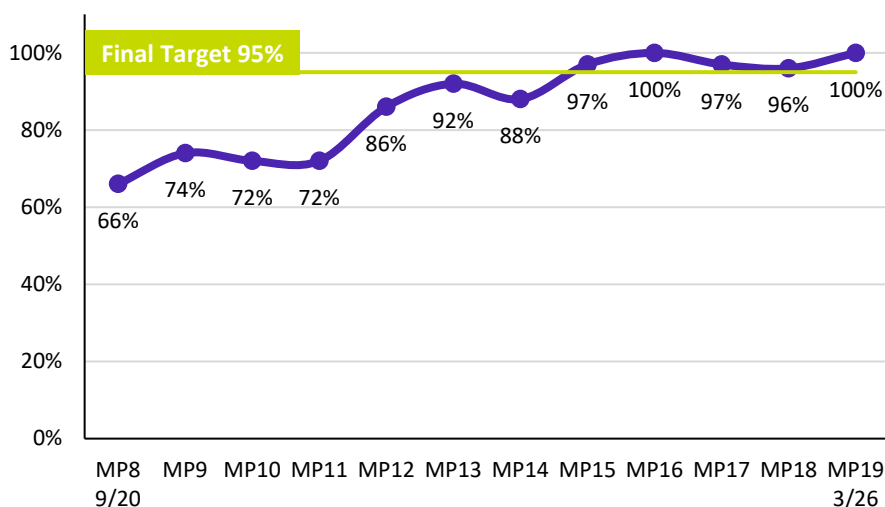
The FSA requires that 95 percent of decisions to “unfound” allegations of institutional abuse or neglect be based on DSS ruling out abuse or neglect or determining that an investigation did not produce a preponderance of the evidence that a Class Member was abused or neglected (FSA IV.C.3.).

In 34 of the 38 OHAN investigations initiated in March 2026 and reviewed by Monitor and DSS staff, the final decision was to unfound the allegations of abuse or neglect. Reviewers agreed that the decision to unfound was appropriate in 100 percent of the investigations (34 of 34) ([Figure 51](#)). The State has met the required performance for this FSA target for the last five monitoring periods. The Court granted Maintenance of Effort status for this provision on December 17, 2025.¹⁴⁸

Figure 51. Appropriate Decisions to Unfound OHAN Investigations

MP8 - 19 (September 2020 – March 2026)

Source: Case record reviews completed by University of South Carolina Center for Child and Family Studies (up to September 2021), DSS, and Monitor staff



¹⁴⁸ Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 387).

Discussion

DSS's performance in MP19 continued to demonstrate consistent practice in investigating allegations of institutional abuse or neglect involving Class Members. A review of investigations initiated in March 2026 indicated that DSS met all four remaining FSA performance targets, each of which has been granted Maintenance of Effort status. The consistency of these results indicates ongoing adherence to required OHAN investigative practices. The improvement in OHAN practices and performance since the start of the lawsuit has been dramatic.

D. Family Connections

When a child is separated from their family, it is life-altering and traumatic; even short-term removals can bring physiological and psychological consequences that may affect the child into adulthood.¹⁴⁹ All efforts must be made to sustain regular and meaningful contact between children and their families, starting as close in time to removal as possible. Family visits sustain connections and alleviate the trauma of separation. Regular, frequent, and dedicated time with family members should occur in comfortable settings and foster positive and nurturing relationships between the child in foster care and the significant people in their life, including siblings in foster care for whom placement together is not possible. Meaningful time with family has been associated with positive outcomes for children in foster care including enriched parent engagement and stronger parent-child attachments, expedited permanency and a higher likelihood of reunification, and improved child well-being.¹⁵⁰

¹⁴⁹ Administration for Children & Families, Children's Bureau, Family Time and Visitation for Children and Youth in Out-of-Home Care, ACYF-CB-IM-20-02, pg. 3 (Feb. 5, 2020).

¹⁵⁰ Ibid.

1. Children's Visits with Their Parents

FSA Requirement	<i>At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless (1) there is a court order prohibiting visitation or limiting visitation to less frequently than twice every month; or (2) based on exceptions approved by the Co-Monitors (FSA IV.J.3.).</i>
Performance Assessment	FSA Requirement Not Met: 64% of children had the required number of visits with their parents.

The FSA requires that at least 85 percent of Class Members with the goal of reunification have in-person visits twice each month with the parent(s) or other individual(s) with whom reunification is sought unless: (1) there is a court order prohibiting visitation or limiting visitation to less frequently than twice every month; or (2) based on exceptions approved by the Monitor.¹⁵¹ DSS's Foster Care Visitation Policy states that within 30 days of a child entering foster care, a visitation plan must be created collaboratively with the child and family team.^{152,153} Unless required by court order, visitation should not be less than twice monthly, with other communication (e.g., text messages, phone calls, etc.) allowed and encouraged as appropriate. Visitation plans are created with input from the child, parents, other significant persons, foster parents or group home providers, and clinical providers, as applicable.¹⁵⁴ The plan details visit logistics, necessary

¹⁵¹ The following are exceptions approved by the Monitor to the parent-child visitation requirement: court order prohibits or limits parent-child visitation; parent is missing or child is on runaway during a calendar month with best efforts to locate; parent or child is incarcerated or in a facility that does not allow visitation in the calendar month despite best efforts; parent refused to participate despite best efforts; parent did not show up to visit(s) despite attempts to successfully arrange and conduct the visit(s); parental rights were terminated in that month; parent visit is infeasible due to geographic distance, with efforts to provide alternative forms of contact (geographic distance will only be allowed as an exception upon individual review of the applicable case by the Monitor); County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child (if an immediate safety incident or concern occurs prior to or during a visit, the case manager is to remove the child from the visit and notify the County Director afterward); and team leader approval for determination that visitation would be psychologically harmful for the child. For the last exception, a DSS team leader must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of a clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision. In all instances, the exception must be supported by documentation of the exception reason and best efforts to foster time between the parent and child.

¹⁵² SCDSS Child Welfare Services Manual, Chapter 5: Foster Care, Policy 510.7.3: Family Visitation (effective February 22, 2022).

¹⁵³ To view the Visitation Implementation Plan, see: <https://dss.sc.gov/media/4evhcpy/3-28-2019-final-dss-visitation-implementation-plan.pdf>.

¹⁵⁴ SC Code § 63-7-1680 (2024); SCDSS Child Welfare Services Manual, Chapter 5: Foster Care, Policy 510.3: Family Visitation (effective February 22, 2022).

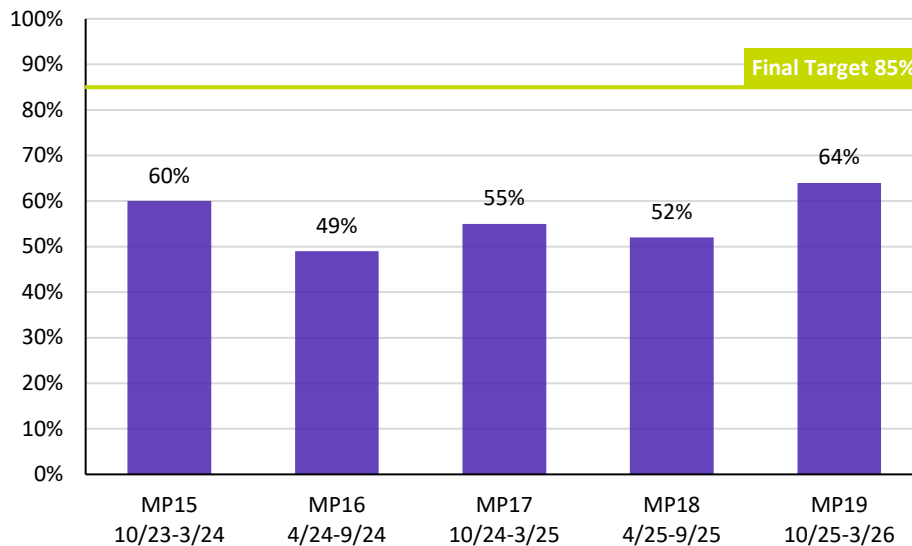
supports, and potential barriers to visits with plans to address them. In line with needs, and as appropriate, family visits may be unsupervised, supervised, or monitored by a case manager or other designated person, including a relative, foster parent, or clinician.

Reviews of CAPSS documentation for the last month of the monitoring period (March 2026) were conducted to determine performance. As of March 31, 2026, there were 1,461 children who had been in foster care for at least 30 days with a permanency goal of “Reunification,” “Extension for Reunification,” or “Not Yet Established.” A sample of 305 children’s cases from this universe was reviewed.¹⁵⁵ DSS and Monitor staff determined that there were 49 cases for which an approved exception applied to both required monthly visits between the child and the parent(s) with whom reunification was sought. Removing these 49 cases resulted in a representative sample of 256 cases. Results from the case record review found that 64 percent of children (163 of 256) with a goal of reunification had the required number of visits with their parent(s). Performance has improved meaningfully from MP18 when 52 percent of children had the required number of visits with their parent(s). However, performance on this FSA requirement continues to fall significantly below the target of 85 percent ([Figure 52](#)).

Figure 52. Parent-Child Visits

Percentage of children visiting with their parent(s) at least twice a month (March 2024 –March 2026)

Source: Case record reviews completed by DSS and Monitor staff



¹⁵⁵ Data are from a case record review conducted by Monitor and DSS staff of a statistically valid sample designed to produce results at a 95% confidence level with a +/- 5% margin of error.

2. Sibling Connections

Placement of Children with Their Siblings

FSA Requirements	<i>At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings (FSA IV.G.2.) [and] [a]t least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors. (FSA IV.G.3.).</i>
Performance Assessment	FSA Requirements Not Met: 74% of children who entered foster care with or within 30 days of their siblings were placed with at least one of their siblings, and 48% were placed with all of their siblings.

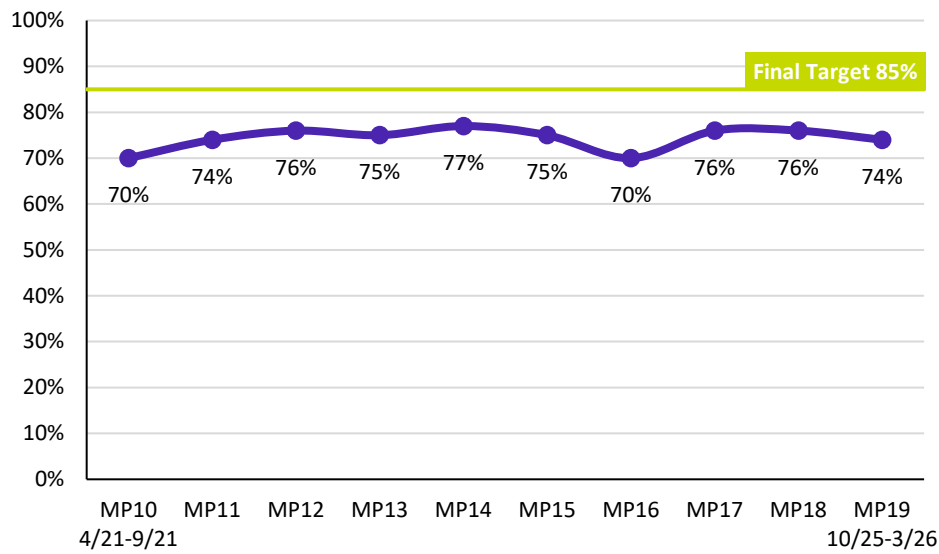
When Class Members enter foster care with or within 30 days of their siblings, the FSA requires that at least 85 percent be placed with *at least one* of their siblings (FSA IV.G.2.) and that at least 80 percent be placed with *all* of their siblings (FSA IV.G.3.).^{156,157} Performance is measured based on whether a child is placed with their sibling(s) 45-days after entering foster care. Between October 1, 2025 and March 31, 2026, 74 percent of children (471 of 639) who entered foster care with or within 30 days of their siblings were placed with *at least one* of their siblings ([Figure 53](#)), and 48 percent of children (304 of 639) were placed with *all* of their siblings ([Figure 54](#)). Performance for both measures declined since the last monitoring period and remains well below the FSA targets.

