Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

South Carolina Comprehensive Program Integrity Review

Final Report

October 2011

Reviewers:
Todd Chandler, Review Team Leader
Leatrice Berman Sandler
Margi Charleston
Debra Tubbs
Joel Truman, Review Manager

Table of Contents

Introduction 1

The Review 1
Objectives of the Review 1
Overview of South Carolina's Medicaid Program 1
Program Integrity Section 1
Methodology of the Review 2
Scope and Limitations of the Review 2

Results of the Review 3
Effective Practices 4
Regulatory Compliance Issues 6
Vulnerabilities 7

Conclusion 13

Official Response from South Carolina A1

Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the South Carolina Medicaid Program. The onsite portion of the review was conducted at the offices of the South Carolina Department of Health & Human Services (SCDHHS). The MIG review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Bureau of Compliance and Program Review (BCPR), which is responsible for Medicaid program integrity in South Carolina. This report describes one noteworthy practice, four effective practices, two regulatory compliance issues, and seven vulnerabilities in the State's program integrity operations.

The Review

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help South Carolina improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of South Carolina's Medicaid Program

The SCDHHS administers the Medicaid program. In the State fiscal year (SFY) ending June 30, 2010, the program served a total of 807,990 beneficiaries, 450,307 of whom were enrolled in 5 managed care organizations (MCOs). Total Medicaid expenditures during SFY 2010 were $5,114,002,220. The State had 40,199 providers participating in the Medicaid program; of these, 14,248 were also enrolled in managed care. During Federal fiscal year (FFY) 2010, the Federal medical assistance percentage (FMAP) for South Carolina was 70.32 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 79.58 percent during FFY 2010.

Program Integrity Section

In South Carolina, BCPR is the organizational component dedicated to anti-fraud and abuse activities. In SFY 2010, there were 38 full-time equivalent positions in the Bureau, with 26 positions allocated to the Divisions of Program Integrity and Surveillance and Utilization Review (SURs). Six of these were vacant at the time of the review. The table below presents the number of preliminary and full investigations, the amount of overpayments identified and total recoupments in the past four SFYs. The amount of overpayments collected does not include global recoveries.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2007	301	11	$6,200,172	$4,823,715
2008	324	7	$6,266,867	$3,487,184
2009	501	16	$8,138,916	$8,061,864
2010	445	12	$9,258,911	$6,830,490

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the Medicaid Fraud Control Unit or administrative or legal disposition. The number of full investigations in this report represents cases that were referred to the MFCU.

Methodology of the Review

In advance of the onsite visit, the review team requested that South Carolina complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as provider enrollment, claims payment and post payment review, managed care, surveillance and utilization review subsystem, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of January 24, 2011, the MIG review team visited the BCPR and MFCU offices. The team conducted interviews with numerous SCDHHS officials as well as with staff from the State's provider enrollment contractor and the MFCU. To determine whether the MCOs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team also reviewed the State's managed care contract. The team conducted in-depth interviews with representatives from four MCOs and met separately with SCDHHS staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity case files, and other primary data to validate South Carolina's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of BCPR, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care contract management, non-emergency medical transportation (NEMT), and provider training. The South Carolina Children's Health Insurance Program (CHIP) operates as a Medicaid expansion program under Title XIX of the Social Security Act and, thus, operates under the same billing and provider enrollment policies as the State's Title XIX program. Accordingly, the same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to CHIP.

Unless otherwise noted, SCDHHS provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information provided.

Results of the Review

Noteworthy Practice

As part of its comprehensive review process, the CMS review team has identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Effective relationship with the State Attorney General's Office on beneficiary fraud cases and beneficiary lock-in program

The MIG's FFY 2008 review identified a noteworthy practice relating to South Carolina's direct involvement in beneficiary fraud cases and its close relationship with the beneficiary fraud unit housed in the State Attorney General's Office. The latter unit is known as the Medicaid Recipient Fraud Unit (MRFU). The 2011 MIG review team noted that the State agency continues to expand its relationship with MRFU and has since developed an effective beneficiary lock-in program.

