Department of Health and Human Services

Centers for Medicare & Medicaid Services

South Carolina Focused Program Integrity Review

Final Report

October 2022

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Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have a fraud detection and investigation program and oversight strategy that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance; (2) providing the opportunity for technical assistance related to program integrity trends; (3) assisting CMS in determining/identifying future guidance that would be beneficial to states; and (4) assisting with identifying and sharing promising practices related to program integrity.

This report summarizes information gathered during a focused review of the South Carolina Medicaid managed care program. The primary objective of the review was to assess the state's program integrity oversight efforts for Medicaid managed care. A secondary objective was to provide the state with useful feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

In August 2021, CMS conducted a virtual focused review of South Carolina's single state Medicaid agency, the South Carolina Department of Health and Human Services (SCDHHS), which is responsible for program integrity oversight of South Carolina's Medicaid program. This focused review helped CMS determine the extent of program integrity oversight of the managed care program at the state level and assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MCOs' Special Investigations Units (SIUs), as well as other primary data, to assess the state's and selected MCOs' program integrity practices. CMS also evaluated the status of South Carolina's previous corrective action plan, which was developed by the state in response to a managed care focused review conducted by CMS in 2016.
During the 2016 review, CMS identified a total of eight recommendations based upon the completed

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

focused review modules, supporting documentation, and discussions and/or interviews with key staff. CMS also included technical assistance resources for the state to consider utilizing for its oversight of managed care. The review and recommendations encompass the following six areas:

State oversight of managed care program integrity activities

1. Provider screening and enrollment
2. MCO investigations of fraud, waste, and abuse
3. Encounter data
4. Payment suspensions based on credible allegations of fraud
5. Terminated providers and adverse action reporting

Overview of South Carolina Medicaid

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency responsible for providing oversight of the medical assistance plans in South Carolina. The SCDHHS administers the state's Medicaid managed care program under the South Carolina Healthy Connections Medicaid Program. South Carolina Healthy Connections Medicaid Program provides comprehensive health benefits to eligible beneficiaries through five designated MCOs: Absolute Total Care (Centene), BlueChoice Health Plan of South Carolina (BlueChoice), First Choice by Select Health of South Carolina, Inc. (Select Health), Molina Health Care (Molina) and Humana Health Care (Humana). As of April 1, 2021, WellCare of South Carolina merged with ATC/Centene (Centene).

The Division of Program Integrity and Surveillance and Utilization Review (DPISUR), within SCDHHS, is the organizational unit responsible for overall program integrity operations. SCDHHS's Managed Care Operations unit is the division responsible for oversight of managed care contract monitoring and oversight. The state reported that oversight of the managed care system in South Carolina is a collaborative effort between SCDHHS DPISUR and Managed Care Operations, the MCOs, and the Medicaid Fraud Control Unit (MFCU).

In FFY 2019, South Carolina's Medicaid expenditures exceeded $7 billion. The Federal Medical Assistance Percentage matching rate for FFY 2019 was 71 percent. As of December 2019, approximately 799,809 (average monthly) beneficiaries, or 65 percent of the Medicaid population, were enrolled in five MCOs. South Carolina's managed care expenditures were approximately $2,996,109,379.

Of the five operating MCOs in the state, three were selected for interview during the virtual program integrity review: BlueChoice, Select Health, and Centene. Table 1 and Table 2 below provide enrollment/SIU and expenditure data for each MCO that CMS interviewed.

	BlueChoice	Select Health	Centene
Beneficiary enrollment total	170,832	331,378	79,716
Provider enrollment total	25,814	22,178	68,171
Year originally contracted	2008	1996	2016
Size and composition of SIU	The SIU is staffed by 405 associates, Nationwide*	The SIU is staffed by 64 FTE's*	The SIU employs a staff of 60+ FTEs, with 2 dedicated to market*
National/local plan	Local	Local	Local

*The SIU staff are not fully dedicated to the South Carolina Medicaid program.