¹⁵⁶ The term “siblings” is defined as “children in foster care who have one or more parents in common either biologically, through adoption, or through marriage of their parents, and with whom the child lived before [their] foster care placement,” see: Placement Implementation Plan, pg. 58, <https://dss.sc.gov/media/cgnjurvv/dss-placement-implementation-plan.pdf>.

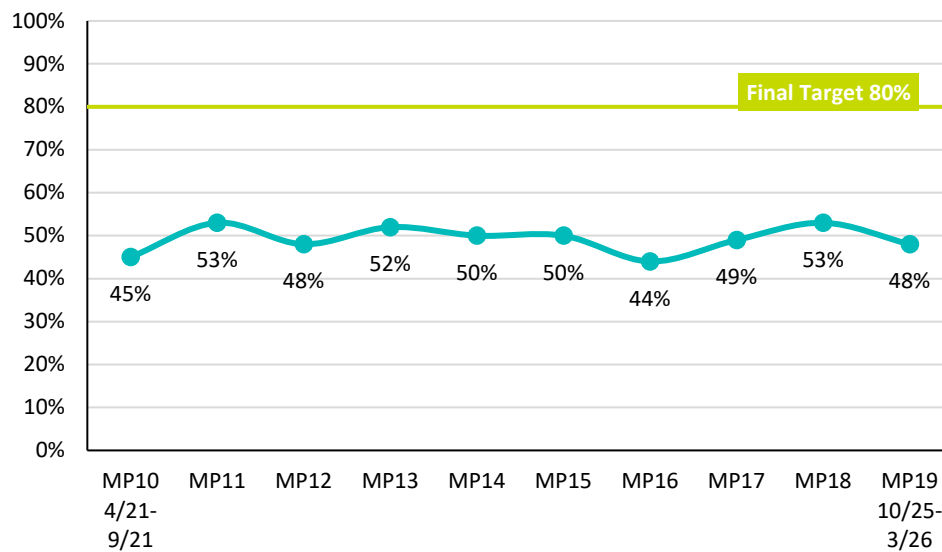
¹⁵⁷ The FSA allows for the following exceptions to the placement of children with their siblings: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Monitor (FSA IV.G.2 & 3.). DSS did not seek approval of any exceptions during MP19; therefore, actual performance may be higher than reported. DSS and the Monitor will develop a process for review and approval of exceptions in a future monitoring period.

Figure 53. Placement of Children with at Least One Sibling*MP10 – 19 (September 2021 – March 2026)*

Source: CAPSS data provided by DSS

**Figure 54. Placement of Children with All Siblings***MP10 – 19 (September 2021 – March 2026)*

Source: CAPSS data provided by DSS



Children's Visits with Their Siblings

FSA Requirement	<i>At least 85% of the total minimum number of monthly sibling visits for all sibling not living together shall be completed, with exceptions when (1) there is a court order prohibiting visitation or limiting visitation to less frequently than once every month; (2) visits are not in the best interests of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) with exceptions approved by the Co-Monitors (FSA IV.J.2.).</i>
Performance Assessment	FSA Requirement Met: 87% of children had the required number of visits.

The FSA requires that at least 85 percent of required monthly sibling visits occur. The State met this FSA target for the first time in the prior monitoring period, and on June 18, 2026, the Court granted Maintenance of Effort status for this provision.¹⁵⁸ Assessing performance on this target is done through a combination of reviewing results from a SafeMeasures® visitation report and a case record review of CAPSS documentation.¹⁵⁹ SafeMeasures® reliably reports sibling visits that occur but does not account for whether there was an approved exception for a sibling visit when a visit does not occur.¹⁶⁰ DSS and Monitor staff review case notes and documentation from a statistically representative sample of cases in which a visit did not occur to determine whether an exception applies.

¹⁵⁸ Order on Motion for Miscellaneous Relief (June 18, 2026, Dkt. 412).

¹⁵⁹ For more information about SafeMeasures®, see: <https://evidentchange.org>.

¹⁶⁰ The following are exceptions approved by the Co-Monitors to the sibling visitation requirement: court order prohibits or limits sibling visitation; child or sibling is on runaway during a calendar month with best efforts to locate; child or sibling is incarcerated or in a facility that does not allow visitation despite efforts; child or sibling refuses to participate in the visit, where age appropriate; sibling visit is infeasible due to geographic distance with efforts to provide alternative forms of contact (geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors); County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child or sibling (if an immediate safety incident or concern occurs prior to or during a visit, the case manager is to remove the child from the visit and notify the County Director afterward); and team leader approval for determination that visitation would be psychologically harmful for the child. For the last exception, a DSS team leader must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of a clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision. In all instances listed above, the exception must be supported by documentation of the exception reason and best efforts to foster time with sibling(s).

DSS identified a universe of 1,839 sibling pairs and pulled a statistically representative random sample of 311 sibling pairs.^{161, 162, 163} The SafeMeasures® report indicated that 237 of 311 sibling pairs visited each other in March 2026, and 74 sibling pairs did not. Results from the case record review of those 74 sibling pairs without a documented required visit concluded that 10 sibling pairs met criteria for an approved exception to a visit during the month; these 10 sibling pairs were subsequently removed from the sample, lowering the sample from 311 to 301.¹⁶⁴ Findings further determined that 24 of the 74 sibling pairs were incorrectly identified in the initial report as not having had a sibling visit in March 2026, although a sibling visit did occur. This resulted in a final determination that 87 percent of sibling pairs (261 of 301) had the required visits in March 2026 (Figure 55). The State continued to meet the FSA target of 85 percent in MP19; however, this was a decline in performance from the prior monitoring period (September 2025) when 92 percent of sibling pairs had the required visits.

¹⁶¹ For the purposes of the review, “siblings” are defined as “children in foster care not placed together who have one or more parents in common either biologically, through adoption, or through the marriage of their parents, and with whom the child lived before his or her foster care placement”, see the Visitation Implementation Plan: <https://dss.sc.gov/media/4evhcpy/3-28-2019-final-dss-visitation-implementation-plan.pdf>.

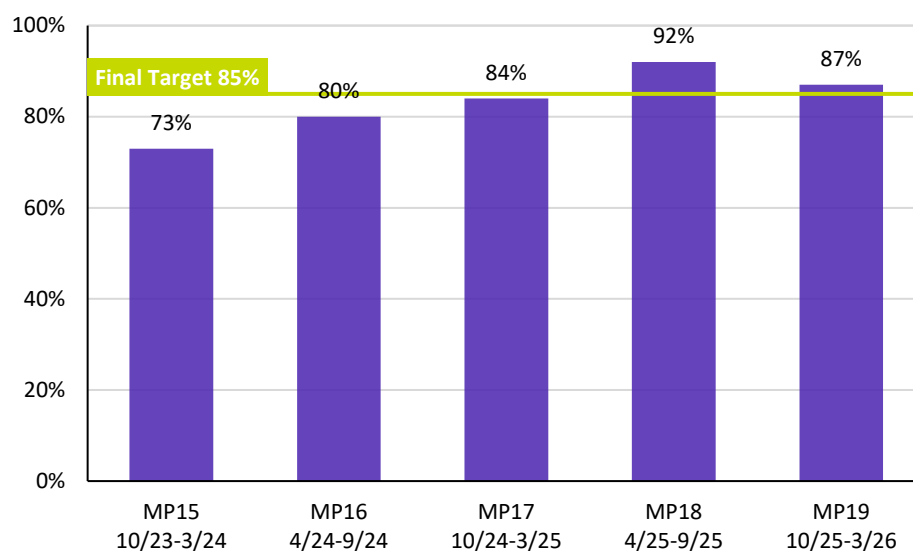
¹⁶² A child is counted for every sibling for whom they should have visitation during the month under review; therefore, a child may be included multiple times in the universe. The universe further includes only those siblings who entered foster care within 30 days of each other and resided apart the entire month under review. Class Members who resided out of state during the month under review are excluded from the analysis.

¹⁶³ Data are from a CAPSS record review conducted by Monitor and DSS staff of a statistically valid sample designed to produce results at a 95% confidence level with a +/- 5% margin of error.

¹⁶⁴ The 10 sibling visit exceptions identified in March 2026 were due to one of the following documented instances: (1) one or both children refusing to participate, (2) one or both children residing in a facility in which visitation was not possible, (3) court order prohibiting sibling visitation, or (4) visitation deemed psychologically harmful to one or both children.

Figure 55. Percentage of Sibling Pairs Visiting At Least Once a Month*MP15 – 19 (March 2024 – March 2026)*

Source: Case record reviews completed by DSS and Monitor staff



Discussion

In order for children who are removed from home to successfully reunify with their families, it is critical that they have meaningful contact with their parents, siblings, relatives, and other individuals significant to them while they are apart. This includes ensuring that all children consistently visit with their parents, prioritizing placement of children with their siblings while in care, and making certain that those who are not placed together have regular visits. After steady improvement over the past several monitoring periods, progress towards placing children with their siblings declined in MP19 from MP18; siblings are not being placed together at the rates required by the FSA.

Performance in ensuring consistent visits between siblings when placed apart continued to meet the FSA target; however, the decline from September 2025 when 92 percent of sibling visits occurred to March 2026 when 87 percent of sibling visits occurred represents the first decrease in performance in five monitoring periods. Notably, the rate of parent and child visits increased, though performance remains significantly below the FSA standard.

DSS reported efforts it has taken to place siblings together in MP19, including prioritizing kin placements, conducting targeted recruitment of and providing concrete supports to non-kin families with space and desire to support sibling groups, and holding staffings to address barriers for those siblings who are separated. Additionally, in its April 10, 2026 Data Submission to the Court, DSS reported its ongoing efforts to increase both the frequency of family visits and the quality of visit documentation to improve performance on FSA measures related to maintaining

family connections.¹⁶⁵ DSS reported pursuing several strategies to increase visits between children in foster care and their families, including conducting periodic skills labs for frontline staff, issuing quarterly “Visitation Matters Tip Sheets,” and engaging county leadership in cadenced review of the accuracy and progress of permanency plans.¹⁶⁶

DSS reported that Child Welfare Services leadership continues to monitor month-to-month performance through a data dashboard, which includes metrics on frequency of parent and child visits by county and region.¹⁶⁷ These data are used to identify and recognize counties that are performing above the state average and to identify any successful strategies that can be implemented in other counties. The dashboard also identifies counties performing below the state average to assess barriers and prompt the development of strategies for intentional improvement. Further, DSS reported efforts to improve the quality and accuracy of visit documentation, specifically adjusting internal reporting to no longer count virtual visits or instances in which a parent does not show up to a scheduled visit as completed visits. This update made DSS’s internal reporting more representative of practice and better reflect the case reviews conducted to determine FSA performance. In March 2026, the State showed promising improvement in rates of parent-child visits, however, additional efforts are necessary to identify and address remaining barriers for all children in care.

¹⁶⁵ Letter from J. Michael Montgomery Providing Information Required by October 15, 2025 Order (Dkt. 381) prior to April 17, 2026 Status Conference (April 10, 2026, Dkt. 401).

¹⁶⁶ Ibid.

¹⁶⁷ Ibid.

E. Health Care

Child welfare systems are responsible for ensuring that children in foster care receive the health care services necessary to support their physical, developmental, mental, and behavioral well-being. Meeting this responsibility requires the capacity to promptly identify children's health needs; ensure timely access to high-quality preventive, acute, and ongoing care; and maintain systems that track service delivery and support the effective sharing of critical health information. The provision of health care to children in foster care is a legal obligation of the State under federal Medicaid mandates for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for all Medicaid-eligible children, which includes children in foster care. Guidance issued by the Centers for Medicare and Medicaid Services (CMS) on September 26, 2024, affirms states' obligations to provide medically necessary services to address children's physical, developmental, mental, and behavioral health needs. This guidance also supports states in strengthening EPSDT implementation to improve health outcomes for children enrolled in Medicaid.¹⁶⁸

The FSA required the development of a Health Care Improvement Plan with enforceable dates and targets for phased implementation of initial and periodic screening services, documentation, and health care services for Class Members in the areas of physical health, immunizations and laboratory tests, mental, developmental and behavioral health, vision and hearing, and dental health. Per the FSA, the Health Care Improvement Plan shall address:

- Developing the capacity to track screening and treatment services for individual children and aggregate tracking data, including but not limited to screens that are due and past due;
- Assessing the accessibility of health care screening and treatment services throughout the state, including the capacity of the existing health care providers to meet the screening and treatment needs of Class Members; and
- Identifying baselines and interim percentage targets for performance improvement in coordinating screens and treatment service (FSA IV.K.1.(a-c)).