The MRFU has three law enforcement staff, one attorney and one administrative assistant assigned to work beneficiary fraud referrals. These staff work closely with BCPR program integrity staff on recipient fraud cases and enable State agency staff to address beneficiary program integrity issues proactively. The MRFU also works with the MFCU when there is evidence of provider/beneficiary collusion in a fraud case. The BCPR is involved in investigations when a single provider appears as the common link in several otherwise unrelated beneficiary cases. Conversely, the MRFU's efforts lend considerable additional support to the State agency's efforts to detect potential provider fraud.

The BCPR staff in the Department of Recipient Utilization review beneficiary profiles in order to identify beneficiaries who may be appropriate for the lock-in program. If beneficiaries meet specific lock-in criteria, they will be placed in the Medicaid lock-in program, which monitors their drug utilization and requires them to use only one designated pharmacy. If additional coordination of care is deemed necessary, a referral will also be made to the managed care division at SCDHHS for outreach to determine if the beneficiary should be required to choose an MCO or a Medical Home Network (South Carolina's primary care case management program). Factors that may lead to a beneficiary being considered for a referral to lock-in include problematic patient utilization indicators, such as:

1. Use of multiple pharmacies and/or prescribers,
2. Any history of prior misutilization, such as abusive, duplicative, or wasteful utilization practices,
3. Utilization patterns that deviate from peer group comparisons,
4. Duplication and inappropriate use of controlled substances or psychotropic drugs,
5. Contra-indications suggesting potential harm to the patient, and
6. Drug-seeking behaviors.

Utilization in the lock-in program is monitored on a monthly basis from the time a beneficiary is placed in the program. The SCDHHS staff monitors utilization through pre and post lock-in comparisons. According to BCPR staff, there were 199 beneficiaries in the South Carolina lock–in program at the time of the review. The BCPR further noted that since the program's inception in January 2009, service utilization by beneficiaries in the program has decreased by 29 percent. This drop in beneficiary utilization represents a total savings of $1,110,698, or an average of $5,581 per targeted beneficiary.

Effective Practices

As part of its comprehensive review process, the CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. South Carolina reported the introduction of a provider self-audit program, development of a contract with the State survey agency to ensure the transmission of ownership and control disclosures, implementation of a managed care audit program, and use of a common provider disclosure form across the fee-for-service (FFS) and managed care programs.

Provider self-audit program

South Carolina has been able to expand the reach of its audit activities by means of a provider self-audit program. The program is voluntary. However, once the State initiates a self-audit request, a provider's refusal to participate can result in a desk audit conducted by the State.

The BCPR SURs division performs data analysis to identify self-audit topics and targets and initially identifies providers whose billing patterns appear out of compliance with Medicaid payment policies. During MIG's 2008 review, SCDHHS was recognized as having an effective practice for its library of over 350 algorithms which are used for these purposes. Providers whose paid claims appear non-compliant are notified by letter with a description of agency policy and how their claims do not comply. The providers are asked to participate in a self-audit, while the State makes it clear that if they do not participate, they may be subject to a desk audit. Also, even if providers participate, the State does not relinquish its right to pursue related overpayments in civil or criminal court if warranted. All associated payments that are incorrectly billed must be repaid to the State agency.

The self-audit protocol requires that providers agree to review identified claims and beneficiary medical records for each billed service in question. If the provider feels a claim was billed correctly, the provider is asked to submit supporting documentation to a State agency reviewer. If the provider agrees that the claim is incorrectly billed, the associated payment must be returned to the State agency. If the State agency reviewer disputes the provider's findings and the dispute cannot be easily resolved, the audit is converted to a desk review.