Table 2. Medicaid Expenditure Data for South Carolina MCOs[3]

MCO	FFY 2017	FFY 2018	FFY 2019
BlueChoice	$361,682,182	$372,882,842	$419,726,969
Select Health	$1,260,655,066	$1,345,001,494	$1,280,100,296
Centene	$242,733,774	$236,934,363	$242,881,344

Results of the Review

CMS evaluated the following six areas of South Carolina's managed care program:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MCO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

CMS identified four areas of concern with South Carolina's managed care program integrity oversight that may create risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

[2] Beneficiary enrollment numbers, for each plan, are as of 12/31/2019.
[3] Each of the MCOs submitted the expenditure data reported in Table 2. The State confirmed expenditure data during the review process. Discrepancies (if identified) were clarified prior to development of this report.

1. *State Oversight of Managed Care Program Integrity Activities*

In accordance with the state monitoring requirements set forth in §§ 438.66 and 438.602, the SMA must have in effect a monitoring system for all managed care programs, which includes mechanisms for the evaluation of MCO performance in several key areas. In the state of South Carolina, these requirements are met through the SCDHHS, who administers the state's Medicaid program. Within the SCDHHS, DPISUR currently oversees Medicaid program integrity through five internal offices: Medical Review, Ancillary Review, Operations and Managed Care Oversight (OMCO), Recipient Utilization, and SUR. The SCDHHS Managed Care Operations Unit is responsible for managed care compliance with the managed care contract, and the DPISUR OMCO is responsible for managed care compliance with regards to Section 11 of the MCO Contract.

The DPISUR consists of 35 FTEs and is responsible for all program integrity, audit, and fraud investigation activities. Positions within DPISUR include; the PI Director, Reviewers (*two of these positions remain vacant at the time of review*), Investigators, Data Analysts (*two of these positions have been recently filled*), Administrative Assistants, Case Triage, Pharmacy Lock-In Coordinator, Hot Line Coordinator, Fiscal Analyst, MCO Oversight Coordinator (*position recently filled*), Sanctions Analyst, and Fiscal Analyst. During the review, CMS noted the above vacant positions and that the State is actively recruiting for all vacant positions and expects to have a full staff by year end 2021. CMS encourages South Carolina to ensure that their levels of staffing are adequate to conduct all necessary program integrity activities. Although staffing resources are sufficient to assist with day-to-day program integrity operations, activities, and contract performance, key positions remain unfilled.

Additionally, SCDHHS contracts with the following subcontractors to conduct program integrity related activities:

1. Unified Program Integrity Contractors (UPICs) – investigate instances of suspected fraud, waste, and abuse in Medicare or Medicaid claims.
2. Health Management Services (HMS) – Recovery Audit Contractor (RAC) who identifies and recovers improper Medicare/Medicaid payments paid to healthcare providers under FFS Medicare/Medicaid plans.
3. DentaQuest – subcontractor who is responsible for the adjudication of dental claims for SCDHHS.

At any point during their investigation, if fraud is suspected, each entity refers the provider to Program Integrity (PI) for further investigation. If PI determines a credible allegation of fraud exists, PI refers to the MFCU for investigation.

In South Carolina, MCOs are contractually required to have administrative and management arrangements or procedures designed to prevent, detect, reduce, investigate, and report known or suspected fraud, waste, and abuse activities in accordance with the requirements at 42 CFR 438.608(a)(1). While the SCDHHS does not contractually require health plans to have a separate Fraud, Waste, and Abuse plan, the MCOs normally attach the plan to all compliance plan submissions. Section 11.2.1 of the contract states, "The Compliance Plan must include written Policies, Procedures, and

standards of conduct that articulate the applicable requirements and standards under the contract, and all applicable federal and state standards and regulations".

The SCDHHS PI Division is the division responsible for the review and written approval of compliance plans, in accordance with the state's contract requirements. CMS observed that all three MCOs interviewed had compliance programs that met the minimum requirements outlined in § 438.608(a)(1). Each of the MCOs were also able to demonstrate fraud, waste, and abuse plans that comprehensively addressed continuity in practices that provide safeguards that protect the state's program integrity environment.