The initial Health Care Improvement Plan, Health Care Outcomes, and Health Care Addendum — approved by the Co-Monitors and the Court on August 23, 2018; December 21, 2018; and February 25, 2019, respectively — established commitments to outcomes and a framework for health care coordination. The framework assigned interrelated responsibilities to the DSS Office of Health and Well-Being, DSS case managers, the South Carolina Department of Health and Human Services (DHHS) and its contracted managed care organizations (MCOs), and foster caregivers and

¹⁶⁸ To view the CMS's guidance in the form of a State Health Official letter entitled, *Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements*, see: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf>.

families.¹⁶⁹ The Plan, Outcomes, and Addendum were approved and ordered by the Court with the understanding that additional details would be determined during implementation and that the efficacy and adequacy of the model and methodology for measuring outcomes would be assessed on an ongoing basis to determine what changes or additions were needed. Beginning in 2023, the Monitor identified in its report to the Court the need to review the Health Care Plan, Outcomes, and Addendum, and make the modifications necessary for improved performance.

Following significant delay on work to develop a revised Health Care Improvement Plan (HCIP), the Court ordered the Parties to develop a revised HCIP to be approved by the Monitor on or before December 31, 2025.¹⁷⁰ DSS submitted a revised plan to the Parties and the Court on December 30, 2025.¹⁷¹ The Monitor provisionally approved the HCIP pending the development of agreed-upon methodologies for measuring DSS's performance in meeting the Health Care Outcomes included in the Plan and required by the FSA.¹⁷² The HCIP, including methodologies, was approved by the Monitor and submitted to the Court on April 3, 2026, and approved by the Court on April 20, 2026.^{173,174}

Efforts to implement the revised HCIP and methodologies for monitoring performance are underway. The newly agreed upon methodologies have been applied to measure performance related to children's receipt of comprehensive medical assessments within 30 and 60 days of entering care.

For this monitoring period, the Monitor was unable to assess and report performance in the following areas: initial medical screens, mental health assessments (following a screening which identified a need for such an assessment), and follow-up care. Performance on periodic preventive visits is also not assessed; however, available and related DSS data are provided. The HCIP revised methodologies will be incorporated into future reporting as the necessary data and processes are established to measure performance. Additionally, on December 17, 2025, the Court granted Exit and Termination for the FSA requirement of timely referral of Class Members under 36 months of age for developmental assessments; therefore, it is no longer monitored or reported.¹⁷⁵

¹⁶⁹ To view the Health Care Improvement Plan, see: <https://dss.sc.gov/media/nescioju/8-23-2018-final-approved-dss-health-care-implementation-plan.pdf>. To view the FSA Health Care Outcomes, see: <https://dss.sc.gov/media/c3ig211y/appendix-b-final-health-care-targets.pdf>. To view the Health Care Addendum, see: <https://dss.sc.gov/media/0bdpenal/2-25-2019-approved-health-plan-addendum.pdf>.

¹⁷⁰ Order directing the Parties to finalize a revised Health Care Plan approved by the Monitor on or before December 31, 2025 (October 15, 2025, Dkt. 382).

¹⁷¹ Letter from J. Michael Montgomery Providing Revised Health Care Improvement Plan Required by October 15, 2025 Order (Dkt. 382) (December 30, 2025, Dkt. 389).

¹⁷² Letter re: Monitor's Provisional Approval of the *Michelle H.* Revised Health Care Improvement Plan, dated December 30, 2025 (January 27, 2026, Dkt. 391).

¹⁷³ Letter from J. Michael Montgomery Providing Revised Health Care Improvement Plan (April 3, 2026, Dkt. 398).

¹⁷⁴ Order following April 17, 2026 status conference (April 20, 2026, Dkt. 404).

¹⁷⁵ Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 388).

Initial Medical Screens

FSA Requirement	<i>At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care. (FSA IV.K.5.; FSA Health Care Outcomes).</i>
Performance Assessment	Not Reported: Performance data are not available. A methodology for measuring performance has not yet been established.

Comprehensive Medical Assessments

FSA Requirement	<i>At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care; [and] at least 95% will receive a comprehensive medical assessment within 60 days of entering care (FSA IV.K.5.; FSA Health Care Outcomes).</i>
Performance Assessment (MP18)	FSA Requirements Not Met: 58% of children received a comprehensive medical assessment within 30 days of entering care, and 77% received a comprehensive medical assessment within 60 days of entering care.

Revised methodology developed as part of the modified HCIP has adjusted how performance on this requirement is assessed. This is the first report that provides a comprehensive assessment of performance by combining Medicaid administrative claims data with case review findings to capture services not reflected in the administrative claims data; this report also evaluates performance for a complete entry cohort of children for the first time.¹⁷⁶ To support this improved methodology, performance is based on a monitoring period that lags by one reporting cycle, ensuring that there is sufficient follow-up time to assess all children in the cohort for each measure.¹⁷⁷ Performance metrics combine timely visits identified through Medicaid administrative claims data with visits confirmed through a case record review of a representative sample of children without Medicaid claims. The incorporation of case record reviews resulted from concern that relying solely on Medicaid administrative claims resulted in an underrepresentation of children receiving timely care. DSS and Monitor staff therefore reviewed a representative sample of 142 children's cases to assess whether visits not reflected in Medicaid administrative claims

¹⁷⁶ Previous methodology only included children who had reached the applicable follow-up period (e.g., 30 or 60 days after entry) by the end of the reporting window. As a result, children entering later in the reporting period were systematically excluded from the measures as sufficient follow-up time was not reached.

¹⁷⁷ Performance is based on MP18 data that is lagged one month and therefore includes all children who entered care between March and August 2025 and remained in care for at least 60 days. Inclusion in the universe is based on a child's duration in care rather than the monitoring period end date, and visits occurring after the monitoring period are still included in the assessment of performance.

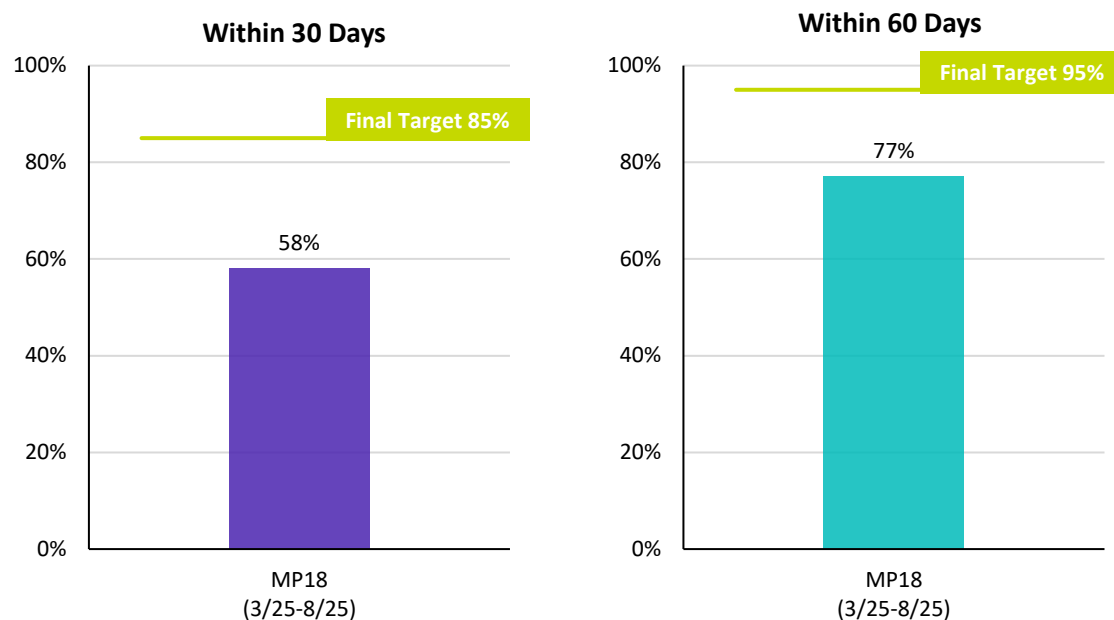
data had in fact occurred and to determine the extent to which claims-based performance data may underestimate actual performance.¹⁷⁸

Among the 1,138 children who entered care between March and August 2025 and remained in care for at least 60 days, 58 percent received a comprehensive medical assessment within 30 days of entering care, and 77 percent received a comprehensive medical assessment within 60 days of entering care (Figure 56). Performance greatly improved on this measure (primarily due to incorporating data collected during case record reviews that showed children had the necessary medical assessments, but Medicaid administrative claims had not been found). Among the sample of children's cases reviewed who did not have a Medicaid claim, case record reviews found that 55 percent had evidence of a comprehensive medical assessment within 30 days and 66 percent within 60 days.

Figure 56. Percentage of Children Who Received a Comprehensive Medical Assessment

*FSA performance assessment for MP18 based on revised HCIP methodologies (March - August 2025)*¹⁷⁹

Source: Medicaid administrative claims data provided by DSS, case record reviews completed by DSS and Monitor staff



¹⁷⁸ Case record reviews were conducted by Monitor and DSS staff for a statistically valid sample designed to produce results at a 95% confidence level with a +/- 5% margin of error from a universe of 223 children without Medicaid claims.

¹⁷⁹ The March through August 2025 review period does not align with the monitoring period due to the timing of reports received for Medicaid claims. Future performance data will be aligned with the applicable monitoring period.

Dental Examination

FSA Requirements	<i>At least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care; [and] at least 90% will receive a dental examination within 90 days of entering care (FSA IV.K.5.; FSA Health Care Outcomes).</i>
Performance Assessment	FSA Requirement Partially Met: 63% of children aged two and above received a dental examination within 60 days of entering care, and 74% of children aged two and above received a dental examination within 90 days of entering care.

Health care data reporting timelines are adjusted each monitoring period to accommodate delays in access to Medicaid administrative claims data. To provide the most up-to-date data for dental visits in Monitoring Period 19, data on initial dental visits use a one-month lag from the end of the monitoring period. For each measure, only children who had reached the applicable follow-up period (e.g., 60 or 90 days after entry) by the end of the reporting window of September 2025 to February 2026 are included. As a result, the denominator varies by measure, with children entering later in the reporting period excluded from measures for which sufficient follow-up time was not reached. Data included in this section were extracted by DSS and DHHS from Medicaid administrative claims data and have not been validated by the Monitor.

DSS reported that 63 percent of children (301 of 479) aged two and older who entered foster care between September 2025 and February 2026 and who were in foster care for at least 60 days had a dental exam within 60 days ([Figure 57](#)), and 74 percent of children (268 of 361) aged two and older who remained in care for at least 90 days had a dental exam within 90 days ([Figure 58](#)).¹⁸⁰

For the fourth consecutive monitoring period, performance continued to meet the FSA target for children receiving a dental examination within 60 days of entering foster care, and this FSA requirement may be eligible for Maintenance of Effort designation. However, DSS did not meet the FSA target of 90 percent of children receiving a dental examination within 90 days of entering foster care.

¹⁸⁰ Data reflect Medicaid administrative claims data only. A comprehensive assessment of performance for a complete cohort of children entering care during MP19 that incorporates both administrative claims and case record review findings will be available in the next MP20 report.