The largest self-audit undertaken in South Carolina was a project involving four pharmacy chains and was related to the use of "brand medically necessary indicators" over a four year period. The project was the result of collaboration

between the SCDHHS Department of Pharmacy and Durable Medical Equipment Review and BCPR's SURs division. In the four SFYs prior to the onsite review, South Carolina reported total recoveries of $17,299,921. Of this figure, $7,173,453 stemmed from provider self-audit activities and of the latter figure, $3,270,575 in collections was returned from the four pharmacy chains.

The provider self-audit program is a valuable tool because it allows BCPR staff to undertake larger scale projects than might otherwise be possible through collaboration with other departments within SCDHHS. It also allows the State agency to augment the efforts of existing staff by drawing more providers into the audit process than State staff alone could review.

Contract with State survey agency

The SCDHHS has contracted with the South Carolina Department of Health and Environmental Control (SCDHEC) for the purchase and provision of survey and certification services. The contract is contingent upon the availability of Federal, State, and local funding for the services. The provisions of the contract require SCDHEC to collect information related to ownership and control and criminal convictions pursuant to 42 CFR §455.104 and 455.106, respectively, when its staff survey institutional providers, such as hospitals and long term care providers. They also require surveyors to communicate new information when they become aware of changes in ownership and licensure in the course of the provider certification and renewal process. Having a contract that binds the Medicaid and State survey agency is viewed by the Medicaid agency as effective in providing updated information on larger health care facilities and key affiliated parties as required by the above regulations.

Implementation of a managed care audit program with contractual authority to recoup overpayments

The BCPR began auditing health plans in 2007 with full cooperation from the Bureau of Managed Care and has increasingly used these audits to look at fraud and abuse issues. The BCPR runs specific algorithms from its SURs division, and its Division of Audits conducts field reviews using standard yellow book auditing procedures (Government Auditing Standards) and random sampling of provider files. These reviews focus on such items as health plan exclusion checking and whether elements of the compliance plan and other contract obligations are documented.

Further, the State has used provisions related to recoupment and State audit authority, found in South Carolina's MCO Policy and Procedure manual and MCO contract (sections 2.5, 11.2.4 and 13.5), to support its authority to recoup funds after a program audit. As a result of an audit conducted in SFY 2010, the State recouped $130,000 from an MCO (approximately $100,000 from the MCO and $30,000 directly from providers) related to maternity and newborn payments in which FFS claims were paid in addition to premiums. A potential obligation of $400,000 was identified in another 2010 MCO audit related to the retroactive enrollment of newborns in which the same type of duplicate payments occurred.

After running algorithms matching capitation payments to enrollee dates of death, the State agency has also recouped premium dollars from the excess payments identified.

Notwithstanding the State's successful auditing initiatives, the team found certain other MCO oversight issues which are discussed in the Vulnerabilities section of this report.

Use of uniform provider disclosure form in FFS and managed care programs

The State requires that its Disclosure of Ownership Form (known as the DOO) is included in MCO provider enrollment credentialing and recredentialing packages. The team confirmed that all managed care plans interviewed were using this form and that the obligation to provide disclosure information pursuant to 42 CFR §§ 455.104 and 455.106 was incorporated in the State's managed care contracts. In general, the State's ability to have the plans use a standardized disclosure reporting tool is a significant step forward in the pre-enrollment screening process.

Notwithstanding South Carolina's achievement in this area, the team found certain other disclosure issues which are discussed in the Findings and Vulnerabilities sections of this report.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to the collection of required ownership and control disclosures and the reporting of adverse actions to the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG).

The State does not capture all required disclosures on ownership, control, and relationships from disclosing entities and subcontractors. (Uncorrected Partial Repeat Finding)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

The SCDHHS revised its disclosure and ownership form following MIG's 2008 program integrity review. The DOO form is currently used by the State's two NEMT brokers and MCOs to identify the ownership of their own organizations as well as by long term care facilities and all FFS providers. The revised form has addressed all of the issues identified in the 2008 review with the exception of one: the DOO form still does not ask for required information about specific persons with ownership interests in subcontractors in which a disclosing entity has ownership or control and the relationships of these persons to those who have ownership and control of the disclosing entity.