In accordance with § 438.602, the state is required to monitor compliance with § 438.608, which stipulates that MCOs must meet certain program integrity requirements. However, at the time of the review, neither the SCDHHS Managed Care Division nor the PI Division performed onsite reviews of MCOs beyond what is currently being performed by the state's External Quality Review Organization (EQRO) contractor. While no on-site reviews have been performed to date, SCDHHS PI does conduct in-depth annual desk reviews of the MCO's Compliance Plans, Strategic Plan and Quarterly Reports as a means of verifying compliance with the fraud and abuse contract requirements. During the interview, the state indicated that a current project is underway to hire an auditor to conduct annual on-site reviews of the MCOs to verify, in-person, compliance with all fraud, waste and abuse contract requirements. The first announced MCO on-site review will be scheduled during the FY 2022.

Pursuant to § 455.500 Subpart F, the DPISUR must procure a Recovery Audit Contractor (RAC vendor). In South Carolina, the only function of this RAC vendor, Health Management Systems (HMS), is to preform RAC-related duties as defined in the RAC request for proposals (RFP). The RFP requires the RAC vendor to develop and implement an electronic reporting process that facilitates SCDHHS tracking of underpayments and overpayments. This electronic reporting process must be approved by SCDHHS and meet SCDHHS and federal and state reporting requirements. In addition, the RAC vendor must provide specific data in the form and manner requested by to satisfy both CMS RAC reporting requirements and SCDHHS internal reporting requirements.

Please note that while at the time of the review, HMS had not yet complied with the RAC RFP contractual reporting requirements, this contractual requirement only applies to MCOs. In SC, HMS is contracted as the RAC vendor. HMS is not required to fulfill the MCO Reporting Requirements. However, HMS must meet the reporting requirements as defined in the RAC RFP.

Recommendation #1: In accordance with § 438.602 and § 438.608, CMS encourages the State to establish a process to conduct on-site reviews of managed care plans to verify compliance with its fraud and abuse contract requirements. The State should continue to utilize the formal matrix/template for the communication to the MCO of approval or disapproval of the compliance plan through the SharePoint site.

2. *Provider Screening and Enrollment*

To comply with §§ 438.602(b)(1)-(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of

the 21st Century Cures Act, all providers furnishing services to South Carolina Medicaid members, including providers participating in an MCO provider network, are required to be screened and enrolled with the State Medicaid Agency (SMA). Per the MCO Contracts, section 6.1.8. that states MCOs must "demonstrate that its Providers are credentialed as required by § 438.214 and section 6.1.9 that MCOs must, "…ensure that all contracted Providers are South Carolina Medicaid Network Providers by verifying ongoing Medicaid Enrollment with the Department." MCOs must ensure that all providers are registered in South Carolina's provider enrollment system prior to contracting and credentialing with the provider. This rule applies to all provider types and specialties and is inclusive of the billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers.

The SCDHHS screens and enrolls providers by conducting the appropriate Federal database checks, in accordance with § 455.436. In addition, all providers are required to obtain a SCDHHS Medicaid provider number as a requirement to enroll with an MCO. However, t**he SCDHHS has not assigned risk levels to providers in accordance with § 455.450, which requires the SMA to screen all initial applications, including applications for a new practice location, and any applications received in response to re-enrollment or revalidation of enrollment request, based on a categorical risk of "limited," moderate," or "high."** High risk and moderate risk providers are subject to enhanced screening that may include onsite visits, Federal Bureau of Investigation (FBI) background checks, and FBI fingerprinting. The SCDHHS reported to CMS that they do not have risk designations for providers. Each provider type is screened and enrolled utilizing the same standards, which do not include onsite visits, FBI background checks, or fingerprinting, when applicable. Further, CMS regulations at § 455.432 require that the state Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers, who are designated as ''moderate'' or ''high'' categorical risks to the Medicaid program. The OIG reported to CMS that there is no current policy or process for ensuring compliance with § 455.450 or § 455.432.

Recommendation #2: The SCDHHS should ensure compliance with the risk designation requirements in § 455.450, and subsequent enhanced screening requirements further listed in § 455.432.

3. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

As required by § 438.608(a)(1) and §§ 455.13-17, SCDHHS has an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs. Section 11 (Program Integrity) of the Medicaid Managed Care contract states, "MCOs are required to submit a written compliance plan and program integrity policies and procedures prior to readiness, annually thereafter, and upon request from SCDHHS. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the SCDHHS and/or the federal government."

The contract also specifies that the compliance plan and program integrity policies and procedures must define how the MCOs will adequately identify and report suspected fraud, waste, and abuse by members, network providers, and the subcontractors. The MCOs must develop a written integrity plan specific to

the contract that identifies the specific resources dedicated to program integrity activities related to claims, members, providers, and subcontractors involved in delivering the services outlined in this contract.

The SCDHHS PI conducts monthly, quarterly, and ad hoc collaborative sessions with the MCOs and other stakeholders to discuss pertinent program integrity issues pertaining to fraud, waste, and abuse matters and relevant contractual concerns. The attendees include representatives from the MCOs' program integrity divisions, the MFCU, and DPISUR staff. During these meetings, SCDHHS staff has provided educational guidance to the MCOs on MFCU referral standards to ensure only quality cases are being referred.

Additionally, on a quarterly basis, the MCOs submit electronically to SCDHHS all activities conducted on behalf of program integrity by the MCOs and include findings related to these activities. The report includes: allegations received and results of the preliminary review, investigations conducted and outcomes, and other activities. Upon submission, SCDHHS reviews the Quarterly Fraud/Waste/Abuse Overpayment Report. This evaluation examines ongoing reporting, as well as the contents of the report to ensure that all contractual requirements are being met. This is supported by the MCO contract as well, which states, "The Contractor will have methods and criteria for identifying and monitoring suspected Medicaid fraud and abuse as required by 42 CFR 456.3, 456.4, and 456.23."

When the MCO identifies suspected fraud (as defined in § 455.2) by one of its providers or subcontractors, it shall be reported to the Department upon discovery, to the SCDHHS PI designee. Any case sent to SCDHHS as a referral of suspected Medicaid fraud will be reviewed by the SCDHHS PI unit for determination and/or escalation to the MFCU and OIG simultaneously.

All referrals submitted by the MCOs are submitted to SCDHHS for quality review before being sent to the MFCU. CMS confirmed that each of the MCOs interviewed have SIUs. The SIU staffing levels reported by all three national plans ranged from 60 to 405 full-time equivalents.

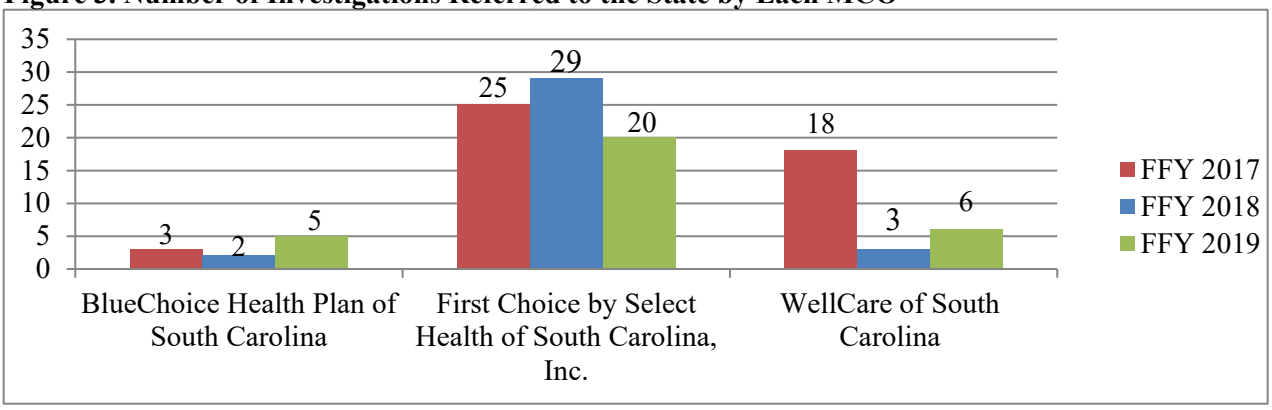
The SCDHHS Beneficiary Explanation of Medical Benefits (BEOMB) letters are generated monthly by the State using both FFS and Managed Care paid claims data. BEOMBs are mailed by the state and, if a beneficiary returns a BEOMB to the state indicating they did not receive an encounter service, SCDHHS PI will forward that BEOMB to the rendering MCO for investigation. Each plan performs an investigation according to their independent BEOMB process.