Figure 57. Initial Dental Examinations within 60 Days

Percentage of children aged two and older who received a dental examination within 60 days of entering care, MP10 - 19 (September 2021 – February 2026)

Source: Medicaid claims data provided by DSS

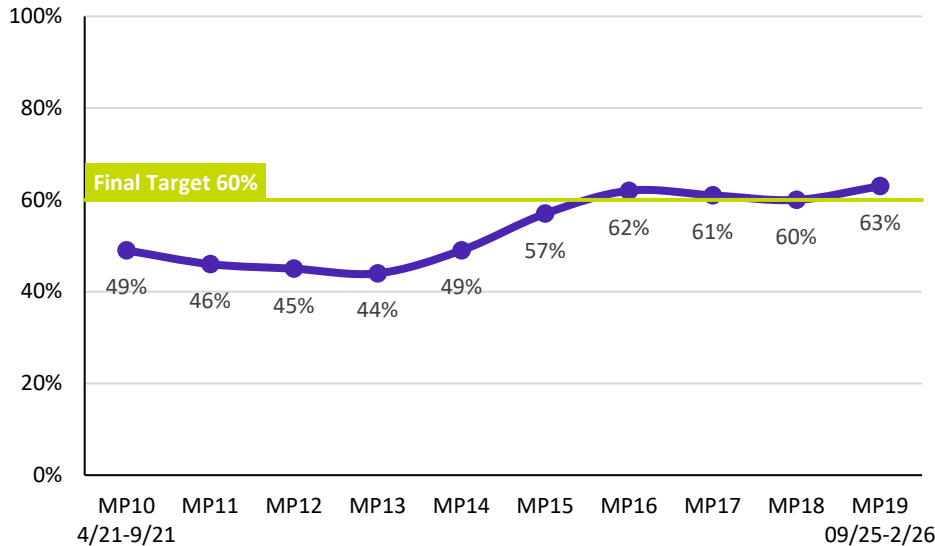
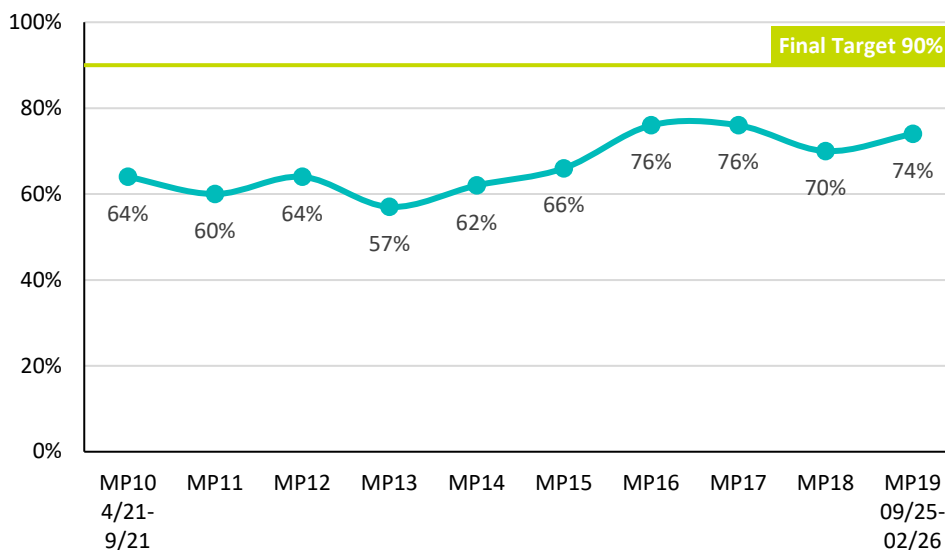


Figure 58. Initial Dental Examinations within 90 Days

Percentage of children aged two and older who received a dental examination within 90 days of entering care, MP10 - 19 (September 2021 – February 2026)

Source: Medicaid claims data provided by DSS



Comprehensive Mental Health Assessment

FSA Requirement	<i>At least 85% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 30 days of the comprehensive medical assessment [and] at least 95% will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment (FSA IV.K.5.; FSA Health Care Outcomes).</i>
Performance Assessment	Not Reported: Performance data are not available. A methodology for measuring performance has been established and is included in the HCIP. The Monitor and DSS are working to implement this methodology to assess performance.

Periodic Preventive Care

FSA Requirement	• At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly. • At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics periodicity guidelines; and at least 98% will receive a periodic preventative visit semi-annually. • At least 90% of Class Members aged three and older in care for six months or more will receive a periodic preventative visit semi-annually; and at least 98% will receive a periodic preventative visit annually (FSA IV.K.5.).
Performance Assessment	Not Reported: Performance data are not available. A methodology for measuring performance has been established and is included in the HCIP. The Monitor and DSS are working to implement this methodology to assess performance.

DSS committed in its Health Care Outcomes that children within its care receive periodic preventative medical visits in accordance with current American Academy of Pediatrics (AAP) periodicity guidelines.¹⁸¹ The Monitor and DSS are in the process of implementing the revised

¹⁸¹ To view the AAP Recommendations for Preventative Pediatric Health Care, see: <https://publications.aap.org/pediatrics/article/155/5/e2025071066/200933/2025-Recommendations-for-Preventive-Pediatric> .

methodology within the HCIP, for collecting and assessing data related to this requirement. Therefore, performance for these FSA requirements is not reported.

While performance is not yet reported for these FSA requirements, data provided by DSS that are used for day-to-day management and quality improvement are described below. These data are entered by case managers in CAPSS and are cross-checked with Medicaid administrative claims data from DHHS and its MCO partner, though not all visits included below have been validated with a Medicaid claim.

As of March 2026, DSS reported that of all children aged 17 years and under who were in foster care for at least 30 days, 68 percent (2,060 of 3,050) were up to date on their well-child visits ([Figure 59](#)). Of the remaining children, 31 percent (937) were past due for their well-child visits, and two percent (53) did not have a well-child visit documented. These data are also reported by the age of the children ([Figure 60](#)). The percentage of children with a visit past due was highest among infants aged five months and under (69%), substantially exceeding all other age groups (ranging from 26-38%).

Figure 59. Well-Child Visits

Percentage of children who were up to date on their well-child visits, MP10 – 19 (September 2021 – March 2026)

Source: CAPSS, DHHS, and MCO data provided by DSS

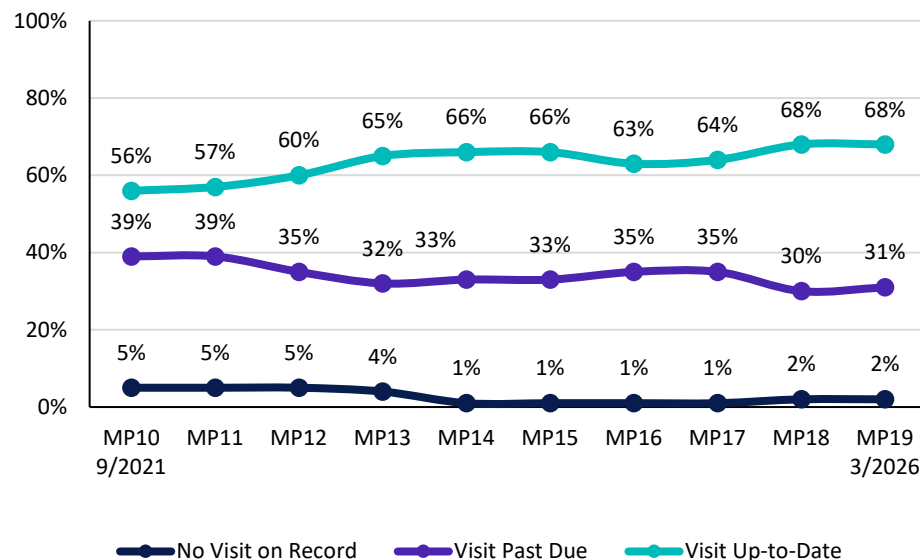
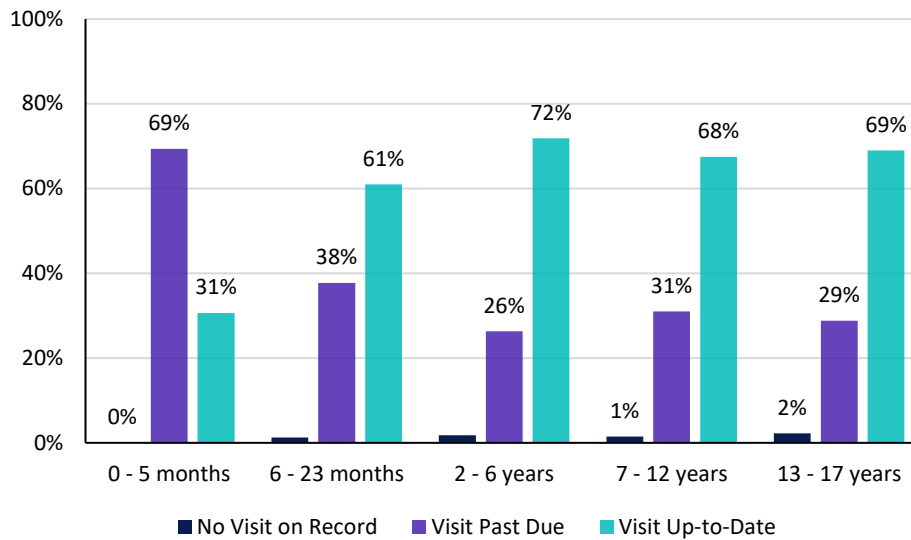


Figure 60. Well-Child Visits, by Age

Percentage of children who were up to date on their well-child visits by age, March 23, 2026

Source: CAPSS, DHHS, and MCO data provided by DSS



Periodic Preventive Dental Care

FSA Requirement	<i>At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually [and] at least 90% will receive a dental examination annually (FSA IV.K.5.; FSA Health Care Outcomes).</i>
Performance Assessment	Not Reported: Performance data are not available. A methodology for measuring performance has been established and is included in the HCIP. The Monitor and DSS are working to implement this methodology to assess performance.

The Monitor and DSS are in the process of implementing the revised methodology within the HCIP, for collecting and assessing data related to this requirement. Therefore, performance for these FSA requirements is not reported.

While performance is not reported for these FSA requirements, data regarding semi-annual dental examinations used by DSS for day-to-day management and quality improvement are described below. The periodic preventive dental care requirements are based on standards from the AAP's Bright Futures and Fostering Health standards, and compliance with periodicity is measured based

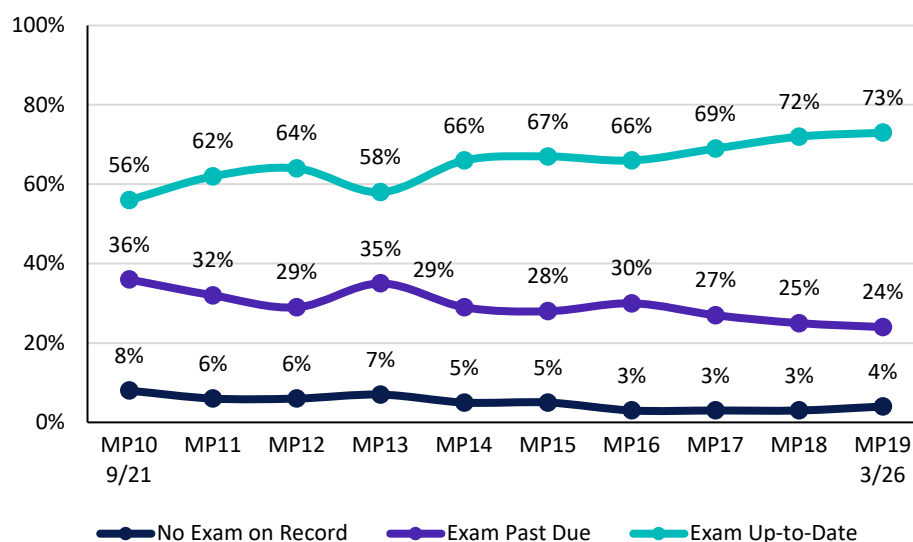
on the semi-annual requirement for preventive dental visits.¹⁸² These data are entered by case managers in CAPSS and are cross-checked with Medicaid administrative claims data from DHHS and its MCO partner, though not all visits reflected below have been validated with a Medicaid claim.