NOTE: The CMS reviewed FFS applications, fiscal agent, NEMT, and managed care contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendation: Modify all provider enrollment applications and contracts to capture the required information about subcontractors owned by disclosing entities and the relationship among persons with ownership and control interests in the disclosing entities and their subcontractors.

The State does not report all adverse actions taken on provider applications to the HHS-OIG.

The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

While SCDHHS notifies HHS-OIG when it excludes a provider from participation in the Medicaid program, it does not report providers whose applications are denied for program integrity reasons. It also does not report fraud or abuse-related suspensions of providers or other actions taken to limit an enrolled provider's ability to participate in Medicaid.

Recommendation: Develop and implement policies and procedures to notify the HHS-OIG when denying providers enrollment for program integrity-related reasons or when limiting a provider's ability to participate in the Medicaid program.

Vulnerabilities

The review team identified seven areas of vulnerability in South Carolina's program integrity practices. These involved limited oversight of the managed care program, failure to collect required disclosures from managed care and NEMT providers, and failure to conduct complete exclusion searches. They also included the failure to verify services provided to Medicaid managed care enrollees and the failure to report program integrity-related adverse actions taken against MCO and NEMT network providers.

Limited State oversight of MCO program integrity activities.
As noted in the Effective Practices section of this report and in the 2008 review, BCPR and the Bureau of Managed Care collaborate effectively in several ways. The creation of a successful managed care audit program is evidence of this. At the same time, the MIG review team noted that oversight of MCO program integrity activities is circumscribed by minimal reporting obligations on the part of participating plans, limited interaction with plan personnel, and a relative dearth of training activities. The State agency could do more to stay current on MCO program integrity activities and build communication and collaboration among BCPR, the Bureau of Managed Care, the MFCU and MCOs.

State requirements on MCO reporting are a case in point. In practice, MCOs currently report only confirmed cases of fraud or abuse to the State agency. Although the MCO contract (section 13.23) requires reporting of any cases of suspected fraud or abuse, including the number of complaints made that warrant preliminary investigation, the review team determined that referrals are usually made after a preliminary investigation takes place and the plan determines that fraud or aberrant behavior exists. The SCDHHS also does not require periodic reporting of fraud and abuse complaints, specific data mining analyses or investigations. This limits the State's knowledge of the scope of MCO program integrity work. For example, the State agency was not aware of the numbers of reported cases being followed by MCOs prior to CMS' request for documentation as part of this program integrity review. Furthermore, the team noted that two of the four plans interviewed have reported few or no fraud or abuse cases in the last four SFYs.

Based on interviews with four MCOs, State managed care staff, and the MFCU director, the team also noted that opportunities for more cross-component collaboration existed. At the time of the review, SCDHHS did not conduct periodic or routine fraud and abuse training for its managed care plans either alone or jointly with the MFCU, and the operational managed care meetings that occur monthly do not routinely focus on fraud and abuse matters. While the State reported that the BCPR director has met with executives of health plans on at least one occasion, SCDHHS does not hold periodic or routine meetings with plan compliance officers or Special Investigation Unit directors to share information about fraud detection strategies, specific data mining strategies in use, or emerging cases/trends. As a result, the State is hindered from gaining a full picture of fraud and abuse throughout the Medicaid program. It is not able to track issues or provider activity across plans or across the managed care and FFS delivery systems. The State has taken initial steps in developing special projects in collaboration with MCOs, but this has just begun. These aspects of South Carolina's program can be strengthened.

Recommendations: Develop and implement policies and procedures to require MCOs to report all investigations of suspected provider fraud and abuse to BCPR. Increase BCPR presence at MCO operational meetings, add BCPR items and program integrity training to meeting agendas, and hold joint trainings and periodic meetings involving MCO staff, BCPR and the MFCU.