MCO Oversight of Network Providers

Section 11.1.17 of the MCO contract also includes contract language requiring the MCOs to verify beneficiary services by generating and mailing their own BEOMBs, in addition to those mailed by the state. All interviewed MCOs complete Recipient Verification (beneficiary verification) as specified by state contract, and in accordance with § 455.20; however, CMS has noted the state should identify and implement performance improvement initiatives to increase greater return in responses received. CMS did not identify any recommendations regarding South Carolina's use of BEOMBs.

Figure 3 describes the number of investigations referred to South Carolina by each MCO. The MCO provider case referrals of the reviewed SIUs appears to be adequate for all three plans.

Figure 3. Number of Investigations Referred to the State by Each MCO



Additionally, even though the three MCOs referred 111 cases to the state during the review period, CMS identified that the SCDHHS PI referred only twenty-two cases to the MFCU. This may have been due to a reduction in acceptable cases during the aforementioned quality review process. The MFCU accepted twenty case referrals related to the MCO's investigations, which CMS deemed adequate in relation to the total referred.

Overpayments

Pursuant to § 438.608(d)(3)-(4), MCOs are required to report recovered overpayments annually to the state. The South Carolina MCO contract contains a provision to support this requirement; Section 11.5.5 of the contract states, "The Contractor must report annually to the Department on their recoveries of Overpayments and Improper Payments identified in accordance with the Managed Care Policy and Procedure Guide and the Managed Care Report Companion Guide." Although the MCOs are not normally required to return overpayments from their network providers to the state, section 11.1.13 of the contract also states that MCOs should, "…be responsible for reporting to the Department the identification and the estimated amount of any Overpayment within thirty (30) Business Days of Discovery." In doing so, the state has a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process. Without these adjustments, MCOs could be receiving inflated rates per member per month. The MCO recoveries have shown an inclining trend since 2014. One positive attribute to the overpayment policy in South Carolina, which has yielded greater recovery is the significance in establishing a three-year lookback period. Tables 4-A, 4-B, and 4-C describe each MCO's recoveries from program integrity activities.

Table 4-A. BlueChoice Health Plan of South Carolina's Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	27	27	$306,251.18	$130,185.17
2018	30	26	$414,321.54	$15,102.64
2019	34	55	$565,347.85	$44,834.96

Table 4-B. First Choice by Select Health of South Carolina Inc.'s Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	31	75	$ 417,966.91	$ 383,800.08
2018	64	88	$1,167,387.32	$ 77,964.00
2019	63	106	$ 1,359,867.80	$ 285,616.98

Table 4-C. WellCare (Centene)'s Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	86	28	$673,744.22	$178,203.24
2018	62	22	$139,860.32	$ 66,943.69
2019	51	25	$164,354.52	$ 5,310.99

CMS did not identify any findings or recommendations related to MCO investigations of fraud, waste, and abuse.

4. Encounter Data

The MCO contract, section 11.6.4.6, with the state requires the submission of an electronic record for every claims level record for all billed services provided for claims processing and financial systems, or other data regarding Medicaid Benefits paid on behalf of its Members, as requested by the Department, its authorized entities, or the South Carolina Attorney General (SCAG). The encounter data from each of the MCOs is collected electronically on monthly basis and algorithms based on the state's established utilization metrics have been developed to compare submitted MCO data to that of the Medicaid Management Information System (MMIS).

CMS did not identify any findings or recommendations regarding South Carolina's use of encounter data for Medicaid program oversight and oversight of fraud, waste, and abuse.