DSS reported that of children aged two through 17 who were in care for at least 30 days, 73 percent (1,936 of 2,657) were up to date on their semi-annual dental examination as of March 2026 (Figure 61). Of the remaining children, 24 percent (627) were past due for their dental exam, and four percent (94) had no dental examination documented. These data are also reported by age (Figure 62). As determined by DSS, performance slightly increased for children aged two through six, with 73 percent up to date on their dental exams as compared to 69 percent during the last monitoring period.

Figure 61. Periodic Dental Examinations

Percentage of children aged two to 17 years who were up to date on their dental examinations, MP10 – 19 (September 2021 - March 2026)

Source: CAPSS, DHHS, and MCO data provided by DSS

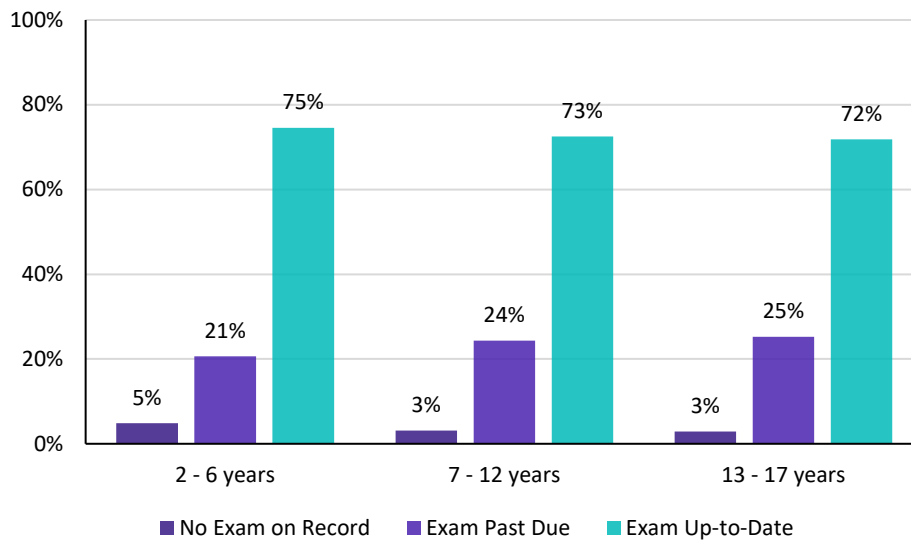


¹⁸² For more information, see <https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/>.

Figure 62. Periodic Dental Examinations, by Age

Percentage of children aged two to 17 years who were up to date on their dental examinations, March 2026

Source: CAPSS, DHHS, and MCO data provided by DSS



Follow-up Care

FSA Requirements	<i>At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs. (FSA IV.K.5.; FSA Health Care Outcomes).</i>
Performance Assessment	Not Reported: Performance data are not available. A methodology for measuring performance has been established and is included in the HCIP. The Monitor and DSS are working to implement this methodology to assess performance.

DSS has been working with the Monitor and a consultant to design and implement a Quality Service Review Protocol (QSR)¹⁸³ to measure performance in meeting the follow-up care needs of Class Members, as outlined in the HCIP. DSS established a multidisciplinary QSR design committee comprised of representatives from key partner agencies, service providers, and DSS staff. The

¹⁸³ The Quality Service Review (QSR) Protocol is a case-based, qualitative process used to assess outcomes for children and families, practice, and system performance to support continuous quality improvement. The QSR approach was developed through the work of the Child Welfare Policy & Practice Group and its Quality Service Review Institute, see: <https://childwelfaregroup.info/>.

design team worked together with the Monitor and the DSS consultant to finalize the QSR protocol, which will be used to examine the timeliness, accessibility, appropriateness, and effectiveness of follow-up care, as well as factors that may affect service delivery, including care coordination, placement stability, provider and service availability, and other barriers to care.

DSS plans to review the cases of 40 children over a 12-month period starting in September 2026, with 10 children selected from each of the State's four regions. Reviewer training is scheduled for September 2026, with the first QSR review of 10 children from the Midlands Region scheduled to begin in November 2026.¹⁸⁴

Discussion

The revised HCIP and methodologies that will be used to assess DSS's performance in meeting the Health Care Outcomes reflect the State's commitment and significant work to meet the health care needs of children in foster care. The Plan strengthens alignment and collaboration among DSS and its key partners; and outlines strategies, implementation timelines, performance targets, and continuous quality improvement processes. DSS, in collaboration with the Monitor and with input from Plaintiffs' counsel, worked to finalize methodologies for measuring performance toward meeting outcomes within the Plan and as required by the FSA.

Since approval of the revised Plan, DSS has made progress implementing the identified strategies and has begun to develop the processes that will be used to assess performance. This work has included establishing processes for data collection and analysis, refining procedures, and advancing collaborative efforts with partners to support achievement of the health care outcomes. Updates on implementation of the key components of the Plan are provided below.

- *Cross-sector collaboration and data sharing mechanisms:* DSS has been working with partners to establish agreements to share additional data. Notable progress in this area includes DSS' work with DHHS and the primary MCO, Select Health, to automate data exchange for healthcare information, with a goal of implementation by the end of September 2026. Although progress is slow, cross-sector staffings, rounds, and regional huddles (comprised of members from DSS, DHHS, and Select Health) are strategies that are in process of being implemented to improve cross-sector collaboration. DSS currently holds huddles in the Pee Dee Region and reports planning to work with DHHS and Select Health toward expansion to other regions.
- *Clarified MCO roles and responsibilities:* DSS and Select Health developed materials and provided trainings regarding the MCO care coordination process for DSS case managers and child placing agencies, which focused on navigating the MCO provider directory and provided clarity regarding roles and responsibilities of the care coordination process. The MCO is also responsible for ensuring continuity of care across providers and transitions, as

¹⁸⁴ Note: insights and lessons learned from the first 20 cases reviewed will be included in the MP21 report. Performance measurement and reporting based on the review of all 40 cases will be included in the MP22 report.

well as scheduling and following up on physical, dental, and behavioral health appointments for children in foster care. Select Health and DSS have also been working collaboratively in cases where Select Health Care Coordinators have been unable to contact caregivers.

- *Landscape analysis:* Although delayed, DSS continued efforts to complete the landscape analysis of behavioral health services and service provider workforce as outlined in the HCIP. The analysis is intended to assess the availability and capacity of behavioral health services across the state and identify gaps and barriers to accessing needed services. In partnership with the Institute for Families in Society (IFS), DSS worked with partner agencies, provider networks, and advocacy/service groups to distribute the landscape analysis survey. Due to initial low responses and limited reach, DSS extended these efforts through June 26, 2026. This resulted in a total of 249 respondents who completed the survey in its entirety. DSS is reviewing preliminary analysis of high-level findings, and a final written report from IFS is due to DSS in mid-August 2026.
- *Establishment of the Foster Care Oversight Committee:* The Foster Care Oversight Committee was convened beginning in late January 2026 to support HCIP implementation, goals, and strategies. The meetings have been ongoing monthly and are led by DSS. The Committee includes representatives from DHHS, the Department of Behavioral Health and Developmental Disabilities Office of Mental Health, Select Health, and a diverse array of medical and behavioral professionals across the state.
- *Implementing standardized initial medical screening practices:* DSS met with several organizations in order to establish partnerships to transition from DSS staff-conducted initial medical screenings for children to screenings performed by community-based healthcare providers within 72 hours of a child's entry into foster care. The final development and implementation of this process has been delayed and DSS is still in the process of determining next steps. Barriers have included establishing the appropriate provider payment codes with Medicaid and finalizing contracts with health care providers.
- *Strengthening early identification of mental and behavioral health needs:* DSS began implementing the methodology for using each child's first finalized, fidelity-administered CANS screening to identify the need for a comprehensive mental health evaluation. DSS is also evaluating regional and state CANS scores to identify trends in children's service needs. These findings will help inform implementation of the revised methodology outlined in the HCIP for measuring performance.
- *Measuring previously untracked outcomes:* DSS began incorporating the approved methodologies into its data collection and reporting processes. For the initial comprehensive medical assessment outcomes, DSS and the Monitor conducted case record reviews in accordance with the new methodology to determine a final performance metric combining case reviews with Medicaid administrative claims data for the first time. Similar processes are being developed for measuring initial dental visits and initial comprehensive mental health assessments. DSS also has been working to implement a QSR to assess follow-up care needs, and the first QSR review of 10 children from the Midlands Region is scheduled to begin September 2026.

- *Enhancing DSS's CAPSS data system:* DSS has created a new field in CAPSS to display the contact information for the MCO care coordinator assigned to each child. As of the end of July 2026, this information was entered for approximately 3,200 children. Guidance was provided via email to DSS staff about the location of the information in CAPSS and when to contact the MCO care coordinators for assistance. DSS and DHHS have shifted their approach to data sharing and are no longer pursuing modifications to the Child and Adolescent Information Portal. Instead, they are exploring an automated data exchange with DHHS to provide more efficient access to health care information. In the interim, DSS is working with DHHS to incorporate weekly health care appointment and encounter data into CAPSS. This interim solution is expected to be in place by the end of October 2026. Work remains to advance data sharing and collaboration between DSS and its partners.
- *Intensive Case Management:* DHHS's January 2025 amendments to the MCO contract required that children in foster care with four co-occurring conditions who meet eligibility criteria receive intensive case management (ICM). As of August 2026, 918 children (26%) in foster care statewide were enrolled in ICM. Of those children, 426 were enrolled as part of the pilot program in Richland County to provide all children in foster care with ICM through the MCO. While DHHS and DSS have not yet conducted a formal assessment of the impact of ICM in Richland County, DSS reported that recent data suggest that ICM may be a positive factor in improving the timely receipt of recommended care.

Significant work remains to fully implement the HCIP, including ensuring completion of initial medical screenings, assessing and ensuring provider network adequacy, operationalizing integrated data systems and information sharing, and evaluating and expanding initiatives. As implementation progresses, continued attention should focus not only on implementing strategies but also on assessing how effectively these strategies are being implemented, identifying and addressing barriers, and determining whether the strategies are achieving their intended outcomes for Class Members. This includes assessing whether HCIP activities have clarified roles and responsibilities between DSS and Select Health, reduced duplication of services, and improved health care outcomes. The Monitor believes that effective implementation of the HCIP and its commitments have the potential to improve health care outcomes for Class Members. This will require sustained cooperation and collaboration among all of DSS's partners along with regular assessment of implementation progress, impact, and areas requiring further improvement.

V. Appendix/Sources

A. Table of Monitoring Periods

Table 3. Monitoring Periods

Monitoring Periods		
MP19	October 1, 2025	March 31, 2026
MP18	April 1, 2025	September 30, 2025
MP17	October 1, 2024	March 31, 2025
MP16	April 1, 2024	September 30, 2024
MP15	October 1, 2023	March 31, 2024
MP14	April 1, 2023	September 30, 2023
MP13	October 1, 2022	March 31, 2023
MP12	April 1, 2022	September 30, 2022
MP11	October 1, 2021	March 31, 2022
MP10	April 1, 2021	September 30, 2021
MP9	October 1, 2020	March 31, 2021
MP8	April 1, 2020	September 30, 2020
MP7	October 1, 2019	March 31, 2020
MP6	April 1, 2019	September 30, 2019
MP5	October 1, 2018	March 31, 2019
MP4	April 1, 2018	September 30, 2018
MP3	October 1, 2017	March 31, 2018
MP2	April 1, 2017	September 30, 2017
MP1	October 1, 2016	March 31, 2017

B. Monitoring Activities

The Monitor is responsible for independent validation of data and documentation to compile and issue public reports on the State's performance with respect to the terms of the FSA. In carrying out this responsibility, the Monitor and staff have worked closely with DSS leadership and staff. The Monitor used multiple methodologies to conduct their work, including verification and analysis of information available through CAPSS; review of individual electronic case records of Class Members; review and validation of data aggregated by DSS; interviews and conversations with DSS leadership and staff; and conversations with external partners, including providers, advocates, and community organizations. The Monitor worked with DSS to establish review protocols to gather performance data and assess current practice for some measures. The Monitor participated in the Richland County Task Force and with each of the five workgroups. The Task Force concluded its work on March 27, 2026 and, at that date, ongoing workgroup-related tasks have been integrated into Richland County's Child Welfare Improvement Team meetings for sustainability. Additionally, the Monitor also met with a range of involved parties throughout and following the monitoring period.