Not collecting full ownership and control disclosure information from NEMT and managed care providers.
The SCDHHS contracts with two transportation brokers for NEMT. The review team reviewed provider application packages used by the brokers when enrolling individual drivers and companies into their provider networks. Based on the material reviewed, one broker requested appropriate information from companies on persons with ownership and control interests, while the other did not. Failure to obtain this information could leave the State vulnerable to contracting with companies owned or controlled by excluded parties or persons debarred from Federal contracting.

In contrast, MCOs are required by contract to use the State's standardized DOO form as part of their network provider credentialing process. In interviews, MCOs confirmed that they use the DOO form. However, since the form is not fully compliant with the Federal regulation as noted in the Findings section, complete identifying and relationship information about persons with ownership and control interests in subcontractors remains unavailable.

NOTE: The CMS reviewed the managed care and NEMT contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of this review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for the provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendations: Revise NEMT contracts to require the collection of all ownership and control disclosure information specified in 42 CFR § 455.104. Revise the DOO form to collect all such information as described earlier. Require the use of the revised standardized tool in the NEMT and MCO provider enrollment application process.

Not requiring the disclosure of business transaction information upon request in MCO and NEMT provider agreements. (Uncorrected Partial Repeat Vulnerability)
The team reviewed the NEMT provider agreements used by both South Carolina transportation brokers when enrolling individual drivers and companies into their NEMT networks. Neither broker's provider agreement included a statement that the provider agrees to furnish required business disclosures within 35 days of a request by the State Medicaid agency or the U.S. Department of Health and Human Services (HHS) as required by 42 CFR § 455.105 for FFS.

The MCO provider agreements likewise do not require network providers/subcontractors to disclose business transaction information on request, which Federal regulations at 42 CFR § 455.105 would otherwise require of FFS providers.

Recommendation: Modify the NEMT and MCO network provider agreements to require timely disclosure, upon request, of the required business transaction information.

Not collecting health care-related criminal conviction information from NEMT service providers.

The SCDHHS contracts with two transportation brokers for NEMT. The review team reviewed provider application packages used by the brokers when enrolling individual drivers and companies into their NEMT networks. Based on the material reviewed, one broker requested appropriate information on persons with ownership and control, agents and managing employees with health care-related criminal convictions, while the other did not. The failure to capture this information leaves the State unable to report such disclosures on a timely basis to HHS-OIG, as the regulation also requires.

Recommendation: Develop and implement policies and procedures to collect and report health care-related criminal conviction information from NEMT service providers as specified in 42 CFR § 455.106.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the List of Excluded Individuals/Entities (LEIE) or the Medicare Exclusion Database (MED) upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the Excluded Parties List System (EPLS) on a monthly basis.

While the State is collecting some of the required disclosures, the State is not conducting monthly searches of the LEIE or the MED. State agency representatives reported that staff check for exclusions based upon notifications received from HHS-OIG on excluded providers. The correspondence from HHS-OIG is not sent to the State monthly and is limited to information for South Carolina and surrounding states. The Medicaid agency also does not conduct monthly exclusion checks for its institutional and non-institutional providers or contractors, such as MCOs and the NEMT brokers.

Concerning the January 2009 SMDL #09-001, SCDHHS did endeavor to comply with this guidance by posting a bulletin in June 2009 on its website informing providers of the responsibility to check their employees and contractors for excluded persons monthly. In addition, several MCOs indicated that they conduct monthly exclusion searches. However, the team determined that these checks only match disclosed provider names against the Federal exclusion databases. They do not cover persons with an ownership or control interest in the provider or agents and managing employees. In addition, the team found no evidence that MCOs check their employees and contractors on a monthly basis.

Recommendation: Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded person or entities.

Not verifying with managed care enrollees whether services billed by MCO network providers were received.