5. Payment Suspensions

Consistent with §§ 455.23 and 438.608(a)(8), South Carolina's Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The MCO contract requires plans to suspend payments to a network provider on notice that the state determined a credible allegation of fraud in accordance with § 455.23. Suspension of payments must be implemented upon notification from the state and applies to all Medicaid claims (FFS and encounter/managed care based) submitted by the provider.

The SCDHHS contract, section 11.1.10, pursuant to §§ 455.23 and 438.608(a)(8), states that "Upon notification by the Department that a Provider has been placed on a payment suspension due to a Credible Allegation of Fraud pursuant to § 455.23, Contractor must suspend payments to any Providers and/or administrative entities involved. Contractor shall effectuate this suspension as soon as practicable." Upon notification from the Department that such a determination has been made, and provided the Department has not determined good cause exists to not suspend payments or to suspend payment only in part, the MCO must suspend payment as soon as possible and no later than the date indicated in the notice from the Department.

Prior to determining a Credible Allegation of Fraud exist, DPISUR consults with both the MCOs and MFCU. If either believes there is a good cause, as defined in § 455.23, to not suspend payments or to suspend payment only in part to such provider or subcontractor, they will relay that information to DPISUR prior to the CAF effective date. After DPISUR evaluates the good cause exception request, and if the request is granted, DPISUR will notify either the MCO or MFCU of their decision. Upon notification from DPISUR of a determination that good cause does not exist, the MCO suspends payments as of the date in the Department's notice. The MCO must send a letter of the suspension of program payments to the suspended provider and a copy of the letter to the agency and a timeframe "as soon as practicable." The letter must address all points in § 455.23(b)(2) and must set forth the provider's right to the state's administrative appeals process."

All three MCOs have a payment suspension policy and comply with the terms of their contract. As such, CMS did not identify any recommendations regarding South Carolina's payment suspension policies and processes.

6. Terminated Providers and Adverse Action Reporting

Consistent with § 438.608(b) and 455, subparts B and E, section 11.12.7 of the South Carolina MCO contract states, "The Contractor must report to the Department any Providers or Subcontractors that have been debarred, suspended, excluded, and/or terminated for cause from participation in Medicaid, Medicare, or any other federal program immediately upon discovery by using the appropriate referral Form and in the form and manner established in the Managed Care Policy and Procedure Guide and Managed Care Report Companion Guide." This information is also reported on a quarterly basis by the MCOs on the *MCO Program Integrity Quarterly Report*.

The three MCOs interviewed by CMS reported that they currently submit providers terminated, either with or without cause, to SCDHHS on both a monthly and quarterly basis, as well as during the MFCU meetings. The state notifies the MCOs of any terminated providers from other plans or providers who have lost South Carolina Medicaid eligibility. This ensures that these terminated providers are not operating in any plan contracted with the state. SCDHHS provided evidence of compliance with the monthly requirement and process for submitting terminated providers for inclusion in CMS' Data Exchange System (DEX).

Overall, the number of providers terminated "for cause" by the plans appears low, compared to the number of providers enrolled with the MCOs and compared to the number of providers dis-enrolled or terminated for cause. However, CMS did not identify any recommendations. Table 5 depicts the number of provider terminations by MCO.

Table 5: Provider Terminations in Managed Care

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs	Total # of Providers Terminated for Cause in Last 3 Completed FFYs
BlueChoice Health Plan of South Carolina	2017 1,641 2018 1,005 2019 1,363	2017 4 2018 7 2019 8
First Choice by Select Health of South Carolina, Inc.	2017 24 2018 18 2019 18	2017 10 2018 8 2019 6
WellCare (Centene)	2017 26 2018 12 2019 21	2017 7 2018 12 2019 14

Status of South Carolina's 2016 Corrective Action Plan

South Carolina's last CMS program integrity review was conducted in May 2016, and the report for that review was issued in June 2017. The report contained 15 recommendations. CMS completed a desk review of the corrective action plan in April 2019. The desk review indicated that all findings had been satisfied. The State was notified of corrective action plan closure on April 11, 2019.

Conclusion

CMS supports South Carolina's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified four areas of concern and instances of non-compliance with federal regulations that should be addressed immediately.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

CMS looks forward to working with South Carolina to build an effective and strengthened program integrity function.