Other specific data collection and/or validation activities conducted by the Monitor for the current period include the following:

- Review of all OHAN investigation records in CAPSS involving Class Members as an alleged victim and accepted in March 2026, to assess for timely initiation, contact with core witnesses, timely completion, and appropriateness of unfounded decisions (FSA IV.C.3.&4.).
- Review of a statistically valid sample of case records in CAPSS for Class Members with documented face-to-face contact between the case manager and the child during the month of March 2026 (FSA IV.B.3.).
- Review of a statistically valid sample of Class Members who entered care between March and August 2025 and remained in care for at least 60 days and for whom there was not Medicaid claims data for initial comprehensive medical assessment (FSA IV.K.5.; FSA Health Care Outcomes).
- Qualitative review of 17 Class Members who entered foster care in October 2025, remained in care for 90 days or more, for whom an initial CANS recommended therapeutic level of placement, and for whom a CFTM occurred (FSA IV.I.2.,3.,&6.).
- Review of a statistically valid sample of case records in CAPSS for Class Members who had been in foster care for 30 days or more on March 31, 2026, and living apart from a sibling also in foster care, to assess whether a sibling visit occurred in March 2026 (FSA IV.J.2.).
- Review of a statistically valid sample of case records in CAPSS for Class Members with a permanency goal of reunification or a permanency goal which had not yet been established in family court, and who were in foster care for 30 days or more on March 31, 2026, to assess whether the child visited with the parent(s) with whom reunification was sought during March 2026 (FSA IV.J.3.).

C. Glossary of Acronyms

AAP: American Academy of Pediatrics

ADR: Office of Accountability, Data, and Research

AFDC: Aid to Families with Dependent Children

CANS: Child and Adolescent Needs and Strengths

CAPSS: Child and Adult Protective Services System

CFTM: Child and Family Team Meeting

CMS: Centers for Medicare & Medicaid Services

CPA: Child Placing Agency

CSSP: Center for the Study of Social Policy

DCA: Department of Children's Advocacy

DHHS: Department of Health and Human Services

DJJ: Department of Juvenile Justice

DSS: Department of Social Services

EPC: Emergency Protective Custody

EPSDT: Early and Periodic, Screening, Diagnostic and Treatment

FFPSA: Family First Prevention Services Act

FMAP: Federal Medical Assistance Percentage

FFY: Federal Fiscal Year

FSA: Final Settlement Agreement

FTE: Full-Time Equivalent

GAL: Guardian ad Litem

GPS: Guiding Principles and Standards Case Practice Model

HCIP: Health Care Improvement Plan

ICM: Intensive Case Management

IFS: Institute for Families in Society

LPHA: Licensed Practitioner of the Healing Arts

MOE: Maintenance of Effort [Designation]

MCO: Managed Care Organization

MST: Multi-Systemic Therapy

OHAN: Out of Home Abuse and Neglect

QRTP: Qualified Residential Treatment Program

QSR: Quality Service Review

RC/RCDSS: Richland County/ Richland County DSS

SC: South Carolina

SFY: State Fiscal Year

D. County-Level Data

Table 4. Children in Foster Care by County of Origin and Rate Per 1,000 Children in the County Child Population¹⁸⁵

March 31, 2026

Source: CAPSS data provided by DSS; U.S. Census Bureau

County of Origin	Children in Foster Care	County Child Population (2025)	Children in Foster Care Per 1,000
Abbeville	8	4,825	1.7
Aiken	89	38,684	2.3
Allendale	12	1,179	10.2
Anderson	108	47,829	2.3
Bamberg	2	2,382	0.8
Barnwell	7	4,793	1.5
Beaufort	45	32,483	1.4
Berkeley	179	62,898	2.8
Calhoun	1	2,596	0.4
Charleston	187	81,694	2.3
Cherokee	33	12,874	2.6
Chester	32	6,979	4.6
Chesterfield	23	10,041	2.3
Clarendon	32	5,598	5.7
Colleton	50	8,448	5.9
Darlington	80	13,951	5.7
Dillon	27	6,711	4.0
Dorchester	55	41,984	1.3
Edgefield	14	5,147	2.7
Fairfield	23	3,444	6.7
Florence	81	31,237	2.6
Georgetown	18	10,443	1.7
Greenville	284	12,8190	2.2
Greenwood	29	14,806	2.0
Hampton	13	3,789	3.4
Horry	233	69,010	3.4
Jasper	24	6,610	3.6
Kershaw	87	16,655	5.2
Lancaster	83	25,271	3.3

¹⁸⁵ U.S. Census Bureau. (2025). *Annual county and Puerto Rico municipio resident population estimates by selected age groups and sex: April 1, 2020 to July 1, 2025 (CC-EST2025-AGESEX-45)* — South Carolina.

County of Origin	Children in Foster Care	County Child Population (2025)	Children in Foster Care Per 1,000
Laurens	101	15,133	6.7
Lee	17	2,809	6.1
Lexington	145	70,830	2.0
Marion	46	5,955	7.7
Marlboro	12	4,889	2.5
McCormick	3	1,018	2.9
Newberry	10	8,197	1.2
Oconee	65	15,067	4.3
Orangeburg	103	16,879	6.1
Pickens	51	25,058	2.0
Richland	422	85,454	4.9
Saluda	15	4,288	3.5
Spartanburg	192	87,165	2.2
Sumter	61	23,656	2.6
Union	18	5,352	3.4
Williamsburg	38	5,331	7.1
York	156	70,808	2.2
State	3,314	1,148,440	2.9

Table 5. Children in Foster Care by Office of Case Management*March 31, 2026*

Source: CAPSS data provided by DSS

Office of Case Management	Children in Foster Care
Abbeville	7
Aiken	74
Allendale	12
Anderson	82
Bamberg	1
Barnwell	7
Beaufort	34
Berkeley	166
Calhoun	1
Charleston	167
Cherokee	28
Chester	22
Chesterfield	20
Clarendon	24
Colleton	44
Darlington	62
Dillon	25
Dorchester	42
Edgefield	8
Fairfield	15
Florence	73
Georgetown	16
Greenville	239
Greenwood	25
Hampton	13
Horry	200
Jasper	24
Kershaw	62
Lancaster	68
Laurens	85
Lee	17
Lexington	117
Marion	45
Marlboro	10
McCormick	2
Newberry	8

Office of Case Management	Children in Foster Care
Oconee	54
Orangeburg	98
Pickens	44
Regional Permanency Lowcountry Charleston	67
Regional Permanency Midlands Columbia	110
Regional Permanency Midlands Orangeburg	29
Regional Permanency Midlands Rock Hill	75
Regional Permanency Pee Dee Florence	89
Regional Permanency Upstate Greenville	136
Richland County	352
Saluda County	15
Spartanburg County	170
Sumter County	53
TSS Division--Midlands	4
TSS Division--Pee Dee	1
TSS Division--Upstate	1
Union County	17
Williamsburg County	32
York County	122
State	3,314

Table 6. Entries and EPC Entries to Foster Care by County and Rate of Entry Per 1,000 Children in the County Child Population¹⁸⁶

MP19 (October 2025 – March 2026)

Source: CAPSS data provided by DSS; U.S. Census Bureau

Office of Case Management	County Child Population (2025)	Entries to Foster Care	Entries to Foster Care per 1,000	EPC Entries	EPC Entries per 1,000
Abbeville	4,825	1	0.2	1	0.2
Aiken	38,684	24	0.6	12	0.3
Allendale	1,179	3	2.5	0	0.0
Anderson	47,829	30	0.6	25	0.5
Bamberg	2,382	2	0.8	0	0.0
Barnwell	4,793	5	1.0	4	0.8
Beaufort	32,483	15	0.5	10	0.3
Berkeley	62,898	88	1.4	62	1.0
Calhoun	2,596	1	0.4	0	0.0
Charleston	81,694	58	0.7	48	0.6
Cherokee	12,874	19	1.5	9	0.7
Chester	6,979	7	1.0	4	0.6
Chesterfield	10,041	16	1.6	16	1.6
Clarendon	5,598	9	1.6	7	1.3
Colleton	8,448	23	2.7	10	1.2
Darlington	13,951	30	2.2	26	1.9
Dillon	6,711	16	2.4	14	2.1
Dorchester	41,984	13	0.3	13	0.3
Edgefield	5,147	4	0.8	0	0.0
Fairfield	3,444	16	4.6	16	4.6
Florence	31,237	46	1.5	36	1.2
Georgetown	10,443	16	1.5	6	0.6
Greenville	128,190	100	0.8	65	0.5
Greenwood	14,806	20	1.4	12	0.8
Hampton	3,789	8	2.1	5	1.3
Horry	69,010	107	1.6	63	0.9
Jasper	6,610	9	1.4	5	0.8
Kershaw	16,655	32	1.9	12	0.7
Lancaster	25,271	32	1.3	31	1.2
Laurens	15,133	38	2.5	17	1.1
Lee	2,809	4	1.4	3	1.1

¹⁸⁶ U.S. Census Bureau. (2025). *Annual county and Puerto Rico municipio resident population estimates by selected age groups and sex: April 1, 2020 to July 1, 2025 (CC-EST2025-AGESEX-45)* — South Carolina.

Office of Case Management	County Child Population (2025)	Entries to Foster Care	Entries to Foster Care per 1,000	EPC Entries	EPC Entries per 1,000
Lexington	70,830	61	0.9	26	0.4
Marion	5,955	28	4.7	22	3.7
Marlboro	4,889	10	2.0	10	2.0
McCormick	1,018	0	0.0	0	0.0
Newberry	8,197	7	0.9	6	0.7
Oconee	15,067	16	1.1	14	0.9
Orangeburg	16,879	38	2.3	29	1.7
Pickens	25,058	23	0.9	13	0.5
Regional Permanency Midlands Columbia	--	2	--	1	--
Regional Permanency Pee Dee Florence	--	2	--	1	--
Regional Permanency Upstate Greenville	--	4	--	0	--
Richland	85,454	166	1.9	128	1.5
Saluda	4,288	1	0.2	1	0.2
Spartanburg	87,165	95	1.1	59	0.7
Sumter	23,656	7	0.3	4	0.2
TSS Division--Midlands	--	2	--	2	--
TSS Division--Pee Dee	--	1	--	1	--
Union	5,352	10	1.9	7	1.3
Williamsburg	5,331	6	1.1	1	0.2
York	70,808	29	0.4	16	0.2
State	1,148,440	1,300	1.1	873	0.8

Table 7. Out-of-County Placements, by County¹⁸⁷*March 31, 2026*

Source: CAPSS data provided by DSS

County of Origin	Children placed Out-of-County	Children in Foster Care	Percent Placed Out-of-County
Abbeville	5	8	63%
Aiken	59	89	66%
Allendale	12	12	100%
Anderson	78	105	74%
Bamberg	2	2	100%
Barnwell	2	7	29%
Beaufort	20	45	44%
Berkeley	112	175	64%
Calhoun	0	0	0%
Charleston	138	183	75%
Cherokee	25	33	76%
Chester	26	32	81%
Chesterfield	19	23	83%
Clarendon	27	32	84%
Colleton	35	50	70%
Darlington	58	80	73%
Dillon	18	27	67%
Dorchester	41	55	75%
Edgefield	11	14	79%
Fairfield	18	23	78%
Florence	49	80	61%
Georgetown	10	18	56%
Greenville	185	280	66%
Greenwood	26	29	90%
Hampton	6	13	46%
Horry	106	228	46%
Jasper	18	24	75%
Kershaw	71	87	82%
Lancaster	55	83	66%
Laurens	76	100	76%
Lee	13	17	76%
Lexington	100	142	70%
Marion	23	46	50%
Marlboro	9	12	75%

¹⁸⁷ This data excludes 34 children who resided in other institutional settings on March 31, 2026.