While South Carolina meets the requirements of 42 CFR § 455.20 by sending explanations of medical benefits (EOMBs) to a random sample of FFS beneficiaries, the State's MCO contract does not require that MCOs similarly verify services with beneficiaries on an ongoing or routine basis. Nor does the State include a random sample of managed care encounters in the EOMBs it sends out. In interviews, none of the MCOs indicated that they were performing routine verification of services with beneficiaries except when there are complaints or specific investigations underway. In the case of one plan, verifications took place routinely after emergency room visits, but this was a utilization control measure to reduce the volume of claims with an inappropriate site of care.

Recommendation: Develop and implement policies and procedures to verify with managed care enrollees whether billed services were actually received.

Not reporting adverse actions on provider applications for participation in the NEMT and MCO programs.

The SCDHHS contracts with MCOs and NEMT brokers do not require the reporting of adverse actions taken to limit the ability of network providers to participate in the program. The failure to report such actions leaves SCDHHS unable to meet its reporting requirements under the Federal regulation at 42 CFR § 1002.3(b)(3). Several health plans stated that they would report a provider network termination *for cause* to the State, despite the fact that this is not a contract requirement. However, in interviews, all MCOs indicated that credentialing denials made for program integrity reasons are not currently reported to the State agency and hence cannot be reported to HHS-OIG.

In addition, the monthly provider report (by provider name) that plans submit to the State does not distinguish terminations for cause from other routine voluntary terminations. During interviews, Medicaid agency representatives indicated that they did not believe they had a legal obligation to report actions taken against providers

under third party contracts. However, managed care staff at the State agency acknowledged that information on MCO adverse actions could be useful in tracking provider fraud and abuse

Recommendations: Require contracted MCOs and NEMT service providers to notify the State agency when they deny credentialing, impose suspensions, or otherwise take actions to limit the participation of providers in Medicaid for program integrity-related reasons. Develop and implement policies and procedures for reporting these adverse actions to HHS-OIG.

Conclusion

The State of South Carolina applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- effective relationship with State Attorney General's Office on beneficiary fraud cases and beneficiary lock-in program,
- provider self-audit program,
- contract with the State survey agency to collect required ownership and control disclosures,
- implementation of a managed care audit program, and
- use of a standardized provider disclosure form across the FFS and managed care programs.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

Although South Carolina has made considerable progress in addressing deficiencies identified during the 2008 MIG review, the identification of two areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, seven areas of vulnerability were identified. The CMS encourages BCPR to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require South Carolina to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of South Carolina will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If South Carolina has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of South Carolina on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Official Response from South Carolina
November 2011

Anthony E. Keck, Director
Nikki R. Haley, Governor

November 7, 2011

Robb Miller, Director
The Division of Field Operations, Medicaid Integrity Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Miller,

On behalf of the South Carolina Department of Health and Human Services, I appreciate the opportunity to respond to the comprehensive program integrity review conducted by the Medicaid Integrity Group. This review will greatly assist the South Carolina Medicaid Program in its ongoing program integrity efforts.

A Corrective Action Plan will be submitted to the Medicaid Integrity Group and will address the two issues of non-compliance and the seven vulnerabilities indentified in the report. We are developing new policies and procedures to correct the instances of non-compliance and the vulnerabilities and will submit them with our Corrective Action Plan. In addition, the Corrective Plan will show how the agency plans to implement CMS' recommendations within the context of the new requirements for provider enrollment and screening.

The South Carolina Department of Health and Human Services is committed to assuring the integrity of the Medicaid program, and we are currently taking steps to enhance our ability to prevent and identify waste, fraud, and abuse above and beyond the corrective actions required by the CMS review. The assistance and guidance provided by the Medicaid Integrity Group will be very important as we move toward our shared goal of strengthening program integrity in the Medicaid program.

As noted, the Corrective Action Plan is still under review but should be submitted shortly. Again, thank you for your assistance.

Sincerely,

Anthony E. Keck
Director

AEK/jp

Office of the Director
P.O. Box 8206 Columbia, South Carolina 29202-8206
(803) 898-2504 Fax (803) 255-8235