County of Origin	Children placed Out-of-County	Children in Foster Care	Percent Placed Out-of-County
McCormick	3	3	100%
Newberry	8	10	80%
Oconee	52	64	81%
Orangeburg	72	102	71%
Pickens	35	50	70%
Richland	232	420	55%
Saluda	10	15	67%
Spartanburg	114	191	60%
Sumter	36	61	59%
Union	13	18	72%
Williamsburg	16	38	42%
York	92	154	60%
State	2,136	3,280	65%

Table 8. Exits from Foster Care within 60 Days of Entry, by County*MP19 (October 2025 – March 2026)*

Source: CAPSS data provided by DSS

County of Origin	Number of Exits within 60 Days	Total Number of Exits During MP19	Percentage of Exits within 60 Days
Abbeville	1	1	100%
Aiken	1	26	4%
Allendale	0	1	0%
Anderson	10	17	59%
Bamberg	0	1	0%
Barnwell	1	3	33%
Beaufort	6	18	33%
Berkeley	23	47	49%
Calhoun	0	0	0%
Charleston	11	54	20%
Cherokee	7	12	58%
Chester	0	16	0%
Chesterfield	1	1	100%
Clarendon	0	6	0%
Colleton	0	27	0%
Darlington	3	20	15%
Dillon	2	5	40%
Dorchester	1	10	10%
Edgefield	0	0	0%
Fairfield	5	9	56%
Florence	22	41	54%
Georgetown	3	10	30%
Greenville	27	65	42%
Greenwood	8	11	73%
Hampton	1	13	8%
Horry	28	74	38%
Jasper	4	14	29%
Kershaw	3	22	14%
Lancaster	12	30	40%
Laurens	8	31	26%
Lee	1	3	33%
Lexington	10	42	24%
Marion	4	22	18%
Marlboro	1	9	11%
McCormick	0	1	0%
Newberry	0	9	0%
Oconee	3	15	20%

County of Origin	Number of Exits within 60 Days	Total Number of Exits During MP19	Percentage of Exits within 60 Days
Orangeburg	7	27	26%
Pickens	5	9	56%
Regional Permanency Lowcountry Charleston	0	33	0%
Regional Permanency Midlands Columbia	0	42	0%
Regional Permanency Midlands Orangeburg	0	5	0%
Regional Permanency Midlands Rock Hill	0	24	0%
Regional Permanency Pee Dee Florence	0	30	0%
Regional Permanency Upstate Greenville	1	98	1%
Richland	27	121	22%
Saluda	0	4	0%
Spartanburg	31	56	55%
Sumter	1	7	14%
Union	3	8	38%
Williamsburg	0	6	0%
York	7	17	41%
State	289	1,173	25%

Table 9. Placement Moves, by County*MP19 (October 2025 – March 2026)*

Source: CAPSS data provided by DSS

Office Of Case Management	Number of Children with Placement Move	Children In Care at Any Point During MP19	Percentage of Children with At Least One Placement Move
Abbeville	5	8	63%
Aiken	38	99	38%
Allendale	5	13	38%
Anderson	41	100	41%
Bamberg	0	2	0%
Barnwell	5	10	50%
Beaufort	22	55	40%
Berkeley	96	212	45%
Calhoun	0	2	0%
Charleston	91	233	39%
Cherokee	17	36	47%
Chester	15	39	38%
Chesterfield	13	21	62%
Clarendon	13	30	43%
Colleton	42	73	58%
Darlington	35	81	43%
Dillon	16	30	53%
Dorchester	22	53	42%
Edgefield	1	8	13%
Fairfield	13	23	57%
Florence	43	115	37%
Georgetown	11	27	41%
Greenville	116	304	38%
Greenwood	17	36	47%
Hampton	10	25	40%
Horry	147	277	53%
Jasper	18	38	47%
Kershaw	48	85	56%
Lancaster	26	98	27%
Laurens	44	116	38%
Lee	16	20	80%
Lexington	71	160	44%
Marion	33	63	52%
Marlboro	14	19	74%

Office Of Case Management	Number of Children with Placement Move	Children In Care at Any Point During MP19	Percentage of Children with At Least One Placement Move
McCormick	1	3	33%
Newberry	3	17	18%
Oconee	27	70	39%
Orangeburg	57	126	45%
Pickens	24	52	46%
Regional Permanency Lowcountry Charleston	45	99	45%
Regional Permanency Midlands Columbia	56	154	36%
Regional Permanency Midlands Orangeburg	9	35	26%
Regional Permanency Midlands Rock Hill	34	101	34%
Regional Permanency Pee Dee Florence	45	125	36%
Regional Permanency Upstate Greenville	125	236	53%
Richland	221	471	47%
Saluda	10	20	50%
Spartanburg	105	226	46%
Sumter	20	61	33%
TSS Division--Low Country	4	9	44%
TSS Division--Midlands	11	28	39%
TSS Division--Pee Dee	3	12	25%
TSS Division--Upstate	6	16	38%
Union	9	25	36%
Williamsburg	15	38	39%
York	46	138	33%
State	1,980¹⁸⁸	4,573¹⁸⁹	43%

¹⁸⁸ The number of children that moved at least once sums to 1,980 rather than 1,978 due to two children who had two different episodes in foster care during MP19 in two different counties and experienced placement moves in both counties.

¹⁸⁹ The number of children in care at any point during MP19 sums to 4,573, while the unduplicated total is 4,571 due to two children who had two different episodes in foster care during MP19 in two different counties.

Table 10. Overnight Stays, by County*MP19 (October 2025 – March 2026)*

Source: CAPSS data provided by DSS

Office Of Case Management	Number of Overnight Stays	Number of Children with At Least One Overnight Stay
Aiken	3	1
Anderson	6	6
Berkeley	6	6
Charleston	2	2
Chester	1	1
Chesterfield	7	5
Colleton	1	1
Dillon	1	1
Fairfield	1	1
Florence	1	1
Georgetown	6	1
Horry	13	9
Laurens	1	1
Lexington	1	1
Marion	4	3
Marlboro	1	1
Regional Permanency Lowcountry	2	2
Richland	2	2
Saluda	2	1
Spartanburg	5	5
York	1	1
State	67	52

Table 11. Emergency Placements, by County*MP19 (October 2025 – March 2026)*

Source: CAPSS data provided by DSS

Office Of Case Management	Number of Children with At Least One Emergency Placement	Children In Care at Any Point During MP19	Percentage of Children with At Least One Emergency Placement
Abbeville	1	8	13%
Aiken	11	99	11%
Allendale	1	13	8%
Anderson	19	100	19%
Bamberg	0	2	0%
Barnwell	0	10	0%
Beaufort	5	55	9%
Berkeley	32	212	15%
Calhoun		2	0%
Charleston	18	233	8%
Cherokee	6	36	17%
Chester	3	39	8%
Chesterfield	11	21	52%
Clarendon	6	30	20%
Colleton	5	73	7%
Darlington	14	81	17%
Dillon	1	30	3%
Dorchester	11	53	21%
Edgefield	0	8	0%
Fairfield	6	23	26%
Florence	16	115	14%
Georgetown	4	27	15%
Greenville	53	304	17%
Greenwood	9	36	25%
Hampton	1	25	4%
Horry	39	277	14%
Jasper	2	38	5%
Kershaw	3	85	4%
Lancaster	6	98	6%
Laurens	18	116	16%
Lee	0	20	0%
Lexington	13	160	8%
Marion	11	63	17%
Marlboro	2	19	11%

Office Of Case Management	Number of Children with At Least One Emergency Placement	Children In Care at Any Point During MP19	Percentage of Children with At Least One Emergency Placement
McCormick	0	3	0%
Newberry	2	17	12%
Oconee	6	70	9%
Orangeburg	6	126	5%
Pickens	9	52	17%
Regional Permanency Lowcountry Charleston	10	99	10%
Regional Permanency Midlands Columbia	6	154	4%
Regional Permanency Midlands Orangeburg	1	35	3%
Regional Permanency Midlands Rock Hill	5	101	5%
Regional Permanency Pee Dee Florence	7	125	6%
Regional Permanency Upstate Greenville	14	236	6%
Richland	86	471	18%
Saluda	1	20	5%
Spartanburg	60	226	27%
Sumter	5	61	8%
TSS Division--Low Country	0	9	0%
TSS Division--Midlands	2	28	7%
TSS Division—Pee Dee	0	12	0%
TSS Division--Upstate	2	16	13%
Union	5	25	20%
Williamsburg	0	38	0%
York	4	138	3%
State	558¹⁹⁰	4,573¹⁹¹	12%

¹⁹⁰ The number of children who experienced at least one emergency placement during MP19 sums to 558, while the unduplicated total is 557 due to one child who had two different episodes in foster care during MP19 and experienced emergency placements in both counties.

¹⁹¹ The number of children in care at any point during MP19 sums to 4,573, while the unduplicated total is 4,571 due to two children who had two different episodes in foster care during MP19 in two different counties.

Table 12. Foster Care and Permanency Specialist Case Manager Caseload Non-Compliance, by County

MP19 (March 31, 2026)

Source: CAPSS data provided by DSS

Office Of Case Management	Total Number of Case Managers Serving One Or More Class Members	Number of Case Managers Out of Compliance with the Standard	Percentage of Case Managers Out of Compliance with the Standard
Abbeville	2	0	0%
Aiken	13	0	0%
Allendale	2	0	0%
Anderson	14	0	0%
Bamberg	1	0	0%
Barnwell	1	0	0%
Beaufort	5	1	20%
Berkeley	10	10	100%
Calhoun	1	0	0%
Charleston	25	3	12%
Cherokee	3	0	0%
Chester	6	1	17%
Chesterfield	2	0	0%
Clarendon	3	0	0%
Colleton	5	0	0%
Darlington	8	0	0%
Dillon	3	0	0%
Dorchester	4	0	0%
Edgefield	-	-	-
Fairfield	2	0	0%
Florence	8	1	13%
Georgetown	2	0	0%
Greenville	25	12	48%
Greenwood	3	0	0%
Hampton	-	-	-
Horry	18	0	0%
Jasper	5	0	0%
Kershaw	9	1	11%
Lancaster	5	3	60%
Laurens	8	4	50%
Lee	2	0	0%
Lexington	13	0	0%
Marion	4	1	25%

Office Of Case Management	Total Number of Case Managers Serving One Or More Class Members	Number of Case Managers Out of Compliance with the Standard	Percentage of Case Managers Out of Compliance with the Standard
Marlboro	2	0	0%
McCormick	1	0	0%
Newberry	1	0	0%
Oconee	7	0	0%
Orangeburg	7	5	71%
Pickens	7	2	29%
Regional Permanency Lowcountry Charleston	9	7	78%
Regional Permanency Midlands Columbia	9	6	67%
Regional Permanency Midlands Orangeburg	4	3	75%
Regional Permanency Midlands Rock Hill	6	6	100%
Regional Permanency Pee Dee Florence	19	3	16%
Regional Permanency Upstate Greenville	36	0	0%
Richland	37	7	19%
Saluda	2	0	0%
Spartanburg	27	0	0%
Sumter	5	0	0%
Union	2	0	0%
Williamsburg	3	0	0%
York	7	5	71%
State	403	81	20%

E. Summary Performance on FSA Requirements

Summary of Performance on Final Settlement Agreement Requirements						
PLACEMENTS						
1. Placement Moves: For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37 (FSA IV.F.1.). <i>(Data for this requirement are produced on an annual basis.)</i>						
Target	Current Status	10/24-9/25	10/23-9/24	10/22-9/23	10/21-9/22	Baseline
≤ 3.37 moves per 1,000 days	Target Not Met	7.90	6.64	6.07	5.70	3.55 (10/16-9/17)
2. Overnight Stays in DSS Offices and Hotels: DSS shall cease using DSS offices as overnight placement for Class Members and shall cease placing or housing any Class Members in hotels, motels, and other commercial non-foster care establishments (FSA IV.D.3.).						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
= 0 children	Target Not Met	52	190	216	188	N/A
3. Emergency or Temporary Placements for More than 30 Days: Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. (FSA IV.E.4.).						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
= 0 children	Target Not Met	8	6	20	22	N/A
4. Emergency or Temporary Placements for More than Seven Days: Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days (FSA IV.E.5.).						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
= 0 children	Target Not Met	132	144	137	216	N/A

Summary of Performance on Final Settlement Agreement Requirements

- 5. Congregate Care Placements:** At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period (FSA IV.E.2.).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 86%	MOE (Designated 6/17/26)	86%	86%	87%	87%	78% (3/2018)

- 6. Congregate Care Placements – Children Ages 12 and Under:** At least 98% of the Class Members 12 years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting Period (FSA IV.E.3.).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 98%	Exit and Termination (Granted 12/17/25)	N/A	98%	99%	98%	92% (3/2018)

- 7. Congregate Care Placements—Children Ages 6 and Under:** Prevent, with exceptions approved by the Co-Monitors, the placement of any Class Member age six (6) and under in any non-family placement (FSA IV.D.2.).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
= 0 children	Exit and Termination (Granted 12/17/25)	N/A	0	0	0	N/A

- 8. Juvenile Justice Placements:** When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or DJJ that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement (FSA IV.H.1.).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
= 0 children	Not Reported	N/A	N/A	N/A	N/A	N/A

Summary of Performance on Final Settlement Agreement Requirements

- 9. Therapeutic Placements and/or Services – Referral for Placement and/or Services:** At least 95% of Class Members that are both identified through an approved CANS as needing therapeutic placement and/or services and recommended for specific therapeutic placement and/or services during a Child and Family Team Meeting (CFTM) will be referred for such recommended placement and/or services within 30 days of the date of the CFTM (FSA IV.I.2.).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 95%	Not Reported	N/A	N/A	N/A	N/A	84% (10/2025)

- 10. Therapeutic Placements and/or Services – Reassessment:** At least 95% of Class Members identified through an approved CANS and a Child and Family Team Meeting as needing therapeutic placement and/or services shall receive an updated assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs (FSA IV.I.3.).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 95%	Not Reported	N/A	N/A	N/A	N/A	100% (10/2025)

- 11. Therapeutic Placements and/or Services – Receipt of Placement and Services:** At least 90% of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family team and incorporated into DSS' case and service plan within sixty (60) days following the date of the CFTM during which the recommendations were made (FSA IV.I.6.).

Interim Benchmarks for the First Successive 12-Month Period of Review:

- 60 percent of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS's case and service plan within 60 days following the date of the CFTM during which the recommendations were made.
- 70 percent of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS's case and service plan within 90 days following the date of the CFTM during which the recommendations were made.

Summary of Performance on Final Settlement Agreement Requirements						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	Not Reported	N/A	N/A	N/A	N/A	47% (10/2025)
Interim Benchmark within 60 days ≥ 60%	Not Reported	N/A	N/A	N/A	N/A	47% (10/2025)
Interim Benchmark within 90 days ≥ 70%	Not Reported	N/A	N/A	N/A	N/A	47% (10/2025)
CASE MANAGER CASELOADS AND CONTACTS WITH CHILDREN						
12. Workload within Applicable Limit: At least 90% of Workers and Worker supervisors shall have a workload within the applicable Workload Limit (FSA IV.A.2.(b)).						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
Case Managers						
OHAN ≥ 90%	Target Met	100%	100%	100%	100%	0% (9/2017)
Foster Care ≥ 90%	Target Not Met	83%	85%	81%	70%	28% (9/2017)
Permanency ≥ 90%	Target Not Met	70%	75%	73%	66%	23% (9/2017)
Team Leaders						
OHAN ≥ 90%	Target Met	100%	100%	100%	100%	100% (3/2018)
Foster Care ≥ 90%	Target Met	90%	92%	92%	91%	42% (3/2018)
Permanency ≥ 90%	Target Met	90%	86%	83%	83%	38% (3/2018)

Summary of Performance on Final Settlement Agreement Requirements

13. Workloads Not More Than 125% of Applicable Limit: No Worker or Worker's supervisor shall have more than 125% of the applicable Workload Limit (FSA IV.A.2.(c)).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
Case Managers						
OHAN 0 (0%)	Target Met	0 (0%)	0 (0%)	0 (0%)	0 (0%)	7 (100%) (9/2017)
Foster Care 0 (0%)	Target Not Met	20 (6%)	22 (7%)	26 (8%)	46 (16%)	136 (59%) (9/2017)
Permanency 0 (0%)	Target Not Met	13 (16%)	17 (18%)	8 (8%)	17 (19%)	45 (62%) (9/2017)
Team Leaders						
OHAN 0 (0%)	Target Met	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%) (3/2018)
Foster Care 0 (0%)	Target Not Met	1 (1%)	0 (0%)	1 (1%)	1 (1%)	26 (36%) (3/2018)
Permanency 0 (0%)	Target Met	0 (0%)	1 (5%)	2 (9%)	0 (0%)	3 (19%) (3/2018)

14. Minimum Monthly Contacts: At least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during the 12-month period shall have taken place (FSA IV.B.2.).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	Target Not Met	42%	N/A	N/A	N/A	24% (9/2019)

15. Minimum Monthly Contacts in Child's Residence: At least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child (FSA IV.B.3.).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 50%	Target Met	69%	N/A	N/A	N/A	22% (9/2019)

Summary of Performance on Final Settlement Agreement Requirements

OUT OF HOME ABUSE AND NEGLECT

16. Intake—No Investigation: At least 95% of decisions not to investigate a Referral of Institutional Abuse or neglect about a Class Member must be made in accordance with South Carolina law and DSS Policy (FSA IV.C.2.).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 95%	Exit and Termination (Granted 10/18/24)	N/A	N/A	N/A	100%	44% (3/2017)

17. Investigations – Case Decisions: At least 95% of decisions to “unfound” investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected (FSA IV.C.3.)

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 95%	MOE (Designated 12/17/25)	100%	96%	97%	100%	47% (3/2017)

18. Investigations – Timely Initiation: The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations (FSA IV.C.4.(a)).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 95%	MOE (Designated 12/17/25)	100%	96%	95%	93%	78% (3/2017)

19. Investigations – Face to Face: The investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four (24) hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors (FSA IV.C.4.(b)).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 95%	MOE (Designated 12/17/25)	100%	96%	95%	93%	78% (3/2017)

Summary of Performance on Final Settlement Agreement Requirements

20. Investigations – Contact with Core Witnesses: Contact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors (FSA IV.C.4.(c)).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	MOE (Designated 6/17/26)	100%	100%	86%	75%	27% (3/2017)

21. Investigations – Timely Completion: At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause (FSA IV.C.4.(d)).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 60%	Exit and Termination (Granted 10/18/24)	N/A	N/A	N/A	90%	95% (3/2017)

22. Investigations – Timely Completion: At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause (FSA IV.C.4.(e)).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 80%	Exit and Termination (Granted 10/18/24)	N/A	N/A	N/A	100%	96% (3/2017)

23. Investigations – Timely Completion: At least 95% of all investigations of a Referral of Institutional Abuse or Neglect not completed within sixty (60) days shall be completed within ninety (90) days (FSA IV.C.4.(f)).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 95%	Exit and Termination (Granted 10/18/24)	N/A	N/A	N/A	100%	93% (9/2017)

Summary of Performance on Final Settlement Agreement Requirements						
FAMILY CONNECTIONS						
24. Children's Visits with Their Parents: At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless an exception applies (FSA IV.J.3.).						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 85%	Target Not Met	64%	52%	55%	49%	12% (3/2018)
25. Placement of Children with At Least One Sibling: At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within 30 days of their siblings shall be placed with at least one of their siblings unless an exception applies (FSA IV.G.3.).						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 85%	Target Not Met	74%	76%	76%	70%	63% (3/2018)
26. Placement of Children with All of Their Siblings: At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within 30 days of their siblings shall be placed with all of their siblings unless an exception applies (FSA IV.G.3.).						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 80%	Target Not Met	48%	53%	49%	44%	38% (3/2018)
27. Children's Visits with Their Siblings: At least 85% of the total minimum number of monthly sibling visits for all siblings not living together shall be completed, unless an exception applies (FSA IV.J.2.).						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 85%	MOE (Designated 6/17/26)	87%	92%	84%	80%	66% (3/2018)

Summary of Performance on Final Settlement Agreement Requirements						
HEALTH CARE						
28. Initial Medical Screens: At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care (FSA IV.K.5; FSA Health Care Outcomes).						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	Not Reported	N/A	N/A	N/A	N/A	N/A
29. Comprehensive Medical Assessments within 30 Days: At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care (FSA IV.K.5; FSA Health Care Outcomes).						
Target	Current Status	MP18 <i>Revised Methodology</i>	MP18	MP17	MP16	Baseline
≥ 85%	Target Not Met	58%	45%	48%	50%	36% (3/2019)
30. Comprehensive Medical Assessments within 60 Days: At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care (FSA IV.K.5; FSA Health Care Outcomes).						
Target	Current Status	MP18 <i>Revised Methodology</i>	MP18	MP17	MP16	Baseline
≥ 95%	Target Not Met	77%	64%	67%	67%	52% (3/2019)
31. Referral to Developmental Assessments within 30 Days: At least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care (FSA IV.K.5; FSA Health Care Outcomes).						
Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	Exit and Termination (Granted 12/17/25)	N/A	93%	94%	96%	19% (7/2017- 12/2017)

Summary of Performance on Final Settlement Agreement Requirements

32. Referral to Developmental Assessments within 45 Days: At least 95% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 45 days of entering care (FSA IV.K.5; FSA Health Care Outcomes).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 95%	Exit and Termination (Granted 12/17/25)	N/A	95%	97%	96%	20% (7/2017-12/2017)

33. Initial Dental Examinations within 60 Days: At least 60% of Class Members aged two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care (FSA IV.K.5; FSA Health Care Outcomes).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 60%	Target Met	63%	60%	61%	62%	35% (3/2018)

34. Initial Dental Examinations within 90 Days: At least 90% of Class Members aged two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 90 days of entering care (FSA IV.K.5; FSA Health Care Outcomes).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	Target Not Met	74%	70%	76%	76%	48% (3/2018)

35. Comprehensive Mental Health Assessment within 30 Days: At least 85% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 30 days of the comprehensive medical assessment (FSA IV.K.5; FSA Health Care Outcomes).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 85%	Not Reported	N/A	N/A	N/A	N/A	N/A

Summary of Performance on Final Settlement Agreement Requirements

36. Comprehensive Mental Health Assessment within 60 Days: At least 95% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment (FSA IV.K.5; FSA Health Care Outcomes).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 95%	Not Reported	N/A	N/A	N/A	N/A	N/A

37. Periodic Preventative Care—Children Under 6 Months Old: At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly (FSA IV.K.5; FSA Health Care Outcomes).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	Not Reported	N/A	N/A	N/A	N/A	49% (3/2019)

38. Periodic Preventative Care—Children Aged 6 to 36 Months—AAP Guidelines: At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics (AAP) periodicity guidelines (FSA IV.K.5; FSA Health Care Outcomes).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	Not Reported	N/A	N/A	N/A	N/A	38% (3/2019)

39. Periodic Preventative Care—Children Aged 6 to 36 Months—Semi-Annual: At least 98% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit semi-annually (FSA IV.K.5; FSA Health Care Outcomes).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 98%	Not Reported	N/A	N/A	N/A	N/A	62% (3/2019)

Summary of Performance on Final Settlement Agreement Requirements

40. Periodic Preventative Care—Children Aged 3 and Older—Semi-Annual: At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually (FSA IV.K.5; FSA Health Care Outcomes).

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	Not Reported	N/A	N/A	N/A	N/A	12% (3/2019)

41. Periodic Preventative Care—Children Aged 3 and Older—Annual: At least 98% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit annually.

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 98%	Not Reported	N/A	N/A	N/A	N/A	58% (3/2019)

42. Periodic Dental Care—Semi-Annual: At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually.

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 75%	Not Reported	N/A	N/A	N/A	N/A	54% (3/2019)

43. Periodic Dental Care—Annual: At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually.

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	Not Reported	N/A	N/A	N/A	N/A	81% (3/2019)

44. Follow Up Care: At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs.

Target	Current Status	MP19	MP18	MP17	MP16	Baseline
≥ 90%	Not Reported	N/A	N/A	N/A	N/A	N/A



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